Prescribing and Mental Health Nursing

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by

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Contents

Preface		*vi*
Acknowledgements		*ix*
Overview		*x*
Chapter summary		*xii*
Section 1	*A history in three parts*	1
Chapter 1	Psychopharmacology	3
Chapter 2	The history of mental health nursing	27
Chapter 3	The history of prescribing	57
Summary of Section 1		77
Section 2	*Prescribing for mental illness*	81
Chapter 4	Schizophrenia and psychotic symptoms	89
Chapter 5	Depression	125
Chapter 6	Anxiety and insomnia	147
Chapter 7	Safety	177
Appendix 1	*Standard operating procedure for nurse/pharmacist supplementary and nurse independent prescribing: NHS Greater Glasgow and Clyde*	197
Index		205

Preface

The growth of mental health nursing scholarship emanating from mental health nurses has been one of the most remarkable developments in mental health care research in the past few decades. The current position contrasts strongly with that which existed less than half a century ago when 'mental nursing', as it was then called, was deemed to have no intellectual basis and to be carried out by people who were fit to do no more than blindly obey orders and adhere to rigid routines. The skills of mental nursing were largely transferred from one generation to the next through an oral culture, and little was written down. Those who taught mental nursing had no specialist knowledge, but were either general nurses or psychiatrists who imparted what they wanted nurses to know and do, as opposed to how nurses might respond to the identified needs of people with mental health problems. Their focus was predominantly on mental illness, on symptoms and aetiology, while little or nothing was taught about how to manage it or, indeed, to prevent it from occurring in the first place, or recurring after an initial episode.

It is not a question of blaming these early teachers and nurses, but rather of recognising where we were in order to assess our progress since. In my long years associated with varying aspects of mental health nursing, I have always been impressed by the brightness, sensitivity and compassion of mental health nurses and, if given the opportunity, I believe that they are capable of doing far more than the 'system' and the culture of mental health services often allows them to do. In fact, the quantity and quality of scholarship in recent years coming from mental health nurses is nothing short of astounding. This encompasses research, literature, service development and policy making. While managers at different levels assume responsibility for directing health care services, it falls to nurses to deliver the bulk of mental health services in the UK and elsewhere. Far away from policy making, nurses have to make difficult decisions, take responsibility for the service and endeavour to provide care for people in an effective and tailored way.

Despite the growth of other mental health professional groups, and of the diversification of services in recent years, nurses remain the backbone of mental health service delivery, and were it not for them, patients and clients today would be receiving a much poorer service. Long ago, astute observers of mental health care such as Alexander Walk and Professor Michael Shepherd, eminent psychiatrists, pointed out that it was usually the case that 'progressive' policies were written by senior psychiatrists and civil servants,

but implemented by nurses (Nolan, 1993). It is now becoming clear that the structure and culture of organisations have historically been responsible for repressing the potential that exists within nursing. Mental health services have been bedevilled by rigid professional boundaries and professional territorialism, by unbreakable managerial hierarchies and a defensive culture that resisted any attempts to contest the status quo.

In *Modernising Nursing Careers* (Department of Health, 2006), the Chief Nursing Officer for England pointed out that a prerequisite for the modernisation of the NHS was the modernisation of the nursing profession. It is now obvious that service users are capable of doing more for themselves than was ever imagined in the past, and so are mental health nurses. Restraining the potential of health care providers by role specifications and titles is a sure means of limiting service provision, while supporting them to do more than was once expected of them liberates them and enhances the services they provide.

I am convinced that one of the most imaginative developments in recent years has been the introduction of non-doctor prescribing. This has opened the way for the creation of new and expanded services, to faster access to health care, and to combining assessment with information provision, health promotion and assisting people to make healthy choices about the ways in which they live their lives. For mental health nurse prescribing to have the impact of which it is capable, we require nurses who are strategic thinkers, enthusiastic teachers, knowledgeable about the context in which services are provided, and analytical thinkers, able to determine what makes medication beneficial for service users and their carers. Various books have emerged over the past few years to address these issues, but I believe that Austyn Snowden's makes a significant contribution, particularly in putting prescribing into a much wider context than has previously been explored. In this one book, he manages to address the history of mental health care medication, the evolution of mental health nursing, the types of conditions for which medication is used and the circumstances under which people taking medication can do so safely.

I know that readers will enjoy this book. They will appreciate the breadth of the author's scholarship and will be impressed by the analysis he undertakes in every chapter. He notes that among the many criticisms which have been levelled at nurse prescribing, attacks on the quality of training and education have been persistent. As was the case in the past when nurses with no experience of mental health care delivered training to people destined to work with mentally ill patients, so today, many lecturers who teach on prescribing courses are far removed from practice; some have no experience of mental health care, while others focus solely on theory and skills. Mental health nurses have complained about a lack of 'big picture' literature about

nurse prescribing. The publication of this book should help them. They now have a text that recognises that there is an ongoing and certainly unresolved debate about the appropriate role of medication in mental health care, and which looks at issues surrounding the treatment of schizophrenia and bipolar disorders, depression and anxiety and many of the common mental health problems presenting in various services today. The author draws on a variety of sources, including the research literature and his personal experience.

I commend this book to all concerned with the improvement of mental health services, and particularly to those concerned with medication. Each chapter contains a wealth of information. Taken as a whole, the book provides a rich critical enquiry into prescribing practice. I would urge all course tutors to make it required reading on their courses. It should also be available within practice settings for staff to access; and users and carers who are invited to contribute to service development and evaluation should also be able to see it.

Finally, I salute the new generation of mental health nurse researchers and writers and I am absolutely confident that they will take the delivery of mental health services to new heights.

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Overview

Mental health nursing has not yet found the best way to engage with the expansion in prescribing rights. Despite being legally able to prescribe since 2003 very few mental health nurses have undergone training to do so. Many of those who have trained are not prescribing. Reasons for this are unclear, but one factor is undoubtedly the lack of a coherent lead on the subject. There is disagreement over whether or not prescribing fits with the current concept of mental health nursing. The 2006 national reviews of mental health nursing in both Scotland (Scottish Executive, 2006) and England (Department of Health, 2006) were ambivalent about prescribing in mental health nursing. They instead advocated the more traditional role of the mental health nurse as therapist and partner on an individual journey of recovery. While clearly expressing the zeitgeist this perspective does not leave much room for interventions which do not immediately appear to align with current concepts of recovery.

Yet while mental health nurses worry about whether and how to put prescribing into practice other nurses are just getting on with it. There is evidence that this is because other nurses feel positive regarding the impact of prescribing on practice whereas mental health nurses do not (Snowden, 2007). One of the more practical reasons for this may be that it is more complex to prescribe psychotropics than antibiotics or laxatives, for example. If this is true it may underpin the finding that mental health nurses do not feel the current independent prescribing course prepares them to prescribe psychotropics (Bradley et al, 2008). Should they therefore be administering them? This hints at a deeper disquiet with mental health nurses and medication management, supported by studies indicating inappropriate use (Baker et al, 2007) and inadequate knowledge (Davies et al, 2007) of administering PRN (*pro re nata*: 'as required') psychotropic medication.

So on the one hand prescribing seems to be philosophically incongruent with person-centred recovery models, and on the other hand psychotropic medication is very difficult to understand. It is no wonder then that many mental health nurses do not want to prescribe, and employers are reluctant to support those that do.

In order to explore and address this topic this book combines a historical and a practical approach. The first section unravels the origins of the current prescribing climate by looking in depth at current theories of psychotropic drugs, prescribing legislation and mental health nursing history. Combining

these stories reveals a clear rationale as to why mental health nurses should therefore learn to prescribe. At the very least they should be familiar with the content of this book if they are to administer medication safely. Ninety-one percent of mental health inpatients take two or more drugs (Healthcare Commission, 2007) so disengagement from drug treatment is not an option.

The second section looks at practical prescribing considerations in mental health nursing by breaking prescribing decisions down into key questions. For example, how do you arrive at a diagnosis? When would you not prescribe an antidepressant? What is the worst that can happen if you do? Why? Highest quality evidence is provided throughout to illuminate these discussions.

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Chapter summary

Section 1 sets the scene on how and why mental health nurses are now able to prescribe. This is achieved through integration of the histories of psychiatric medication development, mental health nursing and medication management. These areas are all covered in great depth elsewhere, and the purpose is not to go over the same ground, but rather to integrate these histories in a manner relevant to prescribing in mental health nursing. That is, the role of prescriber is best understood within context. Understanding what can be prescribed and what it is likely to do is simple on one level. Understanding the broader implications of prescribing decisions involves a deeper engagement with a wide range of different agendas. This is particularly relevant to the mental health nurse, who more than any other nurse practises in a complex world of competing philosophies.

Section 1 is split into three chapters as illustrated in *Figure 1*. The first chapter focuses on the biology of mental illness and the development of psychopharmacology, concluding with contemporary thinking about likely future developments. By illustrating the discovery of clinical application of psychotropic therapeutic agents some of the mystery will be removed from these substances. The element of luck and the role of empiricism emerge as major themes in this story.

The second chapter focuses on the history of mental health nursing. It starts by examining historic attitudes to the concept of madness and care of people suffering mental ill-health, before addressing some larger social factors which saw mental health nursing evolve from the 'basket man' to its modern form. The chapter notes that society has always sought to segregate deviation from the cultural norm, and always required people to police it. Mental health nurses have increasingly professionalised this role but remain public servants first and foremost. They have a long history of pragmatism as a result and are therefore comfortable with complex and competing agendas. In short, they have always been therapists and custodians. The latest manifestations of the mental health acts in both Scotland and England perpetuate this duality with the extension of authority to treat and detain sitting alongside the principle of offering care within 'least restrictive options'. I remember while a staff nurse in 1988 asking a person to return to an acute ward voluntarily or I would have to detain him under the mental health act of the time. This is pragmatism in action, which turns out to be a major theme of this story.

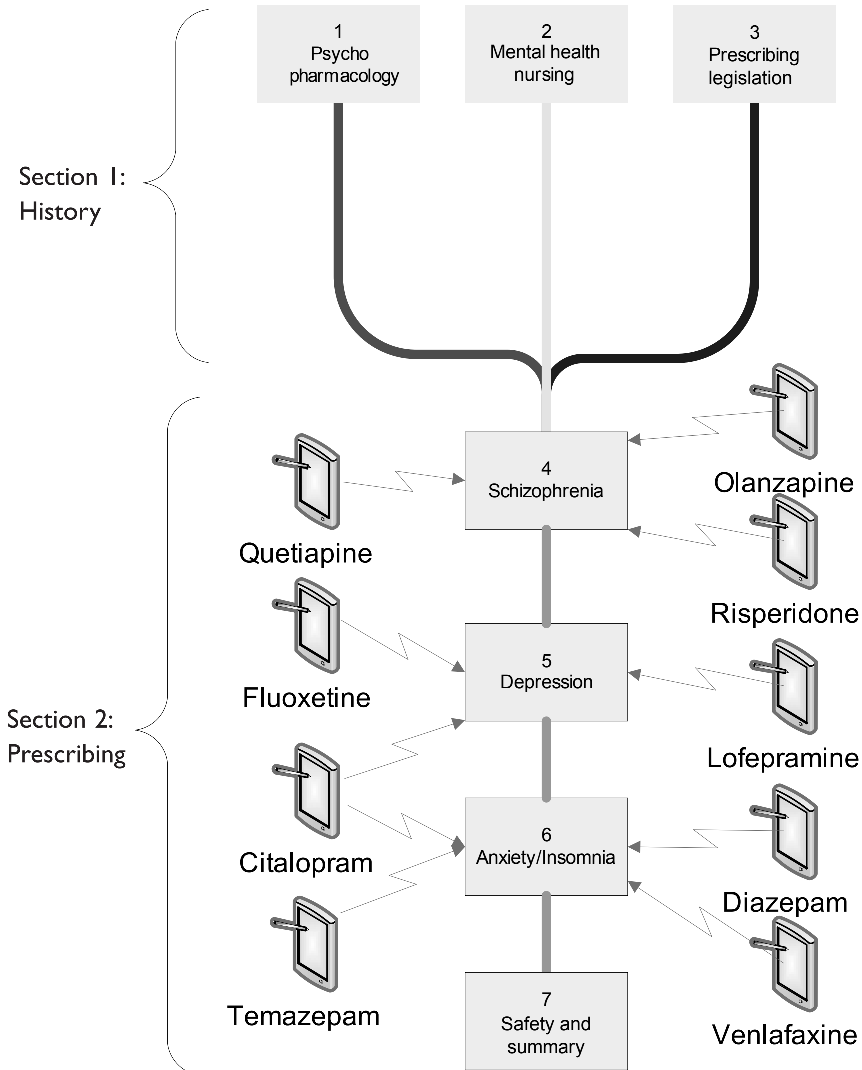

Figure 1. Overview of structure.

The third chapter looks at the history of prescribing and administering medication, beginning with the period when self-prescription of patent medicines was the norm through to medical domination as a consequence of opium regulation. This gives a background to understanding current legal, professional and ethical decisions and why these are now being made by nurses and other health professionals. A striking element of this story is that it is only since 1941 that the medical profession has controlled the prescription of drugs, following the legal creation of prescription only medications. Prior

to this people largely medicated themselves. The themes of power, politics and economics underpin the most significant events in this chapter.

Integrating these chapters reveals various pressures which have helped to create the modern mental health nurse: a 'value for money', semi-professional working as advocate and partner, therapist and jailer, with the skills to aid recovery and the power to detain, who has now been handed a prescription pad to administer treatment many do not believe in. The section concludes that there is nothing particularly new in these dynamic tensions. If prescribing practice and medication management is demonstrably safe, grounded in evidence and supported by the relevant organisation, then it can only enhance patient experience through interaction with more knowledgeable and competent professionals.

Section 2 focuses on practical prescribing decisions in relation to the most common non-organic disorders faced by mental health professionals: depression, psychosis and anxiety. This section focuses on the prescribing of the first-line treatments as recommended by NICE, covering antipsychotics (*Chapter 4*), antidepressants (*Chapter 5*) and anxiolytics and hypnotics (*Chapter 6*). It describes the most frequent effects and side effects of each medication, and examines the clinical evidence for their claimed efficacy. It also describes the 'worst case' scenarios of each of these drugs.

By focusing on this narrow array of drugs and conditions in some detail it is hoped that this section will help practitioners become more confident with the issues surrounding these particular prescribing decisions. More difficult decisions can therefore be based on a solid grounding. That is, the book does not address complex issues such as polypharmacy or prescribing in situations where capacity to consent is questionable. Instead it discusses in detail general consultation skills and specific diagnostics within each area. These are transferable skills requisite to safe prescribing in more complex areas.

The last chapter reviews some of the latest debate and emerging research on mental health nurse prescribing in light of the discussions contained in the preceding chapters. It concludes that nurse prescribing will not be a career choice for every mental health nurse, and that there are many good reasons for this, from the practical to the philosophical. However, it also concludes that some patients will clearly benefit from the initiative as some already have, and outright rejection of the initiative is akin to putting a finger in the dyke. Non-medical prescribing is cheap, safe and effective and so politically, clinically and economically it is unstoppable.

As the book is initially taking a broad historical approach the terms insanity, madness, mental illness, lunacy and mental health problems all broadly refer to the same concept. This is to contextualise each discussion and use the terminology of the time. It is not meant to cause offence.

Dedication

For Mags and Molly with love

Section 1

A history in three parts

CHAPTER 1

Psychopharmacology

This chapter discusses the emergence of psychopharmacology as a significant factor in the treatment of mental illness. Its role in enhancing the credibility of psychiatry and by association mental health nursing is discussed in *Chapter 3*. The focus here is specifically on the development of psychotropic substances and the associated quest of how to explain their observable actions. This has not been a smooth process and biological models of mental illness are still rejected completely by some thinkers. So before current biological models are discussed in any detail it is important to discuss why this is so.

Biological models of mental illness

Prescribing medication involves impacting on biology. That is, there is a biological change in the recipient which results in a change of state. It does not necessarily follow that there is a biological foundation of mental illness. It has been argued that mental illness is instead a construct of Western medicine designed to pathologise any behaviour considered abnormal. The concept of mental illness is just a metaphor for moral conflict (Szasz, 1961), a strategy for coping in a mad world (Porter, 2002) or a justification of medical power (Foucault, 1965). Administering medication is therefore ethically questionable. To support these perspectives critics point out that the American *Diagnostic and Statistical Manual* (the DSM) is developed by consensus as opposed to biology. That is, illnesses are not objectively measurable entities like stroke or cellulitis but creations of psychiatry. One result of this is that specific diagnoses can have entirely different causes. Each cause requires different treatment and thus the DSM does not indicate what treatment is necessary.

These arguments generally precede criticism of the expanding volume of psychiatric disorders. The DSM has grown from 134 pages in DSM-II to 934 pages in the latest revision, DSM-IV-TR. DSM-V is scheduled for 2011 (Moon, 2004), and consultation is well under way. The consensus required for inclusion of a particular disorder ultimately rests with a few individuals, who have attempted to include some contentious categories of mental illness in the past. For example the provisional category of masochistic personality disorder was omitted altogether in 1985 because of protests by

feminist academics, although the watered down compromise category of self-defeating personality disorder made it into the appendix of DSM- III (Kutchins and Kirk, 1997). Some clinicians continue to use its criteria. Self-defeating personality disorder sought to define a pervasive pattern of self-defeating behaviour which resulted in the sufferer becoming attracted to doomed relationships and avoiding positive situations. The reason the category caused such furore was that opponents believed the category not only scientifically invalid, but sexist and dangerous. They feared it would be used as a justification for abusive behaviour (of men) by pathologising the victim. The feminists countered by introducing for consideration the category of delusional dominating personality disorder, a category which sought to pathologise the controlling and grandiose behaviour of its (male) sufferers. They believed this category demonstrated the invalidity of self-defeating personality disorder by holding a mirror up to its creators.

The most regularly cited example used to expose the politics of this classification system is homosexuality. Homosexuality was defined as a mental disease by the American Psychiatric Association until 1975, when it was removed by postal vote. Homosexuals effectively became powerful enough to lobby the ‘disease’ out of the manual. If mental illness were really an illness in the biological sense then the idea of deleting homosexuality or anything else from the categories of illness by having a vote would be absurd (Stevens, 1999). The inference is therefore that the current contents of the DSM may be seen as equally unsound at some future point, when society as a whole views the world differently. So why not view it as unsound now? The logical conclusion of this argument is that mental illness is not an illness. It is merely a question of values, of right and wrong, of appropriate versus inappropriate, and who holds the casting vote on these issues. This argument is generally taken to be a clear demonstration of the frailty of psychiatry’s scientific aspirations. Statements such as the following subsequently follow in order to decry biological conceptions of mental health problems:

> *Contrary to what is often claimed, no biochemical, anatomical, or functional signs have been found that reliably distinguish the brains of mental patients.*
>
> Valenstein (1998: 125)

> *There is no evidence that any psychiatric or psychological disorder is caused by a biochemical imbalance.*
>
> Breggin (2000: 139)

These statements appear to lend support to the modern face of ‘antipsychiatry’. They are written by people in pursuit of genuine clinical