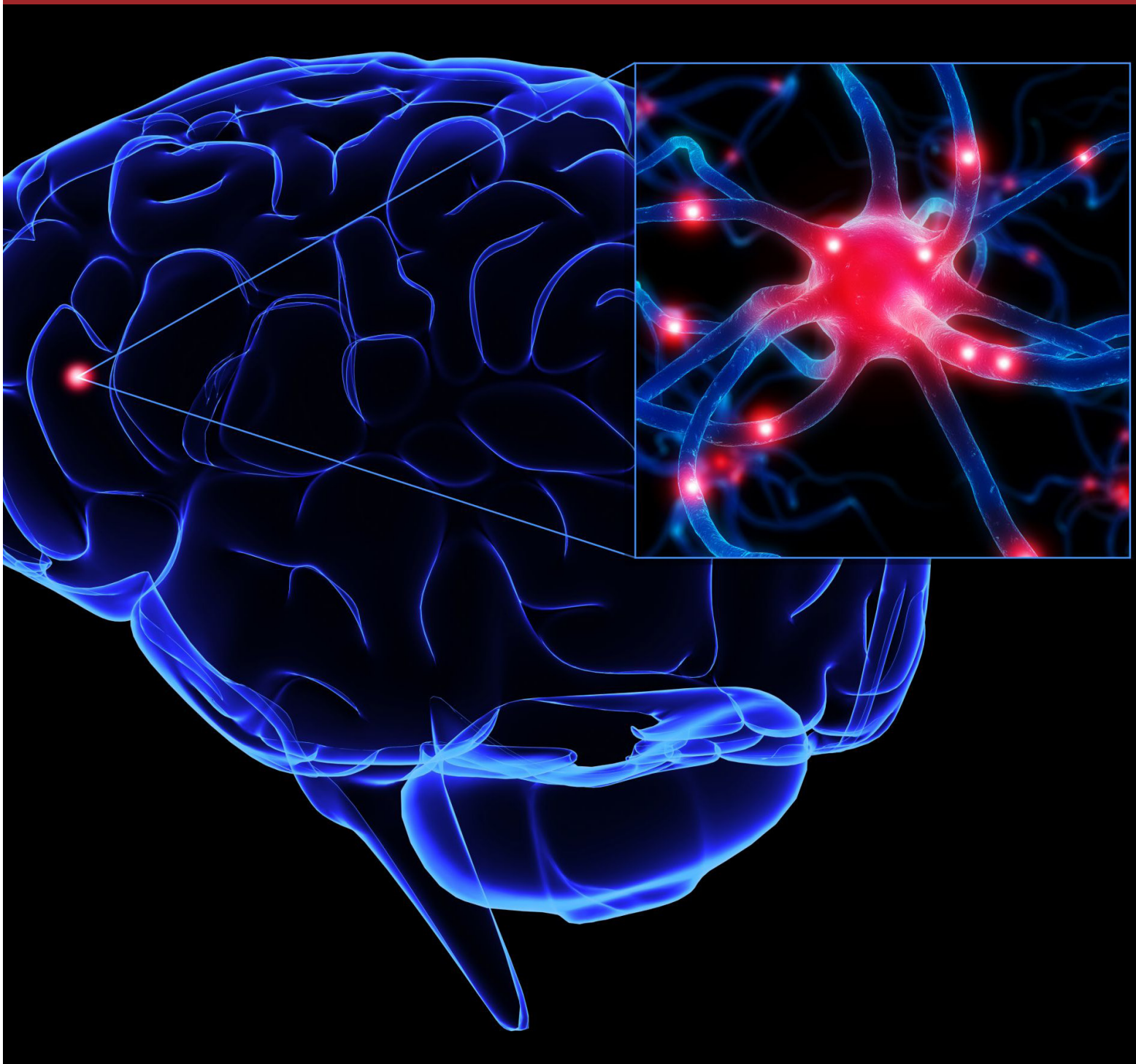


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## FOUNDATION YEARS JOURNAL 2012

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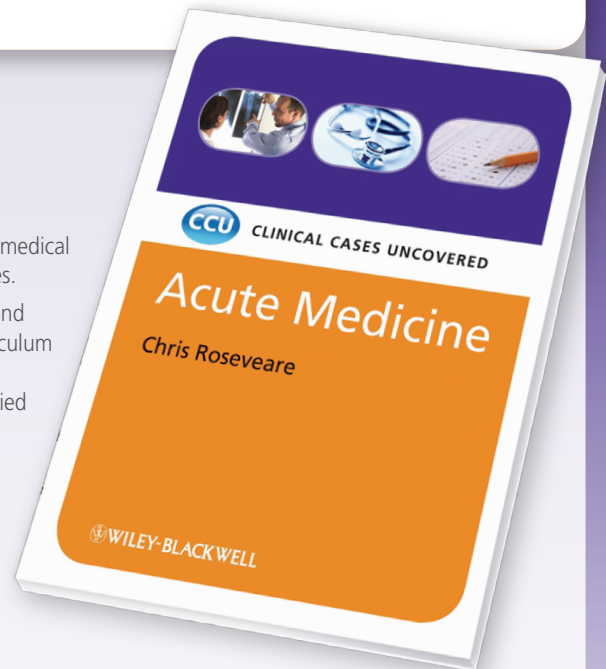
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 WILEY-  
BLACKWELL

# BENZODIAZEPINES AND Z DRUGS: MANAGING INAPPROPRIATE HYPNOTIC PRESCRIBING IN CLINICAL PRACTICE

DS Yadav & RH Davies



## Introduction

Inappropriate hypnotic prescribing is quiet common in clinical practice and is a widespread problem. This may lead to difficulty in withdrawing the drug if the patient has taken it for more than a few weeks. The use of hypnotics is associated with the development of tolerance, dependence and withdrawal symptoms.

The main groups of drugs used to alleviate symptoms of insomnia are the short acting benzodiazepines (nitrazepam, temazepam, lormetazepam, loprazolam). Zaleplon, Zolpidem and Zopiclone (the Z-drugs) are nonbenzodiazepine hypnotics. Although the Z-drugs differ structurally from the benzodiazepines, they are also agonists of the GABA receptor complex and therefore enhance GABA mediated neuronal inhibition[1, 2]. Diazepam, Lorazepam and the above mentioned groups of drugs are therefore the most commonly used hypnotics and anxiolytics.

The National Institute for Clinical Excellence (NICE) and the British National Formulary (BNF) have issued guidance that hypnotic drugs should be used for severe insomnia only, for short period of time and only after non-pharmacological measures have been considered[1, 2].

The Maudsley Prescribing Guidelines and the CSM (Committee on Safety in Medicines) and the Royal College of Psychiatrists have issued advice on how and when to prescribe hypnotics[3, 4 and 5].

## Background

Insomnia is a disturbance of normal sleep patterns commonly characterised by difficulty in initiating sleep (sleep onset latency) and/or difficulty maintaining sleep (sleep maintenance). However, insomnia is highly subjective and although most healthy adults typically sleep between 7 and 9 hours per night, patterns vary greatly between people, and in any given person there are variations from night to night[2].

Insomnia can have a number of different causes. Primary insomnia can be differentiated from insomnia associated with factors such as personal circumstances, physical or psychiatric co-morbidities, concomitant drug treatments or substance abuse (drugs, nicotine, alcohol or caffeine). Prevalence varies from 10-38%. Before a hypnotic is prescribed the cause of the insomnia should be established and, where possible, underlying factors should be treated[2, 3].

## Clinical Scenario

A 30 year old patient is admitted on to the acute psychiatric inpatient ward with a probable differential diagnosis of psychotic depression / acute psychosis. The patient and his family report that the patient has not been sleeping well for the last week or so. How do you proceed?

Concentrating on the sleep problem for the sake of this topic, we devised a treatment algorithm for insomnia followed by a step by step questions and answers to get a good grasp on rational prescribing of hypnotics in clinical practice.

## Treatment algorithm for insomnia

### Was the patient on hypnotic prior to admission? Yes/No

- what was the indication?
- what was the duration of treatment?
- consider the appropriateness of treatment

### Does, the patient have sleep difficulty on the ward? Yes/No

- use sleep chart to objectively document sleep problem;
- find the cause (physical, psychological, environmental);
- treat the underlying cause (physical, psychological, environmental);
- give information and advice on sleep hygiene

### Does, the patient need a hypnotic? Yes/No

- for pharmacological intervention, use NICE guidelines and BNF
- review daily/weekly

### If the patient is discharged:

- Monitoring of hypnotic is to be done: either by GP, CR/HT, or CMHT?

### Also consider:

- Specialist referral to sleep clinic?
- Use of newer drugs (melatonin, ramelteon, agomelatin)?
- CBT

For more advice, see:

[www.rcpsych.ac.uk](http://www.rcpsych.ac.uk)

[www.patient.co.uk](http://www.patient.co.uk)



## BENZODIAZEPINES AND Z DRUGS: MANAGING INAPPROPRIATE HYPNOTIC PRESCRIBING IN CLINICAL PRACTICE

DS Yadav & RH Davies

### Pharmacological Intervention (use NICE guidelines)

#### Consider the appropriateness of treatment:

- review daily/weekly;
- if discharged,

#### Monitoring to be done

- by GP, CR/HT, CMHT?
- Specialist referral to sleep clinic?
- Use of newer drugs (melatonin, ramelteon, agomelatin)?
- Cbt

### Questions

**Q1: What is the difference between a Hypnotic and anxiolytics?**

**Q2: What are the two types/groups of hypnotics commonly used in clinical practice?**

**Q3: What are the other hypnotics prescribed in clinical practice?**

**Q4: Which anxiolytics are indicated/licensed for use as hypnotics?**

**Q5: Which two drugs are the only controlled drugs amongst the hypnotics commonly prescribed?**

*Nitrazepam, Flurazepam, Flunitrazepam, Temazepam, Loprazolam, Lormetazepam, Zaleplon, Zolpidem and Zopiclone, Chloral Hydrate, Clomethiazole, Promethazine Hydrochloride, Melatonin, Barbiturates, Diazepam, Lorazepam and Diazepam.*

**Q6: Which are the cheapest and the most expensive hypnotic amongst the following?**

*Nitrazepam, Flurazepam, Flunitrazepam, Temazepam, Loprazolam, Lormetazepam, Zaleplon, Zolpidem and Zopiclone, Chloral Hydrate, Clomethiazole, Promethazine Hydrochloride, Melatonin, Barbiturates, Diazepam, Lorazepam and Diazepam.*

**Q7: What are the approximate equivalent doses?**

*Diazepam 5mg = ? Lorazepam  
Diazepam 5mg = ? Nitrazepam  
Diazepam 5mg = ? Temazepam*

**Q8: Before prescribing hypnotics, what are the things to consider?**

**Q9: What is sleep hygiene?**

**Q10: When we prescribe a hypnotic how many days does it take for the tolerance to develop?**

**Q11: When and how long do the withdrawal symptoms, develop and last?**

**Q12: What is the CSM's (Committee on Safety of Medicines) advice on the prescribing of hypnotics? What is the advice given by the Royal college of Psychiatrists on prescribing hypnotics?**

**Q13: What is the suggested protocol for patients who have difficulty in weaning off benzodiazepines?**

**Q14: What are the other strategies for discontinuing long-term benzodiazepine use?**

### Answers

**A1:** Hypnotics will sedate when given during the day and most anxiolytics ('sedatives') will induce sleep when given at night[1].

**A2:** Benzodiazepines and Non-Benzodiazepines. Nitrazepam, Temazepam, Loprazolam and Lormetazepam are the commonly used benzodiazepines. Non-Benzodiazepines are Zaleplon, Zolpidem and Zopiclone.

**A3:** Chloral Hydrate, Clomethiazole, Promethazine Hydrochloride and Melatonin. Chloral hydrate is used in the paediatric population. Clomethiazole and Melatonin are used in the older population group. Promethazine is prescribed in the paediatric and adult population.

**A4:** Diazepam, Lorazepam and Barbiturates (only in patients already taking barbiturates) [1].

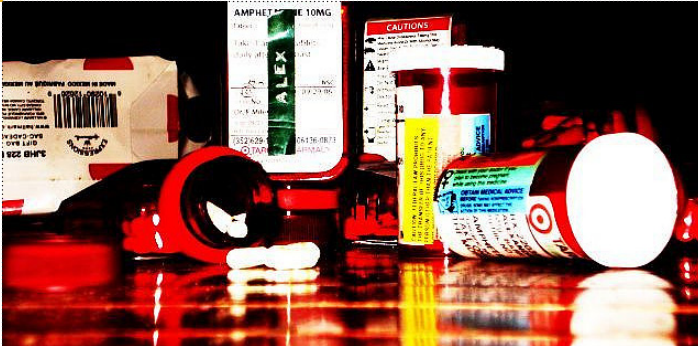
**A5:** Temazepam and Barbiturates are subject to controlled drug regulations and requires suitable storage to fulfil safe custody requirements[1].

**A6:** According to NICE "there is no compelling evidence of a clinically useful difference between the Z drugs and short-acting benzodiazepine hypnotics from the point of view of their effectiveness, adverse effects or potential for dependence or abuse" and therefore recommends using the hypnotic with lowest cost (temazepam) and for a short period of time only (up to four weeks). In 2002, a total of 3.9 million prescriptions were written for zaleplon, zolpidem and zopiclone with a net ingredient cost of £15.9 million[2].

- Diazepam (28 tab = £0.76)
- Temazepam (28 tab = £1.41)
- Zopiclone (28 tab = £ 1.71)
- Lormetazepam (30 tab = £97.81)

## BENZODIAZEPINES AND Z DRUGS: MANAGING INAPPROPRIATE HYPNOTIC PRESCRIBING IN CLINICAL PRACTICE

DS Yadav & RH Davies



### Benzodiazepines and Z drugs: Managing inappropriate hypnotic prescribing in clinical practice Good Clinical Care

#### A7:

- Diazepam 5mg = 0.5mg Lorazepam
- Diazepam 5mg = 5mg Nitrazepam
- Diazepam 5mg = 10mg Temazepam

**A8:** Before a hypnotic is prescribed the cause of the insomnia should be established and, where possible, underlying factors should be treated[3].

1. Is the underlying cause being treated (depression, mania, breathing difficulties, urinary frequency, pain, etc)?
2. Is substance misuse or diet a problem?
3. Are other drugs being given at appropriate times? (i.e. stimulating drugs in the morning, sedating drugs at night) If a centrally acting sedative drug is prescribed at bedtime, additional hypnotic may not be required.
4. Are the patient's expectations of sleep realistic? (sleep requirements decrease with age)
5. Have all sleep hygiene approaches been tried?
6. Whether or not a female patient is pregnant? Risk-benefit analysis is a must.

#### A9: Maudsley Sleep Hygiene Approaches[3]

1. Reduce or stop daytime napping.
2. Increase daily exercise (not in the evening).
3. Reduce caffeine or alcohol intake, especially before bedtime. Avoid caffeine after midday.
4. Use the bedroom only for sleeping
5. Use anxiety management or relaxation techniques.
6. Develop a regular routine of rising and retiring at the same time each day, regardless of the amount of sleep taken.

Sleep Hygiene Approaches (SHA) are not always feasible due to the high number of patients on the ward and sometimes not realistic as hospital wards have been demonstrated as environments that are not conducive to sleep for patients, but nevertheless should be considered. SHA is also recommended by the NICE guidelines.

**A10:** Tolerance to their effects develops within 3 to 14 days of continuous use and long-term efficacy cannot be assured.

**A11:** The benzodiazepine withdrawal syndrome may develop at any time up to 3 weeks after stopping a long-acting benzodiazepine, but may occur within a day in the case of a short-acting one. Some symptoms may continue for weeks or months after stopping benzodiazepines.

Withdrawal should be gradual because abrupt withdrawal may produce confusion, toxic psychosis, convulsions, or a condition resembling delirium tremens.

Withdrawal features can be categorized into physical symptoms or psychological symptoms. The physical symptoms are stiffness, weakness, GI disturbance, paraesthesia, flu-like symptom and visual disturbances. The psychological symptoms are anxiety, and rebound insomnia, nightmares, depersonalisation, decreased memory and concentration, depression, delusions and perceptual disturbances.

**A12:** The CSM advises on usage, dosage and the precautions to be used in prescribing benzodiazepines[4].

#### Uses as Anxiolytics

1. Benzodiazepines are indicated for the short-term relief (two to four weeks only) of anxiety that is severe, disabling, or subjecting the individual to unacceptable distress, occurring alone or in association with insomnia or short-term psychosomatic, organic or psychotic illness.
2. The use of benzodiazepines to treat short-term 'mild' anxiety is inappropriate and unsuitable.

#### Uses as Hypnotics

3. Benzodiazepines should be used to treat insomnia only when it is severe, disabling, or subjecting the individual to unacceptable distress.





## BENZODIAZEPINES AND Z DRUGS: MANAGING INAPPROPRIATE HYPNOTIC PRESCRIBING IN CLINICAL PRACTICE

DS Yadav & RH Davies

### Royal College of Psychiatrists Advice[5]

4. Use the lowest effective dose
5. Use intermittent dosing (alternate nights or less) when possible
6. Prescribe for short-term use (no more than 4 weeks) in the majority of cases.
7. Discontinue slowly
8. Be alert for rebound insomnia/withdrawal symptoms.
9. Advise patients of the interaction with alcohol and other drugs.
10. Avoid the use of hypnotics with respiratory disease or severe hepatic impairment and in addiction-prone individuals.

### A13:

1. Transfer patient to equivalent daily dose of diazepam preferably taken at night.
2. Reduce diazepam dose every 2-3 weeks in steps of about one-eighth. (Range one-tenth to one-quarter). Some patients may tolerate more rapid reduction and others may require a slower taper.
3. If withdrawal symptoms occur, maintain this dose until symptoms improve.
4. Reduce dose further, if necessary in smaller steps. It is better to reduce too slowly rather than too quickly.
5. Stop completely. The time needed to withdrawal can vary from about 4 weeks to a year or more.[183]

### A14:

1. Evidence was found for the efficacy of stepped care in discontinuing long-term benzodiazepine use (minimal intervention- giving simple advice in the form of a letter or meeting to a large group of people, followed by systematic discontinuation- defined as treatment programmes led by a physician or a psychologist). Augmentation of systematic discontinuation with imipramine or group cognitive-behaviour therapy for patients with insomnia was superior to systematic discontinuation alone [6].
2. Other adjunctive treatments include the use of antidepressants, mood stabilizing drugs, and melatonin for people with insomnia [3].
3. CBT (cognitive-behaviour therapy) may be more effective than hypnotics in improving sleep in the long term [7].

### Learning Points

1. The choice of management strategy for insomnia is dependent upon both the duration and nature of the presenting symptoms. Appropriate management of existing co-morbidities may relieve the symptoms.
2. The provision of advice on appropriate routines to encourage good sleep is fundamental to the overall management strategy, for example, avoiding stimulants and maintaining regular sleeping hours with a suitable environment for sleep.
3. Other non-pharmacological interventions (for example, cognitive behavioural therapies) have also been shown to be effective in the management of persistent insomnia.



4. However, although doctors, pharmacists and psychiatrists can deliver appropriate advice and education, access to many non-pharmacological therapies is restricted through a combination of a lack of trained providers, cost and a poor understanding of available options.

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# MADNESS, MENARCHE OR MISOGYNY?

C Fernandes



## Madness, menarche or misogyny? Teaching & Training

### So were women more prone to madness or was just misogyny?

Let me set the scene. In nineteenth century Britain, there were dramatic changes in the ways 'madness' (a wide ranging term for all mental illness, also known as 'insanity') was viewed and treated - namely that the fairer sex was also seen as the mentally feeble sex, and highly susceptible to becoming 'mad'. This is well documented in the literature of the time. It was claimed that women were over-represented in asylums for this reason. But why were women seen to be more susceptible to madness in the eyes of Victorian society, science and the medical profession?

In 1845 the 'Lunatics Act' was passed, which dictated that the state must provide care for the mad. Asylums were built in order to care for those suffering from madness. These not only provided a place for people to put family members that they would have previously kept locked away at home but also an opportunity for doctors to study madness and its causes. Those suffering could be sent there for care and attempted cure. One historian claimed that the male to female ratio in asylums was 'roughly 4:5'.<sup>1</sup>

The new asylums quickly filled. In the rapidly advancing industrialisation of the country, men were seen to suffer from mental disease owing to the increasing socioeconomic pressures put upon them. Their mental difficulties were seen as a sign of the progress that the country was enjoying.

In contrast, women were claimed to be prone to illnesses of the mind because of their weaker constitution. Their physical make up and life stages were key aspects in their apparent frailty: madness often being 'connected with the peculiarities of their sex'.<sup>1</sup> Before I go any further, let me assure you that I do not advocate these views!

### Abstract

In 19th Century Britain women were statistically over-represented in asylums: by 1872, out of 58,640 certified lunatics in England and Wales, 31,822 were women. What then made women 'more susceptible to madness?' Many reasons were suggested.

Apart from weaker constitutions, women were deemed most at risk during puberty, pregnancy, after childbirth and the menopause, when their 'mind would be weakened and ... symptoms of insanity might emerge'. The constant oppression of women in Victorian society could result in frustration and boredom leading them to 'strange thoughts'.

Darwinism theories were also used to elucidate women's natural inferiority to men. Women had 'some degree of moral perversion', for which education and religion was used as a cure.

Feminists argued that asylums ('locking up troublesome women') were a way for men to control women. It is claimed that male doctors wished to maintain their monopoly on the profession.

Others assert that the greater numbers of women were owing to a comparatively higher mortality rate amongst male patients. Longevity in women would dictate that female patients accumulated.

Men's mental health problems were put down to 'hypochondriasis' or socio-economic pressures. So were women more prone to madness or was just misogyny?

## MADNESS, MENARCHE OR MISOGYNY?

C Fernandes

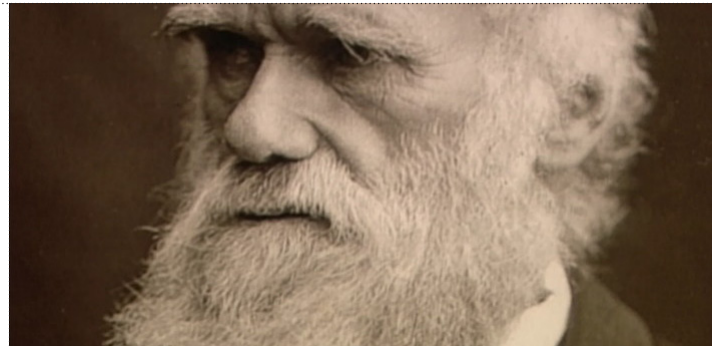
Women were seen to be at higher risk of madness during certain times, including menstruation, shortly after childbirth and the menopause, being 'at the boundary between physiology and pathology'.<sup>2</sup> During these times it was thought that a woman's 'mind would be weakened and the symptoms of insanity might emerge'.<sup>1</sup>

Menstruation was seen as a necessity for, but also a danger to health. The attitudes demonstrated by women during each menstrual period were also viewed as symptoms of insanity. Nowadays, a diagnosis of exclusion, Premenstrual Dysphoric Disorder (PMDD) is used to indicate serious premenstrual distress with associated deterioration in occupational and social functioning preceding menses that cannot be attributable to another disorder.<sup>3</sup> The causation is multifactorial, with further study required. However, it is seen as a separate to depression and other mental illnesses.<sup>4,5</sup>

Puerperal insanity was that which ensued within a month of birth, entailing depression and aversion to the newborn child. In its severest form it culminated in infanticide.<sup>3</sup> This was especially disconcerting in Victorian society when the ideals of marriage and motherhood were paramount. One cause attributing to this was 'lactational insanity' was an affliction of mothers who breast-fed for long periods since they could not afford food for their children and consequently became delusional through malnutrition and anaemia. This was inevitably an illness of lower classes. Other causes of mental illness that seen in the Victorian puerperal period which still occur today include the psychiatric emergency 'puerperal psychosis', ante and post natal depression, and co-current mental illness.<sup>6</sup>

The menopause was another traumatic time for women since it marked the end of fertility. The ceasing of menstruation, a vital part of the well being in women, was seen to cause symptoms of hysteria and other psychological ails such as hot flushes, irritability and melancholy.<sup>1</sup>

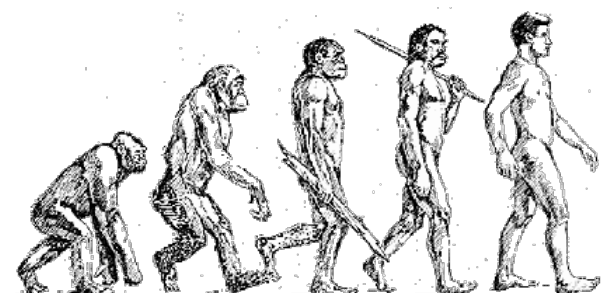
Another popular theory implicating women's predisposition to insanity was the concept of humans having a limited reserve of 'intrinsic energy', as claimed by Dr Henry Maudsley, a prominent physician of the nineteenth century, being the superintendent of the Manchester Royal Lunatic Society and editor of the now British Journal of Psychiatry. In women, it was claimed, this energy was for child bearing and raising children and that any extra energy expended would jeopardise their reproductive systems, making employment or education were hazardous for women to pursue. It was dictated that 'women must therefore, if they are to be good wives and mothers, concentrate on developing their reproductive systems' and not waste energy elsewhere.<sup>1</sup>



Darwinism, which embodied popular theories about evolution, was used to elucidate how weaknesses in women were a sign of the evolution of society and the necessity for their natural inferiority to men. It saw insanity as the product of 'organic defect, poor heredity and a bad environment'. Another Darwinian idea, that of degeneration dictated that insanity was inherited by offspring and became increasingly severe over generations. It was understood that predisposition to lunacy was inherited down the female line and that girls were 'far more likely to inherit insanity from their mothers than from their fathers'.<sup>7</sup>

The ideas of evolution and limited energy sources were central in the opposition to women entering education or employment, lest they should become incapable of bearing and raising healthy offspring and the society suffer. Moral and religious failings were attributed to being a cause of madness. Physicians also believed this. One claimed that in female disorders of the mind 'there is always some degree of moral perversion'.<sup>1</sup> It was believed that the insane needed to be guided back to moral reasoning and sanity through education and religion. Even if the cause of the disease could not be identified, most were in agreement that moral management and 'exercising of will' were crucial for recovery.

One condition that might ensue from excessive energy expenditure, poor heredity or other predisposing factors was hysteria. The word "hysteria" is derived from the Greek word hysteros, "womb." It was seen as a form of madness, a condition describing a range of symptoms from eye rolling to fainting to parasthesia. It is the oldest illness in the history of medicine, along with epilepsy.<sup>1</sup> It was first described by Hippocrates, seen to be a condition caused by the womb which was envisioned as an autonomic organ that could wander the body, especially in the absence of coition, it could rise upwards, causing suffocation, loss of speech amongst others. Hence it was thought to be caused by the 'wandering womb', therefore a malady specific to women.



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As a consequence of these theories, most asylum admissions appeared to be female. Since women were known to experience conditions such as hysteria more frequently than men and doctors wished to study them, more institution space was allocated to the female patients. Other historians assert that the greater numbers of women are owing to a comparatively higher mortality rate amongst male patients. Longevity in women would necessarily dictate that female patients accumulated since they stayed longer and therefore in a snap-shot view would make up a larger proportion of the patient population. There was also known to be a higher insanity incidence amongst the poor and since women were usually financially dependent, more paupers were female.

There was suggestion at the time that it was this constant suppression of women in society that made them susceptible to madness. Their frustration with their poor education and lack of opportunities in life was a chief cause of mental symptoms. Whilst men had work and social commitments occupy them, women were denied 'the amusements and excitements of town' and that this boredom may lead to alcoholism and strange thoughts.<sup>1</sup>

Feminist theories since the nineteenth century claim asylums and the diagnosis of madness to be simply a way for men to exert control over women. Asylums became a convenient way to be rid of troublesome daughters or wives. It is alleged that men wanted women to retain their subservient roles and silence their voices.<sup>1</sup>

The end of the nineteenth century saw another change in the field of psychology with Freud and his ideas of psychoanalysis. His early theories described how sexual trauma in early childhood led to hysteria.<sup>8</sup> His research into dream analysis (the idea that dreams are due to the unconscious mind) was conducted on hysterical women and it was from these observations that he developed his theories.<sup>1</sup> Freud's ideas and those of his colleagues were the beginning of a drastic change in psychology and meant that the insane would come to be seen differently again in the twentieth century.

### Madness, menarche or misogyny? Teaching & Training

In the present day, statistics show rates of anxiety and depression are between one and half and two times higher in women than in men.<sup>9</sup> Rates of self-harm (including cutting, burning and overdose) are two to three times higher in women than in men.<sup>9</sup> Reasons for this gender disparity are complex. Women are more vulnerable to risk factors associated with adverse mental health including gender based violence and abuse, socio-economic disadvantage and low income, or income inequality.

Older women are particularly more vulnerable to factors linked with mental ill health, as they are more likely to experience bereavement and institutional care relating to poverty and social isolation.<sup>11</sup> Gender bias also exists in the diagnosis and treatment of psychological disorders, with women more likely to disclose emotional difficulties than men. Doctors are also more likely to diagnose depression in women compared with men, even with identical symptoms and similar scores on standardized measures of depression.<sup>12</sup>

To conclude, in the nineteenth century it was claimed that women were statistically over-represented in asylums. There were many theories as to why this was, including ideas about their physical make up and life stages, their expected roles in society and moral convictions. It has been debated since whether madness at the time was actually a 'female malady', if the numbers in institutions really had a gender bias and if the idea of insanity was simply an attempt at male domination over women.

There are however extensive collections of work from doctors at the time that document their theories on insanity and their reasons for believing them. It can be seen from these that women were seen as being more susceptible to mental illness and fears existed regarding the future of the species if women endangered their traditional roles by pursuing other enterprises.

Whilst many of these postulations are no longer theorised in modern medicine, women's mental health issues are still prominent in today's society. But whether madness in the nineteenth century women was actually mental illness due to life events such as menarche, or if misogyny was involved, I leave for the reader to decide.

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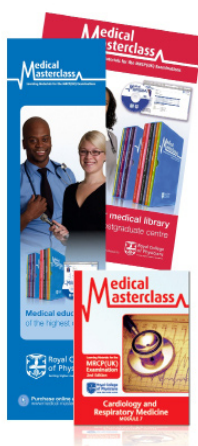
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# RECOGNITION MANAGEMENT OF MENTAL HEALTH PROBLEMS IN HOSPITAL

S Simpson



## Abstract

The prevalence of mental health conditions in people on an elderly care ward is 65% with the commonest disorders being delirium, dementia and depression. Anxiety disorders are also common but less severe with serious mental illness being rare. It is therefore important to consider not only the medical presentation but also the psychiatric presentation of the patient in understanding their treatment. Antipsychotic drugs should not be prescribed outside the specialist psychiatric services. This paper considers the presentation and management of these disorders and the most beneficial method of treatment.

## Introduction

Mental health problems are extremely common in the hospital setting, especially in the elderly care wards. A major psychiatric diagnosis is present in 65% of elderly people occupying a general hospital bed (Goldberg et al, 2011). Therefore it is an essential part of foundation year competence to deal with the common psychiatric conditions in hospital and to be extra vigilant when examining the mental state of elderly people.

## Specific Conditions

### The commonest psychiatric disorders in a hospital setting are:

- Delirium
- Dementia
- Depression

Anxiety disorders such as panic attacks and insomnia are also common, although less serious. Serious mental illness should be rare such as Schizophrenia and Bipolar Affective Disorder as they only affect 1% of the population. Mental health problems impact a lot on the expression of physical health symptoms, therefore medically unexplained symptoms are common in the hospital setting and doctors will benefit from considering psychiatric elements to the patient's presentation thereby gaining an holistic understanding of their symptoms.

## Delirium

**Delirium is a temporary state of confusion caused by a change in health or medication with a resulting change in cerebral physiology and functioning. The symptoms of delirium include:**

- confusion;
- hallucinations (nearly always visual to the extent that auditory hallucinations bring the diagnosis of delirium into serious doubt);
- a marked fluctuation in the level of confusion and hallucinations.

There are various types of delirium, for example overactive behaviour such as agitation, and restlessness but equally delirium can cause an apathetic withdrawal. The latter is harder to recognise as the person will remain quietly in bed and avoid diagnosis.

## Management of Delirium

Delirium is not a psychological phenomenon. It is a metabolic alteration in brain functioning as a result of toxicity in the body. For example a high urea level above 10 mmol/l can affect neuronal function leading to confusion or hallucinations. Management is very much about pursuing a vigorous search for an underlying medical cause of delirium, such as infection, biochemical, metabolic, poly pharmacy, iatrogenic and cerebral and cardiovascular events are also very strong causes. The underlying medical condition should be treated vigorously to help facilitate the restoration of the mental function.

Sedation should be avoided wherever possible as there is no sedation or psychiatric prescription that will improve delirium (BGS, 2006) and the risk is that sedation will make the patient worse by impairing mental function further. However, it is acceptable to use psychotropic medication in certain restrictive circumstances, for example to help slow down or restrain an agitated, very disturbed patient, who is posing themselves or others severe harm or risk, for example through falls or accidental injury or violent interactions. Please follow the guidelines below for rapid tranquilisation and drug treatments of delirium.

## Rapid Tranquillisation

Rapid tranquilisation is the induction of a state of calm as soon as possible in acutely disturbed or violent patient. All hospitals will have a rapid tranquilisation policy, which should be followed when using sedation. Sedation should not be used unless absolutely necessary. It worsens the prognosis for delirium and in particular anti-psychotic drugs are linked with increased risk of death as well as confusion and also cerebrovascular and cardiovascular events (CSM, 2004, Douglas et al, 2008).

The doctor must weigh up the benefits and disadvantages of medication against not medicating the patient. The patient is likely to lack the capacity to understand the need for their tranquilisation and so the guidelines of the Capacity Act should be followed (MCA 2005).

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It is no longer thought to be safe to give injections of anti-psychotic medications to a patient who is being restrained (CSM, 2004). The first line treatment should be Lorazepam ½ - 1 mg stat and repeated after 30 minutes if necessary. The maximum dose should be 2 mg per day for someone over 65 and 6 mg per day for someone under 65. It can also be given orally if the patient is compliant. If the patient goes to sleep under the influence of a benzodiazepine, they should be managed as a medically induced coma.

Their oxygen saturation in particular should be monitored regularly and IV Flumazenil should be given as the antidote to counter any respiratory depression and in particular if their oxygen saturation drops. The medical observations of the patient's unconsciousness should be continued until they recover consciousness. Next of kin or Lasting Power of Attorney must be kept informed if the person lacks capacity.

A psychiatric diagnosis underlying the patient's behaviour should be made and where this is uncertain then an opinion from a liaison psychiatrist should be obtained.

### Capacity Act versus Mental Health Act

Sedation can be used if it is in the best interests of the patient, for example their risk of self-harm or injury to other people is so high that it justifies the side effects from being sedated. This should be discussed with other relevant health care professionals and relatives, the most important of which is either, the person's Lasting Power of Attorney, or next-of-kin.

An effort should be made to contact the Lasting Power of Attorney or their next of kin before proceeding with treatment against someone's will or without their full consent. If sedation needs to be given and relatives have not been found, for example in the middle of the night, this should be documented in the notes.

The next of kin should inform you of any written advance directives for care and whether anyone in the family holds a lasting power of attorney. Where there is a written and available advance directive or family member with a Lasting Power of Attorney, it will be very difficult to make decisions that are against their wishes.

Where the person exhibits a disturbance of mind and they continue to repeatedly behave in a dangerous way or if sedation is being considered more than once, an opinion from a psychiatrist on liaison should be requested, with a view to helping to make a care plan and considering the use of the Mental Health Act. It is important to remember that the Mental Health Act carries no powers of treatment for physical health conditions against the person's wishes and is purely restricted to mental health treatments usually in a psychiatric ward and not in a medical ward.

When a patient refuses medical treatment that poses risk they should have a documented assessment of their capacity. If it is lacking, the principles of the Capacity Act should be followed. When capacity is preserved they cannot be treated without consent.



### Serious Mental Illness

The serious mental illnesses are Schizophrenia and Bipolar Affective Disorder. These conditions are rare and unlikely to present for a first time in a hospital setting. Most patients with severe mental illness will have been identified at the early stages and are known to the Community Mental Health Teams. Your liaison hospital service will be able to put you in touch with the nearest mental health team based on the patient's GP and they will be able to inform you if they have a known diagnosis of Schizophrenia or Bipolar Affective Disorder. It will be necessary to take their condition into account in management to help avoid causing distress or relapse in their condition.

### Medically Unexplained Symptoms

Mental Health conditions impact markedly on the clinical expression of physical symptoms. Symptoms such as pain and immobility can be exaggerated. Many anti-depressants are also licensed to treat pain. Duloxetine, Amitriptyline and Venlafaxine are often the best medicine for pain. Symptoms can also be minimised for example, patients with Schizophrenia and dementia often present with very advanced medical conditions with little in the way of expression of physical complaints. So vigilant medical screening of patients with Schizophrenia and dementia will be more fruitful than expected. This is called the pathoplastic effect of mental illness.

Depression can markedly influence physical symptoms and hypochondriac features of depression are commonly due to the person's focus on bodily symptoms out of proportion with their medical condition. It is therefore very important to screen for depression in people with medically unexplained symptoms. There are a variety of good depression screening instruments such as the Montgomery Asberg Depression Scale (Montgomery et al 1979); a score of above 20 is likely to mean moderately severe depression. For more elderly people the Geriatric Depression Scale is also a valid way of screening and identifying cases of depression. The Gold Standard for doctors is to use the DSM-IV (DSM-IV, 1994) to diagnose major depression. These are as follows.

### Diagnosis of Major Depression (10% of inpatients)

#### The patient must have one of the following:

- low mood representing a change from normality for most days most of the time for at least a 2 week period;
- loss of pleasure in normal acquaintances and activities representing a change from normal and being present for at least a 2 week period.

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### Plus at least four of the following:

- loss of appetite;
- insomnia;
- psychomotor disturbance for example psychomotor agitation or vegetative slowing of mind and body;
- fatigue;
- sad thinking, for example dwelling on past failure and feeling pessimistic;
- poor concentration;
- suicidal features, for example wishing that they were dead and having thoughts of terminating their life, with or without actions.

### Factitious Disorder, Malingering and Hysteria

Patients can often complain of medical symptoms with no underlying physical cause. This can happen in the absence of a Major Depression, and can be caused by Hysteria. Hysteria leads to physical symptoms in the body as a result of emotional traumas that the patient cannot face up to. The physical symptoms are called conversion symptoms. The expression of the bodily symptoms (Conversion) will fluctuate in proportion to the person's emotional state. This is done subconsciously and the patient does not know they are doing it. It is not a wilful manifestation of physical illness and it happens subconsciously. It is not malicious and should be dealt with sensitively and empathically by finding out what the relevant environmental stresses are for that person.

Hysteria is very different from the factitious disorder (Munchausen's syndrome). With factitious disorder the patient is consciously fabricating their physical symptoms with a view to deceive the doctor. The patient has a neurotic internal gain from successful deceit. This usually stems from a severe conflict during their upbringing which has led to problems with authority and they will usually have a long history of factitious presentations to casualty departments and other hospitals. It is important to realise that the person is aware of what they are doing and these are not subconscious processes and require firm boundaries and management to prevent deceptions escalating.

Malingering is different from factitious disorder only in that the patient's gain is not an internal neurotic one but an easily understood external benefit, for example delayed discharge due to fear of going home or losing financial disability benefit.

Malingering, Factitious disorder and Hysteria should never be diagnosed in the presence of the above syndrome of major depression. In particular, beware hysteria in the elderly as it is strongly suggestive of either genuine undiagnosed medical pathology or depression

### Milder Mental Health Problems.

Anxiety, panic attacks and insomnia are common. It is important to do a depression screen to help rule out a more severe underlying major depressive cause see above. For example, insomnia and anxiety symptoms can be part and parcel of a depressive episode. If the patient lacks the full syndrome for major depression above, they are less likely to respond to a biological psychiatric prescription.

Anxiety is best dealt with non-pharmacological means using psychological techniques and relaxation and reassurance. Insomnia can be dealt with without using medication by using sleep hygiene, for example by having a corrected routine for getting up in the morning and activity during the day time. Zopiclone and Temazepam are licensed for short-term use only after non-pharmacological and sleep hygiene approaches have been tried.

### Dementia

Dementia is over represented in hospital settings when compared to community dwelling adults. Approximately 65% of people on an elderly care ward will have a dementia of (Goldberg et al, 2011) some severity and cognitive impairment is common in neurological wards. Parkinson's disease is a major risk factor for dementia and 50% of people with Parkinson's disease will have a Parkinson's dementia after an average of 10 years of their illness.

Alzheimer's disease is the commonest form of dementia and hospital admission magnifies it because the person lacks short-term memory and they become very disorientated in the unfamiliarity of the hospital. Cognitive function often restores dramatically when they return home and so good early discharge planning is important for this condition. Vascular dementia is the second commonest cause of dementia after Alzheimer's disease.

Cognitive function improves for 3 to 6 months after stroke but can become permanent. Enduring cognitive impairment in vascular patients is likely to be a sign of vascular dementia. This can be detected by using the Addenbrookes Cognitive Examination (Dudas et al 2005) and the Crichton Activities of Daily Living Scale for dementia (Robinson, 1965). Good anti-vascular medication and stroke prevention medication should help improve the prognosis for vascular patients.

The current anti-Alzheimer's drugs are of only modest benefit and are symptomatic and can only be initiated by specialists in elderly care or neurology. Patients should be screened and accurately diagnosed according to NINCDS ADRDRA criteria as stipulated by NICE. The local liaison old age psychiatrist will be able to help and advise with a view to starting treatment in discussion with next-of-kin and Powers of Attorney when suitably stable at home or in care.



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### Patient Case Study

A 70 year old lady was admitted to hospital because of gait disturbance, syncope, falls low blood pressure. On admission the patient was confused with fluctuating hallucinations poor mobility, little speech that was slurred in nature and she exhibited a severe Parkinson's syndrome. Her current medication was risperidone 1mg bds, haloperidol 0.5mg tds, aspirin, atenolol and bendroflumethiazide.

Her daughter was the next of Kin and held the lasting power of attorney and came to the ward to give further background history. The daughter said she had no knowledge of the tranquilisers, which must have been started recently and possibly at the previous hospital admission. Her mother had just been rehabilitated from another medical ward 3 months earlier and then placed in a local low level private residential care home. No dementia assessments or diagnosis had been attempted at the previous hospital or in the residential home. A working diagnosis of probable acute on chronic confusion was established. The underlying cause of her delirium was established as probably iatrogenic due to sedation. Antipsychotic drugs should only be used under specialist prescribing and supervision to treat dementia and certainly never in combination.

The patient lacked mental capacity so the principles of the Capacity Act were invoked. The doctor and next of kin decided that it would be in the patient's best interests to stop the tranquilisers immediately and give procyclidine as the antidote for the major tranquiliser's side effects. Social services were contacted to start adult protection proceedings for negligent care and to protect the patient in future. After a week her cognitive function and health improved. A CT scan confirmed atrophy and an ACER cognitive assessment showed a score of 64%, thereby confirming probable Alzheimer's disease as the dominant underlying condition.

Two weeks later a multidisciplinary meeting with the Doctor, nurse in charge of ward, lasting power of attorney and social services was held. Using the principles of the Capacity Act a decision was headed up by the lasting power of attorney that it was in her mother's best interests to remain sedation free and to be rehabilitated home with a care package including day care community psychiatric visits and home care twice a day. The ward discharge letter included a referral to the local Consultant Psychiatrist to be considered for treatment with anti-Alzheimer's medication

### Questions

#### True or false?

1. The Mental Health Act is helpful for physical health treatment in patients who do not consent.
2. The Mental Health Act is used in mainly psychiatric wards.
3. The Capacity Act is helpful in dealing with physical health problems when a patient is not consenting.
4. The lasting power of attorney should be involved in decisions where a patient has capacity.
5. The next of kin should be involved when a patient lacks capacity.
6. Schizophrenia is the commonest cause of hallucinations in hospital wards.
7. Delirium has an underlying organic/medical cause.
8. The antidote for oversedation with Benzodiazepines is procyclidine.
9. The antidote for overdose with lorazepam is IV Midazolam.
10. Hysteria is the conscious fabrication of bodily symptoms.

### Answers

1. False 2. True 3. True 4. False 5. True  
6. False 7. True 8. False 9. True 10. False

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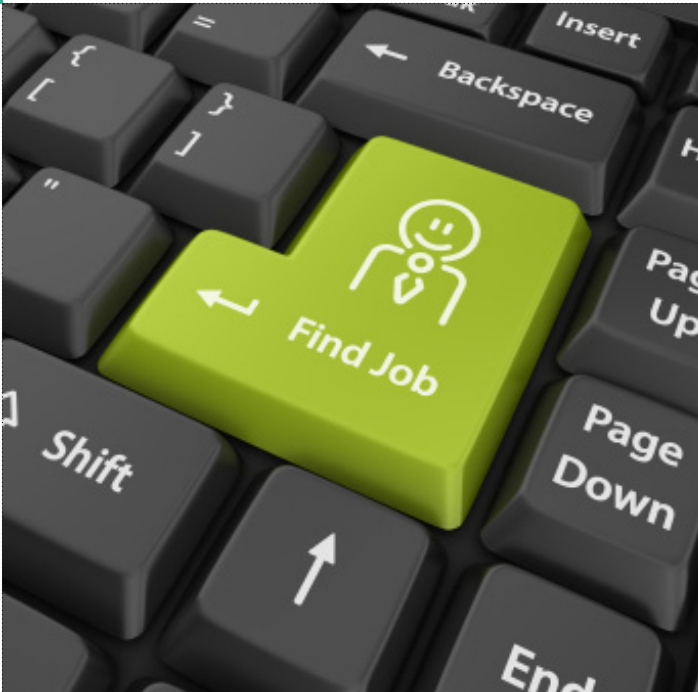
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# TOP TEN TIPS FOR APPLYING FOR SPECIALIST TRAINING JOBS

C Fernandes & M Ashraf



## Top Ten Tips For Applying For Specialist Training Jobs Teaching & Training

### Abstract

Applying for specialist training can be daunting. We have compiled our top ten tips on how to adequately prepare and apply for specialist training posts, compiled from ours and other trainees and trainers' experiences. Adequate early preparation is crucial.

### Introduction

Applying for specialist training can be daunting. We have spoken to many trainees and trainers from different specialties to compile the following top ten tips. These are aimed at being a summary of the most pertinent points to take into consideration for the ST1 applications. There are many websites that contain more detailed information, that, rather than regurgitate, which we have listed here which may be of use also. This advice assumes that you have decided on your chosen speciality/ specialities to apply for. If this is not the case, please see the advice at the bottom of the page.

### Tip 1

Aim for the job that you want. Do not worry about the competition ratios or other people's experiences at interviews that were particularly hard. Many people get the job that they want the first time round. You can do it. The key is to prepare early and in an organised way to be able to have a realistic chance of gaining a place on that speciality.

### Tip 2

Be guided by the Person Specification: Look at this early: it sets out the selection criteria for applicants, that the review and interview panel will be expecting – note there are essential and desirable characteristics. If you do not have the qualifying essential criteria then it is most likely that your application will be rejected. Try and fulfil activities that meet all the criteria – for example, try to obtain evidence for characteristics specified during your foundation jobs e.g. A Directly Observed Procedure (DOPS) as evidence of good hand eye coordination for surgery. Person specifications can be downloaded from the Modernising Medical Careers website .

### Tip 3

Prepare your C.V.: Even though the selection process involves an application form, you will still need a C.V. for your portfolio. This also acts as a It will help you to decide which areas you need to work on to show that you are a good all-round candidate to score the most marks, e.g. if you have nothing in your audit section then you need to perform an audit! Keep it up to date: this will form the basis of your portfolio. However, don't worry if some sections on your C.V. are not filled with evidence of how brilliant you are, for example if you do not have any publications or research. Try to tick these boxes if you can, but at the foundation level of career your interviewers will accept that you may not have had the opportunities to get these things on board. (But it would be a bonus if you do!) Advice on how to structure your C.V. can be found online.

### Tip 4

Compile evidence: Remember, if there is no evidence, did you really do it? Make sure that you have evidence for everything that you have listed on your C.V. e.g. if you have said that you have performed teaching as a junior doctor or medical student, keep the slides, or obtain feedback from students or a supervising consultant. This will be important for your portfolio, and can take a while to gather if you are trying to do it in a rush!

## TOP TEN TIPS FOR APPLYING FOR SPECIALIST TRAINING JOBS

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### Tip 5

**Take a Taster Week:** Use your study leave to undertake a taster week in the career that you are intending to apply for. In some specialities (particularly the run-through ones) this is an absolute essential criterion gaining an interview place. Others are not, but is still good evidence that you are committed to your chosen career without actually much effort and will score you easy points, and can be really important to decide whether a specialty is the right one for you.

### Tip 6

**Speak to trainees and Consultants:** Useful for spearheading audits, helping with research to get a publication, events that you could attend to further your interest, but just as useful for finding out about the training, whether you are suited to speciality, where you may want to work, what has come up in previous interviews!

### Tip 7

**Undertake an audit:** Another easy way of adding weight to your application form, which doesn't necessarily have to be time-consuming. Undertaking an audit forms part of the foundation programme. Kill two birds with one stone by undertaking an audit in your chosen speciality. Points will be awarded for presenting it locally/regionally, nationally and internationally.

### Tip 8

**Organise your portfolio:** It goes without saying that presentation is key! A nice ring binder and plastic wallets will suffice. Some interviews are staged with an interviewer going through your portfolio during the station, so presentation and ease of reading is important, especially if you have lots to show off! A standard portfolio will contain your C.V., key document, such as your qualifications, GMC certificate, work based assessments, research/publications, audits and teaching. These therefore need to be separated into sections. Many applicants use summary pages to highlight contents of each section for ease of reading. If you are applying for more than one speciality this is particularly important as you will need separate portfolios for each to highlight information more relevant to one speciality than another.

### Tip 9

**The application form:** Many applicants use the STAR (Situation Task Action Reflection) technique to answer the questions to maximise your answer. Make a note of all the deadlines for submissions! They are not all the same! You may be allowed to bullet point your answers to make the most of the word limit.

### Tip 10

**The interview:** There are lots of books aimed at tackling some of the generic questions that interviewer like to ask, for example the pillars of audit, which, if you haven't read will be very difficult to try and blag. Find out what came up in previous years, particularly the specialty specific station/s. If you are applying for anaesthetics, for example, you are much more likely to have a simulation resus scenario than spot an abnormality on a CT PET scan!



What if I don't know what to do? You're not alone. Many people even up to the deadline of the application form submissions are still undecided. For some they go into certain careers, but then find out it wasn't quite what they expected. Many reapply to enter different specialities. Obviously, it helps if you get the decision right first time. So what can you do to make it easier? The main thing here is trying to determine your personal influences, values, interests, skills and motivations to find the career suited to you. There are a few programs which may help.

- 1. The Medical Careers website contains self-assessment tools to help understand what you like and dislike, your skill sets and other career influencing factors.**
- 2. The Peninsula Deanery Website offers advice and links to different career planning tools.**
- 3. 'So you want to be a brain surgeon? A medical careers guide.' Outlines the pros and cons of different specialities.**
- 4. The BMJ careers fair. The careers fair is an annual event where you can meet representatives from different Royal Colleges; attend lectures about different careers options and much more.**
- 5. The London Deanery Careers Unit has lots of useful articles about different types of training and personal experience from trainees if different programmes.**
- 6. And if all else fails? Gap years are becoming increasingly popular with young doctors taking a year out to work abroad, to work in a non-medical field or to try something else. It can even be looked on favourably when you are finally ready to apply.**

## TOP TEN TIPS FOR APPLYING FOR SPECIALIST TRAINING JOBS

C Fernandes & M Ashraf



This is a decision not to be taken lightly – and takes thorough preparation. The choice of your specialty is a decision which is going to affect the rest of your career, so thorough research is critical. Don't rely on preconceptions, or things that you experienced at medical school and try not to be swayed by a specialty just because it seems sexy.

Before opting for a particular area, you should have a considerable knowledge of the specialty: the training, the environment in which you'll be working, the patients you will be treating as well as a realistic approach to whether you would be suited to the career, and finally the type of job that you will finally be left with as a Consultant, after all, you will probably be in the post for the next 30 years!

**Good luck.**

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3. Liverpool University [www.liv.ac.uk/medcareers/cv/Example\\_CV\\_5th\\_Year\\_Portfolio.doc](http://www.liv.ac.uk/medcareers/cv/Example_CV_5th_Year_Portfolio.doc)
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# FOUNDATION TRAINEES AND PSYCHIATRY AS A SPECIALTY

G Milner & P Rajput



## Foundation Trainees and Psychiatry as a Specialty Teaching & Training

The aim of the first questionnaire was to ascertain the trainees' past experience of psychiatry, their learning objectives within their placement and their future career plan.

The second questionnaire aims to elicit whether their experience in psychiatry changed their specialty preference. This questionnaire was also devised to determine the nature and quality of their experiences to ascertain whether this changed their perception of psychiatry.

### Abstract

A study was undertaken to assess whether a foundation placement in psychiatry influenced the specialty preference of foundation trainees. Specialty preferences before and after the placement were analyzed. It appears that the majority of trainees had decided their specialty preference prior to the placement and their experience in psychiatry did not change their preference.

### Introduction

The Foundation Programme, which started in the UK in August 2005, aims to offer medical school graduates greater experience across specialties before it becomes necessary for them to make a choice.

There is some evidence that such 'taster' training in Psychiatry increases the likelihood that Psychiatry becomes their specialty of choice. There is also the hope that we continue to recruit doctors most suited to the specialty and this selection process proves to be beneficial, both to the trainee and to the profession.

It has been suggested that the more positive experiences a trainee has in a specialty, either in medical school or as a trainee doctor, the more likely they are to specialize in that field.

### Aims and Objectives

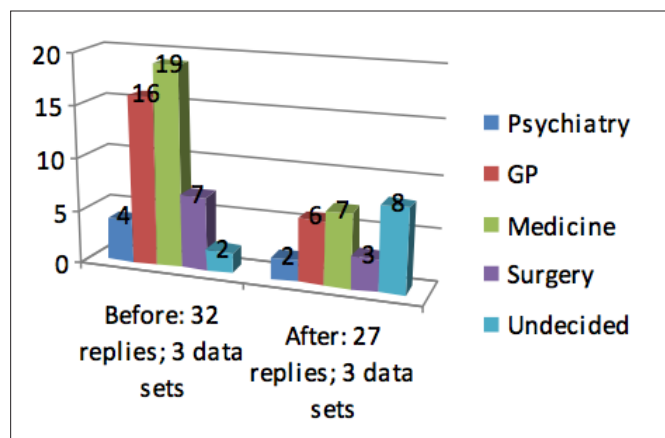
To assess whether a placement in psychiatry in the two Foundation Years serves as an aid to recruitment into this specialty and to determine factors within placements which encourage or deter trainees' choice. We were also hoping to identify whether trainees see a psychiatry placement as beneficial from any other perspective and whether the post helped them achieve that objective.

### Methodology

A semi-structured questionnaire was given to Foundation Year trainees at the beginning and end of their placement. This was carried out for three consecutive rounds starting from the four-month posts commencing in December 2009 until December 2010.

### Specialty Preference of Foundation Year Doctors

Above data includes multiple specialty preference per trainee. A&E, Anaesthesia and Critical Care have been included as medical streams; Obstetrics & Gynaecology as a surgical one.



### Discussion

For Foundation Year trainees, the role of a psychiatry placement seems to be to enhance skills that would benefit patient assessment and management when the doctor is working in another specialty – most commonly General Practice.

It does appear that trainees now expect to encounter patients with mental health issues across specialties and they want to be able to recognize psychiatric conditions and manage them appropriate to their anticipated role in the future, be it a timely referral or emergency management before a full psychiatric assessment can be undertaken.

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### Results

The questionnaires were completed by a group of Foundation Year trainees placed in Birmingham. Most were in Foundation Year 1.

Majority of the trainees' experience of psychiatry was in medical school and all of them reported this as positive. Their aims from the psychiatric placement appear to be reflective of their longer-term aims i.e. capacity assessment, role as GP etc. Most had already decided the discipline of their choice. There was no particular specialty which trainees hadn't been given the opportunity to be placed in.

Most trainees were not intending to pursue a career in this field and the experience did not change their inclination towards psychiatry. For a significant proportion (7 out of 27), the experience encouraged them to consider psychiatry more strongly than when they commenced the post. Managing inpatients in acute wards and outpatient work dominated their work schedule.

Some trainees appreciated the relative freedom in outpatient clinics to come up with a diagnosis and management plan – something that they might miss in other specialties. This seems to be associated with psychiatry as a specialty and the longer period of time necessary for initial assessments.

Psychiatric history taking, mental state examination, risk assessment, capacity assessment, managing acute confusion, and building on their communication skills, especially with challenging patients were what most trainees reported as the positives of the post. This seemed to link with their career in a non-psychiatric setting. Support of colleagues was also highlighted, reflecting its importance, all the more significant for trainees at this stage of their career.

Two trainees highlighted the need for more work and this perhaps is reflective of a particular post. Another felt the need for more variety within the post. One trainee pointed out that being placed in an Early Intervention Team prevented more intense inpatient work.



Too many multidisciplinary team meetings, slowness of decision making, too many professionals appearing to be involved in a single task and hence there being no particular person responsible to take the task to completion and psychiatry being less systematic than medical specialties were seen as a drawbacks by some. Patients fit for discharge but this being delayed for financial or social reasons was also viewed negatively. Changing one's perspective, all these can be said to be related to psychiatry as a specialty and without which psychiatry risks losing its uniqueness.

### Conclusion

Medical school graduates appear certain of their choice of medical specialty prior to Foundation Year 1 training. We need to re-consider the role a Foundation Year training post has in influencing this decision.

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### Acknowledgements

We would like to thank all the Foundation Year 1 and 2 doctors who have trained within our Trust in the past two academic years for responding to our questionnaires.

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# ASSESSING MENTAL CAPACITY: AN ESSENTIAL SKILL FOR ALL CLINICIANS

E Hegazi



## Assessing Mental Capacity: An Essential Skill for All Clinicians Patient Management

A person's capacity to make decisions can be affected by many medical conditions. Some have permanent or long-term effects, while others have only a short-term or intermittent effect. Examples include a stroke, dementia, a learning disability or a mental illness.

As providers of healthcare, all doctors need to be aware of the duties and responsibilities placed on them by the Mental Capacity Act (MCA).<sup>1</sup>

This Act applies to England and Wales. A similar Act (Adults with Incapacity (Scotland) Act 2000) sets out the legal framework in Scotland. In Northern Ireland, specific legislation is likely to be introduced shortly. Until then, decisions should be made based on common law and best practice, acting in the best interest of the patient.

### Consider the following situations:

- A woman who took an overdose of Paracetamol, refuses to accept medical treatment.
- A man was admitted to hospital following a road accident. You ask him to consent to surgical intervention, but he seems confused.
- A man has dementia and lives alone. His safety is now at high risk and 24 hour care at a nursing home is recommended. He insists he wants to stay in his house.

The common theme in the above situations is mental capacity, which refers to the ability of the person to make a particular decision at the time it needs to be made.

### The Mental Capacity Act 2005

It provides the legal framework for acting and making decisions on behalf of individuals who lack the mental capacity to make particular decisions for themselves.<sup>2</sup>

### Five key principles underpin the MCA:

#### 1. Assumption of capacity

*"A person must be assumed to have capacity unless it is established that he lacks capacity" (scenario 1).*

#### Scenario 1

When planning for her retirement, Mrs Arnold made and registered a Lasting Power of Attorney (LPA) – a legal process that would allow her son to manage her property and financial affairs if she ever lacked capacity to manage them herself. She has now been diagnosed with dementia, and her son is worried that she is becoming confused about money. Her son must assume that his mother has capacity to manage her affairs. Then he must consider each of Mrs Arnold's financial decisions as she makes them, giving her any help and support she needs to make these decisions herself.

Mrs Arnold's son goes shopping with her, and he sees she is quite capable of finding goods and making sure she gets the correct change. But when she needs to make decisions about her investments, Mrs Arnold gets confused – even though she has made such decisions in the past. She still doesn't understand after her son explains the different options. Her son concludes that she has capacity to deal with everyday financial matters but not more difficult affairs at this time. Therefore, he is able to use the LPA for the difficult financial decisions his mother can't make. But Mrs Arnold can continue to deal with her other affairs for as long as she has capacity to do so. (Reproduced from the Mental Capacity Act 2005 Code of Practice)

#### 2. Assist people to make decisions

*"A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success" (scenario 2).*

#### Scenario 2

Mr Jackson is brought into hospital following a traffic accident. He is conscious but in shock. He cannot speak and is clearly in distress, making noises and gestures. From his behaviour, hospital staff conclude that Mr Jackson currently lacks the capacity to make decisions about treatment for his injuries, and they give him urgent treatment. They hope that after he has recovered from the shock they can use an advocate to help explain things to him.

However, one of the nurses thinks she recognises some of his gestures as sign language, and tries signing to him. Mr Jackson immediately becomes calmer, and the doctors realise that he can communicate in sign language. He can also answer some written questions about his injuries.



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The hospital brings in a qualified sign-language interpreter and concludes that Mr Jackson has the capacity to make decisions about any further treatment. (Reproduced from the Mental Capacity Act 2005 Code of Practice)

### 3. Unwise decisions

*"A person is not to be treated as unable to make a decision merely because he makes an unwise decision" (scenario 3).*

#### Scenario 3

Mr Garvey is a 40-year-old man with a history of mental health problems. He sees a Community Psychiatric Nurse (CPN) regularly. Mr Garvey decides to spend £2,000 of his savings on a camper van to travel around Scotland for six months. His CPN is concerned that it will be difficult to give Mr Garvey continuous support and treatment while travelling, and that his mental health might deteriorate as a result.

However, having talked it through with his CPN, it is clear that Mr Garvey is fully aware of these concerns and has the capacity to make this particular decision. He has decided he would like to have a break and thinks this will be good for him. Just because, in the CPN's opinion, continuity of care might be a wiser option, it should not be assumed that Mr Garvey lacks the capacity to make this decision for himself. (Reproduced from the Mental Capacity Act 2005 Code of Practice)

### 4. Best interests

*"An act done, or decision made under this act for or on behalf of a person who lacks capacity must be done, or made, in his best interests". It is impossible to give a single description of what 'best interests' are, because they depend on individual circumstances.*

#### Scenario 4

Jo, who has severe brain damage, is looked after at home by her parents and attends a day centre for two days a week. The day centre workers are taking some of the service users riding at the local stables. Jo's parents want her to be included in activities at the centre but are anxious that she won't be able to manage a horse. Jo seems excited at the idea of going to the stables. Her parents and staff discuss the situation and decide to ask a care assistant who has a good relationship with Jo and who can understand her communication to accompany her to the riding stables and keep an eye on her. Acting in a person's best interests can involve negotiating a compromise between different views and wishes. (Reproduced from Mental Capacity Act 2005: Core Training Set)<sup>3</sup>



### 5. Least restrictive act or decision

*"Before the act is done, or the decision is made, regard must be had whether the purpose for which it is needed can effectively be achieved in a way which is less restrictive of the person's rights and freedom of action" (scenario 5).*

#### Scenario 5

Sunil, a young man with severe learning disabilities, also has a very severe and unpredictable form of epilepsy that is associated with drop attacks. These can result in serious injury. A neurologist has advised that, to limit the harm that might come from these attacks, Sunil should either be under constant close observation, or wear a protective helmet. After assessment, it is decided that Sunil lacks capacity to decide on the most appropriate course of action for himself. But through his actions and behaviour, Sunil makes it clear he doesn't like to be too closely observed – even though he likes having company.

The staff of the home where he lives consider various options, such as providing a special room for him with soft furnishings, finding ways to keep him under close observation or getting him to wear a helmet. In discussion with Sunil's parents, they agree that the option that is in his best interests, and is less restrictive, will be the helmet – as it will enable him to go out, and prevent further harm. (Reproduced from the Mental Capacity Act 2005 Code of Practice)

## ASSESSING MENTAL CAPACITY: AN ESSENTIAL SKILL FOR ALL CLINICIANS

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### Assessing Mental Capacity: An Essential Skill for All Clinicians Patient Management

#### Assessment of capacity

##### When is an assessment required?

*Doubts as to a person's capacity to make a particular decision can occur because of:*

- the way a person behaves;
- their health circumstances;
- concerns raised by someone else.

##### Who makes assessments of capacity?

This depends on the nature of the decision. Assessors can be anyone who is directly concerned with the individual at the time the decision needs to be made. For example, family members, a care worker, a care service manager, a nurse, a doctor or a social worker.

A care worker or a family member is the assessor in relation to day-to-day decisions (e.g. person's agreement to be bathed). A district nurse might assess if the person can consent to having a dressing changed. If a doctor proposes treatment or an examination, he must assess the person's capacity to consent. <sup>2</sup> For a legal transaction (e.g. making a will), a solicitor must assess the client's capacity to instruct them.

##### How is mental capacity assessed?

The mental capacity test is 'decision-specific' and 'time-specific'. Some may be capable of making decisions about their day-to-day basic activities, but unable to manage complex financial affairs. Also, mental capacity may change from time to another.

##### It is a two-stage test:

1. Is there an impairment of, or disturbance in, the functioning of the person's mind or brain?
2. If so, is that impairment or disturbance sufficient that the person lacks capacity to make a particular decision?<sup>4</sup>

##### A person lacks capacity to make a decision if they cannot:

- understand information relevant to the decision;
- retain that information;
- use or weigh up that information as part of the process of making the decision, or
- Communicate the decision, whether by talking, using sign language or any other means.

If any of these four criteria is not met, there will be an inability to make the decision.

##### Best interests

For a patient who lacks capacity to consent to a proposed treatment, you will need to decide what would be in his best interests.

##### The Act sets out a checklist of factors that must be considered, in addition to looking at individual circumstances. The following have to be considered:

- past and present wishes and feelings;
- beliefs and values that will be likely to influence the patient's decision if he had capacity;
- views of anyone named by the patient as someone to be consulted, any attorney appointed under Lasting Power of Attorney (LPA), or a deputy appointed by the Court of Protection.

##### The Code of Practice states that "the interests of the person who lacks capacity should prevail, not the views or convenience of those caring for that person". There are two exceptions to the best interests' principle:

1. Where someone has previously made an Advance Decision to refuse medical treatment, while they had the capacity to do so. If applicable and valid, that advance decision has to be respected when they lack capacity (box 1).
2. Involvement in research, in certain circumstances (box 2).

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### Box 1: Advance Decisions

A person aged 18 or above can make an Advance Decision to refuse treatment, which can take effect in the future when they no longer have capacity. The decision can be communicated verbally or in writing, unless it deals with life-sustaining treatment, where strict formalities apply. These formalities are that the decision must be in writing, signed and witnessed. In addition, there must be an express statement that the decision stands “even if life is at risk”, also signed and witnessed.

#### A valid Advance Decision means:

- It has not been withdrawn after it was made,
- A LPA covering the decision in question has not been made,
- The person has not acted in a way clearly inconsistent with the Advance Decision.

#### An applicable Advance Decision means:

- The proposed treatment is the one specified in the Advance Decision.
- Circumstances around the decision have not changed.

### Box 2: Research

To involve a person who lacks capacity in research, the Research Ethics Committee should state that the research is safe, relevant to the person’s condition and cannot be done as effectively by using a person who has capacity.<sup>5</sup> In addition, a family member, friend, or another independent person must be consulted and agree to the person being involved. If the person shows any sign of not being happy to take part, their involvement must end.

#### Emergency treatment

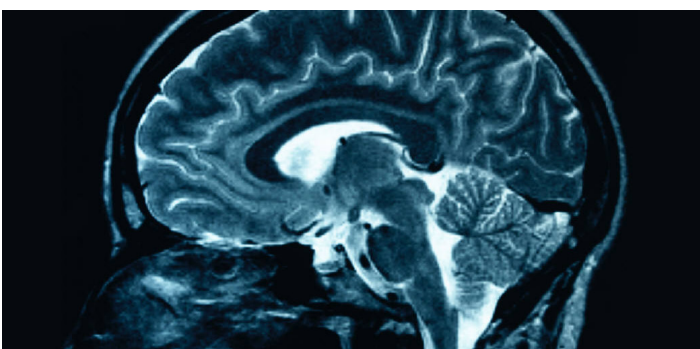
The doctrine of necessity provides a justification for treatment that is urgent and cannot be delayed until you consider the checklist of factors stated above or look for an Advance Decision.

#### Recording your assessment

Records of capacity assessments and decisions should include:

- the reason for considering that the person lacks capacity in relation to a specific decision;
- how the person was helped to make the decision for themselves;
- which of the 4 criteria of capacity was (were) not met.

Full recording of mental capacity will not be needed for all decisions. The more significant the decision is, the more detailed the recording should be.



### Lasting Power of Attorney (LPA)

People over 18 who have capacity can appoint other people to make decisions about their health, welfare, money and property if, in the future, they lose the ability to do so for themselves. The person appointing an LPA is called a ‘donor’, and the person they appoint is called the ‘attorney’ or ‘donee’.

Although an LPA in relation to property and affairs can be used by the Attorney when the Donor still has capacity, an LPA dealing with personal welfare can only operate if the patient lacks capacity in relation to the issue in question. An LPA dealing with personal welfare:

- must be registered with the Office of the Public Guardian (OPG) in order to be effective;
- can be both general, covering all aspects, or specific, relating to particular aspects of welfare or healthcare;
- does not cover life-sustaining treatment, unless the LPA specifically authorises this;
- must always be used in the Donor’s best interest.

The benefit of appointing an attorney is that he or she can respond to healthcare needs as they arise and hence is more flexible than an advance decision.<sup>6</sup>

### Court of Protection (CoP)

The Court of Protection is a specialist court that protects people who lack capacity in a number of ways.

- It can determine the validity of, or cancel an LPA.
- It can appoint a ‘deputy’ with powers to make decisions on a person’s behalf. Deputies are usually relatives or close friends and have similar duties, powers and responsibilities to LPAs.
- It can rule whether a proposed action is lawful for certain serious decisions relating to the provision of medical treatment. Examples include withholding or withdrawal of artificial nutrition and hydration of patients in a permanent vegetative state, and organ or bone marrow donation by a person lacking capacity.
- Decides on cases involving ethical dilemmas in untested areas, or irresolvable conflicts between professionals, or between professionals and family members.

## ASSESSING MENTAL CAPACITY: AN ESSENTIAL SKILL FOR ALL CLINICIANS

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### Assessing Mental Capacity: An Essential Skill for All Clinicians Patient Management

#### Protection from liability

**Healthcare professionals are protected from possible legal action for providing treatment as long as they can show that:**

- they are working within the principles of the Code;
- they have conducted a proper assessment of capacity;
- they believe what they are doing is in the person's best interests;
- they believe that any restrictions of freedom are reasonable, proportionate and kept under review.

#### Questions

**1. Decisions that can be made for or on behalf of a person who lacks capacity do not include:**

- a) Medical treatment decisions
- b) Surgical treatment decisions
- c) Financial decisions
- d) Marriage and divorce decisions
- e) Place of residence decisions

**2. All the following are correct about assessment of mental capacity, except:**

- a) Is decision-specific
- b) Is time-specific
- c) Requires a psychiatrist
- d) Has to be recorded
- e) Includes the person's ability to retain relevant information

#### Answers

**1. Answer: d**

*Explanation:* The Mental Capacity Act provides a framework for the care and treatment of people who lack capacity to make decisions. While personal welfare, including healthcare, as well as finance related decisions are included, some decisions can never be made on someone else's behalf, for example: marriage, civil partnership, divorce, sexual relationships, adoption, voting and consent to fertility treatment.

#### Independent Mental Capacity Advocates (IMCAs)

IMCAs are appointed to safeguard the interests of people who lack capacity to make important decisions if they have no family, friend, attorney or deputy to advise, support or represent them.<sup>4</sup>

**An IMCA must be instructed, and consulted in relation to such patients whenever:**

- medical professionals propose serious medical treatment (such as chemotherapy, major surgery and termination of pregnancy);
- an NHS body or Local Authority wants the person to be admitted to hospital for more than 28 days or a care home for more than 8 weeks;
- deprivation of the person's liberty is required (see below);

An IMCA may also be instructed for care reviews or adult protection cases. IMCAs have the right to see all relevant care records.

#### MCA Deprivation of Liberty Safeguards (MCA DOLS)

The safeguards provide a framework for approving the deprivation of liberty for people who lack the capacity to consent to treatment or care in either a hospital or care home that, in their own best interests, can only be provided in circumstances that amount to a deprivation of liberty. The meaning of liberty here is provided by Article 5 of the European Convention of Human Rights.

The safeguards legislation contains detailed requirements about when and how deprivation of liberty may be authorised. It provides for an assessment process that must be undertaken before deprivation of liberty may be authorised and detailed arrangements for renewing and challenging the authorisation of deprivation of liberty.<sup>7</sup>

## ASSESSING MENTAL CAPACITY: AN ESSENTIAL SKILL FOR ALL CLINICIANS

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### 2. Answer: c

*Explanation:* Depending on the nature of the decision, the assessor can be anyone who is directly concerned with the individual at the time the decision needs to be made. A family member is the assessor in relation to day-to-day decisions. A doctor is the assessor in relation to a medical examination or treatment he/she is proposing. For more complex decisions, formal opinion on the person's capacity might be necessary. This could be, for example, from a psychiatrist, psychologist, or a speech and language therapist. But the final decision about the person's capacity must be made by the person intending to make the decision or carry out the action on behalf of the person who lacks capacity.

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# ELECTROCONVULSIVE THERAPY

L Potter & R Tobiansky



## Abstract

First used in 1938, ECT remains the most effective form of treatment for a minority of severely depressed patients, for whom it may be a life-saving intervention. Foundation Year Doctors should be familiar with the treatment, including the likely benefits and risks associated with ECT. In this article, the authors describe the practical aspects of the procedure and clinical scenarios where it might be used.

## Introduction and History

Electroconvulsive therapy (ECT) is a medical treatment for mental disorder in which seizures are induced by passing electricity through the brain of an anaesthetized patient. It is both one of the most effective treatments available to psychiatrists and also one of the most controversial.

ECT predates almost all of the pharmacological treatments for mental illness that are still in use today. Convulsive therapy dates back to the 1930s when seizures were chemically induced using camphor or pentylenetrazol. This was done under the mistaken impression that epilepsy and schizophrenia do not occur together and are antagonistic. ECT was first used in Italy by Ugo Cerletti and Luciano Bini in 1938. Soon ECT became more common than chemically induced seizures and it became clear that the treatment was more effective at treating depressive disorders than schizophrenia.

At first, ECT was given in unmodified form, that is without the use of muscle relaxants or anaesthesia. The seizures induced could cause injury to the patient including fractures and dislocations. Because of this, most ECT was given with brief anaesthesia and short-acting muscle relaxants by the middle of the 1950s.

Use of ECT continued but use gradually declined with the availability of more drug treatments for mental illness and increasing public concern. This concern led to the production of various guidelines by the Royal College of Psychiatrists followed by surveys examining adherence to these guidelines. The Mental Health Act 1983 allowed detained patients who did not consent to be given ECT with the authorisation of a second opinion doctor.

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In the last few years, the National Institute for Health and Clinical Excellence (NICE) has published further guidance on the use of ECT. The Royal College of Psychiatrists has set up a voluntary ECT Accreditation Service (ECTAS) to confirm that clinics providing ECT are doing so in accordance with agreed quality standards. Most recently, the 2007 amendment to the Mental Health Act has given ECT a unique standing within mental health law.

## Indications for ECT

### Vignette – 1

*Mrs S is a 54 year old woman brought to the Accident and Emergency department. Her husband describes worsening depression and hopelessness over the past eight weeks, with associated deterioration in sleep, appetite and personal care. Over the past few days she has been refusing food and drinking minimal fluids. When assessed by the on-call psychiatrist, she is found to be unkempt with psychomotor retardation. There is marked poverty of speech. She is clearly depressed and flat in affect. When asked about why she is not eating, she replies that she cannot eat because her insides are filled with "black tar". She goes on to say that this is a punishment she is receiving because of the terrible things she has done.*

## What are the options to treat this lady's psychotic depression?

It must first be recognized that this lady's physical health may have been affected, and immediate treatment should be focused on investigating and treating these. She is clearly at risk of dehydration and self-starvation. She should be made safe, and so will very likely require admission.

Psychotic depression can be treated with some success by using a combination of an antidepressant and an antipsychotic, for example citalopram and olanzapine. This is more effective than either medication alone.

Psychotic depression is one of the indications for ECT. Not only is ECT more effective than medication, it is also likely to result in a faster response. ECT may also be more protective against relapse in psychotic depression than in non-psychotic depression. ECT would therefore be a reasonable treatment for Mrs S.

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The National Institute for Health and Clinical Excellence (NICE) published guidance on the use of ECT in 2003. Its recommendations on when ECT should be used are summarized in Box 1.

**Box 1 – NICE indications for ECT**

*It is recommended that ECT is used only to achieve rapid and short-term improvement of severe symptoms after an adequate trial of other treatment options has proven ineffective and/or when the condition is considered to be potentially life-threatening, in individuals with:*

- Severe depressive illness
- Catatonia
- Severe or prolonged manic episode

*The decision as to whether ECT is clinically indicated should be based on a documented assessment of the risks and potential benefits to the individual, including: the risks associated with the anaesthetic; current co-morbidities; anticipated adverse events, particularly cognitive impairment; and the risks of not having treatment.*

Over the course of its history, ECT has been used to attempt to treat many different mental illnesses and, some might argue, no mental illness at all. Most modern practitioners would broadly agree with the NICE guidelines with some caveats.

In depression, NICE recommend that ECT is used either when there is an urgent need for treatment (high risk of suicide, refusal of food or fluids) or there has been no response to a number of other therapies. Other situations where ECT might be considered are with particularly severe depressive symptoms (stupor, marked psychomotor retardation, depressive delusions or hallucinations) or where the patient is requesting it, particularly if there has been a positive response before.

Although NICE do not recommend ECT for schizophrenia, it is sometimes used as a treatment of last resort in patients who do not respond to any medication, including clozapine. It may also be used in Schizophrenia when there are catatonic features or prominent affective symptoms.

ECT may be considered in severe mania which may result in life-threatening exhaustion, or if it has not responded to the first line treatment of a mood stabiliser and an anti-psychotic.

Catatonia is an uncommon condition of multiple aetiologies. The psychomotor symptoms it presents with, including hyperkinesia, stupor, catalepsy, negativism and anomalies of voluntary movement, can lead to dehydration, starvation and violent outbursts. ECT may be a first line treatment in particularly severe or life-threatening cases, otherwise initial treatment is with a benzodiazepine such as lorazepam.

## Explaining ECT to patients and relatives

**Vignette – 2**

*Mr S arrives on the ward after being informed of the possibility that his wife will be prescribed ECT. He asks to speak to the ward doctor about this. He is clearly apprehensive about the treatment, and wishes to know how it can benefit his wife as well as potential side effects.*

## As the ward doctor, what would you tell Mr S?

When discussing any treatment with a patient or relative, it is important to first establish what they already know and understand. This is particularly true with ECT, where individuals may have misconceptions of what modern treatment involves through inaccurate media portrayals or knowing people who had the treatment before the routine use of anaesthesia. Any incorrect assumptions should be tactfully corrected.

It should be explained that ECT is a routinely used, effective treatment for a number of conditions. Compared to medication and talking treatments it is both more effective and faster acting. It can also be used successfully where other treatments have failed.

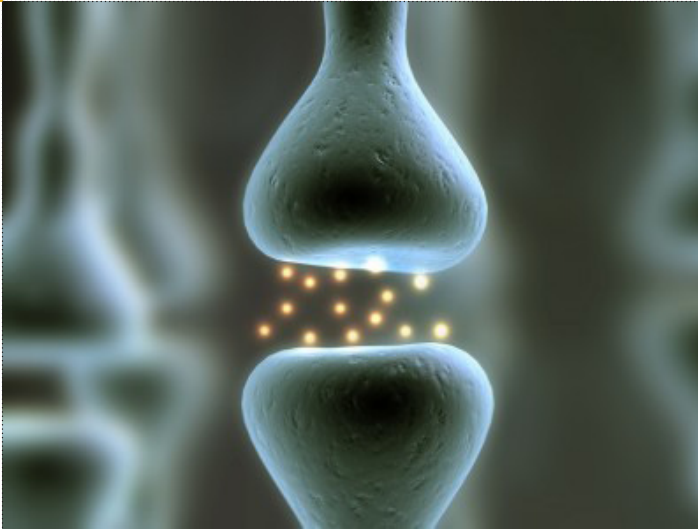
Patients should be reassured that it has not been shown to cause any structural brain damage. Patients often ask how ECT works. While it is not clearly understood it is known that ECT affects some of the neurochemical pathways affected by medication used in psychiatry, including serotonergic, noradrenergic and dopaminergic pathways. ECT has also been shown to enhance the expression of brain derived neurotrophic factor, which antagonizes the neurotoxic effects of stress on the brain. Animal models suggest ECT promotes neuronal survival and growth. All these findings suggest that ECT may arrest or reverse the degeneration and atrophy associated with chronic depression, and promote brain repair rather than cause brain damage.

Whilst there are common adverse effects associated with ECT, these are mostly transient and limited to either the hours after a treatment or the course of the treatment. The main exception to this is the impairment of autobiographical memory which can persist for years in a minority of patients.



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### Box 2 – Risks and benefits of ECT

#### Risks:

- Anterograde memory impairment
- Retrograde memory impairment of autobiographical memory
- Post-ictal confusion
- Headache
- Myalgia
- Transient nausea
- Mortality 1:50,000

#### Benefits:

- Effective (85% partial or complete remission of symptoms in depression)
- Fast acting compared to medication
- Effective in treatment resistant illness

### Consenting to ECT

#### Vignette – 3

*Mrs S has no insight into her depression. When asked whether she would consent to have ECT she agrees to have it as “part of my punishment”. So far she has been passively accepting of the investigations and interventions carried out by the ward staff.*

### How would you proceed with treatment?

Consenting for ECT should be done by the prescribing consultant or responsible clinician. In principle, consenting for ECT is no different to consenting for any other intervention. It should first be established whether the patient has capacity: whether he or she is able to understand the risks and benefits of the treatment proposed and of any alternatives; retain this information; use the information to arrive at a decision; and communicate this decision.

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In the case of Mrs S, it would seem that she lacks capacity to consent to ECT as her delusions mean she is not able to understand the reason for the treatment or to “weigh” this information. There is no legal requirement for her to be detained under the Mental Health Act 2007 (MHA 2007) so she can be treated with ECT under the Mental Capacity Act if it is considered to be in her best interests. This decision should be clearly documented and discussed with her next of kin. Over the course of the treatment she should continue to have her capacity and compliance reviewed.

Patients who are “informal”, that is, not detained under the MHA 2007, and who give capacitous consent should have this clearly documented and can proceed with ECT. Informal patients who lack capacity, occupy something of a grey area from a legal point of view. There is no legal requirement to detain such people on a section of the MHA 2007, but there is no consensus as to what is best practice. The MHA 2007, the Mental Capacity Act 2005 and their respective Codes of Practice are unclear as to whether giving ECT amounts to a “deprivation of liberty”. Research has shown that there is a lack of consistency amongst psychiatrists about when to detain patients in these circumstances, reflecting the lack of clarity in the legislation. A pragmatic approach to resolving this issue would be to establish whether or not the patient shows any dissent or distress in relation to the treatment, in which case use of the Mental Health Act would be appropriate as it confers the additional safeguard of requiring a statutory Second Opinion Appointed Doctor to authorize the treatment.

For patients detained under the MHA 2007, ECT occupies a unique position. If a patient has capacity to consent to treatment with ECT, they may not have ECT imposed upon them if they refuse consent. This differs from all other medical treatments for mental disorder given under the act, which may be given to an individual who has capacity but withholds consent. It is possible to give ECT as an urgent treatment where it is immediately necessary to save the patient’s life or prevent a serious deterioration in the patient’s condition providing there are no irreversible side effects. The act would not allow ongoing treatment in this situation, however, and so this measure should be used with caution.



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If a detained patient lacks capacity to consent to ECT, a second opinion must be sought from an approved doctor to confirm that the person lacks capacity and that the treatment is appropriate. In an emergency - to save the patient's life or prevent a serious deterioration in the patient's condition - the act allows ECT to be initiated without this second opinion having been obtained. Advance decisions and authorised attorneys made under the Mental Capacity Act may also be used to refuse treatment where a patient currently lacks capacity.

It is also a requirement of the act that patients who are to be given ECT receive written information to help them to remember and understand advice about the treatment.

### Preparing a patient for ECT

#### Vignette – 4

*The consultant responsible for Mrs S decides to proceed with ECT and asks you to prepare her for the next ECT list in two days' time. Until recently, Mrs S has been generally fit and well, although she takes an ACE inhibitor for hypertension. Nurses on the ward have persuaded her to accept some food and fluid, although she appears to have lost weight and has dry mucosa.*

### What would you need to do to prepare Mrs S for her course of ECT?

Given that mental illness can be life threatening, it is often said that there are only relative, rather than absolute, contraindications to having ECT. It is therefore necessary to balance the risks and benefits for each individual. A medical history (ideally with collateral information from a GP or family member), physical examination and appropriate investigations (see Box 3) should be carried out. Conditions giving increased anaesthetic risk include myocardial infarction or cerebrovascular accident in the last 3 months; cardiac failure; valvular heart disease; fragile aneurysm; and unstable cervical spine. Where there are concerns, an anaesthetic opinion should be sought as early as possible.

#### Box 3 – Investigations for patients undergoing ECT

- Urea and electrolytes and full blood count in all patients
- Recent INR for patients on anticoagulants
- Morning glucose for patients with diabetes
- ECG for patients on vasoactive drugs, diabetics over 40, men over 40 and women over 55
- Chest X-ray if indicated by history or examination



Various factors can affect seizure threshold. In particular anticonvulsants (which may be given to psychiatric patients as mood stabilizers), monoamine oxidase inhibitors and benzodiazepines raise seizure threshold, which is best avoided if possible. Other medication may lower seizure threshold, including SSRIs and low dose antipsychotics. If the patient is on medicines that may interfere with the anaesthetic, the anaesthetist should be informed. Wherever possible, if a patient is thought to be at greater risk during ECT, consideration should always be given to ways of minimizing risk by modifying medical management or ECT technique.

### Administration of ECT

#### Vignette – 5

*As part of your training you are attending the ECT suite when Mrs S arrives for her first treatment. The consultant in charge asks you to describe the procedure for giving a first treatment of ECT.*

### How would you answer her?

First one should greet the patient and ensure they have not eaten or drunk for six hours prior to the ECT. For a consenting capacitous patient one would confirm that they still consent. If treatment is to be given under the MHA or MCA the appropriate documentation should be checked. The patient should have the procedure explained to them so they know what to expect.

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After leaving the waiting room, the patient will enter the treatment room and lie down on the anaesthetic trolley. They will be connected to various monitoring equipment, including an ECG, a blood pressure cuff, a pulse oximeter, and an electroencephalogram (EEG). This latter is used to monitor seizure activity under the neuromuscular blockade.

The anaesthetist will gain venous access to administer the general anaesthetic, usually a brief induction agent and a muscle relaxant succinylcholine. This will modify the convulsion and minimise the risk of physical injury. Once a bite block is in place the patient is ready to receive the stimulus.

Electrodes may be placed in one of two ways. Bilateral placement means the electrodes are placed 4 cm above the midpoint between the external auditory meatus and the lateral angle of the eye on either side of the patients head. For unilateral ECT, one electrode is placed in this position on the patient's non-dominant hemisphere and the other is placed on the opposite parietal surface of the scalp in an arc 18 cm from the temporal position. Bilateral ECT may be associated with a quicker response than unilateral, but at the cost of more severe adverse memory effects. Where there are particular concerns about possible cognitive side-effects then it is recommended that the patient starts with unilateral ECT. Bilateral ECT is used if this proves ineffective, or if it is imperative to have a rapid response because of patient risk.

Once the electrodes have been applied, the ECT machine is used to check that there is a sufficiently low impedance and the stimulus is then given.

The dose given equates to the charge, measured in millicoulombs. There are a number of ways this can be determined: calculated based on the patient's age; aiming for a "target response" such as the degree of post-ictal suppression of EEG activity; or by titrating the dose up from a very low level to determine seizure threshold (the method of "dose titration"). Whichever method is chosen, a higher dose will be calculated for unilateral ECT compared to bilateral. As the course of treatment progresses, the dose is usually increased depending on patient response.

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After the stimulus is given, the seizure is monitored by observing the modified convulsions and by examining the EEG. It is important that the seizure has been generalized and that modified clonic movements have been observed in all four limbs or that the EEG record shows seizure activity across both hemispheres. Once the seizure is finished the patient is moved to the recovery room until they regain consciousness and are well enough to leave the department.

ECT is typically given twice a week. Between treatment sessions, the treating team should continue to monitor the patient for improvement in their symptoms, onset of adverse effects (in particular impaired memory) and whether there are any changes to capacity or consent.

**Completing a course of ECT****Vignette – 6**

*After 8 sessions of ECT, Mrs S has made significant improvement. Now that her symptoms have started to improve she has sufficient insight to want to be involved in discussions about her treatment. She is concerned about the memory problems and confusion she is having between treatments, but is also frightened of having a relapse of her depression.*

**What information would you give  
to Mrs S to help her in her decision?**

There are no fixed limits on the number of ECT treatments in a course. The number of treatments will be guided by patient response, and if there has been no benefit after 6 sessions then the treatment is usually abandoned. Patients commonly have between 6 to 8 treatments and rarely more than 12.

As Mrs S has responded well to the ECT it would be reasonable for her to stop if she was finding the adverse effects unpleasant. She should be reassured that continuing to take antidepressant medication will reduce her risk of relapse. It would be useful to discuss whether Mrs S would want ECT in the future if she were to relapse.

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### Summary

- ECT is a safe, effective treatment.
- It is most often used for severe depression and also mania and catatonia.
- It is not usually a first line treatment, but is used where a rapid result is necessary or other treatments have been unsuccessful.
- The most troubling adverse effects are memory impairment and the risks associated with anaesthesia.

### Questions

**Q1. Indications: Rank the following presentations from most to least appropriate for ECT, based on NICE guidelines.**

1. A 42 year old woman with a past history of depression that has not responded to a wide range of antidepressant medication. She is starting to become depressed and is asking for ECT which has worked in the past.
2. A 26 year old man with treatment resistant paranoid schizophrenia and command auditory hallucinations telling him to kill himself.
3. A 58 year old man suffering from depression with psychosis. He is very withdrawn, mute and refusing food and fluids.
4. A 37 year old woman with a severe depressive episode but no suicidal thoughts. She has had two trials of different antidepressants without any benefit.
5. A 44 year old man with a severe depressive episode. He was brought to having attempted to hang himself twice and continues to have suicidal intent.

**Q2. Side effects: Which of the following statements are true? Side effects of ECT include:**

1. Gaps in autobiographical memory which may sometimes extend over years.
2. Deficits in working memory.
3. Anterograde amnesia that is relatively short lived.
4. Confusion and post-ictal delirium.
5. Epilepsy.



**Q3. Preparing for ECT: Which of the following tests would be routine for a 44 year old diabetic man on insulin, ACE inhibitors and an SSRI about to undergo ECT for depression?**

1. ECG
2. Chest X-ray
3. Thyroid function test
4. Urea and electrolytes
5. EEG

**Q4. Administering ECT: Which of the following statements are true?**

1. The dose the patient receives with bilateral ECT will be double what a patient receives for unilateral ECT.
2. Unilateral ECT is applied to the non-dominant hemisphere.
3. Bilateral ECT is a better choice if patients are concerned about adverse memory effects.
4. Bilateral ECT is a better choice where rapid treatment response is required.
5. It is important to plan in advance the number of treatments the patient will have in the course of their ECT.

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**3. Answers: T, F, F, T, F**

Although patients have EEG monitoring during their ECT treatment, there is not usually a requirement to have an EEG before.

**4. Answers: F, T, F, T, F**

The dose for unilateral ECT is usually 2½ times the dose for bilateral ECT. Bilateral ECT is thought to act more quickly but give a greater incidence of memory side effects. The number of ECT treatments in a course will depend on how well they tolerate and respond to the treatment.

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#### Royal College of Psychiatrists recommendations on ECT Competencies for Foundation Doctors

*Theory & background awareness 1-13  
Practical aspects of ECT are not required.*

#### Answers

**1. Answers: 3, 5, 1, 4, 2**

Both 3. and 5. are presenting with conditions that are indications for ECT and with immediate risk. Patient 3. might be considered more appropriate as depression with psychosis responds better to ECT than depression alone. As he is refusing food and fluids it might also be difficult to get him to take medication. Patient 1. is likely to respond to ECT based on past history. NICE guidelines, however, state that ECT should be used for patients with severe symptoms or there is an urgent need for treatment. Patient 4. has not responded yet to antidepressants, but there are a range of other treatment options including another trial of antidepressant, augmenting her antidepressant with another medication, and psychological therapy. Patient 2. does not have a disorder that is an indication for ECT.

**2. Answers: T, F, T, T, F**

Anterograde amnesia and, to a lesser extent, autobiographical memory loss are common side effects of ECT. Other memory functions do not seem to be affected. As with generalized seizures of any cause, ECT may result in brief periods of post-ictal confusion but it does not cause Epilepsy.



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**Theory and background**

1. Demonstrate a knowledge of NICE Guidelines.
2. Demonstrate an awareness of Royal College and ECTAS Guidelines
3. Demonstrate a knowledge of local policies and procedures, including
  - a. emergency ECT
  - b. outpatient ECT
  - c. high risk patient
4. Demonstrate a knowledge of the Consent to treatment requirements, including Common Law and MHA documentation/ requirements (p. 20 NICE)
5. Knowledge of the indications for ECT with special reference to NICE
6. Able to describe the contra-indications to ECT
7. Able to describe the possible side effects, risks and benefits of ECT
8. Able to describe the pre-treatment preparations required to be undertaken by referring doctor
9. Able to describe the procedure for the administration of ECT

10. Able to describe the procedure for the referral of an outpatient for ECT.
11. Demonstrate a knowledge of:
 

*NICE Guidance on*

  - a. *Continuance ECT.*
  - b. *When ECT should be discontinued.*

*Unilateral or bilateral treatment*
12. Knowledge of current theories of mechanism of action of ECT
13. Knowledge of physiological effects of ECT

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# OBSESSIVE-COMPULSIVE DISORDER: A CASE BASED DISCUSSION

D Khanna



## Obsessive-compulsive Disorder: A Case Based Discussion Patient Management

Alexandria was having difficulties in her relationship. To lessen her anxiety about making a mistake, she would seek reassurance from her husband, asking him to confirm that she wasn't doing anything wrong. He would sometimes give reassurance, but often get angry at her, criticising her for being annoying and slow. Soon their relationship broke down, and he applied for a divorce.

The criticism that Alexandria had received from the school and her husband reinforced to her that she really had done something wrong, and her self-esteem dropped considerably. She became depressed.

Alexandria approached her GP for help. She saw a locum GP who advised her to resist her compulsions, something she found impossible. Alexandria had read about cognitive behavioural therapy (CBT) and asked the GP to refer her for this. Alexandria waited a year, but still had not received an appointment. She chased the referral, and was told it had been lost. She was told that a re-referral would need to be made, with a further waiting period of at least 18 months. Alexandria appealed, but was informed that her problems were not of an urgency or importance to warrant fast-tracking.

Alone, unemployed, in dire financial difficulties and depressed, Alexandria gave up. She soon became homeless, living on the streets. She accepted this as her destiny.

One day, Alexandria was searching in a rubbish bin for newspaper to keep her warm. She happened to glance at the paper, on which she saw an article about a unit that was specialist in treating OCD. However this unit was 300 miles away, and Alexandria certainly didn't have the funds to get there. She saw this as a sign though, and was determined to get help. She walked the length of the journey, taking a month. When she arrived at her destination, it was evening, and the unit was closed for the night.

### Abstract

A case is described of a patient suffering with obsessive-compulsive disorder (OCD), and the obstacles she has faced in different areas of her life due to stigmatisation. The article also describes circumstances where she was shown quite the reverse: empathy and support. Stigma, discrimination and the outcome for this patient are then discussed.

### Case History

Patient Alexandria had suffered from obsessive-compulsive disorder (OCD) since she was 10 years old. She had made numerous attempts to seek help.

In terms of obsessions (repetitive, intrusive thoughts), these were mainly relating to a need for perfectionism and an elevated sense of responsibility. In terms of her compulsions (acts to reduce anxiety), these manifested as repeated checking behaviour and a need for symmetry.

Just having a shower would take 3 hours, as it would involve having to check repeatedly for the presence of a towel, repeatedly close and open the shower gel lid, wash herself symmetrically (and if the order went "wrong" then to start again), dry herself in a certain pattern, and check each item of clothing to make sure it was put on "correctly". Consequently Alexandria avoided showering. She also avoided other aspects of self-care, and soon appeared very unkempt.

Alexandria worked as a teacher, and also sat on various committees. She arrived at work appearing unkempt, then took too long in each lesson, since she was trying to make sure she hadn't made any mistakes, repeatedly going over the same things. She would get very anxious because of her fear of making a mistake. Nobody at work seemed to understand Alexandria's problems, and she was viewed as a sloppy, lazy, slow worker. She soon lost her job.

## OBSESSIVE-COMPULSIVE DISORDER: A BASED BASED DISCUSSION

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Alexandria decided to visit the local Accident and Emergency (A&E) department to get her feet, which were bleeding considerably, seen to. The attending doctor heard her story, and felt great empathy for her. He arranged for a psychiatrist to see her in A&E. The psychiatrist understood Alexandria's situation. She offered Alexandria the fare back home, and promised to make a direct referral to the specialist OCD unit as soon as possible. Alexandria felt overwhelmed by this generosity, but did not accept the help. A fellow patient in another cubicle heard her story, came to her, handed her the fare home, then ran away before Alexandria could catch up with him. Alexandria returned home and the message was soon passed on to the head of the OCD unit, who took her on for out-patient treatment within a matter of days.

### Discussion

Stigma is a prejudice (negative attitude) based on stereotypes usually leading to discrimination.<sup>1</sup> It is sometimes but not always related to a lack of knowledge about the condition that led to stigmatisation. Stigma can therefore be seen as an overarching term that contains three elements: problems of knowledge (ignorance), problems of attitude (prejudice), and problems of behaviour (discrimination).<sup>2</sup>

In the case of Alexandria, we see that discrimination occurs in several fields. She was stigmatised at work through lack of understanding of her problems. She may have been better off disclosing her illness so that she might get the relevant support. However disclosure of a mental health problem in the workplace can also lead to discriminatory behaviours from managers and colleagues such as micro-management, lack of opportunities for advancement, over-inferring of mistakes to illness, gossip and social exclusion.<sup>3</sup> Discrimination was evident through the exit life event in terms of her marriage break-up. In response to the stigma Alexandria experienced in society, she developed self-stigma which led to further morbidity. Alexandria experienced further discrimination by being denied appropriate and timely health interventions.



There were ways in which Alexandria experienced a lot of support – considerably the opposite to being stigmatised. This is very refreshing to hear. She overcame her self-stigma by deciding that she deserved help, walking 300 miles to obtain it. The doctors in A&E sympathised with her and offered her help. Another generous gesture was made by the patient who overheard her story. The head of the specialist OCD unit fast-tracked her case rather than waiting for things to go “through the system”.

It is interesting to know that Alexandria was later referred to another specialist OCD unit, this time for inpatient treatment. Here she was treated for 10 months. She then also received some intensive home-based therapy. She is now under the care of her local Community Mental Health Team, with follow-up by the specialist units. Her symptoms have improved considerably. She is living back home, is carrying out voluntary work, including sitting on committees, and is seeking employment.

### Questions

#### Q1. Stigmatisation:

- a) is always by others
- b) is the same as discrimination
- c) is always made worse by the media 4
- d) is never by health services
- e) cannot be changed

#### Q2. Stigmatisation:

- a) is usually associated with ignorance
- b) needs live communication in order to be successfully reduced – not DVD material.
- c) against people with mental illness does not take place in the legal system
- d) can be addressed by a Recovery College.
- e) of the self reduces psychiatric hospitalisation.

## OBSESSIVE-COMPULSIVE DISORDER: A CASE BASED DISCUSSION

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### Answers

#### Q1. Answer

- a) Self-stigma can be evident, contributing further to morbidity and status loss<sup>1, 5</sup>.
- b) Stigma is a prejudice usually leading to discrimination.<sup>1</sup> To stigmatise is to describe or regard as worthy of disgrace or great disapproval; discrimination is the unjust or prejudicial treatment of different categories of people.<sup>6</sup>
- c) Although the media often perpetuates unhelpful stereotypes of mental illness, they may alternatively be used to challenge prejudice, inform and initiate debate, thereby helping to combat stigma.<sup>4</sup>
- d) The case describes stigmatisation, and consequently discrimination, by health services.
- e) Not all efforts will provide the required change, but overall there is a hope that things will improve. For example, a study showed that short educational workshops can produce positive changes in participants' reported attitudes towards people with mental health problems.<sup>7</sup>

### Obsessive-compulsive Disorder: A Case Based Discussion Patient Management

#### Q2. Answer

- a) In a study into opinions of the British adult population concerning those with mental illnesses, reasonably knowledgeable answers to questions about treatment and prognosis were received, suggesting that, in most instances, stigmatising opinions were not based on a general lack of knowledge about mental disorder.<sup>8</sup>
- b) A study showed that DVD and live interventions did not differ in three of their four primary stigma outcomes.<sup>9</sup>
- c) Unfortunately, stigmatisation, and consequently discrimination, can take place in any area of life, as evident in the case discussed above. Discrimination ranges from simple avoidance through exit life events (relationship, employment and housing losses) and institutional discrimination (denial of health interventions, insurance, jury service, visa inter alia).<sup>1</sup>
- d) South West London Recovery College is the UK's first mental health recovery study and training facility providing a range of courses and resources for service users, families, friends, carers and staff. The college aims to support people become experts in their own self care and for families, friends, carers and staff to better understand mental health conditions and support people in their recovery journey.<sup>10</sup>
- e) In a study on self-stigma, high self-stigma at baseline predicted psychiatric hospitalisation, independent of perceived stigma and psychopathology.<sup>11</sup>

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# GUIDE TO THE “MENTAL” ACTS

N Preiss &amp; C De Wet



## Guide to the “Mental” Acts Good Clinical Care

### Abstract

The article distinguishes between the Mental Health Act (1983) and the Mental Capacity Act (2005), both of which apply to the care of people with mental health problems and people whose mental capacity may be impaired by general medical conditions. The use of the acts can be confusing for doctors who have not had training in mental health. The article aims to clarify the legal framework for establishing patients' capacity and circumstances where treatment can be given without patients' consent.

Many young doctors when dealing with medical issues, may consider mental health remote from their day-to-day practice and in many instances, subjective in interpretation. Doctors are taught to confirm diagnoses with objective test results. However, this is not the case with disorders in mental state. There are (as yet) no laboratory tests to diagnose psychosis, mania, depression, delirium or dementia. It is not uncommon, therefore, for people with mental health problems to be assessed as suffering with different disorders by different clinicians at different times.

What is more clear and straightforward is the legislative framework by which intervention and treatment can be offered for people who are unable to make decisions for themselves. Mental health legislation in the UK originates in the 18th century with laws allowing confinement of the “furiously mad and dangerous” and laws regulating the treatment of people in mental asylums, to protect their rights while reducing any potential harm they might do to themselves or to other people.

Until recently, however, the care of people with impaired mental capacity beyond the confines of psychiatric institutions was governed by the vast and sometimes vague area of Common Law. While the modern legislation is familiar to those working in mental health, the principles of these Acts also apply to health professionals in many other specialties. The Mental Capacity Act, in particular, might apply to many clinical scenarios in primary care and general hospitals, and it is important that doctors of all specialties are familiar with the principles of this Act.

The two main acts that apply in the UK are the Mental Health Act (MHA) and Mental Capacity Act (MCA) - to be exact, in England and Wales: the Mental Health Act 1983 (as amended in 2007) & Mental Capacity Act 2005; in Scotland: the Mental Health Act 2003 & Adults with Incapacity Act 2000; and in Northern Ireland: the Mental Health Order 1986.

The Mental Capacity Act (or Adults with Incapacity Act) applies to all circumstances where care is provided for a person whose capacity to make their own decisions is impaired (whether by psychiatric or any other medical cause) and the intervention is in the person's best interest. In contrast, the Mental Health Act applies only to people who suffer with a primary psychiatric condition (who may, or may not, have impaired capacity at the time), and may be applied with the intention to protect the person from harm, or to protect others.

### So, what is the Mental Health Act?

This legislation is intended to regulate the care of those who require assessment or treatment for a mental disorder, but are unable (or unwilling) to give their consent. It provides the legislation by which people with a mental disorder can be detained in hospital or police custody, to have their mental state assessed or their disorder treated even if they do not give their consent.

For the Mental Health Act 1983 (as amended in 2007) to apply, a patient must be suffering from a primary psychiatric condition, or “mental disorder”, defined in the Act as any disorder or disability of mind, but not including drug or alcohol dependence (or disorders of personality, in Scotland).

Under the Mental Health Act, a person can be involuntarily admitted to a hospital or “place of safety” if their mental disorder is “of a nature or degree which warrants detention in the interests of their own health, or safety, or for the protection of other persons”.

- In England and Wales, sections 2 and 3 of the Mental Health Act allow for the compulsory admission to hospital for assessment and treatment of a patient with a mental disorder (for up to 28 days, and up to 6 months, respectively). The application for admission can be made by the person's nearest relative or an Approved Mental Health Professional (usually, a specially trained Social Worker) based on the written recommendation of two doctors. In rare emergency situations where only one doctor's recommendation is available, an application can be made to admit a person for 72 hours (under section 4) while a second doctor's recommendation is sought. Once admitted under section 2 or 3 the patient has the right to appeal against their detention.

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- In Scotland, part 6 of the Act allows detention up to 28 days where it is recommended by an Approved Medical Practitioner (a doctors trained under the Section 22) and consented to by the Mental Health Officer (equivalent to AMHP). In emergency situations a person can be detained for up to 72 hours by a registered medical practitioner with the consent from a Mental Health Officer (where practicable) under part 5 of the Act. Once detained, a Mental Health Officer can apply to a Mental Health Tribunal for a person to be made a subject to a further period of compulsory treatment in hospital or in the community under a Compulsory Treatment Order of up to 6 months, under part 7 of the Act.

- In Northern Ireland article 4 allows for admission for assessment for up to 7 days based on an application by the nearest relative or an Approved Social Worker (ASW) supported by one doctor's recommendation. Upon admission to the hospital a report must be submitted by a second appointed doctor who can recommend further detention for treatment for up to 6 months under article 12.

It is worth remembering that any doctor in England And Wales can detain any person already admitted to any hospital i.e. prevent them from taking their own discharge for up to 72 hours (under section 5(2) of the Mental Health Act 1983) for an assessment for further detention under Sections 2 or 3 to take place. Section 5(2) can be used to hold a person in a psychiatric or a general hospital, but cannot be used to detain someone who was not already admitted to hospital (for example, a person being treated in an A&E or outpatient department). In Northern Ireland an equivalent detention would be under article 7(2) for up to 2 days. Another commonly used compulsory measure in England and Wales is Section 136 whereby a Police Officer suspecting a person in a public place of having a mental disorder, can convey them to a “place of safety” where mental health assessment by a professional can take place.

Apart from sanctioning compulsory admission and treatment of a mental disorder, the Mental Health Act enables doctors to treat physical conditions arising directly from a mental disorder. It does not apply to physical health problems unrelated to mental health conditions. Therefore one could not use the Mental Health Act to perform a Caesarean Section on a behaviourally disturbed woman! It could, however, be used to treat hepatic failure as a consequence of a paracetamol overdose in a clinically depressed patient. It would also be applicable to a patient with life-threatening food refusal secondary to delusional beliefs or a clinical eating disorder. In psychiatry regular physical monitoring e.g. blood tests can be undertaken on people receiving psychotropic treatments without their consent under the Act.



### What is the Mental Capacity Act?

When a patient refuses important treatment for physical condition, it may be that their capacity to understand the need for treatment is impaired. The Mental Capacity Act 2005 (and Adults with Incapacity Act 2000, in Scotland) applies to everyone who cares for a person who may lack mental capacity (whether permanent, or temporarily) and is relevant to a wide range of decisions made on behalf of incapacitated people, including medical, social and financial decisions. Legislation on the rights of mental incapacity was introduced in the UK relatively recently, on the heels of the Human Rights Act 1998, and provided the first clear statutory framework where only common law had prevailed (as is still the case in Northern Ireland and Ireland). The Scottish and the English Acts are very similar.

#### The Mental Health Act 2005 has the five following statutory principles:

- A person must be assumed to have capacity unless it is established that he lacks capacity.
- A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.
- A person is not to be treated as unable to make a decision merely because he makes an unwise decision.
- An act done or a decision made on behalf of a person who lacks capacity must be done, or made, in his best interests.
- Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

Capacity might be lost as a result of transient or irreversible disturbance in the functioning of the mind or brain. The disturbance may occur in a wide range of situations, including intoxication, delirium, head injury, mental illness, dementia, learning disabilities, brain damage, or any number of grave physical conditions producing confusion, drowsiness or loss of consciousness, or unwanted effects.

Notably, capacity needs to be assessed by the professional delivering treatment. Capacity is time and decision specific, thus capacity to make a particular decision might be restored after some time (depending on the nature of the impairment). It can also be the case that a patient does not have capacity to make a decision on complex financial affairs, but is able to understand and make decisions on their medical treatment options.

#### For a person to be capable (i.e. to have the capacity to make a decision) they must be able to:

- understand the information relevant to the decision, including the potential consequences of different decisions;
- retain the information long enough to make the decision (this does not have to be permanently);
- use, or weigh the information provided to make a decision;
- communicate the decision (could be by a gesture or sign language).

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Consistent with previous medical definitions of capacity, the Act considers a person with a disturbed or impaired mind to lack capacity, if they are unable to understand, retain, or weigh the information relevant to a decision, or can't communicate their decision. When another person makes a decision on behalf of an incapacitated person they should reasonably believe that they do so in the best interests of the person concerned. Other wishes, beliefs or values of the person (as expressed at a time when they did have capacity) must be taken into consideration. Before making a decision, it is also good practice to consult the views of others interested in the person's welfare (family members, carers, advocates, Independent Mental Capacity Advocate (or IMCA) where appropriate, donee of Power of Attorney, deputy of the Court or any other named person).

### Advance Directives

The Mental Capacity Act makes it legally possible for anyone to make a decision in advance, i.e. Advance Statements or Directives, to refuse all or some forms of medical treatment in the event of them losing their mental capacity in the future. Advance Directives can be used to refuse, but not to request, specific treatment. A valid Advance Directive has the same gravity as refusal of treatment by a person with capacity, and the treatment cannot lawfully be given. If this were the case, the doctor might face civil liability or criminal prosecution, unless, of course, the doctor could not have been aware of the existence of an Advance Directive.

An Advance Directive can only be valid if it has been made by an adult (over the age of 18 years), with capacity, describes the specific treatment to be refused under specific clinical circumstances, and the directive was not made under the influence or harassment of another person, or modified verbally or in writing since it was made. Advance Directives to refuse life-saving treatments must be in writing (by the person, by a family member, by a doctor or on an electronic record), must be signed and witnessed (can be signed by someone else at the person's - the witness is to confirm the signature, not the content of the advance directive), and include a clear express statement that the decision stands 'even if life is at risk'.

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A doctor may decide not to act on an Advance Directive if the person has done anything inconsistent with the advance decision which affects its validity (for example, a change in religious faith), if the current circumstances would not have been anticipated by the person and would have affected their decision (for example, a recent development in treatment that radically changes the outlook for their particular condition), or the doctor is not entirely clear about what should happen. Where there is doubt, the doctor should act in the person's best interest, which, by definition, is to preserve life.

It is important to remember that decisions pertaining to the detention and treatment of people with mental illness are considered under the Mental Health Act, and the principles of the Mental Capacity Act may not apply. For this reason the Mental Health Act includes more rigorous formal safeguard and appeal processes than the Mental Capacity Act.

### What about children and adolescents?

**The valid consent of a child or young person would be sufficient authority for their admission to hospital or treatment. In order to be able to give valid consent, a child or young person must:**

- have capacity/competence to consent to a particular decision being considered; and
- have sufficient information to make the decision; and
- not be subjected to any undue influence when making their decision.

Children under 16 years able to make decisions about their admission to hospital and/or treatment are referred to as being Gillick competent (a child who has attained sufficient understanding and intelligence to be able to understand fully what is involved in the proposed intervention). Gillick competence is a term originating in England and is used in medical law to decide whether a child (16 years or younger) is able to consent to his or her own medical treatment, without the need for parental permission, or knowledge.

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In 16 to 17 year olds the Mental Capacity Act (2005) applies. In those young people who are unable to make a decision, the professionals need to consider whether they may make decisions concerning admission and/or treatment (not necessarily related to mental health) relying on the MCA 2005, or whether those with parental responsibility can consent to the admission and/or treatment on behalf of the young person.

**Those with parental responsibility will be able to consent to the care and treatment on behalf of the young person who is unable to make such decisions (whether or not the young person lacks capacity within the meaning of the MCA 2005), if the decision falls within the “zone of parental control”. That is to say:**

- the nature of the decision falls within usual parenting decisions;
- all indications are that the parent is acting in the best interests of the child;
- the parent has capacity to make the decision in question.

In cases where those with parental responsibility do not agree with the proposed course of action, practitioners need to consider the Mental Capacity Act 2005 or Mental Health Act 1983 (when MCA is not applicable and the person is considered to have mental health problems) or an Application to the Court.

	Under 16 years	Over 16 years
Decisions regarding mental health or physical problems immediately caused by mental disorder	Parental consent or MHA 1983 or Application to the Court	MHA 1983
Decisions regarding physical health unrelated immediately to mental disorder	Parental consent or application to the Court	MCA 2005

**Table 1: Which Act Applies if a Patient Lacks Capacity?**

Knowledge of the above legislation could be invaluable in cases such as that of Kerrie Woollorton, who presented to an A&E department having taken a fatal dose of antifreeze. She had a written statement forbidding any treatment for her overdose, and continued to refuse the treatment. Her wishes were honoured and she died later. Most psychiatrists would agree that comprehensive assessment of the patient’s capacity might have led to a different outcome.



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# CHARLES BONNET SYNDROME

H Dix, J Jenkinson & J Bolton



## Charles Bonnet Syndrome Patient Management

### Discussion

#### What was the nature of the patient’s visual experiences?

PT was experiencing visual hallucinations. Hallucinations are perceptions in the absence of sensory input. They can occur in any sensory modality and have the quality of normal sensory experiences (and can coexist with normal sensation). Sometimes hallucinations form part of “normal” experience; for example, many people will experience transient hallucinations when falling asleep or waking up (hypnogogic and hypnopompic hallucinations). Visual hallucinations tend to be closely associated with organic pathology; they are relatively uncommon in functional psychotic illness.

Another common cause of abnormal sensory experiences are illusions, where there is a misperception of sensory input, such as perceiving a pattern on a carpet as crawling insects. It did not appear that PT was misperceiving sensory information, hence the conclusion that his experiences were hallucinatory.

#### What was the most likely diagnosis?

Charles Bonnet Syndrome (CBS) is a condition characterised by visual hallucinations in the context of visual impairment. The core features of the condition are listed in Figure 1 and the history of the condition is described in Figure 2.

- The presence of formed, complex, persistent or repetitive, stereotyped visual hallucinations
- Retention of insight into the unreal nature of the hallucinations (full or partial)
- Absence of primary or secondary delusions
- Absence of hallucinations in other sensory modalities

**Figure 1: Core features of Charles Bonnet Syndrome**

The term “Charles Bonnet Syndrome” was coined in 1937 by George de Morsier when he described a hallucinatory state in the “elderly with intact cognition”<sup>1</sup>. Charles Bonnet (1720-1793; see accompanying illustration) was a Swiss naturalist whose 87 year old grandfather, who was partially sighted due to cataracts, experienced complex hallucinations, including “figures of men, of women, of birds, of carriages, of buildings...”<sup>2</sup>. Charles Bonnet himself became blind and, in later life, experienced the condition that now bears his name.

### Abstract

We describe a case of visual hallucinations in a man with visual impairment, a common phenomenon that is often under-recognised.

### Case History

An 85-year old gentleman (PT) was admitted to hospital following a stroke. He was referred to the Liaison Psychiatry Service after he reported “seeing things”.

Due to memory impairment, PT could not recall the chronology of his visual symptoms. However, his wife recalled him describing unusual experiences over the preceding two years, including seeing insects burrowing into the carpet, water gushing through the house and a furry animal curled up on top of the toilet. She noted that the experiences had decreased in frequency following a recent cataract operation.

Twice during the consultation PT responded to abnormal visual experiences that were not visible to the assessing doctor. He saw an animal crawling across the floor and later commented that he could see a woman standing in the corner of the room. PT was aware that these experiences were not “real” and he did not find them distressing.

PT had a history of type 2 diabetes mellitus and ischaemic heart disease. Proliferative diabetic retinopathy and cataracts had rendered him virtually blind. He had no past psychiatric history, and drank alcohol only rarely.

Family had noticed a gradual decline in his memory over the preceding six months, with acute deterioration following the stroke. A CT head scan following admission showed a recent stroke and pre-existing small vessel disease.

Cognitive testing showed mild global impairment. PT’s mood was euthymic and no other psychopathology was elicited.

## CHARLES BONNET SYNDROME

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**Figure 2: Charles Bonnet**

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The prevalence of CBS amongst people with impaired vision is about 10-15%<sup>3</sup>. This is independent of age, although CBS is more common in older people as a greater proportion of that age group have visual loss. One study has shown that cognitive impairment and stroke may be also predisposing factors for the condition<sup>4</sup>.

Whilst the diagnosis is not excluded by an absence of visual pathology<sup>3</sup>, CBS is most strongly linked to acquired visual impairment, with Age Related Macular Degeneration being the most common association. CBS does not occur in people with congenital blindness. PT's CBS was thought to be related to retinopathy and cataracts, with early cerebrovascular disease possibly increasing his vulnerability to the disorder.

### How do the visual symptoms arise?

The most widely accepted theory for the pathogenesis of the visual hallucinations in CBS is that they are "release phenomena" in which a decrease in sensory input causes visual regions of the cortex to become disinhibited and fire spontaneously<sup>5</sup>. It can be thought of as a similar process to phantom limb syndrome, and a comparable condition, "musical hallucinosis", occurs in people with acquired hearing loss<sup>6</sup>. The release theory is supported by evidence from functional magnetic resonance imaging. Scans performed on four patients with CBS demonstrated that active hallucinations were associated with spontaneous activity in the occipital lobe<sup>7</sup>.

Whilst the hallucinations experienced in CBS can be simple patterns or shapes, classically they take complex forms, such as those experienced by PT. Patients with CBS commonly see detailed landscapes, and small animals or people. The hallucinations have no emotive content and PT's lack of distress at them is not unusual. However the fear of becoming or being labelled as mentally ill does cause significant concern amongst people with CBS<sup>5</sup>.

### What is the differential diagnosis?

The differential diagnosis for CBS is very broad, including almost any cause of visual hallucinations (see Figure 3)<sup>8</sup>. Delirium, severe dementia and recreational drug use are common differential diagnoses in a general medical setting. Given the potential implications of misdiagnosis it is important to correctly identify CBS. However, making the diagnosis can be challenging since no specific investigations exist to identify it.

#### Neurological Disorders

- Brain-stem lesions
- Hemispheric lesions
- Epilepsy
- Migraine
- Narcolepsy

#### Neurodegenerative disorders

- Alzheimer's dementia
- Dementia with Lewy Bodies
- Parkinson's dementia

#### Psychiatric Disorders

- Schizophrenia
- Affective disorders

#### Toxic or metabolic disorders:

- Hallucinogenic drugs
- Alcohol withdrawal
- Any metabolic encephalopathy

#### Other conditions:

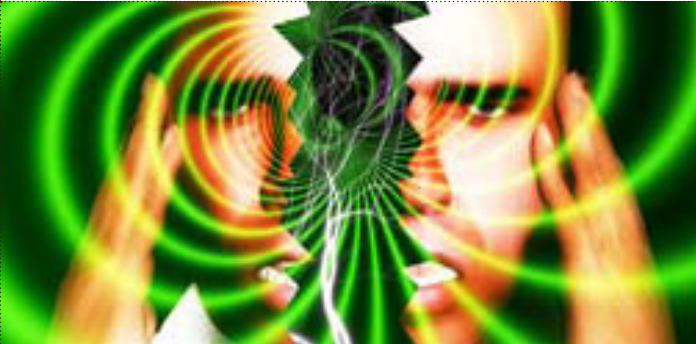
- Delirium
- Hypnogogic/hypnopompic states
- Emotional distress
- Fatigue/ sleep deprivation
- Charles Bonnet Syndrome

**Figure 3: Causes of visual hallucinations**

In PT's case, determining the chronology of the symptoms allowed the possible diagnoses to be narrowed down (for example, dementia was unlikely as the hallucinations predated the onset of cognitive impairment). History is crucial in identifying the core features of CBS (Figure 1) and will help to exclude many differential diagnoses. Other investigations, such as blood tests to rule out infection or metabolic imbalance, or cerebral imaging to exclude brain pathology should be undertaken when clinically indicated.

## CHARLES BONNET SYNDROME

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### Charles Bonnet Syndrome Patient Management

#### What is the management of CBS?

Although there is no definitive treatment for CBS, simple measures can ameliorate symptoms considerably. For example, altering light levels or focussing on distractions such as television or radio can be successful in providing temporary relief.

PT and his family were particularly reassured by an explanation of his symptoms. Research has shown that such a discussion can be therapeutic. In a study of visually impaired subjects with CBS, over 90% patients who were worried about the hallucinations reported benefitting from an explanation, although the hallucinations remained unchanged<sup>3</sup>.

Some case studies have described benefit from various anti-psychotic and anti-epileptic agents<sup>9</sup>. However, others have suggested that, as neuroleptic agents lower the seizure threshold, they may increase the tendency to hallucinate<sup>10</sup>. The risk of adverse effects with psychotropic medications is significant and definitive studies of their use in CBS have yet to be undertaken, so their use is usually reserved for patients who are particularly distressed by their hallucinations. Drug treatment was not recommended for PT.

Where patients have particularly troubling hallucinations and non-pharmacological treatments are ineffective, a trial of a low dose of one of the newer "atypical" anti-psychotic drugs may be considered. Examples include olanzapine, risperidone and quetiapine. These drugs are less likely than the older anti-psychotics to cause adverse effects such as extrapyramidal movements disorders. However, they can have adverse effects of their own which need to be considered when prescribing, such as weight gain and elevations in blood sugar.

#### What is the patient's prognosis?

The clinical course of CBS is variable. In some cases, hallucinations improve after treatment of the underlying visual impairment. A previous cataract operation had led to a transient improvement in PT's symptoms. Other patients find that their symptoms disappear as impairment progresses to total blindness<sup>10</sup>. Many people notice that their hallucinations occur less frequently from about a year after their onset, regardless of changes to their vision<sup>11</sup>. Having CBS does not mean that a patient is more likely to develop dementia or a mental illness, although concurrent dementia may worsen the hallucinations.

#### Conclusions

CBS is an important cause of visual hallucinations in the visually impaired. It is not indicative of an underlying dementing or psychotic illness, although many people with CBS fear that they are "going mad". Whilst there is no definitive treatment, patients can derive significant benefit from a simple explanation of the condition, so it is important to ask about visual hallucinations in susceptible individuals, especially as many people who experience CBS will not volunteer their symptoms. CBS has a benign yet variable course and may remit when sight improves or worsens.

After completing treatment for his stroke, PT was discharged home with a package of care. He was not felt to require further treatment for his CBS, but he and his family felt better able to cope with the condition once they understood the nature of it.

#### Key Learning Points

- **Not all hallucinations are indicative of functional mental illness**
- **Visual hallucinations are commonly organic in origin**
- **Charles Bonnet Syndrome (CBS) is an important cause of visual hallucinations in the visually impaired**
- **Good history taking is key in making a diagnosis of CBS**
- **Reassurance is a simple but important part of the management of CBS**

#### MCQs

**1. A 46-year old man is partially sighted due to glaucoma. He presents to the Emergency Department after seeing insects crawling over the floor of his flat and on his limbs. Of the choices below, which is the most appropriate initial action to take?**

- a) Refer to a psychiatrist for an urgent opinion
- b) Take a detailed history
- c) Prescribe anti-psychotic medication
- d) Explain to him that he has Charles Bonnet Syndrome
- e) Perform a mental state examination



## CHARLES BONNET SYNDROME

H Dix, J Jenkinson & J Bolton



**2. An 84-year old widow with long standing macular degeneration has become distressed about seeing visual hallucinations of small people and animals running around her house. A diagnosis of CBS is made. Which of the following has been shown to be the most effective first line treatment in a case such as this?**

- a) Anti-psychotic medication
- b) Telling the patient to put the radio on when she experiences the hallucinations
- c) Anti-convulsant medication
- d) Reassurance and explanation of the problem
- e) Referring her to social services for residential home placement.

### Answers

**1. b. In any patient it is important to take a detailed history to narrow down the differential diagnoses before proceeding with examination, investigations and treatment.**

- a) Referral to a psychiatrist might be appropriate at a later stage when more information is available and you have ruled out organic causes of his symptoms.
- c) This is inappropriate until an organic cause is ruled out, unless the patient is very agitated and requires sedation, but only after non-pharmacological measures to reduce anxiety have failed.
- d) Charles Bonnet Syndrome cannot be diagnosed until other causes of visual hallucinations have been ruled out. The differential diagnoses in this case includes alcohol withdrawal and other causes of delirium.
- e) This should form part of your examination of the patient after you have taken a history.

**2. d). Studies have shown that this is particularly effective in people who are distressed by their hallucinations and will reassure the patient that there is not a sinister cause for her symptoms.**

- b). This is a simple measure which may be effective, although it does not have a strong research base. Many patients find that distractions such as the TV or radio will reduce the frequency or intensity of their hallucinations. Altering light levels has also been reported to help in some cases.
- a & c). Case studies have shown benefit from these in severe cases, but evidence for use of medications in CBS is limited and hence pharmacological intervention should not be used as first line treatment.
- e) This is inappropriate at this stage with the information given.

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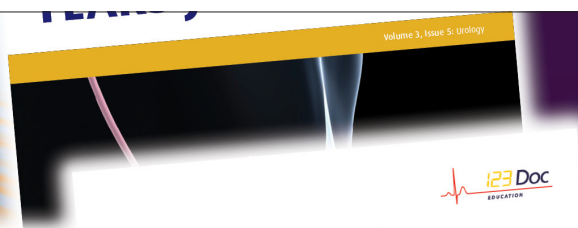
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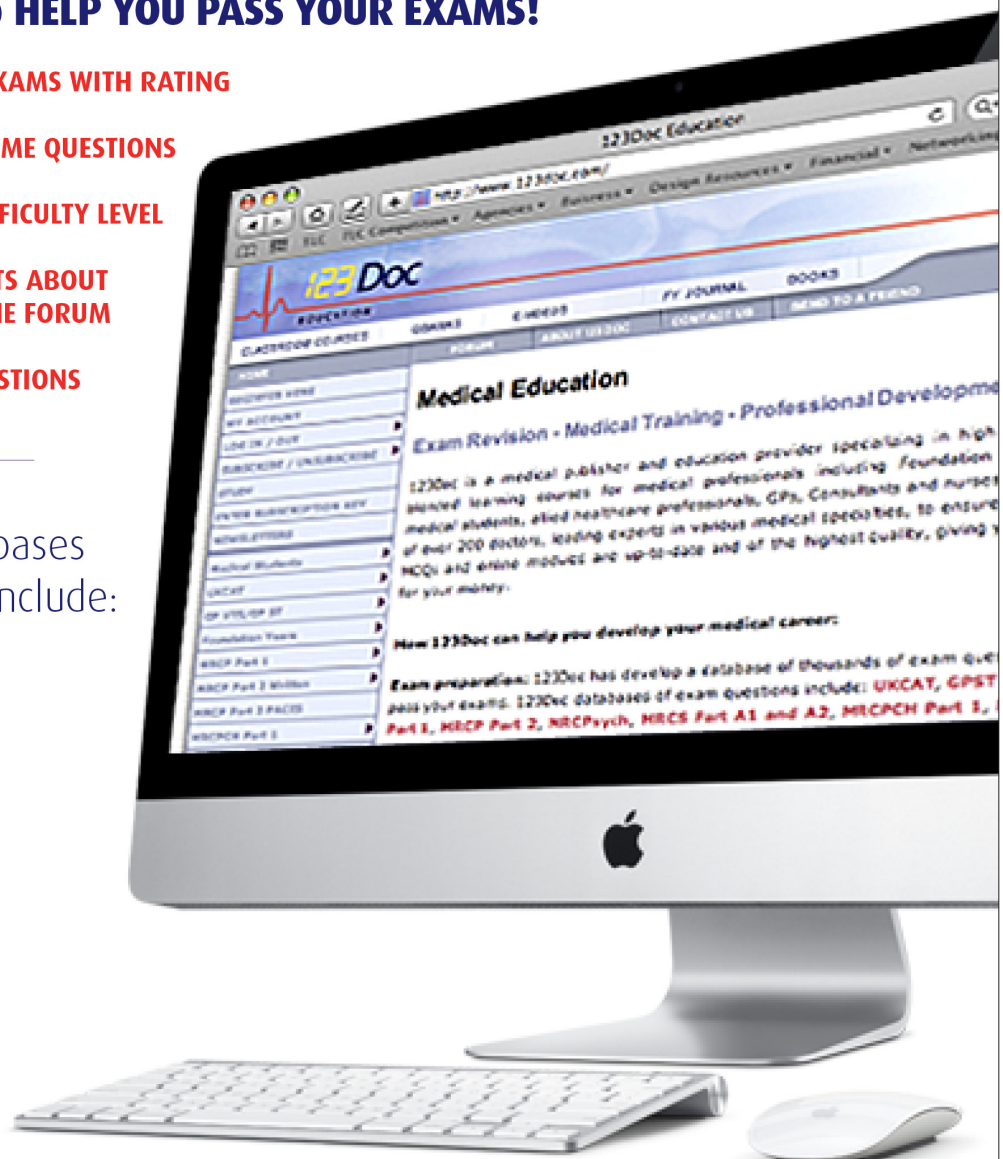
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