Affective Disorders Service

An internationally renowned service for the research and treatment of complex and treatment-resistant affective disorders.
» It was the best treatment I’ve ever had. I have never been so well for so long following any other admission. «  Christie
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Service overview

Our service provides specialist assessment and treatment for complicated or resistant mood disorders.

We have an impressive record in treating resistant cases, and obtain a >50% decrease in standardised depression ratings (Hamilton Depression Rating Scale), in around 70% of inpatients we treat, all of whom have been resistant to multiple treatments over several years.

Our care options are tailored to the needs of the person and the referrer, who both benefit from comprehensive, specialist input, delivered by acknowledged experts utilising the latest evidence-based treatment.

King’s Health Partners

Our service is part of the Mood, Anxiety and Personality Disorders Clinical Academic Group. SLaM has joined with King’s College London, Guy’s and St Thomas’ NHS Foundation Trust, and King’s College NHS Foundation Trust to establish King’s Health Partners, an Academic Health Sciences Centre. King’s Health Partners involves bringing clinical care, research and education much more closely together. Our aim is to reduce the time it takes for research discoveries and medical breakthroughs to become routine clinical practice. This will lead to better care and treatment for patients.

Visit www.kingshealthpartners.org for more information.
Our philosophy

We foster an environment where our patients are encouraged to participate fully in every stage of their treatment, by looking at their problems and setting up and evaluating treatment plans with their primary and associate nurse.

People are encouraged to remain as independent as possible during their stay on the ward, and to make use of the resources available both within the hospital and the community, to assist in their recovery.

» They literally saved my life, and I will be forever indebted. Thank you all. «  Sally
Who is our service for?

We offer specialist inpatient and outpatient services for people with treatment-resistant affective disorders, including depression, bipolar, seasonal affective disorder (SAD) and other mood disorders.

Our service also provides treatment to healthcare professionals who cannot be treated in their local area for reasons of confidentiality.

Eligibility

› 18+ years
› Male or female
› Treatment-resistant mood disorders (unipolar and bipolar disorders)
› Mood disorders in healthcare professionals
› Affective disorders requiring specialist psychological interventions
› Depression with a seasonal pattern (SAD)
› Support of the referring consultant and community mental health teams who fund the admission

Exclusion

› The inpatient service is an open, sub-acute unit, therefore each person is assessed for risk and vulnerability
› Chronic drug or alcohol use
› Lack of engagement with local community mental health team to co-ordinate after-care

» The fact that it is specifically for one type of mental health problem means that all treatment and care feels more in tune with your needs. This makes the stay on the ward less stressful because you know staff understand what you’re feeling and going through, more than on a general psychiatric ward. «  Mark
Interventions

We provide expert assessment and a range of specially designed therapies to improve the lives of our patients.

Clinical assessment
Our assessment incorporates medical, psychological, occupational therapy and nursing, and informs the recommendations for the patient’s treatment plan.

Structured diagnostic interview
In addition to a clinical assessment, a semi-structured interview (SCID, MINI or SCAN) and the computerised diagnostic package, OPRIT+ are administered. These generate research-quality diagnoses according to the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders 4th Edition (DSM IV), the World Health Organisation’s International Statistical Classification of Diseases and Related Health Problems 10th Revision (ICD10), and other operational criteria which supplement the clinical diagnoses.

We also use a range of validated clinician and self-administered tools to monitor treatment responses during an admission.

Occupational therapy
Our onsite occupational therapy department provides the perfect therapeutic environment to aide our patients in their recovery. We offer a wide choice of creative activities including art, gardening, computer skills, textiles, pottery, dramatherapy, Aikido, cookery, woodwork and meditation. We also provide opportunities to develop work skills through our woodwork and gardening work schemes.

Pharmacotherapy
We administer combinations of medications to provide optimal treatment for refractory affective disorders. The combinations are carefully tailored to suit each patient and are closely monitored for therapeutic and harmful side-effects. This is done through the use of blood tests, physical observations and regular reviews by medical staff in weekly ward and management rounds. Blood levels of prescribed psychotropic medication are routinely taken in order to assess compliance, detect potential pharmacokinetic mechanisms for treatment resistance (like fast metabolisers or drug-to-drug interactions), and to ensure optimal treatment dosages.

Psychological therapies
We use a variety of psychological therapies, including behavioural activation, cognitive therapy, cognitive behavioural therapy (CBT), mindfulness-based cognitive therapy (MBCT) for treatment-resistant depression, and interpersonal psychotherapy.
Sexual and couple therapy
Our dedicated couples therapist provides both sexual and couples therapy to help patients and their partners maintain their relationship through what can be very difficult periods. Part of the role of this therapy is to allow space for the carers to understand and respond to the changing presentations that can occur in patients with a treatment-resistant mood disorder.

Specialist and enabling nursing care
Our 24-hour nursing care helps patients carry out their daily living activities, while providing regular one-to-one support to help them achieve and maintain progress.

Physical therapies
We specialise in the design of novel drug treatments for treatment-resistant mood disorders and also offer electroconvulsive therapy (ECT) if it will benefit the patient. Our ECT service is run by dedicated ECT consultants and utilises current best practice, including electroencephalogram (EEG) monitoring and fit threshold titration. We offer light therapy advice and treatment where there is a seasonal component to the affective disorder.

Physical health monitoring and intervention
We monitor each person’s physical health through the use of a magnetic resonance imaging (MRI) scan and routine blood tests. Physical problems which cannot be treated on the unit are referred to other specialists for further investigation and treatment. We pay particular attention to general physical health problems like hypertension, impaired glucose tolerance and raised blood lipids. These problems are common and are often neglected in patients with affective disorders, where they can be exacerbated by medication use, or provide two-way adverse interactions with depression.

Our specialist dietician offers advice and plans many dietary interventions, including ensuring adequate nutrition in those who are underweight, aiding weight loss in those who are overweight, and aiding in lipid-reducing diets.

Assessment of suitability for neurosurgical intervention
As well as providing treatment, we also assess a person’s suitability for a neurosurgical intervention. While the final decision is made by the specialist neurosurgical unit, we advise on what treatments need to be tried before a referral for an assessment for specialist neurosurgical intervention is accepted. Novel neurosurgical interventions like vagus nerve stimulation (VNS) and deep brain stimulation (DBS) are available at King’s College Hospital.

» The help you offer to people like me, who have reached a point of no hope, is live-saving. Without you I would not have made it this far. « John
Our care model

**FAMILY AND CARERS**
- Joint understanding of the illness
- Exploring the needs of the carer and the patient
- Understanding medical risks

**ASSESSMENT**
- Multidisciplinary formulations
- Neuropsychological assessments

**EDUCATION AND VOCATIONAL OPPORTUNITIES**
- Support to achieve or continue with further education
- Support to achieve a return to paid employment
- Support to start voluntary work

**PATIENT**
- Effective illness management
- Improving levels of independent living
- Improving levels of self-esteem
- Re-integration into the community
- Increased periods of home leave

**THERAPIES**
- Psychopharmacological management
- Behavioural activation
- CBT
- Couples therapy
- Interpersonal psychotherapy
- Occupational therapy
- MBCT

**RISK MANAGEMENT**
- Maintaining medical needs
- Routine blood investigations
- Understanding blood results
- Plasma level monitoring for relevant medication prescriptions
- Psychological and physical risk management
- Discharge planning
- Recommendations for managing risk in the community
- Appropriate use of MHA, MCA and DOLS legislation
» I don’t think I would be here now if it wasn’t for the team. The difference between my local psychiatric ward and here was immense. I feel very fortunate to have been given the opportunity to come here. «  

Stuart
Our care pathway – inpatients

- Referral received with funding approval
- Assessment
- Referred back to local team with advice on treatment plan
- Outpatient treatment
- Discharge back to local team with recommendations for further local treatment
- 6 to 8 month admission
Our care pathway – outpatients
Outcomes

We work with our patients to help them effectively manage their disorder and its associated symptoms. We work to improve people’s self-esteem, while providing support and education to their families and carers about the illness.

Outcomes may include:

› Educating the person and their family about the nature of the illness
› Relapse intervention and prevention
› Regular reports and meetings with the referring team, with provision of standardised outcome data
› Discharged back into the local community at the earliest opportunity
› Reduced need to access local mental health services
› Improved functional capacity

Our results
We have systematically assessed the clinical outcomes for more than 250 people admitted to our inpatient unit, including a long-term follow-up of more than 100 patients, where outcomes were assessed up to six years after discharge.

Graph one shows the results of a study which compared the number of admissions and self-harm attempts before and after inpatient treatment. Admission to our unit significantly reduced admissions and self-harm attempts at an average of three years after receiving treatment. The total number of days people were admitted to local facilities fell from an average of 215 to 35 days.

1. Number of admissions and self-harm attempts

» I came out of it a changed person and for that I thank all the staff. They got their judgements and timing right. « Faye
Graph two shows the effects of inpatient treatment on symptoms in people with treatment-resistant unipolar or bipolar depression. There was a significant decrease in people’s depressive symptoms following inpatient treatment, which were maintained up to six years later.

2. Change in depressive symptoms
Our facilities

Our inpatient unit has 13 beds for female patients, five beds for male patients and is located on the grounds of the historic Bethlem Royal Hospital.

The Bethlem has a long history of providing the highest quality care for people recovering from mental health issues. The hospital offers the perfect therapeutic environment for promoting recovery, set in 270 acres of green space, with woodland and meadows that are designed as a ‘site of importance for nature conservation’.

Facilities at the Bethlem include a swimming pool, art gallery, walled garden, a chapel, nature walks and an extensive occupational therapy programme, utilised by many of our patients. This programme provides a wide choice of creative activities which give people the opportunity to rekindle old skills, learn from new experiences and build their confidence on their path to recovery.

We offer:

› Private bedrooms
› Television lounge
› Occupational therapy kitchen and dining room
› Visiting rooms
› Therapeutic rooms
Our team

Our specialist team includes consultant psychiatrists, psychologists, psychotherapists and nurses.

Professor Anthony Cleare  BSc, MBBS, MRCPsych, PhD
Professor | Consultant Psychiatrist

Professor Cleare is a professor of affective disorders and a consultant psychiatrist with our inpatient unit.

Background
Professor Cleare qualified in medicine at Guy’s Hospital and then trained in psychiatry at the Maudsley, Bethlem Royal and King’s College Hospitals. He was appointed as a consultant at the Maudsley in 1998.

He completed his academic training at the Institute of Psychiatry, King’s College London, where he held a clinical lecturer position and a senior fellowship, including time spent at the Hammersmith Hospital and Imperial College London’s Positron Emission Tomography (PET) Unit. He attained senior lecturer status in 1998 and was appointed reader of affective disorders in 2006.

Research
Professor Cleare maintains an active programme of clinical research on depression and is part of the Biomedical Research Centre at the Institute of Psychiatry, King’s College London.

A major focus of his research is continuing work that improves the understanding of the aetiology, neurobiology and long-term outcome of treatment-resistant depression. He published the Maudsley Staging Method, a tool for staging the severity of treatment resistance – a hitherto under-researched area.
**Professor Peter McGuffin** MB, PhD, FRCP, FRCPsych, FMedSci  
**Professor | Honorary Consultant Psychiatrist**

Professor McGuffin is director and professor of psychiatric genetics at the Institute of Psychiatry, King’s College London. He is also an honorary consultant psychiatrist in our inpatient unit.

**Background**  
Professor McGuffin graduated from Leeds University Medical School in 1972, then went on to undertake postgraduate training in internal medicine. Developing an interest in genetics and psychiatric disorders, he trained in psychiatry at the Maudsley Hospital, before being awarded a Medical Research Council Fellowship to study genetics at London University and Washington University, St Louis, Missouri.

In 1982, Professor McGuffin returned to the Institute of Psychiatry as a Medical Research Council (MRC) senior clinical fellow. Then, moving to Cardiff, he became chair of psychological medicine at the University of Wales’ College of Medicine – a post that he held until 1998. Returning once again to the Institute, he was director of the MRC Social Genetic and Developmental Psychiatry Centre until he took the post of Dean of School from 2007 until 2010.

**Research**  
Research interests include genetics and gene-environment interplay, taking into account pharmacogenetics in affective disorders. Professor McGuffin has also been involved in research activity on the genetics of schizophrenia.
Our team continued

Professor Anne Farmer MB, ChB, DPM, MRCPsch, MD, FRC
Lead Consultant | Professor

Professor Farmer is the lead consultant in our outpatient service. She runs the healthcare professionals with affective disorders service, and telemedicine consultation services. She is also a professor of psychiatric nosology at the Institute of Psychiatry, King's College London.

Background
Professor Farmer completed her medical qualifications (MB ChB) in 1972 and her psychiatric qualifications (DPM) in 1976, both in Leeds. She qualified as a member of the Royal College of Psychiatrists in 1980, as a Doctor of Medicine (MD) in 1987, and as a fellow of the Royal College of Psychiatrists in 1993.

Professor Farmer has been in her current posts at the Trust and the Institute since 1998. Other roles have included:

› Professor for the departments of postgraduate education and psychological medicine at the University of Wales College of Medicine, Cardiff, from 1995 to 1998
› Honourary consultant psychiatrist at the University Hospital of Wales, South Glamorgan Health District, from 1994 to 1998
Dr Rina Dutta BSc, MB BS, MRCPsych, MSc, PhD
Honorary Consultant Psychiatrist

Dr Dutta is an honorary consultant psychiatrist for our outpatient service. She runs a follow-up clinic for healthcare professionals with affective disorders and has a clinical special interest in bipolar affective disorder and the mental health of healthcare professionals.

Background
Dr Dutta graduated in 2000 with a first class honours degree in experimental pathology and two distinctions in medicine from Guy’s and St Thomas’, and King’s College London Schools of Medicine. She worked as a house officer at St Thomas’ Hospital and then trained in psychiatry (MRCPsych) as a senior house officer at St George’s Hospital.

In 2005, she became a clinical researcher and honorary specialist registrar (SpR) at the Institute of Psychiatry, King’s College London, and the Maudsley Hospital. In 2007, she was awarded a Medical Research Council (MRC) training fellowship and received the British Medical Association Margaret Temple Research Award.

In 2008, Dr Dutta completed her masters (MSc) degree with a distinction in epidemiology at the London School of Hygiene and Tropical Medicine. Her PhD was awarded in 2010.

Research
Dr Dutta applies a lifecourse epidemiology approach to her psychiatric research. She also has interests in translational research to improve the management of affective disorders.
Our team continued

**Dr Cynthia Fu** MD, PhD  
Honorary Consultant Psychiatrist | Senior Clinical Lecturer

Dr Fu is an honorary consultant psychiatrist in our service and a senior clinical lecturer at the Institute of Psychiatry, King’s College London. She directs the outpatient clinic, which specialises in treating people with mood disorders who have not responded to usual treatments.

**Background**  
Dr Fu completed her training in psychiatry at the University of Toronto, where she was chief resident at the Clarke Institute. She became a Fellow of the Royal College of Physicians and Surgeons of Canada (FRCPC), and was a Wellcome Fellow at the Institute of Psychiatry, King’s College London.

She completed her PhD in 2004 and was awarded clinical senior lectureship by the Higher Education Funding Council for England in 2008.

**Research**  
Dr Fu’s research is regularly cited in the top decile for influential publications in psychiatry and she has been invited to present her work at national and international research centres and conferences, including the International Congress of the Royal College of Psychiatrists (UK), and the World Congress of Biological Psychiatry, King’s College London.

Her research focuses on the brain regions that underlie mood disorders and how these regions are affected by treatment with medication or talking therapy. She has a particular interest in the early stages of mood disorders as there is evidence that effective intervention early in the course of the illness may prevent the development of more serious impairment, thus improving clinical outcomes.
Andrew Harvey RMN, ENBCC 650, Dip Short Term Adult
Behavioural Psychotherapy
Service Lead

Andrew is a principal cognitive behavioural psychotherapist and has overall responsibility for the day-to-day running of the service, including the co-ordination of research.

Research
Andrew is interested in how third-wave therapies can be applied as part of CBT to treat resistant affective disorders. He is trained in the application of mindfulness to chronic depression and is hoping to develop further skills in acceptance and commitment therapy, and perceptual control therapy.
Sara-Jayne Tidman
Service Administrator

Sara-Jayne is our senior administrator. She provides a professional lead to administrative staff, as well as developing, implementing and reviewing standards for good administrative practice.

Sara-Jayne co-ordinates the service’s healthcare professionals clinics and also acts as central administration for the Trust’s practitioner healthcare programme, assisting in providing a comprehensive, confidential service to staff.

Her role includes funding liaison between referrers and commissioners, with provision of appropriate reports.
Tabitha

“Could I have imagined having a mental health problem? I’d have said ‘no’, definitely.”

I was a confident person, I had a good job, I was running a family home and was on a part-time degree course. There were things going on at work though. I’m sure there must have been flags before that, but at work I’d go to the toilet and just cry. I didn’t know what was going on in my head, and when I went to see my GP, I just collapsed in a heap.

We had private health insurance at the time, though I didn’t really improve under private care. I was suicidal and after a while the insurance company refused to pay for more treatment because they felt my condition had become chronic. I stopped work and was at home doing nothing.

“Our community mental health team has been wonderful.”

I can’t fault them. My care co-ordinator visited me on a weekly basis back then and still visits now. The whole community mental health team has been really, really fantastic – wonderful.

Things started to pick up so I decided to go back to work. I was still depressed though, and after working for another four months I just couldn’t go on. I was becoming more and more suicidal and the home treatment team was concerned for my safety. They felt I needed to go into a hospital so I agreed to voluntary admission.

After three weeks on a Bethlem ward, I was transferred to their women’s service, a house with just eight patients and lots of support. The service was very, very good. With three staff members to eight patients, they always gave you time. And, it wasn’t a locked door there.

“Quite often with depression, you need that one-to-one support.”

After nine weeks I felt it was safe to go home, though I still wasn’t well and changes in my antidepressants were causing problems – like putting on weight and finding it difficult to breathe. The staff at the Affective Disorders Service recommended CBT, but I had to wait, during which time I became very unwell and was sectioned to the Gresham Ward.

I was there for six months and, I must say, it was a very difficult time for me. The nurses and members of staff did provide lots of support though, and I appreciated that because quite often with depression you do need that one-to-one support. I also started CBT with a wonderful psychologist, but she was managing me from crisis to crisis so I think it was difficult for her.

An inpatient admission to the Affective Disorders Service was recommended.

“I wasn’t sure what to expect from the Affective Disorders Service.”

One positive thing is that everyone has an affective disorder so it’s a very good place for peer support.
You’re also involved in making decisions about your care, which is great because you quite often find you don’t have a voice in hospital.

I had to do occupational therapy too, whereas I wouldn’t go to it on previous admissions. They don’t force you, but there’s a feeling that you aren’t going to spend all your time sitting on the ward. At the start I’d go to these things and just cry, but people gave me time and the group leaders were so supportive.

I was encouraged to join the cookery group, among others. I have a City and Guilds qualification in cookery but hadn’t cooked for a while because I’d formed some kind of barrier. It was stressful at first because it made me aware of all the things I couldn’t do, but the group helped me to build my confidence again over time.

“I started to have more good days.”

At the Bethlem, all the pressures of managing a home are taken away. I didn’t have to think about housework or cooking, I was able to try different medications and, being on a ward, it was easy to test things out for the CBT. The psychology team was fantastic – really, really good.

I started to have more good days, which was a combination of the medication, CBT and occupational therapy. My mood was better – not every day, but slowly – and eventually there was talk about going home. You spend every weekend with your family and that’s so helpful because there can be hurdles to going home, so you’re kept in touch with what’s going on.

I continued with CBT for a while after leaving and my husband and I started couple’s therapy – because when you’re ill your relationship changes. I lost all my confidence and self-esteem; he became my carer and I let him.

“It’s so good to enjoy life now.”

There was no way that I was 100 per cent when I left, but I was definitely in a place where I could build up my life again. I’ve been at home for five months now and I’m much, much better. Before, I was only thinking about how I could kill myself – I was even planning my own funeral. There’s been a huge change. I’ve come so far away from that.

I had such a laugh when I was out with my sons the other day. We had heavy snow so we all went for a greasy-spoon breakfast, and going across the park, we were throwing snowballs at each other and built a snowman. They’re 19 and 23, my sons, so none of us are that young. Before, I’d lost all ability to have fun. A couple of days ago, I even joined Facebook and uploaded the photos from our snow walk.

Also, it was my husband and my 25th wedding anniversary earlier in the year and we went to Egypt for two weeks. We haven’t been able to go on holiday for five years. He was worried – it can take a carer longer to recover – but I was fine every single day. We had the chance to enjoy each other’s company again and that was lovely.
Conrad

“I was barely hanging on to life.”

Well, I’ve had periods of depression throughout my life and it’s fair to say that they were getting worse. Things came to a head when I was suicidal at the end of 2008. Without my wife and step-daughter, I’m sure I wouldn’t be here today.

When I was admitted to the Bethlem, I was barely hanging on to life. Every moment of the day felt like torture, so admission was probably my last chance really. Still, I didn’t want to go. I said to my wife, ‘you’re not holding back some other option, are you?’ It was such a struggle to leave our house on the day, and it was so frightening when she went home, leaving me behind.

It’s hard for me to describe the first few weeks of my stay in the hospital. Things probably felt worse for a while. I had a radio, MP3 player and books, but I never left my room and I’d jump a metre in the air when someone tapped on the door.

“My primary nurse had a really good understanding of what it felt like to be me.”

We made a connection on the first day and I still feel incredibly fortunate because she was brilliant – absolutely excellent. She had a really good understanding of what it was like to be me and the fears I had. She walks on water, as far as I’m concerned.

It seems that staff at the Bethlem invest a little of themselves into every patient. There’s continued thought and effort to help people improve and they have seemingly boundless patience. I’d drone on, saying the same things over and over, yet someone always listened and had something sensible and comforting to say. It’s extraordinary to find this attitude among so many. It’s part of the culture there, and that attitude has enabled me to improve and has inspired me to try harder.

“I started to see improvements around the sixth week.”

I’m not sure if there was a particular incident that triggered it; it was probably just the result of the continuing kindness and patience from staff.

I was hesitant, to be honest, about sharing how I was feeling at first because I didn’t want to make things worse for myself, but it was such a relief to speak my mind once I realised people were there to help. If someone asks you how you are in the street, they generally don’t care that much about the answer. But there, they do care.
Being honest about how I was doing was critical to my recovery. I’d chat to my primary nurse for an hour every day, talking about how it was going, how I was feeling with the medication and things like that. I was really surprised when the improvements started – so surprised, in fact, that I denied it for a while.

“For brief moments during occupational therapy, I didn’t feel ill.”

Gradually, I got into doing occupational therapy. There were lots of things like arts and crafts, which really aren’t my thing, but someone convinced me to do gardening.

My wife said ‘what, you’re doing gardening?’ when we spoke on the phone, but it was a breakthrough for me. I had something in common with the chap who ran the group and we always found a moment to have a normal conversation, like you’d have at work or on a social evening. Those moments were absolutely critical because, for a brief couple of minutes each time, I forgot I was ill.

The breakthrough led onto other things, like going to the gym. It wasn’t the activity that was helping as much as the contact with people. Socialising with other patients was helpful – it allowed me to realise how ill I was, but I’d meet others who were clearly much worse so it also put things in perspective.

“The depth of expertise at the Bethlem makes all the difference.”

While I was afraid of being taken out of my comfort zone, the staff…well, it’s what they do all the time. Broadly, it’s a place where everyone being treated is depressed. That, in itself, encapsulates the degree to which they are able to help where others can’t. The fact that it’s a specialised service dedicated to depression meant that they had seen people like me before and knew the right things to do and say.

I’ve had a back condition from birth, so I also started seeing a physiotherapist and an acupuncturist there. I had acupuncture two or three times a week and that was excellent because it helped with the pain and the stiffness, but also the depression.

Being able to see specialists regularly is one of the great benefits of the Bethlem and, like the gardening, the acupuncture was something that came completely from left field. When I went home for weekends, my wife would be amazed. She’d say that the change she could see in just a week was unbelievable.
Referring to our service

We accept referrals from all consultant psychiatrists, GPs and GP consortia.

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» We provide in-depth guidance and advice on the optimal treatments for people with resistant affective disorders, as well as offering expert inpatient assessment and care for those who need it. «

Professor Peter McGuffin