BACKGROUND

Clozapine, an antipsychotic drug, which is usually prescribed for treatment resistant Schizophrenia, has proven to reduce symptoms and consequently improve quality of life. Case managers in Community Mental Health Services noted for years that those clients remained stable and well, but remained in secondary mental health services because of the prescribing and monitoring requirements around Clozapine treatment.

Risks associated with the use of this drug could be fatal in about 1-3% due to white blood cell changes, especially at the onset of treatment for up to 18 weeks. Therefore it requires monitoring for side effects and regular blood tests. Medication dispensing by pharmacists only occur when blood test results are safe.

MEDSAFE NZ prescribing conditions changed in 2010. Initially only Psychiatrists were allowed to prescribe, but it became possible for GP’s to prescribe the drug for “stable” clients. This resulted in some discussions in the WBOP Community Mental Health teams about the potential impact of the change as “stable” was not defined, the potential risks of the drug remained, it could have a major impact on caseloads to discharge them, but it could also be liberating and in line with Recovery principles for consumers to be discharged from secondary services. Initially it seemed to be a vague prospect.
TRANSFER PROCESS

Five guidelines were chosen to define what “stable” could mean for a consumer on Clozapine treatment to safely be transferred to GP care.

FIVE INDICATORS FOR A “STABLE” CLOZAPINE CLIENT

1. NO clinically significant HONOS ratings of 3-4 on any item
2. NO Inpatient admissions in past 2 years
3. NO more than 4 SMO appointments per year required
4. NOT a formal patient under the Mental Health Act.
5. NOT in NGO Supported Accommodation

A scoping audit was done in June 2010. The purpose of the scoping audit was to explore the features of the potential population group who would most likely qualify for discharge to GP care. The population group was all Clozapine users in the WBOP as per Novartis Care Link System and the sample group was those who had a HONOS completed in the three months prior and three months after Feb 2010. This produced a sample size of 51, which was 55% of the population group of 93.

Various factors that might have had an influence on the process such as the affordability for consumers to go to GP appointments and length of time in secondary service were explored, as well as identifying those meeting the five “stability” criteria.

Generally a shared care approach was followed, especially at the onset of the process. This implied that secondary service case managers would initially discuss with the GP and Practice Nurses the intent to transfer an individual person and then do a handover of relevant information simultaneous to the Psychiatrist discharge letter. The case managers would usually attend with the person the first GP appointment and may do initial follow up visits after the transfer. The GP would do the prescribing with an option for the person to have 4 more psychiatrist appointments for a year.

Two nurse case managers initiated and introduced a checklist for internal use by case managers to ensure that the transfer process occurs in a planned and safe manner.

A repeat audit was done in Feb 2012 to explore what the outcomes were for those who had been transferred to GP care after two years.

2010 Audit Results

At the time of the audit 93 individuals were identified to be on Clozapine treatment in the WBOP as per Novartis Clozaril Care link system. 51 clients were chosen as the sample group as they had had HONOS scores entered in the selected time frame and 32 of them met the HONOS criteria of not having any scores of 3 or 4 on any items of the HONOS tool. Due to limitations in Outcomes Collection Compliance in the WBOP at the time, 45% of the 93 Clozapine Clients were excluded from the sample group and the opportunity to be considered for discharge to GP care. 25 clients met all five the criteria for “stability”.

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Some general findings from the 2010 audit in relation to the sample group of 51 clients was that the average age was 41 years; 61% were male; only 3 were on higher doses than 600 mg Clozapine per day; 73% lived in independent accommodation; 79% attended 4 or less psychiatrist appointments per year; 84% had no inpatient admissions in the past 2 years; 84 % were Informal in terms of Mental Health Act status, 10% were employed while 90% were on WINZ benefits and 78% had been in secondary service for longer than 10 years. In spite of a higher prevalence of schizophrenia amongst Maori, only 37% of the sample group were Maori. 50% of the 51 in the sample group qualified for transfer to GP care and Eventually 15 clients were transferred to GP care in the 8 months after the prescribing changes were announced, one of them having a score of 3 on one item and therefore not meeting the HONOS criteria.

**2012 Audit Results**

A follow up audit was done in 2012 to establish some outcomes for the clients in the WBOP who had been discharged from secondary service to GP care. 99 clients were identified in the WBOP to be on Clozapine treatment as per Novartis Care link system. 30 of those clients were in GP care. Of the 69 in secondary service, a further 28 met all the criteria for transfer to GP practice. From the 2010 audit 7 clients were no longer part of the group in GP care as 3 had left the area and 4 were no longer on Clozapine as they had a change of medication. Only 4 of the 30 in GP care had made contact with secondary services. Two of them were for medication reviews, one for a one off repeat script due to financial reasons preventing a GP appointment and one presented in a relationship crisis for a brief period of counselling support.

None were re-admitted to the Inpatient Unit or the Community Mental Health Services. The application of HONOS scores and the other four criteria to define “stability” appeared to be accurate indicators for transfer of clients from secondary to primary care.

**THE ROLE OF THE NURSE**

It always seemed paradoxical that a medication so successful in assisting recovery, actually kept clients in secondary service, and in essence prevented 'true' recovery. The role of the nurse in transitioning stable clozapine clients from secondary to primary care was simple but significant, and was an opportunity to do something positive & practical about the above paradox. As nurses we developed a process to enhance the potential success of this project.

The focus for nurses in the process of transferring stable Clozapine clients from secondary to primary care was underpinned by the principles of Recovery. This is especially true from the client’s perspective for whom Recovery is about hope, re-establishing a positive identity, finding meaning in life and taking responsibility for their own lives and living well in the presence or absence of illness, rather than the focus of clinical recovery ie. that of relieving symptoms and improving functioning.

Nurses aimed and advocated for de-stigmatisation and normalisation in their approach to this initiative by integrating “mental health” with “health” and promoting clients with mental health issues to access “regular community services”. As it implied a major paradigm shift that longterm mental health clients with a diagnosis of Schizophrenia or psychosis could be transferred from secondary to primary sector. Especially so as 78 % of the 2010 audit sample
group had been in secondary service for longer than 10 years. Understandably, this transfer of care required significant communication, education and promotion with clients, their whanau/supports, the public, primary sector and even within the secondary service.

A checklist was developed to assist this process, and was a very practical way of ensuring planned, safe and seamless transfer of care. The checklist that was developed and introduced to secondary service colleagues provided a structured approach to what initially seemed to be complex and unclear.

**CHECKLIST**

- **Multidisciplinary Team review** - The client’s case is discussed at Multidisciplinary team review meeting and considered for possible transfer to primary care.

- **Relapse prevention plan** was reviewed, updated and copied to GP, clients’ identified supports. This was particularly important for some clients whom had been well for many years and could not recall any precipitants or early warning signs of relapse, nor what the options to address these would be. This was a way of encouraging ownership of responsibility for self and ensuring strategies were in place to assist wellness (marking on a calendar or setting reminder on a mobile phone when blood tests or prescriptions are due are examples), and to address any signs of relapse, reassuring clients that they can still contact Mental Health crisis service or be re-referred if required.

- **Outpatient appointment with psychiatrist to discuss and confirm discharge**, with a copy of the discharge letter sent to client’s GP and a prescription given to the client and copied to the GP to ensure the GP is aware of the usual way of prescribing (eg monthly blister packs) and when the next prescription is due.

- **GP referral letter (from Novartis GP information pack) completed and sent to the GP**. This highlights particularly pertinent issues for the prescriber to be aware of.

- **GP/Practice Nurse Liaison** was vital to reassure clients and ensure a seamless transition to primary care. Ideally this included secondary service case manager attending GP or practice nurse appointment with the client, and may have involved a joint management plan initially to assist clients with establishing a rapport/beginning relationship with their practice nurse/GP practice whilst remaining under the umbrella of secondary service. This also included handover of metabolic information so this could appropriately be followed up by the GP practice. This was of potential significant benefit to client’s, many of whom did not attend their GP whilst under secondary service.

- **Medlab Forms** was provided to ensure the client had blood test forms or a regular card so they could continue with regular blood tests until seen by the GP.

- **Pharmacy-liaison** to ensure they were informed re the transfer of care to the GP and aware whom to contact for concerns or prescriptions required.

- **Client given copy of ’Clozaril: Your Questions Answered’ pamphlet** & highlighted advice re missed doses and side-effects, especially those that indicate the need to see a doctor immediately, such as flu-like symptoms.

- **Check client awareness of WINZ entitlements** to ensure that the client is on a benefit, especially re Disability Allowance to assist with payment of GP visits and prescriptions.

- **Novartis informed**.

The checklist is then signed & copied to GP’s practice nurse and client file.
REFLECTIONS and BENEFITS

Clients experienced anxieties around the loss of a longstanding relationship with clinicians in whom they confided with their personal issues and whom they trusted for their expertise. It required some work to prepare for the detachment and connection with new health care professionals and attendance of a first GP appointment supported this process. It shifted the notion of dependence to independence.

Cost was a concern for the clients. Secondary service provision is free of charge and it took some explanations about the purpose of sickness benefit as GP appointments are to be paid for. Support was provided by ensuring that benefits were in place. In exceptional circumstances additional supports were put in place for a limited time.

The transfer contributed to better holistic care for clients. It was beneficial for the general health care of clients to attend GP appointments as issues such as blood pressure and other medications that had been neglected in the past also got addressed. Some clients did not have a GP and only attended ED when needed. This required a culture shift with the example given of a car requiring regular oil checks and warrants of fitness and the responsibility of the owner to take ownership for that.

Clients experienced the liberation of discharge from secondary services after many years which gave them hope and ownership for their own health. Many of them had been in service for more than 10 years

Families required preparation and their major concern was if they could get access to secondary service if their loved one relapses. Relapse prevention plans and referral processes were revisited

GPs and practice nurses were initially concerned about risks, process and the fact that not all of them had a call up system to monitor if a client attended an appointment in the required time frame, but practical advice about a diary call up system and education and information sharing reduced their concerns.

Case managers were initially concerned about the impact of a major exodus of clients who responded well to treatment from their case loads to open up capacity for acute referrals, but in fact the numbers who qualified for discharge were limited and manageable and at the same time allowed for more realistic case loads.

The transfer process brought again an opportunity for education. Some clients had forgotten over the years the information they received at the onset of treatment. That in itself created a review of some scenarios such as over salivation and constipation that had been taken for granted by some clients so that they did not report it when it happened.

The transfer process elicited that file reviews were done which challenged the level of complacency about doses with the result that in some cases the doses were first titrated to a minimum dose before the discharge occurred.
A lesson learnt from this process was that another criteria for “stability” could have been added and that is no involvement with any additional secondary service support such as home based care, work programme etc. as it was found that some individuals may have met all criteria for discharge, but because of additional supports in place they first had to be disengaged from those services which are not available in the primary sector. Another lesson was to rather use PHO counselling in the primary sector if a person re-presents in a relationship crisis if the level of severity is appropriate.

SUMMARY

True recovery and liberation close to home was achieved in the WBOP for 30 clients who were on Clozapine treatment and who were transferred from secondary mental health services to GP care during 2010 - 2012. Experience paved the way for clarity in the future.

REFERENCES

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