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The Self and Self-Knowledge after Frontal Lobe Neurosurgical lesions

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Volume II

Clinical Case Studies and Service Evaluation Project

May 2018

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Thesis submitted in partial fulfilment of the degree of Doctorate in Clinical Psychology

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Cognitive behavioural therapy for Generalised Anxiety Disorder in a 10-year old girl

Institute of Psychiatry, Psychology and Neuroscience (IoPPN)

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1. Abstract

This case describes the treatment of Generalised Anxiety Disorder (GAD) in a 10-year old girl, Sophie[1], using Cognitive Behavioural Therapy (CBT). The main goals of treatment were to learn strategies to decrease her anxiety and worry as well as learning to cope with uncertainty. Positive outcomes were achieved at the end of 11 sessions of therapy, including a decrease in anxiety symptoms in both the young client and her mother, as measured using the GAD subtest of the RCADS and the SCARED. More qualitative behavioural gains were also achieved. This case study discusses the developmental considerations needed when adapting CBT for younger children, as well as the benefits of including parents in therapy sessions and in the formulation and intervention of childhood anxiety disorders.

2. Introduction

2.1 Literature Review

Childhood and adolescence is the core risk phase for the development of symptoms and syndromes of anxiety (Beesdo, Knappe & Pine, 2009). Anxiety disorders are the most common form of mental health (Costello et al, 2003). Within this, Generalised anxiety (GAD) is one of the most commonly developed anxiety disorders. It is more difficult to provide precise prevalence estimates of GAD in children and adolescents, because this diagnosis has only been applied to youth since 1994 within the DSM-IV (APA, 1994). Untreated, childhood anxiety can impact family, peer and social relationships (Drake & Ginsberg, 2012), education in terms of both attendance and attainment (Waite & Cresswell, 2014) and lead to further anxiety, depression and substance use later in life (Costello et al, 2003).

The current DSM-V (APA, 2013) defines GAD as excessive and uncontrollable worry about a variety of topics, on more days than not, for a period of at least 6 months. The worry must be disproportionate to actual risk and interfere with everyday functioning. The worry is often accompanied by reassurance seeking behaviour and is experienced as challenging to control. Anxiety and worry must also be associated with physical or cognitive symptoms, and in children only one of these is necessary for a diagnosis.

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[1] For the purposes of confidentiality, all names have been changed

Genetic and environmental factors both impact the development of childhood anxiety and are likely to interact (Drake & Ginsberg, 2012). Increased risk is associated with a family history of anxiety (Schroeder & Gordon, 2002), personality factors and early life events (Beesdo et al, 2009). Parenting factors can also contribute; insecure attachment and parental anxiety have been found to be risk factors in the development of childhood anxiety, while certain parenting styles often contribute to the development of anxious behaviour. Three specific parenting behaviours theorised to be more prevalent in anxious parents and also play a role in the development of child anxiety include over-control, modelling of anxiety, and criticism (often linked to unhelpful parental beliefs about anxiety) (Ginsberg et al, 2006; Laskey & Cartwright-Hatton, 2009). The most consistent research results have been those that link over-protective parenting and childhood anxiety (Becker & Ginsberg, 2011). Overprotection is linked to parental anxiety and may reinforce avoidant behaviours and prevent children from learning that they are able to cope with situations (Affrunti & Ginsberg, 2012).

2.2 Cognitive Behavioural Therapy (CBT) for childhood anxiety

The first protocol driven CBT program for anxiety in children was developed in the early 1990s (Kendall, 1994). It focused on recognising anxious feelings in the body, identifying thoughts in anxiety-provoking situations, developing a plan to cope with the situation, behavioural exposure, evaluating performance and self-reinforcement. Since then numerous reviews and meta-analyses have found CBT to be efficacious in treating childhood anxiety (James et al. 2013; Ishikawa et al, 2007; In-Albon & Schieder, 2007).

2.3 Guidelines and treatment

NICE (National Institute for Health and Clinical Excellence, 2011) guidelines recommend evidence-based psychological interventions, such as CBT as first-line treatment for GAD specifically. It has been suggested that the delivery of CBT to young people must be clinically sensitive and developmentally appropriate (Beidas et al, 2010). Adaptions can be made, including changing the pacing and delivery of content and focusing on behavioural as opposed to cognitive aspects of the intervention (Bailey, 2001). Despite suggested modifications and adaptions made for CBT for children, there is currently a scarcity of studies evaluating adapted treatments in GAD, and a gap for more controlled studies focusing on the treatment components used in CBT for GAD

with children. One study bridging this gap (Fialko, Bolton & Perrin, 2012) highlights successful treatment for GAD in children, although modifications, as described above are necessary.

3. Case Description

3.1 Background

Sophie, a white British female, was referred to the CAMHS, National and Specialist Anxiety and Post Traumatic Stress Disorder (PTSD) clinic by her GP for reoccurring symptoms of anxiety. Sophie was born full term from an event free pregnancy. Developmental milestones were met on time. Sophie lives with her mother and sister and maternal grandmother has a lot of involvement in her care also. She was in her final year at primary school and preparing for her SATS during the period of therapy.

Sophie had two previous CAMHS referrals and from both short courses of psychological therapy were offered and completed. The first course offered CBT for specific phobias (multiple fears) when she was 6 years of age. Sophie attended 3 sessions with her mother focused on recognizing physical anxiety symptoms and anxiety management strategies. She then attended a further 5 sessions of CBT for generalised anxiety when 8 years of age, which focused on strategies for overcoming worry, anxiety and anger. Her Mother attended one independent session focused on parental strategies to enable her to help Sophie overcome anxiety during the latter course of therapy. However, the discussed re-referral was made as improvements following previous therapy were not sustained.

4. Assessment

Brief clinical interview (Session 1)

A thorough history of Sophie's anxiety had already been taken by the National Specialist Anxiety and Trauma team, approximately 3 months before the start of treatment. Results from this assessment diagnostically indicated Generalised Anxiety Disorder (primary diagnosis) and Specific Phobias (secondary diagnosis), for which a course of cognitive behavioural therapy (CBT) was recommended. However, to build rapport and gather updated information on current functioning, a brief clinical interview was conducted in our initial treatment session, covering Sophie's view on her current

difficulties, triggers, maintaining factors and coping strategies, and the impact it was having on Sophie.

In the time since initial assessment Sophie and her Mum reported that she had been coping with changes better and had tackled her phobia of boats in order to go on a school trip. We used pictorial representations of the anxiety curve (beginning some psycho-education) in relation to anxiety habituation linked to her phobia of boats and encouraged her to keep approaching her fears. Mum remained particularly concerned about Sophie's behaviour and reported that she could get angry and upset if unplanned changes were made to plans or routines. However, this behaviour was only ever exhibited at home, with any difficulties that occurred during the day being 'bottled up' until she got home. Sophie's Mum expressed her concerns about a possible ASD diagnosis. However, it was agreed that we would check in on her concerns about this following Sophie's GAD treatment.

We discussed GAD and Sophie's positive beliefs about worry. She reported worry to help her get things off her mind and to know what to expect and feel prepared. Sophie identified three areas she wanted to be different. Sophie wanted to focus on her anxiety and set the following goals to work towards in the sessions:

1) To speak to others more when feeling anxious
2) To be calmer and less anxious at the end of the day when seeing Mum
3) To be less angry towards her sister

5. Case Formulation

Using both background information and current assessment a formulation of Sophie's current difficulties was developed using the 5 p's model (Dudley & Kuyken, 2006). Figure 1 presents this formulation. This was devised by the current author to help plan and direct treatment and aid clinical discussions in supervision.

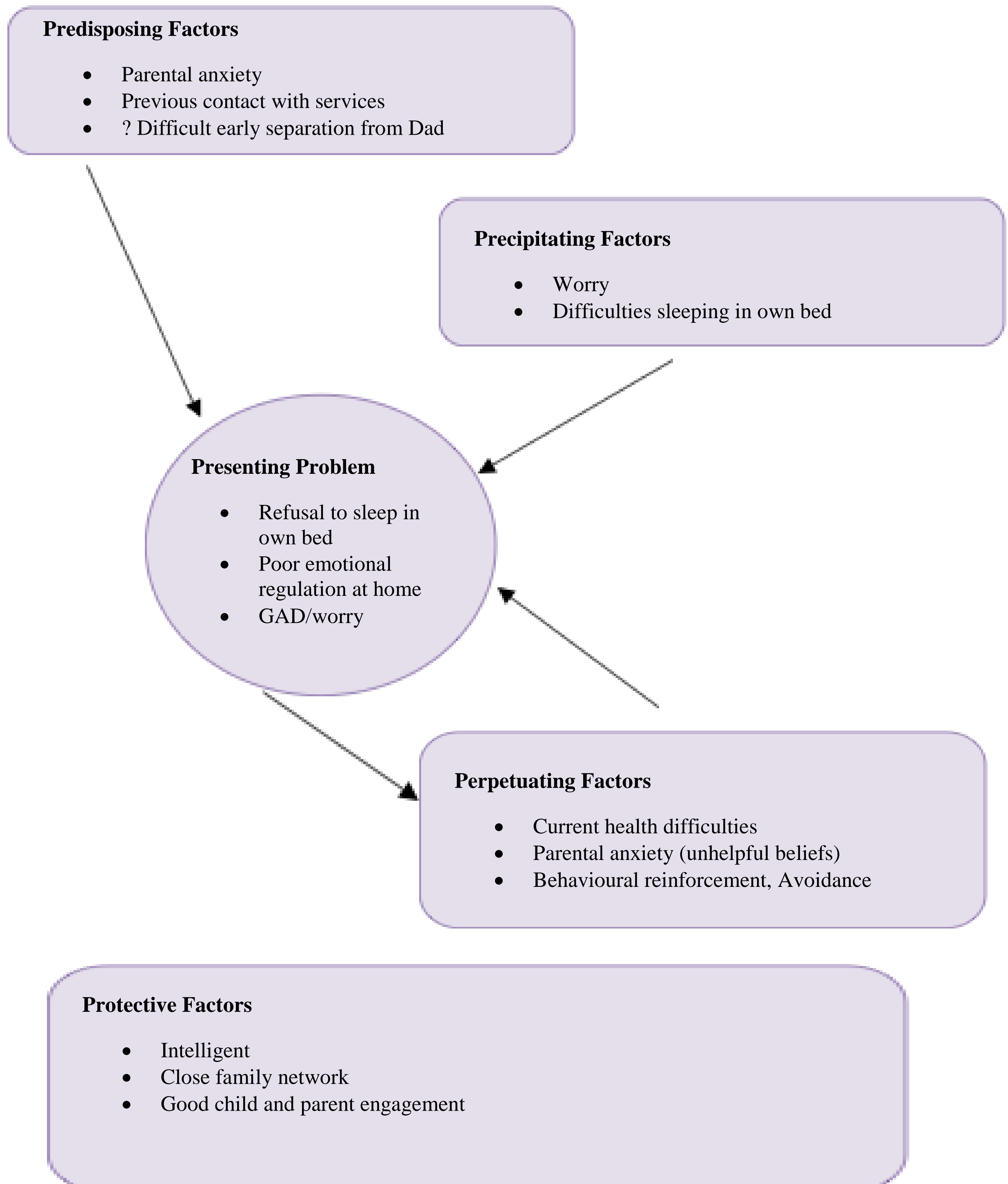

***Figure 1**: 5 P's formulation of Sophie*

However, during treatment a vicious cycle formulation that particularly highlighted maintenance behaviours that we could tackle was more effective to collaboratively create and share with Sophie in session. This formulation particularly related to her difficulties around unplanned changes in routine and plans. An example of this is presented in Figure 2.

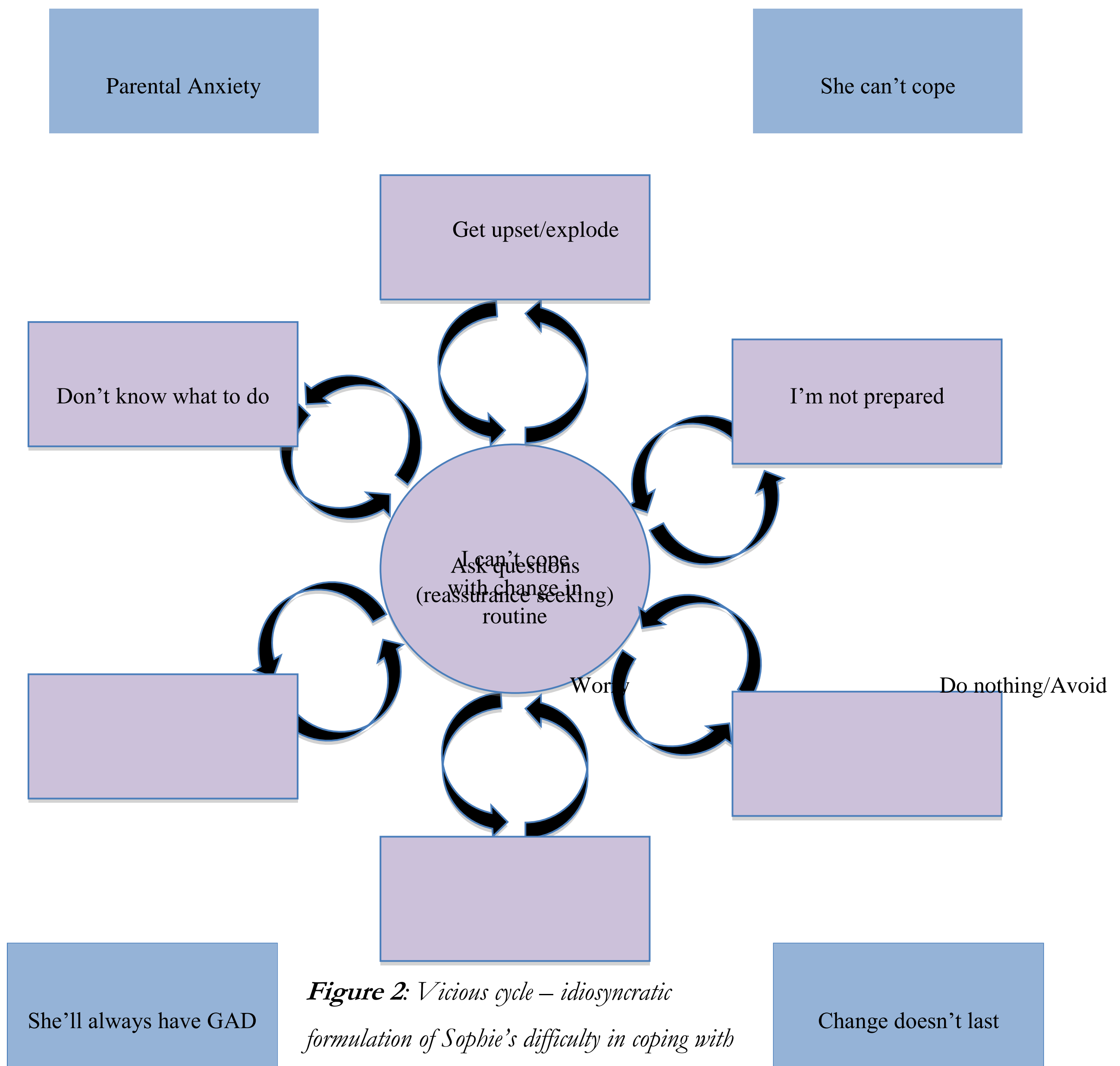

***Figure 2**: Vicious cycle – idiosyncratic formulation of Sophie's difficulty in coping with unplanned change*

Figure 2 show cognitions and behaviours that appeared to maintain Sophie's anxiety. Further maintenance of worry seemed to be partially accounted for by positive

beliefs about worry. The additional blue boxes were not explicitly shared with Sophie, but highlight identified parental anxieties. These specifically included unhelpful, yet understandable parental beliefs that it was felt important to address during treatment and this was discussed in supervision.

6. Hypothesis

Following assessment it was hypothesied that Behavioural factors (i.e. avoidance, safety behaviours) and positive beliefs about worry were playing a large role in maintaining Sophie's anxiety. Because of this, we hypothesized that CBT would be of benefit to Sophie. In addition, the National Institute for Health & Care Excellence (NICE) recommends CBT as a first-line treatment of Generalised Anxiety Disorder (NICE, 2004), although no specific guidance exists for children.

In addition, during the course of therapy it was thought of benefit to provide a one off session for Sophie's Mother to further explore her identified anxieties and agreed that involvement of Mum in subsequent sessions would help Mum manage and support Sophie in terms of identifying anxiety in Sophie and not reinforcing anxious behaviour.

7. Formal measures:

The self and parent report versions of the Screen for Child Anxiety Related Disorder (SCARED; Birmaher et al, 1999) and the Revised Child Anxiety and Depression Scale (RCADS; Chorpita et al, 2000) were used to establish pre and post treatment levels of anxiety specifically. On a weekly basis the GAD subtest of the RCADS was given to both Sophie and her Mum to complete in order to monitor self and parent report of anxiety symptoms during treatment.

The Revised Child Anxiety and Depression Scale (RCADS) is a 47-item, youth self-report questionnaire with subscales including: separation anxiety disorder (SAD), social phobia (SP), generalized anxiety disorder (GAD), panic disorder (PD), obsessive compulsive disorder (OCD) and major depressive disorder (MDD). Items are rated on a 4-point Likert-scale from 0 ("never") to 3 ("always"). Additionally, the RCADS-P – Parent version similarly assess youth's symptoms of anxiety and depression across the same six subscales. A factor structure consistent with DSM-IV anxiety disorders and depression has been reported (Chorpita et al (2000) as well as favourable internal

consistency. Similarly, the RCADS-P shows high internal consistency and convergent validity, and has been shown to accurately assess anxiety and depression symptoms in youth (Ebesutani et al, 2010). The RCADS' ability to help inform diagnoses, track clinical change and further delineate between anxiety and depression disorders shows its strong utility in both clinical and research context (Chorpita et al, 2005).

The SCARED is a child and parent self-report instrument used to screen for childhood anxiety disorders including general anxiety disorder, separation anxiety disorder, panic disorder and social phobia. It consists of 41 items and 5 factors that parallel the DSM-IV classification of anxiety disorders. The child and parent versions of the SCARED have moderate parent-child agreement and good internal consistency, test-re-test reliability and discriminant validity, and it is sensitive to treatment response.

8. Intervention

8.1 Overview

Given the specific presentation of Sophie, Dugas et al's (1997) Intolerance of Uncertainty Model (one of the most empirically tested models in adults, Corvin et al, 2008) was applied. The IU model (Dugas & Robichaud, 2007) conceptualises worry as an avoidant strategy, positing it as an attempt to avoid uncertainty. Specifically the IUM considers an 'intolerance of uncertainty' (IU) to be a driving force behind a predisposition to worry, that is, a dispositional attitude manifesting in negative emotional, cognitive or behavioural reactions in response to uncertain situations and events. In uncertain situations, positive beliefs (PB) that worry will prevent a negative outcome or prepare one for it ensure that it is adopted persistently in reaction. In an attempt to manage worry, behavioural and cognitive avoidance (safety behaviours) are adopted, which act again to maintain anxiety (Dugas & Koerner, 2005). A 'negative problem orientation' (NPO) is additionally implicated in the disorder as a maintenance factor, that is, an attitude manifesting low self-efficacy in relation to problem-solving ability where problems themselves are considered to be generally overwhelming.

In adults, the components of heightened IU have been evidenced to significantly discriminate between clinical (GAD) and non-clinical populations, where IU was the strongest predictor of GAD (Dugas et al, 1998) suggesting good clinical applicability of this model. For the current case, treatment using this model was adapted

to fit with the age and ability of the young client. This was achieved by using a more behavioural model, which was deemed more developmentally appropriate.

8.2 Outline of treatment

Based on the focus of treatment agreed with Sophie and her family, a treatment plan was devised. This consisted of 15 one-to-one CBT sessions with Sophie, of which her Mother joined in a select number that focused on psycho-education and devising and carrying out behavioural experiments. Eleven sessions of CBT were delivered over a period of 5 months. Each session lasted for approximately 60 minutes in length. Sessions typically began with a check-in, home-practice review and agenda setting and finished with Sophie providing a session recap and summary of planned home practice tasks to her Mum.

Below is a general outline of the content of sessions:

Session Number	Content of session
Session 1	Brief assessment and goal setting *(described above)*
Session 2-3	Psycho-education, intolerance of uncertainty, worry awareness
Session 4	Formulation; Discussion of adaptive responses to worry
Session 5	Worry versus problem solving; Create hierarchy ladder to challenge anxiety and anxiety thermometer
Session 6-8	Work on problem solving techniques; Behavioural experiments (tolerating uncertainty); Relaxation techniques
Session 9-10	Review psycho-education on anxiety; Externalising anxiety; Revisit problem solving strategies, role-play
Session 11	Summary of sessions and therapy blue-print

Sessions 2 and 3: The focus of these sessions was on psycho-education, covering worry awareness and intolerance of uncertainty. This included normalising worry, identifying and recognizing the physical sensation of anxiety and identifying adaptive responses to worry. A table listing the pros and cons of tackling anxiety as well as the pros and cons of not tackling anxiety was drawn up. This allowed exploration of

Sophie's beliefs about worry and helped highlight to Sophie that she wanted to change how she managed her anxiety and her reasons for this.

At the end of the third session Sophie's Mum shared her own concerns relating to the prognosis of GAD and her anxieties surrounding the sustained success of this treatment, given that they had been through two previous CAMHS referrals. In order that Sophie's allocated sessions remained her own, Sophie's Mum was offered an independent session with my supervisor, and psycho-education was provided surrounding Sophie's diagnosis and the current treatment offered. Following discussion with my supervisor a decision was made to more actively involve Mum in a number of Sophie's sessions. This was thought sensible as it was hypothesized that Mum's anxieties and beliefs may have been contributing to maintaining Sophie's current difficulties and behaviours (see vicious flower formulation above, Figure 2).

Session 4: An idiosyncratic formulation (as shown in Figure 2) was derived and psycho-education around this assisted Sophie to discover how certain behaviours may be maintaining her anxiety. Sophie found it much easier to identify behaviours than cognitions therefore this seemed an appropriate focus. We discussed creating a hierarchy ladder listing tasks to challenge anxiety and created a 10-point anxiety scale to monitor anxiety.

Session 5: Mum was invited to join this session to be involved in deciding tasks on the hierarchy ladder, as these would form tasks to try as behavioural experiments, all of which were conducted outside of sessions. Sophie and her mother decided the order in which we could tackle each task. Sophie and I then focused on differentiating between hypothetical 'what if' worries versus current problems and Sophie designed a worry diary that we agreed she would keep over the course of therapy and we would review each week. From this it became evident that Sophie presented with more current problems than 'what if' worries. The focus therefore was on promoting her self-efficacy and confidence in her problem solving abilities.

Session 6-8: During sessions 6-8 greater tolerance of uncertainty was fostered via exposure work, facilitated by on-going weekly behavioural experiments. All behavioural experiments involved situations in which unplanned changes occurred (i.e. going into

additional shops than those she was pre-warned during a shopping trip) or situations that Sophie could not control (i.e. being unable to do something asked of her at a particular time). Although careful to ensure that Sophie had independent time in each session, her Mum was more actively involved in these sessions in terms of reviewing and at times re-designing experiments as well as thinking about how both could adapt their behaviour in response to worry. In setting up behavioural experiments, Sophie made predictions, for example, about what would happen if she didn't carry out her reassurance seeking behaviours (i.e. persistently questioning prior to an event occurring) and it was also discussed how Mum would respond to her if she did. Relaxation strategies (including breathing exercises and progressive muscle relaxation) were practised in session, to be used in response to heightened anxiety. Sophie was able to recall discussing these in previous courses of therapy and informed me of other strategies she had tried (e.g. counting). The weekly anxiety ratings provided by Sophie and her Mum were graphed and explicitly shared and both were encouraged to see their anxiety ratings decreasing over sessions.

Sessions 9 and 10: During these sessions we reviewed psycho-education on how anxiety has an important function and can be helpful and how our aim is not to get rid of anxiety entirely but to recognise and respond to it. Sophie was asked to think up a name for anxiety to externalize it, reframing anxiety as a difficulty to be managed rather than a problem within her self. Sophie admitted that often her behaviour stems from boredom as she struggled to think of things to occupy her self. We problem solved a number of activities that may help and shared our discussion with Sophie's Mum. Sophie also shared that she sometimes found it difficult to keep herself entertained on one task, often feeling bored quite quickly. We role-played in session how Sophie may keep her at times inattentive brain entertained, by thinking up varied activities to do.

Session 11: In this final session Sophie created a poster as a therapy blueprint to remind her of specific techniques she found particularly helpful and how she can keep successfully managing her anxieties and worries. An end of treatment letter had been drafted by the therapist (current author) and was discussed with both Sophie and her Mother in session.

Four sessions remained to be used as follow-up sessions with another clinician in the team. These would cover the period from end of therapy into the start of secondary school.

9. Outcomes

Sophie engaged well in therapy. She had good intellectual reasoning ability, which enabled her to quickly grasp the basic ideas of CBT and responded positively. The self and parent report versions of the Screen for Child Anxiety Related Disorders (SCARED) was used to establish pre and post treatment levels of anxiety. As can be seen in Figure 3, pre-treatment scores from both self and parent indicated the likelihood of a generalised anxiety disorder. However, post treatment scores were below the clinical threshold for generalised anxiety disorders.

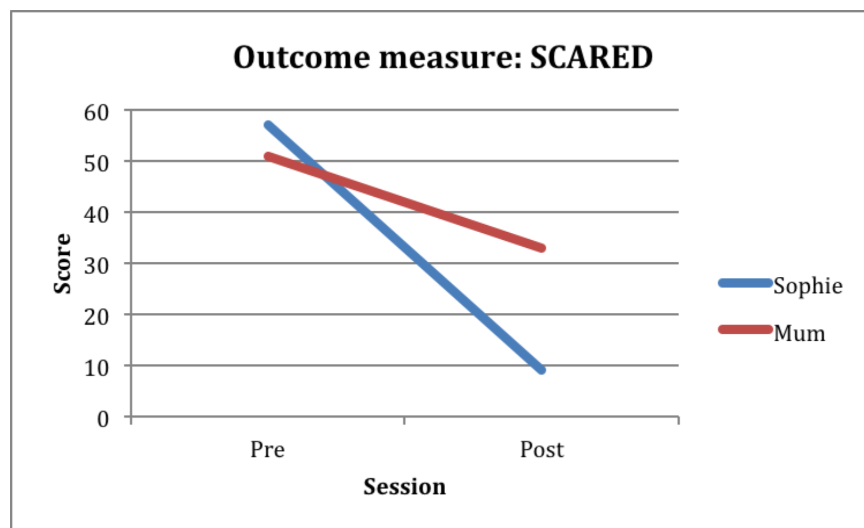

Figure 3: *SCARED scores pre and post treatment*

Additionally the GAD subtest of the RCADS was adopted as a weekly measure of anxiety during the course of treatment and results show a reduction in both self and parent report of across the course of therapy (see Figure 4).

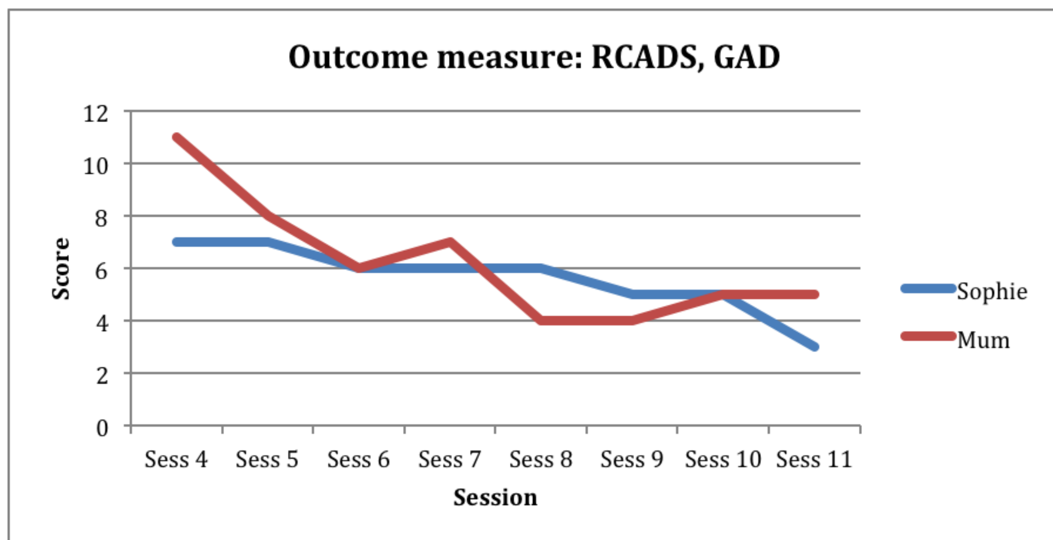

Figure 4: *GAD, RCADS scores over the course of treatment*

In addition to clinical measurements, Sophie demonstrated significant behavioural change over the course of therapy, as did her mother. Externalising anxiety appeared to have a real benefit in shifting Sophie's beliefs that anxiety was something she could manage and monitor. A change was also noted in the way Sophie's mother described and reacted to Sophie's difficulties viewing anxiety as a difficulty *for* her daughter, rather than *with* her daughter. Qualitatively, Sophie engaged well in the therapeutic process and reported a positive experience overall, with all goals reached.

10. Discussion

Sophie presented at assessment with Generalised Anxiety Disorder. She received a course of CBT targeted at overcoming anxiety. By the end of treatment, Sophie showed a decrease in overall anxiety, with GAD scores on the RCADS falling below clinical cut-off over the course of therapy. Sophie achieved all of her goals, although a number of these she succeeded in herself (facing specific phobias) highlighting her own determination and self-motivation. During the writing of this case study I was informed by the clinician leading the follow-up sessions that both Sophie and her Mother continue to report low anxiety and as such the positive outcomes she worked hard to achieve during therapy appear to be maintained.

A number of factors likely contributed to the change that was observed in Sophie's behaviour and self-reported anxiety. Firstly, Sophie was extremely motivated to

achieve her goals. This meant that she was open to trying out behavioural experiments and therapy was never met with resilience. Sophie's own self-motivation in using her knowledge learnt in sessions and applying it outside sessions was crucial in her progress. She was able to apply 'problems versus worries' herself and react to these and reflect on this process. She also applied her knowledge of behavioural experiments and her learning from psycho-education of anxiety to face her phobias of bridges, truly becoming her own therapist.

Considering this case in light of the research literature (outlined in section 2.1), the inclusion and acknowledgement of Sophie's mum's anxiety (which was in part driven by her valid concern about a possible ASD diagnosis) was an important factor in the success of therapy and in its maintenance. Although, Sophie had had previous CAMHS contact, a reason for the maintained progress following this referral may be explained by the deliberate inclusion of Mum in certain sessions, during which Sophie took the lead. Empowering both to externalise and tackle anxiety together allowed both to shift their mind-set to view past and recent difficulties in a new light. This potentially meant that Sophie's mum was able to adapt her behaviour and the environment around Sophie to better support her in meeting her goals. Given that parental anxiety and behaviours can greatly impact their children's self-evaluations (Becker & Ginsberg, 2011), the focus on Sophie's mum's anxiety from early on in the treatment (including formulation) was helpful and likely a large contributory factor to the success of the intervention.

11. Limitations and learning points:

The monitoring of symptoms through questionnaire measures was not consistently taken at the start of therapy, a likely cause for this being that it was my first placement and first time offering CBT. This potentially may have caused me to miss capturing the full progress made in ratings of symptom reduction across therapy. I feel it would have also been useful to ask Sophie to rate the completion of her goals in order to be able to show visual progress of meeting these throughout the course of treatment, objectively evidencing this to the client rather than relying on clinician report. Gaining confidence ratings in Sophie's ability to problem solve may have been beneficial as her increasing confidence concerning her ability to solve problems was evident to the therapist, however could not be objectively shared. Additionally, seeing how powerful

externalising anxiety was on both Sophie and her Mum, in future cases I would potentially bring this earlier in therapy.

12. Personal Reflections

This was one of my first individual cases in my clinical training and was particularly key in facilitating my understanding the importance of systemic considerations when working with anxiety disorders in children. This case allowed me to reflect on the importance of considering both systemic and individual factors in Sophie's presentation.

At times I felt a little anxious myself that the focus of therapy appeared to be more problem focused rather than concerning particular worries. However, discussing this in supervision lead to helpful suggestions as how best to manage. I learnt the benefit of an open therapeutic approach, directly and explicitly asking both Sophie and her Mum whether the focus of the treatment was appropriate and noted this simple method not only helped ensure that both Sophie and her Mum were able to direct sessions, but also acted to reduce my anxiety that I was not addressing the key issues for this client. It also highlighted to me that I may have been putting too much pressure on myself, as the clinician to lead the sessions, when more collaboratively working with what was presented each session fitted much more with the shared CBT approached. Importantly, this case particularly taught me that there is not always 'a right way' of doing therapy and that flexibility and openness are important factors in gaining and maintaining therapeutic rapport.

It also feels important to reflect on the emotional reaction I experienced on hearing Sophie's Mum's unhelpful, yet understandable beliefs surrounding anxiety and treatment, as these were shared in front of Sophie. I felt they might be detrimental to her feelings of self-efficacy. Supervision was invaluable, giving me the space to reflect on my own emotions and the beliefs these might be linked to. In supervision we discussed the importance of valuing parental concerns and anxieties, whilst ensuring sessions remain client (child) centered. I was particularly keen to include Mum in a number of sessions in order to offer indirect opportunities to model constructively talking to Sophie about her anxiety and about anxiety in general. Supervision allowed a space to think collaboratively about how best to involve Mum in treatment.

For me the most striking learning point I took from this case study was the importance and power of modelling. Research, as mentioned earlier in the introduction (section 2.1) suggests that parents may model anxious behaviour and this may play an active role in maintaining child anxiety. However, the power of positive modelling between therapist and parent I felt was evident in the room. Following sessions that included Mum a shift was noted in the way she talked to Sophie and about Sophie's difficulties, acknowledging Sophie's effort in tackling anxiety, not just her success. This, I felt, reflected the type of talk modelled by the therapist in the room.

It was highly rewarding to get to know and work in collaboration with Sophie and her Mum and to see Sophie make such positive gains throughout therapy was extremely rewarding.

Word count: 4225

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Case Study II

Narrative therapy for severe stress response in a 10-year old boy

Promoting coping and resilience

Institute of Psychiatry, Psychology and Neuroscience (IoPPN)

King's College London

Supervised by: Dr Jessica Richardson

N&S Anxiety and PTSD, MRC

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1. Abstract

This case describes the treatment of a heightened stress response in a 10-year old boy, Tommy, experienced in the context of living with his older brother who experiences mental health difficulties and exhibits challenging behaviours. His main treatment goals were to witness fewer behavioural outbursts by his brother and in turn feel calmer, as well as reduce the frequency of intrusive thoughts he was experiencing. Intervention was based on a mix of more trauma focused narrative work and strength focused tree of life work. Positive outcomes were achieved at the end of eight sessions of therapy, including a marked reduction on a measure of PTSD. This case study discusses the significance of working with siblings of children with established mental health difficulties. It highlights this as a particularly under-researched, and under represented, yet highly valuable area of clinical work.

2. Introduction

Mental illness may be both a cause and a consequence of family difficulties. It is a significant issue and the impact of such problems is increasingly recognized. Approximately one in ten children and young people aged 5 – 16 years old experience a diagnosable mental health disorder in any year (Green et al, 2005; The Health & Social Care Information Centre, 2009). The effects on families can be significant (Corrigan & Miller, 2004), and the quality of support and service delivery to affected family members is crucial. The burden of mental health disorders assumes special significance for family relationships for several reasons. One reason is that mental disorders impact not just the individuals affected, but also those around them; this includes both immediate family and other relatives. Additionally, many disorders are chronic or recurrent and they often call for long-term management, not just acute care.

A large number of studies concentrate on how parental mental illness affects family functioning as a whole (Corrigan & Miller, 2004; Sanders, 2004). However, there still exists a relative dearth in research into the impact of mental health difficulties on sibling relationships (Sin et al, 2012).

2.1 Impact on Siblings

The psychological and emotional feelings experienced by siblings have not been well understood or documented. Children with mental health difficulties or disabilities

have clearer and often more demanding needs, while the siblings needs for support are often harder to recognise. Early research (McKeever, 1983) identified sibling populations to be a "population at risk". However, despite this early recognition, research and support groups reacting to this were relatively slow to develop.

Growing up as the typically-developing sibling of a brother or sister with mental health challenges can be difficult (Corrigan & Miller, 2004). Some brothers and sisters are explosive, whilst others are withdrawn; others alternate between periods of normal and inappropriate behaviour. Dealing with the uncertainty on a daily basis can be confusing and at times scary. The siblings of children with mental health issues tend to experience a wider range of highs and lows compared to the lives of most siblings (Sharpe & Rossiter, 2002; Barnet & Hunter, 2012). A number of dynamics are common to siblings of children with mental health issues. These can include confusion, safety, shame, independence, overprotectiveness, competing for attention, love/hate relationship and anger and resentment (Kinsella et al, 1996).

In cases of extreme physical and verbal aggression, some siblings develop symptoms of Post-Traumatic Stress Disorder (PTSD) (Margolin & Vickerman, 2007). Offering support interventions for these siblings can help mitigate the onset of PTSD symptoms. When siblings accommodate themselves to their brother's or sister's dysfunctional behaviours they can learn an unhealthy model for building relationships in the future. However, it is important to note that having a brother or sister with a mental illness is not an exclusively negative experience. Siblings may feel more compassionate and tolerate of others who experience hardship (Jewell, 2000) or may report benefits to the family unit, such as more resilience and more family supportiveness (Sin et al, 2008). As such, siblings may need the opportunity to address their conflicting feelings about their complicated families outside of the family in a safe and nurturing setting.

Individual and/or family therapy can be extremely beneficial for siblings (Griffiths & Sin, 2013). However, although the need for services to support at risk siblings has been identified and sounds reasonable, as Sharpe & Rossiter (2002) assert, it is important that these services do not over-pathologise the sibling. As the literature alludes, it is important to note that having a sibling with MH difficulties does not

predict the need for support, as these stress reactions are noted in some siblings, but not all. Therefore, treatment options that do not rely on a diagnosis may be best suited.

2.2 Possible treatment options

2.2.1 Tree of Life work (Denborough, 2008)

Tree of Life work is thought to have value when working with individuals who have experienced hard times. It does not rely on a diagnosis but instead allows people to speak about their lives in ways that make them stronger. The Tree of Life enables people to speak about their lives in ways that are not re-traumaitising, but instead strengthens their relationships with their own history, culture, and significant people in their lives. The Tree of Life has been used with children, young people and adults in many different contexts and evidence is growing in its support (Denborough, 2008).

2.2.2 Trauma focused-Narrative therapy (Cohen & Mannarino, 2008; Deblinger et al, 2011).

The trauma narrative is a psychological technique used to help survivors of trauma to make sense of their experience, while also acting as a form of exposure to painful memories. As with any form of exposure therapy, pscyho-education should always come first to ensure the client understands the importance of treating trauma and how exposure therapy works. Sharing and expanding upon a trauma narrative allows the individual to organise their memories, making them more manageable and diminishing the painful emotions they carry.

The current study employed both trauma focused narrative techniques and more positive psychology, strength focused tree of life based treatments.

3. Case Description

3.1 Background

Tommy, a white British male, was referred to the CAMHS, National and Specialist Anxiety and Post Traumatic Stress Disorder (PTSD) for support in relation to significant stress and worry he experiences in relation to the challenging behaviour he has experienced and witnessed from his brother (who is known to CAMHS). Tommy's mother expressed her concerns about him to the psychologists supporting his older brother and a referral for a short course of treatment was made.

Tommy was born following an event free pregnancy and all developmental milestones were met on time. Tommy lives with his mother and father. At the start of treatment his

brother was residing at a boarding school in the week returning home each weekend. Tommy was in his final year at primary school and sitting entrance exams to various secondary schools during the period of therapy.

4. Assessment (session 1)

Tommy attended the first assessment session with his Mother during which a clinical interview was conducted. Initially both Tommy and his Mum were seen together in order to explain the format of the session. Following that Tommy and I discussed his current and ongoing situation and the stress that brings him, whilst his Mother met separately with my supervisor to gather more general background information. This allowed all relevant information to be gathered efficiently and importantly ensured both had the opportunity to voice any concerns or questions independently of each other.

5. Hypothesis

During assessment Tommy specifically reported intrusive memories of some past events involving his brother's behaviour and he did score above threshold on a measures of PTSD. However, the difficulties that Tommy's brother experiences and challenging behaviours he displays are ongoing and therefore, likely to be maintaining Tommy's stress and worry. It was therefore hypothesized that Tommy may benefit from a short course of treatment aimed at identifying and increasing his coping skills to deal with his current situation, rather than any specific treatment related to PTSD. Both PTSD-focused narrative techniques, as well as more strength -focused tree of life based treatments were planned. These treatments have been noted to have value when working with individuals who have experienced hard times and may contain painful memories to feel more manageable.

6. Case Formulation

The lack of strong diagnosis made following a specific treatment model difficult and therefore in order to utilise all the information acquired during the assessment stage, a formulation of Tommy's difficulties was developed using the 5 p's model (Dudley & Kuyken, 2006). Figure 1 presents this formulation.

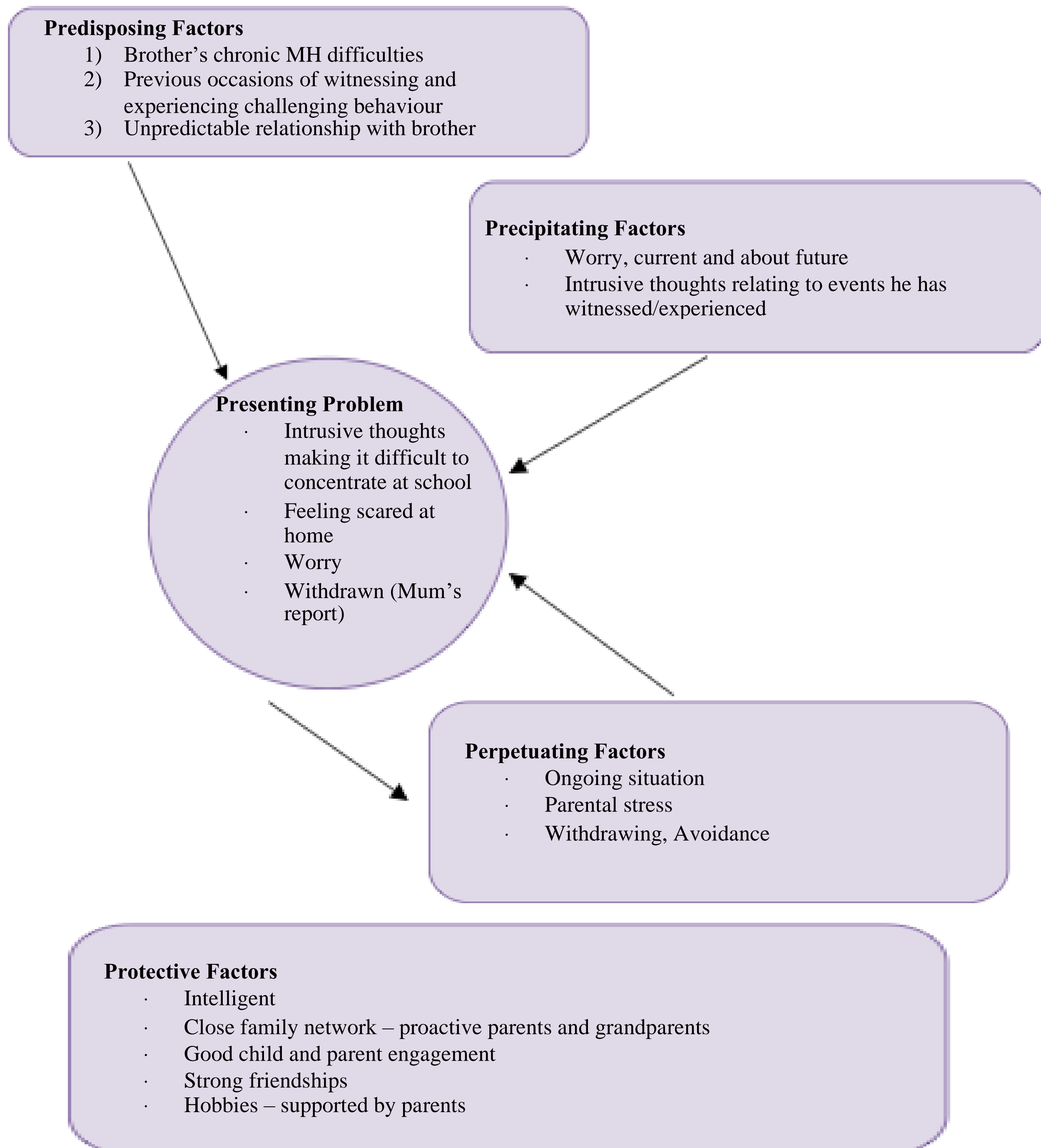

***Figure 1**: 5 P's formulation of Tommy*

7. Outcome measures

The self and parent report versions of the Mood and Feelings Questionnaire (MFQ; Angold et al, 1995) and the Screen for Child Anxiety Related Disorder (SCARED; Birmaher et al, 1999) were used to establish pre and post treatment levels of difficulty. The Child PTSD symptom Scale (CPSS; Foa, Johnson, Feeny & Treadwell, 2001) was also administered pre and post treatment in order to assess the frequency and nature of some of the thoughts related to past events experienced that were often troubling Tommy. Tommy was also given the CYP-RMQ (CYP Regular Monitoring Impact Questionnaire) to complete on a weekly basis in order to monitor his self-report of functional impairment experienced during treatment (see Appendix 1 for a full description of each measure).

8. Intervention

8.1 Overview

The focus of treatment was to provide Tommy with a safe space to talk about what he has experienced and witnessed in relation to his brother's behaviour. The sessions offered included individual work with Tommy as well as a joint session with his Mother. Individual work involved talking through any current worries or anxieties, psycho-education around intrusive memories after witnessing or experiencing distressing events, talking through some of these intrusive thoughts that were distracting him during his school day and 'Tree of Life' work to identify personal and family strengths to promote coping and resilience. Joint sessions focused on ways to increase Tommy's sense of control during his brother's 'outbursts' and his assertiveness at home.

8.2 Outline of treatment

Session 1: Assessment

As stated in section 4 above, session 1 provided the assessment session in which both Tommy and his Mother met with my supervisor and myself before splitting into two groups. In this session it was apparent that Tommy's mother was keen for him to get support and her reasons for this. His Mum appeared to hold some guilt that Tommy may feel a little neglected, as so much of the family's energy and time is spent on his brother. However, less clear were Tommy's thoughts on the therapy support being offered.

Sessions 2 & 3: Rapport building and goal setting

These sessions were both 1:1 sessions with Tommy and myself. Time was spent building rapport, with particular focus given to getting to know Tommy and his hobbies. This offered him a platform to express himself, as an individual, before exploring what he thought about having sessions aimed at discussing his home life and the relationship he has with his brother. During these more neutral discussion topics Tommy appeared to relax quite quickly and was able to discuss his home life. In particular, he shared, what he does when his brother has a 'meltdown' (Tommy's label for challenging behaviours), including how he feels during each stage. Tommy talked through two scenarios, one where he gets to his room, avoiding the meltdown and one where he witnesses the meltdown. We created an anxiety thermometer and used this to discuss how scared/anxious Tommy feels on a scale of 0-10 (10 = very anxious) during his brother's outbursts and how quickly he can feel calmer afterwards. We also discussed what makes him feel calmer. We focused on which areas of his life he felt were most affected, which he reported as concentration at school due to intrusive thoughts/memories related to his brother's behaviour.

Tommy came up with two therapy goals:

- To get to his room more quickly during outburst, to witness less and feel calmer quicker.
- Have less intrusive thoughts at school

Sessions 4 & 5: Intrusive thought monitoring

Tommy shared that he experienced intrusive thoughts. Initially Tommy was unsure whether he wanted to share these memories with me and he also seemed unsure as to how frequently these intrusive thoughts occurred. He did agree to create and keep a thought diary in order to monitor how frequently these thoughts occurred and highlight their content. This was reviewed in session five. After completing the diary Tommy shared that the content of these intrusive thoughts often related to two salient incidents, which he admitted he might like to talk more about, but he was unsure how helpful it would be. He did give me permission to discuss with him psycho-education

around the presence of intrusive thoughts after witnessing distressing events and the rationale for thinking and talking about these. We agreed to revisit this next session.

Session 6: Narrative based re-scripting

During this session Tommy told his story of his relationship with his brother and the family. A number of themes came up when he was telling his story, in particular confusion (in relation to his brother's unpredictable behavior) and safety (e.g. concerns for the safety of himself and other family members, as well as his brother, which appeared to be fuelling a lot of worry). Tommy described his brother's behaviour as unpredictable at times and described his rapidly shifting mood. He spoke of how sometimes he felt that family and friends interact with his brother in a different way to him, suggestive of an incongruence between the way family treat him and his brother. We thought about these issues throughout the session. Additionally, Tommy was keen to share two particular stories relating to his brother, one relating to behaviour he experienced and one he witnessed. Tommy had a particularly strong memory of the events themselves but less clear was his recollection of what happened before or after the events. We spent time gently revisiting these events and re-scripted each with specific focus on how each incident was resolved. The rationale for this being to give each some closure and lessen the uncertainty and anxiety associated with both.

Session 7 (joint session): Practical problem-solving

Joint work focused on ways to increase Tommy's sense of control during his brother's 'outbursts' and his assertiveness at home. Together we problem-solved how Tommy may be able to get to his room to feel calmer and safer when his brother displays prolonged distress. The themes that Tommy shared in his previous session of safety and confusion were also revisited during this session, with his permission. Tommy's Mother was supportive in promoting Tommy's confidence to speak up if he is worried or feels something is unfair. She also reminded him about being aware of noticing his brother's behavioural triggers and removing himself from the situation before things escalate. This was something they were going to continue discussing outside of sessions.

Session 8: 'Tree of life' and therapy blueprint

During the final session we completed the 'tree of life' work focusing on Tommy and his families strengths, coping and resilience. Tommy described strengths and positives that he has given to significant others as well as identifying what he received from others (family and friends). The strengths identified were used to direct a therapy blueprint and to think about strategies and skills he has as well as the support that others provide that may help him cope with and overcome any future difficulties.

9. Outcome

Tommy attended all sessions and engaged well. Over the course of therapy, Tommy's self-report of how he was managing and feeling about his situation improved. As can be seen in Figure 2 his pre-treatment score on the Child PTSD Symptom Scale (CPSS) indicated the likelihood of PTSD. However, post-treatment this dropped significantly below the clinical threshold. Tommy reported a significant reduction in intrusive thoughts, which he shared made concentrating at school a little easier.

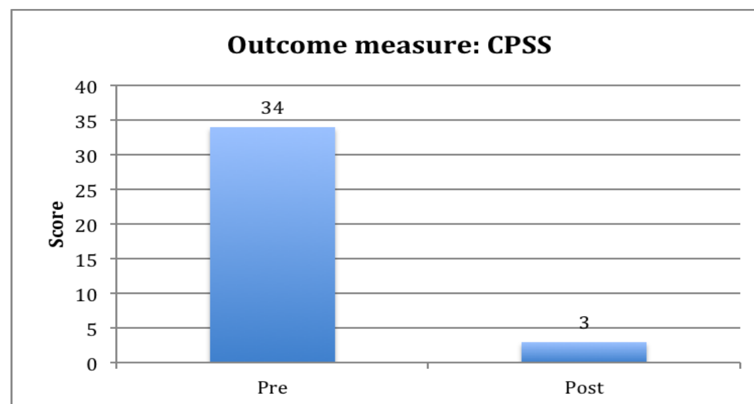

***Figure 2**: CPSS scores pre and post treatment*

His scores on both the SCARED and MFQ were below the clinical threshold pre-treatment, and remained at similar levels, moving from 14 to 12 and 6 to 3 respectively, over the course of therapy (see Figure 3).

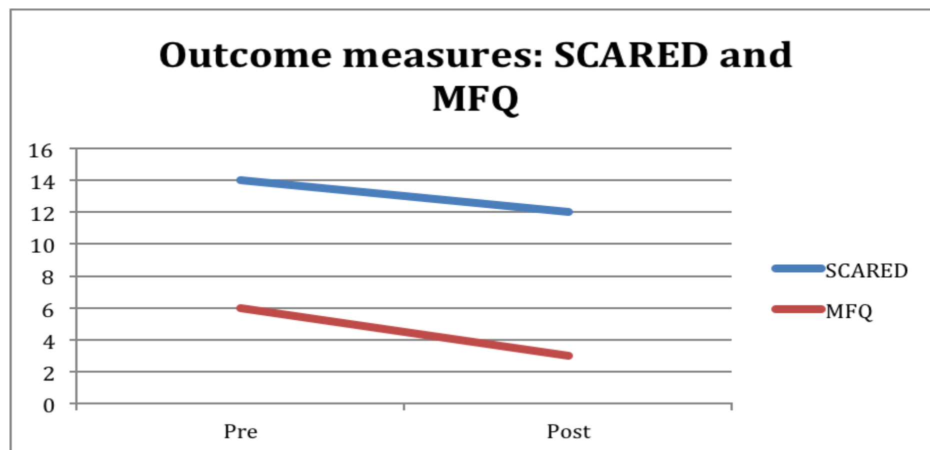

Figure 3: *SCARED and MFQ scores pre and post treatment*

Qualitatively, from the tree of life work, Tommy was able to identify not only his own personal strengths, but those of other family members too. He was also able to explain how all the identified strengths in himself and others may help him cope with and overcome any future difficulties.

During the course of therapy the family had a significant change with Tommy's brother returning to the family home permanently, having been away for schooling previously. Tommy was able to articulate how his brother may feel about the change and was very thoughtful in his consideration that it may take time for the whole family to get used to the new situation.

10. Discussion

Tommy presented at assessment with an elevated score on a measure of PTSD and was reporting continued stress and anxiety around his brother's challenging behaviours. He received an eight-week course of treatment primarily targeting his ability to cope with these on-going behaviours, although attention was given to try and offer Tommy some closure and reduce the uncertainty and anxiety associated with two specific trauma memories. Tommy achieved one of his goals, to have less intrusive thoughts, which he shared was the issue causing him most distress. The other goal of getting to his room so as to avoid prolonged exposure to his brother's, at times, challenging behaviour was not met. This was, however, complicated by the permanent return of his brother from residential school, which required a period of adjustment for

the whole family. Tommy and his Mum did begin to discuss how to manage this and it was something they planned to continue to monitor.

The lack of a strong diagnosis was the most striking aspect of this case. PTSD can be experienced after a threatening and stressful situation, which causes distress. Treatment for PTSD is typically undertaken when the situation surrounding the individual is stable and calm, in essence providing the individual with a safe space to address the trauma. However, although Tommy identified past traumatic events, this was complicated by the fact that his situation was still ongoing in that similar events could and at times did arise. The work completed, therefore, was more trauma informed narrative work which took the form of psycho-education and subtle re-scripting of the story in order to make sense and diminish negative or uncertain feelings surrounding these past events. This, arguably gentler approach appeared successful with a reduction noted in PTSD score. Additionally, given the ongoing challenges, the treatments offered focused on promoting coping and resilience were deemed more suitable and appeared effective.

An interesting alternative therapeutic intervention may have been to offer IPT with a trauma focus. Given that in this case the situations that may cause distress were current and ongoing, the reduced focus on exposure work in IPT and increased focus on other aspects that appeared key in this case (e.g. interpersonal dynamics, asserting himself etc.) may have suited this case well. There is limited evidence for this approach, however, given the atypical referral pathway and profile of this case, it may have been a suitable to try.

As attested to in the introduction there needs to be better services supporting siblings. Therefore, making use of platforms such as clinical case sharing to highlight cases such as these may be of some benefit. However, it is important to be mindful not to create a problem where there isn't one and I completely agree with the sentiment that we should not over pathologise siblings. It did at times feel difficult during treatment, having no clear diagnostic focus. However, this I feel was more a reflection on my need as a therapist for guidance in treatment direction. The treatments offered did not require a strong diagnosis and their effectiveness in this case was evident, particularly

given the marked reduction in PTSD scores. In addition and arguably of greater importance, the improvements noted strongly support the need for sibling work.

11. Limitations and learning points

It was relatively difficult to engage Tommy to create therapy goals, as intially he fluctuated between being a little annoyed at having to come to therapy sessions and OK with having sessions. He was reluctant to fully disclose why. I reflected on this a lot during treatment in that he was being asked to do yet another thing because of his brothers behaviour. Even though this was directed at supporting and helping him it may still have felt unfair to Tommy. This potentially could have been explored further, with Mum too. It was very evident that his Mum wanted him to have some support. Therefore, engaging Tommy and reminding myself that these were his sessions, whilst also aiming to satisfy Mum, was a constant presence in my mind. Being aware of the incongruence between Tommy and his Mum in how necessary the sessions were deemed at the start of the therapy process was useful. Sessions felt very patient (child) lead, and efforts were made to ensure this was the case. Importantly, both Tommy and his Mum ended therapy very positively, and it was felt both had valued the time.

Sessions were very much lead by the client in terms of how much he wanted to discuss, although he was very open to and engaged well with all activities suggested. Tommy was happy to discuss many different topic of personal interest to him (e.g. hobbies) but needed some encouragement to focus on the reason for the sessions. The completion and review of the CYP-RMQ at the beginning of each session was helpful in building therapeutic alliance and in directing discussions to relevant areas and in setting and keeping a focused therapy agenda.

The relatively short timeframe for treatment was in part guided by my remaining time on placement, and the eight sessions completed were often interrupted by school holidays. This resulted in sessions being a little inconsistent in occurrence. Therefore, this supports the decision made to complete a more trauma-informed approach as opposed to direct trauma work that would have required more continuous and regular sessions for it to be most effective and containing.

12. Personal reflections

I found this case particularly interesting to work on considering the atypical referral and focus of the work. It was interesting to work with an individual who, although scored highly on a measure of PTSD, did not particularly report any major distress or impact in his everyday life. I was very aware that the situation that was causing Tommy distress was ongoing and therefore Tommy was continuing to experience challenging times throughout the therapy process. Reflecting on this in supervision was helpful to contain my feelings surrounding this.

At the time of therapy I worried that dedicating only one session to the trauma-narrative work was not enough, and felt that I would have liked to have given more time to this. However, reflecting now that therapy has ended, the subtle re-scripting of these intrusive memories that took place was comfortably completed within the session. As mentioned in the introduction, it is important not to overpatholgising siblings. Therefore maybe this offering of some space and safety to talk was all that was needed. The feeling of wanting to give more time to this potentially came more from me as a therapist rather than being asked for or required by the client.

This case facilitated me to learn about other therapeutic methods, as opposed to CBT. This was greatly valued in terms of my continued training. Overall, working with a client without a strong diagnosis was incredibly enjoyable. It required quick thinking, particularly as he was an incredibly bright and able boy. He grasped explanations and task concepts quickly. The pace of therapy in this sense felt much faster than other cases in which the diagnosis is stronger. This case appealed to a particular area of interest for me, in terms of working with families and support networks around individuals who experience mental health difficulties. Therefore, I am very grateful to have been offered the opportunity to work with Tommy.

Word count: 3868

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Appendix

Mood and Feelings Questionnaire (MFQ; Angold et a, 1995)

The MFQ consists of a series of descriptive phrases that relate to how an individual has been feeling or acting recently. Scoring reflects whether the phrase was descriptive of the individual most of the time, sometimes, or not at all in the past two weeks. The instrument should be used as an indicator of depressive symptoms and not as a diagnostic tool, and therefore does not indicate whether a child or adolescent has a particular disorder.

Screen for Child Anxiety Related Disorder (SCARED; Birmaher et al, 1999)

The SCARED is a child and parent self-report instrument used to screen for childhood anxiety disorders including general anxiety disorder, separation anxiety disorder, panic disorder and social phobia. It consists of 41 items and 5 factors that parallel the DSM-IV classification of anxiety disorders. The child and parent versions of the SCARED have moderate parent-child agreement and good internal consistency, test-re-test reliability and discriminant validity, and it is sensitive to treatment response.

The Child PTSD symptom Scale (CPSS; Foa, Johnson, Feeny & Treadwell, 2001)

The CPSS is a self-report measure designed to assess the severity of post-traumatic stress disorder among children and adolescents, ages 8 to 18 years old. The measure has a total of 24 items and includes two parts; the first has 17 items and measures the type and frequency of PTSD symptoms (mapping directly onto DSM-IV criteria), while the second has 7 items and measures degree of functional impairment these symptoms cause. A total score for the 17 items corresponding to the DM-IV criteria is rated on a scale from 0 to 3. Therefore, the range of the total score is 0 to 51, with higher scores indicating more severe symptoms. A clinical cutoff of 15 or greater is appropriate for diagnosing PTSD. Scores for the functional impairment items are scored dichotomously (either absence '0' or present '1'). Scores range from 0 to 7, with higher scores indicating greater functional impairment.

Children and Young Person - Regular Monitoring Impact Questionnaire (CY-RMQ; REF)

The CY-RMQ is a brief questionnaire completed at the start of each treatment session. The answers were reviewed jointly at the beginning of each session. The CY-RMQ focuses on three things; change in the recent past 'Have things improved since last time?'; Impact of everyday life at present, 'To what extent are current difficulties interfering with home life, friendship, learning and leisure?'; and hope for the future, 'How much improvement does the respondent anticipate in the next month?'. Respondents are asked to rate the questions on a 5-point scale (0-4) assessing whether the difficulties they are experiencing are much worse (0), a bit worse (1), about the same (2), a bit better (3), much better (4).

Case Study III

Behavioural Activation for depression in a 71-year old lady: Motivated to get motivated!

Institute of Psychiatry, Psychology and Neuroscience (IoPPN)

King's College London

Supervised by: Dr Grace Wong

Southwark Talking Therapies (IAPT)

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1. Summary

This case study describes a Behavioural Activation treatment package completed with Mary, a 71-year old lady experiencing depression. Mary's depression or low mood as she felt more comfortable naming it, appeared in the context of chronic lumbar back pain. It was discussed with Mary how both CBT and BA may be helpful for her. Mary expressed a preference to try BA. Although BA was the model of treatment delivered it was useful to think about techniques used in Acceptance and Commitment therapy (ACT) and incorporate these into treatment where appropriate.

This case study firstly provides a brief literature review of depression and treatment in older adults. This is followed by description of the assessment and formulation of the case. The treatment components are detailed, followed by an evaluation of the outcome of the treatment. Personal reflections are considered at the end.

2. Introduction

2.1 Depression in older adults

For research and service provision purposes older adults are defined as those people aged 65 years plus. It is often debated whether older adults are at increased risk of experiencing depression (Roberts, Kaplan et al, 1997). Aging is associated with numerous changes spanning different domains, physical and biological changes, social changes, losses/transitions in roles and relationships and psychological changes. These changes may present a number of challenges for individual's, however despite this it is important that depression is not considered 'inevitable' in older adults and that treatable depression is not overlooked by professionals (National Service Framework of Older people, DH, 2001). According to the Adult Psychiatric Morbidity Survey (2007), a large UK study, older people have a lower rate of common mental health disorder including depression than younger people. Prevalence for depression of 10-15% is found in older adult community samples (Beekman, Copeland & Prince, 1999) although prevalence rates have been found to be much higher in non-community samples (Seitz, Purandare & Conn, 2010)

Depression is characterised by low mood and/or loss of pleasure in activities. Other symptoms can include poor appetite or overeating, insomnia or hypersomnia, low energy or fatigue, low self-esteem, poor concentration or difficulty making decisions

and feelings of hopelessness (DSM-5; APA, 2013). Symptoms should be present for at least two weeks and should represent a change from previous functioning. Although there is no separate diagnostic category of depression in later life, depression without sadness has been suggested to be more common in older adults (Gallo et al, 1999). Fiske, Wetherell and Gatz (2009) summarise findings suggesting that symptoms of depression may present differently in older and younger life. Compared to younger clients, certain aspects of depression may be more common in older adults including somatic complaints, minimal expression of sadness, motivational symptoms and subjective complaints of poor memory and concentration.
A 'depletion syndrome' characterised by withdrawal, apathy and lack of vigour has also been described as a manifestation of depression in the elderly (Newman et al, 1991). Inclusion of the descriptor 'hopeless' alongside sadness and emptiness as subjective indicators of depressed mood (DMS-5, p.160; APA, 2013) allow the diagnostic threshold to be crossed in the absence of subjectively depressed mood (Sachdev et al, 2015). It has been asserted that DSM-5 criteria are therefore more likely to identify depression in the elderly. This would be of benefit as existing literature reports that depression is often under-reported and under-treated in older adults (Nordhus, 2008).

2.2 Treatment / BA in older adults

Individual cognitive behavioural therapy (CBT) and Interpersonal Psychotherapy (IPT) are both recommended as the first choices high-intensity psychological intervention for depression in the general adult guidelines. However, group CBT, interpersonal therapy, behavioural activation, behavioural couples therapy and mindfulness-based cognitive therapy are also recommended in the guidance where appropriate (NICE, 2009). Specific recommendations are not made for older adults.

Many older people express a preference for a talking treatment (Givens et al, 2006) and there is good evidence for the effectiveness of a number of psycho-social interventions such as Cognitive Behavioural Therapy (CBT), IPT (Reynolds et al 1999) Behavioural Activation (BA) and Problem Solving Treatments in this population (Woods & Roth, 2005; Laidlaw, Davidson & Toner et al, 2008; Serfaty, Hamworth & Blanchard et al, 2009).

2.3 Adaptations to psychological therapy for older adults

There exists a growing body of literature demonstrating the efficacy of cognitive behavioural interventions in older adults. Whilst adaptations will not be necessary for all older adults (Gatz et al, 1998), some modifications allowing for cognitive, physical and sensory impairment can help certain individuals to access therapy more easily and maximise treatment effectiveness in this population (Gallagher-Thompson & Thompson, 1996; Satre, Knight and David, 2006).

The importance of exploring age-related factors in this group has also been noted. Laidlaw and colleagues (2004) have expanded the cognitive model (Beck et al, 1979) to develop a comprehensive conceptualisation framework that includes specific challenges faced by older adults, which may contribute to depression and should be considered in formulation (Laidlaw, Thompson & Gallagher-Thompson, 2004). These comprise cohort beliefs, transitions in roles, intergenerational linkages, socio-cultural context and physical health problems. This framework helps clinicians to consider more systemic factors specific to older adults when working with this client group and may help direct sensible treatment goals.

In addition, it has been posited that older adults may be less familiar with psychological concepts and have difficulty with abstract thinking (Laidlaw, 2008) and a focus on behavioural experiments rather than directly challenging cognitions may be appropriate. This links with research by Fiske et al (1999) who suggest that a common pathway to depression in older adults may be a curtailment of activities (Fiske et al, 1999). Although, accompanying self-critical thinking may exacerbate and maintain a depressed state. As such behavioural activation may be a good treatment option, as it is designed to facilitate structured increases in enjoyable activities that increase opportunities for contact with positive reinforcement (Polenick, 2013). Behavioural activation has been demonstrated to be effective in reducing depression and increasing healthy behaviour in older adults (Polenick, 2013).

3. Case Description

3.1 Background information

Mary is a 71 year old, white British lady. She is divorced and lives alone although is in regular contact with her children with whom she has a good relationship. Mary has two children; a son and a daughter. Her son lives in Australia with his wife and young son with whom she has regular phone contact, and her daughter lives locally with her husband and children, who she sees twice a week. Mary is particularly close to her grandchildren that live locally.

She worked as a deputy manager in a home for people with learning disabilities. Whilst working in this role Mary experienced a depression that she attributed to work stress that caused her to take long-term sick leave. She returned to work following this and retired from this post aged 68.

4. Assessment

4.1 Referral

Mary self-referred to the service following being told by her physiotherapist that she may be experiencing depression.

4.2 Presenting problem

Mary described herself as low and unmotivated rather than depressed. She accepted however, that she had noticed a change in herself and needed help to improve motivation and feel better. The main changes and difficulties she noticed were feeling low because of the various physical health issues she experiences. She has a degenerative problem in her spine and reports her pain stops her from walking any distance and gardening, both things she used to enjoy. She also has oedema between her ankle and her knee that result in itching which disrupts her sleep, as well as underactive thyroid, atrial fibrillation and arthritis. She admitted that both pain and low mood have resulted in her doing much less than was doing eight months previously.

4.3 Client goals

Mary had four initial treatment goals. These were to manage/cope with pain, to manage sleep, to go out more and to complete more tasks around the house.

She also had a longer-term goal to feel healthier, for which we created two SMART goals: to increase exercise, attending the gym at least once a week and to cook and prepare healthier meals.

4.4 Outcome measures

The following measures were completed at assessment and every subsequent session (see Appendix 1 for details):

- Depression, PHQ-9
- Anxiety, GAD-7
- Daily function, WSAS

- A subjective scale to assess change in Mary's feeling or ability to cope with or manage her pain was used. Mary rated her belief in the statement 'I am able to cope with and manage my pain' at the beginning, mid-point and end of treatment from 0-10 (10 = 'always able to cope').

5. Formulation

From the screening assessment information it appeared that a BA treatment model would be a good therapeutic approach for Mary. Veale (2008) points out that the key issue in the formulation is determining the nature of the avoidance and using this to guide the planning of alternative 'approaching' behaviours. Mary's BA formulation was developed in the early sessions of therapy and helps explain her depression as a consequence of her avoidance of behaviours or thoughts. Avoidance results in low levels of positive reinforcement and narrowing of her normal repertoire of activity, which results in maintaining the low mood experience. Figure 1 below is based on Veale (2008) and represents the various coping strategies that maintain her experience of low mood.

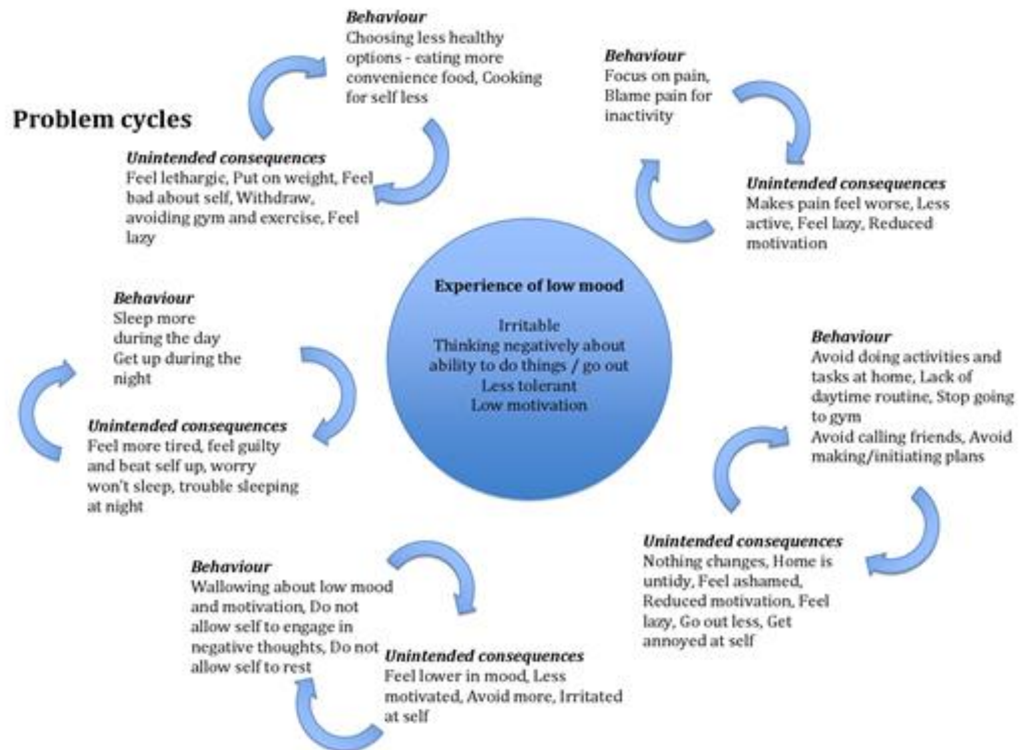


Figure 1: Mary's formulation of her low mood experience and the problem cycles that may have been maintaining it.

Helping Mary to break these vicious maintenance cycles by either challenging her negative thoughts/rumination or encouraging her to change her behaviours should help to improve Mary's mood. Helping Mary to develop a better sleep routine could also be beneficial as currently tiredness appears to result in Mary lacking motivation to do previously enjoyed activities. Getting up in the night and waking herself further also gives Mary more time to worry and ruminate on her negative thoughts. Increasing motivation, by targeting activity could help raise Mary's mood. Re-establishing a good sleep routine and re-engaging in previously enjoyed activities should further promote this. Some work aimed at pain tolerance may also be of benefit and not avoiding activities because of pain could provide evidence that pain is not such a barrier as anticipated.

Although formulated in the BA way attention was paid to Mary's beliefs about aging in terms of setting realistic and achievable targets (SMART goals) particularly around

physical activity and graded return to exercise. Attention was paid in ensuring goals were in line with her own personal values in order to maintain motivation.

6. Intervention

6.1 Overview

Mary attended 12 sessions. She engaged well in the therapy sessions and regularly completed home practise tasks. Mary completed weekly outcome measures and found the graphing of her scores at both mid and end of therapy really encouraging. Mary's goals were based around re-engaging in previously enjoyed activities and completing necessary tasks, with the overall aim of therapy being to allow her time to understand and improve her mood. Additional strategies borrowed from Acceptance and Commitment therapy (ACT; Hayes Strosahl & Wilson, 1999) were applied to help Mary cope with her pain.

6.2 Socialisation to the model and psycho-education

A thorough history of Mary's difficulties had already been taken at the initial telephone assessment approximately 8 weeks before treatment. However, to build rapport and gather updated information on current functioning, a brief clinical interview was conducted in our initial treatment session covering Mary's view on her current difficulties, maintaining factors and coping strategies and the impact it was having on Mary. Socialisation to the therapy model was undertaken, particularly highlighting the links between behaviour and mood. During the first three sessions we discussed her current behaviours and the possible unintended consequences of these, which were used to create her BA formulation (see Figure 1 above). Further psycho-education around motivation and how this impacts on both behaviour and mood was shared and explored. Mary shared her uncertainty with her diagnosis of 'depression' as she didn't see how she could have it given her understanding of it, or how it linked to pain. We discussed her understanding of depression as well as the links between mood and pain management (coping). We also explored what it is that Mary felt she was experiencing (e.g. reduced motivation, negative thoughts) and the impact these are having on her day-to-day life. This information help create her personalised BA formulation.

6.3 Sleep hygiene

Early sessions focused on sleep as Mary identified it as the issue causing her the most distress. Psycho-education for sleep hygiene was undertaken through which we discussed and Mary experimented with different techniques to monitor and manage her sleep routine. We created a sleep diary to highlight any unintended consequences to behaviours engaged in. Mary found that having a fixed time to get up in the morning, thereby creating a routine was helpful. She also found staying in the bedroom even if she wakes in the night and doing more restful activities to resettle herself like reading or a crossword meant she got back to sleep faster. She also cut out night time snacking and watching T.V as she identified these as things that increased her alertness, the opposite of what she intended. She also noted that by cutting out daytime napping she more often got a better night sleep and by the end of therapy had stopped daytime napping altogether. Although she still experienced sleep difficulties, by the end of therapy she was having fewer disturbed nights and was able to better manage her sleeping habits and patterns.

6.4 Behavioural monitoring, activation and scheduling

Mary acknowledged that she had a reduced daily routine and was doing much less than she used to in general. The link between mood and behaviour was explored in greater detail focusing on the idea that when we are depressed it is common for us to stop doing things we used to do, because it just takes too much effort and seems too hard. This reduction or avoidance of opportunities for a person to gain pleasure or a sense of achievement can lead to a worsening of mood. It was then recapped how the BA treatment model aims to break this vicious cycle by focusing on activity scheduling to encourage patients to approach activities that they are avoiding and in turn increasing opportunities for pleasure and achievement. Mary initially monitored her mood and activities before beginning to schedule a range of activities that would give her both pleasure and a sense of achievement or purpose. Time was dedicated to correcting an understandable misconception, in which Mary thought all activities had to be active. We discussed the importance of having a range of activities both active and passive which provide a sense of pleasure, achievement and purpose. Over sessions Mary's activity diaries included a more positive balance of activities that she engages in. Mary fully engaged in this work and was often able to generate ideas herself. Although able to think of activities or tasks to plan, guidance was initially needed in ensuring these were simple and achievable. Mary identified that breaking tasks down into small steps

resulting in her achieving more, and this sense of achievement then motivated her to do more. These ideas were explored in relation to her longer-term goals to continue after the termination of therapy, with Mary fully taking the lead in latter sessions in how to break these goals into steps and how to plan and monitor these.

6.5 Identifying challenging thoughts and thinking errors

Mary identified that she often thinks negatively and hadn't thought about how things that she engages in could be positive. We discussed positive mindfulness and Mary agreed to note one positive thing she does, feels or notices each day. She reported this positive focus having a beneficial impact on her level of activity and mood. Mary came up with the idea of keeping a 'positive diary' herself during the middle of our sessions together. As Mary began to really understand the effect of her thinking and behaviour on mood, she wrote down at least one thing that she achieved, this included rest time. I reinforced the use of this diary and explained how it was very similar to a positive data log frequently used in CBT. The use of this positive data log really seemed to cement the change in Mary's thinking and activity patterns.

6.6 Applied ACT principles and discussions around aging and cohort beliefs

Mary experienced chronic pain and to better cope and manage this was one of her main treatment goals. In the case of chronic pain, causal and maintaining factors may be unclear and efforts to reduce or eliminate the pain may be unsuccessful. In these cases, continuing attempts to control pain may be maladaptive, especially if they cause unwanted side effects or prevent involvement in valued activities (McCracken, Carson, Eccelston & Keefe, 2004). A lot of encouragement was needed for Mary to continue with activities and she often avoided activities due to the fear of experiencing increased pain. Acceptance and commitment therapy (ACT; Hayes Strosahl & Wilson, 1999) is an acceptance and mindfulness based approach that can be applied to many problems and disorders, including chronic pain. Whereas CBT principles are often more about changing thoughts and feelings, ACT emphasizes observing thoughts and feelings as they are, without trying to change them, and behaving in ways consistent with valued goals and life directions. In the case of chronic pain two primary aspects of pain acceptance have been shown to be important. The first is a willingness to experience pain and the second is engaging in valued life activities even in the face of pain. These ideas were discussed with Mary and ACT principles applied. This was also tied into

discussions she raised about her age and the impact this had on her ability to engage in certain activities, particularly exercise. Discussions around Mary's beliefs about aging in combination with the potential limits of her pain allowed open and realistic discussions about goal setting and activity scheduling and seemed to provide her with greater psychological flexibility in relating to her thoughts, feelings or behaviours associated with pain. As such these strategies appeared to complement the BA approach well.

6.7 Relapse prevention and therapy blueprint: Relapse prevention work was mainly done in our last two sessions and focused on facilitating Mary to continue with the techniques she had learnt. In the initial of these two sessions we revisited her earlier vicious flower formulation in terms of behaviours engaged in and unintended consequences. This was then compared to a virtuous flower formulation we created identifying all the positive behaviour cycles she was now engaging in (see Figure 2). This helped to highlight all the changes that Mary has achieved and allowed us to see the impact these behaviour changes had in raising her mood and motivation levels. We identified signs that might signal a relapse (such as doing fewer activities) and planned what to do if she noticed these. We spent some time predicting problems or difficulties that may arise, such as an unavoidable event meaning we are forced to change our plans. We normalised this happening, as does so in real life and planned ways of overcoming these difficulties so they don't impact on motivation. Mary had already experienced this the week previously and therefore we could recap on her success at managing this situation and how to maintain this. As Mary had some ongoing goals we thought about how to continue towards these given that therapy was ending.

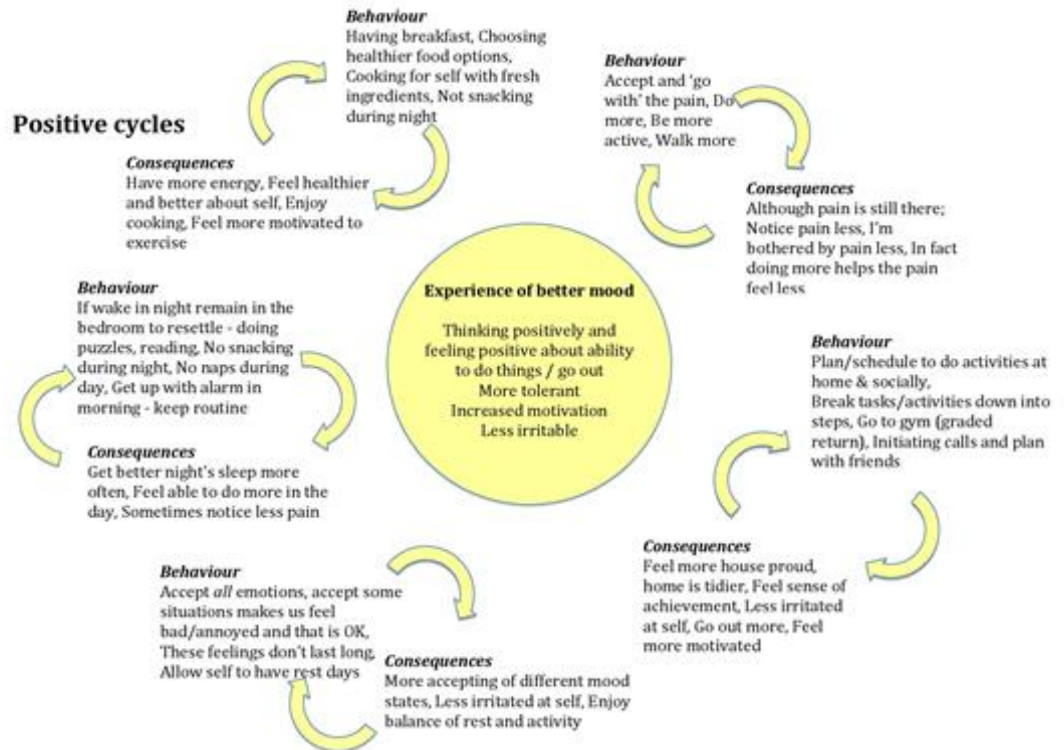


Figure 2: Mary's formulation of improved mood and the positive cycles that have helped achieve this and that could help maintain this state.

7. Outcomes

7.1 Qualitative outcomes

Mary achieved many of her initial goals set within the time frame of therapy and was working well towards her more long-term goals that she felt she would continue to work on after the end of therapy. At the start of treatment her confidence in her ability to manage and cope with her pain was 2/10 and mid-way through this increased to 6/10. At the end of treatment this had further risen to 9/10. She reported feeling subjectively better and more confident at the end of treatment.

Mary felt that she had regained some of her confidence in going out, in exercising and in her ability to achieve tasks that she set her mind to. She had been able to return to the gym, was walking and getting the bus rather than taking taxi and was making arrangements to call and see her friends as well as sticking to plans. She also reported achieving a better understanding of life balance, not feeling guilty for having rest or 'lazy' days and a heightened acceptance of any continuing difficulties with pain

or sleep, applying a more mindful day-to-day approach to the impact these had on her ability to engage in activities and tasks.

7.2 Quantitative outcomes

Depression

At screening Mary's scores for depression (PHQ-9) fell in the moderately severe range. Figure 3 indicates the change in depression scores over time. Mary's scores showed a steady declined as therapy progressed. At the end of treatment her score fell in the healthy range.

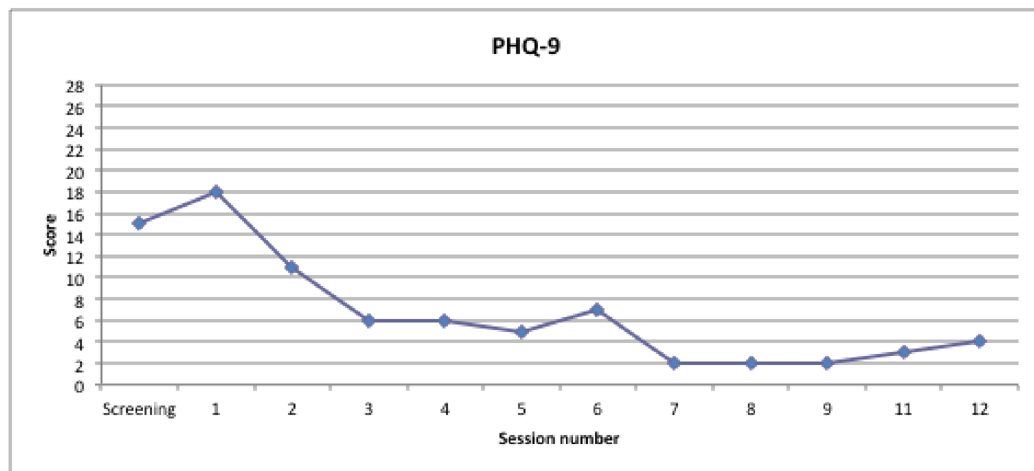


Figure 3: PHQ-9 score across sessions

Anxiety

Mary's anxiety score (GAD-7) was in the mild range at screening and this had risen to the moderate range by the start of treatment and generally declined as treatment progressed (Figure 4). At the end of treatment she scored in the 'healthy' range.

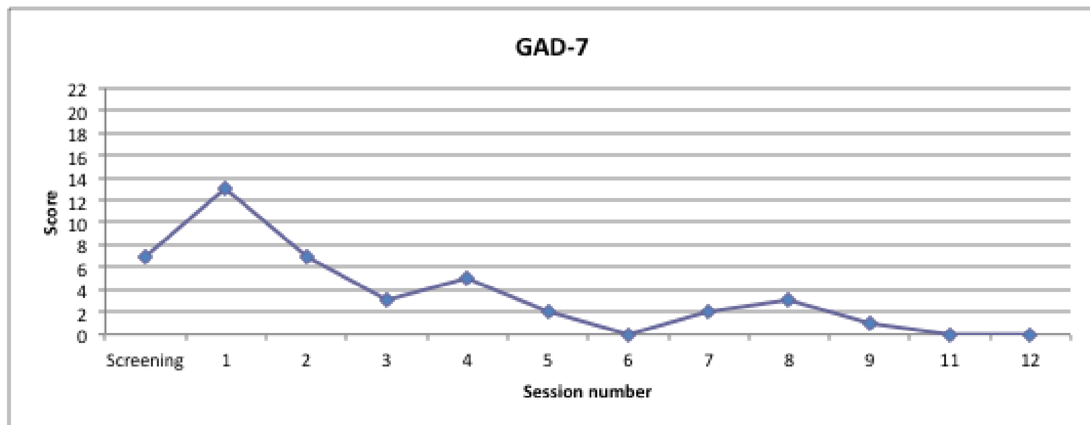


Figure 4: GAD-7 score across sessions

Functional impairment

Mary scored relatively high on the WSAS at the screening assessment, indicating a significant impact on her daily functioning. As Figure 5 displays these scores showed a similar decline across the course of therapy and to the end of treatment.

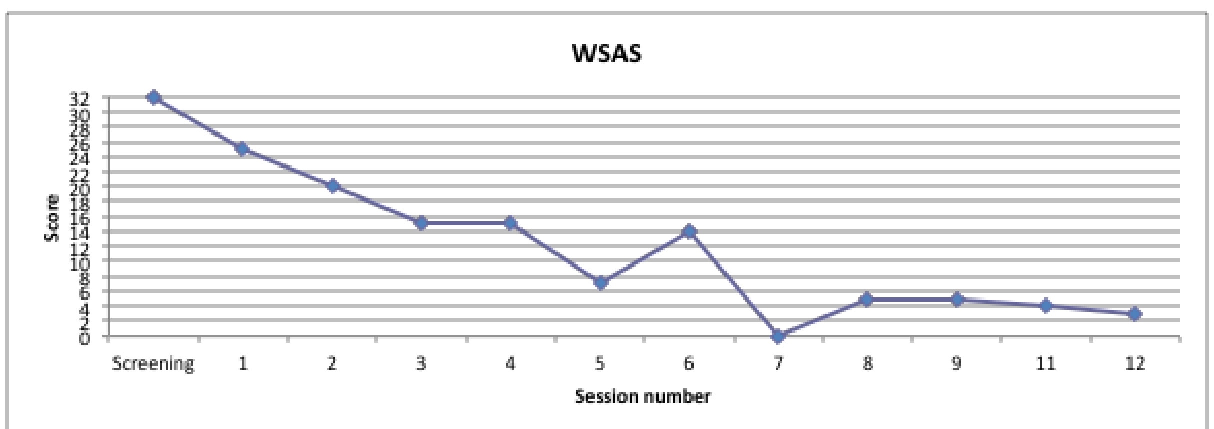
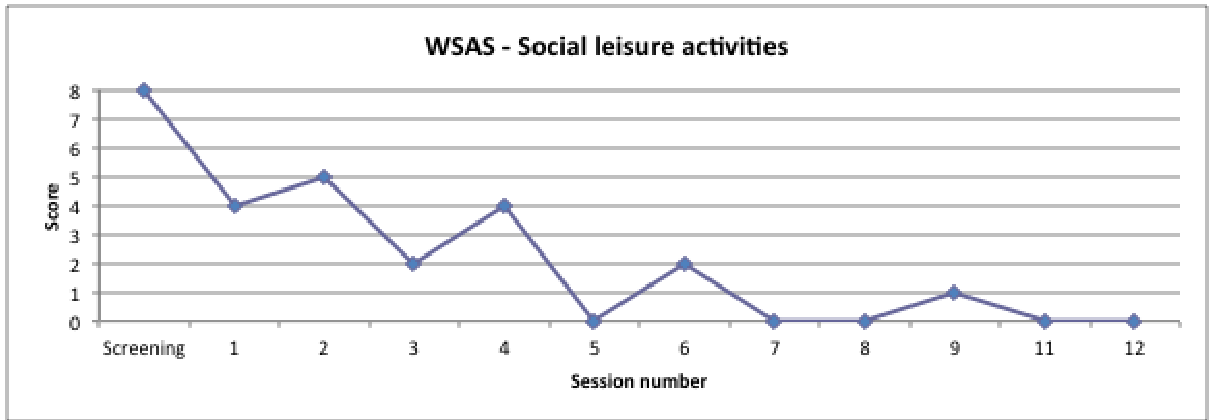


Figure 5: WSAS score across sessions

Of particular relevance to Mary's goals was the specific impact on social activities (e.g. outings) and home management. As such these impact scores are graphed separately (see Figure 6). Both show severe impact at the start of treatment, which reduce markedly over the course of therapy.



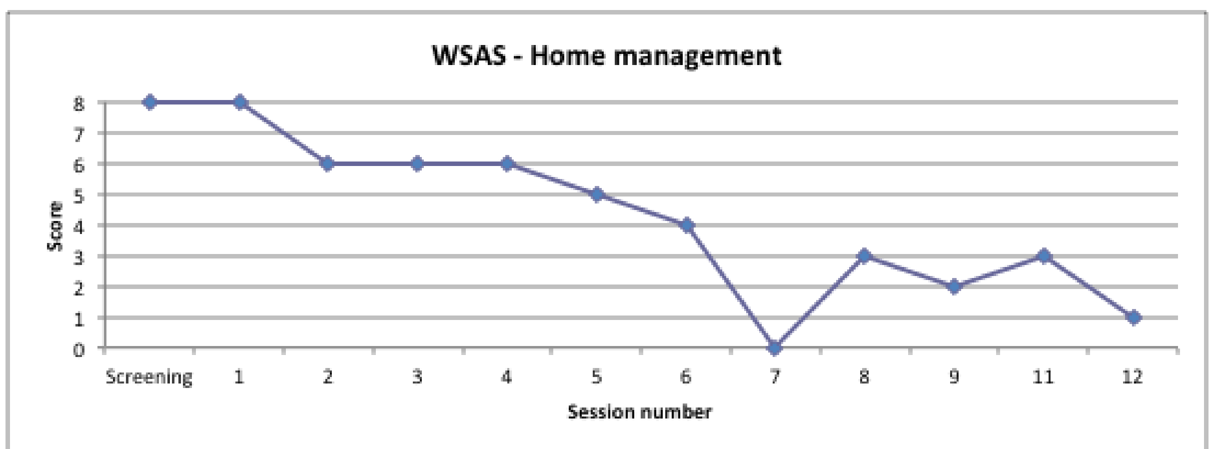


Figure 6: Social leisure activities and home management WSAS scores across sessions

For all graphs session 10 has no scores, as the measures were not completed. This was a result of the nature of the session in which the client took the lead and the therapist felt it more important to prioritise the session content rather than interrupt to complete measures.

8. Discussion

Mary was very honest about her reservations as to the effectiveness of therapy in our initial sessions, yet despite this she engaged well and was able to make substantial progress towards all her goals, with a significant reduction in her symptoms of anxiety and depression. At the end of treatment all Mary's scores were in the healthy range suggesting Behavioural Activation to be a successful approach for Mary. Mary appeared to gain a greater understanding of her difficulties and the process maintaining her low mood. She was very quick to grasp ideas and appeared to find it easy to generalise outside of sessions, which helped the therapy maintain a good pace and move forwards.

Although a BA treatment model was adopted I feel that the acceptance strategies borrowed from ACT (e.g. focusing on behaviours despite of symptoms) helped with her pain acceptance and with continuing to do activities despite still experiencing some discomfort. In the literature acceptance of pain has been correlated with lower self-rated pain intensity, less self-rated depression and pain-related anxiety, greater physical and social ability and less pain avoidance (McCracken et al, 2004). It was therefore positive to note changes in these areas for Mary. For this case these ACT strategies appeared to fit well with the BA approach, particularly in terms of enabling activity scheduling. This case study supports previous findings that BA is an effective treatment for depression in older adults.

An interesting alternative therapeutic intervention may have been to offer IPT, as it is a structured therapy for people with moderate to severe depression. It may have been helpful to think about some of her social avoidance and self-isolating behaviours that were maintaining her low mood within this framework. Additionally, thinking more about her support network in terms of identifying people to help her maintain the progress she has made could have positive longer-term outcomes.

9. Limitations and learning points

Mary presented with several goals, not all of which were possible to address within the limited timeframe of therapy. Consequently, Mary's difficulties around sleep were not fully resolved by the end of treatment. However, given her on-going physical health issues, this would not realistically be expected. However, she did show increased acceptance of the fact that changes to sleep routine may take time and understanding of the types of behaviour that may hinder or help her. A subjective rating scale was used to monitor Mary's ability to manage or cope with her pain and I feel a similar scale would have been helpful to apply to her goal concerning sleep management. This would provide more concrete and objective evidence of her progress in this area rather than relying on clinician report. Additionally, applying the principles of ACT to help her address her sleep problems may have proved beneficial. Given the lack of follow-up data, the longer-term impact of the therapy for Mary cannot be measured. However, she was given the option of having a follow-up session which Mary declined and this was interpreted as a positive that Mary felt able and confident to continue with her journey on her own making use of the tools and strategies she learnt during therapy.

10. Reflections

The positive therapeutic relationship and Mary's motivation, full engagement and continued progress made this an extremely rewarding experience for me as therapist. I felt that this case increased my confidence particularly in the collaborative elements of therapy. Mary grasped ideas and concepts quickly and had many ideas of tasks she could plan or data she could monitor, which allowed the collaborative nature of the work to feel very natural. Given the presenting problem was working with low motivation I was struck by how motivated Mary was. Mary appeared incredibly psychologically minded which supported the therapy process. The formulation process created a shared understanding of what it was Mary was feeling and experiencing. Using the client's own language is encouraged when using therapy models within the family of behavioural and cognitive psychotherapies, and it was particularly helpful to be able to abandon the diagnostic label of depression and explore and use descriptions that Mary felt more comfortable with. However, I think the conversations and discussion we dedicated to this topic was useful as it helped Mary not to see 'depression' as a word or label in such a negative light, personalising the word or 'label' in itself. It allowed an openness that enabled us early on to share a common understanding of her problem as she perceives and labelled it. This case, although relatively straightforward still involved aspects of other work (e.g. ACT) and highlighted the importance of listening to and working with clients cohort beliefs. Helpful conversations initiated by Mary were had concerning her realisation of age and the potential adaptions that may be necessary to continue with activities previously enjoyed, like exercise. This can be particularly important in this client group and was helpful in setting realistic targets and goals. The ending of treatment was particularly satisfying with Mary sharing that she hoped not to see me again! It was encouraging that Mary felt confident to continue alone without feeling the need for follow-up.

Word count: 4367

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Appendix 1 – Psychometric properties of quantitative measures

Patient Health Questionnaire (PHQ-9; Spitzer, Kroenke & Williams, 1999).

The PHQ-9 is a self-administered screening and severity questionnaire of nine multiple choice items to facilitate the recognition and diagnosis of depression in primary care patients (Lowe et al, 2004). It can be used to monitor change in symptoms over time. Respondents are asked to rate depression symptoms over the past two weeks on the following scale:

0 – not at all, 1 – several days, 2 – more than half the days, 3 – nearly every day. Scores are summed to produce a total score out of 27. Clients scoring above 10 are considered to be suffering from clinically significant depression symptoms. Scores above 20 are considered severe. It has good reliability and validity (Kroenke, Spitzer & Williams, 2001).

Generalised Anxiety Disorder 7 item scale (GAD-7; Spitzer, Kroenke, Williams & Lowe, 2006).

The GAD-7 is a self-administered screening and severity questionnaire for anxiety disorders consisting of seven, multiple-choice items. It was initially designed to assess generalised anxiety disorder, however it has relative validity for detecting panic disorder, social anxiety and post-traumatic stress disorder. Respondents are asked to rate anxiety symptoms over the past two weeks on the following scale: 0 – not at all, 1 – several days, 2 – more than half the days, 3 – nearly every day. Scores are summed to produce a total score out of 21. Clients scoring above 8 are considered to be suffering from clinically significant anxiety symptoms. Scores above 15 are considered severe.

Work and Social Adjustment Scale (WSAS; Mundt, Marks, Shear & Greist, 2002).

The WSAS is a 5-item self-report, multiple choice measure designed to assess the perceived impact of an individual's mental health difficulties on their ability to function at work, home management, social and private leisure and personal/family relationships. Each item is scored 0-8 (no impact to severe impact) and a total score is obtained by summing the items scores. It has good reliability and validity (Mundt et al, 2002).

Case Study IV

Cognitive Behavioural Therapy for anxiety with a 77-year-old lady

Institute of Psychiatry, Psychology and Neuroscience (IoPPN)

King's College London

Supervised by: Dr Grace Wong

Southwark Talking Therapies (IAPT)

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1. Summary

This case study describes the treatment of anxiety in a 77-year-old women, Ina, using Cognitive Behavioural Therapy (CBT). The main goals of treatment were to increase her understanding of the impact that fear and anxiety can have on behaviour and vice versa, as well as increasing her confidence to travel by both bus and train. Positive outcomes were achieved at the end of 15 sessions of therapy, including a marked decrease in anxiety symptoms, as measured using the GAD-7. More qualitative behavioural gains were also achieved. This case study discusses considerations needed when adapting CBT for older adults, as well as how age-related difficulties such a mild cognitive impairment (MCI) may impact on the therapy process.

2. Introduction

2.1 Anxiety in older adults

Prevalence estimates of anxiety disorders in older adult community samples range from 1.2% to 15% (Bryant et al, 2008; Gould et al, 2012). These rates are slightly lower than those for younger adults (Wolitky-Taylor et al, 2010). However, difficulties may exist with recognising anxiety disorders in older adult populations as older patients are less likely to report psychiatric symptoms and more likely to emphasize their somatic symptoms (Gurian & Miner, 1991;Lenze et al, 2005).

Generalised anxiety disorder (GAD) is the most common anxiety disorder among older adults (Schuurmans & van Balkom, 2011), though anxiety disorders in this population are frequently associated with traumatic events such as a fall or acute illness (Brenes et al, 2005) and finances and family (Person & Borkovec, 1995). Among older adults, presence of a 12-month anxiety disorder is noted to be associated with female sex, lower education, being unmarried, and having three of more chronic conditions (Gum et al, 2009).

2.2 Treatments for Anxiety in Older Adults

The Department of Health (2001) recommends that older adults with mental health problems should have access to the same range of therapies as younger adults. The literature suggests that both pharmacotherapy and psychosocial interventions can decrease symptoms of anxiety disorders in older adults (Pinquart & Duberstein, 2007).

2.2.1 Pharmacological treatment strategies

Older adults receive most of their mental health services from their primary care providers (GPs) (Cheng, 1990). Therefore, it is not surprising that 50% of older patients with anxiety disorders are prescribed anxiolytics or antidepressants, and, that psychosocial treatments are minimal (Fuentes & Cox, 2000). However, it is important to be mindful of the effects these medications can have on older adults e.g. increased medication sensitivity and effects on comorbid physical health conditions (Coupland et al, 2011). As such these medications need to be used cautiously.

2.2.2 Psychosocial interventions

A growing body of research supports evidence-based treatment for late-life anxiety. Cognitive-behaviour therapy (CBT) interventions have been found to be effective for older adults with anxiety (Wilson et al, 2008; Hendricks et al, 2008; Gould et al, 2012), although support is not as robust as for younger adults (Wetherell et al, 2005; Ayers et al, 2007). Interestingly, research has highlighted that older adults view psychological treatment for mental health problems as more credible and acceptable than medication (Landreville et al, 2001).

2.3 Adapting CBT for older adults

Recommended modifications for older adults involve a greater emphasis on psycho-education, increasing patient motivation and repeating the explanation of new coping strategies (Schuurmans & van Balkom, 2011). Adaptations to CBT protocols that have yielded better results involved the use of learning and memory aids and more attention to the (repeated) explanation of the rationale of treatment (Mohlman et al, 2003). This highlights that a number of modifications, relating to both procedural and content factors, can be applied to CBT with older adults. Laidlaw et al (2004; Laidlaw et al 2003) developed a case conceptualisation framework for older adults that accounts for the complexity of age-specific issues commonly faced by older adults. This framework invites us to consider an individual's cohort beliefs, transitions in role, intergenerational linkages, socio-cultural context and physical health when formulating their difficulty.

3. Case Description

3.1 Background information

Ina is a 77 year old, white British lady. She described a happy childhood. She was an only child, although she was very close to her cousins growing up. She described that despite being an only child herself, she had always wanted a big family of her own.

She is divorced following a difficult marriage. She has five children and has variable contact with them. She is in regular contact with two of her daughters. One of her daughters lives in Canada and due to a recent event their relationship has become quite strained. Ina has a close relationship with her grandchildren who live locally. She has lived alone for many years, however, during the course of treatment, her 19 year old Granddaughter moved in with her for a short period whilst settling into a new job. Ina described herself as a social lady, who particularly enjoys being in the company of others. She attends various clubs and social groups as well as a local church each week. She shared that she has always an emotional person and someone who cries easily.

4. Assessment

4.1 Referral

Ina was referred by her GP to receive support in relation to anxiety and fear of travelling on public transport, specifically buses and trains.

4.2 History of presenting problem

Ina reported a history of depression and anxiety and shared that she has a long-standing fear of dying and of being alone. Ina is prescribed an SSRI to treat her depression and anxiety symptoms, which she had taken for a number of years, and on which she remained for the duration of our treatment. Recently Ina had completed an assessment at the memory clinic to assess for possible cognitive decline. She was given the all clear from the memory clinic with regards to a dementia diagnosis, but reports did note some mild cognitive impairment (MCI).

4.3 Presenting problem

Ina's difficulties with travel had a relatively recent onset and she was unsure what triggered it. Ina was quite emotionally labile and often found it difficult to stay focused in conversations, possibly related to the MCI. To help with this, a timeline was drawn to highlight the relatively recent onset of the problem and to have a visual representation of the problem to refer back to. Ina had experienced some family upset in relation to her avoidance behaviours, in particular a fall out with one of her children when, due to panic, she was unable to board the plane and fly to visit her. Ina marked this as the start of her difficulties. Ina also shared that family dynamics often added to her worry, however, it was agreed that the focus of our sessions to be on her fears around travel. She shared that this was most important to her at the current time. Ina reported feeling very anxious on buses, which had begun to result in her often avoiding using them. Also, she had completely stopped travelling by train, something she has loved to do since she was a young child.

4.4 Client goals

Ina had two clear treatment goals; these were to be able to travel more confidently on buses and to be able to travel on trains again. Both of these she felt would have a positive impact on other areas of her life, as they would allow her to visit close friends who she regards as a strong source of support.

4.5 Outcome measures

The following measures were completed at assessment and every subsequent session (see Appendix 1 for details):

- Depression, PHQ-9
- Anxiety, GAD-7
- Daily function, WSAS

5. Formulation

Although Ina has a history of long standing anxiety, it is important to bear in mind that she has coped well for a long period before her recent change in mood and behaviour.

From the screening and assessment information it was felt that CBT for anxiety would be a good therapeutic approach for Ina. This would need some adaption given her difficulties with attention and memory. Ina understood the key principles of CBT, including interrelatedness of thoughts, feelings and behaviours. Due to Ina's cognitive profile, comprehensible mini-formulations were shared with Ina. The wider intergenerational, cohort and role factors (identified by Laidlaw as important with older adults) that linked to her current presentation were discussed in a narrative fashion, and links were drawn to the formulations presented through discussion only, in order to keep formulation simple and easy to follow.

The different vicious cycles developed with Ina included: understanding a simple fear/avoidance cycle (see Figure 1) and psychologically understanding how her current anxiety led to avoidance behaviours that actually maintained her fear.

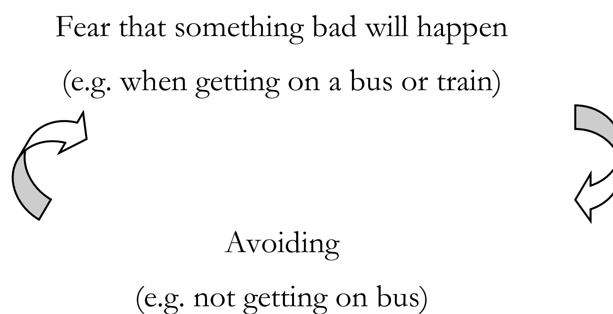

Figure 1: *Simple fear avoidance cycle*

Ina believed 80-100% that the fears she held would happen, which resulted in her beginning to avoid getting buses and trains. If she was ever able to get on a bus she became hyperviligent. Avoiding travelling meant not seeing friends as she used to and led to feeling isolated and reducing motivation. The longer she engaged in this avoidance behaviour, the more she believed her fears would come true. When anticipating her fears Ina reported feeling physical symptoms of muscle tension and low energy. Ina found these anxiety feelings so uncomfortable that she would remove herself from situations in which they occur, e.g. getting off the bus immediately or avoiding transport altogether, which acted to confirm her fears that something bad

would happen. These fears led to Ina gradually avoiding more of her weekly activities, such as visiting friends and family and attending social events in the community.

Ina's avoidance behaviour reduced her confidence and increased her feelings of isolation. We formulated Ina's avoidance and anxiety within a simple hot cross bun model (Padesky & Mooney, 1990; see shared formulation below, Figure 2).

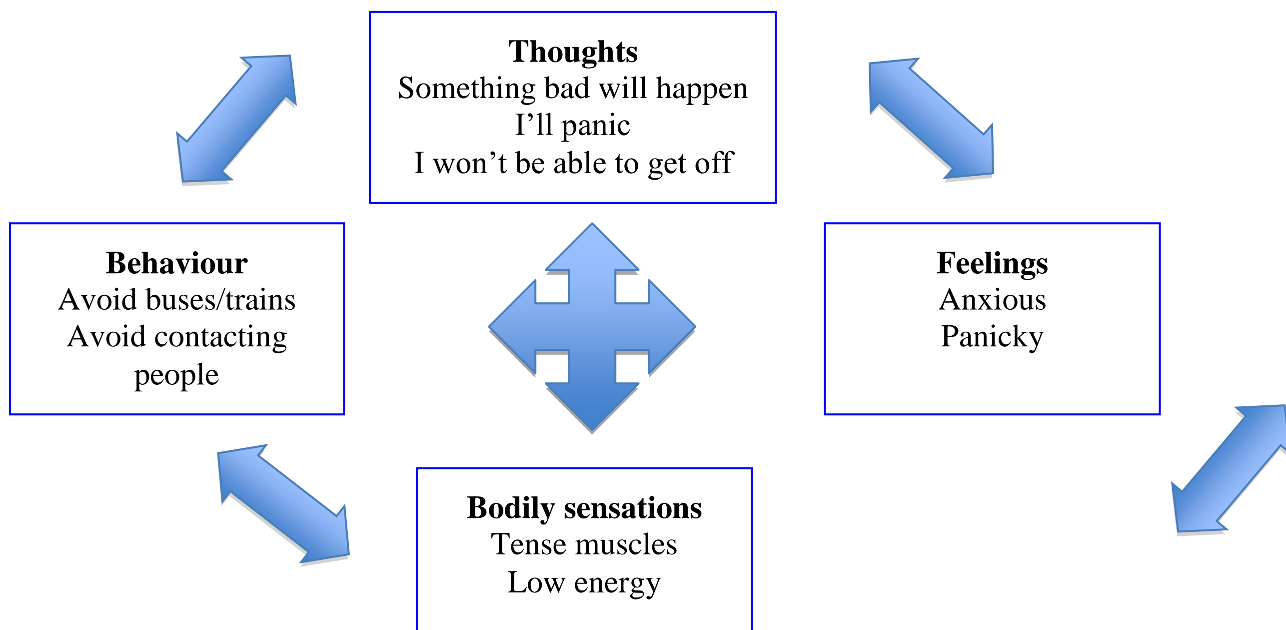

Figure 2: *Padesky & Mooney's (1990) hot cross bun model of Ina's anxiety (vicious cycle)*

Although not included in our shared formulation we discussed how Ina did not feel able to seek help or reassurance from her daughters. The incident in which she couldn't get on a plane to visit her daughter and her recent visit to the memory clinic left her ruminating on her relationships with her family, particularly how they viewed her capabilities. As she felt she couldn't talk to her family, this led her to isolate herself more and resulted in a lack of support or encouragement to overcome her fears. Discussions around these issues were influenced by the factors that Laidlaw recognised as important in older adults. We discussed her current feelings in relation to how she viewed her role within the family, how this may differ to her family's perspective (role factors) and what her expectations were in terms of family support, compared to those of her daughters and granddaughters (intergenerational factors).

Through discussions we began to think about what would happen were she to get on a bus and train. We adopted a therapy catchphrase "Just do it" and drew out a more virtuous cycle formulation that consisted of positive thoughts and proactive behaviours. This was helpful to refer back to when planning behavioural experiments. See Figure 3 below for the virtuous cycle.

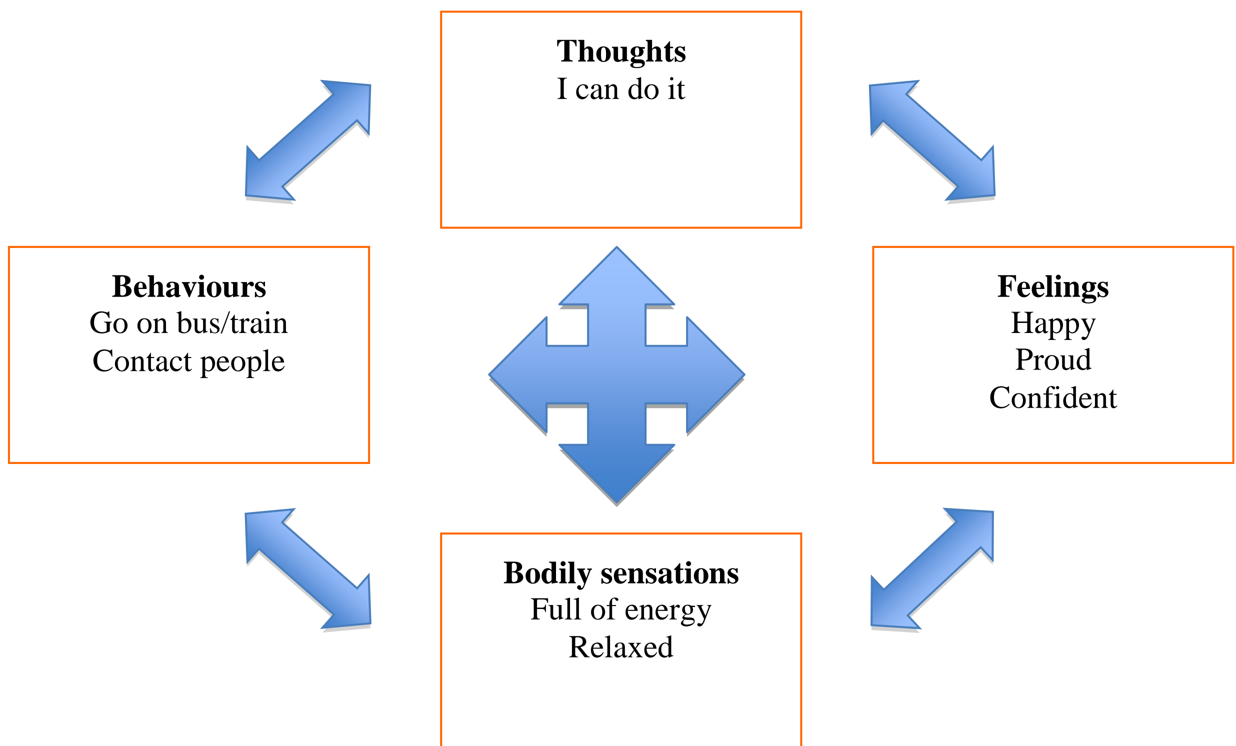

Figure 3: **Padesky & Mooney's (1990) hot cross bun model (virtuous cycle)**

6. Intervention

6.1 Overview

The main focus of treatment was CBT for anxiety. Fifteen sessions of CBT were delivered over a period of four months. Sessions were held on a weekly basis. Each session was 60 minutes in length. Therapy goals were around increasing her understanding of the impact that fear and anxiety can have on behaviour and vice versa, as well as increasing her confidence to travel by both bus and train. We agreed to target her anxiety, avoidance behaviours and associated catastrophic beliefs. The emphasis during sessions was on the more concrete behavioural maintaining factors (avoidance) of her anxiety. Due to Ina's mild cognitive difficulties, this appeared easier for her to grasp. It was hoped that this would increase her ability and confidence to travel more

freely and independently and thereby stay connected with friends and family, which was a strong value of hers.

6.2 Socialisation to the model and Psycho-education

To facilitate the normalisation of Ina's experience of anxiety, pscyho-education around anxiety and emotional regulation was shared. We explored the need for some anxiety making reference for how anxiety prepares an individual for the flight or fight response, when faced with a threat and used metaphor examples (such as the car alarm) to illustrate how this system can sometimes become oversensitive, which was helpful for Ina. We differentiated between real and feared threats, where one could still experience symptoms of anxiety unhelpfully.

The anxiety curve was presented, including how anxiety gets worse until a peak. After this peak, anxiety starts to decline the longer one remains in a feared situation. Emphasis was put of how anxiety cannot remain at peak levels in the body due to its natural tendency to reduce. Information was shared about habituation, and how the more times she faced a situation she feared, the less anxiety she would feel over time. We demonstrated how the anxiety curve worked using a behavioural example from her life to make it more concrete.

Socialisation to the CBT model was offered focusing on increasing her understanding of how behaviours, thoughts and feelings are linked. We explored how negative avoidance cycles may maintain the problem and what changes may be made to better deal with anxiety.

6.3 Behavioural Experiments

Behavioural experiments were conducted to explore the consequences of Ina stopping her avoidance behaviours, and reviewing if the fear driven predictions she feared occurred. A personalised exposure hierarchy was collaboratively devised in sessions comprising a number of behavioural experiments. The tasks involved graded exposure to anxiety provoking situations related to her goals of using the train to visit her best friend (see Figure 4). Ina was encouraged to approach situations rather than escape them and remain with her anxiety until she noticed her symptoms had reduced.

Different experiments were collaboratively planned in sessions and Ina worked through these behavioural tasks of increasing anxiety between sessions, for homework.

1. Get the bus to therapy sessions (even when don't need to)
2. Go to train station
3. Go to train station and walk nearer to train barriers
4. Go through train barriers
5. Get on a train and travel one stop
6. Get on a train to Sidcup and travel to see best friend

Figure 4: *Graded hierarchy of behavioural experiments*

The outcome and learning points from these were discussed throughout therapy. Predictions Ina made before the experiments were compared to the reality that occurred, and how that impacted on how she felt. Following each experiment, Ina's anxiety reduced and she become increasingly confident to continue to activate herself. She even completed two steps (step 4 and 5) at the same time, which she put down to an increase in confidence and excitement at nearing her goal.

6.4 Thought Challenging

Ina's thoughts about avoiding situations in which she feared the outcome were challenged via verbal discussions. We spent time identifying how her fear lead to thoughts that may have become distorted, and finding evidence currently for and against her fears. We identified occasions when Ina's fears had not been realised, where she had not avoided and explored the consequences of these. This highlighted that avoidance was a big issue for her and highlighted how negative avoidance cycles may maintain the problem and what changes may be made to better deal with anxiety. A simple formulation was shared with Ina to visually present this (see Figure 5). The behavioural experiments provided us with evidence to challenge many of the Ina's catastrophic thoughts about travelling on buses and trains.

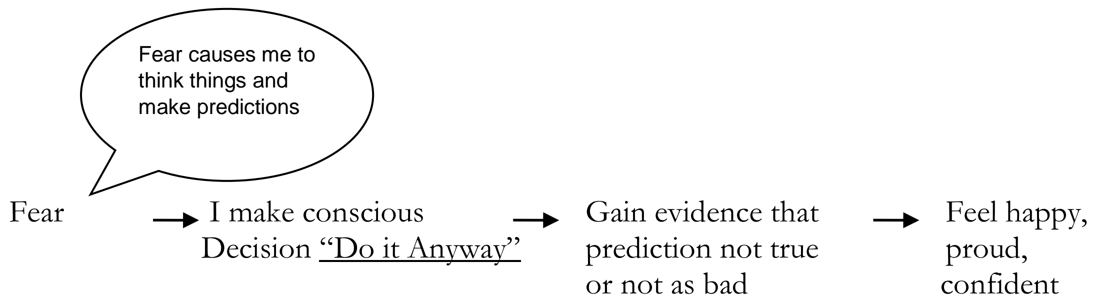

Figure 5: Linear formulation to highlight the impact of a more virtuous cycle of behaviour

6.5 Relaxation Techniques

It became apparent that Ina had difficulty managing her anxiety and engaging in behavioural experiments when we were facing the more anxiety provoking task, at the top of the hierarchy. These were the experiments that concerned actively getting on a train. We decided she might benefit from some relaxation techniques at times when she began to notice physical and psychological signs of fear. We discussed and practiced different relaxation techniques, including deep breathing and progressive muscle relaxation. We also used imagery as a way to positively reframe journeys as an adventure or fun day out, encouraging her to think about what she will do when she reaches her destination, as a means of positive distraction. Ina practised these techniques for homework, during behavioural experiments.

6.6 Process of therapy

The process of therapy was a little tricky initially due to Ina's mild cognitive difficulties. These were discussed with her and we problem-solved what may be an effective solution. We agreed to trial a therapy pack, which involved ensuring that a summary sheet was created at the end of each session for her to take away. This simply stated the key points discussed, the homework plan and the time and date of the following session. I encouraged Ina to bring this folder to each session for us to add to. This particularly helped the continuity and flow of therapy as it meant that previous sessions

could be briefly recapped, as opposed to needing revisiting. The process of therapy therefore, was an important factor in the recovery of this client.

6.7 Relapse prevention

Towards the end of therapy a blueprint was drawn up in collaboration with Ina. The blue print provided her with a means of summarising how the problem had developed and had been maintained. This included our initial formulation detailing vicious cycles of avoidance. Also detailed were reminders about specific techniques that she had found particularly helpful and important learning throughout therapy. It also summarised a positive formulation that included facing her fears, rather than avoiding them, that she had engaged in to achieve her goals. Finally, it included ways of continuing to challenge herself, thoughts about future goals and means of preventing relapse.

7. Outcomes

7.1 Qualitative outcomes

Ina engaged well in sessions and achieved her goals of being able to travel by both bus and train. She reported that the therapy pack we devised had been helpful in keeping continuity between sessions and in times of providing a reference to help motivate her with home exposure tasks to challenge her anxiety. She reported increased awareness of her thoughts and feelings and her reactions to these as well as in feeling motivated and confident to continue to travel by both bus and train regularly.

7.2 Quantitative outcomes

Depression

During the course of therapy Ina's scores on a measure of depression (PHQ-9) remained low showing a slight reduction from the mild to healthy range (see Figure 6). This was unsurprising given that her difficulty was more anxiety related.

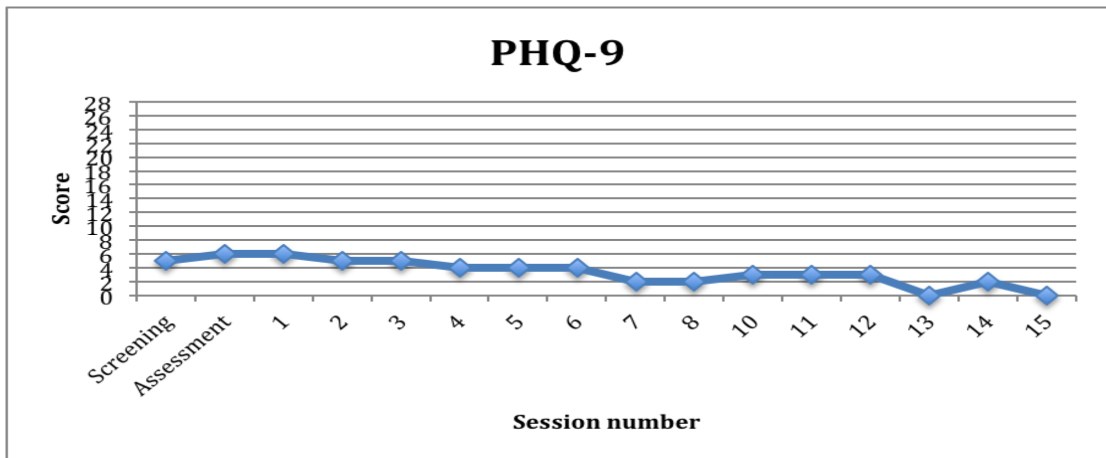

Figure 6: *PHQ-9 score across sessions*

Anxiety

Ina's anxiety score (GAD-7) was in the severe range at the start of treatment. Although scores fluctuated during the course of treatment, by the end she scored in the healthy range. The graph depicts a rise in her scores at session 5 which coincided with a difficult week with family. The latter fluctuation at week 12 coincided with an increase in the more challenging behavioural experiments and 'exposure' element to treatment. These fluctuations provided an opportunity to acknowledge that it is normal for mood to fluctuate in response to life stressors, but that with time we can adjust back to a comfortable state. These occurrences during therapy allowed her the opportunity to realise that she can cope with anxiety herself and will be able to cope in the future when she has dips that are a typical occurrence of everyday life.

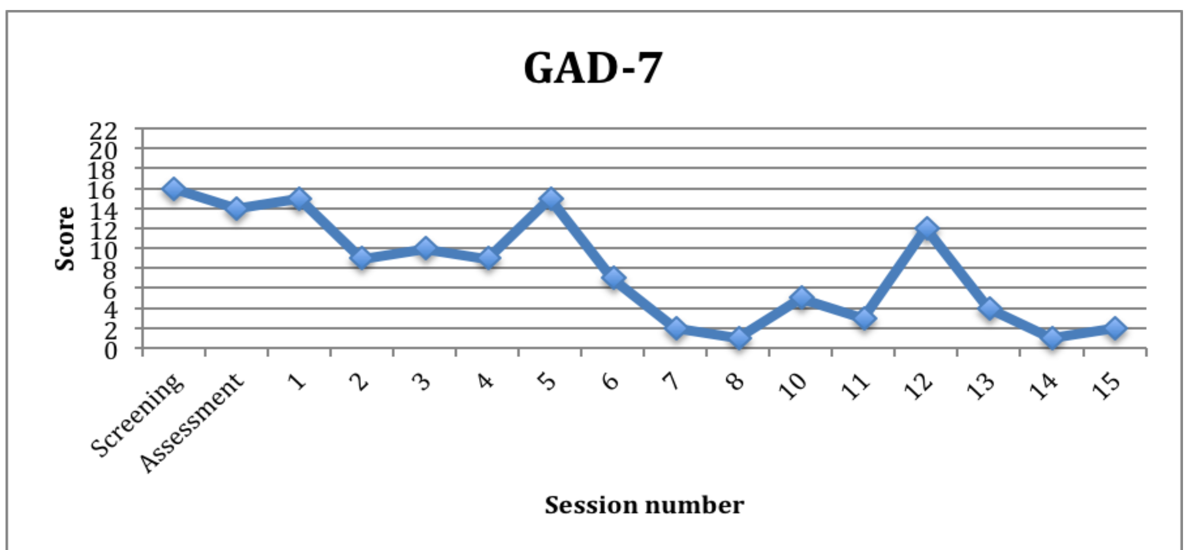

Figure 7: **GAD-7 score across sessions**

WSAS

Ina scored highly on the WSAS at the start of therapy, indicating a significant impact on her daily functioning. As Figure 8 displays these scores showed a significant decline across the course of therapy and to the end of treatment.

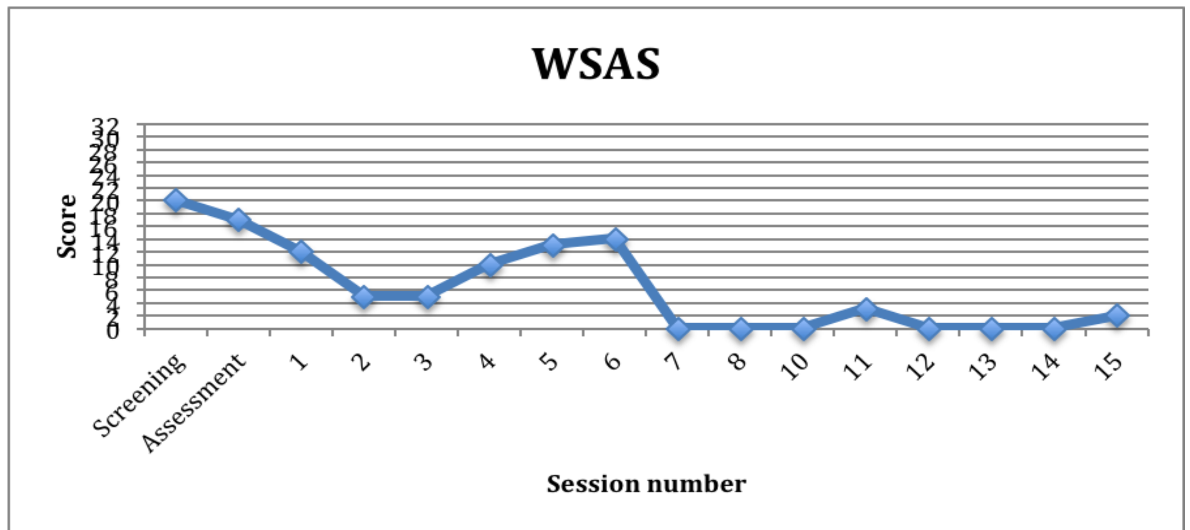

***Figure 8**: WSAS score across sessions*

For all graphs session 9 has no scores, as the measures were not completed. The session was cancelled, as Ina was unwell.

8. Discussion

The current case study presented details of assessment and treatment of an anxiety disorder in an older adult. Working on a collaborative formulation was helpful for Ina in understanding her difficulties and helped tailor the cognitive-behavioural intervention. Ina was often preoccupied with why her difficulties had started. If we entertained discussions, which attempted to address her lifelong anxieties and beliefs, this appeared to instil further worry and she became emotionally labile. It also made maintaining focus and working towards specific goals difficult. However, explicit discussions about this, highlighting the benefits of a focused intervention were helpful. Ina appeared, at times, to struggle to work cognitively in therapy, benefitting more from a behavioural focus. Ina was willing to receive help for her difficulties and was able to grasp and accept her part in her current difficulties. These protective factors helped support Ina in working towards her goals. Ina had a high level of motivation to reach

her goals. She was interested in discussing and understanding her problems within a psychological framework, and a marked reduction was noted in her symptoms of anxiety. The findings of the case study suggest that anxiety can be successfully treated with Cognitive Behavioural Therapy techniques, and that successful adaptions can be made for individuals with Mild Cognitive Impairment.

9. Limitations and Learning points

The presentation of family issues that often arose during 'check in' each session, for example, arguments within the family, made maintaining session focus difficult at times. She would often be a little disinhibited in the number of stories she shared. Given her recent memory clinic appointment she shared that she had felt a little unsupported by her family and felt they may be questioning her capabilities. Within therapy attempts were made, through short discussions, to encourage her independence and to promote her sense of control in certain family situations. However, with repetition, Ina grasped the need for therapy to have a specific focus in order to be most effective. These interpersonal issues weren't specifically added to the shared formulations. Given Ina's cognitive difficulties, it felt important to keep formulations focused and simple in order to support Ina to maintain focus and provide optimal opportunities for her to access the information shared. However, it may have been informative to think with Ina about whether she would like support with these interpersonal issues given the frequency in which she reported them.

10. Personal Reflections

I found it interesting, but also challenging working with Ina. She was highly motivated to improve, but also minimised her role in this improvement. She was also very eager to please and often overly enthusiastic about my contribution to her progress. I found that finding the right balance between giving reassurance and empowering Ina to have an internal locus of control was at times difficult. However, with repetition and consistency, she appeared at times to value her own efforts. Although I was mindful not to minimise my contribution, given that Ina felt talking to an external person (not a family member) was important to her, I was able to redirect to the fact that she sought and accepted help, which was very brave and played a large part in her initially receiving treatment and engaged well, which supported in her positive progress. It was very rewarding for me, as the treatment progressed to see a notable shift in Ina's attribution

of her progress, where she moved away from stating her progress was due to me to stating it was due to the way she was 'thinking' and to 'doing more'.

Practising this therapy helped me to understand the importance of setting foundations at the beginning of therapy, outlining expectations and in particular ensuring a focused session agenda. Creating a therapy pack, that summarised each session helped manage her MCI and associated cognitive behaviours. Preparation for the therapy pack did take time and planning. However, it appeared worthwhile as Ina's motivation and efforts in looking through the pack between sessions, to remind herself of our discussions, was a likely contributor to the success of the treatment.

I wondered whether a mindfulness-based cognitive therapy (MBCT) approach for anxiety (Sharma, et al, 2012) might have benefitted Ina. MBCT has been shown to be a promising treatment for anxiety, with evidenced effectiveness for older people (Helmes & Ward, 2017). She often struggled to stay present focused and the attention given to this in this approach may have been particularly helpful to practise. This I feel is especially true given her success during therapy with de-centring from her negative thoughts, therefore not having the opportunity to engage in rumination when practising relaxation and positive distraction techniques.

Word count: 3706

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Volume I

Service Evaluation Project

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Identification of Dual Diagnosis prevalence (and related treatment plans) in a community PR Psychosis team (Lambeth NE)

Supervised by Dr James Duffy, Principal Clinical Psychologist (START Homeless Outreach Team)

Institute of Psychology, Psychiatry and Neuroscience

King's College London

Thesis submitted in partial fulfilment of the degree of Doctorate in Clinical Psychology

South London and Maudsley
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Identification of Dual Diagnosis prevalence (and related treatment plans) in a community Promoting Recovery Psychosis team (Lambeth NE)

09.10.17

Audit Report

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Executive Summary

Aim

The 'Adult Mental Health' (AMH) model, an initiative developed by SLAM NHS Trust, states that Dual Diagnosis (DD) is an area in which professionals should be specialising. Additionally, in line with the NICE Psychosis with Substance Misuse (PSM) guidelines (NICE, 2011), CMHTs have responsibility for holding the clinical care of service users with substance misuse problems as well as severe mental health difficulties. Ideally, substance misuse difficulties should be systematically identified, assessed and treated. The extent to which current practice deviates from this ideal is unknown, and an audit will be the first step in addressing any shortfalls in provision. As part of the audit, attainment of Trust targets concerning the completion of the AUDIT assessment measure of alcohol use with every client will be assessed. Therefore, the current proposal aims to provide a service level audit offering a clear and up to date picture of:

1. Current rates of reporting substance use and Dual Diagnosis
2. Completion rates of trust recommended 'AUDIT' form (a 50% target for the Trust Quality Indicator was set in 2015 and continued into 2016), as well as drug and alcohol screen and SASS completion rates.
3. The action taken following identification of DD (i.e. support offered and recovery plans relating to additional drug and alcohol needs).

Methodology

The audit broadly comprised of three parts:

1. A review of electronic Patient Journey System (ePJS) clinical records. Demographic information was noted and data was extracted from various tabbed sources that store records of the completion of measures relevant to substance misuse.
2. Based on collated data a judgement was made by the auditor as to whether records indicated historic or current misuse. This was validated by the Promoting Recovery (PR) team's Consultant Psychiatrist and care co-ordinators.
3. For those identified to be currently misusing substances a manual search of 'events' notes recorded on ePJS records for information on support and interventions offered in the past year (January – December 2016).

Results Summary

The audit process confirmed DD as a difficult idea to conceptualise and define. Given the definition adopted for the current project a higher number of DD cases than identified by cluster labels on ePJS was highlighted. Demographics of the DD group are in keeping with literature: higher rates of males and BME groups. This was also in keeping with local demographics given the service location (Lambeth, South London). The completion rates for measures of substance use showed an increase each year (and a trend for this to continue in 2016); however, these were still below targets set by the Trust. The most commonly reported substances are cannabis and alcohol. A range of monitoring and intervention strategies are being carried out within the PR service. However, in keeping with DD literature, a review process could be of value to ensure appropriate matching of interventions to the motivational stage of change of the service user.

Conclusions

This is an initial trial of an audit system (involving one PR team), so conclusions should be interpreted with caution. The findings from this audit suggest that a number of service users who are misusing substances are readily identified from the questionnaire measures completed and recorded on ePJS. However, the number of service users identified as currently misusing substances is higher than the number listed under the DD cluster label, which may need addressing. Speculation as to the reasons for lower than expected completion rates of measures assessing substance use could also be further explored in future projects. The manual search of the events highlight that staff are often actively engaged in a range of interventions aimed at monitoring and aiding management of substance misuse. Further projects could address the reasons that referrals are not being made following discussions with clients. From the current auditors observation the most common reason was that clients refused the support offered. Even when this was the case, continued attempts and encouragement was made. However,

looking into this more rigorously and by including the views of both SU's and professionals would serve as a good future project.

Recommendations

This audit includes recommendations on:

- Recording of substance use - Closer monitoring of substance use measure completion rates.
- Improving service delivery – Revisiting training on the Stages of Change model and appropriate interventions with staff; Making use of team discussions and DD leads more effectively.
- The care plan – promoting multi-agency working and discussing barriers to this
- Suggestions for future projects are also offered as well as possible additions to ePJS (e.g. search terms for CRIS and a tick box option to mark current misuse).

1. Introduction: Background

1.1 Dual Diagnosis

The term 'dual diagnosis' has various operational definitions in different contexts. It has been applied to a number of different groups of people with two co-existing conditions, for example, personality disorder and mental health problems and learning disability and mental disorder (Banerjee, Clancy & Crone, 2002). Of particular relevance to the current project, the term 'dual diagnosis' (DD) has become synonymous with people who have both mental health and substance use problems.

According to the National Collaborating Centre for Mental Health (NCCMH; Megnin-Viggars et al, 2015, pg. 8):

"Dual diagnosis refers to people with a severe mental illness (including schizophrenia, schizotypal and delusional disorders, bipolar affective disorder and severe depressive episodes with or without psychotic episodes) combined with misuse of substances (the use of legal or illicit drugs, including alcohol and medicine, in a way that causes mental or physical damage)".

As a label it is relatively limited, it tells us very little about the nature and the severity of the person's problems, or what kinds of substances and mental health problems they experience (Banerjee et al, 2002; Todd et al, 2004).

The label dual diagnosis also implies that there are only two problem areas, when in fact there are usually several, all of which need addressing. These may include other mental health problems, physical illnesses and a wide range of social problems. It may be more useful to conceptualise this group as having 'complex needs' rather than two distinct problems. For this reason an individualised approach to assessment, formulation, and intervention is crucial.

1.2 Prevalence of dual diagnosis

All mental illnesses, including mood, anxiety, personality, and schizophrenia-spectrum disorders, are associated with an increase in co-occurring substance use disorder compared to the general population (Todd et al, 2004). Research indicates that approximately one third of people who use mental health services will also have a concurrent substance use problem, and about half of people who use addictions services will have a mental illness (Banerjee, et al, 2002). Surveys of people with a diagnosis of schizophrenia or bipolar disorders indicate lifetime prevalence rates for substance use disorders of about 50% (Kavanagh, Waghorn et al, 2004) and rates for current or recent substance disorder in the range of 23-35% (Graham, Maslin et al, 2001). Caution should be taken however, as given the nature of the problem, it is likely that the prevalence figures under-represent the true picture as people are often reluctant to admit their substance use, and not everyone with dual diagnosis is prepared to participate in research interviews nor engage with services. Additionally, how current use is defined (last two weeks, a month, six months, or a year) can vary across studies making the comparison of results from prevalence studies difficult. Demographic characteristics, including race and culture predict differences in type of substance abuse (Mueser et al, 1992), however this too is often overlooked and not differentiated in study findings.

Specific services will show a variance in prevalence rates. Of relevance to the current project, it is reported that for Community Mental Health Team's (CMHTs) 20-30% of clients are likely to have co-existing substance misuse problems (Carra & Johnson, 2009). A review by the NCCMH (2015) reports that severe mental illness (including schizophrenia, psychosis and bipolar disorder) coexists with drug and alcohol misuse in approximately 40% of users of secondary care mental health services. However, although prevalence is relatively high, it is often noted that detection is less so.

1.3 Importance of recognising this group

Overall, people with dual diagnosis are a vulnerable group for whom the outcomes are worse than for other groups of service users under the care of MH services. A number of studies have compared people with dual diagnosis with those with serious mental illness alone. These studies suggest that people with dual diagnosis tend to be single, male and have lower educational and employment attainment, longer inpatient stays and more social difficulties (Kavanagh, Waghorn et al, 2004; Menezes, Johnson et al, 1996). Furthermore, people with a dual diagnosis are more likely than other groups to have contact with the criminal justice system (Theriot & Segal, 2005). Evidence also suggests that these individuals have problems accessing services, will be difficult to engage in services and are also more likely to disengage with services (Mitchell et al, 2007; Crome et al, 2009). Given the high prevalence, poor outcomes (and associated higher costs) and the fact that many people will not be ready to make changes to their current use, numerous attempts have been made to provide better services for people with dual diagnosis (McCrone et al, 2000).

1.4 Assessment, Management and Treatment of dual diagnosis

There now exist several key guidance and policy documents that highlight an evolving awareness of the challenges that are associated with co-morbid mental health and substance use problems. These also promote a drive for the development of services to meet these clients' complex needs. The Mental Health Policy Implementation Guide: Dual Diagnosis Good Practice Guide (DDGPG) (DH, 2002) was the first published policy dedicated specifically to dual diagnosis. It advocates for 'mainstreaming' the care of people with severe mental health problems and problematic substance misuse i.e. that they should not be treated under addictions services unless they have specialist needs. This postulates that that working with people with dual diagnosis, in line with the integrated treatment model, is a core part of the CMHT's work. This approach aimed to avoid service users being shifted between services and falling through the net of care. Hughes and Kipping (2008) report:

"In a review of the progress of the implementation of the National Service Framework for Mental Health NSF-MH (DH, 2005), dual diagnosis was viewed as 'the most challenging clinical problem we face' that requires 'urgent attention' with a broad co-ordinated response including better collaboration between agencies, training in assessment and clinical management, preventative work and prevention of drug misuse on inpatient units."

Closing the Gap, the dual diagnosis capability framework (Hughes, 2006) describes the core competencies required to deliver effective care to people with a dual diagnosis and the NICE Psychosis with Substance Misuse (PSM) guidelines (NICE, 2011) provides recommendations for the delivery of good practise in the assessment and management of service users with a dual diagnosis of psychosis and substance misuse. NICE PSM (2011)

guidelines were reviewed and a surveillance report completed in November 2016, but no amendments were deemed necessary. In 2015 the 'Adult Mental Health' (AMH) model, an initiative developed by SLaM NHS Trust, was started for adults with severe mental illness. It aims to invest resources into community services allowing more effective early intervention for those in crisis. This supports its key objective, which is to reduce relapse rates and the frequency and number of inpatient admissions (essentially moving from bed based to community care) (Bristow, NHS Providers; SLaM NHS Foundation Trust, Strategic Plan 2014-19 summary). Key areas of investment include substance misuse/DD, physical health, carer support/Family Intervention and CBT. As well as investing in additional staff (e.g. full-time psychologist, named DD lead per team), there is also an emphasis on training and staff development in these specialisms.

A number of measures exist to assess and record substance use (those audited in the current project are detailed in Appendix 1). NICE guidance standards (standard 1.2.1) recommend that all healthcare professionals should routinely ask clients with known or suspected psychosis about their use of alcohol and/or prescribed and non-prescribed (including illicit) drugs. Additionally, specifically within SLaM NHS Trust, a quality indicator was set highlighting the importance of completing various measures assessing substance use. Treatment typically follows the Four Stage model (Osher and Kofoed, 1989), which is a framework used within the integrated treatment model. Based on the Cycle of Change (Prochaska and Di Clemente, 1983), the model focuses on the person's internal state of motivation; Osher and Kofoed describe what the health professional should do in relation to each stage in the cycle. It is noted as important to use motivational enhancement consistent with the client's specific stage of recovery (Centre for substance abuse treatment, 2005).

In summary, the current AMH model states that Dual Diagnosis (DD) is an area in which professionals should be specialising. Additionally, in line with NICE guidelines, CMHTs have responsibility for holding the clinical care of service users with substance misuse problems as well as severe mental health difficulties. Ideally, substance misuse difficulties should be systematically identified, assessed and treated. The extent to which current practice deviates from this ideal is unknown, and an audit will be the first step in addressing any shortfalls in provision. As part of the audit, attainment of Trust targets concerning the completion of an AUDIT outcome measure relating to alcohol use with every client will be assessed. Therefore, the current project aims to provide a service level audit targeting three main aims listed below.

2. Aims

The current project aims to provide a service level audit offering a clear and up to date overview of:

1. Current rates of reported substance use/Dual Diagnosis
2. Completion rates of Trust and nationally recommended 'AUDIT' form (a 50% target for the Trust Quality Indicator was set in 2015 and continued into 2016), as well as drug and alcohol screen and SASS completion rates.
3. The action taken following identification of DD (i.e. support offered and recovery plans).

It will also offer service recommendations for ways to improve practise where potential opportunities are highlighted, e.g. encouraging the appropriate use of monitoring and intervention strategies with identified DD service users.

3. Objectives and Standards

The overall project includes both audit and evaluation components. The project is consistent with the general principles of the NICE (2011) guidance to offer psychological interventions widely, with equality of access, and to ensure that the therapy offered is sensitive to particular individuals' needs. The information will assist in service planning for this DD group. It will also provide information on the future development and evaluation of psychological therapies in Lambeth PR ensuring appropriate services are offered in terms of both mental health and substance misuse needs.

Key objectives:

1. To gain a current and accurate representation of rates of substance use in a local PR team.
2. To identify action taken following DD (or current misuse) identification in line with the AMH model.

4. Methodology

Audit approval for the project was granted from the Clinical Governance team within the Psychosis CAG (Appendix 2). This project did not require ethical approval because it did

not deviate from normal clinical practise. This project was not a research study; it entailed operational improvements to the service that would ensure a consistent approach towards all patients. There was no additional burden imposed on, or additional risk posed to service users.

The audit broadly comprised of three parts:

1. **A review of the electronic patient (ePJS) clinical records.**
   Demographic information was noted. Data was extracted from various tabbed sources (see Table 1 below) that store records of the completion of measures relevant to substance misuse. From this information a judgement was made by the auditor, to whether records indicated 'no misuse', 'historic misuse only' or 'current misuse'. A relatively crude definition of 'current misuse' was applied (described below) to make this decision.

2. **Validation of the identified 'current misuse' group.**
   The collated data was checked by the PR teams consultant psychiatrist and relevant care co-ordinators to ensure that service users identified as 'currently misusing' drugs and alcohol were correctly identified as such.

3. **Manual search of 'events' tab on ePJS records**
   For those identified to be 'currently misusing' substances a manual search of 'events' notes on ePJS records was carried out for information recorded on monitoring, support and interventions offered in the past year (January – December 2016) in relation to substance misuse.

4.1 Procedure

The auditor sampled a full caseload (N=180) of the Lambeth NE PR team accessed from the team administrator on 25th May 2016.

A review of the electronic patient (ePJS) clinical records was undertaken over a period of 4 months (June to September, 2016). This involved manual checks and data extraction of:

- Demographic information: service user age, gender, ethnicity and cluster noted
- Completion rates of various measures to assess and record substance misuse (see Table 1).

Table 1: Details of the reviewed measures related to substance misuse

Measure	Information noted	ePJS source
AUDIT	Year completed and score given	Assessment tab
Current Drug and Alcohol Screen	Year completed and the substances listed	Assessment tab
SASS	Year completed and form read through fully for any mention of substance misuse used	Assessment tab
HoNOS	Year completed and score for question 3: Problem-drinking or drug taking	Outcomes tab
Summary of Need	Both of these records were checked in order to ensure all mention of substance misuse was found and noted	Plan/Rev tab
Risk Assessment		Risk/Safeguarding tab

Once all this information had been collated, a decision was made by the auditor, from the information obtained, as to whether the recorded notes for each service user indicated 'no substance misuse', 'historical substance misuse only' or 'current substance misuse', thus creating three service user subgroups. In order to make this relatively crude decision a working definition of 'current substance misuse' was applied. The service user was identified as having problems with alcohol and/or drugs and allocation to the current substance misuse group was made if they met one or more of the following criteria:

- If the AUDIT was completed, a score of 8 or above was considered as indicative of misuse (measure of alcohol intake).
- A score of 2 or above on the HoNoS question 3 was considered as indicative of a problem with drugs or alcohol (relating to drug and alcohol use).
- Risk Assessment and Summary of Need forms were checked to establish whether alcohol or illicit substances were noted as contributing to relapse of mental health.

These scores were taken from the most recently completed assessments, irrespective of the year that they were completed, but at least one of these had to be completed within the last year 2015/2016 to be considered in the 'current misuse' group.

This grouping was subsequently checked by the PR team's consultant psychiatrist in order to confirm the 'current substance misuse' decision made with regards to each service user. The consultant also reviewed the historic misuse group to ensure all opportunities to identify current misuse were given. Where the consultant psychiatrist was unsure, care co-ordinators were asked to confirm.

Once confirmation was complete a subset of service users was identified, namely those for whom current substance misuse was noted from electronic patient records and confirmed by team staff. For this group, further data exploration was conducted by the auditor in which the 'events' tab of ePJS was manually searched for any mention of substance misuse and the health professionals' response to it. This was in order to ascertain any active intervention that could be identified as being offered, discussed, and carried out with this complex group of service users in order to both indirectly monitor and directly address service users' noted substance misuse difficulties. This search was completed in January 2017 as it allowed the auditor to search all 'events' records for the previous year (January – December 2016).

5. Results

5.1: Substance misuse subgroup identification

A total of 180 cases were searched between 25/5/2016 and 30/9/2016. All service users had a mental illness diagnosis. Records of relevant measures targeting assessing substance misuse were reviewed. Based on this data service users were divided into subgroups. Table 2 shows the number of service users by subgroup, highlighting whether they have misused substances historically, currently or both or not at all.

Table 2: Number of service users by subgroup

	Freq.	**%**
No misuse (past nor current) Mental illness only	81	45
Past misuse only Mental illness and history of substance misuse problem	48	27
Past and current misuse Mental illness and co-occurring substance misuse problem	51	28
Total	*180*	*100*

Of the total 180 cases, 20 (11%) were listed under the Dual Diagnosis cluster. Of these 20 cases, 17 (85%) were identified as currently misusing substances, and the remaining 3 (15%) have historical but not current misuse reported.

The total of 51 (28%) cases that were identified from the full caseload as currently misusing substances (see Table 2), suggests that a higher number of service users could potentially be listed under the DD cluster (using the working definition adopted for this project, described in section 4.1 above).

ICD-10 codes indicated that a psychotic disorder had been diagnosed in 63% (32/51) of cases identified with current substance misuse (e.g. F20.0 – paranoid schizophrenia; F29 – unspecified non-organic psychosis; F25 - schizoaffective disorder). Three people (6%) had been diagnosed with bipolar affective disorder (F31). Nine people (18%) had a diagnosis related to their alcohol and/or drug use recorded (both mental and behavioural disturbance due to alcohol use). Four people (8%) had both primary and secondary diagnoses listed in which one related to their

mental health and the other to substance misuse (e.g. F20 - schizophrenia and F10.2 Mental and Behavioural disturbance due to alcohol dependence syndrome; F20.0 schizophrenia and F12.1 – Mental and Behavioural disturbance due to cannabinoids, harmful use). Three people (6%) did not have a specific diagnosis recorded (F99 – mental disorder not otherwise specified).

5.2 Sample Demographics

Demographic information for the full caseload sample (n=180) and subsequent subgroups is presented. For the whole sample, when looking at gender there were no notable differences, with approximately equal rates of male (58%) to female (42%) referrals to the PR team. However, when comparing across subgroups the historic and current misuse groups appear to have a larger proportion of male to female service users (see Figure 1). This is in keeping with prevalence rates in this DD group as identified in the literature (Kavanagh, Waghorn et al, 2004).

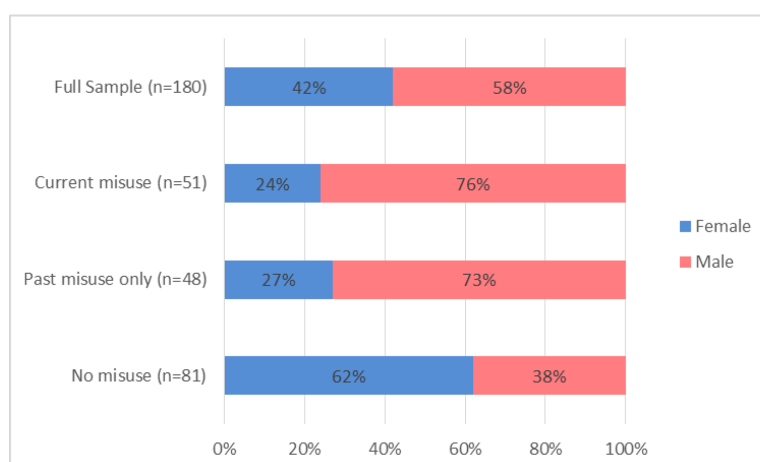


Figure 1: Distribution of service users by gender for each subgroup

The distribution of age of service users in all groups was relatively similar (see Figure 2). It appears from Figure 2 that there are a lot more people in the Current misuse group aged 40-49 years than 20-29 years. However, it is unlikely that this age group is actually using more substances given that the distribution (overall) reflects the distribution of age in the full case load. More probable is that the younger adult age group are picked up and supported by Early Intervention (EI) services, whereas PR services traditionally support the older age groups (above 35 years).

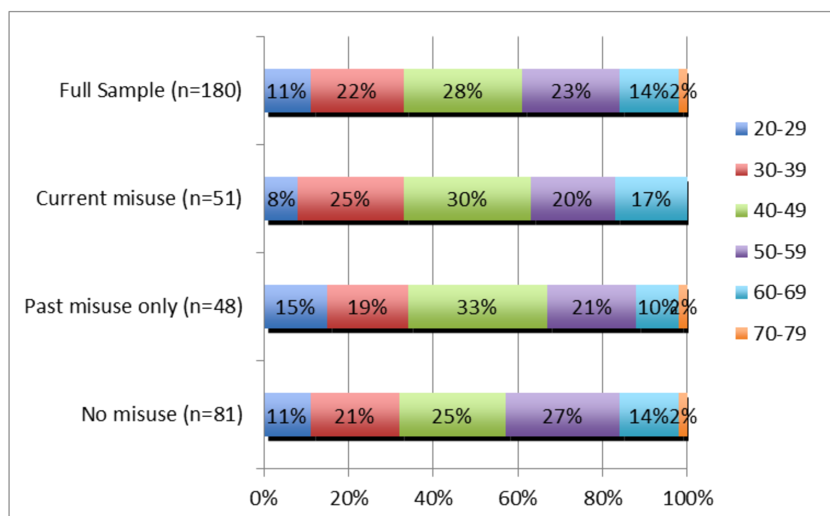


Figure 2: Distribution of service users by age for each subgroup

When comparing the ethnicity of service users across the subgroups there were no notable differences. The pattern seems to indicate comparatively higher numbers of service users identifying as from BME backgrounds than clients identifying as White or Other ethnicities (see Figure 3). This is consistent with previous prevalence studies that report higher rates of psychosis in clients from BME backgrounds (Kirkbride, Barker, Cowden et al, 2008). It is also in keeping with local demographics given the service location (Lambeth, South London; Lambeth Demographic factsheet, 2015).

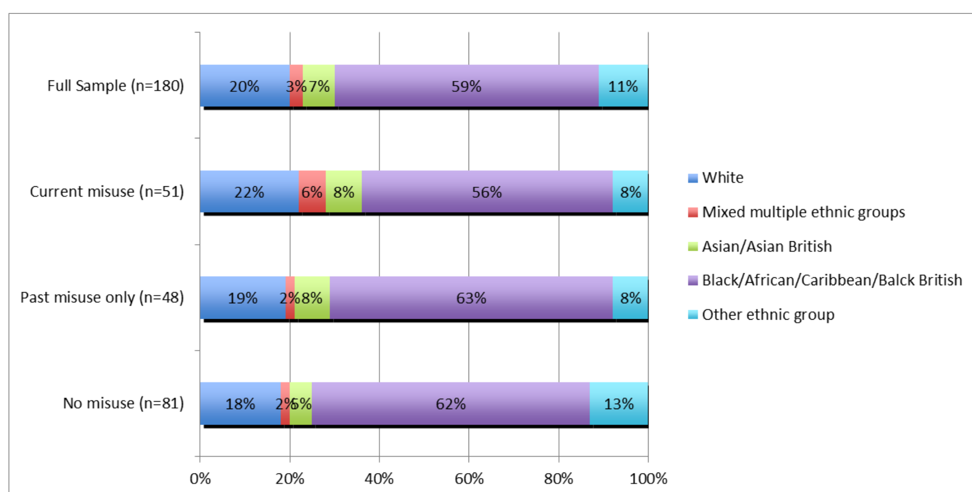


Figure 3: Distribution of service users by ethnicity for each subgroup[2]

[2] Categorisation based on that currently identified for ethnicity surveys in England and wales by The Office for National Statistics (ONS, 2012).

5.3 Completion of measures relating to substance use

Service users' ePJS records were examined to determine whether the key measures that assess substance misuse were completed and if so, the year of completion. It is important to note that for both the full sample and current misuse group these were completion rates as of September 2016 (so it is likely that more were completed post this stage of data collection, making this an underestimate of 2016 completion rates). The following results are valid for the timeframe of this audit. Table 3 displays the number of service users for whom each of the measures that assess substance misuse were completed and recorded within the project time period. The most frequently completed measure was the Drug and Alcohol screen, followed by the AUDIT, then the SASS.

Table 3: Completion rates of measures recording substance misuse for full sample

Measure	Freq completed	% completed
Drug & Alcohol	149/180	83
AUDIT	116/180	65
SASS	75/180	42

Figure 4 presents the proportion of each measure by the year of completion. Of the 116 AUDIT's completed only 26% of these were done so in 2015 and 14% in 2016. Given the completion rates for both 2015 (January-December) and 2016 (January-September) were below 50%, looking more specifically at completion rates within the timeframe set for the Trust quality indicator (April 2015-April 2016) the target of at least 50% was not met. However, for all measures the completion rates showed a trend to increase each year up to 2015. The completion rates for 2016 are lower than 2015; however it is not for the whole year (this stage of data collection was terminated in September, 2016). If we were to double the recorded 2016 rate to predict continued completion for the full year this increase trend would remain for all measures except the SASS.

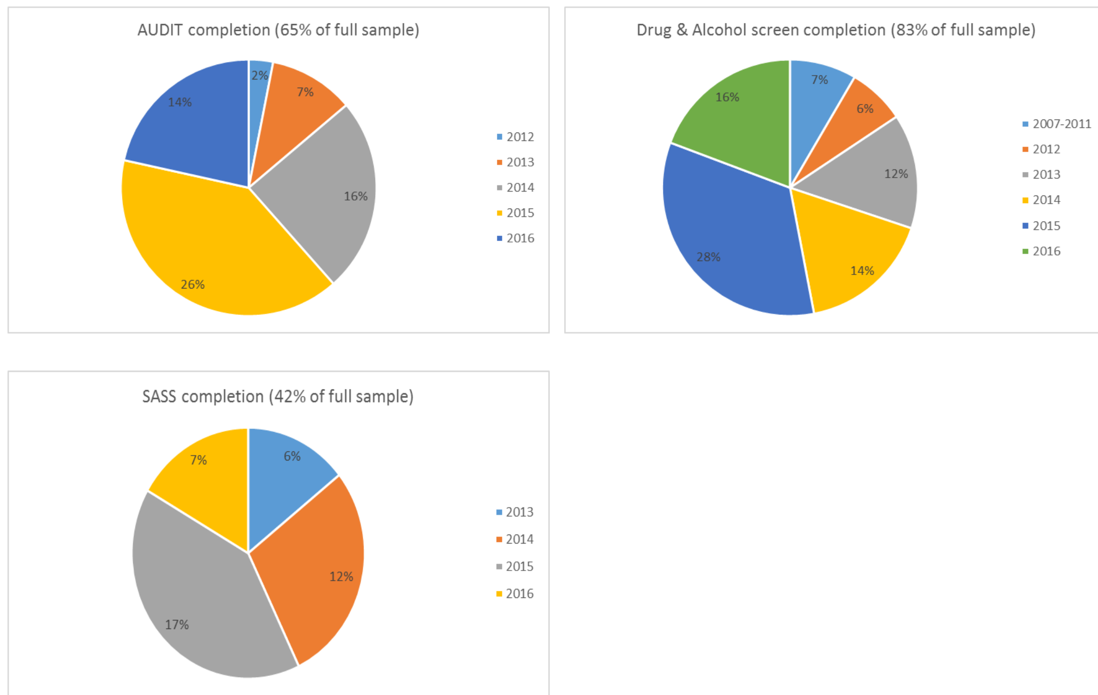


Figure 4: Proportion of measures completed by year

Table 4 shows the same information but for the current misuse group only. Again the Drug and Alcohol screen was more frequently completed and the SASS the least.

Table 4: Completion rates of measures recording substance misuse for current misuse sample

Measure	Freq completed	% completed
Drug & Alcohol	45/51	88
AUDIT	38/51	75
SASS	14/51	28

For this group the completion rates appear to peak in 2015. The Drug and alcohol screen appears the only measure likely to show a trend for increase completion rates into 2016 if the reported 2016 rate is doubled. Both the AUDIT and SASS have much lower completion rates for 2016 and even if doubled to pre-empt end of year completion would not surpass the 2015 figure. Again, the Trust quality indicator target of at least 50% completion from April 2015-April 2016 was not met.

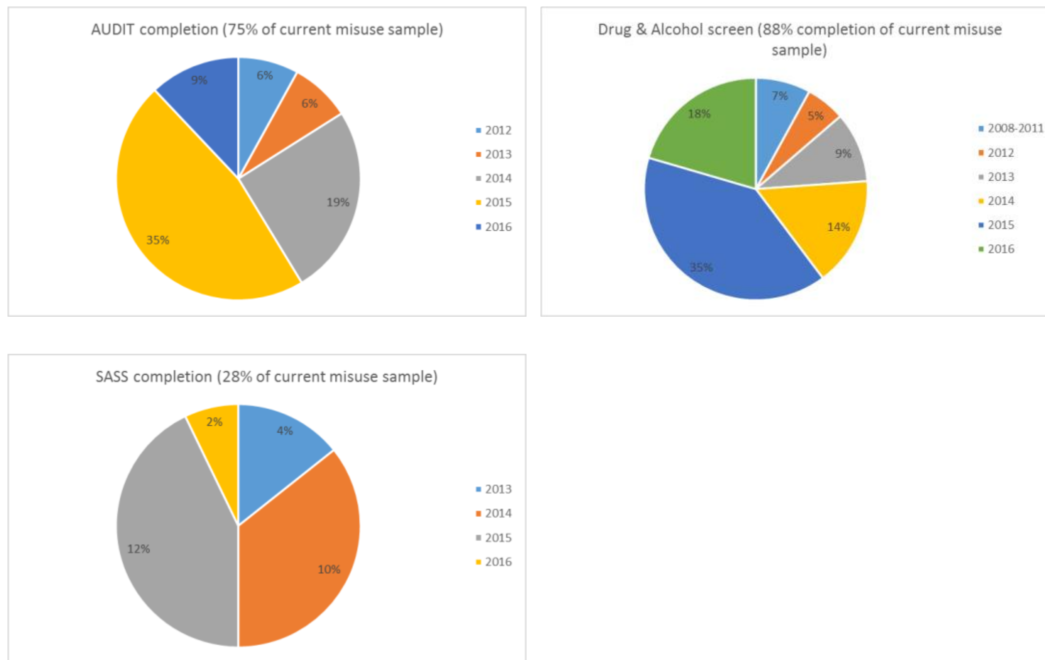


Figure 5: Proportion of measures completed by year

Main findings

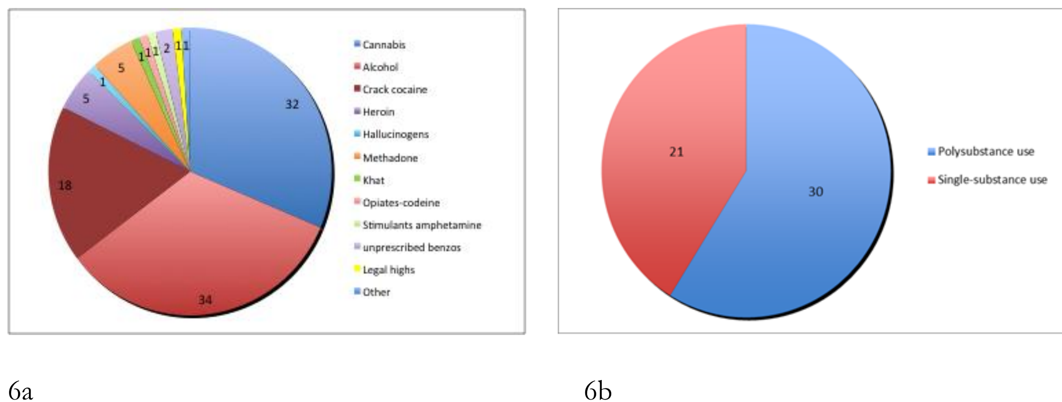
The trust quality indicator set was not met with completion rates for all measures within this timeframe (April 2015-April 2016) below 50%. Positively, in line with NICE standard 1.2.1 service users are being asked about their substance use using a range of measures; however from the dates of completion this may not be being updated as regularly as is expected.

In the current misuse group 33% (17/51) of service users had a 'summary of need' completed in 2015 and 43% (22/51) of service users did in 2016, in which substance misuse was noted.

For the same group, 29% (15/51) had a risk assessment completed that referenced substance misuse in 2015 and this increased to 59% (30/51) in 2016. However, the level of detail in the content of these forms varied greatly. Although there were positive exceptions, most forms stated only that service users use substances and did not provide a clear explanation of how substance use impacts on risk and/or how this should be managed. Therefore, service users are being asked and clinical records made regarding substance misuse; it may just be on varying forms and the type of information recorded may need revisiting.

5.4 Substances listed for the current misuse group only

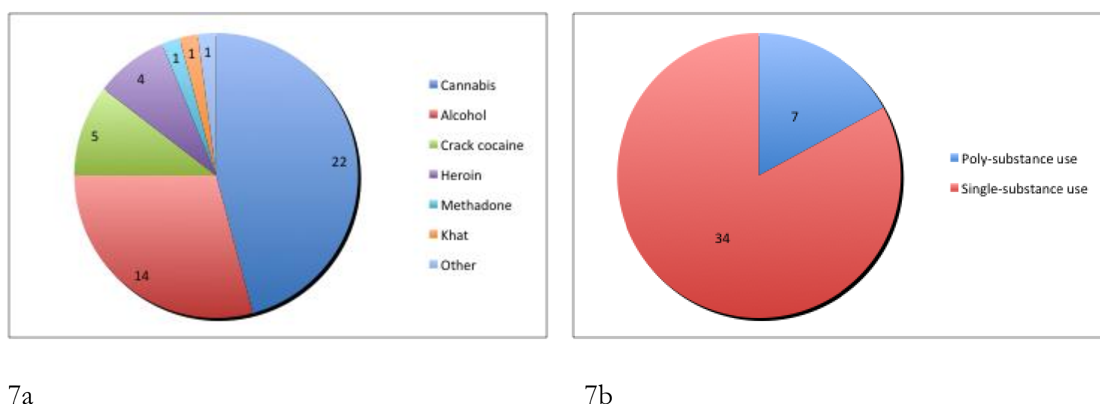
Figure 6 displays the frequency of all substances listed in the Drug and Alcohol screen for the current misuse group. Data are presented solely as numbers. From 6a it is clear that reported misuse of cannabis and alcohol is relatively equal and that these are the most frequently identified substances. Crack cocaine also has relatively high reports of use. 6b displays the frequency of poly-substance use versus single substance use recorded, highlighting single-substance use to be slightly more common overall.



6a 6b

Figure 6: Frequency of all recorded substances for the current misuse group

By comparison Figure 7 displays only the primary substances noted for the current misuse group. From 7a it is clear that cannabis had the highest frequency of recorded misuse, followed by alcohol. Figure 7b highlights that for primary substances the recorded frequency of single-substance use is substantially larger than poly-substance use and of these cannabis was the most frequently recorded single use substance, followed closely by alcohol (frequency ratio 10:12).



7a 7b

Figure 7: Frequency of recorded primary substance use for the current misuse group

5.5 Interventions

Of the 51 service users identified in the 'current misuse' group, 14 (27%) had previous involvement with Drug and Alcohol services.

Table 5 displays the number of service users in the 'current misuse' group who have had some sort of monitoring or active intervention carried out during 2016.

Table 5: Service users in 'current misuse' group for whom some form of monitoring or active intervention is recorded

Intervention period	**Freq**	**%**
Past 3 months (Oct – Dec 2016)	28/51	55
Past 6 months (July-Dec 2016)	38/51	75
Past 12 months (Jan-Dec 2016	47/51	92

From this it is clear that for all but 8% (4 clients) of the current misuse caseload some mention of substance use monitoring or intervention was reported. For the interventions actively engaged in over the last year, I have just marked once if it was engaged in. For some service users there were numerous attempts at discussions regarding misuse noted and for others only one or two attempts. This cannot be differentiated from this data as I have just marked a '1' if this action was undertaken at all with the client. Therefore it can be translated that for X number of clients X intervention was carried out (at least once, possibly more). Table 6 below displays the type of intervention offered and the number of service users in the current misuse group (N=51) to whom this was offered. Appropriate interventions to relevant stage of change were retrieved from information shared at the Pan 5-day DD training within SLaM.

Table 6: Type of intervention offered to 'current misuse' group in relation to substance misuse specifically

Intervention type	Example	Frequency	%
No mention	*No mention in ePJS notes of substance use*	4	8
Monitoring	*Noted observation of use, paraphernalia around home or on person, noted if intoxicated*	23	45
Client directly asked	*Client directly asked regarding use, client did not engage or respond to initiation or denied use, client told or advised to abstain*	9	18
Engagement	*Build trusting relationship, provide outreach, gain permission, practical support, assessment – assess goals and readiness to change*	23	45
Persuasion	*MI, pros and cons, advice shared on harm minimization and risk reduction, psycho-education*	27	53
Signposting	*Information offered regarding drug and alcohol support, discussions of referrals for support groups and 1:1 support*	22	43
Referral made	*Referral for drug and alcohol support made*	2	4
Engaged in active treatment	*Engaged in skills building groups, 1:1 support, psychology, self-help groups, detox, receive methadone script*	8	16
Relapse prevention	*Planning, recovery lifestyle, social support*	3	6
Discussions within CHMT	*Includes discussions of clients substance use in team meeting, CPA review, formulation groups and DD supervision groups*	15	29
Discussed between involved agencies	*Refers to any contact concerning substance use between services involved in client care (e.g. police, hospital, drug services, housing, care-coordinators), external agencies invited to CPA reviews*	28	55
Liaise, meet, discuss with family/friends of client	*Refers to any noted contact between family and friends of clients and professionals concerning substance misuse concerns to any service involved.*	11	22

5.6 In-patient admissions

Of the current misuse group, 15 service users (29%) had recorded IP admissions during the time period reviewed for the audit. Eleven of these were admitted following Assessment under the Mental Health Act (1983), three were admitted informally and one was admitted to a physical brain injury ward following a stroke. According to recorded notes, 12 of these 15 service users (80%) had their substance misuse issues discussed at ward rounds and for three inpatients (20%) there were discussions about engaging with inpatient substance misuse services, although these were not further specified. Occupied bed days ranged from 12 days to 319 days (mean 86 days). Three service users at the time of end of audit data search (January 2017) remained IPs. Additionally one service user presented self to A&E but was not admitted, however notes concerning substance use were documented in this case also.

5.7 Brief Results Summary

Aim	**Audit data**
DD identification in PR team	20 cases (11%) of full caseload listed under DD cluster. Only 17 of these 20 identified with current misuse of substances. 51 (28%) cases from full caseload identified as currently misusing substances given working definition for project. Only 9 service users in the current misuse group (17%) had an ICD-10 diagnosis related to drug and alcohol use recorded and 4 service users (8%) had both primary and secondary diagnosis listed; one related to MH and the other substance misuse.
Sample demographics	DD group demographics in keeping with literature with higher rates of male to female service users (76% to 24% respectively) Majority DD SUs ages between 30-49 years (reflective of the distribution of ages across the service) 56% identify as from BME backgrounds, in keeping with psychosis prevalence studies and consistent with local demographics given service location

Completion of measures relating to substance use. *NICE standard 1.2.1* *Ask service users about use of alcohol and drugs (substances used, quantity, frequency, duration)*	Of the full sample (n=180): 83% (149/180) had the drug and alcohol screen completed 65% (116/180) had the AUDIT completed 42% (75/180) had the SASS completed. For the DD group specifically (n=51): 88%(45/51) had the drug and alcohol screen completed 75% (38/51) had the AUDIT completed 28% (12/51) had the SASS completed. Main substances reported were alcohol and cannabis
Trust quality indicator target: 50% completion of AUDIT measure set for 2015	For the whole sample and investigated subgroups the completion rate was below the target set by the quality indicator (<50%). For the full sample, only 26% of the 116 AUDIT's completed were done so in 2015. For the current misuse DD sample, only 35% of the AUDITs completed were done so in 2015.
Monitoring and active intervention with DD service users	27% (14/51) of the current misuse group had previous involvement with Drug and Alcohol services. For 92% (47/51) of the current misuse group some mention of active substance use monitoring or intervention was reported. A range of interventions was offered covering all stages of change.

6. Conclusions

Working with people with dual diagnosis, in line with the integrated treatment model (DH, 2002), is postulated as a core part of the Promoting Recovery Teams' work. This audit aimed to review the assessing and reporting of substance use and subsequent Dual Diagnosis in a community psychosis PR team. The findings indicate that there are differences in the demographics according to service users' substance misuse history, with a higher proportion of male service users making up both the historical and current substance misuse groups. This is in line with published literature. The higher number of service users identifying as from BME backgrounds is also in-keeping with prevalence studies in the area of psychosis as well as local demographics given the service location (Lambeth, South London).

This is an initial trial of an audit system (involving one PR team), so conclusions should be interpreted with caution. The findings from this audit suggest that a number of clients who are misusing substances are readily identified from the questionnaire measures completed and recorded on ePJS alone. However, the audit appeared to highlight a discrepancy between the number of service users actively listed under the DD cluster label and the number identified with current problematic substance use, with a higher number of service users identified as currently misusing substances from the measures completed than were listed under the DD cluster. This highlights that although awareness and detection of dual diagnosis clients may be accurate, cluster labelling appears to remain an issue and may need more frequent review. This is particularly relevant when considering the financial implication of cluster categories, although this is complicated by the fact that there exists overlap between clusters, often creating confusion for teams as to which category people should be labelled.

Regarding the completion rates for substance misuse measures, positively these were shown to be increasing over the years up to 2015. However, they did not reach the trust quality indicator target of 50%. We can speculate as to the reasons for this. One possibility relates to the number of forms that are available for staff to complete. There exist at least four specific measures assessing substance use (AUDIT, SASS, Drug & Alcohol screen, HONOS) and information regarding this can also be noted on the risk assessment and summary of need, with these measures often covering similar information. These make up only a small subsample of the total number of forms that care co-ordinators are required to complete. This could potentially be overwhelming for staff with multiple demands on their time. We could also hypothesise that staff fail to update a form if they have reviewed it and no changes

are needed, resulting in the form appearing out of date, as no amendments have been made. However to confirm this, staff would have to be spoken to directly. Reviewing the number of forms to be completed, for example, by encouraging staff to complete the AUDIT and at least one other formal substance use measure annually may aid in maintaining updated records of current use. Alternatively, better prompting from the systems (e.g. ePJS) or better use of CPA meetings may also encourage more regular review of the necessary forms. The method for identifying current misuse required at least one of the measures to be completed within the last year. All identified cases were confirmed as correctly identified by the team Consultant Psychiatrist thereby supporting the idea that as long as the form is up to date, one measure may be enough to accurately screen and identify Dual Diagnosis. Therefore, given the success of the method used in the current audit to successfully define and identify current misuse, ensuring one measure is completed and up to date may be reasonable, although this would need further exploration.

Positively, the team hold a lot of knowledge about individuals on their caseload, and appear able to detect and identify those with DD and act accordingly. The manual search of the 'Events' notes highlight that staff are often actively engaging service users in a range of interventions aimed at monitoring and aiding management of substance misuse. It can be speculated, from the interventions offered, that most service users appear in the pre-contemplative or contemplative/preparation stage. However, from the information recorded and audited, this cannot be confirmed, as this information is rarely explicitly stated in clinical notes. Where clients were motivated to make changes to their substance use, the PR team evidenced and reported quick action linking into specialist addictions services, even accompanying service users to first appointments. However, reports of linking in with drug and alcohol services to support service users were not common, and exploring the reason for this is something that could be addressed in future projects. From reviewing the notes, frequent reports of clients refusing to discuss support options or resistance to change were noted. According to Miller & Rollnick (2002) resistance occurs when the worker is using strategies inappropriate to the stage of change of the service user. Discussing and revisiting staff training on stage of change and appropriate use of intervention could help this, as ensuring accurate assessment of motivational state and pitching intervention approaches accordingly is a good way to minimise resistance.

Overall, Care provision was good in respect of:

- A number of service users who are misusing substances are readily identified from the assessment measures completed and recorded on ePJS.
- In line with NICE standard 1.2.1 service users are being asked about their substance use using a range of measures.
- The manual search of ePJS events highlights that staff are actively engaged in a range of interventions aimed at monitoring and aiding management of substance misuse. This suggests that service users are having access to integrated care, as advised by the DH (2002).

There was room for improvement in the areas of:

- Completion of substance use measures. Although service users are being asked about their substance use using a range of measures, the dates of completion are not being updated as regularly as expected.
- The trust quality indicator for a 50% completion rate on the AUDIT measure in 2015 was not met, and this should be completed with every service user.

Key focus for improvement needs to be given to:

- Ensuring training of staff on stages of change and appropriate interventions. In line with AHM intentions, ensuring all staff are refreshed on their previous Level 2 (5 day) DD training and that DD Leads are taking a proactive role in supporting other team members.
- Confronting the challenge of high staff turnover, which exacerbates the above point (However, this is a bigger and wider challenge within the PR services).
- The number of forms that assess substance use often cover the same information and therefore, if possible, they need to be reviewed and simplified which may help improve completion rates. Alternatively, a method of automatically pulling information effectively across forms of ePJS could be beneficial.

7. Limitations and possible future projects

As mentioned above, the results relate to a specific PR team and therefore are not easily generalisable. Methodologically, close attention was paid to carefully defining Dual Diagnosis and current misuse, which was important as similar difficulties noted in the literature arose. Additionally, how to define and code the varying types of intervention reported also proved difficult. To guide the coding of data collated for the audit, appropriate interventions to the relevant stage of change were retrieved from information shared at the Pan 5-day DD training within SLaM. However, attributing certain notes into relevant categories was still relatively subjective and attempts could be made to formalise this in future projects.

Importantly for this audit, conclusions could only be made on the records completed. Therefore professionals may actively be doing more with the client group, but if it was not noted on ePJS it could not be reviewed and included in the audit. Speaking to staff to gain additional information on their work with these service users would help resolve this, however given the relatively short timeframe allocated to project completion and the auditor's limited time in the service this was not achievable for the current audit. However, it may be worth exploring in future projects.

This audit provides a baseline on which to build further investigation. Further projects could address the reasons for low referral rates to drug and alcohol services following discussions with clients. Attention should be given to the additional barriers of having a severe and enduring mental health problem that may make it harder to engage with addictions services. We need to ensure that service structures put in place to assess motivation by specialist drug and alcohol/addictions services (e.g. preference for self-referral and early morning 'first-come-first-served' appointments) do not disadvantage our DD client group and we have collaborative and flexible working arrangements between services.. From the current auditors observation, the most common reason was that service users refused support offered. If this is the case then not referring seems entirely appropriate given the stage of change of the service user. However, from the events notes on ePJS it often appeared that continued similar engagement attempts were made by staff, despite these potentially getting similar resistance responses. Exploring this more rigorously by including the views of SUs and professionals would serve as a good future project to expand our understanding of this barrier to engagement. Finding out more about the client's preconceived ideas about psychological support for substance misuse or the support provided by substance misuse services may also help reduce resistance and add valuable information to why some service users are reluctant to engage with services. Additionally, as service user refusal appears a common and consistent difficulty across service users and noted by staff, it may be

sensible to raise and explore this at a team formulation group. These groups are often run by DD Leads within teams whose role within the AMH model is to support and guide the wider MDT on DD issues. This would provide validation that this is a shared difficulty as well as allowing a platform to re-train staff on appropriate intervention methods.

8. Recommendations

Results were shared with both Lambeth and Southwark DD leads as well as with the PR team psychologist and DD lead for the CMHT in which the audit was conducted. Outcomes from the latter meeting were fed back to the wider PR team in which the audit was completed and suggested recommendations from all parties are detailed in Table 8 below. Findings from this audit will be reviewed by the policy lead and the CAG leads for dual diagnosis in Psychosis. Recommendations and action plans will be made for all areas highlighting areas for improvement with agreed action plans.

Table 8: Recommendations in response to key findings from the current audit

Aims and Outcomes	Recommendations	Suggested by
DD identification in PR team.	Ensure cluster noted is monitored and up to date (supported and encouraged by team DD lead).	Team psychologist and DD lead
Higher number of service users identified as DD than listed under the DD cluster	Inclusion of tick box on ePJS to easily mark if service user's substance abuse is historic or current	Auditor
Completion of measures relating to substance misuse was lower than expected	Closer monitoring and updating of substance use measures – annually or bi-annually. This could be aided in a number of ways: 1) with the use of CRIS; 2) with better prompting from systems highlighting when forms need reviewing or 3) better use of CPA meetings.	Team psychologist and DD lead
	Reduce or limit the number of forms assessing substance use to be completed, particularly when covering the same information	Auditor

Trust quality indicator not reached	Closer monitoring of AUDIT measure. Ensure completed with every service user and updated at least annually	Auditor
Various monitoring and intervention strategies identified for DD SUs Although repeated engagement attempts noted by staff, these often continue to be met with resistance	Praise and encourage staff to maintain positive efforts with engaging service users. May be beneficial to recap on stages of change and appropriate use of intervention, as well as appropriate strategies. Do so in team discussion or using formulation group	Auditor Auditor
Unsure of reasons for low completion rates of substance use measures or reasons for minimal referrals made to Drug & Alcohol services	Exploring the views of SUs and professionals to expand our understanding of the barriers to engagement. Finding out more about the client's preconceived ideas about psychological support for substance misuse or the support provided by substance misuse services	Auditor Auditor
Other	Following the manual data search undertaken for this project, recommendations for search terms for CRIS that may speed up the search of ePJS records if a similar audit were to be repeated have been provided (see Appendix A).	Auditor and Team Psychologist

9. Dissemination and Leadership

Following an invite from the Trust's dual diagnosis lead (Dr Cheryl Kipping), preliminary results on sample demographics and recorded frequency of substance use from this audit were presented at the DD leads day in psychosis CAG on 21st September, 2016. Following this a request was made to share this presentation with Doctors of other PR teams to use as a template to inform and direct future audit projects, as other PR teams expressed interest in conducting a similar audit. An additional request was also made by the trust DD lead to write the current audit up using the SLaM psychosis CAG audit template in order for it to be published on the DD SLaM page for trust wide dissemination.

The complete project findings were presented to the specific NE PR team in which the audit was conducted. This was to inform them, specifically, of the DD clients identified who may need additional support and increased attention in this area, as well as commending their excellent efforts in managing these cases. In addition, specific to the PR team through which the audit was conducted, a password-protected spreadsheet was shared with their team leader, team psychologist and DD lead. This presented a list of service users identified as DD, the stage of change they appeared at based on the reported intervention currently being offered to them, a list of clients currently engaged in drug and alcohol support and type of support received, as well as a list of all the substance use support services being mentioned to clients. This was hoped to have more direct clinical benefit from the project.

Building on the recommendations of this audit, a second service evaluation project is currently being undertaken that is looking into the feasibility of using CRIS as a search tool for DD prevalence. This is being carried out within the START Homeless Outreach Team that works with entrenched rough sleepers in Lambeth and Southwark, who are homeless because of severe mental health problems. Plans around combining the findings from these two projects, once the second is complete, in order to write up for publication are in discussion.

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Appendix 1

HoNOS

The Health of the Nation Outcome Scale (HoNOS) is an assessment and outcome measure. In 1993 the UK Department of Health commissioned the Royal College of Psychiatrists' Research Unit (CRU) to develop scales to measure the health and social functioning of people with severe mental illness. The initial aim was to provide a means of recording progress towards the Health of the Nation target 'to improve significantly the health and social functioning of mentally ill people'. Development and testing resulted in an instrument with 12 items measuring behaviour, impairment, symptoms and social functioning (Wing, Curtis & Beevor, 1996). The scales are completed after routine clinical assessments in any setting and have a variety of uses for clinicians, researchers and administrators, in particular health care commissioners and providers. The scales were developed using stringent testing for acceptability, usability, sensitivity, reliability and validity, and have been accepted by the NHS Executive Committee for Regulating Information Requirements for entry in the NHS Data Dictionary. The scales also form part of the English Minimum Data Set for Mental Health. The use of HoNOS is recommended by the English National Service Framework for Mental Health and by the working group to the Department of Health on outcome indicators for severe mental illnesses.

AUDIT

The Alcohol Use Disorders Identification Test (AUDIT) is a 10-item screening tool developed by the World Health Organisation (WHO) to assess alcohol consumption, drinking behaviours, and alcohol-related problems. Patients should be encouraged to answer the AUDIT questions in terms of standard drinks. A chart illustrating the appropriate number of stand drinks in different alcohol beverages is included for reference. A score of 8 or more is considered to indicate hazardous or harmful alcohol use. The AUDIT has been validated across genders and in a wide range of racial/ethic groups and is well-suited for use in primary care settings. Detailed guidelines about use of the AUDIT have been published by the WHO and are available online: http://whqlibdoc.who.int/hq/2001/wo_mds_msb__01.6a.pdf

Current Drug and Alcohol Screen

This is a standalone assessment measure that records the substances a client uses as well as the frequency of use. The form requires the following sections to be completed by a member of the care team: summary of drug and/or alcohol use (including type, route and frequency), when

substance/s last used including a 5 day summary, physical complications, psychological complications and social complications. Recently some changes have been made with a view to make this form more user friendly and more comprehensive. Additional questions have been added to the form (e.g. ' does the service user view use as a problem? Yes/No/Unsure'). It is hoped this will provide a guide on whether care planning should focus on harm reduction or working towards reduction/linking with Substance Misuse service.

SASS

This is an assessment tool specific to SLaM that is used in the A&L and Home Treatment Teams. It was first developed in Southwark and the plan was for it to be rolled out across the whole of SLaM. This tool records the reason for referral, biographical information, mental health history, Risk assessment, Drug and Alcohol use (as described above).

Summary of Need

This tool is specific to SLaM. It records information concerning the client's mental health (e.g. client's feelings as well as symptoms), Physical Health, Relationships (considering isolation, family stress/illness, problems with neighbours, discrimination etc.), Occupation and Education (e.g. client's strengths and interests to obtain full time employments where appropriate), Activities of daily living, Accommodation, Finance, Ethnicity/Culture/Diversity, Drug/Alcohol use, Religion/Spirituality/Guiding Values, Child need and Risk, Risk and Fair care access. It includes the Drug and Alcohol section (as mentioned above) as a way of prompting staff to consider this when preparing for CPA reviews.

Risk Assessment

This tool is specific to SLaM. It requires the completion of the following: an overview of Parent/Carers views of current risk, answers to a number of questions of violence and aggression, answers to questions on suicide (e.g. past attempts, suicidal thoughts, intent), answers to questions on self neglect, answers to questions on other risks (e.g. wandering, cultural isolation), answers to questions assessing the service user's environment, precipitant and triggers to mental health, protective factors and a brief case formulation section.

Appendix 2

Recommended CRIS search terms:

Drugs

Alcohol

Substance use/misuse

Illicit substance

Cannabis

Alcohol

LHH

Addictions

UDS

Intoxicated

Rehab

Dependency

Abstain

Drug abuse