

# The Primary Care Guide to Managing Severe Mental Illness

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The Sainsbury Centre for Mental Health is a registered charity, working to improve the quality of life for people with severe mental health problems. It aims to influence national policy and encourage good practice in mental health services, through a co-ordinated programme of research, training and development. The Centre is affiliated to the Institute of Psychiatry, King's College London.

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## Preface

This short booklet is intended to provide some information that will be of use to general practitioners and their primary health care team colleagues in developing services for people with a severe mental illness.

Primary care services need to be able to demonstrate that they are providing effective care for all people registered with their practices. The new General Medical Services Contract 2003 (nGMS) has for the first time included people with severe mental illness in the 'Quality and Outcome' rewards; this guide explains how practices can make the most of opportunities offered by nGMS through providing care for people with a severe mental illness. It aims to explain what the term 'people with a severe mental illness' means within the context of nGMS, why it is important, and how practice teams can deliver care that meets the targets.

In common with previous editions the booklet is presented as a collection of bullet points. It is not intended to be a textbook covering every aspect of care, but to act as a signpost to show the way.

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# Patients in this group



**The definition in the new GMS Contract 2003 (nGMS) is intentionally broad, and vague. The intention of nGMS was to support high quality evidence based medicine, and the evidence for the morbidity and mortality associated with severe mental illness is quite specifically limited to people with schizophrenia and bipolar affective disorder.**

**The Sainsbury Centre for Mental Health recommends that any register compiled under the terms of nGMS should only include people with schizophrenia and bipolar affective disorder.**

## How is severe mental illness defined?

Over the years there have been numerous attempts to define 'severe mental illness', with only partial success. Originally the concept had three components – the 'three Ds':

- Diagnosis
- Duration
- Disability

Later work by Strathdee (Department of Health, 1995) added two further components:

- Safety
- Informal or formal care

Hence the acronym 'SIDDD' as a way of describing severe mental illness.

There have been other attempts, the most recent of which was in the *National Service Framework (NSF) for Mental Health (DoH, 1999)* which defines severe mental illness as follows:

“There must be a mental health disorder as designated by a mental health professional”,

and either

“There must have been a score of 4 (very severe problem) on at least one, or a score of 3 (moderate) on at least two of the HoNOS items 1 – 10 (excluding item 5: physical illness or disability problems) during the previous six months”,

or

“There must have been a significant level of service usage over the past five years as shown by

- A total of six months in a psychiatric ward or day hospital, or
- Three admissions to hospital or day hospital, or
- Six months of community psychiatric care involving more than one worker, or the perceived need for such care if unavailable or refused.”

## How many patients are likely to have severe mental illness?

This table shows the expected numbers of patients on the average GP's lists. A list of 1,650 is an optimal size; 2,000 is a common size in areas where there is a shortage of GPs.

Diagnosis	Weekly prevalence per 1,000 adults aged 16-64 years	No of patients on GP list of 1,650 (assuming 63% of GP list is aged 16-64 years)	No of patients on GP list of 2,000
Psychotic illness	4	4	5
Mixed anxiety and depression	92	96	116
Generalised anxiety	47	49	59
Depressive episode	28	29	35
All phobias	19	20	24
Obsessive compulsive disorder	12	12	15
Panic disorder	7	8	9
All neuroses	173	180	218
Drug dependence	42	44	53
Alcohol dependence	81	84	102

(ONS, 2000)

A GP with a list of 1,650 can expect:

- One new presentation of schizophrenia every five years.
- An average of five to six patients with a severe mental illness at any one time. However this can range from 0 to 18 patients depending on local factors.

Local factors that are likely to increase the number of patients with a severe mental illness who are registered with your practice are:

- The practice is in an urban or inner city location.
- The practice looks after homeless patients.
- The practice is located near a mental hospital.
- The practice has mental health professionals attached to it.
- There are group homes or hostels located near the practice.
- The practice has doctors with an interest in psychiatry.

# Clinical presentation

## 2

### The key facts

- 1 in 100 people (16-64 years) will suffer from schizophrenia in their lifetime.
- The peak age of onset of schizophrenia is 16-24 years and is earlier in males.
- The peak age for onset of bipolar disorder is 32 years.
- Between 30% and 50% of people with a severe mental illness are only in contact with primary care.
- On average, people with severe mental illness have 12-14 consultations with their GP per year (national average is 3-4).

### What are the needs of people with severe mental illness?

People with severe and enduring mental illness have physical, psychological and social needs. To deliver high quality care it is essential that all are addressed.

*The Mental Health Policy Implementation Guide: Community Mental Health Teams* (DoH, 2002) defines their role as to provide psychological advice and treatment, to co-ordinate care for people with a severe mental illness, and to communicate effectively with primary health care teams (PHCTs).

The new GMS contract makes clear that the provision of physical health care to people with a severe mental illness is the responsibility of primary care, as is the need to communicate effectively with the community mental health team (CMHT).

Effective communication between CMHT and PHCT is essential, and should be the responsibility of both teams.

### Physical health

The physical health of people with schizophrenia and bipolar affective disorder is significantly poorer than in a comparative population without these conditions.

The ONS Survey, *Psychiatric morbidity among adults living in private households* (ONS, 2000) found that 62% of those with psychosis reported a physical condition, compared to 42% of those without psychosis.

Schizophrenia and bipolar disorder co-morbidity:

- Cardiovascular disease – causes death up to four times as frequently as in a normal population;
- Respiratory disease – causes death up to four times as frequently as in a normal population;
- Diabetes – up to 5 times as common, i.e. 10% of people with schizophrenia or bipolar disorder will have diabetes compared to 2% of the normal population;
- HIV and Hepatitis C – both are more common, HIV up to 8 times as common, and Hepatitis C up to 15 times as common;
- Movement disorders – drug related and iatrogenic;

- Rheumatoid Arthritis – people with schizophrenia and bipolar disorder seem not to suffer from RA (a negative relationship).

### Health promotion data relating to people with severe mental illness

- 25% were obese (BMI > 30)
- 53% were smokers
- 11% were hypertensive (BP systolic > 160, diastolic > 90).

(Burns & Kendrick, 1997a)

Data from America (Meyer and Nasrullah, 2003) indicates that up to 80% of people with schizophrenia smoke, yet only around 30-40% of people with bipolar disorder smoke. The difference is thought to be due to the effect that nicotine has on the dopaminergic receptors that are responsible for the hallucinations that occur in schizophrenia. It appears that people may smoke more to reduce these distressing symptoms.

There is no data on other aspects of health promotion, but some information on the frequency with which information is recorded:

- |                    |      |
|--------------------|------|
| ■ smoking          | 23%  |
| ■ BP               | 38%  |
| ■ cervical smear * | 28%  |
| ■ mammography *    | 8%   |
| ■ alcohol use      | 20%  |
| ■ weight           | 27%  |
| ■ cholesterol      | 2.5% |

(\* percentage of women patients)

(Burns & Cohen, 1998)

Finally, there is increasing evidence that social stigma, deprivation, fragmented social networks and poor housing contribute to the seriously mentally ill having poorer access to physical health care. Recent evidence from the US suggests that this situation can be improved; for instance while patients with schizophrenia are less likely to report physical symptoms spontaneously, systematic questioning is effective in revealing physical illness in this group (Jeste *at al.*, 1996).

# The GP's role

## 3

**A GP's responsibilities toward people with severe mental illness fall into four main groups:**

### **1 The early detection of people who are at risk of developing a psychotic illness:**

- identification of high risk group e.g. positive family history;
- early (prodromal) signs of schizophrenia include: significant and persistent change in behaviour such as odd behaviour, mood disturbance, loss of interest, social withdrawal, self-absorbed attitude, unexplained academic decline, incoherence of thinking, feeling muddled, derealisation, persecutory thinking and preoccupation with pseudophilosophical or unusual ideas such as the occult.

### **2 Physical health problems:**

- management of physical health problems.

### **3 Mental health needs:**

- appropriate referral;
- appropriate management within existing skills and support;
- involvement in co-ordination of care through care programme approach (CPA) reviews.

### **4 Social support:**

- appropriate linking to other agencies such as housing, benefits, and education departments.

## **What is the GP's role in a new presentation?**

- Identification of an 'at risk' population.
- Early detection and identification of people with psychotic symptoms.
- Mental state assessment.
- Rapid referral to specialist services.
- Carer/family support.
- Joint assessment with members of the mental health team.
- Early emphasis on drug compliance.
- Providing information e.g. practice leaflet or booklets.

## What is the GP's role in continuing care?

- Assessment and treatment of physical morbidity.
- Prescription of medication.
- Development of shared-care protocols with other agencies for monitoring lithium, clozapine etc.
- Education of patients and carers.
- Identification of patterns of relapse.
- Monitoring of the mental state.
- Ensuring early prevention of relapse.
- Identification of risk factors for suicide: depressed mood, voicing suicidal ideation, hopelessness, recurrent relapses with inadequate symptom control. Groups generally at a higher risk of suicide include single young men, those recently discharged from hospital, those with comorbid drug or alcohol misuse, poor social support or family history of suicide.
- Being proactive in relapse prevention by informing CMHT if patient fails to collect repeat prescription.
- Crisis intervention (prepare a crisis plan and suggest patient carries a crisis card which explains who to contact in the event of a relapse).
- Identification of local networks and support groups.
- Co-ordinating care with social services, including housing and education, and the mental health trust.
- Ensuring that any female patient with a history of a serious psychiatric disorder (postpartum or non-postpartum) is assessed by a psychiatrist in the ante-natal period.
- The GP should pursue continuing medical education such as keeping abreast with legislative changes (e.g. Mental Health Act) and newer treatment options.

## How often should a patient see their GP?

As a minimum, every stable person with a severe and enduring mental illness should have a physical and psychological review on an annual basis.

The British National Formulary (BNF) advises that patients on lithium should have serum lithium levels checked every three months, once they are stable. Additional checks on renal function and thyroid function should also be undertaken; no interval is specified, but every 12 months seems practical. There may be locally developed shared-care protocols with other services which specify local agreements about lithium monitoring.

## Where do patients go for primary care?

Ideally this would be very clear-cut, but inevitably individual patients will require pragmatic solutions.

As a rule, primary care is becoming well set up to provide planned care for patients with long-term diseases. Practices are becoming accustomed to managing registers on computers, recalling patients, providing structured care, and accurately recording the data. Secondary care systems cannot yet rival this.

The experience of practice nurses in managing, for example, diabetes, obesity, smoking cessation and cardiovascular diseases is growing all the time – these skills apply directly to the care of the physical needs of patients with severe mental illness, and could well be useful in the care of inpatients in psychiatric hospitals.

Workers in specialist mental health services are generally more experienced in the psychological management of severe and enduring mental illness than those in primary care. Decisions about psychological management should be taken by them, or in discussion with them.

# The GMS contract and mental health

## 4

The new General Medical Services Contract for General Practitioners 2003 (nGMS) contains five mental health quality indicators (MHs) that can be audited, and three other applicable general indicators. On the basis of these, practices can receive extra remuneration.

These indicators can be summarised as:

- Having a register of patients with severe and enduring mental illness.
- Using the register to check on physical health and co-ordination arrangements with secondary care.
- Monitoring the serum levels of drugs used in bipolar disorder i.e. lithium.
- Performing regular thyroid function and renal function tests for those on lithium.
- Ensuring that lithium levels are within the therapeutic range.
- Having in place a process to institute a review if a patient fails to attend for a depot injection.
- Having regular reviews in the general practice of critical incidents. Such critical incidents can be of any type, from any part of general practice care, but it is required that there are at least twelve individual cases reviewed over a three-year period, and that these include a suicide, and/or a case of compulsory admission under the Mental Health Act (1983), if these have taken place.
- Caring for carers.

The register produced for MHI is the key to achieving the standards required by the MHs. In mid-2003 only around 180 General Practices in England and Wales did not have a practice computer system, so we will assume that a computer will be used to create the register. The first five indicators award quality points for achieving a better than 25% coverage for each indicator, with the points being allocated on a pro rata basis up to the maximum threshold.

Indicator	Points	Max
<b>MHI.</b> The practice can produce a register of people with severe long-term mental health problems, who require and have agreed to regular follow-up	7	n/a
<b>MH2.</b> The percentage of patients with severe long-term mental health problems with a review recorded in the preceding 15 months. This review includes a check on the accuracy of prescribed medication, a review of physical health and a review of co-ordination arrangements with secondary care	23	90%

Indicator	Points	Max
<b>MH3.</b> The percentage of patients on lithium therapy with a record of lithium levels checked within the previous six months	3	90%
<b>MH4.</b> The percentage of patients on lithium therapy with a record of serum creatinine and thyroid stimulating hormone (TSH) recorded in the preceding 15 months	3	90%
<b>MH5.</b> The percentage of patients on lithium therapy with a record of lithium levels in the therapeutic range within the previous six months	5	70%

### **MH1. “The practice can produce a register of people with severe long-term mental health problems, who require and have agreed to regular follow-up”**

A technique that works well to create this register is to:

1. Search by diagnosis Read codes Eu 2... and Eu 3...
2. Search by medication BNF chapter 4.2
3. Check information with staff/receptionists etc.
4. Check information with CMHT.

and then flag (electronically) the notes: Read code 9H8

We would encourage all practices to use accurate diagnoses on the practice computer, as this will make the process much easier.

The guidance published with the nGMS contract intentionally does not clarify which patients should be included in the register; the population covered is left up to the individual practice. However, the Sainsbury Centre for Mental Health strongly recommends that it should cover only people with:

- schizophrenia and all its sub-types
- bipolar affective disorder, including mania and hypomania.

Do not include patients with personality disorder, depression, or anxiety; if you wish to care for these patients as well, a separate register should be constructed, and the patients cared for under the enhanced service agreement. They form no logical part of this indicator.

Some patients will decline treatment: care must be taken to make an assessment on a case by case basis, to ensure that this is a properly informed choice, based on the correct information, and is not made as a consequence of inappropriate beliefs or ideas resulting from the illness itself. This highly sensitive issue requires careful consideration and advice should be sought from colleagues in mental health services as appropriate.

To comply with the current advice on exception reporting, you will need to keep a record of those individuals who have declined care. The preferred Read coding for people who decline to be on the register is 9H7.

## Setting up the register

Keep it simple to avoid confusion:

a) Search for:

Mental and behavioural disorders		
	[X] Schizophrenia, schizophreniform disorders, acute psychotic and delusional disorders	Eu [X] 20
	(X) Mood/Affective/Bipolar disorders	Eu [X] 31

b) The Read codes also contain some administrative codes that you may find useful to use or search for:

Mental health admin	9H...00
Depression screen	689I
Anxiety with depression	E2003
Neurotic depression – reactive type	E204
Postnatal depression	E204
On injectable phenothiazine	6656
On lithium	6657
Psychiatric monitoring	8A2Z
Psychotherapies	8G
Mental health admin NOS	9HZ
CPA enhanced level	8CG3
CPA standard level	8CG4
CPA key worker	918B
Carer	13HH
Social worker involved	13G4
Seen in psychiatric clinic	9N1T
Seen in institution	9N16
Seen by CPN	9N2a

- c) Also search for drugs used:
- All antipsychotic medication (BNF chapter 4.2), taking care to exclude phenothiazines used for nausea and vomiting.
  - Lithium.
  - Use of carbamazepine or valproate as mood stabilisers, taking care to exclude patients taking these drugs for epilepsy or other non-mental health indications.
- d) Once these searches are complete discuss the list with other members of the primary care team, including doctors, practice and district nurses, health visitors, receptionists and secretaries. All of these workers may know of patients that no-one else does. Some patients will be added and some removed at this point.

- e) This list should then be discussed with a link worker from the local community mental health team, who should provide a list of CMHT patients with a severe and enduring mental illness who are registered with your practice. Again some patients will be added and some removed at this stage.
- f) The resulting definitive list of people can then be tagged with the Read code 9H8; this creates a simple way of maintaining the register and demonstrating to your PCT that this work has been done.

**MH2. “The percentage of patients with severe long-term mental health problems with a review recorded in the preceding 15 months. This review includes a check on the accuracy of prescribed medication, a review of physical health and a review of co-ordination arrangements with secondary care”**

Using the list created for MHI you should recall every patient each year to attend an ‘annual MOT’. A simple prompt, very close to the time of the appointment may encourage attendance. A simple orientation type letter appears to be more effective than a phone call.

It may be appropriate for this review to be conducted by a practice nurse, who has had basic training in mental health matters, as well as ‘usual practice nurse experience’. It would be helpful to ask the patient to bring their medication with them.

This review should include:

- Smoking status, cessation advice if appropriate, specific enquiry for smoking related diseases such as COPD, IHD, PVD;
- Alcohol use, and other drug use;

- Advice on heart disease, including history suggestive of arrhythmias;
- Calculation of the BMI, and the offer of appropriate advice if the patient is morbidly obese;
- Urinalysis for sugar, with fasting blood sugar if positive;
- Blood pressure check;
- Annual influenza vaccination;
- A check to ensure that the patient is actually taking what the practice and hospital notes say they should be;
- Regular preventative care as usually appropriate e.g. cervical cytology;
- Serum lithium, creatinine and thyroid function tests for those people taking lithium (appears as one of the later indicators, but it seems sensible to do it as part of an annual review);
- A review of co-ordination arrangements with secondary care, checking that CPA plans and relapse plans are in the notes, and that the services being received are summarised, with contact details of the key worker. This ensures that the patient receives prompt support if they experience a sudden relapse.

Once the review is complete add Read code 8B3S, to show that the annual review has been done.

The practice will be required to report on the percentage of patients who have been reviewed in the previous 15 months, and must ensure that records have been made to corroborate this.

### **MH3. “The percentage of patients on lithium therapy with a record of lithium levels checked within the previous six months”**

Where a practice is prescribing lithium, it must check that levels have been checked, or if they have not been, that the practice has in place a call/recall system to invite patients for tests, and follow up defaulters. This can be done by searching for prescriptions of lithium, and using a similar method to that applied in MH2.

Many PCTs advise practices that lithium should not be prescribed generically, as different formulations have different bioavailability. As part of the review of the patient, this may be a good opportunity to ensure that a proprietary version of lithium is being prescribed. Use Read code 44W8% to record the lithium level.

### **MH4. “The percentage of patients on lithium therapy with a record of serum creatinine and thyroid stimulating hormone (TSH) recorded in the preceding 15 months”**

These tests can be incorporated into the ‘annual MOT’ performed for MH2.

Record thyroid function tests using Read code **442%**  
Record serum creatinine using Read code **443%**

### **MH5. “The percentage of patients on lithium therapy with a record of lithium levels in the therapeutic range within the previous six months”**

This is based on the record from MH3 and should be calculated using the local laboratory reference range. The practice will need to develop a procedure for recalling patients with abnormal levels and advising them on how to change their dose to achieve optimum levels.

### **Medicines Management Indicator 7. “Where the practice has responsibility for administering regular injectable neuroleptic medication, there is a system to identify and follow up patients who do not attend”**

This only applies to patients given injections by the practice team, not those given by a CPN on the practice premises.

It appears that the software houses are developing Read codes to help with this, and specific codes will soon be added to make the responsibility very clear, and to enable easy construction of a computerised recall system.

A manual system could be used, alternatively:

- Tag patients notes with Read code 6656 ‘On injectable phenothiazine’;
- Add a record of ‘Injection given’ at every attendance, with a diary or recall date for the date of the next visit, an appointment for which should be made before the patient leaves;
- Perform a weekly search for patients who have passed the due date, or failed to attend;
- Look in the records for the details of the key worker, and inform them, both in writing and by phone;
- If a patient has been discharged from secondary care, the GP should contact the service to discuss follow-up care.

It may be appropriate for the GP to discuss medication with the patient, if continuing with depot neuroleptic is the treatment of choice for that individual. If a change is agreed to a newer oral or depot atypical anti-psychotic, it is important to discuss this with the CMHT and the consultant psychiatrist, so that a plan for titrating the

dose can be agreed, and extra support is made available for the patient during this change.

**Education Indicator 7. “The practice has undertaken a minimum of 12 significant event reviews in the past three years which include (if these have occurred):**

- One suicide
- One section under the Mental Health Act”

All team members involved should attend the reviews, which should take the form of a meeting to discuss the case. This should be summarised in a report, which can be in two formats:

- Description of event
- Learning outcome
- Action plan

or

- What happened?
- Why did it happen?
- Was insight demonstrated?
- Was change implemented?

The PCT may wish to view both the report, and the minutes of the meeting.

**Management Indicator 9. “The practice has a protocol for the identification of carers and a mechanism for the referral of carers for social services assessment”**

There is no simple way to build this register. Suggested methods can be built around asking the question: “Are you the main carer for someone with an illness or disability?”

- On registration
- At regular checks in chronic disease clinics
- On a poster in the waiting room
- In reception
- During other consultations.

This is a particular problem if the person cared for is not registered with the practice, as is frequently the case in urban areas.

People who respond positively can be:

- Given a leaflet, with details on how to access a carer’s assessment, and how this could help.
- Asked if they would like to be on the practice ‘carers register’ (Add Read code 9I8G – ‘is a carer’).
- Asked if they wish to be referred for an assessment if they do not wish to self refer.

# Beyond GMS

Further approaches to  
primary care for people  
with severe mental illness

## 5

The nGMS indicators represent only a first stage in the care that primary care can give to patients with severe and enduring mental illness.

If the patient is still being reviewed by secondary care, then it is not necessary for the GP to take additional action. Good practice for CMHTs indicates that people with severe mental health problems should not be discharged from their care. However in some cases, the individual will not wish to remain in contact with the secondary services, but will remain in contact with primary care services.

## The annual review

Adding a psychological and social element to the review is appropriate. This should include an individual needs assessment.

It is important to ensure that if you are taking on this aspect of care, you are:

- a) suitably trained to do so;
- b) able to demonstrate that your training is up to date;
- c) able to access the other multi-disciplinary services that are needed by the patient.

## Suggested questions to ask

Physical symptoms	“How have you been feeling recently?”
Anxiety	“Have you felt more anxious, frightened or tense recently?”
Depression	“How cheerful have you been?” “Have you felt depressed, sad, or tearful?”
Delusions	“Have you been worried that people are talking about you, plotting against you?”
Hallucinations	“Have you been hearing voices or seen strange things when there was nothing to explain it?”
Thought content	“Have you any problems with your thinking?”
Medication	“Have you suffered any side effects of your medication?”
Drug/alcohol use	Enquire sympathetically (increase in drug/alcohol use can be a relapse indicator, especially in the young).
Apathy	“Have you managed to get out on most days?”

Some signs that may indicate relapse:

Bizarre behaviour	Postures, grimaces, flippant remarks, loss of social restraint
Slowness/under-activity	Sits abnormally still, moves slowly, poor eye contact
Anxiety	Tense, nervous gestures, sweating profusely
Depressed mood	Tearful, sad or blank expression
Hostility	Irritable, verbally or physically aggressive
Self neglect	Clothes, hygiene, nutritional status
Incoherence of speech	Difficult to follow speech
Medication side effects	Movement disorders/ weight gain

The social aspect can be covered as described in the adjacent table. Any problems found here should result in a referral to the CMHT for a social assessment, and consideration of a CPA review.

Accommodation	“Do you have any problems with where you are living?”
Social contact	“Do you manage to see either your friends or family on most days?”
Finances/benefits	“Do you have enough money to live on?”
Daily occupation	“Do you go somewhere every day?”

## Nurse training

Practice nurses responsible for administering depot neuroleptics can occasionally be the only point of contact with health services for people with serious mental illness. Even CPNs who run such depot clinics are part of a wider team for support and access to other services.

**It is considered poor care if the only contact that a person with severe mental health problems has**

**with the health care service is with the practice nurse who administers a depot neuroleptic.**

Practice nurses who do administer depots should be appropriately trained and supported, and should ensure that the person is reviewed at regular intervals by the GP or a visiting member of the CMHT.

Having a system in place to monitor collection of repeat prescriptions could provide early warning of relapse.

# A structured approach to the provision of care

## 6

A structured approach has been outlined in a recent review of the primary care management of schizophrenia by Burns and Kendrick (1997b), which is summarised here:

- a) **Identify your patients, and arrange a regular review**
  - Create a disease register
  - Check the medical record for
    - Last contact with specialist mental health services
    - Current status (CPA level)
    - Use the database/register to check that the patient is seen at least once every six months
    - Invite the patient for an annual comprehensive review.
- b) **The comprehensive assessment**
  - Social and environmental factors
  - Mental state
  - Physical state
  - Medication.
- c) **Information and advice for patients and carers**

Symptoms, management, drug effects and side effects, prognosis and genetics

  - Who to contact in a crisis
  - Financial matters, benefit entitlements, housing, and training opportunities
  - Respite care, night sitting, and holidays
  - The role of the voluntary organisations, SANE, MIND, etc.
  - Advice about over involvement and high 'expressed emotion'.
- d) **Indications for considering involvement of specialist services**
  - Review of medication
    - Persistent symptoms
    - Persistent side effects
    - Polypharmacy
    - Five year consultant review.

- Relapse
  - Sudden or gradual change in behaviour.
- Increased risk of relapse
  - Poor adherence to treatment
  - Major life events
  - Substance abuse
  - Family conflict.
- Newly registered patents
- Any problem with which the GP cannot deal confidently.

## e) Crisis management

- Planning for a crisis
  - Ensure clear mechanisms for obtaining specialist advice in an emergency
  - Identify day and night time telephone numbers for duty psychiatrist, duty social worker, ambulance and police
  - Consider status and experience of mental health worker who will make the assessment
  - Consider locus of review – home, surgery, street, or accident and emergency department
  - Carry oral and parenteral drugs in Black Bag, including MHA forms.
- Acute situation
  - Assess risk of self harm or violence **before** seeing patient (based on past experience, records, and circumstances)
  - Discuss situation with other professionals before leaving, and ensure that somebody knows where you have gone, and when you are likely to return

- Ensure that physical help is present, if necessary
- Avoid being left alone with the patient, with no quick means of exit
- Assess whether the patient’s mental state has changed:
  - Consider drug treatment if the patient is willing
  - Consider informal admission
  - If compulsory admission is appropriate:
    - Contact duty approved social worker (ASW)
    - Contact duty psychiatrist
    - Contact s.12 doctor.
- Review crisis, and identify any lessons that may be learnt for future crises.

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This summary does not contain discharge agreements, which can be negotiated in a similar fashion. Questions that may be useful to ask/agree are:

- When does an individual no longer need to be an inpatient?
- What process does the inpatient team go through to decide when an individual is fit for discharge?
- Who is informed of this decision?
- What services and plans are put in place to discharge the patient?
- Who is informed of the discharge and when are they informed?

The same set of questions can be applied to a patient being discharged from a CMHT.

# The evidence base

## 7

“Over 60 years ago the BMJ reported an association between mental illness and poor physical health. Subsequent research, in many countries, has consistently confirmed that psychiatric patients have high rates of physical illness, much of which goes undetected.”

*British Medical Journal* Editorial (Phelan *et al.*, 2001)

Several articles have examined the increased mortality associated with mental illness, the most comprehensive of which is the meta-analysis undertaken by Harris and Barraclough (1998). They analysed 20 papers which related specifically to schizophrenia, covering a population of 36,000 from nine countries. Using this data they calculated standardised mortality rates (SMR) for this group as a whole and for specific causes of death. The SMR for males with schizophrenia for all causes of death was 156 (95% C.I. 151 – 162) and for females with schizophrenia was 141 (95% C.I. 136 – 146). The SMR for infectious diseases as a cause of death in people with schizophrenia was 455 for males and 490 for females. The SMR for respiratory diseases causing death was 214 for males and 249 for females. Whilst there was no specific mention of influenza as a direct cause of the increased mortality, significantly increased SMRs in both respiratory and infectious causes of death make such an infection significant.

### SMR for people with schizophrenia

SMR	All causes	Infectious diseases as the cause of death	Respiratory diseases as the cause of death
Males	156	455	214
Females	141	490	249

Harris and Barraclough (1998) also examined the conditions of ‘Psychotic Disorder NOS (DSM III R 298.90)’ and ‘Bipolar Disorder (DSM III R 296.4x-296.70)’. The evidence in these groups is less detailed, and in some cases based on a single study. In the former group the SMR for all causes was 199, and for the latter 202. In the former group the SMR for infectious diseases was 185, and for respiratory diseases, 191. In the latter group, the SMR for infectious diseases was 40, but the SMR for respiratory diseases was 1034. However these results are based on a single study from Israel, and Harris and Barraclough suggest that the certification of death criteria may be different from the other papers studied.

SMR	All causes	Infectious diseases as the cause of death	Respiratory diseases as the cause of death
Psychotic disorder NOS	199	185	191
Bipolar disorder	202	40	1034

The conclusion that can be drawn from the meta-analysis undertaken by Harris and Barraclough is that people with severe and enduring mental illness (schizophrenia, psychosis, and bipolar disorder) have a significantly increased risk of death due to infections and/or respiratory disease.

There are few papers that describe the overall health of people with a severe and enduring mental illness, or provide an explanation for their increased mortality. Kendler (1986), based on a study of twins in the National Academy of Sciences/National Research Council Twin Registry, put forward an environmental model which proposes that the consequences of the illness on the lifestyle of people with schizophrenia make them more likely to die from diseases, rather than by trauma or suicide.

In the general population there is evidence that cigarette and heavy alcohol use (Harris and Barraclough, 1998), poor diet (DoH, 1994), and lack of exercise (Paffenbarger, 1986) all contribute significantly to the increased mortality rates.

Burns and Kendrick (1997a) studied 101 people with a severe and enduring mental illness living in the community, and found that 26 were obese (BMI > 30), 53 were current smokers, and 11 were hypertensive. Twenty-one reported daily cough and sputum, 24 shortness of breath, 11 wheezing and seven chest pain on exertion. These rates were significantly higher than population rates in a contemporary national survey. Nearly all the risk factors were recorded in the general practice records but few attempts to intervene were apparent. He concluded that primary care teams should make special efforts to tackle risk factors among this group.

Brown *et al.* (1999) reviewed the health of 179 local patients with schizophrenia over a 15 year period. They identified that 20 deaths were associated with cardiovascular or respiratory disease, and calculated the SMR at 225 (C.I. 137 – 334). They also prospectively surveyed the lifestyles of 140 people with schizophrenia, and found that their diet was unhealthy (higher in fat and lower in fibre than the reference population), they took less exercise than the reference population, and also smoked significantly more.

Burns and Cohen (1998) looked at the quantity of health promotion data recorded in GP notes for people with a severe mental illness. They showed that although the consultation rate (consultations per year) was significantly higher than normal – 13-14 consultations per year, compared to an average consultation rate of three – the amount of data recorded for a variety of health promotion areas was significantly less than normal, even in those practices that were gaining extra remuneration for recording health promotion data for the general population.

Diabetes is up to five times as frequent in patients with schizophrenia and bipolar affective disorder, than in the general population. There are a number of reasons for this increased frequency. The increased association between diabetes and schizophrenia had been noticed as early as the 1920s, well before the introduction of phenothiazines, and the more recent introduction of the newer atypical anti-psychotics. Possible explanations as to the cause of this increased frequency include lifestyle: their diet is frequently poor, they may be obese, and they access health care services less well than other groups. More recently, phenothiazines and the newer atypical anti-psychotics have been shown to increase both central obesity, and to be associated with diabetes. Careful analysis of data in

America (Meyer and Nasrullah, 2003) suggests that young people with schizophrenia are as likely as others their own age to develop diabetes, but that the risks increase much faster as people get older, and the risks over 60 are considerably increased.

HIV and Hepatitis C are also more common in people with schizophrenia and bipolar affective disorder. Once again only data from America is available, but these figures suggest HIV is up to five times as common as in the general population, and Hepatitis C up to fifteen times as common. Explanations include the risk taking behaviour that can characterise early stages of these disorders.

The publication *Medical Illness in Schizophrenia* (Meyer and Nasrullah, 2003) sets out the evidence relating to the co-morbidity associated with schizophrenia in considerable detail and is recommended for those who would like further reading on this subject.

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