Psychosis

Clinical Academic Group

KING'S HEALTH PARTNERS

An Academic Health Sciences Centre for London

Pioneering better health for all

King's Health Partners has:

- Three of the UK's leading NHS Foundation Trusts
- A university ranked 19th in the world
- 4.2M patient contacts each year
- Over 36,000 staff
- More than 25,000 students
- A combined annual turnover of £3.1bn
- Clinical services provided across central and outer london locations, including nine mental health and physical healthcare hospitals and many community sites
- A comprehensive portfolio of high quality clinical services with international recognition in cancer, diabetes, mental health, regenerative medicine, cardiac and clinical neurosciences
- A major trauma centre and two hyper-acute stroke units.

About King's Health Partners

King's Health Partners Academic Health Sciences Centre brings together one of the world's top research-led universities, King's College London, and three of London's most prestigious and highly regarded NHS Foundation Trusts – Guy's and St Thomas', King's College Hospital and South London and Maudsley.

The partnership provides an unrivalled combination of complex clinical specialties that cover a wide range of physical and mental health conditions and a breadth of research expertise that spans disciplines from medicine and biomedical sciences to the social sciences and humanities.

There are three parts to our mission: to achieve excellence in research, education and clinical care.

To support our mission, we will be developing and delivering programmes of work to:

- Join up mental and physical healthcare so that we treat the whole person, mind and body
- Increase the value of the care we provide and the outcomes it achieves for our patients and service users
- Integrate care across local primary, secondary and social care services to make it easier for people to get the care and support they need
- Improve the public health of our local community by tackling inequalities and supporting people to make healthy lifestyle choices.

We are uniquely structured to deliver our mission for excellence – our 21Clinical Academic Groups (CAGs) bring together all the clinical services from the three trusts with the relevant academic departments of King's College London.

Foreword

Professor John Moxham, Director of Clinical Strategy

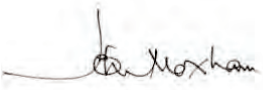
Across King's Health Partners we are committed to providing accurate and timely information about patient care and believe that identifying, measuring and publishing healthcare outcomes results in a culture of improvement and increased value. This is why we are publishing a series of outcomes books that will help patients and referring clinicians make informed decisions and drive up the quality of the care we deliver.

The books report key outcomes for treatments that are provided by our 21 Clinical Academic Groups (CAGs). They are designed for a clinical and lay audience and contain a summary of patient volumes and measures (e.g. length of stay, re-admissions, patient experience), clinical outcomes, educational activities, technological and research innovations and publications. CAGs form the building blocks of our Academic Health Sciences Centre. We believe that by bringing together our clinicians and academics across teaching, training and research, we can achieve better outcomes for patients. The primary purpose of King's Health Partners is to improve health and wellbeing locally and globally. We must deliver this goal against a challenging economic environment, with rising demand for, and costs of, healthcare. We will only achieve sustainable health improvement if we strive always to increase value. We define value in terms of outcomes that matter to patients, over the full cycle of care, divided by the cost of producing those outcomes. By publishing outcomes books we have more information to support us measuring the value of the healthcare we provide.

These books are a work-in-progress. Our goal is to increase the depth and breadth of reporting each year. Outcomes data will be updated and reported on annually to demonstrate progress against our mission to achieve world-class research, education and clinical care. We hope you find these data valuable, and we invite your feedback.

Please send comments and suggestions to us at kingshealthpartners@kcl.ac.uk For more information please visit our website at www.kingshealthpartners.org.

Yours faithfully,



Professor John Moxham, Director of Clinical Strategy, King's Health Partners
August 2014

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Integrating mental and physical healthcare within King's Health Partners

Mental and physical integrated healthcare

King's Health Partners aims to create a centre where world-class research, education and clinical practice (the 'tripartite mission') are brought together for the benefit of patients.

We want to make sure the lessons from research are used more swiftly, effectively and sympathetically to improve healthcare services for people with physical and/or mental health problems.

We will achieve this transformation of healthcare for the whole person, through our commitment to integrated mental and physical healthcare, research, education and clinical delivery, across our breadth of services and from conception to the last days of life.

We aim to:

- Transform outcomes for patients with both mental and physical health conditions, to ensure that care in all healthcare settings addresses the whole person, and is patient centred
- Expand our internationally recognised programme of mental health research and provide comprehensive innovative staff education programmes

- Develop and evaluate novel and integrated mental and physical healthcare pathways in collaboration with commissioners, patients and primary care colleagues.

More specifically, we will:

- Address underlying physical health risk factors which contribute to the excess mortality and morbidity experienced by patients with enduring mental health problems
- Reduce the adverse impact of mental health disorders on outcomes of long-term conditions and medically unexplained symptoms
- Integrate service provision for the whole person throughout all of our specialties.

Academic integrated care system

We are committed to working with our partners across local boroughs to integrate services at a local level to improve patient care. To this end we will use 2014/2015 to test the provider offer of new models of care to enable a more integrated academic healthcare system.

We are a founder member of Southwark and Lambeth Integrated Care (SLIC), a movement for change aiming to genuinely transform how care services are delivered so they are coordinated around the needs of people, treating mental health, physical health and social care needs holistically.

This programme is vital to address the crisis within our healthcare economy and quality must improve significantly so people receive effective care and experience it positively.

A lot has already been achieved. Work to date has built an ever deepening shared understanding of the issues, a commitment to action, and an understanding of the options to reduce avoidable emergency admissions, speed up delays in discharge, improve mental and physical health liaison and reduce admission to residential care.

Public health integrated care system

Public health has been identified as a priority for King's Health Partners and is one of our biggest challenges. We have developed a strategy approved by our Board – over the next five years we aim to be recognised internationally for our academic and service innovation in urban public health in addressing local and international issues, with a focus on inequalities in health and healthcare delivery, particularly with regard to ethnicity and deprivation.

Our Clinical Academic Groups (CAGs) and the south east London sector will be an innovative test bed to develop and trial solutions in prevention and management of long term conditions of public health importance, thereby achieving academic, training and service delivery to improve public health excellence.

In order to reduce morbidity and premature mortality whilst reducing health inequalities in south east London, all CAGs are responding to the call for increased action on smoking and harmful drinking. We are implementing both an alcohol and tobacco strategy which has so far helped us in:

Alcohol strategy

- Developing appropriate resources for clinical staff and patients
- Developing and implementing training for all staff on alcohol early identification and intervention
- Establishing ourselves as a centre of excellence for integrated research, training and practice in the management and prevention of alcohol misuse
- Attracting funding for future alcohol clinical, training and research initiatives
- Monitoring the impact of the strategy on indicators of alcohol related harm.

Tobacco strategy

- Supporting all cags to be smoke-free
- Developing an informatics structure for routinely and systematically recording smoking status
- Support, referrals and treatment uptake for smoking cessation across the partnership
- Co-producing clinical care pathway for nicotine dependence treatment
- Co-producing nicotine dependence record card for service users
- Developing and implementing training packages for smoking cessation interventions for all our healthcare professionals
- Monitoring the impact of our smoking cessation strategy in relation to knowledge and uptake of skills by staff, uptake of smoking intervention, outcomes of intervention, user satisfaction, prevalence of smoking, cost-effectiveness of interventions.

Introduction to The Psychosis Clinical Academic Group (CAG)

The Psychosis CAG brings together the largest group of psychosis expert clinicians, researchers, academics and clinical staff in the world, working across King's College London and the South London and Maudsley NHS Foundation Trust.

The Psychosis CAG provides treatment for 9,600 service users across Southwark, Lambeth, Lewisham and Croydon.

5,700 of our service users are on the Care Programme Approach (CPA), although not all CPA service users are inpatients and we have:

- 270 acute inpatient beds
- 32 psychiatric intensive care (PICU) beds
- 86 rehabilitation beds
- 300 supported accommodation placements.

Our primary aim working with service users is to support them in their recovery.

We received national recognition for the four-part documentary series called 'Bedlam' about the South London and Maudsley NHS Foundation Trust, by winning a BAFTA television award this year.

The four-part documentary series SLaM made with Channel 4 and Garden Production was declared the winner of the 'best factual series' category.

SLAM's Chief Executive Matthew Patrick said:

> *"I am absolutely delighted and incredibly proud to announce that Bedlam has won a BAFTA television award. Bedlam was a pioneering series which was sensitively made and reflects the realities of living with mental illness. We took part to help raise awareness of mental illness and from the public reaction so far*

we have gone some way to achieving that. I am honoured we were part of it and want to thank our staff and patients for their time, dedication and commitment to the series. Now it appears that mental health is very much on the map and hopefully here to stay."

Incidence of psychosis within our boroughs in comparison to other London boroughs

There are very high incidences of psychosis within the London boroughs, with an incidence rate ratio for all psychoses of 40.6 per 100,000 (compared to a national figure of 24 per 100,000).

This elevated incidence of psychosis disproportionately affects minority ethnic groups and has been evident in the South London and Maudsley Trust activity data over many years.

The London borough of Lambeth has the third highest number of new cases of psychosis in London, and in addition the incidence rates in Lambeth and Southwark are more than twice the average rates for England.

The four boroughs where we provide services are in the highest nine of the thirty three London boroughs for new psychosis cases and in the highest 20 Local Authorities in England and Wales. It is predicted that locally there will be around four hundred new case of psychosis each year.

Kirkbride et al, 2013 – *'more resources are required to help with the tide of psychotic illness in inner cities'.*

Incidences of psychosis in London boroughs

The following graphs indicate the incidence rates and number of cases of psychosis in our boroughs compared to other London boroughs. Data are taken from Version 1.0 of PsyMaptic (2014), details of the methodology used are in Kirkbride et al, British Medical Journal Open (Feb 2013).

Figure 1 | Incidence per 100,000 (2014)

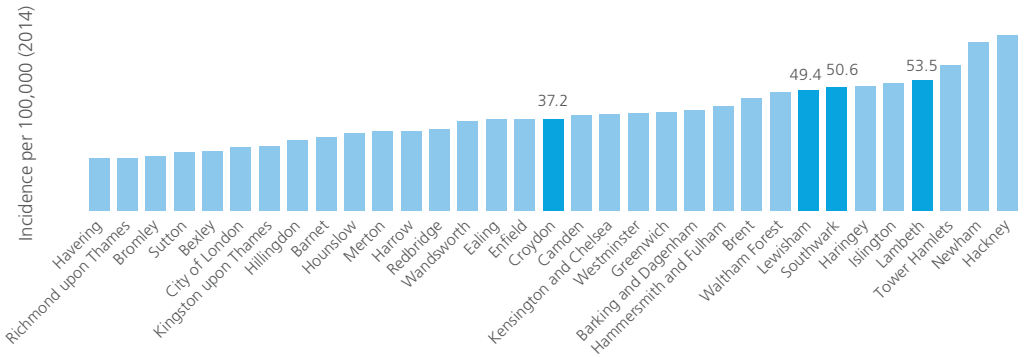
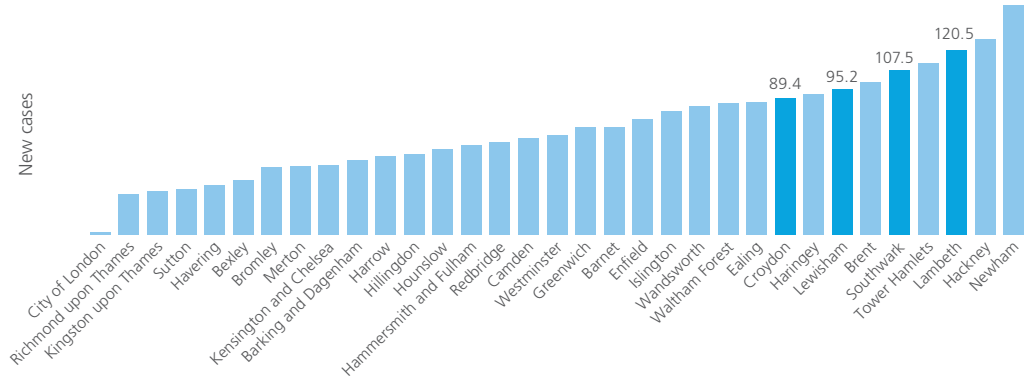


Figure 2 | New cases (aged between 16–64) 2014



List of services

Early Intervention Care pathway

- Early Intervention Teams
- Early Onset Services (OASIS)

Promoting Recovery Care pathway

- Psychosis Community Teams
- Social Inclusion Services
- Primary Care Mental Health Service
- Improving Access to Psychological Therapies (IAPT) for people with psychosis
- START Homeless Service
- SHARP
- PICUP
- TREAT
- Specialist Community Teams

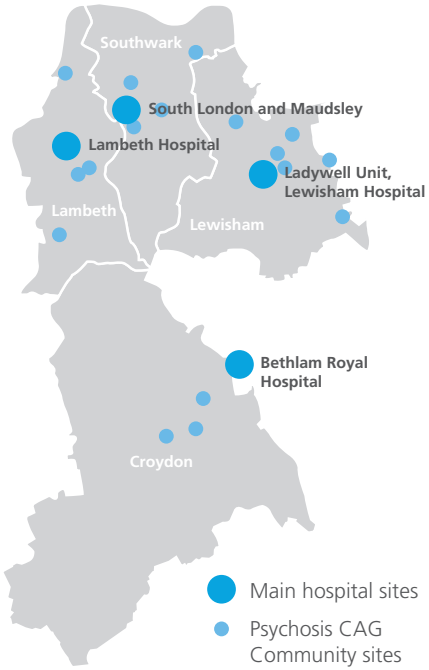
Acute Services Care pathway

- Acute Inpatient Wards for men and women
- Early Intervention Unit
- Psychiatric Intensive Care Units (PICU)

Complex Care pathway

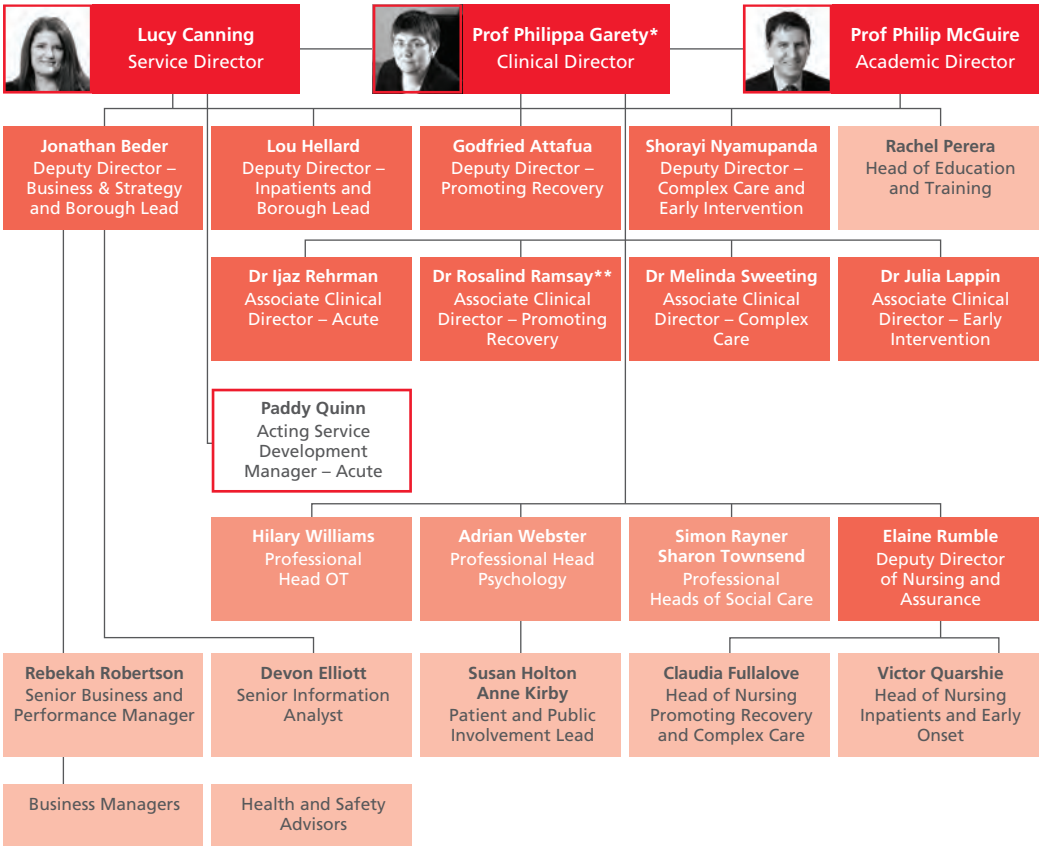
- National Psychosis Unit and Outpatients
- Community Forensic Services
- Placement Management Teams
- Rehabilitation Inpatient Units
- Challenging Behaviour Units

Figure 3 | Where our teams are based




NHS STAFF

Team structure



* Role temporarily covered by Dr Rosalind Ramsay until 30.9.2014

** Role temporarily covered by Dr Steve Church

Our vision and strategy

Our aim is to develop the first comprehensive, stage specific psychosis service in the world, based on four 'care pathways' in order to improve service user and carer experience whilst at the same time improving clinical and social outcomes.

Our care pathways are:

- **Early Intervention:** provides community care for people at high risk of psychosis, and people experiencing a first episode of psychosis
- **Promoting Recovery:** provides community care for people with a psychotic disorder who are not in an acute crisis, but require continued treatment
- **Acute:** provides inpatient care across fourteen acute wards and three psychiatric intensive care wards
- **Complex Care:** provides rehabilitation services across four inpatient wards, as well as community based placement monitoring and review services. It also covers the CAG's national service, the National Psychosis Unit, which provides services for service users with complex and co-morbid psychosis.

Each care pathway is led by a Deputy Director and an Associate Clinical Director who are responsible for the operational and clinical performance of their pathways.

Our pathways are organised CAG-wide across four boroughs, thereby ensuring equity and consistency. We also recognise organising care locally that interfaces with other appropriate CAGs providing operational borough focus, is of the highest importance to us in ensuring the smooth running of our services.

Research activity is also organised within each care pathway. This has fostered the development of early intervention, relapse prevention and treatment resistance as academic subspecialties in their own right.

In order to achieve this our clinical priorities are:

- Specialisation of general adult mental health services into clinical-academic psychosis services with provision of stage specific care and treatment in our four care pathways
- Staff focus on a particular set of interventions and development of specialist expertise

- Ensuring service users find it easier to understand what they are being offered at each stage of their illness
- In addition to providing treatment we help service users recover and find fulfilment in their lives through education or employment
- Ensuring effective links between physical and mental healthcare, especially in primary care (GPs)
- Developing structures for effective service user involvement which puts service users and carers at the heart of service developments.

What is recovery?

"Recovery simply means living as well as possible"

The concept and idea of recovery for our CAG has emerged from stories and experiences of our service users with mental illness.

We know there are many ways to realise recovery through personal journeys and we are constantly taking into account service user journeys to ensure we provide the optimum environment for recovery.

The idea of recovery from mental illness has grown in recent years and challenges the view that severe mental illness is ever lasting, gets worse and prevents people from engaging in society. Fortunately for service users, carers and staff, the view now is much more aligned to an understanding that people can and do recover.

There are two main meanings of recovery and recognising the difference is important:

- Clinical recovery comes from the expertise of mental health professionals and involves the improvement in mental wellbeing, so symptoms no longer cause distress or impede functioning, restoring social functioning and 'getting back to normal' i.e. how you were before your illness
- Personal recovery comes from the expertise of people with lived experience and means something different to clinical recovery (Rethink 2014).

An often quoted definition of recovery is: "… a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and/or roles. It is a way of living a satisfying, hopeful and contributing life even with the limitations caused by illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness." (Anthony1993).

There is no set model of recovery and it is better to speak about recovery ideas or concepts such as;

- Recovery is about individualised approaches and as the definition suggests, it is about having a satisfying and fulfilling life, as defined by each person
- Recovery does not necessarily mean 'clinical recovery' (usually defined in terms of symptoms and cure) – it does mean 'social recovery' – building a life beyond illness without necessarily achieving the elimination of the symptoms of illness
- Recovery is often described as a journey, with its inevitable ups and downs, and people often describe themselves as being in recovery rather than recovered.

Key building blocks emerging from peoples stories of their own recovery with mental illness are:

- **Finding and maintaining hope** – believing in oneself; having a sense of personal worth; being optimistic about the future
- **Re-establishment of a positive identity** – finding a new identity which incorporates illness, but retains a core, positive sense of self
- **Building a meaningful life** – making sense of illness; finding a meaning in life, despite illness; becoming engaged in life
- **Taking responsibility and control** – feeling in control of illness and in control of life.

References

Anthony, WA (1993) *Recovery from Mental Illness: the guiding vision of the mental health services in the 1990s, Innovations and Research*, 2, 17–24.

Rethink Website www.rethink.org/living-with-mental-illness/recovery

Psychological therapy outcomes

Psychological therapists work across all the Psychosis CAG services with people who experience distress or adverse life events which impact on their mental health. Anyone can be referred, and the National Institute for Health and Care Excellence (NICE) recommendation is that all service users with psychosis should have the opportunity to participate in individual therapy, while all families of people with psychosis who live with, or are in close contact with the service user should be offered family intervention.

Psychological therapies are particularly indicated if the person wants help with managing their experiences or symptoms, or if they report unusual and distressing life experiences and emotional difficulties. Different evidence based

or best practice approaches are used, depending on the presenting difficulties and the service user's preferences. The most common approach is cognitive behavioural therapy (CBT) where the service user and psychological therapist meet regularly for a period of therapy, to look together at difficult experiences, and find new, helpful ways of coping with or thinking about them. Psychological therapists can see people individually, in groups or with their families, whichever is most helpful.

There is increasing evidence people experiencing psychosis can and do recover from their difficulties. Even if people continue to have some difficulties, they are able to "stay in the driver's seat" of their life. A number of common aspects of the experience of recovery include: "redefining self and accepting illness; overcoming stigma; renewing a sense of hope and commitment; resuming control over and responsibility for one's life; exercising one's citizenship; managing symptoms; being supported by others; and being involved in meaningful activities and expanded social roles". Recovery researchers emphasised that recovery is not a 'one-off' event; rather, it is better understood as an ongoing process or journey.

Psychological therapies for people with psychosis are carefully tailored to match the person's stage of recovery and facilitate their progress towards their recovery goals.

The improving access to psychological therapies for people with severe mental illness (IAPT-SMI) initiative is part of the government's four-year plan to increase access to talking therapies, to improve provision of NICE recommended psychological therapies for people with bipolar disorder, personality disorders and psychosis.

South London and Maudsley (SLaM) NHS Foundation Trust is one of two national IAPT-SMI demonstration sites for psychosis, which started in November 2012.

Our IAPT-SMI demonstration site comprises of three clinical teams in our CAG:

- Early Intervention team (STEP)
- Specialist Recovery service (SHARP)
- Psychological Therapy team (PICuP).

These teams work across two care pathways providing specialist community mental health care for people with psychosis.

Those care pathways are, Early Intervention pathway for first presentations of psychotic difficulties and the Promoting Recovery pathway for people with persisting difficulties.

The teams operate across primary and secondary care, working closely with the wider multidisciplinary community teams.

The IAPT-SMI service offers cognitive therapy for psychosis, an adaptation of CBT for emotional disorders tailored to the needs of people with

psychosis, and also family intervention for psychosis, a talking therapy involving both the person with psychosis and their carers.

One service user's feedback from their psychological therapy quotes:

"Therapy has given me a set of tools that will help me to move forward with the future. I now feel confident recognising when stress builds up and how to cope with this."

Pharmacological outcomes

The majority of service users in SLaM will receive medication at some stage in their treatment. In addition, the use of medicines forms part of the roles and responsibilities of our clinical staff. We aim to ensure the use of medicines is safe, appropriate and cost-effective, whilst providing service users with a choice in the medicines they are asked to take.

The Trust agrees each year, certain medicines related outcome measures. In addition, a programme of survey and quality improvement is defined each year to ensure these outcomes are met.

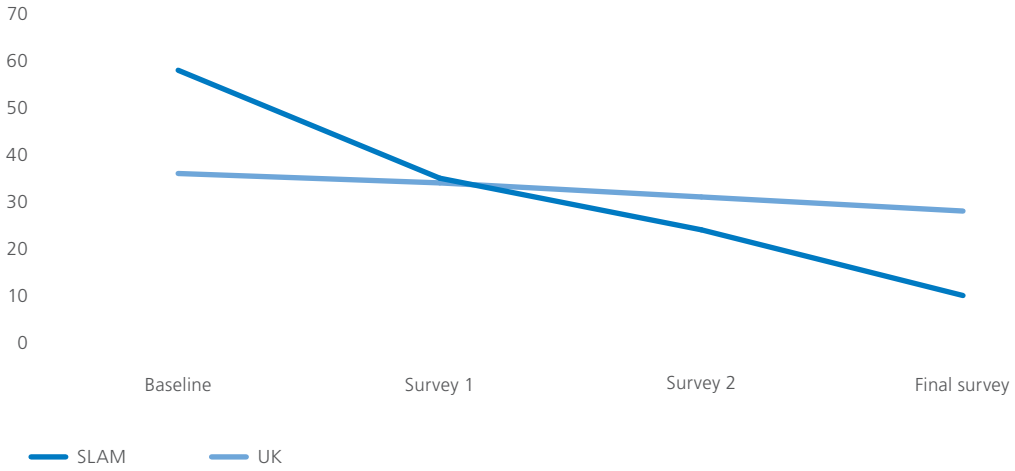
Examples of outcomes achieved in 2012–13

Reduction in the rate of prescribing of high-dose anti-psychotics in SLaM

In March 2006 we participated in a national survey (POMH-UK) of antipsychotic prescribing. Results showed a higher rate of high-dose antipsychotic prescribing in SLaM than in the average national sample. We designed and implemented a programme aimed at improving practice.

Results of the March 2012 national POMH-UK audit showed not only had we reduced significantly the rates of high-dose antipsychotic prescribing between 2006 and 2012 but that rates in our trust are now lower than in the rest of the UK.

Figure 3 | Reduction in the rate of prescribing of high-dose anti-psychotics in SLaM



Psychopharmacology in the Psychosis CAG

Introduction

Psychopharmacology in the Psychosis CAG exemplifies the King's Health Partners tripartite mission in which high quality teaching, international calibre research and expert clinical management is integrated to improve service user outcomes.

Below are some examples of what successful treatments and research we are involved with to improve service user outcomes.

Powerful treatments

Psychiatric medications are amongst the most effective treatments across the whole of medicine. Careful individually-tailored prescribing can keep people mentally-well and functioning for years.

Expert evidence based assessment

Before any prescribing takes place accurate assessment and diagnosis is vital. Accurate and early diagnosis is paramount so service users can receive the correct treatment. Our Early Intervention pathway has developed standardised physical and laboratory assessments for all new service users, so neurological and immunological disorders can be recognised early. Our research enables such knowledge to be disseminated rapidly within the range of CAG teaching programmes we provide.

Effective treatment for the first episode of psychosis

The Psychosis CAG primarily helps people in the midst of their first psychotic breakdown. The overwhelming majority of people suffering a first episode psychosis will recover with first-line pharmacological treatment, overseen by expert prescribers.

Data from the Early Intervention pathway in the Psychosis CAG illustrates over ninety percent of people will experience clinically significant improvements with first-line anti-psychotic medication.

Treatment for optimising recovery and reducing relapse

After resolution of an initial episode of psychosis, our focus is on optimising recovery, restoring functioning and in preventing relapse. At this stage psychopharmacological treatments blend well with psychological treatments, family work, and social interventions. A significant effort is aimed at decreasing the chances of relapse. Relapse can be catastrophic, leading to a further cycle of illness, loss of functioning, and in some cases to hospitalisation. Cannabis abuse for instance can lead to a rapid re-emergence of symptoms.

Work in the CAG over a number of years demonstrates strong forms of 'skunk' cannabis are particularly hazardous for mental health. Such findings have had an international impact.

The single most important factor responsible for relapse is discontinuation of medication. Recent work by clinical academics has shown people who stop their anti-psychotic medicine have a much higher chance of becoming unwell than those who remain on treatment.

Over an eighteen month follow up period those service users who discontinued anti-psychotic medication were five times more likely to experience a relapse.

Clearly any intervention which facilitated compliance with anti-psychotic treatment within the population of service users would impact upon relapse rates. For the individual service user, it is about tailoring the prescribing to maximise benefits over undesired effects and working on psycho-education and insight.

Specialist clozapine service and the National Psychosis Unit

The majority of psychotic episodes respond to first-line anti-psychotic pharmaceuticals. However there are a group of service users who remain unwell despite treatment. Thankfully a proportion will experience a significant recovery with clozapine, which is the most powerful of all anti-psychotic medicines and there may be potential side-effects which need to be monitored.

We have a dedicated clozapine clinic, the 'Treat Service', set up to provide a high quality pharmacological management for this particular group of service users. Many of our service users in this service have the opportunity to participate in cutting-edge research in brain neurochemical imaging.

The National Psychosis Unit (NPU) provides expert assessment and management of the most complex cases of psychotic illness. Many of our service users referred to the NPU suffer from physical co-morbidity, intractable psychosis or require enhanced monitoring for the initiation of clozapine. At the NPU we are leading large-scale projects designed to improve physical health outcomes in service users living with psychosis.

One of the major questions in this field is 'What differentiates the neurochemistry of those service users that make a poor recovery from those who do well with existing treatments?'

Clinical academics in the Treat Service and at the NPU are at the forefront of the international effort to understand and predict treatment response in psychotic illness, and have already made several pivotal contributions to the literature.

At the Treat Service and the NPU we are pro-active in sharing our expertise in a number of formal and informal teaching sessions within the CAG, to the benefit of the next generation of mental-health workers.

The Clinical Trials Office: Next generation anti-psychotic treatments

A new initiative funded by the Biomedical Research Centre (BRC) at King's Health Partners is a dedicated trials office based in the Psychosis CAG.

The principle is, service users and their families should have the opportunity to hear about the development of potential new treatments for psychosis, and have the opportunity to volunteer as participants if they wish.

Currently we have three programmes in operation looking at the molecules, cannabidiol (CBD), nitric-oxide, and the antibiotic minocycline. All are safe, well tolerated, and show promise to those service users involved in the trials.

The Psychosis CAG is ideally placed to be leading the search for new and improved pharmacological treatment strategies for both current and future service users.

Improving physical health and plasma level monitoring in service users prescribed lithium

change to National Institute for Health and Care Excellence (NICE) recommends all service users prescribed lithium should have their renal and thyroid function and lithium plasma levels monitored regularly during treatment. In 2009 we participated in a national (POMH-UK) audit of lithium use. Results showed that monitoring for service users was undertaken less frequently in SLaM than in the average national sample: we therefore introduced an improvement programme.

Results of the June 2013 national (POMH-UK) audit showed an overall improvement in the physical health and plasma level monitoring for service users prescribed lithium. Monitoring of renal and thyroid function was found to be better in SLaM than in the national sample.

“I really value the input that my psychologist has into my life. My self-regard is getting better”

Figure 4 | Proportion of service users in SLaM and the UK prescribed lithium for whom there was evidence of testing of renal function at each survey

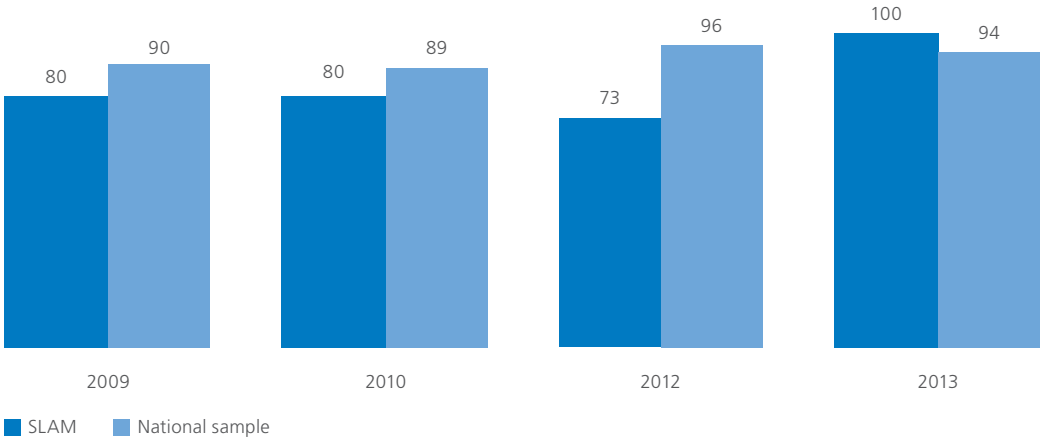
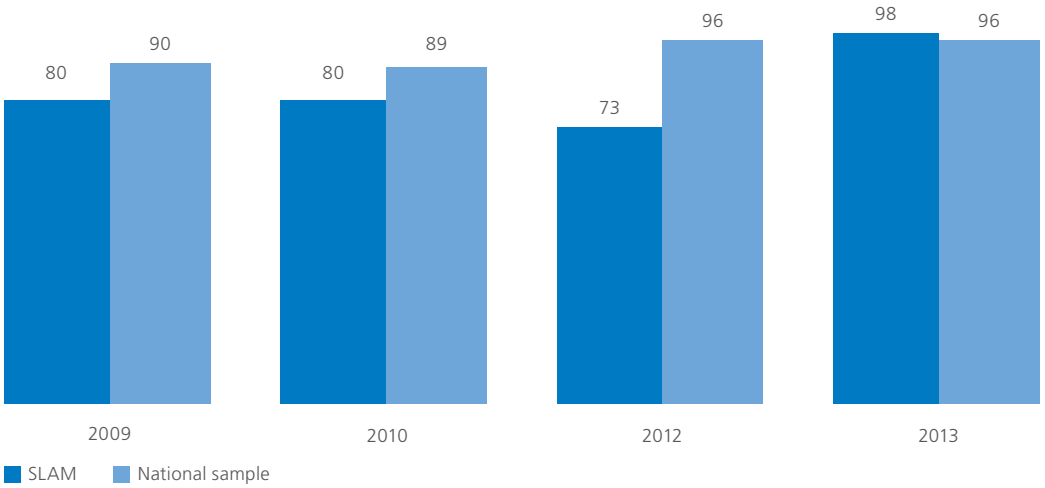


Figure 5 | Showing the proportion of service users in SLaM and the UK prescribed lithium where there was evidence of a lithium plasma level monitoring at each survey



Improving physical health monitoring in service users prescribed an antipsychotic

In December 2012, the National Audit of Schizophrenia reported that fewer service users in SLaM prescribed an antipsychotic had their plasma glucose and lipids monitored as recommended compared with the average national sample. Indeed, our own trust-wide surveys had previously revealed low rates of physical health monitoring.

In November 2013 we introduced a programme aimed at increasing rates of physical health monitoring. Results of our trust-wide survey in December 2013, following the improvement programme, illustrated all inservice users prescribed an antipsychotic were offered a test for plasma glucose, lipids and electrocardiogram monitoring.

Figure 6 | Percentage of service users prescribed an antipsychotic offered an ECG on admission to a SLaM inpatient unit. Results of the most recent physical health monitoring audit showed an increase in the proportion of service users offered an ECG during their in-patient admission (95% in November 2013 vs 55% in September 2011).

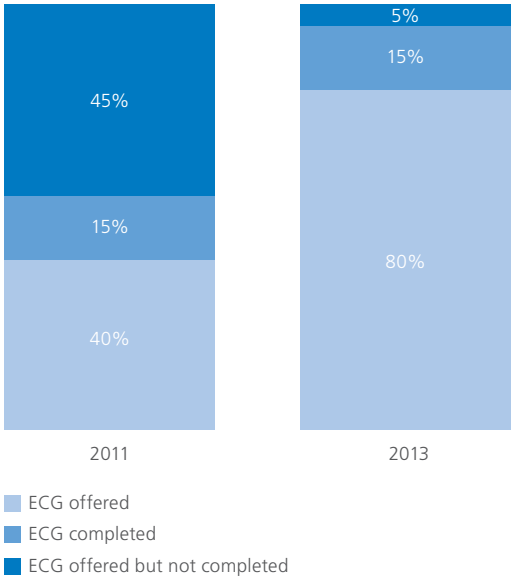
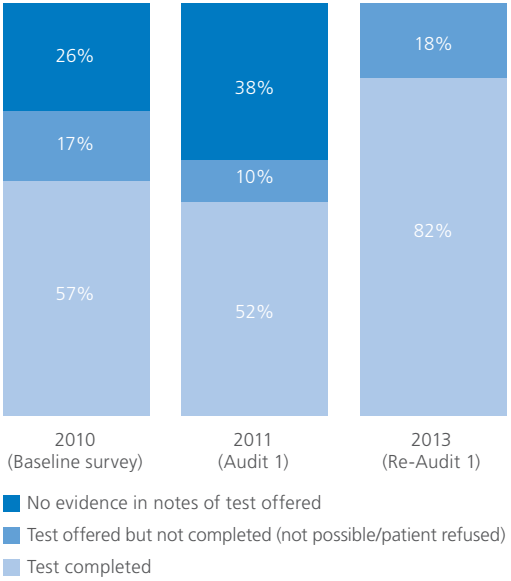


Figure 7 | The proportion of service users offered both glucose and lipid monitoring on admission



Service user experience

In January 2013, we introduced a programme aimed at improving service users' satisfaction with information they receive about medications they were prescribed.

Results of the 2013 National Patient Survey showed SLaM (previously amongst the worst performing trusts) is now one of the best performing trusts on questions related to medications.

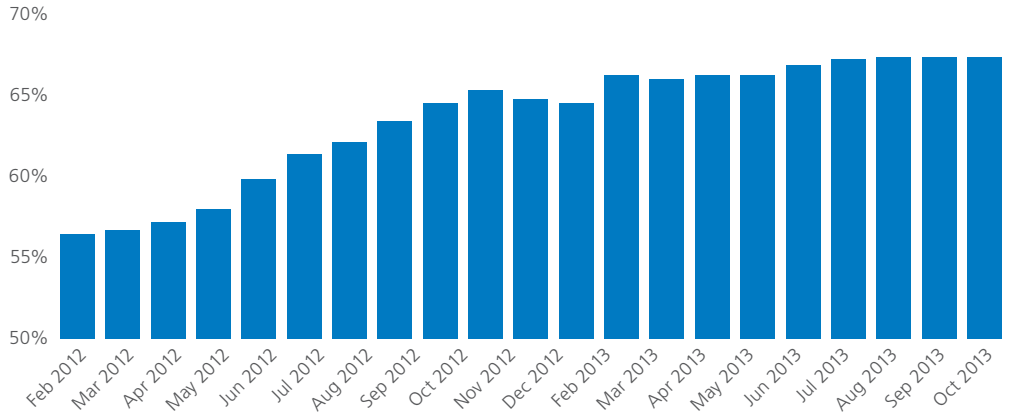
National Audit of Schizophrenia and how we compare with other organisations

People with diagnoses of severe and enduring mental illnesses are at increased risk from a range of physical illnesses and conditions, including coronary heart disease, diabetes, infections, respiratory disease and greater levels of obesity.

The Royal College of Psychiatrists published a paper in 2010 on public mental health "No Health Without Public Mental Health, which included a summary of the research evidence, demonstrating the links between mental health and physical health.

With this, there is a greater emphasis on mental health trusts checking the physical health of all their service users as an important part of their ongoing treatment and physical wellbeing.

Figure 8 | Physical health screening of service users in our CAG



Quality of care compared with other organisations in the National Audit of Schizophrenia

The care of people with schizophrenia is a national priority. The National Audit of Schizophrenia (NAS) audit standards and outcomes with the purpose of measuring the following:

- Practice in the prescribing of antipsychotic drugs
- Quality of physical health monitoring and interventions offered
- Service users' experience of care and treatment and outcomes
- Carers' satisfaction with the support and information they have received.

The measures developed from relevant guidance literature, including guidelines (CG82; NICE 2009) produced by the National Institute for Health and Care Excellence (NICE), the Royal College of Psychiatrists' (2006) consensus statement on high-dose antipsychotic medication and in national consultation, which included the NAS advisory group and a service user focus group.

This audit therefore set out to explore the application of these guidelines and attempts to develop a comprehensive picture of the quality of care people with schizophrenia receive throughout England and Wales.

The following is a sample of the outcomes data from the audit that look at how we compare to other organisations. NAS standards were drawn from the NICE Schizophrenia Guideline (CG 82; NICE 2009) and are based on nationally agreed standards of care.

Sample question	Indicator	National average	Our Trust
Service users report their experience of care was positive	As good as this	76%	**82%**
	Very much worse than this	7%	4%
Carers are satisfied with the support and information they received	Very satisfied	49%	**54%**
	Somewhat/very dissatisfied	19%	15%
Essential physical health indicators were monitored	All monitored	23%	**25%**
Clinical staff report that service users who were prescribed an antipsychotic were involved in the choice of medication	Yes	62%	53%
Service users are prescribed a single antipsychotic. The prescription of more than one antipsychotic at a time is sometimes appropriate	One antipsychotic	79%	**85%**
	Two or more antipsychotics	17%	15%
Service users with treatment-resistant illness have had an adequate trial of clozapine	Yes	81%	**100%**
Service users whose illness was not responsive to antipsychotics where offered appropriate psychological therapy	No psychological therapy offered	34%	**2%**

Overall the indicators showed our Trust performed in the middle range on most of the key standards in 2012, scoring a 100% on indicators such as the prescribing of clozapine. The bold figures show where we did better than the national average.

The indicators also show above average performance on service user experience of care and the offering of psychological therapies to treatment resistant service users.

Figure 9 | Carers' satisfaction with information and advice given

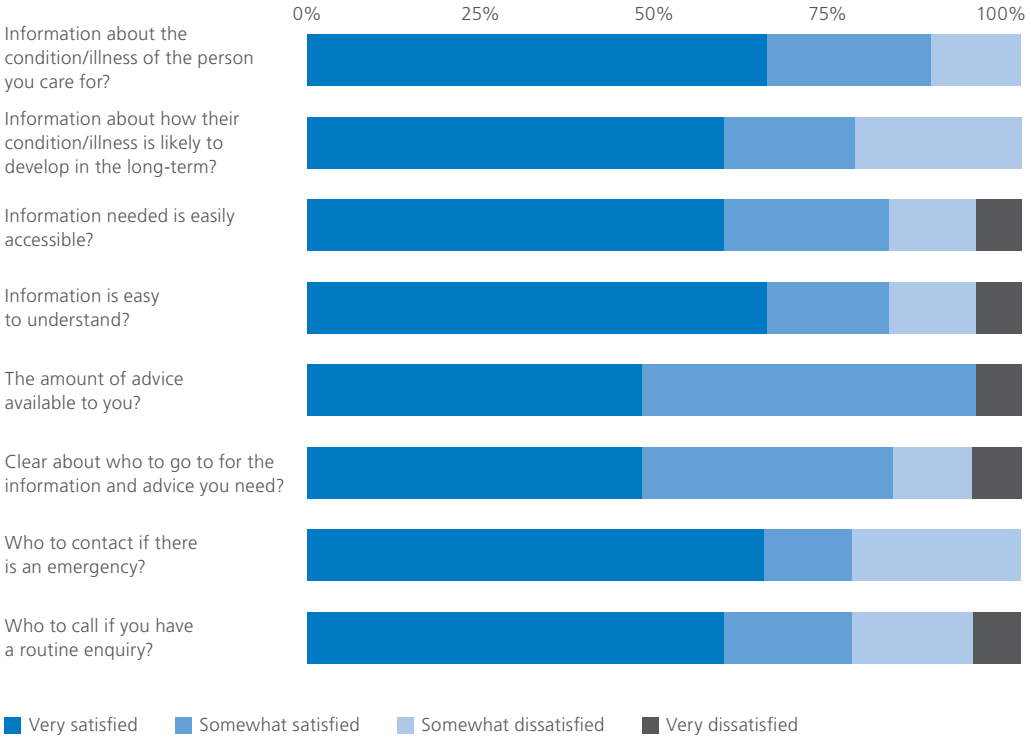


Figure 10 | Carers' involvement in treatment and care planning

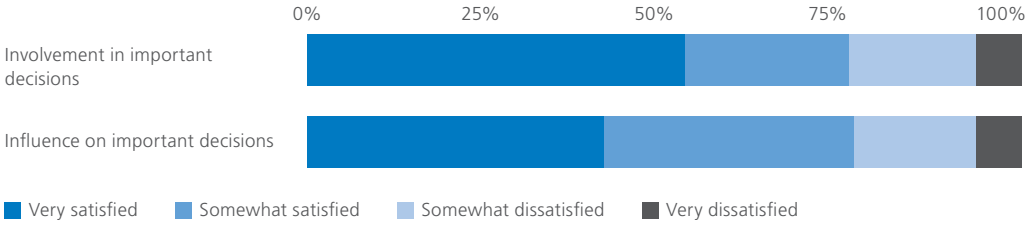
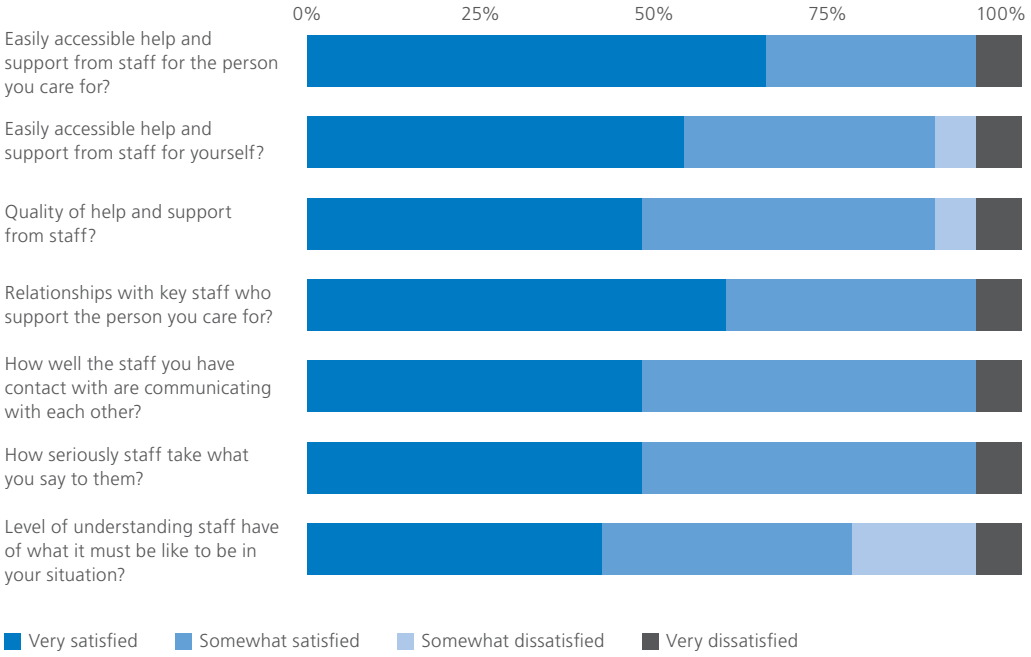


Figure 11 | Carers' satisfaction with support from medical and/or care staff




Merry Christmas

Clinical outcome measures in the Psychosis CAG

Clinical outcomes

Clinical outcomes are measurable changes in the health or quality of life of service users resulting from the care they have received. The constant review of clinical outcomes establishes standards against which we can continuously improve all aspects of clinical practice.

HoNOS

In 1993 the Department of Health commissioned the Royal College of Psychiatrists' Research Unit to develop scales to measure the health and social functioning of people with severe mental illness. The initial aim was to provide a means of recording progress towards the health of the nation target 'to improve significantly the health and social functioning of mentally ill people'.

Development and testing over three years resulted in the Health of the Nation Outcomes Scales (HoNOS), an instrument with twelve items measuring behaviour, impairment, symptoms and social functioning (Wing, Curtis & Beevor, 1996). The scales are completed after routine clinical assessments in any setting and have a variety of uses for clinicians, researchers and administrators, in particular health care commissioners and providers. The scales were developed using stringent testing for acceptability, usability, sensitivity, reliability and validity.

The 12 HoNOS scales

The HoNOS scales cover a wide range of health and social domains- psychiatric symptoms, physical health, functioning, relationships and housing:

1. Overactive, aggressive, disruptive or agitated behaviour

2. Non-accidental self-injury
3. Problem drinking or drug-taking
4. Cognitive problems
5. Physical illness or disability problems
6. Problems associated with hallucinations and delusions
7. Problems with depressed mood
8. Other mental and behavioural problems
9. Problems with relationships
10. Problems with activities of daily living
11. Problems with living conditions
12. Problems with occupation and activities

How they are scored:

0 = no problem

1 = minor problem requiring no action

2 = mild problem but definitely present

3 = moderately severe problem

4 = severe to very severe problem

Clinical outcomes team

We are able to evidence the clinical effectiveness of services with support from the Trust Clinical Outcomes Team. This small team was founded by the South London and Maudsley NHS Foundation Trust in 2006 and has been led since inception by Professor Alastair Macdonald. The team implements routine clinical outcomes measurement in Adult and Older Adult Mental Health services provided by the Trust. The team trains clinical staff to use HoNOS and supports our CAG clinicians with feedback to services of their clinical outcomes data and encourages services to engage in clinical research.

The team is a nationally recognised leader in influencing the implementation of clinical outcomes measurement in secondary mental health services across England. They make recommendations to the Department of Health on outcomes and payment by results policy developments and assist other mental health trusts with their outcomes implementation programmes. The Trust possess an extensive outcomes dataset, developed over many years, which provides practice based evidence of the clinical effectiveness of our services.

CORE outcomes

The Clinical Outcomes in Routine Evaluation Outcome Measure (CORE-OM) is a thirty four item generic measure of psychological distress, which is pan-theoretical (i.e. not associated with a school of therapy), pan-diagnostic (i.e. not focused on a single presenting problem), and draws upon the views of what practitioners considered to be the most important generic aspects of psychological wellbeing health to measure. The CORE-OM comprises of four domains:

1. Wellbeing (four items)
2. Symptoms (twelve items)
3. Functioning (twelve items)
4. Risk (six items)

Psychological therapists also routinely use formal outcome measures to check the effectiveness of their work with service users and families.

Service users are asked to complete specific questionnaires at the beginning and end of therapy. CORE-OM is the main scale currently used across the Trust to collect this outcome feedback. A shorter version called the CORE-10 (Barkham et al. 2013), is specifically designed for psychological therapy.

Respondents rate subjective wellbeing, problems, functioning and risk, on a scale from 0 to 4, with higher scores indicating greater severity of problems.

Scores are combined into an overall average distress score (Possible range: 0–4). Aggregated outcome information is collected centrally from our electronic records system. The information is then analysed anonymously and summarised into "before therapy" and "after therapy" scores. Comparing the before and after therapy paired scores using statistical analysis is one way of looking at the outcomes of therapy.

Quality of care outcomes

We aim to ensure all service users get the most effective care in a timely and efficient manner. Quality of care is a guiding principle in assessing how well the health system is performing in its mission to improve the health of service users. The quality of care outcomes we collect assess the health system's performance and measure how safe, effective, service user-centred, timely, efficient and equitable the care we provide is.

Included in this book are quality outcomes including incidents, the number of service users on the Care Programme Approach (CPA) and the number of service users that have a recovery and support plan in place.

The recovery and support plans were introduced on to ePJS (electronic Patient Journey System) in December 2012 following an eighteen month development process involving a variety of stakeholders.

The recovery and support plan is a personalised care plan. The service user uses this with their care team to plan their recovery. This is the document to use if the service user's care and support is offered through the Care Plan Approach (CPA) or if they are in receipt of a personalised budget.

The plan includes sections to help the service user think about what they can do to meet their personal goals and remain well. It is also an opportunity for the service user to let others know how they can best be supported.

The plan is jointly owned by the service user and the care team and, once agreed the care coordinator or mental health worker will input the information into the recovery and support plan documented on ePJS.

Service user experience

Collecting and analysing data about service users' experiences of healthcare is essential to achieving high quality care. Across King's Health Partners we are committed to using service user experience data to improve the quality of the care we provide.

Currently SLaM has a trust-wide tool which allows for systematic capturing of service user feedback: the Patient Experience Data Intelligence Centre (PEDIC).

PEDIC, provided by our technology partner Fr3dom Health, is an online data centre which provides a centralised and consistent approach for the purpose of measuring service user experience and allows the Trust to coherently analyse and report on feedback.

The online data centre is able to integrate both internal survey and external national survey data. The PEDIC system also makes use of electronic handheld devices able to house up to forty questions. These devices provide a means of reaching a wider portion of our service user population as they can display questions in five different languages and offer the functionality to use iconography.

The PEDIC devices are also able to explore and capture the qualitative experiences of service users either by enabling them to speak directly into the device or by inputting their comments through a keyboard.

Our service user questionnaires are devised in partnership with service users. Currently, PEDIC is incorporated into all the Psychosis CAG service types in order to capture systematic service user experience information across all of our services.

“This service has been a great help in helping me establish stability in my life”

Early Intervention Care pathway

The ethos of early intervention (EI) is to provide intensive support through a range of interventions including pharmacological and psychological therapies and also vocational, peer, and family support to young people (14–35 years) who are experiencing a first episode of psychosis and for the three years thereafter.

The EI community model demonstrates that best outcomes are achieved through intensive support delivered during episodes of need to service users, followed by a return to primary care where possible, once illness and symptoms are sufficiently treated and managed.

All service users have dedicated clinical psychological support, a dedicated consultant, and access to specialised family and vocational workers. Practitioners work in a recovery focused way, promoting an optimistic outlook. The aim is to aid young people to achieve realistic goals across clinical, social and occupational domains. Care co-ordinators typically work with a caseload of twenty clients; this has gradually increased over recent years from the recommended fifteen due to increase in demand, yet our aim remains that clients are assertively outreached and followed up and a collaborative working relationship is established with their care co-ordinator.

Clients suffering from psychotic symptoms may suffer from a range of illnesses on the psychotic spectrum (e.g brief psychotic episode; psychotic depression; bipolar affective disorder; schizophrenia); all are treated within the EI pathway and treatment and interventions are tailored to an individual's needs rather than their diagnosis. Often, specific diagnoses are avoided in favour of the general terms "psychotic illness" or "psychotic episode".

EI care offers psychological and pharmacological treatment to young people. Antipsychotic drugs are the mainstay of treatment, offered at low doses initially, with the aim of relieving distressing symptoms, and thereafter preventing further episodes.

The EI pathway within our CAG comprises of five community teams working closely with the LEO ward which is the Early Intervention Unit at Lambeth hospital.

Each of the four boroughs has a stand-alone EI service (Lambeth: LEO; Southwark: STEP; Croydon: COAST; Lewisham: LEIS) which provides intensive support to those aged 18–35 who develop psychosis for the first time.

In addition, all boroughs except Croydon have an outreach and support in south London service (OASIS) which provides input and support to those deemed to be at Clinical High Risk (CHR) for the development of a psychotic illness.

The duration of a period of care working with a service user is typically three years, in keeping with EI recommended policy in the UK.

Following a period of care the aim is, where possible, to have enabled a service user to achieve recovery and to function independently so they no longer require intensive mental health team support. Currently, typical discharge rates from EI community teams to primary care average 50%.

The Early Intervention Unit is a stand-alone inpatient unit which provides intensive care and support to young people experiencing an acute episode of psychotic illness which requires treatment in hospital. The unit is managed as part of the Acute Care pathway and is a key component in the treatment of service users in Early Intervention services.

The EI unit has a youth focus, with daily activities available to service users, such as psychological groups, art therapy, physical healthcare and exercise, and many others. The ward staff are specialised in the recognition of psychotic symptoms and the associated distress often caused, and provide both practical and emotional support.

There is a strong collaborative focus, encouraging young people and their families and carers to be actively involved in their care planning. The ward provides service users and their carers with information about psychotic illness and signposts helpful resources in the local community available to them on discharge.

The EI unit works closely with each of the community teams, and regular care review meetings are held on the ward with the service users, their carer, and their care co-ordinator in order to ensure continuity of care when service users are well enough to be discharged.

Other priorities for the EI Care pathway include:

- Monitoring of physical healthcare in the EI population, both in ward and community settings in order to promote a holistic approach to mental and physical health
- Optimising treatment in the early stages of psychosis in order to give the best chance of recovery as early as possible. It is well documented the longer people suffer untreated psychosis, the worse they will

be in the longer term, in terms of both symptoms and social function

- Minimising length of stay in hospital which can often be a stigmatising experience, thus community teams actively facilitate discharge
- EI pathway hosts many research projects, particularly those working with first episode psychosis service users
- EI pathway provides significant teaching and clinical supervisory input to the Masters of Science degree in Early Intervention, currently in its first year at the Institute of Psychiatry.

The outreach and support in south London service (OASIS)

The OASIS Team is one of the world's most established detection services for people at high risk of psychosis. They currently cover a wide urban area in south London (Lewisham, Lambeth and Southwark), which as we know has one of the highest rates of psychosis in the UK.

The service provides advice, practical support and treatment for young people (14–35 years) who are having psychological and emotional problems that might be the early stages of psychotic illness, known as the ultra high risk state. The ultra high risk state is characterised by the presence of attenuated (less severe or less frequent) psychotic symptoms, which might include any of the following:

- Changes in thoughts and feelings of how a young person sees the world
- Unusual perceptual sensations (for example seeing or hearing things other people cannot)
- Becoming preoccupied with new ideas
- Withdrawing from friends and family
- Difficulties coping with day-to-day activities.

These experiences are confusing and distressing and may lead to a young person dropping out of their school, work or social commitments.

Young people are referred by a range of professional, community and family sources, and are usually seen at a place familiar to them, often their GP surgery. Up to 30% of people at ultra high risk will develop a psychotic disorder within two years, and OASIS provides clinical support for two years. The aim of the service is to help people at ultra high risk with their presenting problems, and to reduce the risk of later psychosis.

OASIS is also very active in research, with the aim of improving understanding of how and why psychosis develops.

OASIS's extensive research programme includes work on genetics, epidemiology, psychopathology, cognitive function, and neuroimaging.

These research studies have provided new information on the psychosocial and neurobiological factors that influence the development of psychosis, and have informed the development of new treatments for ultra high risk stage.

Early intervention – psychological therapy

Psychological therapists work across all the Psychosis CAG services with people who experience distress or adverse life events which impact on their mental health. Anyone can be referred, and the change to National Institute for Health and Care Excellence (NICE) recommendation is that all service users with psychosis should have the opportunity to participate in individual therapy, while all families of people with psychosis who live with, or are in close contact with the service user should be offered family intervention.

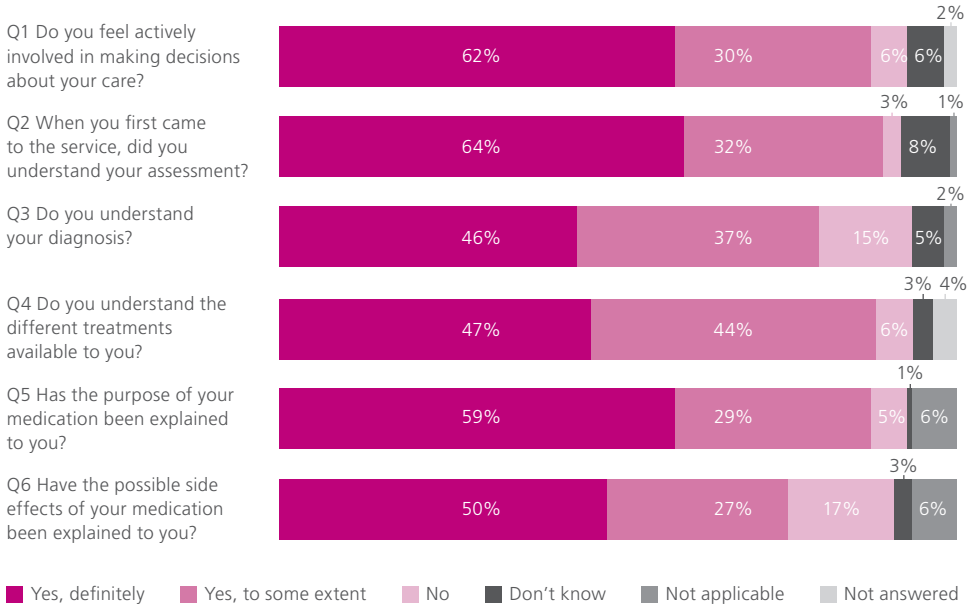
Psychological therapies are particularly indicated if the person wants help with managing their experiences or symptoms, or if they report unusual and distressing life experiences and emotional difficulties. Different evidence based or best practice approaches are used, depending on the presenting difficulties and the service user's preferences. The most common approach is cognitive behavioural therapy (CBT) where the service user and psychological therapist meet regularly for a period of therapy, to look together at difficult experiences, and find new, helpful ways of coping with or thinking about them. Psychological therapists can see people individually, in groups or with their families, whichever is most helpful.

There is increasing evidence people experiencing psychosis can and do recover from their difficulties. Even if people continue to have some difficulties, they are able to "stay in the driver's seat" of their life. A number of common aspects of the experience of recovery include: "redefining self and accepting illness; overcoming stigma; renewing a sense of hope and commitment; resuming control over and responsibility for one's life; exercising one's citizenship; managing symptoms; being supported by others; and being involved in meaningful activities and expanded social roles". Recovery researchers emphasised that recovery is not a 'one-off' event, rather, it is better understood as an ongoing process or journey.

Psychological therapies for people with psychosis are carefully tailored to match the person's stage of recovery and facilitate their progress towards their recovery goals.

Service user experience

Figure 12 | Patient experience survey 2012/13



Service user feedback and comments

LEO Ward

"Was pleased to be admitted felt safer than I did before"

"Understanding and kind"

"Very good and kind staff and link workers"

"Really so helpful, professional, reliable, caring and practical"

"This service has been a great help in helping me establish stability in my life"

"Very friendly service, very welcoming – easy to talk to and I would without a doubt advise friends to use the service"

Service user story – my experience of psychosis

My illness grew worse and worse over a period of three years. It was triggered by stress, and started with me becoming suspicious of my mother and thinking that she hated me, and wanted to hurt me. At the worst part of my illness, I believed that I was being "possessed" by demons that were influencing my actions and I strongly started believing in conspiracy theories such as those of the 'illuminati.' I also believed that people were "draining" my energy from me, and I believed that people were performing voodoo, black magic, and witchcraft on me. It was a very scary time for me and I felt very alone.

Because of my illness, I began to become aggressive with my family members and was arrested when my mum called the police for breaking a picture that was hanging on the wall. In the police station I was praying out loud for protection against the people who I thought were trying to harm me. I was assessed by a psychiatrist because of my actions and also because my mum had told the police that I needed to be assessed to find out what was wrong with me.

The psychiatrist was concerned about me and decided I needed to be 'sectioned' so doctors could assess me further and find out what was wrong with me. I was put into a mental hospital. In hospital, I was given 'risperidone,' – an anti-psychotic medication. After about four weeks of treatment, the medication started to take effect, and I began waking up to realise that I had a mental illness.

It turned out I had been suffering with psychosis over a period of about three years where the illness gradually grew from bad to worse. Having found out I was ill, I was able to recover and begin to piece my life back together again. While I was ill, no matter how much my family told me to go and get help I would not listen because I believed there was nothing wrong with me, but after I got better I realised how wrong I was.

One of the things that helped me to realise that I was mentally ill was reading somebody's testimony of their experience of psychosis and noticing how they were going through the exact same experiences that I was going through. Reading this made me think to myself maybe I was ill and the advice everyone was giving to me to seek help was actually good advice.

The thing is, while you're going through psychosis it can be hard to realise that you are in fact mentally ill, so I am writing this testimony in the hope that it will help somebody who is in the same position I was in when I had an episode of psychosis to wake up.

Mother's story – family intervention treatment for her daughter in recovery

The family therapy series of meetings has been a real eye-opener and we have learned much from them. All the scepticism which we (my husband) had in the beginning has turned to positivity and valuable lessons have since been learnt. All barriers between ourselves and our son have disappeared and we are able to communicate freely and without reservation and this engendered greater trust among us all. We endeavour to continue these meetings as and when we are able to, and we are also hoping to include other members of the family.

Learning to speak to my daughter without arguing or getting distressed also getting to know about her mental state. I also think I can try to think about myself when I know I need time out i.e. go out with my husband every other week and set goals.

Service user feedback on psychological therapy in the Early Intervention pathway

Here are some recent comments from service users who have had psychological therapy within the Early Intervention services, it summarises how therapy can help people in their recovery efforts.

Service user overcoming stigma

"I can be more open with friends about my condition"

Service user redefining self and accepting illness

"There were other people who experience similar things – I didn't feel so alone. Just being able to say, 'I hear voices' and not be judged negatively for it was a big boost"

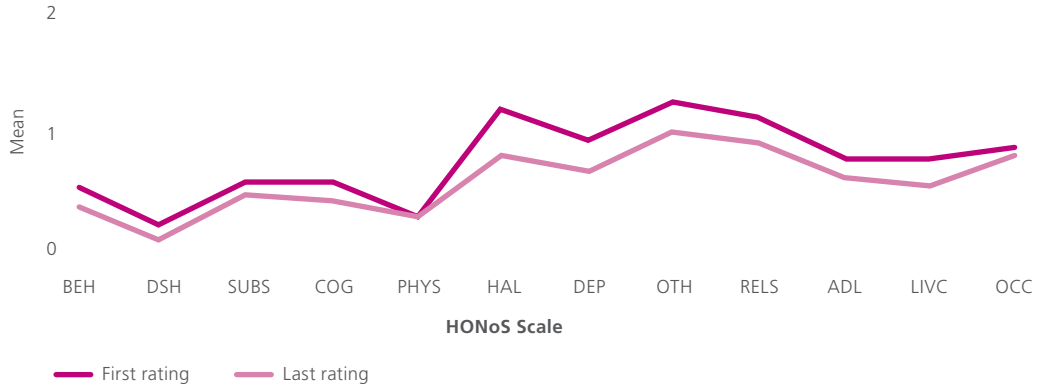
Clinical outcomes

Change in HoNOS items

Figure 13 profiles need at first and last HoNOS ratings in the Early Intervention sample. At first HoNOS rating the profile is characterised by severity of psychotic symptoms, depressed mood and other symptoms (HAL, DEP, OTH) combined with relationship problems (RELS).

At last HoNOS rating there has been a significant reduction in psychotic symptoms, depressed mood and relationship problems (HAL, DEP, RELS) which achieve a small effect size. There has also been a reduction in behavioural disturbance (BEH) and problems with living conditions (LIVC) which achieve a small effect size.

Figure 13 | Change in HoNOS scale – early intervention



Early intervention – psychological therapy outcomes

Demographic information for all those undertaking a course of therapy is shown in the table below. Approximately 27% of those undertaking therapy in the pathway have completed a pair of before and after-therapy CORE outcome measures, and approximately 60% have completed an initial measure, but no ending measure.

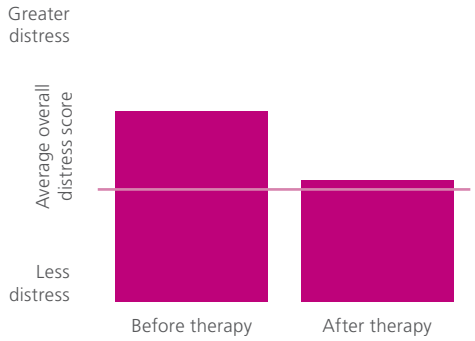
The data indicate no systematic differences of note between those completing a paired CORE and other therapy cases in terms of problem severity, age, gender and ethnicity.

It is important to note, the analysis has only been completed on those service users who have completed a pair of CORE-OM or CORE-10 measures.

Given the small number of cases, the results of this analysis need to be interpreted conservatively. This is not a summary of general psychological therapies activity within the Early Intervention Care pathway. It is also important to note there are limitations of the CORE measures when used with people with more severe illnesses.

		Clients who received psychological therapy; without a pair of COREs		Clients with a pair of pre- and post-therapy COREs	
		Number	Mean (SD)	Number	Mean (SD)
Age (years)		175	24–75 (SD: 4.97) Range: 16–36 years	66	25.79 (SD: 4.86) Range: 18–36 years
There was no significant difference in age between those with a pair and those without a pair					
		Number	%	Number	%
Gender	Male	103	58.9%	42	63.6%
There were no significant associations between gender and paired status					
Ethnicity	White	67	38.3%	28	42.5%
	Black or black British	60	34.3%	20	30.4%
	Other ethnic group	24	13.7%	11	16.8%
	Asian or Asian British	12	6.8%	1	1.5%
	Mixed background	4	2.3%	2	3.0%
	Not known	8	4.6%	4	6.0%
	Total	175	100%	66	100%
There were no significant associations between ethnicity and paired status					
		Number	Mean (SD)	Number	Mean (SD)
Pre-therapy mean CORE score		77	1.61 (SD: 0.78)	66	1.61 (SD: 0.74)
There were no significant associations between mean pre-therapy CORE score and paired status					

Figure 14 | Before therapy and after therapy global distress scores measured using CORE



From this analysis we know on average, service users' distress is significantly reduced after therapy, see Figure 14. This is based on CORE scores collected since October 2010 on over 60 people in the Early Intervention Care pathway.

One way to look at effectiveness of therapy is statistical significance, where analysis can be performed on the average before and after therapy scores. It can then be determined whether the difference in the before and after therapy scores is not caused by chance but is likely to be a meaningful difference brought about by the therapy. This difference can also be calculated as an effect size, which informs you whether the amount of change is small, medium or large.

When analysing the findings from the Early Intervention Care pathway, the effect size was statistically significant and large (Cohen, 1992) in size (FIgure 15). A large effect size for psychological therapy with people who have complex and enduring difficulties is a very good outcome, and is larger than the effect size found in the original research trials.

We also know from further statistical analysis the effect of therapy is the same across different ethnic groups.

This is important because it demonstrates what we do works equally well for people from different ethnic backgrounds. We also found the effect of therapy is the same for both men and women. The data also demonstrates service users who are in more distress at the beginning of treatment benefit more.

Figure 15 | Average scores before and after therapy

Client category (All pairs)	Number of Pairs	Pre-therapy mean CORE score	Post-therapy mean CORE score	Effect size
All pairs	66	1.61 (SD: 0.74)	1.04 (SD: 0.60)	0.86 (Large)
T-test	Change in scores: t (65) = 7.919, p<0.001 Statistically significant			

To summarise, the results demonstrate for those individuals assessed using the CORE, psychological therapies delivered in the Early Intervention Care pathway are effective, with a large effect size.

At the moment we have data on 27% of those who undergo therapy, and the Early Intervention Care pathway psychologists are working to increase the number of people who complete outcome measures. Nevertheless, these findings are encouraging, viewed in the context of therapy occurring in secondary care settings where users predominantly have significant and long-term mental health needs.

Quality of care measures

Care programme approach (CPA)

In order to support service users' engagement with care planning we aim for service users on the care programme approach to be at least offered a copy of their care plan. These plans are routinely reviewed by care coordinators, the multi-disciplinary team (as appropriate) and the service user/carer jointly.

We have always maintained a high standard and with implementation of the 95% target in 2012, we have managed to sustain it's performance above target.

Figure 16 | Number of service users on the care programme approach (CPA) who have been at least offered a copy of their review created from their CPA meeting

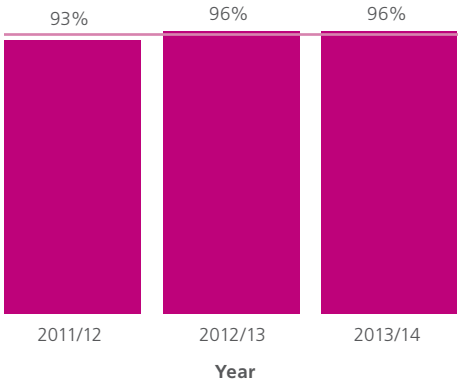


Figure 17 | Number of service users on the care programme approach (CPA) that have had a recovery support plan

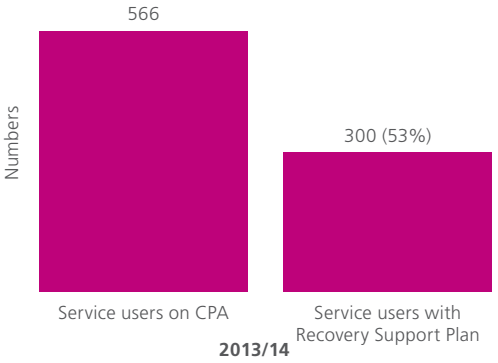


Figure 18 | Number of service users who had a physical health screen

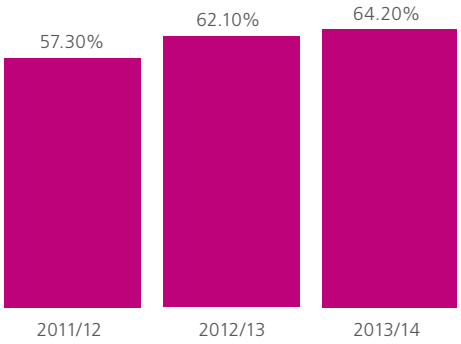
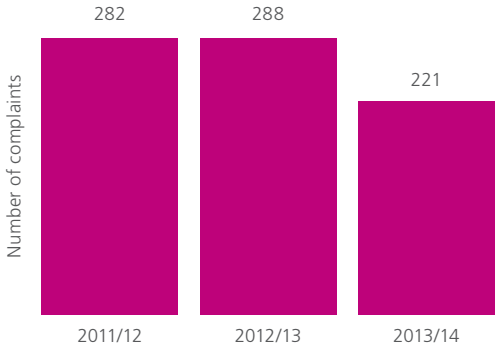


Figure 19 | Number of complaints




South London and Maudsley
NHS
Bonnie
Segwagwe

Promoting Recovery Care pathway

The Promoting Recovery Care pathway's primary aim is to work with service users to support them in their recovery. Recovery is a process focusing on the individual's defined goals and aspirations.

The Promoting Recovery Care pathway helps service users achieve these in ways and settings which are meaningful and acceptable. Hope is a key element of recovery and staff will promote hope in their work with service users and their carers, recognising that recovery takes time and can involve setbacks. As service users go through the different stages in the Promoting Recovery Care pathway, we will work with them to own their care through active participation and service user focus in carrying out assessments, support and recovery care planning and reviews, so that service users ultimately become independent of the service.

Who the Promoting Recovery Care pathway is for

The Recovery Care pathway is for adults aged over 18 with an established diagnosis of psychosis i.e. schizophrenia or Bipolar disorders with a history of psychotic symptoms, in second or subsequent episodes.

This pathway is not for people experiencing their first episode of psychosis, who will be treated by the Early Intervention Service.

What we offer

We provide assessment, treatment, advice and support.

Assessment

The assessment phase can take up to twelve weeks for standard referrals. It includes health and social care assessment following NICE guidelines, with a completed support and recovery care plan and crisis plan. It also includes treatment during the assessment period.

Treatment

- Medication and medication management
- Psychological intervention
- Psychosocial intervention
- Vocational intervention
- Family work
- Relapse prevention
- Help with substance misuse

Support and advice to the service user

- Self-directed support for care packages, meeting varying social care needs
- Care coordination
- Social inclusion services to support re-enablement and recovery
- Carer's assessment
- Information about services, diagnosis, treatment and care

Information for service users and carers

Quality written information about services, diagnosis, treatment and care and community resources will be offered at key stages of the care pathway to support informed choice and to empower service users and carers.

Support and advice to other agencies, for example primary care, housing, social services and service users' forums

- Medication and treatment options
- Managing symptoms in the psychotic spectrum
- Managing crisis
- Access to other services

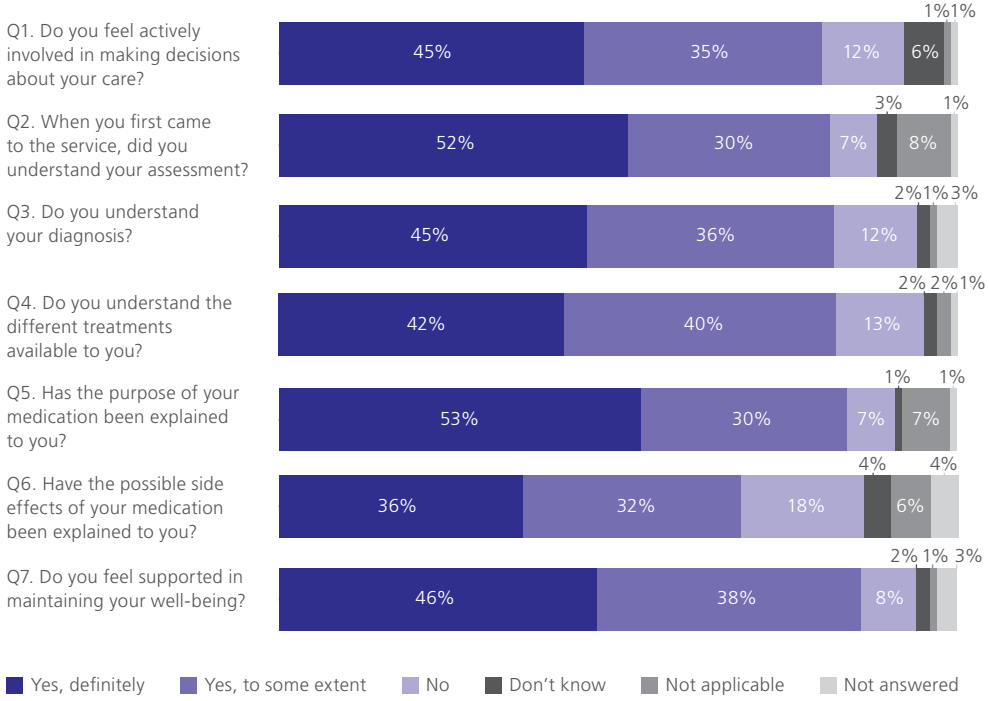
Discharge

We offer episodes of care and, once stable or needing very low levels of care, service users will be discharged to GPs where appropriate and if risks are manageable.

GPs will be informed about the discharge process, with the following information: assessment, treatment and care plan, progress, crisis plan and risk assessment.

Service user experience

Figure 20 | Patient experience survey 2012/13



Service user and carer feedback quotes

"I really value the input that my psychologist has into my life. My self-regard is getting better"

"I learnt how to deal with the voices – what to do, what not to do"

"The voices don't trouble me so much, it's like I've made peace with them and myself"

"I can move forward, there is hope for the future. There's a very big chance I may have a good life"

What did you find most useful about seeing a psychological therapist?

"It was helpful in the sense that my visit allowed me and my doctor to gauge and put my fears into perspectives"

"Talking openly"

"This is based on my experience with CBT session I found I was able to express myself and how to manage my anger"

"Being able to talk about my thoughts and to think about my thoughts in a different way"

Do you have any other comments about the service provided by your psychological therapist?

"The service gave me and the psychologist opportunity to discuss my concern one to one like intelligent grown adults with good understanding of the issues involved"

"I found CBT very good the staff were very professional and friendly"

"I was happy that a therapist was able to see me in good time"

"You are made to feel comfortable and I felt the psychologist wanted to help me"

Psychological interventions clinic for outpatients with psychosis (PICuP)

Our service offers cognitive behavioural therapy (CBT) and family interventions for people with distressing positive symptoms of psychosis (including those with a diagnosis of bipolar disorder), such as delusions and hallucinations, or those with a history of psychosis whose main difficulties are secondary emotional problems. However, it is not for those who have predominantly negative symptoms, learning disabilities, are not distressed or do not want help. Our service is psychology-led, headed by internationally recognised clinical and academic experts.

PICuP is part of the Recovery care pathway of the CAG and it is also one of two national demonstration sites for IAPT-SMI (psychosis).

We strive to:

- Treat people with dignity and view our service users as experts in their own experiences
- Place no pressure on people to change their view of the world and always work collaboratively with service users towards achieving their goals
- Include families, carers and other mental health professionals involved in the person's care, if the service user wishes to
- Disseminate knowledge and skills to other mental health professionals through training and supervision, both in the UK and overseas
- Work towards improved quality of life for people with psychosis through clinical research and audits.

We provide a range of continuous professional development packages, both in the UK and overseas, which include:

- In-house group supervision. Group supervision is aimed at therapists already trained in CBT or family intervention who want to develop specialist skills in CBT or family intervention for psychosis. Therapists can work with our service users and receive free fortnightly supervision at our clinic. We run outreach groups for supervision of therapists' own service users, at a negotiated fee. Supervision can be run through video-conferencing facilities for therapists working outside of London or overseas.
- Outreach supervision groups
- Full-day and half-day workshops
- Outreach customised training packages

- Providing workshops and customised training packages for mental health professionals working with people with psychosis who require further training in general CBT as well as CBT for psychosis.

Our service user outcomes have resulted in:

- Reduction in distressing psychotic symptoms
- Enhanced coping and self-management of symptoms
- Improved mood
- Improved quality of life
- Reduction in post-traumatic stress symptoms
- High satisfaction with therapy
- Achievement of individual recovery goals.

Psychological therapies – National demonstration site for IAPT-SMI

Our CAG is a leader in the development, research and provision of psychological therapies for psychosis. This was recognised in November 2012, when we were chosen, in a national competition, as an Increasing Access to Psychological Therapies for Serious Mental Illness (IAPT-SMI) Demonstration site for Psychosis.

We have developed a service model, with funding from the Department of Health, to increase access to psychological therapies for psychosis. This model incorporates training at different levels, and the coordinated provision of evidence based psychological therapies for psychosis. The service is closely aligned with but separate from community mental health teams. This includes a structure for training staff; a central point of referral for therapy coordination; close highly skilled centralised supervision; and systems of routine outcomes monitoring.

Within the first nine months of implementing this system, waiting times reduced by 40% compared with the previous year and paired service user reported outcomes data was collected for all service users completing therapy.

“When I came I was seriously considering suicide, but now I know if I work hard at keeping well there is hope for my future happiness eventually, plus as a mum, it’s just so nice to have someone take care of me for a change”

Our commitment to improving service user experience

Social inclusion, hope and recovery project (SHARP)

A service committed to improving the service user experience

We are a community based service providing a range of group and one to one therapies aimed at supporting people build resilience, coping skills and a positive identity beyond mental illness.

Clear values underpinning SHARP including; Valuing people's experiences, empathy and compassion, using creative approaches and a positive environment

Experience based co-design with service users and staff exploring the emotional journey through SHARP

Workshops co run with service users and staff, including depression, budgeting, self esteem and sleep

We aim to capture the experience of people using our service so that we can continually review and improve the quality of SHARP

Outcome measures used measuring satisfaction, wellbeing and social inclusion

Statistically significant shifts in outcome measures

Focus groups of service users from interventions, including mindfulness, health and wellbeing group and aqua aerobics

"I waited three years to feel confident enough to live on my own. The training has given me the confidence to feel I can do it, I moved in one month ago."
Health and wellbeing group

What next? Experience Based Co-Design again, collect narratives, re-establish service user advisory group and share good practice

Examples of innovative practice within our CAG

Example 1: Reducing occupied bed days for service users under a psychosis recovery and support community mental health team

The North Lambeth Recovery and Support Service is a community mental health team supporting service users with psychotic illnesses.

With the pressure on mental health beds in our Trust, community management of service users needed to be reviewed in order to:

- Reduce crisis situations resulting in inpatient admission
- Enable earlier intervention to reduce the severity of relapse and length of any unavoidable admission.

We undertook a project to review working practices.

Our objectives

- Community team to make changes to our working practices within boundaries of team staffing and financial resources using improvement methodologies new to a SLaM community team
- Stretch target of 35% reduction in occupied bed days for service users on the team's caseload over one year from March 2013
- Identification of good working practices to be adopted by other teams in our Trust
- Shift in focus for a community team to incorporate a team performance measure.

Our achievements

- 24% reduction from April 2013 to March 2014 in occupied bed days achieved for team's caseload without change in overall caseload size.

Next steps

- Ongoing review of team practices to identify further possible changes

- Continued use of outcome measure data to provide continuous feedback on effectiveness of changes made
- Electronic whiteboard to be installed to enable live updates of zoning and intervention decisions and link with electronic service user record
- Incorporation of changes to practices within other SLaM community teams.

Example 2: The START Team – a study of our outcomes after one year for rough sleepers with a mental illness admitted to hospital under the Mental Health Act

START is an assertive outreach team for homeless people with mental health problems and we provide assessment, diagnosis and treatment for the homeless in Lambeth, Lewisham and Southwark.

If you are homeless you are more likely to have:

- Unmet healthcare needs
- Elevated levels of psychiatric disorders
- Mortality rates amongst the homeless much higher than the general population.

One of our interventions was to undertake a Mental Health Act assessment and admit service users to hospital under a 'section'. The Mental Health Act assessments can be very distressing for service users, time consuming and costly.

Aims of the study

- Establish whether the intervention of a Mental Health Act assessment leading to hospital admission is effective in treating rough sleepers with mental illness
- Service users for the study were taken from a paper list of service users referred to START from November 2010 to December 2012.

Objectives of the study

To establish whether the intervention of a Mental Health Act assessment leading to hospital admission is effective in treating rough sleepers with mental illness. This study looks at outcomes one year after discharge from hospital/ point of appropriate discharge with emphasis on the following:

- Engagement with team
- Medication compliance
- Accommodation status
- Readmission to hospital
- Engagement in social activities
- Employment: voluntary/paid
- GP registration.

Outcomes of the study

Background of service users

Figure 21 | Ethnicity

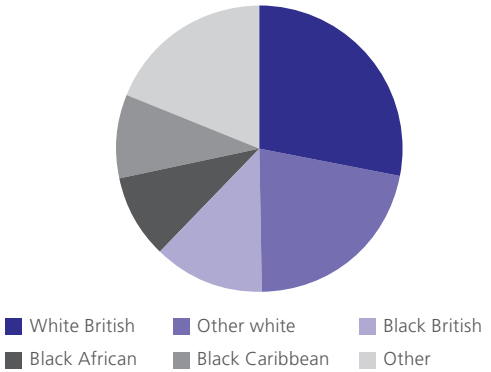


Figure 22 | Diagnosis

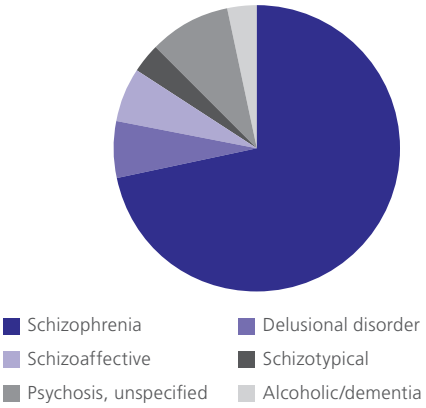
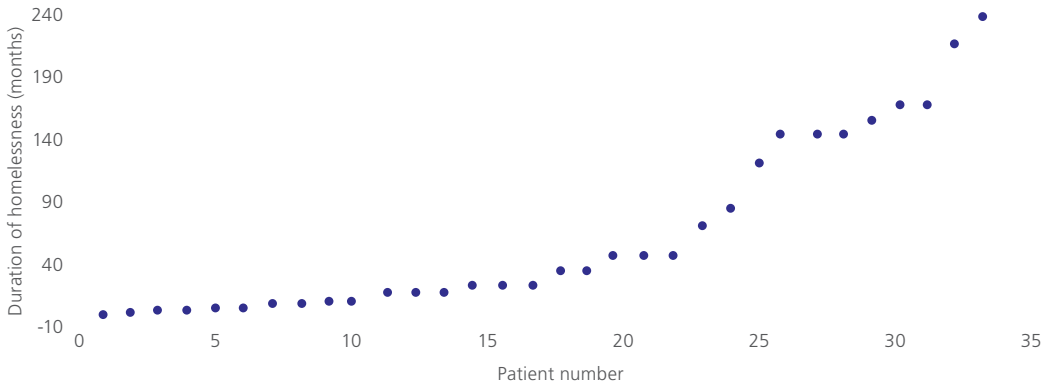


Figure 23 | Duration of homelessness



Outcomes

Figure 24 | Engagement at 1 year

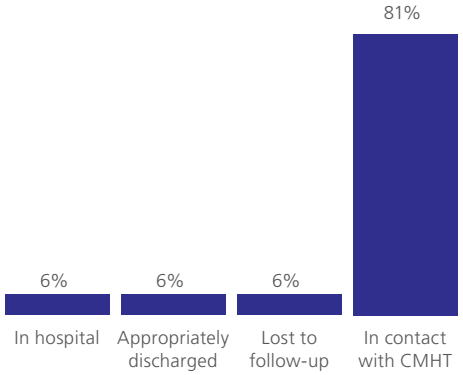


Figure 25 | Medication compliance

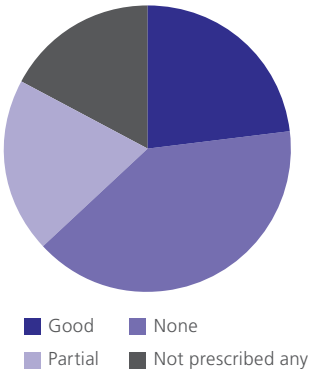


Figure 26 | Accomodation status after 1 year on the programme

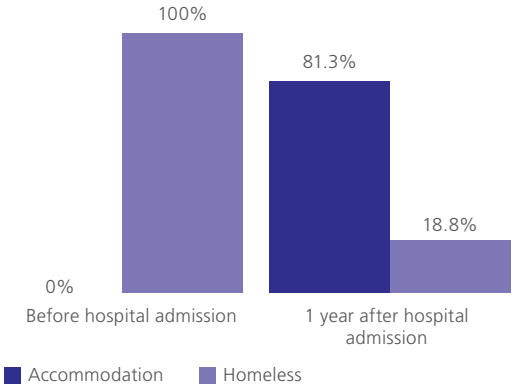
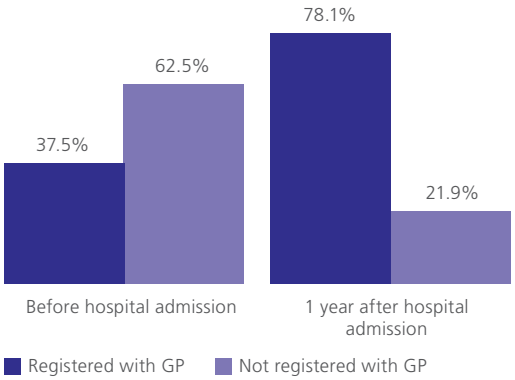


Figure 27 | Accomodation status after 1 year on the programme

Accommodation type	Number of service users
Supported accommodation	18
Shared accommodation with no support	1
Residential care home	1
Flat	6 (2 flats funded by NRPF Panel)
Homeless	6

Figure 28 | Registration with a GP



Further work for this project

- Increase sample size-look at longer follow-up (e.g two years)
- Further use of statistics/data

Example 3: The TREAT Service (Treatment Review and Assistance Team)

Overview of the service:

The TREAT service is the first dedicated community service for people with schizophrenia and related disorders who have persistent symptoms despite treatment.

The team provides:

- A comprehensive assessment of physical and psychological factors preventing recovery
- The initiation of specialist treatments to address non-response to treatment
- Structured assessment of outcomes.

A particularly innovative aspect of the team's work is that we provide service users with access to specialist treatment in the community. This includes managing the initiation and titration of clozapine treatment at home. The team has increased the number of service users able to start clozapine in the community for the first time by over 200%.

The team comprises of doctors, nurses and other health care professionals. It receives referrals from across the CAG. TREAT works alongside community mental health teams in order to provide continuity of care.

Service user comments:

"I wish I had been given this help … over 20 years ago. I hope other people in my situation get this help sooner because it could make a difference"

"Since TREAT helped me … I have been able to get out more, make friends and exercise … I wish I had this medication sooner because it's been the first thing that helped me"

"I have been feeling alright since the clozapine. I definitely wish I had been referred to TREAT sooner"

Treat service outcomes

The Positive and Negative Syndrome Scale (PANSS; Kay, Fiszbein & Opfer, 1987) is used to provide a detailed, structured measure of outcomes. The PANSS is a widely used 30-item semi-structured clinical interview that measures positive, negative and general symptoms. This was given to service users with treatment refractory psychoses at their initial and discharge appointments.

Using a paired-samples t-test, statistically significant decreases were observed in total symptoms between intake (M=49.67, SD=23.70) and discharge (M=26.73, SD=15.98) demonstrating an overall reduction of 46%; t=4.516, p=<.001. Significant decreases were seen in all symptom domains: positive symptoms (t=4.601, p=<.001), negative symptoms (t=3.737, p=.002) and general symptoms (t=4.193, p=.001) (see Figure 29).

The Clinical Global Impression Scale (CGI; Haro et al., 2003), a scale used to rate overall illness severity, was also administered at the initial and discharge assessments.

Using a paired samples t-test, a significant reduction was observed in CGI scores from intake (M=5.2, SD=1.01) to discharge (M=3.6, SD=0.9); t=5.527, p=<.001; see Figure 30). This represents an average change from markedly ill to mildly ill at discharge.

Figure 29 | Reductions in psychopathology measured by PANSS following intervention by TREAT

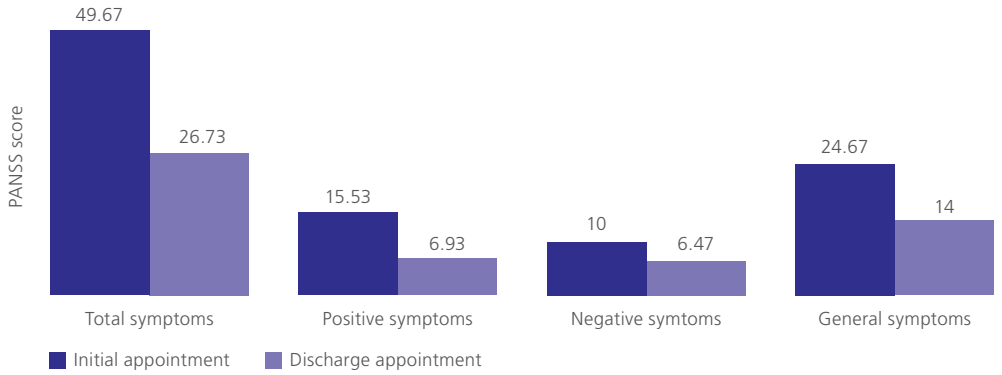
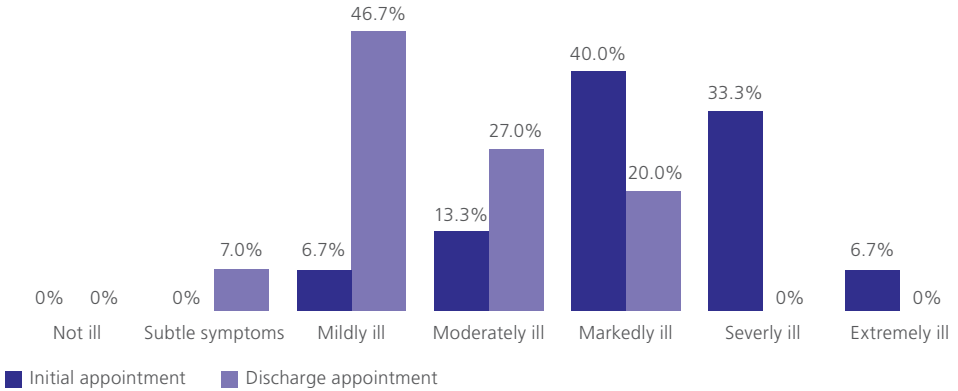


Figure 30 | Reductions in overall illness severity measured by CGI following intervention by TREAT



Quality of care measures

Recovery and support plan

The recovery and support plan is a personalised care plan introduced in January 2013. We are committed to supporting a recovery focused, jointly owned care planning approach. We had a target of 50% of service users to have recovery and support plans by April 2014 starting from a baseline of zero twelve months prior.

With support from commissioners through CQUIN initiatives, clinicians, carers and service users, we made a huge achievement of exceeding this target across all pathways.

This in total amounted to over 2,000 recovery and support plans completed jointly between service users and staff and we are continuing this initiative over the next year with an aim to reach 85%.

Physical health screening

As part of our mental and physical health integration objective of Kings Health Partners, monitoring the physical health of service users with mental illness is paramount to ensuring better health and wellbeing for our local communities.

Having pathways across both inpatient and community settings allows us to be holistic in our approach to physical health monitoring. Within the community based pathways, strong relationships and joint working with GPs is vital for

continuity of care, which is why we aim to ensure physical health screening occurs at least annually.

Inpatient pathways ensure we undertake many of the health checks relating to cardio metabolic risk factors on the wards with input from community pathways and GPs.

All pathways within our CAG have improved in physical health screening year on year, and with additional emphasis and evidence based practice outlined in the latest NICE guidelines for Schizophrenia, together with CQUINs for this year, we aim to continue and improve upon this trend.

Figure 31 | Number of service users on the care programme approach (CPA) who have been at least offered a copy of their care plan created at their CPA meeting

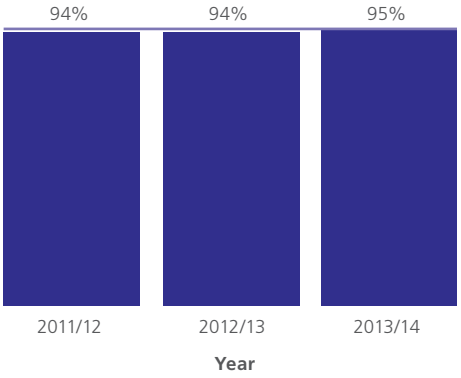


Figure 32 | Number of service users on the care programme approach (CPA) that have a recovery support plan

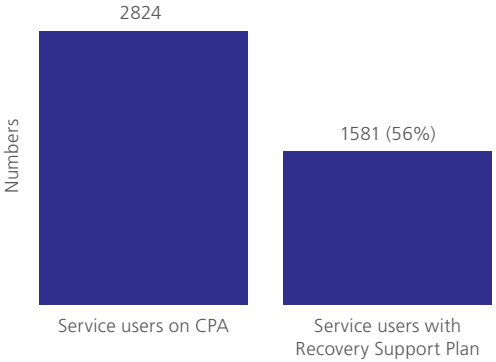
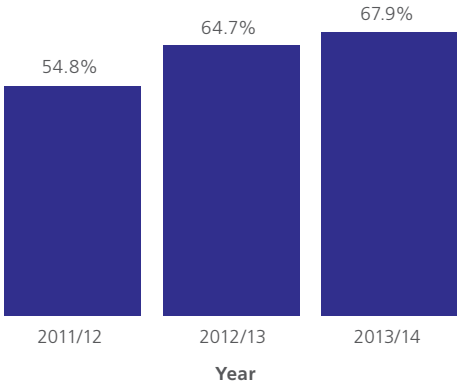


Figure 33 | Number of service users who had a physical health screen over the last 3 years



The Adult Mental Health (AMH) model

There are higher rates of mental disorder in south London compared to other parts of the country. Compared to national figures, evidence suggests incidence rates for psychosis are 61% higher in south London. Compared to national rates, levels of anxiety or depression are 6.9% higher in Croydon, 27.0% higher in Lambeth, 19.6% higher in Lewisham and 20.0% higher in Southwark.

In comparison to the national average the use of mental health services is higher in Croydon, Lambeth, Lewisham and Southwark with similarly increased proportions of the population on the care programme approach (CPA).

There is a clear need to focus on early identification for this group of people and ensure we are delivering interventions early in community settings to prevent people relapsing.

The AMH Model has been developed by the South London and Maudsley NHS Foundation Trust and together with social care partners. It is a whole system approach to the delivery of services. It is intended to create a significant change in the treatment of service users within community services to reduce the rate of relapse, increase the quality of care and help manage demand in secondary care services including the use of hospital beds. It is developed in line with recovery principles and supports the full roll out of the personalisation agenda.

It is fundamentally a clinical solution to current pressures of the substantial increase in rates of severe mental illness within south London and financial austerity affecting all parts of the care system.

The three key principles that underpin the AMH model of care are:

1. Enhanced assessment services

A service which provides ease of access to an enhanced assessment and triage function ('gatekeeper'), ensuring rapid intervention for service users and GPs and the referral of service users to the most appropriate part of the mental health care system, whether that be within primary care, secondary care or within voluntary organisations.

2. Enhanced crisis services

To provide earlier intervention in crisis situations to reduce the duration and severity of relapses, ensuring wherever possible crises are managed within the community setting, however, where an admission to hospital is required the length of the admission is minimised and the person supported to return home as soon as it is safe.

3. Enhanced community based engagement and treatment services

These services provide a more proactive evidence based, stage and disorder specific treatment on defined care pathways, for service users who are known to services and are assessed to be at moderate or high risk of relapse. This service reduces the number and severity of relapses in this service user population, the number of unplanned admissions and the length of stay for those service users who do relapse and require admission to an inpatient bed.

The AMH model was developed from the best available research evidence, including research in Early Intervention in Psychosis Services (Craig et al, 2004; Petersen et al, 2005; Garety et al, 2006; Burns et al, 1993; Murphy et al, 2012), Home treatment, (Leucht et al, 2012; Eisner et al, 2013; Winton-Brown et al, 2013) and treatment services for people with Bipolar Affective Disorders, (Kessing LV, Hansen HV, Hvenegaard A et al, 2013).

Many of the interventions described within the AMH model have been identified by the Rethink Mental Illness Schizophrenia Commission, the London School of Economics research into cost effective interventions and the Clinical Guidelines from the National Institute for Health and Care Excellence (NICE) on psychosis and schizophrenia in adults: treatment and management. All are proven to be effective in the long term management of people with psychosis and generate savings or value for money gains through reduced admissions to hospital or through other routes, such as reduction in reliance on benefits (Knapp et al, 2014).

The AMH model is an integrated health and social care model. It provides an opportunity to develop a cluster of professionals within employment and social inclusion hubs and to develop networks of support with housing services too.

The impact of a mental illness on a person's physical health and life expectancy has been well documented, with up to fifteen to twenty years reduced life expectancy. The need to have more effective and closer interfaces with primary care will reduce the potential for silo working and enhance the ability to achieve parity between mental and physical health.

Reasons for using the AMH Model

- Creating an integrated, cost effective health and social care service for people with severe and enduring mental health problems, which supports the development of full implementation of personalised budgets
- Closer working relationships with primary care to facilitate moves into and out of the services supporting people in their recovery

- Enhanced assessments with a single point of entry into the service for clear communication and easy access into services when required
- Closer working relationships with voluntary sector organisations and partner organisations within the local community to support recovery and ensure services are provided in the most appropriate environment
- Increased levels of evidence based, cost effective interventions in the community to provide effective treatment and reduce relapses
- Decreased caseloads for community staff to allow more time for better engagement with service users to ensure compliance with treatment and to identify relapses early
- Early intervention and support to people in a mental health crisis to support engagement with treatment and reduce the duration and severity of relapse
- Reduce the reliance on bed based services.

Benefits from using the AMH Model

- **Improved service quality and service user experience:** enhanced levels of interventions and early intervention in crisis will lead to fewer, and less severe relapses for service users and a better quality of life
- **Stronger demand management:** stronger gatekeeping function will enable us to focus on managing those service users with the most significant mental health care needs and who access a high proportion of mental healthcare resources
- **Most appropriate treatment:** improved availability of evidenced based interventions will ensure service users are treated by the secondary care services most appropriate for their specific needs, leading to better outcomes
- **Cost effectiveness:** proposed model supports the reduction in the reliance on inpatient beds through enabling more service users to be cared for outside of hospital, reducing the number and severity of relapses and through enabling timely discharge
- **More joined up working:** greater clarity and improved communication between the CAGs within SLaM, better linkage between primary, community and secondary care and between health and social care
- **A single point of access for GPs:** providing a simpler system for primary care to enable access into secondary care services.

Acute Care pathway

The Acute Care pathway provides admissions for all SLaM borough adults requiring inpatient care. Acute services offer holistic and timely assessment and treatment for service users who have a mental health need and require intensive support in a hospital setting. The pathway itself can be considered an intervention within the Promoting Recovery Care pathway.

The acute services traditionally followed a model where service users requiring acute inpatient care were admitted directly to the ward to receive assessment and treatment on the same ward for varying lengths of time. Now services increasingly work with the Triage Care pathway within the Psychological Medicine CAG. Triage provides a buffer by focusing on the initial assessment and treatment initiation. This enables the Acute Care pathway to focus on treatment interventions and recovery and maintain a calmer and more therapeutic environment for service users.

Discharge from acute services will be arranged with the support of the local community mental health teams within Psychosis and Mood, Anxiety and Personality CAGs and in particular the home treatment teams that sit within the Psychological Medicine CAG.

Who the pathway is for

The Acute Care pathway is for SLaM borough residents aged over 18 years old, if they have a known or suspected mental health disorder and need to be cared for within an inpatient environment. Inpatient care can be used to manage the immediate risks posed by the service user's ill-health. We accept service users with a substance misuse problem or a learning disability but only if a co-existing mental health disorder is their primary diagnosis.

The acute services are based at the Trust's four main hospital sites:

- Bethlem Royal Hospital
- Lambeth Hospital
- Ladywell Unit at Lewisham Hospital
- Maudsley Hospital.

The majority of the wards are gender specific with two wards which are mixed gender with privacy and dignity maintained.

Referral process

Service users are primarily accepted from Triage wards. Currently service users will be admitted following:

- Assessment and transfer from a triage ward (currently in three out of the four boroughs)
- Assessment, treatment and referral from psychiatric intensive care units (PICUs)
- Assessments by secondary mental health services and subsequent review by the home treatment team which has found that the person is unsuitable for home treatment as an alternative to inpatient admission
- Assessments by Mental Health Liaison Service staff in Accident and Emergency departments where inpatient admission is assessed as the only safe option
- Outcome of Mental Health Act assessments – either formal admissions or informal admissions to hospital.

What we offer

We are a multidisciplinary team, trained to offer various treatments. We carry out high quality and speedy assessments including assessments of social needs, dual diagnosis concerns and personality issues to establish a treatment plan as quickly as possible following admission.

We aim to provide a well organised and calm environment for our service users. We carry out daily assessments to come up with a clear care plan for each service user from day one of admission. This care plan is developed with the service user to ensure they get the most suitable treatment and interventions.

When a service user arrives we welcome them onto the ward, show them to a prepared bedroom and explain the admission process. We then check and look after their property and make contact with their carers.

We explain their rights under the Mental Health Act (if the service user is detained under this act).

The main interventions we offer are designed to be initiated and then to continue in the community. They include:

- Medication therapy
- Initiation of assessment tools used to monitor progress and risk assessments
- Support with Mental Health Act status
- Medical and physical health tests
- Psychosocial interventions
- Carers needs assessment
- Smoking cessation screening
- Safeguarding screening
- Support with immediate benefit and accommodation planning.

Our care planning follows the recovery model and focuses on removing the barriers to discharge and enabling the service user to be discharged with the least restrictive package of care in place.

We achieve all this by working collaboratively with the service user and their carers as well as other agencies that are critical to improve the service users' mental health and recovery.

Discharge / transfer to other services

When a service user is discharged or transferred from an acute ward it is vitally important to ensure those involved in their care and aftercare – the service user themselves, their relatives, community services and the service user's GP are as fully informed as is possible to ensure continuity of service. In this regard, the acute services always ensure that a seven day follow up has been arranged before the service user is discharged home.

On the day when a service user is discharged home:

- Community team will be informed of the discharge and a seven day follow up appointment date will be given to the service user and their carer/ family
- Discharge notification form will be faxed/ emailed to the GP within twenty four hours of discharge. The notification provides the immediate information for discharge aftercare and a more detailed discharge summary will be sent within three weeks of discharge
- Service user's family or carer will be notified especially where they will be directly involved in the aftercare to the service user.

When a service user is transferred to another acute ward the service user's community team and family or carer will be notified by ward staff of the transfer and new contact details.

What is a psychiatric intensive care unit (PICU)?

Within the Acute Care pathway, psychiatric intensive care is provided in psychiatric intensive care units (PICUs). PICU is for service users who are in an acutely disturbed phase of a serious mental disorder. There is associated loss of capacity for self-control, with a corresponding increase in risk, which does not enable their safe, therapeutic management and treatment in a less acute and/or less secure inpatient ward.

The philosophy of care and unit operation in a PICU is underpinned by the principles of acute and dynamic clinically focused risk management. This is not to be seen as distinct from the move towards recovery oriented practice within inpatient settings. The goal is one of therapeutic containment and clinical progression within a recovery framework.

Who the PICU is for

The PICU is primarily for SLaM borough residents aged over 18 years. Service users will have a known or suspected mental disorder, and will present within the acutely disturbed phase of a serious mental disorder; there is an associated increase in risk which needs immediate or short-term management. Primary diagnostic categories include most mental illnesses, but comorbid personality disorders, substance misuse problems, and physical health problems are not uncommon. The PICU service in SLaM is gender specific with two male wards and one female ward.

Referral process

Service users are admitted from a variety of sources, indicative of the multiple interface points for the PICU. The common referral sources include:

- Psychosis CAG inpatient wards
- Psychosis CAG section 136 places of safety suites
- Psychological Medicine CAG Triage wards
- Planned or emergency admissions direct from the community setting
- Court liaison and diversion schemes interfacing with all SLaM CAGs which manage adult service users
- Prison services interfacing with all SLaM CAGs which manage adult service users
- Forensic services from SLaM's Behavioural and Developmental CAG
- General medical hospital based services interfacing with a SLaM CAG.

What we offer at PICU

The PICU multidisciplinary team is trained to manage service users with acute disturbance allied to mental disorder. The PICU multidisciplinary team receives input from a wide variety of disciplines including: psychiatry, nursing, occupational therapy, pharmacy, psychology and forensic psychiatry.

The core interventions include:

- Psychiatric treatment focused on the aetiology of acute disturbance
- Intensive medication management, with pharmacy input
- Intensive psychiatric nursing
- Physical healthcare management
- Acute and dynamic risk assessment and management
- Acute occupational therapy input
- Acute psychological support and assessment
- Interface liaison (e.g. with the criminal justice system).

Transfer to other services

It is envisaged that the average length of stay within the PICU will be around four weeks. This should be understood in the context of the heterogeneous nature of PICU service users, some of whom require a short length of stay (i.e. significantly lower than four weeks) and others who require a much longer length of stay in the PICU. PICU length of stay must be appropriate to clinical need, but would not ordinarily exceed eight weeks in duration.

Most service users in PICU will be transferred to a general adult psychiatric inpatient ward where future community discharge can be a realistic short-term goal. In this context, PICU should be viewed as a component of the acute inpatient care pathway managing a subset of service users with a specific critical clinical and risk need.

A small number of service users in PICU will be transferred to more specialised clinical services due to severity or complexity of clinical or risk profile.

ES1 Psychiatric intensive care unit (PICU) for women

The Maudsley Hospital Psychiatric Intensive Care Unit (PICU) is for women who are in an acutely disturbed phase of a serious mental disorder. Women in these circumstances can have a loss of self-control, which creates an increase in risk with their safety and that of others.

The philosophy of care and unit operation is underpinned by the principles of acute and dynamic clinically focused risk assessment and management. It is in harmony with the move towards recovery oriented practice within inpatient settings; our goal being one of therapeutic containment and clinical progression within a recovery framework.

The PICU is a sub specialism requiring an approach sensitive and specific to the complex needs of women. The basis for this is the empirical evidence which indicates women present and respond differently to men, in the context of acute disturbance allied to serious mental disorder.

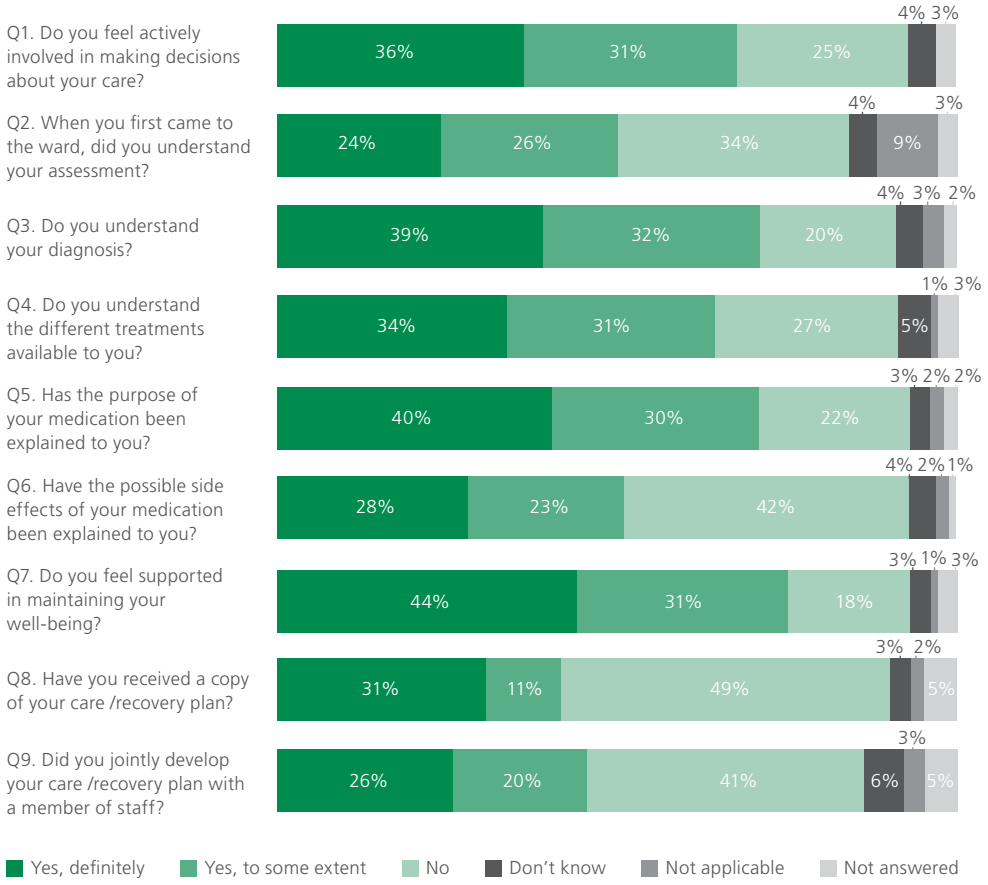
The PICU for women is conceptualised, designed, staffed, managed and led in a women-sensitive manner.

“The service gave me and the psychologist opportunity to discuss my concern one to one like intelligent grown adults with good understanding of the issues involved”

Patient experience 2012/13

To improve the quality of the service user experience, we are also focussed on reducing violent incidents, increasing physical health checks and increasing the dedicated time for therapeutic activities on inpatient wards.

Figure 34 | Acute



Service user comments

"My care plan has really worked as the plan helped me to recover properly"

"I have found this time here very helpful on all aspects of my recovery"

"I think I have been offered an excellent service. I fell very happy with the whole experience and it has definitely made a huge difference to my mental health and overall wellbeing"

"When I came I was seriously considering suicide, but now I know if I work hard at keeping well there is hope for my future happiness eventually, plus as a mum, it's just so nice to have someone take care of me for a change"

"Thank you for taking care of me"

Examples of innovative practice within our CAG

Improving service user and staff experience

Nelson ward is an acute ward for women in Lambeth. The majority of our service users are detained under a section of the Mental Health Act. Acute psychotic illnesses such as schizophrenia and bipolar disorder are the most common presentations, followed by personality disorder. Admission can range from days to months.

SLaM's Quality Improvement (QI) team organised a course in lean thinking. They subsequently supported us to develop our own project. In June 2013 we held three away days to engage our team and the QI team has continued to facilitate the project through monthly steering group meetings. Fr3dom Health provides advice and technological support for our data collection.

Our Kaizen project

KAI
CHANGE

ZEN
GOOD
(for the better)

KAIZEN
CONTINUAL IMPROVEMENT

The focus is on improving service user and staff experience as they are inextricably linked. If a quality initiative is to be both effective and sustainable, its development should be grounded in collaboration between service users and staff, and our outcomes need impact on both groups.

Our drivers for improvement

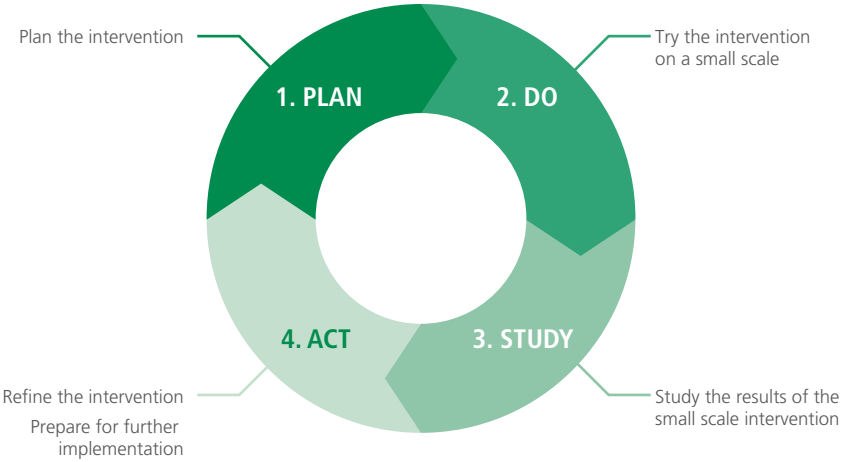
We are targeting the following:

1. Improving ward experience = environment; facilities; food; activities
2. Improving ward processes = service user engagement; reviews; medication management
3. Improving teamwork = communication; handover; celebrating success
4. Improving external working relationships = IT; community teams; supplies; estates
5. Promoting recovery = focus on service users' perspective; formulation; relapse prevention

How we are introducing change

Each intervention is developed and tested using PDSA cycles (plan-do, study- act). Initially the intervention is trialled on a small scale, and then refined (or abandoned) depending on feedback from service users and staff.

Figure 35 | PDSA Cycle



Objectives of the quality improvement team

- 100% of both service users and staff to be either extremely likely or likely to recommend the standard of care on Nelson ward
- 100% of staff to be either extremely likely or likely to recommend a job on Nelson ward as measured by the friends and family test (FFT).

Achievements

Above all we established a framework for on-going involvement for both service users and staff in driving improvement and measuring success which included:

- Weekly meetings for both service users and staff to discuss new ideas and collate feedback
- Data collection in collaboration with Fr3dom Health: daily rating of the day by both service users and staff using a tablet, with comments added if desired and results displayed on a screen in a public area of the ward; weekly service user PEDIC ratings for selected key PEDIC questions; discharge FFT for service users and monthly staff survey including FFT
- Consultant and team leader weekly review of the data to respond to pressing issues
- Monthly meeting for all staff to review feedback.

What we have achieved

1. Developed a set of staff commitments to underpin the project
2. Changed all handovers to the SBAR system (situation-background-assessment-recommendation)
3. New task and shift allocation systems and protected office time support a focus on direct service user engagement for the majority of the shift
4. Weekly ward rounds have been replaced by daily consultant-led morning meetings, with clinical reviews spread across the week and the offer to all service users to request to see a doctor daily
5. Additional therapeutic groups are running on the ward
6. Weekly evening Friends and Family Clinic with the consultant and a nurse
7. New job descriptions for all trainee medical staff to improve both their training experience and their therapeutic input to the ward.

We are now focusing on

- A new service user information booklet to orientate service users to the ward and set the tone for how we hope to engage in a therapeutic relationship, whilst honestly acknowledging the difficulties of admission and its challenges
- A new supervision structure
- Regularly planned daily rounds
- Developing our work with family and carers.

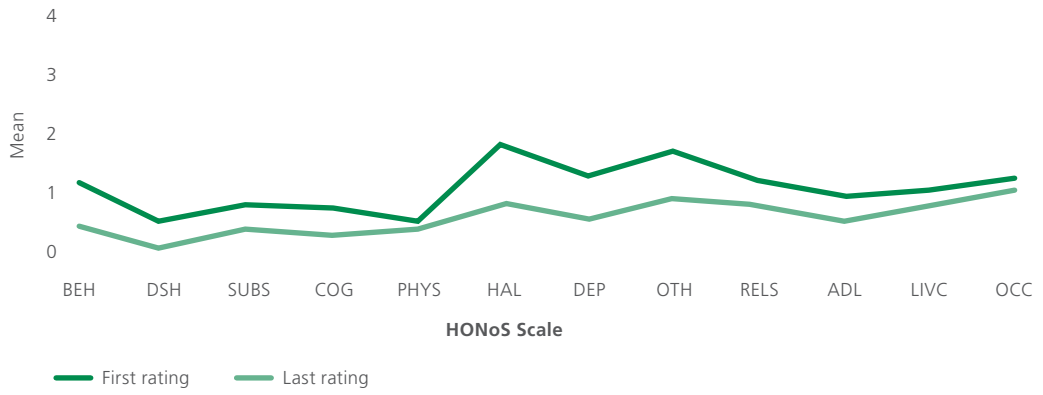
Clinical outcomes

Change in HoNOS items – acute inpatients:

The graph below profiles need in the acute inpatient sample, plotting mean scores on each scale at first rating, usually when service users are first admitted to a ward (data points on dark green line) and the outcome of inpatient treatment showing mean scores at last rating, usually when service users are discharged from a ward (data points on light green line).

At first HoNOS rating the acute inpatient needs profile is characterised by elevated scores on the scales measuring behavioural disturbance (BEH), psychotic symptoms (HAL), depressed mood (DEP), other symptoms (OTH) and relationship problems REL). At last HoNOS rating there has been a significant reduction in severity on all of these scales generating a medium effect size for all except problems with relationships where a small effect size is recorded. A small effect size is also reported for reduction in self harm (DSH), drug and alcohol use (SUBS), cognitive problems (COG), activities of daily living (ADL) and problem living conditions (LIVC).

Figure 36 | Change in HoNOS items – acute inpatients



Change in HoNOS items – Psychiatric Intensive Care Units (PICU)

The PICU sample is characterised by extremely elevated average scores at first rating on the scales measuring behavioural disturbance (BEH), psychotic symptoms (HAL) and 'other' symptoms (OTH). Highly elevated average scores are also recorded on the scales measuring drug / alcohol misuse (SUBS), cognitive problems (COG), relationship problems (RELS) and problems with activities of daily living (ADL). At last HoNOS rating there has been a significant reduction in severity on all of these scales, generating a large effect size on the scales measuring behavioural disturbance and psychotic symptoms. Medium and small effective size statistics are recorded on seven other scales.

Figure 38 | Number of admissions

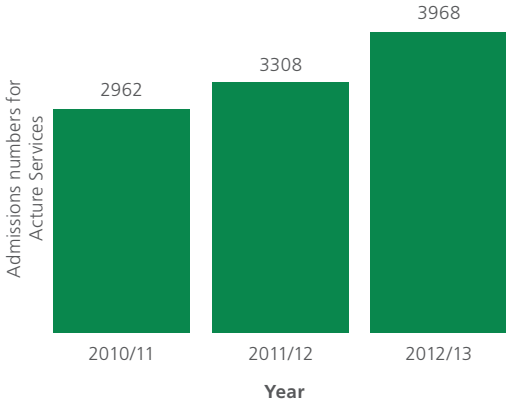
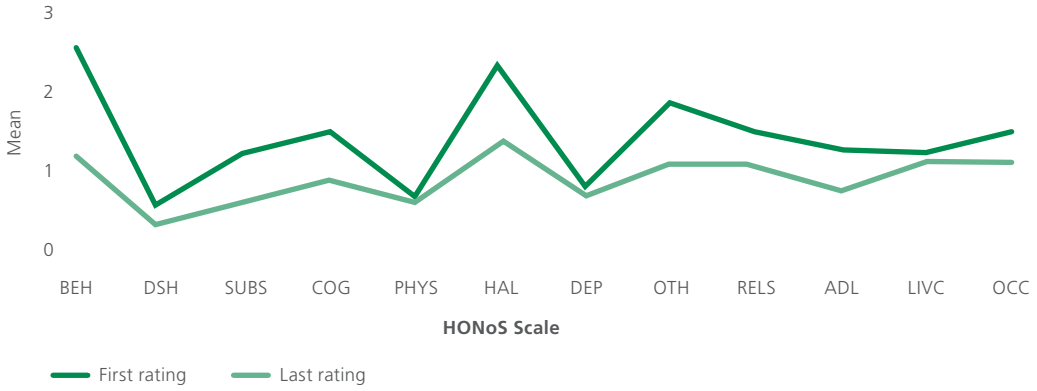


Figure 37 | Change in HoNOS items – PICU

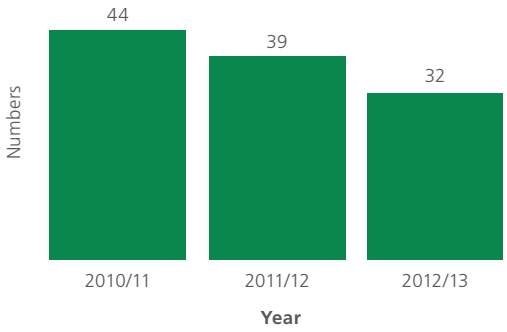


Length of service user stay

The Acute Care pathway is linked with the Triage pathway managed within the Psychological Medicine CAG in Lewisham, Lambeth and for males in Croydon. These two pathways form the journey most service users follow during a hospital admission. Triage wards specialise in assessment and initialising treatment. Triage was in place in Lewisham prior to the creation of CAGs, and implemented in Lambeth in October 2011 and Croydon (male only) in 2012. Roughly 50% of service users who enter triage are discharged by day seven. The remaining 50% are transferred to psychosis acute wards. Therefore, the figures below cover the length of stay for those on psychosis wards. (The total number of days spent in a hospital during a single admission).

The CAG's length of stay figures have reduced steadily since the start of the CAG as the graph below demonstrates.

Fig 39 | Service user length of stay



Readmissions

Services aim to care for people with the minimum of upheaval and restrictions and as close to home as possible. There may be instances of a person needing readmission and this can be caused by many factors which have impacted on a person's life since their time of discharge.

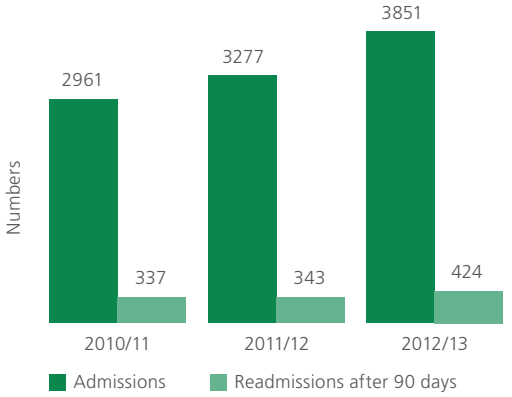
We seek to reduce the need for readmissions to hospital as each admission in crisis results in significant upheaval and disruption to service users' lives. In SLaM adult acute inpatient services we closely monitor readmission rates back into hospital, with a view to keeping these to a minimum.

There are many initiatives taken to prevent readmission such as scheduling a community appointment with service users within seven days after discharge from an inpatient ward, as there is evidence a significant number of readmissions and suicides occur within this time period.

Seven day follow up is in place to ensure contact is made with the service user within seven days to ease the process of returning back to the community and help ensure stability of their mental state.

While length of stay has been substantially reduced, the level of readmissions has remained largely static, with only a slight increase in 2013/14. Again, this is despite very significant pressure on acute beds.

Figure 40 | Number of readmissions after 90 days



“I used to view things worse than they actually were. Now I can better judge whether things really are as bad as I thought they were, which helped me hugely. Cognitive therapy has worked for me. I can definitely recommend it first-hand”

Complex Care pathway

The Complex Care pathway is for service users whose needs are highly complex and who require longer term care and support. Service users treated within these services are those who are often the most challenging given the complexity of their problems, which along with a diagnosis of psychosis may include: substance misuse, significant vulnerability, a history of offending or personality disorders.

This pathway includes services for those service users who are placed in specialised individually tailored residential services known as placements; those who are treated in SLaM complex care inpatient wards and those who live in supported housing, often with twenty four hour care. Additionally the community forensic teams will also support people in their own homes as well as specialist placements.

Complex Care

The Complex Care pathway describes services for individuals whose primary problem is psychosis and who also have complex needs and require a high level of support.

Many of our service users will have conditions that are hard to treat and may also have other conditions which also need to be considered (such as substance misuse or learning difficulties). Our service users have often gone through multiple episodes of inpatient treatment or lengthy admissions. They may be extremely difficult to engage with as a result of their mental illness.

Complex Care wards and teams share a core value of working in partnership with service users, encouraging them to take increasing responsibility for their own recovery and life choices.

The focus within the pathway work is on increasing quality of care by identifying the core interventions which are appropriate to complex care and ensuring consistency across both SLaM and private sector provided care.

The Complex Care pathway is for:

- Individuals with severe and enduring mental health problems who have experienced a decline in their social functioning
- People over 18 years of age.

Referral process

We accept referrals from:

- Psychosis Care pathways:
  - Early Intervention
  - Acute Inpatient
  - Promoting Recovery
- Other CAGs, including:
  - Psychological Medicine
  - Addictions
  - Mood and Personality.

We accept service users who have:

Psychosis (including schizophrenia, schizoaffective disorder, bipolar affective disorder) and who are in the second or subsequent episode of their psychosis.

We do not accept service users who have:

A primary diagnosis of personality disorder or substance misuse and learning difficulties (LD).

What we offer

- Assessment – A multi-disciplinary team (MDT) assessment to ascertain the individual's ongoing support needs
- Six to nine month admission (treatment and interventions outlined below)
- Brief admission for clozapine titration.

Treatment

We offer a holistic MDT approach which includes:

- Physical health screening and routine and specialist investigations
- Pharmacological or treatment review, defining treatment resistance and optimising treatment
- Nursing – individualised nursing care plans and one to one work
- Psychological therapies
- Occupational therapy – including activities of daily living (ADL) assessment, vocational and educational support, engagement with community services, creative therapies, budgeting assessment and interventions
- Occupational performance areas of self-care, productivity and leisure
- Including assessment and interventions that address the physical and mental health aspects of the person from an occupational perspective
- Psychosocial interventions
- Therapeutic engagement through group work

- Financial and legal assistance – including help with benefits, legal advice around the Mental Health Act (MHA) and other issues such as advocacy, who the appointee should be, and court of protection processes.
- Social inclusion – developing a measured approach to social inclusion and identifying agencies in the third sector to support this process
- Building meaningful activities
- Risk assessment
- Carer support.

Discharge

Before a service user is discharged from our care, we:

- Identify their placement or discharge pathway
- Undertake a referral and assessment by placement
- Ensuring the safety of their home environment (if the service user is to be discharged back to their own home)
- Confirm care packages needed for a safe discharge
- Arrange visits to placement as appropriate and overnight leave
- Use escorted and unescorted leave to carry out theraputic activities in the community settings prior to discharge
- Hold a discharge care programme approach (CPA) meeting prior to transfer to appropriate team/different service.

National Psychosis Service

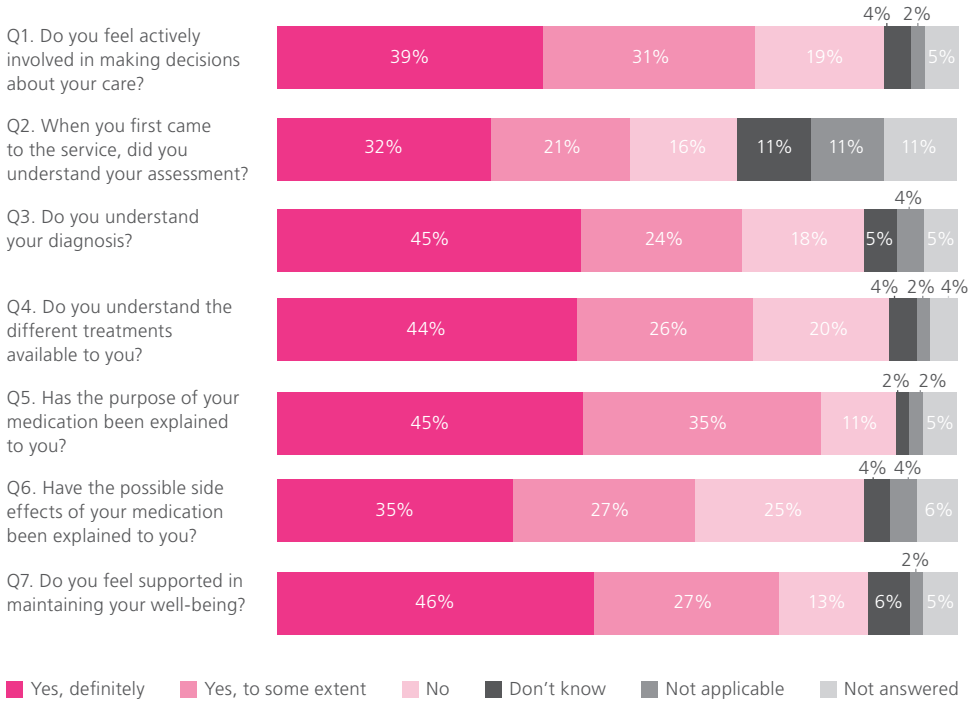
The Complex Care pathway also includes the National Psychosis Service which is a specialist service for service users with treatment resistant psychosis, and sees service users from across the country. It specialises in expert, evidence-based treatment for people with complex and co-morbid psychosis, to enhance their quality of life through recovery and substantially reduce the risk of readmission or expensive long-term care costs.

We have an internationally renowned team, pioneering treatment interventions and helping people who had no treatment options. Our doctors, nurses, pharmacists, physicians, occupational therapists, social workers and psychologists attached to our service are experts in their field, with the majority also undertaking research into the causes of psychotic disorders and the effectiveness of both existing and new treatments.

Every person undergoes an assessment with the team, and an individual physical and mental health treatment plan is developed.

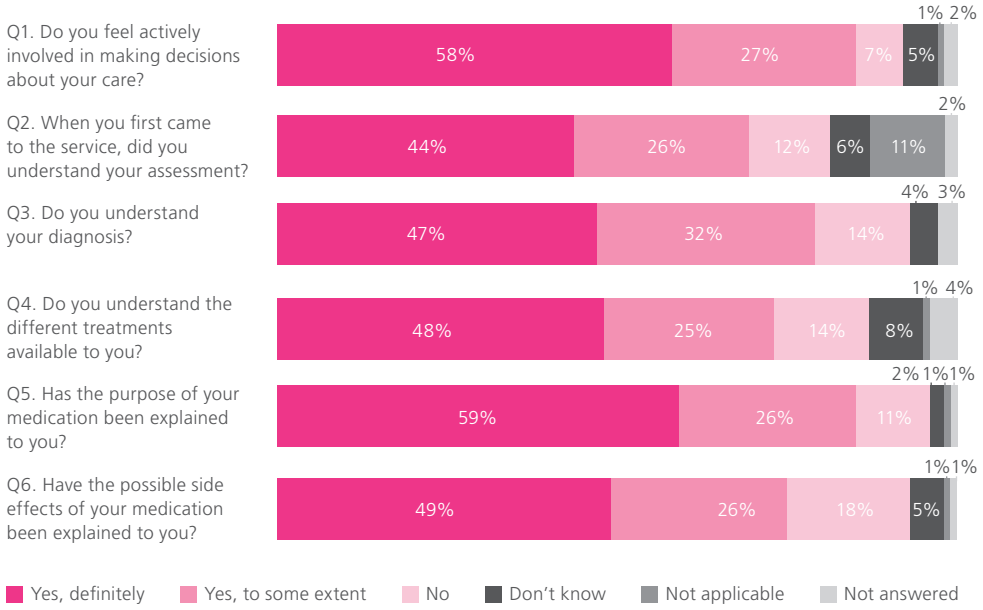
Service user experience – Complex Care inpatients

Figure 41 | Complex Care – inpatients



Service user experience – placements and supported housing

Figure 42 | Complex Care – community placements



Service user comments

"The staff on the ward do a good job"

"I have always found it to be most helpful and always ready to take care of me"

"I am well cared for and given a lot of support and attention"

"It is very healing to talk to people"

"Going to the LARC group helps sort things out"

"Once the spirit/ soul is gone, they're not coming back – it gives you hope"

Lewisham Active Recovery Community (LARC); by Lewisham Enhanced Recovery Team (Complex Care). Quip done by trainee. From Antony Daly (psychologist; Lewisham Enhanced Recovery Team).

Service user experience from Lewisham complex care forensic team

"Psychological therapy made a difference to my health in my case being fortunate to have had face to face psychological treatment.

This over time has meant a huge difference to my quality of life. Cognitive therapy has helped me stand back from my problems and work things through: put things in perspective and as a consequence learn to build up, rather than watch my life fall down.

My therapist has taught me various coping skills and techniques which kept me well I may soon return to work.

I used to view things worse than they actually were. Now I can better judge whether things really are as bad as I thought they were, which helped me hugely. Cognitive therapy has worked for me. I can definitely recommend it first-hand."

Clinical outcomes

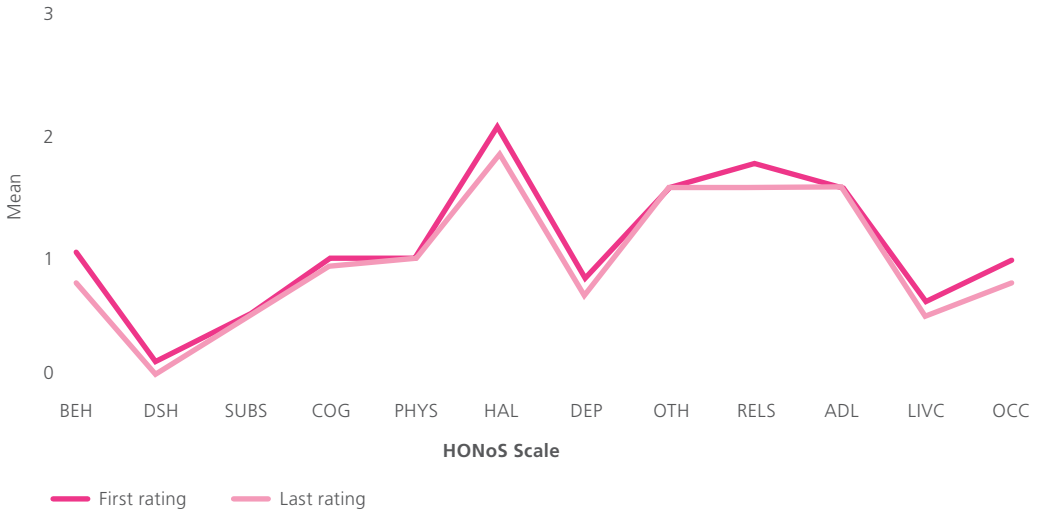
Change in HoNOS items for inpatients

Figure 43 profiles the needs of the complex care inpatient sample. The severity of behavioural disturbance (BEH) is similar to that observed in the acute inpatient sample. There is greater severity of cognitive impairment (COG) than is typically seen in any other pathway except for PICU service users. Severity of physical illness / disability (PHYS) is greater than is typically seen in non-organic pathways.

Severity of psychotic symptoms (HAL) is greater than the average for acute inpatients (exception PICU service users). There is evidence of significant relationship problems (RELS) and problems with activities of daily living (ADL) in the context of chronic, severe psychotic symptoms that are difficult to moderate.

At the last HoNOS rating improvement is evident in the scales measuring behavioural disturbance (BEH), psychotic symptoms (HAL) and severity of depressed mood (DEP), all of which achieve a small effect size. There has also been an improvement in relationship problems (RELS) and in occupation / activity (OCC) which did not reach the threshold for a small effect size in this sample.

Figure 43 | Change in HoNOS scale items for complex care inpatient services



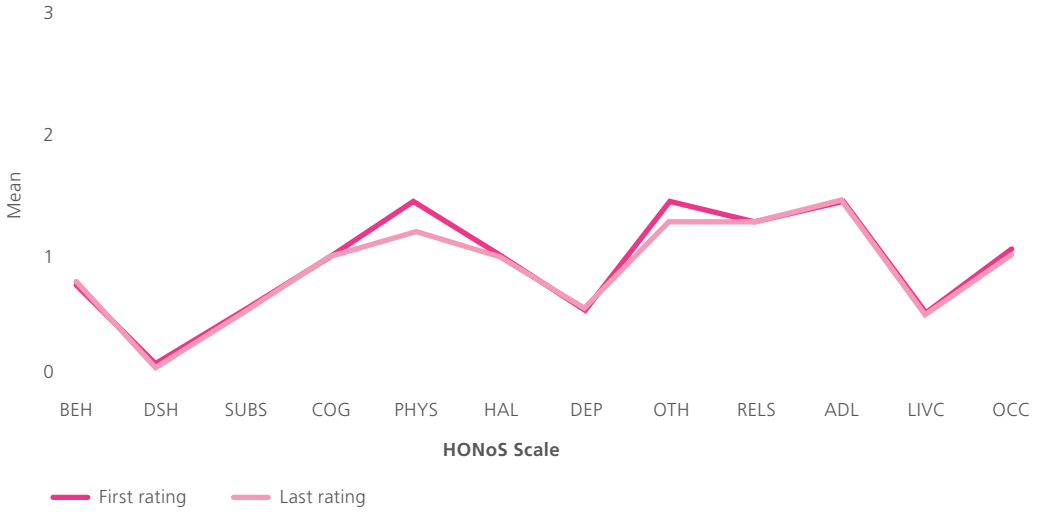
Change in HoNOS in the community

Figure 44 below profiles the complex care community sample which is similar to the promoting recovery sample, but with greater severity of cognitive impairment (COG), physical illness / disability (PHYS), and problems with activities of daily living (ADL).

At last rating in these episodes there is evidence of reduced physical impairment (small effect size) but an otherwise stable profile with little change over time.

As with the promoting recovery sample this profile is sensibly interpreted as evidencing clinical effectiveness in a service user group with chronic relapsing conditions and complex needs with high levels of impairment. As noted with the promoting recovery sample some service users will be significantly improving and others will be significantly deteriorating at any time but this is obscured by the averaging of scores.

Figure 44 | Change in HoNOS items – complex care community



Clinical outcomes for the National Psychosis Unit

Our service aims to help people gain control over their psychotic symptoms, enable service users and carers to develop an understanding of psychotic disorders, and better manage the likely causes and consequences of their illness. Outcomes are tailored to the requirements of each person. The service is particularly focused on improving function and reducing level of care.

Outcomes include:

- Reduction in psychosis
- Improved quality of life
- Reduced care costs
- Less frequent episodes of illness
- Improved social functioning
- Improved engagement with treatment plans
- Improved understanding of the illness by the service user and carers
- Better physical healthcare leading to reduced morbidity.

Figure 45 | Displays the results for the last 3 years since the CAG was in operation from an inpatient audit of effect size symptoms from admission to discharge in the last 150 admitted service users. Overall a significant improvement was recorded

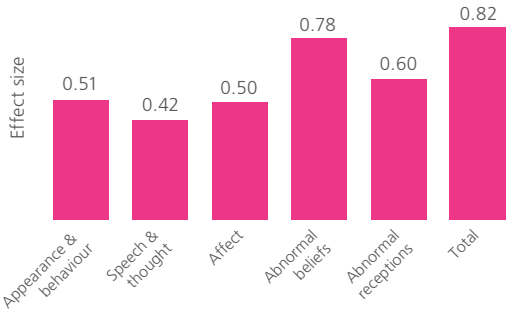


Figure 46 | Displays the audit results of the symptom scores on admission and discharge from the Psychosis Unit using the OPCRIT. A highly significant improvement was seen in service users audited

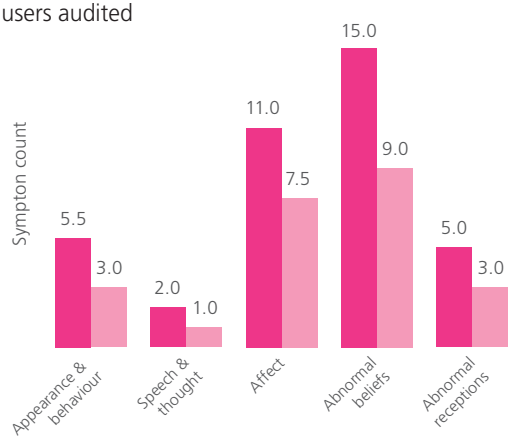
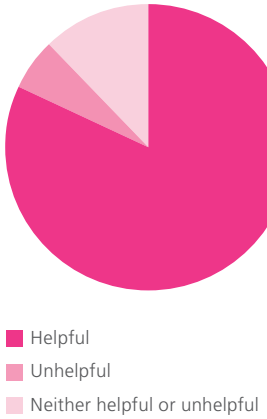


Figure 47 | Shows the results of feedback from referrers on the value of recommendations made by our service



Quality of care measures

Figure 48 | Number of inpatient admissions over the last 3 years

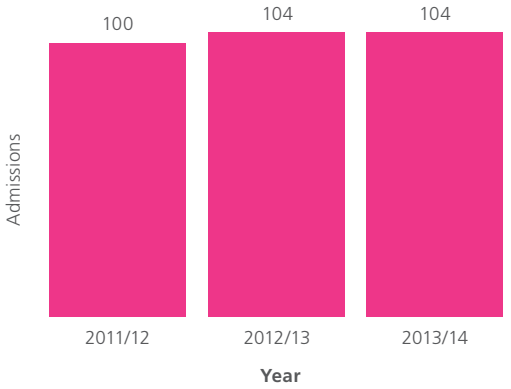


Figure 49 | Number of service users on the care programme approach (CPA) with recovery and support plans

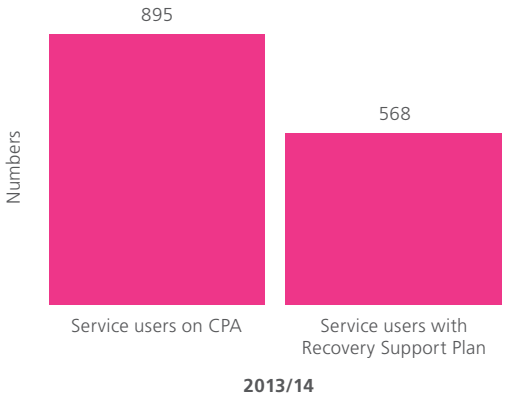


Figure 50 | Number of service users on the care programme approach (CPA) who received a copy of their care plan from their CPA review meeting

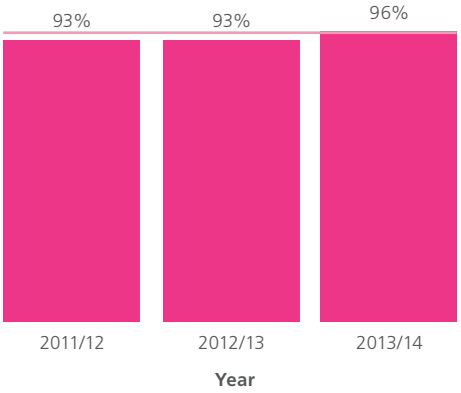
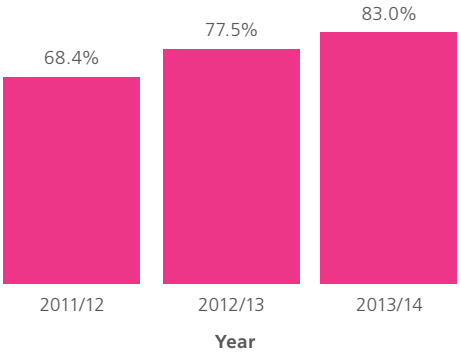


Figure 51 | Number of service users who had a physical health screen




POET'S
CORNER
Thursdays From 10:45 Onwards

Improving access to psychological therapies for people with severe mental illness (IAPT-SMI)

What we do

The improving access to psychological therapies for people with severe mental illness (IAPT-SMI) initiative is part of the government's four-year plan to increase access to talking therapies, to improve provision of NICE recommended psychological therapies for people with bipolar disorder, personality disorders and psychosis. South London and Maudsley (SLaM) NHS Foundation Trust is one of two national IAPT-SMI demonstration sites for psychosis, which started in November 2012.

Our IAPT-SMI demonstration site comprises three clinical teams in our CAG:

- Early Intervention team (STEP)
- Specialist Recovery service (SHARP)
- Psychological Therapy team (PICuP).

These teams work across two care pathways providing specialist community mental health care for people with psychosis (Early Intervention pathway for first presentations for the under 35s; Promoting Recovery pathway for people with

persisting difficulties). The teams operate across primary and secondary care, working closely with the wider multidisciplinary community teams.

The IAPT-SMI service offers cognitive therapy for psychosis, an adaptation of CBT for emotional disorders tailored to the needs of people with psychosis, and also family intervention for psychosis, a talking therapy involving both the person with psychosis and their carer.

Demographics

Figure 52 | Number of assessments from Early Intervention service – Male

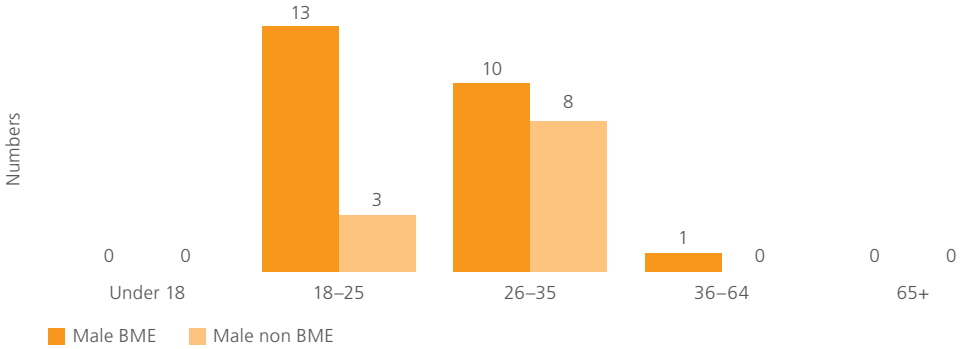


Figure 53 | Number of assessments from Early Intervention service – Female

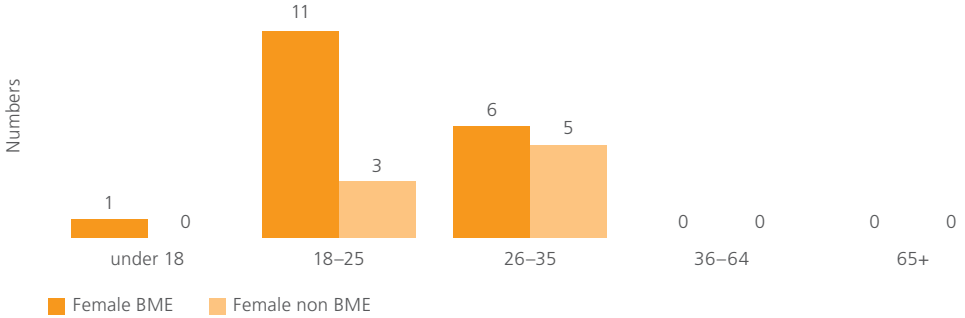


Figure 54 | Number of assessments from Promoting Recovery service – Male

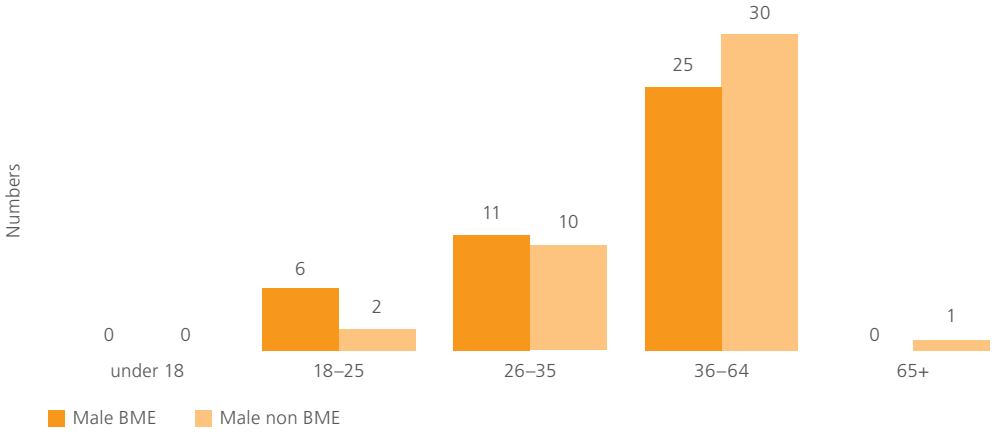


Figure 55 | Number of assessments from Promoting Recovery service – Female

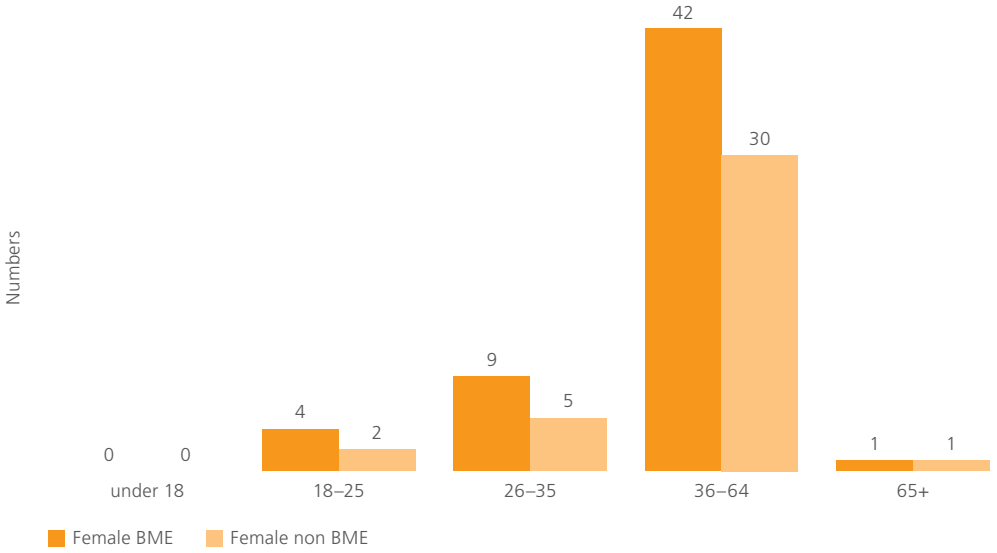


Figure 56 | Number of assessments from Promoting Recovery service – Male

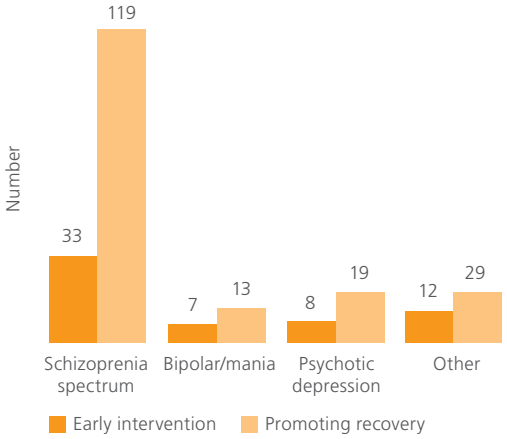
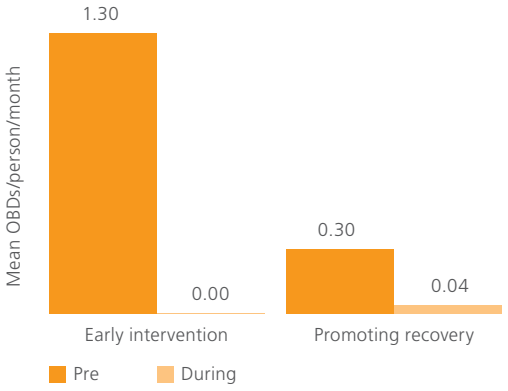


Figure 57 | Number of assessments from Promoting Recovery service – Female



Service user experience

Figure 58 | How satisfied are you with the therapy – Early Intervention

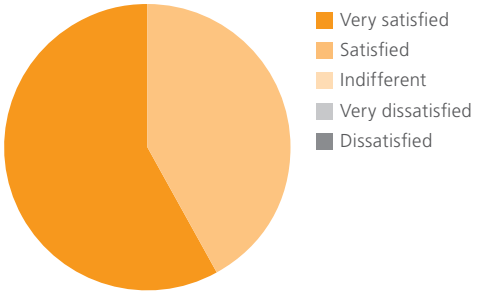
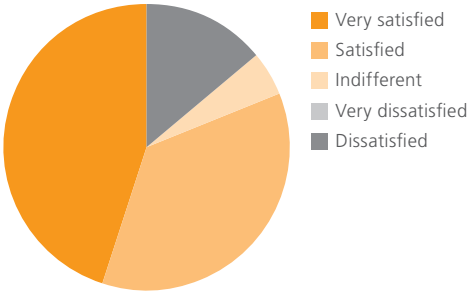


Figure 59 | How satisfied are you with the therapy – Promoting Recovery



Service user feedback

Early Intervention pathway

"Therapy was excellent and I feel I have bettered myself. My self-confidence has improved and I am able to meet my goals."

"CBT has been the best part of this whole process. It was reassuring to talk to someone who listened to me and reflected back with me on the things I said in the past to see myself getting better."

"Therapy was helpful as it has given me the motivation to do things, even when I am feeling low. It was useful to learn techniques to notice my thoughts and stop myself from ruminating."

"Therapy was really helpful and it was useful to learn distraction techniques to cope when out by myself."

"Talking to the therapist was useful and it has helped me to see life in a different way. I realise I am a good person and better than what the voices say about me. I feel stronger and more confident to fight back against my difficulties."

"Therapy was very beneficial. It helped me to understand my ways of thinking and to look at my thoughts from a different perspective. My confidence has improved – now if I face a problem, I feel I have the skills from therapy to help cope with the problem."

"Therapy has helped me to deal with my anxiety and paranoid thoughts. I am confident I will be able to cope if I have any negative thoughts in the future. I now feel able to move forward with my life. One of my goals before starting therapy was to find a job, which I now have."

Promoting Recovery pathway

"I am very pleased with therapy and now feel happy inside and more confident. The most helpful part was learning techniques to manage my voices. Things would have become a lot worse if I had not had the therapy."

"Therapy was life-changing and empowering. My therapist was the best I have ever had. I have a better understanding of my problems, particularly the triggers and contributions to them."

"Therapy was life-saving in helping me to cope with life, which does not seem so scary now. My therapist helped me realise how events in my childhood have contributed to how I am now, which I had never considered before. The most helpful part of therapy has been learning to look at things from different perspectives."

"Therapy has given me a set of tools that will help me to move forward with the future. I now feel confident recognising when stress builds up and how to cope with this."

"My therapist has helped me more than anyone ever could. It was helpful to learn about my thinking, considering alternative perspectives and seeing the positive sides of a situation."

"The therapy was fantastic. It was nice to be asked 'What do you think?' in the sessions, which gave me a feeling of being in control. The most helpful technique was coping with the voices."

"Therapy has been really helpful. I feel more confident to stop my repetitive habits and to do things by myself. I feel more positive and have more faith in myself. A very helpful strategy has been positive talk, reminding myself that 'Things will work out."

"Therapy has been a fantastic experience. I now have a better understanding of why I hear voices and how to cope with them. Therapy has helped me take control over the voices and I now feel less stressed and much happier in myself."

Friends and family test

We ask a sample of our service users this particular question:

"Think about the experience you have received. How likely are you to recommend our service to friends and family if they needed similar care or treatment?"

- Extremely likely
- Likely
- Neither likely nor unlikely
- Unlikely
- Extremely unlikely
- Don't know.

Figure 60 | Early Intervention

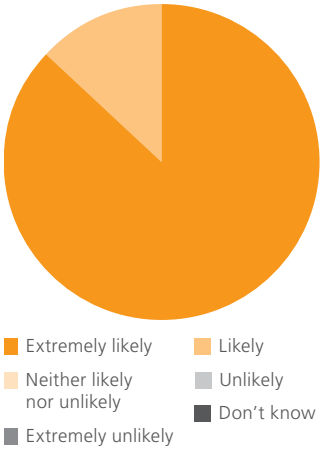
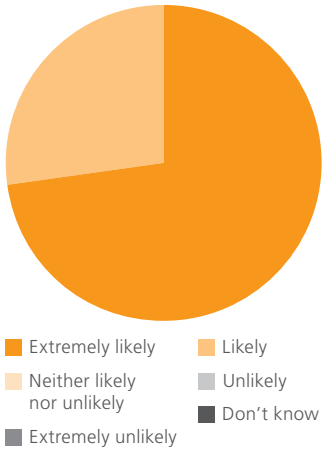


Figure 61 | Promoting Recovery



Clinical outcomes

Figure 62 | % of service users who completed treatment – Early Intervention

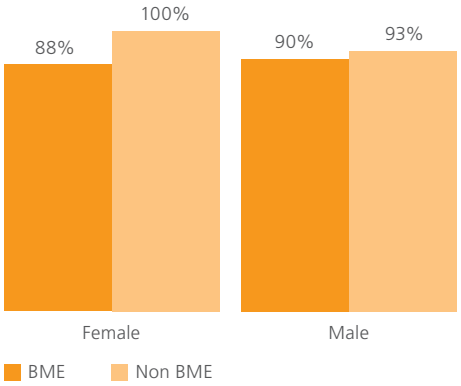


Figure 63 | % of service users who completed treatment – Promoting Recovery

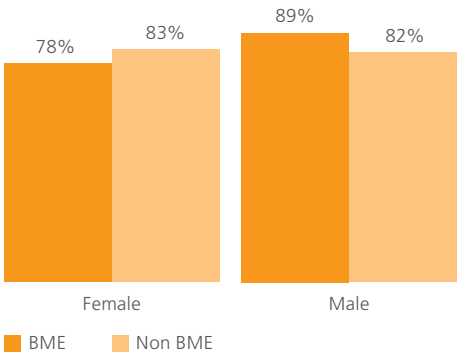
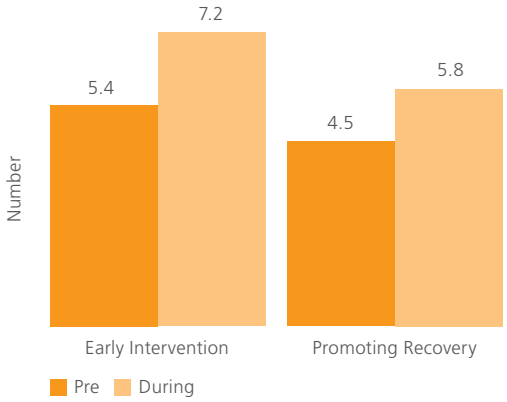


Figure 64 | Service user reported wellbeing: CHOICE



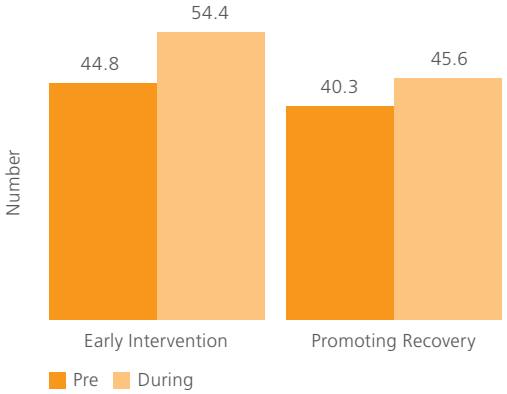
The CHOICE measure is one of a number of measures that has been selected for outcome measurement of formal psychotherapy for psychosis as part of the IAPT-SMI. The CHOICE measure has been adopted as the service user reported outcome measure with which to evaluate psychological therapies for psychosis in SLaM.

CHOICE is a brief self-report measure for service users. It was originally developed in collaboration with service user researchers and through focus group consultation with psychosis service users in PICuP (Greenwood et al. 2010). A new 11-item short form is used here which assesses psychological recovery from a service user perspective.

In keeping with the original measure, one additional space is included to enable service users to record a personal goal at the start of therapy. This is then included alongside the 11 items, in order to evaluate outcomes in terms of service users' broad psychological recovery and their own personal goal.

The measure is self-reporting however, service users can be supported to complete this with their therapist. A mean score is calculated for the core 11-items. The personal goal score is reported separately for service users who provide their own goal.

Figure 65 | Service user reported wellbeing: WEMWBS



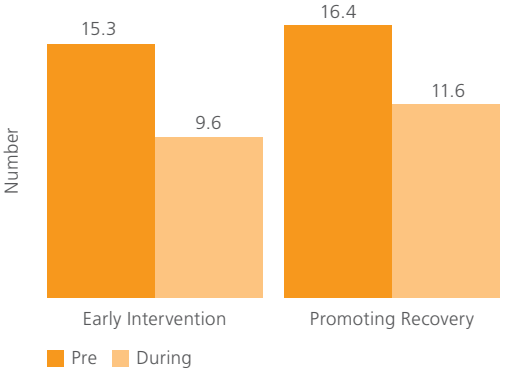
The Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS) comprises of 14 items relating to an individual's state of mental wellbeing in the previous two weeks. Responses are made on a 5-point scale ranging from 'none of the time' to 'all of the time'. Each item is worded positively and together they cover most, but not all, attributes of mental wellbeing including both hedonic and eudemonic perspectives.

Areas not covered include spirituality or purpose in life. These were deemed to extend beyond the general population's current understanding of mental wellbeing and their inclusion was thought likely to increase non-response.

WEMWBS aims to measure mental wellbeing itself and not the determinants of mental wellbeing, which include resilience, skills in relationship, conflict management and problem solving, as well as socioeconomic factors such as poverty, domestic violence, bullying, unemployment, stigma, racism and other forms of social exclusion.

WEMWBS was developed through research conducted at Warwick and Edinburgh Universities.

Figure 66 | Service user reported distress: CORE-10




London and Maudsley
NHS
NHS Trust
Welcome to
Ladywell Unit

Patient safety

Figure 67 | Violent incidents over the last 3 years

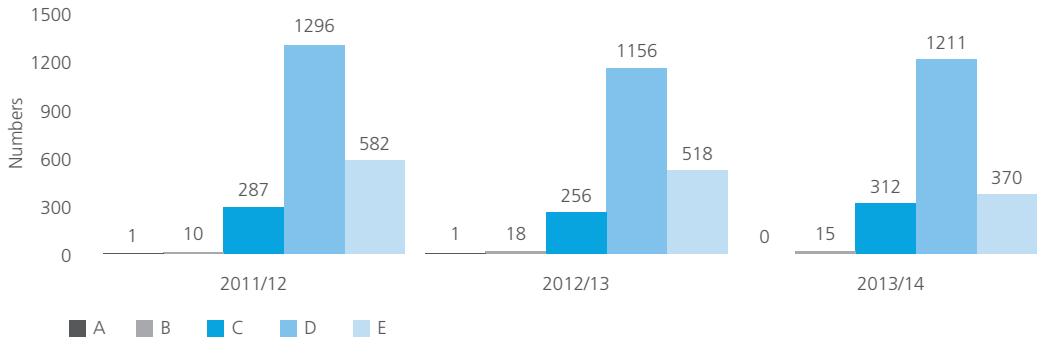
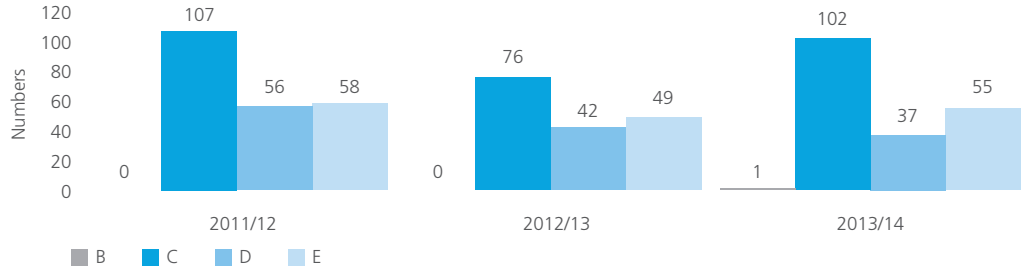


Figure 68 | Medication incidents over the last 3 years



Incidents key

A – Fatality/fatalities (including non-preventable deaths, homicide, suicide, death by accidental causes and sudden and unexpected deaths).

B – Injury requiring immediate hospital admission for more than 24 hours.

C – Injury causing member of staff to take more than 3 days absence from work.

D – Abrasions/bruises, minor injury, or 3 days or less sickness absence.

E – No injury.

Focusing on incidents and safety

Over the past three years incidents for violence, aggression and medication have seen a positive reduction in our CAG. The CAG Violence Reduction Group has membership drawn from direct care staff and clinical managers who have helped to deliver these improvements.

Reducing Acute Care pathway incidents

There has been more of a focus across the CAG on violence reduction initiatives, which has helped to shape and focus the work to have more impact locally. The influence of the group impacted on the content of the Promoting Safe and Therapeutic Services (PSTS) training and has seen an increase in the uptake of PSTS training from staff in the pathway.

One of the criteria for recruitment into the pathway is to have up to date PSTS training. The PSTS training focuses on de-escalation rather than physical interventions.

The Safe-ward Research Pilot was completed in five of the acute pathway wards, this included intervention for staff and service users which impacted on increased therapeutic engagement and violence reduction.

Improving safety in Complex Care pathway

One Complex Care area changed its' specification within the usual timeframes, admitting more complex and acutely unwell service users. Recently we have seen an increase in unprovoked attacks by patients on patients resulting from more acute complex service users being admitted across the pathway.

Many incidents occurred at night when staffing levels were comparatively lower than during the day and possibly were managed by non-permanent staff. Incidentally a number of these services are 'stand-alone' in the community. The CAG is currently reviewing its staffing profiles with the possible use of float staff to assist where there is a clinical need.

The pathway has increased its uptake of PSTS attendance and we are working with PSTS trainers to develop a de-escalation programme for the staff group in these areas to attend.

A number of incidents relate to the implementation of current Trust wide polices. We are working with staff and reviewing our policies to support violence and aggression reduction within the Trust e.g. rapid tranquilisation, access to smoking cessation therapy and shared care planning.

Whilst we have seen an overall reduction in the number of medication incidents there has been an increase that appears to relate to self- administration projects which are being undertaken in the care pathway to support service user's independence and recovery.

This has included either omissions of medication, spilling of medication and loss of medication when given home leave. The project is a very positive one staff involved ensured the practice is under constant review to ensure we address any increase in this area.

Staff satisfaction

Effects on service user care

Studies have shown satisfaction levels among hospital staff are closely linked to the quality of healthcare they provide. Previous research has tended to focus on single aspects of staff experience or one staff group.

Associations between various aspects of staff wellbeing and service user experience have been reported, mostly at whole-hospital or systems level. For example, the national staff and service user surveys have been compared and the national staff survey has been compared with various service user outcomes.

Research suggests situating staff experience (as well as service user experience) centre stage maybe one of the best actions senior leaders can take.

Analysis of the staff and service user experience surveys indicate seven staff variables that are linked to good staff-reported experience. These are:

- A good local team/work group climate
- High levels of co-worker support
- Good job satisfaction
- A good organisational climate
- Perceived organisational support
- Low emotional exhaustion and
- Supervisor support.

Overall Trust score

The overall indicator of staff engagement has been calculated using the questions that make up key findings relating to staff members perceived ability to contribute to improvement at work, their willingness to recommend the trust as a place to work or receive treatment and the extent to which they feel motivated and engaged with their work.

Figure 69 | Overall score of staff engagement compared to previous year and the national average for 2013

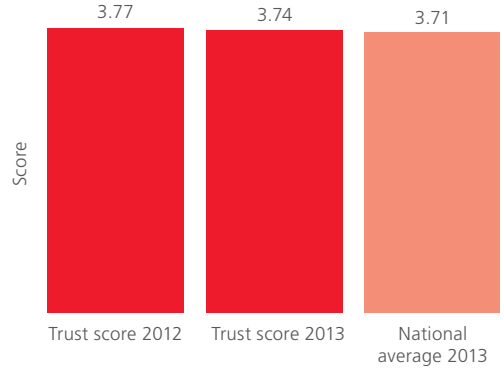
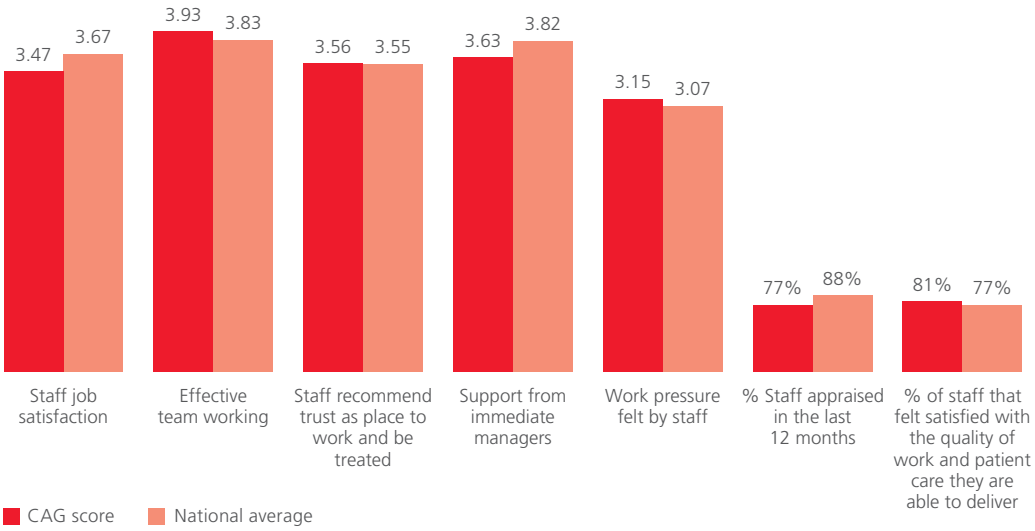


Figure 70 | Psychosis CAG scores for the 7 variables linked to good staff reported experience

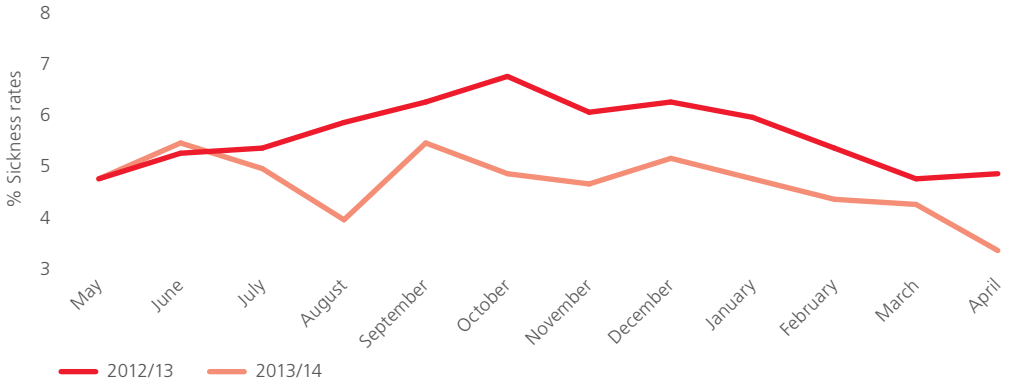


Key

- Staff job satisfaction **(the higher the score the better)**
- Effective Team Working **(the higher the score the better)**
- Staff recommend trust as place to work and to be treated **(the higher the score the better)**
- Support from immediate managers **(the higher the score the better)**
- Work pressure felt by staff **(the lower the score the better)**
- % staff appraised in the last 12 months **(the higher the score the better)**
- % of staff that fell satisfied with the quality of work and service user care they are able to deliver **(the higher the score the better)**

Staff sickness rates

Figure 71 | Staff sickness rates over the last two years



The figure above illustrates there could be a close correlation between improving staff reported experience in the work place and the decreasing staff sickness rates over the last two years.

Our CAG has focused on staff sickness intensively over the past year. From an operations perspective it is important we address the welfare of our workforce by ensuring sickness is addressed and individual staff are supported appropriately.

High sickness also has adverse effects on staffing numbers which in some services have to be maintained at a certain level in order to remain safe and assure levels of high quality care are maintained, which if sickness is high will result in services needing large numbers of temporary staff to cover shifts which would impact on quality and would be an additional cost pressure on the service.

By reducing our levels of sickness we are:

- Assuring the health of our workforce is being addressed
- Reducing the costs of temporary staff to cover shifts
- Ultimately helping maintain safer and better quality services.

Education and training

We have a track record in providing innovative education and training such as being the first Trust in the country to set up postgraduate training courses in Cognitive Behavioural Therapy (CBT) and Family Intervention Therapy for Psychosis. However, it is acknowledged further development is required and we are currently focused on the development of an education and training leadership team to drive the implementation of our strategy.

Education and Training priorities:

- Creation of a new education and training leadership team within our CAG
- Enhancement of the skill base of existing staff by developing psychosis specific training for frontline staff e.g. communication skills and assessment
- Enhancement of the skill base of new staff by recruiting more staff with degrees and specialised training
- Improvement of student satisfaction with undergraduate medical education
- Improvement of Core Trainees' and Specialist Registrars' specific knowledge of psychosis
- Increase in the number of postgraduate trainees, expansion of the MSc programme, CBT and specialised clinical teaching programmes in psychosis
- Development of training for non-clinical staff, carers and service users.

Internal education and training will be linked to stages within the pathways and will include psychosis specific communication skills and assessment, a randomised controlled evaluation of recovery approach training, as well as development of a Managerial Competence Programme and increasing the numbers of MSc's in Psychosis offered and delivered. The development of nursing excellence is being supported via the process of gaining MAGNET accreditation. The close alignment of research and clinical practice via the care pathway approach will ensure the CAG develops a culture of learning informed by research.

A key strength of our CAG education and training structure is its inter-professional nature.

Integration of provision across professional groups, and between the Trust and academic institutions is excellent. However, increasing training provision for non-clinical staff, service users and carers is a priority as we understand the importance of this particular training area.

The multicultural population we serve along with a high prevalence rate of psychosis provides us with a unique opportunity to develop innovative research and link it to clinical practice, and this research will be systemically and proactively linked to the different stages of the care pathways.

The new model developed by us will provide the opportunity to revolutionise how psychosis is prevented, identified and treated locally and potentially also at a national level and beyond.

Education and training developments

We have our own Head of Education and Training in post since 2012. As with research, our education and training is being developed to align with the four care pathways.

A new Masters course in Early Intervention for Psychosis has been developed, and started in autumn 2013. This course combines expert teaching with clinical experience in relation to Early Intervention services, and has proved very popular, with more than double the expected number of students enrolled this year.

We also provide clinical attachments for MSc degree in Mental Health Studies and Psychiatry Research. These are large, well-established courses (100 and 50 students, respectively) and most of the students plan to go on to a clinical or academic career in mental health.

Pathway-specific training is complimented by generic training applicable to all staff. For example, a course focused on communication with people with psychosis has been developed for all front line staff, regardless of which pathway they work in, and has been trialled with administration staff. Further examples of new programmes/ consolidation include:

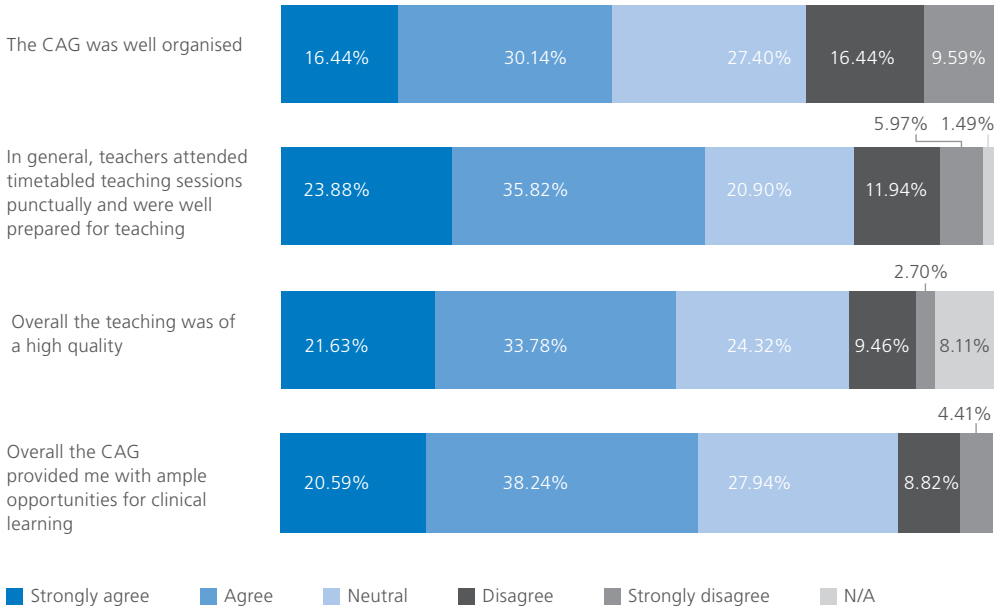
- Cognitive behavioural therapy (CBT) for Psychosis educational pathway has been developed at four levels from graduate certificate to postgraduate diploma in response to our requirements to develop different levels of practitioners. The graduate certificate programme in carer engagement skills and brief manualised therapeutic interventions has been successfully piloted for eight nursing staff in the Early Intervention Care pathway
- To support the development of advanced skills for psychologists in our clinical teams additional modules have been developed along the PG Diploma CBT Psychosis pathway in 'supervised practice' and 'supervisory practice

- Development of the staff in our CAG Acute Care pathway will enable more efficient and effective services for the future. The short course 'enhanced skills for in-patient staff' is being reviewed to incorporate the latest psychosis specific competencies and evidence for delivery in spring 2013.

Student satisfaction survey

Below is a sample of the questions and their responses on the overall quality of the teaching from the 2012/13 student satisfaction survey for students taught in the Psychosis CAG.

Figure 72 | Psychosis CAG Phase 3 – Student experience survey 2012/13



Academic research and innovations

We have a particularly strong track record in innovative research. The Department of Psychosis Studies is one of the largest research groups for psychosis in the world, and we have close links with psychosis researchers working in other CAGs and Basic Research Groups across King's Health Partners, including the Departments of Psychology, Genetics, and Health Services and Population Research.

Our research strategy is explicitly translational, with a focus on work in developing new assessments and treatments and improvement of clinical care.

The clinical specialisation greatly facilitates research as well as focusing on psychosis, within our clinical care delivered by care pathways corresponding to different phases of illness. Research activity is aligned to this clinical framework, with distinct research programmes focused on the early phase of psychosis (hosted by the Early Intervention pathway), psychopharmacology (Acute Inpatient pathway), relapse prevention (Promoting Recovery pathway), and treatment resistance (Complex Care pathway). This unique clinical infrastructure ensures our research is informed by the key clinical issues in each domain, and new research findings can rapidly impact on clinical policy and practice.

Research priorities include:

- Engagement of all clinical services and clinical professions as partners within the research programme
- Large scale translational research projects to shape clinical practice and health policy
- Developing and evaluating novel treatments in collaboration with industry and government agencies.

Research highlights

Environmental risk factors

We have demonstrated a number of social and environmental factors which significantly increase the risk of psychosis, including belonging to an ethnic minority or migrant group, exposure to childhood stressors, and cannabis use. (Morgan et al, 2010 Schizophrenia Bulletin 36 (4) , pp. 655–664; Boydell et al, 2013 Acta Psychiatrica Scandinavica, Volume 127, Issue 3, pages 202–209, March 2013; Kirkbride et al, 2013 – PLoS ONE, Volume 7, Issue 3, 22 March 2012, Article numbere31660; Morgan, C., Kirkbride, J., Hutchinson, G., et al., 2008. Psychol. Med. 38, 1701–1715.; Reininghaus et al, Schizophrenia Research 124 (2010) 43–48). The studies on cannabis have contributed to a change in the legal classification of the drug.

We have also used neuroimaging to demonstrate how some of these factors, such as cannabis use (Bhattacharyya et al, Arch Gen Psych 2009) can influence brain function to alter the risk of later illness. We have also shown how their effects on the brain depend on genetic factors (Bhattacharyya et al, Mol Psych 2012), and are examining how environmental and genetic factors interact in psychosis as part of the EU-GEI multi-national programme (www.eu-gei.eu).

People at high risk

Work in the OASIS service has provided some of the first evidence that the structure, function and chemistry of the brain are perturbed before the first episode of psychosis.[T1] (Mechelli et al, Arch Gen Psych 2011; Howes et al, Arch Gen Psych 2009; stone et al, Biol Psych 2009). These findings have led to a major EU-funded programme (PSYSCAN; www.psyscan.eu) to work with industry to develop a clinical tool that can use these measures to predict clinical outcomes in high risk individuals.

Predicting therapeutic response

Our neuroimaging research has shown for the first time that the individual response to antipsychotic treatment depends on both brain dopamine and brain glutamate levels. [Demjaha et al, Am J Psych, 2012; Egerton et al, Neuropsychopharmacology 2012; Demjaha et al, Biol Psych 2013]. This has major implications for the early identification of service users who are resistant to conventional treatment, and has led to ongoing work in a multi-centre research programmes (OPTIMISE; http://ec.europa.eu/research/health/medical-research/brain-research/projects/optimise_en.html; STRATA) that is designed to develop clinical tools that can be used to predict therapeutic responses (Mechelli et al, Arch Gen Psych 2011; Howes et al, Arch Gen Psych 2009; stone et al, Biol Psych 2009; Demjaha et al, Am J Psych, 2012; Egerton et al, Neuropsychopharmacology 2012; Demjaha et al, Biol Psych 2013; Mourao-Miranda et al, 2012).

Evaluation of new treatments

We are conducting a range of studies designed to evaluate the safety and effectiveness of novel psychological, and pharmacological treatments for psychosis. For example, we have shown that CBD, an ingredient of cannabis, has great potential as a treatment for psychosis (Bhattacharrya et al, Neuropsychopharmacology 2010; Englund et al, Journal of Psychopharmacology 2013).

Physical health

There is increased awareness of the extent to which physical health is affected in people with psychosis. The IMPACT study was one of the first research programmes to demonstrate the severity and prevalence of metabolic and cardiovascular alterations in psychosis (Gaughran, F., BMC Psychiatry 2013), and has led to new work designed to evaluate novel interventions designed to improve physical health in our service users. These include clinical trials of e-cigarettes, and of vitamin D supplements.

Impact case studies

- Developing a new treatment: cognitive behaviour therapy for psychosis
- Improving mental health services for people experiencing domestic violence
- Reducing mental health stigma across England
- Family intervention for psychosis

An example of how we are leading the way with research and innovation in the Psychosis CAG

Increasing public awareness of cannabis use and psychosis

Research at King's College London (KCL) showed the use of cannabis, especially high potency types such as 'Skunk', increases the risk of psychosis.

Our work has demonstrated that adolescents who start early and carry some genetic vulnerability are at highest risk and that experimental cannabis administration alters brain function and induces transient psychosis. KCL research has led to increased public awareness of the adverse effects of cannabis use on mental health, in the UK and abroad, and sparked a public debate in the UK on the legal status of the drug ending with the Government reclassifying cannabis from Category C to Category B.

King's College London research:

- On brain function has collaborated with the industry to develop new psychiatric medication
- On the role of cannabis use in the aetiology of psychotic disorders has led to public awareness of the connection between patterns of cannabis use and mental health and to the UK Government considering and

incorporating the issues surrounding cannabis use into policy and information

- Has had industry impact by helping to advance the development of new medicines that act on the brain endocanniboid system to ameliorate psychiatric symptoms.

KCL research has had a major impact on the public's perception of the risks of cannabis use on mental health and has helped in the understanding of why the drug can have adverse effects in some users but not others.

These studies generated a high level of media interest and KCL experts have conveyed the importance of their findings in a number of interviews in high profile UK television programmes, radio programmes and newspaper articles.

In 2007–9, the UK Government re-considered the issue of the legal categorisation of cannabis, following its 2004 downgrading from Category B to Category C. One of the main reasons given by the Prime Minister during his announcement was that this was "because of concerns about stronger strains of the drug, particularly Skunk, and the potential mental health effects they can have." Evidence from KCL researchers to the Advisory Council on the Misuse of Drugs resulted in their 2005 and 2008 reports accepting the effect of cannabis on psychosis and emphasising that education concerning the risks of cannabis was important.

Initially Government information on cannabis on their website 'Talk to Frank' contained no information on the adverse effects of cannabis on mental health. However, as a result of KCL research, in 2009 the Department of Health launched a major TV, radio and online campaign to demonstrate the role cannabis can play in the development of mental health problems.

Number of CAG service users enrolled in research projects

Year	# Service users recruited (interventional)	# Service users recruited (observational)	Total number recruited
10/10 to 9/11	958	949	1907
10/11 to 9/12	982	654	1636
10/12 to 7/13	376	286	662

Research income

Figure 73 | Level of income received from 2008 to 2012

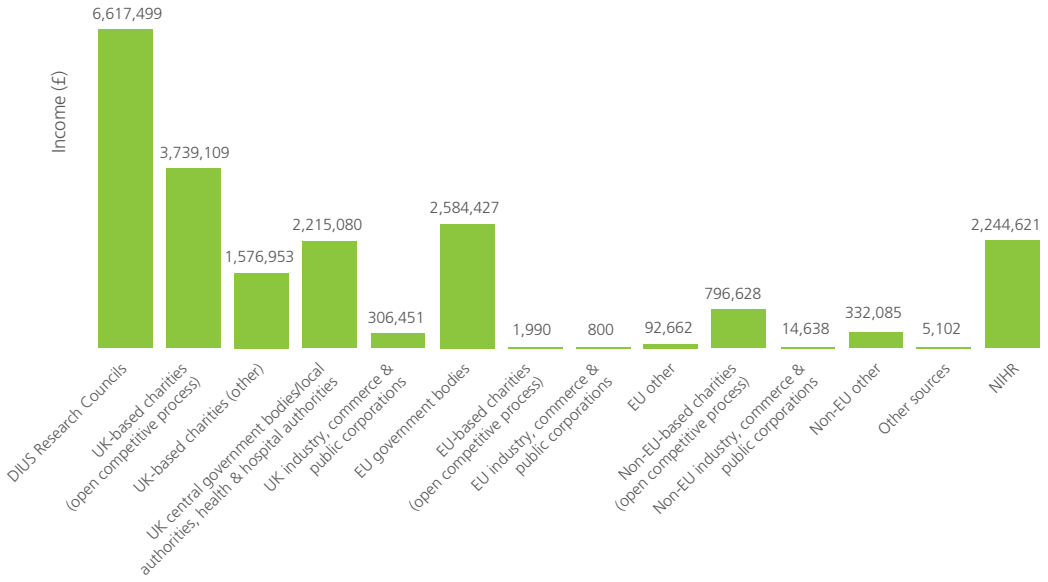
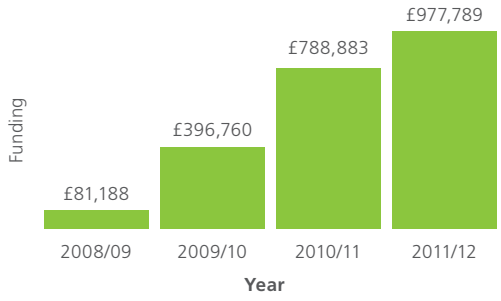


Figure 74 | Funding from the NIHR



Publications

List of key CAG publications	Journal
Demjaha, A, Egerton, A, Murray, R, Kapur, S, Howes, O, Stone, J, McGuire, P. (2014) Antipsychotic treatment resistance in schizophrenia associated with elevated glutamate levels but normal dopamine function.	Biological Psychiatry
Reynolds, N., Wuyts, P., Badger, S., (...), Mcguire, P., Valmaggia, L. (2014) The impact of delivering GP training on the clinical high risk and first-episode psychosis on referrals and pathways to care.	Early Intervention in Psychiatry
Brett, C., Heriot-Maitland, C.,McGuire, P., Peters, E. (2014) Predictors of distress associated with psychotic-like anomalous experiences in clinical and non-clinical populations.	British Journal of Clinical Psychology
Valmaggia, L.R., Day, F.L., Jones, C., (...), Byrne, M., McGuire, P.K. (2014) Cannabis use and transition to psychosis in people at ultra-high risk.	Psychological Medicine
Gilleen, J., Michalopoulou, P.G.,Reichenberg, A., (...), Lewis, S.W.,Kapur, S. (2014) Modafinil combined with cognitive training is associated with improved learning in healthy volunteers – A randomised controlled trial.	European Neuropsycho-pharmacology
Shergill, S.S., White, T.P., Joyce, D.W., (...), Wolpert, D.M., Frith, C.D. (2014) Document Functional magnetic resonance imaging of impaired sensory prediction in schizophrenia.	JAMA Psychiatry
So, S.H.W., Peters, E.R.,Swendsen, J., Garety, P.A., Kapur, S. (2014) Changes in delusions in the early phase of antipsychotic treatment – An experience sampling study.	Psychiatry Research
Vernon, A.C., Crum, W.R., Lerch, J.P., (...), Williams, S.C.R., Kapur, S.(2014) Reduced cortical volume and elevated astrocyte density in rats chronically treated with antipsychotic drugs – Linking magnetic resonance imaging findings to cellular pathology.	Biological Psychiatry
Howes, O.D., Murray, R.M.(2014) Schizophrenia: An integrated sociodevelopmental-cognitive model.	The Lancet
Morgan, C., Lappin, J., Heslin, M., (...), Doody, G.A., Dazzan, P. (2014) Reappraising the long-term course and outcome of psychotic disorders: the AESOP-10 study.	Psychological Medicine
Reis Marques, T., Taylor, H.,Chaddock, C., (...), Kapur, S.,Dazzan, P.(2014) White matter integrity as a predictor of response to treatment in first episode psychosis.	Brain

Fusar-Poli, P., Nelson, B.,Valmaggia, L., Yung, A.R.,McGuire, P.K. (2014) Comorbid depressive and anxiety disorders in 509 individuals with an at-risk mental state: Impact on psychopathology and transition to psychosis.	Schizophrenia Bulletin
Goghari, V.M., Brett, C., Tabraham, P., (...), Byrne, M., McGuire, P. (2014) Spatial working memory ability in individuals at ultra high risk for psychosis.	Journal of Psychiatric Research
Birchwood, M., Michail, M., Meaden, A., Tarrier, N., Lewis, S., Wykes, T., Davies, L., Dunn, G. & Peters, E.R. (2014) The MRC COMMAND trial: results of a multi-centre, randomised controlled trial of cognitive therapy to prevent harmful compliance with command hallucinations.	Lancet Psychiatry
Howes, O.D., Williams, M.,Ibrahim, K., (...), McGuire, P.K.,Turkheimer, F. (2013) Midbrain dopamine function in schizophrenia and depression: A post-mortem and positron emission tomographic imaging study.	Brain
Roiser, J.P., Howes, O.D.,Chaddock, C.A., Joyce, E.M.,McGuire, P. (2013) Neural and behavioral correlates of aberrant salience in individuals at risk for psychosis.	Schizophrenia Bulletin
Day, F.L., Valmaggia, L.R.,Mondelli, V., (...), Pariante, C.M.,McGuire, P. (2013) Blunted Cortisol Awakening Response in People at Ultra High Risk of Developing Psychosis.	Schizophrenia Research
Codjoe, L., Byrne, M., Lister, M.,McGuire, P., Valmaggia, L. (2013) Exploring perceptions of wellness in black ethnic minority individuals at risk of developing psychosis.	Behavioural and Cognitive Psychotherapy
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Howes, O.D., Vergunst, F., Gee, S., McGuire, P., Kapur, S., Taylor, D. (2012) Adherence to treatment guidelines in clinical practice: Study of antipsychotic treatment prior to clozapine initiation.	British Journal of Psychiatry

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King's Health Partners
Ground Floor
Counting House
Guy's Hospital
London SE1 9RT

Tel: 44 (0)20 7188 4058
Email: kingshealthpartners@kcl.ac.uk
Website: www.kingshealthpartners.org
Twitter: @kingshealth

King's College London
Guy's and St Thomas' NHS Foundation Trust
King's College Hospital NHS Foundation Trust
South London and Maudsley NHS Foundation Trust