Cardioprotective medication prescribing in people with severe mental illness: an exploratory qualitative study of general practitioners' experiences

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BACKGROUND

Reduced life expectancy: People with severe mental illness (SMI) die 10-20 years sooner than the general population

Increased cardiovascular disease (CVD) risk and poorer outcomes: mortality and further vascular events are more likely after heart attack

Diminished prescribing rates: patients with SMI less likely prescribed cardioprotective medication than general population by GPs – limited qualitative data on why

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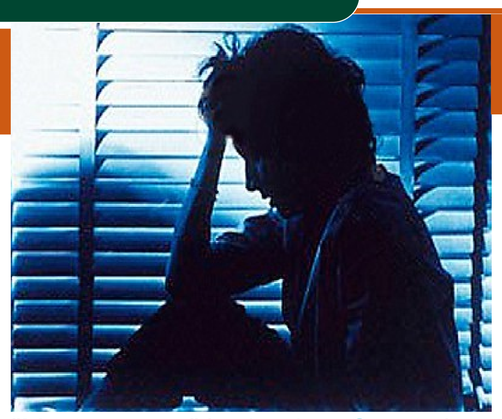
AIM

Explore challenges/barriers faced by GPs in cardioprotective prescribing for people with SMI

METHODS

- **Approach:** Semi-structured, 1-2-1 qualitative interviews with 15 GPs practising in 2 Scottish health boards Oct-Nov 2022
- **GP practices:** Deep End GP practices (treating patients in most socio-economically deprived areas) targeted but not exclusively focused on
- **GP participant criteria:** at least one year post-speciality GP training experience and fairly regular contact with patients with SMI
- **Data analysis**: Braun & Clarke's (2022) thematic analysis approach and NVivo analysis software



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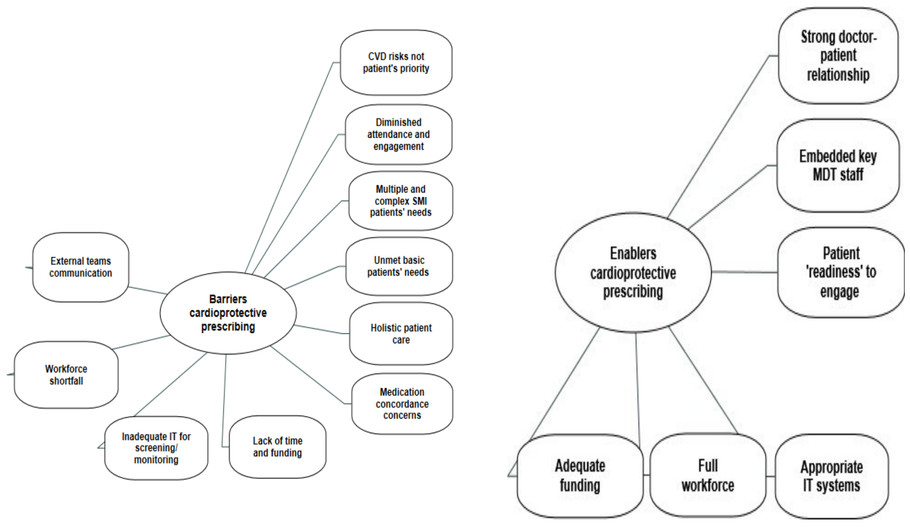
GP PARTICIPANT DEMOGRAPHICS

Health Boards - Health Board A: 10 GPs and Health Board B: 5 GPs
Gender - Females: 9 and Males: 6
Age Bands - 35-39: 1; 40-49: 4; 50-59: 6; 60-64: 2; 70 or more: 2
GP role - Partners: 7; Salaried GPs: 5; Locums/Out-of-hours: 3

FINDINGS – BARRIERS AND ENABLERS



KEY FINDINGS AND PARTICIPANT QUOTES

BARRIERS TO PRESCRIBING

- **Not priority of patients with SMI**
- **Unmet basic needs and multiple / complex needs – need addressed**
- **Medication concordance concerns**

ENABLERS TO PRESCRIBING

- **Strong doctor-patient relationship and continuity of care**
- **Embedded MDT staff e.g. mental health nursing; pharmacists**

Patient priorities:

*"The **highest priority** is probably making sure that they are **safe from a mental health point of view,** that's often **what is being presented**. People **present in crisis**…they're **unlikely to want to follow [primary prevention] advice**."*

Unmet basic needs:

"***Before** we **worry about cholesterol and blood pressure**, should we not be **worrying about [them] having any food to eat**? Is their **accommodation stable**? Can they **heat the house**?"*

Medication concordance:

*"The patients that I deal with who have **severe mental illness**, are they going to **understand that**, is that going to be a **priority for them**? Are they just going to say, **I don't want to take that [medication]**, and leave that one? **Compliance…is one of the key concerns**. "*

Strong doctor-patient relationship & continuity of care:

"Relational model of primary care…if I ring up out of the blue and say hi, I'm X, you've never met me before but I'm very concerned about your cholesterol. They're just going to think well, I'm not concerned about it. I would have to have a relationship with that person for them to see that I take it seriously and therefore they should take it seriously."

Embedding MDTs

"Because if you've got your mental health worker embedded in you, you work together…They can bring that professionalism, that training. ..and we know how our patients work. So I think having them embedded in the practice would make a huge difference."

SOLUTIONS / ASPIRATIONS

- Bolstering and sufficiently funding primary care
- Improving IT systems for screening and monitoring
- Enhancing communication between physical and mental care teams:1. Patients attending MDT meetings, 2. Joint mental and physical health consultations
- Improving patients' baseline quality of life through the provision of lifestyle community interventions
- Embedding core workers e.g. mental health nurse, pharmacist, link worker
- Providing key person for patient physical health discussions

CONCLUSIONS

- GP participants aspired to prescribe cardioprotective medication to patients with SMI
- Professional, system and patient-level barriers make this challenging, particularly in deprived areas due to patient complexity and the inverse care law
- Strength of doctor-patient relationship built up over time and the complexity of this patient group's needs are key factors influencing prescribing
- Structural issues currently facing general practice e.g. workforce instability and shortfalls and time and funding deficits play large role

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