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Risk Factors**

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Personal Experiences

and more...

**Advancing
Practice
in Bedfordshire**

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Editorial: *considering some priorities*

by John Butler
Chair of Editorial Group

Welcome to Edition 3(3) of the Journal of Bedfordshire & Luton Partnership Trust – our ninth regular issue, in which we are featuring a series of personal journeys and reflections.

Before introducing some of the articles in this issue, I thought it might be interesting to offer a few thoughts on the current developments and challenges for mental health services, which are influenced by some thought provoking presentations at a recent conference (Valuing & Developing Mental Health Nursing Leadership – 4th Annual Conference of the Association of Nurse Consultants: November 2006). I was particularly struck by presentations given by Professor Peter Nolan (Professor of Mental Health Nursing, University of Staffordshire & South Staffordshire Foundation NHS Trust), John Stanton (Director of Board Development) and Paul Badham (Associate Director, NHS Clinical Governance Support Team).

It is clear that providing service-user centred care that is timely, accessible and of a high quality must be the key aim for all practitioners, particularly in the context of the move towards a competitive market-place for service providers, where real choice becomes more available – services will be available from NHS Trusts, private and voluntary organisations. Indeed, by 2008, there is an expectation that some 15% of care will be delivered by the private sector (Department of Health 2004 – Priorities & Planning Framework 2005-08), allowing different providers to compete in providing services and promoting choice from a diverse provider group.

This emphasises the need for services to seriously consider and demonstrate high standards of care, supported through processes of internal and external audit and inspection – this has certainly become an accepted feature of health care over recent years, in particular.

Considering the well-known National Standards for Better Health framework, service providers therefore need to focus upon the delivery of standards-based clinically effective care and managing transitions along specific care pathways through new service models and patterns of care.

The priorities for services must surely be considered in preparing for this changing pattern of health care – reinforcing oft-cited

statements and guidance, these must include:

- actively engaging the service-user within their own care and assisting a re-engagement with their social world;
- providing care organised around efficient individualised pathways;
- providing care that is based upon the available evidence;
- demonstrating quality and health outcomes for service-users and satisfaction with care services – this would seem to necessitate the use of forms of measurement and monitoring;
- improving professional standards;
- developing the skills and competencies of the workforce – this clearly requires meaningful, relevant and effective forms of education.

With this in mind, our contributors for this edition show clear examples of focusing upon one or more of these priorities: three service-users share their very personal journeys towards recovery; Dr Iqbal Mohiuddin reflects upon his own development and discovery of the Human Givens approach, as an addition to the repertoire of the more well-known therapeutic approaches; Dr Bushra Hasnie highlights the importance of evaluating physical health risk factors; Dr Raj Kathane and Seema Jassi outline a focused audit of national guidance on post-traumatic stress disorder within local child and adolescent mental health services, clearly demonstrating high levels of compliance; and, Allison Crampton shares some of her own reflections on her practice in the context of some of the published literature. This edition is completed with a short

informative review of the Mental Capacity Act 2005, by Dr Tadi – as this becomes live from April 2007, this will hopefully be of interest to most practitioners.

So are you ready for the changing scene? Are you considering and progressing the emerging priorities? Perhaps you'd like to share your own initiatives – the journal offers an opportunity for you to do this.

Personal Experiences: *the Dunstable Child and Adolescent Mental Health Service (CAMHS)*

a service-user

Dunstable Child & Adolescent Mental Health Service

Bedfordshire & Luton Mental Health & Social Care Partnership NHS Trust

PERSONAL JOURNEYS

Editorial Comment:

In continuing our theme of personal service-user experiences, we are very pleased to commence this edition with a service-user's first-hand account of the Dunstable Child and Adolescent Mental Health Service. (*John Butler – Chair of Editorial Group*)

'I began treatment with the Dunstable CAMH service in August 2002, after having been referred for treatment by my GP. He had expressed concern at my self-mutilation, depression and obsessive compulsive symptoms.

'I was to begin CBT (Cognitive Behavioural Therapy) in conjunction with anti-depressants. The idea was to alleviate the symptoms of my condition whilst learning new coping mechanisms, which could be put into practice when it came to lowering the medication.

'CBT is helpful, as many psychological disorders are, in essence, disorders of thought, and since one's actions rely rather heavily on thoughts, it is logical to assume that in order to change maladaptive behaviour one must change the maladaptive thought processes that lie behind it.

'At the beginning of my treatment I did not appreciate this. I was not at all impressed by the idea of therapy. I felt like a failure and found it very difficult to talk about my thoughts and feelings, and was probably really rather infuriating. This is the tricky part you see – getting the person to realise what, exactly, is the purpose of therapy. It is, unfortunately, something one must come to a conclusion about oneself, and in his own sweet time. In my case this took just under a year. In April 2003, I finally came to the conclusion that if I was serious about coping on my own I would need to start opening up to my counsellor. Oh, the joy of capitulation! I would definitely mark this as a major hurdle in my sessions. It was noticeable, too, the difference in me when I finally started talking about the things that were really eating me.

'The main reason for the inevitable yielding of my defences was the stance my therapist took. He made me see that I did not need to be 'cured' from myself – I needed to learn better ways of coping with some of my more negative thought processes. Throughout the

whole year of my reluctance to talk, he had remained the same: always reliable, always honest and, due to this, always helpful. He never judged me or acted as though he knew better, nor did he think or treat me as if I was being silly – and I fully trust and believe this to be a truthful portrayal of what he did actually think. I had never really met anybody like that before. I always felt that people were only being nice to me because they had some sort of hidden agenda to fulfill – it never occurred to me that there were genuinely nice people about, such as this, who wanted nothing more from me other than my own happiness. I do not quite know how they have mastered it – for surely it is an art, this never seeming impenetrable behind protocol, and yet with a professionalism of manner unparalleled by any other institution I have encountered. I both trust and respect my therapist, which has shown me that I can do just that with anybody else – I am capable of trusting and of being helped too. The very idea that I could ever admit to benefiting from outside influences such as therapy was at one time utterly unthinkable – now it is a cause for celebration.

'It has worked, too. I explain my thoughts, which transpire into my feelings, which in turn govern the way I behave. I really cannot even begin to articulate just how much of a positive difference having this service to guide me through this has been.

'I found the service very accessible. Upon being referred, I was offered an appointment straight away. I have always been given a choice of venue for my counselling sessions. My first appointment was at the Dunstable clinic, which was fine as I had a number of people from whom I was able to scrounge lifts. If a network of lift-givers is

not readily available to the person, however, then there are many regular buses to Dunstable at reasonable rates. Since then, however, I have attended both clinics according to which suits me best at the time. For instance, when at school or work, it is often more convenient to attend the evening clinic in Dunstable so as not to take time off from said institutions. Whilst on holiday (or just unemployed!), however, it is usually more convenient for me to attend the Leighton Buzzard clinic, as it is closer to where I live. I do not have a preferred venue, as I find both clinics equally comfortable and relaxing – besides which, it would be very difficult not to feel at ease with such genuinely caring and clearly very well trained professionals.

'Two years into my treatment a situation occurred which caused me to have a rather severe lapse in my control over my OCD (Obsessive-Compulsive Disorder). I had stopped going into school, left my part-time work and was generally finding everything quite difficult. It was at this point that I was referred to a psychiatrist from within the CAMH service. Once again the action taken was swift and efficient. I had thorough talks on a regular basis with a psychiatrist as he guided me through what would be the best course of action based on my symptoms. I found his input both comprehensive and helpful. He prescribed medication which was more suited to my condition than my previous SSRIs (Selective Serotonin Re-uptake Inhibitor anti-depressants). I soon felt well enough to continue my studies. The combination of the right medication and regular meetings with the psychiatrist had made a world of difference to my capacity to cope with my OCD. I was also given the choice of having my counsellor present for the

meetings with the psychiatrist, for extra support. I continued to see the psychiatrist at weekly or fortnightly intervals until he and I were quite certain that I no longer required such regular contact. I have met with him at monthly intervals since then to discuss my level of medication and how I am coping, and there is the ever-present reassurance that I can ring the clinic up to schedule an earlier appointment should I need it. I am certain that my recovery, and its sustainment, from this episode was, unequivocally, by virtue of the psychiatric intervention of the CAMH service and my regular counselling sessions.

'I can honestly say that I can think of nothing to improve within the CAMH service – and as I have reaped the benefits of this exemplary service it is with sincerity that I can say never in my life have I been so thankful to have absolutely no suggestions whatsoever! I'm afraid all I can offer is gratitude for and humility towards the Dunstable Child and Adolescent Mental Health Service and the people who work within it. I am certain I speak for others like myself when I say my experience of the service has been very positive indeed.'

Evaluating the physical health and health risk factors of low secure mental health in-patients who are prescribed anti-psychotic medication

Dr Bushra Hasnie

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CLINICAL AUDIT Introduction

The aim of this audit was to evaluate the physical health and health risk factors of psychiatric in-patients who are prescribed anti-psychotic medication in a low secure psychiatric hospital. There is an association between those with mental illness, particularly schizophrenia, and poor physical health. The excess morbidity and mortality may be due to a number of factors including physical disorders, substance misuse and the effects of the different types of long term anti-psychotic medication.

People with mental illness may have problems in seeking help for their physical problems. In addition, they may have lifestyle risk factors for cardiovascular disease, such as being heavy smokers, exercising less and eating diets that are high in fat. It is therefore important that secondary care services should assist primary care professionals in monitoring these indicators, and particularly where the service-user may otherwise have little regular contact with primary care (NICE 2002).

An audit of consenting in-patients who were prescribed anti-psychotic medication was undertaken through a review of case notes, fasting blood testing and brief physical examination. The audit identified high risk groups among these in-patients. It enabled staff to target any care gaps in the service and to develop strategies, such as referring to specialist / primary care services, to address these in the future.

It was decided to focus this audit upon three key areas of physical health risk factors:

- metabolic syndrome
- body mass index (BMI)
- hyper-prolactinaemia

Metabolic Syndrome

The Adult Treatment Panel 3 of the US National Cholesterol Education Program (NCEP) propose the following definition for metabolic syndrome, which was developed for clinical use—if

people meet three of the following criteria, they qualify as having metabolic syndrome:

- a raised blood pressure (>130/85mmHg)
- a low serum concentration of HDL (high density) cholesterol (<1.04 mmol/l in men; <1.29 mmol/l in women)
- a high serum triglyceride concentration (>1.69 mmol/l)
- a high fasting plasma glucose concentration (>6.1 mmol/l)
- abdominal obesity (waist circumference of >102cm in men and >88cm in women)

Metabolic syndrome is associated with future coronary heart disease events and type 2 diabetes. The NCEP definition predicts mortality. Having even one or two features of the syndrome was associated in one study with increased risk of mortality from coronary heart disease and cardiovascular disease (Khunti & Davies 2005).

BMI

Body Mass Index is a well-known measurement that is calculated as follows: body weight in kgs / height in metres squared. The calculated BMI is interpreted in the following way:

- starvation: BMI is less than 15
- anorexic: BMI is less than 17.5
- underweight: BMI is less than 18.5
- ideal weight: BMI is more than or equal to 18.5 but less than 25
- overweight: BMI is more than or equal to 25 but less than 30
- obese: BMI is more than or equal to 30 but less than 40
- morbidly obese: BMI is more than or equal to 40

Obesity and being overweight pose a major risk for chronic diseases, which include type 2 diabetes, cardiovascular disease, hypertension and stroke, and certain forms of cancer (World Health Organisation).

Hyper-prolactinaemia

The prolactin levels of in-patients were tested, as clinically significant symptoms tend to occur where prolactin levels are in the range of 600 to 1200mU/L. A diagnosis of hyper-prolactinaemia, which impacts on sexual functioning, was made if prolactin levels were raised on two separate occasions, above 374mU/L (local laboratory reference). A referral to the Consultant Endocrinologist was made if the patient was symptomatic (CNWL Trust 2006).

Method

This audit study was conducted on 12 July 2006 at the Orchard Low Secure Unit.

Audit Group

All in-patients prescribed anti-psychotic medication, regardless of being prescribed any other medication, were included. They did not have to consent to all tests to be included in the audit study. In-patients who were not prescribed anti-psychotic medication were excluded from this study – two service-users were therefore excluded. Those who refused to consent to any test, or whose mental state was deemed too disturbed, or who were deemed incapable of giving informed consent were also excluded from this study.

Twelve in-patients were thus recruited into this audit study, of whom nine agreed to blood testing. Of the original twelve in-patients, all except one were male.

Consent

Written consent was sought from in-patients prior to any testing, which involved explaining the purpose of the audit and the proposed measurements. All in-patients were informed that the processing and presentation of the study findings would be anonymised.

Data-Collection

Each in-patient was fasted overnight prior to testing. The data was collected by the medical and nursing staff using a data sheet that was stored in each person's clinical record.

Findings

Of this group of twelve in-patients, the eleven males were aged between 24 and 52 (mean age 36) and the sole female in-patient was 19 years old. Eight in-patients had a diagnosis of paranoid schizophrenia, two had schizo-affective disorder, mania with psychotic symptoms, and two had bipolar affective disorder, mania with psychotic symptoms.

As shown in Table 1, only two in-patients were prescribed the older style

Table 1: Anti-Psychotic Prescribing

Drug	No. of In-Patients
Haldol	1
Depixol	2
Amisulpride	1
Clozapine	2
Quetiapine	2
Olanzapine	1
Risperdal Consta	2
Amisulpride + Clozapine	1

anti-psychotic medication (intra-muscular depot medication), with the remainder being prescribed atypical anti-psychotic medication. One in-patient was prescribed a combination of Amisulpride and Clozapine. Of those prescribed the newer anti-psychotic medications, one in-patient was prescribed the depot injection.

The duration of treatment with anti-psychotic medication ranged from two to 308 weeks, with a mean duration of 59 weeks. In addition, some in-patients were prescribed mood stabilisers (sodium valproate, carbamazepine and lithium) and/or anti-depressants (citalopram and fluoxetine).

Blood pressure (BP), abdominal obesity and BMI measurements were obtained for all twelve in-patients. However, only nine agreed to blood testing – the findings for this group are shown below.

Metabolic Syndrome

The findings obtained for Metabolic Syndrome are shown in Table 2.

In summary: a third of in-patients met the criteria for metabolic syndrome; half had two or more risk factors; two thirds had one or more risk factors; and, almost half of the group were abdominally obese, including the one female in the study.

In addition, one of the in-patients who met the criteria for metabolic syndrome also had a strong cardiac history, was on cardiac medication and had consumed a sugary drink on the morning of the blood test.

The prevalence of metabolic syndrome may in fact be higher, as a quarter of patients did not consent to blood testing.

Table 2:
Findings for Metabolic Syndrome

Findings for Metabolic Syndrome	% of In-Patients
Has metabolic syndrome	33
Has 2 or more risk factors for metabolic syndrome	50
Has one or more risk factors for metabolic syndrome	67
Does not have any risk factors for metabolic syndrome	22
Breakdown of Risk Factors	
Has a raised BP	17
Has low HDL cholesterol	67
Has high triglyceride levels	44
Has high fasting plasma glucose	11
Has abdominal obesity	42

Table 3: Risk Factors for Metabolic Syndrome by Anti-Psychotic Medication

Drug	No. of Patients	No of Risk Factors
Haldol	1	2
Depixol	2	0 – 3
Amisulpride	1	3
Clozapine	2	2 – 3
Quetiapine	2	0
Olanzapine	1	1
Risperdal Consta	2	0 – 3
Amisulpride + Clozapine	1	1

It is also interesting to note the number of risk factors for metabolic syndrome according to different anti-psychotic medications, as shown in Table 3.

In this audit, those prescribed Quetiapine were the only in-patients not to show any risk factors for metabolic syndrome.

BMI

The findings obtained for BMI are shown in Table 4.

Table 4: Findings for BMI

Findings for BMI (Body Mass Index)	% of In-Patients
underweight, anorexic, starvation	0
ideal	25
overweight	58
obese	17
morbidly obese	0

In summary: only a quarter of in-patients had an ideal BMI, and these patients were prescribed anti-psychotic medication that included Depixol, Quetiapine, and Amisulpride + Clozapine in combination; over half were overweight, with only Olanzapine not represented in this group; and, two in-patients were obese (although one was not abdominally obese) and were prescribed Olanzapine or Risperdal Consta.

Hyper-prolactinaemia

The findings obtained for prolactin levels are shown in Table 5.

In summary: around 50% of in-patients, who consented to blood tests, had a

Table 5:
Findings for Hyper-prolactinaemia

Findings for Prolactin Testing	No. of In-Patients
No. of people with raised prolactin levels in Test 1	5
No. of people with raised prolactin levels in Test 2	4*
% of people with hyper-prolactinaemia	44%

** one person was transferred to another unit before the test could be repeated*

raised prolactin on first testing, with one in-patient having a prolactin level that was nearly 4 times higher than the laboratory reference range. Upon re-testing, four in-patients had raised prolactin levels. Another was transferred to a different unit before a repeat prolactin sample could be obtained, therefore a recommendation was made to the team to repeat the prolactin test and screen for symptoms of hyper-prolactinaemia.

Of those diagnosed with hyper-prolactinaemia, two were prescribed Amisulpride, one was prescribed Risperidal Consta depot, and one had just been commenced on Quetiapine. The patient prescribed Quetiapine was not symptomatic and did not require referral to a specialist.

Of those diagnosed with hyper-prolactinaemia, three were also on one or more mood stabilisers (Lithium Citrate, Lithium Carbonate and Lamotrigine).

Actions

The GP and relevant sector psychiatric team (Consultant and/or Care Coordinator) were advised of the results and recommendations for individual in-patients if risk factors were uncovered.

Metabolic Syndrome

- Those who met the criteria for metabolic syndrome were referred to a specialist Consultant Endocrinologist.
- Those who had one or more lipid / glucose risk factors were referred to a specialist Consultant Endocrinologist if they were long stay patients, otherwise the GP was informed.
- Those who were abdominally obese were offered the option of referral to a dietician and their care plan was updated to encourage exercise.

BMI

- Those who were overweight and obese were offered the option of referral to a dietician and their care plan was updated to encourage exercise.

Hyper-prolactinaemia

- Those diagnosed with hyper-prolactinaemia were asked about risk factors and symptoms.
- For those who had this diagnosis and were symptomatic, a referral was made to a specialist Consultant Endocrinologist, with details being provided of risk factors and symptoms, for management and to exclude other non-psychotropic causes of hyper-prolactinaemia.
- For those who had this diagnosis and were not symptomatic, it was

planned to re-test prolactin levels within 3 months.

- If no cause for the raised prolactin level is established, consideration will be given to switching the anti-psychotic to a non-prolactin elevating drug (for example: Clozapine, Olanzapine, Quetiapine, Aripiprazole or Ziprasidone) (Taylor et al 2005).

Discussion

This audit was conducted within a secure unit and consisted predominantly of males in their mid-thirties with long term psychotic illnesses, who tended to be prescribed newer style anti-psychotic medications. A future audit might seek to examine the physical health of those who have been admitted to the acute unit, who are of a broader demographic profile and have alternative diagnoses such as depression and anxiety. This would help adjust for two of the variables in this audit: the chronicity of the illness; and, the length of treatment with anti-psychotic medication. This audit raises the issues of where and how referrals are made after the discovery of risk factors, which will often require liaison with the specialist medical team.

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Working with Offenders who have a Learning Disability: *relating practice to the literature*

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REFLECTION ON PRACTICE Introduction & Background

The National Service Framework for Mental Health Standard Two (DH 1999) recognises that service-users need to be offered effective interventions, which may include referral to specialist services for assessment, treatment and care. However, in my experience there are often difficulties in achieving effective care and treatment within the workplace. One of the most salient issues within my workplace is that the service-user group have a borderline learning disability and a history of offending with associated violence.

After an extensive literature search, I initially identified the possibility that violence and aggression could impact on the therapeutic relationship. My search led me to focus on the issue of the therapeutic relationship and the management of violence and aggression. Many of the major authors within the forensic field, working with people who have a mental health problem with an associated intellectual disability, describe violence and aggression as an indicator of poor communication and frustration between the nurse and service-user, and often suggest that the nurse / therapist should consider a different therapeutic approach.

As early as the 1950's, Goffman (1968) described the residents of psychiatric institutions as being frequently harmed, degraded and dehumanised. Further, Masson (1990) stated that the violence and aggression exhibited by psychiatric service-users was a justifiable response to the care and treatment they received. Masson suggested that a negative cycle of interaction takes place for both the service-user and professional, and that a more 'person centred' approach should be adopted. Rogers (1951) stated that a humanistic approach should be facilitated, focusing on relationships as the medium by which problems can be solved.

To enhance my professional development, I decided to review some of the literature on approaches to the effective management of violence and aggression. This was considered a better focus than reviewing the use of physical approaches such as control and restraint, as these should be reserved as a last resort option to

managing violence and aggression (Stirling 1997, Masson 1990, Royal College of Nursing 1997, DH 2002). Sullivan (1998) makes the point that procedures such as restraint 'have serious physical and psychological effects on clients which are not therapeutic and can emphasise control at the expense of care... The challenge is to develop nursing interventions which have a more therapeutic orientation'.

I therefore sought evidence for the most effective interventions / approaches that may be used for service-users within my workplace, which would help me to consider whether my therapeutic approach should be further adapted.

The principle question for my review was therefore: *'What is the most effective therapeutic approach for use with people with an intellectual disability?'*

The subject of violence and aggression has long been an emotive subject, and contemporary reports and guidance still recognise the challenging issue of managing violence and aggression. The Royal College of Nursing (2004), Department of Health (2002) and the UKCC (1999) all emphasise that the aggression, violence and the consequent restraint of service-users are reactive interventions. Such reports and guidance promote the belief that aggression and violence could be minimised if those caring for the service-user had a greater understanding and increased level of skill in providing therapeutic interventions such as cognitive behavioural intervention.

However, whilst I first believed that the issues and messages identified in the literature would be clear and consistent, these are in fact very varied.

Furthermore, whilst I first thought that control and restraint is the last resort intervention for managing aggression and violence within the practice setting, this does not always appear to be the case. It is worth noting that nurses and carers on acute admission wards often face an aggressive and violent in-patient and, perhaps in part due to having only a limited history of the person around the time of admission, have little choice other than to restrain if s/he suddenly decides to attack. This appears to go against all policies on control and restraint, which reiterates that de-escalation techniques should be used first and foremost.

This particular situation has not really been addressed within my work environment other than to have been acknowledged, as in all NHS Trusts, through a Zero Tolerance Policy to violence and aggression. This has served as a warning to all in-patients that this kind of behaviour will not be tolerated, although this is not always effective, and particularly not with those who have an intellectual disability or psychotic mental illness.

A Review of Two Studies

Interested in a search of the literature in which therapeutic interventions with service-users who have an intellectual disability had been investigated, I hoped to find several quantitative and qualitative research studies. Although the research in this area seems very limited, I discovered two research studies which could be compared and contrasted in forming some useful conclusions with respect to my work environment.

Cognitive Behaviour Therapy (CBT) has long been the therapy of choice for

people with cognitive distortions and unhelpful thought patterns, although it has been adapted and published in many forms – for example: as Rational Emotive Therapy by Albert Ellis, in the 1970's; and, as the Mind over Mood programme by Christine Padesky, in the 1990's. A considerable body of research and more contemporary national guidance highlight this approach as the therapy of choice for an ever-increasing variety of problems. The rationale for CBT is described with reference to influential figures, such as Epictetus & Socrates, highlighting the influential role of interpretations upon emotions and behaviours.

Readiness for Cognitive Therapy

Willner's (2005) research study examines issues such as current assessment practice, consideration of cognitive ability, and the adaptations to current therapy which have so far shown promise. Of immediate interest to me was the method for monitoring and judging success. Considering the context of my work with offenders, success could be measured through a comparison between a group receiving adapted therapy and a control group, ultimately considering recidivism (re-offending) rates.

Whilst Willner's (2005) research focuses upon behavioural change, to behaviour that is healthier and more adaptive, this study lacks any clear measure and merely comments on reported successes with individual service-users. There is little acknowledgement that the intervention in the case examples differ substantially and in different ways from conventional cognitive therapy. Nevertheless, improvements are reported using the same model of encouraging changes in thoughts and beliefs.

Willner (2005) describes a baseline assessment, whereby the person was interviewed for their response to a set of questions, which provided an indication of their basic cognitive functioning with respect to standard emotions – for example: 'It's your birthday. How would you feel?' He found that 3/4 of respondents reported being 'happy', as for the other six similar questions. This appears to be a very basic baseline and somewhat limited assessment, with only six questions. Perhaps the development and use of a questionnaire which was expanded to incorporate more in-depth questions may have eliminated the need for further assessment – for example: 'What makes you feel happy on your birthday?' Asking this additional question may have revealed further evidence of social skills – for instance: if they shared their birthday with family; and whether the event was insular or environmental to the client.

Those with an intellectual disability are often found to have extremely low self esteem (Battle 1992). However, in this research study, the author describes a further assessment, whereby more in-depth questions are asked during assessment, although not as suggested above – for example: 'Your friend shouts at you and you feel sad – would you feel I'm a good person or I'm a bad person?' Simply suggesting to a person with low self-esteem that they *could* be a bad person may be enough to trigger a biased response, whether or not they have the cognitive ability to recognise the distortion.

Therefore, a more robust baseline assessment could be developed which eliminates all statements that infer 'good or bad' and the common expectations of society. Following through the above example of the birthday party question, if

the person has an intellectual disability, low self-esteem and shows little social interaction, their birthday may be the source of great sadness. The consequence may be that the person is deemed unsuitable for treatment, as they did not give the required response, although they may be able to convey sadness, even if not the reasons why.

Willner (2005) acknowledges the lack of research and quite rightly discusses his uncertainty about what is effective. However, he has started to publish articles that have raised argument and which he hopes will lead to the further investigation of adapting a very robust therapeutic intervention (CBT) for use with this select service-user group.

Finally, it is acknowledged that therapy should never be offered purely on these cognitive ability assessments, which were produced purely for research. Willner (2005) states that readiness for therapy is only a small indicator of success and that a 'holistic' approach which incorporates the opinions and support of carers, together with an open-minded and creative approach, is the best indicator for successful treatment and overcoming problems.

I personally found that this article reflected my practice within the Service for People with a Learning Disability, even though I would have expected a much clearer picture to be presented of how treatment with this service-user group should progress.

Adapting Individual Psychotherapy

As a contrast, I selected a second article, by Whitehouse et al (2005), that focused on adapting individual psychotherapy for adults with intellectual disabilities. Published at the same time as the afore-mentioned study, the

authors were working within different NHS Trusts, thus representing a good collaboration of experts with varied qualifications, experiences and ideas, and perhaps a greater degree of direct experience with service-users.

A further internet search confirmed that all four authors were actively involved in delivering therapy and could report their direct experience of the effects of therapy. Indeed, Kroese held a split academic and practice post that assisted the link between theory, research and the application of psychotherapeutic interventions – for example: 'translating cognitive-behavioral techniques to suit the needs of people with a learning disability.'

From the outset, Whitehouse et al (2005) clearly state their intention and review several studies, which incorporate a varied approach, before reporting on the adaptations that could be used within therapy. They also comment about which approaches are used within their field of work.

There is good use of comparison studies and their findings are reported in both quantitative and qualitative forms. Rather than reporting on individual cases, they present on twenty five studies and report 94 adaptations. They point out that researchers have so far given unclear descriptions of the adapted therapeutic interventions that are used – this is also a criticism of the Willner (2005) study.

They provide several well-respected reports which support their argument that, to date, researchers and therapists are reluctant to stray from traditional 'models' of therapy, perhaps through fear of criticism. They state that the Royal College of Psychiatrists (2004)

have, in their report on psychotherapy and the learning disabled, criticised well-established delivery for its rigidity, as it actively excludes people with a learning disability from receiving treatment.

The authors' aims are stated, and they identify their focus as reporting process rather than outcome. This could be interpreted as a weakness by the reader who wishes to use some of the suggested adaptations and processes, as the value (outcome) of using such adaptations is not given.

Their method of identifying studies is described, which includes their specific search terms – a potential aid for the unskilled researcher. They also identified inter-rater reliability issues, and involved the use of a second researcher during the process of reviewing references obtained from the search and identifying adaptations.

Although not having the scope to report on all 94 of the identified adaptations, following further examination they amalgamate the highest reported adaptations, which is a very useful aid to reflecting on clinical practice and considering ways of implementing evidence-based findings.

They report that the combination of both cognitive behavioral therapy and the psychodynamic approach provides the most useful and reported adaptation of using flexible methods, rather than adhering to static models of therapeutic intervention. This can be related to the Royal College of Psychiatrists viewpoint that rigidity excludes the learning disabled person.

In their discussion, the various difficulties that were encountered are described, such as the problems with

replicating and developing approaches that are often not adequately described nor clear as to how they differ from the methods of traditional therapy.

In spite of reviewing an extensive amount of prior research, I did feel that Whitehouse et al (2005) could have identified those areas or adaptations that were not considered to be useful, and were least reported in order to offer further guidance in targeting both further research and influencing current interventions.

Conclusion

Whilst both articles recommend that further research is discussed, Whitehouse et al (2005) also highlight the particular research studies that were found to be most insightful and deserve further consideration. Rather than being purely descriptive, their study provides evidence for further targeted research.

It seems important that future research studies should not merely be narrative and descriptive, but also explore the facts and conclusions of quantitative research approaches.

Considering my own practice, I have often been criticised for adapting a manualised approach based upon cognitive-behavioural intervention, which was written some time ago, for use with my service-user group. Furthermore, my peers have often expressed the view that a consistent approach should be adopted with all service-users, using exactly the same approach whatever their cognitive differences. I have always disagreed with this, as I felt that this would mean offering an inflexible approach that is not person-centred, nor acknowledges acceptable differences between people, whatever their

intellectual ability.

The recommendations of Whitehouse et al (2005) and the Royal College of Psychiatrists (2004) are helpful, highlighting the need to adopt a flexible approach. This reinforces my current approach to practice as one that is ethical and accepted in the field of research within learning disabilities.

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Personal Experiences: *the Dunstable Community Mental Health Team*

PERSONAL JOURNEYS **Editorial Comment:**

We are delighted to include two more highly personal service-user experiences – this time by two service-users of the Dunstable Community Mental Health Team. You will hopefully find some helpful insights from these personal reflections. In order to preserve confidentiality, pseudonyms have been used for our two contributors. (*John Butler – Chair of Editorial Group*)

My Journey

by Stephen – a service-user

‘My journey is a slightly misleading title, as it implies a straight path from A to B to a known destination. Whereas in actual fact, there have been several paths all criss-crossing each other at different times and places. What I really want to write about is the help I have received along the way that has eventually enabled me to stand on my own two feet. I suppose in a nutshell that is the journey, to go from high dependency on others to independence.

‘So, how did my journey begin? The short answer is that I was diagnosed with manic depressive psychosis some 18 years ago. My girlfriend, now my wife, had been on holiday with me, during which time I had become increasingly more ill until I eventually ‘cracked’ and became psychotic. I had tried all week to seek help from the local hospital, but the psychiatrist there thought that I was merely having panic attacks. I knew otherwise and so it was proved as I was arrested a few nights later for streaking and other public order offences. The police were not helpful. They suspected that I was either drunk or on drugs. The following morning, I was fined £200 by the magistrate, along with two other men who had tried to stop the police from arresting me as they thought I was mentally ill and needed care.

‘With the holiday over, I returned to my home where I was living with my mother. There were many arguments and eventually my mother was forced to call the local police, who were very understanding. Whilst one officer calmed me down in my bedroom, the other contacted my GP and arranged for the team to convene that would commit me to Fairfield Hospital. At some point I was sectioned under the Mental Health Act and interred in Ward 8 – a lock up ward. Now although this was pretty traumatic for everyone involved, one positive thing came out of it all; it showed that I was illness aware. This gave me a great advantage in that I was able to detect hypomania within myself and do something about it, such as

contacting the psychiatric services, before it progressed into mania or even psychosis. Depression, on the other hand, develops slowly and creeps up on me; I have to depend upon my wife and friends to spot it.

'Psychiatrist and other professionals have been largely good to me. Perhaps this is because I didn't see them as the 'enemy' and was not antagonistic towards them. I was always interested in what they had to say about my illness and they generally listened to me. There was only ever one who I had had problems with. Fortunately however, my assertiveness training came in handy! But like I say, psychiatrists have helped me over the years. My first psychiatrist did several very useful things for me. He got me onto an anxiety management course, referred me to the Befrienders and supplied me with information about the Manic Depression Fellowship (MDF) when I asked about self-help groups. I don't remember much about the anxiety management course except perhaps that it is essential for me to balance 'me time' with what I do for others, so that I don't overload myself. The MDF were extremely helpful and were tremendous fun. The people there helped me to develop coping strategies and not to be afraid of my emotions. Since my diagnosis, I had been scared to be happy or sad in case I was becoming manic or depressed. The MDF hosted guest speakers on current research and other related subjects. Then there were social events that were tremendous fun. One of the best events was a Christmas party held in a member's home. The food was all laid on and there was even mulled wine! Oh those were good times; sadly the Luton chapter of the MDF went into decline in the early 1990s. Still I learnt a lot about how to live with manic depression from those guys.

'Over the years, the Befrienders have helped me very much. They have taught me to stand up for my rights, the rights of others and to regard myself as worthwhile. I was a member representative for a number of years. They didn't ask me to be one at first; initially they helped me in recovery. There were lots of classes like pottery and yoga, designed to help you relax, but the Befrienders main mission seems to be that through education, moral support and the giving of responsibility is to give one of the best tools possible in order to achieve one's fullest potential. I spent years as a member representative. Initially it was just at a local level, bringing up members' ideas and concerns to the Dunstable Befrienders Members Forum. Then it went up a gear so that I was representing the club at national conventions about mental health issues and representing the Befrienders on the Stakeholders Group for Townsend Court (the local acute mental health in-patient unit). All of this gave me the confidence to try other things, like joining other organisations and trying adult education at college rather than taking in-house courses. Other organisations that I tried included Bedfordshire & Luton Advocacy Service, now Rethink, when it was starting up under the aegis of the National Schizophrenia Foundation. At that time, they were looking for volunteers to be mental health advocates and to be part of the panel responsible for interviewing applicants for paid jobs within the service. Unfortunately, when it came to being a volunteer advocate, I found it too stressful. It wasn't a complete disaster though, as I completed an assertiveness course with the service.

'One of the bedrocks of my life has been my marriage to my wife. When I was first

ill, we had been engaged for only a short while. I said to her: 'if you want to leave, then I will understand'. I did not know how ill I was going to be. I only had my father as an example; he had a poorly controlled bipolar (manic depression) condition. Neither my family nor I realised that the latest medication gave much more control than the older generation of drugs. So my wife had both her own family and my family trying to dissuade her from continuing her relationship with me. She took a week out to decide to stay with me; neither of us has ever regretted that decision. Our marriage has lasted 15 years to date and we have spent a total of 19 years together. We are mutually dependent on each other. Ten or more years ago, she developed diabetes with complications. Our marriage has literally been 'in sickness and in health', but it doesn't matter – I love her and she loves me and that's all we need.

'The other bedrock of my life has been the drive to develop myself, both as a human being and as an artist.

'The first part of developing myself starts with illness management – the pills are important, but what has made things easier are the strategies and life changes that I have discovered either from other people or for myself. There are a number of paths I take towards this: guided relaxation either live at Befrienders or by listening to a tape at home; and, doing my hobbies – especially gardening an art.

'The second part of developing myself has been the years of therapy with my CPN (Community Psychiatric Nurse). I was referred to him about six or seven years ago, and after discussion we decided that exploring my past would not be any good for me – he then put

forward the concept of cognitive-behavioural therapy. This is basically the technique of challenging negative thoughts and finding / creating a positive posture. It was not an easy technique to acquire. Sometimes my thoughts were challenged so much that I came out of the session punch drunk. These days though I can do it for myself – for instance, I was having problems writing or even starting this article. The big issue was the number of words required by the deadline. Two thousand words seemed like an awful lot. I asked around for suggestions on how to tackle this. My CPN suggested that I break it down into smaller parts; someone else I knew suggested making a mind map of my ideas; and, finally, I saw an interview on television of a writer who said when he was stuck that he would just start writing – the first 500 words or so would be complete rubbish but after that the piece would start to flow.

'The final pathway towards my self-development is my religion and philosophy. This is based on many influences – Christian, Buddhist, Pagan, Taoist and New Age. The one book which has helped me the most has been the Ye Jing (I Ching) or The Book of Changes. Whenever I am troubled and I cannot find the answer myself or through friends and family, I consult the Ye Jing. There is always something in it that inspires me, whether with an idea for a solution or a way to endure the situation.

'It is now four years since I was last in the unit and two months ago my CPN discharged me from his care. It would seem that with the help of the mental health team, especially my CPN, my wife, friends and family in focusing on my strengths rather than my weaknesses have been the winning

strategy. I thank them all from the bottom of my heart. I look forward to many happy and productive years.

'I hope that any person with mental health issues who reads this article finds within it some idea that helps them. Wishing you all the best of health.'

Shaking off the Stigma

by Anna – a service-user

'My name's Anna, I'm in my mid 20s and a married mother of two wonderful children. So what? I hear you ask. Well, just over a year ago I suffered a psychotic episode that left me hospitalised for three months. This is my story.

'The book I was reading was fantastic. It was called *Psychic Power* and taught the reader clairvoyancy and mediumship. It had only taken me a day to read and already I found myself beginning to 'hear' messages from the spirit world. I was elated that I had picked it up so quickly. That night, I awoke suddenly. There was someone watching me, waiting for me. I awoke my husband. He quickly told me I must be dreaming and returned to his sleep.

'I went downstairs. My heart was racing, my palms sweaty. Then I heard a voice in my head: 'Hello Anna'. This was not like the voices I had heard before. It didn't feel comforting and pleasant. This was something sinister. 'I'm going to get you', it said. 'My time has come'.

'My head began swimming, my thoughts became muddled. I felt that if I allowed myself to relax, then this evil spirit would take over my body. I couldn't allow it to do that. I sat on the sofa and read some passages from the Bible over and over

again. It was if the pages were speaking only to me – that it had been written purely for myself. I prayed and read until the daylight came. As it got light, I felt myself return to my normal state. The 'presence' had gone. I was safe.

'And so this pattern continued. Each day I would hear words of encouragement and comfort in my head, but by night-time I was fighting a battle between good and evil. Although the sinister voice didn't speak again, the feeling of there being somebody evil in the room continued, and my fight against the possession grew harder and harder as I lost more and more sleep.

'The inevitable happened – hallucinations caused by sleep deprivation kicked in. I would look at my reflection and my facial expression would change into an evil snarl. My face would alter into an imp like creature. All the time though, I was telling myself that these were hallucinations and were not real. Although I truly believed that I was being contacted by the dead, my natural faith in God remained and I believed that with him by my side I would not come to any harm.

'By this time, I had begun to tell people what was happening, although I held back some of the details through fear that I would lose my children. I knew that I was not a danger to anyone and still believed that apart from the hallucinations, I was going through a psychic learning experience!

'It was mid-afternoon on a sunny spring day that I realised I needed help and could no longer deal with this alone. I was alone, playing with my daughter, who at the time was three-months old, when she started looking at me oddly. I didn't like the look she was giving me.

Her eyes began to grow red, like a photograph taken in the wrong light. This was too much. I placed her gently in her cot, made sure she was safe and comfortable, and ran out of the room faster than an atom bomb before phoning my husband and parents. I was concerned that my hallucinations had now begun to involve others around me. I knew I had to get help and be away from the children. If nothing else, my constant talking to myself and 'healing rituals' would have freaked out my six year old son! It was time to leave.

'The next few weeks are a bit of a blur to be honest. Where, as before, I was still 'there' and able to talk myself through certain situations, I was now completely lost in my psychosis. I am told by my parents, my carers at the time, that I became many different people during this time: a monk, who spent most of time bowing at many different objects around the house; an angel, welcoming people into the pearly gates (I am told that this was my dancing stage); the young girl, in a real version of the exorcist film and very scary for all involved; and, a victim of voodoo magic. I also became the head of the Italian Mafia family, and a witch!

'I have a vague recollection of the Crisis Team coming twice a day, however, although they were an excellent support for those around me, all they did for me was become leading roles in my next psychotic stage. I was secretly trained to become a spy for a government agency, and the Crisis Team were their secret researchers!

'Following a few trips to Accident and Emergency, where I totally lost the plot and took all my clothes off whilst running around the department singing 'high ho, high ho, it's off to work we go', I ended

up at the local psychiatric unit (Oakley Court). For me, this was a very difficult transition. I was used to being constantly around people that I knew. Now I was surrounded by strangers. My father visited as often as he could and as he had been my carer through the previous few weeks, he was used to my strange behaviour and was able to differentiate between the real me and the psychotic me. For my mother, it was harder. She had been working during my time spent at their house and it was a shock every time she came home from work. She had also found me absolutely petrifying during my 'exorcist stage' and I believe hadn't at this time accepted that the real me was still underneath the layers of madness. She dealt with it by becoming the practical one, sorting out my benefits and dealing with the finances. My husband visited every day of course, but having had to suddenly give up work and become a single dad of two for all intense and purposes, he could only stay for short periods.

'The other difficulty was that I was surrounded by other ill people, some of whom were going through similar experiences to myself and therefore, unintentionally, fed my psychosis. There was a resident there who was very ill indeed and spent his time in the reception area vocalising his thoughts. My room was just up the corridor and so I could always hear him. The things he spoke about stuck in my mind and I became so involved in the psychosis that I ran away from the hospital! With no money to pay the taxi driver, I ended up at the police station informing the poor WPC on the front desk that I was her superior and my expenses account would deal with the taxi! Needless to say, I was swiftly returned to the hospital, where I was seen by the psychiatrist.

'I explained that although the staff were fantastic, I could not settle there, and after a night's stay in one unit (Cainwood Court), I was transferred to another (Townsend Court). This was the star of my recovery as I felt near to home. It was so much quieter and a smaller unit, which I obviously needed, and the rooms were lighter and felt more spacious because of this.

'I am told that my diagnosis was incredibly hard. At first it was believed that I was schizophrenic and, since reading up on this condition, it is easy to see why. However, I began to have obvious periods of mania when I would dance around the corridors and do my own version of Tai Chi, followed by evenings of severe depression. It was this that led to my final diagnosis of Bipolar Affective Disorder, and as my medication began to set in, I was able to catch up on the much needed sleep that I had lost, and slowly, I was bathing and eating again. (I had previously believed that getting in the bath water was a devil's baptism and I was too scared to be alone in a shower. I had also believed that my food was being poisoned.)

'I knew I was getting there when I became desperate to get home. I wanted my children and my life back and after a while of battling with the psychiatrist, my day visits became overnight visits, which were gradually extended until I persuaded the team that I could be discharged. I will admit now that at this stage I was 99% out of my psychosis, but I still did the odd bit of tree hugging now and again, and lit candles to say thank you to all the 'spirits who had kept me safe and supported me!' Within a few weeks of being home and having my children and friends around me to take my mind off things, this stopped.

'The next stage of recovery for me was almost physical. I tired very easily, I still slept a lot and couldn't cope with too much noise and activity, but I had an excellent mental health nurse constantly at beck and call. My stamina recovered to the extent that I had so much new found energy, I was always active, either visiting friends, indulging in a hobby or doing a fitness video. Of course there were days that were better than others. There were times when I found it hard to get motivated to do the simplest things, but I used a technique of breaking things down into tiny steps and concentrating on one step at a time, rather than the overall picture.

'I made a surprisingly rapid recovery. It was originally thought that it would take me around two years to recover, but within a year my mental health nurse had persuaded me to do The Prince's Trust Team Course, where I excelled beyond all expectations. I discovered new skills, found that I was actually a well-liked person and was respected for my openness about what I'd been through. I have since been offered a job as a support worker for people with learning disabilities and am looking forward to the new challenges this will offer me.

'So what caused my illness? Hindsight is a wonderful thing! I had gone through a lot as a teenager and had been treated on and off for mild clinical depression and post-traumatic stress disorder. In reality, I can see that I was actually suffering from manic depression. I was constantly on the look out for danger and excitement, which inevitably led me on to narcotics and alcohol. The departure of my first child's father following frequent liaisons with other women had left my confidence battered and I turned more to alcohol and drugs

to try and fill the part of me that was missing. I am sure that this didn't do my brain any good – in fact, recent scientific discovery has proved that the use of cannabis can act as a trigger for underlying psychiatric conditions.

'In the end, the team decided that although it could have been any of the above, or a combination of them that caused the psychosis, it was more likely that my condition was post-natal – not a surprising conclusion when I think back to how I felt after the birth of my first child.

'I'm one of the lucky ones. I sought the help needed, I had the support of those around me, received excellent care from all involved and made a rapid and full recovery. In fact, I feel better and happier now than I can ever remember feeling and can laugh about some of my experiences. However, for some sufferers it is a different story. Many people are too scared or embarrassed to seek medical help, some still see taking medication as a taboo and many do not have the loving support of people

around them. Some sufferers are still misunderstood. They are viewed by others as dangerous and scary, not realising that the person they once knew is still underneath the condition, fighting to get out.

'Each time I go to bed at night I say a prayer, not only of thanksgiving for my recovery and for those who helped me through, but also for support and help to all those people struggling to deal with their condition.

'I am adamant that I will one day write a book about my experiences. I am happy in my own skin. My condition is now just a part of who I am, and is not the thing that controls my life or me. I am open to people. I joke about my medication and my time in hospital and find that as I am not embarrassed, people want to learn more about the condition and what I experienced. The more people know about mental health, the more they will learn to accept it and hopefully, one day, we will be able to finally shake off the stigma that we are fighting so hard to lose.'

The Mental Capacity Act 2005: *a review*

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REVIEW Introduction

The Mental Capacity Act has been introduced after being presented to Parliament on 17th June 2004. It received Royal Assent on 7th April 2005. It enshrines the current best practice and common law principles concerning people who lack mental capacity and those who take decisions on their behalf. The Act has been drafted after extensive discussions with various professional bodies and voluntary organisations involved in the care of people with general and mental health problems. Although it has been broadly welcomed, there are some concerns from user organisations about the potential for abuse of the Act.

Historically, the code of good practice has been to emphasise the importance of discussing the person's choices and preferences with them, be it medical treatment options, financial decisions or decisions relating to their welfare. Unfortunately for some, an incapacity to make decisions can affect their quality of life and might place them in a vulnerable situation. In order to protect their rights, legislation needed to be put in place. Prior to the Mental Capacity Act 2005, decisions regarding the care of people who are incapacitated had been piecemeal and based on examples from case law.

The concept of informed consent dates back to the 1700s in the history of medical practice. In 1890, the status of 'voluntary boarder' was incorporated in the Lunacy Act, which was later termed 'voluntary patient' in the Mental Treatment Act of 1930. The concepts of 'Best Interest' and 'Common Law' were laid down following an example of case law in the 1960s. The criteria for incapacity were set following an example of case law in 1994. This established the 'Eastman Test of Capacity', which is '...to comprehend, take in, retain information, believe it, and weigh it up in order to make a choice'. In the following year, the Law Society and British Medical Association (BMA) produced a joint definition of capacity for clinicians. Following this lead, the Law Commission made recommendations for a 'Mental Incapacity Act'. Based on the recommendations and proposals for law reform that the UK Government had issued (Lord Chancellor's Department 1999), ensuing work paved the way for the current Mental Capacity Act 2005.

This Act deals with the assessment of capacity and introduces a framework for use by everybody involved in the care of a person to make decisions on a person's behalf, provided that the decision has been taken in the best interests of the person at that current point of time. The Act also introduces legislation for the offence of neglect or ill treatment to prevent misuse of the Act.

The Structure of the Act

The Act is divided into three parts, as follows:

- **Part 1** provides definitions of persons who lack capacity and sets out a checklist to be used when assessing capacity. It covers the liability for actions in connection with the care or treatment of a person who lacks capacity to consent. Lasting powers of attorney are discussed in the Act and it sets out new Court of Protection arrangements for making declarations, orders, and powers to appoint substitute decision makers. This part of the Act covers the use of advance directives in refusing medical treatments and creates new safeguards regarding any research that involves people who lack capacity. It also promotes independent advocacy for vulnerable people.
- **Part 2** covers the Court of Protection and the Public Guardian. Provision is also made for the Court of Protection Visitors.
- **Part 3** covers miscellaneous and general issues such as international law, to check that the application of the Act does not lead to any contradictions relating to unlawful killing or assisted suicide.

Definitions

In the context of this short review, it is worth considering some of the main components and principles of the Act.

Definition of the Person Lacking Capacity:

in **Section 2** of the Act, a person lacking capacity is defined as a '...person who at the current point of time is unable to make a decision for himself / herself in relation to the matter because of an impairment or a disturbance in the functioning of the mind or brain.' The impairment or disturbance could be permanent or temporary and that lack of capacity cannot be established merely by reference to one's age, appearance or his / her behaviour which might lead others to make unjustified assumptions about their capacity.

Assessment of Capacity: the above definition states that a person lacks capacity if s/he is unable to make a decision for him/herself in relation to the matter because of an impairment or disturbance of mind or brain. The clinician or professionals involved in the care of the person should: ascertain if a disorder is present or not; then, explore whether this impairs capacity. These legal questions are to be answered by everyone who is involved in caring for anyone – whether involved in their day-to-day care or regarding serious medical treatments. A draft code of practice has been issued for the purpose of providing information to lay persons.

The Definition of 'Best Interest': in **Section 4** of the Act, it states that any person taking a decision on behalf of a person who lacks capacity should take into consideration the fact that the person might regain capacity at any point of time and when that is likely to be. S/he must encourage or improve the

person's ability to participate in any decision affecting him / her. Due consideration must be given to the person's past and present wishes and feelings. In particular, if any advance directives are given by the person, consideration should be given to the beliefs and values that would be likely to influence his / her decision if they had capacity.

Emphasis has been given to practices that promote the regaining of capacity. The Act does not distinguish between temporary or permanent loss of capacity and states very clearly that every step should be taken to consider that the person might regain capacity in the near future.

Lasting Power of Attorney: Section 9

deals with lasting powers of attorney (LPA), which are defined as powers that the donor bestows on the donee(s): the authority to make decisions about another's personal welfare or property. For a LPA to be issued, the person must have reached 18 years of age and have the capacity to execute it. Safeguards are put in place as to the appointment of donee or donees. These issues are covered in **Section 10** of the Act, where it is stated that the person appointed should have reached 18 years of age and not be bankrupt.

The present system of 'Enduring Power of Attorney' (EPA) is expanded to incorporate the new concept of LPA. This provision enables one to make decisions regarding ones welfare and finances should they reach a stage where their capacity is affected and they are incapacitated. There are fears that this provision might be abused and statistics from the Joint Committee on the Draft Mental Incapacity Bill 2003 report that abuse was noted in 10-15%

of cases. One of the legal checks that can be applied to mitigate against any abuse is to appoint different donees or different attorneys for different decisions. This is of relevance if one anticipates a situation where a conflict of interest might arise. It is noteworthy that one weakness concerns the period when the EPA is set up: either involved party can take decisions until the donor loses capacity. The Act makes it statutory for a LPA to be registered and open to scrutiny as it is set up. LPAs are made infallible by dividing them into financial and welfare LPAs, with strict inclusion and exclusion criteria. However, financial LPAs are operational once they are established, even before the donor loses capacity, whereas welfare LPAs are operational only when the donor loses their capacity.

Court of Protection: The Act makes a provision for the appointment of the Court of Protection in situations where a person lacks capacity and has not appointed a LPA. The Court of Protection is involved in taking decisions on the behalf of the person. The function of the Court of Protection is to make a judgement as to the validity of any advance directive or LPA. It can make a decision as to whether a person has capacity or not. It can appoint a deputy if a situation arises which is long-term in nature and where there is a need for ongoing decision-making. **Section 19** deals with the appointment of deputies by a court.

Advance Directives: Section 24 deals with advance decisions to refuse treatment, and states that an advance decision is one made by a person after reaching 18 years of age, provided they have capacity to do so. An advance decision refers to decisions about the commencement or continuation of

proposed future treatment options, such that in the event of the person lacking capacity to consent to a proposed treatment option in the future, then that treatment should not be carried out or continued.

This provision in the Act allows the person to specify treatments that they would wish to refuse should they lose capacity in the future. The major concern is that this provision might encourage euthanasia by the back door. Advance directives that involve the withholding of life-sustaining treatments should be made in writing and witnessed. All professionals involved in the person's care should ensure that they know the contents of the advance directive if they have a reason to believe that one has been agreed. In the case of doubt or controversy, help should be sought from the Court of Protection. The current legal position is that only advance refusals are legally binding. However, advance preferences are recognised as important decisions by voluntary organisations advocating patient autonomy.

Advocacy Service: *Section 35* deals with the appointment of independent mental capacity advocates in representing and supporting persons who lack capacity to whom serious medical treatments / provision of accommodation by the NHS or local authority are being proposed.

Individuals without any assistance from friends or family members can be helped by the provision of advocacy services. Organisations such as 'The Making Decisions Alliance' and the 'Alzheimer's Society' have been providing commendable services towards improving quality of life for the afore-mentioned groups of individuals.

Other Key Sections of the Act: *Section 21* deals with transfer or proceedings relating to people who are under 18 years of age; *Section 30* covers any research that involves people who lack capacity to consent; *Section 44* deals with any ill treatment or neglect, making it an offence that can lead to a conviction.

Implications of the Mental Capacity Act 2005 on psychiatric practice

The Act defines 'lack of capacity' and has set up a legal framework for carers and professionals who are involved in the care of incapacitated persons. It provides guidance for all doctors, including psychiatrists, when making clinical decisions regarding their patients. Decisions can now be made without the need to resort to common law practice and examples from case law. Mental health professionals, such as psychiatrists, can expect to be asked to assess capacity in various situations, which might put a strain on already stretched services. In order to have uniformity across the board, it is important to provide training to all professionals who are likely to be involved in assessing capacity, which is likely to require funding and resourcing. It is to be hoped that a heightened awareness of the Mental Capacity Act 2005 will improve standards of practice.

Discussion

It is important to note the timing of the introduction of the Mental Capacity Act 2005, which is being introduced prior to the new Mental Health Act – a much discussed and somewhat controversial development in itself. Obviously, there are some common areas where both pieces of legislations will overlap. As suggested by the Richardson Report, a test of capacity could form the basis for deciding whether or not treatment could

be given to mentally ill people who are detained under the Mental Health Act, against their wishes. However, the Draft Mental Health Bill does not include a test of capacity as a criterion for detention. The Mental Capacity Act 2005 can be viewed as an arm of legislation that refers to the provision of services regarding decision-making for those without capacity, whereas the Mental Health Act is an arm of legislation that refers to the care of people who are actively refusing treatment for a mental disorder.

Currently, patients suffering with a mental disorder will be treated in accordance with the Mental Health Act 1983, which will have precedence over the Mental Capacity Act 2005. This approach leaves people without capacity being deprived of the particular safeguards of the Mental Health Act, such as the right to appeal and the right to a second opinion. The well-known Bournemouth case (1998) is a case example, where a man with autism was detained in hospital for treatment without any provision of the services offered under the Mental Health Act, as it was deemed that he lacked capacity. The European Court of Human Rights (HL v UK, 2004) has ruled that the patient was deprived of his basic liberties. This leaves a grey area, which requires further thought.

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Author's Note:

This paper is only a short review of the Mental Capacity Act 2005.

For further information, please refer to the Department of Constitutional Affairs website: <http://www.dca.gov.uk>

What..... no medication? *An introduction to the Human Givens approach*

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THERAPEUTIC APPROACHES

“It has become appallingly obvious that our technology has exceeded our humanity.”

Albert Einstein (1879-1955)

“To open one's spirit to what is going on now, and discover in that present process whatever structure it appears to have . . .”

Carl Rogers (1902-1987)

What are the 'Human Givens'?

Human Givens or *Human Givens psychotherapy* is a school of psychology that has been around since the mid 1990s. It was founded by two pioneers in the field of psychological research, *Mr Joseph Griffin* (author, research psychologist, psychotherapist & Director of Studies, Mindfields College) and *Mr Ivan Tyrell* (author & Principal of Mindfields College). It has already been influencing psychotherapy and education. It asserts that psychological understanding is best advanced by acknowledging that we have innate physical and emotional needs and that nature has given us the resources to help fulfill them. These needs have evolved over millions of years and they are our common biological inheritance, regardless of our respective cultural background. It is because these needs and resources are incorporated into our biology that they are called '*givens*' (known or established facts).

This organising idea has produced improved ways of treating mental distress and illness such as anger, depression, anxiety disorders, psychosis and addiction.

Theoretical Ideas

The Human Givens theorises that our *innate needs* seek their fulfillment through the way we interact with our environment using the resources which nature 'gave' us. When our physical and/or emotional needs are not being met, or when our resources are being used incorrectly, unwittingly or otherwise, we suffer considerable distress, as do those around us.

It is by meeting our physical and emotional needs that we survive and develop as individuals and as a species.

As animals, we are born into a material world where we need air to breathe, water to drink, nutritious food to eat, as well as sleep. These are the paramount **physical needs**. Without them, we quickly die.

We also need the freedom to stimulate our senses and exercise our muscles. In addition, we instinctively seek sufficient and secure shelter where we can grow and reproduce ourselves and bring up our children. These physical needs are intimately bound up with our emotional needs which are the main focus of human givens psychology and therapy.

There is widespread agreement amongst psychologists as to the nature of our emotional needs, which include:

- *security* – a stable home life, safe territory to live in and an environment which allows us to develop fully;
- *attention* (to give and receive it) – a form of nutrition;
- *emotional connection to others* – through friendship, fun, love and intimacy; to know that at least one other person accepts us totally for who we are, ‘warts ‘n’ all’;
- *sense of autonomy and control* – having volition to make responsible choices;
- *feeling part of a wider social community* – which satisfies our need to belong;
- *sense of status* – within social groupings;
- *sense of self-competence and achievement* – through maturity, learning and the application of

skills;

- *privacy* – the opportunity to reflect and consolidate experience;
- *meaning and purpose* – which come from being stretched in what we think and do.

Our resources include:

- *curiosity* – the ability to build rapport, empathise and connect with others;
- *long term memory* – which enables us to add to our innate knowledge and learn;
- *a conscious rational mind* – that can check out emotions, question, analyse and plan;
- *imagination* – which allows us to focus our attention away from our emotions in order to use language and problem solve more creatively and objectively;
- *a dreaming brain* – that preserves the integrity of our genetic inheritance every night by metaphorically defusing expectations held in the autonomic arousal system because they were not acted out the previous day;
- *the ability to ‘know’ and understand the world and other people* and extract deeper meaning unconsciously through *metaphorical pattern matching*;
- *an observing self* – an awareness of oneself; that part of us that can step back, be more objective and be aware of itself as a unique centre of awareness, separate from intellect, emotion and conditioning.

It is these emotional needs and resources, which are built into our biology, that, together, make up the

Human Givens, nature's genetic endowment to humanity. They are best thought of as inbuilt patterns – *innate biological templates* – that continually interact with one another and (in 'undamaged' people) seek their natural fulfilment in the world in ways that allow us to survive, live together as multi-faceted individuals in a great variety of different social groupings, and subsequently flourish.

It is the way these needs are met, and the way we use the resources that nature has given us, that determine the physical, mental and moral health of an individual. When we feel emotionally fulfilled and are operating effectively within society, we are more likely to be mentally healthy and stable.

It is now widely observed that most problem behaviours and psychological distress can be traced to innate physical and emotional needs not being met, for whatever reason, or to the misuse of a particular innate resource (such as *imagination*, for example, when it generates worrying, envy, or excessive greed). When we work closely in alignment with the 'givens' of human nature, rather than with just the techniques derived from limited ideologies, then doctors, psychotherapists, nurses, social workers and teachers are more effective.

Human Givens Practice

The Human Givens approach to treating depression emerged from research into sleep and especially the rapid eye movements (REM) seen during dream sleep. It theorises that excessive worrying whilst awake arouses the autonomic nervous system which then increases the need to dream in REM sleep. This subsequently deprives the

individual of the refreshment of the mind normally brought about by regenerative slow wave sleep. It sees worry as a misuse of the imagination. A worry is a form of expectation (negative in nature), and expectations arouse the autonomic nervous system which can then lead to physical symptoms of anxiety. Any expectation that is not acted out during the day-time is acted out metaphorically in dreams. This is referred to as the 'Expectation fulfillment theory of dreams'. This, Human Givens therapists say, is why depressed people dream more intensely than non-depressed people and why all depressed people wake up tired and find it difficult to motivate themselves. The balance of their sleep is upset.

Human Givens therapists use a number of techniques to get the subject to use their imagination in a healthier way e.g. deep relaxation, visualisation and guided imagery, use of metaphors, which then restores a healthier sleep pattern and lifts the depression.

The technique was developed by Mr Joe Griffin and Mr Ivan Tyrell in the mid 1990s from observations in sleep research and efficacy studies of different schools of psychotherapy.

The theory has been further extended to give a plausible possible cause of schizophrenia (a waking REM state). The Human Givens also has a theoretical explanation and treatment for PTSD (cue-review technique – a visual / kinaesthetic disassociation (VKD) technique (Bandler et al 1979) & eye movement desensitisation & reprocessing (EMDR) (Shapiro 1995)).

The Human Givens has also been described as the missing heart of the positive psychology movement – the

scientific study of 'human happiness' and mental well-being as opposed to mental illness.

Human Givens Models (APET & RIGAAR)

There are two simple models used by Human Givens therapists. The first, referred to as **APET** (see below), describes the process involved in any behaviour or emotional state and helps one to effectively understand and then target predisposing, precipitating and perpetuating factors.

The second, referred to as **RIGAAR** (see below), relates to the process of effective history taking and therapy.

Summary

I have found the Human Givens approach an effective type of psychotherapy and counselling which is eclectic and brief in nature. It has helped me to treat many of my patients and I can confidently say that my need for prescribing medication has significantly reduced. This coincidentally appears to be what increasing numbers of patients also want for fear of experiencing horrendous side-effects from psychotropic medication. Many patients do prefer a more natural or alternative approach. I have also found that I am

able to treat more patients in fewer sessions than before I completed my diploma. This can be especially helpful in our current climate of endless targets and the immense pressure on clinicians to treat and discharge patients as soon as possible.

This is not to say that this type of psychotherapy can cure severe and enduring mental illness. The psychiatrist's role will always be to prevent, assess, diagnose, treat and rehabilitate mental illness with the appropriate psychotropic medication and other non-medical approaches that are available, according to the best evidence-based practice, as well as hopefully satisfying the Hippocratic Oath and following the guidance laid down by the General Medical Council. Of course, there is a time and a place for medical and non-medical interventions and this is left to the treating clinician's discretion and must always be in the best interests of the patient.

The Human Givens has its place within the NHS, along with all the other types of psychotherapy currently available – *for example*, psychoanalysis, cognitive-behaviour therapy, systemic therapy, family therapy, art therapy and drama therapy. All of these types of psychotherapy offer extra tools which anyone could potentially use as a

- A:** Activating trigger / agent (stressor)
- P:** Pattern matching (previous negative/ traumatic events)
- E:** Emotional response / arousal
- T:** Thought(s) evoked

- R:** Rapid rapport building
- I:** Information gathering
- G:** Goal setting
- A:** Accessing resources (e.g. past successes)
- A:** Agreeing a strategy
- R:** Rehearsal (e.g. visualisation, guided imagery & practice)

mental health professional in helping to provide emotional, mental and physical well-being for our patients. I am not suggesting for a moment that the Human Givens approach is some kind of panacea for mental distress and illness or that it is even more effective than any other form of treatment. However I do believe that it can be effective when used appropriately for mild to moderate mental distress or illness, and when used in combination with more traditional medical interventions such as prescribing psychotropic medication. The combination of psychotherapy with medication is usually the most effective treatment option and this view is supported by extensive scientific research in the field of psychiatry. Unfortunately, very real financial and time constraints can limit what is available and lead to a pressure on clinicians and practitioners to just prescribe medication in the hope of quick results. However, this is not always effective and can leave many patients needing and wanting much more.

The Human Givens approach is already being used by many organisations around the country, such as MIND in Hartlepool, many GP surgeries, several large insurance companies in the treatment of PTSD, as well as schools and child and adolescent mental health clinics. Furthermore, Dr Gina Johnson, a local GP for over 20 years in Stopsley, Luton, has been so impressed by the Human Givens that she has already commenced research into the Human Givens approach. She is being supported and supervised by Mr Joe Griffin, co-founder of the Human Givens, and Dr Farouk Okhai, Consultant Psychiatrist in Psychotherapy at Milton Keynes PCT and Human Givens Therapist. Hence the future looks promising for the Human Givens.

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Further Information is available on-line from the following sources:

- www.humangivens.com
www.hgfoundation.com
www.wikipedia.org

I'd like to finish with a further quote—this time from Dr William Edwards Deming (1900 – 1993), an [American statistician](#), college professor, author, lecturer, and consultant, who taught that by adopting appropriate principles of management, organisations can increase quality and simultaneously reduce costs (by reducing waste, re-work, staff attrition and litigation while increasing customer loyalty). The key is to practice continual improvement and think of manufacturing as a system, *not as bits and pieces*.

'Learning is not compulsory... neither is survival.'

Dr William Edwards Deming (1900-1993)

Dr Deming's philosophy was summarised by some of his Japanese proponents as the following a-versus-b comparison:

- a) *When people and organisations focus primarily on quality, as defined by the following ratio:*

$$\text{Quality} = \frac{\text{Results of work efforts}}{\text{Total costs}}$$

then quality tends to increase and costs fall over time.

- b) *However, when people and organisations focus primarily on cost, then costs tend to rise and quality declines over time.*

My Journey to Humans Givens: *a short reflection*

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PERSONAL REFLECTION

I have loved psychiatry as a medical specialty since my medical school attachments at University College London, being fascinated by its somewhat abstract ideas and how it affects each individual differently. The word “*psychiatry*” derives from the Greek for “*healer of the spirit*”. I had also been curious about the unusual yet enlightening works of *Sigmund Freud (1856-1939)*, the ‘*father of psychoanalysis*’, from a young age, despite many of the prevailing negative perceptions of him and his work.

My medical training and BSc in Neuroscience helped me to understand somewhat better the neuro-biological basis for certain psychiatric and psychological processes and illnesses. I also believe in a mind-body connection and in treating these as one entity as opposed to trying to treat each one separately. They are intrinsically dependent on one another whilst one is alive. As to what happens after death, this is also dependent upon one’s own belief system.

It soon became apparent to me that too much of a biological or reductionist approach towards psychiatry and mental illness was probably over-simplistic and sometimes even inappropriate. Of course, the purely medical approach had clear benefits. The immense advancement of available psychotropic medications over the last 50 years has been quite breath-taking and has completely revolutionised the practice of psychiatry forever. Pharmaceutical companies continue to spend millions on research and randomised control trials in their continued efforts to find that ever-elusive panacea, as well as to further increase their profits – after all, they are businesses with shareholders to please. The pure medical approach, however, also appeared to have some flaws. One clear example of this was the fact that psychotropic medication did not work for everyone and even made some people feel a lot worse. This appeared to go against part of the Hippocratic Oath (that as a doctor, ‘*I will prescribe regimens for the good of my patients according to my ability and my judgment and never do harm to anyone*’). I can appreciate that one can not afford to be too naïve and idealistic in this modern world that we live in as we know that sometimes we have to break a few eggs to make an omelette. But we also cannot forget the fact that we are dealing with real human beings and their respective lives and difficulties. We are in a privileged position but we remain public servants after all. It is also important to note that our Community Mental Health Teams (CMHTs) are fortunately of a multi-disciplinary nature, with different

professionals coming from very diverse backgrounds e.g. nursing, social work, occupational therapy, psychotherapy. With them they bring a whole wealth of knowledge and experience which allows us to practice a more balanced bio-psycho-social approach to psychiatry and mental illness.

During my psychiatric training as an Senior House Officer, I was lucky enough to be exposed to a lot of psychotherapy: from John Butler, a keen and able practitioner and trainer in psychological therapies, I was able to learn about *Cognitive Behavioural Therapy (CBT)* and *Behavioural Family Therapy* by keenly attending his workshops several years ago; Dr Raj Kathane (*Consultant Psychiatrist in Child & Adolescent Mental Health*) taught me about *Systems Theory*, *Systemic Therapy* and *Structural and Family Therapy*; he and Dr Jennifer Stein (*Consultant Psychiatrist in Psychotherapy*) are very interested in the practice of *psychodynamic psychotherapy*, and would often give very informative and engaging tutorials to the training Senior House Officers, as they still do. I had the wonderful experience of working with Dr Kathane's excellent multidisciplinary CAMH Team in Rush Court, Bedford (Mid-Bedfordshire Family Consultation Clinic), which taught me that people, in this case children and adolescents, could actually be treated without the need for medication. Of course, medication was often not a realistic option in this patient group but it meant that one had to be much more creative and skilful. This placement fine-tuned my psycho-therapeutic abilities and gave me some new hope and direction.

Whilst working and training at Rush Court, I started my Diploma in Human Givens psychotherapy, being drawn to this psycho-therapeutic approach as it appeared to acknowledge that both physical and emotional needs had to be met for real psychological health and well-being. It seemed to reinforce my belief that there was a clear mind-body connection. The approach seemed to make sense to me and bring together many well-established ideas and effective psychological techniques e.g. *Jungian psychology*, *CBT*, *Person-Centred Therapy*, and, *Maslow's hierarchy of human needs*. The Human Givens appeared to use everything that was known to be effective according to scientific research. It was eclectic and brief in nature. The Human Givens also focused on current and on-going research in the biological, psychological and social fields and hence appeared to be very dynamic and forward-thinking. It also seemed to reinforce another simple philosophy which I try to follow myself – that we should learn from our past, live in the present and hope for the future. The Human Givens also emphasised the fact that medication was not always the best solution for everyone (much to the dismay of many hardcore medics!).

Earlier this year, I completed my Diploma in Human Givens, with distinction. This involved attendance at 16 different seminars and workshops over several years, a two-week intensive training and consolidation course and a final practical and written assessment.

Post-Traumatic Stress Disorder – an audit of NICE Guidelines within Child & Adolescent Mental Health Services (CAMHS)

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CLINICAL AUDIT Introduction

Post-traumatic Stress Disorder (PTSD) can arise following exposure to an exceptionally traumatic event, symptoms of which include: re-experiencing the ordeal through flashbacks; recurring images and nightmares; sleep disturbances; emotional numbing; and, anxiety and depression. Avoidance of triggers or reminders can therefore also become a subsequent core symptom of PTSD. In children, re-experiencing can occur through re-enactments of the experience and play, although the content of this is not in a recognisable form.

The prevalence of PTSD in adults has been identified and treated for some time but it's recognition in children and young people has been a much more recent discovery, and despite the similarity in symptom presentation, the diagnosis cannot be established via the same means. This can result in mis-diagnosis due to the developmental, neurological and cognitive differences between adults and children. As the research in this area is limited, the effects of various interventions and treatments in children are still somewhat unknown and further research is therefore indicated.

The National Institute for Health and Clinical Excellence (NICE) issued guidance on PTSD in March 2005. NICE publications are based on up-to-date research / audit and expert consensus, and it is essential therefore that the Trust raises awareness of this and encourages practice to become aligned with their recommendations. The Child and Adolescent Mental Health Services (CAMH) therefore felt that it was necessary to conduct an audit within their directorate to measure compliance against the NICE guidance.

Aim

The aim of this audit was to assess the Trust's compliance with the NICE guidance on PTSD.

Objectives

Two objectives were agreed for this audit:

- To raise awareness of best practice as detailed within the NICE guideline;
- To improve compliance with the NICE guideline.

Methodology

A small group was formed to scope the audit project and discuss how it could be taken forward, following which the Clinical Audit Department (CAD) developed and piloted an audit tool. Some alterations were subsequently made to the audit tool, following which a successful second pilot was completed, enabling data collectn to commence. The audit sample included children up to the age of sixteen who had experienced a traumatic event, although upon data-collection it seemed that not all of the clinical records identified actually qualified for the audit – some of these children had not in fact experienced a traumatic event and thus were excluded from the audit. Data was collected on children from all four CAMH clinics.

Following data-collection by audit group-members, data was forwarded to the CAD for an analysis of the results and the production of an audit report. A summary of the findings is presented below.

Summary of Findings

Data was gathered at all four CAMH clinics – as follows:

Location of CAMH Clinic	No. of Clients	% of Audit Sample
Luton	26	51%
Mid Bedfordshire	12	23%
Dunstable	11	22%
North Bedfordshire	2	4%

Diagnosis

- Of the sample of 51 clients, 90% (46/51) had experienced a traumatic event.
- 9% (4/51) of clients had been

given a diagnosis of PTSD. For those given this diagnosis, this was achieved by using the ICD-10 (International Classification of Diseases) in one of these four cases, the DSM-IV (Diagnostic & Statistical Manual of Mental Disorders) in one case and by reviewing the history of the client in one case. The method used for diagnosis was not indicated in the fourth case. All four of these clients were diagnosed as having 'severe' PTSD.

- 24% (10/51) of clients had been given a diagnosis of post-traumatic stress symptoms. In most cases, this diagnosis was made by reviewing the history of the client.

Intervention

- None (0/14) of the clients (with PTSD or post-traumatic stress symptoms) were offered a single-session intervention (de-briefing).
- 50% (2/4) of clients who were not offered, or declined, an active intervention, were offered a follow-up appointment within 4 weeks of first contact with the service. Where a follow-up appointment was not offered, this did not appear to be required as the client had already accepted an appointment or they had already declined contact with the service.
- Two of the four clients (50%) who were diagnosed as having severe post traumatic stress symptoms or severe PTSD and had been seen within one month of the event, were offered a trauma-focused psychological treatment (for example: trauma-focused cognitive behavioural therapy (CBT) or eye movement

desensitisation and reprocessing (EMDR)).

- Of these two clients that were offered a trauma-focused psychological treatment, both (100%) were offered at least five planned sessions. Only one of these clients completed all of the planned sessions.
- 24% (12/51) of clients were seen more than one month after the event. Of these twelve clients, eleven (92%) were offered a trauma-focused psychological treatment – mostly CBT (in seven cases) or family intervention (in three cases). For 10 (83%) of these clients, 8-12 sessions were planned. 58% (7/12) of these clients completed all planned sessions – in the cases where this did not happen, this was due to the client cancelling appointments or failing to attend sessions.

In summary, the majority of audit data was collected in the south of the county. Whilst a large proportion of the audit sample had experienced a traumatic event, only about a third of these clients were diagnosed with PTSD or post-traumatic symptoms. Approximately a quarter of clients were not seen until one month after the traumatic experience and the vast majority of these were offered the opportunity of undergoing a trauma-focused psychological treatment – mostly CBT or family intervention. Between 8 and 12 sessions were planned for the majority of clients and approximately a third of clients completed all planned sessions.

Conclusions

The sample identified within this study is too small to draw conclusions which can be generalised across services. This

would suggest that although many clients are referred to CAMH having experienced or witnessed a traumatic event, only a small number have severe symptoms which lead to an actual diagnosis.

In this audit, where a diagnosis of PTSD is given, this is regarded as severe, and although ICD-10 and DSM-IV are used to achieve this diagnosis, the client's history is also taken into account when making this diagnosis. History is also relevant when grading post traumatic stress symptoms.

Of the total number of clients that had experienced a traumatic event, none had been offered a single-session intervention (debriefing), which is in keeping with NICE recommendations which state that such should not be offered routinely. The empirical studies observing the effectiveness of single-session debriefing following exposure to the distressing event show little difference in symptom relief between those groups receiving and not receiving this intervention.

Due to the nature of PTSD, with the need for clients to confront the event or ordeal which has distressed them, clients may sometimes be reluctant to attend and engage in therapy, which can result in a high number of clients failing to attend appointments. When clients refuse therapy, it is essential that staff make efforts to follow up clients and encourage attendance, as symptoms and the fear or avoidance of reminders of the traumatic event will only worsen in the absence of an active intervention, which may require more extensive therapy at a later stage.

Clients with PTSD or post traumatic stress symptoms, including those who

had been seen within a month of experiencing the traumatic event or after this period, appear to be offered a trauma-focused psychological treatment such as trauma-focused CBT or EMDR. The number of intervention sessions offered are in line with NICE recommendations and are completed by the majority of clients.

The findings of this audit therefore show high compliance with NICE guidance on PTSD.

The Project Lead raised some concerns about the guidance itself, which does not mention anything about the use of diagnostic tools that are appropriate for use when determining a diagnosis of PTSD. A subsequent lack of consistency in achieving a diagnosis can result in much subjectivity which could be regarded as problematic. It would have been useful to have included advice on this within the current NICE guidelines. However, use of ICD-10 or DSM-IV criteria to systematically evaluate symptoms is regarded as good practice, although professional judgment can and should impact upon this. It should also be routine for the professional to measure the severity of the disorder so as to choose an appropriate treatment path for the client – the Impact of Event Scale-Revised (IES-R) for adults and the Children's Impact of Events Scale (IES) for children are useful for this purpose. However, there are some concerns that the IES is not being used throughout CAMH services for evaluating the severity of PTSD in children.

Recommendations

- For CAMH to commend staff on the excellent results achieved in this audit.
- For CAMH to ensure that clients

who fail to attend appointments or withdraw from treatment are followed up and encouraged to return.

- For CAMH services to consider engaging in and submitting further audit / research activity in expanding knowledge on intervention efficacy in children and young people, which is currently an under-researched area.
- For CAD to prepare a poster to share the results of this audit with staff throughout CAMH and to raise awareness of the national guidance on this topic.

Action Plan

- The Project Lead will contact NICE to discuss the possibility of incorporating advice on approved methods for reaching a diagnosis within the current guidelines.
- The benefits of using standardised nosological systems, such as DSM-IV and ICD-10, and details of the IES are to be shared and promoted within CAMH so as to encourage staff to make use of these.

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