Non-medical prescribing considerations in emergency mental health services

Abstract

The role of the emergency mental health practitioner involves immediate management for those who present in mental health crisis. Independent nurse prescribing supports this service through timely access to pharmacological and non-pharmacological measures of cognitive behavioural strategies. This case study involves a service user diagnosed with Bipolar Type II disorder who presents with suicidal ideation, and outlines the prescribing options available for short term crises and long-term risk management. There is a complex balance of appraising physical and mental health including capacity, assessment of risk of self-harm and harm to others, and working in consultation to optimise adherence and concordance. It highlights the importance of using a person-centred approach, which includes family, carers and their wider support network to develop a therapeutic relationship which promotes positive outcomes. This is further supported by utilising the most recent and up-to-date policy, guidelines and legislation, including local and national policies.

Keywords

Bipolar type II disorder; non-medical prescribing, mental health prescribing; suicide ideation Quetiapine; Lorazepam; Lamotrigine.

Introduction

The role of the emergency mental health practitioner involves immediate management for those who present in mental health crisis. The service provides mental health review, risk assessment and short-term input prior to referral to secondary care for ongoing therapy. Independent nurse prescribing supports this service through timely access to pharmacological treatments to manage symptoms and ease the distress associated with a critical episode (Inman, 2017). For the nurse prescriber autonomous decision-making and the ability to discuss all treatment options with service users can optimise adherence and concordance (Kelly, 2018)

The aim of this case study is to review the pharmacological management of a patient with Bipolar Type II disorder who presented in a mental health crisis. Bipolar disorder is a chronic recurrent condition which is characterised by fluctuations in mood state. Bipolar Type II is associated with less severe manic symptoms of hypomania combined with depressive episodes (Grande et al., 2016).

Case study

Jane, a 30-year female, had a long-standing history of low mood, anxiety, periods of poor sleep and one episode of hypomania. She had previously been prescribed several different Selective Serotonin Reuptake Inhibitors with various degrees of efficacy. Jane was noted to have poor engagement with services and non-adherence with treatment which may have contributed to the limited efficacy of the anti-depressants but also crucially highlights the importance of establishing a therapeutic relationship to aid concordance (Rae, 2021).

Jane was diagnosed with Bipolar Type II Disorder 3 years ago following the birth of her first child. She was prescribed her current medication, Lamotrigine 200mg, on diagnosis. Lamotrigine is an antiepileptic class drug and used as monotherapy or adjunctive therapy of bipolar disorder. It is indicated to prevent seizures and treat mood by stabilising pre-synaptic neuronal membranes and inhibiting the release of excitatory neurotransmitters.

Lamotrigine requires frequent drug plasma concentration monitoring before, during and after pregnancy due to fluctuating drug levels which can increase rapidly after birth (BNF 2022). Jane gave birth to her second child 9 months ago and subsequently drug monitoring requirements have reduced but additionally this has led to less contact with health professionals.

Consultation

Jane presented in a mental health crisis with features of low mood, insomnia and intrusive thoughts. She was struggling to care for herself and her children. Her intrusive thoughts included driving her car off the road, self-harm and suicide. She voiced suicidal ideation and had made plans to overdose on her prescribed medication.

The consultation process and mental health assessment took place during the height of the COVID-19 restrictions which required practitioners to review their conventional practice and facilitate virtual consultations when possible. Within the emergency mental health service this added additional complexity for already vulnerable individuals. Taylor et al. (2021) reported that whilst experiencing a bipolar depression15% will complete suicide therefore it was imperative to identify barriers which may impede Jane from accessing services. Foye et al. (2021) also noted that for those who are not comfortable or competent using remote media this can affect their engagement with services and compromise both ongoing treatment and monitoring of medicine efficacy. The pandemic and widespread lockdowns could also have played a role in the deterioration of Jane's mental health as low mood, stress, loneliness and boredom have been reported to be common symptoms precipitated by COVID-19 and its implications on daily life (Razai et al, 2020). Consultation settings had to be considered on an individual basis, with the clinical situation weighed against the risks of potential exposure and virus transmission (Churchouse et al. ,2021). On discussion with Jane, she was unwilling to leave her home and felt uncomfortable using video call. Given

Jane's past treatment non-concordance, it was decided that a home visit with direct contact was the most appropriate consultation method (Murdie et al, 2021).

The principle of concordance advocates a holistic approach to shared decision making and the formation of a therapeutic relationship (Khokhar et al, 2015). This considers an individuals' beliefs, concerns and expectations of the prescribing decision and facilitates adherence through mutual agreement and respect (Qureshi and Maxwell, 2014).
The acceptability of medications can be influenced by cultural or ethical beliefs and impact on treatment concordance as ultimately individuals have bodily autonomy and control over whether they adhere to their medication regime (Dowell et al, 2018). However, a mental health consultation must assess whether there is capacity to make informed decisions on treatment adherence.
Jane engaged well with the consultation process including a physical and mental health examination and an assessment of capacity using principles of Adults with Incapacity Act (Scot Gov 2003). This legislation sets out provision for protecting the welfare of adults with a mental health disorder who may be unable to make some decision for themselves. It guides practitioners to act in the benefit of the patient, providing the least restrictive treatment possible and takes into account the wishes of patients and their carers when making prescribing decisions. A risk assessment was carried out using Sainsburys risk assessment tool, which supports decision making through documentation of risk factors and management plan for these, as well as informing prescribing practice on quantity of medication to be supplied based on risk of overdose (Morgan, 2000). (Table 1).

Sainsbury risk assessment tool	
Risk Assessment	Risk indicators- suicide, neglect, aggression, other factors Situational context of risk factors Historical and/or current context of factors Summary of 'positive' resources and potentials Summary of 'risk assessment'
Risk Management Considerations	Opportunities for risk prevention Short term crisis management options Long term risk management options Positive risk options- and support needed
Responsibilities for Actions	Personnel Timescale and/or dates

Table 1: Sainsbury risk assessment tool (Morgan, 2000)

This tool indicated a medium risk due to mental state and decision making, and it was evident that a main debilitating factor in Jane's presentation was poor sleep. There is a well-documented relationship between sleep disorder and psychiatric disorders and considering the extent to which sleep deprivation impacted Jane's mental state guided the prescribing decision (Sedky et al, 2020). Short term crisis and long-term risk assessment both indicate medical, medication and psychosocial interventions as management options.

Medication management

In consultation with Jane and her husband a medication treatment plan was made for short term crises relief and long-term management (Table 2). Immediate key treatment goals for Jane were rapid symptom relief to improve sleep and reduce anxiety and distress.

Lorazepam 1mg at bedtime was the prescribed choice for short term crises relief as this drug aids sleep and reduces distress. With a maximum dose of 4 mg indicated for insomnia and anxiety this gave scope to increase as required (BNF 2022). Benzodiazepines act to provide

rapid symptomatic relief and are used in periods of acute anxiety. It is recommended that they are prescribed at the lowest possible dose for the shortest possible length of time but no longer than 4 weeks. Use is only advised in severe and debilitating distress, because of the risk of physical dependence and withdrawal (Taylor et al, 2021). Due to suicidal ideation and present risk of overdose, as part of the risk assessment precautions, Lorazepam was supplied as a small quantity, enough for 2 days. Jane's partner would manage this medication and keep it safely stored in a locked box, out of reach from Jane and the children (NICE, 2018).

Alternative drug choices considered for short term crises relief were Zopiclone and Diazepam. Zopiclone was excluded as it is indicated only for use in insomnia and would not relieve the major mood disruption or distress that required urgent management. Diazepam was excluded, although it is indicated for insomnia associated with anxiety, due to its longer onset of action and prolonged half-life (Taylor et al, 2021)

Lamotrigine has proven to be ineffective as prophylaxis of bipolar depression and therefore this was deprescribed by reducing incrementally by 50 mg over 2 weeks to reduce the risk of any side effects or withdrawal (Taylor et al, 2021).

Quetiapine was prescribed for long term management and treatment of Jane's depression in bipolar disorder. Recommend first line treatment option for bipolar depression is Quetiapine monotherapy or Fluoxetine and Olanzapine in combination (NICE, 2020). Quetiapine was selected as Jane had already tried Fluoxetine and found it mania inducing. Alternative drug choice considered was Lurasidone which is also a first-line option recommended by British Association of Psychopharmacology guidelines (Goodwin et al, 2016). This was not selected as although Lurasidone produces good effect, is less effective than Quetiapine or Olanzapine and its action is dose related (Taylor et al, 2021).

Side effect profiles should be considered when selecting medication, due to unwanted or possibly desirable side effects. Quetiapine and Lurasidone list sedation as a side effect,

which could be considered beneficial for Jane to avoid the long-term use of Lorazepam. Lurasidone has a smaller side effect profile of sedation and Akathisia. Akathisia is defined as a psychomotor restlessness with an inability to remain still and is associated with antipsychotic medication. Lurasidone requires to be taken with a meal, and as Jane reported lack of appetite, this may have a negative impact on adherence.

Medication management	**Pharmacology properties**
Deprescribe Lamotrigine reduced incrementally by 50 mg over 2 weeks.	Class: Antiepileptics Monotherapy and adjunctive treatment of bipolar disorder. Prevents seizures and treats mood by stabilising pre-synaptic neuronal membranes and inhibiting the release of excitatory neurotransmitters. Side effects include skin reaction, such as a rash or hypersensitivity. Links with blood disorders, signs may be anaemia, bruising or infection.
Short term crises relief Lorazepam, 1g - maximum 2mg at night.	Class: Benzodiazepam Indicated for insomnia associated with anxiety. Target area for effect is the GABA receptors, where it acts to increase frequency of chloride ion channel opening. May cause dependency and short-term use indicated. Paradoxical increase in hostility and aggression and adjustment of dose may attenuate impulses.
Long term management Quetiapine 50mg/day 1 and increase incrementally by 100mg per day to 300mg/day 4.	Class: second-generation antipsychotic. Quetiapine monotherapy indicated as first line treatment of depression in bipolar disorder. Response monitored and dose adjusted to maximum daily dose of 600mg. Acts on Dopamine neurotransmitter receptors, adrenoceptor and histamine receptor antagonist to improve both depressive and manic symptoms of bipolar disorder.

Table 2: Medication management

Non-pharmacological therapies

During consultation it is vital to give realistic expectations of what pharmacological interventions can achieve to support concordance. Jane and her partner had to understand that medication alone would not combat every symptom (Iglesias-González, 2021). Utilising non-pharmacological approaches and social prescribing can improve patient outcomes by

providing holistic support to manage stressors that are not treatable through pharmacological approaches (Ninot, 2021). NICE (2020) recommend a combination of pharmacological and non-pharmacological approaches for managing bipolar disorder. Psychological intervention such as cognitive behavioural therapy, interpersonal therapy or behavioural couples therapy are potential strategies that could be employed in Jane's ongoing management.

Follow up

A verbal safety plan was agreed with Jane and her partner, who was considered as a protective factor for reducing risk (McClatchy et al, 2018). The emergency mental health team liaised with the community practitioners to develop an intensive home treatment plan. Daily home visits were put in place to monitor mood, risk factors, response to medication and any side effects that may present. This would enable non-pharmacological input through a behavioural activation approach, which aimed to stimulate energy and confidence, improve motor activity and increase interest. Physical health can help to enhance wellbeing and reduce anxiety, encouraging Jane to be physically active with a hobby she enjoys may facilitate improved mood and mental state in conjunction with the pharmacological and non-pharmacological approaches.

Conclusions

Independent prescribers with responsibility in bipolar disorders should familiarise themselves with the guidelines and range of pharmacological and non-pharmacological treatments available in order to know when and how to deploy them safely and effectively. The selection of medication should be based on mental health, physical and risk assessment of individual circumstances including assessment of capacity. Utilising a person-centred approach should aim to build a therapeutic relationship to minimise issues that may adversely impact on concordance and adherence to treatment regimes. Prescribing enables the emergency mental health nurse to offer fully holistic and individualised management to ensure expedient

access to treatment and optimise outcomes not only for the service user but the family as a whole.

Key points

1. Benefits of independent prescribing for the mental health nurse includes the ability to discuss and instigate a range of management options for service users which can expediate treatment.
2. Immediate management of a patient in a mental health crisis involves risk assessment for patient, dependents and public using validated assessment tools.
3. Awareness of concordance issues experienced by the service user and how to work in a person centred, holistic manner is recommended to facilitate engagement and optimise treatment outcomes.
4. Management of mental health disorders should involve a combination of non-pharmacological interventions and pharmacological management

Reflective questions

1. How can you stay up to date with research into bipolar disorders and interventions to ensure you are following the latest evidence?
2. What factors influence concordance and how can practitioners work with patients in a person-centred way to encourage concordance and promote engagement?
3. Consider the importance of carers and families in the assessment process and how this can inform treatment and management plans.

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