Croydon Joint Strategic Needs Assessment 2012/13

Key Topic: Schizophrenia

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The full membership of the JSNA implementation group is given in *Appendix 1*

Thanks also to Fiona Assaly, Project Coordinator, who provided project support and Jenny Hacker, Consultant in Public Health, who edited the chapter.

2 Summary of recommendations

This section lists all of the recommendations in the document grouped into themes.

Future planning

SR-3 It is recommended that the Clinical Commissioning Group(CCG) and the council raise awareness among providers and commissioners that the number of people with schizophrenia is growing and that commissioners and those planning services take account of their changing need in strategies, commissioning plans, contract negotiations and financial modelling.

SR-2 It is recommended that Public Health Croydon review projections of future numbers of people with schizophrenia in the light of revised changes in size of risk factors for schizophrenia following publication of full census 2011 data and any relevant local data.

Service User involvement

SR-6 It is recommended that Mental Health (MH) commissioners ensure that there is full and meaningful involvement of service users and carers in service developments and reconfigurations.

SR-31 It is recommended that commissioners improve user involvement in choice around care and treatment decisions and ensure the workforce is developed to meet users expressed needs for a more recovery focussed approach to care.

Physical health of people with schizophrenia

SR-13 It is recommended that as a priority, local area teams of NHS England and Croydon CCG reduce GP practice variation in physical health monitoring for people with severe mental illness through supporting poorer performing practices and learning from areas of good practice.

SR-4 It is recommended that the CCG and the council ensure that commissioners and providers of both physical and mental health services, and lifestyle and wellbeing services, are aware of the greatly increased risk of mental and physical health problems and early death in people with schizophrenia or other serious mental illnesses and take account of these risks in developing and reviewing services with the aim of reducing them.

SR-17 It is recommended that MH commissioners strengthen stop smoking services for people with Severe Mental Illness (SMI) and that MH commissioners train staff, delivering this intervention, to

understand the importance of good communication with prescribers of changes in smoking status.

Treatment Services

Treatment of the acute episode. **SR-10** It is recommended that as a priority, MH commissioners, providers and community and service user representatives support efforts to manage demand for acute services through strengthening both acute services and provision in the community, particularly recovery services. This should take a whole systems, pathway approach and take account of evidence and best practice, engaging service users and carers.

Early detection service. **SR-9** It is recommended that MH commissioners review the current effectiveness and cost effectiveness of the early intervention services and consider developing / extending an early detection service in Croydon.

Psychological therapies. **SR-21** It is recommended that the MH commissioners improve access to psychological and talking therapies for people with schizophrenia.

SR-22 It is recommended that MH commissioners consider increasing the availability of family intervention therapies.

Out-of-hours provision. **SR-11** Commissioners should explore the impact of current out-of-hours provision on use of secondary care services and crisis support.

Antipsychotic medication

SR-15 It is recommended that clinicians engage closely with service users to agree together what medication regime works best for them and to ensure that this is kept under regular review.

SR-18 It is recommended that commissioners and pharmacy leads provide ongoing training for GPs in antipsychotics prescribing.

SR-19 It is recommended that there is ongoing support for the development and implementation of antipsychotic shared care protocols both for oral antipsychotics and depot injections.

SR-16 It is recommended that consideration is given to how all health care professionals in primary care: GPs, community pharmacists and nurses can support people to improve decision making and have systems in place to identify and resolve issues of poor compliance with treatment.

Pathways and interfaces

SR-5 It is recommended that MH commissioners take a whole system approach to strategic planning whereby relevant agencies work and plan together with the aim of increasing integration.

SR-14 It is recommended that MH commissioners continue to support the development of the primary care service for people with stable serious mental illness. Furthermore, that the commissioners review the interface between primary and secondary services in the light of the outcome of this work.

SR-30 It is recommended that the commissioners act on the findings of the review of eligibility criteria to some services.

Recovery Services (housing, employment, benefits, debt)

SR-12 It is recommended that decision makers take account of the impact of recovery services on quality of life, wellbeing and demand for other services when developing and reviewing service provision.

SR-20 It is recommended that commissioners look at the community mental health recovery services in more detail in order to understand the strengths and gaps in this service.

SR-26 It is recommended that commissioners ensure that the housing needs of people with schizophrenia and other severe mental illnesses are adequately addressed.

SR-27 It is further recommended that the commissioners and providers review the type of housing commissioned to maximise independent living.

SR-28 It is recommended that commissioners review eligibility to employment support and ensure that effective models are implemented.

SR-29 It is recommended that commissioners ensure that the provision of benefits and debt advice meets the current and future needs of people with schizophrenia and other serious mental illnesses.

Support for carers

SR-23 It is recommended that MH commissioners' effective information sharing with carers and others is improved through training and other approaches so that practitioners feel more confident in balancing patient rights to confidentiality with risk management.

SR-24 It is recommended that the CCG and the council support the health and wellbeing of carers of people affected by schizophrenia by referring them for carers assessments, ensuring assessment are taken.

SR-25 It is recommended that mental health commissioners support the development of more carer support groups in areas where service provision is low.

GP Recorded schizophrenia

SR-1 It is recommended that the CCG asks public health to investigate the reasons behind the unexpected pattern of GP recorded schizophrenia prevalence by ethnicity.

Data quality and availability

SR-7 It is recommended that the mental health partnership develops a shared understanding of the information required by commissioners and strategists to evaluate services, monitor performance, understand and improve value for money and gain a better understanding of current and future need.

SR-8 It is recommended that commissioners ensure that providers are incentivized to provide outcomes, data and intelligence with the aim of evaluating services, monitoring performance, and improving value for money.

3 Executive summary

Introduction

This JSNA chapter on schizophrenia is one part of the wider 2012/13 JSNA on mental health. The wider 2012/13 JSNA includes an overview chapter on mental health and well-being, chapters on depression and on the emotional health and wellbeing of children, as well as a key dataset of broader issues around health.

Background – what is schizophrenia?

- Schizophrenia is a major psychiatric disorder, or cluster of disorders. It is characterised by psychotic symptoms that alter a person's perception, thoughts and behaviour, although an episode of psychosis may be a symptom of other illnesses.
- The disorder affects about 1 in every 100 people during their lifetime. It is most likely to start between the ages of 15 to 35.
- Policy on severe mental illness such as schizophrenia has broadened its focus from the more clinical aspects of care and treatment, towards a greater emphasis on the promotion of wellbeing, the prevention of mental illness, and recovery focused care.
- Current government policy is to mainstream mental health in England, giving it parity with physical health, making mental health everyone's business, and ensuring that more decisions are taken locally, based on need.

Why is schizophrenia important?

- It comes at a huge financial cost. For Croydon, the annual cost of schizophrenia is estimated at £104 million to society, and £62 million to the public sector.
- Costs will grow as numbers of people with schizophrenia increase.
- A diagnosis of schizophrenia is still associated with considerable stigma, fear and limited public understanding.
- The first few years after onset can be particularly upsetting and chaotic, and there is a higher risk of suicide.
- The symptoms and behaviour associated with schizophrenia can also have a distressing impact on family and friends.
- In Croydon, people with schizophrenia are 19 times more likely to have attempted suicide or self-harmed. They are also 14 times more likely to have a personality disorder and 8 times more likely to have an addictive behaviour.
- People with severe mental illness have more long term physical health conditions compared to the general population and more likely to have

less healthy lifestyles. Smoking is responsible for much of the excess morbidity and mortality. People with schizophrenia are twice as likely to smoke, more like likely to have a high Body Mass Index (be overweight or obese), much more likely to have diabetes, hypertension (high blood pressure), Parkinson's disease and epilepsy.

- People with schizophrenia live for 15-20 years less than other people.
- ***It is recommended that the CCG and the council ensure that commissioners and providers of both physical and mental health services, and lifestyle and wellbeing services, are aware of the very increased risk of mental and physical health problems and early death in people with schizophrenia or other serious mental illnesses and take account of these risks in developing and reviewing services with the aim of reducing them.***

How common is the disorder?

- Just over one percent of Croydon's population is registered as having a serious mental illness (SMI). This is similar to the rates for London and higher than the rates for England. Of those registered as having a serious mental illness, just less than half (44%) have schizophrenia (1,735 adults).

Who does it affect?

- In Croydon, schizophrenia is more common in men up to age 60. Over this age, the reverse is true. This reflects national trends.
- However, local ethnicity data does not reflect national trends. Nationally, Black African and Caribbeans are known to have a much greater risk of schizophrenia. In Croydon, the difference is much lower than would be expected, and prevalence is much higher in the 'mixed' ethnic category.
- ***It is recommended that the CCG asks public health to investigate the reasons behind the unexpected pattern of GP recorded schizophrenia prevalence by ethnicity.***
- Schizophrenia is associated with deprivation, much more so than illnesses such as depression.
- In Croydon, schizophrenia is four times more common in the most deprived than the least deprived groups. Higher rates are seen in the north of the borough where there are some areas of higher deprivation and a greater proportion of the population from BME backgrounds.
- Other groups at risk of schizophrenia are those living in specialised institutional settings such as judicial and custodial services, homeless shelters and residential homes.
- For the last 60 years, the incidence of schizophrenia and psychotic disorders nationally has been relatively stable, with any local increases

being explained largely by changes in the ethnic make-up of the relevant community.

- In Croydon, the number of people diagnosed with the disorder has been increasing each year since 2007 typically by about 40 additional cases a year.
- Based on this recent trend, we would expect an additional 400 cases over the next ten years, representing a **24% increase** in the number of people diagnosed with schizophrenia, all other things being equal. However, this projection is likely to **underestimate** the true burden of schizophrenia facing Croydon in coming years. This is due both to changes in the population of Croydon, with increases expected in groups with a higher prevalence of schizophrenia (such as certain ethnic groups, and the more deprived) and changes in the circumstances of those living in or coming into Croydon which include risk factors for mental illness, such as homelessness and unemployment.

- ***It is recommended that Public Health Croydon review projections of future numbers of people with schizophrenia in the light of revised changes in size of risk factors for schizophrenia following publication of full census 2011 data and any relevant local data.***
- ***It is recommended that the CCG and the council raise awareness among providers and commissioners that the number of people with schizophrenia is growing and that commissioners and those planning services take account of this changing need in strategies, commissioning plans, contract negotiations and financial modelling.***

Service provision in Croydon

Quality of data on services in Croydon

- Difficulties were faced in obtaining data about services, particularly around outcomes and activity. Improving access to high quality, timely and relevant data about services is essential.
- ***It recommended that the mental health partnership develops a shared understanding of the information required by commissioners and strategists to evaluate services, monitor performance, understand and improve value for money and gain a better understanding of current and future need.***

Organisations providing services for Croydon

- A number of organisations provide services for people with schizophrenia in Croydon. South London and Maudsley Mental Health

NHS Foundation Trust (SLAM) is the main provider of a range of secondary care mental health community and in-patient services. NHS primary care is provided by GPs, pharmacists and primary care staff. Current core aspects of care for people with severe mental illness relate to physical health care, early detection and identification of mental health problems and referral to secondary care. Some GPs undertake antipsychotic prescribing with secondary care under shared care protocols. Croydon Council provides a range of services that deliver advice, support, care and services. Many of the services provided by SLAM are also jointly integrated and staffed by the council. The local voluntary and independent sectors provide a wide range of services to people with serious mental illness that include information, advice, advocacy, social inclusion, support, recovery and wellbeing activities, a consumer voice and carer support.

Engagement of service users

- The Mental Health Forum and Hear Us are two of the main organisations that provide a voice for service users in Croydon. One of the themes arising from the chapter consultation was the need to strengthen the engagement of service users and carers in service developments and to include measures of service user experience when monitoring service provision.
- ***It is recommended that MH commissioners ensure that there is full and meaningful involvement of service users and carers in service developments and reconfigurations.***

Support for people with schizophrenia

People with severe mental illness need to access services to meet the needs that we all have for accommodation, income, employment, meaningful activity, friends etc, as well as clinical provision. Service provision can be split into early intervention, treatment of an acute episode, and promoting recovery.

Early intervention in psychosis services

- NICE recommends that Early Intervention in Psychosis (EIP) services be offered to everyone experiencing a first episode of psychosis, regardless of age or the duration of untreated psychosis and there is evidence that this is cost effective. User satisfaction with Croydon's EIP service (COAST) is high and this service was identified as an asset in the stakeholder consultation. Current caseloads of COAST are 25% higher than recommended by the 2001 Policy Implementation Guide. In addition, people in Croydon stay in the service for two rather than the recommended three years.

- ***It is recommended that MH commissioners review the current effectiveness and cost effectiveness of the early intervention services and consider developing / extending an early detection service in Croydon.***

Treating the acute episode

- There is strong evidence of growing demand for acute and crisis service:
    - Croydon's Home Treatment Team caseload is approximately 25% higher than recommended by the 2001 Policy Implementation Guide.
    - pressure on in-patient provision in Croydon is growing
    - the use of overspill beds has risen, causing service users and carers to travel further.
    - bed occupancy is higher than recommended in SLAM, and often at 100%. Delays in admission resulting from higher rates of bed occupancy may cause a person's illness to worsen and be detrimental to long term health.
    - Croydon ranks significantly worse than the England average for in-year bed days for mental health.
    - The proportion of hospital admissions which were formal as opposed to informal) is higher in SLAM than nationally and has grown between 2006/7 and 2010/11.
    - A&E attendance rates for psychiatry have also grown.
- ***It is recommended that as a priority, MH commissioners, providers and community and service user representatives support efforts to manage demand for acute services through strengthening both acute services and provision in the community, particularly recovery services. This should take a whole systems, pathway approach and take account of evidence and best practice, engaging service users and carers.***

- Between 4pm and 9am GPs cannot refer to the home treatment team directly and their only option is to direct patients to A&E.
- ***Commissioners should explore the impact of current out –of-hours provision on use of secondary care services and crisis support.***
- The psychiatric liaison team, based in Croydon University Hospital, provides a 24 hour service, covering both A&E and in-patient wards, taking referrals for 16-65 year olds for whom a psychiatric assessment is required. Monthly commissioned activity targets are exceeded each month.

Promoting recovery, social inclusion and wellbeing

- A key theme arising from the chapter consultation was the need for greater emphasis on a recovery approach. Services such as befriending, volunteering, income generation and welfare benefits advice were especially highly valued. Employment, housing, meaningful activity, friends and looking after one's own health are some of the key components of recovery. Service users and their carers are experts in what helps to make a difference to their recovery and thereby prevent relapse. Croydon's assets in terms of recovery are outlined in the overview chapter of this JSNA.
- ***There is a need to raise awareness of the impact of recovery services on quality of life, wellbeing and demand for other services.***

Physical health and primary care support

- Primary care is fundamental to recovery. In local consultation for the chapter, GPs were seen as an asset, although one of the key issues identified was the need for greater recognition and better management of physical health problems
- In Croydon, there is wide variation in primary care quality. In some practices, between 19% and 29% of patients are not getting at least one of the components of the physical health review and 22% do not have a comprehensive, agreed care plan.
- ***It is recommended that as a priority, local area teams of NHS England and Croydon CCG reduce GP practice variation in physical health monitoring for people with severe mental illness through supporting poorer performing practices and learning from areas of good practice.***
- Stakeholders have flagged the need for better integration between primary and secondary care and between statutory and voluntary sector services. Work has recently commenced, initiated by Croydon GP Clinical Commissioning Group and SLAM, to implement and develop a primary care mental health service to support GP practices in the provision of mental health care to patients with stable, low risk severe mental illness.
- ***It is recommended that MH commissioners continue to support the development of the primary care service for people with stable serious mental illness. Furthermore, that the commissioners review the interface between primary and secondary services in the light of the outcome of this work.***
- In whatever setting the patient is managed, regular medication reviews are required, as are regular physical health checks. Smoking status

also needs to be considered carefully for patients taking these medications as the blood levels of the drug can be affected by smoking. Additional monitoring is required for people who alter their smoking habits as they may experience increased side effects or reduced clinical effect.

- ***It is recommended that MH commissioners strengthen stop smoking services for people with SMI and that MH commissioners train staff who are delivering this intervention, on understanding the importance of good communication with prescribers of changes in smoking status.***

Antipsychotic medication

- Antipsychotic medication is the most effective treatment for schizophrenia and psychosis but the medication often has unpleasant side effects. Research has shown that 10 days after starting a medicines, 30% of patients are already not taking their medicines as intended. In the chapter consultation, service users and carers reported the need for greater involvement in medication decisions
- ***It is recommended that clinicians engage closely with service users to agree what medication regime works best for them and to ensure that this is kept under regular review.***
- Prescribing of antipsychotics is generally initiated in secondary care. There is potential for stable patients taking these medicines to be fully integrated back into primary care if appropriate support measures such as shared care protocols for antipsychotic prescribing are in place. The CCG is working to discharge more patients into primary care.
- ***It is recommended that there is ongoing support for the development and implementation of antipsychotic shared care protocols both for oral antipsychotics and depot injections.***

Psychosis Recovery Teams

- Secondary care community mental health provision in Croydon is provided by the two (East and West) Psychosis CAG Recovery Teams. Caseload per WTE is almost 50% higher than recommended by the Policy Implementation Group.
- ***It is recommended that commissioners look at the community mental health recovery services in more detail in order to understand the strengths and gaps in this service.***

Psychological therapies

- Cognitive Behaviour Therapy, which is highly valued by practitioners, service users and their families in Croydon, is provided from a number of teams in Croydon. There is a lack of access to psychological

therapies for people not using secondary MH services. Whilst some services can be accessed through self referral (voluntary sector and IAPT), they are less likely to be able to offer appropriate support to people with schizophrenia or psychosis because their needs are usually relatively complex.

- User satisfaction with psychological therapy services is high, however, **current** waiting times are about three to six months and access to psychological therapies appears poor. There appears to be substantial unmet need for psychological therapy for people with psychosis in Croydon.
- ***It is recommended that the MH commissioners improve access to psychological and talking therapies for people with schizophrenia.***
- Family therapy has been shown to reduce the likelihood of relapse for people with schizophrenia and provides additional cost benefits.
- ***It is recommended that MH commissioners consider increasing the availability of family intervention therapies.***

Family and Carers

- Families and carers can play an important part in supporting someone with schizophrenia and are often a vital part of recovery. Healthcare professionals should ask people with schizophrenia whether they would like their family or carers to be involved in their care. Compared to other trusts, there is evidence that SLAM involve families less than the service users would like.
- ***It is recommended that MH commissioners' effective information sharing with carers and others is improved through training and other approaches so that practitioners feel more confident in balancing patient rights to confidentiality and risk management.***
- ***It is recommended that mental health commissioners support the development of more carer support groups in areas where service provision is low.***

Housing

- Suitable housing is a fundamental aspect of effective recovery. Lack of appropriate accommodation is associated with delaying discharge from hospital, increasing readmission rates, over-use of residential care and sometimes out of area or other high-cost services. There is a shortage of housing in Croydon and homelessness is a particular issue.
- ***It is recommended that commissioners ensure that the housing needs of people with schizophrenia and other severe mental illnesses are adequately addressed.***

Employment, benefits and debt advice

- Employment and meaningful activity are also central planks for peoples' recovery and most people with schizophrenia and other severe mental illnesses want to work. However, only between 5%-15% are in employment. Employment support in Croydon for people with severe mental illness is mainly provided by MIND Employment Support Service, Status Employment and Croydon Community Opportunities Services (CCOS).
- ***Review eligibility to employment support and ensure that effective models are implemented***.
- Many working age people with schizophrenia are unable to work some or all of the time and hence are dependent on benefits. MIND are contracted to provide welfare benefits advice but only to those service users who have complex welfare benefits claims and where the initial decision by the authorities is being challenged by the client. Service users with less complex claims are encouraged to use other provision such as Croydon Councils' welfare rights advice. There is some historical evidence of under-claiming of benefits in Croydon.
- Given the scope of the welfare reforms and the reduction in benefits it will cause, there is a need for more, not less, benefits and debt advice. Delay in clarifying benefits can delay hospital discharge, increase personal stress and vulnerability to relapse and may lead to homelessness.
- ***It is recommended that commissioners ensure provision of benefits and debt advice meets the current and future needs of people with schizophrenia and other serious mental illnesses***

Eligibility Criteria

- There is a need to raise awareness of the impact of good recovery services on the quality of life of people with schizophrenia, on their likelihood of relapse and their wellbeing. There was widespread concern about the eligibility criteria for some of the services and this is currently under review.
- ***It is recommended that the commissioners act on the findings of the review of eligibility criteria to some services.***

Stakeholder consultation

Views about service provision in Croydon were obtained from service users, carers, providers and members of the general public through a number of routes including forums, one to one meetings and an online survey. A number of key themes emerged and these included a need to: provide more support, integrate services better, increase information about services, increase user choice in medication, increase service user choice and involvement, modify attitude of some staff, develop a strategic vision, provide support for carers, .

- ***It is recommended that commissioners improve user involvement in choice around care and treatment decisions and ensure that the workforce is developed to meet users expressed needs for a more recovery focussed approach to care.***

4 Introduction and background

4.1 Aim

The 2012/13 JSNA is made up of **five separate chapters**, each of which are available on the Croydon Observatory website. An Overview chapter describes the big picture of health and well-being in Croydon and considers the impact of demographic change on population mental health in Croydon. The other chapters are:

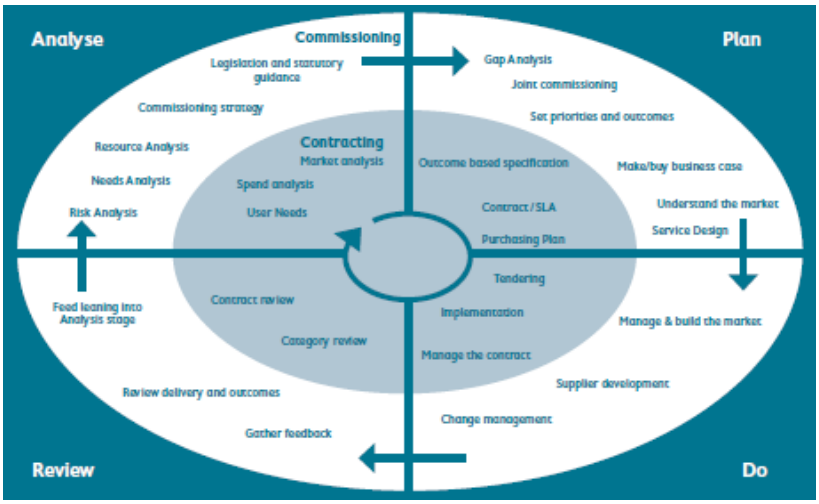
- Schizophrenia in adults
- Depression in adults
- Emotional health and well-being of children

These four chapters should also be viewed in conjunction with the updated **Key Dataset for Croydon** which describes Croydon's position relative to London and England for over 200 indicators relating to health and well-being.

The schizophrenia chapter aims to identify current and future health and well-being needs of people with schizophrenia and recommend areas for development in the light of existing services in Croydon. While the focus of this JSNA is on working age adults with schizophrenia (aged 16-65) many of the findings will be applicable to people of all ages who experience severe mental illness and psychosis.

The chapter is a **crucial tool for commissioners** and other decision makers in Croydon. The findings and recommendations can and should be used to improve outcomes through strengthening commissioning. Understanding needs and identifying gaps is the essential first step in developing effective commissioning and the JSNA can inform at least three of the four key elements of the commissioning cycle shown in **Figure 1**.

Figure 1: The commissioning cycle



Source: Croydon council (2012) Commissioning Strategy

4.2 Methodology

The development of the JSNA was overseen by an Implementation Group, consisting of mental health commissioners from the NHS and the Council, service providers and service users (see *Appendix 1*). The implementation group used a range of methods to answer key questions:

Key Questions	Method
What is schizophrenia? What causes it? Why is schizophrenia important?	Literature review. See *Appendix 2*
Where should our efforts be focused? What are the policy drivers? What works?	Literature review. see *Appendix 3* and *Appendix 4*
In Croydon, how many people have schizophrenia? How many will have it in the future?	Analysis of population (epidemiological) data combined with estimates of prevalence.
What services do we provide? How do they compare to other areas? What are the gaps?	Data on service provision, activity and outcome from routine data sources, providers and commissioners. This section is structured around a framework based on NICE guidance.[1]

[1] *Collaborating Centre for Mental Health. NICE clinical guideline 82.* Schizophrenia: core interventions in the treatment and management of schizophrenia in adults in primary and secondary care. *March 2009. National Institute for Health and Care Excellence.*

What do people think of the services we provide? What are we doing well? What could we do better?	Consultation with stakeholders including: • An online survey, • Consultation event, • Mental Health Forum events • One to one meetings. The findings from the consultation are given in full in *Appendix 5*

There was limited consultation on the final document because of the pressures of transition, change in staffing and revised timescales.

5 Background

5.1 What is schizophrenia?

Schizophrenia is a major psychiatric disorder, or cluster of disorders, characterised by psychotic symptoms that alter a person's perception, thoughts, affect, and behaviour. It is a condition which affects thinking, feeling and behaviour and causes people to have abnormal experiences. It is most likely to start between the ages of 15 to 35 and will affect about 1 in every 100 people during their lifetime.

Psychosis is a symptom, while schizophrenia is an illness (or group of illnesses). Psychosis may be a symptom of schizophrenia or another illness, such as bipolar disorder or Parkinson's disease, or result from misuse of drugs or alcohol or other conditions. Where an episode of psychosis may signal the start of schizophrenia, the general term "psychosis" is preferable, at least in the early stages, because of the stigma generated by a diagnosis of schizophrenia and the possibility of other causes and diagnoses. [2]

It is thought that schizophrenia and related psychoses result not from one single cause but from a range of interacting biological, psychological and social factors. Heavy use of amphetamines and cannabis has also been shown to increase risk

Schizophrenia is associated with a higher risk of other mental health problems, poorer physical health, less healthy lifestyles and lower life expectancy. People with schizophrenia die on average 15-20 years earlier than other people.

Schizophrenia can also have a major impact on people's personal, social and occupational lives due not only to recurrent episodes/symptoms but also to

[2] The Schizophrenia Commission. *The Abandoned Illness.* Rethink Mental Illness, November 2012

the side effects of treatment, social problems, isolation, poverty, and homelessness and the associated prejudice, stigma and social exclusion.

The total annual societal cost of schizophrenia in England was estimated at £11.8 billion per year (2010/11 prices).[3] These issues will be explored throughout this chapter. For in-depth detail and information about the condition, causes and impact see *Appendix 2*.

5.2 National policy context, key policy agenda and guidelines

National policies

A number of key policy documents have been published in recent years which influence how care for people with schizophrenia is provided:

- **1999** National service framework for mental health.[4]
- **2008** Foresight report Mental Capital and Wellbeing: Making the most of ourselves in the 21st century[5]
- **2009** New Horizons: A shared vision for mental health[6]
- **2011** The coalition Government published their strategy No health without mental health.[7]The two themes which underpin this strategy are: **population wellbeing** and **high quality, safe treatment**. It aims to mainstream mental health in England giving it parity with physical health. It takes a life course approach, and has six key objectives:

    1. More people will have good mental health
    2. More people with mental health problems will recover
    3. More people with mental health problems will have good physical health

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[3]Knapp 1997 cited in National Collaborating Centre for Mental Health. NICE clinical guideline 82. *Schizophrenia: core interventions in the treatment and management of schizophrenia in adults in primary and secondary care.*Updated edition 2009.National Institute for Health and Care Excellence.

[4]Department of Health.*National service framework for mental health - modern standards and service models.* 1999. Crown copyright http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4006057

[5]Foresight Mental Capital and Wellbeing Project.*Making the most of ourselves in the 21st century Final Project report - Executive summary*.Government Office for Science.

[6]Department of Health.*New Horizons: a shared vision for mental health.* 2009. Crown copyright http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_109705

[7]HM Government/Department of Health.*No health without mental health: a cross-government mental health outcomes strategy for people of all ages*. February 2011. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_123766

4. More people will have a positive experience of care and support
5. Fewer people will suffer avoidable harm
6. Fewer people will experience stigma and discrimination

The recently published *No Health without Mental Health: Implementation Framework* considers how this strategic vision can be translated into reality.[8]

Key policy agendas

Promoting recovery

Over the years, policy thinking on schizophrenia has broadened its focus from the more clinical aspects of care and treatment to the promotion of well-being, the prevention of mental illness, and recovery focused care. The guiding principle of recovery is hope – the belief that it is possible for someone to lead a meaningful life, despite serious mental illness.

Preventing relapse

Relapse, whereby people experience a crisis that may lead to in-patient admission has a negative effect on the individual's health and well-being and is costly. Hence approaches that reduce hospitalisation and relapse, and potentially enable people with schizophrenia to return to active employment, could significantly reduce the societal burden of schizophrenia.

Focusing on outcomes

Many of the outcome measures and indicators in the government's outcomes framework for social care, public health and the NHS have a direct bearing on people with schizophrenia:[9] [10] [11]

Guidelines

The National Institute for Health and Care Excellence (NICE) produces best practice guidance on a range of health, and in the near future social care, issues. The NICE schizophrenia guideline[12] (2009) covers the treatment and management of schizophrenia and related disorders in adults. It sets out best

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[8] Centre for Mental Health, Department of Health, Mind, NHS Confederation Mental Health Network, Rethink Mental Illness, Turning Point. No health without mental health: Implementation framework. July 2012.

[9] Department of Health. *The NHS Outcomes framework 2012/13*. December 2011.

[10] Department of Health. The *Adult Social Care Outcomes Framework 2013/14*. November 2012.

[11] Bennett A, Appleton S and Jackson C. *A framework for Local Authority and NHS commissioners of mental health and wellbeing services. Volume 1: Setting the scene*. Joint Commissioning Panel for Mental Health, 2011.

[12] National Collaborating Centre for Mental Health. NICE clinical guideline 82. *Schizophrenia: core interventions in the treatment and management of schizophrenia in adults in primary and secondary care.* March 2009. National Institute for Health and Care Excellence.

practice in terms of delivery of care across all phases; initiating treatment (first episode); treating the acute episode; and promoting recovery. This guideline is currently being updated . The publication date has yet to be confirmed.[13]

For more detailed information about the policy context and national guidance see *Appendix 3*

6 Schizophrenia in England and Croydon

This section looks at the impact of schizophrenia on mortality. It goes on to consider how common schizophrenia is (prevalence), how many people develop it each year (incidence), and how many people may have it in the future (projected prevalence) both in Croydon and England. It looks at variation in prevalence of schizophrenia by age, sex, ethnicity, deprivation and by wards in Croydon. Where possible, levels of need in Croydon are compared to other areas, such as those that are demographically similar to Croydon, national levels of need or need based on the literature. The section ends with a description of the increased risks of other health conditions that people with schizophrenia experience.

6.1 Excess mortality

People with schizophrenia on average **die 15-20 years earlier** than other people.[14] The reasons for this are complex, resulting from lifestyle factors, poorer access to healthcare, [15] side effects of medication and higher rates of suicide, accidental and violent death.[16]

Figure 2 shows that out of the 33 London boroughs, Croydon has the fifth highest **excess mortality rate** in adults under 75 years of age with serious mental illness. However, numbers are small, confidence intervals are wide and Croydon's rate is not statistically significantly different to the England average.

[13] Centre for Clinical Practice. *Scope: Psychosis and schizophrenia in adults: treatment and management*. National Institute for Health and Care Excellence.

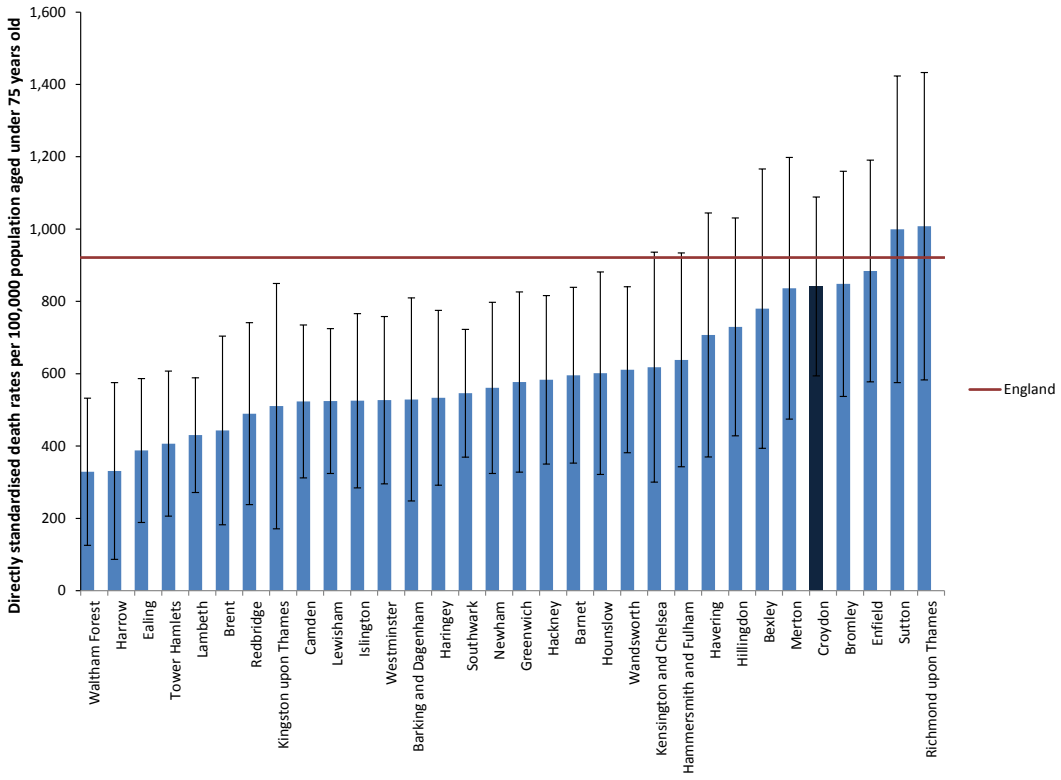
[14] Chang C-K, Hayes RD, Perera G, Broadbent MTM, Fernandes AC, et al. (2011) Life Expectancy at Birth for People with Serious Mental Illness and Other Major Disorders from a Secondary Mental Health Care Case Register in London. PLoS ONE 6(5): e19590. doi:10.1371/journal.pone.0019590

[15] Lawrence D and Kisely S. Inequalities in healthcare provision for people with severe mental illness.J Psychopharmacol. 2010 November; 24(4_supplement): 61–68.

[16] Thornicroft G (2011) Physical health disparities and mental illness: the scandal of premature mortality. British Journal of Psychiatry, 199: 441-442.

In 2010/11 the excess mortality rate for people under 75 years of age with serious mental illness in Croydon was 841/100,000.[17] An extremely rough estimate of the number of deaths per year can be obtained by applying this rate to the number of people with schizophrenia (1735) giving an estimated 15 deaths per year. We do not have cause of death for this group of individuals.

Figure 2: Excess mortality rate in adults under 75 years of age, with serious mental health condition, London Local Authorities, (with 99% confidence intervals) 2010/11



Source: NHS outcomes Framework Indicators. The NHS Information Centre, July 2012.

Croydon's death rate from suicide is lower than rates in London and England: between 2009 to 2011, the suicide rate in Croydon was 4.9 per 100,000, which was lower than both London (6.9 per 100,000) and England (7.9 per 100,000) The three year trend is improving. Between 2007 and 2011 there were 75 deaths from suicide in Croydon of which three quarters (78%) were men. Almost all (69/75) were in people aged under 75 years. [18] Over the same time period, and in all age groups, there were a further 14 deaths from undetermined injury.[19]

[17] Croydon Key Dataset 2012/13 indicator number 191
[18] Suicide local Croydon data (ICD10 codes X60 to X84)
[19] Undetermined injury local Croydon data ICD10 codes Y10 to Y34

Croydon's death rate from accidental deaths is similar to rates for London and England: between 2008 and 2010, 78 people aged less than 75 years died from accidents in Croydon (82% were men).[20]

Because we do not know how many of the people dying from these causes had a serious mental illness, we cannot estimate the contribution that these causes of death make to excess mortality.

6.2 Prevalence (total number of cases)

Just over one percent of the Croydon population is registered as having a serious mental illness (SMI). Croydon's rate is similar to the London rate (1%) and higher than the England rate of 0.82% (**Figure 3**)

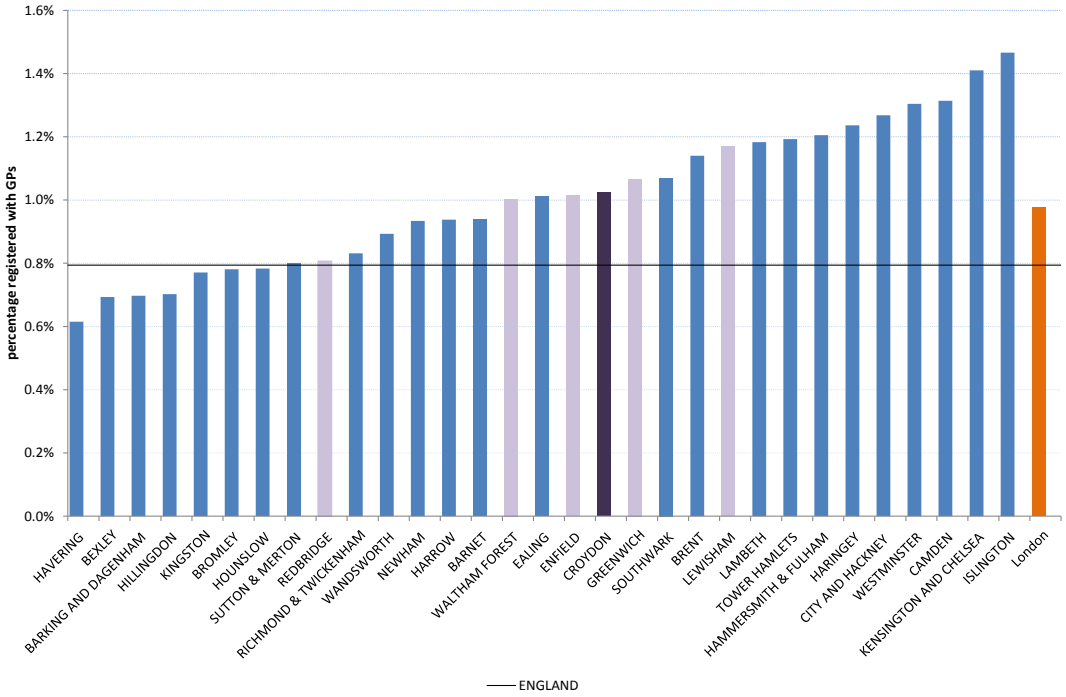
At the end of March 2012, 3,922 people registered with Croydon GPs were recorded as 'ever having' a serious mental illness: 1,735 (44%) of these with schizophrenia, 1,331 (34%) 'other psychosis' and 856 (22%) bipolar disorder.[21] People with a diagnosis of schizophrenia were identified using the Read codes listed in *Appendix 6*. Croydon has an adult schizophrenia prevalence rate of 0.6% (1735/291,700). This is in the mid range of estimates of national lifetime prevalence (0.4% to 1.4%).[22]

[20] https://indicators.ic.nhs.uk/webview

[21] Nicholson R and Osborne D. *Appendix 1: Prevalence of Mental health conditions in Croydon*. Croydon Joint Strategic Needs Assessment 2012/13. An overview of mental health and wellbeing in Croydon.

[22] Kirkbridge JB, Errazuriz A, Croudace TJ, Morgan C, Jackson D, McCrone P, Murray RM & Jones PB. *Systematic review of the incidence and prevalence of schizophrenia and other psychoses in England*. Conducted for the Department of Health Policy Reseach Programme, February 2011.University of Cambridge.

Figure 3: GP recorded Serious Mental Illness prevalence in London 2011/12: Croydon and its demographic neighbours are highlighted. Black horizontal line represents England average



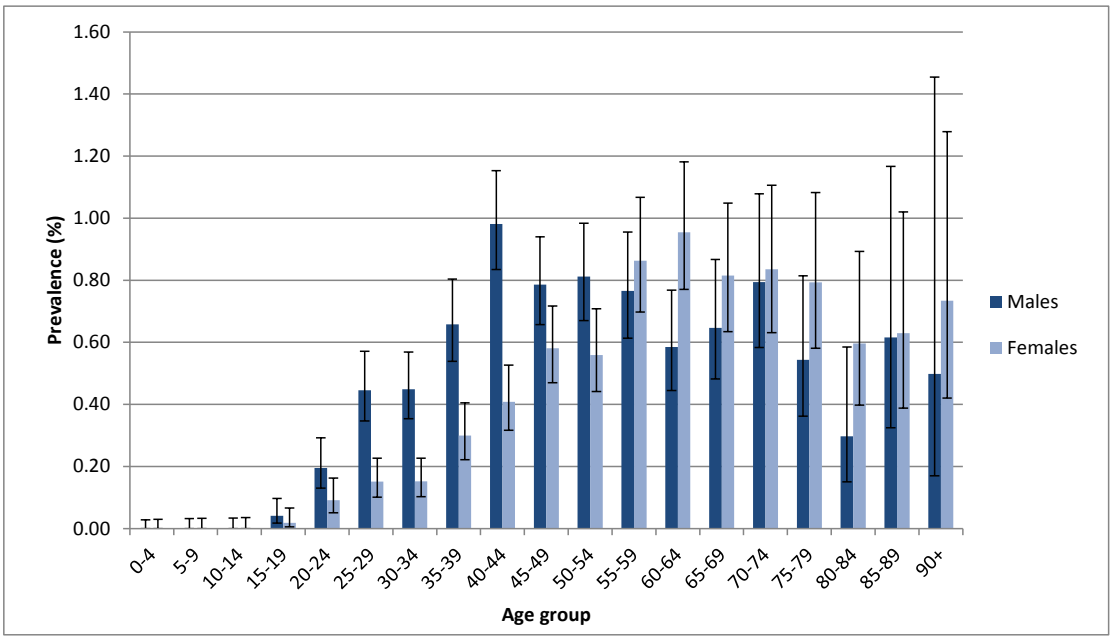
Source: QOF - http://www.ic.nhs.uk/statistics-and-data-collections/audits-and-performance/the-quality-and-outcomes-framework

6.3 Prevalence by age and gender

In Croydon the prevalence of schizophrenia is statistically significantly higher in men than in women in all 5 year age bands between 25 and 45. From age 60, the prevalence amongst women is greater than in men although confidence intervals are wide and the difference is not statistically significant within 5 year age bands. Overall the prevalence rate for men in Croydon is 0.47 per 100 and for women 0.36 per 100. This pattern agrees with the literature that finds higher rates in younger men and an older age of onset among women.[23] (**Figure 4**).

[23] Kirkbridge JB, Errazuriz A, Croudace TJ, Morgan C, Jackson D, McCrone P, Murray RM & Jones PB. *Systematic review of the incidence and prevalence of schizophrenia and other psychoses in England*. Conducted for the Department of Health Policy Reseach Programme, February 2011.University of Cambridge.

Figure 4: Prevalence of schizophrenia by age group and gender, Croydon, March 2012



Source: Data from Croydon General Practices, March 2012

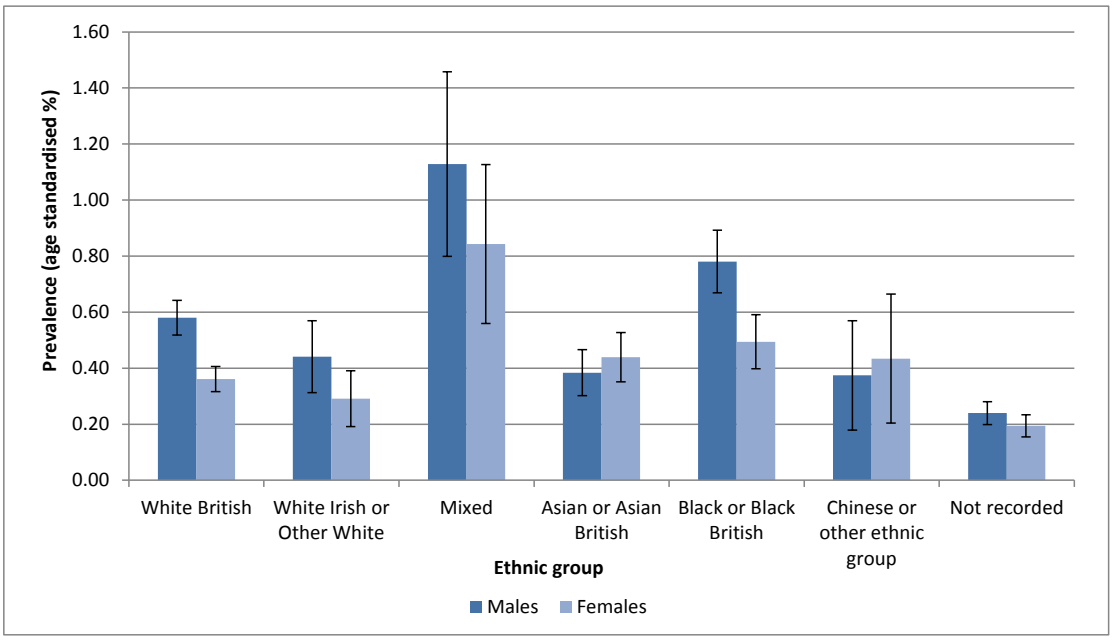
6.4 Prevalence by ethnicity

Nationally, ethnic minority groups are at increased risk for all psychotic illnesses. **African-Caribbeans** and **Black Africans** have a particularly high risk for schizophrenia and bipolar disorder. The reasons for this are not well understood, although socioeconomic factors are partly responsible with risk being higher amongst those who live in an urban environment, experience poverty, adversity and discrimination.[24]

Figure 5 shows that the pattern of schizophrenia prevalence in ethnic minorities in Croydon is lower than that seen nationally and in research studies. The highest prevalence rates for schizophrenia in Croydon are found in mixed ethnic groups – with rates twice as high as for white British groups. Rates in black/black British groups are only a third higher than in white groups (35/37% higher in males/females respectively), and this difference is not statistically significant in females.

[24]Paul Fearon, James B. Kirkbride, Craig Morgan1, Paola Dazzan, Kevin Morgan, Tuhina Lloyd3, Gerard Hutchinson, Jane Tarrant, Wai Lun Alan Fung, John Holloway, Rosemarie Mallett, Glynn Harrison, Julian Leff, Peter B. Jones and Robin M. Murray, on behalf of the AESOP Study Group. Incidence of schizophrenia and other psychoses in ethnic minority groups: results from the MRC AESOP Study.*Psychological Medicine*, 36 (11). pp. 1541-1550, November 2006.

Figure 5: Prevalence of schizophrenia by ethnic group, Croydon, March 2012



Source: Data from Croydon General Practice, March 2012

This finding is surprising. There have been close to twenty studies comparing rates of schizophrenia and other psychoses in African-Caribbeans and Whites (variously defined) in the UK. They have reported incidence rates for the African-Caribbeans to be between 2 and 18 times higher than Whites. The AESOP study – conducted in South East London and two other UK areas - found rates between 6 and 9 times higher.[25] Under recording of ethnicity is unlikely to explain this. Even if we were to assume that everyone with ethnicity missing in their GP record is White British, the rates in Black or Black British groups would still only be 1.9 (for men) and 1.7 (for women) times higher than White British.

It may be that there are lower than average rates of schizophrenia among Croydon's Black and Black British population. However this is not supported by the high rates of people from Black and Black British backgrounds in the early psychosis services (**see 7.2.2**).

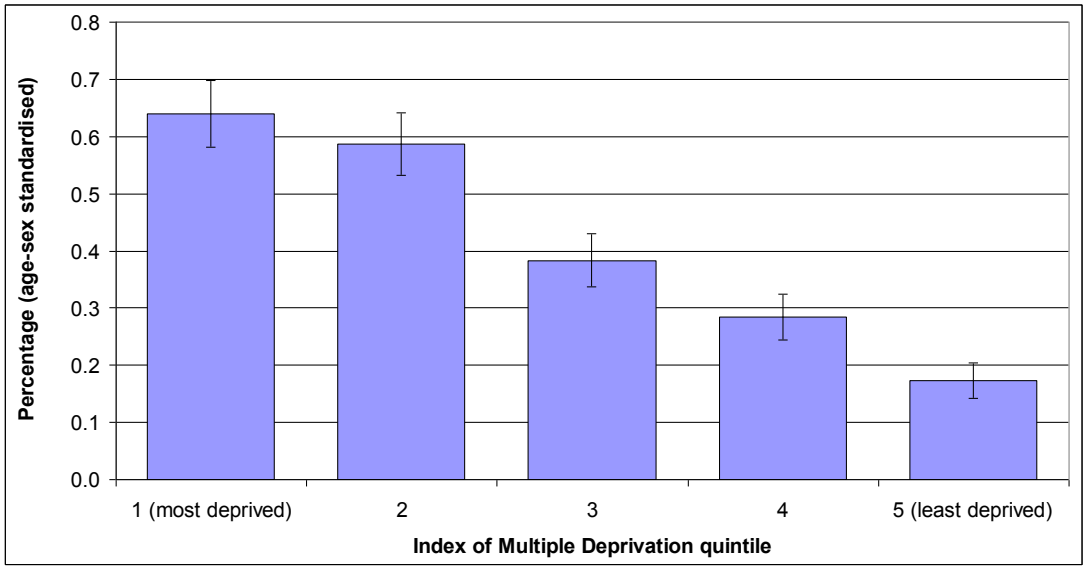
Recommendation:
SR-1 It is recommended that the CCG asks public health to investigate the reasons behind the unexpected pattern of GP recorded schizophrenia prevalence by ethnicity.

[25] Morgan C, Dazzan P, Morgan K, Jones P, Harrison G, Leff J, Murray K, Fearon P; AESOP study group. First episode psychosis and ethnicity: initial findings from the AESOP study. World Psychiatry 2006 ; 5: 40– 6.

6.5 Prevalence by level of deprivation

As identified in the literature, the prevalence of schizophrenia increases with increasing levels of deprivation (**Figure 6**). In Croydon, those living in the **most deprived** quintile are nearly **four times more likely** to have a diagnosis of schizophrenia than those living in the least deprived. The relative difference in rates for the least and most deprived quintile is greater for schizophrenia than for common mental health disorders such as depression.[26]

Figure 6: GP recorded schizophrenia prevalence (age sex standardised) in Croydon by deprivation quintile, March 2012



Source: Croydon GP practice data

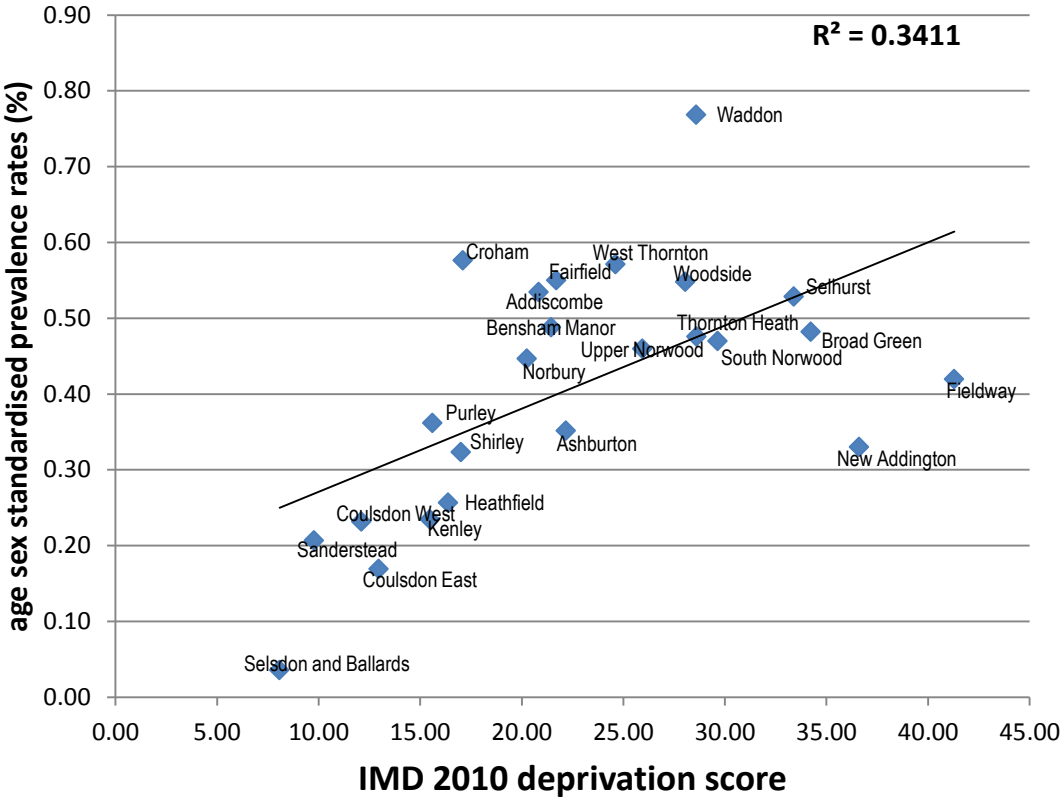
6.6 Prevalence of GP recorded schizophrenia by electoral ward

Figure 7 is an indication of the relationship between burden of schizophrenia and deprivation across Croydon. It suggests that only **a third of the variation in schizophrenia in wards across Croydon can be explained by its association with deprivation.** [27] The remaining variation is likely to be explained by other factors including the ethnic mix of the ward and some natural variation. For example New Addington and Fieldway are areas of high deprivation but relatively low prevalence of schizophrenia. This may be explained by the ethnicity of the two wards. Overall, 55% of Croydon's population is white; New Addington and Fieldway have higher larger proprotions of white people (76% and 66% respectively).

[26] Overview chapter

[27] R^2, the correlation coefficient was 0.34

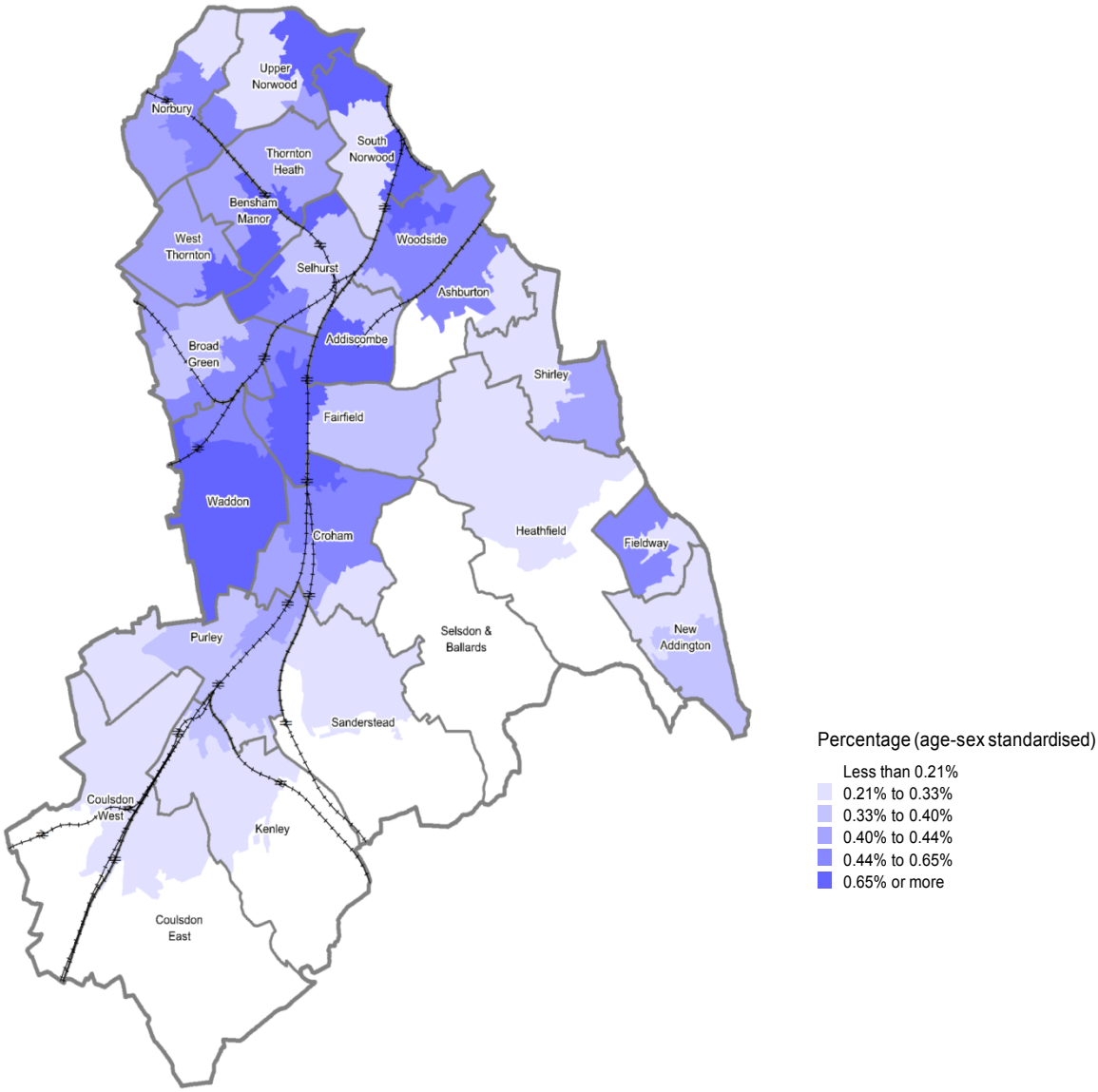
Figure 7: Association between prevalence of GP recorded schizophrenia and deprivation by ward, Croydon March 2012



Source: Croydon GP practice data 2012

Figure 8 shows the geographical distribution of GP recorded schizophrenia prevalence. Higher rates are seen in the north of the borough where there are some areas of higher deprivation and a greater proportion of the population from BME backgrounds.

Figure 8: GP recorded schizophrenia prevalence (age and sex standardised) map of Croydon middle super output areas, March 2012



Source: Croydon GP practice data, March 2012

6.7 Projected future prevalence

Nationally, the incidence of schizophrenia and psychotic disorders has been relatively stable over the last 60 years. Any increases that were found could be explained by changes in the ethnic make-up of the relevant community. [28] There is some variation however at regional and local level. A south London study of incidence data in Camberwell found a doubling in the incidence of schizophrenia over three decades between 1965 and 1997.[29]

In Croydon, the number of people on the GP register for serious mental illness with schizophrenia has been increasing each year since 2007 typically by about 40 additional cases a year. Based on these trends, local estimates find there is projected to be a 24% increase in the number of people diagnosed with schizophrenia in Croydon over the next 10 years, equivalent to 2.4% per year. The number of people is likely to rise by 400 cases from 1,735 in 2012 to 2,152 by 2021 (**Table 1**).

Table 1: Estimated numbers of adults diagnosed with schizophrenia projected to 2021

	Diagnosed with SMI	Diagnosed Schizophrenia
2007	3431*	1519
2008	3529*	1562
2009	3619*	1602
2010	3688*	1633
2011	3798*	1681
2012	3922*	1735
2013	3985	1764
2014	4094	1812
2015	4203	1861
2016	4314	1910
2017	4418	1957
2018	4523	2004
2019	4630	2053
2020	4738	2102
2021	4847	2152

Source: 2012/13 overview chapter
*figures from QOF register

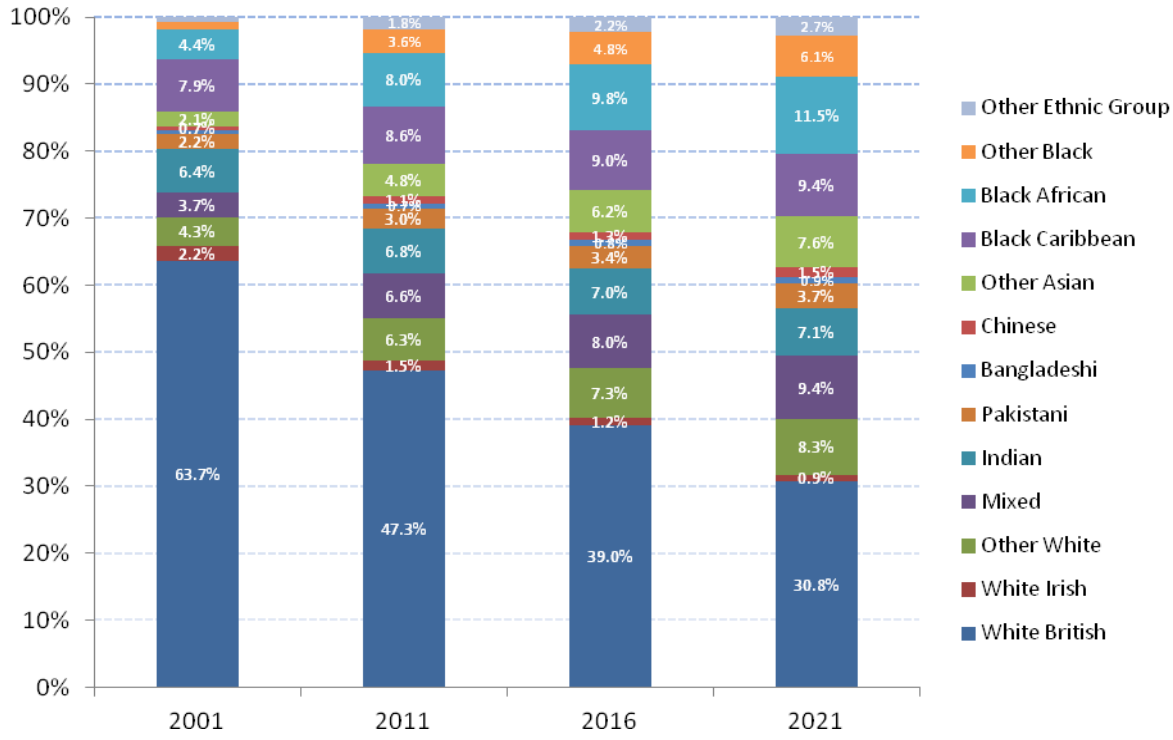
[28] Kirkbridge JB, Errazuriz A, Croudace TJ, Morgan C, Jackson D, McCrone P, Murray RM & Jones PB. *Systematic review of the incidence and prevalence of schizophrenia and other psychoses in England*. Conducted for the Department of Health Policy Reseach Programme, February 2011.University of Cambridge.

[29] Boydell (2003) Incidence of schizophrenia in south east London between 1965 and 1997, The British Journal of Psychiatry (2003) 182: 45-49

However, this is likely to be an underestimate because the size of the some of the groups at higher risk of schizophrenia is set to grow in Croydon:[30]

BME populations. The proportion of the population from BME groups has been shown to have an important bearing on the incidence of psychosis in a locality.[31] Between 2011 and 2021, there is expected to be an increase from 16.8% to 20.9% in the proportion of the population from Black African and black Caribbean populations. Overall there is expected to be a 35% increase in Croydon's Black population[32] from 22% in 2011 to 30% in 2021 Detailed predictions are given in **Figure 9**.

Figure 9: Projected ethnicity* distribution for Croydon' s population based on trends in the the last two census'[33]



Source: Data from 2001 and 2011 Census

Homelessness.
Between 2009/10 and 2012/13, there was a steady increase in the number of

[30] Overview chapter
[31] Kirkbridge JB, Errazuriz A, Croudace TJ, Morgan C, Jackson D, McCrone P, Murray RM & Jones PB. *Systematic review of the incidence and prevalence of schizophrenia and other psychoses in England*. Conducted for the Department of Health Policy Reseach Programme, February 2011.University of Cambridge.
[32] Black Caribbean, Black African, Other Black and Other Ethnic Group (mixed Black groups)
[33] Records with White and black African, White and Black Caribbean, and White and Black Asian are included in the Other ethnic groups

homelessness acceptances from 425 to 1010.[34] Homelessness is expected to be an ongoing challenge for Croydon

Unemployment. In November 2011, 13.2% of working age people in Croydon were on out-of-work benefits compared with 12.6% for London and 12.2% for England.[35] Over the last 10 years, the proportion of people on out-of-work benefits has been rising at a greater rate within Croydon than in London and England, particularly since the economic recession began in 2008. A study of South London residents found that rates of psychosis are high amongst unemployed people and extremely high amongst Black Caribbean and Black African unemployed people. [36]

Deprivation. Croydon is currently the 19th most deprived borough in London out of 33. Between 2004 and 2010, levels of deprivation in Croydon increased more than in any other borough in the south of London. If Croydon continues to grow more deprived at the same rate as recent years, by 2020 it will be the 12th most deprived borough in London.[37]

Recommendation:
SR-2 It is recommended that Public Health Croydon review projections of future numbers of people with schizophrenia in the light of revised changes in size of risk factors for schizophrenia following publication of full census 2011 data and any relevant local data.

Recommendation
SR-3 It is recommended that the CCG and the council raise awareness among providers and commissioners that the number of people with schizophrenia is growing and that commissioners and those planning services take account of this changing need in strategies, commissioning plans, contract negotiations and financial modelling.

6.8 New cases (incidence) in England

This section looks at new cases of schizophrenia in England. National estimates found that every year, there were an estimated 32 new cases of psychotic disorder per 100,000 people, and of these approximately half were for schizophrenia.

Incidence rates were found to be higher in men before the age of 45 years, but more equal thereafter. Rates of psychosis were higher in black and

[34] Overview Chapter 2012/13
[35] NOMIS, DWP benefit claimants - working age client group, November 2011
[36] Boydell etc al (2012) Unemployment, ethnicity and psychosis. Acta Psychiatr Scand.
[37] Projections are based on a continuation of the trend by lower super output area between 2001 and 2008, using the Index of Multiple Deprivation 2004, 2007 and 2010.

minority ethnic (BME) groups than in the general population for both men and women. Annual incidence of schizophrenia is 5.6 times higher for black Caribbean groups, 4.7 times higher for black African groups, 2.4 times higher for South Asian groups.[38] The national review found that raised rates were strongest, and most consistent, amongst migrants and their descendants of black Caribbean and black African origin. Higher rates were found in more disadvantaged communities and neighbourhoods.

Studies have estimated the lifetime prevalence of schizophrenia to be 0.4 – 1.4 per 100.[39]

6.9 New cases (incidence) in Croydon

In Croydon, 134 people (131 adults and 3 children) received a new diagnosis of schizophrenia in 2011/12 (the last period for which data was available at the time of writing) giving an incidence rate of 36 per 100,000 patients per year (or 47 per 100,000 adults). This means that for every 100,000 people registered with Croydon GPs, there were 36 new cases of schizophrenia (or 47 in every 100,000 adults).[40] **The GP recorded incidence rate of schizophrenia in Croydon (36/100,000) is more than double that identified in the literature (15/100,000).**[41] Croydon's raised incidence rate is to some extent artificial. GPs record a new diagnosis code of schizophrenia not only when a person develops schizophrenia but also when a person, who already has a diagnosis of schizophrenia, joins the GP practice.

There is likely, however, to be a true underlying difference that is difficult to quantify. It is known that the incidence of schizophrenia varies across different parts of the country. Some of this variation is explained by differences in ethnic demography of the population and population density and Croydon has a large and growing BME population (**Figure 9**).

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[38] Kirkbridge JB, Errazuriz A, Croudace TJ, Morgan C, Jackson D, McCrone P, Murray RM & Jones PB. *Systematic review of the incidence and prevalence of schizophrenia and other psychoses in England*. Conducted for the Department of Health Policy Reseach Programme, February 2011.University of Cambridge

[39] National Collaborating Centre for Mental Health. NICE clinical guideline 82. *Schizophrenia: core interventions in the treatment and management of schizophrenia in adults in primary and secondary care.*Updated edition 2009.National Institute for Health and Care Excellence.

[40] Croydon general practices, March 2012

[41] Kirkbridge JB, Errazuriz A, Croudace TJ, Morgan C, Jackson D, McCrone P, Murray RM & Jones PB. *Systematic review of the incidence and prevalence of schizophrenia and other psychoses in England*. Conducted for the Department of Health Policy Reseach Programme, February 2011.University of Cambridge.

Incidence of first episode psychosis

PsyMaptic is a recently published tool that forecasts the expected incidence of first episode psychoses in different regions of England and Wales per year.[42,43]

Table 2 shows that in Croydon, approximately two thirds (65%) of the predicted cases of psychosis in people aged 16 to 64 fall within the age band 16 to 35. This proportion is similar to that for England.

PsyMaptic predicts that the overall incidence of new cases of psychosis is 44% higher in Croydon than in England and it predicts 81 new cases in Croydon per year. It does not look at how this might change in the future. The rates in Croydon are similar to the levels found in Croydon's demographic neighbours.

Table 2: Table of predicted annual cases and incidence of psychosis in Croydon and other areas that are similar demographically to Croydon

	New cases (aged 16 to 35) – 2009	New cases (aged 16 to 64) – 2009	Incidence per 100,000 population (aged 16 to 35) – 2009	Incidence per 100,000 population (aged 16 to 64) – 2009
Croydon	53	81	57.1	35.8
Greenwich	38	54	52.8	35.4
Enfield	43	65	53.8	34.2
Lewisham	60	89	69.1	47.4
Waltham Forest	45	65	64.7	42.9
Redbridge	45	65	56.6	36.9
Merton	36	52	53.5	36.0
England(National)	5826	8565	41.2	24.8

Source: psymaptic tool http://www.psymaptic.org/prediction/psychosis-incidence-data/

6.10 Financial impact

In England, schizophrenia is estimated to cost society £11.8 billion per year and the public sector £7.2 billion.[44] This amounts to an average annual cost to society of £60,000, and to the public sector £36,000, per person with

[42] http://www.psymaptic.org

[43] Kirkbridge JB, Jackson DJ, Perez J, Fowler D, Winton F, Coid JW, Murray RM, Jones PB (2013) *A population-level prediction tool for the incidence of first-episode psychosis: translational epidemiology based on cross-sectional data* BMJ Open;3:e001998 doi:10.1136/bmjopen-2012-001998

[44] Andrew A, Knapp M, McCrone PR, Parsonage M, Trachtenberg M (2012) Effective interventions in schizophrenia: the economic case. Personal Social Services Research Unit, London School of Economics and Political Science, London, UK

schizophrenia. About a third of the societal costs relate to direct expenditure on health, social care and institutional costs; more than half result from lost productivity through unemployment and premature death; the remaining proportion relate to informal care costs incurred by families and carers. There are further costs of approx £16,000 per person with schizophrenia that fall within the public sector that include social security payments and forgone tax.[45] Inpatient care for people with schizophrenia accounts for roughly 38% of the total health, social care and institutional costs.[46]People with schizophrenia use over 60% of the inpatient provision.[47]

For Croydon, assuming a total of 1,735 people with schizophrenia, the **cost to society is £104 million per year in Croydon** and £**62 million per year to the public sector in Croydon**. The costs will grow as numbers of people with schizophrenia increase.

6.11 Social Impact

The first few years after the onset of schizophrenia can be particularly upsetting and chaotic, and there is a higher risk of suicide. Once an acute episode is over, there are often additional problems with social functioning resulting in social exclusion, difficulties in getting back to work or study and problems making new relationships. Such interruption in personal and social development can have lifelong effects and results in much of the disability experienced by people with chronic mental illness. The symptoms and behaviour associated with schizophrenia can also have a distressing impact on family and friends. The World Health Organisation has calculated that at a family level the burden and human suffering caused by psychosis was only exceeded by quadriplegia and dementia.[48] In addition, the diagnosis of schizophrenia is still associated with considerable stigma, fear and limited public understanding.

Figure 10 shows that compared to England, Croydon has a significantly smaller proportion of adults with mental illness who are in paid employment and a significantly greater proportion of adults with mental illness who live independently with or without support. These issues are discussed in more detail in sections 7.4.6 and 7.4.7.

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[45]National Institute for Health and Care Excellence*. Psychosis and schizophrenia in adults: treatment and management. Scope final version.* 2012. NICE.

[46] Andrew A, Knapp M, McCrone PR, Parsonage M, Trachtenberg M (2012) Effective interventions in schizophrenia: the economic case. Personal Social Services Research Unit, London School of Economics and Political Science, London, UK

[47]Knapp 1997 cited in National Collaborating Centre for Mental Health. NICE clinical guideline 82. *Schizophrenia: core interventions in the treatment and management of schizophrenia in adults in primary and secondary care.*Updated edition 2009.National Institute for Health and Care Excellence.

[48]IRIS initiative.*IRIS Guidelines Update*, September 2012

Figure 10: indicators of social care outcomes

Indicator	Croydon	London	England	England Range	1 Year Trend	3 Year Trend	Time Period
95 Adults with mental illness in paid employment (%)	4.9%	5.9%	8.0%		◄	no data	2011/2012
96 Adults with mental illness living independently, with or without support (%)	71.4%	73.8%	57.8%		►	no data	2011/2012
26 Clients and carers who find it easy to find information about services (% easy of survey	70.9%	72.0%	73.8%		no data	no data	2011/2012

Source: Croydon key dataset 2012/13

6.12 Health impact

Schizophrenia is associated with a higher risk of other mental health problems, poorer physical health, poorer lifestyles (smoking and substance misuse) and lower life expectancy.

This section is subdivided into:

- Associations with other mental health problems
- Associations with physical health problems, smoking and obesity

6.12.1 Other mental health problems

People with schizophrenia are more likely to have depression, anxiety, post-traumatic stress disorder, personality disorder, and substance misuse.[49] **Table 3** shows that in Croydon people with schizophrenia have very much higher rates of other mental health problems and self-harming behaviours than people without schizophrenia. Compared to the general Croydon population, people with schizophrenia are **19 times more likely to have attempted or be at risk of attempting suicide or self-harm.** They are 14 times more likely to have a personality disorder, 8 times more likely to have an addictive behaviour.

Table 3: Increased risk of comorbid mental health conditions in people with and without schizophrenia. Croydon, March 2012

	With schizophrenia (1,553 people)	Without schizophrenia (374,154 people)	Increased risk (95% Confidence Intervals)	What does the evidence say?
Condition	**Number with Condition**			
Self-harm or suicide	69	894	19 (15 to 24)*	A systematic update from 2012 shows that suicide is the major cause of premature

[49]National Collaborating Centre for Mental Health. NICE clinical guideline 82. *Schizophrenia: core interventions in the treatment and management of schizophrenia in adults in primary and secondary care.*Updated edition 2009.National Institute for Health and Care Excellence.

				death among patients with schizophrenia[50].
Learning disability	95	1,512	15 (12 to 19)*	A population-based cohort study of Swedish army recruits confirmed the importance of low intellectual ability as a risk factor for schizophrenia and other psychoses[51]
Personality disorder	22	370	14 (9.3 to 22)*	Schizoid personality accentuation (PA) is considered part of the schizophrenia spectrum and a risk factor of psychosis[i52]
Other neurotic disorder	68	1,298	13 (10 to 16)*	No new evidence
Organic mental disorder	53	1,558	8.2 (6.3 to 11)*	No new evidence
Addictive behaviour	61	1852	7.9 (6.2 to 10)*	Substance abuse comorbidity is very common in schizophrenia but the evidence is unclear on the aetiology, whether this is indicative of co-occurrence or shared neurochemical vulnerability[53]
Autistic spectrum disorder	20		4.1 (2.6 to 6.3)*	No new evidence
Eating disorder	3	287	2.5 (0.8 to 7.8)	No new evidence
Anxiety	60	9,538	1.5 (1.2 to	There is an increased

[50] Lopez-Morinigo, JD, Romos-Rios D, Anthony S, Dutta R (2012) Insight in schizophrenia and risk of suicide. A systematic update *Comprehensive Psychiatry* 3 (4) 313-322

[51] David AS, Malmberg A, Brandt L, Allebeck P, Lewis G (1997) IQ and risk for schizophrenia: a population-based cohort study *Psychological Medicine* 27 (6) 1311-1323

[52] Schultze-Lute F, Klosterkotter J, Michel C, Winkler K, Ruhrmann S (2012) Personality disorders and accentuations in at-risk persons with and without conversion to first-episode psychosis. *Early intervention in Psychiatry* 6 (4) 389-398

[53] Buckley PR, Miller BJ, Lehrer DS, Castle DJ (2009) *Schizophrenia Bulletin* 35 (2) 383-402

disorder			1.9)*	prevalence of anxiety disorders among patients with schizophrenia.[54]
Depression	51	8,397	1.5 (1.1 to 1.9)*	Routine outcome monitoring in patients with psychotic disorders reveal a high prevalence of depressive symptoms. [55]
Stress and adjustment reaction	15	3,416	1.1 (0.6 to 1.8)	Studies show that trauma is common in patients with schizophrenia and childhood trauma is a risk factor for psychosis[56]. A small cohort study showed that impaired stress tolerance was associated with a wide range of prodromal symptoms. [57]

Source: Croydon GP practice data 2012

*Statistically significant

6.12.2 Physical health problems and lifestyle factors

People with severe mental illness have more long-term physical health conditions compared to the general population and are more likely to have unhealthy lifestyles. Smoking is responsible for much of the excess morbidity and mortality. Adults with mental health problems, including those who misuse

[54] Pokos V, Castle DJ (2006) Prevalence of comorbid anxiety disorders in schizophrenia spectrum disorders *Current Psychiatry Reviews* 2, 285-307

[55] Lako IM, Taxis K, Bruggeman R, Knegtering H, Burger H, Wiersma D, Sloof CJ (2012) The course of depressive symptoms and prescribing patterns of antidepressants in schizophrenia in a one-year follow up study. *European Psychiatry* 27 (4) 240-4

[56] Morgan C, Fisher H (2007) Environment and schizophrenia: environmental factors in schizophrenia: childhood trauma – a critical review. *Schizophrenia Bulletin* 33 3-10

[57] Devylder JE, Ben-David s, Schobel SA, Kimhy D, Malaspina D, Corcoran CM (2013) Temporal association of stress sensitivity and symptoms in individuals at clinical high risk for psychosis *Psychological Medicine* 43 (2) 259-268

alcohol or drugs, smoke 42% of all the tobacco used in England.[58] When smoking rates in the UK fell between 1980 and 2004 (from 39% to 25%) rates for people with schizophrenia remained at about 70%.[59]

People with MH problems are a priority population in the 2013 smoking cessation contracts and they attract higher payments for smoking quits. However it is felt that current smoking cessation services aimed at people with SMI need more support.

Table 4 shows that, compared to the general Croydon population, people with schizophrenia are **twice as likely to smoke** and **1.7 times more like likely to have a high Body Mass Index (be overweight or obese)**. They are 3.3 times more likely to have **diabetes**, and 1.8 times more likely to have **hypertension** (high blood pressure). And whilst the numbers of people affected are much smaller, they are more than five times more likely to have **Parkinson's disease**, and around four and a half times more likely to have **epilepsy**.

Comparing the last two columns of **Table 4**, shows that the increased risks of physical health problem and unhealthy lifestyles in people with schizophrenia in Croydon are similar to those found in the literature.

Table 4: Increased risk of comorbid physical health conditions and unhealthy lifestyles in people with and without schizophrenia. Croydon, March 2012

	With (1,516 people)	**Without (368,147 people)**	**Increased risk in Croydon (95% Confidence Intervals)**	**Increased risk cited in literature (see *Appendix 7*)**
Condition	**Number with Condition**			
Parkinson	11	496	5.4* (3 to 9.8)	
Epilepsy	30	1664	4.4* (3.1 to 6.3)	
Diabetes	217	16050	3.3* (2.9 to 3.7)	2.7 to 3
COPD	32	3501	2.2* (1.6 to 3.1)	
CKD	78	8722	2.2* (1.7 to 2.7)	
Stroke	33	3761	2.1* (1.5 to 3)	2

[58]McManus et al 2010 cited in HM Government/Department of Health.*No health without mental health: a cross-government mental health outcomes strategy for people of all ages*. February 2011. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_123766

[59]Brown, S., Kim, M., Mitchell, C., *et al.* (2010) Twenty-five year mortality of a community cohort with schizophrenia. *The British Journal of Psychiatry*, *196*, 116-121.

Smoking	613	55912	2.1* (2 to 2.2)	2.37
Hypertension	300	39872	1.8* (1.7 to 2)	1.6
High BMI	540	53577	1.7* (1.6 to 1.9)	0.6 to 2.1 (men) and 3 (women)
Heart Failure	10	1520	1.6 (0.9 to 3)	
Coronary Heart Disease	42	7657	1.3 (1 to 1.8)	1.3 (men) 1.5 (women)
Asthma	73	14486	1.2 (1 to 1.5)	
Cancer	34	7223	1.1 (0.8 to 1.6)	1.5 to 2.6

Source: Croydon GP practice data

**Statistically significant*

Recommendation

SR-4 It is recommended that the CCG and the council ensure that commissioners and providers of both physical and mental health services, and lifestyle and wellbeing services, are aware of the very increased risk of mental and physical health problems and early death in people with schizophrenia or other serious mental illnesses and take account of these risks in developing and reviewing services with the aim of reducing them.

7 Service provision in Croydon

7.1 Background

From the early 1960s onwards, UK mental health policy promoted a shift away from institutional to community care. In 1999, the National Service Framework for Mental Health (NSF)[60] intended to address the wide variation and perceived failure of community mental health care, raised the profile and resource for mental health. A key feature of the strategy was the creation of three new specialist service models for people with severe mental health problems: **Crisis resolution and home treatment teams** (CHRT); **Assertive outreach teams** (AO); **Early intervention teams** (EI). As in other areas these were established in Croydon. The more recent *No Health without*

[60]Department of Health.*National service framework for mental health - modern standards and service models.* 1999. Crown copyright http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4006057

Mental Health: A cross Government strategy for all ages[61] takes a less prescriptive approach to service configuration

Croydon services for people with schizophrenia are illustrated in Table 5, using a framework adapted from the NICE schizophrenia guidance. It has three key sections of:

1) Early intervention
2) Treating the acute episode
3) Promoting recovery, social inclusion and wellbeing

Many services span more than one area of the framework, although the framework has value in providing an overview of how services fit together. In addition to clinical provision, people with severe mental illness such as schizophrenia need to access services to meet the needs that we all have for accommodation, income, employment, meaningful activity, friends, etc. The system is complex and there are a number of organisations that provide services for people with schizophrenia in Croydon: the NHS, local authority, voluntary and independent sectors. Some of the themes arising from the chapter consultation touch upon the need for greater integration, a more strategic approach that looks across the whole pathway.

Recommendation

SR-5 It is recommended that MH commissioners take a whole system approach to strategic planning whereby relevant agencies work and plan together with the aim of increasing integration.

Table 5: Framework of support services for people with schizophrenia in Croydon adapted from the NICE schizophrenia guidance

Early Intervention	• Primary care recognition • CAMHS Early Intervention for psychosis (up to 18 yrs) • COAST (18 to 35 yrs)
Treatment of the acute episode	• Early Intervention Services • Home Treatment Team • Inpatient admission including triage ward • A&E • Assessment (recovery teams) • Psych Liaison if at CUH
Promoting	• GP annual physical health review

[61] HM Government/Department of Health. *No health without mental health: a cross-government mental health outcomes strategy for people of all ages*. February 2011. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_123766

recovery	• Comprehensive care plan in place • Psychosis recovery teams (East and West) • Psychological therapy services • Rehabilitation and recovery for people with more chronic conditions • Reablement • Medication • Information • Support for Carers • Employment support • Housing • Benefits advice; debt advice • Social inclusion services –social networks, furniture services, befriending, volunteering, drops ins • Drug and alcohol services • Advocacy • Lifestyle services eg smoking cessation, weight loss, physical activity promotion • Forensic community team

The main organisations that provide support to people with schizophrenia are described below.

The **South London and Maudsley Mental Health NHS Foundation Trust** (SLAM) is the main provider of a range of secondary care mental health community and in-patient services for people with schizophrenia and severe mental illness. Between 2010-12, SLAM's Croydon adult mental health services underwent a reconfiguration to form Clinical Academic Groups (CAGs). The rationale for this change is to promote greater alignment between research, training and clinical practice, thus facilitating quicker implementation and integration of best practice into daily service delivery. People between the ages of 18-64 years with schizophrenia, in the main receive a service from the Psychosis CAG.

NHS primary care is provided by GPs, pharmacists and primary care staff. Current core aspects of care for people with severe mental illness relate to physical health care, early detection and identification of mental health problems and referral to secondary care. Some GPs undertake antipsychotic prescribing with secondary care under shared care protocols.

Croydon Council provides the local authority care. The council provides a range of services that deliver advice, support, care and services. Many of the services provided by SLAM are also jointly integrated and staffed by the council.

The local **voluntary and independent sectors** provide a wide range of services to people with serious mental illness that include information, advice, advocacy, social inclusion, support, recovery and wellbeing activities, a consumer voice and carer support. Some services receive funding from the NHS and /or the council, other rely on alternative sources of funding.

The remainder of this section looks in more detail at some of the services listed in the table. Further detail about the NHS services is provided in *Appendix 8*. A mapping of service provision was undertaken for this chapter and is summarised in *Appendix 9.*

Overall 1766 people from Croydon are either being treated within the psychosis CAG or are inpatients under the psychological medicines CAG. Of these, two thirds (68%, 1209 people) have a diagnosis of schizophrenia.[62] The remainder do not have a diagnosis or have another psychotic condition such as bipolar disorder.

Two thirds (68%) of people in secondary care with a psychosis have a diagnosis of schizophrenia. This is 55% higher than the proportion of people with a psychosis who have schizophrenia in primary care (44%). In other words, people with schizophrenia are more likely to have contact with secondary care than people with other psychotic conditions.

People with schizophrenia fall within HoNOS (Health of the Nation Outcome Scales) clusters 10 to 17.

Table 6: Croydon secondary care service users by cluster. All service users in the psychosis CAG or inpatients from the Psychological Medicines CAGs. April 2013

	Latest HoNOS Cluster Value	Total
Psychosis Clusters	10: First Episode Psychosis	157
	11: Ongoing Recurrent Psychosis (Low symptoms)	292
	12: Ongoing or recurrent Psychosis (High Disability)	527
	13: Ongoing or Recurrent Psychosis (high symptom and disability)	263
	14: Psychotic Crisis	52
	15: Severe Psychotic Depression	9
	16: Dual Diagnosis	43
	17: Psychosis and Affective Disorder - Difficult to Engage	74
Other Cluster		349
Total		1766

Source; SLaM business support, April 2013

[62] ICD10 code of F20 to F29

Service user and carer experiences

The **Mental Health Forum** and **Hear Us** are two of the main organisations that provide a voice for service users in Croydon. Both collect the views and experiences of service users and feed them back to providers and commissioners. One of the themes coming out of the chapter consultation was the need to strengthen the engagement of service users and carers in service developments and to include measures of service user experience when monitoring service provision.

Recommendation

SR-6 It is recommended that MH commissioners ensure there is full and meaningful involvement of service users and carers in service developments and reconfigurations.

Data quality

In writing this chapter, the authors had difficulties in obtaining data about many of the services, particularly around outcomes and activity. This is not a new finding. A local review of mental health outcomes and investment by both the NHS and the council, found that lack of information was a significant barrier to identifying areas for disinvestment and investment.[63] In response to this review, a MH outcomes subgroup was formed that reports to the MH partnership. The subgroup aims to identify and define mental health outcomes that are important to the people of Croydon.

Partly because of the lack of good quality data, the amount of information provided about services in this section does not necessarily reflect the size of the contribution the service makes to supporting people with schizophrenia.

Improving access to high quality, timely and relevant data about services is essential to effective commissioning, monitoring performance and evaluating changes

Recommendation

SR-7 It recommended that, the mental health partnership develops a shared understanding of the information required by commissioners and strategists to evaluate services, monitor performance, understand and improve value for money and gain a better understanding of current and future need.

Recommendation

SR-8 It is recommended that commissioners ensure that providers are incentivized to provide outcomes, data and intelligence with the aim of evaluating services, monitoring performance, and improving value for money.

7.2 Early Intervention

In broad terms, early intervention has two objectives:

[63] Alves B. *Croydon PBMA review: programme budget*, April 2012. NHS South West London: Croydon Borough Team

- **Early detection**: to prevent the onset of schizophrenia in people with prodromal symptoms[64]
- **Early Intervention in Psychosis:** to provide effective treatment to people in the early stages of their first psychosis, with the goal of reducing the ultimate severity of the illness.[65]

It is important to note the distinction between **early intervention (EI)** as a general term and **early intervention in psychosis (EIP)** which refers to a specific intervention / set of interventions.

7.2.1 Early detection

Early detection services are sometimes called prodromal services. Proponents of early intervention argue that intervening during the prodromal or "at-risk" phase, before the first episode of psychosis, can reduce the duration of untreated psychosis if psychosis develops and reduce the risk of psychosis developing at all. A recent review of effectiveness in the 'at risk' phase found a lower risk of developing psychosis at 12 months, however the long term effectiveness remained questionable.[66] A Cochrane Review also found that there is emerging, but inconclusive evidence indicating that early detection services can be beneficial.[67]

One of the four recommendations made by participants at the **consultation event** to prevent hospital admissions was to "make a prodromal service available in Croydon" (see section 9). SLAM delivers an early detection service (OASIS) as part of an early intervention service in South London, although this is not available to Croydon residents. OASIS manages individuals that have an ARMS (at risk mental state) for psychosis and has become one of the largest early intervention services for people at high risk of psychosis. [68]

There is evidence that services that permit early detection of people at high risk of psychosis may be cost saving[69] although further studies of the potential

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[64] period of time when the person experiences changes before development of the first psychotic symptoms

[65] Marshall, M & Rathbone,J (2011) Early Intervention for Psychosis (Review). The Cochrane Collaboration. www.cochrane.org

[66] Valmaggia LR, McGuire PK, Fusar-Poli P, Howes O, McCrone P. (2012) Economic impact of early detection and early intervention of psychosis. Curr Pharm Des.;18(4):592-5

[67] Marshall, M & Rathbone,J (2011) Early Intervention for Psychosis (Review). The Cochrane Collaboration. www.cochrane.org

[68] Fusar-Poli, P. et al. 'Outreach and support in South London (OASIS), 2001-2011: ten years of early diagnosis and treatment for your individuals at clinical high risk for psychosis' *European Psychiatry* doi: 10.1016/j.eurpsy.2012.08.002

[69] Valmaggia LR, McCrone P, Knapp M, Woolley JB, Broome MR, Tabraham P, Johns LC, Prescott C, Bramon E, Lappin J, Power P, McGuire PK. (2009) Economic impact of early intervention in people at high risk of psychosis Psychol Med. Oct;39(10):1617-26.

longer term economic benefits of early detection and early intervention are required.[70]

7.2.2 Early Intervention in Psychosis (EIP)

NICE recommends that EIP services should be offered to **everyone** experiencing a first episode or first presentation of psychosis, regardless of age or the duration of untreated psychosis. There is evidence that early intervention psychosis teams, which work with young people in their first episode of schizophrenia or bipolar disorder **are cost effective**, saving the economy £18 for every pound spent on them.[71]

GPs are often the first to identify psychotic symptoms and can make a referral in Croydon to COAST, Croydon's early intervention in psychosis team. COAST is aimed at people aged 18 to 35 who are experiencing a first episode of psychosis. There is a specialist link worker role between COAST and CAMHS services.

The service was established approximately eight years ago to reflect the advised model in the 2001 Mental Health Policy Implementation Guide (PIG)[72]. The IRIS (Initiative to Reduce the Impact of Schizophrenia) guidelines, updated in 2012 bring together some of the most up to research evidence and best practice.[73]

Table 7 compares 2012 COAST activity information with PIG guidance and finds that **caseload of COAST is 25% higher than recommended** by PIG and that people stay in the service for only two rather than three years.

Table 7: Activity data for COAST = total caseload of 171 people

PIG guidance[74]	Reported characteristics	Comments
Caseload of 12 to 15 people per WTE	Caseload of over 20 people per WTE[75]	No vocational support, although it can be accessed via Croydon Community Opportunities Services (CCOS). < 18 looked after by CAMHS

[70] Valmaggia LR, McGuire PK, Fusar-Poli P, Howes O, McCrone P. (2012) Economic impact of early detection and early intervention of psychosis. Curr Pharm Des.;18(4):592-5

[71] Knapp M, McDaid D, Parsonage M (2011) Mental Health Promotion and Mental Illness Prevention: the Economic Case, Department of Health

[72] DH (2001)The Mental Health Policy Implementation Guide. www.dh.gov.uk

[73] IRIS (2012) GuidelinesUpdate. IRIS Initiative Ltd.

[74] United Kingdom, Department of Health. Mental Health Policy Implementation Guide: Community mental health teams. DoH June 2002

[75] COAST team 2012

Stay in service for 3 years	Stay in service to 2 years	

In the year between 1/12/11 – 31/10/12 the COAST team dealt with a caseload of 240 people. Table 8 shows that the caseload rate for this early intervention in psychosis service was over **8 times higher in black or black British population** compared to white populations. This is an interesting finding as it differs markedly from the pattern of schizophrenia by ethnicity seen in primary care (6.4) but is similar to the increased rates of psychosis seen in Black groups reported in the literature.

Table 8: COAST Team caseload by ethnic group (01/11/11 - 31/10/12). Expressed in rates per 100,000 population using 2009 population estimates.

Ethnicity	Male	Female	Persons
All groups	99.5	44.0	71.2
White	41.2	20.4	30.6
Mixed	109.6	40.5	74.8
Asian or Asian British	87.8	50.0	69.1
Black or Black British	377.9	147.4	254.3
Other	204.5	41.7	119.6
Total	99.5	44.0	71.2

Source: COAST team December 2012

http://data.london.gov.uk/datastore/package/ethnic-groups-broad-ethnicity-age-and-gender-borough

User satisfaction with this service **is high** and COAST was identified as an asset in the stakeholder consultation.

Recommendation
SR-9 It is recommended that MH commissioners review the current effectiveness and cost effectiveness of the early intervention services and consider developing / extending an early detection service in Croydon.

7.3 Treatment of the acute episode

At times of crisis, people need extra support. For those within primary care, this may mean a period of contact within secondary care, or for those already within secondary care, it may mean contact with more intensive services or an in-patient admission.

7.3.1 Croydon Home Treatment Team

The aim of home treatment is to resolve crises. Thus the functions of crisis resolution and home treatment are integral parts of the same team and the service is sometimes called crisis resolution home treatment (CRHT).[76] NICE[77] recommends that CRHT teams should be considered to support people with schizophrenia in an acute episode, thereby preventing some admissions, and to facilitate early discharge from hospital.

The CRHT team in Croydon is known as the Home Treatment Team (HTT). On average people receive a service for about three weeks. Almost everyone admitted as an in-patient was first seen by the HTT. Over the two years July 2010 to July 2012, between 96% and 99% of people admitted to acute wards were seen by the HTT.[78] User satisfaction with this service is high - see list of assets mentioned in the stakeholder consultation (7.3.1).

Table 9 compares Croydon's HTT caseload with that recommended by PIG and finds that caseload is approximately 25% higher.

Table 9: Home Treatment Team caseload compared to PIG guidance

PIG guidance[79]	**Reported characteristics**	**Comments**
Ideal caseload of 20 to 30 per WTE	Caseload of 38 people per WTE	HTT reports growing pressure

The HTT reports growing pressure on its services. Overall, comparing 2012/13 to 2011/12[80]

- Referrals were almost one fifth higher (19%) although the pattern varied across the year (see figure 10)
- Contacts (phone calls and letters) were 5% higher in 2012/13
- Home visits were 11% lower

The service reports that home visits have dropped because staff numbers have not changed and referrals have grown thereby leading to increased pressure on staff time.

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[76] Bidgett C, Flowers M, Ford K, Hoult J, Lakhani N and McGlynn. *Crisis Resolution Home Treatment: A practical guide.*Edited by Patrick McGlynn.The Sainsbury's Centre for Mental Health, 2006.

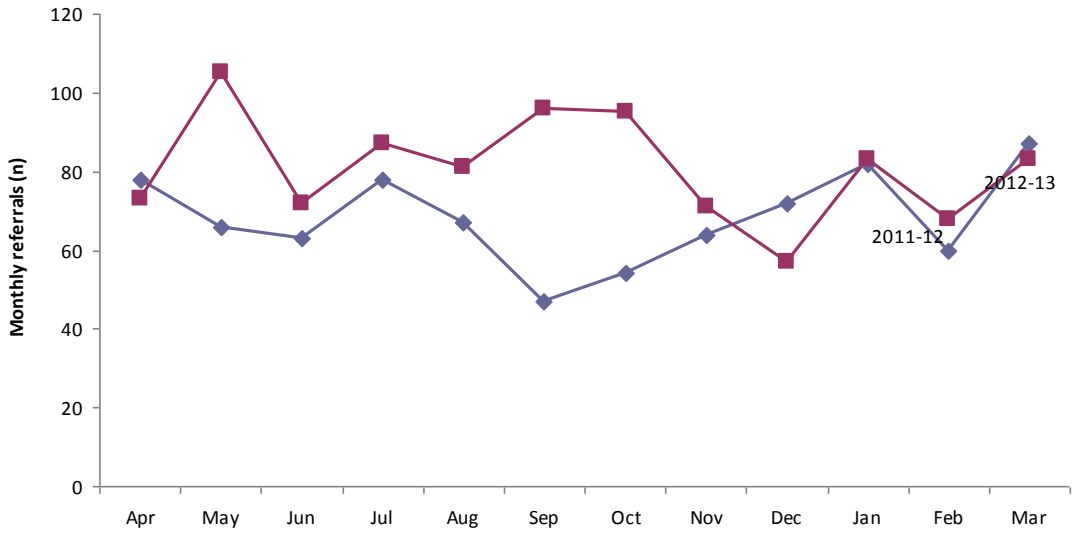
[77]National Collaborating Centre for Mental Health. NICE clinical guideline 82. *Schizophrenia: core interventions in the treatment and management of schizophrenia in adults in primary and secondary care.*Updated edition 2009.National Institute for Health and Care Excellence.

[78] Department of Health. Mental Health Community Teams Activity Data Downloads

[79] United Kingdom, Department of Health. Mental Health Policy Implementation Guide: Community mental health teams. DoH June 2002

[80] Data provided by SLaM Home Treatment Team, April 2013

Figure 11: Trend in Home Treatment Team Referrals 2011/12 2012/13



Source: SLaM Home Treatment Team, April 2013

7.3.2 Inpatient admissions

In-patient provision in Croydon is provided in the following wards:

- Gresham I – 22 female beds
- Gresham II – 25 male beds
- Gresham PICU – 8 intensive care beds
- Foxley Lane – 8 beds to voluntary admissions (women only service based in the community)
- Ashburton Road – 7 crisis beds (men only)
- Triage ward– 11 short stay beds(opened beginning of December 2012)

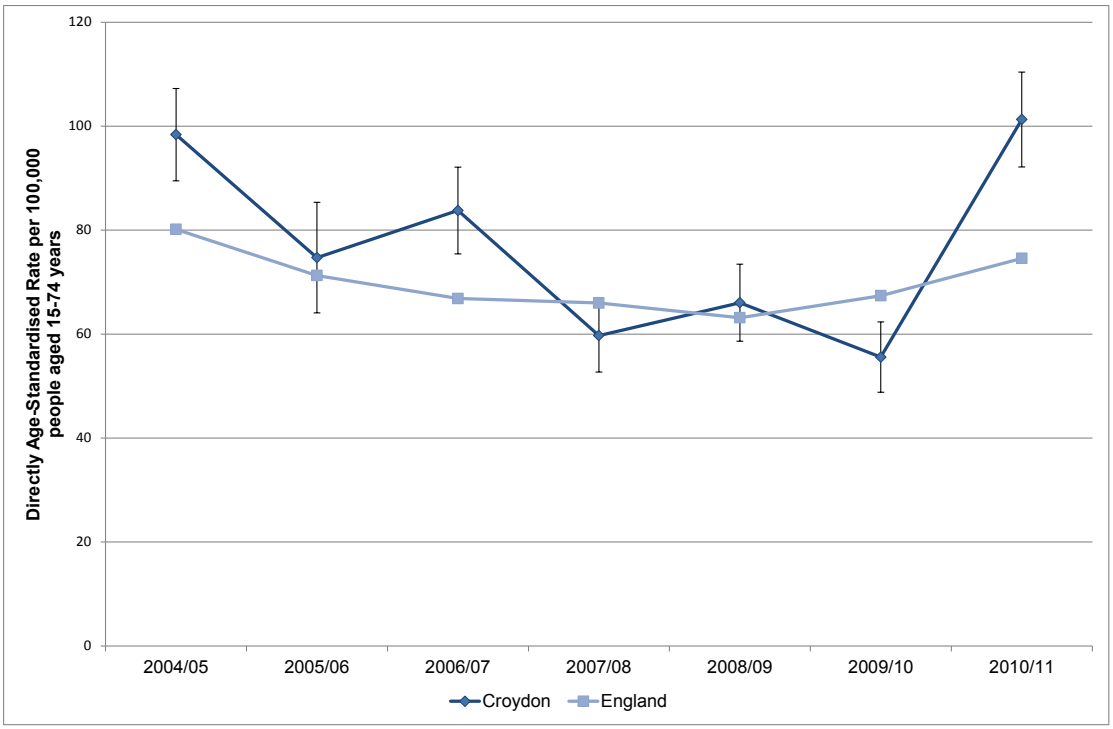
Commissioners, providers and services users, report that pressure on inpatient provision in Croydon is growing and this is supported by national and local data. **Figure 12** shows that the trend in hospital episode rates[81] for people with schizophrenia in Croydon was similar to that in England between 2004/05 and 2009/10 showing a general decline. The England rate declined more gradually. However between 2009/10 and 2010/11 the rate in Croydon rose rapidly by 80% (from 55.6 to 101.3 per 100,000); whilst the rate in England increased only slightly.

Although the national data only extends to 2010/11, local data shows that between 2011/12 and 2012/13, there was a further 25% increase in in-patient admission for Croydon residents (rising from 727 to 910).[82] Whilst this is not

[81] defined as a period of admitted patient care under one consultant within one healthcare provider
[82] Figures provided by SlaM Business Support, April 2013

specific to schizophrenia, nor is it age or sex standardised, it strongly suggests that demand is growing.

Figure 12: Trend in Hospital Episode Rate (DSR) for Schizophrenia in people aged 15-74 years, Croydon and England 2004-05 to 2010-11

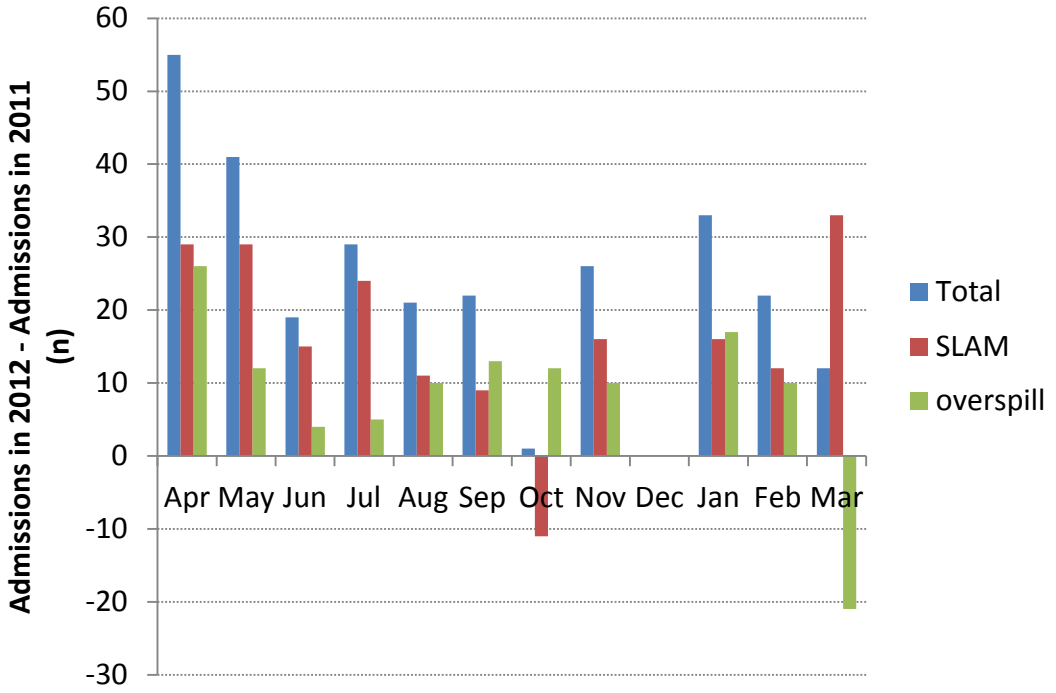


Source: Compendium of clinical indicators http://nww.indicators.ic.nhs.uk

7.3.3 Inpatient admissions to overspill beds

The use of overspill beds is another indicator of growth in demand. Where SLAM cannot accommodate Croydon patients in beds intended for Croydon residents, it will either use beds intended for patients from other boroughs (data on this was not available) or "overspill" beds purchased from a private hospital in Sussex. The use of overspill beds rose sharply in February 2012 and since then, although it has been variable, use of overspill beds has been high. For all months in 2012/13 except March, use of overspill beds was higher than in the corresponding month in 2011/12 (**Figure 13**). The use of overspill beds has a negative impact on service users and carers who need to travel further.

Figure 13: Change in admissions for Croydon residents between 2011/12 and 2012/13



Source: SLaM Business Support, April 2013

Bed occupancy

Bed occupancy, said to be a key driver of inpatient care standards is higher in SLAM than recommended. The optimal bed occupancy rate recommended by the Royal College of Psychiatrists (RCPsych) is 85% because this allows for the inherent variation in the use of beds. It is reported that bed occupancy rates in SLAM often reach 100%. Delays in admission resulting from higher rates of bed occupancy may cause a person's illness to worsen and be detrimental to long term health.[83]

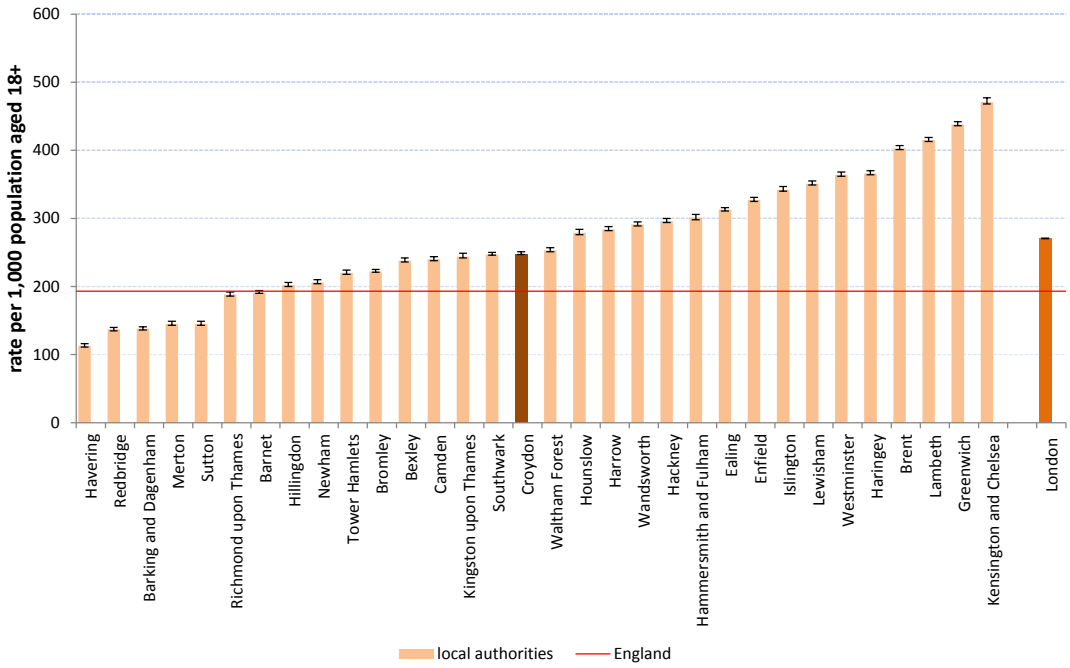
Bed days

Croydon ranks significantly worse than the England average for in-year bed days for mental health.[84] The Croydon rate is 345 per 1000 population (equivalent London and England figures are 389 and 313 respectively)

[83]Khan M and Daw R.*Do the right thing: how to judge a good ward*. Ten standards for adult in-patient mental healthcare. Occasional Paper OP79, June 2011. London: Royal College of Psychiatrists.

[84]North East Public Health Observatory. Croydon community mental health profile 2012. www.nepho.org.uk/cmhp

Figure 14: In-year bed days for mental health, rate per 1,000 population[85] (aged 18+), 2010/11



Source:Community Mental Health Profiles, Public Health England[86]

Formal vs informal admission

People who spent at least one day formally detained in hospital under the Mental Health Act 1983 (or previous related legislation) are known as formal admissions. The proportion of admissions that are formal is higher in SLAM than nationally reflecting the higher levels of need in London. Both nationally and in SLAM the proportion of admissions that are formal has grown between 2006/7 and 2010/11. This SLAM data covers not just Croydon but other SLAM boroughs (Lambeth, Southwark and Lewisham) (

[85] excluding City of London

[86] http://www.nepho.org.uk/cmhp/index.php?view=E09000002

Figure 15)

Figure 15: Number of inpatients detained under the MHA nationally and in SLaM

	SLAM Hospital	All Providers
Year	% formal	% formal
2010/11	55.4%	50.9%
2009/10	49.7%	39.4%
2008/9	49.3%	31.8%
2007/8	48.1%	30.8%
2006/7	36.1%	26.5%

Source: MHMDS: Mental Health Minimum Dataset
http://www.mhmdsonline.ic.nhs.uk/statistics/?report_ID=2&results_type=provider&sha_ID=Q36&provider_ID=RV5&natyear=&n=&remember=report_ID%3D2%26results_type%3Dprovider%26sha_ID%3DQ36%26provider_ID%3DRV5

A&E attendances

A&E attendance rates for psychiatry have grown. The A&E attendance rate for psychiatry in Croydon has increased over the last three years from 3.5 per 1,000 in 2009/10 to over 5 per 1,000 in 2011/12.

The data on A&E attendance rates for self-harm was not available at the time of writing.

In summary

There is strong evidence of growing demand for acute and crisis services such as HTT, inpatient services and A&E. There are a number of possible reasons for this increase:

- Growing need due to the changing population, impact of welfare reforms, growing levels of homelessness
- Change in the capacity of the community mental health teams such as the recovery teams
- Change in the capacity of community and recovery resources, for example, the loss of day care centres, reduction in voluntary sector funding, levels of housing and employment support,
- Increasing rate of relapses

The set of services that provide support to people with schizophrenia at times of crisis are complex and there are no simple solutions. There is ongoing work by commissioners and by SLAM to redesign services to match the growing demand. This work is a priority because not only has demand for services grown, the demand is likely to grow still more in the future because the numbers of people with schizophrenia is projected to increase. One of the suggestions arising from the chapter consultation was to monitor the social

reasons behind referral to treatment teams and admission to inpatient wards. This may help in understanding how demand can best be managed.

Developing services to meet need is a particular challenge at a time of limited financial resources. Commissioners, providers and those involved in service redesign need to take account of the whole pathway. Demand for inpatient provision will be influenced not only by the quality of the inpatient provision but also by the availability of community services such as the community mental health teams, recovery services, primary care provision, support provided by the voluntary sector and levels of self care.

Where possible, service planners should take account of best practice and the evidence of effectiveness. They should ensure that good quality data is collected routinely particularly around outcomes. Increasing access to meaningful data, would enable decision makers to monitor the effectiveness of services and evaluate changes to its provision.

The views of service users and carers is central in providing high quality service and they should be fully engaged in service redesign processes

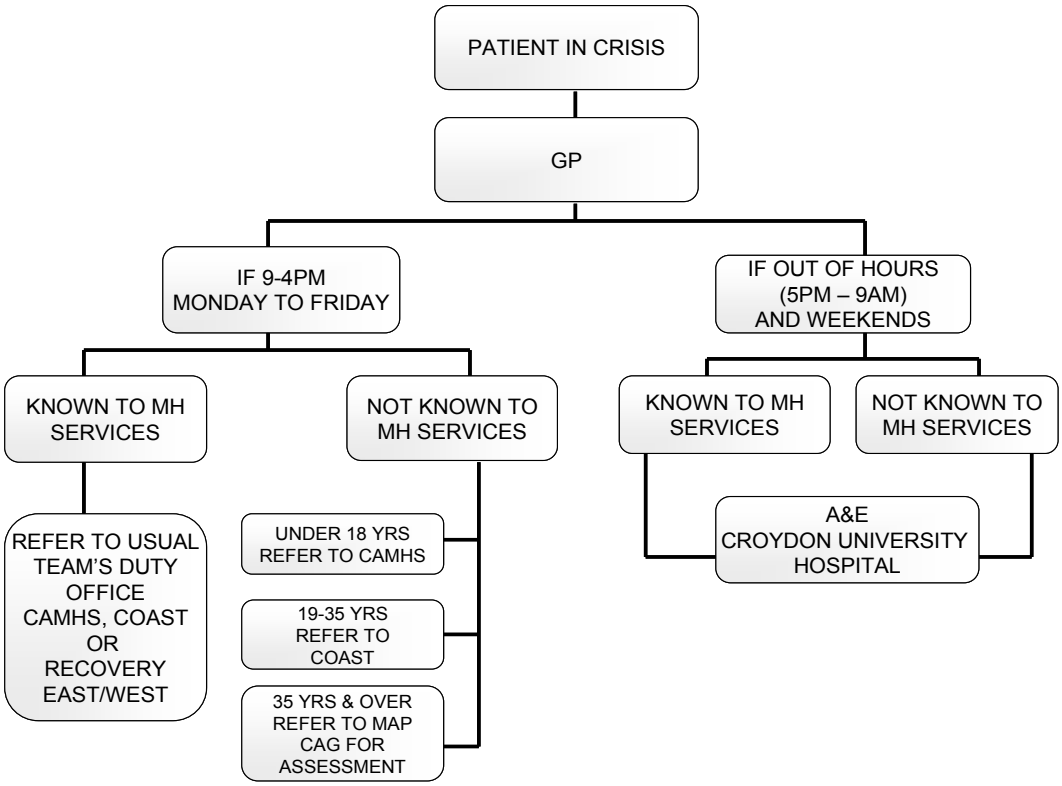
Recommendation
SR-10 It is recommended that as a priority, MH commissioners, providers and community and service user representatives support efforts to manage demand for acute services through strengthening both acute services and provision in the community, particularly recovery services. This should take a whole systems, pathway approach and take account of evidence and best practice, engaging service users and carers.

7.3.4 Access to services out-of-hours

One of the issues raised by stakeholders as part of the chapter consultation was the need for better out of hours support. GPs perceive that there are difficulties in accessing secondary care support particularly out of hours.

Figure 16 shows that between 4pm and 9am, the only option open to GPs who have concerns is to direct them to A&E. GPs cannot refer to the home treatment team directly.

Figure 16



No information was available at the time of writing about the impact on service users of this pattern of service provision. Out-of-hours support is one component of secondary care support to service users.

Recommendation

SR-11 Commissioners should explore the impact of current out-of-hours provision on use of secondary care services and crisis support.

7.3.5 Liaison Psychiatry Service

The psychiatric liaison team is based in Croydon University Hospital, a general hospital with over 500 beds. It provides a 24 hour service, covering both A&E and in-patient wards, taking referrals for 16-65 year olds for whom a psychiatric assessment is required.

In 2011/12 the team conducted a total of 2,203 assessments, an average of 184 per month (ranging from 151-221 per month) of which 56% were for people known to the mental health services and 44% unknown. [87] The monthly commissioned activity target (141) was exceeded each month.

[87] SLaM contract monitoring report

7.4 Promoting recovery

The concept and philosophy of recovery underpins the way mental health and social care is delivered. There is no single definition of the concept of recovery for people with mental health problems although one such definition is given here:

> *"Recovery is about building a meaningful and satisfying life, as defined by the person themselves, whether or not there are ongoing or recurring symptoms or problems."* [88]

The guiding principle of recovery is hope – the belief that it is possible for someone to regain a meaningful life, despite serious mental illness. Recovery is often referred to as a process, outlook, vision, conceptual framework or guiding principle.

In a survey conducted by the Schizophrenia Commission[89], respondents highlighted the following factors as important for recovery:

- Support from family (61%)
- Stable housing (57%)
- Self management strategies (48%)
- Support from friends (32%)
- Help finding or keeping a job (28%)

The overview chapter outlines many of Croydon's assets that help with recovery. These include services, resources and activities that maintain individual well-being, promote self-management strategies and provide social inclusion opportunities. A significant proportion of provision to support recovery is provided by the voluntary, private and independent sectors.

The recovery services play a vital role in supporting people with schizophrenia. A key theme arising from the chapter consultation was the needs for greater emphasis on a recovery approach. Services such as befriending, volunteering, income generation and welfare benefits advice were especially highly valued. Provision of recovery and treatment services should be seen as components of a whole system. Strong recovery services can play a role in freeing up blockages in other parts of the system.

Recommendation

SR-12 It is recommended that decision makers take account of the impact of recovery services on quality of life, wellbeing and demand for other services when developing and reviewing service provision.

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[88] Shepherd, Boardman and Slade (2008) *Making Recovery a Reality.* Sainsbury Centre for Mental Health Making Recovery a Reality

[89] The Schizophrenia Commission. *The Abandoned Illness.* Rethink Mental Illness, November 2012.

7.4.1 Physical health and primary care support

The role of primary care is fundamental to the success of the mental health of its practice population. The expectation is that most people will be managed most of the time under the care of their GP. What is currently available from general practice **varies** and is dependent on staffing, premises, historic funding arrangements, practitioner expertise and clinical priorities. There is growing interest in enhancing mental health care provision in primary care.[90] However models of integrated-collaborative-shared ways of working between secondary and primary care, for people with serious mental illness which includes schizophrenia, are varied, often poorly understood and currently have a limited evidence base[91]

In local consultation for the chapter, GPs were seen as an asset, although one of the key issues identified was the need for greater recognition and better management of physical health problems (see section 9)

The Quality and Outcomes Framework (QOF)[92] for serious mental illness was introduced as part of the General Medical Services contract in 2004 to improve the quality of mainly physical care in primary care for people with serious mental illness. This QOF requires GP practices to keep a register of people with serious mental illness (defined by QOF as having schizophrenia, bipolar disorder or other psychosis). The emphasis of QOF payments may change on an annual basis but generally include a requirement that all patients on the serious mental illness register have a comprehensive care plan in place and an annual review of their physical health.

Table 10: QOF primary care SMI performance indicators, 2011/12

Expressed as percentages							
	Average			Croydon		Percentile	
Indicator (2011/12)	Croydon	London	England	Best	Worst	10th	90th
Comprehensive care plan agreed (MH10)	88.4	88.7	88.4	100	42.2	77.8	97.9
Alcohol consumption recorded in last 15 months (MH11)	88.7	88.5	89.6	100	41.4	77.9	100
Body mass index recorded in last 15 months (MH12)	88.8	87.4	88.7	100	51.6	75.8	97.4
BP recorded in last 15	90.7	90.0	91.7	100	64.3	81.3	98.0

[90] Joint Commissioning Panel for Mental Health (2012) Guidance for commissioners of primary mental health care services.

[91] Kelly et al. (2011) Shared care in mental illness: A rapid review to inform implementation: www.ijmhs.com/content/5/1/31

[92] NHS Employers and the British Medical Association. *Quality and Outcomes Framework for 2012/13. Guidance for PCOs and practices*. NHS Employers, April 2012.

months (MH13)							
Cholesterol/HDL recorded in last 15 months (MH14)	80.8	79.4	81.9	100	46.2	71.4	93.3
Blood glucose recorded in last 15 months (MH15)	82.0	80.6	84.8	100	56.1	71.9	94.7
Cervical screening in last 5 years (MH16)	87.9	86.1	88.0	100	68.2	79.0	100

Source: http://www.hscic.gov.uk/qof

Table 10 shows that overall, the care provided by GPs in Croydon to people with SMI is similar to that in London and England. However, there is wide variation. In some practices, between 19% and 29% of patients with SMI are not getting at least one of the components of the physical health review and 22% do not have a comprehensive agreed care plan.

Given the very high increased risk of physical health conditions and unhealthy lifestyles, **supporting the worst performing practices to improve is a priority**. We do not have information on whether the information collected in the physical health reviews led to interventions, treatment or behaviour change. Efforts to improve reviews should be linked to efforts to improve outcomes and improve lifestyles around smoking cessation, exercise and diet.

The Integrated Physical Health Pathway, developed by Rethink Mental Illness, is a resource that supports health professionals to coordinate physical health monitoring for people affected by mental illness and ensures information is communicated effectively between services.[93]

Recommendation:

SR-13 It is recommended that as a priority, local area teams of NHS England and Croydon CCG reduce GP practice variation in physical health monitoring for people with severe mental illness through supporting poorer performing practices and learning from areas of good practice.

Primary secondary care interface

One of the key issues raised by stakeholders as part of the chapter consultation was the **need for better integration**, particularly between primary and secondary care and between statutory and voluntary sector services. One of two key concerns was the perceived reluctance of some GPs to "take back" people discharged from secondary care, particularly around managing their medication.

Work has recently commenced, initiated by Croydon GP Clinical Commissioning Group and SLaM, to implement and develop a primary care

[93] www.rethink.org/phc.

mental health service to support GP practices in the provision of mental health care to patients with stable, low risk severe mental illness. It will deal with relatively small numbers initially (200 people) however it is an opportunity to improve capacity and interest in more integrated care. It aims to:

- Provide care to a greater number of SMI clients and people experiencing mental health problems in primary care
- Provide improved care at greater efficiency and reduced cost
- Demonstrate maintained or improved outcomes (particularly physical and mental health care)

The initial work of this development will be in acting as a catalyst for change in addressing current barriers to effective patient flows between primary and secondary care. So far, potential barriers identified by the project steering group include:

- Lack of detailed information on patient groups to inform planning and decision-making
- Deficit of a contractual framework that facilitates a more cohesive provision of mental health delivery in primary care
- Competing clinical priorities in primary care
- Variation in mental health interest and expertise in primary care
- Current Croydon Prescribing Committee guidance and practice particularly relating to antipsychotic prescribing and depot administration in primary care
- Current lack of good quality information and communication systems between primary and secondary care
- Lack of appropriate and timely access to and from secondary mental health services

Recommendation

SR-14 It is recommended that MH commissioners continue to support the development of the primary care service for people with stable serious mental illness. Furthermore, that the commissioners review the interface between primary and secondary services in the light of the outcome of this work.

7.4.2 Antipsychotic medication

Antipsychotic medication is the most effective treatment for schizophrenia and psychosis but the medication often has unpleasant side effects.[94] Side effects include weight gain, diabetes, heart disease, drowsiness, sexual dysfunction

[94] The Schizophrenia Commission. *The Abandoned Illness.* Rethink Mental Illness, November 2012

and restlessness.[95] Research has shown that 10 days after starting a medicines, 30% of patients are already non-adherent i.e. not taking their medicines as the prescriber intended, almost half of these (45%) do so intentionally.[96] This figure is applicable to people taking antipsychotic medicines.

The schizophrenia commission found that while some people may have to stay on medication, others can gradually reduce and eventually come off their antipsychotics.[97] . In view of the side effects, patients report that they would like an individualised approach to ensuring they are receiving the minimum effective dose for the control of their condition. In the chapter consultation, service users and carers reported the need for greater involvement in medication decisions

Recommendation:
SR-15 It is recommended that clinicians engage closely with service users to agree together what medication regime works best for them and to ensure that this is kept under regular review.

SR-16 It is recommended that consideration is given to how all health care professional in primary care - GPs, community pharmacists and nurses can support people to improve decision making and have systems in place to identify and resolve issues of poor compliance with treatment.

Prescribing of antipsychotics is generally initiated in secondary care and patients will continue to be seen on an out-patient basis. GPs may prescribe under a shared care protocol once patients have been stabilized on the antipsychotic, although responsibility for the overall management of the clinical condition remains with the specialist/secondary care. Prescribing of unusual drugs, unlicensed indications, complex dosages or drug combinations will continue to be prescribed and monitored in secondary care.

In whatever setting the patient is managed, regular medication reviews aim to ensure people are on the most appropriate drug and dosage to control their symptoms and minimise side-effects. Regular physical health checks are also required to monitor the patient's general health. Smoking status also needs to be considered carefully for patients taking these medications as the blood levels of the drug can be affected by smoking. Additional monitoring is

[95] Royal College of Psychiatrists (2012) Antipsychotic medication. Series Editor: Dr Philip Timms.
http://www.rcpsych.ac.uk/expertadvice/treatmentswellbeing/antipsychoticmedication.aspx
[96] N.Barber et al. Patients' problems with new medication for chronic conditions. Qual Saf Health Care 2004; 13:172-175
[97] The Schizophrenia Commission. *The Abandoned Illness.* Rethink Mental Illness, November 2012

required for people who alter their smoking habits as they may experience increased side effects or reduced clinical effect. Support and monitoring for such patients is thought to be insufficient at present and we have seen (section 6.12.2) that people with SMI are more likely to smoke and less like to quit.

Recommendation
SR-17 It is recommended that MH commissioners strengthen stop smoking services for people with SMI and that MH commissioners train staff who are delivering this intervention, on understanding the importance of good communication with prescribers of changes in smoking status.

There is potential for stable patients taking these medicines to be fully integrated back into primary care if appropriate support measures are in place. However issues can arise if patients are discharged from hospital, or care is transferred to the GP, without the GP receiving detailed enough information on the discharge letter e.g. indication, duration of therapy, relapse plan to support prescribing in primary care. In order to address this issue, eligibility criteria for discharge and a core data set of discharge information are currently being piloted in a small group of patients within one service.

GPs may also not be in a position to take on clinical responsibility for prescribing due to the lack of experience and familiarity with prescribing in this field. Some GPs report that they need additional training and guidance to enable them to be more confident about prescribing antipsychotics and reducing dosages safely. Educational events are planned for later in 2013.

Recommendation
SR-18 It is recommended that commissioners and pharmacy leads provide ongoing training for GPs in antipsychotics prescribing.

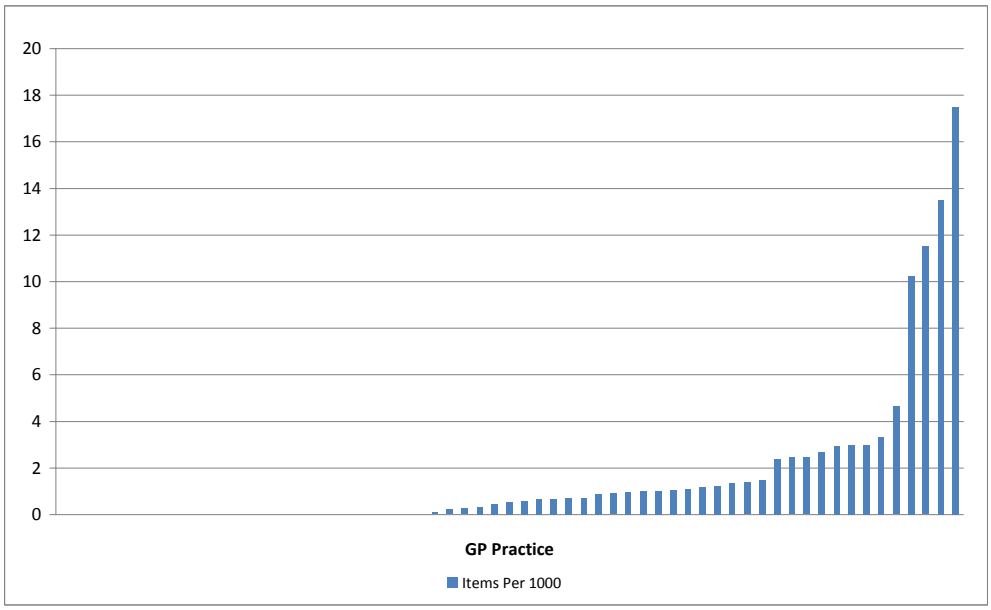
In addition, it is thought that systems need to be created to support patients with other medication issues including compliance problems. This could include practical measures such as community pharmacy repeat dispensing schemes, targeted Medicine Use Reviews, assessment and appropriate use of compliance aids.

Currently shared care only applies to oral atypical antipsychotic agents and a shared care protocol was formally agreed by Croydon Prescribing Committee in 2009 for the prescribing of amisulpride, aripiprazole, olanzapine, quetiapine and risperidone in primary care. Another agent called clozapine remains a hospital only drug due to its complex monitoring requirements. The protocol contains information for GPs about when to seek further advice/support from the consultant psychiatrist. The implementation and uptake of this shared care guideline has been limited.

At present patients receiving depot injections of antipsychotic medicines are mainly managed in secondary care. GP prescribing of depot antipsychotics is

variable and guidance to support GPs in this area is in development for both shared care and discharge of stable patients (**Table 11**).

Table 11: Antipsychotics Depot Injections - Items Per 1000 patients Sep 11 to Aug 12



Source: ePACT September 2012.

Recommendation

SR-19 It is recommended that there is ongoing support for the development and implementation of antipsychotic shared care protocols both for oral antipsychotics and depot injections.

Prescribing Committees

There are a number of committees in Croydon that shape prescribing practice:

- Croydon Prescribing Committee (CPC) reviews the evidence for new or unlicensed drugs and makes local recommendations based on the evidence. There is mental health representation at CPC.
- The Drugs and Therapeutics Committee at SLAM (which has CCG pharmacy representation) also makes prescribing recommendations.
- A commissioner-led South East London Area Prescribing Committee is also being set up. It will include input from SLAM and it is expected that the committee will take responsibility for decisions affecting primary care based prescribing of these drugs for the 6 CCGs involved.

Joint working and communication between these three committees is encouraged further.

Cost

The cost of GP practices mental health prescribing in Croydon is around £2.75 million (327,768 items), approximately £1.1 million of which is for drugs

used in psychoses and related disorders (43,296 items) accounting for around 39% of the total cost and 13% of the total items. Prescribing data to reflect secondary care prescribing was not accessible at the time of this publication.

Quality of secondary care prescribing

The National Audit of Schizophrenia (NAS)[98] explores the application of NICE guidelines in the community assessing the quality of community prescribing of antipsychotic drugs and also how care is provided. Of the 63 Trusts/Health Boards that took part, SLAM performed particularly well in relation to clozapine prescribing. For people with treatment resistant illness, 100% of patients in the audit had an adequate trial of clozapine. The national average was 81%.[99]

7.4.3 Psychosis Recovery Teams

Secondary care community mental health provision in Croydon is provided by the two (East and West) Psychosis CAG Recovery Teams. These services provide treatment and care to people between the ages of 18-65 years. They have emerged from the previous more generic Community Mental Health Team (CMHT) model as recommended in the PIG.[72] The dedicated assertive outreach model recommended in the PIG guidance[109] (aimed at people who found it more difficult to stay in touch with services) was absorbed into the Recovery Teams approximately two years ago.

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[98]National Audit of Schizophrenia.Baseline Audit NAS 0202. Trust Level Report: South Londond and Maudsley Foundation Trust. April 2012. http://ccs.sagepub.com/content/early/2011/09/14/1534650111420863

[99] National Audit of Schizophrenia; Trust level report 2011. April 2012. Standards S12

Table 12 compares 2012 Recovery CAG activity information with PIG guidance and finds that the caseload per WTE is almost 50% higher than recommended by PIG.

Table 12: Caseload in psychosis recovery CAGs compared to guidance

PIG guidance[100]	Reported characteristics	Comments
Ideal caseload of 25 people per WTE where patients have psychosis	Caseload of 37 to 38 people per WTE	For those with more intense need, it is reported that it is difficult to provide level or frequency of contact previously provided

There was limited information available about the effectiveness of this service which is the mainstay of support for many individuals.

Recommendation:

SR-20 It is recommended that commissioners look at the community mental health recovery services in more detail in order to understand the strengths and gaps in this service.

7.4.4 Psychological therapies

In a recent survey of care provision for people with schizophrenia, CBT was highlighted as one of the interventions that practitioners, service users and their families most valued alongside medication.[101]

There is no readily available overview of total provision for people with schizophrenia because individual therapy for people with schizophrenia/psychosis in Croydon is provided from a number of teams. Predominantly it is delivered via the psychology service based within the two promoting recovery teams. However, it is also provided by psychologists working with the COAST service, rehabilitation & recovery teams, forensic team and in-patient wards, all of which collect their own data. In addition, a pilot aiming to increase access to psychological therapies in people with serious mental illness has recently been established to serve Croydon, Lambeth, Southwark and Lewisham. The pilot has uncertain longer term funding.

Because people with psychosis need to be in contact with secondary care services to access psychological support, there is a lack of access to psychological therapies for people not using secondary MH services. Whilst some services can be accessed through self referral (voluntary sector and

[100] United Kingdom, Department of Health. Mental Health Policy Implementation Guide: Community mental health teams. DoH June 2002

[101] The Schizophrenia Commission. *The Abandoned Illness.* Rethink Mental Illness, November 2012.

IAPT), they are less likely to be able to offer appropriate support to people with schizophrenia or psychosis because their needs are usually relatively complex.

User satisfaction with psychological therapy services is high - see list of assets mentioned in the stakeholder consultation (see section 9) and the 2012 community mental health survey found that the quality of talking therapies provided by SLAM is good. The Survey looked at people's experience of community mental health services and found that service users scored SLAM better than most other trusts for "receiving talking therapy that was helpful". [102]

Current waiting times are about three to six months and access to psychological therapies appears poor. A review of the current caseload estimated that just under 10% (105/1064) of the psychosis caseload get access to/are offered psychological services. NICE guidance states that CBT should be offered to everyone with schizophrenia. If it is assumed that around 50% of those with a schizophrenia spectrum diagnosis would not take up the offer or complete a full course (as found in research trials) **then there appears to be substantial unmet need for psychological therapy for people with psychosis in Croydon**.

The picture is mixed however in that the national Audit of Schizophrenia finds greater capacity in SLAM than in some areas. In SLAM, only 21% of patients whose illness was not responsive to antipsychotics were NOT offered psychological support. This is better than the national figures of 34%. [95]

Recommendation
SR-21 It is recommended that the MH commissioners improve access to psychological and talking therapies for people with schizophrenia.

Family therapy describes a range of psychosocial interventions for people who have a significant emotional connection to someone with schizophrenia. There is good evidence that psychosocial interventions within families, to reduce expressed emotions (hostility, criticism or over-involvement), will reduce the likelihood of relapse for people with schizophrenia[103] A recent modelling of cost savings indicates that family intervention would bring a saving of £1004 over a three-year period.[104]

[102] Care Quality Commission. Patient survey report 2012. Survey of people's experiences of community mental health services. South London and Maudsley Foundation Trust report. CQC,
[103]Pharoah F, Mari J, Rathbone J, Wong W. Family intervention for schizophrenia. Cochrane Database of Systematic Reviews 2010, Issue 12.
[104] Andrew A, Knapp M, McCrone P, Parsonage M, Trachtenberg M (2012) *Effective interventions in schizophrenia: the economic case* . London: LSE.

Family intervention can also help to resolve the confidentiality issues that carers often face by improving relationships between service users and carers.

Recommendation
SR-22 It is recommended that MH commissioners consider increasing the availability of family intervention therapies.

7.4.5 Family and carers

Families and carers can play an important part in supporting someone with schizophrenia and are often a vital part of recovery. It is estimated that around 50% of people with severe mental illness have family who are actively involved in their care.

Healthcare professionals should ask people with schizophrenia whether they would like their family or carers to be involved in their care. If a family member is supporting someone with schizophrenia it is important that they are assisted and given information and education to learn about schizophrenia and ways to minimise the chance of relapse. It is also important that family members feel they are listened to and understood and barriers to information sharing should be removed. Health professionals should value families and carers as a resource that can make a huge difference in helping their loved one find the right treatment, cope with symptoms and provide a structured and supportive environment to aid recovery.

Compared to other trusts, there is evidence that SLAM involve families less than the service users would like. The 2012 Community Mental Health Survey looked at people's experience of community mental health services.[105] Services users scored SLAM worse than most other trusts for "involving family or someone else close to them as much as they would like"

Two measures in the Adult Social Care Outcomes Framework relate to carers: their overall satisfaction with social services; the proportion who report that they have been included or consulted in the discussion about the person they care for. Data is not yet available as the first reporting period is 2012/13.

Caring for someone with schizophrenia can place an incredible amount of stress on family members and their needs are often neglected. Therefore, it is important to bear in mind the impact of caring on a carer's own health and well-being.

The Croydon Carers Strategy 2011-16 recognises the immense contribution that carers make to the health and social care system. It acknowledges that they too, should enjoy safe, healthy, fulfilling and independent lives in the

[105] Care Quality Commission. Patient survey report 2012. Survey of people's experiences of community mental health services. South London and Maudsley Foundation Trust report. CQC,

community. There are a number of services in Croydon that support carers which are all linked to a universal information hub (provided by the Carers Information Service). This helps carers make decisions about which services best fit their particular circumstances. Together, the Carers Information Service and the service providers form the Carers' Support Network. Carer support groups, especially those run by carers are important in providing peer support. A number of these groups are held across Croydon and are highly valued.

The take up of carer assessments is reported to be low and there has been no recent review comparing level of need with service provision. Such a review could inform further development of this service.

One of the five most important changes recommended by stakeholders was to improve support and inclusion of carers (see section 9)

Recommendation:
SR-23 It is recommended that MH commissioners effective information sharing with carers and others is improved through training and other approaches so that practitioners feel more confident in balancing patient rights to confidentiality and risk management.

Recommendation:
SR-24 It is recommended that the CCG and the council support the health and well-being of carers of people affected by schizophrenia by referring them for carers assessments, ensuring assessment are taken up appropriately and signposting to local support.

Recommendation:
SR-25 It is recommended that mental health commissioners support the development of more carer support groups in areas where service provision is low.

7.4.6 Housing provision

Suitable accommodation and **housing is seen as a fundamental aspect of effective recovery. Lack of appropriate accommodation is associated with delaying discharge from hospital, increasing readmission rates, over-use of residential care and sometimes to out of area or other high-cost services.** Investment in housing and housing-related support can contribute significantly to reducing demand on acute and specialist services.[106]

[106] Joint Commissioning Panel for Mental Health. *Practical Mental Health Commissioning. A framework for local authority and NHS commissioners of mental health and wellbeing services*.Volume 1.Setting the Scene.Produced by Andy Bennet, Steve Appleton and Catherine Jackson.

There is a shortage of housing in Croydon and homelessness is a particular issue, with Croydon ranking significantly worse than the England average for homelessness.[107]The proportion of adults with mental illness living independently with or without support in 2011/12 in Croydon is 71.4% which is similar to the London figure of 73.8% and statistically significantly better than the England figure of 57.8%.[108]

Recommendation:
SR-26 It is recommended that commissioners ensure that the housing needs of people with schizophrenia and other severe mental illnesses are adequately addressed.

Recommendation:
SR-27 It is further recommended that the commissioners and providers review the type of housing commissioned to maximise independent living

7.4.7 Employment support

Employment and meaningful activity are also central planks for peoples' recovery and most people with schizophrenia and other severe mental illnesses want to work. [109] However, only between 5%-15% are in employment.[110]

The proportion of adults in contact with secondary mental health services and in employment at the time of their most recent review was 7.6% in 2009/10 9% in 2010/11 and 9.9% in 2011/12.[111] The data available nationally from the MHMD submissions found lower rates, but the former have been used as they are thought to be more accurate. Hence no comparisons could be made with London or comparator PCTs.

Employment support in Croydon for people with severe mental illness is provided, in the main, by MIND Employment Support Service, Status Employment and Croydon Community Opportunities Services (CCOS). These services are contracted to provide an Individual Placement and Support model/approach which has been shown to be more effective than pre-vocational training approaches (see *Appendix 4* evidence review).

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[107]North East Public Health Observatory.Community mental health profile 2012. www.nepho.org.uk.
[108] Key dataset
[109]Marwaha S (2005) Views and experiences of employment among people with psychosis: a qualitative descriptive study. *International Journal of Social Psychology* 51 (4) 302-316
[110]The Schizophrenia Commission.*The Abandoned Illness.* Rethink Mental Illness, November 2012.
[111]Croydon Borough Council. Department of Adult Services Health and Housing (DASHH) performance report, Quarter 2 2012/13.

Configuration of employment services are being examined as part of Croydon's voluntary sector review and are likely to change.[112] One of the key issues raised about employment support is that providers felt that restricting provision to those on CPA meant that they were frequently working with people who were not sufficiently motivated or able to secure paid work; others who they could have helped were turned away because they did not meet the eligibility criteria.

Recommendation:
SR-28 It is recommended that commissioners review eligibility to employment support and ensure that effective models are implemented.

7.4.8 Benefits and debt advice

Many working age people with schizophrenia are unable to work some or all of the time and hence are dependent on benefits.

MIND are contracted to provide welfare benefits advice but only to those service users who have complex welfare benefits claims and where the initial decision by the authorities is being challenged by the client. MIND provides clients with representation where cases are taken to an appeal hearing. Their service has proved very successful with over 90% being decided in the client's favour in 2011/12

Service users with less complex claims are encouraged to use other provision such as Croydon Councils' welfare rights advice. Monitoring would suggest that this has occurred, however the extent to which people with schizophrenia or severe mental illness have been supported and the associated outcomes are not available at the time of writing.

There is some historical evidence of under-claiming of benefits in Croydon. A study of people using community mental health services in Croydon, published 10 years ago, found that two-thirds (66%) of people were under-claiming.[113]

Given the scope of the welfare reforms and the reduction in benefits it will cause, there is a need for more, not less, benefits and debt advice. Delay in clarifying benefits can delay hospital discharge, increase personal stress and vulnerability to relapse and may lead to homelessness.

[112] Review of adult mental health services provided by voluntary and community sector providers, NHS Croydon (2012)

[113] Frost-Gaskin M, O'Kelly R, Henderson C, Pacitti R (2003) A Welfare Benefits Outreach Project to Users of Community Mental Health Services Int J Soc Psychiatry December 2003 vol. 49 no. 4 251-263

Recommendation:
SR-29 It is recommended that commissioners ensure provision of benefits and debt advice meets the current and future needs of people with schizophrenia and other serious mental illnesses

7.4.9 Social support/ inclusion

People with severe and chronic mental ill health may struggle with the common activities of everyday life; interventions such as creative therapies, work-based therapy, recreational activities, and life skill teaching have all been shown to have some impact of improvements in the quality of life.[114]

Social isolation is a barrier to recovery. A number of services have been commissioned and funded to facilitate social inclusion, such as:

- Active MINDS
- MIND social networks
- MIND furniture
- Imagine Befriending
- Imagine volunteering
- Association for Pastoral care drop-ins
- Imagine drop-ins

Information about service provision is available in the Voluntary and Community Services (VACS) review which considered the years 2010/11 and 2011/12. Other than the drop-ins, access to social inclusion services is restricted to those whose care is coordinated under a Care Programme Approach (CPA) or those meeting higher levels ('critical' and 'substantial') of the Fare Access to Services (FACS) eligibility criteria.

In the second year most services saw a reduction in funding as part of the Council's efficiency savings plan. One of the issues raised in the consultation was concern over cuts to voluntary sector organizations (7.4.9)

7.4.10 Advocacy

MIND in Croydon is commissioned to provide two advocacy services: a professional advocacy service and an Independent Mental Health Advocate (IMHA) service. The latter is a statutory requirement under the Mental Health Act and is open to clients of all ages subject to compulsion under the Act. Common issues raised by clients (ref VACS review) include: housing ; 'concerns about clinical care'; 'admissions, discharge and transfers'.

[114]Tungpunkom P, Maayan N, Soares-Weiser K. Life skills programmes for chronic mental illnesses. Cochrane Database of Systematic Reviews 2012, Issue 1.

7.4.11 Personalisation

Self-directed support was introduced to provide people with more opportunity to choose the kind of support services they would like. The percentage of all social care clients receiving Self-Directed Support (Direct Payments and Individual Budgets) has increased from around 6% in 2009/10 to 47% in 2011/12.[115] There were 131 working age adults with mental health problems in receipt of Self Directed Support at the end of November 2012. However it was not clear at the time of writing what proportion of all working age clients with mental health problems this represented. Personal budgets are available to those who meet the eligibility criteria for social care. Other London Boroughs are piloting personal health budgets. The Schizophrenia Commission report[116] suggests that far more integration between health and social care budgeting is required to deliver value for money.

The number of people with direct payments/self-directed support is growing and will change the pattern of service provision as people begin to express their needs.

In summary:
There is a need to raise awareness of the impact of good recovery services on the quality of life of people with schizophrenia, on their likelihood of relapse and their wellbeing. There was widespread concern about the eligibility criteria for some of the services and this is currently under review. Employment, housing, meaningful activity, friends and looking after one's own health are some of the key components of recovery. Service users and their carers are experts in what helps to make a difference to their recovery and thereby prevent relapse.

Recommendation:
SR-30 It is recommended that the commissioners act on the findings of the review of eligibility criteria to some services.

8 Investment in Mental health service provision

The Programme Budgeting Marginal Analysis work looked at investment in detail.[117,118] In 2010/11, of the estimated £67.6 million spent on mental health problems (where mental health was the main presenting complaint)

[115] Department of adult services, health and housing performance report, Croydon Borough Council
[116] The Schizophrenia Commission.*The Abandoned Illness.* Rethink Mental Illness, November 2012.
[117]Alves B. *Croydon PBMA review: programme budget*, April 2012. NHS South West London: Croydon Borough Team.

In 2009/10, the largest spend was in South London and the Maudsley (SLAM) accounting for 61% (£43 million) of the total expenditure. In 2010/11 spend investment in SLAM was 60% of the total (£40.4 million). In-patient services account for over half the cost of adult and older adult services (£22.9 million).

Expenditure on mental health, as a proportion of total NHS spend, has reduced over the last two years both for Croydon and the Cluster average, and is less than 12% of total expenditure across all programme budget categories. For four of the last five years (2006/7 to 2010/11) Croydon PCTs' expenditure on mental health per head of population was lower than the average spend of the cluster. In 2010/11 Croydon ranked 66th highest out of the 152 PCTs in England in terms of expenditure per weighted head of population. However little is known about health gain from this investment.

In 2010/11, Croydon Council invested £13.3 million in mental health services for adults (£7.9 million) and older adults (£5.3 million). Over 55% (£4.4 million) of the adult budget was spent on accommodation such as supported housing and 67% (£5.3 million) of the older adult budget was spent on residential care. Overall 60% was spent on accommodation or accommodation related services.

A very detailed review of mental health investment in Croydon is underway and will report in early summer 2013.[119]

9 What do people think about local service provision and how it could be improved

Views about service provision in Croydon were obtained from service users, carers, providers (from the voluntary sector, user-led organisations, GPs and secondary care) and even some members of the general public.

Consultation took several forms:

- One-to-one meetings with service provider representatives (18)
- Mental health forum meetings with users & carers (30 people)
- Online survey available to anyone (54; including 20 users & carers)
- Consultation event open to a range of service providers & users (42)
- Review of issues raised in the Hear-Us linkworker reports.[120]

The one-to-one meetings and the first mental health forum meeting asked people to identify the key issues about service provision for people with

[118] Alves B. Croydon mental health PBMA review: final report and recommendations, April 2012. NHS South West London: Croydon Borough Team.
[119] Mental Health Strategies, Croydon Mental Health Value for Money Review
[120] http://www.hear-us.org/

severe mental illness in Croydon. The consultation event, the on-line survey and the second mental health forum meeting asked about available assets, current challenges, and changes needed to help keep people with severe mental illness/schizophrenia out of hospital. A number of key themes emerged:

1. **More support needed**. Many of the comments and issues were around a perceived lack of support. People felt there needed to be greater support or capacity in the following areas:

   Recovery Teams; Home Treatment Teams; Support on discharge; Housing ; Benefits; Support from voluntary and community sector services; Psychological therapies; Out of hours and crisis support; Activities when an inpatient; medication decisions; inpatient beds; home visits
2. **Greater integration.** Between primary and secondary care and between health and social care. Issues included:
   - Easier access to secondary care support from primary care by GPs
   - Easier discharge back to primary care supported by shared care protocols for the prescribing of anti-psychotics
3. **Better information** about services, how to access them and how they are linked.
4. **Strategic improvements.** Need for a strategic vision, better measurement of outcomes, greater understanding of reason behind relapses. Need for a rebalancing of investment between prevention and treatment, primary and secondary care, medical and social support, statutory and voluntary sector provision.
5. Need to view provision as a whole system
6. **Greater service user choice and involvement**. In treatment options, and medication decisions.
7. More emphasis on recovery focused activities
8. Overcoming stigma and discrimination
9. Better recognition and management of physical health conditions
10. Improved access for BME populations
11. Greater support for carers
12. Reducing variation in quality of staff, services and staff attitude

The following assets were identified:

- GPs and primary care
- Many secondary care services; Home Treatment Team, Coast, Care Coordinators, Foxley Lane, psychology therapies, SUN, COS
- Voluntary sector support and social inclusion services – Mind in Croydon, Imagine and Rethink were named.

Participants at the consultation event made the following key recommendations to prevent hospital admission:

- Expand existing social inclusion services, reducing eligibility so they are more inclusive, preventing delayed access and relapse
- Bring back open access support services seven days a week and out-of-hours
- Ensure consistently good discharge meetings including all involved, and regularly review plans
- Make a prodromal service available in Croydon

Further detail is provided in *Appendix 5.*

Much of what was found in the service section was also identified in the consultation. However, additional issues were raised within the consultation, particularly:

- More information needed eg understanding CAGs, SDS
- User choice – in medication
- Staff attitude
- Need for a strategic vision in MH
- Support for carers

Recommendation
SR-31 It is recommended that commissioners improve user involvement in choice around care and treatment decisions and ensure the workforce is developed to meet users expressed needs for a more recovery focussed approach to care.

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