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Kent Journal of Psychiatry

Dedicated to Psychiatry trainees and trainers

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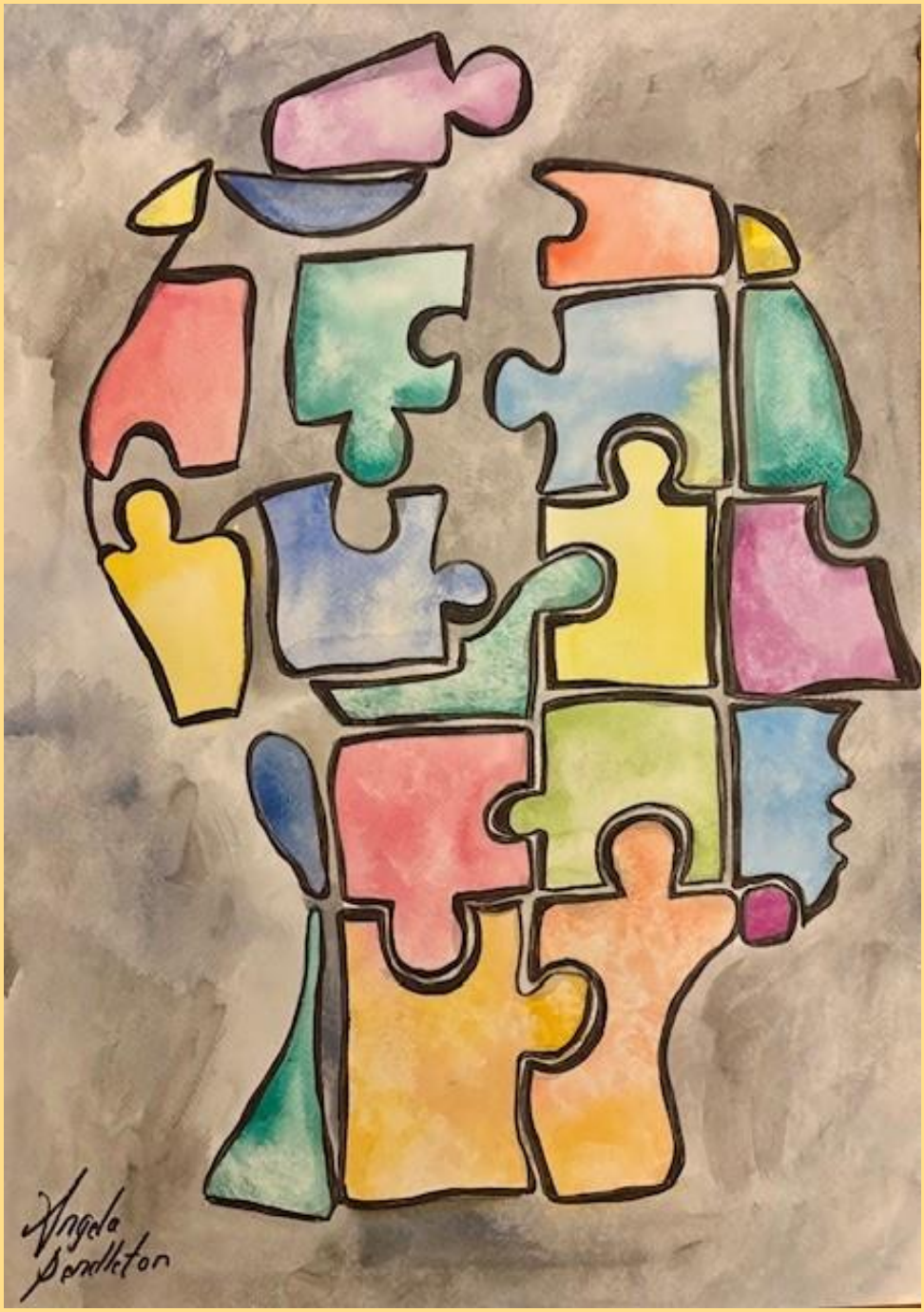

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Kent Journal of Psychiatry is a psychiatric journal with emphasis on the publication of research by psychiatry trainees and their mentors. This traditional source of new medical knowledge is under pressure due to the logarithmic growth of journal submissions; this journal attempts to redress this balance.

The editors will offer support to young authors in the presentation of their findings. This is followed by rigorous peer reviews. The procedure will enable the journal to fulfil a valuable educational and developmental role in addition to presenting high-quality research to a wider readership.

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Editorial

Welcome to the first edition of KJPsych in 2025. This issue explores a diverse array of compelling themes in psychiatry, thoughtfully presented by dedicated psychiatry trainees working across various organisations in the UK.

Our featured articles delve into critical topics such as the factors influencing the efficacy of Eye Movement Desensitization and Reprocessing (EMDR), the decline in Lithium prescribing and its underlying reasons, the complexities of diagnosing dementia in acute care settings, and a quality improvement initiative for a single point of access service for community referrals. Additionally, we shed light on the emerging threat posed by serial code manipulators.

With heavy hearts, we also remember our esteemed colleagues who are no longer with us. Jinny Macdonald, one of our cherished editors, passed away last year, leaving an indelible void in our community. As we were still mourning her profound loss, we also bid farewell to Prof. Tony Hale, an eminent member of our advisory board and a mentor to many. We extend our heartfelt condolences to their families and loved ones, and we honour their remarkable contributions to the field of psychiatry. May their souls rest in peace.

Factors that impact on the efficacy of EMDR:
A systematic review of the factors associated with increased efficacy of EMDR as a trauma treatment in adolescents

Charlene Amey & Julio Vaquerizo Serrano

Abstract

Background

Current UK NICE guidelines (NG 116; 2018) advocate the use of both trauma-focused CBT (TFCBT) or Eye Movement Desensitisation and Reprocessing (EMDR) therapy for the treatment of psychological trauma in adolescents; TFCBT should be first line and EMDR offered only where there is non-engagement in or TFCBT is unsuccessful. This is due to the comparatively greater number of studies evidencing TFCBT's efficacy in adolescents. This systematic review sought to identify any factors indicative of a preferential response to EMDR as a modality in adolescents.

Methods

Multiple relevant databases were searched in 2022 and 2024, via Clarivate Web of Science, to identify suitable studies of adolescents aged 12-17 years old, inclusive, that offered a direct comparison of manualised EMDR with another manualised trauma therapy e.g. TFCBT. Quality assessment tools used were the Cochrane Risk of Bias tool or the Newcastle-Ottawa Quality Assessment Scale.

Results

2 studies met the strict inclusion criteria, incorporating 97 participants. Results from both studies showed favourable results of EMDR relative to TFCBT or TAU in symptom reduction and efficacy of therapy. The studies, though heterogeneous, evidenced the relative clinical efficacy of EMDR for both sexual trauma and psychological trauma post-environmental events.

Discussion

This study focused on 12-17 years old, reviewing therapeutic modalities for varied types of psychological trauma, across different cultures, countries and languages. It made direct comparisons of EMDR and TFCBT. Many studies were excluded due to participant age, or lacking a manualised EMDR protocol or therapeutic comparator. Research is needed to compare manualised EMDR with other manualised modalities to inform guidelines and clinicians.

Introduction

Eye movement desensitisation and reprocessing (EMDR) therapy is an empirically validated psychotherapy for psychological trauma [1] introduced by Francine Shapiro in 1989. EMDR utilises multiple well-established psychotherapeutic techniques such as mindfulness, resource development, imagined exposure, identifying core beliefs, cognitive appraisal of the trauma, desensitisation, cognitive change, and accessing adaptive memories [2].

It has eight recognised phases:

1. client history: general history and development of a treatment plan;

2. preparation, including psychoeducation and resource development;
3. assessment in which an image of the target memory is accessed, negative cognitions and desired positive cognitions are identified, the validity of the positive cognition is rated, the emotions accompanying the memory are identified along with a rating of the subjective units of distress (SUDS) and the location of the physical bodily location of the distress;
4. desensitisation where the target memory and all related channels of association are processed towards an adaptive resolution;
5. installation of adaptive memories;
6. body scan to detect any residual somatic disturbance that can then be reprocessed;
7. closure;
8. re-evaluation of past, present, and future [3].

EMDR aims to remember, rather than re-experience so that adaptive responses to the trauma can be made in the present. It works on both explicit narrative memories that can be brought to conscious awareness and implicit, non-verbal, somatic memories. As such, it can be used to treat traumas where the client cannot consciously recall the details of what happened for example where they may have been under the influence of drugs during or post medical procedures, or where the trauma occurred before language was fully developed [4].

In the UK, NICE guidelines for the treatment of post-traumatic stress disorder (PTSD) and trauma symptoms in adults state that EMDR can be offered first line for symptoms between 1-3 months post-trauma where the client expresses a preference for EMDR over trauma-focused cognitive behavioural (TF-CBT) therapies. Alternatively, EMDR can be offered first line, for a non-combative trauma, where the trauma was experienced over 3 months ago [5].

However, for children and adolescents, current NICE guidelines state that EMDR can be offered to young people aged 7-17 only after they do not respond to or engage with TF-CBT interventions and where the trauma is over 3 months ago [5].

Historically, cognitive behavioural therapy (CBT) studies have been considered more robust than EMDR studies with a more standardised protocol and often a greater number of CBT therapists in the study relative to EMDR-trained therapists [6].

Unlike trauma-focused CBT, EMDR does not require the participant to complete homework in between sessions, nor to “re-tell” the trauma narrative in detail to the therapist which some young people find challenging. Arguably EMDR may offer a shorter duration of treatment [7] and hence quicker symptom resolution and increased cost-effectiveness than TF-CBT; however, evidence has been inconsistent [8], though EMDR was noted to give further symptom improvement at 3 – 12-month follow-up [7].

What is not clear is which young people may not respond to or engage with TF-CBT, or those who may show a preferential treatment response to EMDR over trauma-focused CBT.

This paper seeks to review the evidence to identify which adolescent population groups or individuals may show a preferential treatment response to EMDR over TF-CBT. We also looked to review the evidence to see if we could alternatively identify any trauma types that may be more likely to respond better to EMDR, e.g. single versus multiple traumas and whether the nature of trauma was environmental, war-related, accident, abuse, developmental etc.

Method

Clarivate Web of Science was used to access multiple relevant databases. A search for relevant literature was conducted using the following search terms: *"Eye movement desensitisation and reprocessing"* (wildcard used to capture both UK and USA spellings); *"adolescent*"* (8 to capture adolescence, adolescent, or adolescents); *"youth", "child"; "young people"; "youth"; "teenagers"; "jeuvenilles"; "paediatric"; "school age"; "trauma*"* (* used to capture post-traumatic, traumas, traumatic and plurals; "PTSD"; "post-traumatic stress"). This search was conducted on 4th April 2022 and repeated on 4th April 2024 to update and include any more recent papers.

We looked to include randomised controlled trials (RCT), clinical trials, case-control studies, case studies, cross-studies, and longitudinal studies, with a comparator to EMDR.

Our inclusion criteria were:

a) Studies utilising the 8-phase EMDR protocol in 12–18-year-olds;
b) published in English;
c) measuring trauma-related symptoms or if meeting the threshold for a trauma-related diagnosis;
d) including a comparator, e.g. an alternative therapy or different type of participant or different type of trauma.

We excluded studies if:

a) they did not include the full 8-phase protocol;
b) they were not published in English;
c) participants were outside the age range of 12-18 years old;
d) the authors did not report on trauma symptoms;
e) were measuring outcomes not related to trauma.

Once the final papers were selected for inclusion as per the PICO criteria [9], the papers were read in full and any relevant data to the research question was extracted and recorded in a spreadsheet database.

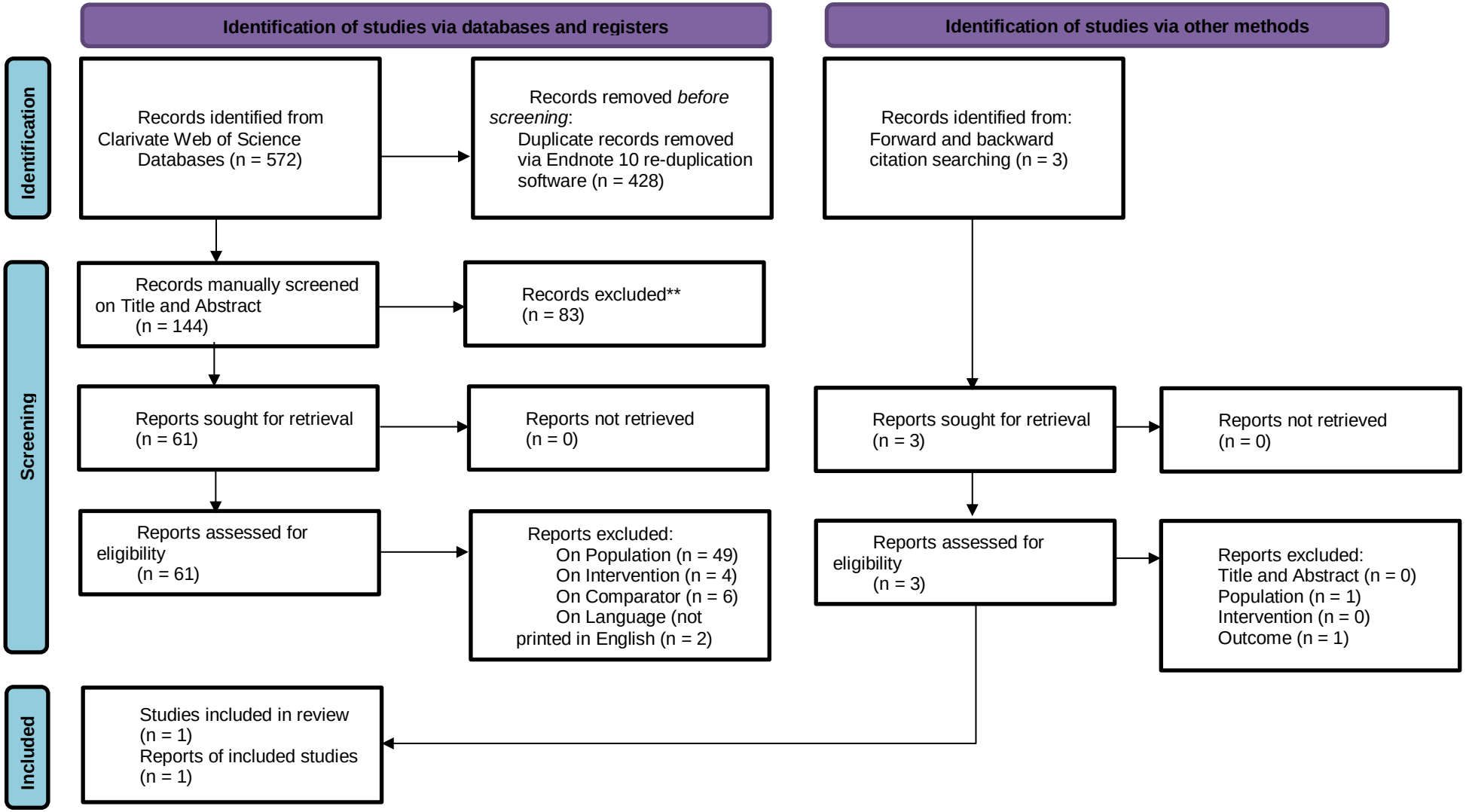
Data extracted from the final selected studies included:

- first author and year of publication;
- name of the study;
- design of the study;
- setting;
- country;
- topic investigated;
- design;
- diagnosis of patients;
- participants' sociodemographic characteristics, (e.g., age, sex, ethnicity, location, education);
- participants' clinical characteristics, (e.g., use of medication, trauma history, current and past diagnoses of mental disorders, levels of post-traumatic stress, anxiety, and depression, living difficulties, well-being, quality of life, emotional/psychological distress, functioning, other interventions for mental health, concurrent additional therapy pharmacological or otherwise); if a comparison group was present, (if so what this consisted of);
- type of trauma being treated, (e.g. single trauma, multiple trauma, complex trauma, war trauma etc.);
- symptom scale used;
- any other factors noted by the authors;
- key findings;
- quality assessment.

The quality assessment of included studies was either the Cochrane Risk of Bias tool [10] for randomised control trials, or the Newcastle Ottawa Quality Assessment Scale [11] for case-control studies.

Results

Figure 1. PRISMA 2020 flow diagram for new systematic reviews which included searches of databases, registers and other sources



Source: Page MJ, et al. BMJ 2021;372:n71. doi: 10.1136/bmj.n71. For more information, visit https://www.prisma-statement.org/
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Table 1: Included Studies

Study Title	Authors	Year	Location	Study Type	Final Number of Participants	Age of participants in years	Sex of participants	Co-morbidities	Trauma Type	Number receiving EMDR	Control Group Intervention	Measures Used	Mid or post intervention Drop Outs
A Comparison of CBT and EMDR for Sexually-abused Iranian Girls	Jaberghaderi, N. Greenwald, R.* Rubin, A. Oliaee Zand, S. Dolatabadi, S.	2004	Iran; outpatient setting	RCT	14	12-13 inclusive Mean ages not specified	Entirely female	Not recorded	Single and multiple sexual trauma	7 (ie 50%)	CBT (skill management of symptoms and exposure	CROPS; PROPS; Rutter teacher scale	0
Eye movement desensitization and reprocessing for treating psychological disturbances in Taiwanese adolescents who experienced Typhoon Morakot	Tang, T. C. Yang, P. Yen, C. F. Liu, T. L.	2015	Outpatient though in-school setting	Case control	83	12-15 inclusive Mean age 14.24 EMDR group; Mean age 14.48 TAU group	34 male 49 female EMDR group 19 male 22 female TAU group 15 male 27 female	Not specified though participants included if PTSD or Major depressive disorder or Moderate/ high Suicide risk	Environ mental Trauma	41 (49%)	TAU: Weekly group psychoeducation	C-IES-R MASC-T CES-D	0

From our database searches, we initially identified 572 potential papers. After de-duplication using reference management software, this was reduced to 144. These 144 were manually screened on title and abstract. A further 83 were removed, leaving 61 papers to be read in full. Of these 61:

- 49 were excluded on population, (often because they included children under 12 or adults over 18),
- four on intervention, (for example not using the standard 8-phase EMDR protocol but a model combining EMDR with another intervention, e.g. MASTR [12]),
- six for not having a comparator,
- two because they were not printed in English.

Following a backward and forward citation of the included papers, we retrieved a further three possibly eligible papers. The same process was repeated, and one was excluded on population [13], as it included children under 12, and one was excluded on outcome [14] since it was a research proposal which did not have data at the time of writing.

Two studies met our final research criteria of only including participants aged 12-18 inclusive, having the full 8-phase EMDR protocol and having a direct comparator, of either CBT [15] or psychoeducation [16].

Characteristics of included studies

A total of 102 participants were enrolled. In the first study [15] 19 participants were enrolled; however, only 14 remained until the end of the study with equal dropouts over both the intervention and control groups. A total of seven participants received EMDR.

In the second study [16], 97 participants were recruited, and of these, 41 received EMDR and 42 received psychoeducation as treatment as usual. There were no dropouts in either group.

The combined age range of the studies was 12-15 years. The first study only included females. The second study had a sample composed of 34 males and 49 females, though found no difference in the distribution of sex between the EMDR (19 male, 22 female) and control (15 male, 27 female) groups ($\chi 2$ 2.90, $p = 0.33$). The number of EMDR sessions varied between four and eight sessions.

Both papers were concentrated in one country each, Iran [15] or Taiwan [16]. The first did not explicitly report recording of any mental health co-morbidities other than using the Rutter Teacher Scale where teachers can record problematic behaviour including: hyperkinetic behaviours, antisocial externalising behaviours, internalising difficulties, relationship problems, and dysfunctional habits [15] though did not report the breakdown of these difficulties. The second [16] included children defined as having any diagnoses of PTSD, moderate depressive disorder, or moderate or high suicide risk on the MINI-KID as the researchers wished to capture all psychological disturbance in adolescents related to experiencing typhoon Morakot. The authors did not breakdown how many participants were respective to each diagnosis.

Risk of bias

For the first study [15] we used the Cochrane Risk of Bias Tool (see supplementary document Table W), which showed a low risk of bias. For the second study [16], which was a case-control, we used the Newcastle Ottawa Quality assessment tool (see supplementary document Table X). We awarded this study eight stars, indicating it was a “good to high-quality study”.

Synthesised findings

Both studies investigated the use of EMDR exclusively in adolescents. Jaberghaderi et al. investigated its use following sexual abuse. The sample used was girls aged 12-13 years [15]. Tang et al. reached their conclusions using EMDR in youth who were exposed to an environmental event, reporting data on boys and girls aged 12-15 years [16].

Jaberghaderi et al findings

For this study [15], 19 girls were selected to participate based on:

- having scored 19 or higher on the Child Report of Post Traumatic Symptoms (CROPS) indicating a clinically significant level of post–traumatic symptoms;
- having endorsed being sexually abused via the Lifetime Incidence of Traumatic Events checklist, and
- having undergone a structured interview that determined they had experienced a qualifying sexual abuse experience (unwanted oral, anal, genital or breast contact with another person occurring six months or more prior to the study).

All the participants were in the same socio-economic group (de facto by attendance at the same school) and all lived with their biological parents. Participants were randomly assigned to either EMDR or CBT treatment group; however, blocking and randomisation took place to promote equivalence between groups, e.g. to equally distribute experiences of penetration, a single abuse experience, or incest (two in each treatment group).

All participants had at least six months since the trauma and follow-up measures were completed at the end of the intervention, which was within three months of start of treatment for both conditions.

The pre- and post-intervention measures used were the Child Report of Post Traumatic Symptoms (CROPS); the Parent Report of Post-traumatic Symptoms (PROPS); the Persian version of the "Rutter Teacher Scale", and the Subjective Units of Distress Scale (SUDS).

Each intervention group was offered up to 12 sessions of either CBT or EMDR for the trauma related to the sexual abuse. Treatment was terminated if the SUDS went down to between 0-2 for the abuse memory. For CBT, one participant had 10 sessions, one had 11, and the remaining five had 12 sessions of which three had to be referred for ongoing treatment after the study. The 12 CBT sessions were complete. For the EMDR group, two had four sessions, one had five sessions, one had six sessions, and three had eight sessions. Zero EMDR participants required referral for ongoing treatment after up to eight EMDR sessions. The pre-intervention demographics between the groups were very similar and there was a final group size of seven in each group after dropouts, (one from each group had started treatment, the other dropouts occurred prior to treatment starting).

Jaberghaderi et. al. [15] found on paired samples t-tests that there was a significant improvement on the CROPS post-EMDR ($p<0.05$), though not for post-CBT ($p=0.116$); however, the difference in improvement between the groups (analysis of covariance) was not significant. Both the EMDR and CBT groups improved significantly ($p<0.05$) on the PROPS and Rutter scales (paired samples t-test) but again the difference in improvement between the groups was not significant on analysis of covariance with pre-test scores serving as the covariate. The effect sizes of the change from pre-test scores to post-test scores were large for both the EMDR and CBT groups in the CROPS and PROPS (suggesting large clinical significance) and medium for both interventions on the Rutter scale.

The authors then reported on the significance of their findings with reference to clinical significance by looking at how many participants in each intervention moved from a clinically significant score for each measure to a score that would indicate they no longer met the clinical threshold for a disorder. All 14 participants across both groups were deemed to have pre-intervention CROPS scores in the clinical range. At post-intervention, two CBT participants and three EMDR participants shifted below the clinical range. For the PROPS, five in each group were deemed in the clinical range pre-intervention. Post intervention, four of the EMDR group shifted into the non-clinical range but only three of the CBT group did. As for the Rutter scale: in the CBT group, the two that scored within the clinical range pre-intervention shifted to non-clinical post-intervention, but in the EMDR group of the two that

were in the clinical range pre-intervention, only one shifted to the non-clinical range post-intervention. However, the authors noted that this participant had the worst pre-intervention score of all participants in the study and showed the greatest change between pre- and post-intervention scores (of 33 to 15) across all participants, indicating a strong effect of the intervention. Overall, it appeared that a greater number of participants in the EMDR group shifted to non-clinical scores post-intervention than did those in the CBT group.

The authors also calculated the reliable change index (RC) by dividing each participant's pre- and post-intervention change score by the standard error or measurement. If the RC exceeded 1.96 the change was considered unlikely to be due to imprecise measurement. For the CROPS, all seven of the EMDR participants, and four of the CBT participants, met this criterion. On the PROPS, five of seven EMDR participants, and six of seven CBT participants, had RCs more than 1.96. For the Rutter Teacher scale, four of seven EMDR, and four of seven CBT participants, met this criterion.

The dropout rate in both interventions was equal so there was no differential acceptability of one treatment over the other with respect to EMDR or CBT. Nonetheless, with regards to efficiency, the mean number of sessions required by EMDR participants was 6.1 whereas it was 11.6 for CBT, and this difference was statistically significant $t = 7.1$, $df = 12$, $p = 0.000$). Hence the mean change per session was greater for EMDR across all 3 post-intervention measures. The authors also noted a trend, though not statistically significant, of post-intervention self-reported symptoms favouring EMDR over CBT.

Tang et al

In this study [16], 271 male and female participants aged 12-15 were diagnostically interviewed based on DSM-5. Of these, 97 were identified as having PTSD, or having a major depressive disorder or having a current moderate or high suicide risk related to Typhoon Morakot. Of these 97, 83 gained parental consent and remained in school to complete the interventions.

Participants were allocated to either four sessions of EMDR (41 participants) or Treatment as Usual (42 participants), which consisted of four to six, structured, 40-minute sessions of a weekly psychoeducation group. This intervention followed a devised programme comprising the installation of hope, education about symptoms of PTSD and depression, and encouragement to verbally express distress and ask for help where needed. Both interventions targeted trauma symptoms related to Typhoon Morakot to reduce disaster-related anxiety, generalised anxiety or depressive symptoms.

Both interventions in this study commenced three months after the typhoon. The follow-up was only for four weeks, i.e. immediately after the interventions ended and approximately four months after the typhoon.

The pre- and post-intervention measures used in the second study [16] were: the Chinese version of the Impact of Events Scale-Revised (C-IES-R); the Taiwanese version of the multidimensional Anxiety Scale for Children (MASC-T); the Mandarin Chinese version of the Centre of Epidemiological Studies Depression Scale (CES-D).

Using MANCOVA, Tang et. al. found that when pre-intervention scores, sex and age were used as covariates, the EMDR group showed significantly lower post-intervention scores than the treatment-as-usual (TAU) group on the MASC-T ($p=0.03$) and CES-D ($p=0.01$), indicating EMDR exerted a significantly greater effect on reducing general anxiety and depressive symptoms related to the trauma. Furthermore, the EMDR group had significantly lower post-intervention C-IES-R scores than the TAU group ($p=0.05$), suggesting it has greater efficacy in reducing disaster-related anxiety. The Cohen's d (effect size) of the EMDR was 0.16 on the C-IES-R, 0.49 for the MASC-T, and 0.16 for the CES-D. There were zero dropouts in either intervention group.

In this second study, 14 participants dropped out before receiving any intervention either because their parents did not consent or

because they were absent from school where the interventions were taking place. This left 83 (41 in the EMDR group, 42 in the TAU group). Of the remaining participants, no group differences were found in age or sex between the groups. Once treatment began there were zero further dropouts, which the authors suggest indicates the acceptability of both interventions.

Discussion

This systematic review sought to look at EMDR versus other modalities of trauma treatments specifically in adolescents, that is children aged 12-17 inclusive.

The main strengths of this study were the ability to include only studies that could isolate data for this age range and could make direct comparisons between manualised EMDR for psychological trauma with another manualised psychological trauma therapy. The included studies had a varied type of trauma: either sexual trauma or psychological trauma as a result of an environmental catastrophe. They included both single-event trauma and multiple-event trauma. They also included both male and female adolescents and covered multiple countries, cultures and languages all of which increase the generalisability and external validity of the synthesised findings in this review.

This 12 to 17 year old age group was selected to identify if there were any preferential modalities at this stage of a child's emotional, cognitive and social development, compared to what research may show is preferential for adults or younger children who are at very different stages of brain development. Currently, the NICE guidelines make a distinction for adults versus children [5] but no differentiation for adolescents versus younger children. Yet we know that adolescence is a time of rapid brain development and plasticity thought to bring about brain changes second only to that in gestation and infancy. Hence the impact of trauma and trauma treatments during this age range has great significance and may be different to that for younger children or adults. Furthermore, how it presents may differ between children and adolescents: adolescents may be better able to self-identify and report trauma symptoms, whereas for younger children any changes in trauma symptomology may need to be identified by parents [17].

Oras et. al. [17] described a hypothesis of child-specific trauma and PTSD criteria where they postulated that the high functioning of children with PTSD could be a marker of hypervigilance. Moreno-Alcazar et. al. [18] noted that EMDR reduces symptoms of PTSD-associated depression and anxiety in adults but in children only reduces PTSD-associated anxiety. Also, female adolescents may preferentially respond to EMDR compared to male adolescents [18] [19]. Along with gender differences in the ways people respond to trauma (e.g. females are more likely to develop PTSD in relation to interpersonal trauma than males [18]) we need to understand more about how trauma and trauma interventions impact brains of different ages and stages [20]. It was noted that EMDR has the greatest effect in deactivating the insula and regions of the hindbrain and Pierce et. al. [20] have reported on the action of EMDR in different brain regions. The interplay between its impact on these regions and the stage of the developing brain has not yet been commented on.

It has also previously been identified that for children the best treatment response is when family life is stable [17]. Nonetheless, it is not clear if this shifts into adolescence when the impact of relatively stable peer relations and other factors may have a growing influence on treatment outcomes. Furthermore, we need to understand more about what forms and adaptations of EMDR may best suit the adolescent population; it has already been suggested that younger children may prefer bilateral stimulation in the form of tapping [21] and that children can have difficulty identifying the positive and negative cognitions required in the EMDR protocol or rate SUDS [22].

Whilst EMDR is considered to have established a solid evidence base as a trauma treatment it has long been identified that more research is needed into the factors that affect its efficacy [23] and specifically to identify predictive

factors [24]. These studies would need to have sample sizes of over 10,000 to identify a statistically significant difference between EMDR and TF-CBT [24]. For example, some studies suggest that trauma treatments (both EMDR and TF-CBT) can elicit a greater treatment response in adults and children if there is additional co-morbidity [23]. It has also been postulated that due to the relative lack of narrative input required by recipients, EMDR may be better suited to those with language difficulty [23].

Indeed, EMDR has been found to work well with those with intellectual disability or autism and where parents are also receiving treatment [25] as well as children with severe intellectual disability [26]. For those with intellectual disability, there may also be additional benefits of having EMDR alongside physical activity to reduce trauma symptoms, impairment and reduce the number meeting the clinical threshold for a PTSD diagnosis intellectual disability [21].

If considering which trauma therapy modality may best suit a young person based on their impairment and symptom profile, there is some suggestion that where hyperarousal is a key issue EMDR may not be best suited [27]. Similarly, parents reported that post-EMDR conduct and hyperactivity problems were worse [24]. Another study comparing cognitive-behavioural writing showed that EMDR is superior in reducing PTSD symptoms in children where there is a more severe symptom profile at baseline based on child self-report of symptoms and that EMDR had superior results at 3-month follow-up [28].

With regards to whether trauma type has a differential response to EMDR again early evidence suggests not; statistical analysis on single trauma versus multiple traumas did not show a preference for one of either EMDR or TF-CBT [24]. EMDR is already evidenced to be effective for single trauma [29] and for adolescent sexual abuse [30]. Another study found that it was the professional background of the therapist rather than the trauma type that affected EMDR treatment response [31]. This highlighted the importance of therapist training and skill as the EMDR protocol was not as effective when administered by teachers.

Some moderators and mediators of treatment response have been identified as: parental functioning, treatment dose, explicit exposure and sudden gains [32]. Treatment modality, cumulative exposure, age and sex of the child were not found to moderate treatment outcomes [32]. This contrasts other findings where EMDR was found to be less effective in males compared to females [18] [19]. Where there was noted maternal post-traumatic stress syndrome, this was not found to moderate the child's treatment response; however, maternal depressive symptoms and unhelpful parental trauma-related beliefs did. Nevertheless, one of the included studies found that for child sexual abuse none of these moderators were significant. Where there were sudden gains, there were larger overall improvements in PTSS and depressive symptoms [32].

Existing research trying to differentiate any preferential response to TF-CBT or EMDR is further compounded by methodological challenges as many of the studies utilising EMDR also utilise cognitive techniques [33] making it difficult to attribute treatment effects. Some research has focused on biochemical markers such as cortisol levels pre-treatment or basal cortisol secretion and found that respondents had relatively higher pre-treatment basal cortisol compared to non-responders [34]; however, the clinical application of this remains to be worked out.

One of the main limitations of this systematic review is the small number of studies that met the inclusion criteria. In part, this was due to the strict criteria of needing studies that utilised the full EMDR protocol and had a comparator either in the form of another trauma modality or in the form of another trauma type being treated. Many studies did not compare EMDR to another evidence-based treatments. However, the main limiting factor on study inclusion was the strict age criteria of children aged 12-17 inclusive and excluding studies that included adults 18+ years old or children aged 0-11 years old or where the study

didn't differentiate results or intervention groups for 12 to 17 year olds. 49 or 61 possible papers were excluded on this criteria.

As for the 2 studies this review was able to include there are a number of limiting factors in each. For the first study [15] there was a very small sample size (10 participants) which limits the power of the study. This limits its external validity. The methodology was such that the effect of the therapist could not be distinguished from the effect of the therapy modality as there was just one TF-CBT therapist and one EMDR therapist. This also meant adherence to the relative protocols of both treatments was not formally monitored so replicability is unclear. Each treatment modality had a different minimum number of sessions: 10 for TF-CBT whereas there was no minimum for EMDR. The researchers postulate that this creates a risk of differential expectancy effects including extending the number of CBT sessions beyond what may be needed, although they did only have 1 participant who finished TF-CBT at 10 sessions. Furthermore, EMDR as a therapy is structured to reduce the SUDS as soon as possible, (which in this study leads to a completion of treatment), whereas TF-CBT also includes skills training, and so TF-CBT may, by its methodology, lead to a later SUDS reduction. The effects of each modality longer term is also not known as no follow-up was carried out weeks, months or years after treatment for either modality. The authors also highlight that some aspects of the methodology favoured TF-CBT. This is because EMDR treatment could be stopped as soon as the target memory SUDS were down to between 0-2. However, this could be the case for the target memory, yet other related memories could continue to drive trauma symptoms and thus the measures indicate a reduced treatment response for EMDR as multiple trauma symptoms may still be present.

Whereas for TF-CBT the CBT skills could, in theory, be more broadly applied to multiple trauma-related memories and symptoms. Additionally, for the CBT arm to terminate treatment, participants also needed a reduction in anxiety symptoms that may not be specifically referenced to the index trauma. Hence the therapy methodology may more comprehensively reduce all trauma-related symptoms on post-treatment measures, regardless of if they are directly related to the index trauma or target memory. In this study, the outcome measures targeted global symptom measures rather than memory-referenced post-traumatic symptoms. This means it may have been fairer to the EMDR group to continue treatment until all trauma-related memories were resolved up to the 12-session maximum. Despite all of this, the authors note that EMDR had larger effect sizes on each outcome compared to TF-CBT making it significantly more efficient [15].

For the second study, [16] which compared EMDR with TAU (treatment as usual included group psychoeducation, see results above and table of included studies) the EMDR treatment only lasted 4 sessions. It is unclear how clinically applicable 4 sessions of EMDR for adolescents would be. The authors were keen to point out that this was the first study to report that EMDR alleviated general anxiety symptoms on the MASC-T. They postulated that identifying intrusive trauma memories and desensitising them and the related emotional distress might then lead to reduced harm avoidance, and this may account for the treatment effects of EMDR. The authors also note that EMDR protocols for children can have different components to those from adults and in their study the EMDR focused on efficient desensitisation of the traumatic memory (i.e. reducing the SUDS similar to the first study). They noted that EMDR can have a greater ability to reduce physiological disturbances, and this too may aid processing [16]. The main limitations of this study are again the small sample size (N=83), which limits its power. Furthermore, again, there was no long-term follow-up. Treatment effects were only measured for 4 weeks so the study could not determine a preferential response in coming weeks, months or years since the trauma. The trial design was non-randomized, so it could not control for group differences in all domains, so there were unbalanced preintervention scores and PTSD diagnoses between the treatment groups. The allocation to the relevant treatment groups in this case-control study was based on the opinion of parents and the school principal which may have

been influenced by their perception of the severity of the psychological disturbance [16].

In conclusion, there is a wealth of research supporting both the use of EMDR and TF-CBT to treat adolescent PTSD and PTSS. However, at this time, there continues to be insufficient evidence to suggest which young people or which trauma types may show a preferential response to one modality over the other. It, therefore, remains the judgement of the treating clinicians, which modality to use based on local guidance, (NICE guidelines in the UK as well as local protocols), young person preference, local resources, therapy accessibility, cost and wait list time. More high-quality, large-scale, randomised controlled trials and other high-quality studies are required that directly compare manualised EMDR with manualised TFCBT, specifically in the adolescent age group, to treat psychological trauma. As more research emerges it may be prudent to also design studies that can enable comparisons with other trauma therapies.

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Falling Out of Favour: Lithium prescribing in a South East England and beyond

Patrick F.M. Corbett

Introduction

Bipolar disorder is a chronic mental health condition characterised by episodes of mania and depression, which can severely impact quality of life. Globally, it ranks among the top 10 leading causes of disability, reflecting its profound societal and individual burden [1]. When untreated, bipolar disorder is associated with a significantly reduced life expectancy, with patients losing an estimated 10–20 years of life due to its high suicide rates and strong links to physical health comorbidities such as cardiovascular disease [2].

Lithium has been a cornerstone of treatment for bipolar disorder since its properties as a mood stabiliser were discovered in the mid-20th century. It is one of the most extensively researched psychotropic medications and is celebrated for its efficacy in reducing suicide risk and risk of relapse [3]. This is reflected in NICE guidelines which recommend as first-line drug in long-term treatment of bipolar disorder [4]. In addition to this, lithium is shown to be an effective treatment in unipolar depression both as a monotherapy and an adjunct to enhance antidepressant efficacy [3].

Despite these well-documented benefits, there is evidence of lithium's declining use in clinical practice, raising concerns about its negative perception among clinicians and patients alike [5]. Contributing to this trend are misconceptions about lithium being an outdated medication, its need for monitoring, and its potential side effects, including the risk of acute kidney injury.

Simultaneously, other psychotropic medications, such as second-generation antipsychotics, antidepressants, and anticonvulsants, are rising in popularity [6]. While these alternatives are marketed as more modern options, they also come with extensive side effect profiles and often require similar levels of monitoring [7].

This article examines lithium prescribing practices, using a mental health trust in South East England as an example, aiming to determine whether it is, indeed, underutilised. It delves into the factors contributing to its declining popularity, highlights the compelling evidence supporting its continued role in managing bipolar disorder and addresses common misconceptions surrounding its use.

Benefits of lithium

Despite evidence of lithium's beneficial effects in unipolar depression and effects at a non-morbid population level, this article will be examining its use specifically in Bipolar disorder.

Lithium is highly protective against the recurrence of both mania and depression. A 2014 meta-analysis, demonstrated that lithium significantly outperforms placebo in preventing mood episodes [8]. Furthermore, there is evidence that it is more effective in reducing the risk of manic episode recurrence compared to anticonvulsants [9]. When specifically compared to quetiapine, lithium showed superior outcomes across nearly all measures after one year of treatment, including relapse prevention, functional outcomes, and cognitive performance [10]. Lithium is also well-supported as an effective treatment during acute manic episodes, proving to be at least as effective as other anti-manic agents including quetiapine [11]. Moreover, is the only medication in bipolar disorder to have been shown to have a specific anti-suicidal effect over and above its effect on mood [12]. Given that bipolar disorder carries such a high risk of suicide, this unique property of lithium is of even more importance. Lithium is also shown to reduce readmission to hospital for both psychiatric and physical health and as it avoids the associated

metabolic side effects of long-term antipsychotic therapy [7].

From an administrative perspective, lithium stands out as an exceptionally cost-effective treatment. Its status as a naturally occurring salt prevents it from being patented, making it remarkably affordable [13]. Additionally, lithium's extensive use over the past half-century has generated a vast body of literature detailing both its advantages and potential risks. This wealth of evidence provides a level of understanding and safety assurance unmatched by many newer alternatives, which often lack comparable long-term data. As a result, lithium remains one of the most reliable and well-documented treatments available [14].

Prescribing in an NHS Trust in South East London

As of September 2024, all patients within the trust with a recorded diagnosis of bipolar disorder were identified across both inpatient and outpatient services. From this cohort, every 10th patient was selected through numerical sampling. For those not prescribed lithium, a review of their medical notes was conducted to determine whether lithium had been considered and, if so, the reasons for its omission.

From a cohort of 214 patients with bipolar disorder, the analysis of lithium prescribing practices revealed that 32% had no mention of lithium in their medical notes, 14% were considered for but not offered lithium, and 27% had discontinued it after prior use. Only 20% were actively receiving lithium at the time of the review. This indicates that nearly half of the bipolar patients in the trust were not offered lithium.

Longitudinal Outcomes for Patients Prescribed Lithium in 2018

To assess long-term lithium continuation rates, all patients prescribed lithium in 2018 were identified and cross-referenced with 2023 prescription records to determine who had discontinued treatment. This analysis included both inpatient and outpatient populations within the trust. For patients who had stopped lithium, a review of medical records was conducted to identify the reasons for discontinuation.

Of the 401 patients prescribed lithium in 2018, 63% remained on therapy, 23% had discontinued (with side effects cited in a quarter of cases), and 11% had died during the time period, including five suicides among patients with sub-therapeutic lithium levels. Notably, no deaths were attributed to end-stage renal failure. As of 2024, a total of 361 patients within the trust were receiving lithium therapy.

Prescribing trends internationally

The patterns seen in lithium prescribing trends are not unique to South East London. Lyall et al [6] examined lithium prescribing patterns in Scotland between 2009 and 2016 and found that only 22% of bipolar patients received lithium compared with 26% at the start of the study period. This was seen alongside an increase in antipsychotics and antiepileptics. Similarly, a study by Kessing et al [15] reported a significant reduction in lithium prescriptions across Denmark between 2000 and 2011. Over this period, lithium shifted from being the most commonly prescribed treatment for bipolar disorder to the least, compared to three other agents. A similar downward trend has also been evident in the United States for some time. Baldessari et al [16] found that a disappointing 7.5% of patients with bipolar disorder in the U.S. were prescribed lithium.

These trends underscore a concerning global decline in lithium use despite its well-documented benefits.

Why is Lithium falling out of favour?

Marketing

Lithium is a well-established treatment with decades of robust research supporting its efficacy and safety. However, it is unable to be patented by pharmaceutical companies, limiting commercial incentives to promote it. As a result, clinicians are very unlikely to encounter drug representatives advocating for lithium’s benefits [14].

Conversely, newer medications for managing bipolar disorder are frequently marketed in ways that position them as superior to lithium, often perpetuating the misconception that lithium is a “dirty drug” [14]. In reality, lithium’s extensive research history makes it one of the most well-understood and evidence-backed treatments available. This stands in contrast to newer antipsychotics, which, while increasingly prescribed, lack the same depth of long-term safety and efficacy data as lithium. For example, the significant metabolic side effects of quetiapine and olanzapine, such as weight gain and diabetes, were only fully understood after years of clinical use [14]. Lithium’s well-documented profile, supported by a wealth of literature detailing both its benefits and risks, highlights its unique status as a reliable and safe treatment option.

Monitoring

Lithium is notorious for having a slim therapeutic index which requires titration of the drug followed by further monitoring, with plasma concentrations ideally being kept between 0.6-0.8mmol/L [4]. Upon starting treatment, levels should be checked after one week, then one week after every dose change, and weekly until the levels are stable. Once levels are stable, levels are usually measured every 3-6 months [4]. In addition, monitoring of renal function (urea and electrolytes) and thyroid function is recommended at these intervals, given lithium's known effects on these systems [4].

While these monitoring requirements are often viewed by clinicians as burdensome and require significant patient engagement, monitoring also provides a distinct advantage. Regular checks enable clinicians to confirm that patients have an effective plasma concentration of lithium and to adjust dosages as needed, a level of precision that is not possible with most other treatments [14]. This tailored approach can ensure an efficacious dose of the drug, reinforcing lithium’s value as a treatment option despite the perceived inconvenience.

Toxicity

There is a well-documented risk of toxicity when using lithium, typically when levels rise >1.5mmol/L [4]. Symptoms of toxicity can include significant neurological and renal complications. However, this risk is substantially mitigated through effective monitoring and comprehensive education on symptoms for both clinicians and patients [17].

Contrary to common concerns, the severity of lithium toxicity may be overestimated. A long-term study following 1,340 lithium patients over 17 years reported no deaths directly attributable to toxicity [19]. This evidence underscores the importance of proper management and monitoring in ensuring lithium’s safety as a treatment option.

Kidney injury

Lithium is renally excreted and is known to have a nephrotoxic effect on the kidneys, sometimes leading to acute kidney injury (AKI) and chronic kidney disease [17]. However, recent data suggests this effect is much overstated. Tondo et al [19] studied 517 bipolar patients on lithium therapy and found that reduced estimated glomerular filtration rate (eGFR) only occurred after 10-15 years of treatment with low eGFR only seen in patients after 30 years of treatment. This is potentially reflected in the Oxleas data where there were no deaths in the patient cohort due to end-stage renal failure (ESRF), although further analysis would be required. Furthermore, research indicates that kidney damage is more closely linked to episodes of lithium toxicity rather than sustained therapeutic levels [20]. This suggests that diligent monitoring and prompt management can significantly reduce the risk of renal complications. While lithium’s nephrotoxic potential is not disputed, emerging data challenges the extent and inevitability of these effects, emphasising the importance of proper monitoring in reducing risks.

While concerns about lithium’s nephrotoxicity remain, it is essential to compare its risks with those associated with alternative treatments. Antipsychotic medications commonly used in bipolar disorder, for example, are linked to severe cardiovascular and metabolic side effects [21]. These include prolonged

QT intervals, which can result in sudden cardiac death. In addition, these drugs can produce significant increases in lipids and blood glucose levels, often leading to type 2 diabetes [21]. This systemic metabolic dysfunction, in turn, can adversely affect multiple organs, including the kidneys. When weighed against these risks, lithium's benefits and manageable side effects highlight its continued value as a treatment option.

Tremor, hypothyroidism, hypercalcaemia

These side effects are relatively common alongside lithium use; however, they are all significantly modifiable. Tremor can be managed with beta-blockers and despite perception by patients and clinicians, does not necessarily indicate toxicity [17]. Hypothyroidism affects approximately 15% of patients on maintenance lithium therapy but is easily managed with standard thyroxine supplementation, the same as the treatment of primary hypothyroidism [3]. Hypercalcemia, typically a result of lithium-induced hyperparathyroidism, can often be monitored if mild or managed the same as primary hyperparathyroidism [3].

In lithium responders, these modifiable side effects should not be a reason to discontinue treatment, provided they are appropriately addressed and managed.

Moreover, lithium's side effect profile is relatively mild when compared to many newer psychotropic medications that are becoming increasingly popular. For example, atypical antipsychotics like olanzapine and quetiapine are frequently linked to significant weight gain and sexual dysfunction [21]. These drugs are also associated with other common side effects, such as sedation and anticholinergic symptoms [21].

Teratogenicity

Lithium is well-known for its teratogenic potential, particularly its association with Ebstein's anomaly, a condition involving displacement of the tricuspid valve in the heart [22]. However, research shows that the overall risk of adverse neonatal outcomes or delivery complications is comparable to that of the general population [23]. Furthermore, the risk of Ebstein's anomaly is confined to the first 12 weeks of gestation, during the period of congenital heart formation.

As a result, lithium is not absolutely contraindicated in pregnancy. For lithium responders, it is often recommended to continue treatment with appropriate counselling and close monitoring to prevent discontinuation, which could increase the risk of relapse during this crucial period [24].

It is also important to note that teratogenicity is not unique to lithium. Valproate, one of the mood stabilisers increasingly replacing lithium in clinical practice, is notorious for its teratogenic effects, including a twentyfold increased risk of neural tube defects [25]. Teratogenic effects can also be seen in carbamazepine, another popular mood stabiliser in BPD [26]. This underscores the need to weigh carefully the risks and benefits of all treatment options during pregnancy.

Conclusion

Despite its long-standing status as a cornerstone treatment for bipolar disorder, lithium is increasingly falling out of favour in this South East London NHS Trust, reflecting a concerning global trend. Contributing to this shift are several misconceptions surrounding lithium, including concerns about its safety, exaggerated risks of toxicity and acute kidney injury, as well as the perceived logistical challenges associated with its monitoring [14] [19]. Additionally, the marketing of newer medications has influenced prescribing practices, further reducing lithium's prominence [14].

This decline in lithium use is accompanied by a rise in the prescription of alternative psychotropic medications. However, these alternatives often present significant drawbacks that may outweigh the risks associated with lithium. Atypical antipsychotics, such as quetiapine and olanzapine, are associated with a high risk of metabolic dysfunction, including weight gain, type 2 diabetes, and dyslipidemia [20], which can lead to cardiovascular and kidney disease. These medications may also commonly cause sexual

dysfunction and drowsiness [21]. Furthermore, alternative mood stabilisers like valproate and carbamazepine carry substantial risks during pregnancy (25, 26). The lack of extensive long-term data for many newer treatments further underscores the importance of carefully weighing their risks.

The trend of declining lithium use stands in stark contrast to the pile of evidence supporting lithium's efficacy in managing bipolar disorder. It remains highly effective in preventing manic and depressive episodes, reducing suicide risk, and offering long-term stability with manageable side effects. Its unique properties, including its protective effects against relapse and suicide, should encourage clinicians to reconsider its use more widely.

Given the significant burden of bipolar disorder on individuals and healthcare systems, it is imperative that clinicians prioritise evidence-based treatments like lithium. By addressing misconceptions, emphasising proper monitoring, and ensuring informed patient discussions, lithium can continue to play a critical role in improving outcomes for those living with bipolar disorder.

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Diagnosing dementia in acute settings – considerations and pitfalls

Joanne Hew & Benson Benjamin

Abstract

In the UK, dementia is usually diagnosed in community memory or mental health clinics. Given the high prevalence of dementia in acute hospital settings, we believe there is merit in diagnosing dementia in these settings, if treatment and care access can be improved with the diagnosis. However, there are certain considerations and confounders to the diagnosis, such as depression or delirium, in the acute hospital setting, which need to be taken into account when assessing a patient.

Diagnosing dementia – best practice

Dementia is a neurocognitive disorder, characterised by marked impairment in cognitive domains such as memory, executive function, attention, language, social cognition and judgment, psychomotor speed and visuoperceptual or visuospatial abilities. It is associated with a decline in functioning, which is more than expected given the person's age and premorbid functioning [1].

In 2019, a report by the Alzheimer's Society estimated that there were about 885,000 older people living with dementia in the UK, with a prevalence rate of 7.1% [2]. It was estimated that the number of older people with dementia would increase to about 1.6 million in the year 2040 [2].

The National Institute for Health and Care Excellence (NICE) guidelines suggest referral of a patient with suspected dementia to a specialist dementia diagnostic service (for example a community memory clinic or old age psychiatry service), once reversible causes of cognitive decline have been ruled out. Within specialist services, it is recommended that dementia can be diagnosed after an assessment ruling out reversible causes and confirming cognitive decline. If the diagnosis or subtype is unclear, neuropsychological testing can be conducted. Structural imaging can also be used to assist with subtype diagnosis and rule out reversible causes of cognitive decline [3]. Therefore, the diagnosis of dementia usually occurs in secondary services and relies mainly on clinical history and judgment, with adjunctive tools used to further clarify the diagnosis.

Dementia in acute hospitals

The national audit of dementia in 2022 – 2023 found that the number of patients with reported dementia admitted per year ranged between 33 – 29,769 across all hospitals, accounting for 0.1-15% of total hospital admissions [4].

Patients with dementia are more likely to be hospitalised than patients without a diagnosis, regardless of physical comorbidities [5] [6]. They are also more likely to have multiple comorbid medical illnesses, increasing with the severity of dementia [7] [8]. In a study, 50.6% of patients with newly diagnosed dementia were admitted to the hospital in the year after diagnosis, with 75.9% admitted during a median 2.5-year follow-up [6]. Emergency hospitalisation rates of patients with dementia were also found to be increasing over time [6].

Why identify dementia in acute hospitals?

People with dementia in acute hospitals suffer adverse outcomes, such as increased length of stay, delayed discharge and increased care requirements in the community [9]. They are also likely to experience falls, readmissions, pressure

ulcers and violent incidents [4], with poorer functional and nutritional status [10]. Identifying patients with dementia in the hospital allows the multidisciplinary team to provide and plan care as well as plan discharge accordingly [4].

Psychiatric liaison services allowing early diagnosis of dementia with personalised care plans could avoid prolonged admissions and re-admissions [11]. Further, early diagnosis of dementia allows patients a chance to come to terms with their diagnosis whilst they are still able to understand its implications and make key decisions about their future care [12]. A diagnosis could afford benefits such as accessing services, paid sick leave, support groups and disability payments [13]. Lastly, initiating early treatment for dementia may also slow down the progression of the disease over the maximum time period, allowing functioning to be preserved and patients to remain in the community for longer [14].

Delirium – a confounding factor

Delirium is defined by NICE as "a common clinical syndrome characterised by disturbed consciousness, cognitive function or perception, which has an acute onset and fluctuating course." [15] Delirium is associated with adverse outcomes such as increased length of stay, hospital-acquired infections, admission to long-term care and death [16].

Cognitive impairment is the most important risk factor for delirium, apart from age [17], and the risk of delirium is increased five-fold in people with dementia, with the risk increasing with the progression of dementia [15]. In the national audit of dementia 2022 – 2023, it was found that 72% of patients with dementia in hospitals were diagnosed with delirium [4]. Conversely, it was found that over half of older people with delirium in hospital have undiagnosed dementia [18].

NICE guidelines suggest that in patients in hospital with a cognitive impairment with an unknown cause, the Confusion Assessment Method or Observational Scale of Level of Arousal can be used to distinguish delirium from delirium superimposed on dementia [3]. However, in patients with delirium without a prior diagnosis of dementia, clinical assessment of dementia is tricky and may be inaccurate. The use of cognitive assessment tools may not be useful in detecting and differentiating delirium from dementia [19] [20]. Patients may also be unwell from their medical illness, resulting in difficulties in engaging with assessments.

Depression – a mimic

Depression is characterised by symptoms such as depressed mood, diminished interest in activities, poor concentration, feelings of worthlessness or excessive/inappropriate guilt, hopelessness, suicidal thoughts, changes in appetite and sleep, psychomotor agitation or retardation and reduced energy or fatigue, for at least 2 weeks [1].

Epidemiological studies suggest that major depression is less frequent among older than younger adults [21] [22]. However, in particular subsets of the older adult population, rates of major depression are increased [23]. In medically ill hospitalised inpatients, the rates have been found to be as high as 10-21% [24].

Presentation of depression in older adults may differ from presentation in younger adults. One difference is increased subjective complaints of poor memory and concentration, with executive dysfunction and slower cognitive processing speed found in objective testing [25]. Therefore, depression may be mistaken for cognitive impairment, if a full assessment of mood symptoms is not carried out.

The role of psychiatric liaison teams in diagnosing dementia

The waiting times from referral to diagnosis of dementia in the community is increasing - in 2019, the average waiting time was 17.7 weeks [26]. In addition, there are increased rates of non-attendance of community clinics in patients with dementia [27]. As such, we argue that an assessment for dementia may be helpful for certain patients in the acute hospital setting. For example, for patients admitted with confusion, in

whom an acute medical illness has been ruled out and no signs or symptoms of delirium found. A diagnosis in hospital could afford benefits, such as early treatment, access to health and social care services and more robust personalised discharge planning.

Whilst in the acute hospital, patients have access to blood tests to rule out reversible causes of confusion, head imaging and observational assessments of their presentation. Informant-rated questionnaires have also been found to be accurate in detecting dementia in patients, even with delirium [28]. These tools, along with the clinical history, can allow liaison teams to make a provisional diagnosis of dementia.

Psychiatric liaison teams are also experienced in assessing mood disorders in patients with comorbid physical health conditions. This will enable them to distinguish mood disorders presenting as cognitive impairment.

In patients where there is a superimposed delirium, clinical history is unclear or if there is no reliable informant history, we must exercise caution in concluding a diagnosis. In these patients, we would refer to community memory services for further assessment and follow-up. However, we are still able to contribute to the assessment by conducting baseline cognitive screening, obtaining bloods and head imaging. This reduces the carer burden and enables patients to have fewer investigations in the community settings while evaluating Dementia.

Psychiatric Liaison Teams work collaboratively with acute medical specialities and thus while physical health concerns are being addressed, cognitive evaluation can also be conducted further in a ward environment.

Conclusion

Diagnosing dementia in acute hospitals has its merits; it can allow early treatment and improve care planning for patients, whilst reducing the burden on community memory clinics. Given that diagnosing dementia is primarily based on clinical history, if this can be obtained in the acute setting with supporting investigations, a diagnosis of dementia would likely be accurate. However, clinicians should be aware of confounding factors on presentation such as delirium or depression and be able to rule these out definitively before making a diagnosis. Psychiatric liaison teams have experience in reviewing patients with dementia, delirium and functional mental illnesses such as depression or psychosis, and therefore are arguably well-placed to assess patients with possible dementia.

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An SPA re-referral Quality Improvement Project (QIP)

M. Manning, E. Lawson, T. Wickramarathna, H. Rahmanian

Background

Primary Liaison Recovery Service (PLRS) serves as a single point of access for all referrals to community mental health services in Sutton. The team aims to assess all referrals and either accept or signpost to appropriate services. In 2023, the service received 584 re-referrals for patients previously under the service. This reflects a significant burden on services.

Methodology

This audit will retrospectively analyse data from all patients re-referred to Sutton PLRS between July to December 2023. Data including diagnosis, referrer source, outcome, discharge source and discharge reason will be analysed.

Results

We identified 288 re-referrals between July and December 2023. The most prominent month of re-referrals was shared by both July and October at 23% each.

Patients aged 26-35 and 45-55 years old were the age categories with the highest referrals back into our service, at 22%. When analysing the impact of gender on re-referrals, this was shown to have minimal impact. 51% of the referrals were female and 49% male.

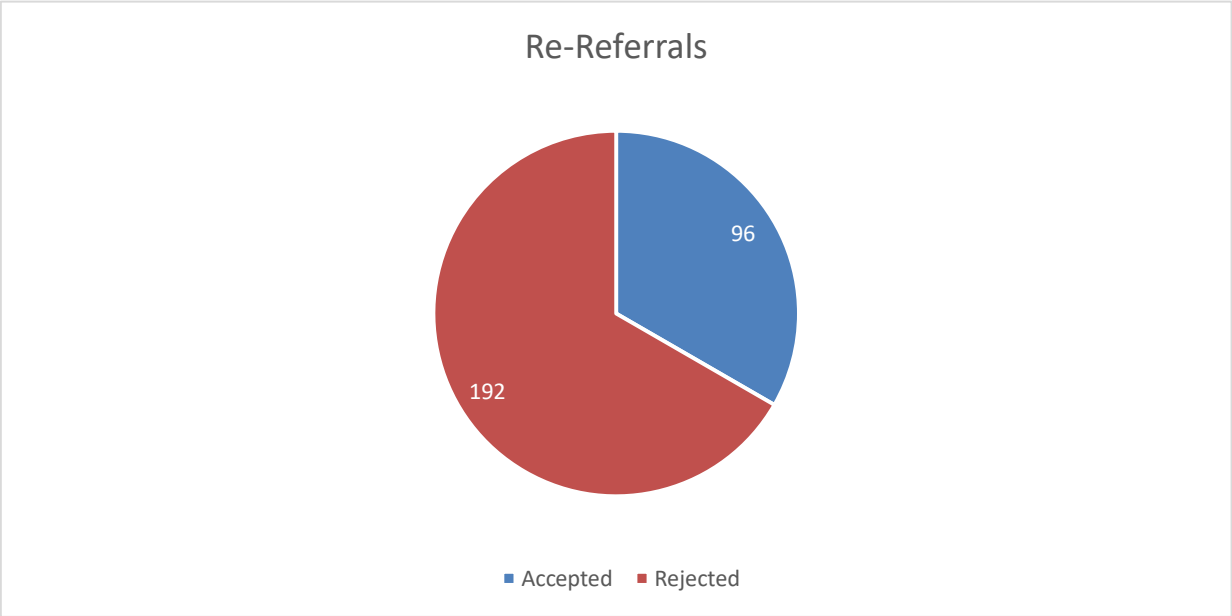
Re-referral time varied. Most re-referrals were in the first 5 months, accounting for 73% of all re-referrals. The largest number of re-referrals were made after 1 month, this accounted for 16% of total referrals made back into the service.

Reasons for discharge from Sutton PLRS varied however collectively the largest reasons for initial discharge was 'did not engage/opt-in' and 'inappropriate referral' which accounted for 32% and 30% respectively. Sutton Single Point of Access (SPA) was responsible for the largest number of discharges at 77%. The most common reason for client referral back into services was due to symptoms of their mental health, accounting for 36% of the total referrals. It was highlighted that 5% of patients had an unclear reason for re-referral. GP and police safeguarding referrals (MERLIN) were the source of our highest referrals, equating to 32% and 30% of re-referrals. Out of all re-referrals, 33% (96 clients) were accepted. 53 clients were declined. They were declined due to; already under the appropriate team (4%) or inappropriate referral (15%) as percentages of the whole cohort.

Conclusion

In conclusion, only 33% of referrals were accepted into the team, reflecting a significant proportion of inappropriate referrals to an already under-pressure service. A large source of the referrals was from the GP. An intervention to combat this will be to educate and encourage GPs to use advice and guidance pathways, for example allowing GPs to email and gain advice without making a formal referral or the utilisation of primary care wellbeing practitioners in the community, both of which could be set up in the future.

Figure 1. Number of referrals accepted or rejected to the Sutton Primary Liaison Recovery Service



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The threat of serial code-makers in the UK

Michael Jewell

Summary

Since recently returning to the UK from working in psychiatry in New Zealand, I have been reflecting on the differences between their respective mental healthcare systems. In particular, the former's over-reliance on rules and regulations (i.e., codes) in defining medical expertise. I aim to show that the UK's overemphasis on codes in medical practice is theoretically misguided and has significant consequences, leading to de-professionalisation and de-moralisation. My strategy blends ideas from the philosophy of psychiatry with current events, including the Lucy Letby case. The resulting lessons forged from philosophy and abroad help to shed light on UK psychiatric practice.

Introduction

Over-regulating doctors should be cautioned. Contrasts between the UK and New Zealand (NZ) mental healthcare prompt my concern, especially the growing cycle of regulations/regulators in the UK, termed 'code inflation' by philosophers [1]. I challenge code inflation by arguing that individual judgement is necessary for, nor do codes diminish its role in, guiding medical practice based on the uncodifiability of values. Values denote the social norms of good/bad [2]. Finally, I explain the harmful effects of code inflation on medical and a fortiori psychiatric expertise, diagnosed 'professional deflation' by philosophers [1]. If so persuaded, a novel response to the Lucy Letby case can be framed.

Contrasting UK and New Zealand mental healthcare

Soon after returning from NZ to start my UK higher training in psychiatry, I observed junior and senior doctors on strike, indicating low morale. Relatedly, another observation identified the rising codification of UK medical expertise, known as code inflation. Codification refers to marshalling expertise into a general set of rules or regulations (i.e., codes). I suggest that codes overly influence how UK medical practice is implemented. For example, while in a senior clinical role in NZ, a patient's suicide prompted a swift analysis by regulatory groups, leading to concise and timely lessons learned within a month. In contrast, the UK's patient safety responses tend to be prolonged, resulting in increasingly cumbersome forms, procedures and protocols. In other words, there is a cycle of continually augmenting rules and regulations in response to scandals seeking to accommodate all future contingencies. The lesson is that doctor morale is higher and code inflation is less problematic in NZ, prompting the question of whether codes should constrain medical practice so extensively in the UK.

The need for individual judgement

I suspect a theoretical assumption supports the extensive constraint of codes on medical practice. It posits that codes, such as protocols, procedures and guidelines, sufficiently guide clinical judgment. The notion is evident in Immediate Life Support (ILS) training. Clinicians are pressed to manage standard cases of acutely unwell mannequins by mindlessly following ILS protocol (Airway, Breathing, Circulation…), akin to a central processing unit blindly following computational instructions. If codes alone guide clinical judgement, clinical problems become solvable by simply following algorithms.

However, ILS courses, delivered in abstract and ideal terms, mask the complexity of practical situations. Such complexity gives rise to circumstances where codes inadequately guide action because they conflict, such as biomedical ethical principles like beneficence versus autonomy in involuntary psychiatric treatment [3].

Consequently, in practice, codes can indeterminately guide action. Beyond codes themselves, an extra resource is needed to balance code conflict successfully. Thornton suggests this resource is a skilled form of individual judgement that rules or codes cannot express [4]. It is uncodifiable, similar to Aristotle's concept of phronesis [5]. Phronesis is a practical wisdom that necessarily guides the success of judgment [5]. However, it is often neglected because this type of craft knowledge, gained from experience rather than 'book learning', is tacit [1]. Consequently, a temptation to prioritise explicit codes over individual judgement in defining expertise persists (viz. ILS algorithms).

To clarify, codes are not all bad. The guidance of codes can significantly and relevantly constrain clinical judgement. I simply seek to relax the over-reliance on codes in medical practice. Yet, despite the apparent need for uncodifiable judgment, more codes might signal progress because they have seemingly superior qualities. On the one hand, codes' explicitness looks to confer transparency and non-arbitrariness on the authority of medical expertise and, on the other, individual judgement is susceptible to subjective whimsy that could harm patients. This view appears consistent with evidence-based medicine ranking expert opinion as the weakest quality of evidence [6] In short, code-making aims to foster patient safety by standardising clinical judgement through minimising a doctor's individual contribution.

The folly of code inflation

This section suggests that codes are not the panacea that patient safety gurus might assume. To indicate this, I reject the code maker's aspiration to limit the role of individual judgement in medical practice because values resist full codification in medicine. Paradigmatically, values appear in medical ethical judgment. Moral values that are universally shared are aptly marshalled into codes [3]. They provide the basis for biomedical ethical codes like Beauchamp and Childress' four principles [3] [7]. However, in any particular moral situation, there are multiple legitimate perspectives that express a variety of values, from individual preferences, e.g., an individual's desire for a specific medication, to universal morals, e.g., the population's wish for doctors not to cause harm [3]. This multiplicity highlights the possibility of disagreement over what is good/bad (e.g., when an individual prefers a medication that will cause them harm) and the need for skilled judgment to balance conflicting values in specific cases [3]. So, medical ethical judgement is tasked with identifying and balancing the diverse array of human values in play where only some are codified [3].

With an adequate description of ethical judgement in view, the misguidedness of the aspiration to limit individual judgement might become clearer. The problem arises from codes seeking not only to express universal morals but also to cover all loopholes and contingencies by sufficiently pinning down the concrete particulars of practical situations [1]. The more energetically a code attempts the latter, the greater the opportunities for codes to be abstracted from perspectives that express more local (i.e., time- and situation-specific) values indicative of individual preferences [1]. Pinning the specifics down of codes in one way may be consistent with the values of some individuals within the population [1]. Still, given the variation in human values, it will be inconsistent with the values of others [1]. So, the more detailed codes become through encapsulating increasingly local and unshared values, combined with the normativity of values, the greater the tendency for their guidance to conflict. Hence, an unexpected result is that over-enthusiastic code-making moves further away from codes alone guiding clinical judgement towards a greater reliance on an individual to successfully navigate code inconsistency using uncodified skill or phronesis.

Now, suppose all medical concepts are thoroughly value-laden (championed by Fulford but rejected by Wakefield) [8] [9]. Then, more detailed codes generate a propensity for conflicting guidance beyond ethics in medicine. Thus, code inflation amplifies the complexity of medical practice simpliciter. These issues are compounded in mental health where values are particularly

diverse [10]. Hence, the negative impact of an over-reliance on codes in medical practice is felt most acutely by psychiatrists. Modern football is an example where more protocols and technology, like video-assisted referees, create greater complexity, requiring more, not less, uncodified skilled judgment to get decisions right [11]. Given code inflation's shaky theoretical basis, a closer inspection of its practical consequences is warranted.

Diagnosing professional deflation

Codes are an essential response to the abuses of clinical practice. But there is a balance to strike between, say, ethical codes protecting patients from medical abuses, such as Nazi human experimentation, on the one hand, and excessive code-making and, relatedly, over-regulation deflating professionals on the other.

Code inflation may have contributed to the rise of hospital managers and independent agencies whose job, in part, is to give authority to codes that regulate healthcare professionals [12]. Such regulators, emboldened by codes, can deleteriously obstruct uncodified judgment. The recent Lucy Letby case is illustrative of professional deflation in two ways. First, managerial regulation directly suppressed the doctors' uncodified skilled judgement that suspected Letby's criminality [13]. Second, a regulatory body indirectly stifled said judgement because whistleblowing paediatricians were threatened with regulatory body referrals [14]. Moreover, codes undermine the nature of expertise itself. Too great an emphasis on codes rather than medical phronesis, especially when balancing values, cuts the craft from beneath the feet of doctors [1]. For example, when guidelines become mandatory in practice, individual judgement is side-lined. Codes are literally de-professionalising [1].

I suggest, then, that the conventional wisdom seeking managerial regulation following Letby's conviction turns on a possible misdiagnosis of what thwarted doctors' efforts to raise concerns [13] [14]. An alternative diagnosis might be code inflation de-professionalising doctors. The over-regulation of doctors, not the under-regulation of managers, is more problematic. Therefore, a key therapeutic approach should reverse medical de-professionalisation. The proper recommendations re-establish craft or tacit knowledge's role in medical expertise. Let's entertain the conventional wisdom of a regulatory body for managers. Managers are, in some sense, regulators themselves. Inevitable future scandals will call for more regulators at even higher levels… ad infinitum. Code inflation is not only theoretically questionable but now we risk enduring its absurd and impractical consequences. Stressing phronesis to regulate the quality of medical expertise bypasses the impractical regress. A response shaped like this could help shift the balance away from over-regulation.

Conclusion

Code inflation mistakenly aims to diminish the need for craft knowledge or phronesis in medical expertise. Ironically, the response to Dr Shipman's case led to over-regulation, contributing to the de-professionalisation of doctors aiming to protect patients from another serial killer. NZ and philosophy suggest that best practice hinges on uncodifiable skills gained through experiential training, especially in richly value-laden specialities like psychiatry. Impeding phronesis through over-regulation is professionally demoralising and, worse, deadly.

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