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2. To promote debate and commentary on issues relevant to mental health.
3. To publish and bring to awareness developments in mental health service provisions.
4. To promote and support research and service development in all aspects of mental health and psychiatry in the developing world.

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This one day seminar will discuss recent advances in the psychological and pharmacological management of psychiatric disorders. To be held at the Holiday Inn, Hanger Lane Roundabout, Ealing, London. Date: 29th August 2009. Course fee £200+VAT. To reserve a place, call the conference organiser on 0208-9630961 (e-mail:consult@psycholhealth.co.uk).

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This course covers all aspects of child and adolescent psychiatry, including relevant socio-cultural factors in child up-bringing, legislation relevant to child and adolescent psychiatry, and child protection issues will be dealt with. Course date: 19th -20th November, 2009. Course fee, £200.00+VAT. For information, call the conference organiser on 0208-9630961 (e-mail:consult@psycholhealth.co.uk).

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Personality Disorders: A Commentary

Dr Y M Mafullul

The concept of personality disorder originates from the work of Pinel (1), who referred to a group of individuals manifesting the usual signs of insanity, but without the experience of hallucinations or disturbances of consciousness (manie sans delire). Further work on the subject of personality disorders was reflected in the work of Pritchard(2), who viewed personality disorders as morbid perversion of feelings, affections, and active powers (volitional activity), without 'erronous convictions' (delusions), or illusions (hallucinations). Pritchard used the term 'moral insanity' in reference to personality disorders, a concept which remained in clinical use, in British psychiatry, until the 1920s(3). The works of Kraepelin(4) Kretschmer(5) and, Schneider(6) have played major roles in our understanding of the concept of personality disorders, and, in the current classificatory systems on personality disorders (7-8).

The concept of personality disorder will remain of major significance in psychiatric practice for the following reasons:

1-Psychiatric disorder in an individual often appears to extend from the pre-morbid personality. Also, individual subtypes of personality disorder have an increased susceptibility to psychiatric illness. For example persons with anankastic personality disorder are at increased risk of developing obsessive-compulsive disorder. Similarly, the individual with cyclothymic personality will when unwell, most likely develop manic-depressive disorder; and, persons with antisocial, and, schizoid personality disorders are at risk of developing schizophrenia.

2-Differences in individual personality constitution/structures, can exert differences in response to psycho-physiological and immunological stresses.

3-Differences in personality constitution/structures, may, to some degree account for differing propensity to develop diseases such as hypertension, cardiac disease (myocardial infarction), cancer, and, psychiatric disordner (suicide). It is noteworthy that where such relationship is observed or exist, the nature of the causative link is uncertain. Characteristics such as extra-version, may be associated with life-styles, and, activities that influence disease.

4-Personality disordered individuals are important service users, particularly, in the emergency and forensic services. They present different and indeed considerable problems in management than most other psychiatric disorders.

5-Personality disorder co-existing with psychiatric disorder, may complicate, or, impact adversely, therapeutic and prognostic outcomes.

6-Enduring personality changes may follow particularly, severe and/or long-term psychiatric illness.

7-Morbidity and Mortality rates are higher in the personality disordered, than in the general non-psychiatric population.

The past three decades have witnessed significant advances in our understanding of personality disorders. Such understanding has predominantly been in matters of clinical description, diagnosis, and, classification. A consequence of this, is a greater interest in the scientific study of the treatment and management of personality disorders, than was previously the case. Increased scientific study of personality disorders, has led to the improvement of established therapeutic approaches, and, the formulation of novel/alternative therapeutic approaches.

The need to treat persons with personality disorder, is underlined by the awareness that persons with personality disorder do suffer subjective distress (and/or social disability), and may inflict considerable suffering on others. Although various therapeutic approaches have now been formulated in the management of personality disorders, the management of personality disorders remains a major therapeutic challenge to clinicians (9-14). Therapeutic success rates are often poor, and may be limited in degree, and extend. Consequently, novel approaches that advance efforts in relieving personality disordered individuals of their suffering and, the social distress arising thereof, will always be welcome. In this regard, we welcome in this edition of the journal, the paper by Scott and Attwood: Integrative Psychotherapeutic Work: a way forward in the treatment of personality disorders (pg 2 - 1st original paper).

It is worth noting that despite of advances in our understanding of personality disorders, in particular, their treatment, there remain gaps, in our understanding of therapeutic approaches. In this edition of the journal, Scott and Attwood, have presented a comprehensive review on the treatment of personality disorders, which we hope will be of refreshing value to our readers (1st review article). The concept of personality disorders will remain a most challenging and controversial area of psychiatry, and continuing scientific debate and study of the subject, leading to effective therapeutic approaches will remain of fundamental importance.

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ORIGINAL PAPER

Integrative Psychotherapeutic Group Work: a way forward in the treatment of personality disorders

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Abstract

Although the government's policy of comprehensive specialist service provision for people with personality disorder identifies psychological treatments as core, current evidence does not suggest superiority of any single model.

This paper describes a clear framework of integration of psychotherapeutic models to provide a needs-responsive treatment programme conceptually understood to be a mini-therapeutic community.

Preliminary outcome results suggest a trend of clinical and functional improvement and economic benefits. This will need to be replicated and tested with a larger sample to confirm these findings.

Background

Personality disorder (PD) often goes undiagnosed, but morbidity is high, with clinically significant and sustained social problems relating to housing, employment, and offending behaviour and involves access to many agencies of care. There are marked interpersonal difficulties, frequent GP attendances[1], emergencies, and difficult consulting behaviour[2]. There tends to be high use of psychotropic medication[3] and frequently a revolving door syndrome with repeated psychiatric hospitalisations is recorded[4].

Epidemiological studies show prevalence of 4.4% in community samples, higher in the age range 25-44, greater in men than women across categories except Schizotypal PD[5]. In primary care, 24% of attendees are diagnosable with PD, predominantly in Cluster C[6].

The prevalence of diagnosable PD in psychiatric populations show that 59-81% of psychiatric outpatients and that in psychiatric inpatients, 36% of new admissions and 67% of existing inpatients were diagnosable with PD[6].

The Department of Health (DoH) guidance "No Longer a Diagnosis of Exclusion" [7] highlighted the need for specialist PD services. Consequently the DoH funded eleven national pilot projects. A further DoH publication "The Capabilities Framework" [8] advised on staff recruitment, development and retention. More recently PD strategy has become an assessed 'traffic light' criterion for NHS commissioning.

There are a number of studies and publications examining the value of manualised treatments such as Cognitive Behaviour Therapy[9], Dialectic Behaviour Therapy[10], Mentalization-Based Therapy[11, 12] and broader approaches including Therapeutic Community (TC) [13] models amongst others. Although many therapies used in treating personality disorder are necessarily integrative in order to meet the complex psychosocial needs associated with a diagnosis of personality disorder, very little literature exists which captures this[14].

This paper provides a description of a treatment framework which relies on coherent, needs-responsive integration of psychotherapy models used in the Wallingford Group, conceptually a mini-TC[15]. It is supported by preliminary audit results.

Method

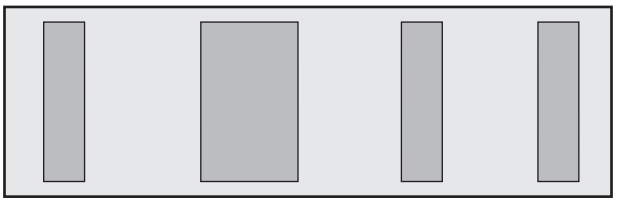
Description of Treatment Programme

The Oxfordshire Complex Needs Service (OCNS) is a specialist, non-residential psychological treatment service for people diagnosable with PD[16, 17]. It covers the largest population of all eleven DoH-funded national pilot projects. It is a multidisciplinary team adhering to The Capabilities Framework and working clinically to promote a recovery model, by facilitating significant functional improvement. Its ethos is one of recovery and is underpinned by the premise that PD is not a lifelong debilitating mental illness, but that with appropriate psychotherapeutic interventions the associated morbidity can be reduced to such an extent, that people can resume a functional and rewarding life.

Referral criteria are broad and self-referral is encouraged. Audit data suggests that self-referrers are more likely to attend assessment appointments. The OCNS uses the Structured Clinical Interview for the DSM-IV Axis II Disorders (SCID-II)[18] as the standard diagnostic tool for the service. There are few **exclusion criteria**, but acute schizophrenia, significant cognitive impairment and forensic history of sexual offences are contra-indications.

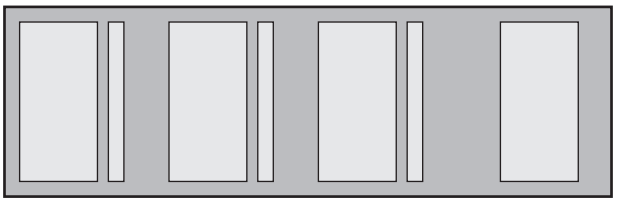
The service is functionally and geographically tiered as a "hub-and-spokes" model which offers stepped care responsive to individual needs, while encouraging active client participation in treatment.

Tier 1:
Assertive Engagement and Options in 'Hub' & 'Spokes'



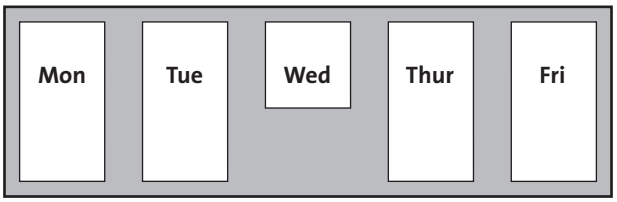
OCNS staff contact clients in a variety of settings. Following assessment clients enter pre-intensive therapy 'Options' group for up to 12 months. It is forum for familiarising clients with group work and exploring issues to work on in intensive therapy.

Tier 2:
Part-time outpatient 'Spokes' in Banbury, Whitney, Wallingford



Intensive outpatient psychotherapy within TC framework using different models of group & individual therapy. The groups meet twice weekly for 18 months with a maximum of 14 per group.

Tier 3:
Day programme in 'Hub' Oxford



Whole time democratic day TC programme[13] using a variety of models of group psychotherapy, social activities and administrative groups. A maximum of 24 clients attend at any one time and the duration of therapy is 18 months. **In tiers 2 & 3 clients support each other out of hours through a telephone support network.**

Tier 4:
Graded disengagement in Moving On group

Two hour group fortnightly, with overlap into last 8 weeks of tiers 2 or 3. Liason with non-statutory agencies to facilitate seamless re-integration into society.

Adapted with permission from R. Haigh PP presentation

It is within this framework that the Wallingford Group was established as a Tier 2 service model and developed to provide an integrative psychotherapy service for PD. It has been running since March 2005 with a catchment population of 92 941 adults of working age.

The structure of the programme demonstrates integrative practice and includes:

• A once weekly 3-hour integrative large group based on democratic TC principles with a maximum of 14 members. It incorporates theoretical and practical aspects of psychodynamic psychotherapy, psychodrama and action methods, sociometry[19], cognitive behavioural therapy (CBT)[20], cognitive analytic therapy (CAT)[21], and biological psychiatry.

• A once weekly 75 minute analytic small group.

• Fortnightly individual sessions employ aspects of mentalization based therapy (MBT)[22] and also addresses administrative tasks of therapy including care program approach (CPA) paperwork, evaluation tools and completion of the SCID-II.

Upon entry each member receives a copy of a Wallingford Group welcome pack which contains practical information about the group structure, safety guidelines and useful contact details.

Establishing a sense of containment for the members is a priority to facilitate disclosure and safety. It is achieved by adhering to clear pathways and processes of entry into, engagement throughout and exit from the group. Throughout, use of a twenty-four hours telephone peer support network encourages a shift away from reliance on professionals during crisis situations while all of these contacts are reported back in the next group.

The group has very clear boundaries around attendance, behaviour and commitment to work. Any breach is discussed in the group and an appropriate management strategy formulated to facilitate the individual s further engagement.

The service holds full clinical responsibility for the group members which allows management of psychiatric emergencies. This psychiatric assessment/treatment is regarded as an out-of-group contact and is fed back in the next group while maintaining therapeutic confidentiality.

Containment is further facilitated by a clear line of continuity of care which begins with a seamless move from the weekly

pre-therapy options group into the Wallingford Group by a democratic vote of the existing members following a presentation by the prospective member outlining difficulties and goals for therapy.

The eighteen month programme is non-negotiable and agreed to on entry.

At sixteen months, members enter the moving on group alongside regular therapeutic activities. It is a fortnightly eight session program completed by a six-month follow-up session prior to discharge from the OCNS. This group is designed to bridge the gap between therapy and social re-integration by:

- Complementing the psychotherapeutic ending process.
- Reinforcing competence, consolidating individual strengths and bolstering self-esteem.

When members are subject to a therapeutic discharge or drop out , their care remains with the OCNS for a further six months and if appropriate at the end of this period, a referral to a CMHT is activated. The facilitators include a psychiatrist, a registered mental nurse (RMN) with community PD experience and a RMN with forensic experience. In addition, two are qualified psychodrama psychotherapists and one is a CAT practitioner. They also have extensive experience in psychodynamic psychotherapy and CBT and have attended training in administering SCID-II. The team itself has weekly supervision for ninety minutes.

The Wallingford Group Therapeutic Process

The entire service is underpinned by an integrative philosophy in which the deliberate multi-model structure of the sessions enhances the learning potential for group members.

In addition to the theoretical and practical integration of psychodynamic psychotherapy, psychodrama and action methods, sociometry, CBT, CAT, and biological psychiatry, an understanding of nidotherapy[23] also promotes personal responsibility in enhancing an individual s environment. This is complemented by psycho-educational components to the integrative large group activities.

This integrative model is a conceptual framework developed by the staff team which incorporates therapeutically beneficial techniques and strategies from existing models indicated for the management of specific needs of group members. It enables staff to plan sessions based on themes observed in the group and usually results in the mapping of difficulties initially on paper using CAT, CBT or sociometric tools; this map is then explored using psychodynamic interpretation and psychodramatic techniques.

It provides a learning environment for both the group members and the staff which is supported by annual staff satisfaction surveys and feedback from students and professionals on placements in the group. Staff develop the ability to moderate self-disclosure and leadership style conferred in part by individual ideological schools, but also personal characteristics such as caring, meaning attribution, executive function and emotional stimulation exercised in the groups. Group supervision supports this process with encouragement to explore issues of transference and counter-transference to improve understanding of group/individual difficulties.

The curative factors of group therapy described by Yalom, are easily visible in the group[24]. These are enhanced by the integrative approach, which is needs-responsive to. In particular, high group cohesion is reflected by the low drop-out rate. This may be a result of tolerance of socially unacceptable feelings through supportive identification and challenge of associated behaviours by peers.

There are potentially significant benefits to integrating various psychotherapy models individually underpinned by different learning theories. Recent studies suggest that no one model of learning theory is superior to another, but that approaches which incorporate a number of models offer a greater possibility of contextualising the individuals learning needs and motivation which can lead to enhanced learning[25].

Bandura's 'social learning theory' is significant as the slow open structure of the group allows the experience of more mature members to facilitate learning for newer members, giving access to the potential benefits of altruism[26].

This model is also active for the audience in psychodramatic enactments. The audience is able to experience both observational insight and catharsis as part of a self-directing process[25].

More mature members are encouraged to take an active part in facilitating the integrative large groups so that individual members familiar with particular therapeutic models have co-facilitated groups with staff. This is demonstrated by the example of a member who, in her fifteenth month of therapy, expressed an understanding of the CAT formulation of a thought diary[27] and was able to explain it with such clarity, that she was invited to share this with the group in a formalised manner. She produced a written handout and showed peers how to complete the paper diary using personal examples while encouraging others to explore their own examples with her. The other members both objectively and subjectively appeared to grasp the ideas much faster, even those who had habitual difficulties with cognitive tasks in the group. This raised interesting questions about the possible impact of language, peer identification, and engagement style on learning in a therapeutic environment. Perhaps, more importantly, it supports the growing realisation that service-user involvement is vital in appropriate service delivery across healthcare.

Psychodynamic and group analytic elements of the program help members to develop self-reflection and gain understanding of psychological factors underpinning their problems. Implicit in this approach is the possibility of inter- and intra-personal learning in the context of understanding their families of origin.

These are exemplified by psychodramatic enactment which allows individuals to un-learn in action what they have learned in action during formative stages of life[19].

This concept is supported by Vygotsky's activity theory of learning which explains cognitive development in the context of action and interaction with others. It suggests that internalised representations of external interpersonal experiences are intrinsic aspects of personality development and that this process is largely unavailable to conscious reflection[28].

Psychodramatic enactment can 'show' this process, making it available for conscious appraisal and can also allow members to test out new intellectual insights. This experimentation with change may be considered within a framework of behaviourism so that aspects of complexes of self-damaging behaviour can be identified, separated out using CBT/CAT tools and changes to these enacted in various ways to reduce the potential for actual self-damage. This is exemplified by a relatively new member, who has particularly marked borderline and dissocial personality traits and frequently agrees to go out drinking with friends who encourage him to become intoxicated. It inevitably results in aggressive, unlawful behaviour subsequent arrest and detention in police cells where he feels contained and 'safe'. A CBT thought record enabled him to identify an alternative strategy to manage his difficult emotions.

Situation	Mood/Feeling	Automatic Thoughts	Balanced Thoughts/Reponses
I just got home from work. My friends called me to go for a drink, promising that they would take care of me.	Frightened	I can t be alone because I ll be forced to think about terrible things. I can t cope with my thoughts or feelings.	I don t have to be alone. I don t have to go out for a drink to get support. I can talk to a group member about my feelings so that they don t overwhelm me.

(Adapted from Padesky)[20]

He 'practised' using peer telephone support in the session and later reported that the use of this exit outside the group resulted in similar feelings of containment and safety as being in a police cell, but eliminated the guilt associated with his self-harming and unlawful behaviour.

Certain psychodramatic techniques like doubling and role reversal are specifically employed to develop empathy, often lacking in interpersonal relations in PD. The technique of doubling involves another member of the group standing beside the protagonist (the individual who is enacting a scene) and usually acts out some aspect, thoughts or emotions implicit in the situation and obvious to the auxiliary, but not available to the protagonist for conscious appraisal. It is a powerful method of depicting the nature of internal conflict. There appears to be a tendency for thoughts and/or emotions to become polarised so that people are good or bad, right or wrong, etc. This opens up the potential for generating significant blind-spots in appraising external situations and the consequent internal anxiety of the protagonist for e.g. a good child does not feel anger towards his/her parents.

Given this understanding, doubling can also free the protagonist from internal restrictions maintained by the super-ego and to some extent by cultural constructs. Therefore the double can rage safely when "anger is destructive"[29].

Role reversal [19, 29] is a particularly useful tool in exploring role conflicts, and exploring reciprocal roles that are habitually, but unhelpfully employed. It allows the protagonist to "see" him-/herself through the eyes of an-other as though in a mirror and this can lead to greater self-knowledge through a conscious experience of both roles in a reciprocal role complex for example someone who is feeling bullied can then experience the role of the bully.

Many people diagnosable with PD have a tendency to act and react in an unspontaneous, habitual and predictable manner particularly in situations that feel somehow unsafe and when emotions are unmanageable[19].

This style of coping can embody many different strategies, but once the habitual reaction is engaged, the individual or dyad becomes stuck in a predictable pattern of interaction. Role reversal becomes an invaluable tool in getting 'unstuck' in these situations[29].

The mirror technique helps to concretise transferential relationships, allowing an observation of the self engaging in the original relationship which has resulted in the current transferential difficulties. This enables the individual to focus on authentic here-and-now interpersonal interactions in the group shifting away from transferential interactions[19].

A group member with significant narcissistic, passive-aggressive and borderline traits had become stuck in a transferential dynamic with a conductor in the analytic small group. This led to the group becoming stuck and she therefore agreed to explore the situation in the integrative group. She commenced with a thought record.

Situation	Mood/Feeling	Automatic Thoughts	Balanced Thoughts/Reponses
Previous analytic small group. I told the group that I had felt pleased that I had been able to express my feelings of sadness in the last large group. Nobody acknowledged this and L (conductor) asked me what made it difficult to talk about my feelings generally.	Hurt Angry	I m never heard. Nobody understands me, so it s better to just be quiet. If they don t acknowledge me, I m not good enough. I ll never get what I want. It s always been like this with my mother.	People were silent because they were listening to me. The question was related to having been heard and understood. If I don't clearly state my needs they may not be met.

(Adapted from Padesky)[20]

Initially during the enactment she was unable to take the role of the conductor. A double suggested that it was difficult because the conductor reminded her of her mother. As the transferential block had been resolved, she was able to take the role and through role reversal with the conductor , recognised that she had been heard. In the mirror position she was able to see that she had not communicated her needs clearly. When she resumed her own role in the scene, she was able to ask for feedback clearly and to receive the support she needed.

The greater capacity for responsiveness conferred by this group to individual and/or group needs is specifically related to the skilled,coherent and spontaneous employment of different models. Using a flexible approach to integration allows responsive adaptations to the models[30].

This point is best illustrated with further examples of how the therapeutic models/approaches are combined.

The OCNS has piloted a collaborative use of SCID-II in the group setting[31]. Scoring is explained to members and done in session by the group facilitators. Examples are preferably drawn from interactions observed/experienced in the group and supplemented by information from the historical narrative and/or medical notes.

Intrinsic to this process, is the exploration of what personality and PD means to individuals and the group. A psycho-educational approach with discussion around developmental and aetiological aspects helps to destigmatise PD. Personal responsibility is emphasised as essential in the recovery model as it encourages active participation in the learning process.

The trait statements from the SCID-II[18] are explored psychodramatically. It encourages experimentation with using different, more appropriate responses to difficult thoughts and emotions rather than habitual, problematic responses associated with PD. There appears to be more openness to tolerating potentially socially 'unacceptable' thoughts and emotions through supportive identification and challenge of the associated problematic behaviours. Group members choose one/more single trait statement cards with which they most identify. A psychodramatic 'connections' exercise allows members to identify with each other. Individuals 'call' their statement stepping into the circle and inviting others who also identify with it into the circle. A brief discussion about the shared experience usually follows and after a few statements, there appears to be a greater willingness to disclose and share more difficult traits. This is followed by an opportunity to explore a specific trait in more depth looking at its origins and identifying and practising helpful changes.

Enabling groups to work directly with group dynamics is difficult, particularly when there is an active process of scapegoating. For this reason, the construction of a sociometric role analysis diagram within the group is valuable. It allows individuals to identify (on paper) the roles they and others use in their interactions in the group. This diagram can help group members to reflect on unhelpful transferential enactments, leading to insight into their capacity to enact both 'poles' of a role complex for example the capacity to bully and be bullied not unlike the reciprocal role procedure theory from CAT[27]. It is the authors' experience that the process aids honesty and provides material for further exploration in analytic groups. It can also be explored by psychodramatic representations of action sociograms of individuals within the group or of the group as a whole. This often highlights sociometric constructs such as stars, isolates, pairs, etc. in the group and can give an indication of the level of group cohesion. An individual who is chosen by more people than can be expected by mere chance is termed a star. One who does not choose, is not chosen at all, or chooses an absent person is called an isolate. Very few choices; less than can be expected to result from chance, is known as a neglectee. If an individual s choices are more frequently reciprocated i.e. pairs, it can be an indication of good attachment/integration in the group[32].

Sociometry is not the only means of analysing roles in the group. CAT reciprocal roles are explored by mapping them on paper initially, with members helping each other to construct them[27]. This exercise allows greater group-insight into individuals patterns of interacting so that these can be recognised with relative ease and highlighted at crucial times to help individuals' move away from unhelpful role enactments.

These reciprocal roles can be explored in action allowing individuals to experiment with change. An example of this was a member who identified a bullying and bullied reciprocal role procedure when attending hospital appointments with a male surgeon. She practiced explaining her difficulties to him assertively rather than aggressively and reported later that for the first time, she had experienced her needs being met in a consultation!

Having an awareness of these repeating patterns of role enactments can empower the individual and the group to devise strategies of managing the feelings in less damaging ways. An example of this was when a particular member habitually responded to feeling got at in the group by verbally attacking others. This was explored in terms of reciprocal roles and a contract was proposed to enable the group to challenge this role and for her to consequently stop and think and modify this role enactment.

Often individuals have difficulty identifying feelings and responding to them authentically because of inhibiting experiences earlier in life.

A particular difficulty arises with anger. Within the Wallingford Group, there is an anger module which is an abridged version of a traditional CBT module[14]. It incorporates identifying feelings, associated physiology, and constructing anger cycles with individual members using charts and diaries and employing educational elements. These are then explored using psychodramatic action to enhance action insight. Members then have the option to take material back to analytic groups to gain further insights.

These examples show how the integrative model can facilitate a more intense process of psychological and emotional learning. The options are unlimited, and can be viewed as a function of the spontaneity of the group and facilitators. What is paramount is that facilitators are grounded by sound theoretical orientations and extensive clinical experience. This is required to engender a sense of safety and trust in each other and group members.

Outcome Measures

The OCNS utilises a number of evaluation tools including the global assessment of functioning (GAF), clinical outcomes in routine evaluations (CORE) and minimum dataset (MDS) which comprise the following elements:

- Standardised Assessment of Personality - Abbreviated Scale (SAPAS)[33]
- Service Utilisation Questionnaire
- Social Functioning Questionnaire [34]
- Self harm Inventory
- Drug and Alcohol Inventory
- Five-item Mental Health Screening Test [35]
- Client Satisfaction Questionnaire-8 and Service Satisfaction Scale 30 [36]

These measures are used on entry into the options group, on entry into and exit from the Wallingford Group and at six-month follow-up. Ethical approval for data collection was obtained during the DoH pilot phase and consent is obtained from individuals at assessment.

Results

The results only reflect data from 7 planned exits from therapy for the period 03/05 to 03/07 and also include a cost savings analysis. Data was analysed using paired t-tests and results reflect two-tailed p-values.

Table 1: Data for period 03/05 03/07

Entry into therapy	**18**
PD diagnosis using SCID	**All > 2 diagnostic categories**
Drop-outs	**1 at 2 months**
Therapeutic discharges	**1**
Planned exits	**7**

The group has a slow open structure which means that there is some flux as members leave and new members join. The 7 planned exits therefore do not reflect a 55% success rate. For the stated period there was retention of 89%. The member who left the programme prematurely returned to GP-only care while the member discharged for therapeutic reasons returned to the options group and eventually re-entered the Wallingford Group.

Table 2: Core Scores in 4 Domains

		Well-being	Psychiatric symptoms	Functioning	Risk	All Items
Prior to entry	Mean	12.17	31	28.33	4.50	76.00
into therapy	SD	3.60	9.70	10.35	4.04	23.71
at exit	Mean	4.50	15.56	7.50	0.17	27.83
from therapy	SD	3.56	9.09	4.76	0.41	16.76
p-value		0.0137	0.018	0.0042	0.0519	0.0035
t		3.7213	3.4537	4.9620	2.5398	5.1971

The improvements across the domains of well-being, symptoms, functioning and all domains are statistically significant while the p-value for risk falls just outside of the significant range. The apparent reduction in risk to self is supported by MDS data reflecting a reduction in acts of self harm.

Table 3: MDS Data (self-report)

	Annual prior to entry into therapy	Annual after exit from therapy	Percentage reduction
Suicide attempts	3	0	100%
Acts of Self Harm	82	10	88%
Client Satisfaction Scores	10	21	52% improvement

Table 4: Service Utilisation

	Annual prior to entry into therapy	Annual after exit from therapy	Percentage reduction	Statistical Analysis
GP attendance (self report)	100	30	70%	p-value 0.4582
A & E attendance (self report)	4	0	100%	numbers too small for statistical analysis
CMHT, Crisis & Day attendance (hospital records)	305	59	81%	p-value 0.0170 t 3.2735 df 6
Psychiatric admissions (hospital records)	139	4	97%	p-value 0.2363

Only the reduction in utilisation of CMHT, crisis services and psychiatric day hospital is statistically significant. Sample sizes of the other groups are generally too small i.e. A&E and psychiatric admissions represents just two individuals in the sample to show statistical significance.

Table 5: Annual Cost Savings for Seven Planned Exits

	Annual prior to entry into therapy	Annual after exit from therapy	Percentage reduction	Calculation based on PSSRU	Annual cost saving
GP attendance	100	30	70%	£55.40 x 70.00	£4,000
A & E attendance	4	0	100%	£77 per attendance	£300
CMHT, Crisis & Day attendance	305	59	81%	£135 per contact	£33,200
Psychiatric admissions	139	4	97%	£195 per day	£26,300
Psychological medications	£3200	£500	84%	BNF Prices	£2,700
Total annual cost saving					£66,500

This represents an annual saving of £9,500 per person. Given the duration and capacity of the group, it is expected that 10 clients will complete the programme annually. This represents an annual cost saving of £95,000 which is a recurring year-on-year saving.

The annual capacity of the service is 30 active engagements across the four tiers, but the savings illustrated do not reflect the expected savings from Tier I engagement/attendance.

The annual cost of providing this service is £65,000. This includes a pro-rata calculation of staff salaries, accommodation, and supervision and trust overheads across all four tiers of the OCNS. The annual anticipated cost-offset is therefore £30,000 with an expected cost-offset of £150,000 in five years.

The authors suggest that the annual cost of providing this as a stand-alone Tier II service could be substantially lower, and while undoubtedly it would benefit patients with complex emotional and psychological needs diagnosable with PD, its long-term sustainability would need to be tested[33, 34].

Discussion

It is likely that due to the small sample size the results do not appear to demonstrate convincing statistical significance, although a clear trend of improvement is evident across the CORE domains, service utilisation and client satisfaction scores(evident from as early as six months in certain individuals). An appropriately powered prospective study is needed to confirm the effectiveness of the treatment programme which the service is currently underway in setting up. Interestingly Duggan et al (2007) suggest that CORE-OM is a suitable standardised outcome measure in PD treatment studies and that effective treatment should also demonstrate concomitant cost effectiveness.

These various outcomes appear to be inter-related, serving to reinforce each other in a 'virtuous circle'.

Social and interpersonal functioning improvement is supported by improvements in family and social relationships outside the group, and objective changes in behaviour and social interaction in the group itself. These changes are also demonstrated by reductions in contact with other statutory and non-statutory agencies: the unhelpful patterns of help-seeking behaviour are reduced or eliminated.

We recognise that, in addition to the economic benefit, there is a potential physical benefit from reduction in the amount of psychological medication prescribed, which may be directly linked to reductions in physical side effects and also to negative effects of overdose in this client group. There is also objective improvement in the experience and expression of physically painful conditions which leads to less use of pharmacological analgesia. The management of medication reduction occurs in set medication groups where members collaboratively construct reduction plans. Improvement in physical health as a result of lifestyle changes such as improved nutrition and exercise is also noted.
Verbal and written feedback from these members describes the significant qualitative changes in their lives following their attendance of the Wallingford Group. These include statements about physical health, reliance on medication and alcohol, reduction of self-harming acts and behaviour, increased independence and improved inter-personal relationships outside the group.

Some reflections include:

- *"I hadn t realised how far I ve come until seeing some of my old ways in newer members"*
- *"I can identify my feelings now and respond to them much better"*
- *"The group has helped me make many positive changes in my life"*
- *"I never believed I could survive without benzo's"*
- *"I can talk more easily to my brother about our childhood and feel less angry at my parents"*
- *"I am now able to live independently I don t need my son to be my carer"*
- *"I can use a bus for the first time in years"*
- *"Since arriving here I have enjoyed the experience and empowerment and mutual support offered by all of the members and the staff and I hope to continue to grow and learn and cope with my labile mood, and all the ups and downs in life and my various problems."*
- *"I have witnessed emotional struggle, anger, support and laughter; all of which are so important to making a difference."*

Perhaps the most important evidence of success is the feedback given by group members reflecting the qualitative improvements in their lives.

Conclusions

The authors have highlighted some of the difficulties in employing an integrative model, given that there is no standardised definition or protocol which describes the process with any rigour. It is therefore not possible to draw comparisons with other integrative approaches. Future research into long-term effectiveness is needed, and the service is committed to this.

The authors have also highlighted the therapeutic value of employing this integrative approach, which is a logically coherent response to clients presenting such an array of complex needs. These benefits are relevant both to individuals, their family and friends, and their wider social communities.

The work also clearly demonstrates the potential for significant economic benefit. The economic implications are important in the current climate of financial shortfalls, but they are not and should not be the only driving factors in any service delivery in healthcare.

The authors believe that an integrative approach such as this is potentially generalisable across mental health care settings, but the extent to which it is replicable with different constituted staff teams, and in non-specialist services, deserves further investigation.

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Declaration of Interest
None.

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ORIGINAL PAPER

Problems and Carer Strain amongst Outpatients Clinic Attendees on Cholinesterase Inhibitors: A two-year longitudinal observational study

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Abstract

In the earlier stages of dementia sufferers live independently but gradually rely increasingly on loved ones or formal carers for support as the illness progresses. This two year longitudinal study looks at the impact of cholinesterase inhibitors on patients and their carers.

The Problems Checklist and Carer Strain, the Minimental State Examination (MMSE) and a proforma were used to assess all patients on cholinesterase inhibitors who attended a memory clinic over a six-month period and repeated the assessments, two years later.

102 patients were initially assessed and at follow-up two years later, 58 (56.8%) of these patients were still on acetyl cholinesterase inhibitors. There were significantly higher initial Problem Checklist and Carer Strain scores in those patients who were no longer on acetyl cholinesterase inhibitors compared to those who were still on treatment.

Greater severity of problems and carer strain along with lower cognitive scores were associated with shorter duration of cholinesterase inhibitors being prescribed possibly due to poorer response and prognosis.

Key words: Alzheimer's dementia, carer distress.

Introduction

Studies revealed that caregivers of cognitively impaired patients have increased physical and psychological morbidity and use a relatively high proportion of healthcare resources (Schulz et al. 1995). There is high level of burden and mental distress in spouse carers for people with Alzheimer's disease and suggested avenues for the primary and secondary prevention of burden include addressing clinical issues (e.g. behavioural disturbance); public attitudes and education (e.g. negative social reactions); economic support for carers (e.g. financial dissatisfaction); and higher risk groups (e.g. younger spouse carers) (Schneider et al. 1999)

Outpatients' clinics for the prescribing of cholinesterase inhibitors may help to address some of the issues leading to carer distress through drug treatment, education of patients and their carers as well as linking patients to the social care support available when required. Cholinesterase inhibitors like Donepezil have significant efficacy in the treatment of neuropsychiatric symptoms in patients with mild to moderate AD (Holmes et al. 2004) and this can lead to a reduction in caregiver burden.

This is a longitudinal observational study of patients attending an outpatients dementia drug treatment and monitoring service looking at patients' problems and carer strain. It involved patients living at home who had informal care from spouses, other relatives or friends irrespective of their living situation. The aims were:

1. To see what impact outpatients' prescribing of cholinesterase inhibitors has on the problems of patients with Alzheimer's Dementia and Carers Strain.
2. To compare the outcome of outpatients' prescribing of cholinesterase inhibitors two years later.

Method

All patients who have informal carers attending an Alzheimer dementia treatment and prescribing service were assessed over a period of six months using a proforma to obtain sociedemographic details, the Mini-Mental State Examination (MMSE) (Folstein et al. 1975) and the Problem Checklist and Strain Scale (Gilleard 1984). Those patients who were initially assessed and were still on cholinesterase inhibitors were reassessed two years later using the same assessment tools. Local ethics committee approval and informed consent of patients were obtained and all approached agreed to participate.

Instruments used in study

1. The Mini-Mental State Examination (MMSE) was developed to aid in the assessment of cognitive impairment [Folstein et al. 1975]. It is easy to administer with scores ranging from 0 to 30. MMSE scores with scores < 26 suggestive of possible dementia.
2. The Problem Checklist and Strain Scale was developed from the 'Edinburgh Research studies' and 'Machin's scale' (Gilleard 1984). The Problem Checklist consists of 34 items with each item rated 0 – none, 1 – occasionally occurring and 2 – frequently/continually occurring. It was developed from carers of day hospital attendees who were asked to identify problems they were currently facing. Examples of items rated include 'Unable to dress without help', 'Demands attention' and 'Unable to get in and out of chair without help'. The strain scale consists of 13 items with rated 5 - most of the time, 4 – sometimes and 3 – never. It includes such items as 'Do you fear accidents concerning the elderly person?' 'Do you ever feel embarrassed by the elderly person in any way?' and 'Is your sleep ever interrupted by the elderly person?'

After obtaining approval from the East and North Hertfordshire Hospitals Local Research Ethics Committee, over a six months period all patients attending the cholinesterase inhibitors prescribing clinic, at Lister Hospital based in Stevenage were approached to participate. Those patients who had an informal carer who monitored and / or administered medication where recruited into the study. The Alzheimer's Dementia Treatment and Prescribing Service covers North Hertfordshire which has a catchment population of about 28,000 people, aged over 65 years. It is run in outpatients' clinics staffed by two consultant psychiatrists, an associate specialist and a dementia care specialists nurse.

Statistics The Statistical Package for Social Services version 12 (SPSS) was used to carry out statistical analysis such as analysis of variance, paired and unpaired t tests and chi-squared tests with level of significant set at $p < 0.05$.

Results

102 patients were assessed of whom 73 were females and 29 males. 57 were married, 38 widowed, 5 divorced and 2 were single. 59 (56.7%) lived with their carer and 43 (41.3%) lived alone. 70 (67.3%) patients were prescribed Donepezil, 22 patients were Galantamine and 10 were on Rivastigmine. At initial assessment the mean age of patients were 80.3 (S.D 6.7) years and carers was 64.2 (SD 13.3) years. The mean initial mini-mental state examination score was 21.1 (SD 4.4).

At follow-up, 11 (10.8%) were deceased, 25 (24.5%) were now placed in residential / nursing homes and 59 (56.7%) living at home and 4 (3.9%) living in sheltered accommodation. At the time of initial assessment, all patients had been living at home either alone or with relatives.

58 (56.8%) patients were still on cholinesterase inhibitors in the follow-up study, and 41 (40.2%) had stopped taking medication due to death, side effects or ceasing to benefit (3 patients had moved out of the area). At follow-up, 44 (43.1%) patients were prescribed Donepezil, 10 (9.8%) patients were prescribed Galantamine and 4 (3.9%) compared to 70 patients on Donepezil, 22 patients on Galantamine and 10 patients on Rivastigmine at the onset of the study. Comparing initial and follow-up assessments, the minimental state examination and problem checklist were significantly lower and higher respectively on follow-up (Table 1).

Comparing those patients, who lived with their carers and those who did not, revealed both carers and patients who lived with each other were significantly older than those who did not. Patients who lived alone had significantly higher minimental state examination scores than those who lived with carers, but no significant differences in problem checklist scores and carer strain at both onset and follow-up (Table 2).

The initial mean Problem Checklist and Carer Strain scores in those patients who were no longer on acetyl cholinesterase inhibitors at the time of follow-up were significantly higher than those who were still on treatment (Table 3). In terms of individual items on the Problem Checklist at the time of initial assessment, using chi-squared tests, there was a greater proportion amongst patients who had stopped treatment at follow-up compared to in those patients who were still on cholinesterase inhibitors who had problems in the following areas:

1. Physical aggression. (27.3% v 6.9%)
2. Temper outbursts (50% v 29.3%).
3. Rude to visitors (9.1% v 0%).
4. Cannot be left alone for an hour (34.1% v 15.5%).
5. Unable to hold a sensible conversation (61.4% v 25.9%).
6. Show no concern for personal hygiene (22.7% v 6.9%).
7. Unable to take part in a family conversation (44.6% v 36.2%).
8. Show no interest in news about the family and friends(38.6% v 17.2%).
9. Unable to occupy himself/herself doing useful things (59.1 % v 38%).

In the case of items on the Carer Strain scale at initial assessment, it was only in the 'demand for attention', that there was a greater proportion of carers of patients (47.7%) who had stopped cholinesterase inhibitors at the time of follow-up compared to in those carers of patients (25.8%) who were still on cholinesterase inhibitors at the time of follow-up using chi-squared test analysis.

Table 1: Comparing initial and follow-up assessment scores in patients who remained on cholinesterase inhibitors at the time of follow-up two years later (paired t test)

	Initial assessment	Follow-up assessment	P
Minimental State Examination	21.6 (SD 4.3)	17.5 (6)	< 0.001*
Problem Checklist Score	10.9 (8.1)	16.4 (12.0)	< 0.001*
Carer Strain Score	44.9 (4.3)	45.3 (5.3)	0.53 (N.S)

Key: N.S – Not Significant. * - P < 0.05

Table 2: Comparing patients who lived at home alone with those who lived with their carers using unpaired t test

	Living with informal carers	Living alone	P
No of patients at onset of study	59	43	
No of patients at follow-up two years later	33	22	
Mean Patients age	79.1 (6.6)	81.9 (6.6)	0.04*
Mean Carers age	71.8 (9.6)	53.8 (10.5)	< 0.001*
Mean Initial MMSE scores	20.3 (SD 4.4)	22.2 (SD 4.2)	0.037*
Mean Follow-up MMSE scores	15.3 (SD 7.1)	20.2 (SD 3.8)	< 0.01*
Mean Initial Total problem checklist score	14.9 (SD 11.1)	12.5 (SD 9.7)	0.25 (N.S)
Mean Initial Carer strain score	46.2 (SD 4.9)	45.4 (SD 5.0)	0.42 (N.S)
Mean Follow-up Total problem checklist score	17.9 (SD 12.7)	14.1 (SD 10.7)	0.25 (NS)
Mean Follow-up Carer strain score	46.1 (SD 5.6)	44.1 (SD 4.5)	0.17 (N.S)

Key: N.S – Not Significant. * - P < 0.05

Table 3: Comparing initial assessment scores (standard deviation) in patients (61) still on treatment with cholinesterase inhibitors and those who have stopped (41) at follow-up (unpaired t test)

Assessment scales	Patients who are still on treatment	Patients who have stopped treatment	P
Mean MMSE scores at onset of study	21.5 (4.3)	17.9 (6.3)	< 0.01
Initial Mean Problem checklist score	10.6 (8)	18.7 (11.9)	< 0.0001*
Initial Mean Carer Strain score	44.9(4.3)	47.4 (5.6)	0.011*

Key: N.S – Not Significant. * - P < 0.05

Discussion

Opinions of patients, relatives and general practitioners have been positive towards outpatients care for dementia patients involving memory clinics on the usefulness of assessments and provision of information. In a systematic review of cholinesterase inhibitors in dementia, Birks (2006) found there was evidence of benefits of treatment seen on measures of cognition, activities of daily living and behaviour. As a result combination of support, education and drug treatment of Alzheimer's dementia this may lead to less caregiver burden or strain.

In this study, 102 patients who were on treatment at the onset, 58 (56.8%) patients were still on cholinesterase inhibitors at follow-up two years later, 11 (10.8%) had died and 41 (40.2%) had stopped taking medication due to side effects or ceasing to benefit. Of the 41 patients who had ceased to benefit, 25 were now placed in residential / nursing homes. The latter is lower than the observed admission rate for those not on treatment reported by Knopman et al. (1988) where after two years 35% of patients with mild dementia had been placed in nursing homes and 62% of more advanced cases. In comparison to two similar studies by Lopez et al (2002) and Larner (2007) covering between two and three years follow-up, patients in this study were older (80.3 yrs compared to 72.7 years and 63.9 years respectively). This may explain why in comparison more patients ended up in permanent residential or nursing home placements (24.5% compared to 8.2% and 5.9%).

In those patients still on cholinesterase inhibitors, their cognition and problems experienced by their carers had worsened, however there was no significant difference in carer strain. As Alzheimer's dementia gets progressively worse despite the use of cholinesterase inhibitors the worsening of behaviour problems and cognition is an expected outcome albeit at a slower rate than in those not on treatment. In this study, we did not have a control group of patients who were not on cholinesterase inhibitors to compare with. The stability in carer strain could be explained by the continued support and health education on what to expect and how to manage problems received through the clinic as well benefits of cholinesterase inhibitor therapy. Ulstein et al. (2007) found that psychosocial interventions led to carer burden worsening significantly less than in those patients than in the control group.

Patients' living alone had higher MMSE scores at onset and follow-up though their problems and carer strain were not significantly different compared with those who lived with their carers. The patients living alone were older and the carers who lived with patients were older than those who did not. The difference in ages amongst carers was a reflection of their relationships in which spouses tended live with patients and whereas those living alone where cared for mainly by their children.

Patients who had stopped cholinesterase inhibitors two years later had poorer cognition, greater severity of problems and carer strain at the time of initial assessments. There were 9 problem areas, which were more frequent in those who had stopped treatment and included poorer communication skills and greater aggression. At the onset, carers had also found the demand for attention greater amongst those patients who had stopped treatment. These findings suggest poorer cognition and greater severity of problems could lead to poorer outcome or response to cholinesterase inhibitors.

Conclusions

Greater frequency and severity of behaviour problems along with poorer cognition were associated with poorer response and prognosis in the prescribing of cholinesterase inhibitors in this study. As there was no control group, the study is limited in the scope of its conclusions but does point to an area of study still needing further investigation, which is identifying the positive and negative prognostic factors when prescribing cholinesterase inhibitors. This may help in better informing health care professionals, patients with Alzheimer's dementia and their carers of the expected response if these finding are further corroborated in other studies.

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Treatment of Personality Disorder: A Review

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Abstract

In recent years evidence for the treatability of personality disorder has increased significantly. Numerous psychological and pharmacological interventions have been researched but because of the inherent complexity of personality disorder and the lack of standardised practice in research in the field amongst other problems, the evidence is difficult to interpret. None the less there is evidence of some treatment efficacy for a variety of psychological interventions. The evidence also suggests that pharmacological interventions have some positive treatment effects on the symptoms of personality disorder. In both cases the evidence is not sufficiently robust to make definitive recommendation on what it best for whom at present and there is therefore an urgent need for more high quality research within a more coherent standardised system.

Current expert opinion supports the use of complex psychological interventions as the mainstay of treatment while pharmacological interventions are viewed as an adjunct. This is reflected in the recent draft guidelines for borderline personality disorder from the National Institute for Clinical Excellence.

Background

Personality disorder (PD) has long been a controversial diagnosis and opinions regarding treatment have also been divided. Appleby and Lewis in 1988 "...suggest that the clinical diagnosis of personality disorder has no justification and should be abandoned".[1] In 2003 however, this notion was firmly dispelled by the government white paper "No Longer a Diagnosis of Exclusion" [2] which recognised the need for specialist services for PD in the context of inadequate existing service provision, high service utilisation [3,4,5] and changing mental health legislation.

Consequently there has been increasing clinical interest in PD treatment as the evidence base for its 'treatability' is growing with a wide variety of interventions demonstrating efficacy.[6,7]

It is generally thought that psychotherapy is the mainstay of treatment while pharmacological interventions are only an adjunct to effective treatment for PD.[8,9]

This article provides an overview of current treatment options and their evidence base.

The Evidence

Because a diagnosis of PD implies a complex, multi-layered presentation frequently associated with significant co-morbidity, much of the evidence base for its treatment relies on explanatory studies constituting trials of efficacy as opposed to effectiveness.[10]

Research studies need to be of high quality to inform sound evidence based practice as in all other medical disciplines. Furthermore, it is essential in the process of diverting traditional opinion away from 'un-treatability' towards one which recognises the possibility of recovery and ultimately to encourage acceptance of a 'new' treatment ethos.

The National Service Framework for Mental Health broadly identifies five types of evidence:

(I) at least one good systematic review including at least one randomised controlled trial (RCT)

(II) at least one good RCT

(III) at least one well designed intervention study without randomisation

(IV) at least one well designed observational study

(V) expert opinion from service users and carers.[11]

Although the available literature identifies PD treatments as demonstrating type I evidence, Duggan et al (2007) describe it as "weak" and make a strong case for a more coherent and systematic approach to future research.

Given the systemic impact which PD has, it is vital that a comprehensive review of treatment interventions also reflects the 'expert opinions' of service-users and their' carers.[12,13] The National Institute for Clinical Excellence (NICE) recently published draft guidelines for the treatment of borderline PD (BPD) which devotes a significant consideration to it.[9]

Interpreting the Evidence

There are a number of inherently problematic factors of PD (listed in box 1) which warrant consideration when interpreting the evidence for PD treatment.

Box 1 – Problematic factors in interpreting the evidence

- Ten categories of PD and significant co-morbidity within Axis II
- Relative temporal instability of PD over time
- Vulnerability to and association with Axis I disorders
- Large number of outcome measures with no standard measures
- Defining recovery
- The need for long-term follow-up studies

The fourth edition of the Diagnostic and Statistical Manual (DSM-IV)14 identifies ten categories of PD in Axis II grouped into three clusters as listed in box 2.

Box 2 – Axis II PD Categories

Cluster A	Cluster B	Cluster C
Paranoid	Borderline	Avoidant
Schizoid	Anti-social	Obsessive-Compulsive
Schizotypal	Narcissistic	Dependent
	Histrionic	

Co-morbidity within Axis II is high. A prevalence study of PD by Coid et al (2006) found that, of the participants positively diagnosed with PD, 53.5% met diagnostic criteria for only one specific category, 21.6% for only two, 11.43% for only three and 14% met criteria for between four and eight i.e. 46.5% met diagnostic criteria for two or more categories.[15] Considering individual category prevalence and comparing it to the literature BPD appears to be over represented while others are neglected or entirely ignored.

Table 1 - category prevalence compared to number of RCT's in each category

PD Categories	Coid et al % Prevalence	Torgensen et al % Prevalence	Duggan et al (2007) Sytematic Review - RCT's/PD category included in review
Cluster A	1.6		
Paranoid	0.7	2.4	
Schizoid	0.8	1.7	
Schizotypal	0.06	0.6	
Cluster B	1.2		Mixed Cluster B - 1
Borderline	0.7	0.7	Borderline - 14
Anti-social	0.6	0.7	Anti-social - 2
Narcissistic	0	0.8	
Histrionic	0	2.0	
Cluster C	2.6		Mixed Cluster C - 1
Avoidant	0.8	5.0	Avoidant - 5
Obsessive-Compulsive	1.9	2.2	
Dependent	0.1	1.5	Mixed all categories - 8

Note: Duggan et al (2007) however do not include RCT's related to therapeutic communities representing mixed-PD diagnoses.

According to Bender et al (2001) treatment utilisation by BPD patients significantly exceeds that of other PD, while that of schizotypal PD patients significantly exceeds that of avoidant and obsessive-compulsive PD. [16]The service utilisation measured includes psychological interventions, day and in-patient psychiatric services in addition to psychological medication use. It is important to note that although the numbers are significantly higher for BPD, schizotypal PD service and medication utilization is significant in its own right, highlighting the paucity of literature for Cluster A.

The temporal stability of personality difficulties has been shown to be lower than previously thought. [17]

Zanarini et al (2005) found a remission rate in BPD of 74% in 6 years, with suicidality resolving quickly while other features like chronic feelings of abandonment and anger were slower to improve. [18] The clinical presentation of PD also fluctuates over time and Clark et al (2003) suggest that this is a function of mood fluctuations [19] which leads to the importance of considering the significant co-morbidity with Axis I 14 disorders. [15]

People with a diagnosis of PD have an increased vulnerability to developing in particular anxiety [20], depression [21, 22, 23] and substance abuse/dependence [24]. Bender et al (2001) report a lifetime prevalence approaching 100% of at least one co-morbid mental illness. [16]

Moran (2002) raises the added complication of diagnostic overlap particularly between BPD and post-traumatic stress disorder/ bipolar affective diorder, avoidant PD (AvPD) and social phobia, and antisocial PD (AsPD) and substance misuse disorders. [25]

The interaction between PD expression and Axis I disorders is problematic since any change in one may result in a mutual change in the other. This makes the evaluation of a genuine treatment effect potentially difficult.

These factors imply that complex interventions are necessary in the treatment of PD (Campbell et al 2000) [26] and have to include comprehensive 'multi-axial' assessment. [14]

Current evidence indicates that no single intervention appears to be more effective than another. [7, 27] Livesley's (2007) 'common factor approach' suggests that psychotherapeutic interventions have broadly ***generic*** aims of offering opportunities for new learning to increase self-knowledge and experimentation with alternative behaviours or responses which may be augmented with ***specific*** interventions from different models targeting defined individual problems eg. pharmacological interventions. [6]

This model not only provides a conceptual framework for understanding current evidence, but also allows for the development of a coherent integrative and integrated service model which can capture the complex needs of people with PD.

These generic and specific interventions may have effects both on individuals and their' environments including changes in personality status, symptoms, interpersonal relationships, and service utilisation in health, social services and the criminal justice system. Each of these domains results in a large number of outcome measures being used, making cross study comparisons difficult. [7, 27] Duggan et al (2007) therefore suggest that researchers attempt to use at least some 'standard' outcome measures in trials. [7]

Duggan et al (2007) included 27 studies in their systematic review of PD treatment. Only 14 of these demonstrated statistically significant results and ***all favoured the intervention***. [7] The findings are summarised in table 2 and it is important to note that this review did not include studies of therapeutic communities (TC).

Table 2 – Summary of Duggan et al (2007) systematic review.

6 studies with treatment as usual or waiting list control	8 studies with another active intervention as the control
A meta-analysis of 3 studies for DBT in BPD	CM compared to standard methadone substitution for AsPD and opioid dependency
ER for BPD	DBT compared to community treatment by experts for mixed PD
Psychoanalytically oriented partial hospitalisation (MBT) for BPD	DBT oriented treatment compared to client centred therapy for BPD
Brief adaptive psychotherapy for mixed PD	Schema-focused therapy compared to transference-focused therapy for BPD
Short-term dynamic psychotherapy for mixed PD	Psycho-education +pharmacotherapy compared to unstructured intervention + pharmacotherapy for mixed PD
MACT for mixed PD	Wellness and lifestyle group compared to creative coping group for mixed PD
	Short psychodynamic supportive psychotherapy + anti-depressants compared to anti-depressants alone for mixed PD
	CBT compared to brief dynamic therapy for AvPD

DBT – dialectical behaviour therapy; CM - ; CBT – cognitive behavioural therapy; ER – emotion regulation group intervention; MACT – Manual-assisted cognitive behavioural therapy

This summary demonstrates that numerous interventions are effective and the authors maintain that no definitive conclusion can be made about which intervention is superior. The review clearly supports the view that there is an urgent need for further high quality research to inform evidence-based practice in this field.

It is important that evidence reflects both clinical efficacy and cost-effectiveness and that the treatment effects are maintained over time. [7, 27]

Psychological Treatments

As stated previously, identifying aims of any psychological intervention is important given the inherently complex nature of PD. Livesley (2007) suggested that psychotherapies generally have similar generic aims and that the differences are centred around the predominant focus in each on a particular generic aim. [6] Table 4 lists some of these aims and links them to particular models of psychotherapy.

Table 3 – Summary of aims of interventions used in PD treatment

	Aims of intervention	Single modesl/interventions	Complex interventions
Generic	1. Increase in self-knowledge • *Improved reflective functioning* • *Recognition and appropriate expression of emotions* • *Interpersonal understanding* • *Altering dysfunctional core beliefs* 2. Behavioural change • *Reduction in self-injury* • *Change in patterns of maladaptive behaviour incl. addiction*	*Psychodynamic therapy* *Psychodrama/ creative therapies* *Cognitive analytic therapy* *Cognitive behavioural therapy* *Behaviour therapy*	MBT DBT
Specific	1. Symptom control • *E.g. psychosis* • *Co-morbid mental illness* **Any intervention can be used alongside another to target a specific problem/need as defined above.**	*Pharmacological interventions*	TC

Campbell et al 2000 distinguishes complex interventions (more than one modality delivered by a team of professionals) from single modality interventions. [26] In addition Livesley (2007) widens this to encompass an integrative ethos of a needs-responsive utilization of different models of psychotherapy. The literature is increasingly supporting the use of such complex interventions in the context of an organisational level of treatment planning. [6, 9, 27]

Single Modality Interventions

The models described below have generally been adapted for use in both individual and group treatments.

Psychodynamic

Psychodynamic psychotherapy has a long history of adaptation for use in the treatment of PD and some of these will be described further. A RCT for BPD by Winston et al (1994) showed that both brief adaptive psychotherapy and short-term dynamic psychotherapy were superior to waiting list control on several outcome measures [28], but as with many interventions it lacked follow-up evidence and has not been replicated.

Transference focused psychotherapy (TFP) [29] is a manualised individual psychodynamic psychotherapy which focuses on analysing and interpreting the here and now therapeutic relationship. The main techniques are exploration, confrontation and interpretation so that an integration of good and bad self/other internal representations is the goal of treatment. TFP comprises individual twice weekly 1-hour sessions and Clarkin et al (2007) note that at the beginning of treatment, the client undertakes a contract to be employed or in voluntary work during the therapy. [30]The possible effect of this on the outcome results is not addressed in the RCT comparing TFP, DBT and dynamic supportive treatment (DST) measuring outcome domains including aggression, impulsivity, suicidal behaviour, anxiety, depression, and social adjustment following year-long treatment. All three treatments demonstrated effectiveness broadly, but TFP was superior to DBT and DST across all the outcome measures with TFP and DBT significantly associated with improvement in suicidality. [30]

Although these results are promising, they need to be replicated with a larger sample and long-term follow-up study.

Cognitive

Cognitive analytic therapy (CAT) is a manualised integrative therapy developed for treatment of BPD. [31] It is an adaptation of cognitive behavioural therapy combined with psychodynamic interpretation of the transference in the therapeutic relationship to construct diagrammatic reformulations. The aim is to identify maladaptive patterns of responding to unmanageable feelings and to formulate viable alternatives. It comprises 24 weekly sessions with 4 follow-up sessions over 1 year and has also been adapted for group work. Although some studies suggest positive treatment effects these have not been shown to be statistically significant and further research is required to evaluate its efficacy. [32, 33]

Cognitive behavioural therapy (CBT) for PD is a structured individual treatment which focuses on problem solving using cognitive strategies to alter maladaptive core beliefs and behavioural interventions to reduce maladaptive behaviour. A large RCT for BPD by Davidson et al (2006) [34] demonstrated improvements across a range of outcome measures, but these were not shown to be statistically significant. [7]

A RCT for AvPD comparing CBT, brief dynamic therapy (BDT) and a waiting list control group demonstrated statistically significant improvement compared to BDT on two measures of behaviour post-treatment (6 months). [35]

Systems training for emotional predictability and problem solving (STEPPS) is a group programme 20 weekly 2 hour sessions in addition to one 2 hour session for significant others. It has 3 phases: 1. a psycho-educational group to increase understanding of PD, 2. skills training to increase emotional regulation, and 3. behaviour skills training. A RCT for BPD showed little effect on suicidality, impulsivity and affective symptoms, but demonstrated some improvement in general functioning. [36]

Manual-assisted cognitive behavioural therapy (MACT) is a brief individual therapy for people who repeatedly self-harm. It comprises up to 5 sessions with an optional booster session. [37, 38]

Evans et al (1999) showed in a mixed cluster B RCT that MACT is superior to TAU on mean social functioning questionnaire scores at six months post-treatment. [37] Weinberg et al (2006) showed that MACT is significantly superior to TAU in self-harm frequency and severity and suicidal ideation. [39] Although the efficacy of MACT compared to TAU has not been conclusively demonstrated, it does appear to be cost effective. [40]

Schema focused therapy (SFT) is an ***integrative*** cognitive therapy. [41] Schemas are conceptualised as pervasive patterns of thinking, feeling and behaving. SFT is based on the assumption that within BPD there are four specific schema modes in operation. Therapeutic techniques involve cognitive, emotive, interpersonal and behavioural strategies to facilitate exploration of past life experiences, real life experience outside of the therapy and the therapeutic relationship itself in order that dysfunctional schemas are confronted and challenged. The therapy comprises weekly individual 50-minute sessions and recovery is presumed when dysfunctional schemas no longer predominate.

A 3 year effectiveness RCT comparing TFP and SFT for BPD found that SFT was superior to TFP when measuring retention to the programme and also demonstrated reliable clinical improvement in BPD severity and quality of life. [42]

Generally there is little evidence for the efficacy of single interventions and more robust research is indicated [7, 9] although as has been noted previously, the clinical complexities that a diagnosis of PD inherently presents, prescribes a complex approach.

Complex Interventions

Mentalization based therapy (MBT) is a manualised treatment originally described as a psychoanalytically oriented partial hospitalisation programme for BPD. [43, 44] The original programme (over 5 days for 18-months) comprised once weekly individual psychoanalytic session, thrice weekly 1-hour group analytic session, once weekly 1-hour expressive therapy session using psychodrama, once weekly 1-hour community meeting and a monthly meeting with case administrator and psychiatrist for medication review. Informal 'milieu' contact is also a feature of the programme.

The structure is not dissimilar to the integrative treatment approach of TC's, but lacks amongst other aspects the democratic nature of UK TC's for PD. The postulated mechanism of change is enhanced reflective function 45 but linking it exclusively to the manualised psychoanalytically oriented MBT as the active component in the programme is problematic as many commonly used psychodramatic techniques are employed specifically to develop reflective function. [46, 47]

A RCT compared MBT to the control group receiving standard treatment in general psychiatric services. The results on all outcome measures including service and medication use, global functioning and reduced suicidality are statistically significantly in favour of the MBT programme. The results of

follow-up 5 years after completion of the therapy demonstrate that the MBT group continued to show statistical superiority to the control group. At follow-up, the diagnostic status was that 13% of the MBT group met diagnostic criteria for BPD compared to 87% of the control group. [48] Cost effectiveness has also been established. [49]

Dialectical behaviour therapy (DBT) is a manualised programme developed for repeated parasuicide behaviour and BPD. [50] It is adapted from behaviour and cognitive therapy and is conceptualised as a five-stage model from pre-treatment through achieving behavioural control, emotionally processing the past, and resolving problems in daily life to developing a capacity to experience sustained joy.

The manualised programme comprises a weekly 1 hour individual sessions, a weekly 2-2.5 hour psycho-educational and skills training group in addition to telephone coaching from the therapist out of hours. The duration of the programme is usually 1 year. Most research has been focused on achieving behavioural control. Although numerous studies have indicated positive treatment effects in outcome measures of treatment retention and suicidality compared to treatment as usual (TAU) [50, 51, 52, 53], the long-term maintenance of treatment effect has not been established. Linehan et al (1991) showed that at 6 month follow-up DBT was superior to TAU with respect to reduction in parasuicide behaviour, but no between group difference was demonstrated at 1 year follow-up. A further study by Linehan et al (2006) comparing DBT to community treatment by experts for BPD found no between group difference in parasuicide behaviour and use of crisis services at 1 year follow-up. [54] Furthermore, when combining the data for the treatment year and post-treatment follow-up year, it appeared that the patients in the DBT arm were 50% less likely to attempt suicide than those in the control group, but this difference was not reflected when the post-treatment year data evaluated alone. [45]

Clarkin et al's (2007) RCT comparing TFP, DBT and DST on outcome measures including aggression, impulsivity, suicidal behaviour, anxiety, depression, and social adjustment demonstrated effectiveness in all three treatments, but TFP was superior to DBT and DST across all the outcome measures with TFP and DBT significantly associated with improvement in suicidality.

Linehan et al (1991) and Bohus et al (2000) showed a response rate in DBT of 50% [50, 55] whereas in MBT, 87% of the sample no longer met diagnostic criteria for BPD at follow-up. [48] Another potential difficulty with the evidence of the efficacy of DBT is overwhelmingly female study samples.

A therapeutic community (TC) is defined as 'a consciously designed social environment and programme within a residential or day unit in which the social and group process is harnessed with therapeutic intent. In the therapeutic community the community is the primary instrument'.[56] Programmes generally include a range of psychotherapy models usually delivered in groups including analytic, cognitive, psychodrama, TA, art therapies, social problem solving, psycho-education amongst others and generally TC' s use more than one model. This runs alongside regular community meetings and structured socio-therapy sessions.[56] TC's, like MBT, are essentially integrative models in which the precise mechanisms of change are difficult to ascribe exclusively to any one intervention.

An international systematic review of the effectiveness of TC'c identified 10 RCT's, 32 studies using a control, but no randomisation and a further 10 cross-institutional studies which yielded a meta-analysis of 29 studies with clear outcome criteria and control groups which demonstrates positive treatment outcome for TC's. This provides Type I evidence (NSF for MH; DoH 1999). There is stronger support for concept TC's in the USA for addictions than for democratic TC's for PD in Europe. [57]

Chiesa et al 2006 demonstrated in a controlled study comparing long-term (12 month) in-patient TC (OSP), medium-term (6month) in-patient TC + long-term out-patient twice weekly group psychotherapy (SDP) and TAU that both TC models showed significant improvement in social and global level of functioning, symptom severity and total number of symptoms at 4year follow-up after expected end of therapy, but the SDP showed significantly greater improvement maintenance across most outcome measures. OSP however showed faster rates of improvement and significantly greater rate of employment compared to TAU/SDP. SDP – 60%; OSP – 26%; TAU – 13% PD patients showed significant clinical improvement in at least two of the three outcome measures (GSI, SAS, GAS). In-patient treatment comprises sociotherapy (daily unit meetings, community meetings, structured activities) and formal individual and group psychoanalytic psychotherapy. [58]

Although Tyrer and Bateman (2004) suggest that TC's are not easily generalisable[27], new developments of mini -TC's are likely to make this possible so that complex interventions will be more easily developed by service providers and therefore more readily accessible to clients.[59] Scott and Attwood (2008) indicate that preliminary findings of positive treatment effects of mini-TC's for mixed PD are promising and they also demonstrate cost effectiveness of this 'new' model.[60]

Davies and Campling (2003) describe economic benefits of TC's in the UK as largely due to acute in-patient bed occupancy with statistically significant reduction between 1 year prior to Admission to Francis Dickson Lodge (FDL), Henderson Hospital and Cassel and 3years post admission to FDL and 1year post-admission to Henderson Hospital and Cassel respectively.[61]

NICE guidelines for psychological interventions in BPD

The current draft guidelines for BPD have recently been published and the draft guidelines for AsPD will also be available for consultation later this year.[9]

The development of these guidelines will potentially legitimise PD as a bona fide clinical diagnosis with viable treatment options to guide clinicians in a new or different approach to managing PD. However as has been discussed earlier, the high intra-axial co-morbidity of PD will have to be addressed at assessment to ensure that the 'complex interventions' offered to individuals recognise and respond to co-morbidity appropriately. The guidelines described below provide a comprehensive framework which is potentially flexible and adaptable enough to be generalisable to PD more broadly as conceptualised by Livesley (2007).[6]

The guideline states that when psychological treatment is indicated, it should comprise of therapy in at least two modalities in the context of a well-structured programme adhering to a coherent theory of practice. Brief psychotherapy interventions of less than 3 months duration should not be used specifically for BPD or individual symptoms of the disorder. This does not mean that brief interventions may not be used within the context of a long-term structured programme to target specific problems or symptoms.

Pharmacological Treatments

Prescription should be guided by a clear rationale informed by good evidence. [62, 63] There are a number of components of this clear rationale particularly given that the evidence base for pharmacological interventions is weak at best. [9, 63]

Siever and Davies (1991) suggested a sub-syndromal conceptualisation of PD on a continuum:
mental health → axis II disorders → axis I disorders.[64]
The validity of this approach is challenged by the increased vulnerability that patients with PD have to developing co-morbid mental illness. [16, 25, 65]

However there is some evidence to support a neurotransmitter 'theory' in PD symptomatology with numerous neuromodulators and neurotransmitters implicated corresponding to Axis I disorders. [66, 67, 68]

Soloff (1998) proposed a symptom approach which recognises four symptom domains: cognitive perceptual, affective dysregulation, impulse-behavioural dyscontrol, and anxious-fearful. [69]

Table 4 – Inter-relation of psychobiological theories of PD

PD Category	Sub-syndromal theory linking PD to Axis I	Neurotransmitters implicated in PD symptomatology	Symptom domains in PD
Cluster A	Schizophrenia	Dopamine	Cognitive perceptual
Cluster B	Affective disorders Impulsive/aggressive disorders	Nor-adrenaline Serotonin	Affective dysregulation Impulse-behavioural dyscontrol
Cluster C	Common anxiety and phobic disorders	Adrenaline	Anxious-fearful

Soloff(1998) suggests that the choice of pharmacological agent is determined by the predominance of the symptom domain. [69] In clinical practice however the frequent concurrent expression of symptoms across clusters [15] or symptom domains may result in inappropriate poly-pharmacy. As with psychological interventions there is an overwhelming focus in the literature on BPD while other categories are neglected. [63]

Table 5 - category prevalence compared to number of RCT's in each category

PD Categories % Prevalence (Coid et al)	Duggan et al (2008) Sytematic Review – RCT's/ PD category included in review
Cluster A1.6 Paranoido.7 Schizoido.8 Schizotypalo.06	Schizotypal-1
Cluster B1.2 Borderline 0.7 Anti-social 0.6 Narcissistic 0 Histrionic 0	Mixed Cluster B - 1 Borderline - 25 Anti-social - 3
Cluster A2.6 Avoidant 0.8 Obsessive-Compulsive 1.9 Dependent 0.1	Avoidant - 1 Mixed all categories - 4

Duggan et al (2008) examined a total of 35 RCT's identifying 47 significant outcome comparisons. The average duration of trials was 13.2 weeks although 5 trials were for 6months and 1 lasted for 52 weeks. Only 2 trials had follow-up components: 1 at 6months and 1 at 2 and 15 months.[63]

The summary presented in this paper only reflects the statistically significant outcomes from the systematic review and will follow Duggan et al's presentation within Soloff's symptom domains. [63]

In the **cognitive perceptual domain**, Aripiprazole was superior to placebo for paranoid ideation and psychoticism [70] and Topiramate was superior to placebo for somatization [71].

In the **affective dysregulation (depression) domain**, 1 meta-analysis of 2 RCT's for Aripiprazole [70] and Olanzapine + DBT [72] demonstrated that atypical anti-psychotics were superior to placebo.

There were 13 significant outcome comparisons from 7 RCT's of which 6 showed that anti-psychotics were superior to placebo, 5 showed that antidepressants were superior to placebo and 1 showed that omega fatty acids were superior to placebo. [63]

In the **affective dysregulation (anger) domain**, meta-analysis of 3 RCT's for BPD for Topiramate [73, 74] and Lamotrigine [75] demonstrated that these anticonvulsants were superior to placebo in outcome measures of state anger, trait anger, anger-in, anger-out and anger control. Atypical anti-psychotic Aripiprazole was superior to placebo in an individual RCT for BPD using the same outcome measures. [70]

There were 21 significant outcome comparisons from 8 RCT's for anger in BPD of which 14 demonstrated that anticonvulsants (Topiramate and Lamotrigine) were superior to placebo, 6 showed that anti-psychotics (Aripiprazole) were superior to placebo and 1 found Fluoxetine to be superior to placebo. [63]

In the impulse behavioural dyscontrol domain RCT's for BPD showed 1 significant outcome comparisons for Phenelzine over placebo [76] on hostility, and Nortriptyline was superior to placebo on substance use in AsPD [77].

In the **anxious fearful domain**, meta-analysis of 2 RCT's for BPD showed that the atypical anti-psychotic, Aripiprazole 70 and Olanzipine + DBT [72] were superior to placebo.

Of 9 significant outcome comparisons, 4 from 1 RCT showed that anti-psychotics were superior to placebo, 4 from 2 RC T's showed that anticonvulsants (Divalproex and Topiramate)

were superior to placebo and 1 showed Phenelzine to be superior to Haloperidol 76 . Duggan et al concludes that the evidence is "weak". [63]

There is also no evidence that medication reduces suicidality.[9]

Similar inherent factors to those listed in box 1 are potentially problematic when interpreting the evidence for pharmacological interventions and in addition, the absence of good quality head-to-head trials, the short duration of trials and the lack of follow-up studies need to be addressed by future research. This leads to the conclusion that while there is some evidence to support judicious use of medication for symptom control (possibly only in the context of a co-morbid Axis I diagnosis), more robust research is needed.

NICE guidelines for pharmacological treatment of BPD

Pharmacological treatment should not be used specifically for BPD or individual symptoms of the disorder. Sedatives may be used in the short-term in crises for no longer than 1 week and anti-psychotic medication should not be used for medium- or long-term treatment of BPD. [9]

Conclusion

This review has highlighted that the evidence for the treatability of personality disorder has grown significantly in recent years and that a number of psychological interventions have demonstrated promising positive treatment effects which need to be replicated in high quality RCT's using standardised outcome measures in head-to-head studies. Furthermore, any future research endeavours would be greatly aided by a more unified conceptualisation of the core features of personality disorder, the mechanisms of change and ultimately what constitutes recovery.

There is a clear rationale for employing a complex psychological intervention approach with pharmacological interventions as an adjunct. This is reflected in the recent draft guidelines for borderline personality disorder from the National Institute for Clinical Excellence.

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Ethno-cultural Influences In Psychopharmacotherapy

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Abstract

Objective

To review published works and highlight findings cognate to services for culturally diverse populations.

Method

An extensive review of the literature using information from two credible databases: Medline and the Educational Resources Information Centre - ERIC.

Result

There is ample evidence that racial, and, cultural factors exert tangible influences on the clinical effects of psychotropic drugs prescribed for common psychiatric disorders. The influences are discernible in therapeutic response to, and to an extent side effect of these drugs. Non-pharmacologic issues, for example, placebo effect can have a cultural component and informed caution should be exercised to avoid spurious inference on drug use outcome. Variations in drug metabolism, pharmacokinetics, both explicable by genetic anlage, local belief systems, dietary habits and the embers of trado-cultural therapies are putative mechanisms. The role of social support remains poorly understood but there is some convergence of view on its potential for drug effect modification.

Conclusion

Clinicians and health service planners should be mindful of cultural issues which need to be considered in the provision of care for multiethnic communities.

Introduction

It has been increasingly apparent that multiple factors determine the effects of a drug other than its veritable physio-chemical actions (1). Consequently eclecticism is a sine qua non to any attempt to achieve optimal therapeutic effect. Of particular concern is the discernible neglect of ethnic and cultural processes attributable to parallel paths of biological and cross-cultural components of mental health (2) in contrast to the trend in non-psychiatric disciplines such as medical genetics (3) and general pharmacology (4). For example in internal medicine, illustrative cases of racial influences include; primaquine haemolysis reported in indigenous Africans (5), the inordinately prolonged apnoea in some patients on a standard dose of succinyl-choline attributable to genetic variation of the drug's biotransformation (6) the demonstration of ethnic differences in the side-effects profile and rate of acetylation of isoniazid (7) and the significant ethnic variation in responses to use of alcohol (4, 8).

With these considerations and to explore, the relationship between culture and psychotropic drug action in some detail, we conducted a search of the literature for relevant information which may be helpful as guidelines for prescribing psychotropic medication in multicultural communities.

Method

We searched two databases: The MEDLINE (1950 - 2006) and the ERIC (1980 - 2006) using combination of keywords - Racial, Ethnic, Cultural and Psychotropic. For the MEDLINE, we obtained 118 hits and from ERIC, 124 hits. Additionally on the MEDLINE, we searched the period before 1950 for information of historical interest and this particular search yielded one reference on a 1927 publication - the very first systematic account on race and a physiological response.

Taking into account overlapping of publications between the 2 databases and excluding papers with insignificant clinical relevance to the theme of the paper, we obtained a list of 83 papers which we reviewed.

Result

The first general finding that emerged was the realisation that there is a plethora of intertwining ethno-cultural factors which can influence drug action. These factors can be descriptively clustered into five groups viz: the placebo effect, use of concomitant drugs, pharmacodynamic factors, pharmacokinetic factors and dietary and other environmental issues. These factors are significant in a three-fold way. Firstly, they bear considerable import for clinical practice in that there had been since World War II, almost unbridled international migrations such that physicians in recent times encountered certain patients with peculiar ethnic and cultural background and unexpected responses to conventional drug treatment. Secondly, knowledge of variations in ethnic substrates of pharmacology would facilitate rational determination of dose requirement and prediction of susceptibility to side-effects and toxicity. Thirdly, ethnic variations in response to drugs and their side-effects profile would justify advocacy for drug trials across different ethnic or racial boundaries!

What Is Culture, Race, Ethnicity?

Before commenting on each group of the ethno-cultural influences, it is pertinent to stress the problem of getting an acceptable definition of ethnicity usually compounded by its erroneous inter-changeability with race as espoused in scholarly reviews (9, 10). Race is a large phylogenetic group recognisable mainly by skin pigmentation from which three major sub-groups (Caucasians, Negroids, and, Mongoloids) have emerged in the course of evolution. This differentiation is undermined by an alternative view which contends that the number of alleles and other tangible differences is a small proportion of the total gene pool. Indeed differences in alleles have been found more frequently within each subgroup than between them (11) such that on omnibus conception coupled with derogatory labelling have rendered the word 'race' less helpful. The word ethnic is 'safer' and refers in this discourse to a group of people who share some racial physical attributes, country of birth, self-identifications, history, beliefs, and, customs. We can therefore refer to Afro-Caribbeans, Irish-Americans, Asians, Mexican-Americans, etc.

However, it should be stated that this definition may suffice for research purposes in as much as it fits social conventions, but a residual pitfall is intra-group differentiations, particularly amongst immigrants contingent to assimilation of mores of the dominant community and other sociological imperatives.

The Placebo Effect

Fundamentally, the term placebo connotes a non-pharmacological effect of a drug and encompasses several issues classifiable into four basic groups namely:

i. Characteristics of the drug (e.g. colour, shape, name)
Ii. Personality and status of the prescriber
Iii. Personality, level of literacy and socio-cultural background of the patient
iv. The setting in which the drug is offered and/or administered (clinic, road side laboratory, or a social group occasion).

It should be stated that these groups are not mutually exclusive, therefore a vast majority of individual drugs will produce varying therapeutic effects and side effects under a combination of these factors.

Conventionally, placebo is often an inert substance (pure placebo) usually administered blind in clinical trials and used for some protracted neurotic disorders such as psychogenic pain and hypochondriasis. Also a placebo effect can be indicated by the pharmacologic action of a genuine drug with a sub-therapeutic dose or administered in a setting where it is unlikely to produce its effect (impure placebo). However, placebo effect could have a wider meaning in that it can be produced by a procedure or even a persuasive remark! Thus it has been defined broadly as the psychological or psycho-physiologic effect of medication or procedure administered with therapeutic intent which is independent of, or, minimally related to the pharmacologic effect of the medication or to the specific effects of the procedure and which operates through psychological mechanisms (12). Placebo effects play significant role in all forms of healing and even influences feelings and responses in mundane interactions and it is to a significant degree culture-bound, with magnitude varying in different settings. For example, cross-culturally, two important components of the therapeutic effects of a drug are the sharing of cognitive systems between the healer and the patient and emotional dependence (faith in) on the healer. The Shaman of Nepal, the Babalawo of the Yoruba of Nigeria and the Hakims of the Asian communities in the United Kingdom are traditional healers who share conceptions of health and illness with their clients within their respective ethnic groups (13) and have wielded considerable influence. It is known that common cognitive systems and attitudes in general provide an acceptable basis for finding meanings in psychological experiences in a particular society which in some other cultures would be regarded as deviant. In many parts of the Third World, faith in the healer derives from his authority, status and perceived prowess to heal - a relationship which had been regarded as analogous to the infantile basis of trust - mistrust maneuvers in Erickson's theroy of personality development. The basic therapeutic effect is further reinforced by the 'therapeutic' climate of the shrine and the mystifying paraphernalia of the traditional healers, which are similar to Western healing complexes comprising the stethoscope, the white coat, an attending nurse in uniform etc. Furthermore, drugs in general can serve symbolic functions in the life of the patient such as hopefulness, security, belonging and the role of the much wanted figure. (14)

Therapeutic Dualism

A notable practice in contemporary Third World is combining Western treatment with traditional (herbal) healing preparations either at different times or simultaneously, in the course of an illness and notwithstanding the appeal of the increasing number of psychotropic drugs of proven usefulness it has been widespread among Africans, (15, 16) Asians, (13) African-Americans (17) and Hispanics (18) living in the United States. However, some traditional medicinal preparations have been found to have dangerous constituents (19). For instance, it has been demonstrated that several concoctions prescribed by the Hakims (traditional healers) contained pharmacologically active substances like napthaquinone, alkaloids, digitalis, atropine and arsenic. For example, an aphrodisiac-Kushy, and a baby tonic - Bal Javan Chamco prescribed for control of convulsion are known to contain dangerous ingredients such as lead and mercury. Sometimes traditional healers engaged in uninformed and harmful augmentation of Western psychotropic drugs with local concoctions. For example, severe hypoglycaemia had resulted when a medicinal vegetable, karela, interacts with chlorpromazine (19) and psychosis has been precipitated by the use of Japanese herbs such as Swertia Japonica and Kamikihit (20) or a Cuban traditional concoction Datura candida in combination with tricyclic anti-depressants (21). Also the hyno-sedative effect of a nueroleptic may be dangerously potentiated by concurrent use with the root of schumanniophyton problematicum used in Nigeria as an anti-psychotic (22).

Clinical Response

Comparative clinical trials provide useful pointers to ethnic differences in therapeutic response to drugs as much as pharmacokinetics but the latter are crucial to gaining an objective insight into rational use of drugs and as such it is instructive to consider the two aspects separately, while integrating both where necessary.
The probable role of ethnic factors as determinants of the therapeutic action of a drug was formally highlighted by the correlation between reduction in mydriasis and degree of pigmentation of the iris among Africans and Asians regarding response to intramuscular administered (im) atropine, (23) - a link not observed in albino blacks indicating genetic rather than pharmacokinetic mechanism. A similar finding was reported among blacks and contrasts to Caucasians regarding response to Im atropine and scopolamine (24). Specifically for psychotropics, posological requirement across national borders has shed much light on ethnic differences in therapeutic actions, indeed there is some evidence of probable ethnic differences in the therapeutic response to psychotropic drugs with more favourable response reported among non-Caucasians than Caucasians in some studies where similar doses were administered. For example, in a multi-center Veterans Administrations study of treatment with amitriptyline and nortriptyline. Overall et al (25) reported better outcome among black-Americans than the Caucasians. And Henry et al (26) found that African-Americans and Hispanic patients responded better to a benzodiazepine or tricylic anti-depressant than Caucasian American; findings which have been replicated regarding response to amitriptyline and nortriptyline (27). Also Escobar and Tuanson (28) demonstrated better response of Columbian manic-depressives to trazodone and placebo compared with Caucasian Americans though the Columbians reported more cholinergic side effects. In Asia, there was a review of prescribing practices of psychiatrists in 10 east Asian countries who treated patients for 'endogenous' depression (29). The authors concluded that Asians required lower doses of amitriptyline and imipramine compared with American Caucasians. Similarly, lower dose requirement for Chinese compared with Caucasians was found also in the United States (30) and in Canada (31).

Another important variable to consider is steady plasma drug levels expected to provide reliable information since these levels more genuinely determine clinical response (32) but critical reviews revealed inconsistency in inter-ethnic comparisons. For instance a study (33) measured tricyclic

anti-depressant plasma concentrations within three Asian patient groups (Vietnamese, Cambodians and Mien) and found that the dose requirements among them are very much comparable with those of the Caucasians to attain the minimum therapeutic level of 180ng/1. On the other hand, some studies reported higher but significant plasma TCA concentrations in African-Americans than Caucasians (34). Blood lithium level also varies according to ethnicity of patients though the mechanisms are probably not via metabolic channels. A review (35), marshaled the evidence for the substantial differences in the therapeutic serum levels of lithium between Caucasians and East Asians. For example, bi-polar manic-depressive patients in Japan responded to lower dose of lithium and correspondingly lower therapeutic blood levels of 0.4 to 0.8 mEq/L and in two studies conducted independently of each other in Shanghai and in Taipei, significant therapeutic lithium concentrations of 0.73 and 0.71 mEq/L for the two Chinese groups domiciled in socio-economically dissimilar environments were found. More pertinently, these blood levels were much lower than the mean of 0.98 mEq/L of the matched Caucasian-American patients and, for the therapeutic level generally reported in Europe and North America. (35)

Regarding neuroleptics there has been extremely few studies with scanty findings, but these were not different from those on anti-depressants. For example, employing steady state plasma concentrations in a study comparing Chinese with non-Chinese, it was demonstrated that the plasma levels of reduced haloperidol were three-fold higher in the non-Chinese patients. Furthermore, Chinese patients with extra pyramidal symptoms had relatively high plasma levels of reduced haloperidol. The investigators inferred that there may be ethnic differences in the capacity to metabolise haloperidol just as was hypothesised by Lin and Poland (35).

Table 1: Clinical studies* on response to TCA

Author(s)		Comparison Populations	Drug(s)	Dose (Daily)	Result
Yamashita Asano (1979)	i ii	East Asian Groups Caucasians	Amitriptyline Imipramine	Varies	Lower mean daily dose for Asians
Kleinman (1981)	i ii	Chinese (in the Republic) Caucasians (US)	Dozepin Imipramine Amitriptyline	75mg	Lower therapeutic dose for Chinese
Kinzie & Manson (1983)	i ii	Indo-Chinese Caucasians	Mostly Imipramine	110mg <110mg	Lower therapeutic dose for Chinese
WHO (1986)		Several countries (most from the 3rd World)	Varies (375mg - 250mg)		Lower in Bombay (India), Colombia, Japan, Switzerland. Higher in the United States
Rosenblatt & Tang (1987)	i ii	Asian Caucasians	Amitriptyline Imipramine		Lower therapeutic dose in Asians

*Selected as examples illustrating thematic findings
TCA=Tricyclic antidepressants

Distribution

The process of absoprtion and distribution are important determinants of plasma drug concentration and bioavailability. Unfortunately, there is no reliable information on ethnic differences on absoprtion of psychotropic drugs but empiricism indicates that sub-clinical infectious, diet and mal-nutritional tropical diseases may play a part in gastro-intestinal absoprtion of drugs in the developing countries in ways different from Western countries. On a more positive note, better insight has been gained into the distributionn of psychotropic drugs through their binding to plasma proteins, the two best known groups being alpha-acid glycoproteins (36) and alburnins (37). The main axiom in this regard is that the extent of protein-binding is inverse, to the concentration of free (unbound) drug fraction in the plasma (38) which will readily cross the blood-brain barrier to produce significant clinical effect (39). The protein binding to the TCAs has been estimated to be at least 90% with more binding to the tertiary amines: amitriptyline and imipramine than their associated metabolites nortiptyline and desipramine; and there are suggestions that ethnic variations in the structures of the plasma proteins could be genetically determined. (40) However, there is a paucity of systematic enquiry, which firmly elucidates cross-ethnic differences in the concentrations of plasma proteins.

Metabolism

In contrast, considerable amount of research has been carried out on the activity of enzyme systems in the metabolism and excretion of psychotropic drugs with the fundamental biochemical information emerging from general pharmacology and molecular genetics. To ensure water solubility and hence facilitation of excretion, most drugs need to undergo two important metabolic processes, namely functionalisation and conjugation. The former essentially is mediated by hepatic cytochrome P450 enzymes (41) which are believed to have evolved phylogenetically in animals as a defence against harmful foreign microbes common in their habitat. Two important P450 isozymes relevant to psychiatry and which have been subject of recent enquiry are the debrisoquine hydrolase (CYP2D6) and mephenytoin hydroxylase (CYP2C19) whose frequency distributions in any population are bimodal in that some individuals are Extensive Metabolisers (EM) while others are Poor Metabolisers (PM). Further enquiry has identified two subsytems of CYP2D6 namely Ultra-rapid Metabolisers (UM) and Intermediate Metabolisers (IM) with each determined by a specific genotype (42) which may also be racially differentiated.

In relation to these differences, a fundamental phenomenon is polymorphism defined as a variation in DNA sequence of more than 1%. In enzyme systems, it predominantly determines disposition of drugs through alterations in the delivery of a drug or its metabolites to the active pharmacologic site and it has been classified as either cosmopolitan to population (race or ethnic) specific. Cosmopolitan polymorphisms are usually found at higher allele frequency in comparison to population-specific polymorphisms and it is believed the former (cosmopolitan) emerged before migrations of humans from Africa and hence generally older than population-specific polymorphisms (43) and large scale sequence studies in ethnically diverse populations in the United States demonstrate that African-

Americans have the highest number of population specific polymoprhisms in comparison to European-Americans, Mexican Americans and Asian Americans (44). Furthermore, there have been reports of an association of PM phenotype of the debrisoquine hydrolase with marked cross ethnic differences. For example, the frequency of PM varies 6 - 10% in Caucasians (42), 0 - 3% in Egyptians (45) and Saudi Arabians (46) and 0 - 8% in sub-Saharan Africans (47, 48). On the other hand, PM of mephenytoin hydrolase are more frequent in Asians (49, 50). There is evidence that these two enzymes are involved in the metabolism of several psychotropic drugs such as desipramine (51), benzodiazepine (52), barbituates (53), neuroleptics (54), and, selective serotonin re-uptake inhibitors - fluoxetine and paroxetine. Mephenytoin hydrolase also plays an important role in the metabolism of TCAs through catalysis by demethylation. For example, demethylation of imipramine correlated significantly with hydroxylation of mephenytoin and variations between Asians and Caucasians have been demonstrated (55).

Aside the aforementioned phenomena, a specific mutation, CYP2D6 has been identified as occurring in up to 70% of Asians but found rarely in Caucasians or black African (56) such that the clinical effect of its reduced activity is most probably responsible for the response of Asian schizophrenics to lower doses of neuroleptics and more likely to exhibit severe extra-pyramidal side-effects more than any other ethnic group. Generally, from several studies, compared with their Caucasian counterparts, Asians required a 50% lower dose of neuroleptics for similar clinical and pharmacokinetic effects.

With regards to African-blacks, studies from West Africa and Zimbabwe reveal patterns of slower metabolism in a large percentage of African-blacks, induced a definite mutation CYP2D6Z identified in 40% of Zimbabweans is responsible for slow metabolizing (57). Similar findings among African-Americans were reported from Tennessee (58).

Methodological Considerations

The evidence for ethnic differences in clinical response to a variety of psychotropic drugs marshalled above need re-addressing in future research for firmer conclusions in view of some methodological pitfalls. Notable mitigants are communications and diagnostic difficulties, use of concomitant drugs, differences in dietary habits, failure to control for severity of illness and for the mean age of comparison groups.

Diagnostic Issues

In contemporary psychiatry, the limitations imposed by dissimilar cultural contents of mental state and communication difficulties have reinforced the saliency of cultural congruence between the physician and the patient. For example, momentary verbal hesitancy of a patient due to a language problem may be interpreted as though blocking and prolonged gaze in search of appropriate words may present a picture similar to blunted affect. The hearing of 'God's voice' by an Ashanti native of Ghana or the East London Pentecostal black is not necessarily indicative of clinical hallucination, but may be interpreted to be so if reported by a typical European Caucasian! Furthermore, the significance of emotions expressed by facial countenance, non-verbal behaviour and the meanings of words descriptive of some important aspects of phenomenology vary across national and ethnic boundaries (59) and as such, they pose problems in making diagnostic inferences based on diagnostic schemes designed in the Western countries.

The enormous problems related to language in the provision of mental health services to ethnic minorities have been observed in Britain (60) and United States (61). One aspect is the use of interpreters which makes sense prima faciae but may be complicated by a breach of confidentiality particularly in close-knit minority communities added to the fact that the axis of the rapport may be patient-interpreter or doctor-interpreter rather than patient-doctor. Family members as interpreters probably out of ignorance or 'enforced commitment' tend to make errors of omission, addition, condensation and substitution (62) and may exaggerate to facilitate hospitalisation or relief of burden of care or may 'trivialise patients' complaints to avoid psychiatric stigma. Use of trained bilingual interpreters has been recommended (63) but problems in evaluation of psychopathology may arise when one interview is conducted in the primary language and another in a second language (64). Ideally, interpreters should be trained and possess basic knowledge of mental health services for a multiethnic community as exemplified by services provided in transcultural psychiatric units such as Lynfield Mount Hospital, Bradford, England, and in New South Wales, Australia (65). A critical overview (66), highlights the importance of these diagnostic issues and even suggest that the race and culture of the clinician should be considered before commencement of drug treatment.

Concomitant Medication

Use of concomitant drugs can modify clinical efficacy of psychotropics. Nicotine, caffeince, and, alcohol, are important modifiers. Hepatic enzyme inducers such as oral contraceptives (and other steroids) and barbiturates can lower TCA concentration, while drugs that increase TCA concentration include phenothiazines, stimulants, and, fluoxetine (67).

Dietary Habits

Dietary habits vary considerably across ethnic boundaries and it is not unreasonable to implicate variation in absorption, distribution and metabolism of the drugs that are influenced by them. Hindus are typically vegetarian and Islam forbids pork. Several traditional Third World communities often have curry, garlic and other spicy ingredients in their diet (68); due to poverty and much of the sub-Saharan diet is dominated by carbohydrate and high fibre constituents. Specific effects have not been clearly elucidated and our present postulations need to be replaced by findings from controlled enquiry. Perhaps the most credible findings to date stem from studies on another family of cytochrome isoenzymes CYP3A4 (nifedipine oxidase) which differ in different ethnic groups.

CYP1A2 is induced by tobacco, charcoal, broiled beef, cruciferous vegetables and a variety of chemical toxins. CYP3A4 is readily induced by steroids and carbamazepine as well as inhibited by some agents e.g. naringin - a constituent of grapefruit juice - therefore differences in clinical response to drugs could be environmentally influenced as reported in pharmacokinetic studies of theophylline and antipyrine in Sudanese and Asian Indians who exhibited a slower metabolic rate of these substances while resident in their own country but when they moved to London their pharmacokinetic patterns were not different from those of the British whites (69). A similar finding has been reported in a comparison of the pharmacokinetics of clomipramine between Asian Indians and British whites, which are explicable to a degree by difference in dietary habits (70).

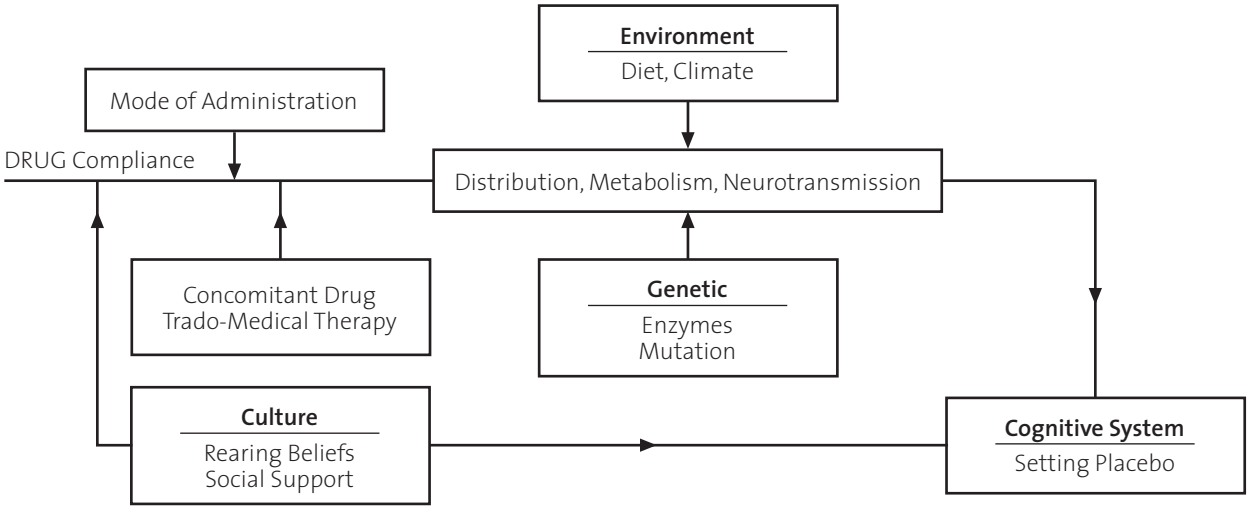
Social Suppport

There is evidence that social support reduces the risk of psychiatric morbidity (71) and the level of social support can indirectly influence therapeutic response to psychotropic drugs in patients undergoing stress attributable to interpersonal friction (72). Specifically, it has been found that intensity of social support varies in different ethnic groups. For example, Lin et al (73) reported that more Asian patients than Caucasian patients received support from their relatives. A similar finding (74) demonstrated greater support by relatives of Hispanic patients compared with relatives of

Caucasian patients, and the international prospective studies conducted by the World Health Organisation (75) showed that non-Western patients had better prognosis than Western patients-a difference ostensibly due to more social support proffered to patients in non-Western countries.

The nature of social support in terms of concept of Expressed Emotion (EE) has been implicated in response to neuroleptic treatment. High EE in a family is associated with high relapse rate in neuropleptic treated patients (76) and it has been reported that Hispanic families tended to have much lower EE scores compared to Caucasians in the United States and Britain (77).

Holistic Scheme of Influences on Drug Action



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Conclusion

There is ample evidence that cultural, ethnic, and racial factors, influence the actions of psychotropic drugs. Perhaps a clinical application of these culture-related variations is to undertake screening of patients in clinics in multi-cultural communities for rate of enzyme action to assist in determining dose requirement of individual patients. Such a screening practice would not only minimise cost of drug in slow metabolisers, but also reduce the risk of undesirable side effects. A virgin area for research is the role of the nerve cell receptor activity where some evidence points to ethnic differences of receptor acivity as found for propranolol action in studies comparing Asians, African-Americans and Caucasians (78, 79), and significantly, higher basal level of lymphocytic cyclic AMP (C-AMP) and greater response to the effect of isoprenaline which suggests more beta-2-adrenoreceptor activity have been demonstrated in black Africans and African-Americans (80). Furthermore, significant ethnic differences in the prevalence of two alleles (A1 and A2) of gene for dopamine D2 receptor have been reported (81). Further works on receptor activity are required to complement or clarify existing clinical and psychopharmacological findings. A recent critical appraisal (82) of the role of pharmacogenetics specifically recommends choice of dose informed by the race of the patient, however, at the present time such a practice is hindered by the complexity of the human genome and the confounding influences of the environment.

May we also add that recent application of some principles of pharmacogenomics to explicate variations of genetic constitution based on nucleotide polymorphisms, thousand of which have been identified (83), should shed further light on racial and ethnic differences in response to psychotropic drugs.

Finally, the scope of research on differenes in psychotropic drugs is enlarging but existing literature findings would need to be revised taking cognisance of the multifaceted sources of error inherent in comparing people from different ethnic backgrounds. Current ideas will certainly have heuristic value and if the escalating interest in the subject is maintained, trans-cultural psychopharmacology may become a distinct discipline in the not too distant future.

Declaration of Interests: None

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'Making Prescribing Decisions That Are Legally Robust'

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Abstract

Prescribing for any psychiatric condition can be a difficult task. Psychiatric disorders can be difficult to treat, side-effects of psychiatric drugs can be unpleasant and an ever changing legal climate makes prescribing a challenging venture. The following article looks at a number of legal issues that clinicians need to consider when prescribing for any psychiatric disorder in order to make their practice more robust to legal challenge.

Article

Everyday psychiatrists around the United Kingdom make thousands of different prescribing decisions for their patients. Whether psychiatrists are treating patients with schizophrenia or managing patients with chronic anxiety all the decisions have a common aim of controlling the illness, minimising side-effects and improving function.

As psychiatrists only know too well prescribing medication for any psychiatric disorder is not an easy task. It is also an endeavour made more difficult by issues such as harmful side-effects, patient non-compliance and inadequate response to treatment.

In recent years there has also been considerable focus on the actions of doctors by politicians, lawyers and the general public. Psychiatrists are now practising in a climate of enhanced scrutiny and must have considerable regard to the legal factors that are prevalent in contemporary times in order to defend their practice.

While it is expected that psychiatrists would have considerable expertise in the medical issues related to prescribing it is likely that many would be less aware of the broader legal issues that exist. Furthermore, when situations do arise where mistakes are made or things go wrong ignorance can rarely be used as a defence when a clinician may be judged by legally trained individuals with little understanding of medicine.

This article examines a number of common questions related to prescribing and cites medico-legal cases that have arisen considering these issues with the aim of helping psychiatrists make their practice more robust to legal challenge.

Informing Patients Of The Side-Effects Of A Drug – How Much Is 'Enough'?

The prescribing of any drug is never without hazard and psychiatrists routinely warn their patients about common side-effects of a drug whether it is the likelihood of weight gain with olanzapine or the possibility of sedation with mirtazapine. However, a quick browse through the BNF will reveal that psychiatric drugs are often associated with a whole range of side-effects many of which are uncommonly found and not routinely explained to patients. While most patients will not develop uncommon side-effects where does a doctor stand if he or she has not informed a patient of a particular side-effect that subsequently develops causing harm to a patient?

In a 1985 case known as Sidaway [1] the treating surgeon took consent for an operative procedure and explained the commoner complications of the operation. Unfortunately, the patient suffered from paraplegia as a result of the operation which was one of the rarer complications of which the patient had not been informed. In Sidaway the court ruled in favour of the doctor rather than the patient stating that the doctor had not acted negligently and that it was a matter of clinical judgement for the doctor to decide which adverse effects of a procedure should be reported to a patient

However, a later case of Chester v Afshar [2] involved the court finding against a doctor who had failed to warn a patient of the possibility of nerve damage that occurred during an operation. The chance of this nerve damage occurring was estimated to be between 1-2%.

There is considerable similarity between the performing of an operative procedure and the prescribing of medication in that both are procedures regularly undertaken with an inherent risk that the procedure itself carries the possibility for adverse results.

The clear difficulty in prescribing appears to be determining just how much a patient is told about the side-effects of a drug. In any individual case it will always be the court that makes the final decision as to whether ample information was provided to a patient but certainly a policy of reporting "more rather than less" about the side-effects of a drug would make clinical practice more robust to challenge. Furthermore, the provision of written material to patients detailing side-effects in accordance with local policy would help to safeguard a clinician in the face of legal challenge.

Is Your Prescribing In Accordance With Established Guidelines And Amenable To Logical Analysis?

Prescribing for any psychiatric condition is not an easy endeavour. While a satisfactory response to treatment is the desired outcome all psychiatrists know that there are patients who do not readily respond to commonly used therapeutic regimens and require alternative treatment strategies. There are times when treatment is administered which is not in keeping with guidance issued by local policies or bodies such as NICE.

These areas represent an interesting and sometimes challenging arena for doctors. In 1957, the famous Bolam[3] case examined the duty of care owed to a patient by a doctor and found that a doctor would not be held negligent so long as that doctor acted in a way that would be seen to be acceptable by a 'responsible body of medical opinion.' Thus, in accordance with Bolam two psychiatrists with very different prescribing preferences could both be deemed as having acceptable practice so long as both psychiatrists could demonstrate that there existed a body of medical opinion that would support their practice.

Critics of the Bolam test have argued that the decision by the judge in Bolam in effect gave doctors the right to do what they wished so long as they could find other medical opinion that would support their practice. Thus if a particular doctor acted in a certain manner that was not in keeping with accepted practice but could find other medical practitioners to support his decisions then this would not have been negligent in terms of the Bolam test.

However, the views expressed in Bolam were challenged in the case of Bolitho. In this case, a two-year-old child unfortunately developed breathing difficulties over a period of hours which led to a respiratory arrest and subsequently

a cardiac arrest. The paediatric registrar was called on two occasions to see the child but did not attend. The doctor was found negligent for not having attended.

The court however also examined the role the doctor would have played had she attended and the role intubation would have played in likely preventing further respiratory complications. A number of medical experts attended who had opposing views as to whether intubation would have been appropriate in the circumstances. The paediatric registrar herself had stated that had she attended she would not have intubated. Thus this case represented a particular set of circumstances where the judge had to satisfy himself after listening to expert opinion that had the paediatric registrar attended and not intubated this would have been acceptable practice for the doctor to have followed.

It wasn't enough that there existed a body of medical opinion which had deemed intubation as inappropriate. The court had to be satisfied that not performing such an action would have been appropriate.

Bolitho represented a move away from Bolam in that the court had enquired further into whether a doctor's actions were appropriate and had to be satisfied that a particular doctor's actions was able to withstand logical analysis. Some may argue that it represented the judge enquiring about and understanding matters that would not be easily comprehensible by a person without medical training.

Bolam and Bolitho may represent somewhat opposing views. However, what is clear is that the medical practitioner in today's climate must be able to justify his or her practice. There must be a clear understanding behind the rationale for prescribing that would be seen as being inconsistent with established medical opinion. In practical terms this will mean acting in accordance with guidance issued by bodies such as NICE and local policies where possible. However, in difficult cases where such guidance cannot always be easily followed the medical practitioner must be able to make his or her argument for that particular choice in prescribing. Any deviation from established prescribing rationale must be justifiable, evidenced-based and robust enough to withstand analysis.

The Current Legal Climate

Legal factors that impact upon doctors consist not only of common law declarations made through legal cases but also acts of parliament and European legislation which affects the climate in which a psychiatrist will practice. Over recent years there has been considerable change in the legal climate with the advent of the Human Rights Act, the Mental Capacity Act and the reform of the Mental Health Act.

When it comes to prescribing the psychiatrist must be aware of the fundamental difference between an informal patient and a patient detained under the Mental Health Act.

For those patients who are informal the psychiatrist must be aware of the patient's right to refuse treatment. It is not possible to administer treatment without consent to an informal patient who has full capacity to make decisions. Any form of coercion could be seen as violating the patient's rights and lead to legal challenge.

If a patient lacks mental capacity and is informal it needs to be convincingly shown that the patient does lack mental capacity and is not able to make an informed decision. Additionally, in keeping with the principles of the Mental Capacity Act all reasonable steps must be taken to ensure that the patient has been given ample assistance in trying to determine for themselves their own preferred course of action.

If it is established that the patient lacks capacity the psychiatrist can treat the patient in their best interests under the Mental Capacity Act. However, due regard must be given to the possibility of advanced directives a patient may have previously made refusing the particular treatment in question. The compulsory treatment of an informal mentally incapacitated patient in the presence of an advanced directive refusing that particular treatment could lead to legal challenge.

Where criteria are met for the use of the Mental Health Act a clinician will be given statutory authority to compulsorily treat the mental disorder in question. However, even in such circumstances the clinician must bear in mind guidance issued by the court in order to prevent breaches of human rights.

In the Wilkinson[5] case the patient who was detained under the Mental Health Act contested that he was forcibly injected with an antipsychotic that endangered his life as he had a heart condition which amounted to a breach of his human rights. The court held it would be necessary for the court to reach its' own view in the case and determine whether the treatment would be a breach of fundamental rights under the Human Rights Act such as the right to life and the right to be free of torture and degrading treatment.

The court also held it had to reach its' own view as to whether such treatment could be justified as proportionate and necessary or whether there had been a violation of the right to privacy. In another case where a human rights challenge has arisen the court has declared that the standard of proof required is that the court should be satisfied that medical necessity has been "convincingly" shown[6].

In a further case[7] the court held that there could be a breach of human rights by compulsorily treating a patient detained under the Mental Health Act if the medical necessity for therapeutic treatment had not been convincingly shown to exist.

So Where Does This Leave The Psychiatrist When Prescribing?

If a psychiatrist ever has the misfortune to be involved in a legal challenge with respect to prescribing decisions the arbitrator of the final outcome will be the judge. However, the chances of problems arising and of being held negligent by the court can be reduced by learning to think a little like a lawyer.

The treating doctor has a duty of care he or she owes to his or her patients. The duty of care can involve prescribing medication. In such circumstances, patients should be given opportunity to make their own decisions about treatment. A patient should be provided with ample information about side-effects and alternatives to proposed treatment. Any proposed treatment should as far as possible be consistent with accepted practice and be able to withstand logical analysis as to why such treatment had been proposed.

Furthermore, due regard must be given to the current legal climate. It must be assumed that patients have capacity to make their own decisions unless it can be convincingly shown that a patient lacks the capacity to make a specific decision. Any decision made on behalf of a patient must be convincingly shown to be in their best interests and be the least restrictive option. Due regard must be given to advanced directives and for patients who are detained under the Mental Health Act consideration should be given to whether the proposed treatment was necessary, proportionate and the medical need for such treatment convincingly shown to exist.

A primary consideration for the court is the upholding of patients' rights including the right to refuse treatment even is this is deemed an unadvisable course of action according to clinicians. A presiding judge will always be looking to

balance an individual's rights while ensuring a clinician has performed his or her duty of care. Due regard must be given to the legal rights of individuals. If it is deemed that there is a violation of an individual's rights then this could lead to significant problems for the prescribing clinician.

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Capacity, Forcible Treatment and Human Rights: A Review of Case-Law and Implications for Psychiatrists

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Introduction:

The European Convention of Human Rights (ECHR) is an international treaty which sets out basic civil and political rights. It came in to force on 3rd of September 1950. The UK has ratified the treaty, though not in its entirety[1]. The fundamental human rights and freedoms are contained within the articles of the Convention[2]. The Convention is intended to guarantee not rights that are theoretical and illusory but rights that are practical and effective[3].

The Human Rights Act (HRA, the Act) 1998 came in to force on 2nd October 2000. The HRA incorporates provisions from the ECHR in to the UK law which are reproduced in Schedule 1 of the Act[4]. These provisions are particularly relevant in the mental health field as people with mental disorder are the only group of patients whose liberty is deprived in their own best interests, and whose circumstances frequently engage civil, legal and human rights[5].

Domestic law must be in conformity with the convention[6] and as far as protecting convention rights is concerned, a greater degree of protection must be provided under the domestic law[7]. Prior to the Act, there was no mechanism for an individual to enforce their convention rights through the domestic courts. The only way the convention could be effected was to change the primary legislation itself. Section 3 of the HRA now imposes strong obligation upon the courts and tribunals to interpret primary legislation in compatible manner with convention rights and only make declaration of incompatibility as a last resort[8]. Such declaration in turn may lead to correction of the legislation by the parliament. Moreover all public authorities must act in a convention compliant manner[9].

When the Act came in force there were fears that there would be a flood of litigations. This has been true to some extent. Since its enactment and as of May 2006 there have been 18 declarations of incompatibility and 11 more cases are standing[10].

This article concerns the impact of the HRA on challenges to compulsory treatment of psychiatric patients and this can be conveniently discussed first by discussing the procedural issues followed by discussion of challenges in court in respect of relevant articles of the convention and finally conclusions and discussion.

HRA and procedural issues:

As Bartlett and Sandler point out the HRA has raised the standard of judicial review but that substantial issues fare less well[11]. Such procedural issues mainly concern article 6 which gives right to a 'fair trial'.

It has been argued that the Second Opinion Appointed Doctor (SOAD) procedure[12] under the Mental Health Act 1983 (MHA) breaches article 6 rights of the patient as it is not a 'fair hearing' for the patient's grievances regarding the Responsible Medical Officer's (RMO) treatment plan. The Court in Wilkinson[13] however held that judicial review was open to the patient and therefore article 6 rights were not breached. However, as explained in the next paragraph, the very nature of judicial review then came under scrutiny.

Section 58 and 63 of the MHA have, in the main, been the subject of controversy[14] as they allow compulsory treatment of even a competent patient. The precedent from the Brady[15] case was that it would be undesirable for the court to intervene to challenge a properly carried out process, unless it was seen not to be rational (Wednesbury reasonable). The ruling in the Daly[16] case however was that the courts hearing judicial review cases must now themselves form a judgment whether a convention right has been breached, whether such breach is allowed under ECHR and whether the infringement of the rights is proportional. Thus the Brady approach was no longer thought as appropriate in the case of forcible treatment of detained patients and instead the review must be of greater intensity[17].

The next question was whether the court should then adopt a more 'primary decision making role'. The court decided in Wilkinson case that forcible treatment of a patient had the potential to breach his human rights, principally those under article 3 and 8, and as there was no statutory mechanism to determine the lawfulness of treatment in advance of that treatment, administrative court on judicial review should reach its own view on whether the treatment was a medical necessity and whether this has been convincingly shown to exist, both requirements as per H v Austria[18]. Taking on 'primary decision making role' meant that cross examination was necessary[19]. However this cross examination requirement was later watered down in the case of R (N) v Dr M where the court ruled that "issues requiring cross-examination of medical witnesses should not often arise"[20]. The current position[21] would seem that the need for oral evidence and cross-examination in such cases would be exceptional rather than routine[22].

Another procedural change and the clearest impact of the HRA was the decision in R v Feggetter[23] where Brooke LJ held declared that fairness requires that a decision by a SOAD which sanctions the violation of the autonomy of a competent adult patient should be accompanied by reasons.

3. HRA and Compulsory Treatment of Mentally Disordered: Article 2:

Article 2 states that 'Everyone's right to life shall be protected by law'. This of course includes life of the psychiatric patient[24] and life of any other member of public who may be at risk from a psychiatric patient[25]. In order to fulfil the obligations under this article, the state may need to impose treatment on patient(s) and in doing so the state may have to breach the patient's article 3 rights[26]. This does not mean that an individual does not have right to integrity of self and self determination. These remain fundamental human rights[27] and a death wish of a capacitated patient is honoured under article 2[28].

For the purposes of this article, as the next paragraphs demonstrate, the relevant case is Osman v UK[29] where the Strasbourg Court stated that "It is thus accepted by those appearing before the Court that Article 2 of the Convention may also imply in certain well-defined circumstances a positive obligation on the authorities to take preventive operational measures to protect an individual whose life is at risk from the criminal acts of another individual". It

therefore follows that 'preventive operational measure' which may include detention and forcible treatment can occur solely on the basis of risk the patient may pose to others[30].

Article 3:

Article 3 states that no one shall be subjected to torture or to inhuman or degrading treatment or punishment. No derogation is permitted[31].

Section 58 and Section 63 of the MHA 1983 however permit forcible treatment of patients. Such treatment(s) may themselves be thought of as inhuman and degrading (for example ECT[32]) or such treatment(s) may cause side effects and therefore engage that patient's article 3 rights[33]. Such treatment/detention moreover causes intrusion in his/her privacy and family life, thereby engaging article 8 rights. Section 3 of the Act requires that 'so far as it is possible to do so' statutory provisions be exercised in a manner compatible with rights under the ECHR. Thus Section 3 of the HRA 1998 offers a route to challenge provisions of part IV of the MHA 1983[34].

Inhuman or Degrading treatment:

For a claim to succeed under article 3, it must be shown that the treatment in question is inhuman or degrading. Although article 3 permits no derogation, the concept of 'medical necessity' was imported in to the article 3[35]. In general terms the courts have been reluctant to categorise either psychiatric treatment, no matter how disagreeable[36], or institutional conditions as inhuman or degrading. European courts have consistently held that treatment which, to the untrained eye, clearly looks as if it should qualify as 'inhuman or degrading' does not need to attain the level of severity required to trigger article 3[37]. The severity test is thus to be determined according to all the facts of the case including the medical considerations[38] though reaching the minimum level of severity would require actual bodily injury or intense physical or mental suffering[39].

In the context of this European case law, a claim in domestic court that a certain treatment was inhuman or degrading was bound to fail. For example seclusion will not normally amount to inhuman or degrading conditions though this may depend on the conditions, duration, purpose and the effects on the person concerned[40]. Also seclusion must be justified under article 8.2[41]. ECT will reach minimum level of severity for it to be classed as inhuman or degrading only if given to incapacitated patient or given when not medically necessary[42]. Side effects of the medication, it would appear, would not reach to severity of inhuman treatment if they could be overcome with another medication[43] or if an alternative medication with less serious side effects was available[44].

As the matters currently stand article 3 would be violated if the proposed treatment of the patient reaches the 'minimum level of severity' and if the 'medical or therapeutic necessity' for the treatment has not been convincingly shown to exist. This two prong test which was put forward by Silber J in the case of PS has come under criticism, the argument being that establishing 'medical necessity' becomes a separate hurdle rather than 'medical necessity' being one of the facts of the case to be considered with other facts[45].

Capacity and article 3:

It has been argued that section 58 and section 63 of the MHA 1983 breach article 3 and 8 of the convention in that they allow forcible treatment of a capacitated and refusing patient without qualification rather than limiting such treatment to clearly and strictly defined exceptional circumstances[46].

In Wilkinson the argument was that compulsory treatment particularly that of a capacitated and refusing patient, even if medically justified, was degrading and an invasion of privacy unless it was necessary 'for protection of others'. The defence had no case law to cite in relation to the criteria of 'for protection of others' though they relied on the summary report of the Committee for the Prevention of Torture and Inhuman and Degrading treatment which notes that any overriding of competent refusal requires 'clearly and strictly defined exceptional circumstances'. Simon Brown LJ and Hale LJ commented on this issue and although the comments were obiter, they provide an insight in to how the judiciary is divided on this issue. Simon Brown LJ[47] felt that a refusal of a capacitated patient ought to be honoured though Hale LJ did not take the view that capacitated patients can only be treated against their will for the protection of others or for their own safety[48].

In the case of PS[49], which followed that of Wilkinson, the argument was that overriding of consent of a competent refusing patient violated article 3, 8 and 14. Silber J here preferred the approach of Hale LJ in Wilkinson. Although he held that refusal of a competent patient was an important factor, it is not clear in what sense this would be important as wishes of such patients could be overridden. Peter Bartlett[50] argues that the issue of forcible treatment of competent refusing patient and whether this comes under the scope of 'inhuman or degrading treatment' has not been addressed in domestic or European courts. The only case law available is that of Grare v France[51] where it was held that side effects such as blurred vision and attention deficit did not reach the standard of gravity to trigger article 3. However this was decision of commission and not court and Bartlett therefore argues that the views of the Strasbourg court are a matter of speculation based on a case, H v Austria where the patient lacked capacity. Silber J however believed in PS that the principles established in H v Austria applied to capacitated patients as well.

Thus the situation at the time of PS hearing was that capacity of the patient was not a determinative factor in deciding whether article 3 was violated or not and no specific guidance as to the importance of capacity in respect of article 3 breach was available either in domestic or European court. In the case of B[52], which was effectively a challenge against the PS case, Silber J once again held that article 3 was not automatically breached merely because the patient had capacity. This was confirmed by Charles J[53] in Admin court 2 who also added that the refusal of the patient and the fact of compulsion was more important than capacity, a view later shared by the Court of Appeal[54]. The Court of Appeal here relied on H v Austria, a case dealing with incapacitated patient, as well as N v Ukraine[55] where capacity of the patient was not under question but the Strasbourg Court had applied the same principles. Under the English MHA the criteria for detention and treatment do not depend on capacity[56]. The essential thrust of the Court of Appeal argument in this case was that the MHA provided for an integral package of detention and treatment and it was not desirable that an individual is detained but not treated or that a higher standard for administration of treatment is necessary compared to the standard for detention. As Paul Hope argues what this means is that one of the automatic consequence of loss of liberty therefore is loss of any right of self-determination[57]. However as other European case law suggests detention of a patient in hospital without any treatment for that disorder could potentially give rise to violation of article 3[58] and in that sense the approach of the Court of Appeal in the B case was the right one.

The issue of medical necessity:

The two prong test that is 'minimum severity test and medical necessity test' was proposed by Silber J in the case of PS. Previously the court in Wilkinson had affirmed that that imposition of compulsory treatment, as under Section 58 and section 63 of the MHA for example, can amount to

inhuman and degrading treatment unless the medical necessity has been convincingly made out. As per the JB case the nature of mental condition for which treatment is required need not be precise[59]. Where medical necessity can not be shown then right to refuse treatment will need to be superimposed[60].

Following the Wilkinson case the Court in of R v Dr M developed a checklist of 7 factors in determining whether the medical necessity had been made out. The Court of Appeal also took the view here that Bolam[61] test had to be satisfied but that by itself it would not be enough to show that medical necessity had been convincingly made out. The Court will need to decide in light of all evidence whether the treatment could be permitted.

Although Silber J had held that medical necessity has to be convincingly shown to exist rather than it existing on the balance of probabilities, the Court of Appeal ruling in the case of JB was that the need for medical necessity did not have to be proved to any specific standard and what was required was probably satisfaction of medical necessity on the civil standard of proof, - on the balance of probabilities - or that it would be 'likely' to provide therapeutic benefit.

Article 8:

Article 8 states that everyone has the right to respect for his private and family life, his home and his correspondence.

Treating a competent patient in a psychiatric unit without his consent would breach his article 8 rights though this may be permissible under article 8(2) that is if the treatment is 'necessary in a democratic society', 'for the protection of health', 'if there is corresponding social need', 'if the aim is proportionate and legitimate' and if it 'is in accordance with law'. The threshold for 'minimum severity' is much lower[62] than that required for article 3 breach and the mere fact that a competent patient was being treated without his consent will be enough[63] to breach his article 8 rights unless such treatment could be justified under article 8 (2). The relationship between capacity and article 8 rights is however less clear. In H v Austria the patient's claim under article 8 was dismissed as the patient was incapacitated. Thus the situation could have been different if the patient had capacity[64].

There have been a number of unsuccessful challenges in respect of article 8. In the case of PS, Silber J held that eventual rehabilitation and release of PS and improvement in his mental state were legitimate and proportionate aims. In another case the prohibition on cross dressing was held not to breach article 8 rights[65]. More recently[66] an application that the word 'shall' that appears in Section 73 of the MHA and in the conditions imposed by tribunal when granting conditional discharge with respect to taking medication breaches article 8 rights was refused on the basis that S 73 does not impose any sanctions for failure to take medication.

The main issue however in relation to compulsory treatment has been the meaning of 'in accordance with law'. A variety of tests are available. These include the statutory test under Section 58 of MHA, the Bolam test and lastly the Best Interests Test[67] developed under common law. The SOAD is required to apply the Bolam test when certifying compulsory treatment[68]. For a treatment to be 'in accordance with law', Silber J held in PS that it had to comply with the Best Interest Test. As Peter Bartlett notes PS was being treated under the MHA and not common law and therefore it was unclear as to why Silber J would rely on a common law test to satisfy the condition of 'in accordance with law' unless it was because the MHA merely provides for a procedure for overriding consent and not justification[69]. Also the Best Interest Test was developed in relation to incapacitated patients whereas PS had capacity. Silber J later made it clear that 'in accordance with law' meant both the Best Interest Test and the statutory requirement under Section 58 of MHA. Charles J[70] however disagreed with Silber J stating that 'in accordance with law' meant only statutory provisions under Section 58 MHA. The Court of Appeal here did not make it clear what exactly is meant by 'in accordance with law' though it observed that both tests are different and that the common law test should be applied by SOAD in any case. Paul Hope argues that the court here lost the opportunity to incorporate the Best Interest Test, both for incapacitated and capacitated patients, in to the article 8 (2) requirement of 'in accordance with law'[71].

Article 5:

Although article 5 is only concerned with the issue of diagnosis, risks[72] and detention[73] and not treatment[74] or treatability[75], it should be mentioned here briefly here as compulsory treatment in community will not breach article 5 rights on the basis that such treatment is not deprivation of liberty[76]. Given the very wide definition of treatment[77], it is relevant that detention of so called untreatable[78] or asymptomatic[79] patients does not breach their article 5 rights.

Article 14:

Article 14 prohibits discrimination on any grounds. The issue arose in the case of PS, who claimed violation of his article 14 rights as he, a competent patient, was being forcibly treated whereas W's[80] refusal of consent to treatment of his wounds, resulting from self harm, was honoured. The claim did not succeed as for Silber J the fact that W's psychopathy was untreatable, and therefore not subject to MHA, meant that no comparison could be made to the case of PS. Peter Bartlett[81] argues that in the case of W the issue was treatment of wounds, which were treatable, and not his psychopathy. Therefore strictly speaking a proper comparison between these two cases was possible. Bartlett further argues that even if W was untreatable, this fact in itself can not distinguish this case from that of PS as informal treatable patients are able to refuse treatment.

The issue of capacity has been covered in relation to article 3 and 8 above but it would be useful to note here that the issues of forcible treatment, if decided on the basis of capacity or lack of it, can breach article 14 rights of the patient on the basis that there was discrimination between those who had capacity and who did not[82].

(4) Summary and Implications:

Autonomy, at least theoretically, is much valued by the judiciary and Lord Donaldson's comments[83] in this respect in Re T are well known. In attempting to marry the patient's human rights with the need for compulsory treatment the central issue has been whether a competent patient's consent can be overridden and if yes, then under what circumstances. The argument has been that a competent patient's consent should not be overridden unless protection of others is a concern, and indeed such a scheme was proposed by the Richardson report[84]. Apart from Simon Brown LJ's obiter comments in Wilkinson, this argument has not yet found any support. The idea of a capacity based legislation[85] is attractive though as Peter Bartlett points out such an approach may fall foul of patient's article 14 rights[86].

There are only two circumstances where autonomy can be overridden: patients who lack capacity and patients who are detained under the MHA. Proper determination of capacity is therefore important. It, therefore, further does not help the situation if the procedure for determination of capacity itself and the threshold for presence or absence of it is under doubt. If we accept Silber J's comments in R (B) then the very presence of mental disorder would mean that all patients lack capacity.

The domestic and European courts however made it clear that medical treatment that has been shown to be therapeutic necessity, no matter how disagreeable, will not contravene article 3. From the competent patient's perspective the problem is that the word treatment is a many faceted one. Its definition is wide, its scope has been stretched by the courts and it is not confined to the category of classification[87]. The issue of capacity has never been addressed head on either in domestic or European courts and the current situation is that capacity is simply not relevant or determinative in establishing whether rights under article 3 have been breached or not.

Putting issues of capacity on one side, it remains the fact that judiciary is reluctant to class any treatment as inhuman or degrading provided the medical necessity for it has been convincingly made out. This necessity does not have to be proved to any specific standard. The SOAD procedure has come under much criticism. It was agreed that judicial review was open to the patient for article 6 purposes though the initial strengthening of the review process has been later watered down and even where the review is of greater intensity involving cross examination, the judiciary is deferential to the witnesses thereby compromising the patient's rights[88].

It would be fair to say that despite a number of challenges to compulsory treatment of psychiatric patients, the current situation is no different and if anything, the judiciary has widened the powers available to the mental health professionals. Mentally ill persons are branded as dangerous and risk management always takes priority[89]. As Paul Hope comments everybody rests easy when the control is in professional's hands90.

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An audit on managing challenging behaviour in a learning disability unit.

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Aim and Method:

To assess the practical application of current guidelines on management of challenging behaviour in a learning disability inpatient unit. A survey tool was developed amalgamating current guidelines from NICE, the Royal College of Psychiatry, the British Psychological Society, and the University of Birmingham. Results were collated from admissions between 2003-2006 to a 16-bedded Learning disability in-patient unit based in Lincoln.

Results:

36 patient admissions were identified. The patients' level of L.D., diagnosis, behaviour, risk assessment, referral, intervention, formulation, person centred plan, factors, feedback and evaluation were recorded in the case notes. However, C.P.A. level, patients' capacity, staff attitude, care-coordinator, legal concerns, feedback from the patient and after substantial revision to the care plan were not being adequately recorded.

Clinical Implications:

This ensures that service users' involvement, capacity; consent and CPA level are constantly highlighted, monitored and documented in view of their clinical and legal implications.

Introduction:

The term "Challenging Behaviour" has been defined as a culturally abnormal behaviour of such intensity, frequency or duration that the physical safety of the person or others is likely to be placed in serious jeopardy; or a behaviour which is likely to seriously limit or deny access to the use of ordinary community facilities. (Emerson et al 2001).

Challenging behaviour is over-represented in learning disability (LD) populations, and can range from minor antisocial behaviours to seriously aggressive outbursts. In one UK study, a total of 16.7% of people with administratively defined L.D were identified as exhibiting challenging behaviour in both community and in-patient settings (Suresh& Abort, 1992). 10-15% of individuals with L.D. may also present with challenging behaviour, with 5-10% exhibiting severe challenging behaviour (Elsevier Psychiatry Journal 2006).

Possible causes for such behaviour include mental illness that may lead to self-injury; trauma such as sexual abuse; and pain or physical illness. 25% display active epilepsy, 33% display sensory impairment, 40% display physical disabilities, and 50-90% have communication difficulties. B-endorphin release may maintain self-injury by acting as a reinforcer owing to its opiate characteristics. (Elsevier Psychiatry Journal 2006).

Challenging behaviour is understood commonly through 2 steps: learned behaviour and functional analysis. The former encourages us to move away from the pathological or illness behavioural model. The antecedents are identified, the following behaviour is noted, and the consequences of the behaviour are conceptualized as the reinforcers.

Functional analysis or 'functional assessment' is a process by which the functions of the challenging behaviours are determined and used as the basis for intervention. Information is collected and used to develop a hypothesis concerning the nature of the behaviour and the meaning of the antecedents and consequences to the patient. This information is then tested out either in vivo or by manipulating the variables that have been identified as relevant to the behaviour. Identifying the function of the behaviour enables the design of intervention(s) based on the person's individual needs, to encourage the replacement of dysfunctional behaviour with more functional patterns.

Development of the survey tool:

The following Guidelines were amalgamated: The British Psychological Society (2004), The British Psychological Society and Royal College of Psychiatrists (2006), NICE Guidelines (2005), and

The University of Birmingham and Royal College of Psychiatrists (2006).

The following areas were included in the tool: age, date of admission, level of learning disability, diagnosis, care programme approach (CPA) level, consent (of the patient, their capacity, and consent of carer); personnel, clinical and social variables, descriptions of the behaviour, risk assessment, care-coordinator, multidisciplinary team availability, nature of interventions, therapeutic approach, legal concerns, feedback, and evaluation of the behaviour.

Method

An initial pilot study was performed on data collected from 5 patients admitted to Long Leys Court (a 16 bedded Learning disability in-patient unit in Lincoln). It revealed that a separate audit on medication use was being conducted and therefore this was excluded. The pilot also revealed that no list of admissions prior to 2003 was available, so only patients admitted from 2003 until 2006 were examined. Data was collected during January 2007, specifically on entries or documents dated during the first 12 weeks of admission. (Consistent with standards BPS and RCP # 17).

Sample

Initially 62 admissions were identified. 26 files (42%) were unavailable at the time of sampling and were thus excluded. Thus 36 cases were examined. If specific data was not written and no explanation was indicated to explain its absence, it was defined as 'Not Recorded'.

Results were converted to percentage that was then rounded to the nearest whole number.

Results:

Demographic Details:
Most patients studied were admitted in 2005 (n=13, 36%), followed by 2006 (n=11, 31%). The most frequent level of L.D. recorded was mild (n=16, 44%). 56% of cases had more than 2 diagnoses recorded, but a significant number (n=6, 16%) had no diagnosis recorded at the initial period of admission. The most common diagnosis recorded was Autistic spectrum disorder (28%), closely followed by challenging behaviour (25%), and then by organic causes and epilepsy (19% each). See Table A.

CPA & Consent:
92% of cases (n=33) did not have their CPA level documented in the file. Capacity to consent was recorded in only 14% (n=5) of total cases. Consent from the patient was recorded in 47% (n=17) and from the carer in 92% (n=33) of cases (see Tables B and C).

Variables:
Service users' personal/demographic, and clinical variables were recorded in all cases. Within the social variables, the attitude of staff was not recorded in 58% (n=21).

Behaviour, Risk Assessment & Care-coordinator: Information about the behaviour was documented in most cases (n=35, 97%). All factors for completing risk assessment was recorded in 64% (n=23) of cases.
59% (n=21) did not have a named care-coordinator recorded. However, other factors under care-coordinator, i.e., the care plan, the process for regular reviews and additional mental health needs were recorded in most cases (n=32, 89%).

Multidisciplinary Assessment:
Most patients required more than one specialist assessment (27 cases, 75 %). 97% (35 cases) of patients required referral for functional analysis. All patients needed a psychiatric or biomedical assessment and 25% (9 cases) had no information to assess whether or not there was a problem at the placement organization.

Interventions:
Clarity on the applied formula, enhancing quality of life & medication rationale were each recorded in 79 % of cases (28 cases). Talking treatment, triggers, carers' response, self-management of behaviour & clarity of physical intervention were also each recorded in 75 % of cases (27 cases).

Therapeutic approach & Legal Concerns:
Under therapeutic approach, the observation level was not recorded in 67 % of cases
(N=24). Within person centred approach, the circle of support (support of service user beyond the unit) was only recorded in 67 % of cases (n=24). See Table B and D.

Rapid tranquilization was needed for all the patients at some point during the initial 12 weeks of admission. De-escalation was applied before the use of tranquilization in all cases and its rationale was recorded in almost all cases (99 % 34 cases). Prior discussions concerning its possible use, side effect, risk involved, client's capacity and need for mental capacity act was not recorded in any cases. Advance directives were not applicable in almost all cases (97%, 35 cases). See Graph A.

Not all factors under legal concerns were recorded (9 cases, 25%). Following emergency interventions, the time of doctors' arrival had not been recorded in over half of the cases (72%, 26 cases). Service users account of the intervention had not been documented in 45 % of cases (16 cases). Explanation of care plan to the service user was only recorded in 25 % (9 cases). However respect to the service user and reassessment of the care plan was recorded in all cases (36 cases 100%).

Feedback:
Feedback after the end of the assessment, after an intervention, and to the carers was recorded in all cases. However feedback to the service user was not recorded in most cases, i.e., 81 % (29 cases). In 30 cases (84 %) substantial revision was done to the care plan. Following this revision, feedback was not recorded in 33 % (10 cases) of cases.

Evaluation:
Evaluation of the challenging behaviour was recorded in all cases.

Discussion:

Challenging behaviour occurs in all psychiatric disciplines. Having a clearly defined structure to deal with such behaviour will help to reduce long stay admissions and contribute in forming a clear and defined care plan. . A baseline checklist of challenging behaviour would assist in the process. Such a clear structure may help in diagnoses such as dementia (Andrews 2006) and other co-morbidities (Xeniditis 2001).

The combined guidelines prepared by RCPsych and BPS have clearly defined standards for most areas and reflect a clear approach. Although standards were vague on the use of rapid tranquilization (compared to the guidelines produced by the University of Birmingham) and on assessing feedback and evaluation, all other areas were clearly addressed in its checklist.

Our results showed the following areas were recorded in over 50 % of our sample:
level of learning disability, diagnosis, description of the behaviour, risk assessment, multidisciplinary assessment, intervention, feedback, and evaluation of the care plan. This shows that the formulation of challenging behaviour and consequent care planning was being performed well.

Areas that were less well recorded included the CPA level , and the name of the designated care-coordinator. In the assessment of consent, the least recorded factors were patients' mental capacity and consent. Within the therapeutic approach, the least recorded factors were indication for interventions , and prior discussion with patient and/or carer on the use of rapid tranquilization . Under legal concerns, involvement of patient in the development of their care plan was also poorly recorded. In Lincolnshire's Learning Disabilities Service CPA was only formally adopted in October 2006 and thus the low level of recording in relation to this was to be expected . It is concerning that capacity was poorly recorded, as high levels of incapacity would be expected in this population. However, patients should still be involved in all aspects of their care plan at a level they can understand.

Challenging behaviour as a diagnosis needs further review. The DC-LD* has a category 'problem behaviour' for learning disability patients, which includes different presenting sub-groups. However, it is not included in ICD-10. It has been described as an atypical expression of a mental illness (e.g. Meins 1995) as well as reported in other co-morbidities (Xeniditis 2001 & Andrews 2006). Including such a diagnosis in future editions of the ICD may thus be useful.

The Mental Capacity Act (2005) aims to protect patients who are incapable of making decisions. Under the Act, a person is assumed to have capacity, unless proven otherwise. However, in patients with a learning disability capacity cannot be assumed. Thus, more effort needs to be made to record capacity in this population. Greater awareness of this issue is needed to improve recording in medical notes, particularly in relation to client's capacity to consent and providing information on medication and side effects.

The Valuing People white paper (2001) has provided a blueprint on how to approach people with learning disabilities. It is reported (EastMidlands 2007) that further

development of services was needed to support people with L.D. who still had difficulties in accessing main stream services.ANational Survey(2002-2007), reported a decline of patients' involvement in their care planning. Similar levels were found in this audit. We thus need to aim to fully involve our patients in all aspects of their treatment.

It would be interesting to compare how challenging behaviour is currently being managed in different community settings as most patients with learning disabilities live away from hospital with varying levels of support. Assessing its management in such settings would not only help to reduce admissions but also improve patients' quality of life. It may also encourage better communication between all multidisciplinary team members involved in their care.

Declaration of Interest:

None.

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Table A: Diagnosis

Diagnosis	No. Of Cases	(%)
Epilepsy	7	(19)
Depression	3	(8)
Bipolar	3	(8)
Dementia	1	(3)
Personality Disorder	1	(3)
Schizophrenia	3	(8)
Organic Causes	7	(19)
Autistic Spectrum Disorder	10	(28)
Conversion Disorder	2	(6)
Challenging Behaviour	9	(25)
Psychosis	4	(11)
Generalized Anxiety Disorder	1	(3)
Not Recorded	5	(14)

Table B: Areas recorded in assessing challenging behaviour

Note: only areas with all factors noted were defined as 'Recorded'

Area Assesses	No. of Cases	(%)
Age	36	(100)
D.O.B.	36	(100)
Level of L.D.	22	(61)
C.P.A. Level	3	(8)
Diagnosis	30	(83)
Consent	5	(14)
Variables	15	(42)
Behaviour	35	(97)
Risk Assessment	23	(64)
Care-Coordinator	16	(44)
Specialist /MDT Assessment	36	(100)
Intervention	27	(75)
Therapeutic Approach	0	(0)
Legal Concerns	9	(25)
Feed back	30	(82)
Evaluation	36	(100)

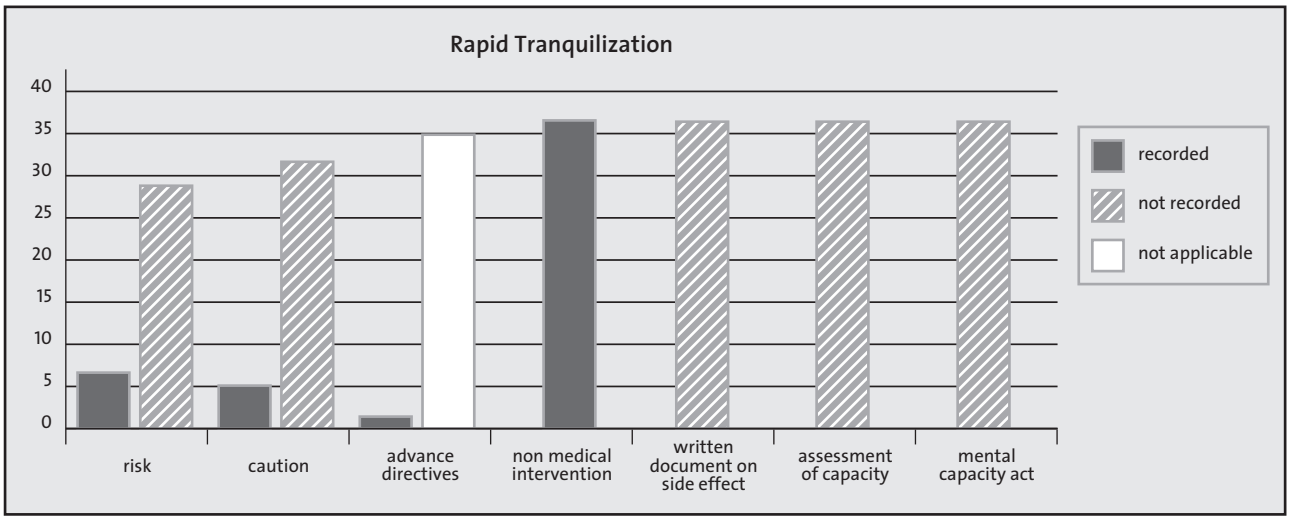
Table C: Factors recorded in assessing consent

Consent	No. Cases	%
Capacity of the patient	5	(14)
Consent of the patient	17	(47)
Consent of the carer	33	(92)

Table D: Factors recorded in assessing Therapeutic approach
Note: areas with all factors noted was defined as 'recorded'.

Therapeutic Approach	No. Cases	%
Person centred approach	24	(67)
Observation Level	12	(33)
De-escalation Level	35	(97)
Altering Bio-behavioural State	31	(86)
Rapid Tranquilization	0	(0)

Graph A: Factors recorded in assessing rapid tranquilization



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