Adherence with NICE guidance on lifestyle advice for people with schizophrenia: a survey

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# Abstract

### Background

Substantial weight gain is common in people taking antipsychotics. NICE recommends these patients are offered physical health screening and intervention. The STEPWISE trial is currently evaluating a lifestyle education programme in addition to usual care. However, it is difficult to define what constitutes “usual care”.

### Aims

To define “usual care” for lifestyle management in people with schizophrenia, schizoaffective disorder and first episode psychosis in STEPWISE study sites.

### Method

Ten NHS Mental Health Trusts participated in a bespoke survey based on NICE guidance.

### Results

Eight trusts reported offering lifestyle education programmes. Nine Trusts reported offering smoking cessation support. Reported recording of biomedical measures varied.

### Conclusions

No consistent lifestyle education programme is currently offered across UK NHS Mental Health Trusts. The survey benchmarks ‘usual care’ for the STEPWISE study on which changes can be measured.

### Declarations of interest

DS is a topic expert for the current update of NICE guidance on psychosis and schizophrenia in children and young people: These are his personal views and not those of NICE.

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All remaining named authors did not disclose any declarations of interest.

# INTRODUCTION

The prevalence of overweight and obesity in people with schizophrenia is approximately two-fold higher in people with schizophrenia compared with the general population and while the prevalence of overweight and obesity has increased in the general population in the last 30 years, the rate of increase is greater in people with schizophrenia1.

Weight gain in people with schizophrenia often occurs after initiation of antipsychotic treatment, and over 50% of individuals gain more than 7% of their initial body weight within the first 12 months of treatment, with up to 86% of individuals gaining weight with some types of antipsychotic2.

Compared to the general population, people with schizophrenia consume more fat and refined carbohydrates, and fewer vegetables 3–5, are less physically active and experience higher levels of deprivation than the general population,4–7 all of which are associated with obesity.

The National Institute of Health and Care Excellence (NICE) recommends that people with psychosis or schizophrenia, particularly those taking antipsychotics, should be offered access to a combined healthy eating and physical activity programme to aid in the prevention of weight gain and its related co-morbidities leading to improved quality of life8. They should be supported by clinicians to make choices about antipsychotic medication, informed by discussions of likely benefits, possible side effects, such as weight gain and metabolic disturbance, and impact on other aspects of their physical health. For those who smoke, help should be offered to stop smoking 8.

The STEPWISE study (ISRCTN19447796) was commissioned to evaluate the extent to which a structured lifestyle education programme, when delivered to adults with schizophrenia, including those with schizoaffective disorder or first episode psychosis, in a community mental health setting, can support weight loss, compared to usual care. In pragmatic trials, practitioners are often allowed “considerable leeway in deciding how to formulate and apply” the treatment in a control arm defined as “usual care”.9 While the result may be reflective of the care received by patients outside the trial, there is often variation in care in an active control arm, which may be difficult to document10,11. For this reason, study teams often try and capture the active content of the control arm of their trials12. In this paper we describe a survey of ‘usual care’ for the management of weight and other lifestyle factors in people with schizophrenia, schizoaffective disorder and first episode psychosis in the ten participating study sites.

# METHODS

## Research Tool

The survey instrument consisted of 14 questions, which were a combination of closed and open design, with the aim of eliciting information about the implementation of the recent NICE guidance on psychosis and schizophrenia at NHS Mental Health Trusts in the UK, and consequently what is offered as “usual care”. The survey was developed for the research study, based on the physical health aspects of the NICE recommendations within Clinical Guideline 178 (Psychosis and schizophrenia in adults: prevention and management). Questions followed the baseline assessment tool published alongside the NICE guidance8.

The instrument was piloted with one study site investigator (JM), on two occasions, after each of which substantial changes were made to the tool. For instance, the second iteration revised questions to ascertain proportions of patients to whom certain criteria apply rather than closed questions such as “are patients referred to a healthy eating programme”. The final version of the tool also clarified which questions related to all patients with schizophrenia, schizoaffective disorder and first episode psychosis, and which questions related to patients with first episode psychosis only (see Appendix 1). This is in line with the additional recommendations specified in the NICE guidance for patients with first episode psychosis, who have recently been prescribed antipsychotic medication; these additional questions were not applicable to the management of patients with established mental illnesses.

## Survey Structure

Trusts were initially asked whether they offered a healthy eating and physical activity programme. Subsequent questions asked more information about these courses, including whether these were combined or separate for healthy eating and physical activity; how patients accessed them; and how often patients are referred to such services. Additional information was sought on the availability of smoking cessation services in this population and whether discussions took place between patients and clinicians prior to antipsychotic treatment initiation; including benefits of treatment, interactions with other substances, and other possible side effects.

In addition, NICE recommend that a number of physiological measures should be recorded both prior to the patient starting antipsychotic medication, and then annually thereafter. Respondents were asked to comment on how likely each measure would be recorded at both of these time points in their trust. Respondents were also asked about how often patients taking antipsychotic medication have their weight recorded. The full survey can be viewed in Appendix 1.

## Sample selection

The STEPWISE trial has ten centres, across a variety of urban, suburban and rural locations across England; Sheffield Health & Social Care NHS Foundation Trust, Leeds & York Partnership NHS Foundation Trust, Bradford District Care NHS Foundation Trust, Greater Manchester West Mental Health NHS Foundation Trust, South London & Maudsley NHS Foundation Trust, Sussex Partnership NHS Foundation Trust, Southern Health NHS Foundation Trust, Devon Partnership NHS Trust, Somerset Partnership NHS Foundation Trust and Cornwall Partnership NHS Foundation Trust. A representative from each of these centres was invited to complete the survey on the physical health aspects of usual care offered in their trust for patients with schizophrenia, schizoaffective disorder and first episode psychosis.

## Respondents

The Principal Investigators at each of the ten centres for the STEPWISE Trial were approached initially, some of whom completed the survey, whilst others delegated to trust Physical Health Leads or equivalent who were better placed to answer the questions.

Contact was made via email in the first instance, with an invitation to attend a teleconference with the STEPWISE Research Assistant (LS) to complete the survey. Reminder emails and/or phone calls were used for those who did not provide a response to the invitation within 4 weeks. Six of the ten sites’ surveys were completed through discussion via teleconference. The remaining four sites’ surveys were completed independently by a trust representative and written responses provided to the STEPWISE Research Assistant.

No sites required more than one reminder email/telephone call in order to arrange completion of the survey. As the survey information was requested from members of a research team, a favourable ethical opinion from an NHS Research Ethics Committee was not sought, and consent was unnecessary. Responses provided organisational data only, and did not collect any personal data. All those surveyed responded. Responses from all sites were received between 22 May 2015 and 28 October 2015.

## Analysis

Descriptive statistics in the form of counts were produced for quantitative variables. Supporting information provided by respondents and information yielded from qualitative questions was summarised in narrative form.

# RESULTS

## Healthy eating and Physical activity programmes

Eight respondents reported that their trust offered programmes, mostly separate healthy eating and physical activity programmes. Supplementary information indicated provision was *ad hoc* and interventions were rarely standardised. Most respondents reported routinely inviting patients to access services such as discounted local gym memberships, cooking groups and activity groups provided by local authorities and third sector organisations. Two trusts reported offering 1:1 advice sessions with healthy living advisors or health trainers, but that these sessions were usually advice-giving and often more clinically focussed rather than on the patient’s physical wellbeing.

Those trusts who offered trust-led programmes reported that they were available in principle to all of their patients rather than specific groups based on diagnosis. However, interventions offered were often accessed only by certain groups of patients, usually through particular clinicians or clinics. One trust estimated that 70% of their eligible patients are referred to such services by mental health professionals, based on recent Commissioning for Quality and Innovation (CQUIN) results; other respondents were unaware of routine data from which they could quantify referrals. Six trusts reported offering lifestyle advice through open-ended group courses, three through courses delivered over a fixed period and four through drop-in sessions.

## Smoking Cessation advice

Six respondents indicated that patients who smoke, were offered help to stop some of the time; three reported all of the time, and one said this was not offered at all. Respondents who selected “some of the time” were unable to quantify this, but felt that this occurred most of the time.

Although it varied whether smoking cessation services were offered by the trusts or external services, most offered a combination of the two. Seven trusts reported offering trust-led smoking cessation services, whilst others had trained smoking cessation advisors, but no formal trust-offered service. Most trusts reported signposting outpatients to external services, some of which were managed by primary care, and that advice leaflets were available within the trust.

## Antipsychotic treatment initiation

Table 1 shows the reported levels of discussion around likely benefits of treatment, as well as potential weight gain, diabetes and metabolic side effects and any other possible side effects, across all respondents.

**Table 1: Respondents report of how often recommended discussions took place with patients when deciding on antipsychotic treatment (n=10 NHS trusts).**

|  |  |  |  |
| --- | --- | --- | --- |
|  | All of the time | Some of the time | Not at all |
| Likely benefits | 7 | 3 | 0 |
| Weight gain | 5 | 5 | 0 |
| Diabetes and metabolic side effects | 3 | 7 | 0 |
| Other possible side effects | 5 | 5 | 0 |

Most trusts who reported “some of the time” felt that this would be most of the time, but there was a lack of evidence to support this. One site reported that discussions would be dependent on the clinician, but that resources were available to clinicians to support these discussions. Another site suggested that these discussions may be part of an ongoing process rather than all in one session, depending on the patient’s level of capacity.

Table 2 shows how often respondents reported discussions taking place regarding the use of alcohol, tobacco, prescribed and non-prescribed medications and illicit drugs, at the time of antipsychotic treatment initiation.

**Table 2: Respondents report of how often recommended discussions around other medications and substances took place with patients when deciding on antipsychotic treatment (n=10 NHS trusts).**

|  |  |  |  |
| --- | --- | --- | --- |
|  | All of the time | Some of the time | Not at all |
| Alcohol | 5 | 5 | 0 |
| Tobacco | 2 | 8 | 0 |
| Other prescribed medications | 3 | 7 | 0 |
| Non-prescribed medications | 0 | 10 | 0 |
| Illicit drugs | 3 | 7 | 0 |

Table 3 shows how likely trusts considered physiological measures would be recorded prior to treatment initiation.

**Table 3: Likelihood of physiological measures being recorded prior to antipsychotic treatment initiation (n=10 NHS trusts).**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Very likely | Likely | Neither likely or unlikely | Unlikely | Very unlikely |
| Weight | 3 | 4 | 1 | 2 | 0 |
| Weight plotted on a chart | 1 | 3 | 1 | 3 | 2 |
| Waist circumference | 0 | 2 | 3 | 3 | 2 |
| Pulse | 3 | 4 | 1 | 1 | 1 |
| Blood pressure | 4 | 2 | 1 | 2 | 1 |
| Fasting blood glucose | 0 | 5 | 1 | 2 | 2 |
| Random blood glucose | 2 | 4 | 0 | 3 | 1 |
| HbA1c | 2 | 2 | 1 | 2 | 3 |
| Blood lipid profile | 2 | 4 | 0 | 2 | 2 |
| Assessment of any movement disorders | 2 | 4 | 2 | 0 | 2 |
| Assessment of nutritional status, diet and level of physical activity | 3 | 3 | 1 | 3 | 0 |

## Ongoing monitoring of weight and other physiological measures

It was clear from the responses that there were variations in recording patients’ weight at the time points recommended by NICE (first six weeks post treatment initiation, at twelve weeks, at one year, and annually thereafter) both between trusts and within trust services. Some confusion exists regarding responsibility for annual patient reviews in the community and whether these should be completed by the GP or the trust. Half of those surveyed reported that it was neither likely nor unlikely that patients would have their weight recorded weekly for the first six weeks, with three other trusts reporting that this was very unlikely. There was an even spread across all response categories as to whether weight was recorded at twelve weeks, but at one year, four of those surveyed reported that patients were very likely to have their weight recorded. Six respondents reported that weight was likely or very likely to be recorded annually thereafter, although this was where the confusion arose regarding responsibility for these reviews.

Table 4 shows trusts’ consideration as to how likely physiological measures would be recorded at least annually, in patients taking antipsychotic medication. One site felt they were unable to answer this question, so data displayed reflect responses from nine trusts.

**Table 4: Likelihood of physiological measures being recorded at least annually for patients taking antipsychotic medication (n=9 NHS trusts).**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Very likely | Likely | Neither likely or unlikely | Unlikely | Very unlikely |
| Weight | 3 | 4 | 0 | 2 | 0 |
| Weight plotted on a chart | 0 | 3 | 3 | 2 | 1 |
| Waist circumference | 0 | 2 | 2 | 3 | 2 |
| Pulse | 2 | 4 | 1 | 1 | 1 |
| Blood pressure | 3 | 4 | 1 | 1 | 0 |
| Fasting blood glucose | 1 | 2 | 5 | 1 | 0 |
| HbA1c | 2 | 2 | 4 | 1 | 0 |
| Blood lipid profile | 2 | 1 | 4 | 2 | 0 |
| Assessment of any movement disorders | 1 | 4 | 3 | 1 | 0 |
| Assessment of nutritional status, diet and level of physical activity | 3 | 1 | 3 | 2 | 0 |

There was no correlation between which of the recommended physiological measures were recorded by trusts prior to antipsychotic treatment initiation, or annually thereafter, although generally those trusts who were likely to record particular measures prior to treatment initiation, were also likely to record the same measures at least annually thereafter.

# DISCUSSION

## Principal findings

It was clear from this survey that there was great variation between different NHS Mental Health Trusts in the provision of healthy eating and physical activity interventions routinely offered to patients, as well as variation between clinicians within the same trust, with interventions often accessed only through particular clinicians or clinics. Commonly, trusts reported signposting or referring patients to programmes offered by external services such as gym memberships and activity classes.

Most patients had access to a smoking cessation service should they require it, and referrals to such services were reported to occur most of the time, if not all of the time at nine out of the ten trusts surveyed, regardless of whether the service was offered within the trust, or run externally.

When deciding on antipsychotic medication with newly diagnosed patients, there was also variability in the reported discussions that took place across trusts. All trusts reported that the likely benefits, weight gain, diabetes and metabolic side effects and other possible side effects were discussed with the patient at least some of the time, as well as the possible interference of other substances with prescribed antipsychotic medication.

Although at the early stages in the course of antipsychotic treatment, it was reported unlikely that trusts would record a patient’s weight as recommended by NICE, by one year after treatment initiation, a larger proportion of trusts reported weight being recorded, a proportion of which increased again for annual reviews thereafter, despite the uncertainties regarding responsibility for undertaking annual reviews in the community.

## Strengths and limitations

A strength of this survey was that its design was based on the NICE guidelines to which Mental Health Trusts should be adhering. This meant that trusts’ compliance with these recommendations could be assessed, allowing us to elicit information on what programmes (if any) trusts were offering in usual practice, and how these compared to what is recommended by NICE. This also allowed us to try and define “usual care” in relation to the STEPWISE study, using a standard approach across all trusts.

The survey was, in principle, a suitable method to elicit the same information from all respondents, however, it was clear from the responses that due to the variability of services offered, it was often difficult to provide a succinct account using this survey tool. The narrative information provided by the respondents proved more useful in providing a fuller picture of their usual care, than the descriptive statistics, which in some cases were a best guess, as clear data were not always available.

Furthermore responses were based on one member of staff’s knowledge of usual care in practice, and although this person was usually best placed to answer the questions, from the survey responses received, knowledge may have been limited, especially as some interventions offered were particular to a specific clinic or clinician and usual care may vary within and between community mental health teams in any given NHS organisation. In addition, how representative ‘usual care’ is in comparison to NHS trusts not taking part in the STEPWISE study remains unknown.

The levels of detail around the content of available services also varied, perhaps if the respondent had more involvement with some programmes than others. Therefore it was considered likely that additional interventions may have been offered within trusts, of which the survey respondent was unaware.

In relation to implementation, a weakness in the survey was highlighted when some responses were received through telephone discussion whilst others were completed by the respondent and returned to the researcher. No systematic differences between telephone and paper copy responses were identified, although more supporting information was often provided through telephone responses, as these were elicited through more of a conversational style discussion. This difference in response methods may have caused questions to be perceived differently, although all telephone participants had a copy of the questionnaire available to them at the time of completion. Perceptions of appropriate levels of detail can change with different methods of completion, which may lead to variation in results. However, as such variation was evident between practices offered as “usual care” in the ten trusts surveyed, the impact of these differences in completion method is considered likely to be small.

The variability in the information elicited has not allowed for a common picture across all sites, as although a type of programme is recommended by NICE, a particular standardised programme is not available across all trusts. However, the information yielded from this survey does provide sufficient baseline information, to allow any changes in usual practice during the course of the STEPWISE study to be monitored at a trust level, rather than across all study sites as a whole. This will allow an assessment to be made at the end of the STEPWISE study as to the extent of potential contamination between the intervention and control arms of the trial, based on changes in practice reported in the survey.

## Context

Although there may be an increased awareness of the potential benefits of some treatments, this does not ensure such treatments are implemented effectively. Evaluations of and methods of improving the implementation of NICE guidelines often has limited attention13.

A systematic review undertaken by Berry et al noted that the research around implementation of NICE guidelines on schizophrenia is relatively limited, suggesting that these patients have poor access to psychological interventions such as CBT. Some barriers to implementation of NICE guidelines were reported, such as insufficient support from trust management, and the needs of organisations. The paper also highlights that whilst NICE considers RCTs to be the gold standard when developing an evidence base for its guidelines, RCTs have also been criticised for their ability to reflect the “real world”. The authors suggest that targeting these barriers is the key in facilitating successful implementation of the guidelines13.

It is therefore key to identify which aspects of the guidance are not currently being followed in order to target these areas for implementation and improve clinical care. Not only is it important to consider the implementation of guidance relating to monitoring of biomedical measures, but also there is likely to be a limited effect unless combined with sufficient intervention in behaviour or treatment. Similarly, the mere presence of guidance or a trial do not necessarily lead to substantive changes or better outcomes. Repeating the survey annually will allow identification of any substantive, systematic changes within the organisations since both the introduction of the NICE guidelines, and throughout the duration of the STEPWISE trial.

From a research perspective, the reported variation also has implications for our study when defining “usual care”. If all trusts adhered to all recommendations in the NICE guidelines, we could be sufficiently confident that contamination between trial arms would be minimal, however, as different levels of compliance with different recommendations were evident, this does not allow for standardised “usual care” across the study. This does mean, however, that usual practice can be compared over time within each trust individually, in order to make an assessment as to how much “usual care” has changed throughout the course of their participation in the STEPWISE study.

The National Audit of Schizophrenia includes standards on the monitoring of physical health in patients with schizophrenia. The audit report in 2014 noted that the provision of interventions is poor when there is evidence of physical health risks. The report highlighted barriers to intervention including availability of staff time, facilities and equipment, the need for formal systems to conduct annual reviews and the need for more formal arrangements regarding responsibility for physical health between primary and secondary care14.

Standard 5 in the audit specifically looks at interventions offered for particular physical health risks. The overall results show that intervention for BMI >25 Kg/m2 was evident in 71% of patients, while interventions for smoking were reported in 59% of patients14.

For the ten trusts surveyed, the audit reported a range of 47-83% of patients receiving intervention for elevated BMI, and 33-67% receiving intervention for smoking. Overall, the audit also showed wide variation in the monitoring of physical health risk factors. For example, the range across all participating Trusts for monitoring of BMI was 5-92% of patients, and the range across trusts for the monitoring of glucose control 16-99%. This is supportive of the information yielded from the survey and highlights the variability in services offered across trusts14.

## Implications for stakeholders

This survey indicates that the ten sites surveyed are not fully compliant with the physical health recommendations within the NICE guidelines on the management of patients with schizophrenia. However, as the guidelines were published in March 2014, this is not surprising, because services require time to commission and set up.

In some respects this alleviates the concerns that the “usual care” arm of the STEPWISE trial may converge with the intervention arm, as there are no reported standardised programmes offered across any of the Trusts surveyed. However, there is such variability observed, that it becomes clear “usual care” is not the same for all participants in the trial, and in the wider population group.

We have not tried to assess the success or potential effect of any one aspect of the physical health programme in comparison with others. Although it may be argued that smoking cessation could have a greater effect on physical health than healthy eating or physical activity programmes despite the lower compliance with NICE guidance, any discussion is likely to be subjective. Furthermore, NICE does not prioritise any one element with an understanding that all aspects are important and contribute to improved physical health.

As a future direction, it may be useful to try and identify patients at higher risk of cardiovascular events, using recording of cardiovascular disease risk factors in combination with risk engines, to calculate risk accurately. This identification process could then drive intervention. This may be of interest to trusts as a method of offering a physical health intervention to those patients who are likely to receive the most benefit clinically. A suitable risk engine to calculate this would be the PRIMROSE cardiovascular disease algorithm, as this has been developed specifically for people with severe mental illness. The PRIMROSE model includes additional variables for psychiatric diagnosis, psychotropic medication, harmful use of alcohol, anti-depressants and social deprivation score, unlike similar prediction models used in the general population. This is perhaps why the PRIMROSE model performed better than some other available published risk models, who may otherwise overpredict the risk of cardiovascular disease in this population.15

## Further research

The survey will be repeated with the same ten NHS Trust representatives at twelve and 24 months after the first iteration. This will allow the STEPWISE study team to consider how Trusts are implementing the NICE guidelines, and consequently whether convergence has occurred between the two arms of the STEPWISE trial at an individual trust level. As STEPWISE progresses, the participating NHS organisations may become more aware of the need to undertake physical health interventions and so ‘usual care’ may improve, potentially diminishing the effect of the STEPWISE intervention.

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# Appendix 1

**Routine Usual Weight and Lifestyle Management Care for patients with first episode psychosis, schizophrenia or schizoaffective disorder**

Site: ­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of completion: ­\_\_/\_\_/\_\_\_\_\_

Role of person completing: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Does your Trust offer a healthy eating and physical activity programme?
   1. Combined healthy eating and physical activity programme
   2. Separate healthy eating and physical activity programmes
   3. Healthy eating programme only
   4. Physical activity programme only
   5. None
2. If a programme is offered, which patients can be referred to the programme?
   1. All patients
   2. Patients with psychosis or schizophrenia
3. What proportion of eligible patients are referred? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. What proportion of patients referred, attend the programme? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. If a programme is offered, how is this accessed?
   1. Ongoing course
   2. Drop-in sessions
   3. Over a fixed period
   4. Other (please give details) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. If a healthy eating and/or physical activity programme is offered by your Trust (a, b, c or d in Q1), please provide the name of the programme and appropriate contact details for a programme representative:
3. Does your Trust offer people with psychosis or schizophrenia who smoke, help to stop smoking, even if previous attempts have been unsuccessful?
   1. All of the time
   2. Some of the time (please state how often) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
   3. Not at all
4. If yes, is this help provided by your Trust, or an external smoking cessation service?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. If a smoking cessation/advice programme is offered by your Trust, please provide the name of the programme and appropriate contact details for a programme representative:
2. How often are the following discussed with the patient when deciding on antipsychotic treatment?

|  |  |  |  |
| --- | --- | --- | --- |
|  | All of the time | Some of the time | Not at all |
| Likely benefits |  |  |  |
| Weight gain |  |  |  |
| Diabetes and metabolic side effects |  |  |  |
| Other possible side effects |  |  |  |

Please use the space below to provide further details (if applicable)

1. How often is the use of the following, and their possible interference with prescribed medication discussed with the patient?

|  |  |  |  |
| --- | --- | --- | --- |
|  | All of the time | Some of the time | Not at all |
| Alcohol |  |  |  |
| Tobacco |  |  |  |
| Other prescribed medications |  |  |  |
| Non-prescribed medications |  |  |  |
| Illicit drugs |  |  |  |

Please use the space below to provide further details (if applicable)

**Please Note: Questions 12 & 13 relate specifically to patients with first episode psychosis.**

1. How likely is it that patients will have the following recorded before they start taking antipsychotic medication?

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Very likely | Likely | Neither likely or unlikely | Unlikely | Very unlikely |
| Weight |  |  |  |  |  |
| Weight plotted on a chart |  |  |  |  |  |
| Waist circumference |  |  |  |  |  |
| Pulse |  |  |  |  |  |
| Blood pressure |  |  |  |  |  |
| Fasting blood glucose |  |  |  |  |  |
| Random blood glucose |  |  |  |  |  |
| HbA1c |  |  |  |  |  |
| Blood lipid profile |  |  |  |  |  |
| Assessment of any movement disorders |  |  |  |  |  |
| Assessment of nutritional status, diet and level of physical activity |  |  |  |  |  |

1. How likely is it that patients will have their weight recorded as follows?

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Very likely | Likely | Neither likely or unlikely | Unlikely | Very unlikely |
| Weekly for the first 6 weeks |  |  |  |  |  |
| At 12 weeks |  |  |  |  |  |
| At 1 year |  |  |  |  |  |
| Annually thereafter |  |  |  |  |  |
| If any of the above are unlikely or very unlikely, is there a reason this is not recorded? |  | | | | |

**Q14 relates to all patients (first episode psychosis, schizophrenia and schizoaffective disorder)**

1. How likely is it that patients will have the following recorded at least annually?

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Very likely | Likely | Neither likely or unlikely | Unlikely | Very unlikely |
| Weight |  |  |  |  |  |
| Weight plotted on a chart |  |  |  |  |  |
| Waist circumference |  |  |  |  |  |
| Pulse |  |  |  |  |  |
| Blood pressure |  |  |  |  |  |
| Fasting blood glucose |  |  |  |  |  |
| HbA1c |  |  |  |  |  |
| Blood lipid profile |  |  |  |  |  |
| Assessment of any movement disorders |  |  |  |  |  |
| Assessment of nutritional status, diet and level of physical activity |  |  |  |  |  |

Other comments: