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PRIMARY CARE MENTAL HEALTH & EDUCATION

Progress **is pleased to bring readers key articles from the journal of the charity Primary Care Mental Health and Education (Primhe), which covers issues relating particularly to mental health in the primary care setting. We feel the articles will be of interest to *Progress* readers in primary care but also to those in secondary care. For more information about Primhe, including member benefits, visit the charity's website at www.primhe.org**

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More institutionalised mental health care – what is behind it?

Despite a lack of formal evidence for benefit, the number of people with psychiatric illness cared for in institutional settings has risen significantly. The cost of this type of care is not insignificant and Professor Priebe discusses whether this trend is a good or bad thing.

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The last 15 years have witnessed a consistent trend in Western Europe: institutionalised care for patients with mental illnesses has been on the increase. The number of forensic beds and places in various forms of supported housing and residential care has significantly risen. In England, forensic beds have increased by 38 per cent and supported housing places by 40 per cent between 1990 and 2002.[1] Also, the prison population has grown, in England by 57 per cent within the same period of time, and several surveys indicate that a substantial proportion of people in prison suffer from mental disorders.[2] While the number of conventional psychiatric hospital beds has fallen in the same period, this does not compensate for the new institutionalised care that has been built up.

The increase may appear surprising as it absorbs large amounts of public funds and is not backed by any scientific evidence. There is no evidence that the number of homicides committed by mentally ill people has increased as a possible explanation for more forensic beds,[3] and equally there is no evidence for the effectiveness of rehabilitation through supported housing as a potential reason for putting more money into that form of care.[4] So, why is there more institutionalised care, and is it a good or bad thing?

Wider perspective

While the data showing the increase in institutionalised mental health care cannot be argued away, the explanation is less clear. Any attempts to come up with specific national factors should be treated with caution, as the increase has been seen across Western European countries despite all the substantial differences in tradition of psychiatry, organisation of health care systems and funding arrangements. Thus, a wider perspective might be helpful.

There are at least four distinct explanations, which are not mutually exclusive. First, the psychiatric morbidity may have increased resulting in a higher demand for institutionalised care. Recent data suggest that the incidence rates of psychotic disorders in inner cities, particularly in metropolitan areas such as London, are much higher than in rural areas. The incidence of psychotic disorders in Copenhagen has been found to be 2.5 times higher than in rural Denmark controlling for confounding factors such as migration. And psychosis rates in London are at least twice as high as in middle-sized towns like Bristol and Nottingham. The changing lifestyle in inner city and metropolitan areas with increasing social fragmentation might have led to more people developing psychotic disorders and ending up in institutions.

Second, social and family support for mentally ill people may have dropped, requiring institutions to step in and provide accommodation and care. Families in which all adults are in full-time employment struggle to look after ill relatives and may expect institutions to provide the care that families themselves cannot offer anymore.

Third, the attitude of the general population to risk may have changed influencing political and clinical decisions. The enormous rise of the prison population in all Western European countries without any consistent evidence for increased crime rates may be seen as a sign of this tendency. As a society, we might be willing to follow an implicit or explicit philosophy of containing risk through putting allegedly dangerous – or unpleasant - people into institutions. This may have persuaded politicians to spend increasing amounts of public funds on institutionalised care and clinicians to refer patients who are otherwise difficult to manage to such institutions.

And fourth, there is a widening health care economy with a range of providers lobbying for more business and expanding the care they provide. Private providers have an obvious tendency to increase profit through more service provision. However, non-profit organisations and the so-called 'voluntary' sector also have an interest to strengthen their position and status, increase their budgets and secure the jobs of their employees. Thus, they will usually campaign for more work and income. Such a tendency exists even in conventional NHS Trusts, which should have no genuine interest to grow. Thus, all provider organisations argue for more business and commonly claim to do that in the interest of the patients.

Lessons from history?

History never repeats itself, but it may be interesting to note that similar issues were behind the rise of asylums in the 19th Century.[5] Psychiatrists argued – very successfully – that industrialisation and urbanisation of society produced more mental illness and that more asylum beds were needed to treat patients early and effectively. Families which, in a rural context, could look after ill relatives no longer had the material means to do that once they had moved into the towns so that asylums took over the supportive role of families. Although some asylums later turned into unacceptable bins, many were originally built according to highest standards, representing the pride of industrialised states to look after the feeblest groups in the society with care and humanity.

The rise of the asylums was also motivated by the wish of psychiatrists to be part of medicine and share the prestige, status, power and income of other medical doctors. They felt this role required hospital beds. The only aspect that was less apparent than it might be today was the debate on risk. The consistency of arguments across a period of almost 200 years may or may not indicate processes generally inherent in industrialised societies.

Good or bad?

Are more mental health care institutions a good or a bad phenomenon? As the asylums in the 19th Century were not necessarily bad – although most of them turned

into abhorrent places in the 20th Century when they were overcrowded and poorly funded – many of the new institutions may provide a pleasant environment and excellent care. Yet, this varies substantially. With respect to supported housing and residential care, some places are run just for profit and have been labelled 'the return of the private madhouse'. Patients who usually stay in those homes for the rest of their life are sometimes treated with little respect and dignity.

Society is in danger of ignoring – again, because this also happened during large parts of the 20th Century – the unacceptable living conditions in some homes and neglecting a most vulnerable group of patients with severe and chronic mental illnesses. On the other hand, there are places described as 'golden cages', which are so pleasant and accommodating that they decrease patients' wishes for more autonomy and independent living and create a new form of institutional dependency.[6]

With respect to vocational rehabilitation, the traditional philosophy was to move patients step-wise from fully protected settings to less and less protected ones until they might find regular employment without any specific support. Scientific evidence has challenged this philosophy and come up with a different paradigm: if the aim is to get as many patients as possible into regular employment, one should rather place them directly into normal jobs and provide support for them – and possibly their employers – within the normal work environment.[7] While this is the best way to ensure regular employment for as many patients as possible, there will always be a number of patients who fail to hold on to their jobs and require, at least for some time, protected environments. However, the more protective environments there are, the more patients will be prevented from moving towards more autonomy given the tendency of providing organisations to keep their patients.

It is a characteristic of institutionalised care that staff feel patients can rarely move on to less intensive care provision, and this belief is shared by many patients after a while. Thus, there will be a balance between a push for full social inclusion with all the required support on the one hand and a range of protected institutionalised care on the other. The judgement on what the most appropriate balance is depends on the evidence for the effectiveness of institutionalised care, but even more on the available funding and underlying values.

Institutionalised care is extremely expensive, and there may be better ways to spend the money; however, that would go against the interest of all provider organisations and their considerable combined influence. This is a political decision, which will reflect the values of how much autonomy patients with mental illness should have, and how much protection they are entitled to.

Quality of life

Over the last 50 years, the situation of patients with chronic mental illness has certainly improved throughout Western Europe. Unlike the USA, formally long-term hospitalised patients in Western Europe have not ended up homeless after discharge from asylums and – by and large – received sufficient professional care in the community to improve their quality of life.[8,9] Political decisions will be required to ensure that this remains so – with or without more mental health care institutions.

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EMDR – effective in primary care counselling

Eye movement desensitisation and reprocessing (EMDR) has proved to be a very effective treatment for post-traumatic stress disorder (PTSD). Sally Worthing-Davies explains this method of therapy and the advantages of its use in primary care.

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The National Institute for Health and Clinical Excellence (NICE) Guidelines state that eye movement desensitisation and reprocessing (EMDR), as well as cognitive behavioural therapy (CBT), are the preferred treatments for post-traumatic stress disorder (PTSD). As a counsellor integrating EMDR in my primary care practice, I want to encourage others to train in this highly effective treatment.

What is EMDR?

EMDR is a scientifically validated integrative psychotherapy used to resolve disturbing emotional material secondary to traumatic or disturbing events in order to facilitate natural growth and healing processes. EMDR uses a phase-oriented approach to treatment, including a uniquely combined protocol, within a standardised procedure, grounded in the theoretical foundation of the adaptive information processing model. It is based on the philosophy that human beings are, under appropriate conditions, capable of naturally moving toward greater health and integration.[1]

Francine Shapiro originated and developed EMDR in 1987.[2] This complex method of psychotherapy integrates many of the successful elements of a range of therapeutic approaches in combination with bilateral eye movements or other sensory alternating dual-attention input, such as hand, leg or shoulder taps, drumming, audio beeps or music, or handheld pods that vibrate. This dual attention input allows the brain to desensitise and process disturbing material.

What issues can EMDR address?

EMDR has proved to be a very effective treatment for PTSD arising from incidents such as road traffic accidents, war trauma, torture, natural or man-made disasters, sexual abuse, assault, domestic violence, or childhood abuse – sexual, physical or emotional. Increasingly, EMDR is also used in treating issues such as phobias, panic disorder, obsessive-compulsive disorder, performance and other anxiety related disorders.

What are the advantages of using EMDR in primary care?

Primary care is the first port of call for patients in the NHS. Most counsellors, psychotherapists and psychologists in primary care have patients referred who fall into the above categories. Some have PTSD symptomatology or, as we begin to treat them, areas of difficulty emerge that can be treated with EMDR.

If EMDR was available more widely at primary care level, there would be benefits to patients because:

- In the Swindon Primary Care Psychology Service, patients are seen initially in two or three weeks, a short period between referral and beginning of treatment within primary care
- In primary care, the counsellor and doctors can work collaboratively, as they are on the same premises
- If patients suitable for EMDR have to be referred on to secondary care, there will almost inevitably be delays before they receive treatment.

What doctors say

• 'Patients who benefit from EMDR include those suffering from anxiety states (especially panic, anxiety and phobias where there is often bewilderment), depression (where ruminations about guilt or pessimism block progress), obsessive-compulsive disorders (to break the vicious circle) and PTSD (where unprocessed memories are re-evoked as flashbacks or nightmares).

'EMDR tends to work quickly once the therapeutic relationship is established and its effects are permanent because once processed the memories are within the patients' control.'

Professor Gordon Turnbull FRCP, FRCPsych

• 'For years I have seen people with post-traumatic stress disorder dominated by nightmares and flashbacks. The waiting list to see a specialist in PTSD was prohibitive. Five years ago I heard of a new treatment called EMDR. This was only available after a six to nine month wait. Patients stayed off work for months waiting for the treatment.

'We now have a practice counsellor who can do EMDR in the surgery. I refer patients to her and within a few weeks they come back with a smile and saying they feel so much better. A lady who gave up on the waiting list to receive help five and a half years ago saw her recently. After a 45-minute session her stress levels on recalling the event had dropped from 10 to one. Every practice should have a Counsellor equipped to do EMDR.'

GP, Victoria Cross Surgery, Swindon

• 'I support the use of EMDR in primary care. We are very fortunate to have as our practice counsellor a therapist who is trained in EMDR. Several patients with PTSD saw Professor Gordon Turnbull, Consultant Psychiatrist, who confirmed the diagnosis, and strongly recommended EMDR as a vital tool in treatment, and like me, has been very impressed with the results of our counsellor's therapy.'

GP, Victoria Cross Surgery, Swindon

How did I come to be using EMDR in primary care?

My primary training and overarching approach is as a systemic psychotherapist. Interest in EMDR came about when I saw a client suffering from PTSD as a result of war trauma while working abroad. He mentioned EMDR had been used effectively with him in an earlier episode of war trauma. I then explored the treatment, trained and began to use EMDR in both my private practice and in primary care immediately after qualifying. The results and feedback from both patients and doctors have been very encouraging and EMDR has become an important aspect of my treatment.

What happens in an EMDR session?

Once the therapeutic relationship is established, prior to actually using EMDR, a full history and the patient's agreement to participate in EMDR are obtained after a clear explanation of the EMDR process and protocol. Preparation for EMDR includes establishing resources such as relaxation techniques and safe place imagery for the safety of the patient as difficult material is processed. The client is told, 'Let whatever happens happen. There are no "supposed to's" in this process.'

The patient is helped to identify issues or memories for work with EMDR. Once chosen, a series of questions prepare the patient for the processing. In focusing on the targeted incident, the EMDR method evokes all aspects of the issue or traumatic memory: visual, emotional, cognitive and, importantly, physical. The client is asked to describe: an image that is associated with the worst part of the incident or issue; negative beliefs arising from the incident; positive beliefs they would hope for instead; related emotions/feelings; and where they notice it in their body. Scaling questions determine and track any changes in the patient's perception of the 'truth' of that positive belief and their level of disturbance.

Next, bilateral stimulation begins using eye movements, sounds or touch, whichever is most comfortable for the patient, while they simultaneously focus on the emotionally disturbing material. EMDR seems to facilitate the accessing of the traumatic memory network and information is adaptively processed with new associations being made between the disturbing memory and more adaptive memories or information. This leads to more complete information processing and alleviation of emotional and physiological distress. If there are earlier unresolved traumas, more recent traumatic incidents rarely process until previous associative events that resonate are processed. The processing seems to involve tracking back through chains of linked emotional and sensory memories including physical or bodily aspects of these, and ultimately finding a more functional and adaptive resolution of the anxiety symptoms related to the targeted event.[3]

Case examples

There are many randomised clinical trials showing the efficacy of EMDR (see www.trauma-pages.com). The two cases that follow provide anecdotal evidence from my own practice.

Case 1

A 45-year-old male had a road accident 10 years ago. The patient appeared uninjured, having no broken bones or open wounds and, in shock, was able to take photos, refuse help, call a taxi and go home. Shortly after, he noticed that he was not functioning well in his work and family life, but did not associate this with his accident. He lost his case against the other driver.

Ten years later, he had a near fatal infection with a very high temperature. He began to have terrifying flashbacks of the earlier accident, body pain where he was flung across the car, sleep disturbance, intrusive thoughts and memories that continued after his recovery from the infection. His work, relationships and health suffered. The patient was referred to a PTSD consultant who then referred him on to me, as he knew I practised EMDR.

We met for four 45-minute sessions. I thought EMDR might be helpful and explained the full protocol to him and asked if he was agreeable to try EMDR, which he was, although he was very dubious about both the process and his ability to improve.

At the second session we did EMDR. The patient was asked to focus on the worst aspect of his road accident, 'seeing the lorry coming through the window of the car', his negative belief, 'I'm completely helpless', and the physiological sensation of an aching neck and upper body. After a set of eye movements, he remembered other disturbing sensations or aspects of the accident. Further sets revealed more situations where he felt helpless in the past, during childhood. Spontaneous free association through a whole network of related memories, sensations and emotions occurred, while I continued to ask for feedback on what he was experiencing. This flow went on into a new understanding of the trauma, helping him make sense of it in a way that led to functional rather than dysfunctional information storage and a change away from helplessness. This new perspective then replaced the neurological imprint of terror with a feeling of empowerment and a sense of safety in the present, enabling desensitisation. I merely facilitated the process by which he found his own adaptive resolution. At the end of the 45-minute session the patient said he felt calmer and better.

When he returned for the follow-up appointment two weeks later, he was amazed to report that his flashbacks had stopped and his wife was noticing a positive difference in his ability to relate to their children and to her. He found he was able to concentrate, his boss had noticed a positive change in his abilities at work and wanted to increase his hours and level of responsibility. He was feeling happier and more confident and continued to be so in a follow-up session two months later. He was now able to consider challenging the legal decision that had resulted in him receiving no compensation.

Case 2

A 30-year-old female was severely sexually assaulted requiring hospitalisation 10 years previously. Before training in EMDR, I had seen the patient as she had made several suicide attempts and self-harmed regularly. She was referred on within the NHS and received many types of psychological treatment from other professionals, was under the care of a psychiatrist and had been prescribed a variety of medications to try to help her. She had been cooperative and always made an effort to carry out treatment programmes. Although she had a good support system from professionals, family and the community, the patient continued to suffer from anxiety, intrusive thoughts, depression, agoraphobia, fear, body pain, flashbacks, sleep problems and difficulty thinking clearly.

She had concerned me for years. After I qualified in EMDR and after she had made a further suicide attempt, I suggested EMDR, which she agreed to try. Three sessions of EMDR changed her life. Beneath the sexual assault of 10 years ago lurked a sexual abuse incident by a family member, which she had never dared to disclose. Both these sexual assaults were processed with EMDR. The next time I saw the patient, her demeanour had changed. She had begun to take very good care of herself and was thinking and speaking clearly. She described herself as a different person and very happy. The fortnightly doctors' appointments were no longer necessary. It is now 10 months since her EMDR sessions and she appears to be functioning well.

Frequently asked questions

How many sessions are required?

This depends on the patient's history and the nature of the issues. For single incident traumas or experiences, it could take as few as three to five sessions. More complex issues may require more and treatment may reveal previous traumas that did not show up earlier. It is important to note that with EMDR the desensitisation and reprocessing may produce healing in clusters of traumas so that treatment times may be lower than expected.

How does EMDR work?

There are many hypotheses about how EMDR works but so far we do not know precisely how it produces its impressive results. The bilateral stimulation seems to process and release information trapped in the body-mind, freeing people from disturbing images and body sensations, debilitating emotions, and restrictive beliefs.[4]

What training is required?

EMDR as a psychotherapy sounds deceptively simple yet is a very powerful technique. It involves a very specialised approach and methodology requiring supervised training for full therapeutic effectiveness and client safety. Clients are at risk if untrained clinicians attempt to use EMDR. A clinical background is necessary to undertake the EMDR training at all levels and is limited to mental health professionals who are qualified to provide treatment in the mental health field.[5] Information about EMDR and EMDR approved training can be found on www.emdr.org.uk.

What about supervision?

For me, supervision is not available yet in primary care. I meet monthly for peer supervision with two colleagues in secondary mental health care, receive supervision with an EMDR consultant for one and a half hours a month and attend a regional EMDR group for peer supervision and discussion two hours per month.

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