

Acute psychotic disorders — F23

Includes acute schizophrenia-like psychosis, acute delusional psychosis, and other acute and transient psychotic disorders

Presenting complaints

Patients may experience:

- hallucinations, eg hearing voices when no one is around
- strange beliefs or fears
- apprehension, confusion
- perceptual disturbances
- aggression, frequent adjudications
- self-harm
- food refusal (they may suspect that food is being poisoned).

Staff or relatives may ask for help with behaviour changes that cannot be explained, including strange or frightening behaviour, eg withdrawal, suspiciousness and threats.

A 'first-onset psychosis' may present at first as persistent changes in functioning, behaviour or personality (eg withdrawal), but without florid psychotic symptoms.^{N1} The first episode of psychosis most commonly occurs in the late teens and early 20s (see **First-onset psychosis**, page 131).

Diagnostic features

Recent onset of:

- hallucinations: false or imagined perceptions, eg hearing voices when no one is around
- delusions: firmly held ideas that are false and not shared by others in the patient's social, cultural or ethnic group, eg patients believe they are being poisoned by neighbours, receiving messages from the television or being looked at by others in some special way
- disorganised or strange speech
- agitation or bizarre behaviour
- extreme and labile emotional states.

Differential diagnosis

- Physical disorders that can cause psychotic symptoms include:
 - drug-induced psychosis and
 - alcoholic hallucinosis

It is not possible to tell from the symptoms alone whether psychiatric symptoms are substance-induced, whether the patient has a psychotic disorder, or both a substance misuse and a psychotic disorder. Check their psychiatric history, keep an open mind (eg in a teenager or young adult, a 'substance-induced psychosis' might be the early stages of schizophrenia) and chart symptoms over time (see **Comorbidity**, page 191). Also:

- infectious or febrile illness and
- epilepsy.
- See **Delirium—F05** for other potential causes (page 41).
- **Chronic psychotic disorders — F20#**: if psychotic symptoms are recurrent or chronic.
- **Bipolar disorder — F31**: if the symptoms of mania, eg elevated mood, racing speech or thoughts, exaggerated self-worth, are prominent.
- **Depression** (depressive psychosis) — **F32#**, if depressive delusions are prominent.

Essential information for the patient and primary support group

- Agitation and strange behaviour can be symptoms of a mental illness.

- Acute episodes often have a good prognosis,^{N2} but the long-term course of the illness is difficult to predict from an acute episode.
- Advise the patient and members of the primary support group about the importance of medication, how it works and the possible side-effects.
- Continued treatment may be needed for several months after symptoms resolve.

If the patient requires treatment under the Mental Health Act 1983, advise the family, if possible, about the related legal issues (see Use of the Mental Health Act, page 163).

Advice and support of the patient and primary support group

- Assess the risks and consider whether a move to the healthcare centre (or establishment with a healthcare centre) is indicated. If there is a significant risk of suicide, violence or neglect, close observation in a secure place or transfer to an NHS hospital may be required. Consider the use of the Mental Health Act for transfer especially, but not solely, if the patient refuses treatment.
 - Order a urine drug screen for medical (not disciplinary) purposes (see **Comorbidity**, page 191).
- If it is decided that it is safe for the patient to live on an ordinary location, seek patient permission to involve the residential manager and other relevant staff (eg workshop manager, teacher, chaplain) in implementing a management plan, including the location, activities, the early response to signs of relapse and the monitoring of medication. Discuss the following:
 - Ensure the safety of the patient and those caring for him/her:
 - Staff, listeners/buddies, family or friends should be available for the patient if possible.
 - Ensure that the patient's basic needs (eg food, drink, accommodation) are met.
 - Minimise stress and stimulation, eg reducing noise, shouting, bullying, teasing.
 - Do not argue with psychotic thinking (you may disagree with the patient's beliefs, but do not try to argue that they are wrong).
 - Avoid confrontation or criticism, unless it is necessary to prevent harmful or disruptive behaviour.^{N3} Respond gently and with reassurance to slow responses to orders (eg slowness in going into cell). Use of control and restraint should be a last resort.
 - Encourage resumption of normal activities after symptoms improve.
 - The information sheet on managing difficult behaviour (psychosis) on the disk may be helpful to staff .
- Especially if the patient becomes depressed, consider options for support, education and reassurance about their psychotic illness, including possible relapse and their future life chances. Mental-health staff may be able to provide individual counselling, goal planning and monitoring of early warning signs of relapse.

Referral and throughcare

Referral to the secondary mental-health services should be made under the following conditions:

- as an emergency, if the risk of suicide, violence or neglect is considered significant
- urgently for **all** first episodes to confirm the diagnosis and to arrange care planning and the appointment of a key-worker. Specific interventions for people experiencing their first episode of psychosis, including specific psycho-education of the patient and primary support group, should be developed⁵
- for **all** relapses, to review the effectiveness of the care plan, unless there is an established previous response to treatment and it is safe to manage the patient in the establishment
- if there is non-compliance with treatment, problematic side-effects, failure of community treatment or concerns about comorbid drug and alcohol misuse.

Particularly on relapse, referral may be to the community mental-health team or to a member of it, such as a community psychiatric nurse (CPN), as well as to a psychiatrist (for more details, see **Managing the interface with the NHS and other agencies**, page 149).

If there is fever, altered consciousness, rigidity and/or labile blood pressure, stop the antipsychotic medication and refer immediately to the on-call physician for investigation of neuroleptic malignant syndrome.

If release is planned, work cooperatively with probation or the throughcare planning officers to ensure that appointments with a general practitioner and specialist in mental healthcare are arranged and that housing, money for food, clothes and heating are arranged.

If release is not planned, inform the local mental-health services that the patient may present to A&E in the area and advise them to look out for him/her (for more information on referral and throughcare, see **Managing the interface with the NHS and other agencies**, page 149).

Medication

- Antipsychotic medication can reduce psychotic symptoms over 10–14 days. Where access to a specialist is speedy and symptoms relatively mild, especially for a first referral, the specialist may prefer to see the patient unmedicated.
- Examples of drugs you may wish to use before the patient sees a specialist include an atypical antipsychotic^{N6} (eg olanzapine, 5–10 mg day⁻¹, or risperidone, 4–6 mg day⁻¹) or a typical drug (eg haloperidol, 1.5–4 mg up to three times per day) (see *BNF*, Section 4.2.1). Patients experiencing a first episode of psychosis require lower doses of medication and may benefit from an atypical drug.^{N7} In a case of relapse where the patient has previously responded to a drug, restart that drug. The dose should be the lowest possible for the relief of symptoms.⁸
- Anti-anxiety medication may also be used for the short term in conjunction with neuroleptics to control acute agitation and disturbance (see *BNF*, Section 4.1.2). (Examples include diazepam, 5–10 mg up to four times per day, or lorazepam, 1–2 mg up to four times per day.) If required, diazepam can be given rectally or lorazepam IM (though this must be kept refrigerated).
- Monitor compliance (eg call up for a review if more than two doses are missed) and check that the patient is not being pressured or bullied into giving the medication to someone else.
- Continue antipsychotic medication for at least 6 months after symptoms resolve.⁹ Close supervision is usually needed to encourage patient agreement.
- Be alert to the risk of comorbid use of street drugs (eg opiates, cannabis, benzodiazepines).
- Monitor for side-effects of the medication:
 - Acute dystonias or spasms may be managed with oral or injectable anti-Parkinsonian drugs (see *BNF*, Section 4.9.2) (eg procyclidine, 5 mg three times per day, or orphenadrine, 50 mg three times per day).
 - Parkinsonian symptoms (eg tremor, akinesia) may be managed with oral anti-Parkinsonian drugs (see *BNF*, Section 4.9.2) (eg procyclidine, 5 mg three times per day, or orphenadrine, 50 mg three times per day).
 - Withdrawal of anti-Parkinsonian drugs should be attempted after 2–3 months without symptoms as these drugs are liable to misuse and may impair memory.
 - Akathisia (severe motor restlessness) may be managed with dosage reduction or β -blockers (eg propranolol, 30–80 mg day⁻¹) (see *BNF*, Section 2.4). Switching to an atypical antipsychotic (eg olanzapine or quetiapine) may help.
 - Other side-effects, eg weight gain and sexual dysfunction.

For more detail on antipsychotic drugs and their differing side-effect profiles, see *Maudsley Prescribing Guidelines*¹⁰. The 2001 edition (ISBN 1-853-17963-9) is available from: ITPS. Tel: 01264 332424.

Resources for patients and primary support groups

Manic Depression Fellowship: 020 7793 2600

(Support and information for people with manic depression and their families and friends)

MIND Infoline: 08457 660163 (outside Greater London): 020 8522 1728 (Greater London)

(National telephone information service on mental health issues)

National Schizophrenia Fellowship: 020 8974 6814 (advice line: Monday–Friday, 10:30 am–3 pm)

(Advice and information for people suffering from schizophrenia, and their families and carers)

SANEline: 08457 678000 (7 nights a week, 12 pm–2 am)

(National helpline for mental-health information and support to anyone coping with mental illness)

Resource leaflets:

Coping with the Side-effects of Medication

Working with a prisoner who has a severe mental illness

Adjustment disorder — F43.2

Including acute stress reaction

Presenting complaints

- Patients feel overwhelmed or unable to cope.
- There may be stress-related physical symptoms such as insomnia, headache, abdominal pain, chest pain and palpitations.
- Patients may report symptoms of acute anxiety or depression.
- Patients may seek drugs to help them deal with their feelings.
- Alcohol use may increase.

Diagnostic features

- Acute reaction to a recent stressful or traumatic event.
- Extreme distress resulting from a recent event, or preoccupation with the event.
- Symptoms may be primarily somatic.
- Other symptoms may include:
 - low or sad mood
 - anxiety
 - worry
 - feeling unable to cope.

An acute reaction usually lasts from a few days to several weeks.

Differential diagnosis

Acute symptoms may persist or evolve over time. If significant symptoms persist for more than 1 month, consider an alternative diagnosis.

- If significant symptoms of depression persist, see **Depression — F32#** (page 47).
- If significant symptoms of anxiety persist, see **Generalised anxiety — F41.1** (page 64).
- If significant symptoms of both depression and anxiety persist, see **Chronic mixed anxiety and depression — F41.2** (page 33).
- If stress-related somatic symptoms persist, see **Unexplained somatic complaints — F45** (page 94).
- If symptoms are due to a loss, see **Bereavement — Z63** (page 23).
- If anxiety is long-lasting and focused on memories of a previous traumatic event, see **Post-traumatic stress disorder — F43.1** (page 82).
- If dissociative symptoms (sudden onset of unusual or dramatic somatic symptoms) are present, see **Dissociative (conversion) disorder — F44** (page 15).

Essential information for the patient and primary support group

- Stressful events often have mental and physical effects. The acute state is a natural reaction to events.
 - Adjustment to imprisonment is commonly stressful (especially if the patient is in prison for the first time, has a high public profile or is a sexual offender) with understandable concerns about their family and the case.
- Stress-related symptoms usually last only a few days or weeks.
- All people are affected by their environment. Symptoms are likely to be fewer and less persistent if the environment can be improved (eg a reduction in the fear of bullying/assault, more time out of the cell, contact with family, access to work and opportunities to be creative).

Advice and support of the patient and primary support group^{N11}

- Review and reinforce the positive steps the patient has taken to deal with the stress.

- Identify the steps the patient can take to modify the situation that produced the stress. There is a problem-solving sheet on the disk . If the situation is within the prison (eg bullying), support the patient in dealing with it (eg discuss the problem with residential manager, with patient permission).
- If the situation cannot be changed, discuss coping strategies. Explore whether the patient is using destructive strategies (eg drugs, aggression, self-injury). Encourage exercise, art, reading, work and contact with others. Consider acting as the patient's advocate to increase access to, for example, suitable work placements that involve contact with supportive people, art materials and exercise.
- If the stressor is recent imprisonment itself, ensure the patient has copy of the *Prisoners' Information Book*. See the disk for a copy of the *Just Imprisoned?* leaflet and the **Resource directory** (page 316) for agencies that offer support . If the patient cannot read, advise him/her to approach the personal officer or listener/buddy with questions.
- Identify relatives, friends, staff and helplines able to offer support, eg listener/buddy, Samaritans, chaplain and personal officer.
- Short-term rest and relief from stress may help the patient. Encourage a return to usual activities within a few weeks.
- Encourage the patient to acknowledge the personal significance of the stressful event.
- Offering a further consultation with a member of the primary-care team to see how the situation develops can be valuable in helping the patient through the episode.

Medication

Most acute stress reactions will resolve without the use of medication. Skilled general practitioner advice and reassurance is as effective as benzodiazepines.^{N12} However, if severe anxiety symptoms occur, consider using anti-anxiety drugs for up to 3 days. If the patient has severe insomnia, use hypnotic drugs for up to 3 days. Doses should be as low as possible (see *BNF*, Sections 4.1.1 and 4.1.2).

Referral

See **Referral criteria for non-urgent referral** (page 152). It is usually self-limiting. Routine referral to the secondary mental-health services is advised if:

- symptoms persist and general referral criteria are met and
- you are unsure of the diagnosis.

Consider recommending a counsellor, if available, or voluntary/non-statutory counselling¹³ services, if available, in all other cases where symptoms persist.

Resources for patients and primary support groups

Childline: 0800 1111 (24-hour freephone helpline)

(For children and young people in trouble or danger)

Citizens Advice Bureau (see the local telephone directory)

(Free advice and information on Social Security benefits, housing, family and personal matters, money advice, and other issues)

Relate: 01788 573241

(Counselling and psychosexual therapy for adults with relationship difficulties. For agencies that provide opportunities for creative activity in prisons, see the **Resource directory**, page 316)

Samaritans Helpline: 08457 909090 (24 hours, 7 days per week)

(Support by listening for those feeling lonely, despairing or suicidal)

Victim Support: 0845 3030900 (supportline: Monday–Friday, 9 am–9 pm; Saturday and Sunday, 9 am–7 pm; Bank Holidays, 9 am–5 pm)

(Emotional and practical support for victims of crime)

UK Register of Counsellors: 08704 435232

(Provides the names and addresses of BACP-accredited counsellors)

Resource leaflets:

Reactions to Traumatic Stress: What To Expect

Getting a Good Night's Sleep

Alcohol misuse — F10

Presenting complaints

Patients may present with:

- a depressed mood
- nervousness
- insomnia
- physical complications of alcohol use (eg ulcer, gastritis, liver disease, hypertension)
- accidents or injuries due to alcohol use
- aggression, frequent adjudications
- poor memory or concentration
- evidence of self-neglect (eg poor hygiene)
- failed treatment for depression.

There may also be:

- legal and social problems due to alcohol use, eg drink-drive charges, driving when previously disqualified because of alcohol use, assault, marital problems, domestic violence, child abuse or neglect, and
- signs of alcohol withdrawal, eg sweating, tremors, retching, hallucinations, seizures.

Patients may sometimes deny or be unaware of alcohol problems. Imprisonment may bring their first experience of withdrawal. Staff may request help before the patient does. Problems may also be identified during routine reception screening or 2–3 days following reception.

Diagnostic features

- Harmful alcohol use:
 - heavy alcohol use (eg > 28 units per week for men, > 21 units per week for women)
 - overuse of alcohol has caused physical harm (eg liver disease, gastrointestinal bleeding), psychological harm (eg depression or anxiety due to alcohol) or has led to **harmful legal consequences** (eg imprisonment).
- Alcohol dependence: present when three or more of the following are present:
 - A strong desire or compulsion to use alcohol.
 - Difficulty controlling alcohol use.
 - Withdrawal symptoms (eg agitation, tremors, sweating, nausea, headache) even when drinking is ceased.
 - Tolerance, eg drinks large amounts of alcohol without appearing intoxicated.
 - Continued alcohol use despite harmful consequences.

Blood tests such as γ -glutamyl transferase (GGT) and mean corpuscular volume (MCV) can help identify heavy drinkers. Administering the AUDIT questionnaire may also help diagnosis. If AUDIT > 8, use of the Severity of Alcohol Dependence Questionnaire (SADQ) can help identify the severity of dependence. Copies of the AUDIT and SADQ are on the disk .

Differential diagnosis

Symptoms of anxiety or depression may occur with heavy alcohol use. Alcohol use can also mask other disorders, eg social phobia and generalised anxiety disorder. Assess and manage symptoms of depression or anxiety if the symptoms continue after a period of abstinence (see **Depression — F32#** or **Anxiety — F41.1**, pages 47 and 33).

Drug misuse may also coexist with these conditions.

Essential information for the patient and primary support group

- Alcohol dependence is an illness with serious consequences.
- Ceasing or reducing alcohol use will bring mental and physical benefits.
- Drinking during pregnancy may harm the baby.
- For most patients with alcohol dependence, the physical complications of alcohol abuse or a psychiatric disorder, abstinence from alcohol is the preferred goal.¹⁴ Sometimes, abstinence is also necessary for social crises, to regain control over drinking or because of failed attempts at reducing drinking. Because abrupt abstinence occurs upon reception into

prison and causes withdrawal symptoms in people dependent upon alcohol, detoxification under medical supervision in a Detoxification Unit is necessary.

- In some cases of harmful alcohol use without dependence or where the patient is unwilling to quit, controlled or reduced drinking is a reasonable goal but may only be pursued after release.
- Relapses are common. Controlling or ceasing drinking often requires several attempts. The outcome depends on many factors, including the motivation and confidence of the patient, the offending behaviour, polydrug use, their mood or other mental disorder.

Advice and support to the patient and primary support group¹⁵

For all patients:

- Discuss the benefits and costs of drinking (including the links between drinking and offending) from the patient's perspective.
- Give feedback information about the health risks, including the results of GGT and MCV.
- Emphasise the personal responsibility for change.
- Give clear advice to change.
- Assess and manage any physical health problems and nutritional deficiencies (eg vitamin B, thiamine).
- Consider the options for problem-solving or targeted counselling to deal with life problems related to alcohol use.
- If there is no evidence of physical harm due to drinking or if the patient is unwilling to quit, a controlled drinking programme is a reasonable goal if the patient is about to be released:
 - Negotiate a clear goal for decreased use (eg no more than a certain number of drinks per day, with a certain number of alcohol-free days per week).
 - Discuss strategies to avoid or cope with high-risk situations (eg release, social situations and stressful events).
 - Introduce self-monitoring procedures (eg a drinking diary) and a safer drinking behaviour (eg time restrictions, deceleration of drinking).

For patients with physical illness and/or dependency or failed attempts at controlled drinking, an abstinence programme is indicated.

For patients willing to stop now:

- Discuss the symptoms, risks of detoxification and management of alcohol withdrawal (especially if they have no previous experience of detoxification).
- Discuss the strategies to avoid or cope with high-risk situations (eg release, social situations and stressful events).
- Make specific plans to avoid drinking (eg ways to face stressful events without alcohol, ways to respond to friends who still drink).
- Help patients to identify family members or friends who will support ceasing alcohol use.
- Consider options for support after withdrawal.

For patients not willing to stop or reduce now and who are about to be released, a harm-reduction programme is indicated:

- Do not reject or blame.
- Clearly point out the medical, legal and social problems caused by alcohol.
- Consider thiamine preparations.
- Make a future appointment with the general practitioner/primary care to reassess their health and alcohol use.

For patients who do not succeed or who relapse or transfer to using a different drug while in prison:

- Identify and give credit for any success.
- Discuss the situations that led to relapse.
- Return to earlier steps above.

Self-help organisations (eg Alcoholics Anonymous), voluntary and non-statutory agencies are often helpful.¹⁶

Medication

- In prison, it is often difficult to confirm a patient's history of previous substance use. Therefore, detoxification should always be undertaken in a supervised in-patient setting (see **Prison Service Order 3550: Clinical Services for Substance Misusers**).

- For patients with mild withdrawal symptoms, frequent monitoring, support, reassurance, adequate hydration and nutrition are sufficient treatment without medication.¹⁷
- Patients with a moderate withdrawal syndrome require benzodiazepines in addition to frequent monitoring, support, reassurance, adequate hydration and nutrition. Detoxification should only be undertaken by practitioners with appropriate training and supervision.
- Patients at risk of a complicated withdrawal syndrome (eg with a history of fits or delirium tremens, a history of very heavy use and high tolerance, significant polydrug use, severe comorbid medical or psychiatric disorder) or are a significant suicide risk may require a transfer to an NHS hospital.
- Chlordiazepoxide (Librium), 10 mg, is recommended. The initial dose should be titrated against withdrawal symptoms, within a range of 5–40 mg four times per day. (See *BNF* section 4.10.) This requires close, skilled supervision.
- The following regimen is commonly used, although the dose level and length of treatment will depend on the severity of alcohol dependence and individual patient factors (eg weight, sex, liver function):
 - Days 1 and 2: 20–30 mg QDS
 - Days 3 and 4: 15 mg QDS
 - Day 5: 10 mg QDS
 - Day 6: 10 mg BD
 - Day 7: 10 mg nocte
- Chlormethiazole is not recommended for craving or detoxification under any circumstances.¹⁸
- Dispensing should be dose by dose and supervised to prevent the risk of misuse or overdose.
- Thiamine (150 mg day⁻¹ in divided doses) should be given orally for 1 month.¹⁹ As oral thiamine is poorly absorbed, transfer the patient immediately to A&E for parenteral supplementation if any **one** of the following is present: ataxia, confusion, memory disturbance, delirium tremens, hypothermia and hypotension, ophthalmoplegia, or unconsciousness. These may indicate the onset of Wernicke's encephalopathy.
- Daily observation is essential in the first few days, then it is advisable thereafter to adjust the dose of the medication, to check for serious withdrawal symptoms and to maintain support.
- Anxiety and depression often co-occur with alcohol misuse. The patient may have been using alcohol to self-medicate. If symptoms of anxiety or depression increase or remain after an abstinence of more than 1 month, see **Depression — F32#** or **Generalised anxiety — F41.1** (pages 47 and 64). Selective serotonin re-uptake inhibitor (SSRI) antidepressants are preferred to tricyclics (TCAs) because of the risk of tricyclic–alcohol interactions (fluoxetine, paroxetine and citalopram do not interact with alcohol) (see *BNF*, Section 4.3.3). For anxiety, benzodiazepines should be avoided because of their high potential for abuse²⁰ (see *BNF*, Section 4.1.2).

For further information on alcohol detoxification, see *Drug Misuse and Dependence — Guidelines on Clinical Management*.²¹

For information on brief interventions for people whose drinking behaviour puts them at risk of becoming dependent, see *Brief Intervention Guidelines*.²²

Referral

Consider referral:

- to the Detoxification Unit if the patient is dependent upon alcohol
- to involve the in-house or secondary mental-health services in addition if the patient has an associated major psychiatric disorder, or if the symptoms of mental illness persist after detoxification and abstinence
- for counselling targeted at problems associated with/triggering drinking and relapse prevention work, if available.

Before release:

- If possible, arrange for on-going rehabilitation support in the community. If it is available, specific social skills training^{N23} (which aims to improve, for example, relationship skills and assertiveness) and community-based treatment packages^{N24} (which provide help with finding a job and social life) both may be effective in reducing drinking.
- Refer patients with a mental illness who are misusing alcohol and who express some motivation to reduce their use to a specialist NHS alcohol service, a mental-health service or both. Ideally, care will be provided by a team skilled in treating both mental illness and substance abuse.²⁵ If either the psychiatric or substance misuse problem appears to predominate, refer initially to that service. Make the rationale clear in the letter/fax. If both types of disorder are of equal significance, then negotiate with both agencies about the preferred initial referral route. It may be that the individual will require support and input by both agencies. Some agencies can provide services jointly. Liaise with the service to ensure continued prescription of psychotropic medication, if appropriate.

- Stress to the patient that relapses are to be expected, are not signs of failure and will not mean a loss of your support and respect.

See **Comorbidity** (page 191).

Resources for patients and primary support groups

Al-Anon Family Groups UK and Eire: 020 7403 0888 (helpline: Monday–Friday, 10 am–10 pm); 0141 2217356
(Support for families and friends of alcoholics whether still drinking or not). Also:

Alateen: for young people aged 12–20 affected by others' drinking

Alcoholics Anonymous: 08457 697555 (24-hour helpline)

(Helpline refers to telephone support numbers and self-help groups across the UK, for men and women trying to achieve and maintain sobriety)

Drinkline: 0800 917 8282 (freephone national alcohol helpline: Monday–Friday, 9 am–11 pm; Saturday and Sunday, 6 pm–11 pm)

The following organisations provide leaflets to support brief interventions for people at risk of becoming dependent on alcohol:

Alcohol Focus Scotland: 0141 5726700

Health Education Board for Scotland: 0131 536 5500

Health Promotion England: 020 7725 9030

Northern Ireland Community Addiction Service: 02890 664 434

Secular Organisations for Sobriety (SOS): 020 8698 9332
(Non-religious self-help group)

Bereavement — Z63

Presenting complaints

An acute grief reaction is a normal, understandable reaction to loss. The patient:

- feels overwhelmed by loss
- is preoccupied with the lost loved one and
- may present with somatic symptoms following loss.

Grief may be experienced on the loss of a loved one and also with other significant losses (eg the loss of a child taken into care, a job, lifestyle or limb, the breakdown of a relationship). It may precipitate or exacerbate other psychiatric conditions and may be complicated, delayed or incomplete, leading to seemingly unrelated problems years after the loss.

Diagnostic features

Normal grief includes preoccupation with the loss of the loved one. However, this may be accompanied by symptoms resembling depression, such as:

- low or sad mood
- disturbed sleep
- loss of interest
- guilt or self-criticism
- restlessness
- guilt about actions not taken by the person before the death of the loved one
- seeing the deceased person or hearing their voice
- thoughts of joining the deceased.

The patient may:

- withdraw from their usual activities and social contacts
- find it difficult to think of the future and
- increase their use of drugs.

Differential diagnosis

Depression — F32#. Bereavement is a process. A helpful model is to think of four tasks to be completed by the bereaved person:

- accepting the reality of the loss — the patient may feel numb
- experiencing the pain of grief
- adapting to the world without the deceased and
- 'letting go' of the deceased and moving on.

Consider depression if:

- the person becomes stuck at any point in the process
- a full picture of depression is still present 2 months after the loss or
- there are signs that the grief is becoming abnormal (severe depressive symptoms of retardation, guilt, feelings of worthlessness, hopelessness or suicidal ideation of a severity or duration that significantly interferes with daily living).

There is a higher risk of an abnormal grief reaction under the following circumstances: where the bereaved person is socially isolated or has a history of depression or anxiety; where the bereaved killed the dead person or their relationship was ambivalent in other ways; where the dead person was a child; and where the death was violent, occurred by suicide or occurred suddenly in traumatic circumstances (especially if the body is not present).

Essential information for the patient and primary support group

- Important losses are often followed by intense sadness, crying, anger, disbelief, anxiety, guilt or irritability.
- Bereavement typically includes a preoccupation with the deceased (including hearing or seeing the person).
- A desire to discuss the loss is normal.
- Inform patients, especially those at greater risk of developing an abnormal grief reaction, of local agencies, such as Cruse Bereavement Care, which offer bereavement counselling and aim to help guide people through their normal grief.²⁶

- Inform patients who have lost or fear losing a child to the care system of agencies that offer advice and support (see **Resources** below). Inform them that they can still be part of their children's lives, eg by exchanging news in letters or talking face to face. If children are in care, an application can be made for children to visit in private conditions or, if this is not desired, application can be made to visit the children at their home. Visiting orders need not be surrendered for this purpose.

Advice and support to the patient and primary support group

- Enable the bereaved person to talk about the deceased and the circumstances of the death or other loss.
- Encourage the free expression of feelings about the loss (including feelings of sadness, guilt or anger).
- Offer reassurance that recovery will take time. Some reduction in burdens (eg work) may be necessary.
- Explain that intense grieving will fade slowly over several months, but that reminders of the loss may continue to provoke feelings of loss and sadness.
- Take into account the cultural context of the loss.²⁷

Medication

Avoid medication if possible. If the grief reaction becomes abnormal (see **Differential diagnosis** above), see **Depression — F32#**, page 47, for advice on the use of antidepressants. Disturbed sleep is to be expected. If severe insomnia occurs, the short-term use of hypnotic drugs may be helpful, but their use should be limited to 2 weeks (see *BNF*, Section 4.1.1). Avoid the use of anxiolytics.

Referral

Recommend the chaplain and voluntary organisations, eg CRUSE, for support through the normal grieving process. Probation officers may provide practical advice and support for women whose children have been taken into care.

Referral to the secondary mental-health services is advised:

- if the patient is severely depressed or showing psychotic features (see the relevant disorder) and
- non-urgently, if the symptoms have not resolved by 1 year despite bereavement counselling.

Consider an in-house counsellor, if available, or non-statutory bereavement counsellors¹³ in all other cases where symptoms persist.

Refer bereaved people who have learning disabilities to the specialist disability team or a specialist learning disability counsellor.

Resources for patients and primary support groups

After Adoption Helpline: 08456 010168 (Monday, Wednesday and Thursday, 10 am–12 pm, 2 pm–4 pm; Tuesday, 10 am–12 pm, 2 pm–7 pm; 0161 839 4932 (office); E-mail: aadoption@aol.com (office)

12–14 Chapel Street, Manchester M3 7NN

(For people whose children have been adopted or may be adopted, those who have lost a child to adoption and are now caring for another child, and those who have been adopted themselves in the North West, Yorkshire and Wales. Provides information, advice, support, individual and group counselling by person, telephone and letter; also books and tapes, and training for professionals. Experience of providing counselling to a prison under contract)

Compassionate Friends Helpline: 0117 953 9639 (Monday–Sunday, 9:30 am–10:30 pm)

(Befriending and support for bereaved parents, grandparents and siblings)

Cruse Bereavement Care Helpline: 08701 67 1677

(One-to-one bereavement counselling; self-referral preferred)

Family Rights Group: 0800 731 1696 (freephone advice line: Monday–Friday, 1.30–3.30 pm); 0800 783 0697 (freephone advice line in Turkish: Tuesday, 10 am–12 pm); 020 7923 2628 (office)

The Print House, 18 Ashwin Street, London E8 3DL. E-mail: office@frg.u-net.com

(Callers speak in confidence to a social worker or solicitor who offers advice and written information free of charge. Offers advice, advocacy and publications to families whose children are involved with social services. Advice sheets, some in Turkish, Somali, Punjabi, Urdu and Bengali, include ones on reuniting children with their families, assistance for

young people leaving care, child protection and many more. *Adoption: Guide for Birth Families*. £2.50 plus postage and packing)

Foundation for the Study of Infant Deaths (FSID): 020 7233 2090 (24-hour helpline)

Papyrus: 01706 214449

Rosendale GH, Union Road, Rawtenstall, Rosendale BB4 6NE

(Refers to support groups for parents of young people who have committed suicide)

Still Birth and Neonatal Death Society (SANDS): 020 7436 5881 (Monday–Wednesday, Friday, 10 am–3 pm)

(Information, emotional and physical support to parents who have lost a baby)

Talk Adoption: 0808 808 1234 (national helpline: Monday–Friday, 3 pm–9 pm); (confidential e-mail:

helpline@talkadoption.org.uk)

(For young people under 25 who have children who have been or may be adopted or have been adopted themselves)

Bipolar disorder — F31

Presenting complaints

Patients may have a period of depression, mania or excitement, with the pattern described below. Referral may be made by others due to lack of insight, complaining of aggression, frequent adjudications, self-harm or food refusal.

Diagnostic features

Periods of mania with:

- increased energy and activity
 - elevated mood or irritability
 - rapid speech
 - loss of inhibitions
 - decreased need for sleep and
 - increased importance of self.
- Patient may be easily distracted.
- Patient may also have periods of depression with:
 - low or sad mood or
 - loss of interest or pleasure.
- The following associated symptoms are frequently present:
 - disturbed sleep
 - poor concentration
 - guilt or low self-worth
 - disturbed appetite
 - fatigue or loss of energy or
 - suicidal thoughts or acts.

Either type of episode may predominate. Episodes may alternate frequently or may be separated by periods of normal mood. In severe cases, patients may have hallucinations (hearing voices or seeing visions) or delusions (strange or illogical beliefs) during periods of mania or depression.

Differential diagnosis

- **Alcohol misuse — F10** or **Drug-use disorder — F11** (pages 18 and 55) can cause similar symptoms.
- Antisocial personality disorder: it can be difficult to assess mood if the patient's premorbid personality is not known. If possible, obtain information from their relatives, staff or former general practitioner.

Essential information for the patient and primary support group

- Unexplained changes in mood and behaviour can be symptoms of an illness.
- Effective treatments are available. Long-term treatment can prevent future episodes.
- If left untreated, manic episodes may become disruptive or dangerous. Manic episodes often lead to legal problems, loss of a job or financial problems (in the community) and problems with debt, adjudications or high-risk sexual behaviour (in prison). When the first, milder symptoms of mania or hypomania occur, referral is often indicated and the patient should be encouraged to see the doctor straight away.
- Inform patients who are on lithium of the signs of lithium toxicity (see **Medication** below).

Advice and support to the patient and primary support group

- If it is decided that it is safe for the patient to live on ordinary location, seek patient permission to involve the residential manager and other relevant staff (eg workshop manager, teacher, chaplain) in implementing a management plan, including the location, activities, signs of lithium toxicity and planned response to relapse or mood swings. Inform staff that bipolar disorder carries the highest suicide risk of all mental disorders.
- During depression, assess the risk of suicide. (Has the patient frequently thought of death or dying? Does the patient have a specific suicide plan? Has he/she made serious suicide attempts in the past? Can the patient be sure not to act on suicidal ideas?) Close supervision by staff may be needed. Ask about the risk of harm to others (see **Depression — F32#** and **Assessing and managing people at risk of suicide**, pages 47 and 204).

- During manic periods:
 - avoid confrontation unless necessary to prevent harmful or dangerous acts
 - advise staff that aggression may be a sign of the illness and to avoid automatic use of disciplinary action
 - assess the risk of violence (see 'Assessing risk of violence' in **Aggression** page 282)
 - advise caution about impulsive or dangerous behaviour
 - close observation by staff is often needed
 - if agitation or disruptive behaviour are severe, transfer to a prison healthcare centre or NHS hospital may be required.
- During depressed periods, consult the management guidelines for depression (see **Depression — F32#**, page 47).
- Describe the illness and the possible future treatments to the patient.
- Encourage staff to refer the patient when signs of depression arise, even if the patient is reluctant.
- Work with the patient and staff to identify early warning symptoms of mood swings to avoid a major relapse.
- For patients able to identify early symptoms of a forthcoming 'high', advise:
 - ceasing the consumption of tea, coffee and other caffeine-based stimulants
 - avoiding stimulating or stressful situations
 - planning for a good night's sleep
 - taking relaxing exercise during the day, eg gym or relaxation exercise in the cell
 - avoid taking major decisions or
 - if relevant, taking steps to limit capacity to spend money.²⁸

Medication

- If the patient displays agitation, excitement or disruptive behaviour, antipsychotic medication may be needed initially²⁹ (see *BNF*, Section 4.2) (eg haloperidol, 1.5–4 mg up to three times per day). The doses should be the lowest possible for the relief of symptoms,³⁰ although some patients may require higher doses. If antipsychotic medication causes acute dystonic reactions (eg muscle spasms) or marked extrapyramidal symptoms (eg stiffness or tremors), anti-Parkinsonian medication (see *BNF*, Section 4.9), eg procyclidine, 5 mg orally up to three times per day, may be helpful. Routine use is not necessary.
- Benzodiazepines may also be used in the short-term in conjunction with antipsychotic medication to control acute agitation **and disturbance**³¹ (see *BNF*, Section 4.1.2). Examples include diazepam (5–10 mg up to four times per day) or lorazepam (1–2 mg up to four times per day). If required, diazepam can be given rectally, or lorazepam IM (although it must be kept refrigerated).
 - Lithium can help relieve mania³² and depression,³³ and can prevent episodes from recurring.³⁴ One usually commences or stops taking lithium only with specialist advice. Some general practitioners are confident about restarting lithium treatment after a relapse. Alternative mood-stabilising medications include carbamazepine and sodium valproate. If used in the acute phase, lithium takes several days to show effects. If lithium is prescribed:
 - there should be a clear agreement between the referring general practitioner and the specialist about who is monitoring the lithium treatment. Lithium monitoring is ideally carried out using an agreed protocol. If carried out in primary care, monitoring should be done by a suitably trained person
 - the levels of lithium in the blood should be measured frequently when adjusting the dose, and every 3 months in stable patients 10–14 hours post-dose (desired blood level is 0.4–0.8 mmol l⁻¹).^{N35} **If blood levels are > 1.5 or there is diarrhoea and vomiting, stop the lithium immediately.** If there are other signs of lithium toxicity (eg tremors, diarrhoea, vomiting, nausea, confusion), stop the lithium and check the blood level. Renal and thyroid function should be checked every 2–3 months when adjusting the dose, and every 6 months to 1 year in stable patients.³⁶
 - **Never stop lithium abruptly** (except in the presence of toxicity) — relapse rates are twice as high under these conditions.³⁷ Lithium should be continued for at least 6 months after symptoms resolve (longer-term use is usually necessary to prevent recurrences).
 - If the patient is on ordinary location, ensure that a residential manager and, if the patient goes to the gym frequently, the physical education staff are aware of the signs of lithium toxicity. The leaflet on lithium toxicity on the disk may be helpful .
- Antidepressant medication is often needed during phases of depression but can precipitate mania when used alone (see **Depression — F32#**, page 47). Bupropion may be less likely than other antidepressants to induce mania.³⁸ Doses should be as low as possible and used for the shortest time necessary. If the patient becomes hypomanic, stop the antidepressant.

Referral

Referral to the in-house or secondary mental-health services is advised:

- as an emergency if the patient is very vulnerable, eg if there is significant risk of suicide or disruptive behaviour or
- urgently if significant depression or mania continues despite treatment.

Non-urgent referral is recommended:

- for all new patients for assessment, care planning and allocation of key-worker under the Care Programme Approach
- before starting lithium
- to discuss relapse prevention and
- for women on lithium planning a pregnancy.

Where a patient is diagnosed with bipolar disorder for the first time, inform his/her solicitor, with patient permission, as the illness may have relevance to the offence.

If release is planned, work cooperatively with both probation or throughcare-planning officers to ensure that appointments with a general practitioner and specialist mental healthcare are arranged, and that housing, money for food, clothes and heating are arranged.

See **Managing the interface with the NHS and other agencies** (page 149) for more information on referral and throughcare.

Resources for patients and primary support groups

Manic Depression Fellowship: 020 7793 2600

(Advice, support, local self-help groups and publications list for people with manic depressive illness)

Manic Depression Fellowship (Scotland): 0141 400 1867

Resource leaflets:

Lithium Toxicity

Inside Out: A Guide to Self-Management of Manic Depression. Available from: Manic Depression Fellowship, Castle Works, 21 St George's Road, London SE1 6ES

Mary Ellen Copeland. *Living Without Depression and Manic Depression: A Workbook for Maintaining Mood Stability.* USA: New Harbinger. £11.95 Oakland 2001

Chronic fatigue, fatigue syndrome and neurasthenia — F48.0

Presenting complaints

Patients may report:

- a lack of energy
- aches and pains
- feeling tired easily or
- an inability to complete tasks.

Diagnostic features

- Mental and physical fatigue, made worse by physical and mental activity.
- Tiredness after minimal effort, with rest bringing little relief.
- Lack of energy.

Other common, often fluctuating, symptoms include:

- dizziness
- headache
- disturbed sleep
- inability to relax
- irritability
- aches and pains, eg muscle pain, chest pain, sore throat
- decreased libido and
- poor memory and concentration.

The disorder may be preceded by infection, trauma or another physical illness.

Fatigue syndrome is considered to be severe and chronic when substantial physical and mental fatigue lasts more than 6 months, significantly impairs daily activities and where there are no significant findings on physical examination or laboratory investigation. It is associated with other somatic symptoms.³⁹

Differential diagnosis

- **Many medical disorders can cause fatigue.** A full history and physical examination are necessary, which can be reassuring for the doctor and therapeutic for the patient. Basic investigations include a full blood count, erythrocyte sedimentation rate (ESR) or CRP, thyroid function tests, urea and electrolytes, liver function tests, blood sugar and C-reactive protein. A medical disorder should be suspected where there is:
 - any abnormal physical finding, eg weight loss
 - any abnormal laboratory finding
 - unusual features of the history, eg recent foreign travel, or the patient is very young or very old or
 - symptoms occurring only after exertion and unaccompanied by any features of mental fatigue.
- **Depression** — **F32#** (page 47) if a low or sad mood is prominent.
- **Chronic mixed anxiety and depression** — **F41.2** (page 33).
- **Panic disorder** — **F41.1** (page 67) if anxiety attacks are prominent.
- **Unexplained somatic complaints** — **F45** (page 94) if unexplained physical symptoms are prominent.

Depression and anxiety may be somatised. Social, relationship or other life problems may cause or exacerbate distress.

- **Postviral fatigue syndrome and benign myalgic encephalomyelitis** (classified under G93.3 'Neurological disorders') are diagnosed where there is excessive fatigue following a viral disease and the symptoms do not fulfil the criteria for F48.0. 'Fatigue syndromes', both chronic and not, both with and without an established physical precursor, may be classified under F48.0 'Neurasthenia'. In practice, there is extensive overlap in symptoms (up to 96%). The choice of coding reflects different recording practices and uncertainty about the aetiology of these syndromes. Although classification is controversial, treatment is similar whatever choice is made about coding.

Essential information for the patient and primary support group

- Periods of fatigue or exhaustion are common and are usually temporary and self-limiting.

- Treatment for mild-to-moderate fatigue syndrome is possible and usually has good results, although the outcome for fatigue syndrome that is severe and chronic is more variable.⁴⁰

Advice and support to the patient and primary support group

- Explore what the patient thinks his/her symptoms mean. Offer appropriate explanations and reassurance (eg symptoms are genuinely disabling and not 'all in the mind' but that symptoms following exertion do not mean physical damage and long-term disability).
- Advise a gradual return to usual activities. This may take time.
- The patient can build endurance with a programme of gradually increasing physical activity. Start with a manageable level and increase a little each week.
- Emphasise pleasant or enjoyable activities. Encourage the patient to resume activities that have helped in the past.
- Discuss sleep patterns. Encourage a regular sleep routine and avoid day time sleep (see **Sleep problems [insomnia] — F51**, page 91).
- Avoid excessive rest and/or sudden changes in activity.
 - Severe chronic fatigue is less common than uncomplicated chronic fatigue. In severe chronic fatigue, a behavioural approach, including cognitive-behavioural therapy and/or a cautious graded programme of exercise and assessment of and assistance with activities of daily living, can be helpful.^{41,42} Ideally, this would take place in a primary-care setting using clinical psychologists, nurse practitioners, practice counsellors, physiotherapists, occupational therapists or other suitably trained practitioners.

Medication

- To date, no pharmacological treatment for chronic fatigue has been established.⁴³
- Depression and anxiety are common in severe chronic fatigue and may respond to pharmacological treatment. In treating depression, selective serotonin re-uptake inhibitors (SSRIs) (see *BNF*, Section 4.3.3) may be neutral or activating, and tricyclic antidepressants (TCAs) (see *BNF*, Section 4.3.1) at full dosage may be sedating.
- In the absence of depression, consider low dose tricyclic antidepressants (eg amitriptyline, 50–100 mg day⁻¹, or imipramine, 20 mg day⁻¹) (see *BNF*, Section 4.3.1), which may be effective for pain and poor sleep.^{44,45}

Referral

See **General referral criteria** (page 152).

- Consider referral to a physician if the general practitioner is uncertain about diagnosis (see **Differential diagnosis** above).
- Referral to the secondary mental-health services or a liaison psychiatrist, if available, should be considered if there are:
 - comorbid mental disorders, eg eating disorder or bipolar disorder
 - a significant risk of suicide (see **Assessing and managing people at risk of suicide**, page 204) or
 - no improvement despite the above measures.

Resources for patients and primary support groups

Institute of Psychiatry's website (URL: <http://www.kcl.ac.uk/cfs>) includes a full patient-management package for the more severe symptoms of chronic fatigue syndrome. It includes information about the disorder and suggestions to aid self-management. It is a useful resource for the practitioner who is working with the patient to overcome the condition

Trudie Chalder. *Coping with Chronic Fatigue*. 1995 Sheldon, London. Self-help manual shown to improve the outcome in primary-care patients with chronic fatigue

M Sharpe, F Campling. *Chronic Fatigue Syndrome: The Facts*. Oxford: Oxford University Press, 2000. Self-help advice for more severe symptoms

For a review of the evidence for the full range of treatments for CFS/ME, see Bagnall AM, Whiting T, Wright J, Sowden AJ. *The Effectiveness of Interventions Used in the Treatment/Management of CFS and/or Myalgic Encephalomyelitis in Adults and Children*. York: NHS Centre for Reviews and Dissemination, University of York, 2001. URL: <http://www.york.ac.uk/inst/crd/cfsrep.pdf>

Chronic mixed anxiety and depression — F41.2

Presenting complaints

The patient may present with one or more physical symptoms (eg various pains, poor sleep or fatigue) accompanied by a variety of anxiety and depressive symptoms that will have been present for more than 6 months. These patients may be well known to their doctors and have often been treated by a variety of psychotropic agents over the years.

Diagnostic features

- Low or sad mood.
- Loss of interest or pleasure.
- Prominent anxiety or worry.
- Multiple associated symptoms are usually present, eg:
 - disturbed sleep
 - disturbed appetite
 - tremor
 - suicidal thoughts or acts
 - fatigue or loss of energy
 - dry mouth
 - palpitations
 - loss of libido
 - poor concentration
 - tension and restlessness
 - dizziness
 - irritability.

Differential diagnosis

- If more severe symptoms of depression or anxiety are present, see **Depression — F32#** or **Generalised anxiety — 41.1** (pages 47 and 64).
 - If somatic symptoms predominate, which do not appear to have an adequate physical explanation, see **Unexplained somatic complaints — F45** (page 94).
- If the patient has a history of manic episodes (eg excitement, elevated mood, rapid speech), see **Bipolar disorder — F31** (page 26).
- If the patient is or has recently been drinking heavily or using drugs, see **Alcohol misuse — F10** and **Drug-use disorders — F11#** (pages 18 and 55).

Unexplained somatic complaints, alcohol or drug disorders may also coexist with mixed anxiety and depression.

Essential information for the patient and primary support group

- Stress or worry have many physical and mental effects and may be responsible for many of their symptoms. Symptoms are likely to be at their worst at times of personal stress. Aim to help the patient to reduce his/her symptoms.
- These problems are not due to weakness or laziness: patients are trying to cope.
- Regular structured visits can be helpful — state their frequency and include arranged visits to other professionals (to assess the progress of any physical disorder and give any advice on handling life stresses).

Advice and support to the patient and primary support group

- If physical symptoms are present, discuss the link between physical symptoms and mental distress (see **Unexplained somatic complaints — F45**, page 94).
- If tension-related symptoms are prominent, advise on relaxation methods to relieve physical symptoms. The *Managing Anxiety* leaflet on the disk includes a relaxation exercise .
- Advise a reduction in caffeine intake,⁴⁶ if appropriate, and a balanced diet, including plenty of complex carbohydrates and vitamins.⁴⁷
- Discuss ways to challenge negative thoughts or exaggerated worries:

- Identify exaggerated worries or pessimistic thoughts (eg when a visitor does not arrive on time, the patient worries that they no longer want contact with them).
- Discuss ways to question these exaggerated worries when they occur, eg 'I am starting to be caught up in worry again. My visitor is only a few minutes late. He will probably be here soon.'
- Structured problem-solving methods⁴⁸ can help patients to manage current life problems or stresses that contribute to anxiety symptoms. Support the patient to carry out the following steps:
 - Identifying events that trigger excessive worry. (For example, a young woman presents with worry, tension, nausea and insomnia. These symptoms began after she learned that her son had been behaving badly in school following her conviction).
 - Listing as many possible solutions as the patient can think of, eg discussing her concerns with a close friend or relative, applying for an extended family visit, writing to her son's general practitioner, contacting a voluntary organisation that helps families of prisoners.
 - Listing the advantages and disadvantages of each possible solution. (The patient should do this, perhaps between appointments).
 - Choosing his/her preferred approach.
 - Working out the steps necessary to achieve the plan.
 - Setting a date to review the plan. Identify and reinforce things that are working.
- Help the patient plan activities that are relaxing, distracting or confidence building. Exercise may be helpful.^{49,50} If necessary, consider advocating for improved access to appropriate activities.
- Assess the risk of suicide. (Has the patient thought frequently about death or dying? Does the patient have a specific suicide plan? Has he/she made serious suicide attempts in the past? Can the patient be sure not to act on suicidal ideas?) See **Assessing and managing people at risk of suicide** (page 204).
- Encourage self-help books, tapes and/or leaflets if appropriate.⁵¹ If the patient has reading difficulties, a member of the healthcare team or another member of staff may be able to discuss the contents of the leaflets *Managing Depression* and *Managing Anxiety* (which are on the disk) with him/her.

Medication

- Medication should be simplified: it should be reviewed periodically and the patient should only be prescribed a drug if it is definitely helping. Multiple psychotropics should be avoided.
- An antidepressant with sedative properties can be prescribed if marked symptoms of depression or anxiety are present, but warn of drowsiness^{N52} (see *BNF*, Section 4.3) For the severity threshold for initiating antidepressants and for specific guidance on these drugs, see **Depression — F32#** (page 47).
- *Hypericum perforata* (known as St John's Wort and available from health food stores) is often taken for mild and moderate symptoms of depression.⁵³ It has mild monoamine oxidase inhibitory (MAOI) properties,⁵⁴ so it should not be combined with other antidepressants and caution may in theory be needed with diet.^{N55} *Hypericum* is an active agent and interactions with prescribed drugs may occur. For further information, see the advice from the Committee for Safety of Medicines.^{N56}

Referral

See **General referral criteria** (page 152).

Referral to in-house or secondary mental-health services is advised:

- if the suicide risk is significant (see **Assessing and managing people at risk of suicide**, page 204) or
- non-urgently for psychological treatments, as available.

Consider recommending voluntary/non-statutory/self-help organisations. Stress/ anxiety management,^{N57} problem-solving,^{N58} cognitive therapy,⁵⁹ cognitive-behavioural therapy^{N60} or counselling¹³ may be helpful and may be provided in primary care or the voluntary sector, as well as in the secondary mental-health services.

Resources for patients and primary support groups

For more resources, see **Depression — F32#** and **Generalised anxiety — F41.1** (pages 47 and 64).

Listeners/buddies, chaplain, the Samaritans

CITA (Council for Involuntary Tranquilliser Addiction): 0151 949 0102 (Monday–Friday, 10 am–1 pm)
Cavendish House, Brighton Road, Waterloo, Liverpool
(Confidential advice and support)

Samaritans: 08457 90 90 90 (24-hour, 7 days per week helpline)
(Support by listening for those feeling lonely, despairing or suicidal)

Resource leaflets:

Managing Anxiety

Managing Depression

Helping You Cope: A Guide to Starting and Stopping Tranquillisers and Sleeping Tablets. Available from: Mental Health Foundation, UK Office, 20/21 Cornwall Terrace, London NW1 4QL. Tel: 020 7535 7400; Fax: 020 7535 7474;
E-mail: mhf@mhf.org.uk; URL: <http://www.mentalhealth.org.uk>

Chronic psychotic disorders — F20#

Includes schizophrenia, schizotypal disorder, persistent delusional disorders, induced delusional disorder and other non-organic psychotic disorders

Presenting complaints

Patients may present with:

- difficulties with thinking or concentration
- reports of hearing voices
- strange beliefs, eg having supernatural powers or being persecuted
- extraordinary physical complaints, eg having animals or unusual objects inside one's body
- poor hygiene
- problems in managing life in prison, work, education or relationships
- self-harm
- food refusal (may have delusions that food is being poisoned) or
- problems or questions related to antipsychotic medication.

Staff or a solicitor may seek help because of apathy, withdrawal, poor hygiene or strange behaviour.

Diagnostic features

- Chronic problems with the following features:
 - social withdrawal
 - low motivation, interest or self-neglect or
 - disordered thinking (exhibited by strange or disjointed speech).
- Periodic episodes of:
 - agitation or restlessness
 - bizarre behaviour
 - hallucinations (false or imagined perceptions, eg hearing voices) or
 - delusions (firm beliefs that are often false, eg the patient is related to royalty, receiving messages from the television, being followed or persecuted).

Differential diagnosis

- **Depression** — **F32#** (page 47) if a low or sad mood, pessimism and/or feelings of guilt.
- **Bipolar disorder** — **F31** (page 26) if symptoms of mania excitement, elevated mood or exaggerated self-worth are prominent.
- **Alcohol misuse** — **F10** or **Drug-use disorders** — **F11#** (pages 18 and 55). Chronic intoxication or withdrawal from alcohol or other substances (stimulants, hallucinogens) can cause psychotic symptoms.

Patients with chronic psychosis may also abuse drugs and/or alcohol.

Essential information for the patient and primary support group

- Agitation and strange behaviour can be symptoms of a mental illness.
- Symptoms may come and go over time.
- Medication is a central component of treatment. It will both reduce current difficulties and prevent relapse.
- Safe, stable living conditions (eg freedom from bullying, occupation) are a prerequisite for effective rehabilitation.
- Voluntary organisations can provide valuable support to the patient and support group.

Advice and support to the patient and primary support group

- Seek the patient's permission to discuss a treatment plan with staff involved in the care of the patient and obtain their support for it. A multidisciplinary care plan might consider options for location, occupation, ways of minimising unnecessary stress, an early response to signs of relapse and the monitoring of medication. Combination locations may be appropriate, eg sheltered work during the day, healthcare or Vulnerable Prisoners Unit (VPU) at night. Jointly

establish appropriate expectations for the individual, to avoid inappropriate relegation to 'basic' status. The information leaflet on the disk for staff about psychotic disorder may be helpful.

- Explain that medication will help prevent relapse, and inform the patient of the side-effects. Be vigilant to ensure that the patient is not persuaded/bullied into giving the medication to someone else. (They have currency, as antipsychotics may have a sedative and anti-Parkinsonian drugs a mood-elevating effect)
- Encourage the patient to function at the highest reasonable level in work and other daily activities.
- Minimise stress and stimulation:
 - Do not argue with psychotic thinking.
 - Avoid confrontation or criticism.³ Staff should respond gently and with reassurance to slow responses to orders (eg slowness in going into a cell). Use of control and restraint should be a last resort.
 - During periods when the symptoms are more severe, rest and withdrawal from stress may be helpful.
- Keep the patient's physical health, including health promotion, obesity and smoking, under review.⁶¹ Weight gain related to medication can be extreme. Heavy smokers may use tobacco to counteract the sedative effects of their antipsychotic medication. If this happens, consider a less sedating antipsychotic. If you suspect co-occurring substance misuse, check for possible physical problems (eg anaemia, chest problems) and nutritional deficiencies.
- If the illness has a relapsing course, work with the patient and staff to try to identify early warning signs of relapse.
- Encourage the patient to build relationships with key members of the healthcare team, eg by seeing the same doctor or nurse at each appointment. Use the relationship to discuss the advantages of medication and to review the effectiveness of the care plan.
- For advice on the management of agitated or excited states, see **Acute psychotic disorders — F23** (page 11).
- If care is shared with the in-house or NHS mental-health services, agree with them who is to do what.
- Especially if the patient becomes depressed, consider options for support, education and reassurance about their psychotic illness, including possible relapse and their future life chances. Mental-health staff may be able to provide individual counselling, goal planning and monitoring of early warning signs of relapse.

If the patient is also using substances:

- Express concern for the patient's well-being and avoid moral disapproval (eg 'I'm really not happy about you taking drugs as it makes your schizophrenia worse'). Focus on building a relationship with the patient, not on pushing an unmotivated patient towards abstinence.
- Discuss the benefits and costs of drug use (including the implications of continuing any form of illicit drug use while in prison) from the patient's perspective. Assess the patient's commitment to change. Thought disorder, suspiciousness and depression may make it difficult for the patient to make such a commitment.
- Educate the patient about the effect of alcohol and other drugs on the body and on schizophrenia (eg 'Drugs such as cannabis, LSD, stimulants and ecstasy all exacerbate the mood you are in when you take it, and so can make you more paranoid, anxious or depressed'). Feedback the results of tests, eg urine tests, changes in weight or other physical examinations.
- Consider options for dealing with prison-related problems that may be increasing the substance use (eg boredom, bullying, low-level depression). Consider:
 - encouraging the patient to spend more time out of the cell and in enjoyable activities, eg attend education, gym, work
 - liaising, with patient permission, with wing officers about reducing stress on the unit (eg noise, bullying, teasing) or increasing activities
 - encouraging the patient to talk to any trusted friend or staff member (eg personal officer, teacher, listener, chaplain) if day-to-day problems arise rather than turning to drugs.

For more information, see **Comorbidity** (page 191).

Medication

- Antipsychotic medication may reduce psychotic symptoms (see *BNF*, Section 4.2.1). Examples include haloperidol (1.5–4 mg up to three times day⁻¹), or an atypical antipsychotic^{N6} (eg olanzapine, 5–10 mg day⁻¹, or risperidone, 4–6 mg day⁻¹).
- The dose should be the lowest possible for relief of symptoms. The drugs have different side-effect profiles. Indications for atypical drugs include uncontrolled acute extrapyramidal effects, uncontrolled hyperprolactinaemia and predominant, unresponsive, negative symptoms (eg withdrawal and low motivation). For more information on the different types of antipsychotic drugs and their side-effect profiles, see *Maudsley Prescribing Guidelines*.¹⁰

- Inform the patient that continued medication will reduce the risk of relapse. In general, antipsychotic medication should be continued for at least 6 months following a first episode of illness, and longer after a subsequent episode.^{N9}
- Monitor compliance and the call up for review if more than two doses are missed.
- If, after team support, the patient is reluctant or erratic in taking medication, injectable long-acting antipsychotic medication may ensure the continuity of treatment and reduce the risk of relapse.^{N62} It should be reviewed at 4–6-monthly intervals. Doctors and nurses who give depot injections in primary care need training to do so.⁶³ If available, specific counselling about medication also is helpful.^{N64} Advise the nurse administering the medication to seek out the patient should he/she fail to attend an appointment.
- Discuss the potential side-effects with the patient. Common motor side-effects include:
 - Acute dystonias or spasms that can be managed with anti-Parkinsonian drugs (see *BNF*, Section 4.9) (eg procyclidine, 5 mg three times per day, or orphenadrine, 50 mg three times per day).
 - Parkinsonian symptoms (eg tremor and akinesia), which can be managed with oral anti-Parkinsonian drugs (see *BNF*, Section 4.9) (eg procyclidine, 5 mg up to three times per day, or orphenadrine, 50 mg three times per day). Withdrawal of anti-Parkinsonian drugs should be attempted after 2–3 months without symptoms as these drugs are liable to misuse and may impair memory.
 - Akathisia (severe motor restlessness) may be managed with dosage reduction, or β -blockers (eg propranolol, 30–80 mg day⁻¹) (see *BNF*, Section 2.4). Switching to a low-potency antipsychotic (eg olanzapine or quetiapine) may help.
 - Other possible side-effects include weight gain, galactorrhoea and photosensitivity. Patients suffering from drug-induced photosensitivity are eligible for sunscreen on prescription.

Referral

Referral to the secondary mental-health services is advised:

- urgently, if there are signs of relapse, unless there is an established previous response to treatment
- non-urgently:
 - to clarify diagnosis and ensure the most appropriate treatment
 - if there is non-compliance with treatment, problematic side-effects or breakdown of the living arrangements, eg problems on ordinary location or with occupation
 - for all new patients with a diagnosis of psychosis to obtain information about and review any existing care plan
 - for all patients who also abuse substances to review their medication to ensure that unwanted side-effects (eg sedation) are not increasing drug use.

Patients with a range of mental-health, occupational, social and financial needs are normally managed by specialist services. Referral for a key-worker under the Care Programme approach should always be considered.

The community mental-health services may be able to provide compliance therapy,^{N64} family interventions,^{N65} cognitive-behaviour therapy⁶⁶ and rehabilitative facilities.

Refer patients who are misusing substances and express some motivation to reduce for substance abuse counselling.²⁵ Liaise with the substance-misuse service to ensure the continued prescription of antipsychotic medication. Stress to the patient that relapses are to be expected, are not signs of failure and will not mean a loss of your support and respect (see **Comorbidity**, page 191).

If release is planned, work cooperatively with both probation or throughcare-planning officers to ensure that appointments with a general practitioner and specialist mental healthcare are arranged and that housing, money for food, clothes and heating are arranged.

If release is not planned, inform the local mental-health services that the patient may present to A&E in the area and advise them to look out for him/her.

For more detail on throughcare, see **Managing the interface with the NHS and other agencies** (page 149).

Resources for patients and primary support groups

Hearing Voices Network: 0161 834 5768

(Self-help groups to allow people to explore their voice hearing experiences)

MIND Infoline: 08457 660 163 (outside London); 020 8522 1728 (Greater London)

National Schizophrenia Fellowship: 020 8974 6814 (advice line: Monday–Friday, 10:30 am–3 pm); 020 7330 9106 (office)

National Schizophrenia Fellowship (Northern Ireland): 02890 402 323

National Schizophrenia Fellowship (Scotland): 0131 557 8969

SANELine: 08457 678000 (12 pm–2 am, 7 nights)

Education and workshops may provide opportunities for creative expression

Education or Psychology Departments may provide basic social skills training

Resource leaflets:

Coping with the Side-effects of Medication

Working with a Prisoner with Severe Mental Illness

Early Warning Signs Form

Healthy Living with Schizophrenia. London: Health Education Authority 1998. Available from: Marsdon Book Services. Tel: 01235 465565

R Coleman, M Smith. *Working With Voices*. Handsell, 1997 Newton le Willows. Workbook to help voice hearers manage their voices

Delirium — F05

Presenting complaints

- Staff may request help because the patient is confused or agitated.
- Patients may appear uncooperative or fearful.
- Delirium may occur in patients hospitalised for physical conditions.

Diagnostic features

Acute onset, usually over hours or days, of:

- confusion (patient appears disoriented and struggles to understand surroundings) and
- clouded thinking or awareness.

Often accompanied by:

- poor memory
- agitation
- emotional upset
- loss of orientation
- wandering attention
- hearing voices
- withdrawal from others
- visions or illusions
- suspiciousness
- disturbed sleep (reversal of sleep pattern) and
- autonomic features, eg sweating, tachycardia.

Symptoms often develop rapidly and may change from hour to hour.

Delirium may occur in patients with previously normal mental function or in those with dementia. Milder stresses (eg medication and mild infections) may cause delirium in older patients or in those with dementia.

Differential diagnosis

Identify and correct the possible underlying physical causes of the delirium, such as:

- alcohol intoxication or withdrawal
- drug intoxication, overdose or withdrawal (including prescribed drugs)
- infection
- metabolic changes, eg liver disease, dehydration, hypoglycaemia
- head trauma
- hypoxia or
- epilepsy.

If symptoms persist, delusions and disordered thinking predominate, and no physical cause is identified (see **Acute psychotic disorders** — **F23**, page 11).

Essential information for the patient and primary support group

Strange behaviour or speech and confusion can be symptoms of a medical illness.

Advice and support to the patient and primary support group⁶⁷

- Take measures to prevent the patient from harming him/herself or others, eg remove unsafe objects, restrain if necessary but use the minimum amount of restraint required and take extra care to ensure no physical harm to the patient (see 'Restraint' in **Aggression**, page 282).
- Supportive contact with familiar people can reduce confusion.
- Provide frequent reminders of time and place to reduce confusion.

- A transfer to hospital may be required because of agitation or because of the physical illness that is causing delirium. There is an appreciable mortality rate with delirium. Patients may need to be admitted to a medical ward in order to diagnose and treat the underlying disorder. In an emergency, where there is risk to life and safety, a medically ill patient may be taken to a general hospital for treatment under common law. In such a case, a medical doctor may make this decision without involvement of a psychiatrist (see **Emergency treatment under common law**, page 168).

Medication⁶⁸

- Avoid the use of sedative or hypnotic medications (eg benzodiazepines) except for the treatment of alcohol or sedative withdrawal.
- Antipsychotic medication in low doses (see *BNF*, Section 4.2.1) may sometimes be needed to control agitation, psychotic symptoms or aggression. Beware of drug side-effects (drugs with anticholinergic action and anti-Parkinsonian medication can exacerbate or cause delirium) and drug interactions.

Referral

Referral to the secondary mental-health services is rarely indicated. Referral to a physician is nearly always indicated if:

- the cause is unclear
- the cause is clear and treatable but treatment cannot safely be provided within the establishment or
- drug or alcohol withdrawal, overdose or another underlying condition necessitating in-patient medical care is suspected.

Dementia — F00#

Presenting complaints

- Patients may complain of forgetfulness, a decline in mental functioning or of feeling depressed, but they may be unaware of memory loss. Patients and staff may sometimes deny, or be unaware of, the severity of memory loss and other deterioration in function.
- Staff or the patient's solicitor may ask for help initially because of failing memory, disorientation and change in personality or behaviour. In the later stages of the illness, they may seek help because of behavioural disturbance, wandering or incontinence or an episode of dangerous behaviour.
- Dementia may also be diagnosed during consultations for other problems, as staff may believe deterioration in memory and function is a natural part of ageing.
- Changes in behaviour and functioning (eg poor personal hygiene or social interaction) in an older patient should raise the possibility of a diagnosis of dementia.

Diagnostic features

- Decline in memory for recent events, thinking, judgement, orientation and language.
- Patients may have become apparently apathetic or uninterested, but may also appear alert and appropriate despite a deterioration in memory and other cognitive function.
- Decline in everyday function, eg dressing, washing.
- Changes in personality or emotional control — patients may become easily upset, tearful or irritable, as well as apathetic.
- Common with advancing age (5% over 65 years, 20% over 80 years),⁶⁹ very rare in youth or middle age.

Progression is classically stepwise in vascular dementia, gradual in Alzheimer's and fluctuating in Lewy body dementia (fluctuating cognition, visual hallucinations and Parkinsonism), but the clinical picture is often not clear-cut.

Owing to the problems inherent in taking a history from people with dementia, it is very important that information about the level of current functioning and possible decline in functioning should also be obtained from an informant (eg relative who visits frequently or residential staff).

Tests of memory and thinking include:

- the ability to repeat the names of three common objects (eg apple, table, penny) immediately and recall them after 3 minutes
- the ability to identify accurately the day of the week, the month and the year and
- the ability to give their name and full postal address.

A very short screening test is set out in the resource section on the disk .

Differential diagnosis

Examine and investigate for treatable causes of dementia. The common causes of cognitive worsening in the elderly are:

- urinary tract, chest, skin or ear infection
- onset or exacerbation of cardiac failure
- prescribed drugs, especially psychiatric and anti-Parkinsonian drugs, and alcohol and
- cerebrovascular ischaemia or hypoxia.

Less common causes include:

- severe depression
- severe anaemia in the very old
- vitamin B₁₂ or folate deficiency
- hypothyroidism and hyperparathyroidism
- slow-growing cerebral tumour
- renal failure and
- communicating hydrocephalus.

Sudden increases in confusion, wandering attention or agitation will usually indicate a physical illness (eg acute infectious illness) or toxicity from medication (see **Delirium — F05**, page 41).

Depression may cause memory and concentration problems similar to those of dementia, especially in older patients. If low or sad mood is prominent, or if the impairment is patchy and has developed rapidly, see **Depression — F32#** (page 47). Helpful tests include: MSU, full blood count (FBC), B₁₂, folate, LFTs, TFTs, U&E, Ca²⁺ and glucose.

Essential information for the patient and primary support group

- Dementia is frequent in old age but is not inevitable.
- Memory loss and confusion may cause behaviour problems (eg agitation, suspiciousness, emotional outbursts, apathy and an inability to take part in normal social interaction).
- Memory loss usually proceeds slowly, but the course and long-term prognosis varies with the disease causing dementia. Discuss the diagnosis, the likely progress and prognosis with the patient and, with patient permission, with his/her primary support group.
- Physical illness or other stress can increase confusion.
- Advise staff that the patient will have great difficulty in learning new information. Avoid placing the patient in unfamiliar places or situations
- The supply of information on dementia for staff involved in care of the patient is essential.

Advice and support to the patient and primary support group

- Seek patient permission to discuss a treatment plan with staff involved in the care of the patient and obtain their support for it. Regularly assess the risk (balancing safety and independence), especially at times of crisis. As appropriate, discuss arrangements for support in the establishment.
- Consider contacting the patient's solicitor, with patient permission, to discuss the possible application for release on grounds of ill-health.
- Regularly review the patient's ability to perform daily tasks safely as well as their behavioural problems and general physical condition.
- If memory loss is mild, consider the use of memory aids or reminders.
- Encourage the patient to make full use of their remaining abilities.
- Encourage maintenance of the patient's physical health and fitness through good diet and exercise, plus swift treatment of intercurrent physical illness.
- Discuss the planning of legal and financial affairs. An information sheet is available from the Alzheimer's Society (see **Resources Directory** page 316).
A probation officer may be able to provide further information.

Medication

- Try non-pharmacological methods of dealing with difficult behaviour first. For example, staff may be able to deal with repetitive questioning if they are given the information that this is because the dementia is affecting the patient's memory.
- Antipsychotic medication in very low doses (see *BNF*, Section 4.2.1) may sometimes be needed to manage some behavioural problems (eg aggression or restlessness). Behavioural problems change with the course of the dementia; therefore, withdraw the medication every few months on a trial basis to see if it is still needed and discontinue if it is not. Beware of drug side-effects (eg Parkinsonian symptoms, anticholinergic effects) and drug interactions (avoid combining with tricyclic antidepressants (TCA), alcohol, anticonvulsants or L-dopa preparations). Antipsychotics should be avoided in Lewy body dementia.⁷⁰
- Avoid using sedative or hypnotic medications (eg benzodiazepines) if possible. If other treatments have failed and severe management problems remain, use very cautiously and for no more than 2 weeks; they may increase confusion.
- Aspirin in low doses may be prescribed for vascular dementia to attempt to slow deterioration.
- In Alzheimer's disease, consider referring the patient to secondary care for an assessment and the initiation of anticholinesterase drugs⁷¹ depending on locally agreed policies.

Referral

- Refer to a specialist to confirm diagnosis in complicated or atypical cases.

- Call a case conference with the relevant staff (eg probation officer, residential staff, occupational therapist, if available) to arrange the practicalities of managing the patient in the establishment.
- Refer to a physician if there is complex medical comorbidity or a sudden worsening of dementia.
- Refer to the psychiatric services if there are intractable behavioural problems or if a depressive or psychotic episode occurs.

If release is planned, work cooperatively with both probation or throughcare-planning officers to ensure that appointments with a general practitioner, specialist mental healthcare and socialcare are arranged, and that housing, money for food, clothes and heating are arranged.

For more detail on throughcare, see **Managing the interface with the NHS and other agencies** (page 149). See PSI 21/2001 for details of the Prison Service requirements about the provision of coordinated health- and socialcare to older people in prison.

Resources for patients and primary support groups

Alzheimer's Society and CJD Support Network: 0845 300336 (helpline);
020 7306 0606 (office)

(Support and advice to people with dementia of all kinds, ie not just Alzheimer's, and their family and friends)

Age Concern England: 0800 009966 (freephone helpline: Monday–Sunday,
7 am–7 pm); 020 8765 7200 (office)

(Information and advice relating to older people)

Age Concern Northern Ireland: 02890 245729

Age Concern Cymru: 02920 399562

Age Concern Scotland: 0131 220 3345

Help the Aged: 020 7253 0253

Counsel and Care: 020 7485 1550 (Monday–Friday, 10:30 am–12 pm, 2 pm–4 pm)

(Advice and information on issues including residential care, for older people and their carers)

Benefits Enquiry Line: 0800 882200 (freephone)

(For people with disabilities)

Carers' National Association: 020 7490 8818; 0808 808 7777 (carersline: 10 am–
12 pm, 2:30 pm–4 pm)

H Cayton, N Graham, J Warner, *Alzheimer's At Your Fingertips*. Class, 1997 London. £11.95. A good book for patients and carers that answers commonly asked questions about all types of dementia

Depression — F32#

Presenting complaints

The patient may present initially with one or more physical symptoms, such as pain or 'tiredness all the time'. Further enquiry will reveal a low mood or severe and persistent loss of interest.

Irritability or increased aggression is sometimes the presenting problem.

A wide range of presenting complaints may accompany or conceal depression. These include anxiety or insomnia, worries about social problems such as financial or marital difficulties, increased drug or alcohol use, or (in a new mother) constant worries about her baby or fear of harming the baby.

Some groups are at higher risk (eg those who have recently given birth, those given a life sentence or a longer sentence than they expected, and those with physical disorders, eg Parkinson's disease or multiple sclerosis).

Diagnostic features

- Low or sad mood.
- Loss of interest and pleasure for most of the day for at least 2 weeks.

Plus at least four of the following:

- disturbed sleep
- disturbed appetite; food refusal
- increased irritability and aggression
- guilt or low self-worth
- pessimism or hopelessness about the future
- fatigue or loss of energy
- agitation (eg pacing) or slowing of movement or speech
 - diurnal mood variation
- poor concentration
- suicidal thoughts or acts
- loss of self-confidence
- decreased libido.

Symptoms of anxiety or nervousness are also frequently present.

The more severe the depression, usually the greater number of symptoms and (most importantly) the greater the degree of interference with normal social or occupational functioning. Biological symptoms are more common in more severe depression.

Differential diagnosis

- **Adjustment reaction** — **F43.2** (page 15). Where symptoms are caused by recent stress (eg being given a prison sentence or bullying; loss of confidence may be caused by the individual's position in the prison hierarchy). Depression is diagnosed when symptoms are severe and continue for more than 1 month, irrespective of whether or not they are linked to life stresses.
- **Alcohol misuse** — **F10** or **Drug-use disorder** — **F11#** (pages 18 and 55) if heavy alcohol or drug use is present. Substance misuse may cause or increase depressive symptoms. It may also mask underlying depression. Depressive symptoms improve in 80% of patients after detoxification. Depression is diagnosed if major symptoms persist or worsen after alcohol, stimulant or opiate withdrawal (see **Comorbidity**, page 191).
- **Acute psychotic disorder** — **F23** (page 11) if hallucinations, eg hearing voices, or delusions, eg strange or unusual beliefs, are present.
- **Bipolar disorder** — **F31** (page 26) if the patient has a history of manic episodes, eg excitement, rapid speech and elevated mood.
- **Chronic mixed anxiety and depression** — **F41.2** (page 33).

Some medications may produce symptoms of depression (eg β -blockers, other antihypertensives, H₂-blockers, oral contraceptives and corticosteroids).

Unexplained somatic complaints, anxiety, alcohol or drug disorders may coexist with depression.

Essential information for the patient and primary support group

- Feelings of helplessness, hopelessness, anxiety and emotional swings are all symptoms of the illness. They do not mean that you are going mad. Depression is a common illness and effective treatments are available.
- It is normal to be sad when separated from family and friends. Depression is diagnosed when symptoms are severe and go on for a long time. Then people often need help to reduce the symptoms so that they can tackle their problems and get on with life.
- Some people use drugs and alcohol as a way of escaping from painful feelings and these may come back when the drugs are stopped. If you are still depressed a few weeks after being drug free, it usually means that there is a problem with depression. This could be an opportunity to try and deal with some of the problems that contributed to your depression and to your substance use.
- Depression is not weakness or laziness.
- Depression can affect people's ability to cope.
- Recommend information leaflets or audiotapes to reinforce the information.⁵¹ If the patient has reading difficulties, a member of the healthcare team or another member of staff may be able to discuss the contents of the leaflet *Managing Depression* (it is on the disk) with him/her.

Advice and support for the patient and primary support group

- Assess the risk of suicide. Ask questions about thoughts, plans and intent (eg Has the patient often thought of death or dying? Does the patient have a specific suicide plan? Has he/she made suicide attempts in the past? Can the patient be sure not to act on suicidal ideas? Involve the mental-health team. There should be close supervision, move to healthcare centre or use of care suite may be needed (see **Assessing and managing people at risk of suicide**, page 204).
- Ask about risk of harm to others (see 'Assessing risk of violence' in **Aggression**, page 282).
- Identify the current life problems or social stresses, including precipitating factors, and what help he/she needs in resolving them. Wing officers may be helpful, especially where problems involve the wing hierarchy. Focus on small, specific steps patients might take towards reducing or improving management of these problems (for agencies providing help for particular problems, see **Resource directory**, page 316). Advise the patient to avoid major decisions or life changes while he/she is depressed.
- Plan short-term activities that give the patient enjoyment or build confidence. Exercise may be helpful.⁷²
- If appropriate, advise a reduction in caffeine intake⁴⁶ and drug use.
- Support the development of good sleep patterns and encourage a balanced diet.⁴⁷
- Encourage the patient to resist pessimism and self-criticism, not to act on pessimistic ideas (eg ending a marriage) and not to concentrate on negative or guilty thoughts.
- Identify someone the patient can confide in. Encourage him/her to seek practical and emotional help from others. Inform the patient about the role and availability of the prison healthcare team and any other support available. Consider supporting him/her to obtain additional telephone calls to family and friends outside or extended family visits.
- If physical symptoms are present, discuss the link between physical symptoms and mood (see **Unexplained somatic symptoms — F45**, page 94).
- Involve the patient in discussing the advantages and disadvantages of the available treatments. Inform the patient that medication usually works more quickly than psychotherapies.^{N74,N75} Where patients choose not to take medication, explore their reasons and dispel any misconceptions, but if they remain of the same mind, respect their decision and arrange another appointment to monitor progress.
- After improvement, plan with the patient the action to be taken if signs of relapse occur.

Liaison and advice to residential and other staff

Ask the patient's permission to discuss the following with the other staff caring for him/her. Inform him/her that you will only do this with their permission, except where there is a significant risk of suicide or harm to others.

- Discuss the outcome of the assessment of risk and discuss ways of managing the risk including the level of monitoring required. Discuss the location, including the shared room or care suite. Discuss the options for staff support outlined on the leaflet on the disk .

- Advise staff not to make judgements about whether giving up on life is to be expected in the face of the patient's life situation.
- Inform staff of the likely impact of the illness on the individual's functioning, eg irritability and aggression can cause an increase in arguments with other inmates or with visitors.
- Promote contact with family and friends, eg extended family visits, telephone calls.
- Consider advocating for access to an appropriate activity, eg art materials, suitable work placement.
- If the patient's illness means that he/she can no longer manage his/her previous routine, eg work placement, discuss the options for replacement activities, eg art, exercise, easier work.

Medication

- There is no evidence that people with only few or very mild depressive symptoms respond to antidepressants.⁷⁶ Moderate-to-severe episodes will need treatment with antidepressants. Consider medication at the first visit.
- Antidepressants are effective even when depression is linked to the presence of life stresses or physical illness. Treatment is indicated by the severity and duration of symptoms.
- Discuss the aims of the treatment and the side-effects; explore the patient's perceptions of treatment.

Choice of medication

At present, there is no evidence to suggest that any antidepressant is more effective than others.^{77,78} However, their side-effect profiles differ and, therefore, some drugs will be more acceptable to particular patients than others (see *BNF*, Section 4.3).

- If the patient has responded well to a particular drug in the past, use that drug again.
- If the patient is older or physically ill, use medication with fewer anticholinergic and cardiovascular side-effects.
- If the patient is suicidal, avoid tricyclic antidepressants (TCAs) or consider supervised ingestion.
- If the patient is anxious or unable to sleep, use a drug with more sedative effects, but warn of drowsiness and problems with machinery.
- If the patient is about to be released and is unwilling to give up alcohol, choose one of the SSRI antidepressants which do not interact with alcohol (eg fluoxetine, paroxetine and citalopram). (See *BNF* Section 4.3.3)
- *Hypericum perforata* (known as St John's Wort and available from health food stores) is often taken for mild and moderate symptoms of depression, both acute and chronic.⁵³ It has mild monoamine oxidase-inhibiting (MAOI) properties⁵⁴ so it should not be combined with other antidepressants and caution may be needed with diet.^{N55} *Hypericum* is an active agent and interactions with prescribed drugs may occur (for further information, see the advice from the Committee for Safety of Medicines^{N56}).

If antidepressants are prescribed, explain to the patient that:

- the medication must be taken every day
- the drug is not addictive
- improvement will build up over 2–3 weeks after starting the medication
- mild side-effects may occur, eg dry mouth, blurred vision, sedation with TCAs and agitation and stomach upset with selective serotonin re-uptake inhibitors (SSRIs), but they usually fade in 7–10 days and
- stress that the patient should consult the doctor before stopping medication. All antidepressants should be withdrawn slowly, preferably over 4 weeks in weekly decrements.

Continue full-dose antidepressant medication for at least 4–6 months after the condition improves to prevent relapse.^{79,80} Review regularly during this time. Consider, jointly with the patient, the need for further continuation beyond 4–6 months. If the patient has had several episodes of major depression, consider carefully long-term prophylactic treatment.^{N81} Obtain a second opinion at this point, if available.

If using TCA medication, build up over 7–10 days to the effective dose, eg dothiepin: start at 50–75 mg and build to 150 mg nocte; or imipramine: start at 25–50 mg each night and build to 100–150 mg.^{N82}

Withdraw antidepressant medication slowly and monitor for withdrawal reactions to ensure that remission is stable. Gradual reduction of SSRIs can be achieved by using syrup in reducing doses or taking a tablet on alternate days.

Referral

The following structured therapies, delivered by properly trained practitioners, have been shown to be effective for some people with depression.^{N83}

- Cognitive-behavioural therapy (CBT).
- Behaviour therapy.
- Interpersonal therapy.
- Structured problem solving.

Patients with chronic, relapsing depression may benefit more from CBT or a combination of CBT and antidepressants than from medication alone.^{84,85} Counselling may be helpful, especially in milder cases and if focused on specific psychosocial problems which are related to the depression, eg relationships, bereavement.^{N13}

Referral to the secondary mental-health services is advised:

- as an emergency, if there is a significant risk of suicide or danger to others, psychotic symptoms, severe agitation or retardation with impaired food/fluid intake and
- as a non-emergency, if:
 - significant depression persists despite treatment in primary care (antidepressant therapy has failed if the patient remains symptomatic after a full course of treatment at an adequate dosage. If there is no clear improvement with the first drug, it should be changed to another class of drug) or
 - there is a history of severe depression, especially bipolar disorder.

If drug or alcohol misuse is also a problem, see the guidelines for these disorders.

Involve non-healthcare support (eg chaplain, counsellor, listener/buddy, voluntary support group) in all other cases where symptoms persist, where the patient has a poor or non-existent support network, or where social or relationship problems are contributing to the depression.⁸⁶

Severely depressed adolescents are difficult to assess and manage, and referral is recommended (see **Emotional disorders in young people**, page 126).

For more details on referral, see **Managing the interface with the NHS and other agencies** (page 149).

Resources for patients and primary support groups

Association for Post Natal Illness: 020 7386 0868

Depression Alliance: 020 7633 0557 (answerphone)

SAD (Seasonal Affective Disorder) Association: 01903 814942

Samaritans: 08457 909090 (24-hour, 7 days per week helpline)

UK Register of Counsellors: 08704 435232

(Provides a list of BACP-accredited counsellors)

Resource leaflets:

Problem-solving

Coping with Depression

Dorothy Rowe. *Depression: Way Out of Your Prison*. An explanatory book

Erika Harvey. *The Element Guide to Postnatal Depression: Your Questions Answered*. Shaftesbury: Element, 1999

Dissociative (conversion) disorder — F44

Presenting complaints

Patients exhibit unusual or dramatic physical symptoms such as seizures, amnesia, trance, loss of sensation, visual disturbances, paralysis, aphonia, identity confusion and 'possession' states. The patient is not aware of their role in their symptoms — they are not malingering.

Diagnostic features

Physical symptoms are:

- unusual in presentation and are
- not consistent with known disease.

Onset is often sudden and related to psychological stress or difficult personal circumstances.

In acute cases, symptoms may:

- be dramatic and unusual
- change from time to time or
- be related to attention from others.

In more chronic cases, patients may appear unduly calm in view of the seriousness of the complaint.

Differential diagnosis

Carefully consider the physical conditions that may cause symptoms. A full history and physical (including neurological) examination are essential. The early symptoms of neurological disorders (eg multiple sclerosis) may resemble conversion symptoms.

- If other unexplained physical symptoms are present, see **Unexplained somatic complaints — F45** (page 94).
- **Depression — F32#** (page 47). Atypical depression may present in this way.

Essential information for the patient and primary support group

- Physical or neurological symptoms often have no clear physical cause. Symptoms can be brought about by stress.
- Symptoms usually resolve rapidly (from hours to a few weeks), leaving no permanent damage.

Advice and support to the patient and primary support group

- Encourage the patient to acknowledge recent stresses or difficulties (though it is not necessary for the patient to link the stresses to current symptoms).
- Give positive reinforcement for improvement. Try not to reinforce symptoms
- Advise the patient to take a brief rest and relief from stress, then to return to usual activities.
- Advise against prolonged rest or withdrawal from activities.

Medication

Avoid anxiolytics or sedatives.

In more chronic cases with depressive symptoms, antidepressant medication may be helpful.

Referral

See general referral criteria (page 152).

Non-urgent referral to the secondary mental-health services is advised if confident of the diagnosis:

- if symptoms persist
- if symptoms are recurrent or severe or
- if the patient is prepared to discuss a psychological contribution to symptoms.

If you are unsure of the diagnosis, consider referral to a physician before referral to the secondary mental-health services.

If release is planned, work cooperatively with both probation or throughcare-planning officers to ensure that appointments with a general practitioner and specialist mental healthcare are arranged along with other needs such as housing.

For more detail on throughcare, see **Managing the interface with the NHS and other agencies** (page 149).

Resource for patients and primary support groups

UK Register of Counsellors: 08704 435232

(Supplies names and addresses of BAC-accredited counsellors).

Drug-use disorders — F11#

Presenting complaints

Patients may present in a state of withdrawal or (more rarely) of intoxication or with physical complications of drug use, eg abscesses or thromboses. They may also present with the legal or social consequences of their drug use, eg prosecution or debt. Occasionally, covert drug use may manifest itself as bizarre, unexplained behaviour.

Patients may have: depressed mood, nervousness or insomnia.

Patients may present with a direct request for prescriptions for narcotics or other drugs, a request for help to withdraw, or for help with stabilising their drug use.

Signs of drug withdrawal include the following.

- Opioids: nausea, sweating, aching, stomach cramps, gooseflesh, dilated pupils
- Sedatives: anxiety, tremors, perceptual distortions, fits
- Stimulants: depression, moodiness, hunger, excessive sleep.

Staff may request help before the patient (eg because the patient is irritable or has a positive result to a drug test). Whatever their motivation for seeking help, the aim of treatment is to assist the patient in remaining healthy until, if motivated to do so and with appropriate help and support, he/she can achieve a drug-free life.

Diagnostic features

- Drug use has caused physical harm (eg injuries while intoxicated), psychological harm (eg symptoms of mental disorder due to drug use) or has led to harmful social consequences (eg criminality, loss of job, severe family problems)
 - Habitual and/or harmful or chaotic drug use
- Difficulty controlling drug use
- Strong desire to use drugs
- Tolerance (can use large amounts of drugs without appearing intoxicated)
- Withdrawal (eg anxiety, tremors or other withdrawal symptoms after stopping use).

Diagnosis will be aided by the following.

- History: including a reason for presentation, past and current (ie in the past 4 weeks) drug use, a history of injecting and the risk of HIV and hepatitis, past medical and psychiatric history, social (and especially child care) responsibilities, forensic history and past contact with treatment services
- Examination: motivation, physical (needle tracks or complications, eg thrombosis or viral illness), mental state
- Investigations: haemoglobin, LFTs, urine drug screen, hepatitis B and C, HIV.

Differential diagnosis

- **Alcohol misuse — F10** (page 18) can coexist. Polydrug use is common
- Symptoms of anxiety or depression may also occur with heavy drug use. If these continue after a period of abstinence (eg about 4 weeks), see **Depression — F32#** and **Generalised anxiety — F41.1** (pages 47 and 64)
- **Psychotic disorders — F23, F20#** (page 11 and 36)
- Acute organic syndromes.

Essential information for the patient and primary support group

- Drug misuse is a chronic, relapsing condition. Controlling or stopping use often requires several attempts. It is particularly hard when the patient also has another mental disorder. Relapse is common
- Abstinence should be seen as a long-term goal. Harm reduction (especially reducing intravenous drug use) may be a more realistic goal in the short- to medium-term
- Stopping or reducing drug use will bring psychological, social and physical benefits
- Using some drugs during pregnancy risks harming the baby^{N87}
- For intravenous drug users, there is a risk of transmitting HIV infection, hepatitis or other infections carried by body fluids. Discuss the appropriate precautions, eg use condoms and do not share needles, syringes, spoons, water or any other injecting equipment

- Where the patient also has a psychotic disorder, advise that substance abuse makes acute symptoms of psychosis (eg hallucinations) worse, even when antipsychotic medication is taken.

Advice and support to the patient and primary support group

Advice should be given according to the patient's motivation and willingness to change.⁸⁸ For some patients with chronic, relapsing opioid dependence, the treatment of choice is maintenance on long-acting opioids (usually methadone).⁸⁹

For all patients, do the following.

- Discuss the benefits and costs of drug use (including the links between drug use and offending) from the patient's perspective
- Feedback information about the health risks, including the results of investigations
- Emphasise the personal responsibility for change
- Give clear advice to change
- Assess and manage the physical health problems (eg deep vein thrombosis [DVT], abscesses, infections, hepatitis, HIV, anaemia, chest problems) and nutritional deficiencies
- Consider the options for problem-solving or targeted counselling to deal with life problems related to drug use.

For patients not willing to stop or change their drug use immediately, do the following.

- Do not reject or blame
- Advise on harm-reduction strategies (eg if the patient is injecting, advise on the risks of needle sharing, not injecting alone, not mixing alcohol, benzodiazepines and opiates) (see the patient leaflet *Harm Reduction* on the disk)
- Clearly point out medical, psychological, social and offending problems caused by drugs
- Make a future appointment to reassess health (eg well-woman checks, immunisation) and discuss drug use.

If reducing drug use is a reasonable goal (or if a patient is unwilling to quit):

- Negotiate a clear goal for decreased use
- Discuss strategies to avoid or cope with high-risk situations (eg release, social situations, stressful events)
- Plan for self-monitoring procedures upon release (eg a diary of drug use) and for safer drug-use behaviours (eg time restrictions, slowing down rate of use)
- Consider options for counselling and/or rehabilitation.

If maintenance on substitute drugs is a reasonable goal (or if a patient is unwilling to quit):

- Negotiate a clear goal for less harmful behaviour. Help the patient develop a hierarchy of aims, eg stopping illicit use and maintenance on prescribed, substitute drugs, reduction of substitute drugs
- Discuss strategies to avoid or cope with high-risk situations, eg release, social situations or stressful events
- Consider withdrawal symptoms and how to avoid or reduce them
 - Consider options for counselling or rehabilitation, or both.

For patients willing to stop immediately:

- Consider withdrawal symptoms and how to manage them
- Discuss strategies to avoid or cope with high-risk situations, eg release, social situations or stressful events
- Make specific plans to avoid drug use, eg how to respond to friends who still use drugs
- Identify family or friends who will support stopping drug use
- Consider options for counselling or rehabilitation, or both.

For patients who do not succeed or who relapse or transfer to a different drug while in prison:

- Identify and give credit for any success
- Discuss situations that led to the relapse
- Return to the earlier steps.

Self-help organisations such as Narcotics Anonymous are often helpful.

Medication

To withdraw a patient from benzodiazepines, convert to a long-acting drug such as diazepam and reduce gradually over 2–6 months (see *BNF*, Section 4.1). For more information, see 'Guidelines for the prevention and treatment of benzodiazepine dependence'.⁹⁰

Withdrawal from stimulants or cocaine is distressing and may require medical supervision. The risk of suicide and self-harm during and following withdrawal from stimulants and cocaine is particularly high. For more information, see **Comorbidity** (page 191).

Both long-term maintenance of a patient on substitute opiates (usually methadone) and withdrawal from opiates should be done as part of a shared-care scheme.⁹¹ A multidisciplinary approach is essential and should include drug counselling/therapy^{N92} and possible future rehabilitation needs.⁹³ The doctor signing the prescription is wholly responsible for prescribing; this cannot be delegated. For more information, see *Drug Misuse and Dependence: Guidelines on Clinical Management*.⁹⁴

- Careful assessment, including urine analysis and, where possible, dose assessment, is essential before prescribing any substitute medication, including methadone. Addicts often try to obtain a higher-than-needed dose. Dosages will depend on the results of the assessment
- For long-term maintenance or stabilisation before gradual withdrawal, the dose should be titrated up to that needed both to block withdrawal symptoms and the craving for opiates^{N95}
- For gradual withdrawal after a period of stabilisation, the drug can be slowly tapered (eg by 5 mg per fortnight)
- Daily dispensing and supervised ingestion are recommended
- In the UK at present, methadone mixture BNF 1 mg ml⁻¹ is the most often-used substitute medication for opioid addiction⁹⁶ (see *BNF*, Section 4.10). Other, newer drugs are, or may become, available (eg Buprenorphine⁹⁷). Specialist advice should be obtained before prescribing these
- Withdrawal from opiates for patients whose drug use is already well controlled can be managed with Lofexidine⁹⁸ (see *BNF*, Section 4.10).

Referral

Consider referral:

- To a Detoxification Unit if the patient is dependent upon drugs
- Involve the in-house or secondary mental-health services in addition if the patient has an associated severe psychiatric disorder, or if the symptoms of mental illness persist after detoxification and abstinence. Ideally, treatment should be provided by clinicians skilled in treating both substance misuse and mental disorder²⁵
- To counselling, assessment, referral, advice and throughcare services (CARATS) workers for counselling targeted at problems associated with/triggering drug use and relapse prevention work
- To in-house rehabilitation programmes and therapeutic communities.

Before release:

- If possible, arrange in good time for on-going rehabilitation support in the community. Help with life problems, employment and social relationships is an important component of treatment⁹⁹
- Where the patient has both a mental illness and a drug misuse problem and expresses some motivation to reduce use, if either the psychiatric or substance misuse problem appears to predominate, refer them initially to that service. Make the rationale clear in the letter/fax. If both types of disorder are of equal significance, then negotiate with both agencies about the preferred initial referral route. It may be that the individual will require support and input by both agencies. Some can provide services jointly. Ideally, a modified form of motivational interviewing that takes account of the additional problems of a patient with a severe mental illness will be used. Liaise with the service to ensure continued prescription of psychotropic medication, if appropriate
- Stress to the patient that relapses are to be expected, are not signs of failure and will not mean a loss of your support and respect.

See **Comorbidity** (page 191).

Resources for patients and primary support groups

ADFAM National: 020 7928 8900 (helpline)
(For families and the friends of drug users)

CITA (Council for Involuntary Tranquilliser Addiction): 0151 949 0102 (Monday–Friday, 10 am–1 pm)
Cavendish House, Brighton Road, Waterloo, Liverpool
(Confidential advice and support)

Heroin Adviceline: 020 7729 9904

(Advice, support and information to drug users and their friends and families on all aspects of drug use and drug -related legal problems)

Narcotics Anonymous: 020 7730 0009

National Drugs Helpline: 0800 776600 (24-hour freephone)
(Confidential advice, including information on local services)

Release Out of Hours: 020 7603 8654 (helpline: Monday–Friday, 6 pm–10 pm; Saturday and Sunday, 8 am–12 midnight)

Resource leaflets:

Harm Minimization Advice

Drug Use Diary

Eating disorders — F50

Presenting complaints

The patient may indulge in binge-eating and extreme weight-control measures such as self-induced vomiting, excessive use of diet pills and laxative abuse. This may be recognised first on reception into prison when low weight is recorded, or it may become more apparent after a period in prison when abnormal eating behaviours have been observed.

Both anorexia and bulimia may present as physical disorders, eg amenorrhoea, seizures and cardiac arrhythmias that require monitoring or treatment.

Diagnostic features

Common features are:

- unreasonable fear of being fat or gaining weight
- extensive efforts to control weight, eg strict dieting, vomiting, use of purgatives, excessive exercise
- denial that weight or eating habits are a problem
- low mood, anxiety/irritability
- obsessional symptoms
- relationship difficulties
- increasing withdrawal and
- school and work problems.

Patients with anorexia nervosa typically show:

- severe dieting despite very low weight: body mass index (BMI) $< 17.5 \text{ kg m}^{-2}$ (BMI = weight [kg]/height [m²])
- a distorted body image, ie an unreasonable belief that one is overweight and
- amenorrhoea.

Patients with bulimia typically show:

- binge-eating, ie eating large amounts of food in a few hours and
- purging: attempts to eliminate food by self-induced vomiting or via diuretic or laxative use.

A patient may show both anorexic and bulimic patterns at different times. Binge-eating may be very difficult in a prison setting and the inability to use this coping mechanism may result in increased anxiety and the use of alternative maladaptive coping strategies, eg deliberate self-harm, aggression.

The medical consequences of severe weight loss include amenorrhoea, dental problems, muscle weakness, renal stones, constipation and liver dysfunction. Medical complications of purging include dental problems, salivary-gland swelling, kidney stones, cardiac arrhythmias and seizures.

Eating disorders are rarer in men than in women. There is an association between eating disorders and childhood abuse.

Differential diagnosis

- **Depression** — **F32#** (page 47) may occur along with bulimia or anorexia.
- Physical illness may cause weight loss.
- There may be coexisting problems such as drugs and alcohol misuse or self-harm.

Essential information for the patient and primary support group

- Purging and severe starvation may cause serious physical harm. Anorexia nervosa can be life-threatening.
- Purging and severe dieting are ineffective ways of achieving lasting weight control.
- Self-help groups, leaflets and books may be helpful in explaining the diagnosis clearly and involving the patient in treatment.

Advice and support to the patient and primary support group

The prison doctor can undertake some simple steps to treat eating disorders, ideally with the help of the counsellors, healthcare staff and/or a dietitian.

In anorexia nervosa:

- Expect denial and ambivalence. Elicit the patient's concerns about the negative effects of anorexia nervosa on aspects of their life. Ask the patient about the benefits that anorexia has for them, eg the feeling of being in control, feeling safe, being able to get care and attention from family. Do not try to force the patient to change if he/she is not ready.
- Educate the patient about food and weight.
- Weigh the patient regularly and chart their weight. Set manageable goals in agreement with the patient (eg aim for a 0.5 kg increase per week; this requires a calorie intake of about 2500 kcal day⁻¹). A supportive member of staff who the patient trusts may be able to help the patient achieve this. Consultation with a dietitian may be helpful to establish the normal calorie and nutrient intake and the regular patterns of eating.
- A return to normal eating habits may be a distant goal.
- Provide counselling, if available, about traumatic life events and difficulties (past and present) that seem significant in the onset or maintenance of the disorder (see **Counselling and other psychological therapies** below).

In bulimia nervosa:

- Use a collaborative approach.
- A food diary can be a useful therapeutic tool in discussions with the patient.
- Educate the patient about the need to eat regularly throughout the day (three meals plus two snacks) to reduce urges to binge.
- Set mutually agreed, gradual goals to increase number of meals eaten, the variety of foods allowed, and to reduce vomiting and laxatives.
- Help the patient identify the psychological and physiological triggers for binge-eating and make clear plans to cope more effectively with these trigger events, eg plan an alternative behaviour.
- Discuss the patient's biased beliefs about weight, shape and eating (eg carbohydrates are fattening) and encourage a review of their rigid views about body image, eg patients believe no one will like them unless they are very thin. Do not simply state that the patient's view is wrong.

Provide counselling, if available, about the difficulties underlying or maintaining the disorder, eg childhood abuse, relationship difficulties or concurrent problems with substance abuse (see **Counselling and other psychological therapies** below).

Additional advice to staff (with patient permission)

- Support will be required around eating to reduce anxiety at those times — critical comments or exhortations to eat will not help.
- Encouraging reasonable levels of activity and exercise to promote a healthy lifestyle is important and can help in re-establishing eating habits and appetite.
- Help to develop alternative coping strategies. Attendance at education and/or work will be helpful.
- Explanations about the disorder and the treatment approaches for personal officers will help them be supportive of the patient day to day.

Medication

- In bulimia nervosa, antidepressants (eg fluoxetine, 60 mg) are effective in reducing bingeing and vomiting in a proportion of cases.^{N100} However, compliance with medication may be poor (see *BNF*, Section 4.3).
- No pharmacological treatment for anorexia has been established to date.^{N101} Psychiatric conditions (eg depression) may co-occur and may respond to pharmacological treatment.
- Order blood tests for urea and electrolytes.

Referral

Refer for urgent assessment (if possible, to the secondary mental-health services with expertise in eating disorders) if:

- BMI < 13.5 kg m⁻², especially if there has been rapid weight loss
- potassium < 2.5 mmol l⁻¹
- there is severe bone marrow dysfunction with loss of platelets
- there is evidence of proximal myopathy
- there are significant gastrointestinal symptoms from repeated vomiting, eg blood in vomitus

- there is significant risk of suicide or
- there are other complicating factors, eg substance or alcohol abuse.

Refer to specialist mental-health services for assessment if there is a lack of progress despite the above measures.

Counselling and other psychological therapies

If available, consider family therapy for appropriate patients, including anorexic patients (under 18 years),¹⁰² individual psychotherapy for anorexic patients over 18, and cognitive-behavioural therapy¹⁰³ for those with bulimia. If detention in prison has revealed an eating disorder for the first time, liaison with community providers for access to therapeutic interventions on release is important.

Consider non-statutory/voluntary services/self-help groups.

Where the patient is on remand or on a short sentence, and especially if the traumatic life events include severe childhood abuse, appropriate types of help will encourage the patient to focus on the present and help him/her deal with current problems for which solutions may be possible.

Resources for patients and primary support groups

Eating Disorders Association: 01603 621 414 (helpline: 9 am–6.30 pm)

(Self-help support groups for sufferers, and their relatives and friends. Assists in putting people in touch with sources of help in their own area)

Centre for Eating Disorders (Scotland): 0131 668 3051

(Information, private psychotherapy, self-help manuals, information packs and a helpline)

Anorexia Bulimia Careline (Northern Ireland): 02890 614440

Overeaters Anonymous: 01454 857158 (recorded message)

(Self-help groups for those suffering from eating disorders or overeating)

Resource leaflet:

Food and Behaviour Diary

U Schmidt, J Treasure, 1993, *Getting Better Bit(e) by Bit(e) Survival Guide for Sufferers of Bulimia Nervosa and Binge Eating Disorders*. Lawrence Erlbaum, 1993 Hove. (Self-help manual of proven efficacy for sufferers of bulimia and binge-eating disorders)¹⁰⁴

J Treasure. *Anorexia Nervosa: A Survival Guide for Families, Friends and Sufferers*. London: Psychology Press, 1997

Both the above books are available from the Institute of Psychiatry: URL:

<http://www.iop.kcl.ac.uk/IoP/Departments/PsychMed/EDU/GuidedSelfCare.stm>; or the distributors Taylor & Francis.
Tel: 01264 343071

CG Fairburn. *Overcoming Binge Eating*. New York: Guilford, 1995. Advice tested in controlled research

Generalised anxiety — F41.1

Presenting complaints

The patient may present initially with tension-related physical symptoms (eg headache or a pounding heart) or with insomnia. Enquiry will reveal prominent anxiety.

Diagnostic features

Multiple symptoms of anxiety or tension include:

- physical arousal, eg dizziness, sweating, a fast or pounding heart, a dry mouth, stomach pains or chest pains
- mental tension, eg worry, feeling tense or nervous, poor concentration, fear that something dangerous will happen and the patient will not be able to cope and
- physical tension, eg restlessness, headaches, tremors or an inability to relax.

Symptoms may last for months and recur regularly. Often they are triggered by stressful events in those prone to worry.

Differential diagnosis

- **Alcohol misuse — F10** or **Drug-use disorders — F11#** (pages 18 and 55) if heavy alcohol or drug use is present. Anxiety is a common symptom during detoxification/withdrawal. It may also underlie substance misuse and become prominent after withdrawal. Substances may be used to self-medicate for anxiety. If symptoms of anxiety remain or increase following detox, suspect an underlying anxiety disorder and/or benzodiazepine dependence (see **Comorbidity**, page 191).
- **Depression — F32#** (page 47) if a low or sad mood is prominent.
- **Chronic mixed anxiety and depression — F41.2** (page 33).
- **Panic disorder — F41.0** (page 67) if discrete attacks of unprovoked anxiety are present.
- **Phobic disorders — F40** (page 79) if fear and avoidance of specific situations are present.
- Certain physical conditions (eg thyrotoxicosis) or medications (eg methylxanthines, β -agonists) may cause anxiety symptoms.
- Anxiety can be a symptom of post-traumatic stress disorder. **Post-traumatic stress disorder — F43.1** (page 82).

Essential information for the patient and primary support group

- Stress and worry have both physical and mental effects.
- Where drugs or alcohol have previously been used to deal with underlying anxiety, prison presents an opportunity to learn alternative ways of dealing with it.
- Learning skills to reduce the effects of stress (not sedative medication) is the most effective relief.¹⁰⁵

Advice and support to the patient and primary support group

- Encourage the patient to use relaxation methods daily to reduce the physical symptoms of tension. The *Managing Anxiety* leaflet on the disk includes a relaxation exercise . If the patient has reading difficulties, a member of the healthcare team or other member of staff may be able to go over the contents of the leaflet with the patient.
- Advise a reduction in caffeine consumption, if appropriate.⁴⁶
- Try to avoid using cigarettes, other drugs or alcohol to cope with anxiety.
- Help the patient plan activities that are relaxing, pleasurable or confidence building. Exercise may be helpful.^{49,50} If necessary, consider advocating for improved access to appropriate activities.
- Identify and challenge exaggerated worries to help the patient reduce anxiety symptoms:
 - Identify exaggerated worries or pessimistic thoughts, eg when a visitor does not arrive on time, the patient worries that they no longer want contact with them.
 - Discuss ways to question these exaggerated worries when they occur, eg 'I am starting to be caught up in worry again. My visitor is only a few minutes late. He will probably be here soon.'
- Structured problem-solving methods⁴⁸ can help patients to manage current life problems or stresses that contribute to anxiety symptoms. Support the patient to carry out the following steps:

- Identifying events that trigger excessive worry. (For example, a young woman presents with worry, tension, nausea and insomnia. These symptoms began after she learned that her son was behaving badly in school following her conviction).
- Listing as many possible solutions as the patient can think of (eg discussing her concerns with a close friend or relative, applying for an extended family visit, writing to her son's general practitioner, contacting a voluntary organisation that helps families of prisoners).
- Listing the advantages and disadvantages of each possible solution. (The patient should do this, perhaps between appointments).
- Choosing his/her preferred approach.
- Working out the steps necessary to achieve the plan.
- Setting a date to review the plan. Identify and reinforce things that are working).
- Identify possible resources for problem solving, relaxation, yoga (eg counsellor, voluntary agency teaching meditation/relaxation; see **Resources Directory** page 316).

Medication

Medication is a secondary treatment in the management of generalised anxiety.^{105,106} It may be used, however, if significant anxiety symptoms persist despite the measures suggested above.

Anti-anxiety medication^{N107} (see *BNF*, Section 4.1.2) can only be used for ≤ 2 weeks. Avoid short-acting benzodiazepines; consider diazepam. Longer-term use may lead to dependence and is likely to result in the return of symptoms when discontinued.

Antidepressant drugs,¹⁰⁸ eg imipramine, clomipramine, paroxetine or venlafaxine, may be helpful, especially if the symptoms of depression are present. They do not lead to dependence or rebound symptoms, but can lead to withdrawal symptoms and so should be tapered gradually (see *BNF*, Section 4.3).

β -Blockers may help control physical symptoms such as tremor.¹⁰⁹

Referral

See **General referral criteria** (page 149).

Non-urgent referral to the secondary mental-health services is advised if the patient's symptoms are sufficiently severe or enduring to interfere with his/her social or occupational functioning.

If available, consider cognitive-behavioural therapy or anxiety management.^{N110} Self-care classes and 'assisted bibliotherapy' can also be effective in the primary care of milder anxiety.^{111,112}

Resources for patients and primary support groups

No Panic Helpline: 01952 590545 (10 am–10 pm); 0800 7831531 (freephone infoline)
(Helpline, information booklets and local self-help groups for people with anxiety, phobias obsessions, panic)

Prison Phoenix Trust: 01865 512521/512522

Prison Phoenix Trust, PO Box 328, Oxford OX2 7HF. Fax: 01865 516011

(Teaches and encourages the use of techniques such as meditation and yoga among prisoners, through correspondence and a network of teachers)

Stresswatch Scotland 01563 574144 (helpline); 01563 570886 (office)

(Advice, information, materials on panic, anxiety, stress phobias. Thirty-five local groups)

Triumph Over Phobia (TOP) UK: 01225 330353

(Structured self-help groups. Produces self-help materials)

Resource leaflets:

Coping with Anxiety

Mind Publications produces booklets on *Understanding Anxiety* and other relevant topics. Available from: Mind England and Wales. Tel: 020 8519 2122; Northern Ireland Tel: 02890 237937; Scotland: Tel: 0141 568 7000

Alice Neville. *Who's Afraid...? Coping With Fear, Anxiety and Panic Attacks*. Arrow, 1991

Panic disorder — F41.0

Presenting complaints

Patients may present with one or more physical symptoms (eg chest pain, dizziness or shortness of breath) or unexplained episodes of intense fear. Further enquiry shows the full pattern described below.

Diagnostic features

The patient experiences unexplained attacks of anxiety or fear, which begin suddenly, develop rapidly and may last only a few minutes.

The panics often occur with physical sensations such as palpitations, chest pain, sensations of choking, churning stomach, dizziness, feelings of unreality or fear of personal disaster (losing control or going mad, sudden death or having a heart attack).

A panic often leads to fear of another panic attack and avoidance of places where panics have occurred.

Differential diagnosis

Many medical conditions may cause symptoms similar to panic, eg arrhythmia, cerebral ischaemia, coronary disease, asthma or thyrotoxicosis. It is not uncommon for individuals with these conditions additionally to suffer from panic. History and physical examination should exclude many of these and should reassure the patient. However, avoid unnecessary medical tests or therapies.

- Drugs may induce the symptoms of panic.
- **Phobic disorders** — **F40** (page 79) if panics tend to occur in specific situations.
- **Depression** — **F32#** (page 47) if a low or sad mood is also present.

Essential information for the patient and primary support group

- Panic is common and can be treated.
- Anxiety often produces frightening physical symptoms. Chest pain, dizziness or shortness of breath are not necessarily signs of a physical illness; they will pass when anxiety is controlled. Explain how the body's arousal reaction provides the physical basis for their symptoms and how anxiety about a physical symptom can create a vicious cycle. A diagram may be helpful.
- Panic anxiety also causes frightening thoughts (eg fear of dying, a feeling that one is going mad or will lose control) and vice versa. These also pass when anxiety is controlled.
- Mental and physical anxiety reinforce each other. Concentrating on physical symptoms will increase fear.
- A person who withdraws from or avoids situations where panics have occurred will only strengthen his/her anxiety.

Advice and support to the patient and primary support group^{N106}

- Advise the patient to identify the early warning signs of an impending panic attack and take the following steps at the first sign of a panic:
 - Stay where you are until the panic passes, which may take up to 1 hour. Do **not** leave the situation. Start slow, relaxed breathing, counting up to four on each breath in and each breath out. Breathing too deeply (hyperventilation) can cause some of the physical symptoms of panic. Controlled breathing will reduce the physical symptoms. Do something to focus your thinking on something visible, tangible and non-threatening, eg look at a picture on the wall.
 - If hyperventilation is severe, sit down and breathe into a paper bag so that the increased carbon dioxide will slow down your breathing (unless the patient has asthma or cardiovascular disease).
 - Concentrate on controlling anxiety and not on the physical symptoms
 - Tell yourself that this is a panic attack and that the frightening thoughts and sensations will eventually pass. Note the time passing on your watch. It may feel like a long time but it will usually only be a few minutes.
- Identify exaggerated fears that occur during panic, eg patient's fears that he/she is having a heart attack.
- Discuss ways to challenge these fears during panic, eg the patient reminds him/herself: 'I am not having a heart attack. This is a panic, and it will pass in a few minutes'.
- If possible, identify someone (a member of the healthcare team or other staff member) who the patient trusts who may support him/her in taking the above actions.
- Monitor and, if necessary, reduce caffeine intake.

- Try to avoid using cigarettes or other drugs to cope with anxiety.
- Self-help groups, books, tapes or leaflets may help the patient manage panic symptoms and overcome fears.¹¹³ If the patient has reading difficulties, a member of the healthcare team or another member of staff may be able to discuss the contents of the leaflet *Managing Anxiety* on the disk with him/her .

Medication

Many patients will benefit from the above measures and will not need medication, unless their mood is low.

- If attacks are frequent and severe or if the patient is significantly depressed, antidepressants, including tricyclics (TCAs) and selective serotonin re-uptake inhibitors (SSRIs), may be helpful.^{N114} Paroxetine and citalopram are currently licensed for panic (see *BNF*, Section 4.3). There can be a slight worsening of symptoms initially, so advise the patient to plan reduced activities for the week following the first prescription.
- Encourage patients to face fears without the use of benzodiazepines. However, where the feared situation is rare, occasional short-term use of anti-anxiety medication may be helpful.^{N115} Regular use may lead to dependence and is likely to result in a return of symptoms when discontinued.

Referral

See **General referral criteria** (page 149).

Non-urgent referral to the secondary mental-health services or a counsellor with appropriate special training is advised for assessment for cognitive-behavioural psychotherapy for patients who do not improve or those whose lifestyle is severely compromised. (This can be particularly effective for patients with panic disorder.^{116,117}) Cognitive-behavioural therapy (CBT), which has been developed in specialist settings, also appears to be effective in primary care.¹¹⁸

Panic commonly causes physical symptoms; avoid unnecessary medical referral for physical symptoms if you are certain of the diagnosis.

Consider self-help/voluntary/non-statutory services.

Resources for patients and primary support groups

No Panic Helpline: 01952 590545 (10 am–10 pm); 0800 7831531 (freephone infoline)

(Helpline, information booklets and local self-help groups for people with anxiety, phobias, obsessions and panic)

Stresswatch Scotland: 01563 574144 (helpline); 01563 570886 (office)

(Advice, information, materials on panic, anxiety, stress phobias. Thirty-five local groups)

Triumph Over Phobia (TOP) UK: 01225 330353

(Structured self-help groups. Produces self-help material)

Resource leaflets:

Managing Anxiety

Mind Publications produces booklets on *How To Cope With Panic Attacks* and other relevant topics. Available from: Mind England and Wales: Tel: 020 8519 2122; Northern Ireland: Tel: 02890 237973; Scotland: 0141 568 7000

Isaac Marks. *Living with Fear*. New York: McGraw Hill 1978. Self-help manual

Alice Neville. *Who's Afraid...? Coping With Fear, Anxiety and Panic Attacks*. Arrow, 1991

Personality (behavioural) disorders — F60–69

Introduction

Many people in prison have a personality disorder. Some have suffered extremes of abuse and neglect as children leading to very disturbed behaviours and ways of relating to others. People with personality disorders are very difficult to manage. However, treatable mental disorders occur frequently in people with personality disorders. The aims of this guideline are to help primary-care staff to do the following.

- Form and maintain a therapeutic relationship with these patients:
 - to treat comorbid mental and physical disorders
 - to recognise and reinforce the patient's capacity to change their immediate situation at times of crisis and
 - to offer support and thus contribute to avoiding further deterioration.
- Identify those patients who may benefit from further assessment and treatment for their behavioural problems by specialists.
- Participate in the multidisciplinary management of very difficult patients.

Presenting complaints

Most patients present with complaints of another disorder rather than the personality problem itself. They may present with anxiety, depression, eating problems or deliberate self-harm, or they may repeatedly seek psychotropic medication. People with personality disorder may experience high levels of distress. Staff or other inmates may express concern about the patient's behaviour, eg overly hostile and/or frequent attempts at self-harm. The patient's personality problem often interferes with treatment for another mental disorder.

Diagnostic features

The features of personality disorder are displayed in a patient's behaviour and relationships, and may also affect the organisation around them.

Behaviour

The patient displays a long-term, stable pattern of experience and behaviour that started in early life, deviates markedly from cultural norms and leads to distress and impairment. The patient behaves in this way most or all the time, in some or all of a range of settings (eg work, home, when out with friends, in prison) without learning from the negative responses of others towards them. There are many different kinds of personality disorders and in prison people most often have features of more than one type. The types of personality disorders most commonly found in prison are the following.

Antisocial or dissocial personality disorder

Most individuals in prison are inclined towards an antisocial lifestyle. Sometimes this rises to the level of a disorder. The features of the disorder include the following.

- A disregard for and a violation of the rights of others, eg violence, theft, cruelty to animals.
- Deceitfulness.
- Reckless disregard for safety.
- Consistent irresponsibility and a disregard for rules and regulations.
- Inability to maintain relationships for any length of time.
 - Low tolerance for frustration, leading to aggression or violence.
- Lack of remorse; a tendency to blame others or rationalise their own behaviour.
- Tendency not to learn from experience, particularly from punishment.
- Often superficially cooperative and charming.

Emotionally unstable disorder (also known as 'borderline personality disorder')

Individuals may be emotionally unstable and, in some, this may rise to the level of a disorder. The features of the disorder include the following.

- Unstable and intense interpersonal relationships, eg extremes of idealising and denigrating the other person, sometimes friendly, sometimes intensely angry, fearful of abandonment.
- Highly reactive, sudden mood swings, eg intense, inappropriate anger, transient, stress-related paranoid thoughts.
- Chronic feeling of emptiness, clinging dependency and terror of being left alone.
- Marked impulsiveness that is potentially self-damaging, eg reckless driving, sexual promiscuity, excessive spending sprees, binge-eating.
- Poor ability to plan ahead and to solve problems.

Paranoid personality disorder

Many individuals in prison display paranoid characteristics and, in some, this may rise to the level of a disorder. The features of the disorder include the following.

- Distrust and suspiciousness, eg unjustified suspicions that others are exploiting or harming him/her, reluctance to confide in others, bears grudges, will not accept rational explanation.
- Being tense, anxious, irritable or angry.
- Preoccupation with justice and rules.

Individual relationships

The individual's problems and feelings of fear, humiliation, anger and need are played out in their relationships. For example, they may:

- bully and attempt to dominate those around them, eg via non-verbal intimidation, critical questioning, threats of complaints or violence
- use charm, flattery, friendly support to obtain special privileges or develop a 'special relationship' that goes beyond the boundaries of a professional relationship
- become very dependent upon you or other staff
- be resistant to authority or
- be critical of you or others who are working with them.

The genuine distress the patient feels may be experienced by the other person as manipulation.

Organisational relationships

The intense feelings and disturbed behaviours and relationships commonly affect both staff teams and the relationships between departments. For example, the patient may idealise and denigrate different members of staff causing the favoured staff member to doubt the good will or professional ability of the denigrated one. This may cause division and conflict within the healthcare staff team and the healthcare staff and other staff, eg discipline officers, probation officers, chaplain, psychologist.

Differential diagnosis

Personality disorder commonly coexists with mental disorder. A history from a relative or close friend may be useful to distinguish the two. Personality disorder is a disorder of relating to others and those symptoms become visible in relationships with others. The symptoms of mental illness are visible when the patient is alone. In mental illness, the patient's behaviour becomes different from what is normal for that patient. In personality disorder, the behaviour is normal for that patient but is different from the norm in his/her culture.

If behaviour, eg 'out of character' aggression, has developed for the first time in adulthood, is of recent onset or is temporary, consider the following.

- **Depression and Anxiety disorders** (pages 47 and 33). Aggression and/or irritability may be a sign of depression.
- **Acute or chronic psychosis** (pages 11 and 36).
- **Post-traumatic stress disorder** (page 82).
- **Adjustment disorder** (page 15).
- Abuse of stimulants or hallucinogenic drugs (see **Drug misuse**, page 55).
- Medical condition causing personality change, eg brain injury, dementia.

Also, consider the patient's cultural, social and family background. Check that the person's behaviour is constant across a number of different settings. For example, ask: 'Do even little things get you very angry?' 'Was this true at home as well as

here in prison?' Check the available records such as the inmate medical record (IMR) and probation records. If criminal behaviour is undertaken for gain and other features are absent, consider 'no mental or behavioural disorder'.

Diagnosis of personality disorder is difficult as many of the diagnostic features are present (though in a lesser degree) in all people. A formal diagnosis of personality disorder should only be made by a specialist and where there is reason to believe that such a diagnosis will lead to the patient being offered improved management, eg assessment for medication or transfer to a therapeutic prison.

Comorbidity

A person may have a personality disorder **and** a mental disorder. Mental disorder (eg psychosis, anxiety, depression) may emerge in times of stress. For example, a personality-disordered prisoner spending time in segregation may experience psychotic symptoms.

- **Self-harm** (eg cutting, drug overdoses) is common in borderline and antisocial types, especially where there are real or perceived relationship problems, rejections or losses.
 - **Depression and substance abuse** are common and increase the risk of suicide.
- Someone with personality disorder may experience **psychotic episodes** when under particular stress.
- Most people in prison with personality disorder show features of more than one type of personality disorder.

Information for the patient and primary support group

With patient permission, the following information may be given to others.

- Change is possible but it is very difficult and requires insight (ie the ability to see that the patient plays some part in causing or maintaining his/her own distress; that it is not all the fault of others) and substantial motivation. Where that motivation is present, long-term specialist treatment is required.
- Depression, anxiety, transient psychotic illness and substance abuse can be treated.
- Problem-solving skills can help the patient cope with particular problems, but they will not change the overall personality.
- Treatment of any sort (including for associated conditions) requires the patient's active involvement. The relationship with the professional(s) concerned is crucial.

Advice and support to the patient

All patients

- Show respect for the patient and afford them dignity, but do not expect to like them.
- Consider your own safety at all times (see **Managing aggression** page 282).
- Assess the risk of danger to yourself, others and the patient (depression and self-harming behaviour are common).
- Be very clear about your role and its boundaries. For example:
 - the timing and duration of appointments
 - do not buy or bring things in for patients
 - do not discuss your own personal details with them and
 - do not develop a 'special relationship' that is secret from your colleagues.
- Be honest, though sympathetic, in communications. Keep promises; conversely, do not make promises you cannot keep.
- Communicate with others in your team and, as much as is possible within confidentiality, with staff in other departments who are involved with the patient. Tell them about the approach you are taking. Ensure a consistent approach.
- Treat comorbid conditions.
- Focus on immediate, everyday problems. The aim is not to cure the personality disorder but to help the patient deal with everyday life.
- Liaise, with the patient's permission, with other staff who may be able to help address any immediate, practical problem. For example, wing staff about bullying, probation about resettlement following release. Be aware of the potential for division and conflict between staff (see **Organisational relationships** above). If problems occur, try seeing the patient together with the other staff concerned.
- Support and reinforce any legal actions or interests that develop self-esteem, eg work, creativity, education, exercise. Help them to develop any existing strengths, but aim low. Modest success can build into larger gains later; failures can undo good work.

Very difficult patients

It is **essential** that very difficult patients are managed in a multidisciplinary way. Consider convening a case conference involving healthcare, mental-health staff, work supervisor, residential (wing) manager, probation officer, psychologist and chaplain as appropriate. Agree a management plan and inform the patient of that plan in the presence of all participants. Sharing responsibility can reduce stress/burnout and risk of dependence on a patient worker (see **Managing prisoners with complex presentations and very difficult behaviours**, page 202).

Antisocial behaviours

- Aim to maintain an open and trusting atmosphere.
- Identify clearly the reason the patient is seeking help. Ask the patient, 'Why did you come to the Centre?' 'What do you think are your difficulties?'
- Start from the standpoint that there is a legitimate problem underlying most requests, eg 'I may not be able to help you with medication at this centre. I could perhaps help you if you were prepared to tell me why you think you need this medication. But otherwise there is nothing I can do for you'.
- Do not accept all information at face value. Seek further evidence to support the patient's statements. For example, if the patient says he/she is depressed, seek out symptoms normally associated with depression using open questions such as 'What other problems have you been experiencing?' 'What have you been doing with your time?' rather than closed questions such as 'And have you lost interest in the things you normally enjoy?' Allow the person adequate personal space — do not crowd them.
- Do not take the patient's comments personally.
- Allow the patient a chance to talk freely about his/her concerns.
- Set limits and clear guidelines about expected behaviour, eg verbal abuse will not be tolerated.
- It is safest to treat all patients in this way, as you may not know in advance which are difficult.

Emotionally unstable (borderline) behaviours

- Set clear limits. Have a very clear management plan: how frequently you will see the patient, what expectations they have and what you can realistically offer them.
- Try to avoid expressing anger or irritation with the patient — remain outwardly calm and objective. Aim to be firm yet caring and do not argue with the patient.
- It may be counter-productive to tell patients that you believe them to have a personality disorder. It may be better to use terms such as 'exceptionally sensitive', ie they react with more pain, fear and anger to the ups and downs of life than do most people, and so tend to experience many crises in their lives. You can then attempt to agree a plan with the patient, and with other staff, to help them deal a bit better with their crises and other day-to-day problems when they arise.
- Make an agreement about contact between scheduled appointments, eg allow only scheduled appointments, or define what constitutes an 'emergency' which will mean that an unscheduled appointment is allowed.
- Establish a team approach. Establish a clear protocol for how all members of the team will respond to this patient if on duty during a crisis. Crisis contacts should be brief, focused and goal-oriented. If possible, give the patient some responsibility for resolving the crisis. The crisis care plan should involve other staff who are involved in responding to incidents of self-harm, eg chaplain, personal officer, suicide prevention team.
- While formal contracts, sometimes signed by all relevant parties, can sometimes help, they require meticulous attention to detail, require regular updating in the light of progress or deterioration and should not be introduced when the professionals concerned are angry.

Paranoid behaviours

- Assess dangerousness, especially if the patient is aggressive as well as paranoid. Be aware of hidden weapons as paranoid patients may hide weapons to protect themselves.
 - Avoid over friendly or inquisitive behaviour — be professional.
- Listen to the patient's concerns.
- Accept but do not confirm the patient's beliefs.
- Plan clear and mutual goals, eg 'How can we work this out together?'
- Explain **everything**, all treatments, medications, etc.

- Empathise with the patient's anxiety, eg 'I realise it can be upsetting to talk about yourself to someone you don't know well. If you have questions, please ask'.
- Share information with the patient, eg allow him/her to read letters you have written about him/her. Write letters bearing in mind that the patient may see a copy at some stage.
- Keep careful notes, documenting interactions where appropriate. Paranoid patients may be litigious.

Advice and liaison with wing and other staff

- If hostility or paranoia is focused on a particular inmate, member of staff, or type of inmate such as a particular ethnic group, make staff aware. Steps should be taken to protect staff and inmates who may be involved in the patient's paranoid thinking. For example, a paranoid inmate should not share a cell.
- Recommend that these patients have an experienced officer as personal officer. There should not be only one unskilled person working alone.
- Ensure the manager of the wing/unit where the patient is located has a copy of the information sheet on *Personality Disorders*, which is on the disk .
- The prison regime is an important part of management. Discuss work, education, exercise and opportunities to be creative.
- Staff working with this group of individuals, whether on wings or in the healthcare centre, need supervision and support to prevent breaches of role boundaries, eg developing a special relationship that is secret from colleagues.
- For very challenging patients, identify a core, multidisciplinary group (wing manager, psychologist and others as appropriate) to develop and monitor a management plan.

Medication

Offer treatment for associated illness.

- See **Depression** and **Anxiety** (pages 47 and 33) for advice on medication for these conditions. If the patient is **abusing substances**, interactions with prescribed medication are possible and the efficacy of antidepressants is lessened. Benzodiazepines should be avoided because of possible interactions with illegal substances.
- People with a personality disorder may suffer episodes of **psychosis** when under stress. For information about medication, see page 70.

There are no drugs for the treatment of personality disorder. Medication may be tried for certain behavioural problems, though evidence of effectiveness is weak. Careful assessment of the benefit versus side-effects must be made. Decisions about patient consent and capacity are also particularly difficult. Therefore, a careful clinical evaluation by a specialist is required before medication for the long-term treatment of behaviours associated with personality disorder is started.¹¹⁹ If there is a poor relationship between the clinician and patient, there is a danger of medication being used by the clinician purely for control or by the patient to self-harm, or to sell to others. Drugs that a specialist may prescribe include:

- **Sedative antipsychotics:** may be helpful if paranoid or dissocial behaviours are prominent and the patient is highly aroused.
- **Antipsychotic drugs:** may help patients who harm themselves impulsively and those who display symptoms suggestive of (but falling short of) frank psychotic illness.¹²⁰
- **Serotonin re-uptake inhibitor (SSRI) antidepressants:** have been reported as useful in reducing aggression in some patients with dissocial and borderline personality disorder.¹²¹
- **Carbamazepine treatment:** has been shown to help reduce aggressive behaviour, especially in patients with a history of head injury, genuine amnesia for assaults, the *déjà vu* phenomenon, olfactory hallucinations and abnormalities shown by electroencephalography or brain imaging.¹²² Careful monitoring is required.

Dealing with cutting or self-harm in the context of personality disorder

Admission to psychiatric hospital or prison healthcare centre should be for treatment of comorbid disorders or indicated by suicide risk. Admission should be part of a carefully prepared crisis plan, agreed in advance by all parties. In-patient contracts, drawn up and signed by the patient and staff, may be helpful but must not make support contingent on ceasing of the self-harming behaviour immediately and should not be drawn up when clinicians are angry (for further advice, see **Assessment and management following an act of self-harm**, page 211). Not everyone who cuts, burns or otherwise mutilates themselves displays the full pattern of behaviour of a personality disorder.

Specialist consultation or referral

Refer urgently to mental-health services if:

- paranoia is marked, excessive, there is a past history of extreme violence and the patient is threatening violence (forensic services are to be preferred, if available) and
- psychotic illness is evident.

Refer for assessment to mental-health services if you are unsure if the diagnosis is personality disorder, mental illness or both.

Although the evidence base for the following treatments is poor, these psychological interventions may be useful for patients motivated to undertake them.

- **Anger management:**

— If the patient shows problems controlling and expressing anger, if they have no, or only very mild, paranoid features, and they can discuss their own behaviour, anger management may be useful in reducing maladaptive behaviour at least in the short-term.¹²³

— If problems in controlling anger or aggression have led to the crime the patient has committed and the patient has at least 1 year of their sentence still to serve, the patient may be eligible for one of the relevant Prison Service offending behaviour courses.

For more details, see **Offending behaviour programmes** (page 117).

- **Structured problem-solving** may be useful for associated problems that trigger self-harming behaviour, though it has not been tested specifically in personality-disordered patients.¹²⁰
- **Assertiveness training, anxiety management, social skills training or cognitive-behaviour therapy** may help if the patient is chronically over-anxious, dependent and fearful.¹²⁴
- **Dialectical behaviour therapy** has been shown to reduce the frequency of deliberate self-harm in people with emotionally unstable (borderline) personality disorder. This therapy is complicated and time-intensive to administer.¹²⁵
- **Psychotherapy** for personality-disordered patients needs to be long- not short-term.¹¹⁹

Consider referral to HMP Grendon Underwood if the patient has:

- a curiosity and a wish to tell their story
- psychological mindedness
- motivation
- ability to see that other people might have another point of view
- more than 2 years left in current sentence
- no appeal against their sentence, current or pending
- objective evidence of being free of substance misuse for 6 months
- no psychoactive medication for 3 months or while at Grendon or
- satisfactory reports from the wing officer, probation officer, chaplain, psychologist and medical officer.

Other prison treatment centres (TCs) include HMP Wormwood Scrubs (Max Glitt Unit), HMP Dovegate TC and the lifers' TC at HMP Gartree.

Prerelease plans

Ensure patients are assessed in good time for both the risk and treatment facilities that may help them if they are willing to engage in treatment. This is particularly important for emotionally unstable patients who react badly to real or imagined abandonment.

For details of prerelease planning appropriate for all patients, see **Managing the interface with the NHS and other agencies** (page 149).

Facilities that provide services for people with a personality disorder include the following.

- **Henderson Hospital:** a centrally funded outreach service based in Birmingham and Crewe that treats people with enduring emotional, relationship and behavioural problems, including impulsive, violent and self-harming behaviour and other associated problems. Patients are expected to be free of medication and not currently detained under the Mental Health Act 1983. South East and London NHS Regions, contact: Dr Alex Esterhuyzen, Henderson Hospital, 2 Homeland Drive, Sutton SM2 5LT. Tel: 020 8661 1611. West Midlands and South West NHS Regions, contact: Dr Ian Birtle, Main House, c/o South Birmingham Mental Health NHS Trust Therapeutic Community Service, 22 Summer Road, Acocks Green, Birmingham B27 7UT. Tel: 0121 678 3244; Northern and North West NHS Regions, contact: Dr Keith Hyde, Webb House, c/o Mental Health Services of Salford, Victoria Avenue, Crewe CW2 7SQ. Tel: 01270 580 770. For patients from

outside these areas or those from Scotland, Wales and Northern Ireland, contact the NHS Mental Health Trust nearest the patient's home address.

- **Cassell Hospital:** treats women with less severe personality disorders. 1 Ham Common, Richmond TW10 7JF. Tel: 020 8940 8181.
- **Francis Dixon Lodge:** provides group-orientated self-help programmes for those with personality and emotional difficulties. Gipsy Lane, Leicester LE5 0TD.
Tel: 0116 2256800.

Resources for patients and primary support groups

Listener or buddy scheme. Where the patient is considered dangerous, steps should be taken to protect listeners, eg personal alarms

Alcoholics Anonymous: 08457 697555 (24-hour helpline)

(Gives telephone support numbers and self-help groups across the UK for men and women trying to achieve and maintain sobriety)

Borderline website: URL: [http://www. BPDCentral.com](http://www.BPDCentral.com)

(Mainly for families of people with borderline personality disorder)

Gamblers Anonymous: 020 7384 3040

PO Box 88, London SW10 0EU

(Provides advice and support to patients with addiction/habit disorders)

Narcotics Anonymous: 020 7730 0009 (helpline); 020 7251 4007 (office)

202 City Road, London EC1V 2PH

(Provides advice and support to patients with drug disorders)

Samaritans: 08457 90 90 90

Understanding Personality Disorders. Available from: MIND Publications,

15–19 Broadway, London E15 4BQ. Tel: 020 8 519 2122. Leaflet with straightforward explanations. It is useful for family members, staff and others

Phobic disorders — F40

Includes claustrophobia, agoraphobia and social phobia

Presenting complaints

Patients may avoid or restrict activities because of fear. They may have difficulty travelling in the prison transport van, taking part in association or eating in front of others. Some common phobias (eg agoraphobia, social phobia) may not manifest in closed prison conditions, but may become evident when the patient transfers to more open conditions.

Patients sometimes present with physical symptoms, eg palpitations, shortness of breath or 'asthma'. Questioning will reveal specific fears.

Diagnostic features

The patient experiences an unreasonably strong fear of people, specific places or events. Patients often avoid these situations altogether.

Commonly feared situations include:

- eating in public
- open spaces
- being confined in an enclosed space
- crowds or public places
- travelling in buses, cars, trains or planes or
- social events.

Patients may avoid being alone because of fear.

Differential diagnosis

- **Panic disorder — F41.0** (page 67) if anxiety attacks are prominent and not brought on by anything in particular.
- **Depression — F32#** (page 47) if a low or sad mood is prominent.

Panic disorder and depression may coexist with phobias.

Many of the guidelines below also may be helpful for specific (simple) phobias, eg fear of water or of heights.

Essential information for the patient and primary support group

- Phobias can be treated successfully.
- Avoiding feared situations allows the fear to grow stronger.
- Following certain steps can help someone overcome fear.

Advice and support to the patient and primary support group¹⁰⁵

- Assess the patient's understanding of the problem and their readiness to change.
- Encourage the patient to practise **controlled breathing methods** to reduce physical symptoms of fear (see advice on **Panic disorders — F41.0**, page 67).
- Ask the patient to make a list of all situations that he/she fears and avoids although other people do not.
- Discuss ways to challenge these exaggerated fears (eg patient reminds him/herself, 'I am feeling anxious because there is a large crowd. The feeling will pass in a few minutes').
- Help the patient to plan a series of progressively more challenging steps whereby they confront and get used to feared situations:
 - Identify a small, first step toward the feared situation, eg if they are afraid of eating in public, eat the meal in the cell, take a cup of coffee into the dining area, sit down but do not drink it.
 - Practise this each day until it is no longer frightening.
 - If entering the feared situation still causes anxiety, carry out slow and relaxed breathing, saying the panic will pass within 30–60 minutes (see advice on **Panic disorder — F41.0**, page 67).

- Do not leave the feared situation until the fear subsides. Do not move on to the next step until the current situation is mastered.
- Move on to a slightly more difficult step and repeat the procedure, eg eat a meal in the cell but sit with a friend in the dining area and drink a cup of coffee.
- Take no anti-anxiety medicine for at least 4 hours before practising these steps.
- Ask a friend or member of the healthcare staff to help plan exercises to overcome the fear. Self-help groups can assist in confronting feared situations.
- Keep a diary of the confrontation experiences described above to allow step-by-step management.
- Avoid using benzodiazepines to cope with feared situations.

Medication

With the use of these behavioural methods, many patients will not need medication.^{N105}

- If depression is also present, antidepressant medication may be indicated. Paroxetine may be helpful in social phobia^{N126} (see *BNF*, Section 4.3.3).
- Encourage patients to face fears without the use of benzodiazepines. Where the feared situation is rare, however, occasional short-term use of anti-anxiety medication may be helpful.^{N115} Regular use may lead to dependence and is likely to result in a return of symptoms when it is discontinued.
- For management of performance anxiety, eg fear of public speaking, β -blockers may reduce the physical symptoms.¹⁰⁹

Referral

See **General referral criteria** (page 152).

Non-urgent referral to the secondary mental-health services is advised:

- if disabling fears persist and
- to prevent problems with long-term sickness and disability.

If available, cognitive-behavioural psychotherapy and exposure¹²⁷ may be effective for patients who do not improve with simple measures outlined above.

Recommend self-help/non-statutory/voluntary services, eg Triumph Over Phobia, in all other cases where symptoms persist.

Resources for patients and primary support groups

Stresswatch Scotland: 01563 574144 (helpline); 01563 570886 (office)

(Advice, information, materials on panic, anxiety, stress phobias. Thirty-five local groups)

Triumph Over Phobia (TOP) UK: 01225 330353

(Structured self-help groups for those suffering from phobias or obsessive-compulsive disorder. Produces self-help materials)

Resource leaflet:

Managing Anxiety

Isaac Marks. *Living With Fear*. New York: McGraw Hill. Self-help manual

Post-traumatic stress disorder — F43.1

Presenting complaints

The patient may present initially with:

- irritability
- memory and/or concentration problems
- associated difficulties in interpersonal relationships
- impaired occupational functioning
- low mood
- loss of interest and
- physical problems.

Presentation may be delayed for several months following the trauma.

Diagnostic features

- History of a stressful event or situation (either short or long lasting) of an exceptionally threatening or catastrophic nature, which is likely to cause pervasive distress to almost anyone. The trigger event may have resulted in death or injury and/or the patient may have experienced intense horror, fear or helplessness.
- Intrusive symptoms: memories, flashbacks, nightmares.
- Avoidance symptoms: avoidance of thoughts, activities, situations and cues reminiscent of the trauma, with a sense of 'numbness', emotional blunting, detachment from other people, unresponsiveness to surroundings or anhedonia.
- Symptoms of autonomic arousal, eg hypervigilance, increased startle reaction, insomnia, irritability, excessive anger and impaired concentration and/or memory.
- Symptoms of anxiety and/or depression.
- Drug and/or alcohol abuse are commonly associated with this condition.
- Significant functional impairment.

Where the traumatic event is related to the index offence, the patient may be reluctant to talk about it, especially before the trial, thus complicating a diagnosis.

Differential diagnosis

- **Depression** — **F32#** (page 47) if preoccupation with, and ruminations about, a past traumatic event have emerged during a depressive episode.
- **Phobic anxiety disorders** — **F40** (page 79) if the patient avoids specific situations or activities after a traumatic event, but has no re-experiencing symptoms.
- Obsessive-compulsive disorder if recurrent, intrusive thoughts or images occur in the absence of an event of exceptionally threatening or catastrophic nature.

Essential information for the patient and primary support group

- Traumatic or life-threatening events often have psychological effects. For the majority, symptoms will subside with minimal intervention. The information leaflet *Reactions to Traumatic Stress: What to Expect* on the disk may be helpful in reinforcing information . If the patient has reading difficulties, a member of the healthcare team or another member of staff may be able to discuss its contents with him/her.
- For those who continue to experience symptoms, effective treatments are available.
- Post-traumatic stress disorder (PTSD) is not a weakness and does not mean the patient has gone 'mad'. The patient needs support and understanding and must not be told to 'snap out of it'.

Advice and support to the patient and primary support group

- Educate the patient and, with patient permission, staff about PTSD, thus helping them understand the patient's changes in attitude and behaviour.
- Avoiding discussion about the event that triggered the condition is usually unhelpful, but be aware of cultural differences in the ways of coping with past difficulties. Encourage the patient to talk about the event when they are ready and in their

own way. This may include not talking about more extreme experiences. The recognition that certain experiences are 'there' but 'unutterable' can be positive.¹

- Explain the role of avoidance of cues associated with the trauma in reinforcing and maintaining fears and distress. Encourage the patient to face avoided activities and situations gradually. It may be possible to involve staff in supporting the patient in this, eg in initially accompanying the patient into an area where they were assaulted and are now avoiding.
- Explain that suppression of painful memories and thoughts may reinforce them and make them more persistent. Encourage the patient, if possible, simply to allow the thoughts to pass through his/her head and not to suppress them actively.
- Where the patient has become scared of going to sleep because of repeated nightmares, it may be helpful for them to talk with someone they trust about the dream, or to write it down, describing it in detail, perhaps several times, and to remind themselves 'It's a dream. It cannot hurt me'.
- Ask about suicide risk, particularly if marked depression is present (see **Assessing and managing people at risk of suicide**, page 204).
- Encourage the patient to use any existing, available sources of support or solace, eg chaplain and other religious leaders, traditional healers, friends, listeners/buddies, the Samaritans.
- Try to avoid using cigarettes or other drugs to cope with anxiety.

Medication

- Consider antidepressant for concurrent depressive illness (see **Depression — F32#**, page 47).
- Antidepressant medication, including tricyclics (TCAs) and selective serotonin re-uptake inhibitors (SSRIs), may be useful for the treatment of intrusion and avoidance symptoms^{N128} (see *BNF*, Section 4.3). Drug treatments for this condition generally need to be used in higher doses and for longer periods than those used for treating depression. There may be a latent period of 8 weeks or more before the effects are seen.
- Startle and hyperarousal symptoms may be helped by β -blockers^{N128} (see *BNF*, Section 2.4).

Referral

See **General referral criteria** (page 149).

Referral to the secondary mental-health services is advised if the patient is still having severe intrusive experiences and avoidance symptoms, and there is a marked functional disability despite the above measures. If available, consider behaviour therapy (exposure) or cognitive techniques.^{N129,N130} The specialist assessment should include cultural factors. Where possible, advise patients of agencies able to provide appropriate therapy after release.

See **Immigration detainees** and **People who have been sexually assaulted** (pages 326 and 260) for more information about the needs of these groups.

Resources for patients and primary support groups

CombatStress: 01372 841600

(Formerly known as the Ex-Services Mental Welfare Association, it supports men and women discharged from the armed services and Merchant Navy who suffer from mental-health problems, including PTSD. Has a regional network of welfare officers who visit people at home or in hospital. Some practical and financial help)

Medical Foundation for the Care of Victims of Torture: 020 7813 7777

(Provides survivors of torture with medical treatment, social assistance and psychotherapeutic support)

Refugee Support Centre: 020 7820 3606

(Provides counselling to refugees, asylum seekers; plus training and information to health- and socialcare professionals on psychosocial needs of refugees)

Trauma Aftercare Trust (TACT): 0800 1696814 (24-hour freephone helpline); 01242 890306

(Provides information about counselling and treatment)

Victim Support Supportline: 0845 3030900 (Monday–Friday, 9 am–9 pm; Saturday and Sunday, 9 am–7 pm; Bank Holidays, 9 am–5 pm); 020 7735 9166

(Emotional and practical support for victims of crime)

¹ Professor Papadopoulos, Tavistock Clinic Refugee Centre, personal communication, quoted in CVS Consultants and Migrant and Refugee Community Forum. *A Shattered World: The Mental-Health Needs of Refugees and Newly Arrived Communities*. London: CVS Consultants, 1999.

Sexual disorders — F52

Sexual disorders — female

Presenting complaints

Patients may be reluctant to discuss sexual matters. They may instead complain of physical symptoms, depressed mood or relationship problems. There may have been sexual abuse — in childhood or later.

Patients may ask for advice about problems with partners outside, or inside, the prison. They may be confused about their sexual orientation. They may ask for help in adjusting to sexual lifestyle changes that relate only to their time in prison. Occasionally, a request for help with gender reassignment may be made.

Special problems may occur in cultural minorities.

Patients may present sexual problems during a routine cervical-smear test.

Diagnostic features

Common sexual disorders presenting in women are:

- a lack or loss of sexual desire, arousal or enjoyment
- vaginismus or spasmodic contraction of vaginal muscles on attempted penetration
 - dyspareunia (pain in the vagina or pelvic region during intercourse) or
- anorgasmia (an inability to achieve orgasm or climax).

Differential diagnosis

- If a low or sad mood is prominent, see **Depression — F32#** (page 47). Depression may cause low desire, or may result from sexual and relationship problems.
- Relationship problems: where there is persistent discord in the relationship, relationship counselling should precede or accompany specific treatment of the sexual dysfunction.
- Gynaecological disorders, eg vaginal infections, pelvic infections (salpingitis) and other pelvic lesions (eg tumours or cysts), although vaginismus rarely has a physical cause. Gynaecological complaints and disorders are common in women in prison. It is important to take them seriously and consider investigation and referral to specialist physical help as appropriate.
- Adjustment to sexual lifestyle changes in the prison situation, eg temporary lesbianism or bisexuality. Consider giving sexual health information and counselling. Consider the possibility that the patient is being exploited or bullied.
- Alcohol intoxication and chronic abuse of illicit drugs (eg opioids, cocaine, amphetamines, sedatives, anxiolytics) may decrease sexual interest and cause arousal problems.
- Side-effects of medication, eg selective serotonin re-uptake inhibitor (SSRI) antidepressants, oral contraceptives, β -blockers.
- Physical illnesses may contribute, eg multiple sclerosis, diabetes, spinal injury
- Lack of desire may be related to confusion about sexual orientation, especially in young people.
- Rarely, sexual problems may relate to the patient's feeling that she is really a man and that she wishes to become a man physically. This is very difficult to manage in prison as the usual community management (living as a man and/or treatment with male hormones for at least 1 year before any irreversible surgical steps are taken) is especially difficult. Be aware of the danger of bullying and of serious self-mutilation. Obtain expert advice, including from the prison Health Policy Unit, and refer to a forensic psychiatrist, who may in turn refer to a gender identity clinic. Consider relocation within the prison to reduce the risk of bullying.

Lack or loss of sexual desire

Essential information for the patient and partner

The level of sexual desire varies widely between individuals. Loss of or low sexual desire has many causes, including relationship problems, earlier traumas, fear of pregnancy, postnatal problems, and physical and psychiatric illnesses and stress. The problem can be temporary or persistent.

Advice and support to the patient and partner

Discuss the patient's beliefs about sexual relations. Check whether the patient and/or the partner have unreasonably high expectations. Ask the patient about traumatic sexual experiences and negative attitudes to sex. Accept that this may take more than one appointment. Give advice about treatment approaches that may be appropriate in the community. Inform the patient that doctors often see partners together as well as individually. Suggest planning sexual activity for specific days. Suggest ways of building self-esteem (eg exercise, education), and advise time and space to herself.

Vaginismus

Essential information for the patient and partner

Vaginismus is an involuntary spasm of the pubococcygeal muscles accompanied by intense fear of penetration and anticipation of pain. It is usually caused by psychosocial factors (eg previous negative sexual experiences). It can be overcome with specific psychosexual therapy.

Advice and support to the patient and partner

Exercises are recommended for the patient, and, later, for the partner, with graded dilators or finger dilation, accompanied by Kegel exercises, relaxation exercises, treatment for anxiety and couple counselling. Treatment often requires intensive therapy, but it has a promising outcome.

Dyspareunia

Essential information for the patient and partner

There are many physical causes, both of deep and superficial dyspareunia. In some cases, however, anxiety, poor lubrication and muscle tension are the main factors. Even where there has been a physical cause and it has resolved, anticipation of pain may frequently maintain the dyspareunia.

Advice and support to the patient and partner

Check if the patient experiences desire/arousal/lubrication. Relaxation, prolonged foreplay and careful penetration may overcome psychogenic problems. Referral to a gynaecologist or GUM clinic is advisable if simple measures are unsuccessful.

Anorgasmia

Essential information for the patient and partner

Many women cannot experience orgasm during intercourse but can often achieve it by clitoral stimulation.

Advice and support to the patient and partner

Discuss the couple's beliefs and attitudes. Encourage self-pleasuring, manually or by using a vibrator. The couple should be helped to communicate openly and reduce any unrealistic expectations. Books, leaflets or educational videos may be useful (see **Resources** below).

Referral

After release, patients can refer themselves to:

- Relate
- Brook Advisory Centres
- family planning clinics and
- genitourinary medicine clinics

Consider referral to a psychosexual specialist if the patient and doctor cannot enter into a programme of treatment or if primary-care treatment has failed.

Sexual disorders — male

Presenting complaints

Patients may be reluctant to discuss sexual matters. They may complain instead of physical symptoms, depressed mood or relationship problems.

Patients may ask for advice about problems with partners outside, or inside, the prison. They may be confused about their sexual orientation. They may ask for help in adjusting to sexual lifestyle changes that relate only to their time in prison. Occasionally, a request for help with gender reassignment may be made.

Special problems may occur in different cultures. Sexual problems are often somatised, expectations may be high, and psychological explanations and therapies may not be readily accepted.

Diagnostic features

Common sexual disorders presenting in men are:

- erectile dysfunction or impotence
- premature ejaculation
- retarded ejaculation or orgasmic dysfunction (intravaginal ejaculation is greatly delayed or absent but ejaculation can often occur normally during masturbation) or
- a lack or loss of sexual desire.

Differential diagnosis

- **Depression** — **F32#** (page 47).
- Problems in relationships with partners often contribute to sexual disorder, especially those of desire. Where there is persistent discord in the relationship, relationship counselling should precede or accompany specific treatment of the sexual dysfunction.
- Adjustment to sexual lifestyle changes in the prison situation, eg temporary homosexuality or bisexuality. Consider giving sexual health information, counselling about harm minimisation and access to condoms. Consider the possibility that the patient is being exploited or bullied (see **Victims of sexual assault**, page 260).
- Alcohol intoxication and chronic abuse of illicit drugs (eg opioids, cocaine, amphetamines, sedatives, anxiolytics) may decrease sexual interest and cause arousal problems.
- Rarely sexual problems may relate to the patient's feeling that he is really a woman and that he wishes to become a woman physically. This is very difficult to manage in prison as the usual community management (living as a woman and/or treatment with female hormones for at least 1 year before any irreversible surgical steps are taken) is especially difficult. Be aware of the danger of serious self-mutilation and of bullying. Obtain expert advice, including from the prison Health Policy Unit, and refer to a forensic psychiatrist, who may in turn refer to a gender identity clinic. Consider relocation within the prison to reduce the risk of bullying.
- Specific organic pathology is a rare cause of orgasmic dysfunction or premature ejaculation.
- Physical factors that may contribute to erectile dysfunction include alcohol abuse and chronic abuse of illicit drugs (eg opioids, cocaine, amphetamines, sedatives, anxiolytics), diabetes, hypertension, smoking, medication (eg antidepressants, antipsychotics, diuretics and β -blockers), multiple sclerosis and spinal injury.
- Patients may have unreasonable expectations of their own performance.
- Lack of desire may be related to confusion about sexual orientation, especially in young people.

Erectile dysfunction (failure of genital response, impotence)

Essential information for the patient and partner

Erectile dysfunction is often a temporary response to stress or loss of confidence and it responds to psychosexual treatment especially if morning erections occur. It may also be caused by physical factors (neurological, vascular), by medication or may be secondary to the ageing process.

Advice and support to the patient and partner

Advise the patient and their partner to refrain from attempting intercourse for 2–3 weeks. Encourage them to practise pleasurable physical contact without intercourse during that time, commencing with non-genital touching and moving through mutual genital stimulation to a gradual return to full intercourse at the end of that period. Progression along this continuum should be guided by the return of consistent, reliable erections. A book containing self-help exercises (see

Resources below) may be helpful. Inform the patient and his partner of the possibilities of physical treatment by penile rings, vacuum devices, intracavernosal injections and medication.

Medication

- Oral: sildenafil 50–100 mg taken on an empty stomach 40–60 minutes before intercourse enhances erections in 80% of patients, whether the cause is psychogenic or neurological.¹³¹ Beware of danger of interaction with cardiac nitrates (see *BNF*, Section 7.4.5).
- Intra-urethral: MUSE (prostaglandin E₁) 125–1000 µg inserted 10 minutes before intercourse produces erections in 40–50% of patients¹³² (see *BNF*, Section 7.4.5).
- Intracavernosal: prostaglandin E₁ 5–20 µg injected 10 minutes before intercourse produces erections in 80–90% of patients,¹³³ but long-term acceptability is low.

These medications are less effective in predominantly vasculogenic cases.

See the current NHS Executive guidelines for prescription of the above, either privately or on the NHS.

Premature ejaculation

Essential information for the patient and partner

Control of ejaculation is possible and can enhance sexual pleasure for both partners.

Advice and support to the patient and partner

Reassure the patient that ejaculation can be delayed by learning new approaches, eg the squeeze or stop–start technique. This and other exercises are set out in self-help books (see **Resources** below). In some cases, delay can also be achieved with clomipramine or selective serotonin re-uptake inhibitor (SSRI) medication, but relapse is very common on cessation. Local anaesthetic sprays, if used cautiously, can delay ejaculation.

Orgasmic dysfunction or retarded ejaculation

Essential information for the patient and partner

This is a more difficult condition to treat; however, if ejaculation can be brought about in some way (eg through masturbation) the prognosis is better. Individual psychotherapy may be required.

Advice and support to the patient and partner

Recommend exercises such as penile stimulation with body oil or masturbation close to the point of orgasm, followed by penetration.

Lack or loss of sexual desire

Essential information for the patient and partner

The level of sexual desire varies widely between individuals. Lack or loss of sexual desire has many causes, including physical and psychiatric illnesses, stress and relationship problems and, rarely, hormonal deficiencies. It may merely represent different expectations.

Advice and support to the patient and partner

Encourage relaxation, stress reduction, open communication, appropriate assertiveness and cooperation between partners. Educational leaflets, books or videos may be helpful.

Referral

When released, patients can refer themselves to:

- Relate
- family planning clinics and
- genitourinary medicine clinics.

Consider referral if the patient and doctor cannot enter into a programme of treatment or if primary-care treatment has failed:

- To a urologist for erectile dysfunction if it is unresponsive to medication and counselling.
- To a psychosexual specialist if the problem is predominantly psychogenic.

Resources for patients and primary support groups

Beaumont Society Infoline: 01582 412220 (24 hours, 7 days per week)

27 Old Gloucester Street, London WC1N 3XX

(National self-help organisation for transvestites, transsexuals, and their partners and families. Advice and information on issues of cross-dressing and gender dysphoria; social functions)

Brook Advisory Centres: 020 7617 8000 (24-hour helpline)

(Free counselling and confidential advice on contraception and sexual matters especially for young people [those under 25])

Out-Side In: 01689 835566

PO Box 119, High Street, Orpington BR6 9ZZ

(Befriending pen-pal service for gay and lesbian prisoners)

Relate: 01788 573241

(Relationship counselling for couples or individuals over 16. Sex therapy for couples. Clients pay on a sliding scale)

Books for women:

Heiman J, LoPiccolo J. *Becoming Orgasmic: A Sexual Growth Program for Women*. Englewood Cliffs: Prentice-Hall, 1988. Self-help exercises for anorgasmia

Brown P, Faulder C. *Treat Yourself to Sex*. Harmondsworth: Penguin, 1977

Goodwin AJ, Agronin Marc E, MD. *A Woman's Guide to Overcoming Sexual Fear and Pain*. Oakland: New Harbinger, 1997

Books for men:

How to Cope with Doubts About Your Sexual Identity and Gender Dysphoria. Available for £1.00 each from: Mind Publications, 15-19 Broadway, London E15 4BQ. Tel: 020 8519 2122

Zilbergeld, B. *Men and Sex*. London: Fontana, 1980. Self-help exercises for erectile dysfunction and premature ejaculation

Yaffe M, Fenwick E. *Sexual Happiness*. London: Dorling Kindersley, 1986

Sleep problems (insomnia) — F51

Presenting complaints

Patients are distressed by persistent insomnia and are sometimes disabled by the daytime effects of poor sleep.

Diagnostic features

- Difficulty falling asleep.
- Restless or unrefreshing sleep.
- Frequent or prolonged periods of being awake.

Differential diagnosis

- Short-term sleep problems may result from stressful life events such as coming into prison for the first time, bullying, acute physical illnesses or changes in their schedule.
- Persistent sleep problems may indicate another cause, for example:
 - **Depression** — **F32#** (page 47) if a low or sad mood and loss of interest in activities are prominent.
 - **Generalised anxiety** — **F41.1** (page 64) if daytime anxiety is prominent.
 - **Post-traumatic stress disorder** — **F43.1** (page 82) if the patient fears going to sleep because of repeated nightmares.
 - Sleep problems can be a presenting complaint of alcohol misuse or substance abuse (see **Alcohol misuse** — **F10** or **Substance abuse** — **F11#**, pages 18 and 55). A patient may also seek benzodiazepines because he/she is still dependent upon them. Enquire about their current substance use and the presence of other withdrawal symptoms. Withdrawal from benzodiazepines needs sometimes to be very gradual (months not weeks)
- Profound sleep deprivation is a part of the experience of major drug withdrawal. Sleep problems may persist for some weeks thereafter. Treatment may be indicated during the very early stages of withdrawal.
- Consider medical conditions that may cause insomnia, eg heart failure, pulmonary disease, pain conditions.
- Consider medications that may cause insomnia, eg steroids, theophylline, decongestants, some antidepressant drugs.
- Consider life style causes: the patient may spend most of the day asleep in his/her cell.
- If the patient snores loudly while asleep, consider sleep apnoea. It may be helpful, with patient consent, to take a history from the cellmate. Patients with sleep apnoea often complain of daytime sleepiness but are unaware of night-time awakenings.
- The patient may be seeking drugs to sell or may be being pressured by others to obtain drugs on their behalf. Wing staff may have useful information where this is suspected.

Essential information for the patient and primary support group

- Temporary sleep problems are common at times of stress or physical illness.
- Sleep requirements vary widely and usually decrease with age.
- Improvement of sleeping habits (not sedative medication) is the best treatment.¹³⁴
- Worry about not being able to sleep can worsen insomnia.
- Stimulants (including coffee and tea, especially if taken in the evening) can cause or worsen insomnia.

Advice and support to the patient and primary support group

- Encourage the patient to maintain a regular sleep routine by:
 - relaxing in the evening
 - keeping to regular hours for going to bed and getting up in the morning, trying not to vary the schedule or 'sleep in' on the weekend
 - getting up at the regular time even if the previous night's sleep was poor and
 - avoiding daytime naps since they can disturb the next night's sleep.
- Daytime exercise can help the patient to sleep regularly, but evening exercise may contribute to insomnia. Consider promoting daytime exercise through custody/sentence planning.
- Simple measures may help, eg a milk drink or use of ear plugs or eye shades.
- Recommend relaxation exercises to help the patient to fall asleep.

- Advise the patient to avoid caffeine in the evenings.
- If the patient cannot fall asleep within 30 minutes, advise him/her to get up and try again later when feeling sleepy.
- Self-help leaflets and books may be useful. The *Getting a Good Night's Sleep* leaflet on the disk includes a relaxation exercise. If the patient has reading difficulties, a member of the healthcare team or another member of staff may be able to go through the contents of the leaflet with the patient.
- Sleep diaries are often useful in the assessment and monitoring of progress.

Medication

- Treat the underlying psychiatric or physical conditions.
- Make changes to medication, as appropriate.
- Consider strictly short-term use of a hypnotic in the very early stages of withdrawal from drugs if sleep deprivation is profound. Explain the risk of developing dependence on these medications to the patient.
- Hypnotic medication may be used intermittently.¹³⁵ The risk of dependence increases significantly after 14 days of use. Avoid hypnotic medication in cases of chronic insomnia (where insomnia is experienced for most nights over at least 3 weeks).
- Consider the timing and method of administering the medication. Sedatives given at 4 or 5 pm by supervised ingestion will be less effective than sedatives taken later in the evening.
- Valerian may have a weak effect on sleep but without a hangover effect the next day.¹³⁶

Referral

See **General referral criteria** (page 152).

If available, consider referral to the in-house therapeutic day centre for relaxation sessions.

Referral to the secondary mental-health services is rarely helpful.

Refer to a sleep laboratory, if available, if more complex sleep disorders (eg narcolepsy, night terrors, somnambulism) are suspected.

Where symptoms are severe and long lasting and the above measures are unsuccessful, consider referral to a clinical psychologist or specially trained counsellor, if available, for therapies such as sleep hygiene training.^{N137,138}

Resources for patients and primary support groups

British Snoring and Sleep Apnoea Association: 01249 701010

1 Duncroft Close, Reigate RH2 9DE. E-mail: snoreshop@britishsnoring.demon.co.uk; URL:

<http://www.britishsnoring.demon.co.uk>

Insomnia Helpline: 020 8994 9874 (helpline: Monday–Friday, 6 pm–8 pm)

Narcolepsy Association UK (UKAN): 020 7721 8904

Craven House, 1st Floor, 121 Kingsway, London WC2B 6PA. E-mail: info@narcolepsy.org.uk

Resource leaflet:

Getting a Good Night's Sleep

Unexplained somatic complaints — F45

Presenting complaints

- Any physical symptom may be present.
- Symptoms may vary widely across cultures.
- Complaints may be single or multiple and may change over time.

Diagnostic features

Medically unexplained physical symptoms (a full history and physical examination are necessary to determine this):

- Frequent medical visits in spite of negative investigations.
- Symptoms of depression and anxiety are common.

Some patients may be primarily concerned with obtaining relief from physical symptoms. Others may be worried about having a physical illness and be unable to believe that no physical condition is present (hypochondriasis).

Differential diagnosis

- **Drug-use disorders — F11#** (page 55), eg seeking narcotics for relief of pain.
- If low or sad mood is prominent, see **Depression — F32#** (page 47). People with depression are often unaware of everyday physical aches and pains.
- **Generalised anxiety disorder — F41.1** (page 64), if anxiety symptoms are prominent.
- **Panic disorder — F41.0** (page 67) misinterpretation of the somatic signs associated with panic.
- **Chronic mixed anxiety and depression — F41.2** (page 33).
- **Acute psychotic disorders — F23** (page 11) if strange beliefs about symptoms are present, eg belief that organs are decaying.
- An organic cause may eventually be discovered for the physical symptoms. Psychological problems can coexist with physical problems.

Depression, anxiety, alcohol or drug disorders may coexist with unexplained somatic complaints.

Essential information for the patient and primary support group

- Stress often produces or exacerbates physical symptoms.
- When people are forced to remain inactive for long periods, it is natural for them to focus on bodily sensations. The sensations may become exaggerated in the process.
- The focus should be on managing the symptoms, not on discovering their cause.
- Cure may not always be possible; the goal should be to live the best life possible even if the symptoms continue.

Advice and support to the patient and primary support group¹³⁹

- Acknowledge that the patient's physical symptoms are real to them.
- Ask about the patient's beliefs (what is causing the symptoms?) and fears (what does he/she fear may happen?).
- Ask how the patient spends his/her day. How long do they spend in the cell? Encourage exercise and enjoyable activities. The patient need not wait until all symptoms are gone before undertaking activities. If necessary, advocate for increased access to appropriate activities. If the patient is under cellular confinement, advocate for access to art materials and, if literate, to reading materials.
- Be explicit early on about considering psychological issues. The exclusion of illness and exploration of emotional aspects can happen in parallel. Investigations should have a clear indication. It may be helpful to say to the patient, 'I think this result is going to be normal'.
- Offer appropriate reassurance, eg not all headaches indicate a brain tumour. Advise patients not to focus on medical worries.
- Discuss the emotional stresses present when the symptoms arose.
- Explain the links between stress and physical symptoms and how a vicious cycle can develop, eg 'Stress can cause a tightening of the muscles in the gut. This can lead to the development of abdominal pain or worsening of existing pain. The pain aggravates the tightening of the gut muscles'. A diagram may be helpful.

- Relaxation methods can help relieve symptoms related to tension, eg headache, neck or back pain.
- Treat associated depression, anxiety or substance misuse problems.
- For patients with more chronic complaints, time-limited appointments that are regularly scheduled can prevent more frequent, urgent visits.¹⁴⁰
- Structured problem-solving methods may help patients to manage current life problems or stresses that contribute to symptoms.⁴⁸
 - Help the patient to:
 - identify the problem
 - list as many possible solutions as the patient can think of
 - list the advantages and disadvantages of each possible solution (the patient should do this, perhaps between appointments)
 - support the patient in choosing his/her preferred approach
 - help the patient to work out the steps necessary to achieve the plan and
 - set a date to review the plan. Identify and reinforce things that are working.

Medication

Avoid unnecessary diagnostic testing or prescription of new medication for each new symptom. Rationalise polypharmacy.

Where depression is also present, an antidepressant may be indicated (see **Depression — F32#**, page 47)

Low doses of tricyclic antidepressant (TCA) medication (eg amitriptyline, 50–100 mg day⁻¹, or imipramine, 20 mg day⁻¹) may be helpful in some cases, eg where there is headache or atypical chest pain.^{141,142}

Referral

- Patients are best managed in primary healthcare settings. Consistency of approach within the practice is essential. Seeing the same person is helpful. Consider referral to a partner or other medical officer for a second opinion. Documenting discussions with colleagues can reduce stress by sharing responsibility within the primary-care team.
- Non-urgent referral to the secondary mental-health services is advised on grounds of functional disability, especially an inability to work, and for the duration of symptoms.
- Cognitive-behaviour therapy, if available, may help some patients, though the willingness of patients to participate is sometimes poor.^{N143}
- Refer to a liaison psychiatrist, if available, for those who persist in their belief that they have a physical cause for their symptoms, despite good evidence to the contrary.
- Avoid multiple referrals to medical specialists. Documented discussions with appropriate medical specialists may be helpful from time to time as, in some cases, underlying physical illness eventually emerges.

Resources for patients and primary support groups

Listeners, buddies, chaplains and personal officers may offer emotional support and/or help with practical problems

Resource leaflets:

Coping with Depression

Getting a Good Night's Sleep

Managing Anxiety. Contains instructions for a relaxation exercise