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Introduction

The National Service Framework (NSF) for Mental Health published in September 1999, was the first NSF to be produced as part of the rolling programme announced in April 1998. It is one of the range of measures to raise quality and decrease variation in services across the NHS.

Although the NSF does not make explicit reference to the contribution that pharmacy can make, the fact that some ninety percent of mental health care is provided by primary care practitioners means that community pharmacists have an important role to play in the delivery of mental health services.

The traditional contact between pharmacists and people with mental health problems has been at the point of dispensing medication. However pharmacists have more contact with the general public than any other health professional, and are therefore ideally placed to recognise early symptoms of mental health problems, identify signs of relapse, help with concordance, encourage good mental health practice, and help to change people’s attitudes towards mental health patients and perceptions of their problems. Not all pharmacists will have the inclination to develop specialist services for mental health service users, but all can make some contribution to improving the care of people with mental health problems and help to implement the targets of the NSF.

Figure 1 - Opportunities for Community Pharmacy

Although it is more than three years since the NSF was published, progress with implementing the standards is patchy. A recent report from the King’s Fund investigated developments in mental health services in primary care in London. This found that only one-third of PCTs had completed the evidence-based guidelines required by the NSF. In most cases implementation priorities have focused on developing services for people with severe mental illness rather than on primary care mental health.
However mental health continues to be one of the four key clinical priority areas for the NHS set out in the planning and priorities framework for 2003 - 2006. NHS organisations will be performance managed on delivery of these targets. Pharmacists therefore need to fully appreciate the content of this NSF and how they can respond to its requirements in the development of pharmacy services.

It should be noted that the NSF applies to England only, with equivalent documents produced for Scotland and Wales.

An Overview of the NSF

Policy Context

The NSF built on the publication, in 1998, of the mental health strategy *Modernising Mental Health Services* which set out the Government’s intentions for ensuring effective mental health services across health and social care services, and made mental health a national priority. This document emphasised three key aims:

- **safe services** – to protect the public and provide effective care for those with mental illness at the time they need it
- **sound services** – to ensure that patients and service users have access to the full range of services they need
- **supportive services** – working with patients and service users, their families and carers to build healthier communities

The White Paper *Saving Lives: Our Healthier Nation* also highlighted the area of mental health, setting a target to reduce deaths due to mental health problems (suicide) by 20% between 1997 and 2010.

Statistics

Epidemiology

At any particular time one adult in six will be suffering from some form of mental illness, making it as common as asthma. Research undertaken by the Office for National Statistics found the most prevalent mental health problems to be mixed anxiety and depressive disorder (88 cases per 1000 population) followed by generalised anxiety disorder (44 cases per 1000 population), with prevalence rates higher among women than men for most neurotic disorders.

Depression is the second most common cause of disability worldwide and is the third most common reason for consultation in general practice. Besides the cost, in terms of suffering to individuals and families, mental illness in England costs almost £12 billion in lost employment and around £7.5 billion in benefit payments.
**Figure 2 - The Burden of Mental Ill Health**

<table>
<thead>
<tr>
<th>Years of Life Lost</th>
</tr>
</thead>
<tbody>
<tr>
<td>• suicide and undetermined injury cause 4,500 deaths every year</td>
</tr>
<tr>
<td>• suicide accounts for 400,000 years of life lost before age 75 years</td>
</tr>
<tr>
<td>• suicide is the leading cause of death among men aged 15 – 24 years and the second most common</td>
</tr>
<tr>
<td>• cause of death among people aged under 35 years</td>
</tr>
<tr>
<td>• over 95% of those who commit suicide had been suffering from mental illness before their death</td>
</tr>
<tr>
<td>• 10-15% of people with severe mental illness kill themselves</td>
</tr>
<tr>
<td>• people with mental illness are also at increased risk of dying early from respiratory disease, cancer</td>
</tr>
<tr>
<td>• and coronary heart disease</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Years of Health Lost</th>
</tr>
</thead>
<tbody>
<tr>
<td>• 16% of the adult population suffers from a common mental disorder such as depression or anxiety</td>
</tr>
<tr>
<td>• 12% of children and adolescents suffer from a conduct or emotional disorder</td>
</tr>
<tr>
<td>• 30% of people over 85 years suffer from dementia</td>
</tr>
<tr>
<td>• four people in every 1000 suffer from a psychotic disorder such as schizophrenia</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Health Disadvantage</th>
</tr>
</thead>
<tbody>
<tr>
<td>• women are more likely than men to seek help for a mental health problem</td>
</tr>
<tr>
<td>• suicide is three times more common in men that in women</td>
</tr>
<tr>
<td>• women living in England born in India and East Africa have 40% higher suicide rates than those born</td>
</tr>
<tr>
<td>• here</td>
</tr>
<tr>
<td>• men in unskilled occupations are four times more likely to commit suicide that those in professional</td>
</tr>
<tr>
<td>• work</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Counting the Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>• treating mental illness costs the NHS and social services an estimated £7.5 billion every year</td>
</tr>
<tr>
<td>• people with mental illness have increased sickness absence, change jobs more often and are more likely</td>
</tr>
<tr>
<td>• to be unemployed</td>
</tr>
</tbody>
</table>

**Prescriptions**

Prescribing of drugs used for mental health problems has increased over the last five years, mainly due to increased use of antidepressants. In 2001 there were 24.3 million prescription items for antidepressants, at a cost of £341.7 million, compared with 20.1 million items at a cost of £315.3 million in 1999. This rise could be due to greater recognition of depression, although antidepressants are also used for other indications.

**Depression and Anxiety**

Selective serotonin reuptake inhibitors (SSRIs) are the most commonly prescribed antidepressant drugs accounting for 12 million items (£228.6 million) per year, with fluoxetine the most frequently prescribed SSRI. Tricyclic and related antidepressants (TCAs) account for 40% of antidepressant items but only 12.8% of cost. Amitriptyline is the most frequently prescribed TCA at 4.3 million items and £9.5 million per year. Other antidepressants, including both newer drugs such as venlafaxine and older products such as the monoamine-oxidase inhibitors (MAOIs), account for the remaining 10% of items and 20% of costs. Prescribing of anxiolytics and hypnotics has shown little change over the last 5 years, although the cost of anxiolytics has increased by almost 50% since 1999.
**Schizophrenia**

Antipsychotics are commonly divided into two classes: the older typical agents (neuroleptics) such as haloperidol and chlorpromazine and the newer “atypical” drugs such as amisulpride, clozapine, olanzapine and risperidone. 37.4% of all antipsychotics prescriptions are for atypical drugs (1.8 million items per year) and this accounts for 87% of the costs (£114.3 million per year). Risperidone is the most frequently prescribed atypical (877,500 items, £36.5 million per year) followed by olanzapine (737,200 items, £62.6 million per year). The licensed indications of atypical antipsychotics vary with some restricted to use in individuals who are unresponsive or intolerant of other treatment while others can be used for indications other than schizophrenia.

Chlorpromazine is now the most frequently prescribed typical antipsychotics (784,600 items, £1.6 million per year) since the CSM recommendation that thioridazone should be reserved for second-line treatment under specialist supervision and not used for sedation and agitation in the elderly.

Pharmacists should be aware that the prescribing rate for atypical antipsychotics is included amongst the proposed NHS Performance Indicators for PCTs, which will be used in summer 2003 to provide PCT performance ratings (see Appendix 1). NICE guidelines recommend prescribing of the newer atypical antipsychotics as more effective and with fewer side effects. Prescribing rates of these drugs should be rising.

**Figure 3 - Prevalence of Mental Health Problems**

<table>
<thead>
<tr>
<th>Condition</th>
<th>Prevalence</th>
<th>Source(s)</th>
<th>Approximate patients / GP*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxiety disorders</td>
<td>2 – 5%</td>
<td>8, 20</td>
<td>36</td>
</tr>
<tr>
<td>Depression - with anxiety</td>
<td>9.2%</td>
<td>8, 21, 22</td>
<td>87</td>
</tr>
<tr>
<td>Depression - without anxiety</td>
<td>2.8%</td>
<td>21</td>
<td>24</td>
</tr>
<tr>
<td>Eating disorders</td>
<td>1 – 2%</td>
<td>23, 24</td>
<td>-</td>
</tr>
<tr>
<td>Post natal depression - puerperal psychosis</td>
<td>3 – 22%</td>
<td>25, 26</td>
<td>-</td>
</tr>
<tr>
<td>Dementia - over 65 years</td>
<td>6%</td>
<td>27</td>
<td>-</td>
</tr>
<tr>
<td>Dementia - over 80 years</td>
<td>20%</td>
<td></td>
<td>-</td>
</tr>
<tr>
<td>Phobia</td>
<td>1.9 – 13.3%</td>
<td>8, 28</td>
<td>13</td>
</tr>
<tr>
<td>Personality disorder</td>
<td>2 – 13%</td>
<td>29</td>
<td>-</td>
</tr>
<tr>
<td>Bipolar disorder (manic depression)</td>
<td>1%</td>
<td>30</td>
<td>-</td>
</tr>
<tr>
<td>Obsessive compulsive disorder</td>
<td>1.3 – 3%</td>
<td>8, 31</td>
<td>14</td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>0.2 – 0.4%</td>
<td>32</td>
<td>5</td>
</tr>
</tbody>
</table>

* based on 1800 list size
Suicide

Suicide is frequently used as a proxy target for mental health. It has the advantage of reliable data, while many mental health policies will lead to reductions in suicide.

Although the overall rate of suicide is falling – by more than 12% since 1982, there are more than 5,000 suicides in England and Wales each year.\textsuperscript{33,34} Suicide rates are higher for men than for women in all age groups, with males aged 25 - 34 the group at highest risk. In men under 35, suicide is the most common cause of death.\textsuperscript{35} Most of the suicides committed each year are attributed to depression.\textsuperscript{1}

**Figure 4 - Mortality Rates from Suicide in England and Wales**

![Mortality Rates from Suicide in England and Wales](image)

**NSF Standards**

The National Service Framework focuses on the mental health needs of working age adults up to 65. It covers health promotion, assessment and diagnosis, treatment, rehabilitation and care, and encompasses primary and specialist care and the roles of partner agencies. Like other NSF\textsuperscript{s} it is a long-term programme for change. A summary of the NSF milestones are included in Appendix 2.

The specific needs of older people with mental health problems are reviewed as part of the National Service Framework for Older People,\textsuperscript{36} however the standards defined in the mental health NSF are equally applicable to older people suffering from mental health problems.

The NSF sets out ten guiding values and principles that underpin the standards and define what people with mental health problems can expect from the services they receive.

Services will:

- involve service users and their carers in planning and delivery of care
- deliver high quality treatment and care
- be well suited to those who use them and non-discriminatory
- be accessible so help can be obtained when and where needed
- promote their safety and that of carers, staff and the wider public
- offer choices which promote independence
- be well co-ordinated between all staff and agencies
- deliver continuity of care for as long as this is needed
- empower and support their staff
- be properly accountable to the public, service users and carers

**Standard One**

It is known that mental health problems can both result from, and cause, social exclusion. Depression is twice as likely to occur in the unemployed; and those who have been abused, victims of domestic violence, and children in the poorest households all have an increased risk of mental health problems; and significant proportions of the prison population and of those using night shelters or sleeping rough have a serious mental disorder.

This standard aims to enhance the psychological well-being of individuals, particularly those at risk due to a life event (such as childbirth or divorce). It also highlights the need for public education to reduce the stigma associated with mental illness, and tackle discrimination.

Since the publication of the NSF an additional document has been launched to support the implementation of Standard One. *Making It Happen* outlines the process that will equip a wide range of groups and agencies to begin some of the strategic development necessary to establish public mental health.

**Standard Two**

One quarter of routine GP consultations are by people with predominantly a mental health problem with a further 40-70% of consultations having a mental health component. Around 90% of mental health care is provided solely by primary care practitioners, and 30-50% of all people with severe mental illness are only in contact with their GP.

One woman in every 15 and one man in every 30 will be affected by depression and every GP will see between 60 and 100 people with the condition. Antidepressant medication is effective in treating depression. However reports indicate that depression is often poorly recognised in primary care, and that treatment outcomes may be poor.

This standard aims to improve the management of mental health problems in primary care including the development and implementation of assessment and management protocols for common mental health problems.

**Standard Three**

Mental health problems do not conveniently occur during normal office hours, and it is important that people can access advice and help at any time of the day or night, every day of the year.
## Figure 5 - NSF Themes and Standards

<table>
<thead>
<tr>
<th>Standard 1</th>
<th>Mental health promotion</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Health and social services should:</strong></td>
<td></td>
</tr>
<tr>
<td>• promote mental health for all, working with individuals and communities</td>
<td></td>
</tr>
<tr>
<td>• combat discrimination against individuals and groups with mental health problems, and promote their social inclusion</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Standards 2 &amp; 3: Primary care and access to services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any service user who contacts their primary health care team with a common mental health problems should:</td>
</tr>
<tr>
<td>• have their mental health needs identified and assessed</td>
</tr>
<tr>
<td>• be offered effective treatments, including referral to specialist services for further assessment, treatment and care if they require it</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Any individual with a common mental health problems should:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• be able to make contact round the clock with the local services necessary to meet their needs and receive adequate care</td>
</tr>
<tr>
<td>• be able to use NHS Direct, as it develops, for first-level advice and referral on to specialist helplines or to local services</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Standards 4 &amp; 5: Effective services for people with severe mental illness</th>
</tr>
</thead>
<tbody>
<tr>
<td>All mental health service users on the Care Programme Approach (CPA) should:</td>
</tr>
<tr>
<td>• receive care which optimises engagement, prevents or anticipates crisis, and reduces risk</td>
</tr>
<tr>
<td>• have a copy of a written care plan which:</td>
</tr>
<tr>
<td>- includes the action to be taken in a crisis by service users, their carers, and their care co-ordinator</td>
</tr>
<tr>
<td>- advises the GP how they should respond if the service user needs additional help</td>
</tr>
<tr>
<td>- is regularly reviewed by the care co-ordinator</td>
</tr>
<tr>
<td>• be able to access services 24 hours a day, 365 days a year</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Each service user who is assessed as requiring a period of care away from their home should have:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• timely access to an appropriate hospital bed or alternative bed or place, which is:</td>
</tr>
<tr>
<td>- in the least restrictive environment consistent with the need to protect them and the public</td>
</tr>
<tr>
<td>- as close to home as possible</td>
</tr>
<tr>
<td>• a copy of a written care plan agreed on discharge, which sets out the care and rehabilitation to be provided, identifies the care co-ordinator, and specifies the action to be taken in a crisis</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Standard 6: Caring about carers</th>
</tr>
</thead>
<tbody>
<tr>
<td>All individuals who provide regular and substantial care for a person on CPA should:</td>
</tr>
<tr>
<td>• have an assessment of their caring, physical and mental health needs, repeated on at least an annual basis</td>
</tr>
<tr>
<td>• have their own written care plan, which is given to them and implemented in discussion with them</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Standard 7: Preventing suicide</th>
</tr>
</thead>
<tbody>
<tr>
<td>Local health and social care communities should prevent suicides by:</td>
</tr>
<tr>
<td>• promoting mental health for all, working with individuals and communities</td>
</tr>
<tr>
<td>• delivering high quality primary mental health care</td>
</tr>
<tr>
<td>• ensuring that anyone with a mental health problem can contact local services via the primary care team, a helpline or an A&amp;E department</td>
</tr>
<tr>
<td>• ensuring that individuals with severe and enduring mental illness have a care plan which meets their specific needs, including access to services round the clock</td>
</tr>
<tr>
<td>• providing safe hospital accommodation for individuals who need it</td>
</tr>
<tr>
<td>• enabling individuals caring for someone with severe mental illness to receive the support which they need to continue to care</td>
</tr>
<tr>
<td>and in addition:</td>
</tr>
<tr>
<td>• supporting local prison staff in preventing suicides among prisoners</td>
</tr>
<tr>
<td>• ensuring that staff are competent to assess the risk of suicide among individuals at greatest risk</td>
</tr>
<tr>
<td>• developing local systems for suicide audit to learn lessons and taken any necessary action</td>
</tr>
</tbody>
</table>
The standard aims to make sure that access to mental health services can be consistently obtained, with sufficient ‘Section 12’ approved doctors, and Approved Social Workers (ASWs) available, liaison arrangements in place in A & E departments, and protocols agreed for emergency access.

**Standard Four**

People with severe mental illness form only a small proportion of those with mental health problems, but have very high rates of psychological and physical morbidity. Many people with severe mental illness are able to live with their families in the community with the support of primary care staff. Where service users are actively involved in the care planning process the quality of care improves.33

The standard aims to ensure that each person with severe mental illness receives the range of mental health services that they require, and that crises are anticipated and prevented where possible, with a prompt and effective response if crisis does occur.

**Standard Five**

When a service user does experience a crisis they should be able to expect prompt and effective help, with timely access to an appropriate and safe mental health place or hospital bed, as close to home as possible. Timely access to services reduces delays in assessment, treatment and care and can also reduce the risk of relapse and potential harm to the service user and others. It has also been demonstrated that in a significant proportion of cases patients admitted to acute psychiatric wards, and secure units, would be better placed elsewhere, at a lower level of security.

The standard aims to offer alternatives to acute psychiatric wards for service users requiring a period of care away from home and to ensure that appropriate arrangements are in place to support the service user when discharged.

**Standard Six**

Carers play a vital role in helping to look after service users of mental health services, particularly those with severe mental illness; a role which can impact on carer’s own mental and physical health. People who provide “substantial care on a regular basis” have the right to request an assessment from social services under the Carers (Recognition and Services) Act 1995. However Social Service Inspectorate reports have demonstrated that implementation within mental health services can be patchy.

This standard requires local health and social care communities to ensure that each carer receives an initial assessment of their caring, physical and mental health needs, repeated at least annually, and resulting in their own written care plan.

Guidance on developing and sustaining mental health carer support services was published in November 2002.

---

1 A doctor who is approved by the Secretary of State for Health under Section 12 of the Mental Health Act as having “special experience in the diagnosis and treatment of mental disorder”. A Section 12 approved doctor is required to give one of the medical recommendations needed for most admission Sections of the Act.
Standard Seven

Mental health is one of the four target areas in *Saving Lives: Our Healthier Nation* with a target to reduce suicide by at least one fifth by 2010. Approximately one quarter of those people who take their own lives have been in contact with specialist mental health services during the previous year, with one in 25 inpatients at the time of their death, and one in 16 discharged from hospital within the preceding three months.

By implementing the other six standards local health and social care communities should help to prevent suicides. In addition this standard requires them to develop local systems to learn lessons from suicides, and to support those individuals particularly at risk, including prisoners.

Related Policy and Issues

The NHS Plan

The *NHS Plan*,64 launched in July 2000, set out an ambitious modernisation agenda for health and social care. For those areas covered by National Service Frameworks, including mental health, the *NHS Plan* reinforced the standards introduced by the NSFs and specified further services and resources.

The NSF set out standards of good practice, but did not specify a precise service model to be implemented nationally. The *NHS Plan* is more structural in approach, detailing services that are expected to be in place. These new service components, in the spirit of but beyond the specification of the NSF, include:

- new graduate primary care mental health workers (now referred to as “Gateway” workers)
- additional early intervention teams to provide support and treatment to young people with mental health problems
- additional crisis resolution and home treatment teams
- additional assertive outreach teams to work with hard to engage service users
- women-only day services
- specialist support for carers
- community facilities for ex-secure patients
- adequate prison mental health care

A summary of the NHS Plan pledges is includes at Appendix 3.

Since the publication of the NSF and *NHS Plan* a series of additional implementation guides have been published providing detailed service models for early intervention, crisis resolution, assertive outreach and primary care services.40,63,65,66,67

The development of a women’s mental health strategy, which recognises the gender-sensitive requirements of mental health care has recently been subject to consultation with the publication of *Women’s Mental Health: Into the Mainstream*. It is expected that service specifications will be published in the form of mental health policy implementation guidance during 2003.
National Suicide Prevention Strategy

Building on the content of the NSF and *Savings Lives* the National Suicide Prevention Strategy sets out a programme of activity to reduce suicide based on six Goals (See Appendix 4). The strategy is not intended as a one-off document and updated versions will be published regularly. The implementation plan will be the responsibility of the National Institute for Mental Health in England (NIMHE).

Action of particular relevance to pharmacy includes the reduction of the maximum pack sizes for over-the-counter sales of paracetamol and aspirin, which appear to have led to an initial fall in overdose deaths using these substances. Future action will include additional steps to promote safer prescribing of antidepressants and analgesics; publicity about the dangers of paracetamol overdose; and safe disposal of unwanted medicines.

Mental Health Bill

A further strand of the Government’s strategy for reforming mental health services is reform of the current mental health legislation was set up in the 1950s. The white paper *Reforming the Mental Health Act*, along with a draft Mental Health Bill launched for consultation, highlight the key points for the new legislation. Its proposals have met with considerable opposition from major mental health organisations and patient groups.

Key changes include proposals for community-based compulsory treatment orders rather than detention in hospital, intended to reflect the fact that most modern mental health services are no longer delivered in hospital; a new Commission for Mental Health to authorise compulsory treatment beyond 28 days; and a single definition of mental disorder.

Updated Drug Strategy

In December 2002 the Government launched the *Updated Drug Strategy*. This builds upon, and adapts the cross-cutting strategy *Tackling Drugs to Build a Better Britain*, published in 1998. The strategy has four main elements, which aim to reduce the harm that drugs cause to society, communities, individuals and their families:

- **young people** – preventing today’s young people from becoming tomorrow’s problematic drug users
- **reducing supply** – reducing the supply of illegal drugs
- **communities** – reducing drug-related crime and its impact on communities
- **treatment and harm minimisation** – reducing drug use and drug-related offending through treatment and support, reducing drug-related death through harm minimisation

Implementation of the updated strategy will expand the provision of substance misuse treatment within the criminal justice system including an increase in the use of Drug Treatment and Testing Orders (DTTOs), and will increase the number of GPs and primary care professionals working with drug users.
**Dual Diagnosis**

Dual diagnosis is a relatively recent term, first used in the United States in the 1980s, to describe the co-existence of mental health problems and substance misuse.

Substance misuse is usual rather than exceptional amongst people with severe mental health problems and the relationship between the two is complex. Possible mechanisms include:

- a primary psychiatric illness precipitating or leading to substance misuse
- substance misuse worsening or altering the course of a psychiatric illness
- intoxication and/or substance dependence leading to psychological symptoms
- substance misuse and/or withdrawal leading to psychiatric symptoms or illness

Studies have shown that substance misuse affects one-third to a half of people with severe mental health problems, with alcohol misuse the most common form.

Historically there has been little attempt to provide a policy framework for people with a dual diagnosis, and separate strands of policy and service provision have focused on mental health and addiction. Guidance has recently been issued under the umbrella of the *Mental Health Policy Implementation Guide* summarising current policy and good practice in the provision of mental health services to people with severe mental health problems and problematic substance misuse.67

Local Implementation Teams (LITs), working in partnership with Drug Action Teams (DATs) are charged with implementing the policy requirements described in the guide.

**NSF for Older People**

Standard seven of the NSF for Older People36 aims to promote good mental health in older people and to provide prompt and appropriate treatment and support for those with dementia and depression.

Under-detection of mental illness in older people is widespread, due to the nature of symptoms and the fact that many older people live alone. Around 10 - 15% of the population aged 65 and over will be suffering from depression at any one time77 and depression in this age group is particularly under-diagnosed,78,79 especially in care homes.80,81 Dementia affects approximately 600,000 people in the UK, with the incidence and prevalence increasing with age.

A report published by the Mental Health Foundation highlights the fact that pharmaceutical support for older people with mental health problems is not routinely available.82,83

**NICE Guidance**

The National Institute for Clinical Excellence (NICE) has produced clinical guidelines for the management of schizophrenia84 and on the use of atypical antipsychotic drugs.17

The former addresses the major psychological and pharmacological treatments and the organisation of services for people with schizophrenia. The first episode of schizophrenia will
commonly occur when a person is between 20 and 30 years old, although it can begin in the teenage years. Although typically there is a pattern of repeated acute episodes, about 20% of suffers will only experience one episode. Schizophrenia is associated with significant mortality - a meta-analysis of 20 studies demonstrated that people with schizophrenia have 1.6 times the mortality rate of the general population and the risk of suicide is nine times higher; the risk of death from other violent incidents is more than twice as high.\textsuperscript{85}

There is evidence that delaying treatment with antipsychotic medication leads to poorer outcomes,\textsuperscript{86} and that the use of antipsychotic medication leads to a reduction in relapse rate.\textsuperscript{87} It is therefore important that the symptoms of schizophrenia are rapidly identified with early referral. Early intervention services are being developed to help minimise the physical, social and legal risks associated with the first few years of psychosis.\textsuperscript{65}

Both documents recommend that the newer oral atypical antipsychotic drugs should be considered in the choice of first-line treatment for individuals with newly diagnosed schizophrenia. It is not recommended that individuals should be routinely switched to these agents they unless they are experiencing inadequate symptom control or unacceptable side effects with older antipsychotics.

Guidance on bipolar disorder is expected in 2003.

**Implementation**

Local health and social care communities are required to have in place a multi-agency Local Implementation Team (LIT) whose responsibility it is to deliver the NSF. By April 2000 all LITs were required to have developed a comprehensive strategy for implementation of the NSF, demonstrating how the targets would be delivered at a local level.

This Local Implementation Plan (LIP) needed to identify service gaps and the short-term and long-term actions necessary to address these service gaps and meet the NSF milestones. Each autumn there has been a requirement to update these plans, with the LIP Stage IV process undertaken in autumn 2002. The 2002 LIP has included updating service and financial mapping, a self-assessment report of progress against a central proforma and submission of action plans in three themed areas of inpatient care, mental health promotion and suicide, and mental health services to prisoners.

**Priorities & Planning Framework**

Significant revisions to the NHS planning process were introduced with the publication of *Improvement, Expansion and Reform*\textsuperscript{3} in October 2002 and its subsequent technical guidance.\textsuperscript{88,89} This announced a move from an annual planning cycle, constrained by time pressures and the requirement for multiple plans, to the development of Local Delivery Plans (LDPs) covering a three-year period to coincide with health services receiving three-year budgets.

LDPs are significantly different from previous plans with the need to identify the expected progress or milestones for each priority area over the three years (termed the “trajectory” of delivery). The Local Delivery Plan will cover a whole Strategic Health Authority (SHA) area but will be based on PCT level plans.

Mental health is included as one of the five target areas focused on improving services and outcomes in clinical or client group areas. Six targets and four national capacity assumptions relate to mental health (see Appendix 5), reflecting the key capacity requirements involved in
increasing the availability, coverage and consistency of mental health services. These must be included in PCT and SHA Local Delivery Plans. The existing Local Implementation Plans will form the basis for the mental health elements of LDPs.

Relevance to Community Pharmacy

The performance of PCTs in delivering the milestones of the NSF for Mental Health and the mental health targets of the NHS Plan will be monitored by the new Strategic Health Authorities and will feature in the Annual Performance Agreements between the two organisations.

*Improvement, Expansion and Reform* identifies the key targets that must be included in PCT and SHA Local Delivery Plans. Although NHS organisations are expected to focus their effort on these key elements, other issues, including other NSF milestones should not be forgotten.

Within the NSF there are some significant statements which provide ideal levers for pharmacy involvement.

Figure 6 - Key Quotes from the NSF

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“people with depression often feel they do not receive adequate information concerning treatment”
“antidepressant medication is not always prescribed in correct doses”

(Standard 2, depression - page 32)

“some side effects of antipsychotic medication may lead people to discontinue their treatment”
“relapse is five times more common if the service user does not take their prescribed medication”
“non-compliance is likely to be a contributory factor in many cases of relapsing psychotic illness”
“simple measures such as written information may help people continue their medication”
“compliance therapy involves a combination of information, education and attention to the factors which may lead to someone stopping medication”

(Standard 4, care planning and review - pages 45 & 46)
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A checklist of potential services, which could be offered by community pharmacists to support the implementation of the mental health NSF, is included as Appendix 6.
Practical Guidance

Mental Health Promotion
Pharmacists have a role to play in supporting standard one of the NSF by providing information to patients about depression and its treatment, and reducing the stigma associated with mental illness.

Many of the factors that influence mental health lie outside the remit of individual health and social care professionals, with mental health promotion relevant to the implementation of a wide range of policy initiatives including social inclusion, neighbourhood renewal, community strategies and health at work.

However exercise, relaxation and stress management have a beneficial effect on mental health; and taking alcohol in moderation, and reducing smoking are also helpful. Pharmacists are well placed to provide advice on these aspects of a healthy lifestyle.

The discrimination faced by many people with mental health problems can be one of the most debilitating aspects of their daily lives. Challenging prejudicial attitudes and improving public understanding play an important role in reducing the stigma attached to mental health problems.

A recent survey of community pharmacists investigated their involvement in the management of depression from patients’ self-diagnosis and self-treatment (for example requests for information about or OTC purchases of St John’s Wort) through to treatment with antidepressants.

The authors suggest that pharmacists could play a much greater role as first-line advisers on depression and its treatment, especially as in some cases pharmacists are attempting to respond to the needs of patients who do not want to consult their GP about depression.

How to go about it
Community pharmacists can contribute to mental health promotion by:

• making available information on local voluntary and non statutory agencies and community groups where people might be encouraged to seek help.
  - A directory of local services should be available from your local PCT and Contact, a directory for mental health giving details of over 160 organisations providing help and information, is published by the Department of Health.
• ensuring that you stock a range of written materials and other information available for patients, if possible in appropriate languages
  - MIND publishes a series of “How to” booklets with simple straightforward advice on mental health problems. The “Family Doctor” series of books from the BMA (and NPA) include mental health titles. The Royal College of Psychiatrists and other organisations also have booklets and fact sheets intended for patients (See Appendix 7).
• in your discussions with patients encourage them to set small realistic goals by which to measure improvement, offer encouragement, refute unrealistic self-blame, and ban statements like “you just need to pull yourself together” from the vocabulary.
  - Educate your staff to behave in the same way.
Supporting Concordance

Medication forms a key element of the treatment of mental health problems in primary care, regardless of the severity of the illness. Supporting concordance is relevant to standard two, in relation to common mental health problems, and to standard four in relation to people with severe mental illness.

Negative beliefs about antidepressant and antipsychotics medication are very widely held, while counselling and alternative therapies are viewed more positively. A survey in 1996 showed that the majority of the public in the UK said they would be embarrassed to consult a GP for depression, mainly because the GP would see them as “unbalanced” or “neurotic”, and a clear gulf has been found between public and professional beliefs about mental health problems.

Such findings were recently reinforced by a study in Denmark, which showed that young women in receipt of selective serotonin re-uptake inhibitors (SSRIs) felt dysfunctional as a result of their emotional problems and stigmatised due to the reputation of the medication.

A small-scale study in Scotland found that the majority of patients cited indications other than depression when asked the reason for being prescribed a tricyclic antidepressant.

Complete or partial non-compliance, unmet information needs, intolerable side effects and lack of appreciation that antidepressants need to be taken long-term have been demonstrated as risk factors associated with relapse or recurrence of depression. Pharmacists need to be sensitive to these feelings in order to enhance their role in the care of mental health patients.

Participation in decisions concerning medication, and the attitudes of health professionals have been found to be the most prominent issues for patients taking long term medication for mental health problems. This indicates that opportunities exist for pharmacists to provide more responsive services that would be valued by people taking long-term medication.

Studies have indicated that approximately 50% of patients who are prescribed an antidepressant will have discontinued treatment by the end of three months, although the minimum recommended treatment period is at least six months after symptoms resolve. The first prescription of antidepressant medication can be a traumatic experience for some people, and information provided by the GP may not be absorbed.

People with depression often feel that they do not receive adequate information concerning their treatment. Pharmacists have an important opportunity to reinforce information about treatment length, expected side effects, time lag to antidepressant effect etc at the beginning of treatment. Research indicates that pharmacists may be more likely to discuss the information provided by the physician, time to onset of benefits and potential side effects with new patients, than to discuss target symptoms, the purpose of the antidepressant, usual duration of treatment and the risk of relapse with premature discontinuation of therapy.

Pharmacists in Wales are participating in a programme called Pharmacist to Patient (P2P) where they will talk to patients with depression, reminding them to collect their medicines and discussing queries or concerns about their treatment.
A number of studies have demonstrated that good compliance with prescribed medication is a major factor in symptom alleviation and delaying relapse into the acute phases of psychotic illnesses such as schizophrenia. However achieving compliance with long-term treatment continues to be a major problem. Patients’ lack of knowledge and understanding about their condition and treatment, side effects, and complex regimens compounded by the lack of insight which often accompanies psychotic illness, reduce the chances of compliance.

Compliance Aids

Review of patient’s medication either in a domiciliary or clinical setting will often identify that they are forgetting to take medicines, or taking them in a chaotic fashion. This is particularly true of patients suffering from a severe mental illness.

Although compliance aids are not the solution to all problems they can have value as a method of maintaining regular medication where discontinuation may result in relapse and readmission to an acute psychiatric ward. One study of elderly mentally ill people attending a day hospital found that the use of a compliance aid provided a visual proof of wastage or non-compliance with medicines, improved communication and increased patient involvement in medication decisions. However another study showed that use of a compliance aid may contribute to increasing patients’ remoteness from their medicines.

Many community nurses fill medication compliance devices, an activity that causes concern regarding responsibility and accountability under their professional body guidelines and is not considered to be best practice. Most compliance aids that are purchased by patients or their carers are unsealed and difficult to label in accordance with the professional and legal requirements.

In order for the provision of monitored dosage systems to work efficiently commitment is required from all involved in the patient’s care, including the patient, carer, CMHT care co-ordinator, general practitioner and community pharmacist. Before supply, an assessment should determine individual needs and an appropriate intervention be made. Where such systems are used medication administration record sheets (MARs) can be useful, particularly where multiple carers are involved.

Dispensing of patient’s medication into monitored dosage systems is more time consuming and less profitable than traditional dispensing. The introduction of patient packs has further increased the time taken to dispense into monitored dosage systems, meaning that community pharmacy contractors increasingly subsidise these systems.

MDS supply for assessed patients is a service which could be commissioned by a PCT and a model bid for providing an MDS service is included as Appendix 8.

Training Carers

Carers operate in a number of different settings - they may be employed staff within a residential or nursing home, employed home care staff, or informal carers; friends and family who take responsibility for caring for an individual who would otherwise be unable to cope on their own.
Whatever the status of the carer, they are likely to have information needs about medication. The CPPE package\textsuperscript{124} *Take Good Care with Medicines* provides training materials, handouts and overhead projector transparencies for pharmacists to use to train care staff. The material is primarily aimed at residential homes staff, but could be used with carers in other situations such as day care and domiciliary care, or to form the basis for discussions with groups of informal carers.

The pack contains a number of core sections covering subjects such as the law relating to medicines, storage and control, and dosage forms. However it also contains a section specifically about medicines for people with mental health problems. Pharmacists may need to supplement the information contained in the mental health section to reflect developments since it was written in 1991.

**How to go about it**
Pharmacists can help concordance with antidepressants and antipsychotics by:

- making sure that your knowledge of mental health issues is up to date, so that you can speak to patients from an informed position
  - CPPE covers mental health in its distance learning\textsuperscript{125} and workshop programmes. The Mental Health Task Force of RPSGB has published a guide on the care of people with mental health problems.\textsuperscript{126}
- trying to make time to counsel all patients taking antidepressants for the first time, or switching from one antidepressant to another
  - The CPPE distance learning package,\textsuperscript{125} MeReC bulletin\textsuperscript{127} and Prodigy guidelines\textsuperscript{101} provide useful pointers for what to include in those discussions. You could produce a simple leaflet to complement your counselling.
- providing training to care home staff, and other carers, to ensure that medication is given appropriately
- trying to provide continuity and consistency of supply of psychotropic medicines and be proactive about explaining any changes in medication to service users.\textsuperscript{126}

**Medication Review**
The aim of medication review services should be to improve the quality of prescribing, improve the patient’s health and avoid inappropriate or unnecessary medication. Periodic review of a patient’s regimen should form part of any repeat prescribing system.

Several studies have found that within psychiatric hospitals a small, but significant proportion of prescription items are prescribed either for unlicensed indications or at doses that exceed the maximum stated by the product license.\textsuperscript{128,129} With an increasing number of patients with severe mental illness now cared for in the community the legal implications need to be fully understood if prescribing passes to general practitioners.

Studies have also shown that antidepressant medication is not always prescribed in correct doses,\textsuperscript{130,131,132} may be over-prescribed,\textsuperscript{133,134} and that second-line treatments such as lithium and electro-convulsive therapy (ECT) provide effective treatment in chronic and severe depression.\textsuperscript{45,135,136}
Medication review can contribute to a number of the NSF standards. General intervention and review of the medication of care home residents are relevant to the achievement of standards two and three. Involvement with day centres, supported housing, intermediate care and hospital discharge are relevant to the provision of effective services for people with severe mental illness and standards four and five.

**General Interventions**
Short-term studies in America, Australia, Canada, New Zealand and South Africa have demonstrated the potential value of clinical pharmacy interventions made at the time of dispensing by a community pharmacist contacting the prescriber. A long-term multicentre study undertaken in the UK found an overall incidence of 75 interventions per 10,000 prescribed items, with approximately 1 intervention per 100,000 prescribed items judged by a multidisciplinary panel to have prevented a hospital admission. Although these studies do not relate specifically to mental health intervention it can be anticipated that similar outcomes could be expected.

**Residential and Nursing Homes**
Psychotropic medication is a common treatment approach to mental health disorders, and is commonly seen prescribed to the residents of residential and nursing homes. The inappropriate prescribing of neuroleptics in care homes has been a subject of concern for some time. Elderly patients are more likely to experience adverse effects from these agents that younger patients due to age-related pharmacodynamic and pharmacokinetic changes.

Depression is often under-diagnosed and older patients have been shown to be more likely to be prescribed a tricyclic antidepressant (TCA) than a selective serotonin reuptake inhibitor (SSRI). Where TCAs are prescribed a significant proportion of patients are prescribed an inadequate dose.

Pharmacists providing clinical advice and services to care homes should be aware of the issues relating to prescribing of neuroleptics and antidepressants and advice accordingly.

**Mental Health Day Centres**
For large numbers of patients suffering from long-term, severe mental health problems regular attendance at a mental health day centre (sometimes called a mental health resource centre) forms an important component of the management of their condition. Such day services may be run by local health and/or social services, or by voluntary organisations, such as MIND.

A number of studies have looked at the provision of informal advice sessions in day centres. There are several advantages to this type of service – the patient is on home territory and can, if they wish, remain relatively anonymous, and sessions can be run on a group basis which can help service users share their concerns about medication.

There is evidence that patients who understand their medicines have reduced levels of anxiety about their medication, suffer from fewer side effects and are more likely to comply with their prescribed treatment. By helping them to understand the nature of their medication and the rationale for its use, they will be more motivated to comply which will have significant benefits in terms of relapse and recovery from relapse.
Supported Housing

Although the principle of community care, with the closure of the large psychiatric hospitals, began to develop in the 1960s, the last decade has seen new commitment to the closure of these asylums. By 2000 over half of the 138 large institutions had closed, and the remainder are likely to close within the next few years.

Community care policies have concentrated on, wherever possible, maintaining people in their own homes. However for some people, who may have been accommodated in mental hospitals for most of their life, such a change would be inappropriate. As part of re provision programmes small “community” homes have been established, often run by housing associations or charitable organisations. These may provide, for example, one-bedded flats, allowing residents a level of independence, but with the security of communal facilities and 24-hour staffing should they be needed.

Although these types of facility must be registered with the local authority under the Registered Homes Act, they do not conform to the traditional image of a residential home. In Essex and Nottinghamshire the provision of pharmacist input to these facilities has been investigated.156,158

Intermediate Care

Intermediate care encompasses a range of integrated services to promote faster recovery from illness, prevent unnecessary acute hospital admission, support timely discharge and maximise independent living. Intermediate care schemes following discharge usually provide domiciliary or residential care for a period of up to six weeks, although on some occasions longer may be needed.

Although the origins of intermediate care are predominantly around rehabilitation related to physical problems, a small number of schemes have been developed which are intended to provide mental health service users with a period of intermediate care between discharge from a specialist mental health facility and them being able to care for themselves at home.

Providing support to individuals in relation to their medication in preparation for them to fully self-medicate at home could form an element of such a scheme.
Hospital Discharge

Admission to hospital, and discharge from it, can be a distressing time for individuals and their carers. It is increasingly evident that effective hospital discharges can only be achieved when there is good joint working between all parties involved - secondary and primary care, social services, housing, voluntary sectors etc.

The Department of Health has recently launched a workbook to provide guidance and practical tools to improve the process of discharge planning. Although primarily concerned with the care of adults with physical ill health, the guide recognises the importance of close working between specialist mental health services, and includes an appendix on medicines management.

Figure 7 - Common medication problems following discharge

- patients view their hospital medication and home medication as different and may take both, thus taking double doses of some medicines
- when home, patients inappropriately revert to their pre-admission medication
- repeat GP computer prescriptions following discharge are not always up to date with the revised hospital medication plan
- GP discharge letter arrives at practice after repeat prescription has been issued
- lack of communication between hospital and patient's community pharmacist

Communication processes need to be in place between mental health services providing acute care and primary care to ensure follow-up of patients at high risk from medication non-compliance including a role for community pharmacists.

How to go about it

Pharmacists interested in getting involved with medication review could start by:

- making sure that your knowledge of mental health prescribing policies is up to date, so that you can speak from an informed position
- talking to the officer-in-charge of the care homes to which you provide a service
  - discuss what you want to review (neuroleptics, antidepressants etc) what you hope to achieve, who will need to be involved; any impact it may have for them
- finding out what community-based mental health services (resource centres, day centres, voluntary sector drop-in centres) operate in your area
  - talk to the team manager of the centre about what you feel you can offer to the service users who attend. You could provide advice on side effects and interactions, help improve patient knowledge of, and adherence with, their medication, and link to their GP or care co-ordinator if they are experiencing problems
- trying to find out whether you have any supported housing schemes in your area, which provide accommodation for former long-stay patients
  - talk to the officer-in-charge about how you can help the tenants achieve as independent a life as possible, by maximising the benefits they get from their medication

You may find it helpful to link with the pharmacists in your local mental health trust for advice and support.
If you want to be involved in the medication review of an independent patient it is important that it is carried out as part of a multidisciplinary process with agreed assessment, referral and follow-up processes. Patients should be assessed to ensure that they meet the criteria for review and give consent. Each patient will need an individual approach and information on the patient’s diagnosis and their attitude to medicine is important in preventing non-compliance. You should use referral forms and study these along with PMRs (if available) before the review to identify/clarify any problem areas.

Reviews are ideally carried out in the patient’s home, or at a mental health day or resource centre as part of their care plan. You will need to liaise to ensure that the patient has knowledge of the visit and can arrange the presence of a representative e.g. carer if required.

Reviews should cover use of all medication including OTCs, storage of medicines, agility, dexterity and visual assessments, side effects/allergies (where appropriate), any difficulties encountered and help needed.

Any removal and disposal of unwanted or out-of-date medicines should be carried out with the consent of the patient and recorded.

Examples of medication reviews are available from barbara.parsons@psnc.org.uk

**Prescribing Advice**

**Working with PCTs and Practices**

The NSF required “prescribing of antidepressants, antipsychotics and benzodiazepines to be monitored and reviewed within local clinical audit programmes” by 2001 and the development of treatment protocols in these areas.

A survey undertaken in April 2001 measured progress with implementation by the (then) health authorities and found that only 6% of health authority areas had achieved these targets.160

Community pharmacists need to be involved in both the development and delivery of those plans, actively participating in the identification of individuals whose medication requires review, and providing advice and support to patients if medication is changed.

NICE has produced clinical guidelines for the management of schizophrenia84 and on the use of atypical antipsychotic drugs.17 A number of guidelines exist for the treatment of depression in primary care101,161,162,163 and the NHS Centre for Reviews and Dissemination have produced a summary of the research evidence on improving its recognition and management.164

The Clinical Governance Research and Development Unit at Leicester University has published an audit protocol for benzodiazepine prescribing in primary care, which identifies those elements which are essential and those which are good practice, to allow a staged approach to tackling the issue.165 PRODIGY guidance is also available on the management of insomnia166 and hypnotic and anxiolytics dependence.167
Figure 8 - Criteria for Auditing Benzodiazepine Prescribing

<table>
<thead>
<tr>
<th>“MUST DO” CRITERIA</th>
</tr>
</thead>
<tbody>
<tr>
<td>These are the minimum criteria that practices need to audit, as there is firm research evidence to justify their inclusion. All practices must include these criteria in the audit.</td>
</tr>
<tr>
<td>1. New benzodiazepines prescriptions should only be issued for short-term relief (no longer than four weeks) of severe anxiety or insomnia.</td>
</tr>
<tr>
<td>2. The records show that a patient receiving a prescription (either new or repeat) for a benzodiazepine has been advised on non-drug therapies for anxiety or insomnia.</td>
</tr>
<tr>
<td>3. The records show that the patient has been given appropriate advice on the risks, including the potential for dependence.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>“SHOULD DO” CRITERIA</th>
</tr>
</thead>
<tbody>
<tr>
<td>These are additional criteria for which there is some research evidence of their importance but the impact on outcome is less certain.</td>
</tr>
<tr>
<td>4. The records show that patients prescribed benzodiazepines are reviewed regularly, at least three monthly.</td>
</tr>
<tr>
<td>5. The records show that, if the patient is aged 65 or over, they or their carer(s) have been given advice on the risks for elderly patients.</td>
</tr>
<tr>
<td>6. Chronic users (use for 4-8 weeks or longer) should be identified and encouraged to reduce.</td>
</tr>
<tr>
<td>7. Before drug reduction is started, the patient has been switched to an equivalent dose of diazepam.</td>
</tr>
<tr>
<td>8. The drug taper should be gradual, with a reduction of 2 - 2.5mg diazepam equivalent every two weeks.</td>
</tr>
</tbody>
</table>

Pharmacists providing prescribing support to either PCTs or individual general practices should work to ensure that prescribing for mental health problems occurs in accordance with available published guidance.

Several studies have investigated pharmacist-led benzodiazepine reduction programmes, including withdrawal clinics at a general practice in Caerphilly, and communication by letter about the disadvantages of taking these medicines regularly and offering support to stop or reduce consumption in Bradford and the West Midlands.

The provision of prescribing advice is relevant to both the primary care standards (two and three) and those relating to individuals with more severe mental health problems (standards four and five).

Working with CMHTs

Medication represents a significant part of the care of people with severe mental illness and is often complex, sometimes causing disturbing side effects. In the community a range of different professionals are usually involved in the care of these patients, as part of Community Mental Health Teams (CMHTs). More detail of the staff that may be found within a CMHT is included as Appendix 9.

The Care Programme Approach (CPA) is applicable to all adults of working age in contact with the secondary mental health system as the means for risk assessment and care planning. For older people the Single Assessment Process will replace CPA unless they are suffering from a severe mental illness such as psychosis, when full CPA will apply.

Several studies have been undertaken where community pharmacists have worked closely with CMHTs to improve the care of people with mental health problems.
In one study participating community pharmacists provided services to between one and five clients and were also linked to the client’s key-worker (care co-ordinator). Forty five percent of interventions were associated with the exchange of information concerning their medication with clients, resulting in an increase in the client’s knowledge about their medication.\textsuperscript{174}

Two studies have involved community pharmacists receiving specialised training, becoming integrated into the CMHT and providing pharmaceutical care for long-term mentally ill patients in the community.

In South Derbyshire the pharmacists made joint domiciliary visits with key-workers (care co-ordinator) to older people with mental health problems. The pharmacists reviewed medication regimens, counselled on the use of medicines, side effects and the importance of adherence, and developed a pharmaceutical care plan, including interventions, compliance aids and collection and delivery services, where necessary.\textsuperscript{83,175} This project has now been expanded as a service across all PCTs in Southern Derbyshire.\textsuperscript{177}

In the other study London pharmacists’ interventions were evaluated by an expert review panel, which considered that 91% of interventions were appropriate and 35% of cases were also clinically significant.\textsuperscript{176}

\textbf{How to go about it}

Pharmacists interested in getting involved with prescribing advice could start by:

\begin{itemize}
  \item finding out who in your area is responsible for the development of the various policies required by the NSF, and volunteer to become involved
  \item working with your local practice to promote the use of effective treatments using an evidence based approach to treatment
  \item identifying your local community mental health team and make contact with the team leader
  \item liaising with CMHT members regarding the care of individual patients where you have concerns
\end{itemize}

An example bid to provide services for people with a mental illness is included as Appendix 10.

\textbf{Specific Services}

\textbf{Instalment Dispensing}

The Suicide Prevention Strategy highlighted the need to promote safer prescribing of antidepressants, including the return of unwanted prescribed antidepressants.\textsuperscript{34} It has been suggested that for patients considered to be at risk, only small supplies of medication should be prescribed with no more than a week’s treatment provided at a time.\textsuperscript{78}
There is no problem giving weekly prescriptions to patients who are exempt from paying prescription charges, but for patients who are not this may act as a deterrent to treatment, particularly at a time when they may be experiencing side effects, but as yet deriving little benefit from the drug. Under the current system in England it is not possible to prescribe antidepressants or antipsychotics in instalments on FP10. Instalment dispensing has been identified as an appropriate contribution that community pharmacists can make to the care of people with mental illness.

The community pharmacy mental health services established in Liverpool included the provision of instalment dispensing, on a daily basis if necessary, for those patients identified as abusing medicines, who were considered to be at risk of overdose, or following a benzodiazepine withdrawal programme.

A project funded by the Department of Health in Croydon included instalment dispensing for schizophrenia patients, where this was identified as beneficial during the care planning process. If the patient failed to collect medication, the community pharmacists would alert the care co-ordinator or carer. Participating pharmacists were also trained to identify signs of relapse so that they could contact the care co-ordinator.

In Sefton community pharmacists provided instalment dispensing for antidepressants. During the initiation of treatment weekly instalments were supplied providing counselling opportunities, with the dispensing interval lengthening as treatment progressed.

### Clozapine Supply

In individuals with evidence of treatment-resistance schizophrenia, the atypical antipsychotic clozapine is now considered to be the treatment of choice. However clozapine use is associated with number of short-term and long-term adverse effects, requiring haematological monitoring to be undertaken on initially a weekly, then fortnightly, then monthly basis throughout treatment. As a result patient, prescriber and supplying pharmacist must be registered with the Clozaril Patient Monitoring Service provided by Novartis which provides for the required leucocyte counts and a drug supply audit. Clozapine can then be promptly withdrawn from any patient who develops abnormal leucocyte findings.

Due to the stringent monitoring requirements many patients receiving clozapine have to return to hospital on a weekly basis to collect their supplies. Especially in rural areas this may be difficult for patients. Two schemes have been established where supply of clozapine is made via community pharmacies.

In Ayrshire a community pharmacy clozapine supply scheme was introduced to overcome the difficulties that patients had collecting their supplies from the hospital pharmacy. Supplies are dispensed at the hospital pharmacy and forwarded to a community pharmacy chosen by the patient, with full regard for the requirements of the clozapine patient monitoring service.

In the Forth Valley community pharmacists were responsible for the supply of clozapine, and monitoring any returned unused tablets and able to monitor other prescriptions for drug-drug interactions. Their increased awareness of early signs for neutropenia meant that any enquiries for cold remedies would result in the pharmacist referring them to their care-co-ordinator or doctor. They are in regular contact with the mental health clinical pharmacist at the local psychiatric hospital, about changes in dosage or duration of prescriptions and blood monitoring results.
**Supervised Administration**

Although administration of medication under the supervision of a community pharmacist is usually associated with methadone treatment for opiate misusers, other circumstances could occur when it may be beneficial.

In Glasgow, where community pharmacist supervised methadone consumption was first introduced, treatment with other medicines, such as benzodiazepines and dihydrocodeine; and for other conditions - for example, Alzheimer’s disease, are being supervised.\(^{185}\)

The introduction of community-based Compulsory Treatment Orders, as proposed in the draft Mental Health Bill can be expected to expand requirements for supervised administration in a community setting. Protocols already exist for the supervised administration of psychotropic medication within some psychiatric hospital pharmacy departments.\(^{186}\) The use of liquids and other non-traditional formulations may help compliance in a supervised administration setting.

**Drug Misuse Services**

CMHTs typically report that 8–15% of their clients have dual diagnosis although higher rates may be found in inner cities. In the past it was not uncommon for individuals to fall between two stools; with mental health services believing that the individual was receiving the support of drug and alcohol services and vice versa. The *Dual Diagnosis Good Practice Guidance*\(^{67}\) recommends that individuals with dual problems should receive care within the framework of mental health services. This may include the establishment of specialist dual diagnosis teams, or close liaison between CMHTs and drug and alcohol services, with a member of the CMHT acting as care co-ordinator.

The need for shared care arrangements in the treatment of drug misusers, including supervised consumption of methadone, has been specifically identified.\(^{187,188,189}\) Supervision of the consumption of methadone reduces “street leakage”, the risks of loss or theft of the drug, binging, injecting and overdose are minimised; and the risk of the drug being consumed by children within the patient’s home is largely removed.

Pharmacists are recognised as having a key role in shared care and supervised consumption schemes in the both *Drug Misuse and Dependence - Guidelines on Clinical Management*,\(^{190}\) and the *Government Response To The Advisory Council On The Misuse Of Drugs Report Into Drug Related Deaths*,\(^{188}\) and were also listed amongst the suggested membership for Shared Care Monitoring Groups.\(^{191}\)

Successful supervised methadone schemes have been reported in many areas, including Berkshire,\(^{192}\) East London,\(^{193}\) Sheffield,\(^{194}\) South Wales,\(^{195,196}\) and Scotland.\(^{197,198}\) As the management of opiate dependence evolves supervised administration schemes are extending to include supervision of sublingual buprenorphine preparations.

Patients in Glasgow with a dual diagnosis are having their methadone and antipsychotic medication supervised.

Many other examples of supervised methadone schemes are available from the PSNC Community Pharmacy Services Database at www.psnc.org.uk
Sources of Funding

Local Delivery Plans
The Government has made a firm financial commitment to the NHS with an annual average increase of funding for the NHS in England of 7.4% in real terms over the 5 years from 2003/4. From April 2003 it is unlikely that the Department of health will distribute ring-fenced or hypothecated funding for any service, care group or professional group. All resource requirements will have to be incorporated into the three year Local Delivery Plans (LDPs) of PCTs.

The existing Local Implementation Plans, developed by LITs since the NSF was launched, will form the basis for the mental health elements of LDPs. These must address the key targets of Improvement, Expansion and Reform, which relate to early intervention in psychosis, crisis resolution and assertive outreach teams, and the management of older people with mental health problems.

Community pharmacists will need to demonstrate that pharmaceutical care is relevant to all these areas, to ensure that resources for pharmacy-based mental health services are incorporated in the financial plan element of LDPs.

Alongside the introduction of new planning arrangements the Government has also introduced fundamental changes to the way that funds flow through the NHS. The proposals include moving towards a nationally agreed set of prices, commissioning at specialty level using Healthcare Resource Groups. The short term focus is on the commissioning of elective care between PCTs and NHS Trusts but as new arrangements in primary care develop, it will encapsulate all commissioning arrangements within the NHS.

Further information about funding is available in the PSNC resource pack - Sources of Funding.

Social Services
Social services departments are responsible for a wide range of services for children, families and adults. These include helping:

- older people live at home by providing them with care in their own home as well as day care and respite care
- people with mental health problems to live safe and fulfilling lives in the community
- people who seriously misuse drugs or alcohol to reduce their misuse and the risks and damage it causes

Some community-based services will be provided directly by social services staff, while others are commissioned from public, voluntary and independent sector organisations.

In other areas pharmacists have participated in projects funded by social services to help patients manage their medication through input from a pharmacist during a domiciliary visit.
Although much training and advice is provided to social care staff, or those working in residential care homes, either informally or as part of providing pharmaceutical advice to care homes, a limited number of pharmacists provide such training on a more formal basis, receiving payment from individual homes or social services departments.202,203

Councils with social services responsibilities receive a Mental Health Grant to invest in developments designed to support implementation of the mental health NSF standards, and service developments set out in the NHS Plan. Use is restricted to services for adults of working age and should be linked to Local Implementation Plans.204

As part of the Social Services Modernisation Fund local authorities receive a “Promoting Independence Grant”.205 Local authorities must provide a written plan, agreed with the health service in their area, setting out how they will use the Grant, which is intended, among other things, to develop services to enable people to live independently and to prevent unnecessary hospital admission.

**Drug Misuse Services**

As part of the Government’s strategy for reducing drug related deaths *Tackling Drugs to Build a Better Britain*,206 significant additional funding has been made available for drug misuse services over the last few years.

Money was made available at the beginning of 2001 specifically for the establishment of Shared Care Monitoring Groups and work to reduce the leakage of prescription drugs. The Crime and Disorder Act 1998 provides magistrates with the option to make drug offenders subject to drug treatment and testing orders (DTTOs), which could require them to undergo substitution therapy with supervised administration.

A number of Drug Action Teams (DATs) have supported initiatives involving pharmacists.

Over the last three years Glasgow DAT has funded the creation of semi-private consultation areas in nearly forty pharmacies, which can be used for supervising the consumption of methadone and for needle and syringe exchange services.207,208

Community pharmacists in Kensington, Chelsea and Westminster were involved in a project funded by the local DAT to improve the oral health of drug users.209 In Wales pharmacists have benefited from the Confiscated Assets Fund established in 1999, with financial assistance for creating private consultation areas.214,215

Community pharmacists in Berkshire have received comprehensive funding for their participation in the shared care of drug misusers via a four-way agreement between drug-team key-worker, GP, pharmacist and patient,211 and the Local Pharmaceutical Committee in South Essex has been commissioned to develop a similar scheme as part of the work to reduce prescription leakage.212

Pharmacists who are interested in developing services for drug misusers should make sure that they are familiar with the relevant Government publications.75,206,190,213,214,215
**Multidisciplinary Working**

Translating the national standards of the NSF into new and better services for people with a mental health problem will require the development of a shared vision and strong partnership working.

The Government’s focus on partnerships and collaborative working has already been demonstrated through the statutory Duty of Partnership placed on health authorities and local councils by the 1999 Health Act. Partnership working at a local level is facilitated through the development of Local Delivery Plans (LDPs) and links with Local Strategic Partnerships (LSPs).

Community pharmacists will need to link into the development of local LDPs, NSF implementation groups, clinical governance frameworks, and other relevant bodies if they are to be successful in assisting with the achievement of the NSF targets for people with a mental health problem. At an individual level they will need to work collaboratively and cooperatively with local specialist hospital pharmacists, general practitioners and their teams, and the staff of community mental health teams (CMHTs). The ultimate goal for all health professionals has to be to achieve better outcomes for patients, whilst benefits for all involved can include a better shared understanding of what each professional can contribute.

In Staffordshire successful multidisciplinary working has lead to the inclusion of a pharmacist within the assertive outreach team (AOT) who is involved in multidisciplinary team meetings as part of the care programme approach. Other members of the AOT recognised that they were not experts on antipsychotics and other drugs used in mental health and value the clinical input and advice to prescribers that the pharmacist can provide.

**Making it Happen**

Having decided that you want to become more involved in supporting the needs of mental health service users, doing so will involve some preparation.

To start with, try to keep it simple, start with small discrete projects or developments which can be introduced within a relatively short timescale, and if these are successful move on to more ambitious plans.

For example, you could start by making small changes to the way you response to mental health issues within your pharmacy: increase the range of information available for patients, standardise your suppliers for antipsychotics, find out about local support groups. Once you are happy with the progress of these think about moving onto something slightly more ambitious such as making contact with your local CMHT to discuss ways of joint working.

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ii intended to support the small number of people with severe mental health problems who have difficulty engaging with services and require repeated admissions to hospital
Getting Started

1. Decide what type of support you want to provide, making the relevant links to the NSF standards, PCT Local Delivery Plan and other local priorities.
   - Appendix 6 provides a checklist of potential services.

2. Identify how what you propose to do can assist the PCT to address its key issues.
   - See Appendix 1 to 5 for PCT targets, goals, milestones and performance indicators

3. Make informal contact with individuals who you think will be able to give you feedback on your ideas.
   - This will vary from one PCT to another and may include: the PCT mental health lead, prescribing adviser or Professional Executive Committee (PEC) pharmacist; Mental Health Trust pharmacist; Community Mental Health Nurse (see Appendix 9); LPC.

4. Identify any learning needs that you may have, and consider whether there is further training that you need to undertake to be in a stronger position to provide this prescribing support.
   - There may be local multidisciplinary training available on mental health issues. Check with your local Workforce Development Confederation.

5. Make sure that you are familiar with the current issues in mental health.
   - This guide provides a useful starting point and the National Institute of Mental Health in England (NIMHE) website is a good source of regular updates on mental health issues. Details of information sources are included in Appendix 7.

6. Make sure that your indemnity insurance covers this type of service provision, especially if it involves a role that is not traditionally undertaken by community pharmacists - perhaps working with a CMHT – See Appendix 9

7. Identify the key individual within the PCT / Mental Health Trust to whom you should make a formal proposal. This will also vary from one organisation to another.

8. Having decided what service you want to supply, the relevant PCT targets and made contact with identified key individuals you should draw up a formal proposal to provide mental health services in your locality. [Information on how to put a bid together, PCT targets and evidence of good practice in mental health services can be obtained from PSNC by contacting barbara.parsons@psnc.org.uk]

9. Ideally the proposed service should be multidisciplinary involving integrated care plans and working in partnership with other professionals. This approach is more likely to be successful in obtaining funding and being incorporated into the PCT’s Local Development Plans.
Appendices
Appendix 1

NHS Performance Indicators for PCTs

Level of 24-hour access to specialist mental health services

Level of 24 hour services provided in area i.e. people on the CPA can, when necessary, see a mental health professional and urgent referrals from primary health care teams can be seen by a mental health professional at any time 24 hours a day, 365 days a year

Rationale: By 2004 all people with a serious mental illness will be able to access a Crisis Resolution Team 24 hours a day

Data Source: SaFFR

Data Year: 2002/03

Suicide audit

Local system for suicide audit implemented

Rationale: PPF Target 2002/3: By 2010 reduce the number of deaths from suicide and undetermined causes by at least 20%, with local services having in place from March 2002: systematic suicide audit programmes; multi-agency protocols for the sharing of information on high risk patients; and staff competent in the assessment of risk of suicide. Developing local systems for suicide audit to learn lessons and take any necessary action is a Mental Health NSF target

Data Source: SaFFR Q4 Data Collection

Data Year: Q4 2002/03

Prescribing rates for drugs acting on benzodiazepine receptors

Prescribing rates for drugs acting on benzodiazepine receptors (age and sex standardised)

Rationale: Prescribing of benzodiazepines should be kept to a minimum and prescribed for a limited period of time for any one individual in a limited number of circumstances. Prescribing rates should be falling to reflect a reduction in inappropriate prescribing

Data Source: PPA Toolkit

Data Year: 2002/03

Prescribing rates for atypical antipsychotics

Prescribing rates for atypical antipsychotics

Rationale: Prescribing rates for antipsychotics is identified in MHNSF standards 4 and 5 on effective services for people with severe mental illness as an indicator of performance. NICE Guidelines recommend prescribing of the new atypical antipsychotics as more effective and with fewer side effects. Prescribing rates for these new drugs should be rising

Data Source: PSU

Data Year: 2002/03

Prescribing rates for anti-dementia drugs

Prescribing rates for anti-dementia drugs

Rationale: The prescribing rates for new anti-dementia drugs should be rising in line with recommended good practice

Data Source: PSU

Data Year: 2002/03
### Appendix 2

#### Summary of NSF Milestones

<table>
<thead>
<tr>
<th>Timescale</th>
<th>Milestones</th>
</tr>
</thead>
</table>
| **By April 2000** | - Health improvement programmes should demonstrate linkages between NHS organisations and partners to promote mental health:  
  - in schools, workplaces and neighbourhoods  
  - for individuals at risk  
  - for groups who are most vulnerable  
  and to combat discrimination and social exclusion of people with mental health problems  
- Service users with severe mental illness have an integrated care plan, with a care co-ordinator responsible for implementing, reviewing and explaining the care plan  
- Local workforce strategies, within a national framework, which ensure  
  - A review of local workforce issues to identify pressures and priorities, including the action needed to match workforce to the local community  
  - A retention strategy including measures to tackle stress and improve working conditions, and provide proper supervision and appraisal  
- Local information strategies, within a national framework, which ensure an annual review is conducted of the appropriateness of bed use and recommendations are implemented  |
| By end 2000     | - Clinical Governance report                                                                                                                                                                                                                                                                                                                  |
| **By April 2001** | - Protocols agreed and implemented between primary care and specialist services for the management of:  
  - depression and postnatal depression  
  - anxiety disorders  
  - schizophrenia  
  - those requiring psychological therapies  
  - drug and alcohol dependence  
- Prescribing rates of antidepressants, antipsychotics and benzodiazepines monitored and reviewed within the local clinical audit programme  
- Service users on enhanced CPA have a written care plan which explains to them, their carer and their GP, how to contact specialist mental health services around the clock  
- Local workforce strategies, within a national framework, which ensures an education and training plan which encompasses recruitment to training grades, continuing professional development, clinical skill acquisition, lifelong learning and team development  
- Local information strategies, within a national framework, which ensure an action plan is completed to implement information systems to support those managing the care of all on CPA, including access on a need to know basis across organisational boundaries; and implementation of the Mental Health Minimum Data Set by March 2003  |
| **By April 2002** | - Assertive outreach in place for service users on enhanced CPA and at risk of losing contact with services  
- Planned increase of 300 in medium secure beds  
- Increase of 50% (over 1999/00 baseline) in percentage of community mental health teams, which integrate health and social services staff within a single management structure  
- A reduction of two percentage points in the rate of psychiatric emergency readmissions from 14.3% to 12.3%  
- 95% of health authorities should have removed mixed sex accommodation in hospitals and no new mixed sex wards will be approved  |
<p>| By 2010         | - Reduction in the suicide rate by at least one fifth                                                                                                                                                                                                                                                                                       |</p>
<table>
<thead>
<tr>
<th>Milestones</th>
<th>Timescale</th>
</tr>
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<tbody>
<tr>
<td><strong>Primary Care</strong></td>
<td></td>
</tr>
<tr>
<td>• Help for GPs on common mental health problems</td>
<td>2004</td>
</tr>
<tr>
<td>• Help for primary care teams, NHS Direct and A&amp;E Departments for people who need immediate attention</td>
<td></td>
</tr>
<tr>
<td>1000 new graduate primary care mental health workers to help 300,000 people</td>
<td>2004</td>
</tr>
<tr>
<td>7500 community mental health staff to help 500,000 people</td>
<td>2004</td>
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<tr>
<td><strong>Community Services</strong></td>
<td></td>
</tr>
<tr>
<td>• Treatment and support for young people and their families</td>
<td>2004</td>
</tr>
<tr>
<td>• Crisis resolution</td>
<td>2004</td>
</tr>
<tr>
<td>• Assertive outreach</td>
<td>2003</td>
</tr>
<tr>
<td>• Services for women</td>
<td>2004</td>
</tr>
<tr>
<td>50 early intervention teams to help young people who experience their first episode of psychosis – around 7,500 a year</td>
<td>2004</td>
</tr>
<tr>
<td>335 teams, treating around 100,000 people a year and reducing pressure on acute inpatient units by 30%</td>
<td>2004</td>
</tr>
<tr>
<td>50 teams, in addition to the target of 170 for April 2001, helping 20,000 people</td>
<td>2004</td>
</tr>
<tr>
<td>Women-only day centres in every health authority</td>
<td></td>
</tr>
<tr>
<td><strong>Carers</strong></td>
<td>2004</td>
</tr>
<tr>
<td>• Respite care</td>
<td></td>
</tr>
<tr>
<td>700 more staff to increase breaks for carers, helping about 165,000 carers</td>
<td>2004</td>
</tr>
<tr>
<td><strong>High Secure Hospitals</strong></td>
<td></td>
</tr>
<tr>
<td>• Reduction in places</td>
<td>2004</td>
</tr>
<tr>
<td>• Long-term secure care</td>
<td>2004</td>
</tr>
<tr>
<td>• After discharge support</td>
<td>2004</td>
</tr>
<tr>
<td>Move 400 patients to more appropriate accommodation</td>
<td>2004</td>
</tr>
<tr>
<td>200 extra beds</td>
<td>2004</td>
</tr>
<tr>
<td>400 more community staff to provide intensive support</td>
<td></td>
</tr>
<tr>
<td><strong>Prisons</strong></td>
<td>2004</td>
</tr>
<tr>
<td>• Better health screening and support for prisoners</td>
<td></td>
</tr>
<tr>
<td>300 more staff to identify and provide treatment. Everyone with severe mental illness will receive treatment and none should leave prison without a care plan and a care co-ordinator</td>
<td>2004</td>
</tr>
<tr>
<td><strong>Personality Disorders</strong></td>
<td>2004</td>
</tr>
<tr>
<td>• Secure accommodation and rehabilitation</td>
<td></td>
</tr>
<tr>
<td>140 new secure places, 75 specialist rehabilitation hostel places and almost 400 extra staff for people with severe personality disorder who pose a high risk to the public</td>
<td>2004</td>
</tr>
</tbody>
</table>
| Goal 1 | To reduce risk in key high risk groups | Actions to include:  
- local mental health services will be supported in implementing *12 points to a Safer Service*, these aim to improve clinical risk management  
- a national collaborative is being established for the monitoring of non-fatal deliberate self-harm  
- a pilot project targeting mental health promotion in young men will be established and evaluated for national roll-out |
| Goal 2 | To promote mental well-being in the wider population | Actions to include:  
- a cross government network will be developed to address a range of social issues that impact on people with mental health problems, e.g. unemployment and housing  
- the suicide prevention programme will link closely with the NIMHE substance misuse programme to:  
  - improve the clinical management of alcohol and drug misuse among young men who carry out deliberate self-harm  
  - make available training in suicide risk assessment for substance misuse services |
| Goal 3 | To reduce the availability and lethality of suicide methods | Actions to be taken include:  
- NIMHE will identify additional steps that can be taken to promote safer prescribing of antidepressants and analgesics  
- NIMHE will help local services identify their suicide ‘hotspots’ e.g. railways, bridges and take steps to improve safety at these |
| Goal 4 | To improve the reporting of suicidal behaviour in the media | Actions to be taken include:  
- A media action plan is being developed as part of the mental health promotion campaign, mind out for mental health, which will include:  
  - Incorporating guidance on the representation of suicide into workshops held with students at journalism colleges: round table discussion sessions with leaders in mental health and senior journalists  
  - A series of road shows at which frontline journalists can discuss responsible reporting  
  - A feature on suicide in media journals e.g. Press Gazette, Media Week, British Journalism Review |
| Goal 5 | To promote research on suicide and suicide prevention | Actions to be taken include:  
- A national collaborative group will oversee a programme of research to support the strategy, including research on ligatures used in hanging and suicides using firearms  
- Current evidence on suicide prevention will be made available to local services through NIMHE’s website and development centres |
| Goal 6 | To improve monitoring of progress towards the Saving Lives: Our Healthier Nation target for reducing suicide | Actions to be taken include:  
- A new strategy group of experts and other key stakeholders will be established  
- The new strategy group will regularly monitor suicides by age and gender, by people under mental health care, by different methods and by social class |
Key Mental Health Targets for Local Delivery Plans

Targets

• Reduce the duration of untreated psychosis to a service median of less than 3 months, (individual maximum less than 6 months) and provide support for the first three years for all young people who develop a first episode of psychosis by 2004.

• Offer 24-hour crisis resolution to all eligible patients by 2005.

• By Dec 2003, deliver assertive outreach to the 20,000 adult patients with severe mental illness and complex problems who regularly disengage from services.

• Increase breaks available for carers and strengthen carer support and networks to the benefit nationally of approximately 165,000 Carers of people on CPA by 2004.

• Improve mental health care in prisons so that all prisoners with severe mental illness have a Care Plan by April 2004 (approximately 5000 prisoners nationally) and ensure appropriate use of secure and forensic facilities by 2004, contributing to the national target of moving 400 patients from high secure hospitals by 2004.

• Ensure that by April 2004 protocols are in place across all health and social care systems for the care and management of older people with mental health problems.

National Capacity Assumptions

• Expanded service capacity in key services, to contribute to national requirements by 2004 of 335 crisis resolution teams; 50 additional assertive outreach teams; 50 early intervention teams; 140 new secure personality disorder places

• Reduced pressure on acute inpatient units by reduction in bed occupancy rate

• All child and adolescent mental health services to provide comprehensive service including mental health promotion and early intervention by 2006

• Increase child and adolescent mental health services by at least 10 per cent each year across the service according to agreed local priorities (demonstrated by increased staffing, patient contacts and/or investment)
Checklist of Potential Services

STANDARD 1: MENTAL HEALTH PROMOTION
Suggested service provision includes:

• helping to raise awareness of mental health issues through provision of health promotion leaflets

• giving advice on healthy lifestyles such as the importance of exercise, health diet, sensible drinking etc

• making information available on mental health issues to service users, families and carers such as treatments available, local services and how to access them, and local self-help groups

• helping to minimise stigma by making factual information available on mental health problems, effectively engaging with vulnerable groups known to be at risk of developing mental health problems

• providing a healthy work environment, ensuring that the workload and conditions placed on staff in the pharmacy is not detrimental to their own mental health

STANDARDS 2 & 3: PRIMARY CARE AND ACCESS TO SERVICES

A. Basic Services
Suggested service provision includes:

• responding to symptoms which are potentially caused by undiagnosed mental illness and referring appropriately

• ensuring continuity and consistency of supply of psychotropic medicines and explain any changes in medication to service users

• providing advice on the common adverse effects of psychotropic medicines, and their management

• identifying patients with mental health problems caused by side effects of medication and referring appropriately

• providing information on local mental health services and self-help groups

• help to ensure that medicines are prescribed in the least complicated possible regimen
B. Enhanced Services
Suggested service provision includes:

- supporting patients and carers in adherence to treatment; helping service users understand when, how and why to take their medication
- promoting the use of effective drug treatments derived from an evidence based approach to treatment
- make contact with members of the local Community Mental Health Teams (CMHT) to identify common caseloads
- liaison with CMHT professionals regarding the care of individual patients; developing care plans for those with special needs; following up patients with particular compliance or side effect problems
- recognise potential signs of non-compliance and refer where appropriate
- liaison with other health and social care professionals to develop local protocols for the management of depression, including how to identify and refer people showing potential signs of depression and those who may be at risk
- providing blood level monitoring services for relevant medication, e.g. Clozaril, Lithium

STANDARDS 4 & 5: 24 HOUR ACCESS AND CARE AWAY FROM HOME

A. Basic Services
As before

B. Enhanced Services
Suggested service provision includes:

- be proactive in monitoring service users for adverse drug effects
- providing support to service users in the community
- pharmacists working together to ensure seamless medication management and support of patients following discharge from specialist units
- liaison with other health and social care professionals to develop local protocols relating to psychotropic drugs
- provide supervised administration of psychotropic medication
STANDARD 6: CARER’S NEEDS

A. Basic Services
As before

B. Enhanced Services
• providing information about medication to carers, and assisting with adherence to treatment
• provision of training for carers on medication issues relating to mental health

STANDARD 7: SUICIDE PREVENTION

A. Basic level services
As before plus

• encouraging service users and their families and carers not to hoard medicines and to return any no longer needed to the pharmacy for disposal

B. Enhanced Services
• developing links with CMHTs and making contact as necessary to protect patients
• working with prescribers to ensure that service users thought to be at risk of suicide do not receive large quantities of medication
• provide instalment dispensing and/or supervised administration of antidepressants in patients identified as at risk of self-harm
• providing blood level monitoring services for relevant medication, e.g. Clozaril, Lithium
• encouraging service users and their families and carers not to hoard medicines and to return any no longer needed to the pharmacy for disposal
Information Sources

Pharmaceutical Services Negotiating Committee (PSNC)

PSNC maintain the Community Pharmacy Services Database and have a range of models bids and resource packs available on selected locally negotiated pharmaceutical services.

Contact: Barbara Parsons, LPC Liaison Officer, Pharmaceutical Services Negotiating Committee, 59 Buckingham Street, Aylesbury, Buckinghamshire, HP20 2PJ (01296 432823)
E-mail: barbara.parsons@psnc.org.uk

National Prescribing Centre


Contact: The Infirmary, 70 Pembroke Place, Liverpool, L69 3GF (0151 794 8134)

Royal Pharmaceutical Society of Great Britain

The Society provides a range of services from support to Pharmacy Development Groups and others wishing to develop their services to clinical governance and audit advice.

Contact: Clinical Governance and Audit Advice - Catherine Dewsbury, Royal Pharmaceutical Society of Great Britain, 1 Lambeth High Street, London SE1 7JN (020 7735 9141 ext 2207)
E-mail: cdewsbury@rpsgb.org.uk

Contact: PDG Advice - Anne Adams, Professional Development Manager, Royal Pharmaceutical Society of Great Britain, 1 Lambeth High Street, London SE1 7JN (0115 939 6465)
E-mail: aadams@rpsgb.org.uk
National Pharmaceutical Association (NPA)

The NPA NHS Service Development Department has a wide range of resources on service development and access to extensive examples of good practice. Nationwide details of current and past local projects are available along with individualised advice on relevant NHS policy and service developments.

Contact: NHS Service Development Department, National Pharmaceutical Association, Mallinson House, 38-42 St Peter’s Street, St Albans, Hertfordshire. AL1 3NP (01727 858687 ext 376 or 231)

E-mail: nhs.dev@npa.co.uk

United Kingdom Psychiatric Pharmacy Group (UKPPG)

The UKPPG exists to ensure best treatment with medicines for people with mental health needs and their carers, by providing a network of support for psychiatric pharmacists. The UKPPG has also established the College of Mental Health Pharmacists, an accreditation body for specialist mental health pharmacists.

Contact: UK Psychiatric Pharmacy Group, 62 Park Hill, Moseley, Birmingham. B13 18DT (0121 434 3270 fax only)

E-mail: contact@ukppg.org.uk

Alzheimer’s Society

National charity providing information and support to patient’s, carers and health professionals relating to Alzheimer’s disease.

Contact: Alzheimer’s Society, Gordon House, 10 Greencoat Place, London SW1P 1PH (020 7306 0606)

E-mail: info@alzheimers.org.uk

Depression Alliance

National charity providing information and support to people affected by depression.

Contact: Depression Alliance, 35 Westminster Bridge Road, London. SE1 7JB (0207 633 0557)
mentality

mentality is the first national charity dedicated solely to the promotion of mental health.

Contact: mentality, 134 – 138 Borough High Street, London SE1 1LB
(020 7716 6777)

E-mail: enquiries@mentality.org.uk

MIND

Mind is the leading mental health charity in England and Wales, and works for a better life for everyone with experience of mental distress.

Contact: Mind, 15 -19 Broadway, London E15 4BQ
(020 8519 2122)

E-mail: contact@mind.org.uk

National Institute of Mental Health for England (NIMHE)

NIMHE aims to improve the quality of life for people of all ages who experience mental distress, and is a part of the Modernisation Agency of the Department of Health.

Contact: NIMHE, Blenheim House, West One, Duncombe Street, Leeds LS1 4PL
(0113 254 3811)
E-mail: ask@nimhe.org.uk

Primary Care Mental Health Education (PriMHE)

PriMHE exists principally to help primary health care professionals achieve and deliver the best standards of mental health care.

Contact: PriMHE, The Old Stables, 2a Laurel Avenue, Twickenham Middlesex TW1 4JA
(020 8891 6593 - administrative queries only)

E-mail: admin@primhe.org
Rethink

Formerly the National Schizophrenia Fellowship, Rethink is the largest severe mental illness charity in the UK.

Contact: Rethink Head Office, 30 Tabernacle Street, London. EC2A 4DD
(020 7330 9100/01)

E-mail: advice@rethink.org

SANE

Initially focusing on schizophrenia, SANE has now developed concern with all mental illness. It offers information and emotional support to those experiencing mental health problems through its national telephone helpline SANELINE (0845 767 8000).

Contact: SANE, 1st Floor, Cityside House, 40 Adler Street, London E1 1EE
(020 7375 1002)

E-mail: London@sane.org.uk

The Mental Health Foundation

National charity working in mental health and learning disabilities, which aims to improve the support available for people with mental health problems and with pioneering research and community projects.

Contact: The Mental Health Foundation, 7th Floor, 83 Victoria Street,
London SW1H 0HW
(020 7802 0300)

E-mail: mhf@mhf.org.uk

The Royal College of Psychiatrists

This is the professional and educational body for psychiatrists in the UK. The College publishes books, reports and educational materials for professionals and the general public.

Contact: The Royal College of Psychiatrists, 17 Belgrave Square, London SW1X 8PG
(020 7235 2351)

E-mail: rcpsych@rcpsych.ac.uk
Appendix 8

Model Bid for Medication Compliance Aids

Introduction
Non-compliance with psychotropic medication presents a major problem, particularly with more dependent patients who are accustomed to playing a largely passive role in their care. The ability to take medication as prescribed is one of the key tasks that must be supported if a person is to remain well and independent. When this task is not supported the consequences can be significant, resulting in relapse and readmission to hospital.

Where patients are forgetting to take medication, or taking them in a chaotic fashion the use of a compliance aid may be one method of maintaining regular medication.

Both the United Kingdom Central Council (UKCC) and the Royal Pharmaceutical Society recommend that any concordance aid, such as a monitored dose container or a daily/weekly dosing aid, should be dispensed, labelled and sealed by a pharmacist. Where a compliance aid is filled by a pharmacist, they are required to comply with standards of personnel, premises and equipment, production and procedures.

Aim
To establish an appropriate, multidisciplinary model that facilitates vulnerable people living at home, to take their medicines correctly.

Objectives
• To keep people, who have problems taking their medicines correctly, living in their own home and out of institutional care
• To ensure that compliance aids are filled to a consistently high standard
• To ensure that all patients have equal access to this service
• To improve the medication management process by:
  - providing help and guidance on correct medication use
  - implementing a system to ensure regular medication review
• To reduce medicines waste and hoarding
• To facilitate nurses and carers in medicine administration
• To utilise the skills of both nurses and pharmacists to their most effective
Methodology

The community mental health team (CMHT) will take a lead role in supporting, monitoring and reviewing the medication compliance of mental health patients whose compliance with their prescribed medication presents a problem. Initial referrals will be made to the service users’ care co-ordinator, and may originate from any source: i.e. GP, CMHT, hospital, social services, community pharmacist, relative or carer.

Each patient admitted to the scheme will have a named care co-ordinator and a clear written care plan that includes a timescale for reassessment and evaluation.

The community pharmacist will be responsible for:

- ensuring that all initial referrals for patients requiring support with medication compliance are directed to the service users’ CMHT
- the selection and supply of an appropriate monitored dosage system
- considering the stability of medication in the device
- liaison with the general practice with regard to the synchronisation of repeat prescriptions
- filling, sealing and labelling of the device
- supplying Patient Information Leaflets, where appropriate
- timely liaison with relevant professionals, carers and patients in addressing any problems that arise

The general practitioner will be required to provide regular repeat prescriptions of no more than 28 days duration, and agree to provide the repeat prescriptions at least 7 days before they are due to commence. In addition all prescriptions will need to include full instruction including full clarification of “prn” doses.

To ensure that the service is of high quality standards must be locally agreed and set, for example:

- service level agreements
- referral criteria
- accredited training for all participants
- standardised assessment protocols
- standardised documentation
- evaluation and audit
Evaluation and Dissemination
The evaluation of the project will include:

- patient benefit following referral by assessment of compliance and overall medicines management by patients before and after pharmaceutical input
- analysis of interventions
- cost effectiveness of review
  - potential (pharmacist recommended interventions)
  - actual (GP agreed interventions)
  - actual (reduction in medicines wastage)
- effectiveness of set standards

Additional evaluation may also include

- patient / GP / CMHT / pharmacist satisfaction survey
- number of patients re-admitted to hospital due to poor compliance or iatrogenic disease

The evaluation report and summary will be presented and discussed with all participants.

Costs

- Set up costs
- Fees to community pharmacists for filling, sealing and labelling monitored dosage systems
- Publishing costs for documentation
- Training costs
- Administration costs including compliance aids
- Audit and report costs
Referral Pathway

Problem with medication compliance identified from any source

Refer to community mental health team for assessment

If patient meets criteria for scheme refer to project administrator

Community Pharmacist identified?

YES

Project administrator contacts community pharmacist to confirm

NO

Project administrator liaises with assessor

Assessor to co-ordinate and review process

Liaise with community pharmacist, CMHT, GP and other agencies until reassessment / discharge
Appendix 9

Community Mental Health Teams (CMHTs)

Care Co-ordinator
Previously known as a Key Worker

A care co-ordinator is a named individual designated as the main contact and support worker for a person who has a need for ongoing care. They do not come from any particular professional background, but could be a nurse, social worker or other mental health worker, depending on the person’s individual situation.

Care Manager
The concept of care management arises from the NHS and Community Care Act 1990. Care management is targeted at service users whose needs are high priority or complex and are likely to require support from a range of different agencies to enable them to live at home. A care manager, who is accountable to the social services department, undertakes care management, and their role includes

- making an assessment of circumstances
- designing the care package or plan with relevant agencies
- monitoring the effectiveness of the plan and tackling any problems that arise

The care manager differs from a care co-ordinator as, to avoid a conflict of interest, they are not involved in the direct service delivery for the services they arrange.

Community Mental Health Nurse (CMHN)
Sometimes known as Community Psychiatric Nurse (CPN)

CMHNs are registered nurses with specialist training who work in the community, and may have additional training in a specialist area (assertive outreach, crisis intervention, dual diagnosis). Most work as part of a Community Mental Health Team (CMHT), although some are attached to GP surgeries or psychiatric units. The role can be very wide and may include:

- offering counselling or anxiety management or exploiting coping strategies with people with acute short term difficulties
- working with people who have had severe mental health problems for many years and require long term support to enable them to establish a rewarding life in the community
- administering psychiatric drugs, e.g. “depot” injections
**Occupational Therapist**

Occupational therapists work in psychiatric units, day hospitals and as part of CMHTs. Their role is to help people with mental health problems build up confidence and skills needed for personal, social, domestic, leisure or work activities. They focus on learning of the specific skills, individual counselling and training activities in daily living.

**Psychiatrist**

Psychiatrists are medically qualified doctors who have undertaken specialist training in mental illness. They work closely with other members of the CMHT, but may be hospital or community based.

**Psychologist**

Clinical psychologists have a first degree in psychology and a Masters degree in clinical psychology. Their training centres on the application of scientific principles to the understanding of human experience and action, including thoughts, feelings and behaviour.

Psychologists offer a wide range of treatments to assist people to change the circumstances in which they are experiencing distress. Interventions include behaviour therapy, cognitive therapy and psychotherapy.

**Social Worker**

Social workers may be involved in mental health in a number of ways and work in a variety of settings, including within a CMHT. They should be able to offer advice on practical matters, such as day care, accommodation or welfare benefits, and work closely with individuals and their families to support them either through crises or in the longer term. An Approved Social Worker (ASW) is a qualified social worker who has undergone additional training and been approved by the local authority to carry out designated functions within the Mental Health Act, 1983. This will include a role in mental health assessment, undertaken jointly with an approved medical practitioner, to determine whether compulsory admission to hospital is necessary.
Proposal to Provide Mental Health Services

Introduction

The National Service Framework for Mental Health presents Primary Care Trusts and primary care providers with some real challenges. It is quite explicit that the majority of mental health problems are best dealt with in primary care.

Issues include ensuring that:

- primary care reaches out to the socially excluded, for example those with co-existent drug problems
- primary care professionals have the skills and knowledge to deal effectively with mental health problems
- primary care has information about available resources (social, welfare and voluntary resources)
- the physical healthcare needs of users are addressed
- systems are co-ordinated enabling communication between all stakeholders involved in the care of a user leading to maximised outcomes for the individual. This can include the development of disease registers
- advice is consistent
- care pathways and protocols are implemented to enhance clinical outcomes, user experience and performance against national target
- carers’ needs are met, e.g. in receiving information about a user’s care plan and medicines
- NICE guidance is implemented
- suicide risk is managed

Community pharmacists are an under-used resource within primary care that can potentially help address some of these issues in mental health. There are many examples of where pharmacy projects have addressed some of these issues, however many have been time-limited pilot projects. Pharmacy in the Future, and the Health & Social Care Act 2001 mean that the environment is better for long-term integration of pharmacists into the primary care team to:

- Meet the changing needs of the NHS including the mental health NSF
- Respond to the changing environment
- Enhance public confidence in the profession
**Aim**
To enhance clinical outcomes including concordance, service user experience and PCT performance against national performance targets, by involving community pharmacists in the care of service users with mental health problems and in particular those with severe mental illness.

**Objectives**
To meet the recommendations contained within the *Practice Guidance on the Care of People with Mental Health Problems* that was published by Royal Pharmaceutical Society in September 2000. These are to:

- ensure continuity and consistency of supply of psychotropic medicines and explain any changes in medication
- help to ensure that medicines are prescribed in the least complicated possible regimen
- help service users to understand when, how and why to take their medicines
- refer complex problems to appropriate member of the healthcare team
- identify common adverse effects of psychotropic medicines, and provide advice on their management
- support service users and carers in maintaining adherence to the treatment regimen
- provide information on local services and self-help groups

In addition community pharmacists may

- become involved in ongoing medicines management
- make contact with the CMHT
- follow up patients with particular problems, especially those with adverse effects or those at risk of poor concordance
- recognise signs of non-compliance and refer when appropriate

**Methodology**
Pharmacists will respond to the information needs of all users with mental health problems, their carers, and other health and social care professionals.

Pharmacists will be proactive about improving outcomes of those patients with severe mental illness. This will include liaising with service users, formal and informal carers (including staff working within residential and nursing homes), the user’s care co-ordinator and their GP.

Particular emphasis could be given to individuals with a dual diagnosis of schizophrenia and drug misuse.
To ensure that the service is of high quality standards must be locally agreed and set, for example:

- service level agreements
- referral criteria
- accredited training for all participants
- standardised assessment protocols
- standardised documentation
- evaluation and audit

**Evaluation and Dissemination**

The evaluation of the project will include:

- patient benefit following referral by assessment of compliance and overall medicines management by patients before and after pharmaceutical input
- analysis of interventions
- cost effectiveness of review
  - potential (pharmacist recommended interventions)
  - actual (GP agreed interventions)
  - actual (reduction in medicines wastage)
- effectiveness of set standards

Additional evaluation may also include

- patient / GP / pharmacist satisfaction survey
- number of patients re-admitted to hospital due to poor compliance or iatrogenic disease

The evaluation report and summary will be presented and discussed with all participants.
**Costs**
- Set up costs, including project manager
- Training costs, including locum cover
- Fees to community pharmacists for intervention
- Publishing costs for documentation
- Administration costs including compliance aids
- Audit and report costs

**Process**

**CMHT / GP ROUTE**
- Care Co-ordinator or GP is concerned about medication
  - Informs patient of available service and refers to project administrator

**PHARMACY ROUTE**
- Patient with mental health problem presents to pharmacy
  - Patient in care home with SMI identified
  - Informs patient of available service and gets patient consent

**PHARMACY SERVICE**
- Patient assessment on understanding of nature of medication, side effects etc.

**CMHT / GP INTERVENTION**
- Polypharmacy
- Concordance
- Medication review
- Physical health review

**PATIENT ADVICE**
- Polypharmacy recommendation
- Concordance
- Medication Review
- Dosage and administration
- Physical health advice

(Based on proposals developed by Hillingdon PCT)
Useful Websites

Alzheimer’s Society
Department of Health
- Mental Health
Depression Alliance
Mental Health Foundation
Mentality
MIND
National electronic Library for Health (NeLH)
National Institute for Clinical Excellence (NICE)
National Institute for Mental Health in England (NIMHE)
National Prescribing Centre
Rethink
(formerly the National Schizophrenia Fellowship)
National Service Frameworks
- Mental Health NSF
NHS Beacon Programme
Pharmaceutical Services Negotiating Committee
Pharmacy in the Future
Primary Care
Research and Development
Royal Pharmaceutical Society of Great Britain
Royal Pharmaceutical Society of Great Britain – Audit Website
SANE
The NHS Plan
UK Psychiatric Pharmacy Group

www.alzheimers.org.uk
www.doh.gov.uk
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www.doh.gov.uk/nsf/mentalhealth.htm
www.nhs.beacons.org.uk
www.pscn.org.uk
www.pharmacyinthefuture.org.uk
www.doh.gov.uk/pharmacyfuture
www.doh.gov.uk/pricare/
www.doh.gov.uk/research
www.rpsgb.org.uk
www.rpsgb.org.uk/audhome.htm
www.sane.org.uk
www.doh.gov.uk/nhsplan/
www.ukppg.org.uk
Abbreviations and Glossary

Assessment - a process whereby the needs of an individual are identified and their impact on daily living and quality of life is evaluated.

Care Package - a combination of services designed to meet a person’s assessed needs.

Care Planning - a process based on an assessment of an individual’s assessed needs that involves determining the level and type of support to meet those needs, and the objectives and potential outcome that can be achieved.

Care Trust (CT) - free-standing statutory trust responsible for health and social services in a geographical area in England.

Clinical Governance – a framework through which the NHS is accountable for continuously improving the quality of services.

Community Mental Health Team - a team of community-based staff (usually health and social care) concerned with the care of individuals with a long-term mental health problem.

Co-morbidity - other co-existing illness in addition to the particular illness which is currently most significant.

Day Hospital - a hospital where patients receive day care only, continuing to live at home.

Domiciliary Care - care provided in an individual’s own home.

Dual diagnosis – the presence of mental health problems and substance misuse.

Health Economy - health authority and the primary care organisations, main NHS trusts, and social services department(s) that are co-terminous with it.

Hospital and Community Health Services (HCHS) – the provision of hospital services mainly by NHS Trusts, and community health services by NHS Trusts or PCTs.

Intermediate Care - a short period (normally no longer than six weeks) of intensive rehabilitation and treatment to enable patients to return home following hospitalisation, or to prevent admission to long term residential care; or intensive care at home to prevent unnecessary hospital admission.

Local Delivery Plan - local strategic plan for the delivery of the health agenda, planned resource usage, and activity at PCT or HA level.

Local Health Group (LHG) - subcommittee of the health authority responsible for health services in a geographical area in Wales.

Multidisciplinary - refers to when professionals from different disciplines - such as social work, nursing, occupational therapy etc, work together.

National Institute for Clinical Excellence (NICE) - a special health authority to promote clinical and cost-effectiveness.

National Service Frameworks (NSFs) – documentation bringing together the best evidence of clinical and cost-effectiveness with the views of service users to determine the base ways of providing particular services.
NHS Executive – part of the Department of Health, with offices in London and Leeds, and eight regional offices across the country. It supports Ministers and provides leadership and a range of central management functions to the NHS.

NHS Trusts – statutory bodies providing NHS hospital and community healthcare

Personal Social Services (PSS) - personal care services for vulnerable people including those with special needs because of old age or physical disability. Examples of services are residential care homes, home helps, and social workers who provide help and support for a wide range of people.

Primary Care – family health services provided by family doctors, dentists, community pharmacists, optometrists and ophthalmic medical practitioners.

Primary Care Investment Plan (PCIP) - current and planned resource use and service development by a PCT.

Primary Care Trust (PCT) - free-standing statutory trust responsible for health services in a geographical area in England.

PRODIGY - Prescribing RatiOnally with Decision-support In General Practice StudY. A decision support system

Secondary Care – specialist care, typically provided in a hospital setting or following a referral from a primary or community health professional.

Social Care – personal care services provided by local authorities for vulnerable people, including those with special needs because of old age or physical or mental disability, and children in need of care or protection. Examples include residential care homes, home help and home care services etc.

Special Health Authorities – health authorities with a unique national or supra-regional function which cannot be undertaken by other kinds of NHS bodies (for example the Prescription Pricing Authority, NICE).
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