Ten top tips to protect the physical health of patients experiencing psychosis

Introduction: People with severe mental illness (SMI: schizophrenia, bipolar disorder, severe depression):
- Die on average 15-20 years earlier than their peers
- 75% of these premature deaths are from physical health’s ‘usual suspects’ of cardiovascular and pulmonary disorders, diabetes, cancer and infections…
- Cardiovascular disease (CVD) is the single largest cause of a widening mortality gap, and far commoner than suicide.

Yet disorders like CVD and diabetes are predictable and potentially preventable.

Psychosis typically emerges in late adolescence to early twenties, causing a young and vulnerable population to become exposed to a toxic interaction between poor mental health, consequential unhealthy lifestyles, obesogenic and diabetogenic antipsychotic treatments, and social disadvantage (Shiers et al, 2015). This can result in an early and rapid escalation in cardiometabolic risk, putting people with SMI on a path towards poor future health at a much earlier age than the general population. The mitigation of this risk with its potentially tragic consequences is the focus of these top-ten tips. Useful resource: Early intervention in psychosis – keeping the body in mind. 2014 update

Paradoxically GPs, while experts in primary prevention and treatment of CVD, have focused on the middle aged or elderly general population, with QOF screening and the NHS Health Check commencing from age 40 years.
- However by the age of 40 people with SMI are already 3-4 times more likely to have metabolic syndrome than the general population.
- The implications for such a young SMI population are that those with metabolic syndrome are twice as likely to die from, and 3 times as likely to experience a heart attack or stroke; and 5 times as likely to develop type 2 diabetes (Alberti et al, 2005) - and all this in a population who are also 3-4 times more likely to smoke.
- Moreover services are often insensitive to these specific needs and clinicians run the risk of framing symptoms of emerging physical disorders as being mental health related; so called ‘diagnostic overshadowing’.

These health inequalities prompted the RCGP and the RCPsych, in a process led by the late Professor Helen Lester, to develop a simple evidence-based assessment and intervention framework to protect cardiometabolic health, the NICE-endorsed Lester Resource with its call for action - ‘Don’t just screen, intervene’.
Useful resources: Lester Positive Cardiometabolic Health Resource – 2014 update:
TEN TOP TIPS for GPs and Primary Care Staff

1. **Engage patients and their families and carers from the onset of psychosis and its treatment** – Useful resource: Healthy Active Lives (HeAL) Consensus Statement
   - Support them in making treatment choices by providing clear and consistent information about the benefits and adverse effects of medications.
   - Help them understand their physical health risks and what they can do to prevent such risks.
   - Explain the purpose, and feedback the results of physical health monitoring.
   - Encourage practical actions to improve physical wellbeing with a physical healthcare plan.

2. Develop collaborative agreement with secondary care on sharing of key information on physical health checks, investigations, treatment plans and clear lines of responsibility for interventions and follow up. Patient and carer involvement is of key importance.

3. ‘Don’t just screen, intervene’ Don’t ignore identified risks. For instance those patients with SMI identified with hypertension (prevalence doubled), if untreated have a 3x risk of dying from hypertension-related disease.

4. **Prescribe safely**: both GPs and psychiatrists have a duty of care to attend to the physical side effects of medications on for example antipsychotic-induced weight gain and metabolic disturbance:
   - **Antipsychotics**: NICE recommends the psychiatrist maintain lead responsibility for monitoring the patient’s physical health and the effects of antipsychotics for the first 12 months following diagnosis or until clinically stable; whichever is the longer; thereafter lead responsibility would normally transfer to the GP for ongoing annual monitoring (NICE CG 178, 2014). However, all clinical staff should always collaborate to prioritise the patients’ best interests.
   - **Lithium**: Follow the NICE recommendations as regards the monitoring of plasma lithium level, renal and thyroid function ensuring all remain in the normal range. (NICE CG 185, 2014)

5. **Promote healthier lifestyles** while helping address key social determinants on practical issues such as poor housing conditions, lack of access to recreation and physical activity, a lack of cooking skills and a limited budget for food.

6. Provide and maintain support to **stop or reduce smoking**, the single largest preventable cause of death. This is important as successful smoking cessation:
   - Offers the best way to increase life expectancy and improve physical health.
   - Improves mild to moderate anxiety and depression at least as effectively as antidepressants.
   - Allows and indeed requires a rapid reduction of some antipsychotics with consequent benefits.
d. And can ease poverty, given that people with schizophrenia may spend a third of their income on tobacco. 
   Useful resource: Primary Care Guidance on Smoking and Mental Disorders 2014 update.

7. Maintain an up-to-date practice SMI register. Start from first diagnosis to combat the frequently aggressive weight gain and metabolic disturbance that may accompany antipsychotic initiation, often compounded by high smoking rates.

8. Using the practice SMI register (and annual QOF review where relevant), initiate an audit cycle based on quality standards derived from the Lester resource to measure and improve how well your practice screens and intervenes.

9. Target particularly those on the SMI register that have a comorbidity such as CVD, DM or COPD, for preventive care in the community:
   a. Prioritise this co-morbid group who are at high risk of complications and hospitalization (e.g. high rates of attending emergency departments, acute medical admission is up to 10 times more common and they have 3 times the length of stay than a patient with the same LTC but without SMI).
   b. Ensure proactive Multi-Disciplinary Team review and care coordination with close collaboration between your practice and other services e.g. acute medical or surgical services, liaison psychiatry and substance misuse services.

10. Make reasonable adjustments to aid and assist access to equality of primary care (a principle familiar to practices in caring for those with learning disabilities & autism):
    a. This might include flagging notes, offering proactive care, providing longer pre-bookable appointments, identifying and supporting carers.
    b. Review those patients who remain disengaged after exhausting all efforts to make reasonable adjustments; consider providing as part of an integrated primary care model a combined outreach approach with the mental health team.
Useful Resources

Lester Positive Cardiometabolic Health Resource 2014 update: www.rcpsych.ac.uk/quality/NAS/resources


Keeping the Body in Mind: this short documentary from RCPsychs adult faculty focuses on the importance of physical health when treating people with mental health conditions: https://www.youtube.com/watch?v=hHnTrCRvV7A

References:


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For their review and helpful comments: Dr Liz England RCGP Mental Health and Whole Person lead, and Dr Belinda Magnus RCGP Clinical Fellow for Mental Health and Well-being

Acknowledgement: In special memory of the late Helen Lester: for her contribution to developing the Positive Cardiometabolic Health Resource and her dedication to improving the lives of people and families affected by mental illness

To cite: Shiers D, Panday S, Campion J. 2017 Ten top tips to protect the physical health of patients experiencing psychosis Royal College of General Practitioners, London.