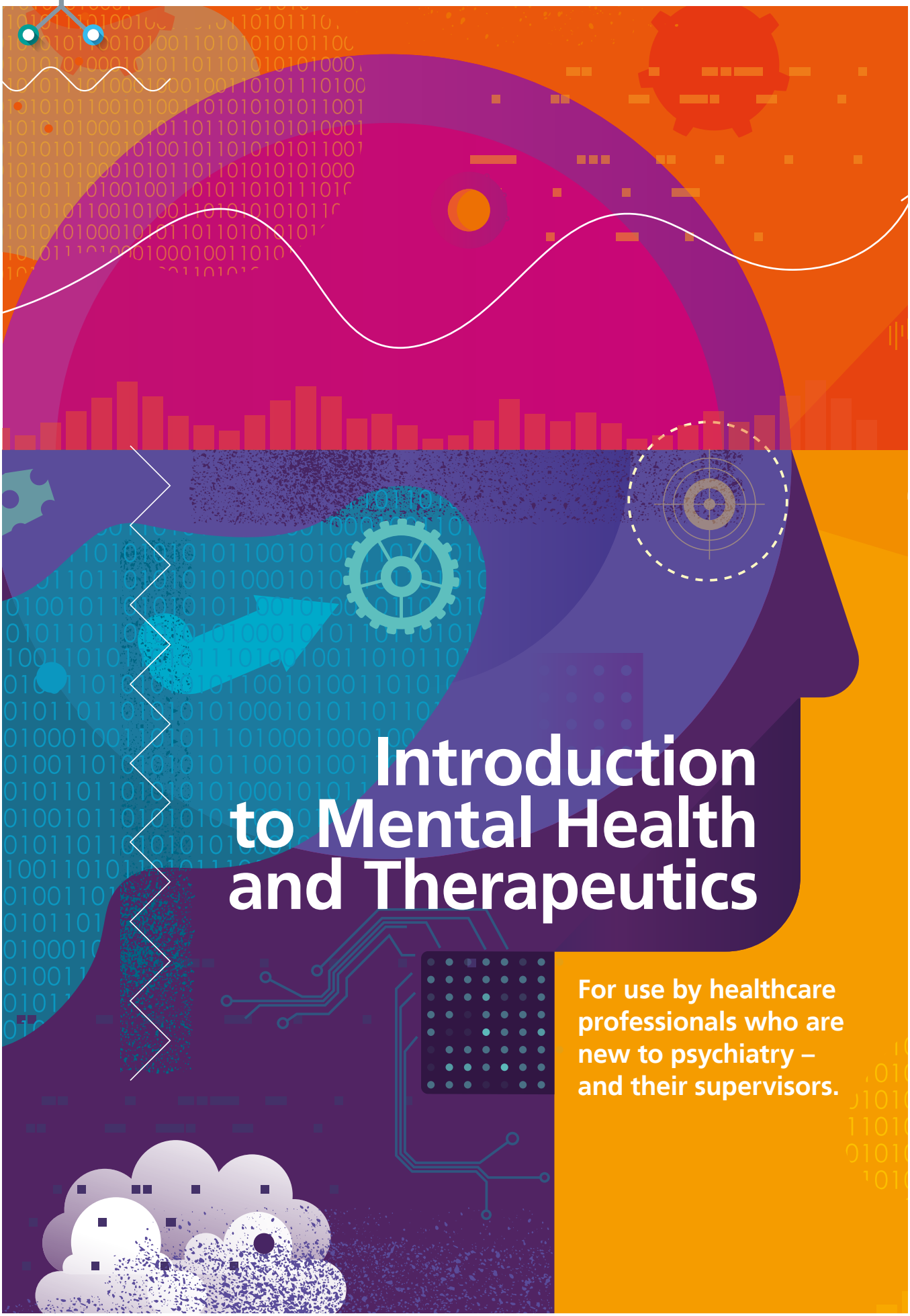
Midlands Mental Health Clinical Pharmacists Network

NHS



Introduction to Mental Health and Therapeutics

For use by healthcare professionals who are new to psychiatry – and their supervisors.

Contents

● *Items highlighted are CORE TOPICS and considered fundamental to the mental health training. They should be completed either before or during the placement.*

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Introduction to this workbook

Welcome to the third edition of the Introduction to Mental Health and Therapeutics workbook.

The electronic workbook is designed to be used online to support an more interactive learning experience.

In this revised version of the workbook, we have provided an expanded overview of the staff involved in the care of individuals with a mental health diagnosis. This ranges beyond pharmaceutical interventions and includes the range of psychological professionals as well as those who provide support for pastoral, spiritual and religious wellbeing. This multidisciplinary team approach is essential in the provision of patient-centred holistic care.

We have also included a new chapter which focuses on the physical healthcare of individuals with enduring mental illness, which is an important consideration as there is an associated increased risk of physical health complications and reduction in life expectancy.

This workbook has been designed as an information and training resource to supplement a placement in mental health for:

- Foundation Trainee Pharmacists
- Pre-registration trainee pharmacy technicians
- Undergraduate mental health nursing trainees
- Undergraduate Allied Health Professional trainees

and other healthcare professionals who have limited experience in the field of mental health.

The workbook includes questions that are designed to test understanding and tasks to enhance and enrich the learning experience. Anyone using this workbook should attempt them, remembering that real learning comes from the experience – the workbook is just a resource!

Mental health is a fascinating and incredibly rewarding field in which to specialise. This workbook is designed to provide you with a flavour of working in a mental health setting and an insight into the nuances associated with working in such a diverse healthcare speciality.

One in four people will experience a mental, neurological or behavioural condition at some point in their life and, as such, you are likely to encounter people with mental health complications in whatever setting you ultimately choose to work. It will help you to understand a little about the conditions and to have a better appreciation for the relationship between therapy and the individual.

This workbook has been presented in chapters focussing on specific mental health conditions or topics. Most chapters have questions associated with them to test your learning whilst many have tasks that can be used to achieve training standards and objectives associated with professional development. It might not be possible to complete all the tasks during a placement, but the more you can do, the more you will gain.

It is not necessary to read every chapter in detail prior to the start of your placement, but it will be useful to you if you can cover the basics of **schizophrenia, depression, bipolar disorder, anxiety, dementias** and little bit about the **law** (these are highlighted as **Core Topics** on the Contents page).

In addition, you should focus on the chapters in agreement with your tutor or manager that might have particular relevance to your individual placement.

You are not expected to know everything there is to know, and you will quickly discover that the rest of your career will be spent learning. Your training is the opportunity to experience what your chosen career has to offer and to start to think about where you might want to work in the future. Your primary responsibilities are to learn and enjoy!

Andrew Down

Chief Pharmacist
Herefordshire and Worcestershire Health and Care NHS Trust

This training package has been produced by the Midlands Mental Health Clinical Pharmacists Network. It is designed to harmonise mental health training across the NHS.

Certain aspects of the training and some of the tasks or experiences will not be available at all mental health settings. This workbook may need to be adapted at local level in accordance with local needs and policies. Please discuss the structure of the training placement and any questions or concerns with your educational supervisor.

Placement Details

Please complete this area prior to commencement of the workbook.

Trainee:

Name

Primary training base

Telephone

Mental health training base

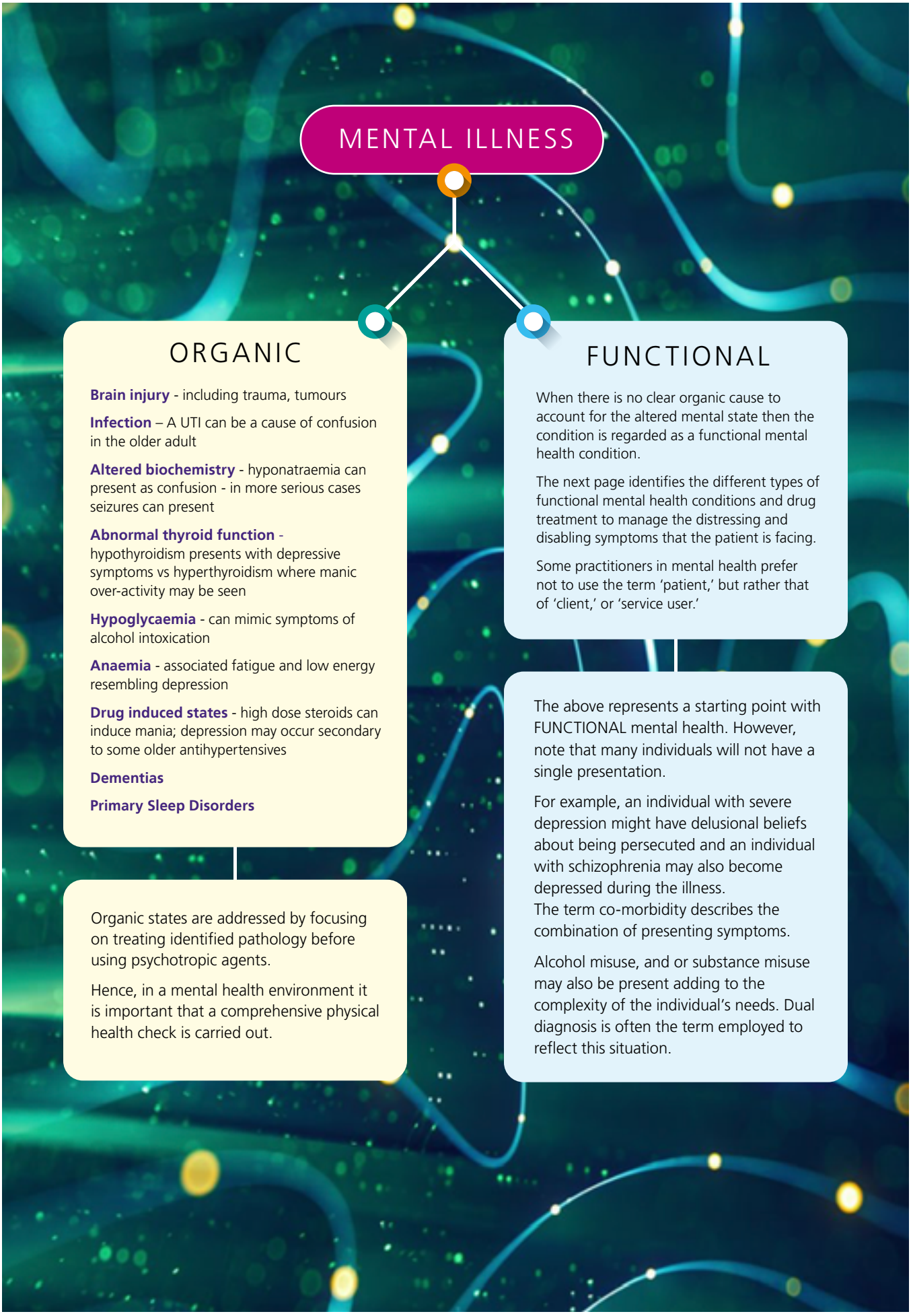
Telephone

Mental Health Training Supervisor:

Name

Contact details

Other notes


MENTAL ILLNESS
ORGANIC
Brain injury - including trauma, tumours
Infection – A UTI can be a cause of confusion in the older adult
Altered biochemistry - hyponatraemia can present as confusion - in more serious cases seizures can present
Abnormal thyroid function - hypothyroidism presents with depressive symptoms vs hyperthyroidism where manic over-activity may be seen
Hypoglycaemia - can mimic symptoms of alcohol intoxication
Anaemia - associated fatigue and low energy resembling depression
Drug induced states - high dose steroids can induce mania; depression may occur secondary to some older antihypertensives
Dementias
Primary Sleep Disorders
Organic states are addressed by focusing on treating identified pathology before using psychotropic agents.
Hence, in a mental health environment it is important that a comprehensive physical health check is carried out.
FUNCTIONAL
When there is no clear organic cause to account for the altered mental state then the condition is regarded as a functional mental health condition.
The next page identifies the different types of functional mental health conditions and drug treatment to manage the distressing and disabling symptoms that the patient is facing.
Some practitioners in mental health prefer not to use the term 'patient,' but rather that of 'client,' or 'service user.'
The above represents a starting point with FUNCTIONAL mental health. However, note that many individuals will not have a single presentation.
For example, an individual with severe depression might have delusional beliefs about being persecuted and an individual with schizophrenia may also become depressed during the illness.
The term co-morbidity describes the combination of presenting symptoms.
Alcohol misuse, and or substance misuse may also be present adding to the complexity of the individual's needs. Dual diagnosis is often the term employed to reflect this situation.

An introduction to mental health

Definition

Mental illness encompasses various conditions characterised by a change in an individual's normal cognitive, emotional or behavioural functioning. This change can be caused by social, psychological, biochemical, genetic or other factors such as infection or trauma.

Notice the presence of the word 'change' in the definition, this is key to any assessment of symptoms and part of the diagnostic process is to compare current presentation with premorbid (i.e. pre-change) state.

Mental illness is commonly divided into **ORGANIC** and **FUNCTIONAL**, as shown on page 6.

Diagnostic Criteria in Mental Health

There are two diagnostic systems in use; the World Health Organisation International Classification of Diseases 11th revision (ICD-11) and the Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM-5). Both identify the 'qualifying criteria' needed for a diagnosis of a particular mental health disorder. ICD-11 covers all conditions, not just psychiatric diagnoses whereas DSM-5 is used purely for psychiatric conditions.

They are not identical!

Whilst the UK primarily uses the ICD-11, a lot of research is conducted using DSM for diagnostic criteria. Therefore, you will find many documents and guidelines in the UK will use terminology taken from DSM. In day-to-day clinical practice patients, might not be assessed against these criteria. Nevertheless, the diagnosis and associated coding may be used for audit, research or evaluative purposes.

Service Structure

In the United Kingdom, local mental health services are provided in a variety of ways. It is not treated however, as a part of the main function of either general acute hospitals or primary care. Instead, services are usually distinct, with their own structure and governance. Whilst mental health services are treated as distinct, NHS trust structures can vary widely:

- Separate mental health trust (including Foundation trusts)
- Partnership trust, where NHS mental health services are provided in partnership with social services
- As a distinct structural element within another trust

Many mental health trusts do not have an operational dispensary service, but instead buy in the dispensing and supply services from elsewhere (e.g. a local acute hospital or community pharmacy).

In addition, a large proportion of mental healthcare is provided by voluntary and other non-governmental organisations.

Mental health services incorporate inpatient treatment and outpatient clinics, but include a large number of service elements and professional groups that are unique to mental health. Details of these specialist professional groups and services are listed in the following chapter.

Alan Pollard, Andy Down

"Mental illness is commonly divided into **ORGANIC** and **FUNCTIONAL"**

Question 1:

a) What type of structure does your local mental health trust have?

b) How does this trust structure help or hinder:

i. Cross-trust working for staff?

ii. Community reintegration for patients?

Task 1:

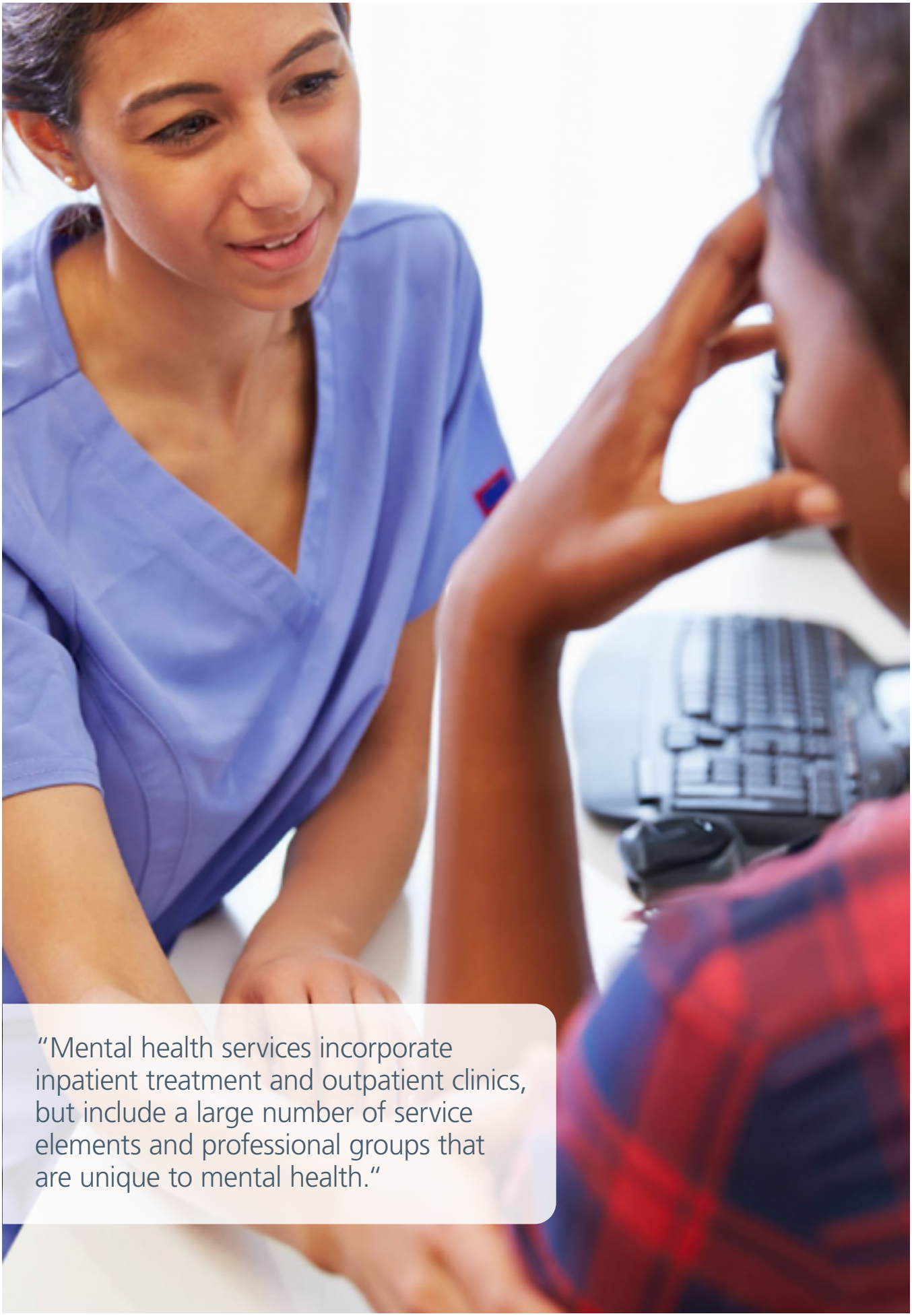
Access the ICD-11 Classification system online and use it to look up a few different conditions, e.g.

- Hypertensive diseases
- Mood disorders
- Tuberculosis

Is there anything that surprises you?

What did you learn?

For more in depth coverage of mental health conditions, visit: www.who.int/publications/i/item/9789240077263


"Mental health services incorporate inpatient treatment and outpatient clinics, but include a large number of service elements and professional groups that are unique to mental health."

Being a Patient or Service User

"I have accessed support from Mental Health services for the last 10 years, but I have never identified with the often-utilised terms 'Service user' or 'Patient'."

These labels carry discreet negative connotations which focus on a deficit of health, implicate little possibility of recovery and reduce one's feeling of control and autonomy over one's own health and wellbeing.

When you seek healthcare support, in the presence of a professional, it's all too easy to forget you are the most important person in the process. You are not just a patient; you're a person with thoughts and feelings about your health and treatment, and importantly not just a passive recipient of care.

The term service user does not point to the active role I have to play in my health and wellbeing, and with language forming the beginning of our perspective, what I think about my condition, diagnoses and prospects for health and recovery matters; is the glass half full or half empty? Are we in the business of restoring health or treating illness? The word "patient" often makes people think of illness or weakness. It focuses the attention on an isolated problem, rather than seeing you as a whole person.

Sometimes, this label sticks and forms a significant part of your identity, limiting ones potential and hinting at ongoing sickness, whether it's physical or psychological. Most people dealing with mental health issues live full, active lives, much like anyone else, wouldn't it be better, therefore, to shift the language to reflect that possibility?

Customer care in healthcare

If you've ever been to a community pharmacy, you might notice that you're treated like a customer. Pharmacists want you to come back, so they aim to offer great service. This means being effective, efficient, and always polite and respectful. If all healthcare services treated us with the same care as a business treats its customers, our overall experience would likely improve. This is especially important now, as we have more choices in who we want to provide our healthcare"

The power of Lived Experience and Peer Support

Lived experience is a powerful concept. It's about understanding people's interactions with health and care services — not from the perspective of professionals or institutions, but from the viewpoint of the individuals who use them. It's about how people experience support, treatment, and care, and what meaning they draw from those experiences.

As Loreen Chikwira put it via The King's Fund:

"People with lived experience bring a different perspective to health and care policy, service design and delivery."

That difference matters. It shifts the focus from theories and assumptions to real, grounded insight.

What is Peer Support?

Peer support is a way of working where people use their own lived experiences to help others facing similar challenges. Whether it's recovery from mental health difficulties, managing a chronic illness, or navigating the health system, peer support workers offer something unique: they've been there.

This is not just about sharing personal stories — though those can be powerful — it's also about offering empathy, practical strategies, and hope. Peer supporters work alongside people, not above them, creating relationships built on trust, respect, and mutual understanding.

Lived Experience Practice (LXP): Beyond the individual story

Lived experience practice takes peer support further. It's an approach where someone with their own lived experience also develops additional skills, competencies, and expertise.

In healthcare, LXP shows up in many ways:

- **Clinical contexts** — as peer support workers within teams.
- **Educational spaces** — as peer trainers or tutors in wellness and recovery colleges.
- **Safety and improvement** — as Patient Safety Partners working to make services safer.
- **Strategic leadership** — bringing lived experience to boardrooms, committees, and design panels.

Crucially, LXP is not just about one person's story. It's about using that personal grounding to elevate collective voices and shared perspectives. It moves beyond "my experience" to "our experience" — with the aim of improving services, shaping systems, and making care more responsive and humane.

Why does this matter?

People with lived experience can see gaps that professionals might miss. They can highlight barriers, challenge assumptions, and offer practical solutions rooted in reality. Integrating lived experience into health and care work is not just "nice to have" — it's essential for creating systems that work better for everyone.

In short: lived experience and peer support bring wisdom, humanity, and connection into spaces that can sometimes feel clinical or distant. And lived experience practice transforms that wisdom into action, change, and leadership. When we recognize and value lived experience, we take a step toward more inclusive, effective, and compassionate health and care services.

Mel Ball *Director for Lived Experience*

Daniel Bacon *Professional Lead for Lived Experience*

Who's who?

The Mental Health Pharmacist

The Mental Health Pharmacist is an expert in psychopharmacology who specialises in the use of medicines for the treatment and prophylaxis of mental health disorders. However, they must remain competent in all other areas of medicine since suffering a mental health disorder does not preclude suffering any 'physical' health condition. In fact, sufferers of mental health disorders are more likely to develop a further physical health condition than the rest of the population.

The role of the Mental Health Pharmacist is incredibly diverse and can include basic ward pharmacy, involvement in multidisciplinary teams, service development, training and education, policy development, medicines information, work with user/carer groups, legal consultation, assessment, care planning and more.

For pharmacists working in mental health, the role of the non-medical prescriber might be the perfect fit. This is due to the fact that they are ideally placed to develop services such as specialist medicines management clinics for patients with complex needs. For instance, those with substance misuse disorders or those on medicines that require enhanced monitoring and specialist knowledge such as lithium and clozapine. This opens the opportunity for the development of the consultant pharmacist role and there are currently a number of mental health specialist pharmacists in such posts.

The professional body for mental health specialist pharmacists within the United Kingdom is the College of Mental Health Pharmacy (CMHP). It provides a support network throughout the country and internationally. The CMHP is responsible for educational programmes and tools accrediting specialist pharmacists as experts in the field of mental health. It is also the organiser and host of the Annual International Psychiatric Pharmacy Conference.

Andy Down

The Mental Health Pharmacy Technician (MHPT)

The role of the mental health Pharmacy Technician is varied and encompasses a variety of differing duties. The role is often carried out in a number of different care settings requiring the technician to be flexible, self-motivated with the ability to work autonomously.

Examples of responsibilities include:

Pharmacy Team responsibilities:

- Review and supply of non-stock medicines
- Maintaining ward stock lists
- Review and development of SOPs and procedures
- Ward audit compliance in conjunction with nursing staff

Inpatient Ward responsibilities:

- Reviewing patients own medication
- Medicines Reconciliation on admission
- Medicine Reconciliation on discharge
- Therapeutic blood monitoring e.g. Clozapine, Lithium
- Patient counselling and compliance support
- Discharge planning, DMS (Discharge Medicines Service); referrals to primary care providers for continuity of Patient care

Community Mental Health Clinics:

- Support with Homecare prescription supply, and monitoring of repeat prescribing of Depots e.g. Paliperidone, Aripiprazole injections
- Patient counselling and compliance support
- Therapeutic blood monitoring service support in conjunction with nursing teams and prescribers, e.g. Clozapine, Lithium
- Prescription review monitoring

Due to the continuing development of the MHPT role, they can also be found working closely with other healthcare professionals in extended roles supporting direct patient care.

MHPT's play a pivotal role in supporting the clinical service within the mental health setting and have to demonstrate a mature and confident approach and be adaptable to various situations and challenges that working in the mental health care setting produces.

Lisa Thompson & Maxine Walker

Psychiatrist

A Consultant Psychiatrist is a medically qualified doctor who has undergone foundational and further specialist training and assessments for around ten years, before passing the entry exam to the Royal College of Psychiatrists. The Consultant provides senior medical advice and leadership to mental health teams. They undertake all aspects of work involving the Mental Health Act (sectioning), assessing and treating people with mental illness in the community and in hospital, as well as having an influential role in the development of services. In addition to this, they also prescribe psychotropic medication and monitor side-effects associated with treatment. The role is varied and involves a lot of contact with the legal profession, prisons and the independent sector.

Rachel Filik

Registered Mental Health Nurse (RMN)

Mental health nurses work with children, adults and older people suffering from various types of mental health conditions.

A mental health nurse holds a distinct qualification to that of a general nurse: Registered Mental Health Nurse vs Registered General Nurse (RGN); although student nurses from both disciplines might initially follow a similar course of study.

Mental health nurses work across a variety of settings, from a clients' home to community-based clinics and inpatient units and highly specialist units and prisons, within the NHS and the private sector. An RMN works closely with other healthcare professionals including psychiatrists, occupational therapists, GPs, social workers and, of course, pharmacists. They help to plan and deliver care using a multidisciplinary client-centred approach. This is designed to help people recover from their illness and help maximise their life potential.

Community Mental Health Nurse (CMHN)

The Community Mental health Nurse is a registered nurse (RMN) with the Nursing and Midwifery Council (NMC) who generally works in the community rather than an inpatient setting. They are an integral part of community mental health services. A CMHN is often the key worker within the NHS mental health system and the first port of call for further referrals to psychiatrists, psychotherapists and other mental health colleagues.

Community mental health Nurses mainly support and visit patients and their families in their own homes, but they also see people in other settings such as GP surgeries or within the community mental health team base. Their skills are wide and varied, often providing many therapies such as talking therapies, administration of medicines and associated monitoring, through to some highly specialised treatment interventions such as DBT (dialectical behaviour therapy), CBT (cognitive behavioural therapy) and prescribing.

Graham Alexander & Francesca Purdy

Social Worker (SW)

Social workers in mental health start with a holistic assessment of need and risk assessment, formulate and implement a care plan (this may include the purchase of services e.g. day care, home care, residential care, nursing care, meals on wheels, etc.) and monitor and review the care plans. Most social workers in mental health services are also Approved Mental Health Professionals. They are responsible for the oversight and management of all Mental Health Act assessment requests. Essentially, the SW is a main resource in mental health care planning, offering support and monitoring for the patient and staff. Some SWs are trained in Early Warning Signs, Behavioural Family Therapy and Dialectical Behavioural Therapy. SWs assist people to access supportive and preventative services and can be involved in instigating Safeguarding in Adults and Children, if a risk is identified.

Mina Ali

Key Worker

People accessing mental health services often see a variety of different healthcare professionals. The key worker has now replaced the role of Care Co-ordinator, to allow a wider range of staff to act as a point of contact for the client. This can include both qualified and unregistered staff in addition to partnership agencies, such as voluntary organisations.

A flexible, responsive and personalised approach following a high-quality and comprehensive assessment means Key workers are involved in drawing up a care plan for the client, taking into account the variety of services required to meet the client's needs.

Francesca Purdy

Approved Mental Health Professional (AMHP)

AMHPs are mental health professionals who are approved by a Local Authority to carry out certain duties under the Mental Health Act. In short, they are responsible for co-ordinating assessments and admissions to hospital for people who are sectioned under the Act. During their day-to-day duties AMHPs cover a variety of tasks to ensure the safety and wellbeing of the patient, as well as others around them. They will arrange for two relevant doctors to attend assessments of the patient in question, informing and or consulting with the nearest relative as defined by the Mental Health Act. Preferably one doctor will have had acquaintance with the patient before. In addition to this, they also arrange for the patient to be interviewed in a manner suitable. This may include finding an interpreter, signer or an advocate to ensure the smooth running of the interview.

During their time with the patient, the AMHP will seek out the least restrictive options of care. This may include the patient receiving treatment at home rather than being detained or being admitted as an informal patient to hospital. If detention under the Mental Health Act is not required, then they will arrange for an alternative care plan to be instigated. Before arriving at the hospital with the patient, the AMHP will write up a report on the patient to ensure the smooth handing over and safety of everyone.

AMHPs can also be social supervisors for people on conditional discharge from section 37 of the Mental Health Act. These patients are restricted and therefore the AMHP must write regular reports to the Home Office informing them of what is going on.

Mina Ali, Elizabeth Coombs

Non-Medical Prescriber (NMP)

A non-medical prescriber is an individual from an approved professional group who, subject to successful completion of an approved training programme, is qualified to prescribe within the area of their clinical expertise.

NMPs are commonly nurses, but can also be pharmacists or other health professionals, such as chiropodists and physiotherapists. In mental health, NMPs are of particular benefit as they often have an established therapeutic relationship with the individual and empower them to make informed choices.

V100/V150: Community Practitioner Nurse Prescriber. Colleagues are eligible to prescribe from the Nurse Practitioner Formulary (NPF) within competency.

V300 Independent/ Supplementary Prescriber.
Colleagues are able to prescribe from the BNF within competency and professional restrictions set by regulatory bodies

Independent Prescribers (IP)
The IP takes full responsibility for clinical assessment, establishing the diagnosis and prescribes from an agreed formulary, with certain exceptions for controlled drugs. Independent Pharmacist Prescribers and Independent Nurse Prescribers may prescribe, administer, and give directions for the administration of schedule 2, 3, 4 and 5 Controlled Drugs (CDs). Neither Pharmacist IPs nor Nurse IPs s will be able to prescribe diamorphine, dipipanone or cocaine for treating addiction, but may prescribe these items for treating organic disease or injury. AHP IPs have restrictions placed with regards to the prescribing of CDs for specific conditions.

Please see the most current BNF for guidance.

SP - Supplementary Prescriber
Supplementary prescribing is defined as a voluntary partnership between an IP, who must be either a Doctor or Dentist; and a supplementary prescriber (not community practitioner prescriber; V100/V150), to implement an agreed service user specific clinical management plan (CMP) with the service user's agreement (DOH, 2003).

Community Practitioner Nurse Prescriber (V100/V150):
These are nurses listed on the NMC professional register with an annotation stating that they hold the Community Practitioner Prescribing Qualification. They can only prescribe within the confines of the Community Practitioner Formulary (please refer to the BNF or NPF for the latest version).

Francesca Purdy

Psychology

The Psychological Professions are a diverse group of professions whose work is informed by the disciplines of psychology and psychological therapy. There are 3 main professional groupings, Psychologists, Psychological therapists and psychological practitioners.

Table 1: The Psychological Professions professional group in the NHS in England.

Psychologists
• **Clinical Psychologists**
• **Counselling Psychologists**
• **Forensic Psychologists**
• **Health Psychologists**
Associate and Assistant roles
• **Clinical Associate in Psychology**
• **Assistant Psychologists**

Psychological Therapists
• **Cognitive Behavioural Therapists**
• **Counsellors**
• **Child and Adolescent Psychotherapists**
• **Adult Psychotherapists**
• **Family and Systemic Psychotherapists**
• **Psychological Therapists** (other)
• **Art, Drama and Music Therapists** (with AHP Professional Leadership[1])
• **Medical Psychotherapists** (with Medical Professional Leadership[2])

Psychological Practitioners
• **Psychological Wellbeing Practitioner**
• **Education Mental Health Practitioner**
• **Children's Wellbeing Practitioner**
• **Mental Health and Wellbeing Practitioner**
• **Youth Intensive Psychological Wellbeing Practitioner**

Notes

1) *Art, drama and music therapists often identify as both allied health professions (AHPs) and psychological professionals. Art, drama, and music therapists will continue to be represented by AHP leadership nationally and regionally,*
2) *Medical psychotherapists also provide psychological therapy and continue to be represented by medical and psychiatry professional leadership nationally and regionally.*

The psychological professions work at individual, organisational and systems levels across a wide range of settings. This includes mental health services, hospitals, primary care services, rehabilitation centres, prisons, local authorities, voluntary community social enterprise (VCSE), and educational settings.

They work to improve wellbeing across the lifespan with children and young people, adults, older adults, families, carers, and with communities across all diverse backgrounds. They also support the NHS workforce, which is particularly important as we restore services, manage current service pressures, and help support the wellbeing of the health and care workforce beyond the pandemic.

The work is varied and includes delivering psychological therapies, carrying out diagnostic assessments, supporting and empowering people living with long-term physical health conditions, mental health needs, autism, learning disabilities, neurodiverse presentations, dementia, in forensic healthcare settings, and providing professional leadership and governance, supervision, training, and research.

Dr Sunny Kalsy-Lillico, *PPN Midlands*

Allied Health Professions

AHPs are the third largest workforce in the NHS. They are usually qualified to degree level and are professionally autonomous practitioners.

Occupational Therapists

Occupational therapists (OT's) are one of the 14 Allied Health Professions (AHP's). OT's have expertise in rehabilitation, enabling people to recover their independence and participation in everyday life activities (occupations) which hold personal importance and meaning.

They are dual trained in mental and physical health at the pre-registration degree level and as with other AHPs they are registered with the Health Care Professions Council (HCPC). OTs use occupation (everyday activities) to assess, treat and evaluate an individual's needs. Occupation refers to meaningful, practical and purposeful activities that allow people to live independently and have a sense of identity. This could be essential day-to-day tasks such as self-care, work or leisure. When a person becomes unwell their ability to engage in occupations is impaired.

An OT will use occupations to assess an individual's needs and in collaboration with the person an OT will enable the development of personalised goals focusing on interventions to support recovery. OTs in Mental Health services can work across inpatient and community settings. The OT support worker (OT assistant) roles are essential in supporting the delivery of occupationally focused interventions. OTs and OTAs work with other professionals as part of a multi-disciplinary team.

Speech and Language Therapists

Speech and Language Therapists (SLT's) work in a variety of different settings including hospitals and the community.

They have two distinct areas of specialism, one focussed on individual's ability to communicate, and the second diagnosing and treating difficulties with eating, drinking and swallowing. Within mental health services, SLT's work as part of the multi-disciplinary team. They offer support and advice to colleagues, service users and carers regarding their understanding of verbal and non-verbal information and their ability to express thoughts, needs and wishes. SLT's provide strategies to help overcome the reduction or loss of communication skills. This includes the use of non-verbal techniques such as photos, graphics, gestures and objects. Those SLT's who are dysphagia competent support people who are at an increased risk of choking and aspiration.

Dietitians

Dietitians assess, diagnose and treat dietary and nutritional problems at an individual and wider public-health level. They are experts in understanding the complex relationship between nutrition, mental health, and the impact on physical health. Their intervention helps to manage dietary concerns that are related to a person's mental health conditions. They use the most up-to-date public health and scientific research on food, health and disease which they translate into practical guidance to enable people to make appropriate lifestyle and food choices.

They often work as integral members of multi-disciplinary teams to treat complex clinical conditions such as diabetes, food allergy and intolerance, IBS syndrome, eating disorders, chronic fatigue, malnutrition, kidney failure and bowel disorders. They support other professions to identify and manage re-feeding risks to reduce harm to patients.

Physiotherapists (PT)

Physiotherapists (PT) help people affected by injury, illness or disability through movement and exercise, manual therapy, education and advice.

They maintain health for people of all ages, helping patients to manage pain and prevent disease.

The profession helps to encourage development and facilitate recovery, enabling people to stay in work or functioning in activities that are meaningful to them while helping them remain independent for as long as possible. Physiotherapy is a science-based profession and takes a 'whole person' approach to health and wellbeing, which includes the patient's general lifestyle and mental wellbeing.

At the core is the patient's involvement in their own care, through education, awareness, empowerment and participation in their treatment.

Art Therapists

Art therapy is an established form of psychotherapy, delivered by trained art therapists (also known as art psychotherapists).

Art therapy uses art as the primary mode of expression, alongside talking with an art therapist. It aims to reduce distress and improve social, emotional and mental health by promoting insight, self-compassion and a sense of agency and self-worth. During art therapy, people are supported by an art therapist to use art to express and articulate often complex thoughts and feelings through art making. This may be following difficult or traumatic experiences which may be hard to talk about.

Music Therapists

Music Therapists draw upon the innate qualities of music to support people of all ages and abilities and at all stages of life; from helping newborn babies develop healthy bonds with their parents, to supporting individuals through trauma, grief and other emotions, to offering vital, sensitive and compassionate care to individuals with enduring mental illness.

Central to how Music Therapy works is the therapeutic relationship that is established and developed, through engagement in live musical interaction and play between a therapist and client. A wide range of musical styles and instruments can be used, including the voice, and the music is often improvised. Using music in this way enables individuals to create their own unique musical language in which to explore and connect with the world and express themselves.

Drama therapist

Drama therapists are both clinicians and artists that draw on their knowledge of theatre and therapy to use as a medium for psychological therapy that may include drama, story-making, music, movement, and art; to work with any issue that has presented itself.

People can explore a wide variety of different issues and needs from autism and dementia to physical/sexual abuse and mental illness in an indirect way leading to psychological, emotional and social changes.

Drama therapists often have a background in theatre, health, or education and can be found in many varying settings such as schools, mental health care, general health social care, prisons and in the voluntary sector. Drama therapists work with people using a very wide range of dramatic techniques in verbal and non-verbal ways. Though vocalisation, story making, and talk are integral parts of dramatherapy, the practice does not necessarily rely on spoken language alone to resolve what a person may wish to address, explore or to seek support with. Embodiment and movement are also vital in our practice. Drama therapists work therapeutically with a diverse range of individuals, groups and organisations who experience significant difficulties. Many drama therapists are also independent artists and/or researchers, who specialise in areas that allow them to develop a unique focus.

Paramedics

These roles are developing and growing within mental health services. Typically employed as first responders in emergency services, paramedic assess people mental health and physical health. They can employ essential community treatment to reduce unnecessary and stressful hospital admissions for those with metal health conditions.

Kerry Langford-Rotton

Support Time and Recovery Worker (STaR)

Support Time and Recovery Workers support individuals in their recovery. They frequently offer their time to help develop strategies for completing recovery and to regain independence. For example, they will support with housing issues, attending vocational services, social activities, a college course and doctor's appointments.

Simon Smart

Independent Mental Health Advocates (IMHA)

Independent Mental Health Advocates were introduced into the Mental Health Act 2007 as a statutory right for people detained under the Act. Patients have the right to be provided with support by an Advocate. The IMHA will provide the patient with information on their rights, medication and any restrictions or conditions to which they are subject. They provide an additional safeguard for patients who are subject to the Mental Health Act.

The IMHA is a specialist advocate who will have appropriate training and experience to carry out the role. It is a service which is independent of the NHS.

Independent Mental Capacity Advocate (IMCA)

In 2007, the Mental Capacity Act 2005 came into force. This set out the legal rights for supporting and protecting vulnerable people who are unable to make their own decisions. As part of this legislation the IMCA service was created to safeguard the rights of individuals who were assessed as lacking the capacity to make decisions in relation to serious medical treatments or changes of accommodation. The Act was further amended in 2009 to include support in relation to Deprivation of Liberty Safeguards.

The IMCA is a specialist advocate who will have appropriate training and experience to carry out the role.

Chaplaincy Services

Chaplains promote pastoral, spiritual and religious wellbeing through skilled compassionate person-centred care. This is available to all patients, their families and carers, and to NHS staff, volunteers and students. They enable people to celebrate according to their religion or belief within NHS settings, and support those facing very difficult situations such as the death of a loved one, psychosis, being diagnosed with life-threatening conditions, and people who are receiving end of life care. Mental health chaplains play a crucial role in providing holistic care that addresses the spiritual and emotional dimensions of mental health, complementing the medical and psychological interventions provided by healthcare professionals. Chaplains offer;

Spiritual Support Guidance, prayer, and religious rituals as requested by those receiving care. This can involve helping patients explore questions of meaning, purpose, and faith in relation to their mental health struggles.

Emotional Support Chaplains provide a compassionate presence and a listening ear. They offer non-judgmental support and encouragement, helping patients process their feelings and experiences in a safe environment. They can also attend multi-disciplinary team meetings (MDT's) as an advocate or to give advice on a treatment plan.

Work in collaboration with mental health professionals, such as counsellors, psychiatrists, and social workers, as part of a multidisciplinary team. This collaboration ensures holistic care that addresses both the spiritual and psychological aspects of well-being.

A non-judgemental support during a crisis

A chaplain's experience calm nature and influence may be involved in crisis situations, offering immediate support and comfort to individuals experiencing acute mental health crises or emotional distress.

Chaplains may advocate for the spiritual needs of patients within healthcare settings and provide education to healthcare providers on the intersection of spirituality and mental health.

Support for Families

Chaplains support families and loved ones affected by a person's mental health challenges, offering guidance and spiritual care during difficult times.

Drew Walker Chaplain

The Integrated Mental Health Team (IMHT) or Community Mental Health Team (CMHT)

It is expected that community teams provide a broad range of functions, generally to include services for the full range of mental health problems; age limits to be determined in line with locally agreed protocols for transition from adolescent to adult and adult to older adult services.

These teams provide help for two groups of people:

- Most patients treated by the team will have time limited disorders. This means they can be referred to their GPs after a period of weeks or months, when their condition has improved.
- A substantial minority, however, will remain with the team for ongoing treatment, care and monitoring for periods of several years. They will include people needing ongoing specialist care for:

  – Severe and persistent mental disorders associated with significant disability, predominantly psychoses such as schizophrenia and bipolar disorder.

  – Longer term disorders of lesser severity, but which are characterised by poor treatment adherence requiring proactive follow up.

  – Any disorder where there is significant risk of self-harm or harm to others (e.g. acute depression) or where the level of support required exceeds that which a primary care team could offer (e.g. chronic anorexia nervosa).

  – Disorders requiring skilled or intensive treatments not available in primary care.

  – Complex problems of management and engagement such as presented by patients requiring interventions under the Mental Health Act, except where these have been accepted by an assertive outreach team.

The role of the community team can be varied but will mainly consist on giving advice and providing treatment. Throughout the day, they will advise on the management of mental health conditions particularly in primary care to enable appropriate referrals to occur. Additionally, they will provide care and treatment for each group listed above, making sure their needs and wellbeing is covered.

Graham Alexander & Francesca Purdy

Crisis Resolution and Home Treatment Services (CRHT)

The CRHT exists to provide treatment for people who are acutely mentally ill, in their own home, as an alternative to hospital admission or to facilitate early discharge from admission. It is important to note that a hospital admission can be a profoundly disturbing event and can take an individual some time to come to terms with.

CRHT teams are usually designed to cover a specific geographical area. Their services are available for anyone experiencing a crisis which may be related to a mental health issue.

Francesca Purdy

Early Intervention Service (EIS)

Early Intervention Services address the needs of people who are experiencing a first episode of psychosis. Support is also available for the family and friends of the person affected.

The service works closely with a variety of other agencies including primary and secondary care, child and adolescent mental health services, education, housing, criminal justice, vocational, advice and advocacy services.

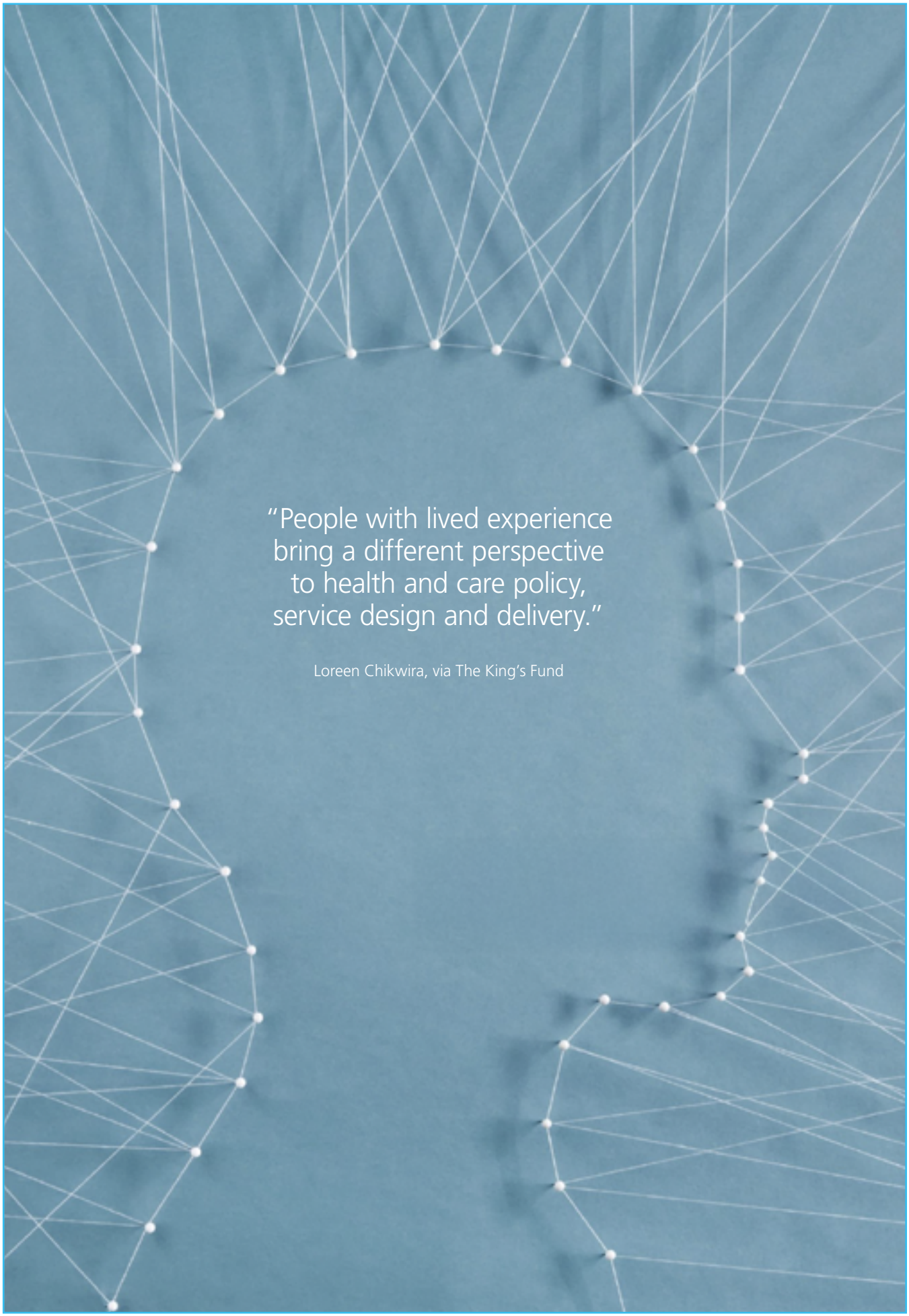
The EIS aims to assist individuals and their families in coping with the experience of the disorder, to promote optimal recovery and to prevent further episodes of illness. The focus for EIS is to help individuals to determine their goals and direction whilst identifying the support needed to enable this. To achieve this, EIS liaises with employment, health and community and education support agencies.

Other specialist services

A range of other specialist services and teams are likely to be available within the context of mental health services including:

- Child and Adolescent Mental Health Services (CAMHS) dealing specifically with younger patients
- At Risk mental state (ARMS)
- Substance Misuse Services (SMS)
- Eating Disorders Services
- Recovery and Rehabilitation Services, and many more.
- Mother and Baby
- Perinatal Services
- Forensic psychiatry - working with people whose mental health disorders have resulted in legal action being taken against them.

The existence of these specialist teams is, somewhat, governed by local need (e.g. a forensic psychiatric unit might provide a service for a region rather than just a county or single trust) and by the skills of staff within the existing service structure. It is unlikely that any two trusts will be structured in exactly the same way.


"People with lived experience
bring a different perspective
to health and care policy,
service design and delivery."
Loreen Chikwira, via The King's Fund

Question 2:

Consider the following potential media headlines:

a) 'Paranoid schizophrenic released into the community'

b) 'Patient discharged to primary care'

What are the differences?

What images or impressions do they create?

What are your feelings?

How would you feel if the person (in either headline) ended up living next door to you?

Task 2:

Arrange to spend time during your placement with a member of staff from a discipline different to your own.
(Refer to Task 22 and the Placement Structure section – Appendices 1A, 1B and 1C, pages 105-13)

Write a reflective review of the time you have spent with the member of staff.

What have you learnt?

What did you want to gain from this task?

What surprised you?

Is there anything else that you would like to know?

How can you apply what you have learned to your practice?

The Mental Health Act

Mental Health Legislation

The Mental Health Act (MHA) 1983, amended in 2007, is the law which sets out when a person can be admitted to hospital for treatment of a mental disorder. Is also includes when a person can be detained or treated in hospital against their wish. This is only done if they are putting their own or someone else's safety at risk and they have a mental disorder. It is possible for a person to voluntarily enter hospital for psychiatric care.

The Mental Health Act has a number of different sections outlining what to do with mentally ill patients. It is used throughout England and Wales. The Act is frequently utilised for detaining people with mental health problems to help them recover and is commonly referred to as being 'sectioned'.

The MHA works in tandem with several different Acts, notably the Mental Capacity Act 2005, the Human Rights Act 1998 (HRA) and the Care Act 2014. For example, treatment provided to patients without their consent breaches Article 8 of the HRA and can be considered a breach of Article 3, if it is not done in accordance with the MHA.

Summarised below are the common sections that you may come across during any placement in a mental health environment.

Mental Health Act 1983 – Parts of the Act

The MHA represents the current legislation concerning all aspects of treatment for mental disorders and applies to England and Wales. Scotland and Northern Ireland have their own working regulations. It has a code of practice that all pharmacists working in mental health should be aware of.

The Mental Health Act itself is divided into ten parts:

Part I Application of the Act

Part II Compulsory Admission to Hospital and Guardianship

Part III Patients Concerned in Criminal Proceedings or Under Sentence

Part IV Consent to Treatment

Part IVA Treatment of community patients not recalled to hospital

Part V Mental Health Review Tribunals

Part VI Removal and Return of Patients within United Kingdom, etc.

Part VII Management of Property and Affairs of Patients

Part VIII Miscellaneous Functions of Local Authorities and the Secretary of State

Part IX Offences

Part X Miscellaneous and Supplementary

Parts II, III, IV and IVA are clearly very relevant to pharmacists. Parts II and III contain the type of detention power to which a patient is subject, parts IV and IVa specifically relate to medication. There is a role for pharmacists working in mental health to act as a Second Opinion Consultee. Pharmacists need to be aware of the legal documents that need to be in place and their correctness when part IV of the Act applies.

Part II

Compulsory Admission to Hospital and Guardianship

Section 2

Admission for assessment

Admission to and detention of patient in hospital for assessment and treatment, lasts for up to 28 days and includes provision for enforced treatment. This section cannot be renewed.

Section 3

Admission for treatment

Admission to and detention of a patient in hospital for "appropriate" treatment which initially lasts for up to 6 months and can be renewed for up to a year at a time.

To start one of these sections, two medical opinions are required as well as an assessment by an Approved Mental Health Professional (specially qualified social worker or nurse). In practice, the sectioning doctors will often be the patient's GP and the other, a consultant psychiatrist. As a minimum requirement, one of the doctors must be competent in psychiatry to the level of being 'Section 12 approved'. This means they are recognised and registered as a medical practitioner with special experience in the diagnosis and treatment of mental disorders.

Section 4

Admission for assessment in cases of emergency

Lasts for up to 72 hours and may be actioned with one medical recommendation alone e.g. GP.

It can be converted to a section 2 when another doctor provides another medical recommendation supporting the detention. The Act does not provide power to treat against someone's will under this section

Note: the application for 'sectioning' may be made by a relative, but this is extremely rare.

Section 5

Section 5 of the Act has two key sections that apply to patients admitted on an informal basis. Section 5 (2) allows a doctor (can be junior doctor but not an F1) to detain an informal patient for up to 72 hours. The other Section 5 (4), allows a suitably qualified nurse (RMN) to detain an informal patient for up to 6 hours.

The Act does not provide the power to treat against someone's will under these sections.

Part III

Patients Concerned in Criminal Proceedings or Under Sentence

For specific details of these sections of the Mental Health Act which relate to forensic psychiatry please see the Forensics chapter, later in this workbook.

Part IV

Consent to Treatment

This is a very important part of the Act for pharmacists as it covers the circumstances and the documents pertaining to legally enforceable treatment. Electroconvulsive therapy (ECT) is also covered under this part of the Act. It is easier to start by recognising those sections and circumstances to which part IV does not apply. This includes circumstances where patients may not have medication for their mental health condition administered against their will.

Part IV does not apply to:

- Voluntary (informal) patients.
- Those detained under sections 4, 5(2) or 5(4).
- Patients managed in the community either under guardianship orders or a Community Treatment Order.
- Patients on remand, or conditionally discharged (see Forensic chapter).
- Patients detained under miscellaneous provisions (sections 135 or 136 – see below).

The next key component of this part of the Act is the documentation forms relating to medication continuing under detention beyond 3 months. At this point in time one of two forms needs to be completed:

- **T2 Form:**
  If the patient understands and accepts their treatment the Responsible Clinician (usually consultant psychiatrist) will complete a form T2. This should clearly identify the medicines and regimens the patient is taking or may take as part of an agreed treatment plan for the purpose of managing the mental health disorder. T2 violations occur if medications or doses (BNF max is always the default standard) are prescribed that fall outside of the T2 specifications. In such circumstances, the whole of the T2 must be re-completed.
- **T3 Form:**
  If the patient is not able to understand the nature or purpose of the treatment (i.e. lacks capacity) or would not freely take medication then a T3 is completed. In these circumstances a Second Opinion Appointed Doctor (SOAD) must be involved to formally authorise the treatment plan. A SOAD will review the treatment, interview the client, and discuss treatment with the primary nurse and one other professional who is NOT a doctor or nurse, but is involved in the patient's overall care. This is where a pharmacist may be formally called to comment on a patient's treatment plan. It is expected that the statutory consultee will have been involved in the patient's care.

Like the T2, the T3 will list the medicines that may be lawfully administered for mental health purposes. Pharmacists need to be vigilant for any T2 or T3 violations that may subsequently arise as its administration is unlawful and poses a litigation risk to the healthcare organisation.

Section 62

Urgent Treatment

Section 62 powers are used when there is a delay in getting the second opinion and interruption to treatment would cause harm to the patient. It allows for emergency treatment to be given to any detained patient when it is:

- immediately necessary to save the patient's life;
- which (not being irreversible) is immediately necessary to prevent a serious deterioration of his condition; or
- which (not being irreversible or hazardous) is immediately necessary to alleviate serious suffering by the patient; or
- which (not being irreversible or hazardous) is immediately necessary and represents the minimum interference necessary to prevent the patient from behaving violently or being a danger to himself or to others.

Part IVA

Treatment of community patients not recalled to hospital

Community Treatment Orders (CTOs) are detention powers in the community. They may be applied to patients who have been detained in hospital under section 3 and who no longer need treatment in hospital but who do need continuing detention powers. Medical treatment cannot be enforced in the community in the way that treatment under sections 2 and 3 can be. A patient can be recalled to hospital if their mental health deteriorates and the patient can go immediately back on to section 3 without the need for a full application.

Part X

Miscellaneous and Supplementary

Section 135

Warrant to search for and remove patients

Allows the police to access a property where a patient may be in danger due to self-neglect or other vulnerability and remove them to a place of safety. As the patient may be already known to services their place of safety may be a direct inpatient admission.

Section 136

Mentally disordered persons found in public places

Allows the police to remove to a place of safety any person suspected of having a mental disorder from a public place. A 'place of safety' may be a custody suite, someone's home, A&E or a purpose built area close to a psychiatric hospital. Many Trusts may have a purpose-built section 136 suite which provides an appropriate environment in which to conduct a fuller mental health assessment.

Other Sections of Interest

Section 17

Leave of absence from hospital

Whilst detained under section, a person can be permitted leave from the ward or unit, under specified circumstances. Section 17 leave might be as little as a few minutes outside, away from the ward, for fresh air, or a number of days and nights at home to prepare a person for discharge.

Section 117

After-care

A requirement on health and social services is to continue to provide services, free of charge, to people who have been discharged following detention under Sections 3 or 37 or are on a CTO (treatment sections). This is to provide the treatment required as a result of the mental disorder. S117 entitlement is discharged when the person has no requirement for treatment or services for a mental disorder. For this to happen it must be agreed by both health and social care services.

Andy Down, Helen Reynolds and Alan Pollard

The Mental Capacity Act

The Mental Capacity Act (MCA) 2005 came into force in October 2007. It protects people over the age of 16 living in England and Wales who cannot make decisions for themselves for any reason. This statutory framework provides clear guidelines for carers and professionals about who can take decisions in which situations.

5 principles underpin the Act:

- Presumption of capacity – every adult has the right to make his or her own decisions and must be assumed to have capacity to do so unless it is proved otherwise.
- The right for individuals to be supported to make their own decisions – people must be given all appropriate help before anyone concludes that they cannot make their own decisions.
- Individuals must retain the right to make what might be seen as eccentric or unwise decisions.
- Best interests – anything done for, or on behalf of people without capacity must be in their best interests.
- Least restrictive intervention – anything done for, or on behalf of people without capacity should be the least restrictive of their basic rights and freedoms.

What is Capacity?

Capacity is the ability to make a specific decision. It will vary according to the complexity of the decision and the individual's circumstances and can also vary over time. For example, a person may be able to choose what clothes to wear, but not know how to look after their money; they may be able to make decisions in the morning, but not when they are tired; or they may have good days when they can make decisions and bad days when they can't.

Assessing Capacity

The Mental Capacity Act sets out a two-stage test of capacity:

- First, one should consider whether the person under assessment has an impairment, or a disturbance in the functioning of their mind or brain.
- Secondly, one should decide whether this impairment or disturbance will affect the person being able to make a specific decision when this is required of them.

In order to determine whether someone has capacity to make a specific decision, the following should be ascertained:

- Do they understand the information necessary to make the decision?
- Can they retain the information long enough to make the decision?
- Can they weigh up the information to make the decision?
- Can they communicate their decision?

If the answer to any of these questions is "No", the person does not have capacity for that decision and it will have to be taken by others in the person's best interest. If this formal capacity assessment is not carried out then the person must be assumed to have capacity to make the decision in question.

Making a capacity assessment is specific to the specific decision and the time at which it is made. Capacity assessments must therefore be repeated as appropriate for particular decisions. It is not permissible to label someone as 'incapable' as a result of a particular diagnosis. Section 2 of the Act makes it clear that a lack of capacity cannot be established merely by reference to a person's age, appearance, or any condition or aspect of a person's behaviour which might lead others to make unjustified assumptions about capacity.

Best Interests

An act done, or decision made for, or on behalf of, a person who lacks capacity must be in that person's best interests. There is a checklist of factors contained within the Act that those making capacity decisions must work through in deciding what is in a person's best interests. People are able to put their wishes and feelings into a written statement if they so wish, which must also be considered. In addition, people involved in caring for the person lacking capacity gain a right to be consulted concerning that person's best interests.

The Act deals with two situations where a designated decision-maker can act on behalf of someone who lacks capacity:

1. Lasting Powers of Attorney (LPAs)

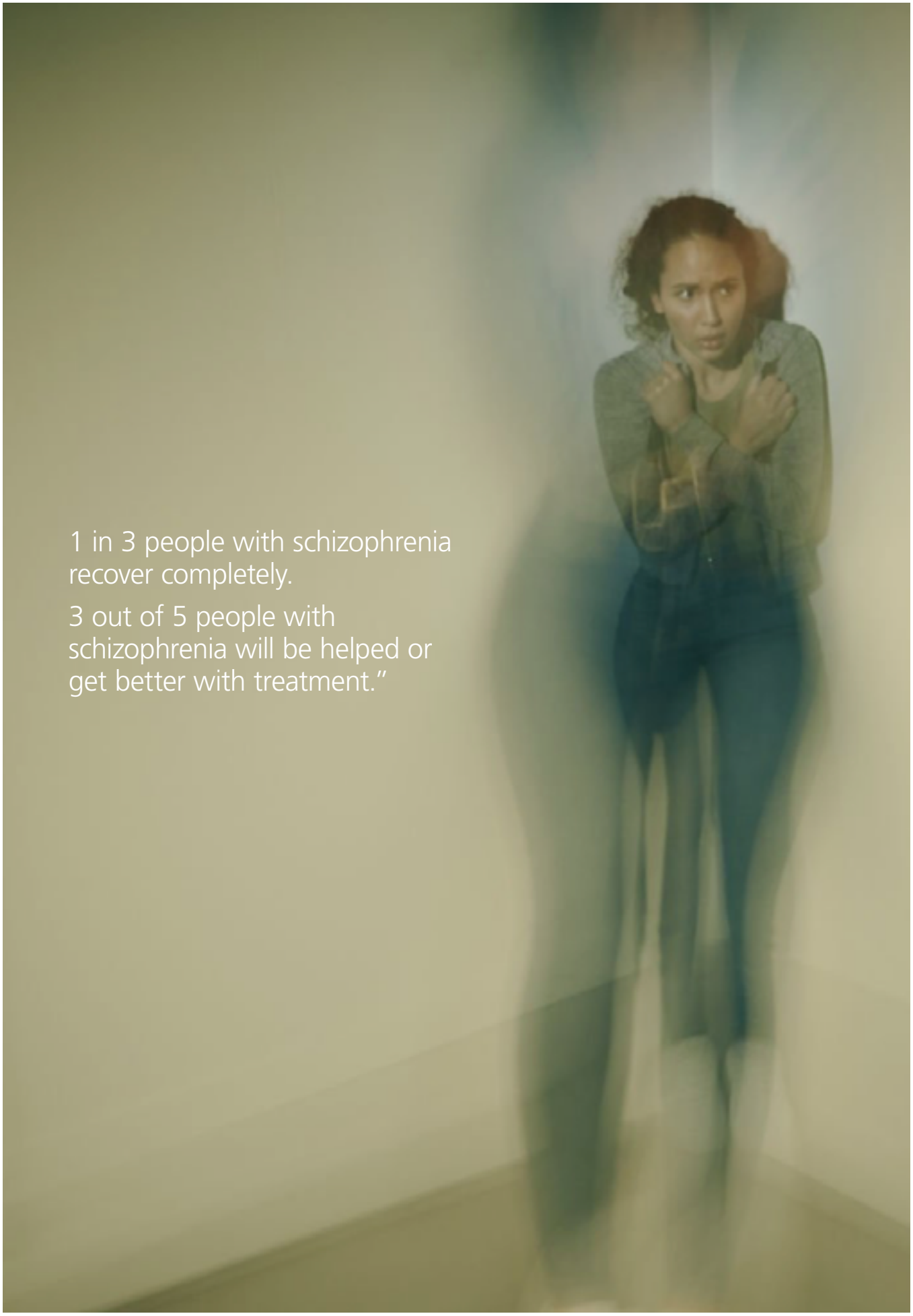
   The Act allows a person to appoint an attorney to act on their behalf if they should lose capacity in the future. This is like the Enduring Power of Attorney (EPA) in relation to property and affairs, but the Act also allows people to empower an attorney to make health and welfare decisions. Before it can be used, an LPA must be registered with the Office of the Public Guardian.

2. Court Appointed Deputies

   The Act provides for a system of court appointed deputies. Deputies can be appointed to take decisions on welfare, healthcare and financial matters as authorised by the new Court of Protection, but are not able to refuse consent to life-sustaining treatment. They will only be appointed if the Court cannot make a one-off decision to resolve the issues.

Independent Mental Capacity Advocates (IMCAs)

This is a type of advocate created by the Act who will be involved in certain decisions for people who do not have capacity. When a service user has been assessed as not having capacity to make a decision about serious medical treatment or a change of home (including coming to hospital for at least 28 days) and they do not have friends, family or unpaid carers to be consulted, then an IMCA must be consulted. An IMCA can also be used when a person without capacity is having their residential placement reviewed, or when there is an adult protection concern about somebody and either the subject or the alleged perpetrator is assessed as not having capacity.


1 in 3 people with schizophrenia recover completely.
3 out of 5 people with schizophrenia will be helped or get better with treatment."

Schizophrenia

Key Facts

- People with schizophrenia are consistently shown to have a significantly shorter life expectancy (by an average of 10–20 years) than that observed in the general population.
- A range of effective care options for people with schizophrenia exist and at least one in three people with schizophrenia will be able to fully recover.
- Globally, schizophrenia affects 24 million people or 1 in 300 people (0.32%) worldwide.
- Schizophrenia is one of the top 15 leading causes of disability worldwide.
- Stigma, discrimination, and violation of human rights of people with schizophrenia are common.

What is schizophrenia?

'Schizophrenia' is a term used to describe a set of symptoms. It is not something that can be measured or tested for. There is a generally agreed set of symptoms that are typically seen in people that have had a psychotic episode. Schizophrenia is only used should someone experience these symptoms more than once.

Symptoms

Positive or psychotic symptoms

Hallucinations

A hallucination happens when someone can hear, smell, feel or see something - but it isn't caused by anything (or anybody) around them. The commonest one is hearing voices. To the person hearing voices, they can seem totally real and they usually come from outside their head, but no one else can hear them. Voices can talk to the person directly or talk to each other about them. They can be pleasant, but are often rude, critical or abusive.

Delusions

A delusion happens when a person has an absolute belief in something while other people think they have misunderstood what is happening. The person with a delusion will have no doubts, but other people see their belief as mistaken, unrealistic or strange. It's an idea, or set of ideas, that can't be explained as part of their culture, background or religion.

Ideas of Reference

People might start to see special meanings in ordinary, day-to-day events. It feels to them as though things are specially connected to them – that radio or TV programmes are about them, or that someone is telling them things in odd ways, for example, through the colours of cars passing in the street.

Thought Disorder

- People's thoughts wander. They drift from idea to idea – but there's no clear connection between them.
- Thought withdrawal; thoughts have suddenly disappeared as though someone has taken them away.
- Thought insertion; thoughts feel as though someone else has put them into their mind.
- Feelings of passivity; their body is being taken over and controlled by an external agent.

Negative symptoms

- People start to lose their normal thoughts, feelings and motivations (known as avolition).
- Losing concentration, energy, emotions and 'get-up-and-go'
- Not feeling excited or enthusiastic about anything (known as adhedonia).
- Not bothering to get up or leave the house and not washing themselves or tidying.
- Feeling uncomfortable with people.

Causes of Schizophrenia

There are several factors that can be implicated in the onset of schizophrenia. There remains evidence that genetic, biological and environmental factors can also play a contributing part in developing schizophrenia.

Genetics

Schizophrenia tends to run in families, but no single gene is thought to be responsible for developing this disorder. It is thought that a combination of genes can make people more vulnerable to develop the condition. However, having these genes does not necessarily mean that an individual will develop schizophrenia.

Genetic factors alone cannot account for the development of schizophrenia and there is thought to be a link with environmental stressors, particularly those that occur early in life.

Social and Environmental

Several risk factors have been associated with the development of schizophrenia. Studies have also shown an increased risk of developing schizophrenia in individuals who have experienced childbirth complications. There are higher numbers of people with schizophrenia who live in urban areas compared with those who live in less densely populated areas, but we don't know if this is a cause or a migration effect.

Childhood trauma, such as abuse, unstable home life, substance misuse, living in poverty, or exposure to racism, can also increase the risk of developing schizophrenia.

Diagnosis

The two most widely used systems for diagnosing mental disorder, DSM-5 and ICD-11 (see Introduction to Mental Health) list a set of symptoms and duration of symptoms for a diagnosis of schizophrenia.

If someone presents for the first time with psychotic symptoms, then they are likely to be assessed by a specialist mental health care team usually known as the Early Intervention Team. They will look at the range of symptoms as a multi-disciplinary team and if they deem that the patient is experiencing psychosis, they will offer antipsychotic treatment and psychological intervention.

Not all people who experience psychosis will go on to develop schizophrenia.

A diagnosis of schizophrenia is made if someone experiences more than one episode of psychosis and by a specialist in the field of psychiatry. It usually involves a detailed assessment of the patient, including their presenting symptoms and detailed life history. This assessment is often referred to as a 'mental state examination'. Psychiatrists usually work as part of a multidisciplinary team and the care of the patient may involve multiple assessments over a period of time.

Prognosis

Most people make a good recovery following a first episode of psychosis. The earlier it is detected and treated, the better the prognosis. Good prognoses are linked to people with a stable relationship and employment. Poorer ones with people with social isolation, younger age of onset, prolonged episodes without treatment and being male.

It is worth noting that people with schizophrenia have a shorter life expectancy by up to 20 years and this is largely due to preventable physical illnesses.

Treatment

NICE recommends both medication and psychological approaches to treating schizophrenia.

Antipsychotic medication is used to treat both positive and negative symptoms. The aim of treatment is to minimise the associated symptoms while improving the quality of life for the individual in question. Treatment is also intended to prevent the potential for relapse. On the whole there is no superior treatment for schizophrenia and it is important the individual patient related factors are taken into consideration when recommending or starting treatment. The side effects of the antipsychotic medicines can often prove difficult for individuals to cope with and in some cases treatments can prove to be ineffective.

The development of medication for schizophrenia is based on the biological theory of schizophrenia. This refers to the theory that an imbalance of neurotransmitters cause the symptoms of schizophrenia. Dopamine is the neurotransmitter most implicated in this theory. This stems from the fact that antipsychotic drugs are dopamine receptor antagonists and their affinity at dopamine D2 receptors is the property that correlates best with their clinical activity. Serotonin (5-HT) also plays a part and it is apparent that 5-HT2A receptor antagonism may contribute to the atypical profile of some antipsychotics. A range of other transmitters may also be involved, including glutamate and gamma-aminobutyric acid (GABA).

Using medication to change how the brain functions is never straight forward; the brain has feedback mechanisms and can adapt to changes from the environment meaning that every person will react differently to medication's beneficial and adverse effects.

For an individual, accepting a mental illness as severe as schizophrenia can prove challenging. The stigma associated with schizophrenia can be severe, and acceptance of the diagnosis and subsequent treatment can be very challenging and further complicated by the very symptoms of the illness such as paranoia. This can affect how someone accepts that they need medication and how regularly they take it.

NICE Clinical Guideline 178 Psychosis and schizophrenia in adults: prevention and management.

These guidelines state that: For people with newly diagnosed schizophrenia, an acute exacerbation or recurrence of schizophrenia, offer oral antipsychotic medication. Provide information and discuss the benefits and side-effect profile of each drug with the service user.

Antipsychotics are used to treat schizophrenia. Traditionally they are divided into two groups:

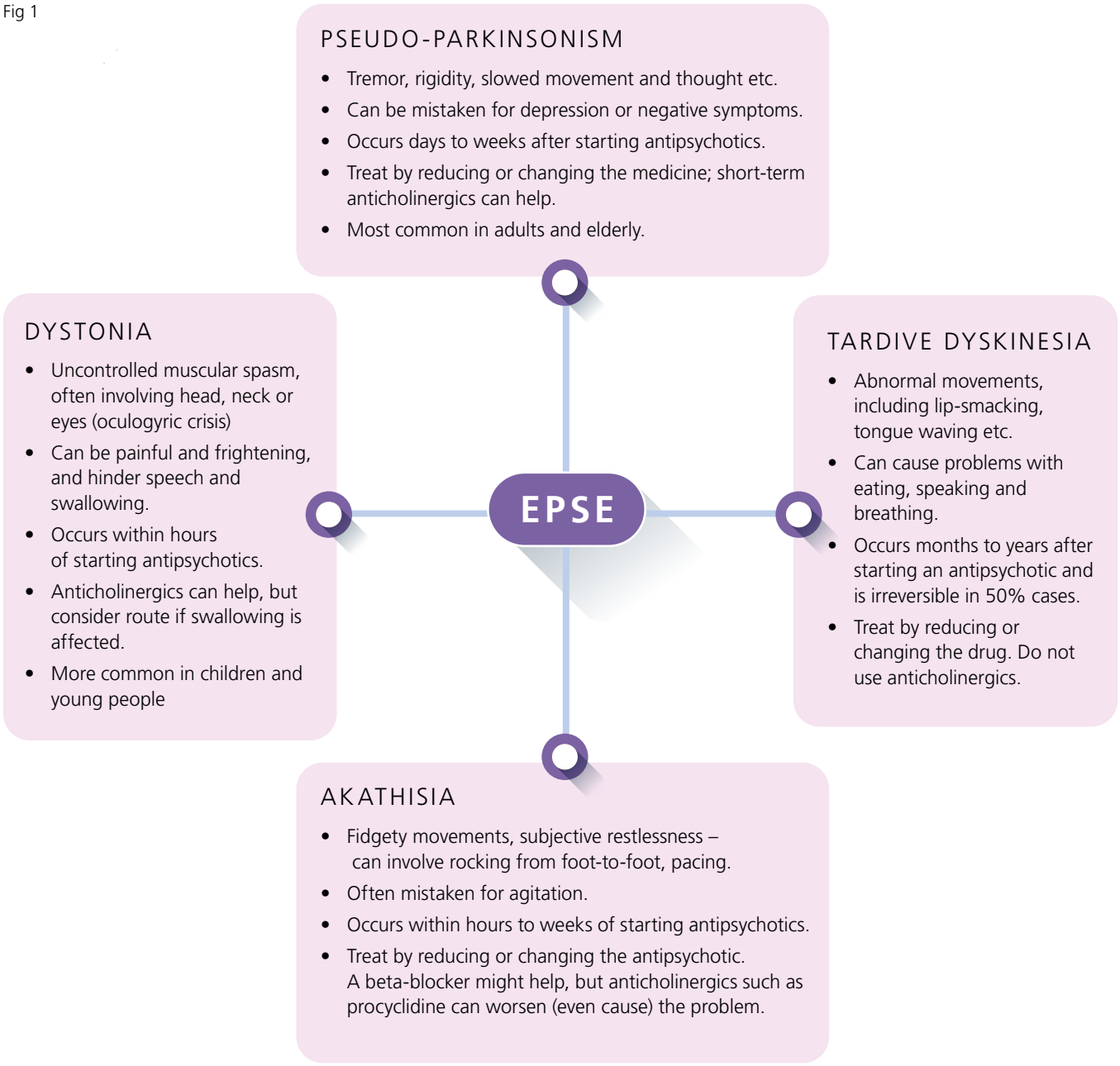
Table 2. First Generation Antipsychotic (FGA or Typical)
Phenothiazines (e.g.chlorpromazine)
Butyrophenones (e.g. haloperidol)
Thioxanthines (e.g. zuclopenthixol, flupentixol)
Substituted benzamides (e.g. amisulpride)
(Amisulpride is sometimes classed as SGA)

Table 3. Second Generation Antipsychotic (SGA or Atypical)
Aripiprazole
Clozapine
Lurasidone
Olanzapine
Paliperidone
Quetiapine
Risperidone

Side-effects

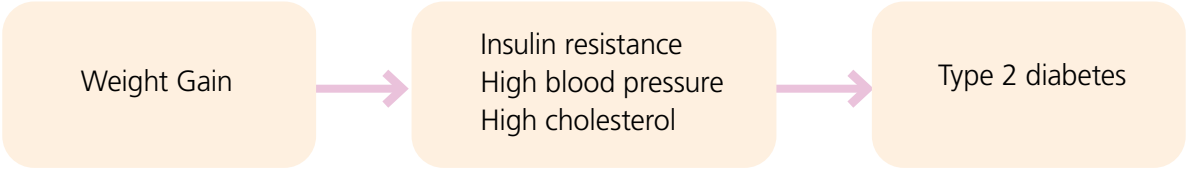
The side-effect profiles of the antipsychotics are varied, but the typical antipsychotics are generally associated with a greater risk of causing extra-pyramidal side-effects EPSE's – see Fig 1 (below), raised prolactin and antimuscarinic side effects.

Fig 1



Atypical agents are more commonly linked with a metabolic syndrome, which includes weight gain, raised blood glucose, raised blood pressure and abnormal lipid levels, and can lead to the development of type 2 diabetes. See Fig 2 (below).

Fig 2



Other important side-effects include sexual dysfunction (which affects roughly 50% of patients taking an antipsychotic agent) and cardiovascular effects including QTc prolongation, postural hypotension and sedation.

Clozapine

Clozapine is indicated in treatment-resistant schizophrenia patients and in schizophrenia patients who have severe, untreatable neurological adverse reactions to other antipsychotic agents, including atypical antipsychotics.

Treatment resistance is defined as a lack of satisfactory clinical improvement despite the use of adequate doses of at least two different antipsychotic agents, including an atypical antipsychotic agent, prescribed for adequate duration.

Clozapine shows its superiority best in refractory patients, hence the licensing and NICE recommendation to use it after two other treatments have failed. Positive and negative symptoms are improved, and quality of life is improved.

Further information can be found in the Clozapine chapter of this workbook.

Depot/long-acting injections

These vary widely in terms of frequency of administration range from weekly to six monthly injections, this way of administering the medication can be useful to reduce relapse rates, as a choice if a patient lacks insight, or if patients want to avoid the stigma of being seen to take regular, frequent oral medication. NICE states that 'they should be considered when service users would prefer this after an acute episode or when there is identified risk of non-compliance with oral medication.'

Non-pharmacological treatments

The best outcomes for people with schizophrenia come if medication and psychological therapies are used together. Psychological interventions used for patients with schizophrenia include cognitive behavioural therapy (CBT), family intervention and arts therapies.

Sue Horton, Andy Down
Reviewed by Juliet Shepherd

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2. World Health Organization. *International statistical classification of diseases and related health problems (ICD)*: ICD-11. Sep 2022
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4. *NHSE 10 key actions: Improving the physical health of people living with severe mental illness.* Jan 2024
5. *World Health Organization Schizophrenia Fact Sheet 10* January 2022

Question 3:

List the patient-related factors that must be considered when initiating a depot/long-acting injectable antipsychotic agent.

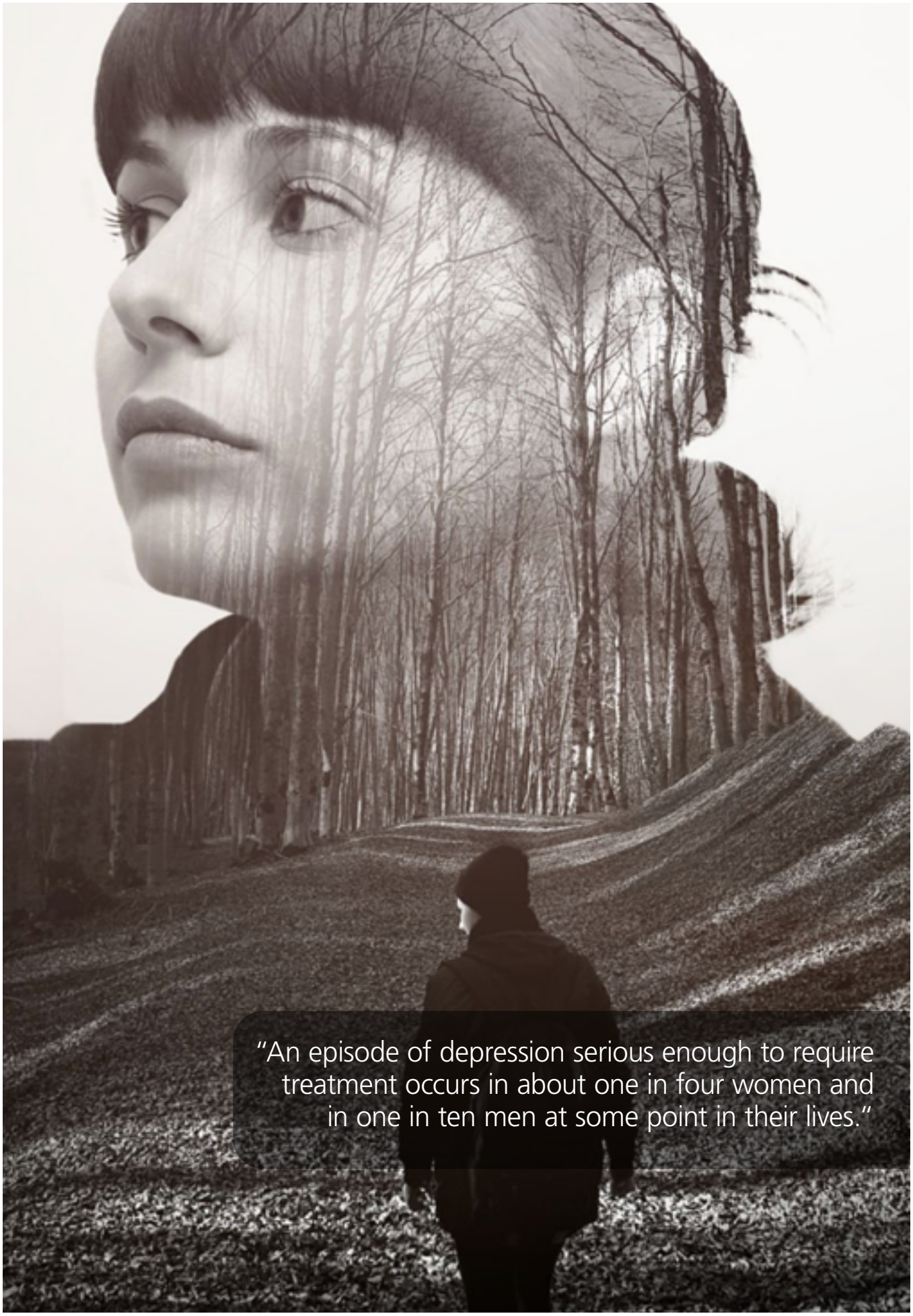
List the advantages and disadvantages of depot/long-acting injections over oral antipsychotic therapy.

Question 4:

Which types of EPSE are anticholinergic medicines not appropriate for and how would you manage these?

Task 3:

Complete a medication history for a patient with schizophrenia.


"An episode of depression serious enough to require treatment occurs in about one in four women and in one in ten men at some point in their lives."

Depression

Key Global Facts

- Depression affects an estimated 3.8% of the population (4% among men and 6% among women).
- 5.7% of adults older over the age of 60 experience depression.
- Approximately 280 million people in the world have a diagnosis of depression.
- Depression is about 50% more common among women than among men.
- More than 10% of pregnant women and women who have just given birth experience depression.
- More than 700,000 people die due to suicide every year.
- Suicide is the fourth leading cause of death in 15–29-year-olds.

What is Depression?

Depressive disorder (also known as depression) is a common mental disorder. It involves a low mood or loss of pleasure or interest in activities for long periods of time, often referred to as an anhedonia. Globally depression affects approximately 4% of the adult population and is currently ranked as the fourth leading contributor to the global burden of disease.

Causes of Depression

There is no single cause of depression, it can occur for a variety of reasons, and it has many different triggers. A traumatic or stressful event such as a bereavement or breakup of a relationship may lead to a depressive episode. In some cases, depression can be linked to personality traits such as low self-esteem or a tendency to be hyper self-critical. Certain life changing events such as pregnancy and giving birth, or the onset of menopause can predispose an individual to a depressive episode.

The COVID-19 pandemic led to a rise in depressive disorders globally, with an additional 76.2 million cases of major depressive disorders diagnosed in 2020. The rise in cases of depression was most notable in women and children.

Challenges in diagnosis

A diagnosis of depression is often based on the presentation of psychological symptoms, however in some patients the presentation can be primarily somatic (physical in presentation) which can include aches and pains, and a lack of energy. Patients and healthcare professionals can often attribute these symptoms to an underlying physical illness.

Cultural factors can also lead to difficulties in diagnosing depression as some groups consider seeking help from a healthcare professional for management of depression unacceptable. It is therefore more common for these populations to present with somatic symptoms, which may be viewed in some cultures as a more appropriate reason to visit a healthcare professional for help.

An episode of depression serious enough to require treatment occurs in about one in four women and in one in ten men at some point in their lives. About two-thirds of adults will, at some time, experience depressed mood of sufficient severity to interfere with their normal activities.

Central to a diagnosis of depression is a low mood and/or loss of pleasure in most activities (anhedonia). The severity of the disorder is determined by the number and severity of symptoms, as well as the degree of functional impairment.

In ICD-11[1], a depressive episode is defined by the concurrent presence of at least five out of a list of ten symptoms, which must occur most of the day, nearly every day, for at least 2 weeks. One of these symptoms must be depressed mood or markedly diminished interest or anhedonia. A diagnosis of depression, whether mild, moderate, or severe is dependent on symptom severity and the individual's ability to function.

The symptoms are shown in Table 4 (below).

[1] The ICD-11 is the eleventh revision of the International Classification of Diseases (ICD). The ICD is developed and annually updated by the World Health Organization (WHO). This tool supports the global standardisation of diagnoses globally.

Table 4. ICD 11 - Symptoms of depression

Key Symptoms	Ancillary Symptoms
Depressed mood	Reduced concentration and attention
Anhedonia	Reduced self-esteem and inappropriate guilt
	Suicidal ideation
	Hopelessness
	Disturbed sleep
	Diminished appetite
	Psychomotor agitation
	Reduced energy or fatigue

In what healthcare setting is depression treated?

Depression is often diagnosed and treated in a primary care setting. Primary care services provide the first point of contact in the healthcare system acting as a 'front door' for the NHS. In more severe cases of depression, treatment is managed in a secondary care setting, which reflects a model of care in which there is specialist expertise and support. A referral from a GP is often required for access to secondary care and will be made if the GP considers the individual to be at significant risk of self-harm or potentially suicide

Screening for depression

Depression can be effectively treated, however, this is dependent on early intervention, as symptoms may worsen and an individual may decline in activities of daily living (basic tasks which keep the individual safe, healthy, and feeling well) if treatment is delayed. Timely treatment can support the individual in maintaining meaningful relationships, employment, and self-worth. Individuals who are severely impacted by depression may under certain circumstances attempt to take their own life. It is therefore imperative that depression is diagnosed in a timely manner with appropriate treatment.

A screening tool is often used in primary care to identify individuals at increased risk of depression, which includes patients with a chronic physical health condition. The National Institute for Health and Care Excellence (NICE) recommends using two screening questions to identify potential depressive symptoms (see Table 5).

These two screening questions are linked to the core symptoms of depression as specified in ICD-11 (see Table 4).

Table 5: Screening questions for depression

During the past month, have you often been bothered by feeling down, depressed or hopeless?
During the past month, have you often been bothered by having little interest or pleasure in doing things?

What are the goals of treating depression?

The goals of antidepressant therapy include:

- Early and effective intervention to reduce mortality and risk.
- To return the patient to an asymptomatic or premorbid state.
- To restore normal functioning.
- To prevent or reduce the risk of recurrence.

However, can an antidepressant medication achieve all of the above?

Treatment with antidepressants can be divided into three phases comprising of acute, continuation and prophylaxis.

Acute Phase

Clinical trials indicate that about three quarters of patients with depression will respond to acute treatment with an antidepressant, provided that an effective dose is maintained for an adequate period of time. This phase, therefore, involves achieving an effective dose and then maintaining it for at least 6 weeks. Trials have shown that all antidepressants are equally effective, with no clear evidence that any one antidepressant or group of antidepressants is superior. This holds true both for the number of patients who respond, and the time taken for the response to occur. Throughout these trials, between 70 and 80% of patients respond to active treatment but about 30% will also respond to a placebo. This placebo response however, is rarely sustained.

Typically, a greater response to treatment may be observed within the first two weeks of treatment, with a more moderate response being experienced between weeks 4-6.

Continuation Phase

Following a remission in the acute phase of treatment, the antidepressant should be continued at an effective dose for at least 6 months. Failure to achieve this greatly increases the risk of relapse. However, the risk of relapse is even less if treatment continues for a year. At the end of six months, if still symptom free, the patient can be considered recovered, and treatment may be gradually withdrawn.

Some if not all patients may experience a relapse or recurrence over their lifetime. There is often confusion between these two terms. A relapse is a re-emergence of symptoms occurring within a single episode of depression. Typically, a patient takes an antidepressant, the symptoms remit, the antidepressant is stopped prematurely, and the symptoms return. Though this is the case for most, a relapse may also occur during treatment. On the other hand, a recurrence is when a new episode of depression occurs, following recovery from a previous episode and with a long symptom-free period in between.

The continuation phase for treatment with an antidepressant can be determined by several factors including a prior history of depression and its severity.

Prophylactic Phase

If the patient has a history of recurrent episodes, treatment should continue after the continuation phase. The aim is to prevent another episode occurring in the future. There is no consensus about how long to continue prophylactic treatment, but in one study of patients with a history of recurrent depression, treatment was continued for 5 years following a new episode and then stopped. The majority of these patients experienced a new episode of depression in the following 12 months, suggesting that for this group of patients, treatment may need to continue indefinitely.

During such long term or chronic treatment, it is important that a patient's general health is carefully monitored. Any deterioration may require a change of antidepressant.

Types of antidepressants

There are over 30 antidepressants in use and they can be broadly considered under the following categories:

SSRIs (Selective Serotonin Reuptake Inhibitors)

These are the most widely prescribed type of antidepressant in clinical practice. They are usually preferred over other antidepressants, as they cause fewer serious side effects and are considered safer in overdose when compared to other classes of antidepressants.

Fluoxetine is probably the best-known SSRI. Other SSRIs include citalopram, escitalopram, paroxetine and sertraline.

SNRIs (Serotonin and Noradrenaline Reuptake Inhibitors)

This class of antidepressants are similar to SSRIs, however, unlike SSRIs which block the uptake of serotonin primarily, SNRIs increase both serotonin and noradrenaline uptake. It was believed that this dual action would make them more effective antidepressants than SSRIs, however, there is no evidence to support this and in clinical practice some people respond better to SSRIs, while others respond better to SNRIs.

Examples of SNRIs include duloxetine and venlafaxine.

NASSAs (Noradrenaline and Specific Serotoninergic Antidepressants)

This class of antidepressants have a notably improved sexual side effect profile when compared with SSRIs and SNRIs but can cause marked drowsiness on initiation.

The main NASSA prescribed in the UK is mirtazapine.

Tricyclics (TCAs)

TCAs are an older type of antidepressant with a more pronounced side effect profile than other classes of antidepressants. They are no longer recommended as the first-line treatment for depression because in addition to a poorer side effect profile, they can be more toxic if taken in overdose.

Examples of TCAs include amitriptyline, clomipramine, dosulepin, imipramine, lofepramine and nortriptyline.

MAOIs (Monoamine Oxidase Inhibitors)

This class of antidepressants are rarely used in clinical practice due to their side effect profile. Usually, they would only be used by specialists in the field of treatment for specific sub-types of depression.

Examples of MAOIs include tranylcypromine, phenelzine and isocarboxazid.

Treatment Augmentation

Where there is a lack of response to antidepressant therapy, switching to another antidepressant should be the next step. Under such circumstances the mode of action of the alternative antidepressant should be taken into consideration.

There is no compelling evidence to support one type of augmentation or combination regime when compared to another, however, both lithium and antipsychotics are used in clinical practice under specialist recommendation when there have been unsuccessful successive trials of individual antidepressants. When considering augmentation therapy, there should be shared decision-making with the patient ensuring their understanding of the potential risks and benefits of the proposed treatment.

Final Thoughts

The treatment of depression should not be reliant purely on pharmacological interventions, but rather, in combination with psychological therapies which can empower individuals to develop broader coping and self-management strategies.

Antidepressants should be used in line with national evidence-based (NICE)[2] guidance, in the management of depression.

There are resources in place to support people suffering from protracted and severe problems associated with antidepressant usage and the pharmacy profession has an important role in supporting individuals to discontinue antidepressant usage where clinically appropriate to do so.

Dr Andrew Campbell

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- British Medical Journal Best Practice 2024. *Depression in adults.* Available from: Depression in adults - Symptoms, diagnosis and treatment | BMJ Best Practice

> "Mental pain is less dramatic than physical pain, but it is more common and also more hard to bear. The frequent attempt to conceal mental pain increases the burden: it is easier to say "My tooth is aching" than to say "My heart is broken."
>
> C.S. Lewis, 'The Problem of Pain'

[2] The National Institute for Health and Care Excellence (NICE) provides national guidance and advice to improve health and social care. www.nice.org.uk

Question 5:

All antidepressants offer effective treatment for depression, providing two conditions are met.

What are these conditions?

Question 6:

Outline four key criteria which may be applied to the selection of an antidepressant.

1.

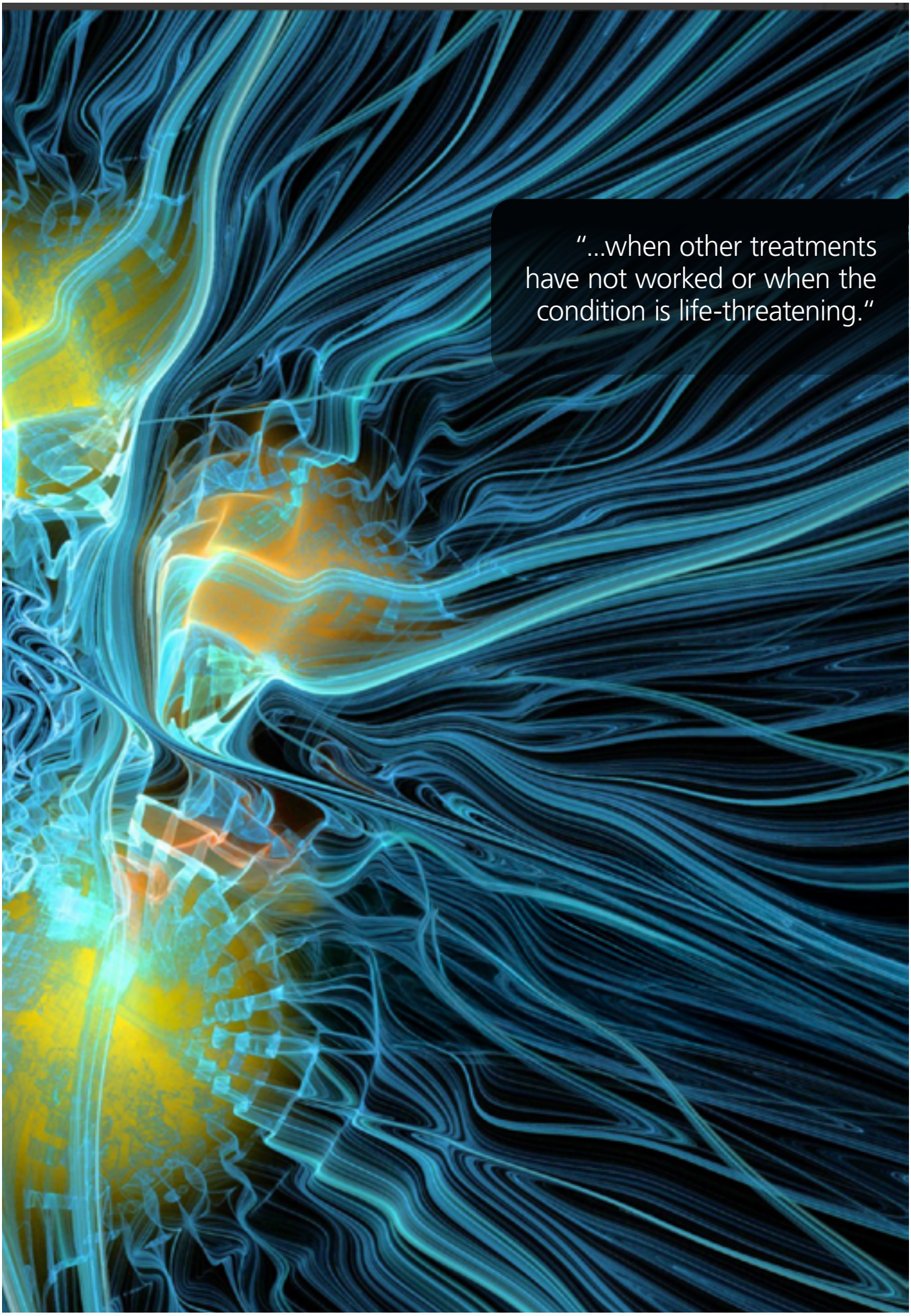
2.

3.

4.

Question 7:

This chapter outlines several factors which are linked to the onset of depression. Can you think of any others?


"...when other treatments have not worked or when the condition is life-threatening."

Electroconvulsive Therapy

Convulsive therapies were introduced in the 1930's, under the erroneous belief that epilepsy and schizophrenia do not occur together. A number of 'treatments' were subsequently developed to induce seizures in an attempt to improve schizophrenia, but it was discovered that the greatest improvements were not to be found in treating schizophrenia, but in severe depressive disorders.

Electroconvulsive Therapy (ECT) is a treatment that can be used in severe mental illness, when other treatments have not worked or when the condition is life-threatening. The treatment involves placing the patient under general anaesthetic and passing a small electric current across the patient's brain to cause a seizure.

> "It is recommended that (ECT) is used only to achieve rapid and short-term improvement of severe symptoms after an adequate trial of other treatment options has proven ineffective and/or when the condition is considered to be potentially life-threatening, in individuals with:
>
> - Severe depressive illness
> - Catatonia
> - A prolonged or severe manic episode"
>
> (NICE Technology Appraisal 59, April 2003)

Electrodes used in the procedure are placed on the scalp on either both sides (bilateral ECT) or one side (unilateral ECT). Bilateral ECT is thought to be more effective than unilateral, but can cause a greater amount of residual confusion. In unilateral ECT, electrodes are placed on the non-dominant side of the brain, in an attempt to reduce cognitive side-effects.

Previously, ECT was used in 'unmodified form', meaning the procedure was carried out without any anaesthesia or muscle relaxants. It does not require a vivid imagination to work out why ECT would be unpleasant, very frightening and why it still carries a negative stigma. Modern ECT is much more refined, safe, humane and evidence-based, being carried out by specially trained staff.

A course of ECT can range from 6 to 12 sessions. Some patients, however, will respond to fewer sessions than these. ECT has also been used in a number of circumstances for maintenance treatment, with good effect. It can be used in an inpatient setting or those requiring treatment can attend as outpatients.

Medication used in ECT

Thiopental sodium

What is it for? Anaesthetic – for safe administration of ECT.

How is it given? Injection into a vein.

What are the side-effects? The main side-effects include changes in heart rhythm, reduced heart muscle contractility, low blood pressure, tissue damage if leaked during injection, electrolyte imbalance, cough, sneezing.

Propofol

What is it for? Anaesthetic – for safe administration of ECT.

How is it given? Injection into a vein.

What are the side-effects? The main side-effects include pain on injection, low blood pressure, changes in heart rate and breathing, headache, feeling sick and muscle twitching.

Muscle Relaxants

A muscle relaxant is given to paralyse voluntary muscle activity and limit the patient's movement during the seizure. This is to stop them and others from being hurt by involuntary movements. The most common muscle relaxant normally used is suxamethonium.

Suxamethonium

What is it for? Muscle relaxant – to reduce the intensity of muscle movements during a seizure.

How is it given? Injection into a vein after anaesthesia.

What are the side-effects? During use it can alter heartbeat and breathing, the patient's skin might flush, temperature can increase and they might produce more saliva. For a short while, muscles might be painful and the patient could have a headache, blurred vision, or feel sick. Following administration, muscle twitching can sometimes be observed. Apnoea ('scoline apnoea') and anaphylaxis are possible serious adverse side effects.

Supportive Treatment

Atropine

What is it for? To reduce saliva or other secretions and to prevent the heart from beating too slowly.

How is it given? Injection, usually into a vein

What are the side-effects? Likely side-effects include dry mouth, dry eyes, difficulty going to the toilet, blurred vision and increased heart rate.

Effects and Side-Effects of ECT

ECT causes disorientation and memory loss. Memory loss can be short or, more rarely, long-term, and can be retrograde (failure in recalling past events) or anterograde (failure in processing and recalling current events). Although side-effects sometimes continue for a short while after the ECT session, they are usually only temporary. The side-effects are more than likely dose-related and can be influenced by the placement of the electrodes.

If the patient is staying on a ward then a member of staff will often stay with them. If they have come as an outpatient, it is important that someone is available to help them get home, because the effects of the drugs (and ECT) can continue for some time after the treatment session.

Medication Plan

Some medication might need to be changed around the time of ECT. For example, it might be necessary to miss a dose of an item that has the potential to alter seizure threshold or interact with the medication which is used as part of the ECT procedure. Pre-existing medication can interact with therapy in three principle ways:

1. interaction with medications used during the ECT procedure
2. interaction that affect the efficacy of ECT (suppressing or enhancing seizure activity)
3. interaction that can increase the risks associated with ECT (eg, increase risk of complications, such as cardiotoxicity).

It is important that patients are encouraged to discuss all of their medication with a pharmacist and/or doctors and seek advice on what to do around the time of ECT.

Pre-ECT clinics are often organised where patients and relatives/carers can look around the unit and ask any questions that they might have.

Andy Down & Dr Nwe Thein

Further Information

- MIND Helpline (Mon - Fri, 9.15 - 5.15): 0845 7660163

  Leaflet available online (through the Information section) via: www.mind.org.uk
- Scottish ECT Accreditation Network (SEAN)
  Questions and answers leaflet available online via:
  www.sean.org.uk

  NB: Scotland has separate mental health legislation – see the section The Mental Health Act.
- The Royal College of Psychiatrists Leaflet available at:
  www.rcpsych.ac.uk/mentalhealthinformation.aspx

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   https://www.nice.org.uk/guidance/ng222

"ECT is used in current UK clinical practice as a treatment option for individuals with depressive illness, catatonia and mania."

NICE Technology Appraisal 59, 2003

Question 7:

You have been asked to provide advice on the action required regarding the treatment of patients preparing for ECT. What would you recommend for each of the following?

1. Fluoxetine, 20mg OD
2. Paroxetine, 30 OM
3. Warfarin, according to INR
4. Olanzapine, 10mg ON
5. Zuclopenthixol decanoate, 400mg fortnightly, IM
6. Lithium, 400mg OD
7. Diazepam, 2mg TDS
8. Sodium valproate, 1000mg BD
9. Carbamazepine, 200mg BD
10. Insulin glargine, 18 units daily.

Question 8:

ECT has been requested for a number of patients; indicate whether each can or cannot receive the treatment, or if they can following approval of a SOAD (or under section 62).

Patient	Patient Details					Can Receive ECT		
	Detained under Section	ECT clinically indicated	Life-threatening situation	Has (mental) capacity	Gives consent	Yes	No	Yes SOAD
A	✔	✔	✔	✔	✔			
B	✔	✔	✔	✔				
C	✔	✔	✔					
D	✔	✔		✔				
E	✔	✔		✔	✔			
F		✔		✔				
G		✔	✔	✔				
H		✔						
I			✔	✔	✔			

Task 5:

Document your feelings about the use of ECT in the modern treatment of mental health disorder.

Attend an ECT session, and reflect your observations below. NB: you will need to arrange this in advance.

What have you learned?

Has your opinion changed? If so, how and why?

Would you be happy to receive ECT (if it were necessary)?

Task 6:

Interview and prepare a brief report on a patient who has received ECT. Use the following points to guide your report.

Provide a brief case description

What were the indications for ECT?

What alternative therapeutic approaches had been tried?

Why had these proved ineffective or inappropriate?

What were the patient's views about treatment?

What side-effects (if any) did the patient experience following ECT?


"Bipolar Disorder ...affects approximately 1% of the population with roughly the same incidence in males and females."

Bipolar Disorder

Aerates, in the second century AD, first used the word mania to describe patients who would 'laugh, play, dance night and day, and sometimes go openly into the market crowned as if victors in some contest of skill'. He noted that later they would appear 'torpid, dull and sorrowful.' The ancient Greeks coined the terms 'mania' and 'melancholia'. It was not until 1686 that Theophile Bonet first connected the two distinct ends of the mood spectrum and coined the term 'manico-melancolicus'.

More recently in 1904, the German physician Emil Kraepelin developed a symptomatic classification for mania and depression, identifying over 100 sub-types of bipolar illness. He was the first to use the term 'manic depressive psychosis' and noted that after periods of acute manic or depressive illness, patients experienced relatively symptom-free periods where functioning was not affected.

Bipolar affective disorder (BPAD), formerly known as 'manic depression', is a serious, often lifelong, mental illness. It affects approximately 1% of the population with roughly the same incidence in males and females. The peak age of onset is 15 to 19 years of age. It is a cyclical mood disorder, with patients experiencing periods of abnormally elevated mood and depression. These can have a huge impact on the way the individual is able to live their life.

Symptoms of Mania

- Elevated mood
- Racing thoughts/distractibility
- Decreased need for sleep and increased energy/activity
- Grandiose ideas and plans
- Rapid speech and pressure of speech
- Impulsiveness and risky behaviour - sometimes sexual or financial
- Irritability
- Sometimes there are psychotic symptoms.

Symptoms of Depression

- Low mood
- Feeling hopeless and helpless
- Feelings of guilt
- Lack of enjoyment in previously pleasurable activities
- Lack of energy
- Poor concentration
- Poor sleep, usually with early morning wakening
- Suicidal thoughts
- Changes in appetite and weight
- Feeling anxious or slowed down.

Current clinical practice reflects two main types of bipolar disorder (I and II), although additional categories are to be found in the literature. For a diagnosis of bipolar I under the ICD criteria, there must have been evidence of at least one episode of mania. In bipolar II, mania has not occurred, but hypomania has. Hypomania is differentiated from mania by the fact that it is not severe enough to cause marked impairment of social or occupational functioning and/or does not require admission to hospital.

Rapid cycling is characterised by a high frequency of mood disorders (minimum four a year), and it is recognised that each mood episode especially depressive periods may last for a shorter duration than those usually observed. Be aware that where depressive and manic symptoms alternate rapidly (i.e. day to day or within the same day) then a mixed episode should be diagnosed instead of rapid cycling.

Cyclothymic disorder is characterised by persistent instability over a minimum of 2 years with both depressive and hypomanic episodes seen but neither mood episode being sufficiently severe, prolonged or symptomatology meeting diagnostic criteria of bipolar disorder (I and II).

For nearly all patients, bipolar affective disorder is a chronic cyclical mood disorder that can be associated with considerable risk. It can damage or destroy relationships, reduce the ability to hold down a job and carries a higher level of morbidity and mortality than in the general population. Bipolar disorder is also associated with an increased risk of suicide: 0.1% of individuals die by suicide annually in the UK. Between 25% and 60% of individuals with bipolar will attempt suicide at least once in their lives, and between 4% and 19% will have died by suicide. With appropriate treatment and support patients are able to live fulfilling and happy with bipolar disorder, including remaining symptom free.

In the acute phase of the illness the aim of treatment is to return the patient's mood to what is normal for them – i.e.. treat the mania or depression. The long term aims of management are to maintain the stable mood, prevent relapse, and optimise social and occupational functioning.

Treatment of manic episode

- Consider discontinuation of any antidepressant medication.
- Consider use of a benzodiazepine to manage agitation/ irritability and possibly a hypnotic to aid sleep.
- NICE guidelines recommend that if a person is not taking an antipsychotic or mood stabiliser, offer haloperidol, olanzapine, quetiapine or risperidone.
- If already taking lithium, check plasma lithium levels with a view to optimising treatment and consider adding haloperidol, olanzapine, quetiapine or risperidone.
- Valproate medicines should only be considered for use when no other treatment is effective or tolerated.
- Treatment selection should take into account tolerability, prior response to treatment, patient preference (including any advanced statements) and physical co-morbidity.

Treatment of depressed episode

- If not on any medication, consider starting either quetiapine or a combination of fluoxetine with olanzapine.
- Lamotrigine or olanzapine without fluoxetine can be offered

as an alternative if the patient prefers.

- If treatment with quetiapine or fluoxetine-olanzapine is ineffective, consider replacing with lamotrigine.
- If already taking lithium, check plasma lithium levels with a view to optimising treatment.
- If the patient is already prescribed valproate, review adherence and consider increasing the dose.
- If an antidepressant is started, then advise the patient of the risks of 'switching' to mania and review the antidepressant regularly.
- Treatment selection should take into account tolerability, prior response to treatment, patient preference (including any advanced statements), physical co-morbidity and the toxicity of the medicines in overdose.

Long-term treatment to prevent future episodes/worsening symptomatology

- Following the management of the acute manic or depressive episode, within 4 weeks of resolution of symptoms, a discussion should be held with the patient to determine whether to continue the acute treatment or switch to maintenance therapy.
- If the acute treatment is continued, it should be reviewed again after 3 to 6 months.
- If long-term treatment is considered, lithium should be offered first line.
- If lithium is ineffective, poorly tolerated or not suitable, offer an antipsychotic.

Use of valproate (valproic acid, valproate semisodium, sodium valproate)

- Valproate has a high teratogenic potential with well documented congenital malformations (11%) and neurodevelopmental disorders (40%) occurring in children exposed in utero. There is a known association with impaired male fertility and the potential for increased risk of neurodevelopmental disorders, in children whose fathers took valproate 3 months prior to conception, further research is currently being undertaken.
- Medicines and Healthcare products Regulatory Agency (MHRA) have strict requirements for initiation and review of valproate. Further advice can be found from the MHRA at Valproate safety measures - GOV.UK (www.gov.uk).

Helen Thurlow
Reviewed by Michelle Lad & Rebecca Keeler

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Case Study

Sarah, a twenty-year-old woman, had an acute psychiatric admission to the ward in May under section 2 of the Mental Health Act. This is her third admission in 4 years for the purposes of protecting her from the consequences of her behaviour. She presented with elevated mood, easily distracted, rapid speech, grandiose ideas and had been without sleep in 2 days. She was agitated and verbally aggressive.

"I am the Queen of England", "I see everything in the universe and move with the stars", "I can grant life and death, and give everyone eternal happiness"….

Sarah has no insight into her illness at the point of admission. Following an initial assessment she was prescribed olanzapine 5mg at night, lorazepam 1mg 4 hourly max 4mg/24 hours and zopiclone 7.5mg once at night when required. The dose of olanzapine was increased over 3 weeks to 15mg at night.

Over the next 4 weeks Sarah's mental state gradually improved and the multi-disciplinary team decided there is need for a longer-term maintenance therapy for bipolar affective disorder, lithium was prescribed.

"Although it's usually a long-term condition, effective treatments for bipolar disorder, combined with self-help techniques, can limit the condition's impact on everyday life."

NHS Living with Bipolar Disorder

Question 9:

In the case study, why were olanzapine and lorazepam chosen as initial treatment for mania?

What other medicines could be used for the treatment of acute mania?

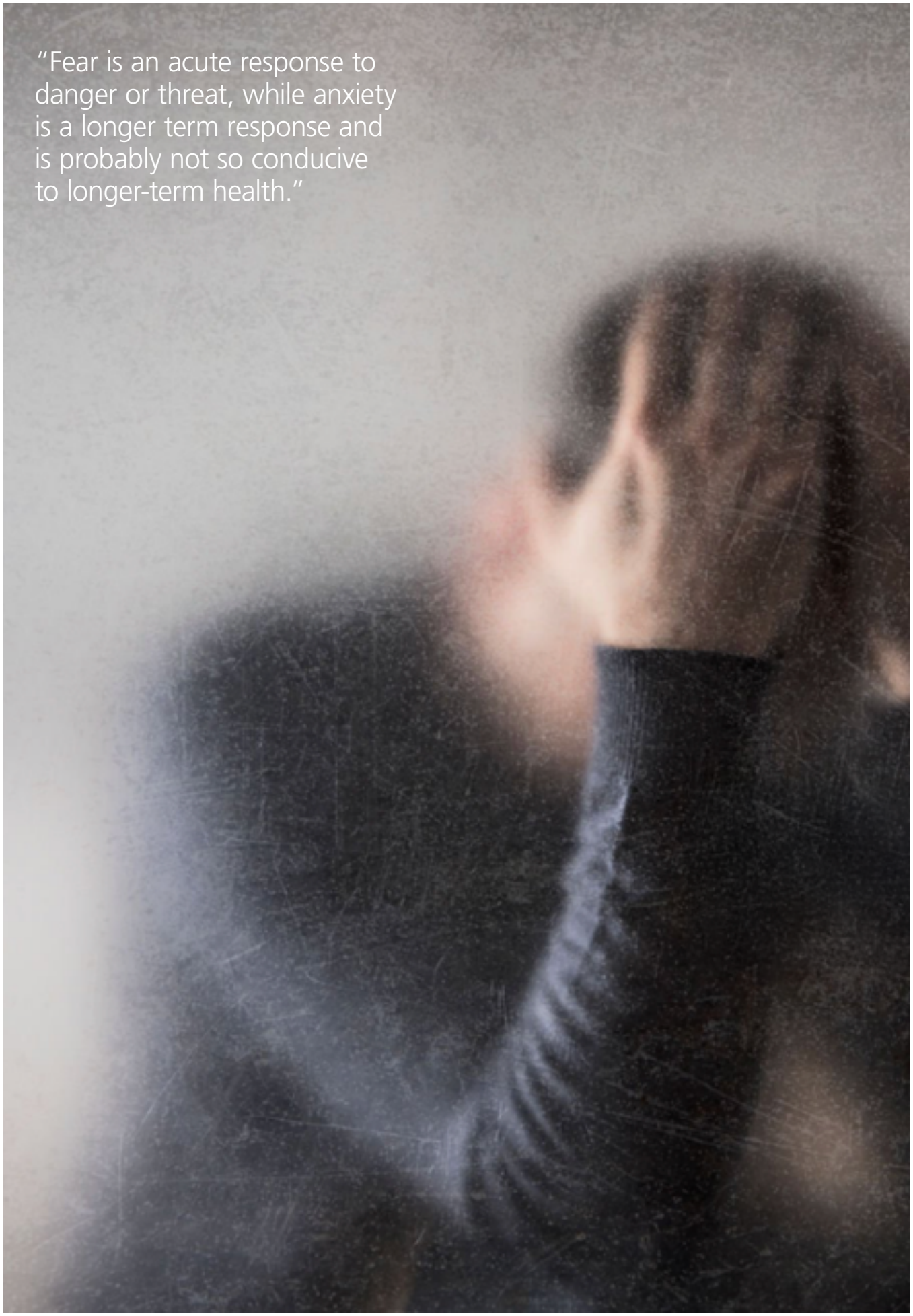
Question 10:

Lithium is chosen as long-term maintenance therapy.

What are the key counselling points that should be discussed with patients prior-to-starting/whilst-taking lithium?

Question 11:

What tests should be done during maintenance lithium therapy, including frequency and rationale?


"Fear is an acute response to danger or threat, while anxiety is a longer term response and is probably not so conducive to longer-term health."

Anxiety Disorder

Fear and anxiety are normal emotions which help to stop us doing something dangerous and help us escape from danger. Through these mechanisms, we learn to avoid danger in the future. Fear is an acute response to danger or threat, while anxiety is a longer term response and is probably not so conducive to longer-term health.

Anxiety disorders are abnormal states characterised by signs of mental and physical symptoms. In generalised anxiety disorder (GAD), anxiety symptoms fluctuate in intensity but are present all the time. In phobic and obsessional states, the anxiety is intermittent. Anxiety occurs in 2 to 4% of the general population and accounts for some 27% of psychiatric GP consultations, while 8% of psychiatric out-patients can present with anxiety symptoms. It usually begins in early adult life and affects females more than males.

Anxiety or fear-related disorders in the ICD-11

6B00 Generalized (GAD)

6B01 Panic Disorder

6B02 Agoraphobia

6B03 Specific Phobia

6B04 Social Anxiety Disorder

6B05 Separation Anxiety Disorder

6B06 Selective Mutism

6B0Y Other Specified Anxiety or Fear-Related Disorders

Causes of anxiety disorders

There are several causes of anxiety. Genetic studies have demonstrated GAD is more frequent in first-degree relatives of subjects who have the disorder. Twin studies have suggested that environmental factors may somehow determine how genetic factors are ultimately expressed. Gene studies have also shown functional abnormality of the serotonin reuptake mechanism. It may account for a small percentage of anxiety-related personality traits in individuals and their siblings.

Abnormalities may exist in anxiety circuits, and several brain systems and neurotransmitters are involved. From animal studies, a key role for the amygdala has been found. This area of the brain is responsible for receiving sensory information. Other important areas are the cortex (role in cognitive processes), the hippocampus (relates memory to present context) and the periaqueductal grey (PAG; major site for processing fear & anxiety and interacts with the amygdala). Imaging studies in a few patients with GAD suggest potential changes in global & regional activity.

Stress may be a trigger to some anxiety states, while unusual major traumatic events can lead to post-traumatic stress disorder (PTSD). Conditioned learning may also result in the development of phobias.

Consequences and symptoms

The consequences of fear and anxiety are emotional and cognitive, with conscious experience of fear, heightened awareness and being distracted. Behavioural reactions include flight or freeze, with sympathetic nervous system (SNS) responses that can present as increased blood pressure and heart rate. If skeletal muscle tension occurs, it can lead to aches and pains.

General clinical features of anxiety disorders often include apprehensive expectations, hypervigilance, disturbed sleep, muscle tension and autonomic arousal.

Neurotransmitters involved in anxiety

- **GABA** (Gamma-Aminobutyric Acid) is the main inhibitory transmitter in the brain. If GABA receptors are inhibited, anxiety rises, whilst stimulating these receptors results in a reduction in anxiety.
- **Serotonin** has important actions by co-ordinating various functions such as mood and sleep. It is thought that serotonin is involved in the pathway which result in unconditioned fear (panic) and GAD. .
- **Noradrenaline** is involved in arousal, attention and learning, and emotional behaviour. In GAD the system which controls noradrenaline might be overactive, leading to more anxiety.
- **Cholecystokinin** is thought to have a modulatory role in anxiety as it is abundant in the brain and interacts with GABAergic, serotonergic and noradrenergic neurotransmitter systems.

Generalised Anxiety Disorder

This is the most common anxiety disorder, affecting 5-6% of the UK population. GAD can be described as a condition marked by excessive worry, feelings of fear, dread, and uneasiness which last for six months or longer. Other symptoms include restlessness, feeling tired, being irritable, muscle tension, not being able to concentrate, not sleeping well, shortness of breath, fast heartbeat, sweating and dizziness. GAD often co-exists with depression.

Panic Disorder

Panic disorder has an incidence of around 1%. It is a disorder in which a person experiences recurrent, unexpected panic attacks and often have a persistent concern about having more panic attacks. Panic attacks are characterised by extreme acute and intense anxiety.

They often begin with intense apprehension and/or a feeling of impending doom. They normally last minutes, but can more rarely last hours. Symptoms can include dyspnoea, dizziness, choking sensation, palpitations, sweating and accelerated heart rate.

Phobias

It is estimated that 10 million people in the UK have phobias. A phobia is a type of anxiety disorder which involves having a strong, irrational fear of something which poses little or no actual danger. Specific phobias include acrophobia (a fear of heights); agoraphobia (a fear of open, public spaces); atychiphobia (a fear of failure). Typical symptoms of phobias include panic, fear, rapid heartbeat, shortness of breath, trembling and strong desire to get away.

Post-Traumatic Stress Disorder (PTSD)

1 in 10 people in the UK are expected to experience PTSD at some point in their lives. PTSD is an anxiety disorder which is precipitated by an experience of intense fear or horror while being exposed to a traumatic (especially life-threatening) event. Symptoms involve intrusive and reoccurring thoughts or images of the event, resulting in the sufferer avoiding anything associated to the event, a state of hyperarousal or diminished emotional responsiveness. Symptoms are present for at least one month; however, the disorder is normally long-term.

Obsessive Compulsive Disorder (OCD)

It is estimated that 1 in every 50 people suffer from OCD during their lifetime. OCD is an anxiety disorder distinguished by recurrent and persistent obsessions or compulsions, they can hinder the individuals daily functioning or can cause distress. OCD sufferers typically have upsetting thoughts (obsessions) and perform repeated actions (compulsions) in an attempt to make these thoughts go away. Anxiety typically occurs when attempts are made to resist the compulsion. Patients are normally able to recognise the strangeness of their actions but feel unable to resist.

Treatment of Anxiety

It is important before treating anxiety that an accurate diagnosis of a person's specific anxiety disorder has been made, as this will allow the individual to understand their condition and ensure they are offered the most appropriate treatment as soon as possible. Other causes such as hyperthyroidism, excessive use of stimulants (such as caffeine), alcohol/substance dependence, should also be considered and ruled out if possible. The different anxiety disorders have different treatment options, and choice of treatment should be made using evidence and guidance, along with patient factors and patient choice. Psychosocial interventions such as low-intensity psychological interventions, individual and guided self-help and psychoeducational groups should be the first steps. Most patients will however require further treatment which will include high-intensity psychological intervention (CBT/applied relaxation/EMDR), pharmacotherapy, or a combination of both.

Psychological Therapy

Evidence-based psychological interventions have been shown to be effective treatments of anxiety disorders and are generally considered first-line treatments. Psychological treatment in some scenarios can help uncover the underlying cause of anxiety and aid in developing ways in managing this anxiety. This can however be more emotionally demanding, take longer to work and is less readily available than medication.

Low-intensity psychological interventions are often used as the first option if appropriate, this includes individual self-help and psychoeducational groups. If the initial treatment has not provided an adequate response, the individual can be stepped up to an individual high-intensity psychological intervention or drug treatment. High-intensity treatments can include cognitive behavioural therapy (CBT), applied relaxation and eye movement desensitisation and reprocessing (EMDR). Note that groupings of therapies into different intensities is not consistent throughout guidance and literature, and any therapy may be appropriate at any point of the patient's journey.

CBT

CBT is the psychotherapy which has the most evidence in anxiety disorders. CBT focuses on the 'here and now', understanding your own thoughts and feelings towards yourself and others, and how these are related to your behaviours. CBT aims to teach patients to be able to identify, evaluate and respond to their unhelpful thoughts and beliefs. There are various types of CBT which seek to achieve these goals using different techniques. Guided discovery is when the therapist questions the patient's thoughts to evaluate their own thinking. The therapist can also create behavioural experiments to directly test their thinking.

In PTSD, CBT is trauma focused, patients are helped to confront traumatic memories, people or objects with the patient being taught techniques in dealing with response to these stimuli.

In OCD, CBT often involves exposure and response prevention, the therapist exposes the patient to their fears in a controlled manner, starting with the easiest situations and gradually building this up, during which the patient cannot perform any of their compulsions.

Pharmacological Treatment

Before prescribing pharmacological therapies the following should be considered:

- Age
- Previous response to treatment
- Risk of overdose or deliberate self-harm
- Tolerability
- Possible interactions with concomitant medicines
- Patient preference
- Cost, when treatments are considered equally effective
- Comorbid disease states

Pharmacological interventions include benzodiazepines, selective serotonin reuptake inhibitors (SSRIs), tricyclic antidepressants (TCAs), buspirone, pregabalin, and beta blockers. Beta blockers are used for reducing the physical signs of anxiety such as a tremor. (Note: not all treatments listed here are used in practice, are licensed in the treatment of anxiety disorders).

The patient should be reviewed regularly at the start of treatment, and after 12 weeks alternative treatments should be considered if there is a lack of effect with the chosen drug.

When stopping treatments for whatever reason(s), the dose should be reduced slowly to reduce the likelihood of withdrawal effects.

Benzodiazepines

Benzodiazepines work by enhancing the action of the GABA neurotransmitter in the brain. They are often prescribed to provide an immediate effect, are generally well absorbed and can have an effect within 30 minutes of oral administration. They are only recommended for short term-use (2-4 weeks) due to the risk of dependence and tolerance developing.

For patients who have been on long-term treatment, caution is advised on discontinuation as there is an increased likelihood of withdrawal effects; this can be debilitating in some cases so withdrawal and discontinuation should be carried out gradually and with regular review. There is also evidence which suggests long-term benzodiazepine use is associated with cognition impairment. They are contraindicated in treating phobia. Side effects include drowsiness, light-headedness, confusion, ataxia, amnesia and dependence.

Selective Serotonin Re-uptake Inhibitors (SSRIs)

SSRIs are considered the first-choice pharmacological treatment option in many anxiety disorders. This is due to them having a broad anxiolytic effect. Various SSRIs have licensed indications for the different anxiety disorders, however there is often supporting evidence for their use outside of their licensed indication also.

Initial worsening of anxiety symptoms is common with SSRI use and this is an important counselling point. Common side effects include gastrointestinal upset (nausea, vomiting, dyspepsia, abdominal pain, diarrhoea and constipation); antimuscarinic effects and sexual dysfunction.

Selective Norepinephrine Reuptake Inhibitors (SNRI)

SNRIs also have a role in the treatment of anxiety disorders and have a similar side effect profile to SSRIs. SNRIs are licensed for the treatment of GAD, social anxiety disorder and panic disorder.

Tricyclic Antidepressants (TCAs)

TCAs have shown to be effective in treating various anxiety disorders, however many currently do not hold a UK license for anxiety indications. TCAs act by blocking norepinephrine or serotonin reuptake.

TCAs tend to cause more adverse effects than SSRIs due to their anticholinergic, antihistaminergic and alpha adrenergic activity. They are also more toxic in overdose than SSRIs, therefore self-harm risk must be considered prior to prescribing. Side effects for TCAs include dry mouth, blurred vision, constipation, drowsiness, confusion and urinary retention.

Pregabalin

Pregabalin activates GABA receptors in the brain. It has a rapid onset of action and holds a license for GAD due its robust evidence. Side-effects include drowsiness, confusion, constipation and irritability.

Beta-Blockers

These are useful in the treatment of physical symptoms of anxiety such as palpitations, sweating and tremor. They can be useful in performance anxiety.

Tim Kingscote-Davies

Reviewed by Zeeshan Ahmed

Question 12:

In generalised anxiety disorder, what are the symptoms a person might describe?

Question 13:

You are speaking to a patient who has been taking 20mg of diazepam daily for several years. They tell you they are thinking about stopping diazepam as they do not think it is working. What would you say to them?

Question 14:

A patient presents with red, quite sore and raw-looking hands, as well as a highly anxious personality.
What might you suspect and why?

Question 15:

Beta-blockers are banned in some sports. What sport are these and why might the ban be in place?

Question 16:

Why is it important to understand the psychological treatments which are available for anxiety?

Question 17:

What are the considerations if a drug treatment is prescribed for an unlicensed indication?


"...the treatment of insomnia should only be considered
once the underlying cause has been established."

Sleep Disorders

Insomnia is a common complaint affecting around one third of the UK population per year. It is more common in women, the elderly and those with medical or psychiatric disorders. Primary insomnia is rare, usually insomnia is secondary to another condition, and the treatment of insomnia should only be considered once the underlying cause has been established. This chapter focuses on the treatment of insomnia in a mental health setting.

Symptoms

To diagnose insomnia one or more of the following symptoms should be found:

- Difficulty falling asleep
- Frequent waking during the night
- Early-morning wakening
- Daytime lethargy
- General loss of well-being due to perceived loss of sleep

Treatment

There are three main treatment options for primary insomnia: sleep hygiene, CBTi (Cognitive Behavioral Therapy for Insomnia) and hypnotic medication. Sleep hygiene should be tried first-line when treating insomnia. CBTi is a cognitive behavioural therapy for insomnia which can be provided face to face or digitally. NICE has endorsed an app called 'Sleepio' as an alternative to medication for insomnia, this includes elements of CBTi.

Hypnotic medication is another second line therapy for patients who do not benefit from sleep hygiene measures alone or for short term use in periods of crisis. This may include for example, a manic episode exacerbated by lack of sleep. Sometimes patients' expectations of sleep are too great, leading to their insomnia, especially in the elderly or inactive, who naturally tend to need less sleep.

Sleep hygiene

Sleep hygiene measures try to eliminate the problems associated with poor sleep by ensuring the body and mind are ready to sleep. Measures can include a variety of steps to ensure a peaceful night's sleep. This can include avoiding certain activities before bed including use of caffeine, alcohol and nicotine for six hours beforehand, and not exercising right before bed. Other measures that may help involve avoiding daytime naps, using the bed only for sleeping and ensuring the bedroom is comfortable (dark, quiet and of a moderate temperature). Use of back-lit screens such as mobile devices and screens in the hour before bedtime should be avoided as they can prevent natural melatonin production by the brain. In addition to this, a daily sleep routine should be implemented, this is a planned schedule for when the patient should go to bed and get up, regardless of the amount or quality of sleep.

Hypnotic medication

The most commonly prescribed types of medication licensed for insomnia are the benzodiazepines and 'Z' drugs.

Both classes bind at the GABA-A receptor to enhance the action of GABA and cause sedation. The main difference between the two classes is that benzodiazepines bind at more of the GABA subunits, therefore acting not only on sleep, but also as an anxiolytic and muscle relaxant. The Z drugs are generally more selective for the alpha-1 subunit, acting more specifically to cause sedation.

The choice of hypnotic is often based on its half-life. The long-acting benzodiazepines e.g. nitrazepam have long half-lives which can lead to accumulation, especially in the elderly, increasing the risk of falls. Long half-lives can also lead to a 'hangover' effect the next day, with prolonged sedation affecting cognition and impairing driving ability. However, this is a risk with all hypnotics. Drugs with a short half-life, such as lormetazepam, are more suitable for people who have difficulty falling asleep, but tolerance and dependence may develop more rapidly.

NICE appraised the evidence for the Z-drugs and concluded that there was no evidence they were more efficacious than benzodiazepines. They recommend that for short-term usage, the cheapest hypnotic should be prescribed.

None of the GABA-A hypnotic medications are licensed for more than four weeks at a time. This is because there is a risk of dependence developing if used for longer, especially with the benzodiazepines. Additionally, if used regularly, hypnotics alter the natural pattern of sleep, leading to rebound insomnia on cessation of the drug.

Melatonin is a naturally occurring hormone that helps to regulate the sleep pattern and, thus, can be used to aid and improve sleep. There are several melatonin products, each with different licensed indications including insomnia in older people, jet lag, and insomnia in children with autism spectrum disorder. It is not uncommon for melatonin products to be used off-label due to the variety of licensed indications, especially if required for long-term use.

Claire Ault

Further reading

- *How to fall asleep faster and sleep better, NHS & Better Health*, accessed via: https://www.nhs.uk/every-mind-matters/mental-wellbeing-tips/how-to-fall-asleep-faster-and-sleep-better/ April 2024
- Bazire S. *Psychotropic Drug Directory,* 2024.
- NICE technology appraisal 77 *'Guidance on the use of zaleplon, zolpidem and zopiclone for the short-term management of insomnia',* April 2004.
- *British Association for Psychopharmacology consensus statement on evidence-based treatment of insomnia, parasomnias and circadian rhythm disorders: An update.* Accessed via: Journal of Psychopharmacology 2019, Vol. 33(8) 923–947
- NICE medical technologies guidance 70 *'Sleepio to treat insomnia and insomnia symptoms',* May 2022
- Barbone F, McMahon AD, Davey PG, Morris AD, Reid IC, McDevitt DG, et al. *Association of road-traffic accidents with benzodiazepine use.* Lancet 1998; 352: 1331–1336.

Question 18:

Compare the licensed indications for Circadin CR tablets, Slenyto CR tablets and Melatonin capsules (Colonis Pharma).

Question 19:

Consider how you would speak to a patient about sleep hygiene measures & when they should be used.

Look through all the prescription charts on an inpatient ward and see what proportion of the patients are prescribed a hypnotic, and for how long.

Try to find out why this is from the pharmacist or nursing staff.

Task 8:

Compare price per dose of the licensed hypnotic agents on the NHS tariff for hospital prices (speak to the person in charge of purchasing in your work base) and in the Drug Tariff in the community.

- What are the cheapest items in primary and in secondary care?

Consider the number of hypnotic prescriptions on the ward you assessed in Task 7.

- What would be the cost for a two-week course for all of these patients?

- What would be the cost difference if all these courses used either the cheapest benzodiazepine or the cheapest Z drug?

- How would the costs change if these patients were being treated in the community?

Using what you have learned, devise some guidance on cost-effective prescribing for:

- Inpatients remaining on the ward (supply from hospital)

- Inpatients requiring continued hypnotic treatment following discharge to the community. (supply from hospital then community pharmacy).

Task 9:

Obtain a copy of a sleep journal e.g. www.patient.info/news-and-features/sleep-diary **and record your sleep habits for a week. Then consider what you have learned about your behaviour and the way it influences your sleep.**

Will you change anything and, if so, what?


"...a progressive deterioration in cognitive function, resulting in a decrease in mental capacity and the ability to perform normal daily activities."

Dementias

Dementia is an umbrella term which is used to describe a range of chronic and progressive generalised cognitive impairments in an individual with clear consciousness. The syndrome of dementia can be caused by many separate disease processes leading to a progressive deterioration in cognitive function. This deterioration leads to a decrease in mental capacity and the ability to perform normal daily activities. Memory loss, mood changes and problems with communication and reasoning are common.

As we age there will be normal changes to the brain which include shrinking and variations of the structure and function. Changes associated with dementia are more severe and widespread than in other people of the same age.

In 2024, it was estimated that around 982,000 people in the UK have dementia, 65% of whom are female.1 Although estimates vary, as the population ages, this may rise to over 1.6 million sufferers by 2040.[1] It is thought that only two thirds of these individuals have a formal diagnosis of dementia, potentially limiting access to treatment and support. This currently costs the NHS around £42 billion and is expected to increase to a staggering £90 billion by 2040 (see also New Treatments, below).[1] In 2022, dementia was listed as the leading cause of death in the UK, accounting for over 74,000 deaths, approximately 11.5% of all deaths.

The most common form of dementia is Alzheimer's disease, which currently affects over 566,000 people in the UK (around 1 in 14 over 65 and 1 in 6 over 80 years old), around 4,000 of whom are under 65 years old. Whilst many people will associate dementia with Alzheimer's disease, it is important to understand that other pathologies may exist, for example:

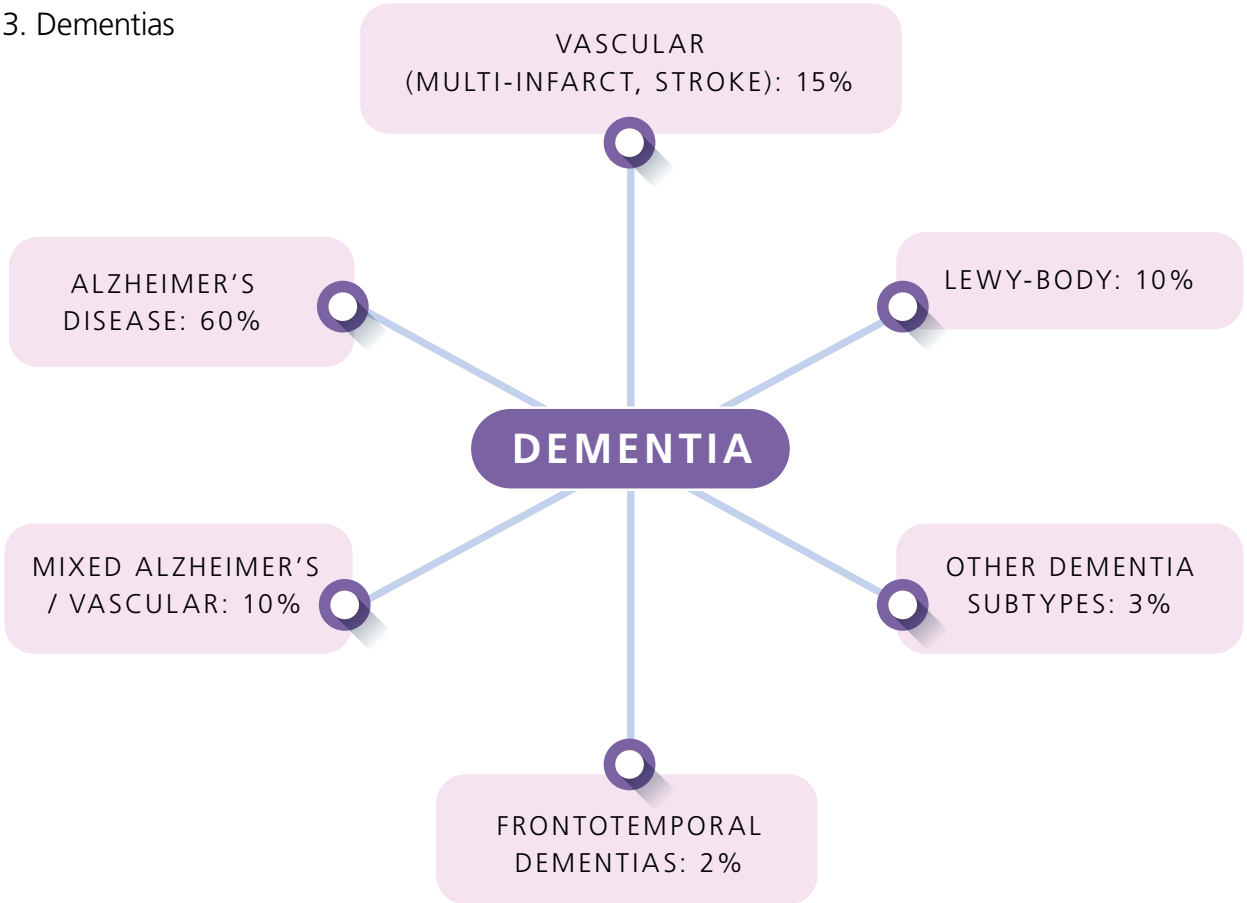
Confusion

Signs and symptoms which indicate that the patient is unable to think with premorbid clarity and logic/reasoning.

Delirium

A reversible and fluctuating state of altered consciousness often accompanied by mood changes, abnormal perceptions and cognitive impairment.

Fig 3. Dementias



Dementia is an acquired global impairment of intellect, memory and personality, but without the clouding of consciousness. Impairments of cognitive function are commonly accompanied and occasionally preceded by deterioration in emotional control, social behaviour or motivation.

Just as there can be many reasons for a person becoming confused, there are several different types and causes of dementia. The diagram below provides further details of the dementia sub-types and table 7 identifies the clinical presentations.

Table 6.
Dementia types and common symptoms

Alzheimer's Disease
Onset - gradual but progressive
Short-term memory loss
Confusion
Accentuation of personality traits (usually negative ones)
Behavioural changes (e.g. wandering)
Disorientation
Loss of familiarity
Restlessness

Vascular Dementias
Onset – Sudden Stepwise deterioration
Linked with poor vascular health
Signs of High BP
Symptoms/signs of focal brain damage
Emotional lability
Preserved personality
Higher incidence of concomitant depression
Secondary seizures may occur
Insight maintained until late stage

Dementia with Lewy Bodies (DLB)
Onset – gradual but progressive
Hallucinations
REM sleep disorder
Parkinsonian movement difficulties
Higher incidence of falls and faints
Language changes, but understanding often retained
Day-to-day variation of symptoms and severity
EPSE and movement dysfunction

Frontotemporal Dementias (e.g. Pick's Disease)
Onset – Varies with pathology
Behavioural disturbances – disinhibition
Language disturbances – mutism
Memory impairment after 5-6 years
No abnormality of spatial awareness
No EPSE or other motor dysfunction
Lack of insight and loss of self-control

Other Dementias include:
Creutzfeldt-Jakob Disease (CJD),
Huntington's Disease,
AIDS-related dementia,
Parkinson's Disease Dementia,
Korsakoff's Syndrome (alcohol)

During assessment for dementia, cognitive evaluation tools may be used, though these should not be used as a single diagnostic tool. The history of the presentation is vital, especially in identifying the likely sub-type. Tools include the Mini Mental State Examination (MMSE), the Montreal Cognitive Assessment (MoCA), Abbreviated Mental Test Score (AMTS) and Addenbrooke's Cognitive Examination (ACE). You will see others referred to in NICE guidelines and use depends on locality and setting.

Some tests are quicker than others to carry out. This is especially relevant if the patient has a poor attention span or cognitive decline. Ensure you are familiar with the more commonly used tests in your working environment.

Treatment

The impact of this illness is devastating for the patient and for the people connected with that individual; It is possible that a close family member may be the primary caregiver for that individual, which could place them under significant emotional and physical stress. As a result, the pressure to prescribe medication can be significant, even when this may be ineffective, or even put the patient at risk.

The pharmacological options for Alzheimer's disease are only able to delay the symptomatic progression of the disease and do not offer a cure or any reversible neuroprotection. The acetylcholine-esterase inhibitors (AChEIs: donepezil, galantamine and rivastigmine) act to support the synaptic levels of acetylcholine (ACh), the chemical messenger most depleted by the condition. Side effects include sleep disturbance and gastric irritation and therefore these medicines should be taken with food. The dose is usually started low and titrated over several weeks to aid tolerability.

The NICE guidance NG97 (June 2018) recommend that donepezil, galantamine and rivastigmine are used for patients with Alzheimer's disease of mild and moderate severity.

Patients should be reviewed on a regular basis by MMSE score (if appropriate) and global, functional and behavioural assessment taken together with the carer's view. Memantine is now recommended as an option for managing moderate Alzheimer's disease for people who cannot take AChEIs, and as an option for managing severe Alzheimer's disease.

When reviewing or changing any of these medications, it is important to be aware that such changes may adversely affect the individual's cognitive function. Usually changes associated with dose titration are tempered by tolerability or side effects, but as the dementia progresses questions about the continued effectiveness inevitably arise. Plans to discontinue these medications should be discussed as part of the MDT (Multi-disciplinary Team) and planned carefully. Cognitive assessments should be completed before any changes are made as a

reference for any alterations, and the dose reduced or stopped (depending on current dose). Further assessments should be carried out at (normally weekly) intervals and if there are any signs of a more rapid cognitive decline, the dose should be re-instated. This is because any cognitive decline at this point may not be totally regained if the medication is re-commenced after a longer period.

Some patients may be changed from the AChEI's to memantine as their condition becomes more severe, while others may have memantine added to their AChEI. The current NICE guidance recommends the use of combination treatment provided that certain criteria are met (NICE, 2018).

Future Treatments for Dementia

Recent developments of disease modifying treatments for dementia (DMDTs) has profoundly altered the future landscape for dementia treatment. Lecanemab and donanemab have been identified as novel agents in the treatment of early-stage Alzheimer's dementia by NICE. Both treatments act by reducing the accumulation of beta amyloid protein within the brain, which as it accumulates, damages neurones leading to the development of Alzheimer's. While these may be a step forward in managing dementia, there are several issues to be addressed before they can be used within the NHS:

- **Cost** – these treatments are extremely expensive, potentially more than doubling the cost of dementia treatments nationally
- **Safety** – while these are relatively new treatments, there are already several severe side effects reported including swelling or bleeding in the brain, worsening confusion and visual changes
- **Efficacy** – these treatments may only work in the early stages of the disease, and services need to change rapidly to improve the accuracy and speed of diagnosis in order to maximise any benefit
- **Administration** – both treatments need intravenous administration and extensive diagnostic testing and scans before and during treatment. This may make it necessary for this to be managed within an acute care service rather than the traditional mental health setting
- **Duration of treatment** – neither of these treatments addresses the cause of the amyloid deposition and as such, it is anticipated that repeated infusions will be needed over the patient's treatment schedule

Taking into consideration the above factors, NICE have decided that the benefits of lecanemab were too modest to justify the costs to the NHS. At the time of writing, NICE have yet to decide if donanemab will be funded for use in the NHS.

Behavioural and Psychological Symptoms of Dementia (BPSD)

As dementia progresses, changes in cognition, mood and other areas may worsen. It is not uncommon to see a significant increase in what is commonly referred to as "challenging behaviour" (more accurately known as BPSD).

The management of this is often one of the most difficult aspects of treating advanced dementia.

The individual may experience dramatic mood swings, be irritable, or in many cases be verbally or physically aggressive. Many practitioners believe such behaviours are a sign of unmet need (e.g. pain, frustration, depression etc.) and as such the best result is usually to resolve the need. This is, of course, much easier said than done as many people at this stage have difficulties in understanding conversations and information. It is very important to be aware that many of these behaviours may arise from frustration at a person's inability to communicate their desire and needs. Care must therefore be taken to ensure that quick assumptions about someone's abilities do not make this worse.

One thing that is often forgotten when dealing with BPSD is that the condition may resolve as the dementia progresses. Sadly though, this is as much to do with a general loss of capabilities as an improvement in the symptoms. It should also be noted that these symptoms may also go through cycles and get better or worse over time.

Traditionally, the mainstay of treatment for BPSD was either a benzodiazepine such as lorazepam or diazepam, or an antipsychotic and it was not unusual to see high doses of these alone or in combination. In 2009 there were two very important documents produced in response to concerns raised about the methods and treatment of advanced dementia. These were:

- *Living well with dementia: A National Dementia Strategy.* Feb 3, 2009 – Department of Health
- *The use of antipsychotic medication for people with dementia: Time for action. A report for the Minister of State for Care Services by Professor Sube Banerjee.* October 2009 – Department of Health

These documents highlighted the risks of the use of antipsychotic medication in this vulnerable group. The findings suggested that for the 180,000 people with dementia (at that time) who were treated with antipsychotics, 36,000 may derive some benefit, but that there would be an additional 1,800 deaths and a further 1,620 cerebrovascular adverse events (of which half would be severe) per year.

Following on from these findings, there has been a huge push nationally to reduce the use of antipsychotics in dementia patients due to increased mortality risk associated with their use. It is important to note that whilst usage has dropped significantly, there are still many patients for whom antipsychotics are deemed necessary. To optimise safety of these patients, antipsychotic use should be regularly reviewed by the MDT and attempts made to reduce or stop them if possible. It is important where appropriate that carers are also included in discussions about medication. As stated above, the symptoms may also change or improve with time and medication and should never be used 'in case'.

Currently, only risperidone and haloperidol are licensed for BPSD when there is risk of harm to self or others. This should be for short-term use only and the risks and benefits must be carefully weighed. Refer to the licensing information for further details.

Graeme Brown, Noel Aslett

Further reading

1. Alzheimer's Society, *About Dementia – Dementia Statistics Hub* Available at: www.dementiastatistics.org/about-dementia/prevalence-and-incidence/ <accessed 15/7/2024>2. National Institute for Health and Clinical Excellence (2011), *Technology Appraisal Guidance 217: Donepezil, galantamine, rivastigmine and memantine for the treatment of Alzheimer's disease* (Review of NICE technology appraisal guidance 111), London: National Institute for Health and Clinical Excellence (updated April 2015) <accessed 15/7/202>.
3. Department of Health. *Living well with dementia: A National Dementia Strategy.* Feb 3, 2009
4. Department of Health. *The use of antipsychotic medication for people with dementia: Time for action. A report for the Minister of State for Care Services* by Professor Sube Banerjee. October 2009
5. Alzheimer's Society, *What is Alzheimer's Disease.* Available via: www.alzheimers.org.uk <accessed 15/7/2024>
6. National Institute for Health and Clinical Excellence (2018), *Dementia: assessment, management and support for people living with dementia and their carers.*
   www.nice.org.uk/guidance/ng97

Question 18:

True or False?

1.	Alzheimer's disease is only suffered by the elderly.	T	F
2.	Patients with dementia can experience hallucinations.	T	F
3.	Galantamine was first isolated from daffodils and crocuses and snowdrops.	T	F
4.	Rivastigmine has been rejected for use in the NHS by NICE.	T	F
5.	Risperidone is not associated with an increased risk of stroke in patients with dementia.	T	F
6.	Rivastigmine patches may be cut in half for patients who cannot tolerate the full dose.	T	F

Task 10:

Read the NICE Clinical Knowledge Summary on dementia care and the recommended role of medication.

https://cks.nice.org.uk/topics/dementia/

Task 11:

Obtain a copy of the Folstein MMSE or the ACE-III (dependent on your local assessment tool)

Test a friend or family member (or tutor). How do they score?

What does this mean?

Task 12:

Obtain and read the summary document for 'A Time for Action'.
Familiarise yourself with the issues raised and solutions it offers.

What safeguards are in place in your area to ensure the patients are safeguarded?


"...a team of professionals... work together to support children, young people and their families."

Child and Adolescent Mental Health

Child and Adolescent Mental Health Service (CAMHS) is a multi-disciplinary service with a team of professionals such as Child Psychiatrists, Clinical Psychologists, Nurses, Pharmacists, Therapeutic Social Workers, Psychotherapists, Play Therapists, Occupational Therapists and Speech and Language Therapists working together to support children, young people, and their families. Children and young people with mental health needs are referred to CAMHS by concerned professionals such as teachers, school nurses and general medical practitioners.

When a referral is received, this is 'triaged/screened' and the young person is offered an 'initial assessment'. Following this assessment the young person is discussed in an MDT to agree on what team the needs to assess, offer support and provide the appropriate interventions.

The CAMHS services are divided into pathways, with assessments tailored to the young person's needs. These needs may include neurodevelopmental concerns such as ADHD and Autism, eating disorders, or core mental health concerns such as mood disorders, psychosis, self-harm, and suicidal ideation.

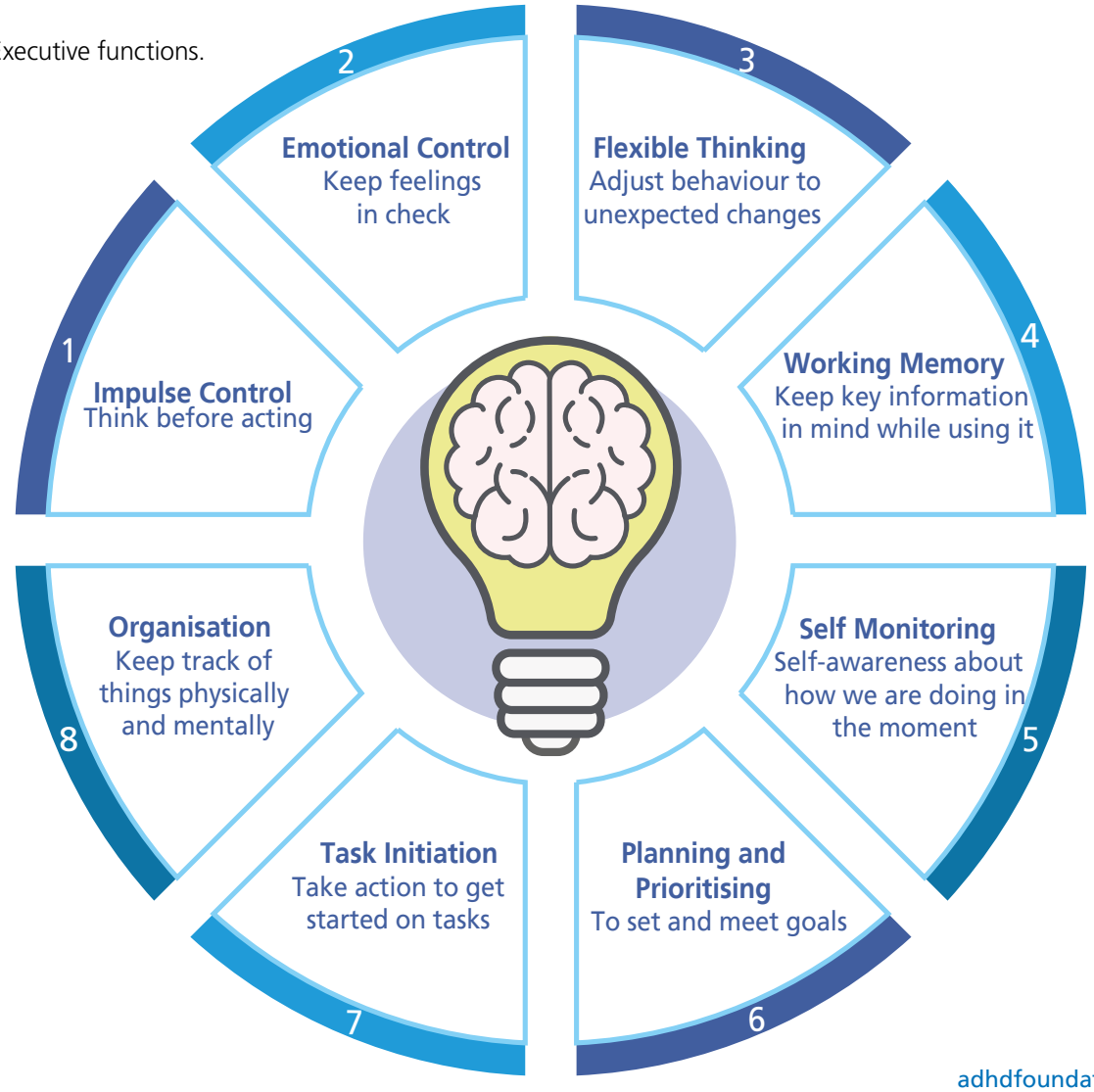
ADHD

Attention-deficit/hyperactivity disorder (ADHD) is a childhood-onset disorder of inattention, hyperactivity and impulsivity. Children with ADHD can readily be recognised in clinics, in schools and in the home. ADHD is described as a clinically heterogenous disorder, which means individuals with the same diagnosis present with a diverse range of clinical symptoms. There is significant variability in how the condition presents itself.

A key reason for the heterogeneity is the rates of comorbidity with other mental health disorders. It is estimated that around 60-100% of children with ADHD also exhibit one or more comorbid disorder. These can include, autism, learning disorder, tic disorder, mood disorder, bipolar and personality disorder.

ADHD is characterised by an under-developed prefrontal cortex (PFC), which plays a crucial role in regulating attention, impulse control, regulating behaviour and emotion - better known as executive functions (Fig 3).

Fig 4. Executive functions.



adhdfoundation.org.uk

Symptoms

The essential feature of ADHD (see ICD 11) is a persistent pattern of inattention and/or hyperactivity-impulsivity that interferes with functioning. ADHD symptoms can be organised in two dimensions – inattentive and hyperactive/impulsive symptoms. Nine symptoms are described for each dimension. Children are diagnosed with ADHD if they have had at least six persistent symptoms of inattention and/or six persistent symptoms of hyperactivity-impulsivity present for at least 6 months before age 12. Symptoms must be present in two or more settings, for example, at home or school or with friends or relatives and interfere with the quality of social or school functioning.

Inattention manifests behaviourally in ADHD as:

- Wandering off task
- Lacking persistence
- Having difficulty sustaining focus
- Being disorganized

Hyperactivity refers to:

- Excessive motor activity (such as a child running about) when not appropriate
- Excessive fidgeting
- Tapping
- Talkativeness
- Restlessness in their activities to the point of wearing others out.

Impulsivity refers to hasty actions that occur in the moment without forethought and that have high potential for harm to the individual (e.g., running into the street without looking). Impulsivity may reflect a desire for immediate rewards or an inability to delay gratification. Impulsive behaviours may manifest as social intrusiveness (e.g., interrupting others excessively) and/or as making important decisions without consideration of long-term consequences. Figure y provides an overview of the symptoms of ADHD.

Fig 5. Presenting symptoms of ADHD adhdfoundation.org.uk

Treatment

Medications for ADHD are designed to increase the prefrontal cortex presynaptic levels of both dopamine and noradrenaline as deficient signalling in the PFC is reflected by reduced neurotransmission and therefore reduced stimulation of the postsynaptic receptors. The medication leads to increased release of these two neurotransmitters which aims to improve executive functioning.

Both stimulants and non-stimulant medications are licensed for the treatment of ADHD. Stimulants are the most prescribed medicines compromising of methylphenidate, dexamphetamine and lisdexamfetamine. NICE recommends methylphenidate as the first line treatment for children and young people and to consider lisdexamfetamine as a 2nd line medication if they have an inadequate response to methylphenidate.

Methylphenidate is available in a number of formulations with the differences in terms of pharmacokinetics. This includes an immediate release formulation, and three separate modified release formulation. Immediate release medication may be taken up to two to three times a day and modified release is often taken as a single dose in the morning, and their duration of action can be between 6-10 hours depending on the formulation chosen. Lisdexamfetamine has a duration of action of up to 12 hours.

Common side effects with stimulant medication include appetite suppression, GI upset, sleep disturbances, headaches, palpitations and blood pressure changes.

Non-stimulant medications are considered as alternatives to the stimulant class of drugs if the young person does not tolerate the stimulant or they have had a sub-therapeutic response to the trial of a stimulant. These include atomoxetine and guanfacine. They work by inhibiting the noradrenaline transporter which helps to increase the levels of noradrenaline and dopamine in the PFC to aid concentration and help with impulse control.

They are less likely to impact appetite however much of the other side effects are similar to stimulants.

Table 7. Stimulant Medicines
Take effect immediately
Short and long-acting preparations
Abuse potential
Schedule 2 Controlled drug
Can be taken only when needed

Table 8. Non-Stimulant Medicines
Takes weeks to see full effect
No options in terms of release profiles
No abuse potential
POM
Taken every day without breaks

Environmental adaptations

To support the young person with ADHD requires a non-pharmacological approach in addition to the medication. The school, parents/carers and the clinician often work closely together to ensure the appropriate support is made available to help the young person engage with the schoolwork and fulfil their potential. This can include timeout cards, which allows the child to take a short movement break out of the lesson. It is also supportive to the child to have lessons with limited time frames to optimise attention and minimise the potential for the young person to become overwhelmed with any associated assignment. This allows the child to reach the goal of each task, thus promoting delayed gratification and sustained attention on the task.

AUTISM

The early history of autism is associated with the work of two prominent researchers, Leo Kanner, a psychiatrist, and Hans Asperger a paediatrician. They were both working independently, and both began describing cases of what is now classified as autism spectrum disorder (ASD).

Autism is a complex neurodevelopmental condition which presents as a triad of features:

- absence or impairments of social interaction
- absence or impairments in communication and the development of imagination
- cognitive rigidity, and a repetitive pattern of activities and interests.

Autistic people struggle to make sense of the world and find it hard to assimilate experiences to help predict what is likely to happen in the future.

Advances in genetics and neuroscience provided compelling evidence for the biological basis of autism. Studies on twins and families with multiple members who meet the diagnosis pointed to a strong genetic component.

Theories of Autism

Theory of Mind

The Theory of Mind (ToM) concept was developed by a leading researcher in the field of Autism called Simon Baron-Cohen. He proposed there is a delay in developing a developmental ability called theory of mind , which is the ability to put yourself in someone else's shoes, to imagine their thoughts and feelings. It allows us to read another person's thoughts and help understand their behaviour – why did the person just give a wry smile to a comment made, what did they really mean by they said, what does their body language tell us. We use ToM to predict social behaviours and interpret social behaviours. The ToM theory proposes that Autistic people are delayed in their development of ToM and as a consequence they find other people's behaviour confusing, unpredictable, and even frightening. This theory can make sense of the social and communication difficulties in autism and can be applied to all individuals on the autistic spectrum, however its main limitation is that it cannot account for the non-social features of autism.

Central coherence theory

In 1989, Uta Frith, a world renowned developmental psychologist in the field of Autism proposed the Weak Central Coherence Theory of autism. "Central Coherence" is the term given to a human's ability to derive the overall meaning from all the details. A person with strong central coherence, will see the forest before they see the trees. A person with weak central coherence will see the detail and struggle to see the bigger picture.

According to this theory many autistic people struggle to generalise the details around them and combine them to form a meaningful narrative. Those who have weak central coherence can be identified by their preoccupation with the details of a situation, they may tell stories that don't make sense to other because their stories contain too much detail without a clear narrative of the synopsis of the story. Having weak central coherence can also account for their amazing strengths. Some autistic people have remarkable abilities in areas such as music, memory, maths, art and many more. Autistic people excel at focusing on extreme detail and so are able to pick up on a tiny element from a mass of complex data.

Monotropism

The Monotropism Theory of Autism was proposed by Dr. Dinah Murray and Wendy Lawson, in 2005, as an alternative perspective to understanding the cognitive and sensory experiences of individuals. Unlike some other theories that emphasize deficits or impairments, the Monotropism Theory focuses on the idea that autistic people are characterised by a cognitive style termed "monotropic attention."

Monotropism is the tendency for autistic people's interests to pull them in more strongly than a non-autistic person. It proposes the model of the mind as an 'interest system' – we are all interested in many things, and our interests help direct our attention. Different interests are significant at different times, a non-autistic person will re-prioritise their interest as dictated by the context of the situation. However in a monotropic mind, fewer interests tend to be aroused at any time, as it requires more sensory processing resources, making it difficult to process things outside of the core focus of attention.

Autistic inertia, is a resistance to change, which manifests as difficulty initiating, halting, or altering actions. It serves as a core aspect of numerous challenges encountered by autistic individuals, characterised by a reluctance to deviate from routine and an aversion to unpredictability. Whatever interest is most aroused in a monotropic mind tends to pull the whole load of processing resources, this therefore makes it harder to change track and recalibrate the processing resources required. An analogy for this is imagine training to run a 5k and then being told in the morning of the race you are now going to run a full marathon. This is not what you prepared for and it will be very difficult for you to adapt to the sudden change in expectations. Autistic people operating within a monotropic framework, find it challenging to shift their cognitive focus and processing resources abruptly. The insistence on routine and resistance to change often stem from a need for predictability and stability, providing a structured environment that aligns with their monotropic attention.

Autism Assessment

Autism is diagnosed using behavioural tests for the core features: communication difficulties, social interaction, and restricted or repetitive behaviours.

Getting an autism diagnosis can be a long and challenging process because the presentation is heterogenous and there is no single presentation of the condition. The assessing clinician will use the Autism Diagnostic Observation Schedule (ADOS), a diagnostic tool to assess an individual's communication, social skills, play and restricted and repetitive behaviours. It is an assessment that can be used with people of all ages, abilities and language skills. It is a semi-structured assessment which enables the clinician to look at how the young person communicates and interacts, how they play and their ability to be creative.

During the assessment the clinician will play some games with the young person, ask some questions about school, relationships and their understanding of emotions. The assessment usually takes up to an hour. In addition to the ADOS the second part of the assessment is conducting a structured interview with the parents of the young person which measures behaviour in areas of reciprocal social interaction, communication and language and restricted and repetitive behaviours.

Autism can be diagnosed by around the age of 2 years old, however some children may not be identified until much later. Two of the biggest challenges to an early diagnosis is the lack of training and understanding of autism and the heterogenous presentation.

Autism is often underdiagnosed in girls because certain features of the condition present differently in girls than boys. Girls often score lower than boys on the ADOS measure of restricted interests and repetitive behaviours.

Being autistic, but not diagnosed can lead to a lifetime of struggles and being misunderstood with negative implications on the individual's mental health. Individuals who have autism but not a diagnosis grow up not understanding why they are sometimes confused in social situations, may not be able to make friends so easily and maintain those friendships. They may experience feeling overwhelmed in social situations and experience feelings of inadequacy, low self-esteem and believe they have a personality defect.

Girls are particularly adept at learning to copy others, which is known as "masking" or "camouflaging". They often mirror the social behaviour of their peers as an effort to fit in, they might have an array of conversational scripts to use in different settings, especially when there is a risk of having to engage in "small talk". Their special interests may be more "acceptable" than boys and may not be readily identified, such interests may include a particular animal, music band, TV show or area of learning and research.

Gurmat Singh Khangura

Question 19:

Why are stimulant medicines categorised as controlled drugs but non-stimulants are not?

Question 20:

Why are young people assessed again once they reach late adolescence to see if they still meet the criteria for an ADHD diagnosis?

Question 21:

Why are environmental adaptations necessary for ADHD?

Question 22:

Based on what you have read, why might it be challenging to diagnose ADHD?

Question 23:

What are the risks of treating ADHD in someone also being treated for schizophrenia?


"Learning Disability should be distinguished from 'Learning difficulty', which is a much broader term used in the UK educational system."

Learning Disabilities

Learning disability is defined by the Department of Health and Social Care as a significantly reduced ability to:

- understand new or complex information,
- learn new skills (impaired intelligence),
- cope independently (impaired social functioning), which predates adulthood.

The ICD-11 classification of learning disabilities is shown in table 9.

Table 9.
Intellectual Disability, IQ & Daily Activities

Severity	IQ	Implications for Daily Activities
Mild	50-69	Likely difficulties in the acquisition and comprehension of complex language concepts and academic skills. Able to manage basic self-care, domestic, and practical activities, and can live and work relatively independently, but may require appropriate support.
Moderate	35-49	Likely to have basic language and academic skills, and may manage basic self-care, domestic, and practical activities. Likely to need considerable and consistent support to live and work independently.
Severe	20-34	Very limited language and academic skills and may also have motor impairments. Likely to need daily support in a supervised environment for adequate care but may acquire basic self-care skills with intensive training.
Profound	<20	Very limited communication skills and may have basic concrete skills. May have motor and sensory impairments, and typically need daily support in a supervised environment for adequate care.

Learning Disability should be distinguished from 'Learning difficulty', which is a much broader term used in the UK educational system. Learning Disability affects a person's general intellectual ability and is associated with difficulties with everyday activities and affects the person for life. A learning difficulty refers to difficulties in specific skill areas and therefore does not affect overall intellectual ability or global skills. Examples of learning difficulties include dyslexia, dyspraxia, and dyscalculia.

Biological, environmental and social factors may contribute to the development of LD. Biological factors are present in 67-75% of people with LD. The most common genetic causes are Down syndrome and Fragile X syndrome.

Health issues

People with LD have significantly more health problems than the rest of the population. In addition, they have a shorter life expectancy compared to the general population.

Considering the health needs of a person with LD:

- 15-52% of adults have major psychiatric or behavioural problems requiring specialist help
- 22% have active epilepsy
- 40% or more have hearing impairment
- 40% have associated major physical disabilities of mobility and incontinence
- 50 to 90% have communication difficulties
- A person with LD is twice as likely to develop obesity compared to the general population

Physical health problems may also contribute to challenging behaviours, leading to further difficulties for both the individual and those caring for them. To help address the health inequalities that people with LD face, GP practices carry out annual health checks (AHCs) for those aged 14 and over, who are present on the practice's learning disability register. These help identification of any health issues at an earlier stage, allowing prompt treatment.

A review was set up to understand why patients with a learning disability were dying at a younger age when compared with the general population. The Learning Disabilities Mortality Review (LeDeR) found the median age at death was 63 for adults with a learning disability, compared with a median age of death of 82 for men and 86 for women in the general population.

The LeDeR programme aims to learn lessons from the care that people who have recently died with LD had received during their lifetime, which is done via reviews of cases. This aims to improve local health and social care services, with a view to reducing health inequalities, prevent premature deaths and drive improvements in the overall standard of care that people with LD receive.

In general, a health condition should be approached in the same way regardless of whether the patient has a learning disability. However, there are several NICE documents related specifically to learning disability:

- QS51 – Autism (Jan 2014)
- CG142 – Autism spectrum disorder in adults: diagnosis and management (June 2021)
- CG128 – Autism spectrum disorder in under 19s: recognition, referral and diagnosis (December 2017)
- CG170 – Autism spectrum disorder in under 19s: support and management (June 2021)
- Autism in adults CKS (May 2020)
- Autism in children CKS (May 2023)
- NG11 – Challenging behaviour and learning disabilities: prevention and interventions for people with learning disabilities whose behaviour challenges (May 2015)

- NG54 - Mental health problems in people with a learning disability: Prevention, assessment and management (September 2016)
- QS101 - Learning disability: behaviour that challenges (July 2019)
- QS142 - Learning disability: identifying and managing mental health problems (January 2017)
- NG96 - Care and support of people growing older with learning disabilities (April 2018)

Prescribing issues in LD

Prescribing in LD can be difficult with many obstacles to overcome. Psychiatric and behavioural problems often present differently in adults with LD. This is due to symptoms being attributed to LD which may prevent the person being diagnosed and treated correctly (diagnostic overshadowing).

Example of Diagnostic Overshadowing

The impact of diagnostic overshadowing is that treatment for patients with LD can be delayed. This is because symptoms are not diagnosed early enough which can lead to serious health conditions developing and avoidable deaths.

Communication difficulties also hinder diagnosis and treatment. Some patients with LD don't understand what is being said to them and can find it hard to communicate problems they are having. This means some symptoms may not be identified. In addition to this, there is a difficulty in recognising the side effects of medications. Some side effects could be confused with symptoms of an underlying condition. For example, a patient with akathisia maybe misdiagnosed with agitation and because of this will have their antipsychotic dose increased. Another example could be a patient with bruising from anticoagulants being interpreted as having experienced abuse. Therefore, care needs to be taken to make sure the correct treatment and diagnosis are achieved. A multidisciplinary approach can help to address these issues, for example, using structured medication reviews by pharmacists to identify adverse effects/inappropriate prescribing or via rigorous behavioural support plans to identify any behavioural changes in the individual.

Generally, prescribing for mental health conditions in a person with LD follows similar guidelines for treatment of the general population, nevertheless there are some points to consider when treating them.

There is some evidence that people with LD have altered pharmacokinetics and pharmacodynamics than the general population. This can then manifest as altered sensitivities to a medication, changing the effect of the medication and creating problems in determining the optimum dose required. Additionally, there is a risk with prescribing antipsychotics to people with LD. They are more likely to experience side effects such as QTc interval prolongation, hepatic impairment, and blood dyscrasias when taking medication due to physiological differences compared to the general population. They are also more likely to develop impaired cognition and suffer from the effects of these with a greater impact. Finally, people with LD should have their dose altered at a speed individual to them. Treatment should be initiated at a moderate dose and with slow dose increases to ensure time for the drug to work and side effects to be determined. Reducing doses should be done at the same rate or slower than the general population. Regular reviews should be central throughout this process.

People with LD may exhibit behaviours that challenge (verbal, physical or other forms). This may be due to physical or mental health problems. It may also be due to communication issues, the environment or as a learned behaviour. Sometimes this behaviour can be very severe, resulting in harm to the individual or others around them. Patients should be assessed to rule out physical and mental health problems or environmental issues that may be causing the behaviour.

Psychotropic medicines should only be prescribed as a last resort for severe aggression where there is an identified high risk to the person or those around them. This should only occur once behavioural interventions and other support measures have been trialled and found to be ineffective. There should be a clear plan of treatment identifying what symptoms are being targeted by the medication, a review date set and the medication discontinued if the target symptoms have not reduced.

Winterbourne View

Awareness about prescribing practice in people with LD was highlighted following the concerns which were raised at the Winterbourne View Hospital. A systematic review provided robust evidence of inappropriate use of potent medicines in people with LD.

They found people with LD were being prescribed psychotropic medicines at a higher rate than the general population and the majority of cases with no clear justification. Alongside this, LD patients were often found to be on medicines for longer periods of time with no review to check that the medication was working and not causing damage. Finally, the reports found that there was a poor communication link between parents/carers and health professionals over treatment and medication.

It was concluded that this is not acceptable practice and must improve. To address this, a "Call to Action" was developed to reduce the inappropriate use of these medicines in people with LD, which developed into the stopping over medication of people with a learning disability, autism or both (STOMP) programme.

Stopping over medication of people with a learning disability, autism or both (STOMP)

STOMP is a national project which aims to stop the overuse of psychotropic medicines for people with a learning disability, autism or both, including medicines for psychosis, depression, anxiety, sleep problems and epilepsy.

People with a learning disability, autism or both are more likely to be given these medicines than other people. Sometimes they are given to people because their behaviour is seen as challenging. These medicines are right for some individuals and can help people stay safe and well. However sometimes there are other ways of helping people so they need less medicine or none at all.

More information can be found here:

NHS England » Stopping over medication of people with a learning disability, autism or both (STOMP)

Other issues for patients with LD

Patients with LD can also have additional complexities which must be accounted for, when providing treatment. Swallowing difficulties are more common in people with LD than the wider population. If this is not managed correctly, then it can lead to respiratory tract infections. This is a leading cause of early death among LD patients. Together with this, patient information leaflets are written at too high a reading age. This means many patients with LD do not understand how to take their medication or to follow their treatment through. To combat this, good sources of patient information at a lower reading level should be used. Suggested sources are listed at the end of this chapter.

Finally, people with LD may have a hard time understanding the world therefore their capacity and consent is hindered. It is the responsibility of a professional treating a patient to judge whether a patient has the capacity to give valid consent. The clinician has a duty to give the patient an account in simple terms of the nature of the treatment, benefits versus risks of the proposed treatment and the main alternative options.

Lilian Baxendale, Heather Beadle reviewed Raj Singh Dhaliwal & Johanne Deeks

Further reading

Bhaumik S, Branford D. *The Frith Prescribing Guidelines for People with Intellectual Disability.* Wiley Blackwell, 4th Ed 2024

Wilcher M. *Handbook on Medication for Carers of People with Learning Disabilities* (PLD). 2nd Ed edited by Johanne Deeks.

Shorter Oxford Textbook of Psychiatry – Chp17: *Intellectual disability (mental retardation)*

Using Medication to Manage Behavioural Problems in Adults with Learning Disabilities. Documents and resources that can be downloaded about Learning Disabilities and medications including:

- Quick reference Guide and Easy Read Guide
- Patient information leaflets (printed and as audio recordings) for use in learning disabilities.
- LD Medication Guideline - University of Birmingham

BILD: British Institute of Learning Disabilities

www.bild.org.uk
A range of resources is available on their website

Mencap

www.mencap.org.uk
Mencap works in partnership with people with a learning disability, and support people to live life as they choose.

www.easyhealth.org.uk
A useful website with a range of accessible information about medication and many other health-related issues.

www.minded.org.uk/Component/Details/742765
Training module, exploring the use of psychotropic medications in people with LD and the STOMP programme

The Challenging Behaviour Foundation

www.challengingbehaviour.org.uk

This is a charity for people with severe learning disabilities whose behaviour challenges. They provide:

- information about challenging behaviour
- peer support for family carers and professionals
- supporting families by phone or email
- Running workshops to reduce challenging behaviour - speaking up for families nationally

NHS England

4th July 2015 NHS England Urgent action pledged on over-medication of people with learning disabilities.

Public Health England.

Health inequalities: Sensory impairment

fingertips.phe.org.uk/documents/Health%20Inequalities_sensory%20impairments.pdf

"People with learning disabilities die, on average, 15-20 years sooner than people in the general population, with some of those deaths identified as being potentially amenable to good quality healthcare."

The Learning Disabilities Mortality Review.
Healthcare Quality Improvement Partnership (HQIP) 2017

Question 24:

A patient is prescribed citalopram 20mg daily for depression, amisulpride 400mg BD for psychosis and gabapentin 300mg TDS for seizures.

A nurse has advised you that the patient is having trouble swallowing their medications.
She is thinking of crushing the tablets and administering them in the patient's mashed potato.

She would like to know if this is Ok. Can you offer any advice?

Question 25:

A patient on phenytoin requires an enteral feed.

Will this affect the phenytoin dose?

Question 26:

Patient has attention deficit disorder and epilepsy.

The consultant would like advice on which medication for ADHD would be the best choice. What do you advise?

Question 27:

A young female patient has been prescribed valproate for seizures.

Is this Ok?

Question 28:

The brand of lorazepam tablets stocked in pharmacy has changed. The tablets are now a different colour.

How might this affect the patient?

Task 12:

As part of the query in Question 22 you look in the Trust's Medicines Management Policy.
There appears to be very little information regarding "covert drug administration".

Having sorted this query can you put a short guide together based on current national recommendations so that your Trust Policy can be updated?

Task 13 Behaviour that challenges

Undertake an internet search to review what changes have been made in the prescribing of medication for behaviour that challenges since the publication of the "Winterbourne Medicines Programme: NHS Improving Quality Report".


"Often, for the SMS services, the challenge is not the science of drug withdrawal processes, but supporting the client with the psychosocial adjustments that breaking away from a drug taking culture presents."

Substance Misuse

Addiction and the misuse of substances can be an emotive area of practice. Indeed, stigma (including from healthcare professionals) can be one of the biggest barriers to people accessing treatment. The reasons why people misuse or become dependent on substances are multifactorial. For example, trauma and adverse childhood experiences (ACEs) are significant drivers. Many people use substances to self-manage the symptoms of poor mental health. As illicit drug use escalates, there are greater risks involved, not only to the individual's safety and health, but also to family, friends and wider society in general.

In the UK, substance misuse services (SMS) are currently commissioned by the Office for Health Improvement and Disparities (OHID – previously Public Health) via local councils. The effectiveness of well-delivered, evidence-based treatment for substance misuse is well established. The right treatment at the right time can be lifesaving. It can also make a huge difference to the wellbeing and recovery of people with problems related to their drug/alcohol use. Psychosocial interventions are the backbone of drug and alcohol treatment, supported with substitution prescribing where available. The Orange Book (Drug Misuse and Dependence – UK Guidelines on Clinical Management 2017) defines the core practice standards used by practitioners working in this field of medicine.

It should be noted that polysubstance use is common. Substances are taken together for their synergistic or conversely opposing effects. For example, benzodiazepines or alcohol may be taken to assist the 'come down' from stimulant use or taken alongside opioids to enhance the sedating effects. Polysubstance use significantly increases the risks associated with drug/alcohol use.

Opioids

In prescribing services, most adult drug misusers in treatment in the UK still report opiates as their main problem drug. This is usually in the form of heroin (diamorphine), although increasingly this includes people dependent on opioid analgesics. Substitution medication (usually either methadone or buprenorphine) allows the person to stabilise on a long-acting opioid so that they can break the cycle of obtaining money / scoring drugs / using drugs – a cycle that can repeat 2-3 times a day. Having a once daily substitute releases time to allow the person to engage with the psychosocial work to address the causes and triggers for the drug use, allowing a real focus on recovery. When the person is ready, the opioid substitute can be gradually reduced until detoxed, or the person can choose to have an in-patient (more rapid) detox in a specialist unit.

Methadone is routinely prescribed in liquid form at a concentration of 1mg/ml. The effective dose range to achieve stabilisation is usually between 60-120mg daily, although each person will need to be titrated to their target dose rather than initiated on it because of cumulative toxicity. Extra caution is needed when methadone is prescribed in the presence of other sedating medication or substances, and also when in the presence of medicines that impact on QTc (such as quetiapine).

Buprenorphine is a significantly safer opioid substitute that is quicker to titrate, has fewer side effects and drug interactions, leaves the person more "clear-headed", and is available in a multiple of formulations (sublingual, oramucosal, depot – it is inactive via first pass metabolism if swallowed). As buprenorphine has a higher affinity for the opiate receptors than most other opioids, it can block the action of illicit opiates such as heroin when prescribed at therapeutic doses (usually 12-16mg), making their use less rewarding. This high affinity means that care must be taken when initiating treatment due to the risks of precipitated withdrawal.

When initiating treatment with methadone or buprenorphine, the titration is usually facilitated by the dose being supervised by the pharmacist on a daily basis. This ensures that the person is being monitored daily by a healthcare professional, reduces the risk of diversion, and means there is verification that the dose has been taken so that subsequent dose optimisation can be done safely. The length of time spent on supervised consumption is determined by an individualised risk assessment.

Naloxone is a short acting opioid antagonist that is now widely available to people who use opioids. Although it is a prescription only medication, under the new legislation it can be supplied to any individual who may witness, or be at risk of, an opioid overdose. Any person can administer naloxone under UK law in an emergency for the purpose of saving life, provided that they have been trained to do so. Naloxone temporarily reverses an opioid overdose to allow time for the arrival of paramedics before getting the person to hospital. As a harm reduction measure, it has saved many lives in the UK.

Cannabis

Most young people accessing treatment report cannabis as their main problem drug (often with alcohol). More generally, cannabis is the most used illicit substance in the UK. Triggers for use are again multifactorial, and now include self-medication for the management of pain and of epilepsy. Heavy cannabis users may experience symptoms such as depression, lethargy, paranoia and memory loss. Cannabis can also trigger symptoms of psychosis and contribute to the development and maintenance of enduring mental health problems, although the precise mechanism and causative link are still being debated. This picture has been further complicated by the emergence of highly potent synthetic cannabinoid receptor agonists (SCRAs). Approximately 10% of cannabis users will become dependent on it and experience withdrawals which can contribute to sleep problems, agitation and risk of self-harm. Cannabis use can also exacerbate depression and it may cause an acute short-lived toxic psychosis, which often resolves on cessation of use although some cases require treatment. Chronic cannabis use may be associated with persistent paranoid symptoms.

There are currently no medications licensed for treating cannabis dependence; psychosocial interventions form the mainstay of treatment for this drug. Given that cannabis is usually used in conjunction with tobacco, clinicians should also be alert to a greater risk of respiratory disease in people that smoke cannabis.

Stimulants

This group of illicit drugs includes cocaine (and the smokable version crack cocaine), amphetamine and methamphetamine ("crystal meth"). As with cannabis, treatment consists of psychosocial work. As with cannabis, psychosocial interventions form the focus of treatment for stimulant users. Historically, dexamphetamine has been prescribed as a substitute in some cases, but the evidence to support its use is weak and this is no longer recommended as a treatment option.

Stimulant users are at significantly increased risk of a cardiovascular event and this risk is further increased in the presence of alcohol due to the formation of cocaethylene in the liver.

Alcohol

Alcohol use is a significant cause of morbidity and mortality for young people (particularly through alcohol poisoning, accidents or violence) and for adults and older people (through a wide range of conditions including heart disease, cancers and liver disease). Problematic and dependent alcohol use can exist on their own or in the presence of illicit drug use. Polysubstance use can be especially challenging due to the increased risks, and the treatment plan is influenced by the balance of risk and on the motivation of the person to address those risks.

Psychosocial interventions still form the backbone of treatment for alcohol dependence and also to support those who are drinking at higher levels (but are not currently dependent) to reduce their intake. Withdrawal from alcohol is extremely hazardous and can be fatal. Medically assisted withdrawal, using tapered down doses of benzodiazepines such as chlordiazepoxide or diazepam, is a safer approach to manage the withdrawal symptoms. Where diet and nutrition are poor, thiamine supplementation is recommended. Oral formulations are routinely prescribed, but where there is a risk of development of Wernicke's encephalopathy, a course of IM thiamine would be indicated.

Benzodiazepines

Managing benzodiazepine dependence is one of the most challenging areas in the addictions field. Abrupt withdrawal can be very traumatic and involve a multitude of symptoms related to rebound overactivity of the nervous system following long term suppression by chronic benzodiazepine use. Symptoms include (but are not limited to) profound anxiety, insomnia, nightmares, perceptual distortions, hallucinations, depression, paranoid thoughts, loss of appetite, and fitting.

People who misuse benzodiazepines or have become dependent on them can broadly be divided into three groups. The first group is iatrogenic in origin and can involve people that have been prescribed these drugs for many years, often decades. The second group includes people who use benzodiazepines as part of their polydrug use, either deliberately to enhance the effects they are seeking, or as a consequence of the fact that heroin in particular is regularly cut with benzodiazepines by drug dealers. The final group are people who use benzodiazepines as their primary drug of choice and will consume huge doses of these drugs each time due to the high degree of tolerance that they have developed.

Broadly speaking, the basic principle to support people dependent on benzodiazepines is a slow taping down of the dose. If more than one benzodiazepine is involved, the total dose is usually converted to the equivalent diazepam dose due to the long-acting nature of this drug, and then a reduction plan of the diazepam dose is agreed. The longer the person has been dependent on the benzodiazepine, the longer the reduction plan will take (often months, sometimes years). The person will need regular reviews and the clinician needs to be prepared to amend the plan if problems arise. For further information and advice in this area, please search for the Ashton Manual in your preferred online search engine.

Novel Psychoactive Substances (NPS)

Previously, now erroneously, referred to as "legal highs" by the press, this rapidly evolving group of synthetic drugs designed to mimic the effects of the more traditional drugs of misuse. Initially marketed and labelled as substances "not for human consumption", they are now controlled under the Psychoactive Substances Act 2016. The number and type of NPS available has grown rapidly; establishing a definitive list of these substances is a huge challenge and would be out of date almost immediately. Broadly speaking, NPS are divided into seven groups based on the drugs that they mimic: stimulants, empathogens, opioids, cannabinoids, psychedelics, depressants and dissociatives. Treatment (especially of acute intoxication).

Alan Pollard & Kevin Ratcliffe

Further Reading

- Benzodiazepines: How they work and how to withdraw (aka The Ashton Manual) www.benzo.org.uk/manual
- Drug Misuse and Dependence (UK Guidelines on Clinical Management) 2017
- CPPE: Substance Use and Misuse

"Across England there were 7,545 hospital admissions with a primary diagnosis of drug-related mental health and behavioural disorders which represents 0.05% of all hospital admissions during 2016/17."

Statistics on Drug Misuse: England, 2018 [PAS]

Question 29:

Identify some reasons why Suboxone® may not be the single answer to the prevention of buprenorphine diversion.

Question 30:

Calculate how many units Jim drinks per week from his tipple list provided below:

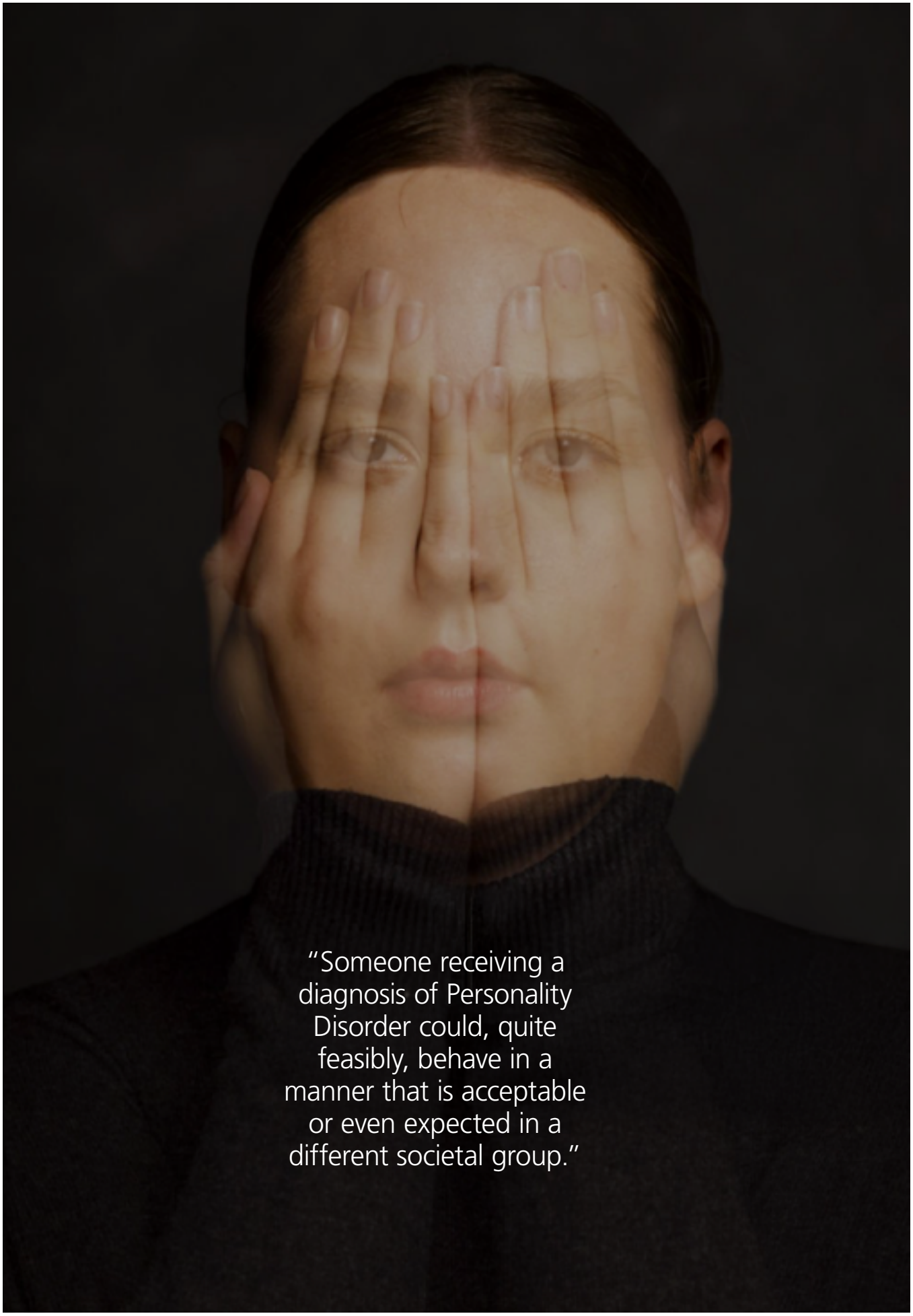
- 2 pints standard beer (3.5%) 5 nights per week
- 1 bottle of wine (12.5%, 75cl) on a Saturday
- 1 bottle of vodka (40%, 70cl) on a Sunday

NB: 1 pint = 568ml

Task 14:

Spend a few moments reflecting on your own thoughts and feelings around clients who misuse substances.

Use the area below to make a few notes and, perhaps, questions.


"Someone receiving a diagnosis of Personality Disorder could, quite feasibly, behave in a manner that is acceptable or even expected in a different societal group."

Personality Disorders

Background

In ancient Greece, actors wore masks when performing on stage. These masks included a hole through which the actors spoke and changing the masks allowed the actors to portray different characters and emotions. The Greek word for this mask is 'prosopion', meaning that it is like a face, but not real, a façade. The Latin name for this mask is 'persona.'

Our persona is that through which we convey our character to society, and which can sometimes be changed to meet the needs of a social situation. Our personality is the sum of our mental, emotional, physical and social characteristics and is unique.

Personality disorder (PD) is an incredibly controversial area. The concept of a disorder of personality is dependent on the acceptance of a standard personality for all. That 'standard personality' itself depends on society and culture. As such, someone receiving a diagnosis of PD could, quite feasibly, behave in a manner that is acceptable or even expected in a different societal group.

Personality disorders are conditions associated with long-term patterns of behaviour and inner experience that result in impairments in interpersonal functioning and functioning of aspects of the self. The causes of PD are unclear, but just as everyone's personality is unique and develops from their individual experiences and genetic make-up, so the causes of PD are considered to be multi-faceted and arising from an individual's genetic, environmental and early life experiences.

Currently there are no medicines licensed in the UK for the management of PD, and there is a lack of good quality evidence to support the use of medicines in its management as a long-term measure; however, PD is associated with high levels of prescribed therapy (Kadra-Scalzo et al., 2021). Where research has been conducted into the use of medicines for the management of PD, the studies are often small and of short duration, with low statistical power, high dropout rates and exclusion of the most severely ill patients (Hancock-Johnson, Griffiths and Picchioni, 2017).

People with PD are often diagnosed with multiple comorbid conditions which can complicate the presenting clinical picture, lead to additional prescribed therapy and result in exclusion from PD-related research. The lack of robust research, conducted in cohorts that do not adequately represent real-world populations, makes it difficult to apply any findings to the patients that clinicians are most likely to see in practice.

A person with PD can have symptoms that present as similar to MH conditions that have a clear biochemical basis; however, the response to pharmacological agents targeting biochemical pathways will be different, due to the lack of a primarily biochemical cause. Access to appropriate psychological therapies is variable and, in the absence of appropriate alternatives, prescribers may feel under pressure to prescribe medication as the only available course of action.

Prevalence

Estimates of the prevalence of PD vary widely, however, evidence indicates a prevalence of 4.4% in the general population and between 33-52% in psychiatric outpatient settings.

Diagnosis

The diagnosis of PD is variable and subject to change. There are two main diagnostic systems used in mental health; the International Classification of Diseases (ICD) by the World Health Organisation, and the Diagnostic and Statistical Manual of Mental Disorders (DSM) by the American Psychiatric Association. They use different terminology, diagnostic names and diagnostic criteria to each other in their current editions; and these fields have also changed between versions of the same diagnostic systems.

You are likely to hear a variety of terms used to describe PD, many of which are historical, superseded or taken from different diagnostic systems.

The most recent version of ICD, ICD-11, has changed the way that PD is classified and removed old diagnostic subtypes which feature in the previous version of ICD and in DSM. Subtype terms such as 'paranoid' PD have been removed from ICD-11, but still exist in DSM-5; 'antisocial' PD in DSM-5 roughly equates to 'dissocial' PD in ICD-10, and may be understood through the trait domain of 'dissociality' listed in ICD-11; DSM-5 includes 'borderline' PD, whilst ICD-10 described emotionally unstable PD and a further sub-type of this being termed 'borderline,' and ICD-11 now includes the description of a 'borderline pattern' of personality disorder.

ICD-11, the general diagnostic requirements for personality disorder are as follows:

- Problems in functioning of aspects of the self (e.g., identity, self-worth, self-view, self-direction)
- Problems in interpersonal dysfunction (e.g., ability to develop and maintain relationships, understand others' perspectives and manage conflict)
- Disturbance existing over an extended period (e.g. 2 years).
- Manifest patterns of cognition, emotional experience, emotional expression, and behaviours that are maladaptive.
- Problems across a range of personal and social situations (i.e. not limited to specific relationships or social roles)
- Presentation not accounted for by social/cultural/developmental factors.
- Not explained by the effects or side effects of medicines or other substances, including withdrawal effects.
- Associated with substantial distress or significant impairment.

Once the diagnosis has been established, it should be described in terms of severity, as mild, moderate, or severe. PD can then be further described using trait domain specifiers, which are

not diagnostic categories, but describe the characteristics of the individual's personality that are most prominent and that contribute to personality disturbance. Multiple trait domains can be applied.

Table 10 (below) provides an overview of the trait domains.

Table 10. Classification of personality disorders

Trait Domain	Overview of trait/pattern
Negative Affectivity	Tendency to experience a broad range of negative emotions with a frequency and intensity out of proportion to the situation, e.g. anxiety, depression, hostility, guilt, shame, etc; emotional lability and poor emotion regulation; negativistic attitudes, e.g. typically rejecting others' suggestions or advice; low self-esteem and self-confidence and mistrustfulness.
Detachment	Tendency to maintain interpersonal distance (social detachment) and emotional distance (emotional detachment); maintaining interpersonal distance – avoidance of intimacy, lack of friendships; being reserved, aloof, and having limited emotional expression.
Dissociality	Disregard for the rights and feelings of others, encompassing both self-centeredness and lack of empathy, and manifested as a sense of entitlement; expectation of others' admiration; attention-seeking and negative behaviours; indifference to whether one's actions inconvenience of hurt others; in the extreme, callousness, ruthlessness; physically violent with little provocation and taking pleasure in inflicting pain. NB: individuals may understand the feelings of others but are not concerned about them and instead are likely to use this understanding to exploit others.
Disinhibition	Tendency to act rashly based on immediate external or internal stimuli (ie sensations, emotions, thoughts), without consideration of potential negative consequences; manifested through impulsivity, distractibility, irresponsibility, recklessness, and a lack of planning.
Anankastia	Perfectionism: concern with social rules, obligations, norms of right and wrong; scrupulous attention to detail; rigid, systematic, day-to-day routines. Emotional and behavioural constraint: rigid control over emotional expression, stubbornness and inflexibility, risk-avoidance, perseveration, and deliberativeness.
Borderline pattern	Characterised by pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity. Indicated by five (or more) of the following: • Frantic efforts to avoid real or imagined abandonment. • Unstable and intense interpersonal relationships: vacillations between idealisation and devaluation. • Identity disturbance, unstable self-image or sense of self. • Tendency to act rashly in states of high negative affect. • Recurrent episodes of self-harm. • Emotional instability due to marked reactivity of mood; triggered internally (eg by one's own thoughts) or by external events. • Chronic feelings of emptiness. • Inappropriate intense anger or difficulty controlling anger • Transient dissociative symptoms or psychotic-like.

The United Kingdom uses ICD for diagnostic classification, but the only two national guidelines for the management of PD, developed by NICE in 2009, refer to 'borderline personality disorder' and 'antisocial personality disorder,' which are terms used by DSM.

Diagnosis can be challenging and stigmatising and in some cases a misdiagnosis can lead to inappropriate treatments (Royal College of Psychiatrists, 2020). The combination of variable terminology and a reluctance to give a diagnostic 'label' hinders the development of an easily understandable and consistent therapeutic approach.

Risks

The impulsive nature displayed in some forms of PD can result in higher rates of injury and/or mortality. PD is associated with a high level of suicide and/or self-harm, particularly with borderline and paranoid PD (Tyrer, Tyrer & Yang, 2021). This is an important consideration when providing medication that could be harmful in an overdose. Individuals with a diagnosis of PD accounted for 11% of all mental health related patient suicides in England between 2010 and 2020, and the data suggests that this is increasing (Department of Health and Social Care, 2023).

Dual diagnosis (where two or more conditions are suffered concomitantly) is common in PD, with the most common being associated with substance misuse. Evidence exists that personality disorders can increase the risk of developing a problem with substance abuse, but they might also affect the course of the dependence.

Due to a lack of understanding, acceptance, and an old belief that PD is untreatable, there is a possibility that an individual with PD will receive suboptimal treatment.

Prognosis

Personality disorder is a lifelong condition. Improvements can occur slowly overtime with age (particularly in antisocial behaviour and impulsivity), but the overall outcome is somewhat variable. Suicide risk is particularly elevated in people with PD compared to those with no, or other mental health conditions (McClelland, Cleare, & O'Connor, 2023).

Treatment

The mainstay of treatment for personality disorders is psychological therapy. A range of therapeutic approaches can be used including counselling, dynamic psychotherapy, cognitive behavioural therapy (CBT), dialectical behavioural therapy (DBT), mentalisation based therapy (MBT), and transference-focussed psychotherapy (TFP). Progress with these treatments can range from months to years depending on the individual circumstances.

Although medication might have some value in the management of certain symptoms, the 2009 NICE clinical guidelines for borderline and antisocial personality disorders stated that medication should not be routinely used for the treatment of the disorders or their associated symptoms. Whilst clinical guidelines are not consistent regarding pharmacotherapy for symptom control, all agree that polypharmacy should not be used (Nguyen et al., 2020)

Andy Down

Further Reading

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- Kadra-Scalzo, G., Garland, J., Miller, S., Chang, C.-K., Fok, M., Hayes, R. D., … Stewart, R. (2021). *Comparing psychotropic medication prescribing in personality disorder between general mental health and psychological services: retrospective cohort study.* BJPsych Open, 7(2), e72. doi:10.1192/bjo.2021.34.
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- National Collaborating Centre for Mental Health on behalf of the National Institute for Health and Clinical Excellence (2009), *National Clinical Practice Guideline 77: Antisocial Personality Disorder: Treatment, Management and Prevention,* Leicester: The British Psychological Society and The Royal College of Psychiatrists.
- National Collaborating Centre for Mental Health on behalf of the National Institute for Health and Clinical Excellence (2009), *National Clinical Practice Guideline 78: Borderline Personality Disorder: Treatment and Management,* Leicester: The British Psychological Society and The Royal College of Psychiatrists.
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- Simonsen, S., Bateman, A., Bohus, M., Dalewijk, H. J., Doering, S., Kaera, A., Moran, P., Renneberg, B., Ribaudi, J. S., Taubner, S., Wilberg, T., & Mehlum, L. (2019). *European guidelines for personality disorders: past, present and future. Borderline personality disorder and emotion dysregulation, 6, 9.* https://doi.org/10.1186/s40479-019-0106-3
- Strategic Health Authorities (2016). *Adult Psychiatric Morbidity Survey: Survey of Mental Health and Wellbeing, England.*
- Tyrer, P., Tyrer, H., & Yang, M. (2021). P*remature mortality of people with personality disorder in the Nottingham Study of Neurotic Disorder.* Personality and Mental Health, 15(1), 32-39.

Question 31:

What are the key criteria for a diagnosis of a personality disorder?

Question 32:

"Personality disorder is just a medicalisation of behaviour that doesn't fit with what society expects or the government wants. Extremes of behaviour and personality are only unacceptable because we have narrow limits on what is culturally 'normal' and we have no right to try and change anyone"

Provide a response.

Question 33:

True or False?

1.	Dual diagnosis is common in personality disorder	T	F
2.	There are no medicines licensed for PD	T	F
3.	Personality disorders are untreatable	T	F
4.	DBT is sometimes used in the treatment of PD	T	F
5.	Borderline PD is associated with self-harming behaviour	T	F

Task 15:

Using the ICD-11 details on personality traits and patterns, list the personality traits that you consider apply to:

1) You

2) A member of your family or a close friend

3) Your employer (or tutor!)

Task 16:

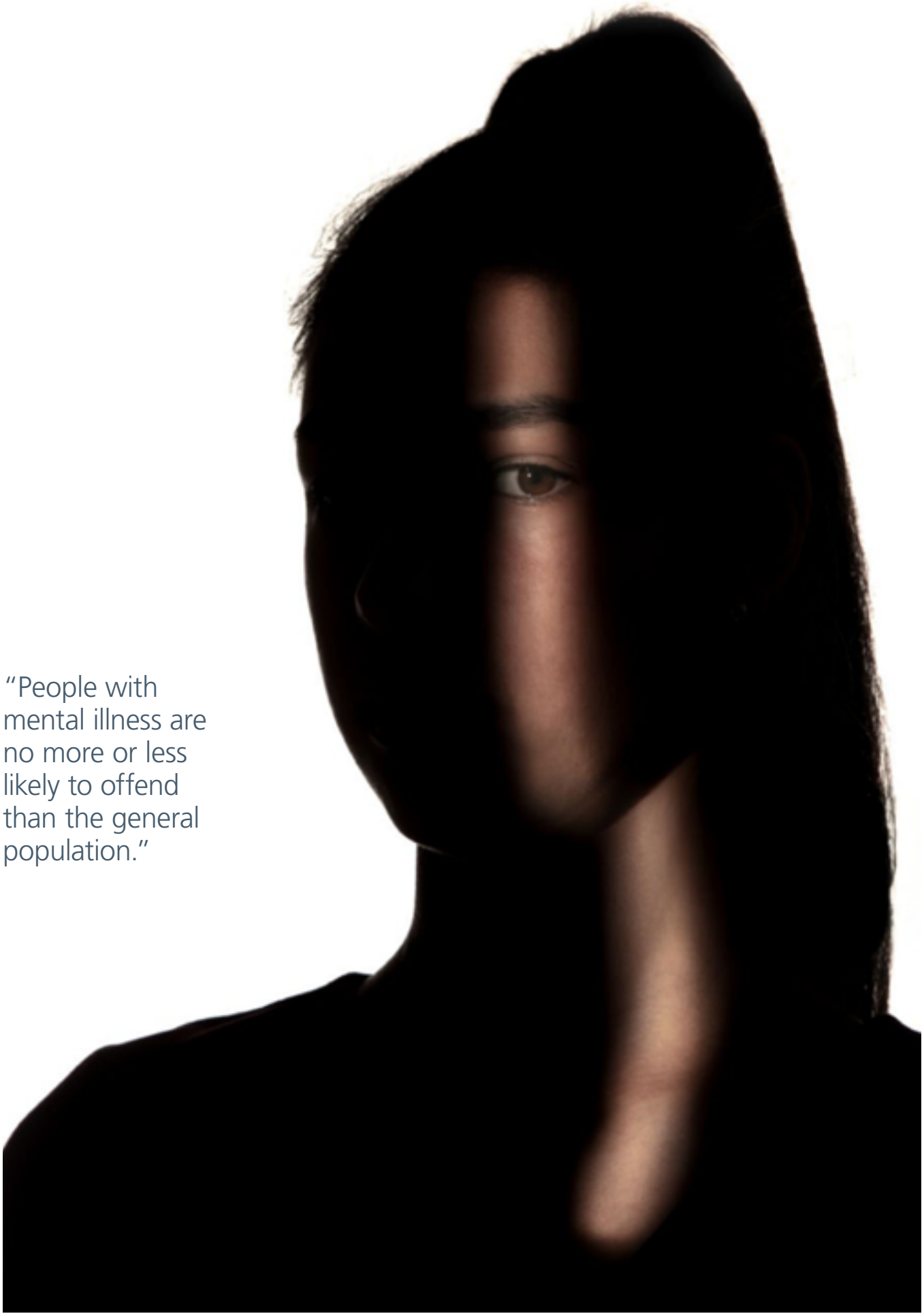
Speak to colleagues in your workplace and on the wards.

1) How many patients have a primary diagnosis of PD?

2) How many patients have a secondary diagnosis of PD?

3) Does the difference influence treatment?

4) What are the views about PD and its treatment within MH services?



"People with mental illness are no more or less likely to offend than the general population."

Forensic Psychiatry

Forensic psychiatry is a branch of general psychiatry that focuses on the relationship between mental health and the law, particularly in relation to offenders with mental disorders, court assessments, and psychiatric-legal issues.

The 1959 Mental Health Act introduced hospital orders for mentally disordered offenders and granted voluntary psychiatric patients the same rights as other hospital patients, including the right to leave hospital without providing 72 hours' notice. However, local psychiatric hospitals were often reluctant to admit offenders with mental health disorders, and Special Hospitals set their own admission criteria, generally only accepting those considered a grave and immediate danger to the public.

In 1975 The Butler Committee on Mentally Disordered Offenders recommended that all regions should take responsibility for service users who did not need high-security care but were not suitable for general psychiatric hospitals. This led to the creation of Regional Secure Units (RSU) to serve as bases for regional forensic services, with funding allocated for secure beds. The committee recommended 20 secure beds per million people and two nurses per resident.

The 1983 Mental Health Act, which still governs psychiatric practice, includes a section specifically addressing mentally disordered offenders and their treatment. It sets out the process for transferring people between the criminal justice system and hospital services, the courts' options for hospital orders, and the role of the Secretary of State in supervising certain cases.

The Mental Health Act does not apply in prison, meaning medication can only be offered but not enforced. As a result, some prisoners need to be transferred to hospital if their mental health deteriorates significantly – especially in cases of unpredictable violence, life-threatening self-harm, or failure to improve with voluntary treatment. Forensic services assess the level of security required and arrange transfers to the appropriate setting, whether a Special Hospital, RSU or local psychiatric hospital. If the person appears in court, the forensic psychiatrist provides a report with recommendations on the most appropriate outcome.

Role of mental illness in offending behaviour

People with mental illness are no more likely to offend than the general population. The factors associated with offending such as gender, young age, substance misuse, childhood trauma and socioeconomic deprivation – are the same for people with and without mental illness.

People with schizophrenia are more likely to be victims of violence than perpetrators. While they may have a slightly higher rate of violent offending compared to the general population, they are also more likely to be detected and arrested.

Schizophrenia

Minor, disorganised offences are more commonly committed by people with schizophrenia than serious offences, due to their disordered thinking. Acting on delusions and paranoia is common in schizophrenia, and may result in acts of violence to themselves, others, or through arson. Sexual offending of someone living with schizophrenia may be due to them misinterpreting social interactions and cues. Different types of hallucinations and thoughts can also lead people with schizophrenia to criminal activity:

- Hallucinatory experiences result in the person living with schizophrenia offending because of command hallucinations or as an attempt to remove the perceived source of 'voices' they hear.
- Olfactory and gustatory hallucinations can lead to delusions of poisoning by others.
- Tactile hallucinations can lead to those living with schizophrenia making accusations of sexual assault resulting in violent behaviour.
- Thought insertion and thought broadcasting can lead to ideas of being controlled by outside agencies, which may then become targets for aggression.

Mania and Hypomania

People who are manic can become grandiose. They may spend money excessively to the extent where they get into debt, leading to criminal behaviour to pay back the money. Some may set up improbable business ventures, leading to fraud or obtaining money under false pretences. Due to this need to pay debts, those living with mania can become extremely irritable and may be violent towards anyone they perceive as preventing them from achieving their aims. In some cases of mania, the person can become psychotic, and delusional ideas can therefore lead to the violent behaviour. In rapid-cycling bipolar disorder, the manic episode may be so short that without close psychiatric observation it may be difficult to detect.

Depression

Individuals living with depression can be associated with the criminal justice system and prevalence data varies. Severe depression in some cases can lead to homicide with the person developing delusional beliefs about the state of the world.[1] Often, the victims will be close relatives to the sufferer such as parents, spouse and children.

[1] *Key findings from analysis of domestic homicide reviews: October 2019 to September 2020.*

https://www.gov.uk/government/publications/key-findings-from-analysis-of-domestic-homicide-reviews/key-findings-from-analysis-of-domestic-homicide-reviews

Sections of the Mental Health Act 1983 relating to Mentally Abnormal Offenders

Underlying principles:

- A mental disorder doesn't need to be connected to a crime (and in fact it may have started long after an offence). This must not preclude someone from receiving treatment in a hospital for their mental disorder if that is indicated.
- If the offence is not punishable by imprisonment, then a court cannot commit someone to hospital under the Mental Health Act.
- The Responsible Clinician cannot move, send on leave or discharge any person under any of the Sections listed below, apart from Section 37.

Section 35

Remand to Hospital for an Assessment Report

A person awaiting trial for an imprisonable offence can be remanded to a hospital for medical reports assessing their mental disorder renewable for two further 28-day periods. For someone to be remanded there must be a recommendation from a registered medical practitioner to suspect a mental disorder. No medical treatment can be given without the patient's consent (unless in emergencies, described under S62 – Urgent Treatment Provisions).

Section 36

Remand to Hospital for Assessment and Treatment

As with section 35, a person awaiting trial can be remanded in hospital for assessment and treatment for 28 days. Nevertheless, for this to happen, recommendations must be given by two medical practitioners one of which must be section 12 approved. Medication treatment can be given for the mental disorder.

Section 37

Hospital Order

A court may impose a hospital order instead of a custodial sentence on a person convicted of an imprisonable offence. This requires two medical practitioners to put forward recommendations, one of whom must be section 12 approved. Unlike the other sections, this section lasts for 6 months and is renewable for six months and then a year. Medication can be given for treatment.

Section 38

Interim Hospital Order

A person convicted but not sentenced for an imprisonable offence may be given an interim hospital order to assess suitability for a hospital order. Like with Section 36 and 37, two medical practitioners must make recommendations that the patient is suffering from a mental disorder. This order can last 3 months and can be renewed for 28 days for a maximum of 12 months. Medication can be given for treatment.

Section 41

Restriction Order

When a Crown Court makes a Section 37 hospital order it may also impose a Section 41 order, if the court considers the individual a significant risk to the public. This overrides the responsible clinician's authority and precludes the person being given leave, being transferred or discharged from the hospital without permission from the Ministry of Justice. With this there is no time limit.

Section 47

Transfer of Convicted Prisoner

This Section enables a prisoner to be transferred to hospital for treatment. For this to happen two recommendations from medical practitioners must be completed, one of whom is Section 12 approved. This remains in place until the end of the sentence. Medication may be given for treatment of the mental disorder.

Section 48

Transfer of Other Prisoner

This Section enables other prisoners to be transferred to hospital for treatment. It again requires two medical practitioner recommendations and allows for medication to be used for treatment.

Section 49

Restriction Order

The Ministry of Justice can also impose a restraining order equivalent to Section 41 with reference to the above categories (47 and 48).

Sometimes a hybrid order may be put in place, where the person, having been found guilty, is sent to hospital. Once their mental health has improved, they are then sent to prison to complete their sentence.

Discharge

Service users with restriction orders Section 41 or 49 can be discharged only with the Ministry of Justice approval or by a First Tier Tribunal (FTT)/Mental Health Review Tribunal (MHRT). People under Section 37 can apply for a FTT/MHRT in the second six months of their section. If they do not apply for a review within three years, then they automatically are reviewed.

For people under a restriction order, the chair of the tribunal is always a judge. The tribunal will generally grant a conditional rather than an unconditional, discharge for these types of service users. The types of conditions imposed are related to risk management with the aim of preventing deterioration of mental illness and re-offending. It may include the address and type of residence, cooperation with psychiatric services, and refraining from use of illicit substances or alcohol.

Consent to Treatment

Residents in forensic units are almost always detained under a section of the Mental Health Act, so they all need consent to treatment documentation (a T2 or T3) after the first three months of treatment. This requirement is the same as for people detained under the Act for non-criminal reasons. Treatment can be given without consent - except for those under Section 35 - if it is necessary to prevent serious deterioration in their condition, to alleviate serious suffering or to prevent harm to themselves or others.

Regional Secure Units (RSUs)

These are the main forensic psychiatric facilities serving courts and prisons in their area. Forensic psychiatrists and their teams prepare court reports recommending appropriate placements for offenders with mental disorders usually after assessment in the RSU. In many regions, they also advise local psychiatric services on managing difficult or violent patients detained under the Mental Health Act Some of these patients may be admitted to an RSU for assessment or short-term care. RSU teams also assess patients from their area who are detained in high-security hospitals or private secure units. This helps track their progress and plan rehabilitation back into their home area when appropriate.

Special Hospitals

Special Hospitals provide high security care for people whose mental health conditions make them a serious and immediate risk to the public. Most residents are offenders with mental health disorders, but some are detained under the Mental Health Act for non-criminal reasons and require this level of security. Each special hospital covers a specific region and accepts referrals from mental health and criminal justice services. After assessment, an admissions panel decides if the person is suitable for the service. Residents in Special Hospitals are detained under the same sections of the Mental Health Act as detained patients and have the same rights to apply for a First Tier Tribunal Mental Health Review Tribunal, dependent on their section.

General Psychiatry

General psychiatry play an important role in the care of forensic patients. They may be involved in diversion schemes and prison assessments, working with the forensic teams when needed. People given a Section 37 hospital order without a restriction order are often treated by local mental health services rather than forensic teams. Patients needing secure care may initially be managed by forensic services, but as they progress in their rehabilitation, local services may take over their care and help with community reintegration.

Drug Choice in Forensic Patients

Forensic services use the same medications as general psychiatric services to treat the same conditions. However, they care for a high number of treatment-resistant patients, who can be particularly challenging to manage. As in other settings, treatment may involve long-acting injections (depots), adjunctive medications, or high dose antipsychotic treatments (HDAT) – sometimes exceeding standard licensed doses when clinically justified. These patients require close monitoring by an experience and well-coordinated multidisciplinary team to ensure their treatment remains safe and effective.

Sheena Mitchell, Nikki Holmes
Reviewed by Nick Sherwood

Further reading

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"There were 84,674 adults in prison in England and Wales in 2016–17, between 10% and 90% of whom are thought to have mental health issues."

House of Commons Committee of Public Accounts 2017. Mental health in prisons. Eighth Report of Session 2017–19.

Question 34:

Spend a few moments reflecting on the pharmacist role in forensic services.

What do you think the similarities and differences are compared to working in general mental health services?

Question 35:

Which ONE is correct? A service user may not be treated against their will in the first 3 months of:

1. Section 3
2. Section 35
3. Section 38
4. Section 37/41

Question 36:

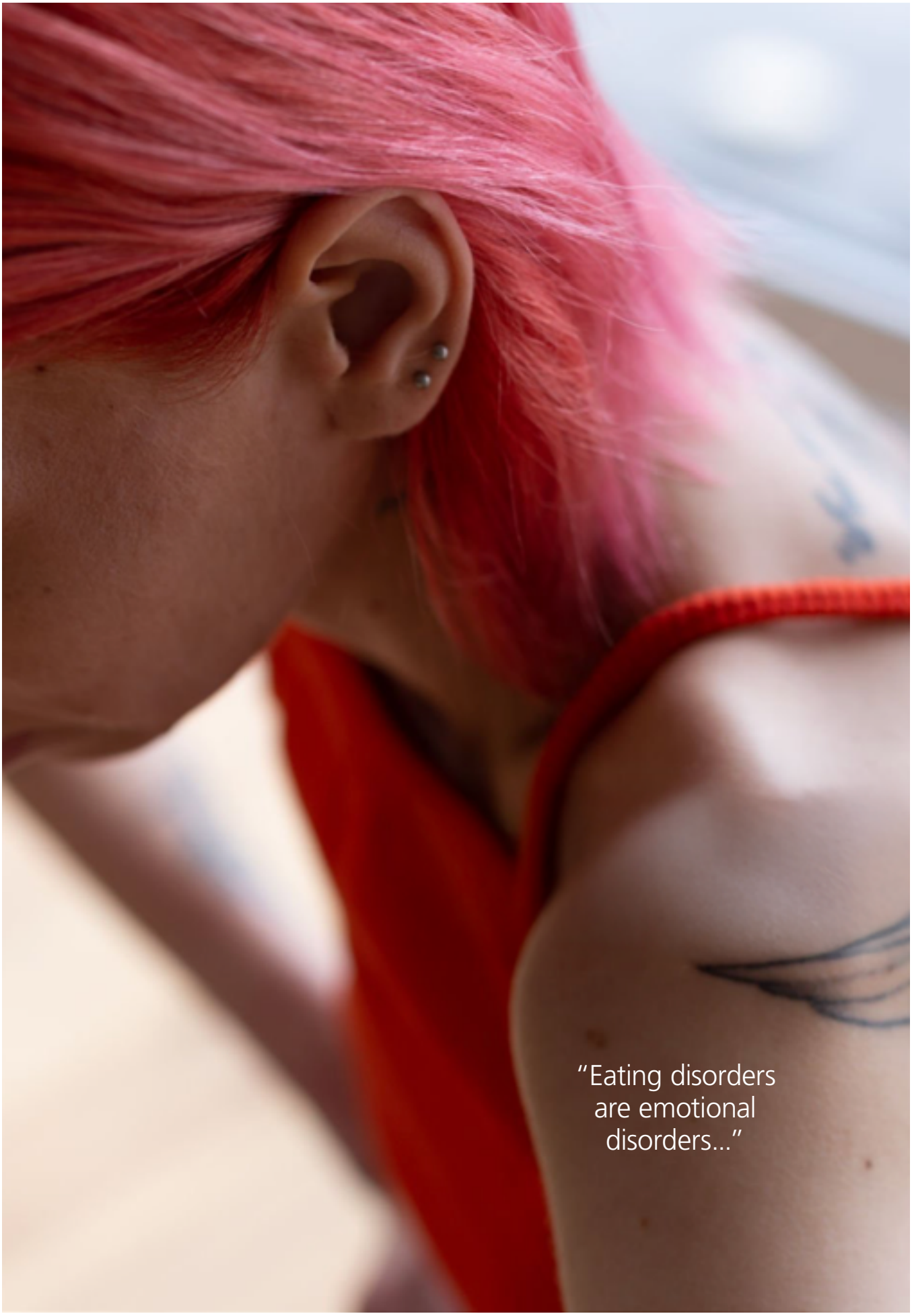
Which ONE is correct? Service users detained under which Section, can be allowed leave by their responsible clinician?

1. Section 48/49
2. Section 37/41
3. Section 37
4. Section 38

Question 37:

When acting as the 'other professional' for a SOAD you must have:

1. Spoken to the patient within the last week
2. Been professionally involved in decisions about the patient's treatment
3. Agreement with the treatment plan given to the SOAD
4. Attended the patient's last case conference


"Eating disorders
are emotional
disorders..."

Eating Disorders

Eating disorders are emotional disorders which focus on food and preoccupation with body size and shape as a way of coping with problems. All eating disorders have the same core features which are not secondary to a general medical disorder or other mental illness. These are:

- A pre-occupation with and over-emphasis of the importance of body weight and shape.
- The use of extreme dietary restriction often with other weight control measures such as excessive exercise, self-induced vomiting, laxative, diuretic and or slimming pill abuse.
- Significant impairment of physical health and/or social functioning.

Eating disorders can be very difficult to diagnose as early symptoms are often non-specific. As a result, it is believed that over half of cases go unrecognised for some considerable time.

Hospital admissions for eating disorders have increased by 84% in 2020/21 compared to 2015/16. This rise in hospital admissions is particularly evident for children and young people.

Classification

The classification of eating disorders is similar between DSM-5 and ICD-11. Eating disorders are conventionally categorised into anorexia nervosa (AN), bulimia nervosa (BN) and binge eating disorder (BED).

Table 11. Eating Disorder Classification

DSM-5	ICD-11
Feeding and eating disorders	Eating disorders
Anorexia nervosa	Anorexia Nervosa
Bulimia nervosa	Bulimia Nervosa
Avoidant / restrictive food intake disorder (ARFID)	Atypical anorexia nervosa
Binge eating disorder	Atypical bulimia nervosa
Other specified feeding or eating disorder (OFSED).	Other eating disorders (e.g. pica)
Unspecified feeding or eating disorder	Eating disorder unspecified
Pica	

Anorexia Nervosa

- Restriction of energy intake relative to requirements leading to a significantly low body weight in the context of age, sex, developmental trajectory, and physical health.
- Intense fear of gaining weight or becoming fat, even though underweight.
- Disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or denial of the seriousness of the current low body weight.

Bulimia Nervosa

- Recurrent episodes of binge eating characterised by both of the following:
  - Eating in a discrete amount of time (within a 2-hour period) large amounts of food.
  - Sense of lack of control overeating during an episode.
- Recurrent inappropriate compensatory behaviour in order to prevent weight gain (purging/induced vomiting).
- The binge eating and compensatory behaviours both occur, on average, at least once a week for three months.
- Self-evaluation is unduly influenced by body shape and weight. The disturbance does not occur exclusively during episodes of anorexia nervosa.

Binge Eating Disorder

- Recurrent episodes of binge eating. An episode of binge eating is characterised by both of the following:
  - eating, in a discrete period (for example, within any 2-hour period), an amount of food that is greater than that which most people would eat in a similar period of time under similar circumstances
  - a sense of lack of control overeating during the episode (for example, a feeling that one cannot stop eating or control what or how much one is eating)
- The binge-eating episodes are associated with three (or more) of the following:
  - eating much more rapidly than normal
  - eating until feeling uncomfortably full
  - eating large amounts of food when not feeling physically hungry
  - eating alone because of feeling embarrassed by how much one is eating
  - feeling disgusted with oneself, depressed, or very guilty afterwards
- Marked distress regarding binge eating is present.
- The binge eating occurs, on average, at least once a week for three months.
- The binge eating is not associated with the recurrent use of inappropriate compensatory behaviour (for example, purging) and does not occur exclusively during the course of Anorexia Nervosa, Bulimia Nervosa, or Avoidant/Restrictive Food Intake Disorder.

Many patients do not fully meet the criteria for these disorders, or they may have some features. They are then diagnosed as having an OSFED. This is characterised as disturbances in eating behaviour that do not necessarily fall into the specific category of anorexia, bulimia, or binge eating disorder. It is the most

common eating disorder diagnosis. Warning signs and related medical/psychological conditions of FED-NEC are similar to, and just as severe as, those for the other eating disorders.

Aetiology of eating disorders

No one factor has been identified as the cause of eating disorders. Like other psychiatric illnesses they are thought to occur because of interaction between genetic vulnerability and various environmental factors. See table 11.

Prevalence of eating disorders*

- Anorexia Nervosa - lifetime prevalence is between 2–4%,
- Bulimia Nervosa - prevalence in Europe is less than 1–2%
- Binge eating disorder - lifetime prevalence in Europe is around 1.9% for women and 0.3% for men.

Complications of eating disorders include:

- **Psychological disturbance** Anxiety and mood symptoms.
- **Social difficulties** Disrupted relationships and isolation.
- **Family/carer stress**.
- **Physical abnormalities** Musculoskeletal, endocrine, cardiovascular, gastrointestinal, haematological, and dental problems.

Table 12. Risk factors for eating disorders

General:
• Female sex • Adolescence/early adulthood • Living in a western society
Premorbid experience of:
• Adverse parenting – low contact, high expectation, arguments • Sexual abuse • Family dieting • Critical comments about eating, weight or shape • Pressure to be slim • Bullying/teasing for being fat • Activities that promote thinness or a particular body shape such as dancing, modelling, working out etc.
A family history of:
• An eating disorder • Depression • Substance misuse (BN) • Obesity (BN)
Premorbid characteristics:
• Low self-esteem • Difficulties in resolving conflict and expressing negative emotions • A perfectionist personality (AN) • High anxiety • Obesity (BN) • An early first menstrual period (BN)

Anorexia Nervosa (AN)

- AN mainly affects females with a sex ratio of 10:1, but the incidence or rate of recognition is increasing in young men.
- Average age of onset is 15 to16 years.

Clinical features of AN:

In addition to risk features in table 11

- Refusal to maintain body weight at, or above, minimum for age and height.
- Deliberate weight loss primarily induced by food intake restriction.
- Weight >15% below the normal reference range (BMI < 17.5) (BMI = weight (kg)/height (m2).
- Intense fear of weight gain, fatness and food.
- Amenorrhoea if post-menarche and not on a contraceptive agent – female.
- Loss of libido – male
- If the onset occurs before puberty, then secondary sexual development is delayed.

Table 13. Physical signs and symptoms of AN

Symptoms:
• Loss of muscle tissue and subcutaneous fat • Sensitivity to/intolerance of cold • Gastro-intestinal – constipation, cramps, bloating, atonic colon • Dizziness, syncope • Amenorrhoea – female • Loss of interest in sex - male • Sleeping difficulties • Fatigue • Irritability, anxiety • Headaches • Fractures secondary to osteoporosis • Overactivity • Poor concentration • Body image distortion.
Signs:
• Emaciation • Dry skin – sometimes of an orange colour due to hypercarotaemia • Cold extremities • Bradycardia, postural hypotension, arrhythmias • Peripheral oedema • Proximal myopathy • Downy hair (“lanugo hair”) on the back, fore-arms and cheeks • Poorly developed or atrophic secondary sexual characteristics • Calluses on the knuckles due to self-induced vomiting • Dental erosions due to self- induced vomiting • Enlarged salivary glands • Scarring - suggestive of cutting or burning • Memory loss/confusion

** NICE Clinical Knowledge Summaries - Eating Disorders 2024.*

Additional features include:

Physical

See table 12, page 89

A range of physical signs and symptoms which get more pronounced as weight loss progresses that can be serious and life threatening. These are the effects of starvation and are exacerbated by the metabolic consequences of vomiting and diuretic/laxative abuse.

Psychological

Body image distortion and fear of fatness are core psychological symptoms which become worse as weight is lost, thus making the disorder self-perpetuating. This is further reinforced by the fact that weight loss brings rewards such as feelings of self-control, peer support and approval, the avoidance of sexual development and parental attention.

Psychiatric

Symptoms of depression, anxiety disorders, obsessive compulsive disorder, and psychosis may be present.

Management of AN

As with other psychiatric illnesses, early recognition and effective intervention, can lead to better long-term outcomes. Some, if diagnosed early enough, can be managed adequately in primary care. For more severe disorders, specialist outpatient treatment is recommended whilst inpatient and day-care are reserved for those with the most severe forms of the illness.

Any treatment should address:

- Food intake, weight gain, body image, attitude to food etc.
- Co-morbid depression, anxiety etc.
- The physical consequences of fasting/starvation both short and long term.

The evidence base is very limited with the result that current guidance is based on expert clinical experience, rather than robust randomised controlled trials.

Psychological

Psychological therapies are the most effective treatments for AN. Family Therapy has the most supportive evidence and is recommended as a first line therapy. Other specialist therapies include focal psychodynamic psychotherapy, cognitive analytic therapy, specialist supportive clinical management and cognitive behavioural therapy (CBT), but there is no robust evidence to support these.

Medical

Medical monitoring is essential for a patient with AN. This includes blood pressure, pulse, temperature and weight, plus ECG and routine blood tests together with fluid balance.

Electrolyte disturbances and biochemical abnormalities should be corrected cautiously because such changes are likely to have been chronic and some physiological adaption may have taken place. Peripheral oedema which can occur during re-feeding should be managed cautiously by the avoidance of excessive fluid intake and elevation of the feet by day and the head by night. Cardiac failure as a potential cause should be excluded.

Constipation is a common problem, especially in those who have misused laxatives. Increasing fluid and fibre intake may be sufficient. However, if the colon has lost its tonicity, then a bulk forming laxative or stool softener may also be required.

Delayed gastric emptying can lead to feelings of early satiety, fullness or bloating. Symtomatic relief may be possible with Peppermint oil, Hyoscine Butylbromide and indigestion products.

Nutritional

The aim of nutritional management is to establish a structured eating pattern which involves three meals and three snacks a day. Food is considered as a "medicine" as it facilitates other interventions. It is offered in "individually prescribed regular doses" which are reviewed and adjusted regularly. Administration needs to be observed, and the individual monitored for adverse effects.

Food is reintroduced slowly, starting with quarter portions or less and moving up through to full portions over a period of time. This may take months or even longer but should be carried out at a pace the patient can cope with. The diet should be high in energy, low in fibre and phosphate rich including milk, eggs and chicken. This reduces the risk of gastric dilation and re-feeding syndrome, the symptoms of which include confusion, convulsions, psychosis and heart failure that occur due to metabolic disturbances.

Psychological interventions are employed to address the acute anxiety which can occur prior to mealtimes, especially before an anticipated planned increase in portion size or "dosage".

On occasions these need to be supplemented with short term use of an antipsychotic or antihistamine.

Pharmacological Intervention

There is no evidence to support the use of antidepressants in the treatment of AN. Until recently there has been little evidence to support the routine use of atypical antipsychotics or antihistamines to promote weight gain. In fact, for a patient with AN, the knowledge that a prescribed medicine has the potential to increase weight, can have a negative impact on adherence and may damage the therapeutic relationship.

Prognosis

Anorexia Nervosa is a potentially fatal disorder and has a higher mortality rate than any other mental health disorder. This is 12 times the all-cause mortality rate for females in the same age group. Death can result from a number of clinical complications including renal failure or ventricular arrhythmias. Twenty per cent of deaths in people with AN are due to suicide.

When occurring in childhood or early adolescence AN can significantly impair growth and development. However, with effective early intervention, 27% to 58% have a good outcome, 13 to 25% have intermediate outcome and 11 to 42% have a poor outcome. 25% of patients are said to remain chronic after 20 years.

The greatest chance of recovery is in the first six years. A poor prognosis is associated with delay in recognition and treatment, adult onset, severe weight loss, vomiting, childhood obesity, low self-esteem, poor social and family relationships, personality disturbances and substance misuse.

Bulimia Nervosa (BN)

- BN is more common than AN.
- It is much more common in women with a sex ratio of 50:1.
- It occurs in 2% of women aged 16 to 35 years.
- Many risk factors are shared with AN.
- It has a slightly later mean age of onset of 18.
- The genetic contribution is controversial, but some studies suggest it to be in excess of 80%.

Clinical features of BN in addition to the core features listed above:

- Repetitive uncontrolled eating binges followed by self-induced vomiting and other activities to negate the calorific effects such as the misuse of laxatives, enemas, diuretics, slimming pills, excessive exercise etc.
- These activities induce the same adverse effects and metabolic disturbances as in AN.
- Recurrent binge eating occurs more than twice a week for 3 months.
- Typically, 1000 to 4000 kcal are consumed in each binge.
- Feelings of loss of control and/or in distress during binges.
- It punctuates an otherwise anorexia nervosa-like pattern of dietary restriction.
- Self-evaluation unduly influenced by body weight and shape.
- The diagnostic criteria for AN are not met.
- The most obvious difference from AN is that body weight is unremarkable.

Differential diagnosis

The following must be excluded before a diagnosis of BN can be applied:

- Anorexia with bulimic features.
- Binging associated with other psychiatric illnesses such as depression or psychosis.
- Medical causes of vomiting.
- Binge-eating disorder.

Management

Treatments are markedly more effective and better evaluated than in AN. They include:

- Self-help manuals, increasingly being used first line.
- A modified form of CBT.
- Interpersonal therapy (IPT). This works but takes longer than CBT.
- Antidepressants, which reduce the frequency of binging and vomiting. The best evidence is for high dose fluoxetine, but relapse often occurs when the antidepressant is stopped.

Prognosis

BN sufferers have less serious medical complications than those with AN. If untreated it has a chronic fluctuating course; 50% patients are fully recovered at 5 to 10 years' follow up.

For those who do achieve remission the relapse rate is of the order of 30%.

A poor prognosis is associated with psychiatric co-morbidity including substance misuse, impulsivity, a pre-morbid or family history of obesity, a history of AN and poor social adjustment. BN is not associated with overall increase in the risk of death.

Binge Eating Disorder (BED)

BED is a serious mental illness where people experience a loss of control and overeat on a regular basis.

People who binge eat consume very large quantities of food over a short period of time (called bingeing) often eating even when they are not hungry. It is not about eating extra-large portions at normal mealtimes.

Binges are usually planned like a ritual and can involve the person buying "special" binge foods. Binge eating usually takes place in private. People will often have feelings of guilt, disgust at their lack of control after binge eating. Unlike those with bulimia, people who binge eat do not purge themselves to control their weight.

Many people with BED are overweight or obese, leading to high blood pressure, high cholesterol, type 2 diabetes and heart disease. BED affects both men and women and tends to be more common in adults than in younger people.

Psychological Management

Self-help is often considered as the first suggestion for the treatment of BED. If BED is still persistent, psychological therapies can be recommended such as cognitive behavioural therapy (CBT), interpersonal psychotherapy (IPT) and modified dialectical behaviour therapy (DBT).

Pharmacological Management

Consideration should be given to offering a trial of an SSRI antidepressant drug to patients with binge eating disorder. Patients with binge eating disorders should be informed that SSRIs can reduce binge eating, but the long-term effects are unknown.

Special considerations

Refeeding syndrome

This potentially fatal syndrome occurs when shifts in fluids and electrolytes happen as a result of the malnourished individual receiving artificial refeeding (whether oral, enterally or parentally). It is characterised by abnormal biochemistry but not in isolation. The neurological and cardiovascular consequences of refeeding syndrome usually occur within 72 hours of the reintroduction of feeding with a range of 1-5 days. In severely malnourished individuals, this can happen later in time and thus, patients who are discharged from services before 20 days require follow up blood tests.

The primary signs and symptoms of refeeding syndrome:

- Severely low electrolyte concentrations:
  - potassium <2.5mmol/L
  - phosphate <0.32mmol/L
  - magnesium <0.5mmol/L
- Peripheral oedema or acute circulatory fluid overload.

- Disturbance to organ function including respiratory failure, cardiac failure or pulmonary oedema, raised liver transaminases.

Diabetes and disordered eating

Type 1 diabetes and disordered eating known as T1DE refers to those with a diagnosis of type 1 diabetes that also present with one or more behaviours to control weight.

- Omission or restriction of insulin
- Restriction of food
- Over exercise
- Self-induced vomiting
- Medication abuse – laxatives, diuretics, thyroid hormones, insulin.

These individuals are of clinical high risk and require specialist interventions with regards to re-insulinisation and refeeding.

Celia Feetam, Abiola Allinson
Reviewed by Helen Wilson

Further Reading

- National Collaborating Centre for Mental Health on behalf of the National Institute for Clinical Excellence (2004), *Clinical Guideline 9: Core interventions in the treatment and management of anorexia nervosa, bulimia nervosa and related eating disorders.* Available via: www.nice.org.uk.
- Cavan J, Connan F. *Eating disorders: Clinical features and diagnosis.* Clinical Pharmacist 2010 2: 9: 325-329
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- Kaplan A.S. Garfinkel P.E. Editors. *Medical issues and the Eating Disorders.* Brunner/Mazel New York 1993
- www.beateatingdisorders.org.uk
- www.gov.uk/drug-safety-update/domperidone-risks-of-cardiac-side-effects
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- Beat. Delaying for years, denied for months. View website
- Beat. Statistics for journalists. View website
- National Institute for Health and Care Excellence. Clinical Guideline NG69. Eating disorders: recognition and treatment. London: NICE, 2017. View guideline
- Royal College of Psychiatrists. Medical Emergencies in Eating Disorders (MEED). View website.

Question 38:

What considerations are required of a clinical pharmacist in the care of a patient with anorexia nervosa?

Question 39:

Which medicines present an increased risk to a person with anorexia nervosa and should, therefore, be avoided? Give your reasons.

Question 40:

What role does a community pharmacist have in supporting the care of an individual with an eating disorder?

Task 17:

Who are the key contacts in your area for the treatment of eating disorders?

Task 18:

Read about transitions and the impact on eating disorders, can you identify possible high-risk situations?
beat.contentfiles.net/media/documents/transitions-best-practice-final.pdf (contentfiles.net)


"... reduce any risk to the individual and others and allow them to receive the medical care they need."

Rapid Tranquillisation

Violence and aggression are actions that can or do harm another person. They can be physical or verbal.

Rapid tranquillisation is the use of medicines to quickly calm a service user who is displaying very agitated or aggressive behaviour. The rationale for treatment is to reduce any risk to the individual or others and allow them to receive the medical care that they need.

In 2015 NICE guideline NG10 defined rapid tranquillisation in terms of the use of injectable medication only with a focus on sedating the individual. The definition of rapid tranquillisation by NICE is given below:

'The 'use of medication by the parenteral route (usually intramuscular (IM) or, exceptionally, intravenous (IV)) if oral medication is not possible or appropriate and urgent sedation with medication is needed.'

Before Prescribing Rapid Tranquillisation

De-escalation techniques should be used to defuse anger and avert aggression. They can include recognising the early signs of agitation and aggression, using techniques for distracting and calming, recognising the importance of personal space, and the use of oral medication. The communication needs of the service user must be taken in to account and adjusted for.

If unsuccessful then rapid tranquillisation may be required. If so, the following should be taken into account prior to its use:

- dignity of the individual
- the service user's preferences
- previous positive or negative outcomes of rapid tranquillisation (if known)
- advance statements
- legal context (use of the Mental Health Act)
- physical obstacles
- physical health
- ECG
- known drug allergies / adverse drug reactions
- current medication
- drugs and alcohol use
- those with Learning Disabilities.

Prescribing Rapid Tranquillisation

The care team, which includes a psychiatrist and a specialist pharmacist, should make a medication plan for the service user, taking into consideration their wishes wherever possible.

When prescribing medication for use in rapid tranquillisation, the initial prescription should be written as a single dose, which should be reviewed for safety and efficacy before further prescribing for the individual.

NG10 makes two main recommendations around choices of rapid tranquillisation:

- intramuscular lorazepam
- intramuscular haloperidol in tandem with intramuscular promethazine

There are some general considerations that should be taken into account when prescribing in rapid tranquillisation.

- If there is insufficient information to guide the choice of medication for rapid tranquillisation, or the service user has not taken antipsychotic medication before, intramuscular lorazepam is the agent of choice unless contraindicated.
- If there is evidence of cardiovascular disease, including a prolonged QT interval, or no electrocardiogram (ECG) has been carried out, the use of intramuscular haloperidol should be avoided.
- If there is partial response to one intervention, consider a further dose if indicated after further de-escalation.
- If there is no response to one intervention, continue de-escalation and consider an alternative option.

After Rapid Tranquillisation

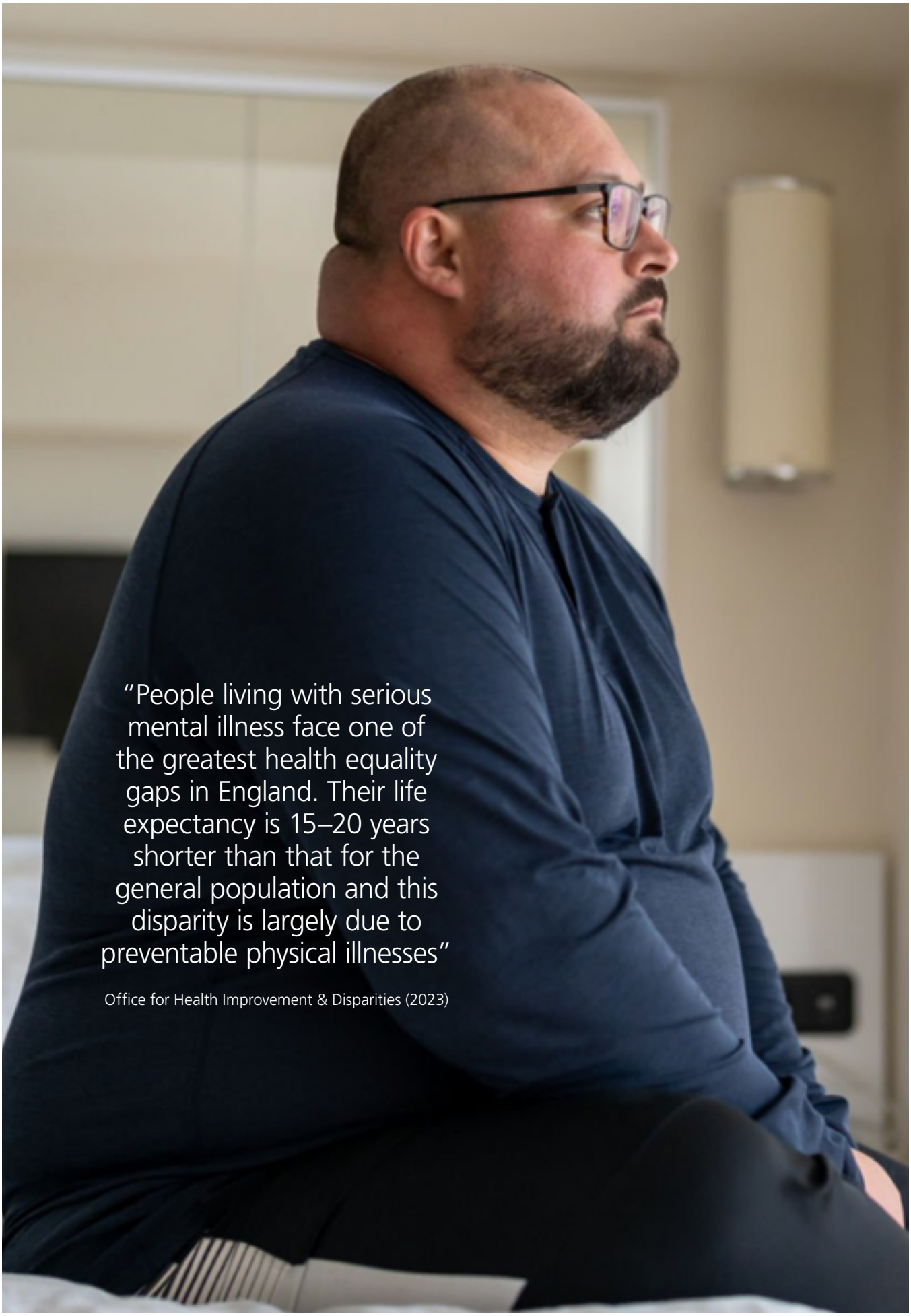
After rapid tranquillisation, the service user's pulse, blood pressure, respiratory rate, temperature, level of hydration and level of consciousness should be monitored at least every hour until there are no further concerns about their physical health status.

More frequent monitoring (every 15 minutes) should be undertaken if any of the following conditions are met:

- prescribing in excess of the BNF maximum doses
- an individual who appears to be asleep or sedated
- an individual who has taken illicit drugs or alcohol
- a known pre-existing physical health problem
- harm resulting from a restrictive intervention.

The care team are to carry out an immediate post-incident debrief to identify and address any physical harm to the service user / staff. The emotional impact on service users, staff, and potential witnesses should also be addressed. At an appropriate time after the event, the care team should talk with the service user to discuss how to avoid future episodes, and how to manage them if they do happen.

Juliet Shepherd
Reviewed by Tim Webb



"People living with serious mental illness face one of the greatest health equality gaps in England. Their life expectancy is 15–20 years shorter than that for the general population and this disparity is largely due to preventable physical illnesses"

Office for Health Improvement & Disparities (2023)

Physical healthcare in individuals with mental Illness

Background

Individuals with mental illness have an increased risk of physical health conditions, in addition to inadequate access to healthcare(1).

There is a growing body of evidence demonstrating that people with mental health conditions have an elevated prevalence of long term physical health conditions, including human immunodeficiency virus (HIV), cardiovascular disease, diabetes mellitus, gastrointestinal, and respiratory diseases(1). The prevalence of physical multimorbidity, defined as any combination of long term health condition with at least one other disease (acute or chronic)(2) as a result of an ageing population and increased exposure to risk factors for long term health conditions(3).

The causes of physical health inequalities experienced by individuals with mental health conditions is a multifaceted, transdiagnostic and global problem. Disparities in physical health are seen across the entire spectrum of mental illnesses in low, middle and high-income countries(4). Risk factors contributing to physical health disparities can be categorized into individual factors (e.g., smoking), health system-related factors (e.g., lack of care coordination and management), and social determinants of health (e.g., stigma and discrimination). (5). As a result, individuals with mental health conditions often face reduced life expectancy, diminished quality of life, and an increased personal, social, and economic burden associated with mental illnesses.(6).

People with SMI experience the greatest health inequalities across the spectrum of mental health conditions, in real terms this equates to a 15-20 year reduced life expectancy when compared to the general population(1) often due to sudden death that, in most cases, is caused by cardiovascular disease (CVD).

The following discussion relates specifically to severe mental illness (SMI) which is defined as schizophrenia, bipolar disorder and any other non-organic psychotic disorder e.g., drug induced psychosis.

Table 14. Evidence about CVD in SMI(7)

Compared to the general population, people with SMI:
• have a five-fold higher risk of cardiovascular mortality and sudden cardiac death. • have a 54% increased long-term risk of ischaemic heart disease including myocardial infarction. • presenting with myocardial infarction are younger with higher rates of cardiovascular risk factors e.g., smoking. • are more likely to have atypical symptoms of myocardial infarction such as atypical angina or dyspnoea and longer symptom duration.

Importantly, both the incidence of CVD and mortality have reduced in the general population over recent decades, mainly due to adjustments in lifestyle behaviour and effective implementation of clinical guidance. However, patients with SMI have not benefitted in the same way and as a result, the mortality gap persists and may even be widening(7).

Why is there an excess cardiovascular disease burden in people with SMI?

The factors outlined above represent potential barriers and challenges that can be specifically targeted, either alone or in combination, to improve cardiovascular health and long-term outcomes in patients with SMI as shown in this graphical abstract(7).This table shows the prevalence and relative risk estimates of cardiovascular risk factors in patients with SMI compared with the general population.

Physical Health Monitoring

Based on the aforementioned factors that are involved in the excess cardiovascular risk in patients with SMI, primary prevention strategies that are tailored to the individual are crucial to decrease the burden of CVD, reduce the mortality gap and improve long-term outcomes. This would be achieved through regular cardiovascular risk assessment including blood pressure monitoring, evaluation of metabolic parameters and CVD risk calculation using risk calculator e.g., QRISK. Finally, following up and implementing interventions as a result of this screening i.e. 'Don't just screen, intervene' - cardiometabolic health resource.

In summary there are seven elements recommended as the 'core' annual SMI physical health check:

Table 15.

Seven elements for 'core' SMI physical health check
• Alcohol consumption • Smoking • HbA1c • Full lipid profile and QRISK • Blood pressure • Body mass index • Smoking status

Anyone prescribed antipsychotics or mood stabilisers (regardless of diagnosis) should also have their physical health monitored from initiation of these medications in line with National guidance, British National Formulary and summary of product characteristics (SmPC). Elements of this monitoring might be done more frequently as clinically appropriate or

indicated. A comprehensive physical health check should also include other elements e.g., sexual and reproductive health assessment and advice (including baseline assessment and contraception), assessment of physical activity levels, substance misuse assessment, medicines reconciliation and monitoring.

Of concern, if people with SMI are not treated for established CVD risk factors then the rates of those risk factors stated in the table previously referred to have been reported to be as high as 88% for dyslipidaemia, 62% for hypertension, and 30% for diabetes(7).

Smoking cessation may be one of the most effective measures for total CVD risk reduction in people with SMI.

Smoking is highly prevalent in patients with SMI; some studies reporting rates up to 80%(8). People with schizophrenia who smoke have an 86% higher 20-year cardiovascular mortality risk than non-smoking patients with schizophrenia(9). Despite these stark figures, smoking cessation interventions are underutilised in people with SMI even though they are generally as effective as in the general population(10).

The role of antipsychotics and other psychotropic medication

There is a complex relationship between the risk factors for CVD, SMI, and antipsychotic medication. Some antipsychotics have adverse effects on CVD risk by stimulating weight gain, hyperglycaemia, and dyslipidaemia. This heat map shows antipsychotic drugs ranked according to associated degree of alteration in bodyweight, body-mass index, lipids and glucose levels in the blood. However, the overall net benefits on all-cause and specifically cardiovascular mortality is positive(7).This apparent paradox is most likely explained by greater stability in mental health through antipsychotic treatment which translates into improved engagement in healthy lifestyle behaviours, greater concordance with medication and interventions and reduced psychotic-related stress. Thereby reducing CVD risk factors and disease.

Clinical practice guidelines by Lambiase et al(11), suggests that death from CVD follows a U-shaped curve in relation to antipsychotic dose with patients taking no medication and those taking the highest doses having the highest rate of death. This indicates that antipsychotic treatment can protect people with SMI against the negative impacts of schizophrenia, including suicide, at low and medium daily doses. Furthermore long term concordance is critical and high doses should be avoided(12).

Patient centred collaborative approach is needed to achieve excellence in care for physical health in SMI.

Collaboration between healthcare professionals across all settings and the person with SMI and any informal carers is crucial in achieving an excellent standard of care to improve morbidity and mortality. This should be patient centred. This requires a multidisciplinary team (MDT) approach and is underpinned by good communication, care coordination, integration of physical and mental health discussions between health care professionals and patient and any informal carers. The healthcare team should ideally include a mental health and general nurse, general practitioner, psychiatrist, psychologist, pharmacist, dietician, physiotherapist and other specialists where necessary depending on the individual needs of the patient e.g. those from cardiology, endocrinology, diabetes care.

Care should be tailored to include long term health care management and be flexible to account for acute situations. Key elements of this may include the following:

- Comprehensive care plan e.g., to include health checks for CVD;
- Shared/informed decision making;
- Desires and wishes of the patient and informal carers;
- Treatment plan including physical and mental health;
- List of key contacts/core MDT.

Due to the challenges outlined and the resulting high rates of morbidity and mortality for this vulnerable group of individuals, it is now urgent that a more integrated patient-centred approach occur within the field of physical health in mental health. Both are inextricably connected and influence each other, thus approaches which consider both body and mind as one interrelated system are more likely to be successful (please see the table below for examples).

Integrated Care for Physical and Mental Health

Research has shown that integrated care models, which combine mental health care with primary or physical health care, can significantly improve health outcomes for individuals with severe mental illness. By treating both physical and mental health concerns in tandem, patients are more likely to manage comorbid conditions such as heart disease, diabetes, and obesity, which are common among people with severe mental illnesses like schizophrenia or bipolar disorder. One study found that people with severe mental illnesses who received integrated care had improved adherence to both psychiatric and medical treatments, leading to reduced hospitalizations and better overall health outcomes(13).

Physical Activity and Mental Health

Exercise has been shown to have significant benefits for both mental and physical health. For people with mental illness, such as major depressive disorder or schizophrenia, physical activity can reduce symptoms of depression, improve mood, and lower the risk of physical health problems like heart disease. Studies have demonstrated that combining exercise with mental health interventions not only enhances mental well-being but also reduces physical health risks, helping improve both morbidity and mortality(14).

Examples of approaches which consider both body and mind as one interrelated system which improve outcomes for people with SMI (13,14).

Dr Dolly Sud

Further Reading.

- Physical health checks for severe mental illness. HEE module
  https://www.e-lfh.org.uk/programmes/physical-health-checks-for-severe-mental-illness/
- LESTER TOOL (endorsed by NICE)
  https://www.rcpsych.ac.uk/docs/default-source/improving-care/ccqi/national-clinical-audits/ncap-library/eip-2024/ncap-lester-tool-intervention-framework.pdf?sfvrsn=21e45dbd_17
- Taylor D, Gaughran F, and Pillinger T. (2021) The Maudsley Practice Guidelines for Physical Health Conditions in Psychiatry, First Edition, John Wiley & Sons Ltd.
- The Mental Elf (part of The National Elf) has some accessible blogs on physical health in mental health
  https://www.nationalelfservice.net/mental-health/

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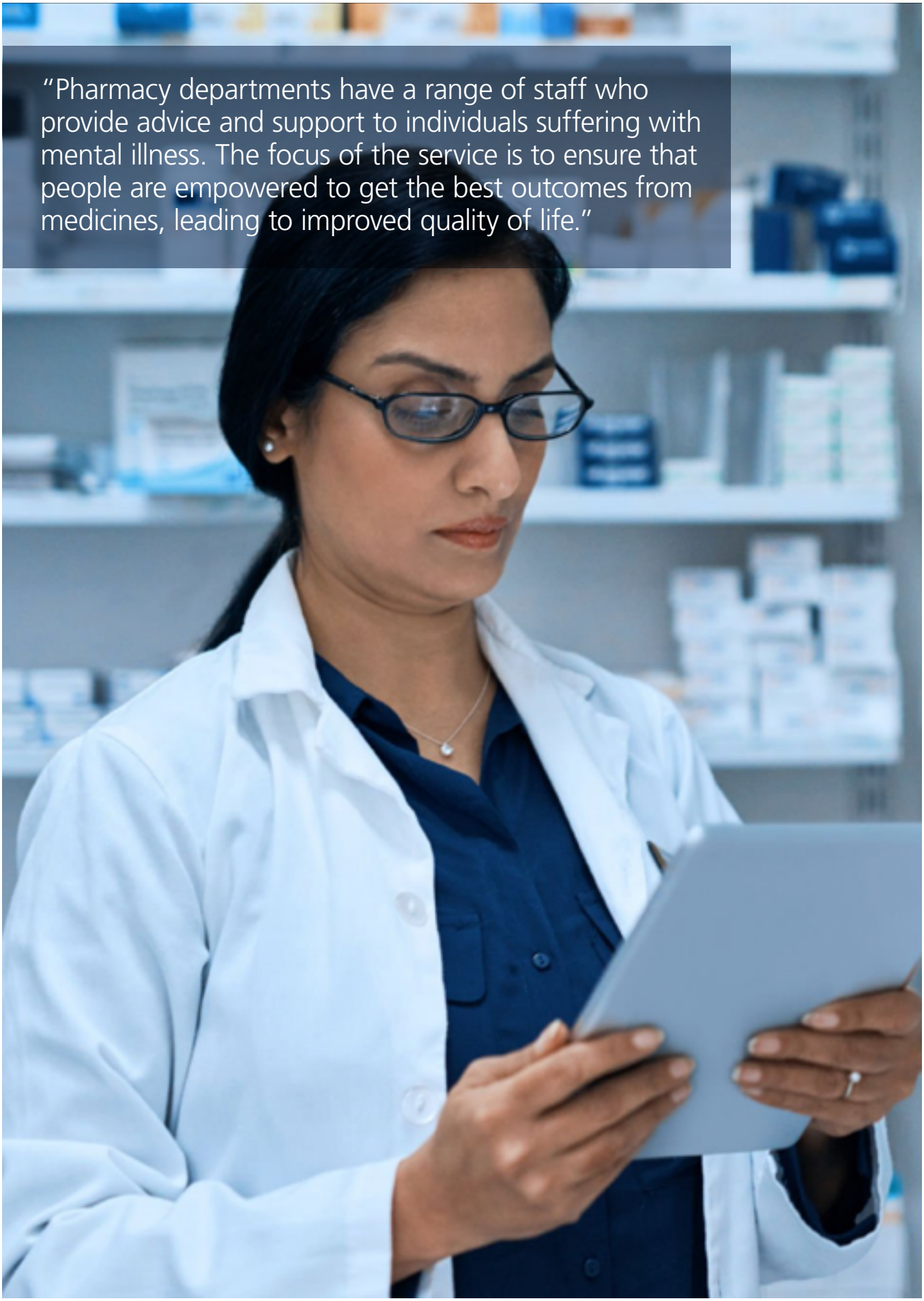
"Pharmacy departments have a range of staff who provide advice and support to individuals suffering with mental illness. The focus of the service is to ensure that people are empowered to get the best outcomes from medicines, leading to improved quality of life."

Dispensary and Support Services

As you might have discovered already, medicine supply in the Acute Trust can often involve using a individuals own medication from admission and then dispensing original packs suitably labelled to be provided on discharge from the hospital setting.

Although this has been shown to be cost effective, it is not always the most practical approach in a mental health setting. Individuals are often admitted due to a mental health crisis and their regular medication may not always be available. For some, admissions can be long-lasting and medication may be altered frequently, with dose adjustments according to patient response particularly in relation to psychotropic medication. Regular reviews are carried out with the multidisciplinary team (MDT) to assess the effectiveness of medications. There is a need to ensure they are contributing positively to the treatment plan and identify if there are any potential side effects or interactions. This needs to be done in conjunction with the patient/carer to support compliance and adherence to medication.

Prior to formal discharge from inpatient care, a service user may be allowed home on leave. Initially it will be for short periods gradually building up to a complete week, with the patient only attending the ward for multidisciplinary reviews.

Even on discharge, the team may feel that the service user should only take home a limited amount of medication due to the risk of overdose. It may also be that, due to the disordered lifestyle that some service users lead, the team may prefer all items to be supplied as the same quantity so that compliance can be monitored easily by community staff.

In the Mental Health Dispensary (or dispensary serving a mental health facility) you will come across frequent requests for leave medication from anything between a single dose to two weeks and a rapid turnaround is required. This involves the packing down of medications to limited quantities, which increased the workload and complexities of discharges/leaves within dispensaries. This can sometimes be awkward for large dispensaries, but it is important to bear in mind that it will be supporting a vulnerable person return to the community in a safe and structured manner and maintain their independence.

Discharge Medicines Service

In addition to optimising the supply of medicines to support the care of the individual, the NHS has introduced the Discharge Medicines Service (DMS). This service provides improved communication of medication changes from a hospital setting to the individuals preferred community pharmacy. This service is especially relevant for patients discharged from mental health services, ensuring that changes to their mental health medications are properly communicated and managed by the community pharmacy of their choice.

Maxine Walker, Elaine Walton & Lisa Thompson

Question 41:

List the reasons that you can think of to limit the number of tablets for some service users on leave or discharge?

Question 42:

Why might short term leave dispensing cause difficulty in a large (general acute) hospital pharmacy department?

Task 18:

Review, assess, dispense, check and supply a range of leave medication prescriptions during your visit or when back at your main pharmacy (as appropriate for your role).

Clozapine

Clozapine is an atypical antipsychotic licensed for treatment resistant schizophrenia (TRS), along with psychosis occurring in Parkinson's disease where other treatment has failed.

Whilst clozapine appears to be the only antipsychotic with superior efficacy in schizophrenia, it is associated with several, serious side-effects. Of particular concern are neutropenia and agranulocytosis (a reduction in the number of white blood cells impairing in the body's ability to fight infection). This is a rare reaction, that is not dose related, but can lead to death. This is the main reason it was withdrawn from the UK in the 1980's.

Later on, after the successful use of clozapine in other countries with this otherwise hard to manage patient group a product licence to manufacture clozapine under strict supply controls was granted in the UK.

Clozapine can only be prescribed under the supervision of a Medical Officer / Consultant doctor and supplied by pharmacists and pharmacies registered with the manufacturer's patient monitoring service. To start clozapine, a service user must also be registered and have evidence of a recent, acceptable full blood count (FBC).

The Clozapine Full Blood Count

Once registered, the service user must have a FBC every week for the first 18 weeks as the risk of serious blood dyscrasias appear to be highest in this timeframe. After 18 weeks of acceptable results, the service user will move to fortnightly FBCs. This carries on until the end of the first year of treatment (week 52) where the monitoring frequency extends to four weeks. This continues for the duration of the clozapine treatment but can revert to more frequent monitoring in certain scenarios.

Depending on the monitoring frequency, the FBC results are valid for a set period:

- **Weekly FBCs** are valid for a period of 10 days after the result of the test
- **Fortnightly FBCs** are valid for 21 days after the result of the test
- **Four-weekly FBCs** are valid for 42 days after the result of the test.

'No valid blood test, no tablets'

Blood results are graded as red / amber / green:

Result	White cell count	Neutrophil count	Action
Green	>3.5	>2.0	Continue to take clozapine and arrange another FBC at the appropriate interval
Amber	3.0 – 3.5	1.5 – 2.0	Continue to take clozapine but requires more frequent FBCs (usually twice a week)
Red	<3.0	<1.5	Clozapine must be stopped straight away, FBCs to be completed daily

All figures are x 10^9L. Different ranges are used for those with confirmed Benign Ethnic Neutropenia.

If a service user has a "confirmed" red result, they might never be allowed to resume clozapine again.

When to test

The sample may be taken at any time of the day, regardless of the timing of the last dose taken.

The Clozapine Assay

Clozapine has a narrow therapeutic index and therapeutic drug monitoring (TDM) is available to ensure doses are appropriate for the individual service user. Variables such as changes in smoking status, significant changes in caffeine intake, age, and gender can affect clozapine levels. TDM is also useful for investigating queries such as:

- the service user is on a low dose but appears to be experiencing more side effects than expected
- the service user is on an appropriate dose but is not responding as expected.

TDM results for clozapine are reported as the level of clozapine and its metabolite norclozapine. The usual reference range

for clozapine is between 0.35 mg/L and 0.5 mg/L. However, it is always important to assess the service user's response before immediately acting on out-of-range results. Some respond well on lower levels; some do not experience issues with higher levels. Levels above 0.6 mg/L are a risk factor for seizures and levels above 1 mg/L need assessing immediately. For norclozapine, its ratio to clozapine is important in assessing the patient's response. The median ratio of clozapine to norclozapine is 1.3 and deviations from this can suggest that:

- the patient is a slow or fast metaboliser
- the patient may not have been fully adherent with treatment
- the sample was not taken 12hrs post dose
- a change in other therapy that interacts with clozapine.

When to test

- Ideally 12 hours after a dose. Where indicated (and possible) withhold a dose until a sample is taken.
- At 'steady-state'. Testing levels after a recent dose change is pointless. Wait at least 4 days for levels to stabilise.

Smoking

Smoking can have dramatic effects on clozapine plasma levels. This is due to the induction of cytochrome 1A2 by polycyclic hydrocarbons in cigarette smoke increasing the metabolism of clozapine. Nicotine itself does not alter the metabolism of clozapine. Therefore, it is important to note that, in the context of a smoke-free hospital, replacing cigarettes with nicotine replacement therapies or electronic cigarettes will still cause an increase in clozapine levels. Cautious reductions in dose are therefore required.

Missed doses

Like other medications such as methadone, service users lose physical tolerance to clozapine's side effects quickly. If a service user has not taken any clozapine for 48 continuous hours, retitration is essential. This usually involves starting at 12.5mg at night. Along with the retitration, the monitoring frequency for FBCs may need to be shortened, depending on the period of no treatment, i.e. fortnightly back to weekly.

Side Effects

Constipation

Constipation is a common adverse effect which, if not acted upon immediately, can have fatal consequences. All service users should be monitored for constipation by actively asking them; they do not always offer this information voluntarily.

Clozapine, due to its high anticholinergic activity, causes a reduction in colonic transit time. Compared to the general population, this reduction is four-fold. If left untreated, this can lead to paralytic ileus or bowel perforation. In those where the bowel transit is slowed to a significant degree, the level of absorption of clozapine is reduced.

The recommended treatments of acute, clozapine-induced constipation include macrogol, stool softening or, stimulant laxatives.

Hypersalivation

Hypersalivation is commonly seen with clozapine treatment. Whilst clozapine causes constipation via its anticholinergic effect, it is postulated that hypersalivation is caused by muscarinic (M4) agonism (amongst others). This effect can be quite pronounced, causing high levels of distress for the service user and carries a risk of aspiration pneumonia.

Non-pharmacological options include chewing sugar-free gum and elevating pillows in bed. In practice, the commonly seen pharmacological options include:

- **hyoscine hydrobromide** tablets (off-label)
- **hyoscine** transdermal patches (off-label)
- **atropine** eye drops used sublingually (off-label)
- **pirenzepine** tablets (unlicensed)

It is worth noting that these also carry an increased risk of constipation.

Myocarditis

The risk of experiencing myocarditis is highest in the first 2 months of treatment. Whilst not all will experience all symptoms, some include:

- chest pain
- arrythmias
- signs of heart failure
- persistent tachycardia at rest.

Referral to cardiology is essential along with reducing the speed of clozapine titration / stopping clozapine.

Richard Heys, Andy Down
Reviewed by Tim Webb

Appendices

Essential additional tasks and placement planning tools

Appendix 1A

Placement Structure Details

This section provides three suggested plans for the structure of the training placement. These should be adapted locally in discussion with your employer or tutor at your primary work base and in the mental health service. The four-week scheme is more appropriate for staff that have the opportunity to undertake a placement that includes experience in a dispensary providing services to the local mental health service where the role involves dispensing, supply and checking.

Some of the 'experiences' are judged to be fundamental to the placement and are included in the example placement plans (e.g. time working with a CPN), to ensure that the trainee receives the most worthwhile and fulfilling placement. The longer example plans include more of these items and any local adaptation should aim to match the contents.

Blocks in the placement plan labelled 'Options' allow the trainee to fine-tune their own training placement. It is the responsibility of the trainee to organise tasks/experiences to fill these gaps. A list of potential 'experiences' is provided below, although certain items will only be available within certain trusts, e.g. forensic experience, and some will only be available at certain times, e.g. attendance at a meeting.

The trainee should contact the appropriate staff, prior to the start of the placement, in order to arrange a mutually acceptable time for the 'experience.' This might necessitate a change to the placement plan. Contact details for appropriate staff will be available from the Mental Health Training Facilitator. There are also a number of additional tasks associated with the individual workbook chapters.

You will have time during your placement for using this workbook, to review information and complete tasks. The placement structure also includes elements of self-directed study, which is hopefully in accordance with your training contract.

The example placement plans allow for 0.5 days per week.

Task 23:

Identify and prioritise your learning needs for the placement. Use SMART objectives.

Using the information in the Placement Structure section of this workbook and the optional tasks, plan your placement to meet these objectives.

You will need to contact staff prior to the start of your placement in order to arrange some elements of the placement. This is your responsibility, not your tutor's.

Task 24:

Evaluate your mental health placement.

Refer to the learning objectives that you identified in Task 23. Have these been met?

If not, what else needs to be done in order to meet these objectives?

What have you identified during your placement that you need to learn?

Appendix 1A – Placement Structure Details

Tasks and Experiences in the Placement Structure

PHARMACIST ACTIVITY	TASKS AND EXPERIENCES	DURATION
Pharmacist ward visit	Shadow specialist pharmacist during routine ward visit to working age adult (WAA), older adult (OA) or specialist ward or unit	2 hours
Ward round/MDT	Accompany specialist pharmacist as they attend ward round or multidisciplinary team meeting with WAA, OA or specialist team	2 - 4 hours

COLLEAGUES	TASKS AND EXPERIENCES	DURATION
Refer to the workbook section 'Who's who?' and Task 2		
Community Psychiatric Nurse (CPN)	Shadow CPN during their routine work. To include home visit	3.5 - 7.5 hours
Occupational Therapist	Attend therapy session	2 hours
Psychologist/ Psychotherapist	Attend clinic or discussion, at discretion of psychologist/ psychotherapist	4 hours
Service users and carers	Attend group/meeting	4 hours
Social Worker	Shadow social worker/discussion	2 - 4 hours
Specialist Pharmacy Technician	Shadow technician during their routine work	4 hours
Non-Medical Prescriber	Attend clinic run by a non-medical prescriber. Write a reflective review comparing your experience to what you believe about clinics run by doctors	4 hours
Other colleagues	Arrange to spend time with another colleague and learn about their role in mental health	2 - 4 hours

OTHER TASKS AND EXPERIENCES		DURATION
Ward shift See Task 28	Work as a member of ward staff for a shift	3.5 - 7.5 hours
Electroconvulsive Therapy (ECT) See Tasks 5 and 6	Attend/observe an ECT session	1 - 3.5 hours
Community Mental Health Team (CMHT)	Attend outpatient clinic and/or CMHT planning meeting	4 hours
Meetings See Task 27	Attend Area Prescribing Committee, Drug and Therapeutics Committee etc. meetings, as available	4 hours
Medicines Reconciliation See Task 25	Perform assessment in accordance with local Trust policy	1 hours
Client discussion	Discuss medicines use with client	1 hours
Case study and presentation See Tasks 29, 30 and 31	Research case, produce and deliver presentation. Case can be hypothetical or real depending on available time	2 - 4 hours
Dispensary shift (optional extra)	Undertake/shadow shift focussing on mental health medication or services	4 hours

Appendix 1B – Example Placement Plan – 1 week

ONE-WEEK

MONDAY	Orientation to department and Introduction to Mental Health
	Lunch
	Pharmacists Ward Visit WAA
	Presentation
	Workbook
TUESDAY	Pharmacist Ward Visit OA
	Medicines Reconciliation
	Client Discussion
	Lunch
	Options
WEDNESDAY	Ward Round MDT – Specialist Team
	Options
	Lunch
	Ward Round MDT - WAA
THURSDAY	CPN
	Lunch
	Options
FRIDAY	Self-Directed Study
	Lunch
	Workbook
	Presentation

Appendix 1B – Example Placement Plan – 2 weeks

TWO-WEEKS	WEEK ONE	WEEK TWO
MONDAY	Orientation to department and Introduction to Mental Health	Ward round MDT – WAA
	Lunch	Lunch
	Pharmacists Ward Visit WAA	Options
	Workbook	
TUESDAY	CPN	Self-Directed Study
	Lunch	Lunch
	CPN	Pharmacist Ward Visit - OA
		Medicines Reconciliation
		Client Discussion
WEDNESDAY	Ward Round MDT – Specialist Team	Ward Round MDT – Specialist Team
	Lunch	Presentation
	ECT	Lunch
	Presentation	Options
THURSDAY	Technician	Ward shift
	Lunch	Lunch
	Options	Ward Shift
		Pharmacist Ward Visit – Specialist Team
FRIDAY	Pharmacist Ward Visit - OA	Pharmacist Ward Visit - WAA
	Presentation	Occupational Therapy
	Lunch	Lunch
	Self-Directed Study	Workbook
		Presentation

Appendix 1B – Example Placement Plan – 4 weeks

FOUR-WEEKS	WEEK ONE	WEEK TWO
MONDAY	Orientation to department and Introduction to Mental Health Lunch Pharmacists Ward Visit WAA Workbook	Ward round MDT – WAA Lunch Dispensary
TUESDAY	Dispensary Lunch Dispensary	Self-Directed Study Lunch Pharmacist Ward Visit - OA Medicines Reconciliation Client Discussion
WEDNESDAY	Ward Round MDT – Specialist Team Lunch Dispensary	Ward Round MDT – Specialist Team Presentation Lunch Options
THURSDAY	Technician Lunch Dispensary	Ward shift Lunch Ward Shift Pharmacist Ward Visit – Specialist Team
FRIDAY	Pharmacist Ward Visit - OA Presentation Lunch Self-Directed Study	Pharmacist Ward Visit - WAA Occupational Therapy Lunch Dispensary

	WEEK THREE	WEEK FOUR
MONDAY	Dispensary	Options
	Lunch	Lunch
	Options	Self-Directed Study
TUESDAY	CPN	Ward Round MDT – OA
	Lunch	Lunch
	CPN	Dispensary
WEDNESDAY	ECT	Dispensary
	Presentation	Lunch
	Lunch	Options
	Ward Visit MDT - WAA	
THURSDAY	Technician	Pharmacist Ward Visit - OA
	Lunch	Pharmacist Ward Visit Specialist Team
	Options	Lunch
		Dispensary
FRIDAY	Dispensary	Pharmacist Ward Visit - WAA
	Lunch	Workbook
	Self-Directed Study	Lunch
		Presentation

Appendix 1C – Blank Placement Plan Template

FOUR WEEKS	WEEK ONE	WEEK TWO
MONDAY	**Lunch**	**Lunch**
TUESDAY	**Lunch**	**Lunch**
WEDNESDAY	**Lunch**	**Lunch**
THURSDAY	**Lunch**	**Lunch**
FRIDAY	**Lunch**	**Lunch**

	WEEK THREE	WEEK FOUR
MONDAY	**Lunch**	**Lunch**
TUESDAY	**Lunch**	**Lunch**
WEDNESDAY	**Lunch**	**Lunch**
THURSDAY	**Lunch**	**Lunch**
FRIDAY	**Lunch**	**Lunch**

Appendix 2A – Additional Tasks

In addition to the optional experiences in the Placement Structure (see Appendix 1a) and the tasks throughout the workbook.

Tasks 25 – 31 are considered to be important. They will provide a fuller appreciation of the operation of a mental health service and the needs of those people under its care.

Task 25:

All NHS trusts (should) have a Medicines Reconciliation policy with clear procedures.

Find out the purpose of Medicines Reconciliation and undertake an assessment, using the local policy and procedures, of a newly admitted patient.

Task 26:

Discuss medication and treatment with a client. You might want to find out about views of treatment and experiences with different medications, but be prepared to answer complicated and challenging questions. Clients with a long history of treatment within the mental health service often know a lot about their medication.

Remember the different types of 'medication' and different sources! Many psychotropic agents (as well as mental health conditions) have significant physiological effects. Lifestyle issues and diet could be highly relevant to overall physical and mental health.

Remember to refer appropriately, if necessary.

Your Mental Health Training Facilitator or another member of staff might be useful in identifying a client who would be appropriate for you to work with, or who would benefit from your expertise.

Task 27:

Attend a professional meeting, if available. Good opportunities might be the Area Prescribing Committee, Drug and Therapeutics Committee etc.

Write a short report on:

- Function of the committee or meeting.
- Scope of topics discussed.
- What you have learned and how this has relevance to your practice?

Remember – confidentiality!

Task 28:

Work as a member of ward staff for a shift or part shift.

Your Mental Health Training Facilitator will be able to suggest a suitable ward, but you will need to contact the ward manager to arrange an appropriate time for the experience.

You will not be expected to undertake skilled tasks that you have not been trained in, but you will be expected to work hard! Remember that you are under the direction of the ward staff, but you take responsibility for your own actions.

Appendix 2B – The Presentation

Task 29:

Presentation:

Write and deliver a 10-15 minute presentation on one of the two options detailed overleaf:

Option A A client who you have seen during your placement.

Option B A hypothetical client (one-week placements only).

The presentation should be delivered to a multi-disciplinary group of staff and include your pre-reg tutor/s.

Consider the structure of your presentation. It must be clear and logical. Introduce the topic, cover the main details and provide a clear summary of your main points. If you try to include too much information, the presentation will become complicated and you risk losing the interest of your audience!

Engage your audience! It can help to ask your audience questions, but remember that you don't have much time!

Task 30:

Write a short (one to two sides of A4) reflective account of your presentation:

- What went well?
- What did not go well?
- How could the presentation be improved if you were to deliver it again?

Seek feedback from those who attended your presentation and include this in your reflection and review.

Task 31:

On return to your primary pre-registration work base arrange to deliver your presentation to your colleagues.

Remember to incorporate any changes identified in Task 30.

Revaluate your presentation.

Option A. Case Study (For tasks 29-31)

Select a patient that you have seen or had some involvement with during your placement. Do not choose someone with an overly complicated presentation or with many problems!

- Provide details of:
  - o Presentation on admission.
  - o Relevant mental health history.
  - o Details of social circumstances and family history.
  - o Medicines history.
  - o Other medical conditions.

- What is the diagnosis/diagnoses?
  - o Link the patient's presentation to the diagnosis.
  - o What is the relevance of medication (including non-prescribed items)?

- Briefly describe any problems or concerns and your ideas to resolve these.

- If possible, provide details of follow-up.

Option B. Hypothetical Case (For tasks 29-31)

If you are on a one-week placement in mental health can use the below information and guidance points as a background to the presentation.

A Case of Bipolar Disorder

A patient is admitted with an acute manic episode of her bipolar disorder.

Patient details:

Age: 23 years old

Sex: Female

Previous history:

Known to MH services since age 16. One previous admission with a manic episode two years ago; frequent presentations to GP suffering from low mood and suicidal ideation.

Concomitant conditions:

Asthma since childhood; IBS.

Current medication:

Seretide 250 inhaler, 2 puffs BD; salbutamol inhaler, 2 puffs when required; Dianette, 1 tablet daily, as directed; sertraline 150mg OM; mebeverine 135mg TDS.

- Describe the sort of symptoms and behaviours she could be displaying or expressing.
- What treatment might be prescribed to reduce the acute symptoms and bring the patient back down to a more euthymic state? Include evidence to support your choice(s).
- If the patient was diabetic or overweight, would that change your choice of medication for treating the acute symptoms?
- If the patient was an older man would that change your choice of medication for treating the acute symptoms?
- The patient has settled and is not showing any signs of mania and therefore needs maintenance treatment. What treatment could be used for long-term management of her illness? Think of the following scenarios:
  1. physically fit patient, first time presentation
  2. physically fit patient, known to service
  3. patient with poor renal function
  4. patient who is overweight

Appendix 3

Reading List, Further Information and Training

By now you should recognise that, wherever you choose to work, you will, inevitably, be involved in providing care for people with a range of mental health conditions. This section provides a list of recommended texts and reference sources that you will find useful in your practice, particularly in dealing with mental health issues, whether or not you choose to specialise in the field of mental health.

In addition, there are details of postgraduate training in the field of mental health and the College of Mental Health The CMHP Foundation Year Trainee Award, which awards two years' free membership of the group and a free attendance at the Annual International Psychiatric Pharmacy Conference of the College of Mental Health Pharmacy for submission of an outstanding project in the field of mental health pharmacy practise.

Reference Source	Comments
The BNF	Chapter 4 – Central Nervous System is of greatest relevance.
Shorter Oxford Textbook of Psychiatry	Key reference source with good detail.
NICE Guidance and Technology Appraisals, via: www.nice.org.uk	Various – see NICE website for available documents.
The Psychotropic Drug Directory	Specialist mental health pharmacotherapy reference book – detailed information.
The Maudsley Prescribing Guidelines	Specialist mental health medicines guidelines
Choice and Medication Website: www.choiceandmedication.org.uk	Website that offers people information about medications used in the mental health setting to help them make informed decisions about medication. This is an excellent resource for patients and professionals which is available via organisational subscription.
Rethink, via: www.rethink.org	Leading national mental health charity and the largest national voluntary sector provider of mental health services. The website provides access to a variety of online information and support resources as well as leaflets, booklets, DVDs and a lot more.
The College of Mental Health Pharmacy, via: www.cmhp.org.uk	The professional body for mental health specialist pharmacists. It provides a support network within the United Kingdom and internationally, is responsible for educational programmes and tools, organises and hosts the Annual International Psychiatric Pharmacy Conference and credentials specialist pharmacists as experts in the field of mental health
The Royal College of Psychiatry, via: www.rcpsych.ac.uk	Professional and educational body for psychiatrists in the United Kingdom. The website has a lot of information on different aspects of mental health; leaflets, podcasts and more.

Appendix 4

CMHP
College of Mental Health Pharmacy

The CMHP Foundation Trainee Pharmacist & Pharmacy Technician Project Awards

Foundation Trainee Pharmacist Award

This award is for projects undertaken in mental health by Foundation Year pharmacy students.

It includes attendance at the College's annual conference, with accommodation and reasonable travel costs, plus a chance for the recipient to present their work as a poster at the conference. In addition to this the award also includes two years' CMHP membership. It will be awarded to a winner and a runner up.

In addition, the winner will receive a monetary prize.

This is a long-standing award, having been first launched in 2002.

Criteria

To be eligible for this award, your project must have been undertaken during your pre-registration training. This may either be as part of an undergraduate sandwich course or as part of postgraduate training. The project could be undertaken in any sector of pharmacy, including community, hospital, academia and industry.

Your project must be wholly or mainly about a subject related to the practice of mental health pharmacy. It is anticipated that most projects undertaken by pre-registration pharmacists will be as part of an audit cycle, a literature search and evaluation as part of service development or a service evaluation. Applications need not be limited to such projects.

The work must have been undertaken wholly by you, the applicant, although the project may have been supervised.

To apply, you must have undertaken their pre-registration training in the year leading up to the call for applications.

You must be willing to present your project as a poster at our Annual International Conference, and we expect to share the winning and runner-up abstracts with the wider membership.

Process of application

Please submit a brief project report describing your work:

- The first page of the report should include the title and author(s) details.
- All subsequent pages must repeat the title as a header.
- All subsequent pages must not mention the author's name.
- For the sake of anonymity in the marking process, the title and text should exclude any identifying names or places.
- An abstract should be included; please use the IMRAD format (Introduction, Methods, Results and Discussion) (maximum 350 words).
- The report should be no more than 1,500 words long excluding tables and references. A word count should be included.
- The report must be typed in at least 12 point, double-spaced with standard margins, and have numbered pages. Tables, figures and references (numerical style) should be on separate pages at the end.
- As the report will act as the only means of assessing the project, it should be self-contained and self-explanatory

Please provide a covering letter that states:

- The full title of your project
- Your full name and correspondence address (that should be valid after 1st September)
- Your telephone, mobile telephone number and e-mail address (all valid after 1st September)
- The name and address of the supervisor(s) for the project (if appropriate) and all other co-applicants.
- The address(es) of the establishment(s) where the project was undertaken (where the data was collected)
- The address(es) of your pre-registration training establishment(s)
- The name and address of the applicant's pre-registration tutor(s)
- A statement confirming that you undertook the work yourself without assistance other than that of a supervisor
- A statement acknowledging that you are willing to present your project as a poster at the CMHP Annual Conference

Further details, including information about previous winners, is available via the College of Mental Health Pharmacy website: www.cmhp.org.uk.

Pharmacy Technician Project Award

This award is for pharmacy technicians and pre registration trainee pharmacy technicians (PTPTs) completing a mental health related pharmacy research or audit project during their pre-registration training course or within the first five years of practice as a registered pharmacy technician (in any sector of pharmacy - hospital, community, GP practice, for example).

The award includes attendance at our annual conference, with accommodation and reasonable travel costs included, and two years CMHP membership. The award will be made to a winner and runner up.

In addition, the winner will receive a monetary prize.

Criteria

The project must have been undertaken either during the applicant's pre-registration training course or within the first five years of practice as a registered pharmacy technician. It can be undertaken in any sector of pharmacy, including community, hospital, primary care, academia and industry.

Eligible projects must be wholly or mainly about a subject related to the practice of mental health pharmacy. The work must have been undertaken entirely by the applicant; although the project may have been supervised. The applicant must have undertaken the project in the past two years.

Applicants must be willing to submit their project as a poster at the CMHP Annual Conference. Winning abstracts may be shared by CMHP with the wider membership.

Process of application

Please pay attention to the requirements when constructing your report and take care to complete all sections.

For your application to be considered, reports must be provided with a covering letter that states all the following in order:

- The full title of your project
- Your details
- full name
- home or work address (that will be valid after 1st September)
- correspondence email address (that will be valid after 1st September)
- telephone/mobile number
- The address(es) of the establishment(s) where the project was undertaken/where the data were collected
- The name, address and email address of the supervisor or tutor for the project and all other co-applicants as appropriate
- A statement confirming that you undertook the work yourself without assistance other than that of a supervisor or tutor
- A statement acknowledging that you are willing to present your project as a poster at the CMHP Annual Conference.
- A signed and dated declaration from your supervisor or tutor that the report is of publication standard and quality.
- We recommend you use the report structure and sub-headings described below and we ask that the overall 2500 word count is not exceeded – this includes the 350 word count for the abstract.

Appendix 5

Further Training

Both of the following courses are accredited by the College of Mental Health Pharmacy. The College provides education bursaries which may be used towards course fees.

Postgraduate Certificate in Mental Health Therapeutics

This online, distance learning course provides essential foundational knowledge for healthcare professionals who are already working in mental health roles, or who are interested in doing so.

Applicants without a degree may be considered based on significant experience in mental health practice.

The programme is delivered over five units. The first covers core principles including assessment, diagnostics, pharmacokinetics, critical appraisal, genetics, and brain imaging. Later units focus on clinical areas such as schizophrenia, affective disorders, anxiety and depression, and dementia.

Students are assessed through written coursework and a final exam.

Postgraduate Diploma in Mental Health Therapeutics

This diploma is open to pharmacy professionals working in specialist mental health roles who have completed the Postgraduate Certificate in Mental Health Therapeutics at Aston University.

The course consists of four modules aligned to the pillars of practice - clinical, leadership, education, and research. Students develop clinical knowledge and skills in the care of individual patients while also considering practice from a wider, service-level perspective.

Assessment includes written coursework and the compilation of a portfolio of evidence demonstrating competence against a range of criteria aligned with specialist practice.

Optional content and assessments allow learners to tailor their study to their individual career trajectory. The portfolio and practice-based assessment form a key element of the course, emphasising practical application of knowledge in real-world clinical settings.

Applications and information

Contact:	**Aston University** **0121 204 3928**
Email:	**Course Director:** Dr Hannah Macfarlane
Programme Administrator:	lhs_psych@aston.ac.uk
or visit:	www.aston.ac.uk/pt

A Midlands Mental Health Clinical Pharmacists Network publication

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