

CLINICAL OUTCOMES OF DEPOT AND WELL BEING CLINIC. RESULTS OF PHYSICAL HEALTH CARE CHECKS

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SUMMARY

Aims and method: To establish the level of physical care of people suffering from severe mental illness attending a psychiatric depot clinic. 37 Records of patients who were on long acting injectable antipsychotics, were reviewed to establish their physical care arrangement against the POMT-UK standards, and also to establish the type of antipsychotics, whether they suffer from metabolic syndrome, or whether other physical illness has been recorded.

Results: Records lacked any reference to baseline arrangements of physical monitoring. 22% suffered from diabetes and 75% of them were identified by The Depot and Well Being clinic (DWBC), 73% had abnormal lipid profile 59% were identified by (DWBC). 22% suffer from hypertension, all of them were identified by (DWBC).

Clinical implication: Physical care is an important aspect of care of people with severe mental illness total care. This study has demonstrated that this area is still not looked after adequately. Improvement in this area will improve the global outcome for these patients.

Key words: schizophrenia – physical health - depot injections

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INTRODUCTION

It has been noted recently that severely mentally ill patients have higher morbidity and mortality rates due to physical illness compared to general population (Brown 1997). This problem can be attributed to many factors, i.e. genetic predisposition, and they suffer from metabolic syndrome and diabetes more than the general population. Life style issues, such as smoking, drinking, abusing drugs, eating unhealthy food and poor exercise, are important illness related factors. These patients lack motivation and spend a lot of time doing nothing. Antipsychotic medication does not help either as they have side effects including putting on weight, inducing diabetes and hyperlipidaemia. They also tend not to look after their physical health or to consult their GPs when they are ill or complain of symptoms. These patients rarely have regular GP visits or check ups.

All these issues made it mandatory for the health strategist to address this problem and recommend guidelines for more efficient and safe clinical practice on a national and international level.

The Prescribing Observatory for Mental Health (POMH-UK) runs national audit-based quality improvement programmes open to all specialist mental health services in the UK. It aims to help specialist mental health Trusts/healthcare organisations improve their prescribing practice. It identifies specific topics within mental health prescribing and develops audit-based quality improvement programmes. Organisations are able to compare their performance against one another and identify whether their prescribing practice meet nationally agreed standards and where it falls short (POMH-UK 2006).

South Essex Partnership Foundation University Trust (SEPT) is a mental health provider covering

Bedfordshire, Essex and Luton. The Taylor Centre is the Practice Development Unit covering the South East of the Trust and serving the area of Southend-on Sea. Responding to this initiative SEPT established the Depot and Well-Being Clinic (DWBC), to improve the physical health of patients attending this clinic, through screening and monitoring their physical health regularly, by applying the National Institute of Clinical Excellence Guidance (NICE 2009), and the Maudsley Guideline (Taylor 2007).

Patients attending the DWBC are not under the care programme approach (CPA) (DOH 2008). They are more stable and more independent compared to patients under CPA, whose needs are more complex, they need a community care coordinator to try to meet their needs and manage their clinical risk.

However, non-CPA patients still need secondary mental health services due the specialist nature of the medication and continual need for monitoring and risk assessment. There is an interchange between being on CPA and non-CPA dependent on the patient's presentation at that time.

Patients attend regularly at six months intervals. Their mental and physical health are reviewed and a set of physical investigations is arranged. This ensures that people at high risk are identified and treated as soon as possible. In addition, they are given advice and help to tackle high risk habits, such as smoking, alcohol intake and poor diet.

AIMS

The aim of this study is to establish the existing level of physical care of these patients, as well as their level of physical morbidity. Other aims were to try to evaluate screening and monitoring practice by the

DWBC, whether physical abnormalities have been identified before or whether they were identified by (DWBC) and finally to assess whether (DWBC) has achieved the aim it was set up for, and make recommendations to improve its performance.

METHODS

We examined 37 patients out of 99 who attended within the study period and complied with all necessary examinations, investigations and consented to participate in the POMH-UK Topic 2a audit. This period was extended another three months to complete all the necessary examinations and investigations.

The clinical variables were collected and recorded on a paper template designed to facilitate the auditing of the service. Patients were asked to consent to participate in the audit and patients who did not consent or expressed concerns about participation were excluded.

Patients were interviewed face to face, physical and mental health issues were reviewed. The mental health review covered checking for psychotic features, side effects and psychological functioning. Physical health included; past medical history, medication for physical illnesses, allergies, family history, weight, height, body mass index, waist measurement, blood pressure, smoking habits, alcohol intake and illicit substance abuse. Blood investigations included Fasting Blood Sugar (FBS). Urea and Electrolytes (U&E), Liver Function Tests (LFT), Gamma Glutamate Transferase (GGT), haemoglobin A1C (Hb A 1C), Thyroid Function Test (TFT) and Fasting Lipids. An electro cardiogram (ECG) was also requested if the patient had not had one within the past twelve months of the review. If the blood pressure measurement was high during the appointment it was taken again after five minutes. If it remained elevated the patient was advised to attend their GP surgery and the readings were given to the patient by hand. The GP is also informed in writing about every appointment.

The patients' medical notes were assessed by HW

using the POMH-UK Audit 2a Screening Tool for monitoring metabolic side effects of patients on antipsychotics. The results were then tabulated by the Audit Dept within SEPT.

Ethical approval was secured from the relevant department in SEPT. Patients' diagnosis was recorded according to the International Classification of Diseases, Tenth Revision (WHO2006). Criteria to diagnose metabolic syndrome, according to the International association of Diabetes (BNF 2010), were recorded although they were not factored in POMH-UK audit. Readings higher than the following figures were considered as abnormal according to National Institute of Clinical Excellence NICE 2009(NICE 2009), waist circumference 102 cm for men and 90 cm for women, HbA1C >48 mmol/l, persistent raised blood pressure > 140/90, hyperlipidaemia total cholesterol/high density lipoproteins >6.

RESULTS

The male to female ratio was 1.85:1. Most patients were above forty years old, Table 1 demonstrates sex and age distribution. 90% were of Caucasian. 87% suffered from schizophrenia as shown in Table 2. A total of 46% were on antipsychotics alone either as depot or in combination with oral antipsychotics. 7.5% of the sample were above the British National Formulary (BNF) limits (Niaz 2007). 48.6% were on other psychotropic medications including mood stabilisers, antidepressants and hypnotics.

Patients who were known to suffer from Non Insulin Dependent Diabetes, were 22%. 75% of them were identified by DWBC review. 73% of the sample had evidence of a disturbed lipid profile, 59% of them were identified by the DWBC review. 22% suffered from hypertension and were all identified by DWBC review. 86.4% had abnormal waist circumference and all them identified by the (DWBC).

All patients smoked tobacco and 35 of them were offered help to stop. They all declined the offer.

Table 1. Distribution of patients according to age and sex

Age group	Male		Female		Total	
	N	%	N	%	N	%
18-30 years	2	5.4	0	0.0	2	5.4
31-40years	2	5.4	1	2.7	3	8.1
41-50 years	6	16.2	4	10.8	10	27
51-60 years	7	18.9	5	13.5	12	32.4
61-65 years	5	13.5	2	5.4	7	18.9
Total	24	64.8	13	35.1	37	100

Table 2. Distribution of Primary ICD-10 diagnoses

Diagnosis	Male		Female		Total	
	N	%	N	%	N	%
F10 - F17	1	2.7	0	0.0	1	2.7
F20 - F29	22	59.4	10	27.0	32	86.4
F30 - F39	0	0.0	1	2.7	1	2.7
F40 - F49	1	2.7	1	2.7	2	5.4
F60 - F69	0	0.0	1	2.7	1	2.7
Total	24	64.8	13	35.1	37	100

Table 3. Demonstrates Type of Medication Prescribed

Antipsychotic	Male		Female		Total	
	N	%	N	%	N	%
Risperidone Long Acting Injectable (RLAI)	7	2.7	2	0.0	9	2.7
Fluphenazine Decanoate	2	59.4	0	27.0	2	86.4
Haloperidol Decanoate	0	0.0	2	2.7	2	2.7
Clopentixol Decanoate	3	2.7	3	2.7	6	5.4
Flupenthixol Decanoate	12	0.0	6	2.7	18	2.7
Total	24	64.8	13	35.1	37	100
Polypharmacy	12	32.4	6	16.2	18	48.6

Table 4. Distribution of the normal and abnormal parameters of the Metabolic Syndrome in the DWBC

Metabolic Syndrome Parameters	Male Normal		Male Abnormal		Male Newly Identified		Female Normal		Female Abnormal		Female Newly Identified		Total	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
	Waist Circumference	2	5.4	22	59.4	22	59.4	3	8.1	10	27.0	10	27.0	37
Fasting Lipids	6	16.2	18	48.6	18	48.6	4	10.8	9	24.3	4	10.8	37	100
HBA1C/Fasting Blood Sugar	16	3.2	8	21.6	6	75.0	13	40.5	0	0.0	n/a	n/a	37	100
BP	16	3.2	8	21.6	6	21.6	11	29.7	2	5.4	2	5.4	37	100

DISCUSSION

The present study highlights the importance of physical care of severely mentally ill patients and indicates that this group of patients are the least to look after their physical health. This was demonstrated by the low level of involvement in the DWBC (37%), in spite of the free medical advice, care and encouragement offered, the response was still poor. The bulk of the sample were men, nearly twice, which is consistent with other studies in the depot populations in the United Kingdom and Europe (Olivaries 2009, Najim 2011). The majority were above the age of 40 years, which again consistent with local and European studies (BNF 2010, Niaz 2007). This indicates chronicity of the illness. It is understandable that the risk of metabolic and cardiovascular illnesses increases with age. Again, 90% of men and 67% of women were overweight which increases the risk as indicated by the International Diabetes Federation (WHO 2006). It is interesting to note that there was a high comorbidity of metabolic abnormalities, i.e. high lipids 73-84% of them were identified by DWBC, diabetes 22-75% were identified by DWBC and all patients with hypertension were identified by DWBC. It is known that these illnesses are silent at the beginning but the more they continue undiscovered the more the damage they cause. This is the benefit of the DWBC were regular follow ups and checks would identify probable cases as soon as possible, which should improve the outcome. POMH-UK conducted a retrospective case-note audit of patient's prescribed antipsychotic medication with a standard of yearly monitoring of blood pressure, measure of obesity, glucose and lipids. The results showed that between 0 and 41% (0 and 48% at re-audit a year later) of trusts were monitoring for all four aspects on an annual basis (POMH-UK 2006), results

that our trust is consistent with these findings (Najim 2011).

It is obvious that this area of care is neglected nationally and internationally. Regular reviewing and monitoring of physical health is not satisfactory and even if it is done, it is not documented or managed properly.

At the beginning, the nonattendance rate was high. A reminder service was therefore developed to improve patient attendance. This entails writing to the patient, to encourage them to attend and liaising with the community mental health team, to remind patients when they attend for their injection. Some patients get their injection at home, their community psychiatric nurse (CPN) reminds them about their appointment at the (DWBC). Some patients require a home visit by HW either because they are persistent non-attenders at the (DWBC) or physically unwell or having a relapse. However, as patients are now more familiar with the clinic, this is often not required anymore.

The patients were non CPA and one would speculate that those who are on CPA may be on higher doses of antipsychotics and on polypharmacy, therefore more at risk of the Metabolic complications. However at present these patients continue to be seen in the generic outpatient clinics and discussion should be initiated to extend this model to all patients on a depot.

CONCLUSIONS

Regular monitoring of the physical health of patients with severe mental illness is an important aspect of total care of these patients, as they have high morbidity and because of the serious consequences of the diseases monitored for. Evidence indicates that care is substandard in this area. Setting up DWBC provides consistent monitoring, which will lead to early

identification and treatment of such problems, which will improve outcome and quality of life of these patients.

Limitation

We had a small sample due to lack of interest and motivation of patients. It included non-CPA patients who are relatively stable and their illness under control.

Recommendations

To extend DWBC to all patients who are on antipsychotic medication. To advocate DWBC activity to promote the recovery model through psychoeducation of patients and their carers.

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Conflict of interest: None to declare.

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