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Caring for people who enter old age with enduring or relapsing mental illness ('graduates')

CR110 2003 12 pp £5.00

This document has been produced jointly by the Faculty of General Psychiatry, the Section of Rehabilitation Psychiatry and the Faculty of Old Age Psychiatry.

Its purpose is to define and encourage good practice in the management of mental disorder in people who suffered from enduring or episodic severe mental disorder throughout adulthood and are

now reaching old age. Such people are sometimes described as 'graduating' from services designed for the needs of adults of working age to those designed for older people. These patients are potentially at risk of neglect or sub-optimal care by services because of changes that have occurred in the organisation and responsibilities of services over the past 30–40 years. Their particular needs have never been addressed in policy documents. The principles of care for people with mental disorder, as outlined in the 'National Service Framework for Mental Health' remain applicable to them, although in many instances their care will fall to specialist services for older people working within the 'National Service Framework for Older People'.

Previous generations of graduates lived out their lives in mental hospitals. Many are now housed in hostels, residential or nursing homes, or may be supported with complicated packages of care in private households. Estimates of the most severely affected range from 11 to 60 per 100 000 population. The majority suffer from chronic schizophrenia or relapsing mood disorder. Many continue to demonstrate evidence of florid symptomatology as well as defect states. Their physical health is often poor and they might have no social infrastructure other than that provided by statutory services. Some have been relocated out of their district of origin as part of a mental hospital closure programme, and might have lost contact with their original services. New graduates often encounter

difficulties when general psychiatry or rehabilitation services feel that they should give way to services for older people.

Recommendations to services

- Each local health and social care economy should identify all graduates as characterised.
- A full reassessment should be made of each individual's current health and social care needs and a care plan should be agreed, designed to meet these needs within available resources. Progress towards improved care and improved health should be monitored by annual reviews.
- For people who are currently approaching the age of 65, their birthday should trigger a comprehensive review of health and social care needs. Following this review, a care plan should be agreed and be subject to annual review.
- Medical responsibility will rest with a principal in general practice or a consultant psychiatrist, and maintenance of continuous review should be the responsibility of the case manager.

It is intended, with the support of the National Institute for Mental Health for England, to monitor progress in the implementation of these recommendations and to publish the findings annually.

reviews

Reading about self-help books on obsessive–compulsive and anxiety disorders – a review

Many treatment manuals were originally introduced for research purposes in psychotherapy to standardise treatment programmes among researchers. On the tail of these treatment manuals came the development of self-help manuals for patients. An example is Barlow & Craske's (1994) self-help publication for anxiety and panic, which was born out of their therapist manual.

The profession has not wholly welcomed the development of self-help manuals for clients. In their favour, such publications increase people's insight into their condition, empower them to take more responsibility for their treatment and give them material to show friends and relatives, helping to provide a more supportive social context for change. They

also give access to methods of improvement for people not wishing to bring their anxiety disorder to the attention of professional services. When used in conjunction with treatment guided by a therapist, self-help publications can be read in advance of therapy and at the end of therapy to consolidate gains. Used under professional guidance, manuals also act as an aide to training for the therapist, enabling a consistent standard of therapy to be maintained.

There are, however, concerns and arguments against such publications. Wolpe (1977) objected to patients with phobia being treated with the same standard technique and highlighted that phobias can have different causes that require different therapeutic approaches. A further argument against self-help therapies is the lack of the reinforcing positive feedback and motivation that a therapist can offer. Ghosh *et al* (1988) found patients with phobia who bought a self-help book, then failed to take its self-help exposure advice until, as part of a

randomised controlled trial, a psychiatrist asked them to follow it and then return to be rated.

Self-help manuals for anxiety and obsessive–compulsive disorders (OCDs) are largely based on empirically-validated cognitive–behavioural techniques, but very few controlled studies have looked at the efficacy of self-help literature for anxiety and OCDs. Those publications with proven efficacy are therefore high on the shopping list.

In a series of controlled studies, White (1995, 1998) has shown that 'Stresspac' a self-help cognitive–behavioural therapy package for individuals with anxiety disorders (White, 1997) produced clinically significant improvement in 67% of the participants at post-therapy, 89% at 1-year and 78% at 3-year follow-up. Ghosh *et al* (1988) showed that behavioural therapy delivered via a book, *Living with Fear* (Marks, 1978), was as effective as therapist-guided behavioural therapy. Eighty-four patients with chronic phobia were randomly assigned to self-exposure

in vivo, instructed by a psychiatrist, a computer or the book. All three groups had shown significant, similar improvement on all study outcome measures after therapy and at 6 months. Pilot work has shown promising results for the Mental Health Foundation's publication, *Managing Anxiety and Depression – A Self-Help Guide* (Holdsworth & Paxton, 1999) and a controlled trial is in progress.

An important aspect of a self-help publication is whether it offers accurate information to the reader on the nature of his or her condition and provides good clinical examples with which the reader can identify. Publications by De Silva & Rachman (1999) and Rachman & De Silva (1998) on panic disorder and OCD offer in-depth and up-to-date information, with many clinical examples. These publications stress the importance of an initial assessment by a professional but offer a chapter on self-help therapy.

Greist *et al's* (1986) publication, *Anxiety and its Treatment* offers an authoritative overview of anxiety disorders and treatment alternatives and has a well-structured chapter on self-help therapy, guiding readers through a clear series of questions to see if self-help behaviour therapy is appropriate for their needs. This self-help treatment chapter has been taken from Marks' (1978) publication, *Living with Fear*. The book offers a comprehensive overview of anxiety disorders, including many clinical vignettes with which people will identify.

Getting Control – Overcoming your Obsessions and Compulsions (Baer, 1991) offers a readable and informative section on the clinical aspects of OCD and then cleverly guides the reader into a chapter that assesses his or her obsessive–compulsive symptoms and their severity. With this information, the reader is taken through self-help behaviour therapy and is able to tailor the therapy to his or her needs. The book also has a useful chapter for 'family, friends and helpers'.

The *Overcoming* series of publications on panic (Silove & Manicavasagar, 1997), anxiety (Kennerley, 1997), traumatic stress (Herbert & Wetmore, 1999), and social anxiety and shyness (Butler, 1999) all offer readable, accurate information on each of the disorders they cover. All publications in the series offer cognitive and behavioural techniques to overcome problems. Herbert and Wetmore (1999) state that their book 'is not intended as a replacement for therapy, and may even encourage you to seek out some specialist help' and it offers invaluable information for both sufferer and therapist. Silove and Manicavasagar (1997) seek to identify those clients for whom self-help therapy is appropriate and those who would need to seek professional help. They then offer advice on the use of behavioural and cognitive techniques for 'panic' and 'in

particular' their publication has two important chapters on preventing setbacks and on troubleshooting. Butlers' (1999) publication on 'social anxiety and shyness' offers an interesting section on the psychodynamic causes of social shyness and an overview of the disorder. The publication then gives a range of cognitive techniques to overcome the problem. Kennerley's (1997) publication on 'anxiety' includes informative, well-structured information on the disorder and cognitive and behavioural techniques to overcome anxiety.

Page (2003) offers a pocket-sized publication, *Don't Panic*, with a quick, useful explanation of anxiety symptoms and some cognitive and behavioural coping techniques.

This article is not complete without mentioning the next generation of self-help psychotherapies for anxiety and OCD, which will be delivered via adaptive computer-delivered systems. Self-treatment computer systems for anxiety and OCDs vary greatly in the degree to which they take on the therapeutic role, decreasing the need for clinician input (Oakley-Browne & Toole, 1994).

At one end of the spectrum, there are basic aids to therapy to be used by the clinician and patient to aid exposure in phobic anxiety, such as computer video-clips of spiders and virtual reality depictions of height (Hassan, 1992). A few systems are closer to becoming complete self-treatment systems, carrying out most of the therapeutic tasks involved in treatment and decreasing the need for input by a clinician by 80–95%.

In terms of therapeutic outcome, there is evidence to suggest that computer therapy is an acceptable approach in the treatment of anxiety (Carr *et al*, 1988) and computer-based interviews have been shown to be acceptable to patients (Erdman *et al*, 1992). There is evidence to support the effectiveness of palmtop computer treatment for panic disorder (Newman *et al*, 1997), BTSTEPS computerised voice-interactive behaviour therapy, accessed via a touch-tone telephone, for the treatment of OCD (Greist *et al*, 2002), FEARFIGHTER, a screen-based computer system for the treatment of phobic anxiety disorders (Marks *et al*, 2003) and *Beating the Blues*, a screen-based computer system delivering cognitive–behavioural therapy for anxiety and depression (Proudfoot *et al*, 2003). There are also promising results from uncontrolled studies for computerised cognitive–behavioural therapy for anxiety disorders (Stresspac; White, 2000), anxiety and depression (BALANCE; Yates, 2000; COPE; Osgood-Hynes *et al*, 1998).

Access to self-help for anxiety and for those with OCD is available in a number of formats ranging from websites putting people in contact with local self-help

groups and fellow sufferers (<http://www.triumpherphobia.com>) through to CD–Rom interactive publications. *Restoring the Balance*, based on BALANCE (Yates, 2000) is available from the Mental Health Foundation (<http://www.mentalhealth.org.uk>) as a CD–Rom publication. *Beating the Blues* software is available from Ultrasis Interactive Health-care (<http://www.ultrasis.co.uk>). FEAR-FIGHTER (Marks *et al*, 2001) (<http://www.fearfighter.com>) is available via internet access.

As the evidence for the cost-effectiveness of computer therapies increases, there is no doubt that such systems will be used more often in everyday clinical practice. In fact, at the time of going to press, computer-delivered psychotherapies for anxiety disorders are being incorporated into therapy services within a number of NHS trusts.

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Rethinking Risk Assessment. The MacArthur study of Mental Disorder and Violence

Monahan J, Steadman HJ, Silver E, Appelbaum PS, et al £29.50 hb

Over-funded, over-hyped, and over there. It is impossible for a British psychiatrist to look at the MacArthur study without a

twinge, if not a spasm, of envy. There are many reasons – 8 million to be specific, that being the dollar cost of this epic. I mean to say, in England, that sort of money could buy you half a dozen homicide inquiries, two Fallon reports or half of a new wall around Broadmoor. Oh well. The freedom to choose how we spend our money is one of the benefits of living in a democracy. Whoever we blame for our choice of priorities, it should not be John Monahan and colleagues.

So, put aside envy and look at how they spent their cash. At first sight, 8 million dollars does not seem to buy much research. The study is a 12-month follow-up of around a thousand patients discharged from general psychiatric hospitals in three US cities. Spending \$8,000 per subject is good going even for biological studies, where one expects to get serious technology for that kind of outlay. But there is serious technology on display here too, even though it is not in the form of chemicals or machines. The money and effort have gone into the measurement of behaviour, with semi-structured interviews before discharge, followed by interviews in the community every 10 weeks. A range of standardised instruments are employed, some developed for the study. Patient interviews are supplemented by the use of informants and official records; one can't have all that effort undermined by someone suggesting the self-report was all lies. The good news is that the self-report does well, picking up far more violence than official records.

There are few studies of outcome in psychiatry, and fewer still that mention violence. This is one of the few academic publications that will make, and deserves to make, money. Buyers will end up wiser, but they will be disappointed if they expect to read the last word on violence by psychiatric patients. The reservations arise from asking why psychiatrists should be interested in violence. The simple answer is that violence is a complication

of some mental disorders, but that does not make all violence equally fascinating. Patients have just as much right to get drunk and hit each other as do people without psychiatric disorders.

The central message of this study is that, for much of the time, patients behave like their friends and neighbours, so far as hitting other people is concerned. Assaults were common, committed by nearly 30% of patients over the year, but less than 10% of the assaults occurred when a patient was psychotic. Once substance misuse was excluded, patients did not have increased rates of violence and their violence followed the normal rules. The best single predictor of violence was personality disorder in the sense of psychopathy, as measured by the Psychopathy Checklist (PCL-R). Violence was also linked to alcohol, to previous violence and to neighbourhood context. This is all good news in the propaganda war between psychiatrists and politicians, but it does not help us with those rare and serious assaults that occur as a direct result of mental disorder. It will not help us to avoid a homicide inquiry. The authors produce a decision tree that classifies their patients efficiently as high or low risk, but the real test is whether it works as well with other groups of patients. Even then, it is unlikely to help us predict the rare, extreme violence that has caused so many problems for British psychiatry.

My personal gripe arises from the authors' claim that delusions were not important in predicting violence. The study is not designed to answer questions about delusions, partly because of the case mix. The more patients without psychosis there are in the sample, the less likely it is to reveal any association between violence and delusions. And what about those patients with psychosis who did not get into the sample because they were labelled as forensic cases? The presence of worrying delusions leads clinicians to assume that a patient is dangerous, thereby introducing systematic bias. A better design would have been to follow a cohort of patients with psychosis, describing how violence and delusions change over time.

The moral is that large-scale statistical studies are not the best way to investigate rare but catastrophic events. It may be heresy in a world where epidemiology is so grossly overvalued, but one can learn more about such events from a careful study of one man (provided it is the right man) than from a survey of thousands. Skinner and his behaviourists had a point when they claimed that the starting point for the study of behaviour is one pigeon, rather than a flock.

My only other criticism is the modest attention given to treatment. The study group was defined entirely by their status as patients and their experience of

