18 - Summary a checklist when prescribing

Summary – a checklist when prescribing

942 The Maudsley® Prescribing Guidelines in Psychiatry CHAPTER 14 Recommendation: Consider treatment preference as one of the decision factors when prescribing. Countertherapeutic use of medication Medication (including overdose) may be used as a way of signalling submission, anger or helplessness. This is especially true in people who lack an emotional vocabulary and secure internal representations of benign care. Medication may become a way of self-management, replacing more developmental coping strategies and relationships. Recommendation: The clinician should consider the meaning of the emotional communication and be curious about alliance ruptures and system failures (and therefore reflect on the clinician's possible contributions to the rupture). Summary – a checklist when prescribing When faced with complex prescribing decisions, a checklist considering the discussed issues from the perspective of the patient, the clinician and the clinician–patient relationship may be helpful. The patient factor Q: 'What is my patient's story? What is my patient trying to communicate using words or, as important, through their actions in the here and now?' Recommendation: A formulation of the patient's underlying psychological difficulties may help. This may include: ■ ■Predominant relational pattern(s) – attachment style and relationship to care/ authority. ■ ■Ambivalence about symptoms – underlying psychological investment in status quo. ■ ■Meaning attached to medication and overall use of medication (including countertherapeutic use of medication). The clinician factor Q: 'How do I feel in response to my patient and how does that influence the action I am considering taking (e.g. do I feel helpless, frustrated, incompetent, guilty in the face of the patient's symptoms)? Am I prescribing to avoid unwanted feelings in my relationship with my patient?' Recommendation: 1 The first step in identifying countertransference pressure is to recognise and accept it, without always resorting to immediate action. 2 Self-review of practice. The clinician may ask: ■ ■Am I working within relevant guidelines? ■ ■Am I doing what I normally do (if not, am I being overly influenced by my countertransference)? ■ ■Do I have strong feelings about this patient? Do I have no feelings about this patient? (Which would be also worth considering.)

Prescribing psychotropics CHAPTER 14 ■ ■Are any circumstances different, for example do I have managers or other colleagues or the patient's family scrutinising me with this particular patient? 3

Seek support. Use supervision with colleagues and ask support from other members of the multidisciplinary team. It is important to work closely with colleagues (including pharmacists) to triangulate decisions when in complex prescribing dilemmas. Choosing to discuss a problem in supervision and outside of the heat of the consulting room can clarify thinking. The clinician–patient relationship Q: ‘What might prescribing a medication – or not prescribing – come to represent in my relationship with my patient?’ Limited consultation time and cancelled clinics might reinforce feelings of rejection and abandonment. Non-adherence to medication or overdose of prescribed medication might be a sign of a rupture in the clinician–patient relationship and further exploration can promote useful insights for patient and clinician. Recommendation: Consider the meaning of medication in the context of the patient, the clinician and the clinician–patient relationship. Cultivate a pharmacotherapeutic partnership and set limits:24 ■ ■Reframe prescribing as a partnership, rather than a one-directional activity of the doctor. ■ ■Provide, as much as possible, a stable and consistent consultation setting. ■ ■Set therapeutic limits, confronting unrealistic expectations of care. (This includes maintaining a realistic humility around the limitations of psychopharmacology, and psychoeducating patients regarding what medications can and cannot achieve and their place in the overall journey to recovery and development.) ■ ■Endorse a stance that can promote the pharmacotherapeutic alliance, characterised by emotional presence and warmth, good and honest communication, and support of the patient’s autonomy and agency. This includes shared decision-making and respect for the patient’s treatment preferences, when clinically indicated. ■ ■Openly discuss overall recovery goals, target symptoms, duration of treatment and potential adverse effects, and address any associated anxieties. ■ ■A clear agreement on treatment objectives, consistent with the overall care plan, and the respective responsibilities of doctor and patient can promote agency and strengthen the pharmacotherapeutic partnership. ■ ■Collaborative crisis planning should be part of this, especially when there are risk concerns.

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