

THE DEVELOPMENT OF AN ASSESSMENT CLINIC (ASPA) IN SOUTH ESSEX PARTNERSHIP TRUST. OBSERVATIONS AND OUTCOMES IN THE PERIOD DECEMBER 2011 – APRIL 2013

Shevonne Matheiken¹, Sajeeva Jaylath¹, Rashid Zaman^{1,2} & Mark Agius^{1,2,3}

¹South Essex Partnership University Foundation Trust, UK

²Department of Psychiatry University of Cambridge, Cambridge, UK

³Clare College Cambridge, Cambridge, UK

SUMMARY

A new Assessment service (ASPA) which has been developed in Bedford within the Community Psychiatric Team has been described.

Demography of patients referred to the service as well as their diagnoses are explained. Outcomes of treatment in this assessment service are also assessed. The most common diagnoses were mood disorders. These were generally equally divided between patients with unipolar and bipolar disorder. The next most common diagnosis was obsessive compulsive disorder. Within the period, approximately one third of patients were referred back to primary care, one third were still in the assessment process, and one third had been admitted to secondary care community services.

Key words: *Assessment service - bipolar disorder - mood disorders - primary care - secondary services*

* * * * *

INTRODUCTION

Mental health out-patient clinics in secondary care often cater to the needs of a large variety of patients including those that require short-term intervention, those that need long term support in the community and those that could be managed with non-psychiatric interventions. In order to make the system more efficient it has been found essential in our situation to re-structure the services so that the available resources of psychiatrists, Community Psychiatric Nurses, mental health support workers and psychologists could provide the most appropriate care based on severity of illness and the possible risk. Such a change was also postulated to aid the quicker return of clients with mild illnesses to independence and social functioning, while being monitored in primary care.

We therefore developed an innovative assessment service within the Bedford Area of the South Essex Partnership University Trust. This service was referred to as the Assessment and Single Point of Access (ASPA) service, and it was hoped that it would serve the above purpose. It was designed to fulfill functions such as screening and assessment of all new referrals, short term treatments for those clients with mild and time-limited disorders that could be then managed in primary care after initial treatment, and to act as gate-keepers for clients requiring long term care within the recovery branch of the Community Mental Health Team. It was also meant to provide information and guidance to referrers on options for management in primary care (Operational Trust Policy 2010). A good example of such a service in primary care is the IAPT services for psychological therapy in primary care.

Clients with stable mental disorders and low risk after assessment, needing psychological therapy as a mainstay of treatment, can be discharged to primary care in order then to access the IAPT service. This would ensure that the client receives assessment and therapy within weeks as compared to months if they had to be on the waiting list for a psychology assessment in secondary care. The ASPA service was also intended to provide onwards signposting to other services within the trust including Eating disorders clinic, Memory assessment service, Learning disability service, Early Intervention in Psychosis team etc.

This study describes the demographical and clinical characteristics of a patient population attending an ASPA clinic, the treatment options used, as well the final outcome after their allocated time within ASPA (3 months) was reached.

METHODS

The data was collected from the personal database of a clinician's ASPA clinic for the time period from December 2011 to April 2013. This included 106 patients and the demographic information available were age, sex, housing status, occupation and ethnicity. The clinical data included primary psychiatric diagnosis, co morbid physical/mental disorders, choice of medication and risk history. Finally the outcome i.e. whether the patient was still open to ASPA, whether discharged back to primary care or whether transferred to recovery team was also available.

Data was analysed using descriptive statistics and presented using tables and graphs.

RESULTS

Of the 106 patients who came to the clinic during the period, a majority of 51 patients (48.1%) belonged to the age group of 18-35 years. Males constituted 53.8% of the study population (Table 1).

Table 1. Age and Sex Distribution

Age group (in years)	Number (%)	Males	Females
18-35	51 (48.1)	29	22
36-55	41 (38.7)	21	20
56-70	14 (13.2)	7	7
Total	106	57 (53.8%)	49 (46.2%)

The ethnicity data showed that 102 patients were Caucasian, with 3 Asians and 1 patient of mixed ethnicity. It was noteworthy that 41 (38.6%) patients were employed while there were 9 each of homemakers and students. 42 (39.6%) were unemployed, although we do not know if they were so because of the illness or even prior to the illness. It is evident from the diagnosis break-up, that 75.5% of our study group had a mood disorder. Patients with dual diagnosis have been separately presented in both the diagnoses clusters in the pie chart, so as to get a clearer picture of the mostly diagnosed illness. The next highest individual diagnosis was of Obsessive Compulsive Disorder; constituting 13.2% of the study population (see Figure 1).

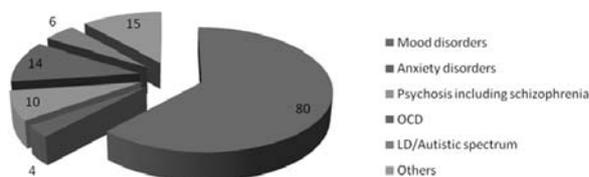


Figure 1. Diagnosis spectrum

We then looked at the distribution within mood-disorders that was the most commonly diagnosed condition. Bipolar II represented 33.7%, unipolar depression represented 25% and Mixed anxiety and depressive disorder represented 13.8% of the 80 patients with mood disorders. If bipolar affective disorder and Bipolar II were combined, then this constituted a large 45% of all mood disorders diagnosed (see Figure 2).

Since Bipolar affective disorder was the highest diagnosed illness in this study group, we looked into the treatment choices made for patients with BAD. 20 out of the 36 patients (55.6%) were on monotherapy, and there were 8 patients each (22.2%) receiving combination therapy and who had not yet been started on medication - See Figure 3.

The combination therapy was further explored and revealed that 6 of the 8 patients were on an anti-

depressant along with an anti-psychotic medication. Monotherapy was almost equally divided between anti-depressant (4 patients), anti-psychotic (5 patients), sodium valproate (4 patients) and lithium (5 patients) - See Figure 4.

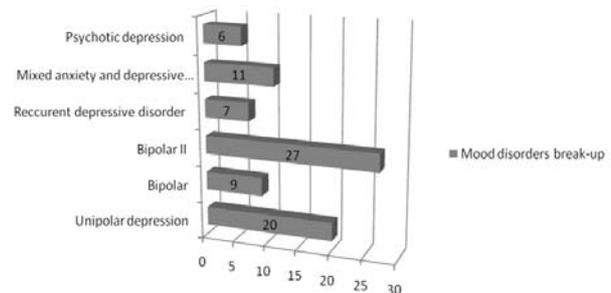


Figure 2. Mood disorders break-up

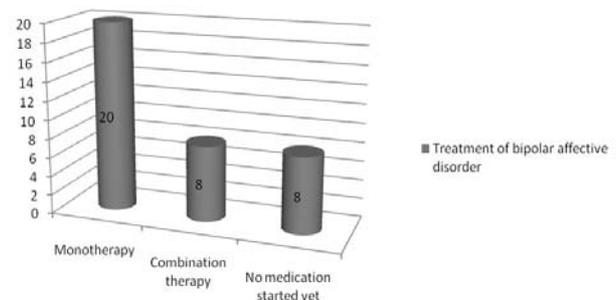


Figure 3. Treatment choices in Bipolar

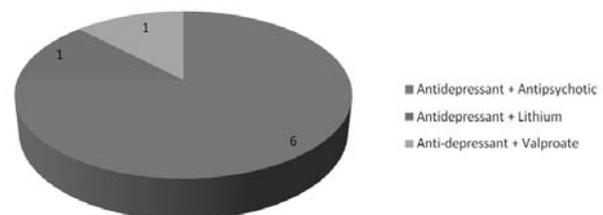


Figure 4. Combination therapy break-up

While noting the outcomes of ASPA patients, it is important to remember that a large proportion were still open to ASPA. Among those who had reached the time period allotted for ASPA, 38 patients were transferred to Recovery team and 25 patients were discharged back to be monitored in primary care - See Figure 5.

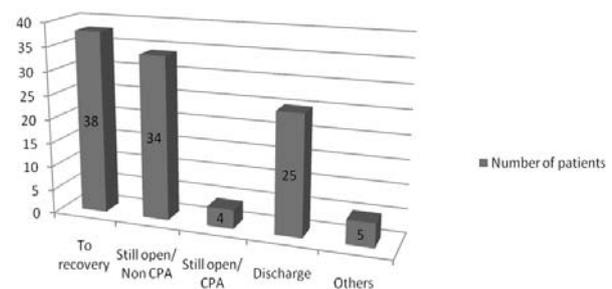


Figure 5. Outcome from ASPA clinic

DISCUSSION

The demographic data revealed that almost half the study population fell in the 18-35 years age group. This is interesting in the context that the most commonly diagnosed condition was bipolar affective disorder. The usual age of diagnosis of bipolar affective disorder from literature seems to be around the early 20s (Loranger 1978). This makes the early diagnosis and prompt treatment of bipolar affective disorder more important, since early age at onset has also been shown to have a poorer outcome, in terms of suicidal risk, rapid cycling course and substance misuse (Cate Carter 2003). These patients may have been previously assessed under Child and Adolescent Mental Health services prior to turning 18, although the diagnosis may or may not have been established due to various reasons. Almost 40% of the study population was employed, with 39.6% unemployed. It is not possible to ascertain whether the unemployed lost their jobs due to the consequences of the illness or were unemployed even before the mental illness set in. Homemakers were grouped separately as they may have opted to be so, and this decision need not be a consequence of mental illness.

The lifetime prevalence of Bipolar I and II are around 0.8% and 1.1% from several studies (Pfennig 2005, Pini 2005, Tohen 2002, Grant 2005, Angst 2004, Waraich 2004, Weissman 1996). However, it is also thought that the inclusion of sub-threshold BAD would show prevalences up to 6% (Merikangas 2007, Angst 2003, Judd 2003). Since the study population is a filtered one with only patients in it, a comparison with prevalence in general population is not justifiable. However, the results illustrate that within our group, Bipolar affective disorder constituted a majority of 45%.

Regarding the treatment options in Bipolar disorder, monotherapy and combination therapy may or may not show significant differences in outcome depending on the individual patient as well components of combination therapy. Lithium or valproate monotherapy has shown longer syndromic remission than those on combination therapy with anti-psychotic (Olanzapine) plus mood stabilizer (Tohen 2003). However, the same study showed longer symptomatic remission with combination therapy.

Finally, we aimed to assess whether the ASPA service was serving the functions that it was designed for. The outcomes show that among the 63 patients who were no longer in ASPA at the time of the study, 38 (60.3%) were transferred to Recovery team and 25 (39.6%) were discharged to the care of the General Practitioner. This illustrates good patient selection by GPs in that there was a good mix of patients who were rightly identified as requiring long-term specialist care as well as those with mild illnesses that could be managed in community after initial treatment by a psychiatrist. It also demonstrates that ASPA was rightly

serving the functions as a gate-keeper and as a short-term treatment service as appropriate.

Limitations

The study was restricted to one clinician's data and could have bias based on personal choices.

The data was retrospective and hence extra information could not be obtained besides what was in the database.

Risk assessment could not be analyzed in relation to different diagnoses.

Acknowledgements: None.

Conflict of interest: None to declare.

References

1. Angst J, Gamma A, Benazzi F, Ajdacic V, Eich D, Rössler W: Toward a re-definition of subthreshold bipolarity: epidemiology and proposed criteria for bipolar-II, minor bipolar disorders and hypomania. *J Affect Disord* 2003; 73:133-146.
2. Angst J: Bipolar disorder: a seriously underestimated health burden. *Eur Arch Psychiatry Clin Neurosci* 2004; 254:59-60.
3. Bauer M, Pfennig A: Epidemiology of bipolar disorders. *Epilepsia* 2005; 46(suppl 4):8-13.
4. Cate Carter, TD, Mundo E, Parikh SV & Kennedy, JL: Early age at onset as a risk factor for poor outcome of bipolar disorder. *Journal of Psychiatric Research* 2003; 37:297-303.
5. Grant BF, Stinson FS, Hasin DS, Dawson DA, Chou SP, Ruan WJ, Huang B: Prevalence, correlates, and comorbidity of bipolar I disorder and axis I and II disorders: results from the National Epidemiologic Survey on Alcohol and Related Conditions. *J Clin Psychiatry* 2005; 66:1205-1215.
6. Judd LL, Akiskal HS: The prevalence and disability of bipolar spectrum disorders in the US population: re-analysis of the ECA database taking into account subthreshold cases. *J Affect Disord* 2003; 73:123-131.
7. Loranger, AW & Levine PM: Age at onset of bipolar affective illness. *Archives of General Psychiatry* 1978; 35:1345.
8. Merikangas KR, Akiskal HS, Angst, J, Greenberg PE, Hirschfeld R, Petukhova M & Kessler RC: Lifetime and 12-month prevalence of bipolar spectrum disorder in the National Comorbidity Survey, 2007.
9. Pini S, de Queiroz VP, Pagnin D, Pezawas L, Angst J, Cassano GB, Wittchen HU: Prevalence and burden of bipolar disorders in European countries. *Eur Neuropsychopharmacol* 2005; 15:425-434.
10. Tohen M, Angst J: Epidemiology of bipolar disorder. *Tsuang M, Tohen M, eds. Textbook in Psychiatric Epidemiology*. 2nd New York, NY John Wiley & Sons 2002; 427-444.
11. Tohen M, Chengappa KR, Suppes T, Baker RW, Zarate C A, Bowden CL & Calabrese JR: Relapse prevention in

- bipolar I disorder: 18-month comparison of olanzapine plus mood stabiliser v. mood stabiliser alone. The British Journal of Psychiatry* 2004; 184:337-345.
12. Waraich P, Goldner EM, Somers JM, Hsu L: Prevalence and incidence studies of mood disorders: a systematic review of the literature. *Can J Psychiatry* 2004; 49:124- 138.
13. Weissman MM, Bland RC, Canino GJ, Faravelli C, Greenwald S, Hwu HG, Joyce PR, Karam EG, Lee CK, Lellouch J, Lepine JP, Newman SC, Rubio-Stipec M, Wells JE, Wickramaratne PJ, Wittchen H, Yeh EK: Cross-national epidemiology of major depression and bipolar disorder *JAMA* 1996; 276:293- 299.

Correspondence:

Mark Agius, MD
SEPT at Weller Wing, Bedford Hospital
Bedford, Bedfordshire, MK42 9DJ, UK
E-mail: ma393@cam.ac.uk