Issues acute trust pharmacists should consider when dealing with patients with a mental health diagnosis

Issue colour codes: Attitudinal Knowledge Communication

	Issues action needed in	Why it's important
1.	**Challenging stigma** - myth-busting surrounding mental illness Confidence, competence and colla	One in three adults aged 16-74 (37 per cent) with conditions such as anxiety or depression, surveyed in England, were accessing mental health treatment, in 2014. Overall, around one in six adults (17 per cent) surveyed in England met the criteria for a common mental disorder (CMD) in 2014. Statistics taken from Adult Psychiatric Morbidity Survey: Survey of Mental Health and Wellbeing, England, 2014. Published September 2016. 69% of service users have personal experience of stigma because of their mental health illness - Time to Change (https://www.time-to-change.org.uk) (2017)
2.	**Identifying patients on mental health drugs** even if they do not appear on a patient's summary care record (SCR) in particular long acting antipsychotic injections (LAAIs), clozapine or lithium.	If there is a diagnosis of schizophrenia, bipolar disorder etc. and the patient doesn't appear to be on any medication to treat it then this should raise concerns. Sometimes if the medication is prescribed by a specialist, it does not appear on the SCR. People with a diagnosis of schizophrenia or bipolar disorder are often on long term medicines. If these are due when the patient is in hospital and are missed, this may negatively impact on the person's mental health and de-stabilise them. The sudden discontinuation of lithium and clozapine is particularly problematic. Lithium is associated with some of the most costly medicines related medico-legal settlements if not monitored properly and may be the cause of hospitalization. Serotonin syndrome and neuroleptic malignant syndrome may not be immediately identified and are associated with some antidepressants and antipsychotics.
3.	**Delirium** - understanding the difference between delirium and mental health conditions, and its management.	Delirium is characterised by disturbed consciousness, cognitive function or perception, which has an acute onset and fluctuating course, and can occur in intoxication, fever, infection and other disorders. People without diagnoses of mental health conditions can experience delirium, and the management can be different.

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4.	**Dementia** Why it is important to try behavioural approaches before medication for challenging behaviour in people with behavioural and psychological symptoms of dementia (BPSD). An example of basic information on non-pharmacological approaches is available at the link below: www.sussexpartnership.nhs.uk/node/1599/attachment The legal consequences of using covert administration need to be understood.	Individuals living with dementia often come into acute hospitals with physical health complaints. Acute trust pharmacists especially those working on care of the elderly or ortho-geriatrics should have a good general background knowledge of current guidance for BPSD management. It is also important to have an understanding of the effects some physical health medicines can have on cognition e.g. anticholinergic medicines. http://www.medichec.com Patients not under the Mental Health Act (MHA) who are not able to give informed consent will usually need a Deprivation of Liberties Safeguarding (DoLS) Authorization if medicines are used to change the patient's behaviour. Staff need to be aware of their organization covert administration policy.
5.	**Prescribing in emotional intensity** (previously called emotionally unstable personality disorder)	People with emotional intensity are particularly at risk of suicide. No medications are licensed for the indication of emotional Intensity in the UK. Drug treatment may be considered in the overall treatment of comorbid conditions of emotional intensity in the short term, but drug treatment should not be used specifically for borderline personality disorder. Prescriptions of sedative medication e.g. benzodiazepines, should be prescribed with a greater caution and only for the short term (i.e. maximum of one week) and the duration of treatment should be agreed with the patient beforehand.
6.	**Risk of overdose** – find what it is it. If history of overdose, consider limited supply	For patients who are admitted with an overdose, limiting the quantity may be helpful to ensure that the risk of future overdoses is limited or that the risk of death associated with future overdoses is decreased. It is crucial that the person's mental health team and GP are made aware if the admission followed a suicide attempt as the risk will remain in the period following discharge.

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7.	**Clozapine issues** Understanding why clozapine should not be stopped unless absolutely essential as it puts the person's mental health at risk, restarting without re-titration can lead severe hypotension and re-titration will involve a return to weekly blood tests. Smoking greatly decreases clozapine plasma levels and this will need to be taken into account if the patient has to stop smoking on admission. Clozapine has some important cardiac side effects and drug interactions Death due to bowel obstruction is a risk on clozapine.	Acute trust staff need to have an understanding of: • Why it is vital that Clozapine doses are not unintentionally missed through lack of supply in terms of treatment breaks and the amount of work involved in re-titration. • The significant interaction between clozapine and cigarette smoke and how to manage it safely. • Interactions between clozapine and physical health meds • The cardiac effects of clozapine and where they can access more information on this if needed. • The importance of managing constipation when on clozapine due to the risks with regards to intestinal obstruction. • Risk of infection (e.g. pneumonia, possibly due to hypersalivation) and the effects of infection on clozapine plasma levels (increased).
8.	What **long-acting antipsychotic injections** (LAAIs) are and how they work (e.g. onset of action/time to steady state/delay of LAAIs) contact local mental health teams or liaison psychiatry for advice	Some LAAIs (depots) take some time to work. This is not the case for paliperidone, aripiprazole or olanzapine LAIs if initiated as per their SPC after two weeks' oral dosing. Some LAAIs can take a number of months to reach steady state. Each LAAI has different pharmacokinetics, but all persist for a number of weeks or even months after being stopped. If an LAAI is missed, it is possible for it to be given at the same dose within a few days or up to two weeks for the three-monthly paliperidone injection without a problem, depending on the formulation. There are potential risks that shorter-acting antipsychotic preparations could be confused with long-acting preparations if not prescribed clearly, i.e. olanzapine, haloperidol and zuclopenthixol.

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9.	**Perinatal mental health**	Women who are pregnant are especially at risk of the sudden emergence of mental health symptoms, even when there has been no previous history.
10.	**High dose antipsychotic treatment (HDAT) and rapid tranquilisation (RT)** - including high risk patients on some oral PRN drugs, needing additional monitoring. HDAT is defined as monotherapy that exceeds the BNF limit or combination antipsychotic therapy that exceeds the BNF limit when the individual doses are added together. RT is when parenteral medicines are given to a person who is very agitated or displaying aggressive behaviour to help quickly calm them. This is to reduce any risk to themselves or others, and allow them to receive the medical care that they need. RT is usually only administered when other de-escalation techniques have failed. What HDAT and RT are and the legal implications, drugs and doses needed - when it's appropriate, and the documentation required Ensure that when writing up RT, the RT guidance written by a local Mental Health Trust is consulted.	HDAT can increase side effects and can increase the risk of cardiovascular events, sudden cardiac death and neuroleptic malignant syndrome. Additional monitoring such as an blood pressure (BP), pulse, liver function tests and an ECG are required. HDAT can occur if RT is used on top of any regular antipsychotics. If this occurs patients are classed as "at risk" and observation involving BP, pulse, temperature, respiration rate, $SP0_2$, and consciousness level. For RT to be given legally, the client must be at risk to themselves or others, and they must be either under section of the MHA, under DoLS, or have no capacity to consent so a best interest decision has been made, which must be documented clearly and assessed regularly. .
11.	**Raising awareness of the local pharmacy mental health teams** and how to contact them if a patient under a CMHT is admitted or for any complex queries	If any patients looked after by mental health services are admitted, you can find out information about them, get advice and guidance from experts.

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12.	**Communicating with community mental health teams** (CMHTs) on discharge.	The mental health team, especially the patient's care coordinator/lead practitioner are not often aware that their client has been into hospital. It is important that they are made aware of any changes to medicines, diagnosis or risks so that they can support their client going forward. If medication changes occur during the hospital stay, and the CMHT are not aware, unexpected drug interactions can occur if the patient's psychiatric medicines are changed. CMHTs clients sometimes use blister packs, so if medication changes have occurred, this is another reason why they would need to be informed.
13.	**Patient choice and involvement** in the use of psychotropic medicines.	Patients with mental health conditions, similarly to patients with some other chronic conditions have low adherence rates. When a new medication is being considered, the patient needs to be consulted and counselled, to ensure that they understand what is going on and if possible their beliefs about medication explored. If starting a mental health medication, the patient's local mental health team can signpost you to what resources are available (e.g. Choice and Medication website) and what resources can be shared with the patient.