Service changes in Croydon / Update on Psychosis

Dr Hugh Jones
Clinical Director Croydon
Croydon Operations directorate

• Dedicated service director for adult services
  Currently Dr Faisil Sethi
• Clinical Director (Hugh Jones) and Medical Lead (currently Dr Sarah Cornick)
• Head of nursing (Julie Hayward)
• There will be managers with specific responsibility for inpatient and community services
Progress to date

• Borough directorate started May 2018
• Introduction was shortly followed by CQC inspection in July 2018
• Thus far still recruiting to management team
Relationship between Croydon and wider trust

• Croydon will manage services (avoids situation where distinct community services were managed by different departments)

• Trust will still have a role in larger initiatives eg MADE (multi agency discharge events).

• CAG’s will have role at this trustwide level rather than local service management
Current service structure

• Adult services currently use psychosis to help organise themselves
• Partly nationally driven (early intervention in psychosis EIP)
• Also reflects local decision making at trust level (Promoting Recovery Teams (PRT) and MAP Treatment teams) and at Borough Level (primary care psychosis team)
Early Intervention in Psychosis

• Standard practice for over 10 years
• Developed on basis of evidence that delaying treatment in psychosis is associated with poorer outcomes and hope that such treatment might delay/ prevent the development of chronic illnesses
• Initially for age range 16-35 but more recently age limit removed (so 16-65).
Early Intervention in Psychosis

• Such teams allowed development of specific interventions eg family therapy, CBT for this specific client group
• Teams set up to manage patients for a 3 year period before transferring either to another secondary care team or primary care
Early Intervention in Psychosis

• Standard is that 50% of individuals with a first onset of psychosis will be receiving NICE guidelines treatment within 2 weeks of referral.

• Definition of First episode psychosis includes symptoms of a duration of at least 1 week.

• Current experience is that EI services struggle to manage potential demand.
Current challenges in EI

• How to manage ‘potential’ demand?
• How to address the needs of individuals who do not meet criteria for EI services?
• How to manage patients at end of EI treatment?
• How to manage the reality of treatment resistance for 10-15% of caseload?
Psychosis not a euphemism for schizophrenia

- EI services often unkeen to make a diagnosis of schizophrenia
- Other options for a psychosis ‘diagnosis’ are available eg F28, F29 (variants of non-organic psychosis)
- EI teams are open to other psychotic disorders (eg depression, bipolar disorder)
- Inevitably a proportion of patients will not have a psychotic illness
Transfer to primary care

- Hopefully most people discharged to primary care from EI will not have schizophrenia.
- Need to be aware that some ‘diagnoses’ are really descriptions (non-organic psychosis) that convey little information about prognosis.
- It is reasonable for you 1) to know functional outcomes 2) likelihood of relapse 3) potential role of medication.
Psychosis teams

• Drivers in developing these did not include discussion with primary care.

• In traditional community teams patients were managed ‘as if’ they were highly dependent with an incapacitating illness.

• Opportunity to develop new treatment interventions (especially psychotherapy) based on experience of EI.
Current reality / challenges

• System is overcomplicated and focus of community services has been diverted away from either managing acute admissions / relapse or being focussed on needs of primary care

• Psychosis is not a clean discriminator between patients / diagnoses