



Spring Edition - Special

Spring Edition - Special Lithium Review

The National Prescribing Observatory for Mental Health (POMH-UK) Topic 7 - Monitoring of patients prescribed lithium

Written by, L.Stoneman

This article is **not** a comprehensive guide to lithium management but a general overview of the National Prescribing Observatory for Mental Health (POMH-UK) and Topic 7—(Monitoring of patients prescribed lithium).



I want to review how new approaches and systems are to be introduced after topic 7 is concluded, as well as during its introduction. I hope it is of interest to those suggested lithium treatment, and to those who prescribe or dispense it and to those who help people taking it. I also hope it is of interest those who want to know a little more about medicine management and how improvements are being made in this area. I mention some aspects of lithium management I have experienced on a personal level. All advice and guidelines with regards to lithium management should be acquired through your prescribing practitioner. Continued on page 3.

Putting
Recovery
Values Into
Action

Dates for future self-help group meetings and other events

Central Herts Bipolar Group (Stevenage)

Meetings held every 4th Wednesday of the month in Stevenage 1.30pm-3.30pm

28.4.10—Ian Smith-Department of Work and Pensions. Presentation on disability living allowance, carers allowance and attendance allowance

26.5.10—Rev. Verity Harvey-spiritual presentation & discussion about working as a Spiritual Care Co-ordinator, and what spirituality means to others.

23.6.10-Self Help Group

West Herts Bipolar Group (Watford)

Meetings held every 2nd Saturday of the month in Watford 10.30am -12.30pm

8.5.10—Self-Help Group

12.6.10-Self Help Group

10.7.10-Self Help Group Walk.

Useful Website Addresses

www.recoveryin-sight.com

www.carersinherts.org

www.shift.org.uk

www.papyrus-uk.org

(Practical advice to young people worried about themselves or friends)

www.rcpsych.ac.uk

(Royal College of Psychiatry)

www.mdf.org.uk

(Manic Depressive Fellowship)

www.nhsdirect.nhs.uk

www.adviceguide.org.uk
(Citizens Advice)

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“InSight” Course

Rupert Young, Mood Foundation

Written by B.Maru & L.Stoneman

Rupert Young, the twin brother of Will Young, suffers with dysthymia which is a depressive mood disorder. After personal experiences of mental ill health, he has set up his own Mood Foundation. Here he talks about his problems, self reflection, and his charity.

Rupert's personal experience of mental health services in the UK left him heading to the USA. What did he feel the American service could offer that wasn't available here? "Everything! Our (UK) systems are awful and they are way too relaxed, and need to learn from America. It would help if our weather was better though..! Out there (USA) they stop access from the outside world and there are no distractions from working on what you need to work on. It is relentless; you no have no choice but to re-wire yourself with their talking therapy, alternative therapy and holistic approach to maintaining body and mind. There were also 100 therapists available 100% of the time, as well as others (sufferers) going through the same process, all together."

Rupert has suffered from mental ill health from a young age. "I suffered from addiction, self harm and major depression since the age of 14." "I didn't know how troubled I really was, I just reacted." He recalls some of his past problems, "self harm was compulsive; words don't describe it other than an inner scream." If someone was self harming now, until they received proper therapy, they "should write down what's on their minds, other than that, I would use ice cubes and press them on my skin."

All this improved when he was able to stop and understand why he felt what he did about himself. "Once I could understand, I went to work on self esteem so stopped drinking. Then I started to learn what I could do for myself rather than what I had to do for others."

His family was very important during his illness. "They supported me through everything, not so much my friends as I kept people out, unless I was drinking with them. It was very tough on my family, and I would (now) like to provide support for families with mental health affecting them." Providing information and support for families affected by mental ill health is an important aspect for everyone. "My family couldn't understand (my illness), all they could do was read up on what was wrong, so if I communicated something then they already had a clue as to what might be going on behind it all."

Rupert highlights the need for more education into mental health, reflecting on his own addiction. "I never knew what an alcoholic was really, it had never been explained to me or taught." He also reflects on the need for peer support; "if I had know that others self harm, then I would have investigated more, and not felt so alone. Everything in my life was private, self harm was just one of those." "I would have liked education to have done what it should have done, and provided me with information from a young age."

Rupert comments that there is not enough, easily accessible, information available for family and friends of mental health sufferers, but says, "We (Mood Foundation) are working on it, it needs a larger campaign."



His Mood Foundation will build a national database of private therapists who can offer free, one to one treatment, for anyone over the age of 18. "It is a charity that (also) wants to educate children about feelings, thoughts and behaviours. We feel if we can enable children to become more visible and help increase their own self esteem, then we might prevent a lot of the behaviours that lead to lower and lower moods. We also want to provide workshops for people struggling with depression, who may be on a long waiting list for talking therapy and need some tools to deal with their emotions. We know this will not only help those working on such issues but also reduce the amount of people flooding into the system by giving them some of their own tools to manage their own mood." "We also want to start workshops for families so people don't quite feel so alone and also have an idea as to what not to do...this is a great starting point."

"The mood foundation has some great relationships, especially in the world of alternative therapy, as we know talking therapy is available on the NHS already. We can offer more options, so use Equine Assisted Therapy, Nutritionists, Massage, Photography, the list goes on. All of these can help lift people."

Other activities Rupert feels are important are physical activity, music and writing. Physical activity is "everything to me, and if I don't get outside everyday then I know something is wrong. To get in motion costs nothing, and has helped me enormously." "Music is important as it is an alternative way of expressing myself; like running or writing, it takes my thoughts and feelings and turns them into something physical, but adds a magical frequency!"

"I am about to write a book (about my experiences) but do not know which part will be useful. Maybe I will just write the truth and it might help one person."

We would like to thank Rupert Young for his time, and would like to wish him every success with The Mood Foundation (www.moodfoundation.com). Stay well, and best of luck with the book.

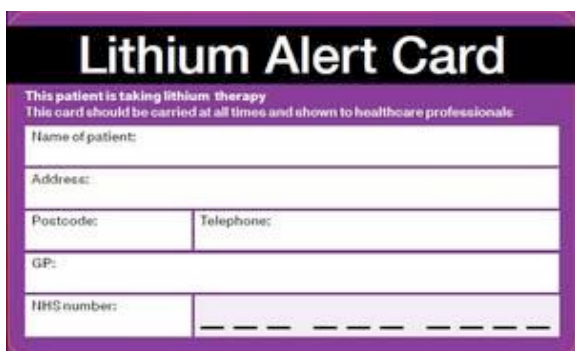
(Continued from 1st page)

I take lithium, to help prevent relapse of mania caused by my bipolar disorder – lithium is used as a first line preventative or prophylactic treatment for this. Over the past decade there has been a steady decline in the use of lithium due to a variety of reasons, one being lack of understanding or lack of communication in the monitoring systems e.g. Blood test result sharing and lack of knowledge. Also there is a lack of consistent systematic approaches to monitoring lithium therapy. All these areas are imperative in managing lithium therapy safely. Lithium is **not** a new drug, but its gradual decline in being prescribed and used is something which disappoints me, as the effectiveness of lithium treatment has been proven.

There are other long term medications that are prescribed to treat bipolar disorder, (Nice Bipolar Guidelines 3, 4, 5 & 6), with the addition of complimentary, psychological treatments and courses offered such as The Recovery In-Sight Centre’s course ‘In-Sight’. These combined can fit together well to help achieve a good balance of treatment to gain recovery and maintain wellness. One new and very positive outcome from Topic 7 was the launch and release of the Lithium Therapy patient pack (pictured), containing vital information and guidance for people taking lithium, including a passport size record book, to record dates of blood tests and results, as well as a credit card sized card to keep in ones purse or wallet (pictured).

The POMH-UK was launched in 2005 and is aimed to help specialist mental health services improve prescribing practice. POMH-UK is partly funded by a tapering grant from an independent charity, the [Health Foundation](#) under its ‘Engaging with Quality’ initiative, and partly from subscriptions from member Trusts. Neither POMH-UK nor the Health Foundation has any links with the pharmaceutical industry.

So far, more than 40 mental health Trusts, including Hertfordshire Partnership Foundation Trust, have participated in POMH quality improvement programmes. Most such programmes comprise a cycle of clinical audit against evidence-based standards and bespoke change interventions, including prompt feedback of benchmarked data that allow Trusts to compare their prescribing practice with other participating Trusts. POMH prioritise areas needing development, and send these topics to participating trusts.



POMH-UK tries to involve service users and carers at all levels of its work. There is a mental health service user on the management team and four service users on the steering group. In addition, because organisations such as Mind and Rethink are part-

ners, the views of other service users and carers are also brought to the programme. When a new topic is decided, a team of expert advisors, including service users (and carers where appropriate) are recruited to advise on all aspects of the programme, including interventions.

Topics POMH-UK has looked at so far:
Topic 1: High dose and combined antipsychotics in acute adult inpatient settings
Topic 2: Screening for metabolic side effects of antipsychotic drugs in patients treated by assertive outreach teams
Topic 3: Prescribing of high dose and combined antipsychotics for patients on forensic wards
Topic 4: Benchmarking prescribing of anti-dementia drugs
Topic 5a: Benchmarking the prescribing of high dose and combination antipsychotics on adult acute and PICU wards (time-series benchmarking)
Topic 5b: Continued benchmarking as Topic 1, using time-series charts
Topic 6: Assessment of side effects of depot antipsychotics
Topic 7: Monitoring of patients prescribed lithium
Topic 8: Medicines Reconciliation
Topic 9: Use of antipsychotic medication in people with Learning Disabilities

POMH UK has developed a number of service user and carer led interventions, including a popular patient-held card advising and promoting annual physical health checks. If you are a service user or carer and would like a free copy of the patient-held physical health card, please email:- POMH-UK@rcpsych.ac.uk. POMH-UK member Trusts can order these cards in bulk.

Locally users and carers may be involved in different ways from the users on the central team. Obviously, since auditing a service usually requires getting information from confidential psychiatric patient notes, service users cannot be involved in this part of the programme. However once the baseline report is received and the interventions are introduced, the local service users on the local POMH team are an extremely important part of the process. They, usually, know what is happening within their services and often also what the other services users and carers in the area want and find helpful. For example, in topic 2 it was suggested that service users on antipsychotics had blood tests to look at their blood sugar and lipid levels. Local service users were able to advise on how to make this convenient and accessible for the majority, and helped enormously to promote the use of patient-held physical health cards in their area.

I got to know about the work of POMH-UK after experiencing medication difficulties last year. I became lithium toxic probably due to an acute gastric upset which caused severe and prolonged dehydration. I was hospitalised and my lithium had to be discontinued suddenly. (continued page 4)

This was not a pleasant experience but all was well eventually and I am now back taking lithium, as I know it helps control my bipolar disorder well. Additionally, I am now personally somewhat wiser in the knowledge of lithium and how to manage my medication. During the recovery from my toxic psychotic episode, I embarked on the Recovery In-Sight Centre course training, which enhanced my recovery.

One of POMHs current topics may be of particular interest to those who take lithium, Topic 7—Monitoring of patients prescribed lithium. After being informed very well, by my Mental Health NHS Trust head of medicines management and POMH-UK, I decided to attend a conference on 1st December 2009, at the Royal Society of Medicine (London) in conjunction with POMH-UK, National Patient Safety Agency (NPSA (a unique reporting and learning system)), represented by Dr Cleary, Royal College of Psychiatrists and College Centre for Quality Improvement (CCQI). The conference enlightened me more about lithium management and Topic 7.

What came across from the conference was that lithium therapy and its management can be and is ‘an error prone process’ which needs regular systematic monitoring. In fact, this process was compared to a similar monitoring system in place for patients on warfarin, where there are special clinics, organised systems and specific records in place to monitor and administer these. Lithium therapy monitoring should be no different.

Maintaining people on lithium within the relatively narrow therapeutic band, 0.4–0.8mmol/l, requires scheduled and careful monitoring in the form of regular blood tests co-ordinated in a systematic and timely way. If this is carried out and the guidelines followed, then lithium therapy should be a very successful treatment in preventing the highs in bipolar disorder. It certainly helps me. If monitoring is not correctly carried out, along with other compromising factors that can occur, toxicity can occur. This should be pointed out when first prescribed by the doctor, and is and included in the new lithium pack.

Toxicity occurs when the drug is not excreted from the body through the kidneys. Kidney function is also tested as part of the regular blood test, along with thyroid levels. In dehydration the body automatically hangs onto fluid in the body to compensate, but it also hangs onto lithium which is in the system, therefore, in extreme cases this is where lithium levels can rise within the blood and toxicity can occur. If the kidneys are not working properly then this will cause problems too.

On a national scale it was stated at the conference that 1 in 1000 adults are treated on lithium and of these 1 in 7 lithium patients did not have appropriate baseline tests measured or recorded when first starting lithium therapy, such as weight, body mass index, kidney, thyroid levels and heart ECG tracing. Half of all patients prescribed lithium had not had a discussion about toxicity. This should be discussed and an understanding **differentiating** side effects from toxicity should be made.

An area where there are shortfalls is communication between primary and secondary care when it comes to sharing blood test

results and having quick and easy access to electronic results. Patient held records may facilitate this—this, again, is where there is very good news for all current and newly prescribed lithium users. A patient folder “Lithium Therapy” (purple), was launched at the conference and presented by Tom Kabir (patient adviser to POMH-UK). The pack has been produced by POMH-UK working in collaboration with NPSA and the National Pharmacy Association. It contains important information for patients, an alert card and record book pack. It is hoped to help with communication of results/blood levels and guidelines for lithium therapy. They will be available from whoever prescribes the medication, e.g. psychiatrists, community pharmacists or GP’s. For reference, a copy of the pack and other information can be seen at www.nrls.npsa.nhs.uk (safer lithium therapy). Also on this website you can find an alert, issued by the NPSA, for all healthcare organisations in the NHS where lithium therapy is initiated, prescribed, dispensed or monitored.

At the conference there was an interesting talk from a representative from Hampshire Partnership NHS Trust. She described their successful lithium therapy clinic which took the pressure off the local GP’s and blood clinics. They were able to keep track of patients and blood tests, and target patients and chase them up if they did not attend for a blood test. Patients were happy to be able to pop in if they had any problems or worries with their lithium levels, which engaged patients with the ‘open-door’ policy. An appointment system exists where patients can come in and have their bloods taken, to coincide with their last dose. Lithium education was on-going to patients. It was further reported that the patients took more responsibility for their medication. The Hampshire service is jointly funded from their PCT. Not many lithium clinics remain under secondary care, as these have mainly been passed to primary care now. I do feel either more clinics such as in Hampshire or local primary care lithium monitoring clinics (staffed by nurse teams trained in lithium monitoring) could be developed regionally, to support people prescribed lithium and on-going monitoring.

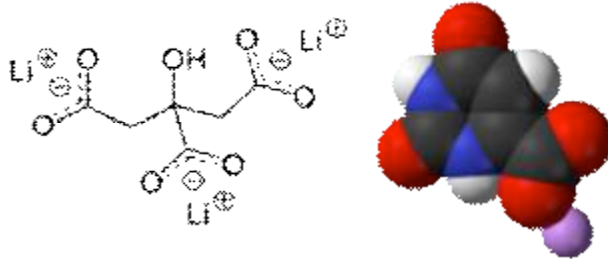
On a personal level, I have not always found it easy to get bloods taken when they should be taken, at the correct time of day, to coincide with 12 hours after last dose. Some blood clinics do not operate on certain mornings as they are dedicated to warfarin blood testing or have limited opening times. Having a knowledge of your local blood clinics and opening times will certainly help. Times are often written on back of blood request form, but your practitioner can inform you. I feel improvements in information sharing and systems to share bloods results still need to happen, simple things like my psychiatrist having access to a blood test result on his computer which I had taken via my GP/local hospital. Again the new ‘Lithium Therapy’ packs can be presented to clinicians and pharmacists to share this information.

A re-audit by POMH-UK to cover areas which are falling short, will take place in April 2010. After Topic 7 is complete I have every confidence that systems will continue to improve in: the monitoring of lithium management, information and results sharing where access should be enhanced for new and existing users, and all practitioners involved with lithium management.

For me, learning about the work of POMH-UK was re-assuring, in that it can only continue to improve services and help maintain standards.

Useful organizations for information about medication and treatments & research

The British National Formulary: www.bnf.org	Rethink: www.rethink.org
Choice and Medication: www.choiceandmedication.org.uk	National Patient Safety Agency (NPSA): www.npsa.nhs.uk
National Institute for Health and Clinical Excellence (NICE): www.nice.org.uk	Medicines and Healthcare products Regulatory Agency (MHRA): www.mhra.gov.uk
The MHRA 'Yellow Card' scheme: www.yellowcard.mhra.gov.uk	The Care Quality Commission (CQC): www.cqc.org.uk/aboutcqc.cfm
Mind: www.mind.org.uk	Team Lithium: www.teamlithium.co.uk



(Li₂CO₃) Lithium Carbonate

Medication Spotlight: Lithium

Written by B.Maru

Lithium (Li) is a metal but occurs naturally as salts in organic ores and has been used in medicine for at least 150 years. In the mid 19th century it was used as a treatment for gout, and in 1865 mania and melancholia were incorporated into the group of gouty diseases, and therefore were treated with salts containing Li. In the 1950s Li salts were widely used in the USA as a salt substitute for cardiac patients, this however resulted in lithium toxicity and subsequent Li induced renal toxicity was identified. It wasn't until the 1950s that an Australian clinician (John Cade) used Li to treat psychotic illnesses and he observed a good response in patients suffering from mania, noting toxicity after early Li use.

It wasn't until as late as 1970 that Hartigan Baastrup published a double blind discontinuation study that showed without doubt the effectiveness of lithium therapy. This helped to understand the pharmacokinetics of Li and the serum concentrations were monitored. In 1977 clinicians were made aware that long term lithium use could induce chronic, irreversible renal damage and it became evident that patients treated with lithium exhibited varying degrees of hypothyroidism. The action of Li is not very well understood, to this day, but there are many theories.

Li is predominantly prescribed as Li carbonate but it available as Li citrate. Patients should be advised to take Li at night in order to reduce the impact of side effects. A few key facts about Li are unfortunately withheld from patients these days by clinicians. Li is almost exclusively removed from the body by the kidneys and removal from the body depends on the persons age and renal function. This is a very important drawback of the treatment. The British Medical Association and Royal Pharmaceutical Society of GB state patients experience serious toxicity when Li concentrations are in excess of 2mmol/L. However, Li toxicity is generally thought to occur at 1.5mmol/L, but can occur with serum levels as low as 1mmol/L.

Patients should be advised, but unfortunately aren't, that toxicity can occur from the obvious, overdose, to loss of salt from the body due to illness, where high temperature, vomiting, diarrhoea and dehydration have occurred. Unsupervised dieting or fasting, as well as low salt diets can lead to toxicity as well as diuretics and painkillers (such as aspirin and ibuprofen etc). Excessive exercise, hot weather and excessive perspiration can all lead to toxicity too, as they all interfere with the salt balance within the body, which, critically, needs to be maintained to maintain therapeutic serum levels of Li. These are simple factors that should be mentioned to patients, and in my experience, too many patients prescribed Li have not had any of this information.

Level of Toxicity	Side Effects
Mild	<ul style="list-style-type: none"> • Slight Apathy. • Sluggishness. • Drowsiness and lethargy. • Reduced concentration. • Muscular weakness. • Ataxia. • Troublesome but regular hand tremor. • Slight Muscle twitch.
Moderate	<ul style="list-style-type: none"> • Apathy. • Sluggishness. • Drowsiness. • Lethargy and sleepiness. • Speech difficulty. • Irregular tremour. • Obvious myoclonic twitchings (shock like contractions of a muscle or a group of muscles). • Muscular weakness and ataxia
Severe	<ul style="list-style-type: none"> • Markedly impaired consciousness. • Hyperreflexia (exaggerated response of the deep tendon reflexes). • Convulsions and epileptic seizures. • Brain, renal and cardiac damage.

In most cases toxic levels of Li are preventable, and to decrease the chance of toxicity patients should stay hydrated by drinking lots of fluids. Patients should not start a low salt or no salt diet with consultation with mental health professionals, and Li levels should be monitored regularly.

Side effects of Lithium	
<ul style="list-style-type: none"> • Indigestion. • Weight gain. • Oedema (not treatable with diuretics). • Acne. • Exacerbation or precipitation of psoriasis. • Leucocytosis. • Headache. • Cogwheel rigidity unresponsive to anti-parkinsonian therapy. • Cardiac arrhythmia. • Hypo- and hyperthyroidism. 	<ul style="list-style-type: none"> • Dry mouth. • Constipation. • Metallic taste. • Blurred vision. • Stuffy nose. • Tinnitus • Flushing • Feelings of unreality. • Limb stiffness. • Body aching. • Nephrogenic diabetes insipidus (reversible upon discontinuation of therapy).

	Baseline	Initiation	Monitoring
Height	*		
Weight	*		Especially in patients with rapid weight gain.
Urea and Electrolytes	*		If urea and creatinine levels rise see below.
Serum creatinine/renal function	*		* 6 monthly (more often if evidence of impaired renal function or if the patient starts taking drugs such as ACE inhibitors, diuretics or NSAIDs). If urea and creatinine levels rise, monitor lithium dose and blood levels more closely and assess the rate of deterioration of renal function. The decision on whether to continue the drug depends on clinical efficacy and the degree of renal impairment. Consider consulting a renal physician.
Thyroid function tests	*		* 6 monthly (more often if evidence of deterioration).
ECG	* Good practice. Essential for patients with cardiovascular disease, or risk factors for it.		
Full Blood Count	*		Annually, and as clinically required.
Lithium Levels	*	One week after starting, and one week after every dose change, and until levels are stable. Aim for the minimum dose to achieve a therapeutic response. Usually in the range: 0.6 to 0.8 mmol/L (NICE) A therapeutic response may be seen at a level of 0.4mmol/L.	Every 3 months. Normally, 0.6–0.8 mmol/L, according to patient response. (A therapeutic response may be seen at a level of 0.4mmol/litre). 0.8–1.0 mmol/L if the patient has relapsed previously on lithium or has subsyndromal symptoms. Also observe/inform patient to be aware of signs of toxicity: blurred vision, GI disturbances, muscle weakness, drowsiness, etc. These usually occur at levels >1.5mmol/litre, but can occur at lower levels. Monitor older adults more closely, as they are at greater risk of developing toxicity. Use lower doses. They may develop symptoms of lithium toxicity at standard therapeutic levels.
Serum calcium	*		* Annually. Lithium may increase calcium levels.
Physical health check	*		* Annually, normally in primary care for people with bipolar disorder (NICE): <ul style="list-style-type: none"> – lipid levels, including cholesterol in all patients over 40 even if there is no other indication of risk – plasma glucose levels – weight – smoking status and alcohol use – blood pressure.
Patients mental state	*		* As needed. Regular reviews of mental state and personal and social functioning, to ensure that symptoms (including sub-threshold symptoms) are treated if they significantly impair social functioning.

***Routine monitoring essential**

The National Institute for Clinical Excellence (NICE) have developed guidelines to ensure Li therapy is safe and effective. It has been classified as an “amber” treatment, and therefore can only be initiated by a specialist. The option of Li treatment of bipolar disorder should depend on the relative risk, and known precipitants, of manic versus depressive of the patient. Physical risk factors, particularly renal disease, obesity and diabetes need to be taken should also be taken into account as well as the

patient’s preference and history of adherence. The benefits, risks and side effects **SHOULD** be discussed with the patient by the prescriber. Baseline monitoring **SHOULD** be performed before prescribing begins and the prescriber **SHOULD** advise patient with regard to adequate fluid balance and sodium intake, and interactions with medications that can be bought over the counter (e.g. NSAIDs).

Interaction	Medications
Decreasing Li concentration	<ul style="list-style-type: none"> • SSRIs • Metronidazole • Tetracyclines • Topiramate • Non-steroidal anti-inflammatory drugs (NSAID) • ACE inhibitors • Thiazide diuretics (may cause a paradoxical antidiuretic effect resulting in possible water retention and lithium intoxication) • Spironolactone • Frusemide • Angiotensin-II receptor antagonists • Other drugs affecting electrolyte balance, e.g. steroids
Increasing Li concentration	<ul style="list-style-type: none"> • Xanthines (theophylline, caffeine) • Sodium bicarbonate and Sodium Chloride containing products • Psyllium or Ispaghula husk • Urea • Mannitol • Acetazolamide
Possibly causing neurotoxicity	<ul style="list-style-type: none"> • Neuroleptics (risperidone, clozapine, phenothiazines, & particularly haloperidol). • SSRIs, Sumatriptan and Tricyclic Antidepressants - may precipitate a serotonergic syndrome. • Calcium channel blockers. • Carbamazepine or phenytoin. • Methyldopa
Other	<ul style="list-style-type: none"> • Lithium may prolong the effects of neuromuscular blocking agents • Thioridazine may increase risk of ventricular dysrhythmias • Iodide and lithium may act synergistically to produce hypothyroidism

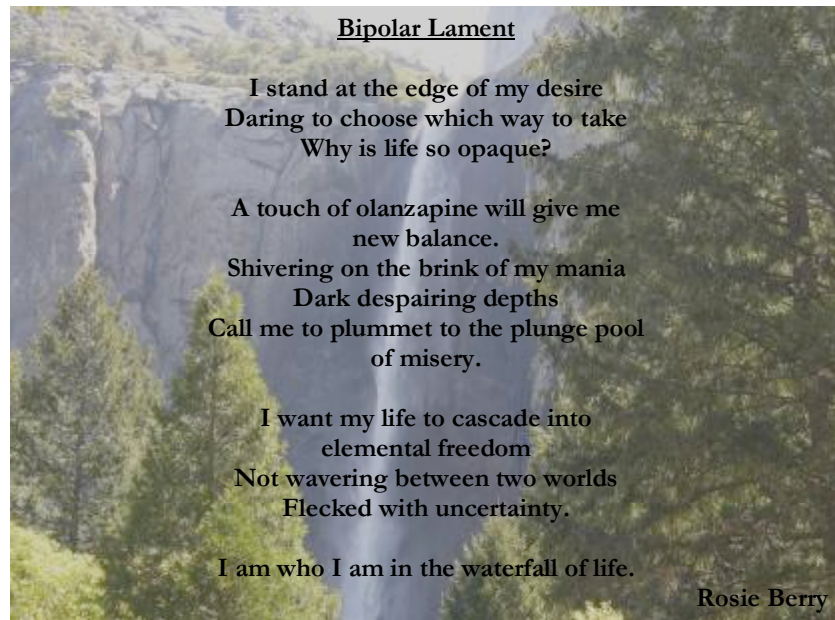
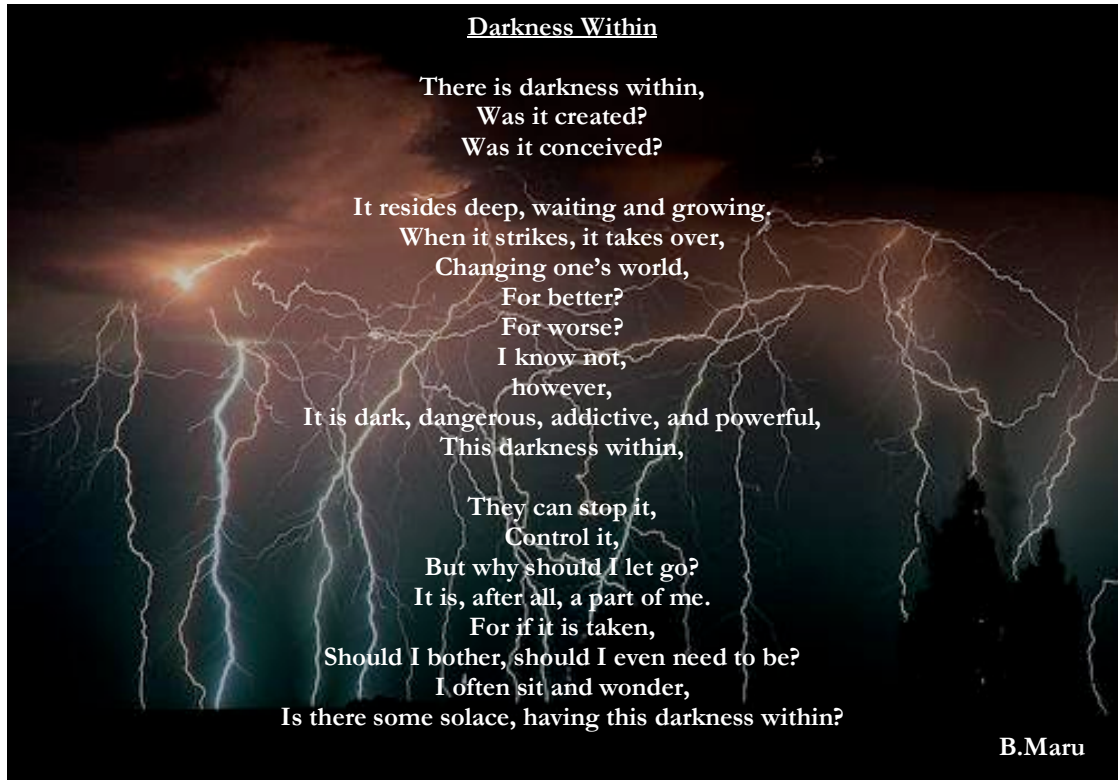
The prescriber should make sure that the time of first sample to check lithium plasma concentration is 5-7 days (renal function dependant) after initiation or dose change and 12 hrs post dose. This is to be repeated every 5-7 days (renal function dependant) until required level attained, and once attained Li plasma levels should be monitored every 3 months. Patients taking lithium liquid (usually taken twice daily) should be monitored 2 hrs post dose for peak concentration. Usually, the full dose is given in a modified-release form as a single daily dose with starting dose normally being 400mg (200mg in the elderly).

It is imperative that the prescriber advise that erratic compliance or suddenly stopping the drug may increase the risk of relapse. The prescriber should also explain that Li should be trialled for at least months to monitor its effectiveness. If Li is to be discontinued then it should be reduced gradually over at least 4 weeks or 3 months. If Li is to be stopped then another antipsychotic could be used, but close monitoring for early signs of mania and depression are required.

Li remains unique and is still the gold standard in the treatment of bipolar mood disorder. It really is incredible that

a simple element can have such an impact on the treatment of a major psychiatric illness. Clearly, there is no doubt concerning its use as a treatment which is preventative against manic-depressive illness, but there is a great need for closer monitoring of patients under Li treatment. However, above all, the medics should examine the patient for early signs and symptoms of neurotoxicity even when no apparent reason exists. Two more problems should be considered; first, Li has virtually no commercial value, which unfortunately will restrict research and Li could some day be unavailable just because of this. Secondly the training of newly qualified medics in the use of Li is rapidly declining, which makes it impossible to safeguard its proper use and monitoring. A special focus on Li training should be included in all training programmes.

Members Page:



Recovery InSight Today would like your articles for publication—It can be anything from your personal experiences, poems, photos, etc. Please forward, ideally, in Word format and email to the Group's email address as shown below, or post to The Recovery In-Sight Centre office (address on back page). Handwritten material is also fine.

Deadline for next newsletter by

Monday, 31st May 2010



Mental Ill Health..?

- ⇒ Are you suffering from mental ill health?
- ⇒ Would you like to build up your confidence?

We can help!

The Recovery In-Sight Centre, based in Hatfield, is a user led organisation for anyone affected by and/or with mental ill health. We Offer:

The 'In-Sight' course -

A comprehensive lifestyle development group training enabling people in their recovery from mental ill health.

Next course every Wednesday 12th May - 7th July 2010

10am - 5pm

- ⇒ Courses run at our modern offices in Hatfield
- ⇒ £50 admin fee to attend this 51 hr course, materials & refreshments provided
- ⇒ Open to a maximum of 12 service users/carers per course
 - ⇒ Please contact us to reserve your place

Putting
Recovery
Values Into
Action

Don't Suffer Alone..!

Bipolar self-help groups -

- ⇒ If you have a diagnosis of bipolar or are a carer of someone with bipolar disorder, come along to our support groups.
- ⇒ Monthly self-help meetings in Watford (every 2nd Saturday morning of the month) & Stevenage (every 4th Wednesday
 - ⇒ afternoon of the month).

New members are always welcome at the groups

Voluntary Opportunities -

Are available with us in administration, marketing, sales & communications.

RECRUITMENT UNDER THE DISABILITY DISCRIMINATION ACT 1995

Reasonable travel costs will be reimbursed

The Recovery In-Sight
Centre

MacLaurin Building
4 Bishop Square
Business Park
Hatfield
Herts
AL10 9NE

Telephone:
01707 284808
01923 239489

Email:
contact@recoveryin-
sight.com

Please contact us for further information

www.recoveryin-sight.com