Correspondence

Psychological therapies for bipolar disorder – adjunct not alternative to pharmacological treatments

The British Psychological Society (BPS) recently published a report, *Understanding Bipolar Disorder– Why Some People Experience Extreme Mood Swings and What Can Help*'.[1] In the foreword they have clarified that the purpose of the report is to provide an overview of current knowledge about the disorder with a special emphasis on the psychological aspects. The authors hope that this report will become an important source of information for everyone and services would be tailored as per their recommendations.

From the outset, the report assumes an anti-psychiatry flavour. The authors have strong views about labelling extreme mood swings as an illness or treating them primarily with medications. They also cast serious doubts about the reliability and validity of psychiatric diagnoses by selectively using the personal anecdotes and evidence from the literature. We would agree with some of their statements and concur that the psychiatric diagnoses are not perfect, but they are based on scientific data about the cluster of symptoms, genetics and presumed aetiology, course and outcome and response to treatment. Furthermore, the arguments put forward can also be applied to many chronic physical health problems such as diabetes, hypertension, etc. However, the authors do not offer any alternatives to the diagnostic systems except that we should asses the degree to which a person is able to regulate his or her mood or behaviour. The running theme of the document is that bipolar disorder is a lifestyle choice and most individuals can control it or can be helped to control their mood swings by psychological therapies. What is shocking is that the authors make these sweeping statements without giving any evidence to support them. They have selectively used the evidence to vindicate their stand while turning a blind eye to other evidence; likewise, at times they have completely misconstrued the available evidence. For example, throughout the report the emphasis has been on the effectiveness of psychological therapy; all the research cited has been done on patients who were on medications, either stable or in a depressed state. We are not aware of any study which was done on either drug-naive or manic patients. The authors have also ignored the evidence that did not suit them. Scott *et al*[2] conducted a large, multicentre randomised controlled trial and compared treatment as usual with cognitive–behavioural therapy (CBT) and found no beneficial effect of CBT. Moreover, the authors of the BPS report also did not mention that one of the proposed mechanisms for the effectiveness of psychological therapies is by improving adherence to medications.[3,4] Therefore, the only conclusion that can be drawn from the available evidence is that psychological therapies, if used in conjunction with the pharmacological therapies, can enhance functional and symptomatic outcomes of bipolar disorder.[5]

The BPS was one of the contributors to the National Institute for Health and Clinical Excellence (NICE) guideline on bipolar disorder, but their current document is at odds with the NICE recommendations. Most guidelines recommend psychological therapy along with pharmacological treatment, not in place of it. Therefore, in its current form the document is misleading and is more an opinion piece than scientific publication.

1 British Psychological Society. *Understanding Bipolar Disorder – Why Some People Experience Extreme Mood Swings and What Can Help*. British Psychological Society, 2010.

2 Scott J, Paykel E, Morriss R, Bentall R, Kinderman P, Johnson T, et al. Cognitive–behavioural therapy for severe and recurrent bipolar disorders. Randomised controlled trial. *Br J Psychiatry* 2006; **188**: 313–20.

3 Lam D. What can we conclude from studies on psychotherapy in bipolar disorder? Invited commentary on . . . Cognitive–behavioural therapy for severe and recurrent bipolar disorders. *Br J Psychiatry* 2006; **188**: 321–2.

4 Miklowitz DJ, Scott J. Psychosocial treatments for bipolar disorder: cost-effectiveness, mediating mechanisms, and future directions. *Bipolar Disord* 2009; **11** (suppl 2): 110–22.

5 Milkowitz D. Adjunctive psychotherapy for bipolar disorder: state of the evidence. *Am J Psychiatry* 2008; **165**: 1408–19.

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doi: 10.1192/pb.35.5.196

The Recovery Star: is it a valid tool?

As a clinical psychologist working in an in-patient psychiatric setting, I am fully supportive of the principles behind the recovery model (or recovery approach) in the treatment of severe mental health problems. As such, I am fully supportive of efforts to ensure that the recovery approach is at the heart of the service delivery.

I have observed that a number of services – including our own – have adopted the Recovery Star model. The model is 'a tool for supporting and measuring change when working with adults of working age who are accessing mental health support services' (www.mhpf.org.uk/recoveryStarApproach.asp). Although I am supportive of the aim to measure such change, I am concerned that the Recovery Star model itself does not appear to have been considered in any peer-reviewed publications. Furthermore, there do not appear to be any available normative data published alongside the instrument, or any statistics indicating its reliability and validity. Given that the authors specifically describe the tool as something to be used to measure change, this is a very notable omission. Without such data it is impossible to know whether, for example, two different scores on two different occasions represent genuine therapeutic change or simply arise out of error; nor is it possible to know the extent to which two different clinicians using the tool would be expected to concur with each other. Furthermore, the tool proposes that ten different factors of recovery exist, yet again there is no mention of a factor analysis suggesting how such factors were derived or how they interrelate.

Although the development of instruments to measure patients' perceptions of engagement in the recovery model is

https://doi.org/10.1192/pb.35.5.196a Published online by Cambridge University Press

very important, I am of the opinion that no psychometric instrument should be used clinically until it has been administered to a suitable sample and the results have been subject to the usual peer-review process. If these vital steps are abandoned as unnecessary, we have no idea what the instrument is measuring or whether results amount to positive therapeutic change. Given that numerous other freely available instruments have been published and validated within a range of clinical samples (see Campbell-Orde *et al*[1] and Burgess *et al*[2] for two excellent reviews), it is puzzling that services are choosing to use an instrument where the basic statistical data are not available.

1 Cambell-Orde M, Chamberlin J, Carpenter M, Leff HS. *Measuring the Promise: A Compendium of Recovery Measures, Volume II*. Human Services Research Institute, 2005 (http://www.power2u.org/downloads/pn-55.pdf).

2 Burgess P, Pirkis J, Coombs T, Rosen A. *Review of Recovery Measures, Version 1.01*. National Mental Health Strategy, Australian Mental Health Outcomes and Classification Network (AMHOCN), 2010 (http://amhocn.org/static/files/assets/afdedaa1/Review_of_Recovery_Measures.pdf).

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doi: 10.1192/pb.35.5.196a

Prioritising the physical health needs of patients on clozapine

During an audit conducted between 2005 and 2007, we examined glucose and cholesterol monitoring in all patients on clozapine in Glasgow ($n = 569$). Using a computerised laboratory results system, we identified whether plasma glucose or cholesterol had been monitored in the preceding 12 months. Demographic data were comparable to the findings of Bolton,[1] with our patients having a mean age of 39 years and 73% being male. We were unable to determine whether blood samples were fasting, but we found only 46% ($n = 263$) had undergone glucose monitoring. Of these, 68 (26%) were $\geqslant 7.8$ mmol/l and 25 (10%) were > 11 mol/l. In relation to cholesterol monitoring, only 192 individuals (34%) had been tested, of whom 123 (64%) had cholesterol $\geqslant 5$ mmol/l. Our findings and those of Bolton indicate that a significant number of patients on clozapine continue to be unmonitored in relation to important metabolic markers, and of those who are tested, a substantial proportion have abnormal results. These factors may be contributing to the increasing mortality gap faced by this group of patients with complexity. As Taylor *et al*[2] demonstrated, standardised mortality rates are significantly increased in patients on clozapine, with a fourfold risk of dying compared with individuals receiving long-acting risperidone injection. Bolton advocates for specialist secondary care physical health clinics to ensure appropriate follow-up and to optimise communication with primary care. We are concerned that within the current economic climate, additional resources will not be made available for service development to address these needs. There is a remaining onus on mental health services to engage proactively and creatively within existing primary and secondary care services and in targeting early non-pharmacological intervention, for which there is an increasing evidence base.[3]

1 Bolton PJ. Improving physical health monitoring in secondary care for patients on clozapine. *Psychiatrist* 2011; **35**: 49–55.

2 Taylor DM, Douglas-Hall P, Olofinjana B, Whiskey E, Thomas A. Reasons for discontinuing clozapine: matched, case–control comparison with risperidone long-acting injection. *Br J Psychiatry* 2009; **194**: 165–7.

3 Álvarez-Jiménez M, Hetrick SE, González-Blanch C, Gleeson JF, McGorry PD. Non-pharmacological management of antipsychotic-induced weight gain: systematic review and meta-analysis of randomised controlled trials. *Br J Psychiatry* 2008; **193**: 101–7.

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doi: 10.1192/pb.35.5.197

Supervised community treatment

Sarah Woolley suggested that given the lack of robust scientific evidence of the benefits of supervised community treatment (SCT), it was questionable whether psychiatrists in England and Wales would take advantage of the new SCT powers introduced in 2008.[1]

Although the collection of SCT data is still in its infancy, we have in recent months seen two reports on SCT usage. The Mental Health Alliance's briefing on SCT[2] highlighted that the use of SCT in its first year was significantly higher than the government expected. From a survey of all active and retired members of the Royal College of Psychiatrists that received 533 responses, 324 members thought the SCT powers useful, whereas 74 did not.

The Care Quality Commission's first annual report on the Mental Health Act[3] confirmed the high use of SCT. In a sample of 208 cases, the Commission found that 30% of patients subject to SCT did not have a reported history of non-adherence or disengagement – 'This suggests that the high use of CTOs . . . could be a result of the powers being applied preventatively beyond the group of patients for whom they were primarily designed'.

We await better data on SCT from the Oxford Community Treatment Order Evaluation Trial (OCTET). In the meantime, however, it does appear that psychiatrists (and, of course, those approved mental health professionals who agree with them) are not being shy in using the SCT powers. In passing, it is worth noting that having an estimated 4000–5000 people living in the community under an SCT has led to no corresponding reduction in numbers of detained in-patients.

1 Woolley S. Involuntary treatment in the community: role of community treatment orders. *Psychiatrist* 2010; **34**: 441–6.

2 Lawton-Smith S. *Briefing Paper 2: Supervised Community Treatment*. Mental Health Alliance, 2010 (http://www.mentalhealthalliance.org.uk/resources/SCT_briefing_paper.pdf).

3 Care Quality Commission. *Monitoring the Use of the Mental Health Act in 2009/10*. Care Quality Commission, 2011 (http://www.cqc.org.uk/mentalhealthactannualreport2009-10.cfm).

Declaration of interest

The Mental Health Foundation is a member of the Mental Health Alliance.

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doi: 10.1192/pb.35.5.197a

https://doi.org/10.1192/pb.35.5.196a Published online by Cambridge University Press