

## Nursing a patient with a severe psychotic illness — for general nurses and healthcare officers

Nurses play a central role in the assessment and treatment of patients with severe, psychotic mental illnesses. Nursing such patients is a skilled job that requires special training. Sometimes, general nurses or healthcare officers without mental-health training may augment the care provided by mental-health nurses. This section provides information to help them to do that. It covers two topics.

- Information about psychotic illness.
- What a generalist nurse can do to contribute to assessment and treatment.

It does not cover specialist topics such as how to assess hallucinations and delusions.

Information about psychosis

What is psychosis?

The word **psychosis** is used to describe a broad range of mental disorders that affect the mind, where there has been some loss of contact with reality. These types of disorders can vary greatly, though certain types of symptoms are characteristic. They include unusual and often extremely distressing experiences such as the following.

- **Disturbances of thinking:** thoughts become confused and may seem to speed up or slow down. Sentences are unclear or do not make sense. Patients may feel as if their thoughts are being put into their head and are not their own thoughts. They may have difficulty concentrating, following a conversation or remembering things. They may then appear to be unresponsive or uncooperative.
- **Delusions:** false beliefs that seem real to the patient and are not amenable to logical argument. They are often very frightening. For example, a person may believe that their food is being poisoned. Common themes for delusional beliefs are persecution, punishment, grandiosity and religiosity. For example, someone acutely ill may believe that he is Jesus.
- **Hallucinations:** patient sees, hears, feels, smells or tastes something that is not actually there. For example, they may hear voices that no one else can hear. Food may taste or smell as if it is bad or poisoned. Hearing voices is a very common symptom of schizophrenia. The hallucinations can range from occasional voices through to an almost constant barrage of derogatory comments from a large number of different voices.
- **Changed feelings:** patients may feel strange and cut off from the world. Mood swings are common and patients may feel unusually excited or depressed. Their emotions may seem dampened — they feel less than they used to or show less emotion to those around them.

Different types of psychotic disorder

There are different types of psychotic illness. These include the following.

- **Substance-induced psychosis:** use of, or withdrawal from, alcohol or drugs may be associated with the appearance of psychotic symptoms. Sometimes the symptoms remit as the effects of the substances wear off. Sometimes the illness lasts longer. It is possible for a patient to both have a more long-term psychotic illness **and** to misuse substances. It is not possible to tell from the symptoms alone whether someone has a substance-induced psychosis or whether they have another psychotic disorder. It is a mistake to think that because a prisoner is a drug user they cannot also have a severe psychotic illness such as schizophrenia.
- **Brief reactive psychosis:** psychotic symptoms arise suddenly in response to a major stress in the patient's life. The patient makes a quick recovery in a few days.
- **Organic psychosis:** physical injury or illness, such as a brain injury, encephalitis, AIDS or a tumour, may cause psychotic symptoms.
- **Schizophrenia:** psychotic illness in which the symptoms have been continuing for at least 6 months. The symptoms and the length of the illness vary.
- **Bipolar disorder (manic depression) and psychotic depression:** psychotic symptoms appear as part of a more general disturbance of mood. When psychotic symptoms are present, they tend to fit in with the person's mood. For example, someone who is depressed may hear voices telling them they should kill themselves. Someone who is unusually excited (manic) may believe that they have special powers and can perform amazing feats.

What causes psychosis?

Schizophrenia is probably caused by a combination of biological factors (such as a family history of schizophrenia) that create a vulnerability to experiencing psychotic symptoms. The symptoms often

emerge in response to stress (eg breakdown of a relationship, being held in solitary confinement, bullying), drug abuse or social changes in vulnerable individuals. This theory of causation is known as the 'stress-vulnerability model'. It helps to explain why psychosis is usually an episodic problem, with episodes triggered by stress and patients often quite well between episodes. It also helps to guide management. International studies show that once a person has schizophrenia, the environment in which he/she lives can help them to stay well or can make them worse. In a calm environment and one where people provide plenty of support and encouragement, those with schizophrenia will suffer fewer psychotic episodes than if they are surrounded by people who push, frighten or criticise them.

Prognosis: do people get better?

Schizophrenia usually begins in early adult life but may occur at any time in an individual's life. Those who develop schizophrenia at a very early age do not tend to do as well as those whose illness begins in middle or old age. Although for some schizophrenia will be a life-long concern, others experience only one episode of the illness and never have a further episode. Generally, 20% of people recover completely, 35% are stable for long periods but have some further episodes of psychosis, and 45% experience long-term problems requiring continuing care. One-quarter of the latter group deteriorate more severely and rapidly and need very high levels of care and support.

When someone is in a very distressed, acutely ill state, it can be hard to believe that they will ever get better. Realistic hope is one of the most important treatments a nurse or healthcare officer has to offer.

What are the treatments?

- **Assessment:** first stage of treatment involves assessment, usually over some time. Mental-health specialists need to develop an understanding with the patient of how and why these symptoms affect them. A range of measures may form part of the assessment, eg the 'Delusion Rating Scale' and the 'Belief about Voices' questionnaire.
- **Medication:** along with other forms of treatment, medication plays a fundamental role in recovery from a psychotic episode and in the prevention of future episodes. The monitoring of side-effects is critical to avoid or reduce distressing side-effects that can lead to a patient being unwilling to accept the medication central to their recovery. Information about the medications used in mental illness is given on page 166.
- **Counselling and psychological therapy:** having someone to talk to is an important part of treatment. A person with acute psychotic symptoms may need to know that there is someone who can understand something about their experience and provide reassurance that they will recover. As recovery progresses, different forms of psychological therapy can:
  - help the patient and those caring for them (on ordinary location) learn how to keep stress levels low in order to prevent further episodes
  - help the patient and those caring for them (on ordinary location) recognise early warning signs that a further psychotic episode is developing and
  - help the patient learn ways of reducing the impact of hallucinations and delusions.
- **Practical assistance:** treatment often also involves assistance with employment, education, finances and accommodation.

What the generalist nurse or healthcare officer can do

Communication (engagement)<sup>1</sup>

In order for the healthcare team to help the patient, the patient has to feel that the team is on their side and be prepared to communicate and, at least to some extent, to cooperate with the team. A trusting relationship with any member of the healthcare team is therefore important to the success of the treatment. Building such a relationship is especially hard with a patient who is psychotic as, at least in the acute stage, they may believe that you intend to harm them. When you talk to the patient, it is likely that you will have to adapt your usual communication style as the patient's memory, concentration and tolerance levels may all be reduced.

- Talking with someone with a severe mental illness:
  - Never leave someone who is mentally ill to guess your intentions or the intentions of other members of the healthcare team. Their imagination will run riot. Always explain why you, the doctor or other person wants to talk with them.
  - Try to ensure that the environment is comfortable and safe for both you and the patient. Ask where in the healthcare centre the patient feels safe/OK to talk.
  - Remember that social interaction can be very stressful for the patient and be prepared to acknowledge this: 'I can see how hard this is for you. I appreciate you making the effort to talk to me'.
  - Be warm and friendly but also prepared to spend time in silence.

- Always be aware of cultural issues. If you are not sure, ask. Finding out as much as you can about the patient's culture will help communication.
- Talking with someone who is hearing voices. If you are not sure someone is hearing voices at this particular time, ask them. If they are, do the following:
  - Acknowledge the difficulty and distress that voices cause. For example, 'It must be really difficult for you having this conversation. I really appreciate you making the effort'.
  - Do not challenge the fact that the patient can hear voices. They are real to the patient. However, you can say in a gentle and matter-of-fact way something like, 'It's your brain playing a trick on you just now'.
  - Talk clearly and slowly if necessary and be prepared to repeat questions.
  - Be prepared to take longer even for a simple matter.
  - If someone is obviously in distress, ask them if they have had enough. Be prepared to come back later.
- Talking with someone who mentions their delusional beliefs:
  - Show some understanding of the person's feelings, eg 'It must be really scary to think that someone else is controlling your thoughts'.
  - Do not argue about the strange ideas but do not pretend to agree with them either. Focus instead on how the delusions make them feel and then change the subject to something neutral or pleasant in real life (eg what is for dinner?).
  - If the conversation is distressing to the patient or to you, it is OK to say, 'I'll talk to you later when you're feeling a bit better'.
- Relating to someone who is withdrawn or isolated:
  - Be prepared to sit with the patient in silence.
  - Doing practical tasks close to the patient can be comforting. Sharing activities without talking can also be helpful.
  - Gently encourage other activities which are not too demanding (eg watching television, washing dishes, playing a board game).
  - Be prepared to keep trying. It can take a long time for some people to respond.
- Talking with someone who is angry or aggressive. People with schizophrenia are usually shy and withdrawn. However, they may also become aggressive, especially when they are experiencing fear or paranoia (feeling that they are being persecuted and that other people are out to get them) or voices (voices can, rarely, command a person to injure others).
- Information about dealing with aggression can be found in **Aggression** (page 282). To reduce patient fears and the potential for aggression, it may be helpful to do the following:
  - Give the patient space. Do not crowd them.
  - Inform the patient about what you are doing and intend to do.
  - Tell the patient that you do not mean them any harm.
  - Talk calmly and evenly.
  - Talk to the patient in a quiet environment.
  - Continually reassure them.
  - Keep your hands in view.
  - Keep your movements to a minimum.
  - Ask them why they are upset.

Observation: contribution to assessment

Nurses and healthcare officers may spend long periods with patients. Your observations of the patient's behaviour are a very valuable part of the assessment. General information about conducting observations is provided in **Observation** (page 200). In psychotic illness, helpful observations include the frequency, intensity and duration of 'positive symptoms' and the extent of 'negative symptoms'.

<b>Positive symptoms include:</b>	<b>Negative symptoms include:</b>
<ul style="list-style-type: none"> <li>• Hallucinations.</li> <li>• Delusions.</li> <li>• Thought disorder.</li> <li>• Paranoia.</li> </ul>	<ul style="list-style-type: none"> <li>• Lack of motivation.</li> <li>• Social withdrawal.</li> <li>• Emotional withdrawal.</li> <li>• Difficulty in forming relationships.</li> <li>• Lack of spontaneity.</li> </ul>

Make your observations as concrete and objective as possible, eg 'Spent all morning in bed. Appeared to watch television in afternoon but showed no reactions to the programmes or to changes of channel by others. Unresponsive to efforts to hold conversation' (rather than 'withdrawn').

Reassure, encourage and support the positives

People with a psychotic illness are likely to feel confused, distressed, afraid and lacking in self-confidence, both during the acute phase and for a long time afterwards. The illness has probably caused them to lose control of their thoughts and to feel overwhelmed by the world around them. As they recover, it is common for patients to:

- sleep for long hours every night (or during the day) for 6–12 months after the psychotic episode
- feel the need to be quiet and alone more often than other people and
- be inactive and feel that they cannot or do not want to do much.

It is helpful to explain to the patient what is happening to them, eg that psychotic symptoms usually appear as a response to severe stresses (see **What causes psychosis** above) and that additional sleep and inactivity is the body's natural way of slowing down to allow the brain to recover following the shock of an acute episode.

It is also helpful, as the patient recovers from the most acute stage of the illness, to encourage them to resume activities gradually that they have been able to do and have enjoyed in the past. Encourage the patient to help with simple jobs around the healthcare centre or to chat with you or to join in any art or other therapeutic activity on offer. If the patient refuses, do not pressure them but make it clear that they are welcome to come when they feel able to join in. Make it clear that they are welcome simply to sit in the company of others and watch or listen to people without joining in more actively. You may find that the patient likes to listen to loud music a lot of the time. This may be a way of drowning out distressing voices or thoughts. Earphones or a Walkman may be helpful.

Most importantly, it is helpful to relate to the patient as a human being who has interests and strengths separate from his/her psychotic symptoms or lack of them. This may be crucial in rebuilding some self-esteem and hope for the future. Find out what the patient's interests are and, if you can, discuss them with the patient. If the patient has contact with family members who are supportive, try to arrange a visit. It may be very helpful for the family members to have information about psychosis. This can be provided by an organisation such as the National Schizophrenia Fellowship (for details, see **Resource directory**, page 316).

Reduce stress and conflict

Because environmental stress plays such a prominent part in triggering episodes of psychosis, reducing such environmental stress is an important part of both treatment and prevention. The particular kind of stress that studies have found to be detrimental to patients with schizophrenia consists of high levels of 'expressed emotion'. This means:

- hostility: not only just bullying or physical aggression, but also angry shouting
- emotional over-involvement, eg 'Can you tidy your cell for me?' and
- criticism, eg calling a patient 'lazy', blaming him/her for being uncooperative.

Staying calm and using the communication tips in **Communication/engagement** above will be helpful. Ensuring that the patients are in an environment safe from bullying is also important. If the patient returns to normal location when the acute episode is over, residential managers should be aware that the way the patient is treated by staff and prisoners will significantly affect the likelihood of relapse. Additional patience and 'giving leeway' may be required.

Look out for depression and suicidal thoughts

People who have psychotic illnesses are at significantly higher risk of depression and suicide. They tend to have low self-esteem, to feel hopeless about their lives, to misuse drugs and alcohol, to lose their social role and be unable to attain their personal goals. In addition, some may hear voices telling themselves to kill themselves.

If the patient expresses depressed or suicidal thoughts to you, do the following.

- Listen to their feelings, but also point out that help is available.
- Express appreciation of the patient's feelings and the fact that he/she confided in you.
- Let the doctor and mental-health nurse know and consider opening a 2052SH form (in Scotland, an Act to Care form).
- Distract the patient by involving him/her in pleasant, low-key activities.

- Help them to be with someone by whom they feel accepted.
- Let the patient know that you accept and care about them.
- Consider whether any stressors can be removed that might be depressing the patient (eg worries about going back to a location on which he had been bullied).

#### Medication

Information on psychotropic drugs is provided on page 188. If you become aware that a patient is not taking the medication, do the following:

- Remind them calmly that the medication helps to keep them well.
- Ask if they are having any side-effects.
- Let the doctor or mental-health nurse know that the patient is refusing to take the medication.

<sup>1</sup> The section on communication was adapted from 'The guide to communicating with people who have serious mental health problems', developed by Katie Glover when she was at START, a Homeless Mentally Ill Initiative Project in London.

# Medications used for mental-health problems

Information for non-specialist nurses

General nurses may be involved in administering psychotropic medication. This section is a brief guide to the main types of drugs used to treat mental disorders. The aim is to help you answer simple questions that patients may ask, and to know what to do if the patient does not turn up to collect their medicine. Further training is needed to help you recognise and deal with the side-effects of medication.

The things to remember are the following:

- A patient can only be given medication they have agreed to take (consent).
- Consent must be voluntary and reflect a continuing agreement to take the medication.
- Patients can change their mind about taking medication.
- When information is given to a patient about their illness and medication, it can increase the chance of consent being given.
- If a patient refuses to take the medication, you should record their views in the notes and report the fact to the prescribing doctor.

Anxiety and insomnia

Benzodiazepines

*What are they?*

Benzodiazepines are drugs used primarily to treat symptoms of the following.

- **Severe anxiety**, eg tension, feeling shaky, sweating and a difficulty in thinking straight. The drugs, known as anxiolytics and (misleadingly) minor tranquillisers, include diazepam (Valium), lorazepam (Ativan), oxazepam (Serenid) and chlordiazepoxide (Librium).
- **Short-term problems with sleeping**. Drugs known as hypnotics include loperazolam, nitrazepam (Mogadon) and temazepam (Normison).

Benzodiazepines also have muscle-relaxing properties and some (eg diazepam) can help the following:

- **Epilepsy**: particularly 'status epilepticus'.
- **Symptoms of alcohol withdrawal** (usually chlordiazepoxide). When someone has been heavily dependent upon alcohol, giving benzodiazepines during withdrawal may help prevent very serious, even life-threatening symptoms such as delirium tremens.

*Side-effects*

## **Common side-effects**

Drowsiness, sleepiness and an inability to concentrate during the day.

## **Rare but important side-effects**

- Patient becomes aggressive, excitable, talkative or disinhibited. Ask the doctor to review the medication.
- Rash: if this occurs, patients should stop the drug and see the doctor.

*When are they not helpful?*

Benzodiazepines are not ideal for the treatment of anxiety and insomnia because they only give symptomatic relief, do not treat the underlying illness and are addictive.

They should not be taken regularly for more than 4–6 weeks. Taking them once per day or every other day (for insomnia) or irregularly, eg for 1 or 2 weeks for panic attacks, reduces, but does not eliminate, the risk of addiction (for more efficacious and longer-term treatments, see the guidelines on **Sleep problems, Panic and Generalised anxiety disorder**, pages 91, 67 and 64). Benzodiazepines should be avoided wherever possible during pregnancy, childbirth and breast-feeding. They can sedate the baby and cause breathing problems. They should not be used routinely to deal with sudden stress (eg bereavement, imprisonment) (see the guidelines on **Bereavement and Adjustment disorders**, pages 23 and 15).

*Important notes about benzodiazepines*

## **General**

- They are commonly traded illicitly on the street and in prison. Ensure that the drug goes to, and is taken by, the person for whom it is prescribed.
- If a patient misses a dose, do not give two or more doses together next time.
- They add to the effect of alcohol. Advise patients who may be released that alcohol is best avoided.
- Many people become addicted to benzodiazepines because of legal prescribing by their doctor.

### **Withdrawal**

- Benzodiazepines should not be stopped suddenly if they have been taken regularly for more than 4–6 weeks.
- Withdrawal should never take less than 6–8 weeks — and often much longer
- Withdrawal symptoms can include anxiety, tension, panic attacks, poor concentration, difficulty in sleeping, nausea, trembling, palpitations, sweating, and pains and stiffness in the face, head and neck.
- The risk of suicide and self-injury increases during withdrawal and the regular monitoring of the suicide risk is required.
- During withdrawal (especially if it occurs quickly), the patient may behave unpredictably and pose a management problem. Advise officers that this may be part of the withdrawal syndrome. They should deal with the patient as calmly as they can. It may be possible to postpone adjudications until after the withdrawal is complete so that any improved behaviour can be taken into account.

Individuals withdrawing from benzodiazepines may benefit from help with anxiety-coping skills. Helplines and organisations providing support for those wishing to withdraw from benzodiazepines is provided below.

Resources for people addicted to tranquillisers

**Battle Against Tranquillisers (BAT):** 0117 966 3629 (helpline: Monday–Sunday, 9 am–8 pm)  
PO Box 658, Bristol BS99 1XP  
(Counselling and support for those considering stopping their tranquillisers and those who have succeeded in doing so)

**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)

**Drugline:** 020 8692 4975  
(Advice and counselling for drug-related problems)

*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](mailto:mhf@mhf.org.uk); URL: <http://www.mentalhealth.org.uk>

*Making Sense of Treatments and Drugs: Minor Tranquillisers.* Available from: MIND, 15–19 Broadway, London E15 4BQ. Tel: 020 8519 2122; Fax: 020 8522 1725; E-mail: [contact@mind.org.uk](mailto:contact@mind.org.uk); URL: <http://www.mind.org.uk/>

### $\beta$ -Blockers

*What are they?*

$\beta$ -Blockers include oxprenolol (Trasicor) and propranolol (Inderal). In lower doses, they can help treat the physical symptoms of the following.

- **Anxiety**, eg palpitations, sweating, shakiness. They do not affect the psychological symptoms (eg worry, tension and fear).
- **Heart conditions** such as hypertension (high blood pressure), angina and arrhythmias.

*Side-effects*

#### **Common side-effects**

Fatigue, cold extremities.

#### **Rare but important side-effects**

Rash or itchy skin, dry eyes, very slow pulse. Advise the patient to consult the doctor immediately.

Important notes about  $\beta$ -blockers

People with asthma should not take them.

- There is no evidence that they are addictive but they should be stopped gradually because of the likelihood of rebound tachycardia.
- If the patient misses a dose, do not give two or more doses at once. This may cause more side-effects.

Hypnotics

*What are they?*

Hypnotics are used as a short-term treatment for insomnia.

- **Non-benzodiazepine hypnotics** include chloral hydrate, chloral betaine (Welldorm), clomethiazole (Heminevrin), promethazine (Phenergan), diphenhydramine (Nytol), zaleplon (Sonata) and zopiclone (Zimovane).

Promethazine and diphenhydramine are antihistamines. Chlormethiazole (Heminevrin) can help agitation and restlessness as well as alcohol-withdrawal symptoms.

*Side-effects*

#### **Common side-effects**

All hypnotics: drowsiness, dizziness, reduced reaction times during the day.

#### **Rare but important side-effects**

- Chloral: rashes/blotches, wheeziness (especially if the patient has asthma).
- Antihistamines: wheeziness (especially if the patient has asthma), palpitations/fast heart beat.
- If any of the above occur, advise the patient to stop the drug and consult the doctor immediately.

#### **Important notes about hypnotics**

- They are commonly traded illicitly on the street and in prison. Ensure that the drug goes to, and is taken by, the person for whom it is prescribed.
- They may cause addiction if taken regularly for longer than 4–6 weeks and should be taken in as low a dose as possible for the shortest time possible. Taking them only when required or every few days (eg on alternate nights) can be a useful way to use the drugs safely.
- It is recommended that chlormethiazole is taken for no longer than 9 days if used to help alcohol withdrawal.
- If dependence occurs, withdrawal symptoms can include anxiety, tension, poor concentration, difficulty in sleeping ('rebound insomnia'), palpitations and sweating.

Antidepressants

*What are they?*

Antidepressants are used to improve mood in people who are feeling low or depressed. Certain antidepressants may also be used to help the symptoms of panic disorder, obsessive-compulsive disorder, social phobia, bulimia nervosa, post-traumatic stress disorder (PTSD) and chronic pain syndrome. All these drugs seem to be equally effective for depression at the proper dose, but they have different side-effects. If one drug does not suit a patient, another may be tried. There are three main types of antidepressants.

- **Tricyclics (TCAs):** include amitriptyline (Tryptizol), amoxapine (Asendis), dothiepin or dosulepin (Prothiaden), Imipramine (Tofranil) and lofepramine (Gamanil).
- **Selective serotonin re-uptake inhibitors (SSRIs):** include citalopram (Cipramil), fluoxetine (Prozac), fluvoxamine (Faverin), paroxetine (Seroxat) and sertraline (Lustral).
- **Irreversible monoamine oxidase inhibitors (MAOIs):** include isocarboxazide (Marplan), phenelzine (Nardil) and tranylcypromine (Parnate). A special kind of MAOI is known as a reversible inhibitor of monoamine oxidase type A (RIMAs). These include moclobemide (Manerix).

There are, in addition, a number of other antidepressants, such as venlafaxine (Efexor), mirtazapine, nefazodone, reboxetine and trazodone.

*Side-effects*

### Common side-effects

- TCAs: sedation, dry mouth, blurred vision, weight gain, constipation, sweating.
- SSRIs: insomnia, stomach upsets, sexual dysfunction.
- MAOIs: blurred vision, dizziness, drowsiness, dry mouth, constipation.
- RIMAs: dry mouth, nausea, headache, dizziness, insomnia.

### Rare but important side-effects

- TCAs: skin rashes: stop medication and consult the doctor immediately.
- SSRIs: skin rashes: stop medication and consult the doctor immediately.
- MAOIs: urine retention: refer to the doctor immediately. Sweating, blurred vision, skin rashes, headache: stop medication and consult the doctor immediately.

### Important notes about antidepressants

- If a patient misses a dose, seek them out and ask how they are. Ask the staff too. It is possible that the patient has not come to collect the medication because he/she has become more depressed, with increased lethargy, hopelessness and an increased risk of suicide.
- If a patient misses a dose, **do not** give two or more doses next time as this may increase side-effects.
- They may require at least 2 weeks before their mood starts to lift and 6 weeks before a full effect is achieved. Some changes (eg increased appetite, energy levels) may occur before this. Inform the patient about this lag in effectiveness. The risk of suicide may rise during this time. Careful monitoring is required.
- With TCAs, overdose attempts are serious and often fatal due to cardiac complications. The symptoms of overdose include: agitation, confusion, drowsiness, difficulty in breathing, convulsions, bowel and bladder paralysis, dilated pupils, and disturbances with the regulation of blood pressure and temperature.
- Tranylcypromine (a MAOI) by virtue of its amphetamine-like properties has a high abuse potential. Take extra care to ensure that the drug is given to, and taken by, the right patient.
- With MAOIs, dietary restrictions are necessary to prevent a tyramine-induced and potentially fatal hypertensive crisis. Tyramine is found in many common foods. Patients should not take any other drug at all (including over-the-counter cough and cold remedies) without consulting a doctor. **If a throbbing headache develops, medical attention should be sought immediately.**
- Most people may need to continue taking antidepressants for at least 4 months and some may need to continue for 12 months or more, especially if they have been depressed more than once, to reduce the chance of relapse.
- Antidepressants should not be stopped suddenly, even if the patient feels better. Their depression may return. In addition, they may experience 'discontinuation' symptoms. At worst, these could include headache, restlessness, diarrhoea, nausea, 'flu-like symptoms, lethargy, abdominal cramps, sleep disturbance and mild movement disorders. These are usually short lived and can even occur with missed doses.
- Despite the discontinuation symptoms, antidepressants are not addictive because they do not produce craving for the drug, or tolerance (ie needing more of the drug to get the same effect).

### Antipsychotic medication

#### *What is it for?*

Antipsychotic drugs are called neuroleptics or, misleadingly, major tranquillisers. They are usually used only for the treatment of severe psychotic illnesses such as schizophrenia, mania and major depression with psychotic features. Their side-effects are common and often serious. They can also be used to help manage confusion, dementia, behaviour problems and personality disorders, or, in smaller doses, to help treat anxiety, tension and agitation. They have an initial, rapid, tranquillising (calming) effect.

Their effect on psychotic symptoms, such as delusions and hallucinations, may not appear for several weeks. There are two main groups of drugs.

- **'Typical' or classical antipsychotics:** include 'low-potency' drugs, such as chlorpromazine (Largactil), which are used in hundreds of milligrams per day, and 'high-potency' drugs, such as haloperidol (Serenace) and fluphenazine (Moditen), which are used in tens of milligrams per day.
- **'Atypical' antipsychotics:** such as risperidone (Risperdal), olanzapine (Zyprexa) and clozapine (Clozaril). Clozapine is an 'atypical' antipsychotic that has, to date, a unique effectiveness with patients who have not improved with other antipsychotics (drug-resistant schizophrenia).

Some typical antipsychotics are available as long-acting 'depot injections', such as fluphenazine decanoate (Modecate) and haloperidol decanoate (Haldol). Antipsychotic drugs have different side-effects to each other. If one drug does not suit a patient, another may be tried.

#### *Side-effects*

There is a wide range of side-effects. Many are common. They can cause significant impairment in functioning and may be the reason why some people stop taking their medication. They occur most commonly with the high potency typical antipsychotics. With appropriate advice and management, side-effects can be minimised. If a patient is distressed by side-effects, advise them to have a discussion with the doctor or mental-health nurse.

#### **Common side-effects**

- Constipation, dizziness, drowsiness, dry mouth, appetite increase, blurred vision. Movement disorders, known as 'extrapyramidal' side-effects, include shaky hands, feeling shaky, involuntary movements of the face, neck, eyes and tongue. Also, akathisia (acute feeling of restlessness in the legs, constant pacing).

#### **Rare but important side-effects**

- **Fever and muscle stiffness** could be 'neuroleptic malignant syndrome', which is rare but potentially fatal. Stop medication and call the doctor urgently. The patient should be cooled, and the body fluids and serum electrolytes monitored. Anticholinergic medication will be needed.
- **Skin rashes:** stop medication and consult the doctor immediately.

#### *Depot injections*

It is sometimes necessary or helpful for antipsychotics to be given as 'depot' injections. A depot injection is a long-acting injection usually given into a buttock. The injection releases drug over several weeks, so the patient does not have to remember to take tablets at regular times each day. Depot injections are no more or less effective than tablets or capsules. They should only be given where essential, as they are painful to receive. The administration of depot injections should be preceded by an assessment of the patient's mental state and general physical health, including side-effects.

#### *Important notes about antipsychotic medication*

- It is essential that medication is taken regularly to avoid a recurrence of psychotic symptoms. If patients fail to turn up for their medication, make contact with them to assess why they have not taken their medication. Report this to the prescribing doctor or mental-health nurse.
- Sedative antipsychotics may impair mental abilities. If alertness is impaired, advise the patient to avoid operating machinery or driving.
- Remind patients, especially anyone who is taking clozapine (Clozaril), to report the sudden appearance of signs of infection (sore throat, fever). A complete blood count should be done immediately to check for the development of agranulocytosis.

#### Anticholinergic medication

##### *What are they for?*

Anticholinergic medication includes procyclidine (Kemadrin) and orphenadrine (Disipal). These drugs are used to reduce some of the extrapyramidal side-effects of antipsychotic medication. Acute dystonia and Parkinsonism respond quite well, tremor responds less well, akathisia responds poorly and tardive dyskinesia can be made worse by the drugs. These drugs should not be prescribed routinely for all people taking antipsychotic medication, but only after symptoms arise. Withdrawal of anticholinergic drugs should be attempted after 2 or 3 months without symptoms, as the drugs are liable to misuse and may impair memory.

#### *Side-effects*

#### **Common side-effects**

- Dry mouth, constipation, blurred vision.

#### **Rare but important side-effects**

- Urine retention: contact the doctor.

#### *Important notes about anticholinergic medication*

- Patients may trade them and may try to obtain an extra dose.
- Drugs have a mood-elevating effect and, when taken on their own, in the absence of antipsychotic medication, may also cause muscles to become stiff or, if enough is taken, to go into spasm.
- Take steps to ensure that the drug is given to and taken by the individual for whom it is prescribed.

Mood stabilisers

*What are they for?*

Mood stabilisers are drugs used to help prevent mood swings (feeling 'high' or 'low') in people who suffer from a bipolar illness (sometimes called manic depression). They include lithium carbonate (Camcolit), sodium valproate (Epilim) and carbamazepine (Tegretol). Lithium is also used in severe, recurrent depressive illness and in aggression. Carbamazepine and sodium valproate are also used to help control epilepsy. Carbamazepine is also used to relieve the symptoms of trigeminal neuralgia (a painful condition of the face) and in a number of other illnesses such as alcohol withdrawal or alcohol dependence, schizophrenia and withdrawal from benzodiazepines.

*Side-effects*

#### **Common side-effects**

- **Lithium:** nausea, diarrhoea, metallic taste in the mouth, weight gain, increased thirst, difficulty in concentrating.
- **Carbamazepine:** drowsiness, dizziness, stomach upset, visual symptoms (eg seeing double).
- **Sodium valproate:** nausea and vomiting, sedation, diarrhoea/nausea.

#### **Rare but important side-effects**

All three drugs can cause serious disorders. A range of blood tests is required for monitoring.

- **Lithium:** blurred vision, shaking and trembling, confusion, slurred speech, nausea and vomiting, diarrhoea, skin rashes. Advise the patient to stop taking the medication, to drink water and to see the doctor immediately.
- **Carbamazepine:** leucopenia, aplastic anaemia and agranulocytosis. Advise patients to report any symptoms of fever, rash, sore throat, infections, mouth ulcers, easy bruising, paleness of skin, weakness, bleeding or small purple spots on the skin.
- **Sodium valproate:** rash, impaired platelet function (patient bruises without reason and bleeds easily), impaired liver function (the patient feels sleepy, is sick, loses appetite, the skin may look yellow). Stop taking the medication and see the doctor immediately.

*Important notes about mood stabilisers*

- It is essential that these drugs are taken regularly. If lithium is stopped suddenly, there is a very high chance that the illness will return. If the patient misses several doses, they may need a new blood test to check their blood levels. If carbamazepine or sodium valproate is being given to help control fits or blackouts, missing a dose can cause the fits to return.
- If the patient does not turn up to collect their medication, seek them out and ask how they are. Ask the staff too. It is possible that the patient has not come to collect the medication because he/she has become more depressed, with increased lethargy, hopelessness and an increased risk of suicide.
- If a patient misses a dose, do not give two or more doses next time, as this may increase side-effects. If a patient misses two or more doses, refer them to a doctor for blood level checks.
- Remind the patient of the importance of reporting and responding to early symptoms of lithium toxicity. Make sure he/she has a copy of the information sheet on lithium toxicity (it is on the disk). The most common cause of lithium toxicity is dehydration, which may occur during hot weather or physical exertion. Other causes are urinary tract infection and illnesses that cause vomiting and diarrhoea. These may occur despite regular blood tests.
- Remind patients taking carbamazepine of the importance of reporting immediately any fever, sore throat, infections, mouth ulcers, easy bruising, paleness of skin, weakness, bleeding or small purple spots on the skin.
- Remind patients taking sodium valproate of the importance of reporting immediately any jaundice and abdominal pain.

Drugs used for treating attention deficit hyperactivity disorder (ADHD)

The most commonly used drug in ADHD is methylphenidate (Ritalin). It is a stimulant and should be used along with educational, social and psychological help. Methylphenidate can help a young person's

abilities to concentrate and reduce over-activity and destructive behaviour. It is usually available from specialist centres only, and from general practitioners under 'shared care' agreements with specialist centres. It is also sometimes used to help narcolepsy (a sleep disorder), depression in the elderly and for ADHD in adults.

### *Side-effects*

The main side-effects are nervousness, lack of sleep, lack of appetite and stomach-ache. These can sometimes be reduced by changing the dose or changing the times of the doses. Sometimes the drug can slow down the rate of growth, although the young person will still end up the height they would have done. Less often, side-effects such as feeling sick and skin rashes can occur.

### *Important notes about medications for ADHD*

- Methylphenidate is a stimulant drug. It can be addictive, especially in adults. Take especial care that the drug goes to and is taken by the person for whom it is prescribed.
- As methylphenidate is a stimulant, it is best not to give it after 4 pm as it may interfere with sleep.

### *Coping with common side-effects of medication*

Some side-effects occur commonly with more than one type of drug. It is important for patients to know that all drugs have unwanted effects, that these vary from individual to individual and depend on the type of drug and dose being given. Sometimes the side-effects disappear after a few days or weeks, while other side-effects are more troublesome and persistent. It is very important that the patient reports any unwanted effects the drug seems to be having to his/her doctor. The unpleasant effects can often be eliminated, reduced in severity or made more tolerable by a range of simple strategies. The strategies the doctor may suggest include the following.

- Changing to a different medication.
- Decreasing the dose.
- Taking the drug in several, smaller doses spread through the day.
- Taking the medication with appropriate food.
- Taking extra medication to counteract the side-effects.

Strategies that you can advise to help patients deal with side-effects include the following:

<b>Side-effect</b>	<b>Strategy for coping with it</b>
Appetite (increase)	Eat a diet low in fat and high in fibre. Avoid sugary or fatty foods. Drink low-calorie soft drinks.
Constipation	Increase exercise. Increase fibre in diet. Increase fluid intake.
Dizziness	Get up slowly from lying or sitting. Avoid excessively hot showers or baths. Avoid alcohol, sedatives or other sedating drugs (eg marijuana).
Drowsiness	Take medication in a single dose before bedtime (talk to the doctor about this first). If you feel sleepy during the day, you should not drive or work with machinery.
Dry mouth	Ensure a regular fluid intake. Limit alcohol and caffeine (both enhance water loss). Use sugarless gums, fruit pastilles and lollies (sugar will promote dental decay). Suck on ice cubes. If it is very bad, ask your doctor about artificial saliva (Luborant).
Stomach upset	Take medicine after food. Consult with the doctor.
Sensitivity to sunburn	Avoid the midday sun. Regularly use sunscreen and wear a hat, sunglasses and shirt. Ask your doctor for a prescription for sunscreen.

A patient information sheet is available on the disk .

### Administering medication: general issues

The main issue in administering medication in a prison setting is how to make sure that the right medication goes to, and is taken by, the right patient at the right time. All psychotropic medications and many medicines used for physical conditions (eg analgesics) also may be used as currency on the wing. Patients may sell or give them to other prisoners or be pressured/bullied into doing so. There is also the possibility that patients may save medication and then use it to overdose.

Other issues, common to administering psychotropic medication in any setting, include the following:

- How to provide information about the medication and its side-effects to all patients, and also those with communication difficulties who may not understand the instructions. Information tends to increase compliance.
- What to do about those patients who are not capable of managing their own medication, eg those with learning disability.
- How to encourage 'compliance' or concordance without infringing the rights of patients to refuse medication they do not want. This is a particular issue with antipsychotic medication especially depot injections.

### *Possible solutions*

A major response to the problem of reducing trading and the hoarding of medication is to supervise consumption of medication — giving it only 'in sight' and not 'in possession'. This solution may, however, bring its own problems. For example, giving medication in sight rather than in possession may:

- mean that the dose is given at the wrong time. For example, a sedative could be given at 4.00 or 5.00 pm and so be ineffective in helping the individual sleep at night
- turn medication into a battle ground between patients and healthcare staff and
- make it difficult or impossible to give medication twice or three times per day.

The decision about whether any particular medication should be given in possession or not is an individual one. It will depend upon the timing of the dose, the number of doses needed per day, the patient's ability to understand his/her medication, the risk of abuse, etc. Whether medication is to be given in possession or not and the reasons for the decision should be documented in the notes.

### *Systems and policies about medication*

Effective programmes for administering medication include the following:

- Tracking and monitoring system that records whether patients are turning up for and taking their medication. Actively seeking out those patients who are considered to be at risk without their medication (including those on antipsychotics, mood stabilisers and some on antidepressants) who do not take it.
- Regular reviews of medication. Reviews will ideally take place in a clinic, be multidisciplinary, and include the prescribing doctor and administering nurse/HCO who together review compliance, the behaviour of the patient with regard to medication and the patient's own report of his/her progress.
- Regularly scheduled patient educational groups related to the use of psychoactive medications. These are important and can reduce the need for in sight administration of medications, with all its attendant problems. They also increase compliance.
- Policy on 'in possession' medication including flexibility within the policy.
- Awareness by all who are involved in administering medication of the need to obtain patient consent and of what to do if a patient refuses to take the medication.

The pharmacist responsible for the prison will be a valuable source of advice in setting up such medication systems.

Resources for patients and primary support groups

**Mental Health Drugs Helpline:** 020 7919 2999 (Monday–Friday, excluding Bank Holidays, 11 am–5 pm)

(The helpline, run by the UK Psychiatric Pharmacy Group and staffed by experienced mental-health pharmacists, provides independent advice and information about drugs to patients and professionals. The Chair of the Group also runs the **Drug information website for mental-health service users**, which contains detailed, user-friendly information on psychiatric drugs:

URL: <http://www.nmhc.co.uk>)

**Prison Service Health Policy Unit: 020 7972 2000**

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(Pharmacy and pharmacy-related information related to the Prison Service)