

Observation to action: Progressive implementation of lifestyle interventions to improve physical health outcomes in a community-based early psychosis treatment program

Simon Rosenbaum^{1,2}, Li Xian Lim³, Hannah Newall⁴, Jackie Curtis^{1,2}, Andrew Watkins^{1,5}, Katherine Samaras^{6,7} and Philip B Ward^{2,8}

¹Early Psychosis Programme, The Bondi Centre, South Eastern Sydney Local Health District, Bondi Junction, Australia

²School of Psychiatry, University of New South Wales, Randwick, Australia

³Faculty of Medicine, University of New South Wales, Randwick, Australia

⁴Discipline of Psychiatry, School of Medicine, University of Adelaide, Adelaide, Australia

⁵Faculty of Health, University of Technology, Sydney, Sydney, Australia

⁶Department of Endocrinology, St Vincent's Hospital, Darlinghurst, Australia

⁷Diabetes and Obesity Program, Garvan Institute of Medical Research, Darlinghurst, Australia

⁸Schizophrenia Research Unit, South Western Sydney Local Health District, Liverpool, Australia

Corresponding author:

Jackie Curtis, Bondi Community Centre, 26 Llandaff St, Bondi Junction, Sydney, NSW 2022, Australia.

Email: j.curtis@unsw.edu.au

DOI: 10.1177/0004867414539400

To the Editor

The prevalence of metabolic abnormalities, including elevated waist circumference, hypertension, dyslipidaemia and impaired blood glucose levels, are a critical issue within first-episode psychosis (FEP) (Vancampfort et al., 2013). In 2011, we reported a retrospective, cross-sectional naturalistic study in which the files of FEP patients ($n=85$) attending the Bondi Early Psychosis Service between 2006 and 2008 were audited (Curtis et al., 2011). Greater than 40% of the sample had an at-risk waist circumference, whilst 12.5% met International

Table 1. Descriptive statistics: demographic and risk factor variables.

	Total ($n=85$)	Male ($n=56$)	Female ($n=29$)	Statistical test
Age, years, mean (SD)	21.4 (2.9)	21.5 (3.0)	21.3 (2.7)	$t = 0.4$, $p = 0.69$, ns
Ethnicity, n (%)				
Asian	17 (20)	9 (16)	2 (7)	
Indigenous	7 (8)	5 (9)	8 (28)	
Caucasian	61 (72)	42 (75)	19 (65)	
Time in EPP, months, median	9.23	9.57	5.2	$t = -0.6$, $p = 0.57$, ns
Smokers (%)	38/78 (49)	25/52 (48)	13/26 (50)	$\chi^2 = 0.03$, $p = 0.50$, ns
FH diabetes (%)	27/71 (38)	16/46 (35)	11/25 (44)	$\chi^2 = 0.6$, $p = 0.30$, ns
FH CVD (%)	30/67 (45)	21/45 (47)	9/22 (41)	$\chi^2 = 1.3$, $p = 0.47$, ns
BMI, mean (range)	25.6 (17.71–39.57)	26.79 (20.16–39.57)	23.35 (17.71–34.77)	
Waist circumference, female ≥ 80 , male $\geq 90^a$ or 94 cm ^b (%)	34/79 (43)	20/52 (39)	14/27 (52)	$\chi^2 = 0.1$, $p = 0.25$, ns
Blood pressure (%)	20/80 (25)	17/53 (32)	3/27 (11)	$\chi^2 = 4.2$, $p = 0.04^*$
Fasting blood glucose (%)	6/58 (10)	6/39 (10)	0/19 (0)	$\chi^2 = 3.3$, $p = 0.07$, ns
Triglyceride (%)	15/64 (23)	11/44 (25)	4/20 (20)	$\chi^2 = 0.2$, $p = 0.66$, ns
HDL (%)	17/58 (29)	13/39 (33)	4/19 (21)	$\chi^2 = 0.9$, $p = 0.34$, ns
IDF metabolic syndrome (%)	9/79 (11)	6/52 (11)	3/27 (11)	$\chi^2 = 0.0$, $p = 0.63$, ns

The denominator varied across different measures as not all were available for each subject.

HDL: males <1.03 mmol L⁻¹; females <1.29 mmol L⁻¹; BSL >5.6 mmol L⁻¹.

ns: not significant; EPP: Early Psychosis Program; FH: family history; CVD: cardiovascular disease; BMI: body mass index; HDL: high-density lipoprotein; BSL: blood sugar level; IDF: International Diabetic Federation.

^aSE Asian, Japanese, Central or South American males; ^bEuropean males.

* $p < 0.05$.

Diabetes Federation (IDF) criteria for metabolic syndrome. In total, 55% of males and 42% of females were overweight or obese (Curtis et al., 2011).

During the data collection period (2006–2008), no formalised screening or intervention protocol existed.

Pragmatic approaches to counteract the modifiable risk factors began to develop, involving dietetic and exercise physiology students, volunteers and a focus on optimal psychopharmacological prescribing. In addition, the role of metformin to attenuate

weight gain was reviewed (Newall et al., 2012). Formal evaluation of this ad hoc intervention was limited by insufficient capacity to offer service-wide implementation. Concurrently, a standardised metabolic monitoring form was developed and adopted as NSW Health statewide policy to improve cardiometabolic screening. Funding was then obtained to evaluate the subsequent formalised intervention – the 'Keeping the Body In Mind' (KBIM) program – a 12-week, individualised lifestyle intervention including the establishment of an in-house gymnasium and cooking facilities, with recruitment beginning in March 2013.

Prior to the rollout of the formal KBIM program in 2013, a secondary audit of an independent sample, from the same service, was conducted in 2011. Results from this secondary audit are presented in Table 1. At a median treatment time of 9 months,

53% of males and 22% of females were found to be overweight or obese. Over 50% of females and 39% of males (43% of the total sample) had an increased waist circumference, with a quarter of the sample being hypertensive (females > men; $p < 0.05$). Elevated fasting blood glucose was detected in 15% of the male patients. Approximately a quarter of the sample had raised triglyceride levels (23%) and 29% of the sample had low high-density lipoprotein levels.

The results confirmed previous findings of the significant rates of cardiometabolic risk in FEP youth. The ongoing KBIM evaluation underpinned by the principles enunciated in the Healthy Active Lives (HeAL; www.iphys.org.au) consensus statement will hopefully demonstrate the potential for sustainable improvements in life expectancy for young people with FEP.

Funding

This research received no specific grant from any funding agency in the public, commercial, or not-for-profit sectors.

Declaration of interest

The authors report no conflict of interest, the authors alone are responsible for the content and writing of this paper.

References

- Curtis J, Henry C, Watkins A, et al. (2011) Metabolic abnormalities in an early psychosis service: A retrospective, naturalistic cross-sectional study. *Early Intervention in Psychiatry* 5: 108–114.
- Newall H, Myles N, Ward PB, et al. (2012) Efficacy of metformin for prevention of weight gain in psychiatric populations: A review. *International Clinical Psychopharmacology* 27: 69–75.
- Vancampfort D, Wampers M, Mitchell AJ, et al. (2013) A meta-analysis of cardio-metabolic abnormalities in drug naive, first-episode and multi-episode patients with schizophrenia versus general population controls. *World Psychiatry* 12: 240–250.

The prescription

John Little

Capital & Coast District Health Board (CCDHB), Wellington, New Zealand

Corresponding author:

John Duncan Little, CCDHB, Wellington 5024, New Zealand.

Email: thelittles81@gmail.com

DOI: 10.1177/0004867414543567

To the Editor

'When my previous therapist took out his prescription pad, I knew I could never tell him anything important' (Gutheil, 1982).

There is a change in the wind, with an increasing focus on the biological differences between people who have and who do not have borderline personality disorder. Given the unsatisfactory

response to current psychotropic medications, the changing paradigm that postulates a central role for the neuropeptides offers new treatment possibilities. However, prescribing as an intervention, whether for medication, case manager allocation or hospitalisation, remains a complex interaction involving the nature of often unspoken meanings, expectations and relationships (Gutheil, 1982; Swoskin, 2001; Winer and Andriukaitis, 1989).

For some patients, the fantasy of the perfect treatment does exist. It is an intervention that is immediate and specific in its effectiveness and is without side effects. Thus, to not prescribe may be perceived as withholding and a lack of caring, reminiscent of earlier life experiences. However, the same withholding may be experienced as a refusal to be distracted from seeing the patient as a person, as highlighted in the opening quotation.

Prescribing is similarly vexed. Treatment choices, adjustments and augmentation strategies may serve to distract both clinician and patient from a psychological understanding of their difficulties. This runs the risk of strengthening a person's defences against change as they continue to hope that the solution is external to him or herself. If symptoms have become a person's armour, their removal is frightening. Finally, side effects may serve both to confirm the patient's unlovability and wound the prescriber – *'Telling a doctor his pills aren't working is like telling a mother her baby is ugly'* (Gutheil, 1982).

Our understanding of the borderline experience will continue to change. The inherent dilemma of prescribing can be approached by an open and shared inclusion of the patient in developing time-limited, testable assertions – *'By making the*