



## special articles

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### **Service innovations: from depot clinic to medication review service – developing an evidence-based service within a community mental health team**

Over the years the 'depot clinic' has become little more than a conveyor belt for patients to receive depot medication from nursing staff within a hospital setting. Indeed, the concept of the depot clinic has not significantly changed since the introduction of neuroleptic medication in the 1950s. A lack of review of the service has resulted in suboptimal treatment, unchecked side-effects and a lack of monitoring of physical health. We describe the redesign of a depot service within an inner city community service, with emphasis on evidence-based practice, regular, patient-centred reviews, support, health promotion and education.

#### **Need for review and development**

In 2002, as part of the ongoing development of services, we undertook a re-evaluation of medication services at our team base in South East Lambeth. Our aim was to provide a 'one-stop shop' for patients, thus minimising the need to attend the local psychiatric hospital. Rather than simply dispense medication, it was envisaged that the service would also provide advice on health and lifestyle issues. The review was informed by developments in other services (Ohlsen *et al*, 2002) and recently published guidelines on evidence-based practice and physical health monitoring, with particular emphasis on diabetes and hypertension, in the management of schizophrenia (National Institute for Clinical Excellence, 2003). Psychiatric patients are vulnerable to physical health problems, which can often be complex to monitor and, if not assessed systematically, can lead to long-term complications and non-adherence to medication.

#### **Medication review service**

The medication review service operates full-time and is nurse led, employing two part-time staff. Although it is

part of the case management team, patients attending the clinic are on the standard care programme approach register; clinic nurses fulfil care coordinating roles. This allows for continuity of care and ensures that patients who fail to attend for medication are followed up assertively, including by home visits. Such a model encourages the development of strong therapeutic links.

Attendees include patients with ongoing and severe mental health problems who are on long-term psychotropic medication which, for a variety of clinical reasons, is not prescribed by their general practitioners. Referrals primarily come from the case management team or out-patient clinics, and include those patients who no longer need intensive support because of ongoing stability. The clinic also provides a dispensing service for patients who are otherwise fully supported by a care coordinator within the case management or assessment and treatment teams. The system therefore permits the movement of patients from other components of the community mental health team, taking pressure off teams and maximising the appropriate use of resources.

#### **Nursing review**

Services focus on the ordering, dispensing and monitoring of medication, including depot preparations, in accordance with Royal College of Nursing guidelines (Royal College of Nursing, 1996). Medicines are supplied by a central pharmacy at the Maudsley Hospital and delivered once every 2 weeks. The frequency of attendance by patients depends on need, and ranges from weekly to monthly.

Patients are regularly weighed and vital signs monitored. Nursing staff are trained to take blood samples for measurement of drugs or for other assays. Electrocardiography (ECG) is carried out by nursing staff as indicated, either before or during treatment. Nurses meet with carers as part of ongoing support. Referrals are made to outside agencies, such as the dietician, welfare advisor or physiotherapist, for advice or treatment. The

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medication clinic provides a useful focus where up-to-date information can be disseminated. A small library and resource information pack is available to all staff, containing relevant updates, guidelines and drug information sheets.

### Medical review

All patients are reviewed on a regular basis by medical staff. The community senior house officer dedicates one session per week to the service and is supervised by a consultant psychiatrist. Doctors who continue to have direct clinical contact with patients, usually through their out-patient clinics, also undertake medical reviews. Most patients are seen every 6 or 12 months, but some are seen more frequently if they are undergoing a change in medication or showing signs of relapse. Medical assessment includes review of mental state, efficacy of psychotropic medication and side-effects. Switching to atypical neuroleptics, including clozapine, is encouraged. Physical examination includes ECG (at least annually) and measurement of body mass index (Ohlsen *et al*, 2002). Cardiovascular risk factors are assessed and routine enquiry and advice given on smoking cessation, alcohol consumption, diet and exercise. Monitoring of metabolic measures, such as glucose and prolactin, is carried out in accordance with American Diabetes Association guidelines (American Diabetes Association *et al*, 2004) and local protocols provided by the South London and Maudsley NHS Trust (available on request). Information is passed on to general practitioners, with a request for further input if necessary. Close liaison with primary care ensures that both teams are aware of all medications being prescribed, thus minimising the risk of serious interactions or adverse effects.

### Role of the pharmacist

A trust pharmacist attends the clinic on a monthly basis. This allows medical and nursing staff to discuss pharmacological issues, including potential problems or drug interactions. Patients have the opportunity to meet the pharmacist individually, and discussions are relayed to clinical staff.

### Therapeutic groups

Groups meet on a fortnightly basis, but are not restricted to clients of the medication service. The focus is primarily on healthy living and general health issues. Two facilitators lead the groups: a clinic nurse and another member of the community mental health team. Advice is given on diet, alcohol consumption, weight management, smoking cessation and exercise. Adherence therapy is available, but most patients are actively involved with treatment and adherence is generally good.

### Clinical profile of the patients

Currently, the medication service caters for around 110 patients (54% men and 46% women), but has the capacity to manage 150 patients. Annual figures suggest a mean of 114 clinic visits per month, 15 of which include taking blood, 5 medical reviews (not including those carried out by other medical personnel) and 8 home visits. Non-attendance rates of 3% per month compare favourably with other parts of the service (Mclvor *et al*, 2004) and reflect the relative stability of this population.

In relation to diagnosis, 67% of patients have a diagnosis of schizophrenia, 14% bipolar affective disorder, 2% schizoaffective disorder and 17% other diagnoses (including major depressive disorder, anxiety disorder and personality disorder). Reflecting the evidence-based development of the service, the most commonly prescribed medication is atypical antipsychotics, followed by typical antipsychotics (the majority being depot medications), mood stabilisers, antidepressants, anxiolytics/sedatives, anti-muscarinics and 'other' drugs respectively (mainly medical preparations such as antihypertensives). Drug combinations are common, with 41% of patients prescribed more than one psychotropic medication.

### Discussion

In this age of evidence-based practice, it is essential that depot clinics are updated. The medication review service has allowed us to optimise the psychiatric and physical care of patients, a model which could be of relevance to mental health services in general. Turning the depot clinic into a medication review service has reduced the clinical case-load of mental health workers within other teams, thereby giving them the opportunity to engage new clients. The service reinforces community-centred care and obviates the need for the patient to attend the local hospital, hopefully encouraging engagement. It is envisaged that many of the patients will be discharged to primary care over time.

Initial financial investment in equipment (an ECG machine, weighing scales, fridge, phlebotomy equipment and assorted furniture) is required. In addition, although not resulting in increased staffing levels, nursing job plans may require review, with some additional training being necessary. Consideration needs to be given to logistical issues such as the storage and transport of blood samples or the interpretation of ECG results.

Informal feedback indicates that patients appreciate the service, with its emphasis on support, health promotion and education. Future development will include formally assessing patient satisfaction, reviewing cost-effectiveness, increasing patient numbers and expanding available services.

### Declaration of interest

None.



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## The Irish Mental Health Act 2001

The Mental Health Act 2001 was formally enacted by the Irish Houses of Oireachtas (parliament) on 8 July 2001 and implemented in full on 1 November 2006. The Mental Health Act 2001 replaces and updates a number of older pieces of legislation, including the Mental Treatment Act 1945. The purpose of this paper is to outline the central provisions of the Mental Health Act 2001 as they relate to psychiatric practice in Ireland. This paper does not aim to examine the issues surrounding delays in the implementation of the Act; these issues are well explored elsewhere (Daly, 2005; Ganter, 2005; Lawlor, 2005; Owens, 2005).

The Mental Health Act 2001 is chiefly concerned with two aspects of psychiatric services in Ireland: (a) involuntary detention of persons with mental disorder in approved psychiatric centres; (b) mechanisms for assuring standards of mental healthcare. The Act is divided into six parts:

- Preliminary and general
- Involuntary admission of persons to approved centres
- Independent review of detention
- Consent to treatment
- Approved centres
- Miscellaneous.

### Preliminary and general

The preliminary section of the Mental Health Act 2001 is primarily concerned with definitions. The term 'mental disorder' is used throughout the Act and includes 'mental illness, severe dementia or significant intellectual disability'. Mental illness is defined as 'a state of mind of a person which affects the person's thinking, perceiving, emotion or judgment and which seriously impairs the mental function of the person to the extent that he or she requires care or medical treatment in his or her own interest or in the interest of other persons'. Severe dementia is defined as 'a deterioration of the brain of a person which significantly impairs the intellectual function of the person thereby affecting thought, comprehension and memory and which includes severe psychiatric or behavioural symptoms such as physical

aggression'. Significant intellectual disability is defined as 'a state of arrested or incomplete development of mind of a person which includes significant impairment of intelligence and social functioning and abnormally aggressive or seriously irresponsible conduct on the part of the person'.

Mental health services are defined as 'services which provide care and treatment to persons suffering from a mental illness or a mental disorder under the clinical direction of a consultant psychiatrist'. Treatment is defined as 'the administration of physical, psychological and other remedies relating to the care and rehabilitation of a patient under medical supervision, intended for the purposes of ameliorating a mental disorder'.

For the purposes of the Act, a child is defined as 'a person under the age of 18 years other than a person who is or has been married'. A relative is 'a parent, grandparent, brother, sister, uncle, aunt, niece, nephew or child of the person or of the spouse of the person whether of the whole blood, of the half blood or by affinity'. A spouse is a 'husband or wife or a man or a woman who is cohabitating with a person of the opposite sex for a continuous period of not less than 3 years but is not married to that person'; same-gender cohabitants are, therefore, excluded from the definition of spouse. For the purposes of making an application for involuntary admission, the term spouse 'does not include a spouse of a person who is living separately and apart from the person or in respect of whom an application or order has been made under the Domestic Violence Act 1996'.

### Involuntary admission of persons to approved centres

A person can be involuntarily admitted to an 'approved centre' on the grounds that the person is suffering from a 'mental disorder'; a person cannot be so admitted solely on the grounds that the person: '(a) is suffering from a personality disorder, (b) is socially deviant, or (c) is addicted to drugs or intoxicants'. The Act does not