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and Adolescence**

**Acute In-Patient Mental Health:  
moving forward in a local unit**

**Crisis Resolution & Home  
Treatment: a carer's personal  
perspective**

*and more...*

## Advancing Practice in Bedfordshire

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a publication of:  
Bedfordshire and Luton  
Mental Health and Social Care  
Partnership NHS Trust



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As randomly selected by the editorial group, the following authors of two articles published in APB Edition 4 will receive a free book:

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**Linda Hiscott, Lead Clinician (SPLD)**

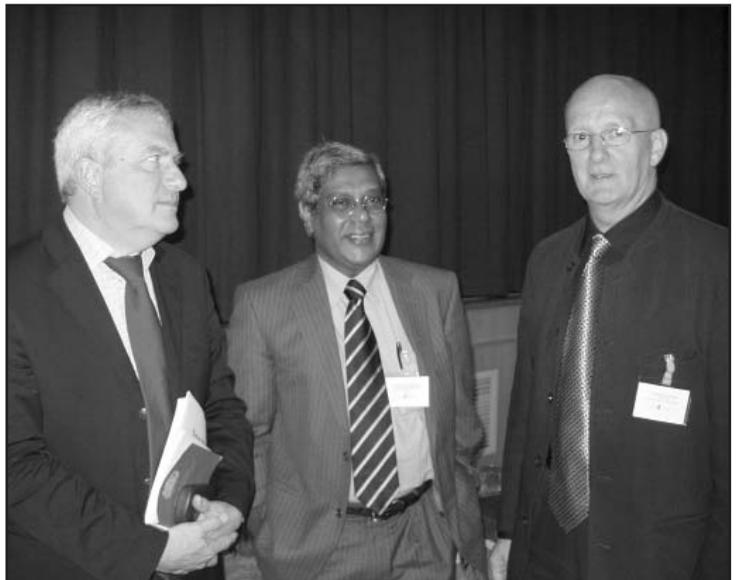
## Editorial

### John Butler

**Nurse Consultant (Acute Psychiatry), Bedfordshire and Luton Mental Health and Social Care Partnership NHS Trust**

As promoted in the last edition, the Trust conference, Advancing Practice in Mental Health & Learning Disability, was held on June 15th at the Silsoe Conference Centre. Chaired by Dr Hameen Markar and Margaret Thornley, the conference got off to a rousing start with an inspiring key-note speech by Dr Mike Shooter, President of the Royal College of Psychiatrists (RCP). His last public presentation before handing over the presidency of the RCP, Dr Shooter talked about the new role of the consultant psychiatrist as a 'grassroots, workforce-led' initiative. Giving strong messages about the need for professionals to listen and involve people and highlighting the need for an integrated service pathway, these proved to be recurrent themes for the ensuing key-note presentations and concurrent sessions. Simon Whitehead, of the Valuing

People Support Team, provided a key-note presentation on Valuing People, and Tim McDougall, Nurse Adviser with the Department of Health, outlined the consultation process for the review of mental health nursing. National, regional and local speakers and facilitators shared their thoughts and innovative work through 12 concurrent sessions, on topics which ranged from the use of advance statements, the concordance skills approach, person-centred planning and therapeutic interventions within clinical practice, to the initial outcomes of the recently established local Crisis Resolution & Home Treatment Services, to wider topical issues, such as the issue of stigma for professionals, nurse prescribing, the legal implications of health-care records and the use of root cause analysis.



**At the Conference:**  
*Simon Whitehead,  
Dr Hameen Markar  
& Dr Mike Shooter*



**After the Conference:** *some of the organising team taking some time out (from left: John Butler, CJ Chin, Tina Mulkerrin, Jay Nair, Nicky Plancherel, C Menna & Renee Bullock)*

An inter-disciplinary learning and development forum for sharing experiences and extensive networking opportunities, the event was very positively evaluated, creating a real 'buzz' among the 171 delegates and speakers on the day. On behalf of the Trust Educators Group, I would like to thank everyone who participated and contributed to making this event a great success. There is now the small matter of deciding whether to do this again next year - what do you think? If so - send us your ideas and suggestions for future conference themes and topics.

In this and the next edition of the Journal, you will find some papers based upon the sessions presented at the conference. Complementing this edition of the quarterly journal, we will also shortly be making a special conference edition available on the web-site: [www.advancingpractice.co.uk](http://www.advancingpractice.co.uk)

We have included a diverse range of papers in this edition, which includes: a critique of some of the literature on social exclusion and a discussion of the implications of current national policy; a short summary of the Healthcare Commission's recent review of local Trust services, emphasising strong

initiatives and identifying areas for focusing improvement; two reviews of the literature - sleep disturbance in Tourette's Syndrome and conduct disorder in childhood and adolescence; a report of a recent clinical audit of ECT (Electroconvulsive Therapy) procedures against national standards, which identified key areas for improving record-keeping and enhancing the quality of the service and care for patients; a short outline of practice development in a local acute mental health unit (as presented at the recent conference); a carer perspective of the recently established Crisis Resolution & Home Treatment Service, highlighting the intended benefits and impact of this new service (complementing the professional perspective of the first 3-month outcomes of this service, as presented at the recent conference); and, a discussion paper on the issue of informed consent, which is particularly topical in light of the Mental Health Bill and the Mental Capacity Act 2005.

We hope you find something of special interest to you in this edition and strongly encourage you to consider making a submission for a future edition.

## Promoting Social Inclusion through Vocational Rehabilitation: implications for professional practice

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Bedfordshire & Luton Partnership NHS Trust

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### CRITIQUE & IMPLICATIONS

#### Introduction:

*"Work is just about the only thing that you can do for eight hours a day" (William Faulkner)*

The government policy document, Mental Health and Social Exclusion (DH 2004), poses the question: what more can be done to enable adults with mental health problems to enter and retain work? Related to the National Service Framework for Mental Health (DH 1999), this requires that health and social services work to reduce stigma and social exclusion. It also relates to the recovery model described in The Journey of Recovery (DH 2001). It can be seen as a more mature and inclusive model of community care. More cynically, it can be regarded as driven by the need to reduce the fiscal burden.

The government intends to offer a real chance of sustained paid work, by implementing evidence-based practice in vocational services. Adults with mental health problems have the lowest employment rate of any social group in the UK (Office for National Statistics 2003), though many want to work. Furthermore, unemployment in the mentally ill rose throughout the 1990s (Perkins 2002). The annual cost to the country is estimated at £7 billion, inclusive of the cost of care, the loss of economically active adults and their premature death (Sainsbury Centre for Mental Health 2003). Unemployment itself is a risk factor for poor mental health and suicide, whereas employment enhances self-esteem, overall functioning and economic independence (DH 2001).

This paper will critically appraise the available evidence on vocational rehabilitation and suggest some implications for professional practice. Having established the most effective schemes, it will reflect further on the ethical and political aspects using the model described by Goodman (1984).

#### Considering the Evidence

According to Boardman et al (2003), employment initiatives fall into three broad categories: sheltered work schemes, which were historically linked to the large psychiatric hospitals; supported

employment in normal work settings; and social firms - businesses set up to provide gainful and socially useful employment. Pre-vocational training is also provided in most areas of the UK. In each model, the aim is that people will move into competitive employment.

In considering the evidence, two randomised controlled trials, a quasi-experimental trial and two systematic reviews are examined.

### **Randomised Control Trial 1**

Drake et al (1999) compared two vocational approaches, Individual Placement and Support (IPS) - a model of supported employment, and Enhanced Vocational Rehabilitation (EVR). IPS involves a rapid search for competitive jobs, which are jobs not set apart for disabled workers, and support from employment specialists integrated within the mental health team. EVR combines a range of vocational services, which include sheltered workshops, with a step-by-step approach.

Set in inner city Washington, their hypotheses were that: a) IPS participants would achieve a higher rate of competitive employment, more total hours in competitive work and higher earnings; b) EVR leads to more hours of sheltered employment, and not to competitive employment; and c) rapid job search does not lead to more negative outcomes, such as hospitalisation. An earlier study in New Hampshire (Drake 1996) showed the effectiveness of IPS, although this could be criticised as the participants had good employment histories, few were from minority ethnic backgrounds, and the control group were all placed with one agency, leaving open the possibility that the results were due to poor performance. The purpose of the current study was to replicate the findings, with a more diverse

sample, placed with a range of agencies.

The sample (N=152) was randomly assigned by computer to the two groups. A baseline analysis of the groups against demographic factors was undertaken to ensure comparability: Drake states that the IPS group were slightly younger and had a higher rate of current substance use, but showed no other significant differences, although the data does show that they had nearly twice as many days in hospital in the previous year (mean 30.3 v.17.4) and less than half the days homeless (mean 14.2 v. 31.2).

Potential participants attended at least one information session before enrolling. It could be said that only well-motivated clients joined this project, thus weakening the study, and the attrition rate was so low that there were too few non-completers to compare statistically with completers. After an initial assessment of diagnosis, self esteem, quality of life, symptoms and prior hospitalisation, the participants were reassessed at 6, 12 and 18 months. Employment data was collected monthly, with job satisfaction data being collected every two months.

Both groups received vocational services during the period, but the IPS group concentrated on job search, whereas the control group did more preparatory work. Once in work, both received the same level of support. The essential difference between the programmes was the speed of seeking real work.

IPS participants rapidly achieved a rate of 22% in competitive employment compared to 5% or less for the control group, and this advantage was maintained throughout the follow up period. IPS participants also earned more per hour (largely because EVR participants worked in sheltered workshops doing piecework). Even those few EVR

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participants who achieved competitive employment did not achieve the same level of job tenure and earnings as the IPS group. Overall, the EVR participants worked more hours and earned a comparable amount, but in sheltered work, and did not move on to competitive work.

There was very little difference between the groups on other outcomes such as job satisfaction, and satisfaction with vocational services, although this favoured IPS over time as participants saw their goals being achieved. Both groups improved over time on global functioning, general quality of life and self-esteem.

Both groups decreased their levels of hospitalisation during the study - although this was not statistically significant, it was clinically significant because of the belief, held by many mental health professionals, that work stress would cause clients to relapse.

There was speculation that the favourable results may have been obtained, not by rapid job search, but by the integration of vocational specialists in mental health teams. Drake makes the untested assertion that separate agencies, though having some advantages, would have difficulty in cooperating closely enough to individualise the service as IPS requires - the IPS programme is not feasible without the integration of services. Drake further asserts that participants in step by step services become stalled by 'conservative forces within sheltered work programmes' (Drake 1999: 632). Whilst it can be shown that EVR participants rarely move on to competitive work, there may be alternative explanations: perhaps clients achieve a substantial part of their aims in a sheltered setting.

### Randomised Controlled Trial 2

Lehman et al (2002) replicated aspects of

the above study, looking at the effectiveness of the IPS model compared to a psychosocial rehabilitation programme. The comparison programme included enhanced vocational services of the traditional type: skills training, counselling, group support, a step-by-step approach, but not sheltered employment.

To achieve a sample, the medical records of 540 patients were screened using a hierarchy of criteria. The inclusion criteria were a DSM-IV diagnosis in the schizophrenia spectrum or other Axis 1 mental disorder, receiving benefits for such a disorder or an extensive history of hospitalisation, and being unemployed for at least 3 months. Patients were screened out if unable to give consent or participate safely (exclusion criteria). To avoid selection bias, the clinic lists were placed in randomised order before screening. From a pool of 314 patients, 219 agreed to enroll, being randomly assigned to the two groups using pre-prepared sealed envelopes. No significant demographic differences were found using t-test analyses.

Participants were assessed at enrolment using the Structured Clinical Interview for DSM-IV and a structured interview looking at quality of life, self esteem, motivation, general health and social support. This was repeated 6 monthly. Employment data, including hours worked, wages earned, type of job and level of integration was collected weekly.

From this data, the researchers looked at the percentage of participants in work, the percentage in competitive jobs, hours worked and wages earned. They also created longitudinal measures to look at change over time.

As they had hypothesised, the researchers found that participants in the IPS group were more likely to work than the other group (42% v 11%), and more likely to be

employed in competitive jobs (27% v 7%). There were significant related differences in the cumulative hours worked and wages earned. However, this was a consequence of being in work. For those who did achieve employment, there were no differences between the groups as to the time they got their first job, how many jobs they held and for how long.

The probability of the results on achieving competitive employment being arrived at by chance is very low ( $p < .001$ ). Achieving these results in an inner city population is impressive, and suggests that the IPS works even in the most adverse settings. Job retention was poor for both groups and pointed to the need for further research.

The achievements of the comparison group were extremely low, in contrast to the comparison group in Drake's study, and there was a higher rate of attrition. Lehman suggests that this may be due to the severe disabilities of the sample: although drawn from a similar inner city area, the level of drug use and the level of prior hospitalisation were much higher. Leyman identifies a further factor: assertive outreach was not available to the members of the comparison group and many did not take up the extensive services offered them. He overlooked another likely factor, as the absence of sheltered employment, and did not consider non-vocational outcomes.

### **Quasi-experimental Trial**

The Rhode Island study by Becker et al (2001) compared the vocational and non-vocational outcomes of clients of two community mental health centres which converted from day treatment / rehabilitation programmes to supported employment programmes, with clients of such a centre prior to conversion.

Although a smaller sample ( $N=127$ ) than for

the previous studies, which could neither be randomised nor 'blind', since it would be clear to the researchers to which group the participants belonged, the interviewers were independent and the three groups were demographically similar, with similar vocational and clinical histories. One of the conversion groups had more Hispanic participants and the other a higher proportion of participants with schizophrenia. The comparison group served a more rural area.

Progress was assessed for the following 30 / 36 months, using well-validated assessment scales. Those who attended the converted centres achieved higher rates of competitive employment than the comparison group (42.2% and 56.7% compared to 19.5%). This is remarkable since all the clients were included, not just the well motivated. Employment rates improved even in the unconverted centre, from 5% to 19.5%, which suggests that aspirations were raised. Other employment outcomes also improved. Overall social functioning and other non-vocational outcomes were unchanged, which Becker suggests requires further research, and hospitalisation neither increased nor decreased.

This study is of particular interest to practitioners as it provided evidence that day treatment programmes could be converted to supported employment programmes with little risk to the clients and considerable benefits. Its conclusions were supported by contemporaneous interviews and ethnographic studies, and replicated in numerous other settings.

### **Systematic Review 1**

Crowther et al (2001) systematically reviewed 11 randomised controlled trials and found that the studies converged to support this conclusion. These studies were

subjected to thorough critical examination. The authors had previously excluded 29 trials that they considered to be less relevant or poor quality trials that were not randomised. They looked at such factors as the adequacy of allocation concealment, the independence of evaluators, and the arrangements for follow-up. The selected studies were all robust in terms of sample size and make up, though it was not possible to ensure 'blindness' in the research design.

As Drake and Lehman had found, the primary outcome was that subjects in supported employment were more likely to be in competitive work than those who received standard community care alone or with other vocational services. The evidence also supported better secondary outcomes, such as earning more and working more hours.

### **Systematic Review 2**

A recent review of the research (Bond 2004) considered 9 randomised controlled trials (RCTs) comparing supported employment to a range of alternative approaches and four studies of the conversion of traditional day treatment programmes to supported employment. The author concluded that the findings of these two lines of research converged. In the RCTs, between 40% and 60% of those on a supported employment programme obtained competitive employment, compared to less than 20% of others. In the day centre studies, the percentage of clients in competitive jobs rose from 13% to 38% on the converted sites, compared to a rise from 13% to 15% in the comparison sites.

Bond reported other benefits such as improved self-esteem and symptom control, though no systematic impact on other non-vocational aspects. Initially the dramatic improvement for clients in supported employment could be because

they had already benefited from years of day treatment, and were well prepared. This was conclusively disproved by a study of new admissions that went directly to the programme and were even more successful (Becker and Drake 2003).

The doubt, which remains, is that these studies may be comparing projects which are new with services that are moribund. New projects may benefit from an enthusiasm that cannot be sustained. It would be interesting to see a study of supported employment ten years later, compared to vocational services that have learned lessons.

Bond declares, at the outset, having a close working relationship with researchers Drake and Becker, who refined the concept of supported employment and named it IPS. The precise conceptualisation is important, because it has allowed the phenomenon to be studied and compared. Bond takes the view that IPS is not just one model of supported employment, but the only model of supported employment based on, and refined by, the evidence. He compares 5 studies that used the IPS Fidelity Scale, and 4 that did not, ranking the success rate in achieving competitive employment - this conclusively supported IPS as a package.

Bond then reviewed the evidence for each of the 7 principles held by IPS practitioners: 1) focusing services on competitive employment (strong); 2) eligibility based on choice, not selection (strong); 3) rapid job search (strong); 4) integration of vocational and mental health services (moderate); 5) attention to consumer choice of job (moderate); 6) unlimited time and individualised support (weak, few studies); 7) benefits counselling (only one study but strong support).

This is a powerful position for an intervention, though it raises the question of

impartiality. The researchers are advocates for this model, though they acknowledge the need for further refinement.

Although the evidence is strong, most studies have taken place in the USA, and there are differences in demographic patterns, diagnostic practice, mental health services and benefit structures. Substantial clinical mental health services continued to be provided throughout the studies, which limits the international generalisability of findings to those countries with developed health services. There is little research available in the UK.

### **Ethical & Political Considerations**

This research addresses an important area of public policy, and can be justified by its implications for the subjects of research and the wider population. People with serious mental illnesses aspire to work and benefit from it, with few drawbacks.

The well-being of control groups was protected by the continued provision of clinical treatment and other services. Clients were screened to ensure that they could participate safely. Some were paid a modest fee to attend interviews, in accordance with the principle of recognising the contribution of service users. There was no evidence of coercion in recruitment. Although the day centre clients had little choice about the conversion of services, there were extended 'consensus building programmes'. Though there was no coercion of individuals to the programmes or the studies, both the US and British governments have modified the benefits system to reduce disincentives to work. The distribution of resources is an ethical and political issue: the New Hampshire study was driven by the need to reduce day centre costs - the British government is explicitly aiming to reduce the numbers of people on Incapacity

Benefit. The unstated value system in this research is the Protestant work ethic - that work is good and that paid employment is a valid goal for the severely mentally ill. Drake acknowledged that value judgments impinged on this research - 'Do we believe it is better to integrate people with mental illness into mainstream society...or keep them segregated from society?' (Drake 1999: 632).

### **Conclusion**

The evidence shows supported employment to be the most effective method of helping people with severe mental illness achieve competitive employment. It is consistently effective across all groups of clients regardless of diagnosis, symptoms, age, gender, prior hospitalisation, disability, education or co-morbid substance abuse, with less evidence on ethnicity. Supported employment programmes are successful in urban and rural settings.

The most clearly defined model, IPS, is replicable in real life settings. The core principles are: 1) commitment to the aim of employment in real jobs; 2) enrolment based on consumer choice, not selection; 3) direct job search, rather than step by step preparation; 4) job coaches integrated into mental health services; 5) the client's choices and preferences being respected; 6) indefinite support; 7) benefits counseling. The first 3 elements are strongly supported by the evidence, the others less so, but fidelity to IPS as a package is also evidence based.

There are beneficial vocational outcomes to supported employment. Non-vocational benefits are less clear, although self-esteem appears to rise with any form of work. There is no evidence of detrimental outcomes, such as hospitalisation. Gaps in the

evidence suggest further research. Why do certain individuals not achieve employment, and would alternative approaches be better for them? There is also little research on job retention or on long-term outcomes.

### Implications for Practice

The establishment of supported employment as evidence-based practice has profound implications for mental health service commissioners, suggesting that resources should be moved from day care / sheltered employment to supported employment programmes. Social and recreational activities may be considered less relevant, particularly to younger adults. Government policy suggests that there will be opportunities for voluntary organisations to expand and refocus their services in the vocational area, but commissioning all vocational services to outside bodies is contra-indicated by the research.

The implication for service providers is that rehabilitation staff should be integrated into Community Mental Health Teams and retrained to focus their efforts on achieving competitive employment for clients. The implication for mental health teams is that employment must be given a higher profile in care plans. All staff will need to be aware of local resources, barriers and incentives to employment, to employ motivational strategies, and work collaboratively with a range of agencies. There is much work to be done with employers, and within the Trust as a model employer, challenging stigma and reducing social exclusion.

The National Institute for Clinical Excellence (NICE 2002: 22) recommends that 'the assessment of schizophrenia should include assessment of their occupational status and potential' and that 'supported employment should be provided for those...who wish to return to work'. The

National Institute for Mental Health in England has produced a resource pack and is mapping inclusive employment projects (NIMHE 2003) - this will identify good practice and advise mental health services.

The Recovery model places on healthcare professionals the duty to be optimistic and positive, enabling and empowering people to take their full place in society. This research shows how it can be done.

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## Clinical Governance Review of Bedfordshire & Luton Community NHS Trust: a summary of the report by the Healthcare Commission

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### CLINICAL GOVERNANCE

As you may be aware, the report from the Healthcare Commission's Clinical Governance Review of the Trust was published in April 2005. It shows that the Trust generally performs well on the criteria being examined. The full report is available on the Healthcare Commission page on the Trust's intranet site, but I'd like to share with you some of the main findings.

'Bedfordshire and Luton Community NHS Trust has dynamic leadership and a strong committed management team which has made substantial progress in developing and implementing structures, systems and processes to support clinical governance. The trust recognises that further work is required to ensure these measures are fully embedded in all areas of the organisation.

Through its quality and clinical improvement groups, the trust has made good progress in developing and implementing structures and systems for safe guarding and improving the quality of care it provides. The trust needs to ensure that its systems for sharing lessons from incidents and for sharing information on evidence-based

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practice are fully embedded at operational level. In addition, there needs to be further integration of clinical audit, clinical effectiveness and risk management activities at operational level. The trust needs to raise awareness of clinical audit training among its staff and to build on its work to involve service users in clinical audit.

The trust board is committed to serving its ethnically diverse community, to providing training and development opportunities for staff and to operating as a learning organisation to improve the experience of service users. It has invested substantial resources in promoting the importance of the experiences of the service users to staff and educating them on how to improve the quality of service users' experiences.

However, management's commitment to improving the quality of the experiences of service users is not reflected in all parts of the trust. Many people from the local healthcare community told the Healthcare Commission that the experiences of service users could be improved. The Healthcare Commission also found that the experience of service users varies depending on where they live and what services they use.

The trust has made considerable progress in developing and implementing structures to involve service users in clinical governance. It now needs to develop these across the organisation creating an environment where the input of service users is valued by all staff and is an integral part of its clinical governance structures and processes. It also needs to ensure that its systems result in a positive experience for service users and carers and that they are consistent throughout the organisation.

### **What the Healthcare Commission found that was impressive at Bedfordshire and Luton Community NHS Trust**

Managers and clinical staff are committed to the implementation of the recovery model at Progress House rehabilitation service in Bedford. The trust involves service users and staff in the project.

The trust's Journal of clinical practice to promote evidence-based practice in clinical practice. Staff are encouraged to contribute articles about good practice to the journal and to share the information with the wider healthcare community. Summaries of successfully completed clinical audit projects are submitted to this journal.'

I hope the above gives you a flavour of how the Trust was evaluated by the Healthcare Commission and would encourage you to read through the full report if at all possible - it is only 32 pages long. As you can see, we have made great strides within our clinical governance activities but, as always, there are things that we need to work on to improve. Clearly, improving the service user experience is of the utmost importance and work is already in progress to ensure that we achieve this.

I'd like to thank everyone in the Trust for the hard work they put in to helping us achieve such a good review result. This shows in an objective manner what we have believed in the last couple of years - that is, the Trust has made great strides forward.

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## Sleep Disturbance in Tourette's Syndrome: a review

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### REVIEW PAPER

#### Introduction

Gille de la Tourette's syndrome (TS) is a neuro-psychiatric disorder that is characterised by multiple motor (movement) and vocal tics. The clinical features usually begin in childhood and persist into adulthood, although symptoms may vary in severity and can wax and wane (Cohrs et al 2001). It occurs more commonly in males than females (Apter et al 1991) and is associated with disturbances of sleep. This paper describes some of the changes that occur in sleep patterns in people with TS (Romano et al 2004).

#### Symptoms in TS

A tic can be defined as a sudden, rapid, recurrent, non-rhythmic stereotyped movement or vocalisation. Vocal tics include grunting, snarling and similar noises. Complex motor tics are slower movements that appear as if they have a purpose, such as touching, biting, head banging and itching. Obsessive Compulsive Disorder (OCD) and Attention Deficit Hyperactivity Disorder (ADHD) occur frequently in people with TS. There are other associated symptoms such as the automatic and pointless imitation of another individual's speech and movements, known as echolalia and echopraxia respectively. Additionally there may be over-activity and difficulties in learning.

#### Pattern of Sleep

Sleep can be considered a stage of extremely reduced or nearly absent voluntary control of cognition, emotion and movement (Cohrs et al 2001). Sleep is usually divided into REM (rapid eye movement) or non-REM sleep. REM sleep is also called dream sleep. Throughout the night the normal pattern of sleep involves 4-5 cycles of alternating REM and non-REM sleep with REM sleep becoming progressively more prominent. The total time spent in REM sleep is ninety minutes or twenty per cent of the total sleep period. Brief periods of wakefulness comprise five percent of sleep and the remaining three quarters of time is spent in non-REM sleep.

#### Sleep Disturbance in TS

Sleep problems can affect up to 60% of people with TS (Romano et al 2004) and complaints about difficulty falling asleep or early wakening

are the most often reported (Cohrs et al 2001). These alterations in sleep occur in people who have both TS and Attention Deficit Hyperactivity Disorder (ADHD), with around 40% of people in this group raising concerns that their sleep was affected (Allen et al 1992). Sleep disorders may be linked to disturbances in the build up or breakdown of chemical transmitters of the brain, particularly serotonin. Sleep disturbances are found more frequently among children with TS than among adults with TS and may be linked to a delay in the normal processes of maturing (Champion et al 1988).

Sleep quality, quantity and motor activity during night sleep in people with TS is also affected. The total time period spent asleep may be decreased in those with TS and a study looking at children with TS who were not on medication at the time, showed decreased sleep. The length of time taken to fall asleep is known as sleep latency and this is increased in patients with TS. That is to say, it takes longer for people with TS to fall asleep than those without TS (Cohrs et al 2001, Kostanecka-Endress et al 2003). An increased sleep latency is also true for people with a combination of both TS and obsessions and compulsions. These obsessions and compulsions may themselves be manifestations of chemical disturbances in the brain involving dream sleep (Drake et al 1992). Overall, the efficiency and therefore effectiveness of sleep in children with TS is also reduced and the more severe the TS in the day, the poorer the sleep efficiency (Cohrs et al 2001, Kostanecka-Endress et al 2003, Drake et al 1992).

There is prolonged wakefulness after the onset of sleep (Kostanecka-Endress et al 2003). This is supported by recordings of electro-encephalogram (EEG) brain wave patterns of people with TS, which show an increased number of awakenings (Drake et al 1992). In tic disorders alone, nocturnal

awakenings and movements are greater. Chronic tics may persist in sleep and cause awakenings. There is a higher reported frequency of sleep walking and night terrors in children with TS. Disorders of initiating and maintaining sleep have also been recorded and there is an association between bedwetting at night (nocturnal enuresis) and TS (Romano et al 2004, Stores 2001). The severity of TS during the daytime is associated with a decreased sleep quality. Sleep with an increased number of awakenings as a sign of reduced sleep continuity is known to be less restorative and children with TS may be more irritable during their waking hours because of their reduced sleep quality (Cohrs et al 2001).

Non REM (or non-dream) sleep is divided into four stages of sleep. Stages 1 and 2 comprise lighter sleep. Collectively stages three and four are called slow wave sleep otherwise known as deep sleep. Generally, the number of sleep stage changes is unaffected (Kostanecka-Endress et al 2003) although a correlation with the severity of TS and sleep stage changes has been suggested (Cohrs et al 2001). Short bursts of brain electrical activity usually occur in stage 2 sleep. These bursts of brain activity are increased in those with TS and therefore sleep is lighter (Silvestri et al 1995). There may be less stage 2 sleep in children with TS (Kostanecka-Endress et al 2003). There is also a greater percentage of stage 1 sleep and therefore people with TS tend to have lighter sleep (Cohrs et al 2001). Deep sleep or slow wave has been shown to vary (Drake et al 1992, Silvestri et al 1995). In those patients with both TS and ADHD, the loss of slow wave or deep sleep is most marked as compared to those with TS, the TS and OCD group and tic disorders alone (Drake et al 1992). This means that children with TS may not feel as rested as those without. Movements that occur typically when awake are seen occasionally during

sleep and are most likely to occur after awakening from sleep (e.g. stage one sleep) and rarely during the deeper phases of sleep. Movements that occur during sleep without awakenings are usually preceded by arousal phenomena and, rarely, by bursts of brain activity (sleep spindles on the EEG) or slow waves (Fish et al 1991).

REM sleep in TS can vary. One study indicated that REM sleep was actually decreased (Silvestri et al 1995). In people with both TS and OCD less time is needed before REM sleep is reached. Another study showed that children with TS and ADHD groups had increases in REM sleep latency, so that more time was needed before dream sleep began. This group had a significantly higher rating of aggressive behaviour.

Tics occur in all sleep stages (Cohrs et al 2001). Tic frequency and regular movements are higher in REM than non-REM sleep. The increased rate of tics during REM sleep parallels the increased movements of patients during REM and non-REM sleep (Cohrs et al 2001). Some people with TS show increased partial arousals out of deep stage 4 sleep. These sudden intense, partial arousals can manifest as night terrors, sleep walking (or somnambulism), bedwetting (or enuresis) or behaviours like forced vocalisations which often take the form of obscene words, phrases (coprolalia) or 'bird-calls'. Both tics and partial arousals from sleep decrease with treatment of TS (e.g. clonidine) (Dhal & Puig-Antich 1990). The poor sleep quality in children with TS following on from increased arousal phenomena could be intrinsic to the disorder or might trigger behavioural problems such as irritability during the daytime. Tic Disorders and REM sleep behaviour disorders co-exist and there is overlap in the pathophysiological mechanisms of both (Trajanovic et al 2004).

Periodic limb and arm movements (PLMS)

during sleep are a frequent finding in patients with TS. The presence of PLMS during sleep in TS may point towards evidence for a relationship between TS and restless leg syndrome, since they both share a disorder of one of the chemical pathways of the brain (dopaminergic system) but this has not been confirmed by the different responses to treatments (Voderholzer et al 1997).

Sleep disorders following treatment with medication have also been described. An irregular sleep-wake pattern can occur with anti-psychotic treatment (e.g. haloperidol) and be restored by using alternative medication (e.g. risperidone). It is possible that the described disruption of the sleep-wake schedule is medication rather than illness-related in TS. Therefore it is important to keep in mind that sleep disorders may be a side effect of medication rather than TS itself (Ayalon et al 2002). However, in one particular case of a boy with TS, an improvement was seen in sleep related symptoms, coupled with less daytime irritability and tiredness following a change in the scheduling of medication to include a bedtime dose.

Serotonin and noradrenaline are involved in sleep regulation as well as in TS. An unaltered serotonergic firing is a prerequisite for sleep maintenance. There is a positive correlation between TS severity and features of disturbed sleep quality, which is compatible with the inverse correlation between tic severity and cerebrospinal fluid changes of tryptophan, a precursor substance of serotonin (Cohrs et al 2001).

TS gene carriers are at increased risk of life threatening apnoeas of infancy. The cause of sudden infant death syndrome is unknown but an impairment of arousal and hyperdopaminergic and hyposerotonergic dysfunction, such as seen in TS, may contribute to the pathophysiology of these

sleep disorders. The prevalence of sudden infant death syndrome in the families of those with TS may be up to five times the prevalence in the general population (Sverd & Montero 1993).

### Conclusion

In summary, there is an association between disturbances of sleep and Tourette's syndrome (Cohrs et al 2001). These sleep disturbances are characterised by changes in the length of time spent asleep, which may be increased or decreased, the greater length of time taken to actually fall asleep, poor sleep quality and reduced sleep efficiency. Prolonged wakefulness after sleep onset is seen with a greater number of awakenings during sleep. There are alterations in light sleep so that there is a greater percentage of stage 1 sleep with less or the same amount of stage 2 sleep. REM sleep quality is reduced or unaffected and slow wave or deep sleep may be increased or decreased. Tics are greatest in REM sleep and partial arousals or movements occur in stage 4 sleep. General movements and periodic limb movements are increased and a REM sleep behaviour disorder has been described in patients with tics. Generally, the sleep wake cycle is disrupted. Further research is required to establish any consistent pattern of sleep changes in TS and the cause of sleep disorders in TS. Medication used in the treatment of TS may be implicated in disturbances of the sleep-wake cycle. The exact nature of sleep disturbance in children with TS remains to be elucidated.

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## Electroconvulsive Therapy: compliance with national guidelines and practice standards

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### QUALITY IMPROVEMENT

#### Introduction

In 1996, an audit of the standards of practice of Electroconvulsive Therapy (ECT) in Bedfordshire & Luton Community NHS Trust (BLCT) was conducted. The catchment area of BLCT is approximately 570,000 people. Whilst subsequent audits were carried out, these were not documented or recorded.

Following a review of the National Institute of Clinical Excellence (NICE) Health Technology Appraisal (NICE 2003), an audit of ECT was identified as a priority in the corporate plan for the year April 2004 - March 2005. This audit was planned as the first part of a programme of regular audits. The criteria for the audit would be based on the national audit tool (NICE 2003). Other relevant protocols and guidance documents were also considered in developing the audit criteria (BLCT Policy GC17, RCP 1994, ECTAS 2004).

#### Aims & Objectives

Aims and objectives were agreed for the audit, as follows:

##### Aim:

To evaluate whether ECT procedures and record keeping in BLCT are in accordance with NICE Guidance on ECT.

##### Objectives:

To assess the compliance of current ECT procedures and record keeping arrangements for patients who received ECT between January 2004 and June 2004 with the NICE Guidelines.

To identify any training needs that are required to meet national ECT standards.

#### Methodology

The Consultant Psychiatrists responsible for ECT in the north and south of the county approved the audit tool as based on the NICE Technology Appraisal (NICE 2003): this incorporated 11 quality standards. The ECT Services Manager and the nurse in charge assisted with data collection.

## Advancing Practice in Bedfordshire 2005: 2 (2)

All patients receiving ECT from January 2004 to June 2004 from the working age mental health and mental health for older peoples services were included in the audit.

As ECT services are provided at two centres over the county, for practical purposes these centres were considered as two units.

A consent form approved by the Department of Health (reference guide to consent for examination or treatment: HSC 2001/023) was used during data collection for Unit 1.

### Summary of Audit Results

A total of 35 service-users were receiving ECT and were included in this audit (21 for Unit 1 & 14 for Unit 2). Of these, documentation for 5% in Unit 1 and 29% in Unit 2 could not be retrieved for audit purposes.

The ratio of males to females was 11:24 and the mean age of service-user was 65 years old. One service-user died during the period, although this was not due to the treatment.

A summary of the audit results for both units is shown in Table 1. As shown, 90% of Unit 1 service-users and 64% of Unit 2 service-users were suffering with a severe depressive illness. 81% in Unit 1 and 57% in Unit 2 had received treatment with a view to gaining rapid and short term improvement. The risks and potential benefits were documented for 95% of Unit 1 service-users and for 29% of Unit 2 service-users. 95% of service-users in Unit 1 and 60% of service-users in Unit 2 had given consent for each session of the treatment. There was good compliance with the standards on involving the service-user's advocate and carer and for providing information for Unit 1 service-users, although this was generally poor for Unit 2 service-users. Only one

service-user had their condition assessed after each ECT session and none had their cognitive functioning formally monitored. Treatment was stopped in the majority of cases when a response had been achieved and a repeat course of ECT was only offered in a small number of cases, and only if the first two standards were met or the service-user had previously shown a good response to treatment. Only 4/35 service-users were receiving maintenance treatment and none were diagnosed with schizophrenia.

Psychiatric and vocational General Practice trainees are involved in the provision of services under the supervision of a Consultant Psychiatrist in charge for ECT. The ECT treatment unit in Luton is the responsible training unit for the trainees in this area and regular Induction programmes are conducted for them. Anaesthetist services are provided by qualified Specialist Registrar Anaesthetists from the local general hospital.

ECTAS recommendations of designated, trained nursing staff members are implemented (ECTAS 2004).

The equipment used for administering ECT is the latest model MECTAS SR2 which has the advantage of simultaneous recording of electro-encephalogram (EEG) during treatment. The Royal College of Psychiatrists recommended protocol for dose titration is followed in both units and a seizure period of 15 seconds duration is considered to be of therapeutic value (MacEwan 2002).

Both units are well-equipped with the latest anaesthetic monitoring and emergency resuscitatory equipment. The units have the recommended patient waiting room, treatment room, recovery room, and post recovery rooms.

Table 1: audit of ECT records

Standard	Criterion	% Compliance Rates	
		Unit 1	Unit 2
1	Indication for ECT is for one of the following: <input type="checkbox"/> Severe depressive illness <input type="checkbox"/> Catatonia <input type="checkbox"/> Prolonged / severe mania	90.5% 5% 0%	64% 0% 0%
2	ECT is used to achieve rapid and short term improvement	81%	57%
3	The risks and potential benefits of ECT have been documented	95%	29%
4	The individual provides consent for each course of ECT	95%	64%
5	The clinician responsible for treatment: <input type="checkbox"/> involves the person's advocate / carer <input type="checkbox"/> provides full information in a suitable format and language <input type="checkbox"/> explains / discusses the general risks and potential benefits <input type="checkbox"/> does not pressure or coerce <input type="checkbox"/> reminds that s/he has the right to withdraw consent	95% 95% 95% 95% 95%	29% 50% 43% 36% 29%
6	The patient's clinical status is assessed after each ECT session	5%	0%
7	The patient's cognitive functioning is monitored	0%	0%
8	ECT stopped if one of the following occurs: <input type="checkbox"/> response is achieved <input type="checkbox"/> evidence of adverse effect <input type="checkbox"/> withdraws consent	90.5% 5% 0%	43% 0% 14%
9	Repeat course of ECT is only given if: <input type="checkbox"/> criteria 1 & 2 are met / previous good response to ECT <input type="checkbox"/> not responded previously but no other effective treatment options	14% 0%	14% 0%
10	ECT used as maintenance therapy	14%	7%
11	ECT used in management of schizophrenia	0%	0%
	Lack of documentary evidence	5%	29%

### Conclusions

Three key conclusions can be drawn from this audit:

1. The documentation of ECT prescription, and the involvement of individuals and carers within decision making needs to be improved.
2. Formal monitoring of the service-user's clinical status and cognitive functioning after each ECT session needs to be implemented.
3. There is a need to ensure that the training needs of staff members and junior doctors are met.

### Recommendations

- The prescription of ECT will include the NICE Guidance criteria and in situations otherwise, the reasons for the prescription of ECT should be documented. In a nation-wide audit of the prescription habits of psychiatrists, the following observations have been made: 'Changing clinicians prescribing practice of ECT is difficult' (Nandhra et al 2004). In the light of such peer review, the practice of ECT prescription in BLCT will be monitored rigorously.
- 'In the UK, only one-third of clinics are rated as meeting College standards. Twenty years of activity by the Royal College of Psychiatrists and three large-scale (nation-wide) audits have been associated with only modest improvement in local practice' (Duffett et al 1998). This peer review highlights that practice standards need to be audited regularly and thus a re-audit should be completed after 6 months (August 2005) in order to check if the recommendations have been implemented.
- The ECT documents should be placed in a separate folder for easy maintenance and reference. This can be facilitated via the provision of colour-coded documents. The current documents need to be reviewed as they are not up-to-date. A set of new

recording forms has now been prepared by the authors.

- The service-user's clinical status and cognitive functioning need to be monitored after each ECT session and a provision for the same has been made in the proposed new recording forms.
- Trust policy regarding the prescription of maintenance ECT needs to be developed.
- Inadequacies in informed consent have been highlighted in a nationwide study (Rose et al 2005) - this needs to be considered for further study in the light of the findings.

### Ethical Obligations

'All doctors have an ethical obligation to keep up to date throughout their careers, and this includes a requirement to be aware of the latest guidelines. Guidelines are just that - they provide guidance. They do not and should not imply that doctors must suspend their clinical judgement in order to follow the letter that has been written down. Because no two clinical situations are exactly the same, it is important for doctors to maintain their freedom to decide on the most appropriate treatment strategy for their patient.' (Colbrook 2005).

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**Acute In-Patient Mental Health: moving forward in a local unit - Townsend Court**

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**Bedfordshire & Luton Partnership NHS Trust**

**PRACTICE DEVELOPMENT**

Townsend Court is a demanding, ever evolving Acute In-patient Unit, always facing the new challenges placed upon it. Three of its twenty five beds are dedicated to substance misuse - drug and alcohol detoxification programmes. An outpatient clozapine clinic is also run from the unit. Townsend Court serves the catchment areas of Dunstable, Houghton Regis, Leighton Buzzard and all the surrounding villages of Luton.



**Townsend Court: Acute mental health unit**

## Advancing Practice in Bedfordshire 2005: 2 (2)

The Unit welcomed the visit at the end of last year from the Healthcare Commission and Health & Safety Executive (HSE), and was fortunate enough to have been highlighted and praised in the recent Healthcare Commission report, having found that the experience of service users had improved in areas such as Townsend Court. The unit is used to the many visitors it receives, and was the first to receive an audit from the new Patient and Public Involvement Forum (PPI) which led to a most complimentary report. The unit was also nominated to host the recent national 'Think Clean Day'. It is always so encouraging for the dedicated multi-disciplinary team to receive the complimentary letters such as after the visit from the Bedfordshire Counsellors.

Townsend Court prides itself on having a lively and enthusiastic Stakeholders Group, and one of the first to be chaired by a carer.

A popular weekly patient's meeting is chaired by the Unit Manager, with an Occupational Therapist and a Rethink Advocacy Worker being actively involved. The Rethink worker then holds an additional bi-weekly patient meeting as an independent forum. Any issues raised that require action are then fed back to the Unit Manager.

A long awaited and greatly needed day care facility has been set up, and is now fully operational. The day care facility provides eight outpatients with a comprehensive structured therapy programme. This facility is aimed at providing that additional support for up to 6 weeks for those patients who have just been discharged.

Recent months have seen the exciting development of the hugely successful Townsend Court '7 Day In-Patient & Day Care Therapeutic Programme' (see Tables 1 & 2). This therapeutic programme is

delivered by the dedicated team of Registered Nurses, Nurse Consultant, Clinical Support Workers, In-reach Community Mental Health Nurse, Occupational Therapists, Occupational Therapy Technicians and Art Therapist, bringing an extensive wealth of knowledge, skills and experiences. The most recent groups to have been introduced are the Healthy Living, Exercise and Gardening Groups. These groups are in addition to numerous other groups such as the Music Appreciation, Sports, Quiz, Creative Writing, Arts & Crafts, Relaxation, Cooking, Yoga, Community, Art Therapy and Goal Planning groups. For the creative person a range of art materials are available, and for those who enjoy sports, a pool table, table tennis, exercise bike, badminton, board and card games are available for use outside of the structured groups. In the very near future a personal computer and printer will be made available for patient use.

Townsend Court is most grateful to our Trust's first Working Age Mental Health (WAMH) Nurse Consultant, John Butler, who has been working hard to help establish a Medication Management Group to enhance the therapeutic patient experience. John Butler also meets with the Registered Nurses each month for their newly established Practice Development Group (PDG).

The Befrienders Charity run a voluntary shop twice a week at Townsend Court. This popular shop just adds to the community spirit and provides an invaluable service of an extensive range of items. A local Christian Church provide a weekly 'Time to Reflect' group on the unit. Quiet rooms are made available for individual prayer and a room is available on request for female patients as required.

The team at Townsend Court is working tirelessly to provide a totally first class

patient experience from the day of admission through to discharge. Patients, carers and visitors are warmly welcomed by the hospitality nurse - a new role that was developed within the last year. This vital role contributes to a reduction in the patient's anxiety levels and promotes good customer care.

The named nurse and patient work closely together to devise a comprehensive

information pack that is carefully individualised for each patient's care, which the patient can receive at anytime from the time of admission through to the point of discharge. Discharge questionnaires and comment cards are freely available and regularly used, providing valuable feedback on the patient experience at Townsend Court.

**Table 1: In-Patient & Day Care Programme - part 1**

	Monday	Tuesday	Wednesday
AM	<p><b>11.00 - 12noon</b>  <b>Goal Planning Group</b> (OT)</p> <p>Ward Art Materials are available throughout the week outside of Occupational Therapy Groups</p>	<p><b>9.30 - 10.00</b>  <b>Gardening Group</b> (OT)</p> <p><b>10.30 - 11.30</b>  <b>Art Therapy</b> (OT)</p> <p><b>11.30</b>  <b>Meal Prep</b> (OT)</p>	<p><b>9.30 - 10.00</b>  <b>Exercise Group</b> (OT)</p> <p><b>10.30 - 11.30</b>  <b>Current Affairs</b> (OT)</p>
PM	<p><b>13.30 - 14.30</b>  <b>Sports Group</b> (In reach CMHN, Nurse &amp; OT Tech)</p> <p><b>13.30 - 14.30</b>  <b>Art Therapy</b> (Art Therapist)</p> <p><b>15.00 - 16.00</b>  <b>Quiz</b> (OT)</p>	<p><b>13.30 - 14.30</b>  <b>Creative Writing</b> (OT)</p> <p><b>15.00 - 16.00</b>  <b>Relaxation Group</b> (OT)</p>	<p><b>13.30 - 14.30</b>  <b>Life Skills</b> (OT)</p> <p><b>15.00 - 15.30</b>  <b>Relaxation</b> (OT)</p>

Table 2: In-Patient & Day Care Programme - part 2

	Thursday	Friday	Saturday	Sunday
AM	<b>9.30 - 10.30</b> <b>Patient Meeting</b> (Unit Manager & OT)	<b>10.30 - 11.30</b> <b>Yoga (OT)</b>	<b>10.30 - 11.30</b> <b>Ward Round</b> <b>Preparation Group</b> (Nurse)  Ward Art Materials are available throughout the weekend	<b>10.30 - 11.30</b> <b>Music Group</b> (Nurse / Clinical Support Worker)
	<b>10.00 - 11.45</b> <b>Community Group</b> (OT)			
	<b>10.30 - 11.30</b> <b>Music Appreciation</b> (In reach CMHN & Nurse)			
	<b>10.30 - 11.45</b> <b>Medication Management</b> (Nurse x 2)			
PM	<b>12noon - 13.30</b> <b>Cooking (OT)</b>	<b>15.00 - 16.00</b> <b>Art &amp; Craft (OT)</b>	<b>15.00 - 16.00</b> <b>Games Group</b> (Clinical Support Worker x 2)  <b>16.30 - 17.30</b> <b>Music Group / Relaxation</b> (Nurse / Clinical Support Worker)	<b>15.00 - 16.00</b> <b>Games Group</b> (Clinical Support Worker x 2)  <b>16.30 - 17.30</b> <b>Music Group / Relaxation</b> (Nurse / Clinical Support Worker)
	<b>13.30 - 14.30</b> <b>Expressive Art</b> (OT)			
	<b>15.00 - 16.45</b> <b>Healthy Living</b> (OT)			

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## Conduct Disorders in Childhood and Adolescence

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### REVIEW PAPER

*The term Conduct Disorder refers to an infringement of the rights of other people and violations of societal rules, despite an intact mental state and social capacities in children and adolescents. There is some controversy over the use of this term as it could be considered a disorder which is principally socially determined and should not be given a medical label.*

### Introduction

Antisocial behaviour has the highest continuity into adulthood of all measured human traits except intelligence. A high proportion of children and adolescents with conduct disorder grow up to be antisocial adults with impoverished and destructive lifestyles. It is the most common reason for referral to child and adolescent mental health services.

Advances in the last two decades have shown a multifactorial aetiology and has clarified many of the mechanisms contributing to the development and persistence of antisocial behaviour, which has led to development of effective treatments. As yet, these are not available widely for children and adolescents who need them.

Interventions are targeted at the people who can influence the child's socialisation process, especially parents and teachers. Behavioural parent- training programmes have been found to be the most effective in the short term. There is some debate amongst child and adolescent psychiatrists as to whether doctors and mental health professionals should be involved in any but the most complex cases (Goodman 1997).

At the present time, psychiatrists continue to contribute to the planning and delivery of appropriate services for this disorder.

General Practitioners frequently encounter this disorder in up to 30% of their paediatric consultations (Knapp et al 1999). Referral to appropriate services should begin as early as possible.

**Diagnosis**

Conduct Disorder is a collection of traits occurring in children and adolescents, characterised by a longstanding and repeated pattern of misbehaviour. This misbehaviour is much worse than would be expected in a child of that age and shows a persistent pattern of violations of basic rights of others and age appropriate societal norms and rules.

Four types of symptoms or behaviour

patterns are recognised in this disorder and the presence of at least three of these specific behaviours for at least six months is emphasised by DSM-IV to make the diagnosis. They include aggression or serious threats of harm to people or animals, deliberate property damage or destruction, such as fire setting, vandalism, repeated violation of household and school rules, law or both, and persistent lying to avoid consequences or to obtain tangible privileges (see Table 1).

**Table 1: Criteria for Conduct Disorder**

<p><b><u>Criteria for Conduct Disorder</u></b></p> <p><u>Agression to people and/or animals</u></p> <ul style="list-style-type: none"><li><input type="checkbox"/> Threatens others</li><li><input type="checkbox"/> Uses weapons to cause serious physical harm</li><li><input type="checkbox"/> Cruel to people or animals</li></ul> <p><u>Destruction of property</u></p> <ul style="list-style-type: none"><li><input type="checkbox"/> Deliberately sets fire with intent of causing serious damage</li></ul> <p><u>Deceitfulness or theft</u></p> <ul style="list-style-type: none"><li><input type="checkbox"/> Steals items</li></ul> <p><u>Serious violation of rules</u></p> <ul style="list-style-type: none"><li><input type="checkbox"/> Stays out late</li><li><input type="checkbox"/> Runs away from home</li><li><input type="checkbox"/> Truancy</li></ul> <p>The above causes clinically significant impairment in social, academic or occupational functioning.</p>
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Two subtypes, childhood onset and adolescent onset, are recognised. Childhood conduct disorder, if left untreated, has a poor prognosis. About 40% of childhood conduct disorder develops into adult antisocial personality disorder (Kazdin 1995). Professor Moffit put forward a developmental taxonomy of these two subtypes. According to this taxonomy, life course persistent individuals' antisocial behaviour has its origin in neurodevelopmental dysfunction and family adversity, and it begins in early childhood and continues persistently thereafter. In contrast, adolescent-limited delinquents' antisocial behaviour has its origin in social peer processes, begins in adolescence and desists in young adulthood. According to this theory, life course persistent antisocial individuals are few, persistent and pathological. Adolescent-limited antisocial individuals are relatively transient and near normative (Moffit 2001).

Distinction of this disorder is important from isolated misbehaviour like shoplifting, skipping school, experimentation with alcohol or marijuana, which often occurs in the context of an external stressor like recent parental conflict, geographical moves or school transitions. Such transient reactions often remit if appropriate structure and support are provided.

### Prevalence

Prevalence in children of 5 to 10 years has been shown by Meltzer et al (2000) to be 1.7% in boys and 0.6% in girls. The incidence increases from childhood to adolescence. Robin (1966) found that 57% of boys had an onset before the age of ten, whereas for girls the onset was mainly between 14 and 16 years of age. Approximately half of them will also meet criteria for at least one other childhood disorder - the most frequent combination is hyperactivity in about 45-70%.

### Aetiology

The aetiology involves an interaction of genetic or constitutional, familial and social factors.

#### *Genetic / Constitutional factors*

It is very unlikely that a single gene or a simple genetic model can account for complex behaviours or criminal activity. However children with conduct disorder may inherit decreased baseline autonomic nervous system activity, requiring greater stimulation to achieve optimal arousal which may account for their high level of sensation seeking activity (Lahey et al 1993). Research has focused on the role of serotonin in aggression.

A strong possible relationship has been demonstrated between behavioural problems and a difficult temperament with emotional constrictedness, a lack of empathy and guilt (Wooton et al 1997).

Rutter et al (1970) found that chronically ill children have three times the incidence of conduct disorder than their peers, and if the chronic condition was found to affect the nervous system, the risk rose approximately five-fold. Cognitive deficits and poor social skills leading to poor academic performance, peer rejection and isolation have also been implicated.

#### *Familial and social factors*

Parental psychiatric illness and substance abuse, marital conflict and childhood abuse and neglect all increase the risk of conduct disorder. Beck (1998) found that maternal postnatal depression could lead to problems of insecure attachment, antisocial behaviour and cognitive deficits. West and Farrington (1973) reported strong links between the presence of an antisocial personality in one or both parents and similar behaviour in the child. Substance misuse and criminality in parents results in deviant role models for

children to imitate, which is compounded by the parent's capacity to care for their children being compromised.

Childhood abuse is regarded as a highly specific risk factor (Finkelhor & Berliner 1995). Maltreated children were found to be commonly aggressive, to use acting out behaviour and to perform badly on cognitive tasks. Another common feature appears to be poor parenting skills (Scott 1998). Poor supervision, inconsistent, harsh discipline, parental disharmony and low involvement in the child's activities and rejection of the child are known to have a long-term association with conduct disorder.

Children with conduct disorder are over represented in lower socio-economic groups. Poverty, homelessness, overcrowding and social isolation predispose children to conduct disorders (American Academy of Child and Adolescent Psychiatry 1997, Carr 1991).

Children with these biological and social factors have been shown to be at increased risk for conduct disorders. The so called resilient children have been shown to have lower levels of risk factors and more protective factors such as high I.Q. and supportive parents.

### Differential Diagnosis and Co-morbidity

Several other common childhood psychiatric conditions have features similar to conduct disorders which makes distinction between them important for ensuring appropriate referrals and the use of available resources. Comorbid psychiatric conditions are also common in children with conduct disorders (Hart et al 1993). A differential diagnosis from Attention Deficit Hyperactivity Disorder (ADHD) can be made as features of disinhibition, poor attention and distractibility are seen in ADHD as opposed to serious aggression and illegal behaviour that is persistently seen in conduct disorders.

Several health related behaviours like cigarette smoking, drug or alcohol use or sexual activity are red flags for conduct disorder apart from frequent running away from home, school suspensions and run-ins with the police. Relative treatability of ADHD with stimulant medication makes its recognition with or without conduct disorder important.

Oppositional defiant disorder may be difficult to distinguish from conduct disorder due to overlapping features such as argumentativeness and non-compliance with rules. These children, however, do not display significant physical aggression and are less likely to have a history of problems with the law. They are more likely to have mood disorder than the antisocial pattern common among children with conduct disorders.

In children and adolescents with major depression and dysthymia, significant acting out may occur. Patients with early onset bipolar disorder may exhibit impulsive violations of rules and aggression. The distinguishing features in such cases typically include pronounced affective symptoms, disturbance of sleep and appetite with marked alterations in energy and activity levels. The coexistence of major depression with conduct disorder increases the risk of impulsive suicidal behaviour.

The key feature in assessing substance abuse, which may overlap with conduct disorder, is the distinction between experimentation and dependence. Details of dimensions like frequency and duration of use and the recognition of typical withdrawal patterns and a stereotyped pattern of use is usually helpful.

Comorbidity with conduct disorder is likely to further reduce impulse control and increase contact with the deviant peer group.

Intermittent explosive disorder does not feature repeated violations of rules or illegal behaviour, distinguishing it from conduct disorder.

### Interventions

During initial visits to a family physician, the seriousness of the patient's behaviour and the possibility of a poor long-term prognosis, if there is no significant parental involvement, should be emphasised. The factors that indicate a poorer prognosis include: severity and number of specific diagnostic criteria; comorbid ADHD and substance abuse; onset of problem behaviour in early childhood; parental abuse; financial hardship; and, lack of supervision. Identifying these dimensions can guide treatment and focusing treatment on comorbid conditions can improve the overall outcome.

A reasonable initial intervention for a general practitioner is to provide parents with instructions about establishing:

- clear and specific communication which is not negative or qualified
- realistic and clearly communicated consequences for non-compliance
- appropriate rewards to reinforce desirable behaviour
- parental monitoring of children's activities
- children's involvement in structured and supervised peer activities
- consistent behaviour guidelines in situations with multiple caregivers

### Pharmacotherapy

Pharmacotherapy may be used as an adjunct treatment to help specific symptoms, though there are no formally approved medications for this disorder. Stimulants, antidepressants, anticonvulsants and lithium and clonidine have been tried.

### Psychological Treatment

Behavioural parent training programmes both in individual and group modalities have been shown to be effective in reducing problem behaviour (Webster-Stratton 1984, 1989).

Family Therapy has been used to improve the overall functioning of the family. Programmes to improve the child's interpersonal skills, such as 'Promoting Alternative Thinking Strategies' (PATHS) (Bierman et al 1996) and the 'Anger Coping Programme' (Lochman et al 1996) have shown treatment gains. Many programmes do not generalise well to other real life situations unless they are part of a more comprehensive programme.

A multimodal approach is likely to result in larger changes. This will include involving the school with the teacher's training in managing difficult behaviour, providing extra tuition where required, parental interventions in cases of parental drug or alcohol abuse and depression, assistance with claiming benefits and financial planning, as well as liaising with social services to look into alternative care for the child, if needed.

### Conclusion

Conduct disorders should not be seen as a 'lost cause' since there are opportunities for prevention through early detection and providing a number of effective interventions, which appear to be more effective when applied earlier.

### Key Points

- Conduct disorders are one of the most common reasons for the referral of young children to mental health services.

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- About 40% of children with conduct disorder will grow up to be adults with antisocial personality disorder.
- Conduct disorder has multifactorial aetiology with predominant social factors precipitating and maintaining problem behaviour.
- It is important to recognise and treat comorbid conditions such as ADHD and substance misuse in achieving better outcomes.
- Identification by primary care physicians is important, so that effective interventions can start early.

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## **Crisis Resolution & Home Treatment: a carer's personal perspective of a new service**

**Maggie Hodgson**  
**Carer Representative**  
**Bedfordshire**

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### **CARER PERSPECTIVE**

I am a carer of a service-user - a term that I use about myself because this is how mental health services identify patients and those who care for them.

I am one of two nominated carer representatives for Bedfordshire. During the 20 months or so that I have held this position, I have been involved with the decision-making process for the improvement of Bedfordshire and Luton's Mental Health Service.

My interest and desire to see improvement led me to become involved with the development of the Crisis Resolution & Home Treatment Service (CRHT), which was officially launched in December 2004.

### **What is the function of the CRHT?**

My purpose is to share with you, as a carer, how I believe this new service will benefit Bedfordshire and Luton in its care of people who experience a mental health crisis. Not only will the service-user benefit, but their carers will have the opportunity to be involved in the care decision process, as well as the practicalities of care - therefore, we will benefit.

At the beginning of December 2004, the CRHT service began. It consists of two teams: a team based in Bedford for all of Bedfordshire; and, a team based in Luton for the Luton area. Initially, the team in Luton began to offer a 9AM - 9PM service, whilst the team in Bedford offered a 9AM - 5PM service. Outside of these hours, the service is accessed via the local Accident & Emergency Department.

### **Benefits for Carers & Users**

I anticipate the following benefits of having new CRHT services:

- Assessment for using this service will be available 7 days per week and 24-hours per day. For a carer, this would be reassuring.
- The response to the crisis by this team should take place within an hour.
- Within the first 24-hours following the assessment, the service-user will be receiving the most appropriate form of mental health care.

- If receiving care directly from the CRHT, the service-user will be receiving an alternative intervention to hospital admission and, as part of that care, will receive intensive support in the home environment.
- This form of care will mean that 'sectioning' will not be necessary.
- The trauma of hospital admission may be prevented. If fewer people are admitted to hospital, there could be a reduction of stigma for people experiencing mental health distress.
- If admission to hospital occurs, the introduction of this team may give the opportunity for early discharge.
- All of the above will help to maintain social interaction, and this would be beneficial to service-users and to their carers.
- It will give more opportunity for family and friends to be involved in times of crisis. The service-user and their carers will be risk assessed daily if necessary. This will help to reduce excessive stress and concern.

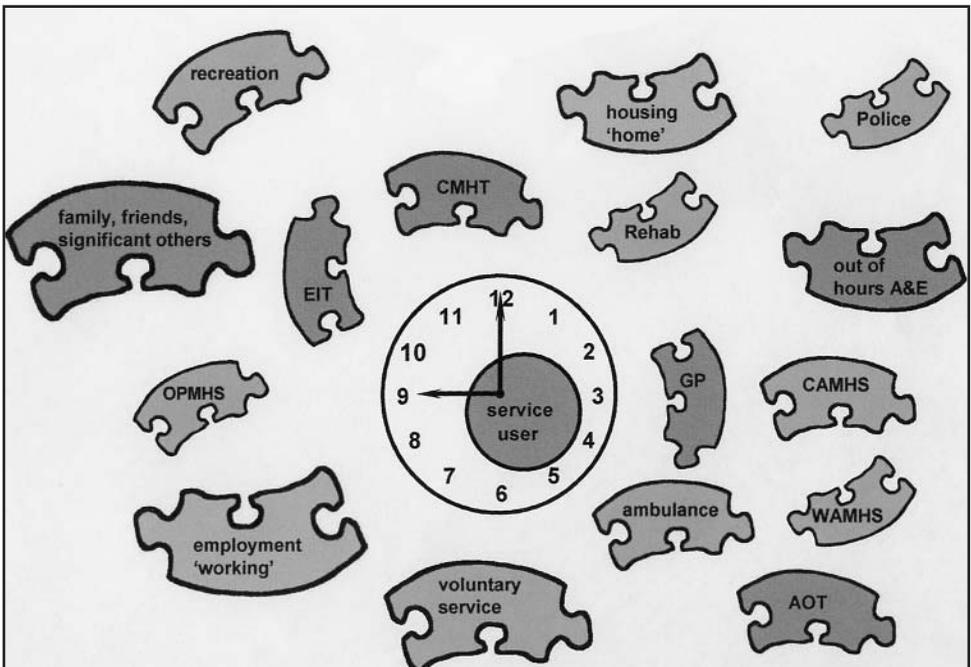
### Visualising the Service

I will use the analogy of a clock and a jigsaw to explain how I visualise the introduction of these teams, and how this could improve the standard of mental health care.

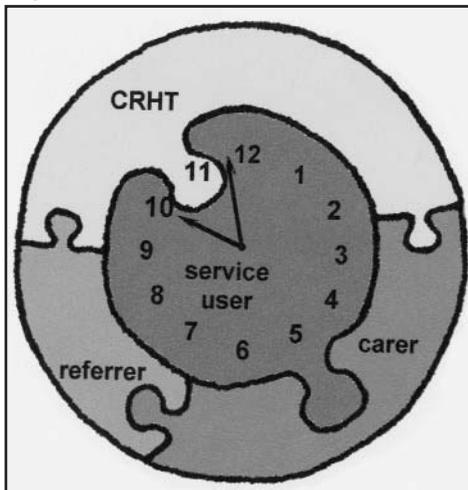
Two new CRHT teams (Bedford & Luton) came into operation. Within one hour of notification of a crisis, the assessment process for care should have begun.

*Fig. 1 depicts the service-user surrounded by those potentially involved in his life / care at the time of crisis. The clock is shown to imply that there has been a change which has altered the response to a person in mental health crisis in Bedfordshire and Luton. The CRHT community service commenced at 9AM on December 1st 2004.*

Fig. 1: In Crisis



**Fig.2: CRHT Assessment**

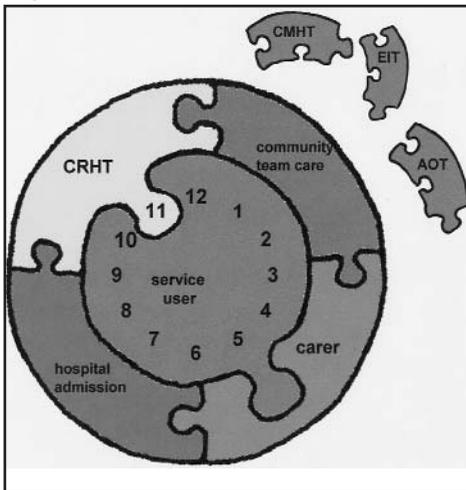


*Fig. 2 highlights this process of assessment. The assessing person works with the referrer and others, where necessary, during the day, with Accident & Emergency liaison nurses providing this assessment during the night. As shown, this process now involves the carer - they will have the opportunity to be present and involved with the decision-making process. This process will decide the route of continued care and should be completed within 24-hours.*

*As shown in Fig 3, two CRHT assessors (during the day) or an A&E liaison nurse (during the night) may: refer the service-user back to the community mental health team, early intervention team or assertive outreach team; arrange admission; or, with the CRHT team, agree to provide intensive home-based care. Referral can occur at any time of the day or week (24 - 7).*

*Fig. 4 highlights the service being provided, with the outer circle representing people who may be included during the process of recovery from the crisis, as well as during the*

**Fig.3: CRHT & Care Routes**



*crisis. There is the option for up to six-weeks of intensive care to support the person's recovery, following which the CRHT team would re-assess with a view to discharge.*

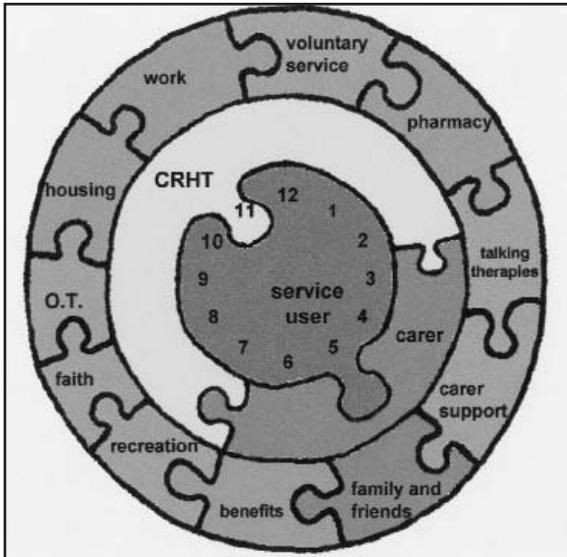
Upon discharge, the same process occurs as for admission (see Fig. 3). Discharge from this team could occur at any time during those six weeks by referral to hospital or to another of the community care teams.

Importantly, full implementation of the CRHT service will offer a single point of access for all referrals.

**Concerns**

All the concerns I have as a carer, I hope, will be addressed during the first year of development, for there will be a group of people in place to monitor the work of these teams across the county, especially concerning equity. I will be part of that group.

- Although I am concerned about the initial tensions which may occur within mental health services as these two teams are introduced into the community, I recognise that the introduction of anything new in



society creates disturbance and I hope there will be an endeavour in the county for mental health services to work together. As with anything else, change causes difficulties, so it's good that the work of these teams will be monitored over the first year.

- I'm also concerned that carers receive appropriate training and education, but I have been assured there will be training for carers that will educate them about their rights. This knowledge would be necessary for them if they are to participate in the provision of care for someone cared for by the CRHT. An example of this is that they have the right to have their own assessment / care-plan and, within that, the right to choose whether they want to, or are able to, care for the service-user with the team during this time of crisis and intensive care.
- I'm concerned that information about support networks in the community for carers of those suffering from mental illness and stress will not be made clear, and this could lead to insufficient support for carers. However, I know that the Carers Steering Group will be looking into this.

- I have concerns that there will not be enough carers' breaks, and the added stress of crisis treatment within the home might become too much for some carers if breaks are not offered. I understand that part of the work of the CRHT will be to provide opportunities for rest / breaks for the carer.
- I'm concerned that in the future people who require in-patient care, because they are unable to live within the community, may fail to receive the service and stable environment that they need. I am aware that management are taking necessary steps to address concerns of this nature.
- I'm concerned about internal communications and communication between staff, users and carers. If the purpose of CRHT teams is not clearly defined, this may delay the recovery process and cause further stress in the lives of service-users and carers. New measures of accountability within the mental health service hopefully will improve communications.

## Conclusion

Despite these concerns, I am confident that these teams working in the community, will provide better care with people in crisis, and as I have said previously, the teams' work and efficiency will be monitored throughout the first year, so that any difficulties can be addressed.

So..... if NHS, Social Services, community, statutory and voluntary services, carers and families work together with this team, with the person who is in crisis, then I believe that s/he will receive better help than previously given in Bedfordshire and Luton.

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## The legal concept of informed consent has the potential for interfering in the clinician's judgment of what is in the best interest of the patient: a discussion paper

Jay Nair

Team Manager

Bedfordshire and Luton Mental Health and Social Care Partnership NHS Trust

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### DISCUSSION PAPER

#### Introduction

It has been the accepted practice that health care professionals must obtain the patient's consent prior to commencing treatment or performing an intervention. There is a presumption that an adult patient is competent to give consent to treatment. Lord Donaldson, in *Re T (Adult: Refusal of Medical Treatment)* (1992) 4 All ER 649, stated: 'The right to decide one's own fate presupposes a capacity to do so. Every adult is presumed to have capacity but it is a presumption that can be rebutted. This is not a question of the degree of intelligence or education of the adult concerned.' It is a patient's prerogative to accept or refuse treatment even in life threatening/saving circumstances. Therefore, consent to treatment is at the very heart of the clinician - patient relationship that is underpinned by ethical and legal concepts. Lord Donaldson, in *Re W (A Minor) (Medical Treatment)* (1992) 4 All ER 627, 633, stated that in this relationship, consent firstly provides legal justification to care and secondly a clinical function in that it is to secure the patient's trust and cooperation. Legal justification protects the clinician from committing a Crime (battery) and a Tort (trespass to person) when physical contact is made with the patient in treatment. The clinical aspect has wider implications and is recognised in English law through the law of negligence. In *Sidaway v Board of Governors of the Bethlem Royal and the Maudsley* (1985) 1 All ER 643, Lord Diplock, in endorsing the Bolam's test, propounded that a clinician may be negligent if he failed to counsel and provide information (including the disclosure of

material risks) in a way recognised by his peers.

In exploring whether informed consent has the potential to interfere with clinical judgment, this paper will firstly examine the ethical concepts of Autonomy and Paternalism, showing how these concepts have not only shaped clinical practice but also, and more importantly, have legal implications. The notion of informed consent is in itself ambiguous and contentious. This widely used phrase may not even be part of English law. Discussion as to what are informed consent and the law surrounding consent to treatment will attempt to clarify the position.

### Ethical Considerations

#### Autonomy

The right to autonomous decision-making and medical paternalism is seen as two opposing notions and nowhere more apparent than in the area of consent to treatment. The principle of autonomy imposes on the clinician the obligation of respect for the patient's self-determination. There is an absolute right to self-determination as long as the patient has the capacity to make decisions. The reason for requiring consent is due to the strongly held view that physical integrity is inviolable in a competent patient. To violate this even in a situation where it benefits the patient is an affront to the deference placed on the notion of bodily integrity. The most famous and frequently quoted statement by Justice Cardozo, in *Schleondorff v New York Hospital* (1914) 105 NE 92, supports this notion of bodily inviolability: 'Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent, commits an assault...'

Mill's Libertarian philosophy affirms the view

that the right to autonomous medical decision making is paramount and the only justification of imposing treatment is to prevent harm to others. '...The only purpose for which power can be rightfully exercised over any member of a civilised community, against his will, is to prevent harm to others. His own good, either physical or moral, is not a sufficient warrant. He cannot rightfully be compelled to do or forebear because it will be better for him to do so, because it will make him happier, because, in the opinion of others, to do so would be wise, or even right.' (Mill 1982: 68).

Mill, on utilitarian grounds, asserted that respect for autonomy furthers human welfare. Although there has been criticism of Mill's approach, there has been support from Oxford Professor R.M. Hare and philosopher John Gray, where autonomy is seen as a corollary of the principle of utility. This is because human happiness is constituted, in part, by the exercise of individual autonomy. Kant, on the grounds that man acts as a rational agent, recognises the requirement to treat people as ends in themselves, as self ruling or autonomous. It is questionable whether all rational agents necessarily recognise the moral obligation to respect others as autonomous. Undoubtedly, whenever one imposes decisions upon people without consulting them, let alone against their will, whether or not these decisions are designed to be beneficial, one is treating them as things or as animals or as children, and not as rational agents, nor as ends in themselves.

It has been asserted that autonomy is the ability to know and understand the situation and seek personal goals free of compulsion. Self-determination implies 'sovereignty over one's life....the right to control what happens to one's person...' (Beauchamp & McCullough 1984). Two reasons are given

to protect this individual sovereignty: the danger of imbalance of power between the individual and the state (others) tilting on the side of the latter; and, the conflict between the individual and others regarding what is in the best interest for the individual. Individual rights reset this imbalance, limiting the power of clinicians and protecting the individual from improper intrusions.

The deference given to autonomy is not absolute. It is one thing to respect the informed and free choice made by a patient capable of making it, but this may be problematic when some mental disability is involved or in the case of children. It is a dilemma in law of where the boundaries of mental capacity are set.

It has been traditionally asserted that the training of doctors clearly places them in the best position to be able to diagnose and treat illness, but many issues relating to health care are not purely clinical matters. There is a need to take account of the values held by patients. This has grown into a dominant ethical principle of autonomy or self-determination - respecting patients' right to make their own choices.

### **Paternalism**

It is asserted that since the development of medical practice, from the Hippocratic times to modern day, the model of paternalism has a significant role to play in the doctor - patient relationship. Paternalism (unlike beneficence), in simple terms, means the doctor knows best and regards himself as the best judge as to what is for the patient's own good.

Following Harris' argument (Stauch et al 2002: 32), as clinicians, the duty to act in the best interest of their patients meant concerns for the welfare of patients. With welfare being paramount, then anyone wishing to act contrary to their well-being

can be ignored because paternalism involves only genuine concerns for the welfare of others, denying the individual control over his life and treating him as incompetent to run his own life as he chooses - respecting others wishes may not be part of the equation.

Hart states that paternalism is the protection of people against themselves and although autonomy is very much part of 20th century life, he believes there is a decline in the belief that we are the best judges of our own interest. He states that there are factors which significantly affect free choice or consent, namely under inner psychological compulsion, in pursuit of transitory desires etc... Hart endowed the autonomous person described by Mill with the features of a middle aged man (a normal person), but in medicine, when in the judgment of the doctor the patient does not display these features (e.g. the person is a child or with mental disabilities), then paternalism is justified i.e. acting in the best interest of the person (welfare). The doctor who is the knowledgeable doer has only the best interest of the patient at heart. The grading of patients in terms of their qualities which results in the way clinicians are entitled to regard them is reflected in case law.

It may be the patient's competence or incompetence that sets the necessary conditions for paternalism. Incompetence, together with the probable harm/risk to the patient, may be a strong reason for paternalistic actions to be undertaken against the wishes or choice of patients. This may not be only in the treatment and diagnosis of patients but also in the disclosure of information, including risks. Although these decisions and judgments are in the clinical realm, they have to fall within the Bolam standard to have any legal impact.

The Hippocratic tradition has perpetuated a potent image of the doctor as a moral force and a reservoir of knowledge, with challenges to this in recent times coming through government policies and through the governing professional body - General Medical Council (GMC 1999). Judicial empathy towards the medical profession is being clearly shown by the House of Lords and the Court of Appeal in the Sidaway case, endorsing medical paternalism. In the Sidaway case in the House of Lords, except for Lord Scarman, all of the other Law Lords with a slight divergence from each other endorsed the Bolam's test (the professional standard test).

### Legal Considerations

#### Consent to Treatment

The principle of autonomy as stated by Justice Cardozo in *Schleondorff v Society of New York Hospital* (1914) has been endorsed by the English courts. This has been vigorously restated in *Airdale NHS Trust v Bland* (1993) AC 789 p 882: 'Any treatment given by a doctor to a competent patient, which is invasive..... is unlawful unless done with the consent of the patient: it constitutes the crime of battery and the tort of trespass to the person.'

Consent could be expressed or implied. Expressed consent would be in written or oral form. It is contended that a written form is some evidence to consent but more importantly whether the patient was in substance told about the procedure/treatment. Consent must only be for the agreed treatment, and any other treatment done in the course of the agreed treatment, even if the outcome is beneficial to the patient, is considered as battery (*Devi v West Midlands RHA* 1981). Such a situation may be defensible in emergencies and life threatening circumstances.

Any consent form is no more than a piece of evidence that the patient agreed to what was done to him. If the patient can show that, despite a consent form, he did not give any real consent, then battery may have occurred. In *Chatterton v Gerson* (1981) 1 all ER 257 p265, Justice Bristow stated: '...once the patient is informed in the broad terms of the nature of the procedure which is intended, and gives consent, that is real consent...' - a position that was endorsed by Lord Donaldson in *RE T (Adult: Refusal of Treatment)* (1992) 4 All ER 649 and by the NHS Executive (1990), which stated: 'it should be noted that the purpose of obtaining a signature on the consent form is not an end in itself. The most important element of a consent procedure is the duty to ensure that patients understand the nature and purpose of the proposed treatment. Where a patient has not been given appropriate information then consent may not always have been obtained despite the signature on the form.'

Consent must be given freely and without being deliberately misled, which may constitute misrepresentation or fraud. Implied consent is when patients, by their actions, indicate acceptance of the treatment e.g. by putting out their hand and pulling the sleeve up for the doctor to either take bloods or give an injection.

#### Valid Consent

For consent to be valid there are three essential elements that have to be fulfilled or established: the patient must be competent to make decisions i.e. have sufficient understanding and the mental capacity to make the decision (*Re T* 1992); the patient must understand the nature and purpose of the treatment, being given sufficient information about the proposed treatment (*Chester v Afshar* (2004) 4 All ER 587); and, the patient must consent to

treatment of his own free will, free from coercion or undue influence (Re T 1992). The presumption that a patient is competent to give consent unless rebutted is accepted law.

Guidance on the issue of capacity was given by Justice Thorpe in Re C (Adult: Refusal of Treatment (1994) 1 WLR 290). He set out three stages of decision-making: comprehension and retention of the information about the treatment (in this case even where the patient is suffering from mental illness, there is the presumption of competence); believing the information; and, weighing up that information in the balance so as to arrive at a choice. This was approved by the Court of Appeal in Re MB (Medical Treatment (1997) 2 FLR 426 Butler-Sloss LJ).

The Mental Capacity Act 2005 sets out the principles and criteria and the protection in the area of capacity. The impact of this Act will depend on how the courts interpret it with existing case law. The issue of capacity and competence has risen in difficult areas of health care such as sterilisation, abortion, treatment withdrawal, euthanasia, mental disabilities and in children. The principles so far stated have relevance to these as well. Some of these areas are also governed by legislation e.g. Mental Health Act 1983 Part IV deals with consent to treatment for a specific category of patients. This is a minefield and the correctness of some of the decisions by the courts are questionable e.g. enforcing physical treatment using the Mental Health Act, which is specifically for the treatment of mental illness only (B v Croydon Health Authority (1995) 1 All ER 683; Tameside and Glossop Acute services Trust v CH (a patient) (1996) 1 FLR 762).

### **Informed Consent**

The expression, 'informed consent', is widely used in relation to medical treatment.

The meaning of the phrase has been vague and ambiguous, leading to a number of interpretations and often being misused. The emphasis on the word 'informed' does not tell us anything about the amount of information required. Maclean thought that it simply referred 'to a particular requirement regarding quantity and perhaps - quality of the information disclosed.' He also suggests that there is no single doctrine but it is a legal term of art in the context of medical treatment.

The distinction between real consent, as defined by Justice Bristow in Chatterton v Gerson (1981) and informed consent, is in the nature of the information disclosed. Real consent meant that the patient is informed in broad terms of the nature of the procedure and gives consent (this does not include the disclosure of risks or the alternative treatment possibilities), so as to avoid liability in battery. Informed consent seems to imply that the disclosure of risks and alternatives are necessary in order to avoid liability in negligence. Both in America and England, the courts have been reluctant to find doctors liable in battery, which has connotations, equating 'the doctor who fails to disclose a risk with a mugger who assaults his victim.' Lord Scarman, in the Sidaway case, condemned the idea to base the law in medical cases of this kind to assault and battery.

The doctrine of informed consent was developed by the landmark case on America Canterbury v Spencer 464 2d 772 (1972). Justice Robinson set out the 'prudent patient' test. 'A risk is material when a reasonable person, in what the physician knows or should know to be the position, would be likely to attach significance to the risk or cluster of risks in deciding whether or not to forgo the proposed therapy.' He stated that the respect for a patient's right of self determination requires an objective standard set in law for the doctors. He was

not prepared to follow the professional standard test in this circumstance, where a duty arises to disclose risks and the alternatives. He also stated exceptions to the test: in a genuine emergency, where the patient is not capable of consenting; and, where harm would result imminently if there was a failure to treat and it outweighs any harm threatened by the proposed treatment i.e. disclosure poses such a threat or detriment to the patient (therapeutic privileges).

In *Sidaway*, Lord Scarman endorsed the 'prudent patient' test of *Canterbury v Spencer* and accepted the exception of therapeutic privilege in relation to harm i.e. disclosure would pose a serious threat or harm (psychological) to the patient. All the other Law Lords in the *Sidaway* case endorsed the professional standard based on the Bolam's test, with some variations. Lord Diplock stated that information may only deter a patient from having the treatment, where the doctor is the best person to decide in the patient's best interest. He indicated that the duty to disclose is part of the duty of care in Bolam's test.

Lord Bridge (*Reibl v Hughes* (1980)) held that based on the patient's right to decide, a judge could find a doctor liable for negligence where: 'disclosure of a particular risk was so obviously necessary to an informed choice on the part of the patient that no reasonable prudent medical man would fail to make it....' Lord Templeman stated: 'At the end of the day, the doctor, bearing in mind the best interest of the patient and bearing in mind the patient's right of information which will enable the patient to make a balanced judgment must decide what information should be given to the patient and in what terms that information must be couched.' He also indicated that a patient has a right to know if

the danger is of a special kind or magnitude or special to the patient.

Following the *Sidaway* case, there have been some indications that the courts have been moving away from the Bolam approach (*Smith v Tunbridge Wells Health Authority* (1994) 5 Med LR 334; *Bolitho v City & Hackney HA* (1998) AC 232; *Pearce v United Bristol Health Care NHS Trust* (1999) 48 BMLR 118). There appears to be a shift from the traditional position of Bolam, but are these actual departures an attempt to move towards the doctrine of informed consent? There is mixed opinion from academics: Kennedy criticised the decision in *Sidaway* for failing to endorse fundamental human rights of making informed choice and also questions why doctors should be placed in a special position compared with other professionals. There is great reluctance by the courts to depart from Bolam. In reading the various judgments in the various cases mentioned above, it appears that Bolam's approach could be interpreted and expanded to meet the patients' rights without having to resort to a new doctrine of informed consent. On the other hand, there is an opportunity to modify and modernise the law in line with present day society, where patients' rights are in the ascendancy, with the doctrine of informed consent protecting such rights in health care. Professor Jones suggests that as professional attitudes change to the question of disclosure of information, patients will be entitled to more information under the Bolam standard (Jones 1999). The change has already begun not by the courts but by the General Medical Council (GMC), which issued guidelines about the disclosure of information (GMC 1999). This may be viewed as a proactive step by the GMC to ensure patients' rights are safeguarded and professionals are protected.

The flawed strict adherence to the models of autonomy or paternalism can hinder the

therapeutic care and, from the NHS experience, increased the cost of litigation. A move towards more collaboration would lead to decision-making based on good communication, openness and trust. The doctor patient relationship is one based on trust and partnership. For this to foster, there has to be a genuine effort on the part of professionals and this is noted by the GMC guidelines on seeking consent. There are obstacles to this 'therapeutic alliance', some of which are created by the parties themselves and others by the system in which health care is provided. It has been noted that the technical nature of the present day training of doctors detaches them from developing the skills of communication with patients. A training that may not overtly propagate paternalistic attitudes is needed. It is difficult to remove from the psyche that doctors want to act in the best interest of their patients and therefore, by virtue of their knowledge, skills and training, maintain professional dominance.

## Conclusion

The deference shown by the judiciary to the medical profession is reflected in case law. The speech of Lord Diplock in the Sidaway case projects the strong base paternalism has when deciding on medical issues. The doctrine of informed consent has not made many in-roads in America and has some judicial support in England. The Sidaway case was probably the first English case to analyse the doctrine of informed consent in the dissenting judgment of Lord Scarman. The ethical concepts of autonomy and paternalism have shaped practice in health care. Any tide to erode the traditional professional standard test with the prudent patient test has been abated. At the present time, the doctrine of informed consent has no place in English law but there are encouraging signs that some recognition is given in the speeches of some judges.

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