Service changes in Croydon / Update on Psychosis

Dr Hugh Jones

Clinical Director Croydon

Croydon Operations directorate

- Dedicated service director for adult services

Currently Dr Faisil Sethi

- Clinical Director (Hugh Jones) and Medical Lead (currently Dr Sarah Cornick)
- Head of nursing (Julie Hayward)
- There will be managers with specific responsibility for inpatient and community services

Progress to date

- Borough directorate started May 2018
- Introduction was shortly followed by CQC inspection in July 2018
- Thus far still recruiting to management team

Relationship between Croydon and wider trust

- Croydon will manage services (avoids situation where distinct community services were managed by different departments)
- Trust will still have a role in larger initiatives eg MADE (multi agency discharge events).
- CAG's will have role at this trustwide level rather than local service management

Current service structure

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

Early Intervention in Psychosis

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

Early Intervention in Psychosis

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

Early Intervention in Psychosis

- Standard is that 50% of individuals with a first onset of psychosis will be receiving NICE guidelines treatment within 2 weeks of referral
- Definition of First episode psychosis includes symptoms of a duration of at least 1 week.
- Current experience is that EI services struggle to manage potential demand.

Current challenges in EI

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

Psychosis not a euphemism for schizophrenia

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

Transfer to primary care

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

Psychosis teams

- Drivers in developing these did not include discussion with primary care.
- In traditional community teams patients were managed ‘as if’ they were highly dependent with an incapacitating illness.
- Opportunity to develop new treatment interventions (especially psychotherapy) based on experience of EI.

Current reality / challenges

- System is overcomplicated and focus of community services has been diverted away from either managing acute admissions / relapse or being focussed on needs of primary care
- Psychosis is not a clean discriminator between patients / diagnoses