

**Prescribing Within a Team Context: One Mental Health Nurse's
Reflection on the Clinical Aspect of Non-Medical Prescribing Training**

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Abstract

Whilst undertaking the Independent and Supplementary Prescribing Course at the University of Sheffield I had the valuable experience of witnessing the prescribing of psychotropic medicines for service users' within a very well organised, competent and compassionate intensive home treatment team based in Rotherham South Yorkshire. This article is a reflective account using a case study that illuminated to me many of the issues involved in the decision-making toward the prescribing of drugs. The reflection also includes a commentary on some of the issues the prescribing nurse must be able work with if they are to competently and safely adopt prescriptive authority to their role.

Key words: Nurse Prescribing, Mental Health Nursing, Depression, Suicide, Intensive Home Based Treatment

Introduction

This journal will be written in the reflective style of using the first person. Webb (1992) alludes to this style of academic writing of realistically personalising the writer's experiences. Thus, my reflections on my involvement of the Crisis/Home Treatment Team in the planning, process and outcomes of prescribing interventions for the service user used as a case study will be analysed in the first person.

Joan is a pseudonym thus protecting her confidentiality as per Nursing and Midwifery Council Guidelines (NMC 2004a). The decision to use 'Joan's' case history was discussed with my supervising psychiatrist and the team as a whole before I undertook the case study.

The structure of the journal will utilise the competency framework outlined by the National Prescribing Centre (NPC 2003). Specifically the consultation, prescribing effectively and prescribing in context competencies will be used to personally critique the structure, process and outcome interventions for Joan.

Background

Joan is a 57 year old lady who lives with her husband Anthony in a bungalow they intend to be their retirement home. Joan has two sons who live long distances from her. Joan had been employed as a doctor's receptionist prior to her present difficulties. Anthony is a self employed builder.

Prior to the referral to the Home Treatment Team (HTT), Joan had experienced both physically and psychologically adverse events. Whilst at a visit to the hairdressers Joan felt a stiffness in her neck and later what

she described as a 'misty eye'. Joan had a consultation with a neurologist. Various investigations were undertaken including two MRI scans and blood tests. The diagnosis varied between Ischaemic Subclavian Steal Syndrome and/or Dorsal Pontine Infarct. Both diagnoses related to the area of the neck and collar bone Joan had complained of as giving pain and stiffness.

Subsequent to the apparent stroke, Joan became low in mood, lost motivation, appetite, lack of sleep and did not find pleasure from life whatsoever (anhedonia). All these symptoms were classically symptoms of clinical depression described in the DSM IV (Gelder et al 1995). Joan was referred privately to a psychiatrist who diagnosed clinical depression and prescribed the anti-depressant Mirtazepine with the dose eventually reaching 45 milligrams as per normal prescribing limits (BNF 2006). Retrospectively Joan's husband and sons noted improvement in her mood, motivation and she had an increased sleep pattern. However the 'recovery' was short lived.

Earlier in the year Joan intended and actioned plans to commit suicide. When her husband had gone to work she took an overdose of mirtazepine and paracetamol along with a bottle of wine. Joan had started her car in the garage and then lay down on the floor fully intending to end her life. Subsequent to this, Joan woke up and rang her husband who alerted the emergency services. Joan physically made a full recovery without any apparent residual harm.

Joan stopped taking mirtazepine and as Anthony spent some time with Joan noted deterioration in mood, motivation, loss of appetite and weight and a poor sleep pattern. Joan was seen by her G.P. and was referred to the HTT as an alternative to hospital care for assessment of mood and mental state and to provide appropriate treatment. A key reason for the referral was the risk of suicide. The referral noted Joan's statements that she both personally regretted the fact she had attempted suicide and would not want to put her family through such trauma again. However, a relapse of symptoms, and past history of a suicide attempt, meant assessment of this risk would be ongoing.

Assessment by the Team

Joan and Anthony were initially hostile as they described being let down by the services they had consulted (i.e. Neurologist/Surgeon/Osteopath). Recent developments also had alienated them from the psychiatric services. The consultant neurologist had changed his diagnosis and could find nothing totally conclusive regarding a stroke. Secondly, and pertinent to the team, a Doctor in the Accident and Emergency Department stated that Mirtazepine, the anti-depressant she had been taking, could have had a major link to Joan's suicidal feelings and subsequent action.

Joan and Anthony described her recent mood, mental state and physical functioning deteriorating in contrast to the improvement seen before the attempt to take her own life. Joan alluded to worries over her neurological condition – worrying that she was developing dementia.

The Consultation

Discussion regarding Joan's immediate needs was done at length in the team meeting prior to a home visit that would discuss treatment options with her and her husband.

Clinical and Pharmaceutical Knowledge/Establishing Options

Prior to the home visit there were immediate issues that needed addressing. Firstly, Joan had deteriorated in mood and mental state which seemed to be related to the discontinuation of the Mirtazepine. Secondly, Joan and her husband were hostile to the idea of anti-depressants due to the information they had received at the Accident and Emergency department regarding Mirtazepine and possible linkage to the suicidal episode. Thirdly, the chance of any post-stroke complications would need to be considered. Finally, as the suicide attempt was recent, continuing risk assessments would have to be utilised.

The findings of the MRI scans seemed to indicate that Joan had suffered a stroke. Post-stroke depression is a common problem and occurs in at least 30-40% of people suffering a CVA (Gainotti et al 1999). The psychiatrist who had seen Joan prior to the suicidal episode had prescribed an appropriate drug Mirtazepine, as this drug not only treats depression but protects against further depressive episodes post-stroke (Taylor et al 2005). Recent reports however have shown that the class of drug called Selective Re-uptake Inhibitors (SSRI) such as Mirtazepine can cause adverse reactions in terms of feelings of agitation/akathisia and active suicidal ideation/intention (Healy et al 2005). In interviewing Joan she had said that she had a fear of being a burden to her family due to her perception that she was developing dementia. It was this worry, rather than any particular feeling of agitation, that made her attempt to kill herself. Thus, there is no conclusive evidence Mirtazepine, an SSRI, had a causal link to the suicidal episode. Added to this, when a person suffering depression begins to regain motivation this can also lead to suicidal ideation (Stuart and Laraia 2001).

The risk-benefit analysis of which anti-depressant to prescribe for Joan (it had been concluded she needed anti-depressant therapy) centred on which drug would be most effective for post-stroke depression (Whyte and Mulsant 2002), and least likelihood of any adverse event related to suicide (Healy and Whitaker 2003). Evidence appeared that Reboxetine a Selective Noreadrenaline Re-Uptake Inhibitor is both an effective therapy for post-stroke depression (Rampello et al 2005), and, has no causal link to suicidal ideation (Tanum 2000). However the HTT had no experience of prescribing Reboxetine. Sertraline, an SSRI antidepressant, was considered appropriate as it has been used successfully in treating a recent case where post-stroke depression had occurred, and, although it has been shown to have a causal link with akathisia induced suicide (Healy and Whitaker 2003), the benefits were judged to outweigh the risk element. Healy and Whitaker (2003), although critical of the marketing of SSRIs regarding the alleged suppression of information in relation to links with suicide, do conclude that SSRIs are an effective treatment for depression and the risk-benefit conundrum should be taken on an individual basis.

In certain types of stroke Warfarin is given post treatment as an anti-coagulant and this can be enhanced by SSRIs (BNF 2005). However, Joan was only prescribed aspirin as an anti-platelet (prophylaxis of cardiovascular episodes), and there was no stated interaction between sertraline and aspirin (BNF 2006).

Communicating with Patients

The decision to discuss with Joan and her husband about the choice of antidepressant was done in the home setting. Dexter and Wash (1997) suggest the practitioner needs to be aware of different dynamics of engaging the service user in their home setting, where often the control is more with the service user and family rather than the clinic or ward context.

There are several models of consultation that can be utilised by the prescriber (Baird 2005). However, I believe the model that Stott and Davies (1979) described as the most appropriate to analyse interaction between Joan and the visiting HTT team members. Stott and Davies (1979) identified four areas that can be explored within each consultation: management of presenting problem; modification of help seeking behaviours review of long term problems; opportunistic health promotion.

Management of Presenting Problems

Engaging the service user and family is key in any consultation (Baird 2005). Joan and Anthony had recently been disappointed with the way the neurologist had communicated the diagnosis with apparent conflicting opinions, and, the apparent link with the SSRI prescribed and her suicidal episode. Before recommendations were made regarding treatment, an opportunity was given for them to ventilate their feelings and relate their understanding of their predicament. Joan repeated her disappointment and anger over previous contacts with the health service. Anthony was particularly assertive in relation to his concerns about SSRIs. Both Joan and Anthony agreed her mental state was putting considerable pressure on their relationship.

Modification of Behaviour

Consultation with the service user was an opportunity to clarify the position the HTT felt was appropriate treatment for Joan and to explain the treatment. Firstly, that daily contact was needed to provide support, assessment and problem solving interventions. Secondly, that antidepressant therapy was necessary and then recommended treatment and why. Thirdly, how antidepressants could help Joan's mood lift and subsequently enable her to function more individually and optimally. Fourthly, that constant risk assessment regarding Joan's mental state would be undertaken by the team, but this needed to be reciprocal and, if low in mood, Joan would need to contact the team as appropriate.

Review of Long Term Problems

Discussion took place about Joan's long term health needs. Joan had some fears that 'something had happened in my head' and that this could develop into dementia. Acceptance of her fears was made (Dexter and

Wash 1997), but reassurance was proffered that although a stroke like event was diagnosed, this did not mean she would develop dementia. Indeed, if the antidepressant helped to lift her mood the fears regarding the worst, dementia, could recede.

Opportunistic Health Promotion

Discussion also took place about how Joan could possibly help herself in terms of managing her depressive symptoms and how these interfered with her life. A brief explanation about how negative automatic thoughts can perpetuate depression was given and how that in certain situations can predominate. Therefore, ways of identifying these thoughts and using strategies to refocus negative thinking can be an aid to recovery. Joan seemed open to re-establishing control of her life but it was agreed that this option would be explored as and when her mood lifted and she felt motivated to work on her thoughts.

Prescribing Effectively - Safely/Professionally/Improving Practice

In discussions regarding the prescribed medication for Joan's care, I witnessed several instances of differences in opinion between psychiatrists about what medication to continue or prescribe. Joan for example remained fixated on her apparent post-stroke symptoms of stiff neck and 'not feeling right in the head'. The fear that Joan would develop dementia was also apparent and something which complicated any outlook by her toward a future. Whilst dementia can arise from a stroke and fixed or delusional beliefs can be part of the picture post-stroke (Whyte and Mulsant 2002, Biran and Chatterjee 2003), how to alleviate her distress/depressive predicament and enable her to recover to the optimum was the concern for HTT.

Much discussion centred about whether to continue with sertraline and increase the dose from 50mg daily as it can be increased to 200mg per day (Taylor et al 2005). This could have elevated her mood and resulted in a lessened negative ideation regarding her health and future. The opposite view was that Joan should have an anti-psychotic medication, Olanzapine, prescribed as any attempt to use psychological interventions had not been successful.

The discussions over a period of weeks included the fact that atypical antipsychotics have been linked with an increase in cardiovascular events (British National Formulary 2006), Joan and Anthony would accept a drug usually used for schizophrenia as they had displayed a negative attitude/understanding toward mental illness. The risk-benefit discussion continued with the decision to start Olanzapine 5mg as it was considered necessary to 'treat' elements of psychotic depression which Joan's belief system appeared to be indicating (i.e. regarding her physical state and dementia) The benefit of prescribing Olanzapine to treat the immediacy of Joan's depressive illness was considered high enough to outweigh the potential hazard of risk of cardiovascular disease, although her physical state would be monitored as per guidelines (British National Formulary 2006).

Reflection

The decision to prescribe Olanzapine was, I feel, undertaken in an appropriate mode with time given for anti-depressant therapy and psychological interventions to be attempted. The decisions I witnessed in the HTT clinical meeting were in the relatively safe confines of a shared decision making process where two senior psychiatrists conducted a dialogue with the team about Joan's care and associated prescribing. I wondered if I were a supplementary prescriber how I could have autonomously made the decision to prescribe for Joan?

Mental Health Nurses have been criticised for lacking the basic knowledge of biology and pharmacology to make effective decisions about medication (Gournay and Gray 2002, Kingsley et al 2006). Doran (2003) contends that prescribing medication for mental health problems is more complex for both service user and practitioner than prescribing antibiotics, analgesics, anti-hypertensives, cardiac and pulmonary medication. The successful management of conditions such as depression requires the MHN prescriber to resolve a number of complex issues surrounding the choice of treatment and expectations of the service user. Lee et al (2006) contend that decision making regarding diagnosis and treatment follows a hypothetico-deductive model that consists of specific stages. Lee and colleagues (2006) also allude to the phenomenological perspective regarding decision making, diagnosing and prescribing of intuitive reasoning. Added to this there are also some personal, psychological and structural variables.

Prescribing is a complex process, and if acting as a supplementary prescriber in the initial development of the Clinical Management Plan (CMP), (a plan of treatment agreed by service user, prescribing nurse and supervising psychiatrist), it may have been that as well as an anti-depressant, use of an antipsychotic would have been added to the CMP. However, as described above, the situation with Joan was complicated by her apparent negative stance toward mental illness as a concept. If the CMP was to be truly agreed between the service user, nurse and psychiatrist (NPC 2005) then a frank discussion regarding what was included on the CMP would have been necessary. I do not believe at the start Joan would have accepted an anti-psychotic with all its negative connotations. Therefore, starting with an anti-depressant to treat the underlying depressive illness and only then adding the second drug as psychotic depression features became more apparent would fit clinical need and give time to explain the reasoning behind it. Prescribing and anti-psychotic medication brings with it the risk of intolerable side effects which may then indicate the need for anti-parkinsonian medication such as procyclidine (BNF 2006).

To overload the service user with such information with Joan's depressive thoughts, and attitude to mental illness would have negated engagement. Thus a staged process, adding medication to the CMP would have been necessary.

Regarding prescribing and psychopharmacological knowledge as the supplementary prescriber (SP) the Nursing Midwifery Council (2006) states the nurse needs to act within their own scope of practise. The processes described above have shown I would need to be able to have sufficient knowledge to be able to consider the appropriate treatment as

well take into account psychosocial and service user issues (Lee et al 2006). Using appropriate channels such as the HTT clinical team meeting, as well as the supervising psychiatrist and mental health specialist pharmacist would need to be utilised.

In terms of my ability to act as a safe and competent prescriber for Joan I feel acting as an SP within the HTT setting with a relative plethora of psychiatrists to consult would provide a sound base on which to practice. If, however, I were acting in the clinic setting as an Independent Prescriber I would question at this stage my ability to be able to act safely and competently. Bailey (1999) recommends the novice prescriber start with a limited formulary with one class of drug (e.g. anxiolytic, anti-depressant, anti-psychotic and anti-manic). Bailey and Hemingway (2006), consider that the Supplementary Prescribing route via the CMP is ideal for the nurse to build up their confidence before perhaps developing as an Independent Prescriber.

As described above there were conflicting opinions of when/if to prescribe an anti-psychotic drug for Joan as well as an anti-depressant. Personal preference is a factor in prescribing (Courtenay and Griffiths 2005). Two Consultant Psychiatrists would have handled the management of prescribing medicines for Joan differently. One psychiatrist (my supervisor) was more cautious, the other would have been more assertive in the earlier use of Olanzapine. I feel the more cautious/staged approach allowed for Joan and Anthony to realise an anti-psychotic was necessary. However I have been party to interactions with psychiatrists when I have disagreed with their prescribing decisions and been overridden. Therefore to disagree with the psychiatrist and act autonomously I would need to be confident that my decisions were based on knowledge of science and up to date facts.

The NHS in Context

Whilst undertaking the prescribing course it became a possibility to prescribe medications independently within my own scope of practice (Department of Health 2006). However I will limit my observations to the supplementary mode of prescribing as that for me is the way forward as a prescriber. The Trust where I have my clinical placement has a policy that only allows for mental health nurses to prescribe in a supplementary mode.

Supplementary prescribing was developed with the intention of working with chronic illness or in the case of mental health with the long term severe and enduring presentations (Davis and Hemingway 2003). This in theory would exclude mental health nurses prescribing for clients in the acute phases of mental illness (Snowden 2006). However if the supplementary prescribing mode is to achieve the aims put forward for non-medical prescribing of greater accessibility, choice, flexibility and at the point of need (Department of Health 1999), then working as a supplementary prescriber within the context of acute mental illness in the home setting is no exception to these aims.

I have witnessed both the rigid use of the Clinical Management Plan where only three to four medications are prescribed in a memory clinic setting. This in practice has resulted in the prescribing nurse making a difference in terms of an improved service as well as validating the role of the specialist

nurse (Smith and Hemingway 2005, Grant et al 2006). Added to this, I have also visited an innovatory mental health nurse in a primary care setting who only prescribes a limited amount of controlled drugs. Through the time he is able to spend with service users' who are drug dependent he has also made a huge contribution to the improvement in care available especially in engaging the person to get some control of their chaotic lives.

The National Prescribing Centre (2005) gives an example of a limited clinical management plan where only a limited set and named drug(s) prescribed. The NPC (2005) also give an example of a broader clinical management plan where the condition is named and that any type of a particular drug can be prescribed (for example anti-depressants). As shown in the clinical management plan for Joan and debated in the previous section of this journal, a broad ranging use of medicines prescribed on the plan is necessary. Thus the potential for mistakes to be made by the nurse prescriber could be greater. Thus the preparation in terms of policies, procedures and administrative tools need to be put into place for the nurse to prescribe confidently, competently and safely. Within the HTT there is a very supportive framework from the senior medical staff, however it would be up to me as an individual to work within trust guidelines, budgetary constraints and protocols.

At the time of writing this journal many nurses who have undertaken the prescribing course both locally and nationally are not practising prescribers after months even years (Latter and Courtenay 2004, Larsen 2005). This situation appears to have been created by organisations not keeping up with national developments in non-medical prescribing.

My own trust is only finalising the policies and protocols for mental health nurses to prescribe supplementarily, and now need to adapt this to the possibility of the independent mode. I have witnessed colleagues losing confidence and motivation toward developing as a prescriber post-course, and I intend to prescribe as soon as possible. The motivation to progress my role as a prescriber could otherwise be compromised by the bureaucracy of the NHS.

The Team and Individual Context

I was privileged to have such an exceptional and forward thinking psychiatrist as my supervisor as well as witnessing the excellent care provided by the HTT. The interactions I have observed and taken part in during the HTT clinical meetings have shown the team as a whole is well informed, as well as service user orientated.

The team sees nurse prescribing as making the service available truly a 24 hour service rather than the more limited cover psychiatrists can resource. Secondary to this, the new working time directive from the European Union which will impact in the near future, and the 'new ways of working' psychiatrists are being encouraged to develop, mean that in reality nurses will be resourcing a gap in service. Whether this is seen as 'dumbing down' of health care (McCartney et al 1999) or truly validating the role that nurses have informally undertaken in the past (Ramcharan et al 2001) are relatively side issues now. The MHN prescriber will need to be an autonomous professional who cannot rely on the umbilical cord every time a prescribing decision is made (Fisher and Vaughan-Cole 2003).

Allied to a new role being created in the team of the prescribing nurse and the impact of this, consideration will need to be given of the changing work pattern of the nurse prescriber (Gournay and Gray 2001, NPC 2005).

Within the HTT context, intervention is an alternative to the ward and is medical in nature, using psychotropic drugs to relieve symptoms of acute mental illness. Within this 'medical culture' it could be suggested that the nurse would have a relatively smooth transition as much of their established role in the team is administering, assessing the therapeutic value of medicines or side effects. Prescribing by nurses, however, will bring about different relationships with psychiatrists and although I feel the supervisory structure is already in situ (ongoing clinical meetings), the nurses who have undertaken the prescribing course in the team (four of us) need to be more proactive in establishing the role of the prescribing nurse within the team. To develop from the underpinnings we are given by the prescribing course and supervision with the psychiatrist, undertaking the process of prescribing will empower nurses, establish the role in the team, and establish it as a new service.

Prescribing has a lot of power elements to it. It is a way of giving a gift to a person in distress, it can validate the prescribing professional (up to recently the doctor) in terms of role, it can also be seen as medicalising care (Walley and Williams 2005). The role of the pharmaceutical industry in the prescribing process also needs to be considered. With nurses adopting prescriptive authority the potential for them to be targeted by the pharma industry is real (Davies and Hemingway 2004). Pharmaceutical companies have appointed people who specifically look at the growth potential of non-medical prescribing. Fears have also been put forward that nurses may be ethically compromised if they allow one company to prescribe a drug rather than what may be appropriate (Davies and Hemingway 2004). Evidence has also shown that doctors are influenced in their prescribing habits by interactions with drug companies (Wattana 2000, Moynihan 2003). Research in nursing has also shown that prescribing decisions made by nurses in the USA have also been influenced by drug companies (Blunt 2005). Also there is a debate whether we should have any contacts with the pharma industry at all (Ashmore and Carver 2001, Hemingway 2003). However the reality is that drug companies are a part of the health care context in the funding of new drugs and sometimes innovatory practice. Some research has even shown information given by pharma representatives to be a somewhat valued resource (Talley and Richens 2001). Blunt (2005) states that interactions with the pharma industry do not necessarily need to be demonised, rather the prescribing nurse needs to critically use information provided. They need to be research aware, understand what is being presented to them, and be able to critically appraise evidence. The NMC (2004b) and ABPI (2006) give guidelines as to what is and is not acceptable. The nurse needs to enter any interaction with a drug representative with their eyes wide open (Davies and Hemingway 2004).

Epilogue

At the time of finishing writing this reflection Joan was on a two week holiday with Anthony. Joan has stated some aspects of her life have improved, she is sleeping relatively better, at times enjoying life (when she forgets she is depressed), renewing some hobbies (i.e. gardening), and is

less preoccupied with the thought she will develop dementia. This is some progress, however, she still states she knows something is wrong, and at times wonders if she can cope with life as it is now. Medication can only help the person cope with a problem and I hope she can get a sense of enjoyment and purpose in life as no clinician can create that for an individual.

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