NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

Health and social care directorate

Quality standards and indicators

Briefing paper

Quality standard topic: Psychosis and schizophrenia in adults

Output: Prioritised quality improvement areas for development.

Date of Quality Standards Advisory Committee meeting: 02 July 2014

Contents

1 Introduction

This briefing paper presents a structured overview of potential quality improvement areas for psychosis and schizophrenia in adults. It provides the Committee with a basis for discussing and prioritising quality improvement areas for development into draft quality statements and measures for public consultation.

1.1 Structure

This briefing paper includes a brief description of the topic, a summary of each of the suggested quality improvement areas and supporting information.

If relevant, recommendations selected from the key development source below are included to help the Committee in considering potential statements and measures.

1.2 Development source

The key development source referenced in this briefing paper is:

- Psychosis and schizophrenia in adults. NICE clinical guideline 178 (2014).

2 Overview

2.1 Focus of quality standard

This quality standard will cover the identification, treatment and management of psychosis and schizophrenia (including related psychotic disorders such as schizoaffective disorder, schizophreniform disorder and delusional disorder) in adults (18 years and older) with onset before the age of 60 years in primary, secondary and community care.

2.2 Definition

Psychosis and the specific diagnosis of schizophrenia represent a major psychiatric disorder (or cluster of disorders) in which a person's perception, thoughts, mood and behaviour are significantly altered. The symptoms of psychosis and schizophrenia are usually divided into 'positive symptoms', including hallucinations (perception in the absence of any stimulus) and delusions (fixed or falsely held beliefs), and 'negative symptoms' (such as emotional apathy, lack of drive, poverty of speech, social withdrawal and self-neglect). Each person will have a unique combination of symptoms and experiences.

2.3 Incidence and prevalence

Psychosis is relatively common mental illness, with schizophrenia being the most common form of psychotic disorder.

A review of the incidence of psychosis and schizophrenia in England between 1950 and 2009 found a pooled incidence of 31.7 per 100,000 for psychosis and of 15 per 100,000 for schizophrenia. Rates varied according to gender and age group, with rates generally reducing with age (although with a second peak in women starting in the mid to late 40s). Men under the age of 45 were found to have twice the rate of schizophrenia than women, but there was no difference in its incidence after this age. The rate of schizophrenia was found to be significantly higher in black Caribbean and black African migrants and their descendants, compared with the baseline population[1].

The incidence of psychosis has been reported to vary from place to place with rates in south-east London (55 per 100,000 person years) being more than twice those in both Nottingham and Bristol (25 per 100,000 person years and 22 per 100,000 person years, respectively)[2].

In 2011 the overall cost of schizophrenia to society in England was estimated at £11.8 billion and in 2007 schizophrenia accounted for approximately 30% of total expenditure on adult mental health and social care services[3].

2.4 Management

Within both hospital and community settings, antipsychotic drugs remain the primary treatment for psychosis and schizophrenia. There is well-established evidence for their efficacy in both the treatment of acute psychotic episodes and relapse prevention over time. However, despite this, considerable problems remain. A significant proportion of service users (up to 40%) have a poor response to conventional antipsychotic drugs and continue to show moderate to severe psychotic symptoms (both positive and negative).

Psychological and psychosocial interventions in psychosis and schizophrenia include interventions to improve symptoms but also those that address vulnerability, which are embedded in developmental processes. The aims, therefore, include: reduction of distress associated with psychosis symptoms, promoting social and educational recovery, reducing depression and social anxiety and relapse prevention.

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[1] Kirkbride JB, Errazuriz A, Croudace TJ, Morgan C, Jackson D, Boydell J, et al. Incidence of schizophrenia and other psychoses in England, 1950-2009: a systematic review and meta-analyses. PLoS One. 2012; 7:e31660.

[2] Morgan C, Dazzan P, Morgan K, Jones P, Harrison G, Leff J, et al. First episode psychosis and ethnicity: initial findings from the AESOP study. World Psychiatry. 2006; 5:40.

[3] Royal College of Psychiatrists Report of the National Audit of Schizophrenia (NAS) 2012

In the last decade, there has been a new emphasis on services for early detection and intervention, and a focus on long-term recovery and promoting people's choices about the management of their condition. There is evidence that most people will recover, although some will have persisting difficulties or remain vulnerable to future episodes. Not everyone will accept help from statutory services. In the longer term, most people will find ways to manage acute problems, and compensate for any remaining difficulties.

Carers, relatives and friends of people with psychosis and schizophrenia are important both in the process of assessment and engagement, and in the long-term successful delivery of effective treatments. The term 'carer' applies to everyone who has regular close contact with people with psychosis and schizophrenia, including advocates, friends or family members, although some family members may choose not to be carers.

2.5 National audit of schizophrenia

The National Audit of Schizophrenia (NAS) is an initiative of the Royal College of Psychiatrists' (RCPsych) Centre for Quality Improvement (CCQI) and is commissioned by the Healthcare Quality Improvement Partnership (HQIP) as part of the National Clinical Audit and Patient Outcomes Programme (NCAPOP).

The first round of NAS took place in autumn 2011 with 60 of 64 eligible trusts and health boards participating, the report published December 2012. The second round of audit is currently being undertaken with a report to be published 10 October 2014.

The key aims of the 2012 audit report were to measure:

- service users' experience of care and treatment and outcomes.
- carers' satisfaction with the support and information they have received.
- practice in the prescribing of antipsychotic medications.
- the use of psychological therapies.
- the quality of physical health monitoring and interventions offered.

Findings from the audit are presented in the current practice sections of this briefing paper, where they relate to a quality improvement area.

2.6 National Outcome Frameworks

Tables 1–3 show the outcomes, overarching indicators and improvement areas from the frameworks that the quality standard could contribute to achieving.

Table 1 The Adult Social Care Outcomes Framework 2014–15

Domain	Overarching and outcome measures
1 Enhancing quality of life for people with care and support needs	***Overarching measure*** 1A Social care-related quality of life** (NHSOF2) ***Outcome measures*** **People manage their own support as much as they wish, so that are in control of what, how and when support is delivered to match their needs.** 1B Proportion of people who use services who have control over their daily life 1C Proportion of people using social care who receive self-directed support, and those receiving direct payments **Carers can balance their caring roles and maintain their desired quality of life.** 1D Carer-reported quality of life** (NHSOF 2.4) **People are able to find employment when they want, maintain a family and social life and contribute to community life, and avoid loneliness or isolation.** 1F Proportion of adults in contact with secondary mental health services in paid employment **(PHOF 1.8, NHSOF 2.5) 1H Proportion of adults in contact with secondary mental health services living independently, with or without support * (PHOF 1.6)
3 Ensuring that people have a positive experience of care and support	***Overarching measure*** **People who use social care and their carers are satisfied with their experience of care and support services** 3A Overall satisfaction of people who use services with their care and support 3B Overall satisfaction of carer with social services 3E Improving people's experience of integrated care ** (NHSOF 4.9) ***Outcome measures*** **Carers feel that they are respected as equal partners throughout the care process** 3C The proportion of carers who report that they have been included or consulted in discussions about the person they care for **People know what choices are available to them locally, what they are entitled to, and who to contact when they need help** 3D The proportion of people who use services and carers who find it easy to find information about support
Aligning across the health and care system * Indicator shared ** Indicator complementary	

Table 2 NHS Outcomes Framework 2014–15

Domain	Overarching indicators and improvement areas
1 Preventing people from dying prematurely	***Overarching indicator*** 1a Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare i Adults ***Improvement areas*** **Reducing premature death in people with serious mental illness** 1.5 Excess under 75 mortality rate in adults with serious mental illness * (PHOF 4.9)
2 Enhancing quality of life for people with long-term conditions	***Overarching indicator*** 2 Health-related quality of life for people with long-term conditions** (ASCOF 1A) ***Improvement areas*** **Ensuring people feel supported to manage their condition** 2.1 Proportion of people feeling supported to manage their condition **Enhancing quality of life for carers** 2.4 Health-related quality of life for carers** (ASCOF 1D) **Enhancing quality of life for people with mental illness** 2.5 Employment of people with mental illness**(ASCOF 1F and PHOF 1.8)
4 Ensuring that people have a positive experience of care	***Overarching indicator*** 4a Patient experience of primary care i GP services 4b Patient experience of hospital care ***Improvement areas*** **Improving people's experience of outpatient care** 4.1 Patient experience of outpatient services **Improving access to primary care services** 4.4 Access to i GP services **Improving experience of healthcare for people with mental illness** 4.7 Patient experience of community mental health services **Improving people's experience of integrated care** 4.9 People's experience of integrated care ** (ASCOF 3E)
Alignment across the health and social care system * Indicator shared ** Indicator complementary	

Table 3 Public health outcomes framework for England, 2013–2016

Domain	Objectives and indicators
1 Improving the wider determinants of health	***Objective*** Improvements against wider factors which affect health and wellbeing and health inequalities ***Indicators*** 1.6 Adults with a learning disability/in contact with secondary mental health services who live in stable and appropriate accommodation * (ASCOF 1G and 1H) 1.8 Employment for those with long-term health conditions including adults with a learning disability or who are on contact with secondary mental health services **(NHSOF 2.5 and ASCOF 1F)
4 Healthcare public health and preventing premature mortality	***Objective*** Reduced numbers of people living with preventable ill health and people dying prematurely, while reducing the gap between communities ***Indicators*** 4.3 Mortality rate from causes considered preventable ** (NHSOF 1a) 4.4 Under 75 mortality rate from all cardiovascular disease (including heart disease and stroke) * (NHSOF 1.1) 4.9 Excess under 75 mortality rate in adults with serious mental illness * (NHSOF 1.5) 4.10 Suicide rate
Alignment across the health and social care system * Indicator shared ** Indicator complementary	

3 Summary of suggestions

3.1 Responses

In total 11 stakeholders responded to the 2-week engagement exercise 07/05/14 – 21/05/14.

Stakeholders were asked to suggest up to 5 areas for quality improvement. Specialist committee members were also invited to provide suggestions. The responses have been merged and summarised in table 4 for further consideration by the Committee.

Full details on the suggestions provided are given in appendix 2 for information.

Table 4 Summary of suggested quality improvement areas

Suggested area for improvement	Stakeholders
Care across all phases • Physical health • Support for carers	COT, HD, JC, L & O, PMHI, RCGP, RCPsych, RMI, SCM
First episode psychosis • Early intervention in psychosis services • Treatment options • Antipsychotic medication	COT, L & O, RCN, RMI, SCM
Subsequent acute episodes of psychosis or schizophrenia and referral in crisis • Psychological and psychosocial interventions	RMI, SCM
Promoting recovery and possible future care • Primary care • Antipsychotic medication • Employment, education and occupational activities	COT, JC, PMHI, RCGP, RCN, RCPsych, RMI, S, SCM
Additional areas • Service user experience • Race, culture and ethnicity • Psychogenomics • Assessment and treatment of coexisting substance misuse • Mental health nurse staff training	JC, SCM
COT, College of Occupational Therapists HD, HQT-Diagnostics JC, Janssen Cilag UK L & O, Lunbeck and Otsuka (joint response) PMHI, Pharmaceutical Mental Health Initiative RCGP, Royal College of General Practitioners RCPsych, Royal College of Psychiatrists RCN, Royal College of Nurses RMI, Rethink Mental Illness S, SANE SCM, Specialist Committee Members	

4 Suggested improvement areas

4.1 Care across all phases

4.1.1 Summary of suggestions

Physical health

Stakeholders highlighted that adults with psychosis and schizophrenia have a mortality gap of 15 to 20 years with the general population. This gap is mostly due to poor physical health including cardiovascular disease, diabetes and obesity. Physical health care promotion, such as referral to physical activity services, physical health monitoring and smoking cessation services can reduce co-morbidity and mortality as well as improve mental health and well-being.

Support for carers

Stakeholders highlighted that carers play an important role in the management of psychosis and schizophrenia. Carers need to be supported for their own needs, such as mental health assessments, as well as being provided a support programme and information about the role they can play in the management of psychosis and schizophrenia.

4.1.2 Selected recommendations from development source

Table 5 below highlights recommendations that have been provisionally selected from the development source that may support potential statement development. These are presented in full after table 5 to help inform the Committee's discussion.

Table 5 Specific areas for quality improvement

Suggested quality improvement area	Suggested source guidance recommendations
Physical health	**Physical health** NICE CG178 Recommendations 1.1.3.1, 1.1.3.3 to 1.1.3.6
Support for carers	**Support for carers** NICE CG178 Recommendations 1.1.5.1 to 1.1.5.7

Physical health

NICE CG178 – Recommendation 1.1.3.1

People with psychosis or schizophrenia, especially those taking antipsychotics, should be offered a combined healthy eating and physical activity programme by their mental healthcare provider.

NICE CG178 – Recommendation 1.1.3.3

Offer people with psychosis or schizophrenia who smoke help to stop smoking, even if previous attempts have been unsuccessful. Be aware of the potential significant impact of reducing cigarette smoking on the metabolism of other drugs, particularly clozapine and olanzapine.

NICE CG178 – Recommendation 1.1.3.4

Consider one of the following to help people stop smoking:

- nicotine replacement therapy (usually a combination of transdermal patches with a short-acting product such as an inhalator, gum, lozenges or spray) for people with psychosis or schizophrenia or
- bupropion[1] for people with a diagnosis of schizophrenia or
- varenicline for people with psychosis or schizophrenia.

Warn people taking bupropion or varenicline that there is an increased risk of adverse neuropsychiatric symptoms and monitor them regularly, particularly in the first 2–3 weeks.

NICE CG178 – Recommendation 1.1.3.5

For people in inpatient settings who do not want to stop smoking, offer nicotine replacement therapy to help them to reduce or temporarily stop smoking.

NICE CG178 – Recommendation 1.1.3.6

Routinely monitor weight, and cardiovascular and metabolic indicators of morbidity in people with psychosis and schizophrenia. These should be audited in the annual team report.

Support for carers

NICE CG178 – Recommendation 1.1.5.1

Offer carers of people with psychosis or schizophrenia an assessment (provided by mental health services) of their own needs and discuss with them their strengths and

views. Develop a care plan to address any identified needs, give a copy to the carer and their GP and ensure it is reviewed annually.

NICE CG178 – Recommendation 1.1.5.2

Advise carers about their statutory right to a formal carer's assessment provided by social care services and explain how to access this.

NICE CG178 – Recommendation 1.1.5.3

Give carers written and verbal information in an accessible format about:

- diagnosis and management of psychosis and schizophrenia
- positive outcomes and recovery
- types of support for carers
- role of teams and services
- getting help in a crisis.

When providing information, offer the carer support if necessary.

NICE CG178 – Recommendation 1.1.5.4

As early as possible negotiate with service users and carers about how information about the service user will be shared. When discussing rights to confidentiality, emphasise the importance of sharing information about risks and the need for carers to understand the service user's perspective. Foster a collaborative approach that supports both service users and carers, and respects their individual needs and interdependence.

NICE CG178 – Recommendation 1.1.5.5

Review regularly how information is shared, especially if there are communication and collaboration difficulties between the service user and carer.

NICE CG178 – Recommendation 1.1.5.6

Include carers in decision-making if the service user agrees.

NICE CG178 – Recommendation 1.1.5.7

Offer a carer-focused education and support programme, which may be part of a family intervention for psychosis and schizophrenia, as early as possible to all carers. The intervention should:

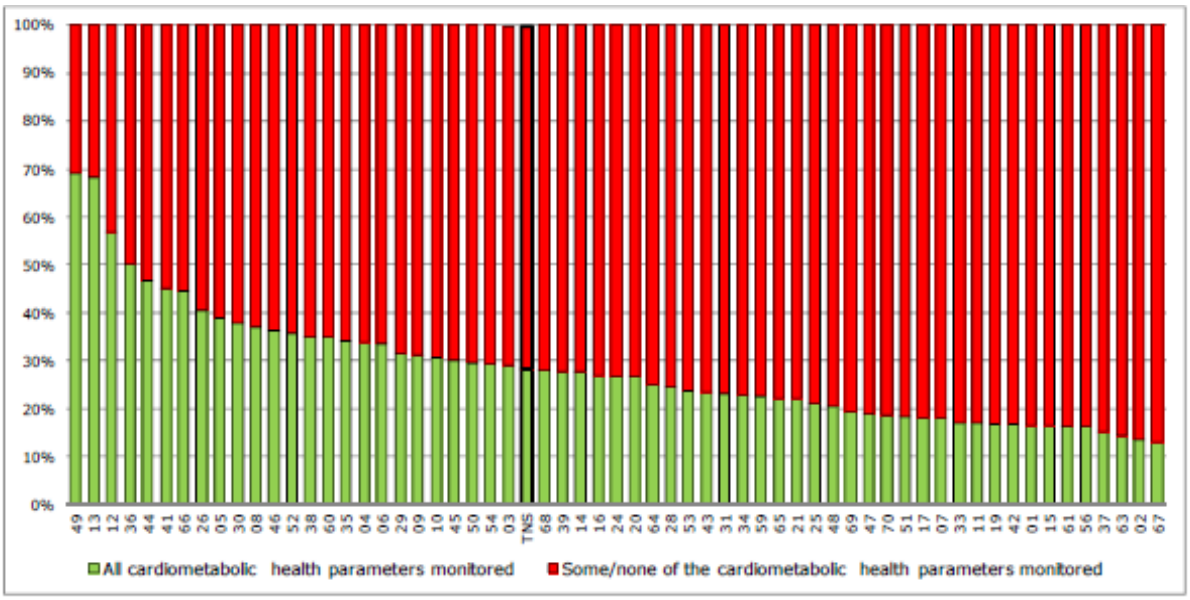
- be available as needed
- have a positive message about recovery.

4.1.3 Current UK practice

Physical health

The 2012 NAS found that while people with schizophrenia have increased risk for developing physical health problems only 29% of this population receive a fully comprehensive assessment, and only 56% of these service users were reported to have been weighed in the previous 12 months. Data per participating Trust is presented in charts below taken from the NAS report.

NAS figure 1: Monitoring of cardiometabolic health parameters, excluding family history and weight, once in the past 12 months

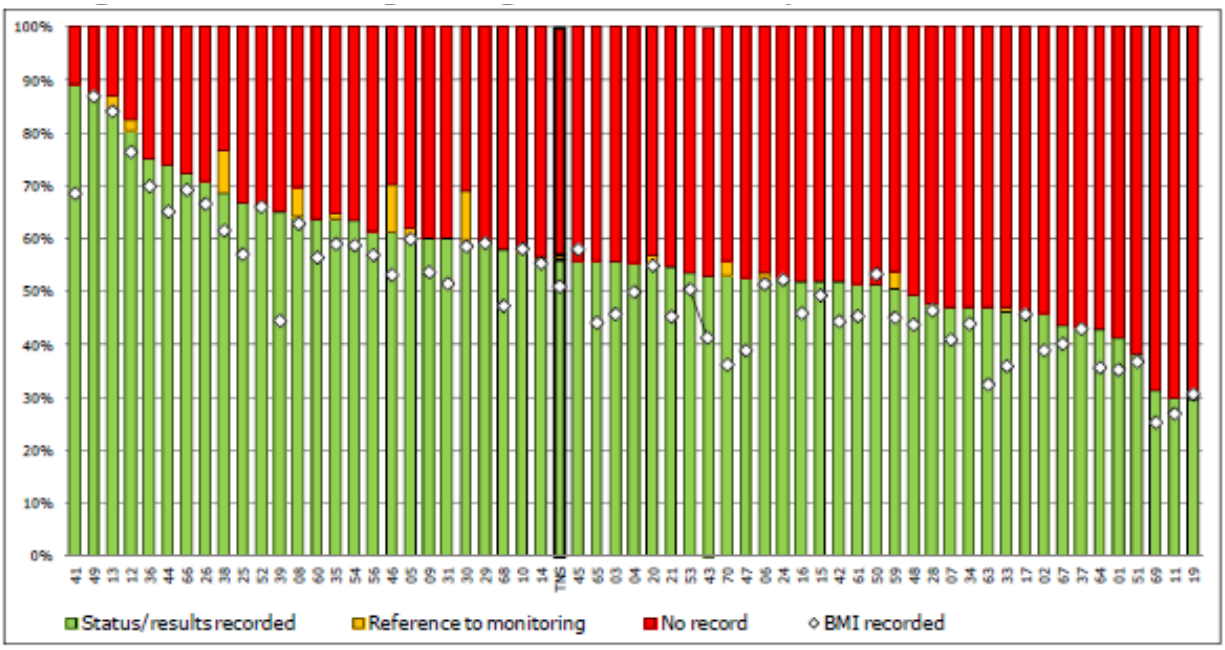


- The data for Figure 24 are taken from Q30 of the audit of practice tool.
- The number of service users included in this analysis is 5,091.

4

[4] Royal College of Psychiatrists Report of the National Audit of Schizophrenia (NAS) Figure 24. 2012

NAS figure 2: Monitoring of weight and BMI in the past 12 months



- The data for Figure 27 are taken from Q30 of the audit of practice tool.
- The number of cases included in this analysis is 5,091.

5

The audit also highlighted that for service users with evidence of a physical health problem, such as high blood pressure and high cholesterol levels, they often have no further investigations or treatment. For example service users with an elevated BMI were given advice regarding diet and exercise in only 76% of cases[6].

NHS England's Commissioning for Quality and Innovation (CQUIN) indicators for 2014/15, support the reduction of the 15 to 20 year premature mortality in people with severe mental illness (including psychosis and schizophrenia). This will incentivise providers to ensure that service users have recorded comprehensive physical and mental health diagnoses, communicated between primary care and specialist mental health clinicians and with the service user. Two indicators have been developed, based on the findings of NAS[7].

Support for carers

The 2012 NAS found that overall 49% of carers reported being very satisfied with the support and information they currently receive[8]. A 2012 report by the Schizophrenia Commission, 'The Abandoned Illness', heard from over 1,000 families (including friends and significant others) who are carers. The feedback showed that carers

[5] Royal College of Psychiatrists Report of the National Audit of Schizophrenia (NAS) Figure 27. 2012
[6] Royal College of Psychiatrists Report of the National Audit of Schizophrenia (NAS) 2012
[7] NHS England. Commissioning for Quality and Innovation (CQUIN) 2014/15 Guidance. 2014
[8] Royal College of Psychiatrists Report of the National Audit of Schizophrenia (NAS) 2012

need better support to enable them to care effectively, this should include the provision of information, support groups, respite care and family education[9].

[9] The Schizophrenia Commission. The Abandoned Illness. 2012

4.2 First episode psychosis

4.2.1 Summary of suggestions

Early intervention in psychosis services

Stakeholders highlighted that it is vital that people with psychosis and schizophrenia receive the necessary support and potential treatment as early as possible, once a first episode has been identified. Early Intervention in Psychosis (EIP) services can facilitate early access to treatment and are associated with better outcomes for the service user.

Treatment options

Stakeholders felt that people who have a first episode of psychosis should have access to a range of evidence-based treatment options. This includes antipsychotic medication, psychological and psychosocial treatment. The treatment that a service user is offered should be informed by an assessment, including any previous trauma and mental health history, and future care planning, to ensure that decisions are made with the service user.

Antipsychotic medication

Stakeholders highlighted that as well as being offered a choice of antipsychotic medication, dependent on the individual and baseline investigations, the range and dose should be limited to reduce the chance of a negative impact on physical and mental health.

4.2.2 Selected recommendations from development source

Table 6 below highlights recommendations that have been provisionally selected from the development source(s) that may support potential statement development. These are presented in full after table 6 to help inform the Committee's discussion.

Table 6 Specific areas for quality improvement

Suggested quality improvement area	Selected source guidance recommendations
Early intervention in psychosis services	**Early intervention in psychosis services** NICE CG178 Recommendations 1.3.1.1 (KPI) to 1.3.1.3
Treatment options	**Assessment and care planning** NICE CG178 Recommendation 1.3.3.1 **Treatment options** NICE CG178 Recommendations 1.3.4.1 and 1.3.4.2

Antipsychotic medication	**Choice of antipsychotic medication** NICE CG178 Recommendation 1.3.5.1 (KPI) **How to use antipsychotic medication** NICE CG178 Recommendations 1.3.6.1, 1.3.6.3, 1.3.6.9 and 1.3.6.10 (KPI).

Early intervention in psychosis services

NICE CG178 – Recommendation 1.3.1.1 (key priority for implementation)

Early intervention in psychosis services should be accessible to all people with a first episode or first presentation of psychosis, irrespective of the person's age or the duration of untreated psychosis.

NICE CG178 – Recommendation 1.3.1.2

People presenting to early intervention in psychosis services should be assessed without delay. If the service cannot provide urgent intervention for people in a crisis, refer the person to a crisis resolution and home treatment team (with support from early intervention in psychosis services). Referral may be from primary or secondary care (including other community services) or a self- or carer-referral.

NICE CG178 – Recommendation 1.3.1.3

Early intervention in psychosis services should aim to provide a full range of pharmacological, psychological, social, occupational and educational interventions for people with psychosis, consistent with this guideline.

Treatment options

NICE CG178 – Recommendation 1.3.3.1

Carry out a comprehensive multidisciplinary assessment of people with psychotic symptoms in secondary care. This should include assessment by a psychiatrist, a psychologist or a professional with expertise in the psychological treatment of people with psychosis or schizophrenia. The assessment should address the following domains:

- psychiatric (mental health problems, risk of harm to self or others, alcohol consumption and prescribed and non-prescribed drug history)
- medical, including medical history and full physical examination to identify physical illness (including organic brain disorders) and prescribed drug treatments that may result in psychosis
- physical health and wellbeing (including weight, smoking, nutrition, physical activity and sexual health)

- psychological and psychosocial, including social networks, relationships and history of trauma
- developmental (social, cognitive and motor development and skills, including coexisting neurodevelopmental conditions)
- social (accommodation, culture and ethnicity, leisure activities and recreation, and responsibilities for children or as a carer)
- occupational and educational (attendance at college, educational attainment, employment and activities of daily living)
- quality of life
- economic status.

NICE CG178 – Recommendation 1.3.4.1

For people with first episode psychosis offer:

- oral antipsychotic medication (see sections 1.3.5 and 1.3.6) in conjunction with
- psychological interventions (family intervention and individual CBT, delivered as described in section 1.3.7).

NICE CG178 – Recommendation 1.3.4.2

Advise people who want to try psychological interventions alone that these are more effective when delivered in conjunction with antipsychotic medication. If the person still wants to try psychological interventions alone:

- offer family intervention and CBT
- agree a time (1 month or less) to review treatment options, including introducing antipsychotic medication
- continue to monitor symptoms, distress, impairment and level of functioning (including education, training and employment) regularly.

Antipsychotic medication

NICE CG178 – Recommendation 1.3.5.1 (key priority for implementation)

The choice of antipsychotic medication should be made by the service user and healthcare professional together, taking into account the views of the carer if the service user agrees. Provide information and discuss the likely benefits and possible side effects of each drug, including:

- metabolic (including weight gain and diabetes)
- extrapyramidal (including akathisia, dyskinesia and dystonia)
- cardiovascular (including prolonging the QT interval)
- hormonal (including increasing plasma prolactin)
- other (including unpleasant subjective experiences).

NICE CG178 – Recommendation 1.3.6.1

Before starting antipsychotic medication, undertake and record the following baseline investigations:

- weight (plotted on a chart)
- waist circumference
- pulse and blood pressure
- fasting blood glucose, glycosylated haemoglobin (HbA1c), blood lipid profile and prolactin levels
- assessment of any movement disorders
- assessment of nutritional status, diet and level of physical activity.

NICE CG178 – Recommendation 1.3.6.3

Treatment with antipsychotic medication should be considered an explicit individual therapeutic trial. Include the following:

- Discuss and record the side effects that the person is most willing to tolerate.
- Record the indications and expected benefits and risks of oral antipsychotic medication, and the expected time for a change in symptoms and appearance of side effects.
- At the start of treatment give a dose at the lower end of the licensed range and slowly titrate upwards within the dose range given in the British national formulary (BNF) or SPC.
- Justify and record reasons for dosages outside the range given in the BNF or SPC.
- Record the rationale for continuing, changing or stopping medication, and the effects of such changes.
- Carry out a trial of the medication at optimum dosage for 4–6 weeks

NICE CG178 – Recommendation 1.3.6.9

Do not use a loading dose of antipsychotic medication (often referred to as 'rapid neuroleptisation').

NICE CG178 – Recommendation 1.3.6.10 (key priority for implementation)

Do not initiate regular combined antipsychotic medication, except for short periods (for example, when changing medication).

4.2.3 Current UK practice

Early intervention in psychosis services

The Rethink Mental Illness report 'The Lost Generation' found that while Early Intervention in Psychosis (EIP) services can significantly improve young peoples (14-35) prospect of recovering from psychosis, including reducing the risk of suicide, 53% of EIP services say the quality of their service has decreased in the past year. The services also reported there are currently delays accessing EIP services, which can reduce chances of recovery[10].

Treatment options

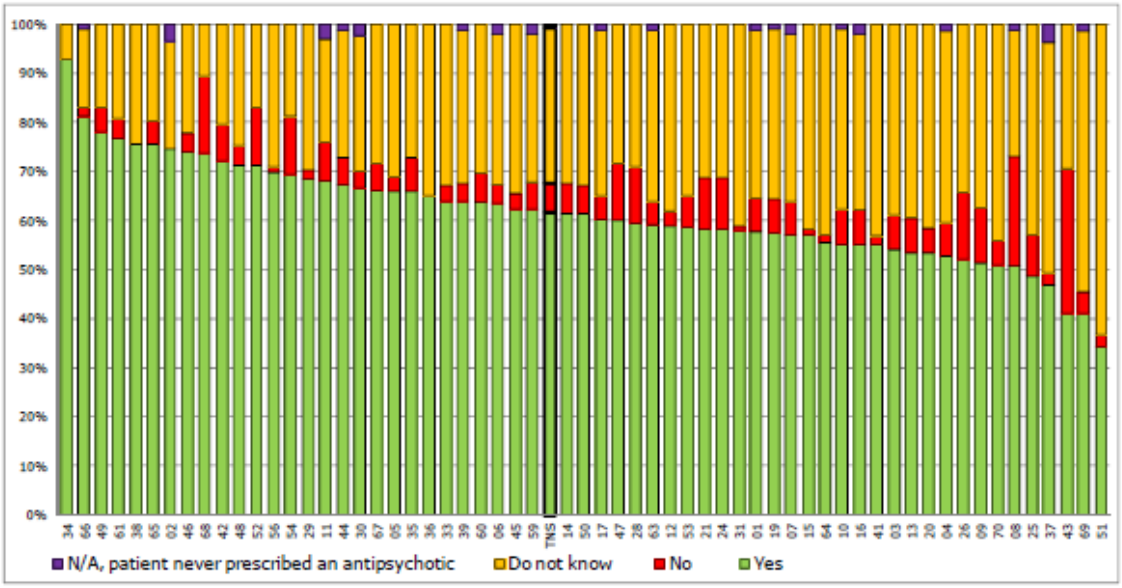
No published studies on current practice were highlighted for this suggested area for quality improvement; this area is based on stakeholder's knowledge and experience.

Antipsychotic medication

The 2012 NAS found that many service users did not feel they were provided with information about their medication in an adequate format. The clinical view was that in 62% of cases, service users were involved in the choice of medication, but only 41% of service users felt their views were taken into account. Data per participating Trust is presented in the charts below taken from the NAS report[11].

[10] Rethink Mental Illness. The Lost Generation. 2014
[11] Royal College of Psychiatrists Report of the National Audit of Schizophrenia (NAS) 2012

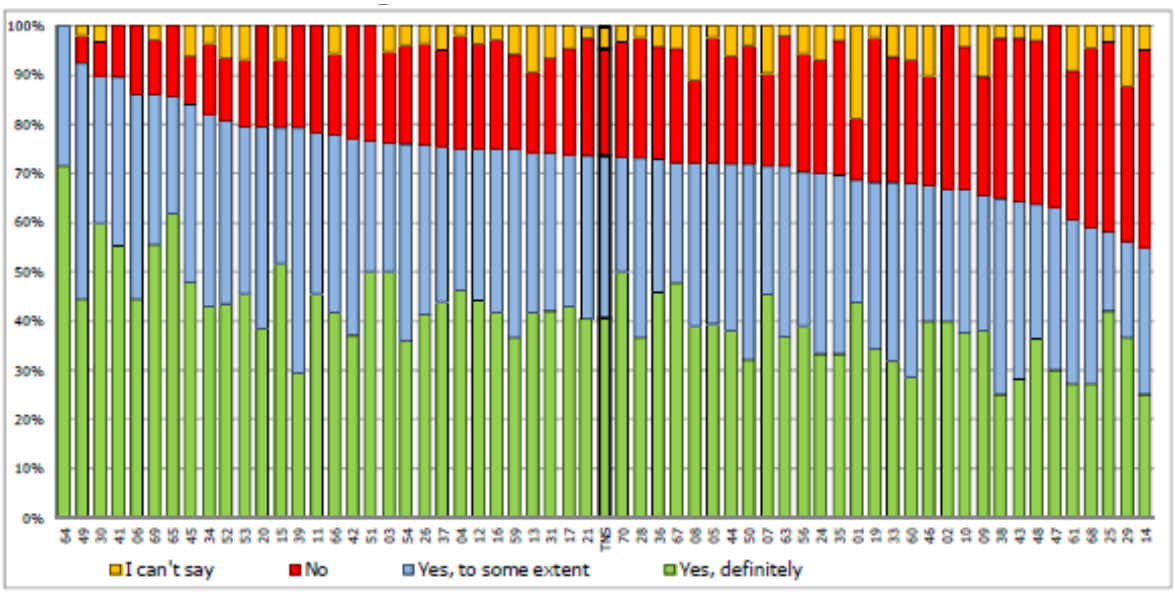
NAS figure 3: Case note recording of involvement of the service user in the decision about which antipsychotic medication was prescribed



- The data for Figure 15 is from Q16 of the audit tool.
- The number of cases included in this analysis is 5,091.

[12]

NAS figure 4: Service users' report on whether their view was taken into account when deciding on medication



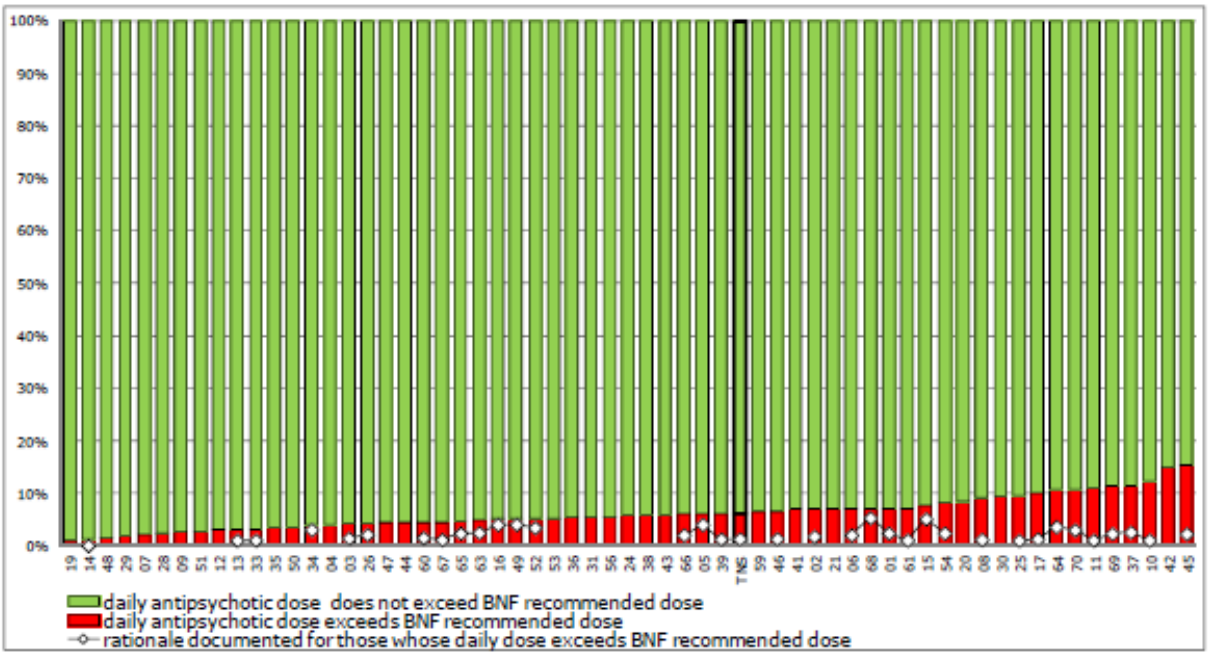
- The data for Figure 16 is from Q3 of the service user survey.
- The number of service users included in this analysis is 2,323. There are 77 missing responses to this question.

[13]

[12] Royal College of Psychiatrists Report of the National Audit of Schizophrenia (NAS) Figure 15. 2012

In the use of antipsychotic medication, the audit found that 16% of service users were receiving more than one antipsychotic drug (up to 30% in some trusts) and 5% were being prescribed medication in higher doses than is recommended by the British National Formulary (BNF) as shown in further detail below.[14]

NAS figure 5: Percentage of service users whose total daily dose of antipsychotic medication exceeds the BNF recommended maximum



- The data for Figure 18 are taken from Q12 and 13 of the audit of practice tool.
- The number of service users included in this analysis is 5,078.
- For some service users there has been documentation in the case notes of a reason for the high dose prescribed and the relevant Trust percentages are shown in the figure.

[15]

[13] Royal College of Psychiatrists Report of the National Audit of Schizophrenia (NAS) Figure 16. 2012
[14] Royal College of Psychiatrists Report of the National Audit of Schizophrenia (NAS) 2012
[15] Royal College of Psychiatrists Report of the National Audit of Schizophrenia (NAS) Figure 18. 2012

4.3 Subsequent acute episodes of psychosis or schizophrenia and referral in crisis

4.3.1 Summary of suggestions

Psychological and psychosocial interventions

Stakeholders highlighted that there is good evidence for the efficacy of psychological and psychosocial therapies for psychosis and schizophrenia. They also highlighted a significant amount of patients will not respond to antipsychotics alone and so it is important that those with ongoing psychosis and schizophrenia have access to these services.

4.3.2 Selected recommendations from development source

Table 7 below highlights recommendations that have been provisionally selected from the development source that may support potential statement development. These are presented in full after table 7 to help inform the Committee's discussion.

Table 7 Specific areas for quality improvement

Suggested quality improvement area	Suggested source guidance recommendations
Psychological and psychosocial interventions	**Psychological and psychosocial interventions** NICE CG178 Recommendations 1.4.4.1 (KPI) and 1.4.4.2 (KPI)

Psychological and psychosocial interventions

NICE CG178 – Recommendation 1.4.4.1 (key priority for implementation)

Offer CBT to all people with psychosis or schizophrenia (delivered as described in recommendation 1.3.7.1). This can be started either during the acute phase or later, including in inpatient settings.

NICE CG178 – Recommendation 1.4.4.2 (key priority for implementation)

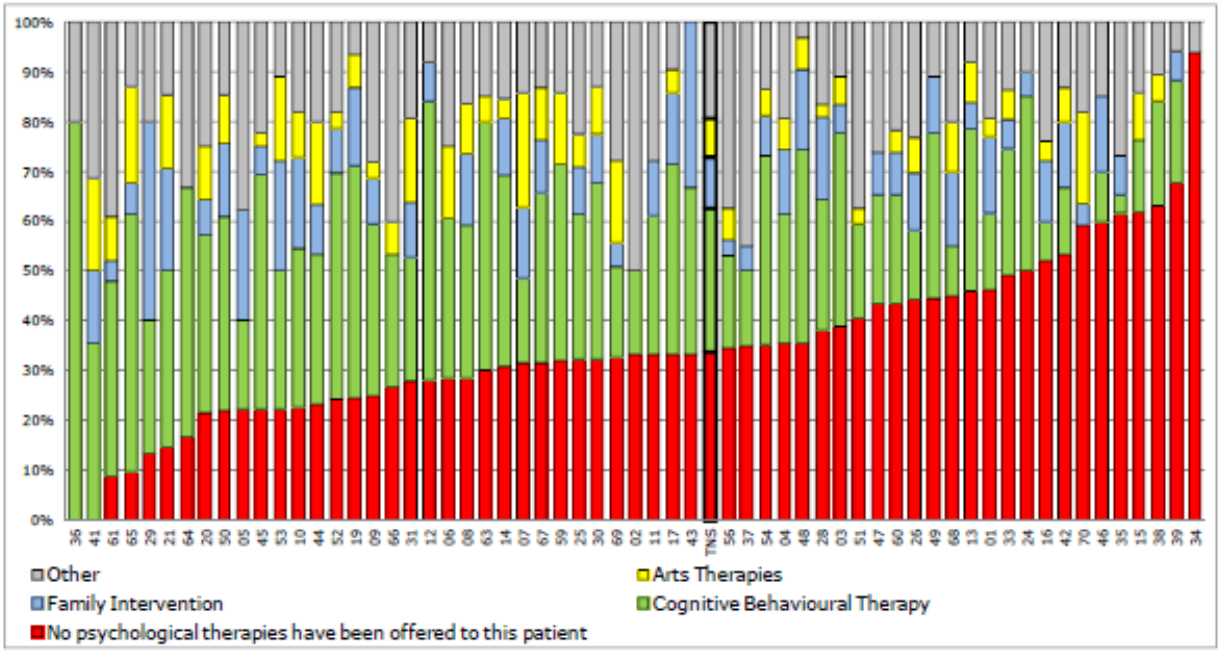
Offer family intervention to all families of people with psychosis or schizophrenia who live with or are in close contact with the service user (delivered as described in recommendation 1.3.7.2). This can be started either during the acute phase or later, including in inpatient settings.

4.3.3 Current UK practice

Psychological and psychosocial interventions

The 2012 NAS found that 34% of service users, who were not in remission, had not been offered any form of psychological therapy[16]. Data per participating Trust is presented in the chart below taken from the NAS report.

NAS figure 6: Percentage of service users by Trust regarded as treatment resistant offered psychological therapy



17

Additionally the Schizophrenia commission estimated that only 10% of people with psychosis had been offered cognitive behavioural therapy (CBT)[18].

[16] Royal College of Psychiatrists Report of the National Audit of Schizophrenia (NAS) 2012
[17] Royal College of Psychiatrists Report of the National Audit of Schizophrenia (NAS) figure 22. 2012
[18] The Schizophrenia Commission. The Abandoned Illness. 2012

4.4 Promoting recovery and possible future care

4.4.1 Summary of suggestions

Primary care

Stakeholders suggested that the treatment of psychosis and schizophrenia in primary care and the community needs to be improved to promote recovery. This includes collaborative work between primary care and specialist health care settings and the referral route service users take into services. This form of management would also identify those who are likely to disengage from treatment.

Antipsychotic medication

Stakeholders highlighted the importance of the use of antipsychotic medication for promoting recovery. The use of clozapine is the gold standard for treating resistant schizophrenia and the delay in this treatment can have a detrimental effect on patient outcomes and symptom control. Improving patient adherence to antipsychotics by using long acting injectable antipsychotics (LAIs) can ensure that symptoms are stabilised and promote recovery for particular groups of patients.

Employment, education and occupational activities

Stakeholders felt that currently not enough is done to promote employment amongst service users. When combined with healthcare interventions employment can improve outcomes as well as reducing societal cost associated with adults with psychosis and schizophrenia.

4.4.2 Selected recommendations from development source

Table 8 below highlights recommendations that have been provisionally selected from the development source that may support potential statement development. These are presented in full after table 8 to help inform the Committee's discussion.

Table 8 Specific areas for quality improvement

Suggested quality improvement area	Selected source guidance recommendations
Primary care	**General principles** NICE CG178 Recommendation 1.5.1.2 **Return to primary care** NICE CG178 Recommendation 1.5.2.1 **Primary care** NICE CG178 Recommendations 1.5.3.1 and 1.5.3.6
Antipsychotic medication	**Using depot/long-acting injectable antipsychotic medication** NICE CG178 Recommendation 1.5.6.1 **Interventions for people whose illness has not responded adequately to treatment** NICE CG178 Recommendation 1.5.7.2 (KPI)
Employment, education and occupational activities	**Employment, education and occupational activities** NICE CG178 Recommendation 1.5.8.1 (KPI)

Primary care

NICE CG178 – Recommendation 1.5.1.2

Consider intensive case management for people with psychosis or schizophrenia who are likely to disengage from treatment or services.

NICE CG178 – Recommendation 1.5.2.1

Offer people with psychosis or schizophrenia whose symptoms have responded effectively to treatment and remain stable the option to return to primary care for further management. If a service user wishes to do this, record this in their notes and coordinate transfer of responsibilities through the care programme approach.

NICE CG178 – Recommendation 1.5.3.1

Develop and use practice case registers to monitor the physical and mental health of people with psychosis or schizophrenia in primary care.

NICE CG178 – Recommendation 1.5.3.6

When a person with an established diagnosis of psychosis or schizophrenia presents with a suspected relapse (for example, with increased psychotic symptoms or a significant increase in the use of alcohol or other substances), primary healthcare

professionals should refer to the crisis section of the care plan. Consider referral to the key clinician or care coordinator identified in the crisis plan.

Antipsychotic medication

NICE CG178 –Recommendation 1.5.6.1

When initiating depot/long-acting injectable antipsychotic medication:

- take into account the service user's preferences and attitudes towards the mode of administration (regular intramuscular injections) and organisational procedures (for example, home visits and location of clinics)
- take into account the same criteria recommended for the use of oral antipsychotic medication (see sections 1.3.5 and 1.3.6), particularly in relation to the risks and benefits of the drug regimen
- initially use a small test dose as set out in the BNF or SPC.

NICE CG178 – Recommendation 1.5.7.2 (key priority for implementation)

Offer clozapine to people with schizophrenia whose illness has not responded adequately to treatment despite the sequential use of adequate doses of at least 2 different antipsychotic drugs. At least 1 of the drugs should be a non-clozapine second-generation antipsychotic.

Employment, education and occupational activities

NICE CG178 – Recommendation 1.5.8.1 (key priority for implementation)

Offer supported employment programmes to people with psychosis or schizophrenia who wish to find or return to work. Consider other occupational or educational activities, including pre-vocational training, for people who are unable to work or unsuccessful in finding employment.

4.4.3 Current UK practice

Primary care

No published studies on current practice were highlighted for this suggested area for quality improvement; this area is based on stakeholder’s knowledge and experience.

Antipsychotic medication

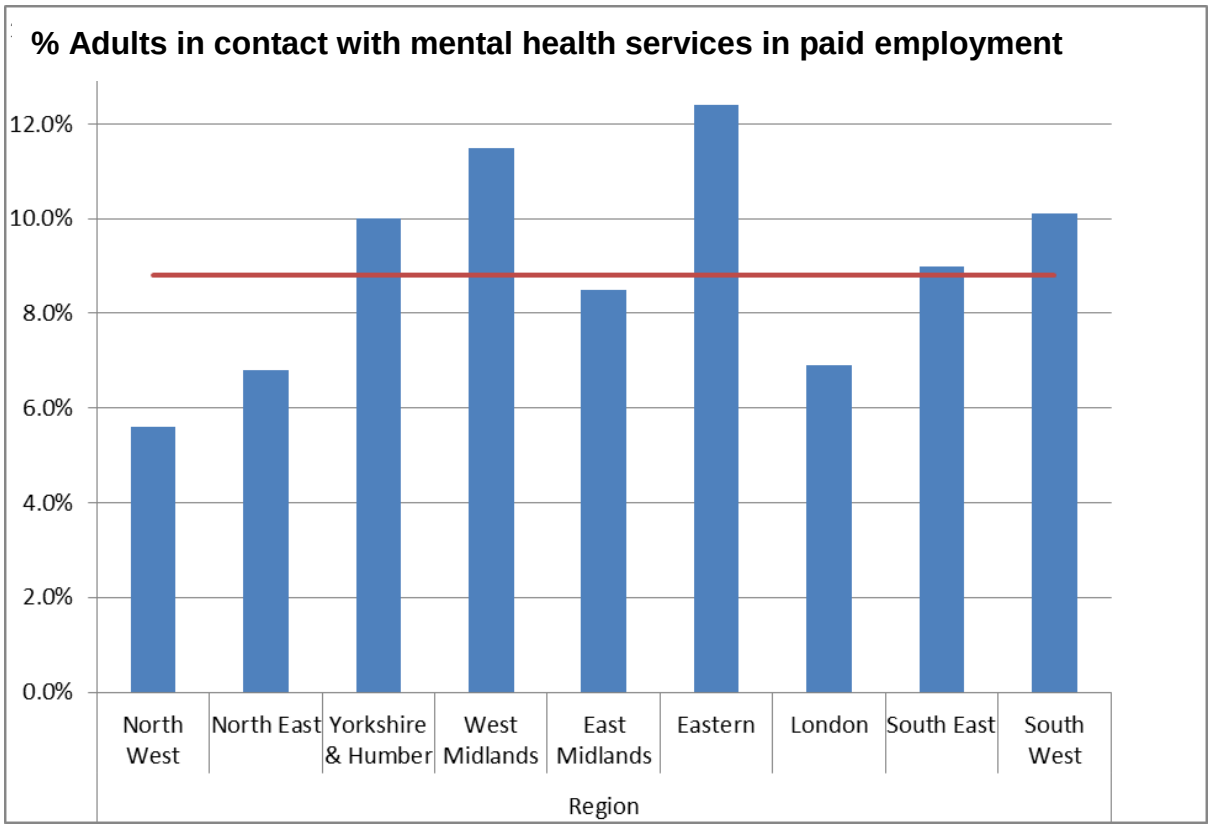
While no published studies on current practice were identified for the use of long acting injectable antipsychotics (LAIs), the 2012 NAS found that 20% of the most severely ill patients are regarded as antipsychotic treatment resistant. While a

proportion of these may not have been offered clozapine for appropriate reasons 43% had not been offered clozapine and no documented reason was given[19].

Employment, education and occupational activities

The Schizophrenia commission reported that only 5-15% of people with schizophrenia are in employment, with only 25% of Mental Health NHS Trusts currently investing in an individual placement and support (IPS) approach to support employment in adults with schizophrenia[20].

The Adult Social Care Outcomes Framework (ASCOF) 2012-13 final data found that 8.8% of adults in England in contact with mental health services were in paid employment though regional variation is present as presented below[21].



[19] Royal College of Psychiatrists Report of the National Audit of Schizophrenia (NAS) 2012
[20] The Schizophrenia Commission. The Abandoned Illness. 2012
[21] The Health and Social Care Information Centre. Adult Social Care Outcomes (2012-13). 2013

4.5 Additional areas

4.5.1 Summary of suggestions

The improvement areas below were suggested as part of the stakeholder engagement exercise. However they were felt to be either outside the remit of the quality standard referral and the development source (NICE guidance) or require further discussion by the Committee to establish potential for statement development.

There will be an opportunity for the QSAC to discuss these areas at the end of the session on 02 July 2014.

Service user experience

Stakeholders suggested that user experience for those who use psychosis and schizophrenia services should be addressed as a quality improvement area. They highlighted therapeutic optimism and positively engaging with service users, particularly in the use of the mental health act. This quality improvement area however, is addressed in NICE quality standard 14, service user experience in adult mental health.

Race, culture and ethnicity

A stakeholder felt that equality and diversity considerations are not currently being addressed; highlighting that disproportionate numbers of black and minority ethnic males are currently sectioned. The quality standard considers equality issues throughout its development and they are formally recorded at statement level (equality and diversity considerations) and within an equality analyses document which is published with the draft and final standard.

Psychogenomics

A stakeholder highlighted that the biggest challenge to service users and health and social care practitioners is appropriate medication. They felt that this could be improved by attempting to rule out medication based on a service users DNA, and therefore recommended research should be conducted. As a result of research still being required no guidelines are available for this quality improvement area and therefore it falls out of the remit of this quality standard.

Assessment and treatment of coexisting substance misuse

A stakeholder highlighted that people with psychosis may have coexisting substance misuse which can lead to poorer clinical outcomes. This quality improvement area is addressed in NICE quality standard 23, drug use disorders, in relation to a mental health assessment of people with drug use disorders.

Mental health nurse staff training

A stakeholder felt that the mental health nurses receive insufficient training, particularly in relation to the monitoring of physical health. Staff training is inherent to the quality standard unless the quality improvement area is felt to be more specific.

Appendix 1: Key priorities for implementation (CG178)

Recommendations that are key priorities for implementation in the source guideline and that have been referred to in the main body of this report are highlighted in grey.

Preventing psychosis

- If a person is considered to be at increased risk of developing psychosis (as described in recommendation 1.2.1.1):
    - offer individual cognitive behavioural therapy (CBT) with or without family intervention (delivered as described in section 1.3.7) **and**
    - offer interventions recommended in NICE guidance for people with any of the anxiety disorders, depression, emerging personality disorder or substance misuse. **[new 2014]**

First episode psychosis

- Early intervention in psychosis services should be accessible to all people with a first episode or first presentation of psychosis, irrespective of the person's age or the duration of untreated psychosis. **[new 2014]**
- Assess for post-traumatic stress disorder and other reactions to trauma because people with psychosis or schizophrenia are likely to have experienced previous adverse events or trauma associated with the development of the psychosis or as a result of the psychosis itself. For people who show signs of post-traumatic stress, follow the recommendations in Post-traumatic stress disorder (NICE clinical guideline 26). **[new 2014]**
- The choice of antipsychotic medication should be made by the service user and healthcare professional together, taking into account the views of the carer if the service user agrees. Provide information and discuss the likely benefits and possible side effects of each drug, including:
    - metabolic (including weight gain and diabetes)
    - extrapyramidal (including akathisia, dyskinesia and dystonia)
    - cardiovascular (including prolonging the QT interval)
    - hormonal (including increasing plasma prolactin)
    - other (including unpleasant subjective experiences). **[2009; amended 2014]**
- Do not initiate regular combined antipsychotic medication, except for short periods (for example, when changing medication). **[2009]**

Subsequent acute episodes of psychosis or schizophrenia and referral in crisis

- Offer CBT to all people with psychosis or schizophrenia (delivered as described in recommendation 1.3.7.1). This can be started either during the acute phase or later, including in inpatient settings. **[2009]**

- Offer family intervention to all families of people with psychosis or schizophrenia who live with or are in close contact with the service user (delivered as described in recommendation 1.3.7.2). This can be started either during the acute phase or later, including in inpatient settings. **[2009]**

Promoting recovery and possible future care

- GPs and other primary healthcare professionals should monitor the physical health of people with psychosis or schizophrenia when responsibility for monitoring is transferred from secondary care, and then at least annually. The health check should be comprehensive, focusing on physical health problems that are common in people with psychosis and schizophrenia. Include all the checks recommended in 1.3.6.1 and refer to relevant NICE guidance on monitoring for cardiovascular disease, diabetes, obesity and respiratory disease. A copy of the results should be sent to the care coordinator and psychiatrist, and put in the secondary care notes. **[new 2014]**

- Offer clozapine to people with schizophrenia whose illness has not responded adequately to treatment despite the sequential use of adequate doses of at least 2 different antipsychotic drugs. At least 1 of the drugs should be a non-clozapine second-generation antipsychotic. **[2009]**

- Offer supported employment programmes to people with psychosis or schizophrenia who wish to find or return to work. Consider other occupational or educational activities, including pre-vocational training, for people who are unable to work or unsuccessful in finding employment. **[new 2014]**

Appendix 2: Suggestions from stakeholder engagement exercise

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
1	SCM1	Therapeutic Optimism	Patients given a diagnosis of schizophrenia or psychosis need to be informed of the statistics of recovery as this will improve their chances of and hasten their recovery	This does not really cost anything so is cost effective	NICE Psychosis and Schizophrenia in Adults Guideline 2014 1.1.1.1 Jobe & Harrow (2005) conclude ' there is heterogeneity of long-term outcome, with between 21% and 57% showing good outcome, depending on the strictness of the criteria used to diagnose schizophrenia'.
2	SCM1	Physical Health Care/diet/Smoking	Patients with psychosis and schizophrenia die much younger (55) than average and these factors are amongst the reasons.	Patients are losing QALYs they need not	NICE Psychosis and Schizophrenia in Adults Guideline 2014 1.1.3
3	SCM1	Race, culture and ethnicity	Studies show this is poor in various ways disproportionate numbers of BME males being sectioned. We need a more inclusive society so less people get ill		NICE Psychosis and Schizophrenia in Adults Guideline 2014 1.1.2
4	SCM1	Choice of Medication	Patients need to be involved in the choice of medication so they do not feel the treatment is being inflicted on them	Patients need to feel self determined rather than having unsuitable treatments inflicted on them	NICE Psychosis and Schizophrenia in Adults Guideline 2014 1.3.5 United Nations Resolution April 11th 2014 Articles 15,16 and 17 Respect for personal integrity and freedom from torture, violence, exploitation and abuse, section 38
5	SCM1	Family support/involvement	Psychosis and Schizophrenia are group conditions and the family needs support	I have visited 40 or so psychiatric hospitals for AIMS and observed there is a way to go here	NICE Psychosis and Schizophrenia in Adults Guideline 2014 1.1.5 Support for Carers
6	SCM1	Psychogenomics research should be conducted	Perhaps the biggest challenge to the patient and the professional is finding a medication that suits. Clearly the reason one man's meat is another's poison with medications lies in the genetic	Clearly cost effective once developed. Not sure a drugs company would want to spend money on this sort of research	

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
			makeup. If a simple DNA check from a mouth swab could indicate which drugs to avoid		
7	SCM2	People experiencing psychosis and Schizophrenia: 15-20 year mortality gap Addressing health inequalities	The mortality gap is mostly explained by poor physical health. Cardiovascular disease (CVD) is the most common cause of this population's premature mortality and far more common than suicide. This population are 2-3 x more likely to experience CVD, type 2 diabetes and obesity. (See short overview of main cardio-metabolic issues in Diabetes UK factfile 13) NICE guidelines recommend systematic monitoring and intervention for cardiometabolic risk (eg NICE CG 178 recommendations for secondary care 1.3.6; and primary care 1.5.3) The new NHSE CQUIN: Commissioning for Quality and Innovation 2014 /15 highlights the importance of improving care in this area.	The National Audit of Schizophrenia (NAS) found only 29% of this population had adequate monitoring of risk factors (BMI/weight, blood glucose, lipids, smoking, family history) for future CVD, diabetes and obesity (e.g 43% had no documented weight measurement within previous 12 months). And yet these risk factors are detectable from within weeks of onset of psychosis, potentially modifiable, and strongly linked to the prescribing of antipsychotic medications. This suggests serious deficiencies in how care is organised for a very vulnerable population, despite clear recommendations in NICE guidelines, and primary care incentivisation in the QOF. The opportunity to encourage pro-active detection and intervention for cardiometabolic risk by a quality standard could help address the current health inequality using resources such as the Lester Positive Cardiometabolic resource (highlighted in the new NHSE CQUIN).	Summary of the main metabolic issues written for Diabetes UK Factfile https://www.diabetes.org.uk/upload/Professionals/Publications/Winter%202012/FactFile-Winter2012.pdf NAS report (Dec 2012) See Executive Summary Findings - section 5 http://www.rcpsych.ac.uk/workinpsychiatry/qualityimprovement/nationalclinicalaudits/schizophrenia/nationalschizophreniaaudit/reports.aspx Schizophrenia Commission Report (2012) http://www.schizophreniacommission.org.uk/the-report/ NICE guideline CG178 Lester Positive Cardiometabolic resource (led by RCPsych, RCGP) www.rcpsych.ac.uk/quality/NAS/resources NHSE Commissioning for Quality and Innovation 2014 /15 http://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2013/09/CQUIN-Guidance-2014-15-PDF-

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
					751KB.pdf
8	SCM2	People experiencing psychosis and Schizophrenia: Early intervention for psychosis service provision	Proactive engagement, avoiding traumatic crisis response and the minimising of treatment delay are - appreciated by service users and families (See Schizophrenia Commission Exec Summary) - supported by an evidence base of clinical and cost effectiveness (NICE CG 178 recommendation 1.3.1 – and its costing statement – section 3.19).	NICE guideline CG 178 recommends that people experiencing their first episode of psychosis should be assessed and treated by a specialised early intervention in psychosis service. Nevertheless the Schizophrenia Commission report wide concerns about availability of early intervention in psychosis services. This was reinforced by the recent 'Lost Generation' report from Rethink revealing that from a position of almost universal availability in 2010 across England, recent financial pressures placed on Provider Trusts have caused a number of these services to be absorbed into more generic community mental health teams (which lack an evidence-base of effectiveness) A reduction in the availability of a service provision which has demonstrated clinical and cost effectiveness, provides a strong argument for developing a quality standard to encourage restoration rather than further de-commissioning.	NICE guideline CG 178 Schizophrenia Commission Executive Summary(2012) http://www.rethink.org/media/514088/TSC_executive_summary_14_nov.pdf Rethink report 'Lost Generation' http://www.rethink.org/living-with-mental-illness/early-intervention NICE CG 178 costing statement http://guidance.nice.org.uk/CG178/CostingStatement/pdf/English
9	SCM2			 Diabetes UK factfile on severe mental illne	 Lester UK adaptation Positive Cardiometab
10	SCM3	Key area for quality improvement 1	There is sound evidence that psychological therapies for	Despite NICE guidelines recommending that CBT and Family	NICE schizophrenia & psychosis guideline (2014):

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
		Access to Psychological Therapies (CBT and Family Interventions) for Schizophrenia and Psychosis.	psychosis (i.e. Family Interventions and CBT) help those with psychosis. Moreover, service users and carers want access to these interventions (Schizophrenia Commission report, 2012) and they are cost effective. They are recommended as a priority for implementation within NICE guidance. A significant numbers of patients do not respond to antipsychotic medication and others have intolerable side effects and yet for the majority, no other treatment options are available.	Interventions should be available for everyone diagnosed with schizophrenia, less than 10% of patients get offered CBT (Schizophrenia Commission Report, 2012) and less than 3% get offered Family Interventions. This is despite Family Intervention having the most robust evidence for relapse prevention of any treatment option and both therapies demonstrating that cost savings could be made if implemented (2014).	http://guidance.nice.org.uk/CG178/NICEGuidance/pdf/English Schizophrenia Commission Report:: http://www.schizophreniacommission.org.uk/the-report/ Investing in Recovery Report: http://www.rethink.org/diagnosis-treatment/investing-in-recovery
11	SCM3	Key area for quality improvement 2 Access to Early Intervention in Psychosis Services	Early Intervention in Psychosis (EIP) Services have been shown to be effective, helping people in many aspects of their personal recovery. They are cost effective with net savings of £6,780 per person after four years. Over a ten-year period, £15 in costs can be avoided for every £1 invested. Moreover they are valued by service users and carers alike. EIP services are recommended as a priority for implementation by NICE.	EIP has the some of the strongest evidence of any form of mental health service model of delivery. However, despite strong clinical and economic evidence as well as service user opinion in favour of EIP, these services are experiencing significant cuts across England. 50% of services have experienced cuts over the last 12 months and more than half of services report that the quality of their service has decreased as caseloads rise and skill mix is depleted. *"After more than a decade of progress and success, EIP is effectively disappearing in some areas of the country".*	NICE schizophrenia & psychosis guideline (2014): http://guidance.nice.org.uk/CG178/NICEGuidance/pdf/English Lost Generation Report (2014): http://www.rethink.org/diagnosis-treatment/investing-in-recovery
12	SCM3	Key area for quality	Being in paid employment is	Despite supported employment	Care Quality Commission (2013)

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
		improvement 3 Access to Employment Support Programmes	associated with improved clinical outcomes, reduced bed usage and overall health service usage. There is consistent evidence that supported employment (IPS) is cost-effective compared to traditional train and place approaches. For young people with a first episode of psychosis, supported employment (IPS) adapted to include support to fulfil educational goals, has demonstrated that a mean of 69% of young people can gain and retain education and employment compared to 35%. NICE recommended that employment support should be offered to all service users with psychosis. This was a priority for implementation.	programmes being a priority for implementation by NICE, the CQC Community mental health survey (2013) showed that almost a third (32%) of respondents on CPA and over half of respondents not on CPA (52%) said they did not receive support from someone in the NHS mental health services in getting help with finding or keeping work but would have liked it.	*Community Mental Health Survey 2013*. London: Care Quality Commission. Rinaldi, M., Killackey, E., Smith, J., Shepherd, G., Singh, S.P., Craig, T. (2010) First episode psychosis and employment: A review. *International Review of Psychiatry* 22, 2, 148-162. Investing in Recovery Report: http://www.rethink.org/diagnosis-treatment/investing-in-recovery
13	SCM3	Key area for quality improvement 4 Access to Routine Physical Health Care Monitoring	People with severe mental illness die and average of 15 to 20 years earlier than the rest of the population. This early mortality is linked to lifestyle factors plus the side effects of antipsychotic medication. The majority of these premature deaths are linked to cardiovascular, pulmonary and infectious diseases rather than suicide and injury.	Despite people with psychosis being at higher risk of serious physical disorders there is evidence that this group often receive suboptimal care. Although NICE recommend that comprehensive physical health monitoring should be carried out at least annually, only 49% of patients report being offered a physical health check and evident cardiovascular risk factors are less likely to be acted upon.	http://www.rcpsych.ac.uk/pdf/physical_health_guidance.pdf
14	SCM4	Key area for quality improvement 5	"People with psychosis or schizophrenia are likely to have	There is a growing recognition of the link between early adversity and the	NICE schizophrenia & psychosis guideline (2014):

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
		Access to Trauma Informed Care	experienced previous adverse events or trauma associated with the development of the psychosis or as a result of the psychosis itself. " (NICE, 2014). The NICE guideline recommends, as a priority for implementation, that patients are asked about any previous trauma and trauma related difficulties are treated with relevant psychological therapies.	development of psychosis. A meta-analysis conducted in 2012 suggested that individuals exposed to early adversity as a child (i.e. sexual, physical and emotional abuse or loss of a parent by death) were three times more likely to develop psychosis. Moreover, a dose effect has consistently been found which shows that the more adverse events a person is exposed or alternatively the more severe the type of adversity, then the higher the likelihood of developing psychosis. Although a large percentage of patients experiencing schizophrenia and psychosis have a history of severe trauma this is often ignored or overlooked. The majority of patients are not asked about this, helped to understand the possible link between past life events and their symptoms, or offered appropriate help.	http://guidance.nice.org.uk/CG178/NICEGuidance/pdf/English Varese F, et al. (2012) Childhood adversities increase the risk of psychosis: a meta-analysis of patient control, prospective- and cross-sectional cohort studies. *Schizophrenia Bulletin* 38:661-71. Read, J., Hammersely, P. & Rudegeair, T. (2007) Why, when and how to ask about child abuse. Advances in Psychiatric Treatment; 13, 101-110, Expert: Prof John Read J.Read@liverpool.ac.uk
15	SCM4	Family Interventions for psychosis and schizophrenia	Family intervention is an effective intervention for the condition which is underutilised.	Family interventions is one of very few effective psychosocial interventions. There is a high degree of variation in the delivery of this intervention in routine practice. This has been a persistent problem for many years, the causes of poor implementation and uptake are multifactorial and therefore require concerted attention and action to overcome.	National Audit of Schizophrenia Schizophrenia Commission.
16	SCM4	Family and carer interventions	Carers meet a substantial proportion of the needs of those	This new recommendation within the guideline, the similarities with the	National Audit of Schizophrenia

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
			with psychosis and schizophrenia. Supporting carers addresses some of the individual, and societal burden of the condition.	recommendation for family intervention suggest that providers may encounter difficulties in implementing it. The recommendation compliments family interventions and offers a range of supports and therefore choice to families and carers.	Schizophrenia Commission.
17	SCM4	Physical healthcare	The unacceptable years of life lost resulting from poor physical health.	Physical health care promotion, monitoring and interventions are simple, effective and easily integrated into routine services. Combined with the potential to improve life expectancy the recommendation represents a high impact action point.	National Audit of Schizophrenia Schizophrenia Commission. Crump, C. Comorbidities and Mortality in Persons With Schizophrenia: A Swedish National Cohort Study. *American Journal of Psychiatry* (2013) doi:10.1176/appi.ajp.2012.12050599
18	SCM4	Individual employment and support	Combined with health interventions employment improves outcomes for people with psychosis and schizophrenia and reduces societal costs.	Psychosis and schizophrenia has an early age of onset. Young people generally have trouble entering the labour market. The presence of psychosis and discrimination represent significant barriers to gaining work and improving clinical and social outcomes. This recommendation is aligned to cross governmental action plans but inter departmental planning and commissioning is difficult particularly when the costs are in one department and the benefits another. Raising this recommendation as a priority area may assist implementation. Centre of excellence exist for this	Centre for Mental Health (2009) Doing what Works Centre of excellence: http://www.centreformentalhealth.org.uk/employment/centres_of_excellence.aspx

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
				work.	
19	SCM4	Early Intervention services	Early recognition and intervention has positive outcomes, currently new and untested models of delivering early intervention services are being used.	The team characteristics of early intervention teams mean that they are more likely to deliver on their objectives that generic teams. There is a move to delivering early intervention through integrated mental health community teams. Whether integrated teams can retain fidelity to the principles and practice of early intervention is uncertain. Early intervention services are a proven vehicle through which to deliver evidence based interventions and are likely to do so more effectively than community mental health teams. Keeping such teams active should be a priority.	National Audit of Schizophrenia Schizophrenia Commission. West, M. et al. Effectiveness of Multi-Professional Team Working (MPTW) in Mental Health Care. (National Institute for Health Research, 2012).
20	SCM5	Early detection/diagnosis of psychosis	There is evidence that shorter duration of untreated psychosis (DUP) is associated with better long term functional outcomes.	Early intervention teams were established to try to reduce DUP. Evidence has not confirmed that EI teams are have been effective at reducing DUP, but there is evidence that they improve short term outcomes. There is evidence that delays within mental health services remain long (6 months). Factors associated with this delay include the use of opt in letters and failure to recognise psychosis in CMHTs. Assessment by specialists in early psychosis is recommended in the Psychosis guideline, but may not be	Systematic review on inititievs to reduce DUP. http://bjp.rcpsych.org/content/198/4/256.full Evidence on EI services in NICE guideline Article on delays to treatment within mental health services. http://bjp.rcpsych.org/content/203/1/58.abstract Letter published in the psychiatrist detailing concerns about the use of opt in letters for people with psychosis

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
				happening in practice.	http://pb.rcpsych.org/content/37/10/340.1#BIBL
21	SCM5	Improving physical health screening	Well known and publicised findings that people with SMI including psychosis/schizophrenia have reduced life expectancy rates, higher morbidity and standardised mortality rate.	Evidence from the National Audit of schizophrenia suggests that overall screening is not done well and practice is very variable across the country. Improved screening may lead to earlier detection of physical disorders (esp metabolic and cardiovascular risk factors/conditions). There is evidence from the general population that intervention can reduce risk and it seems likely that this would be true for people with psychosis – there is less evidence, but the evidence there is suggests intervention is possible and some short term gains can be made eg lifestyle interventions can lead to weight loss and/or reduce rate of weight gain for people taking antipsychotics. A national CQUIN has been introduced to promote screening, but this only applies to a small proportion of people with psychosis.	National audit of schizophrenia. Schizophrenia commission report Some studies cited in NICE psychosis guideline National CQUIN N3
22	SCM5	Access to evidence based treatments	Evidence based treatments can improve outcome	Key evidence based treatments for all phases of psychosis are 1) antipsychotic medication (CBT) 2) Cognitive behavioural therapy for psychosis 3) Family interventions (FI) The research evidence suggests that people with a first episode psychosis are more likely to have access to	Evidence of efficacy is in NICE psychosis guideline. Evidence relating to access is in schizophrenia commission report, NAS, local and regional knowledge.

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
				psychosocial treatments if they receive care from an EI team than if they receive standard care. This has been shown to lead to improved outcomes at the end of the EI period, though those improved outcomes are not sustained at follow up. This suggests that some people may need a longer period of care from an EI-like team than is often used in practice. In many areas EI teams are under threat or have been cut. This may lead to less access to evidence based treatments for people with first episode psychosis. People with a longer term psychotic illness can benefit from the same treatments, but there is a lack of access to CBT and FI. This is despite clear recommendations in NICE guidelines for psychosis and schizophrenia dating back to 2002.	
23	SCM5	Assessment and treatment of substance misuse	People with psychosis who also have problems with substance misuse have worse outcomes eg more symptoms, more & longer admissions, higher morbidity, mortality and suicide rates.	Substance misuse is often under recognised and under treated and/or seen as a barrier to treatment of psychosis. Psychosis may be a barrier to access to treatment for substance misuse. If the treatment of both conditions is improved it is likely that the outcome for the individual will be better. NAS data showed that for people who were treatment resistant only 80%ish	Evidence is covered in NICE psychosis and substance misuse guideline.

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
				(range 33-100%) had alcohol/substance misuse considered. The figure may well have been lower for those not considered to be treatment resistant.	
24	SCM5	Vocation	Only a small proportion of people with schizophrenia are in employment (figures vary, but approx 15%).	Vocational activity is important in terms of quality of life, finance, etc. There is some evidence for interventions to support people into employment, but provision is variable.	Evidence reviewed in NICE psychosis guideline.
25	SCM6	Key area for quality improvement 1 More specific emphasis in applying the Mental Health Act, Code of Practice guiding principles of: Purpose; Least Restrictive Option; Respect; Participation and 'Effectiveness, Efficiency and Equity'.	The existence and use of Mental Health Act powers has a profound influence on both the perception of 'mental illness' within our society and the experience of those who have psychotic episodes and their carers. Annual rates of detention to hospital under the Mental Health Act continue to increase. Human Rights, dignity, safety, entitlement, effective treatment/care and resources are all key issues. Negative perceptions of the MHA contribute to mental health stigma. Therefore the consistent use of the sort of positive value framework set out in the CoP Ch1 is crucial.	Service users frequently experience disempowerment through the use of the MHA. If MHA assessments consistently followed the Code of Practice guiding principles and these were consistently applied then service users, carers and professionals would be better able to form better working partnerships. Although there is already considerable guidance for practitioners and ongoing emphasis on alternative community and care options the CQC is expressing concern at the increasing use of MHA provisions across the country and the frequent lack of involvement by service users in decisions.	NICE Quality Standards for service user experience in adult mental health (QS14): Statement 7 (…understand[ing] the assessment process ...) and Statement 11 (… service users formally detained under the MHA are routinely involved in decision making.). NICE Clinical Guidance: Service user experience in adult mental health. (CG136). CQC: Monitoring the Mental Health Act in 2012/13.
26	SCM6	Key area for quality improvement 2 Further development in providing integrated, multi-disciplinary Early Intervention in Psychosis services - including the	There is evidence that 'integrated' (NHS plus Local Authority staffing) can enhance the effectiveness of community mental health services. Social work skills and values are particularly well suited to the EI in Psychosis approach. However, in	The distinctive contribution which social workers can make to EI services is under-developed in some areas and under-researched. In the current environment where resources are allocated critically, there is a strong case for the inclusion of social workers	'The Role of the Social Worker in Adult Mental Health Services'. (2014) Ruth Allen. The College of Social Work. Requirements placed by The Care Act 2014 on Local Authorities to

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		regular inclusion of qualified social workers in these teams, together with specific training to enhance their contribution – such as 'systemic family work/therapy'- in addition to more traditional expertise in areas such as 'personalisation' and housing.	recent years some Local Authorities have withdrawn their workers from 'integrated' secondary mental health services.	AND the specialist further development of their existing skills.	provide 'preventative' and 'integrated' services.
27	SCM6	Key area for quality improvement 3 Strong emphasis on very sensitive first-time prescribing of anti-psychotic medication involving service users as much as possible through education and shared decision making. Positive engagement to continue if service users wish to have a service without medication.	Service users can easily become alienated from secondary mental health services when initial medication is experienced as coercive and side effects debilitating. This can be particularly significant in compulsory admission and treatment situations. Thus limiting therapeutic engagement and, ultimately, recovery.	Services should always endeavour to engage positively with service users whatever the service users' attitude to prescribed medication. Engagement is key in long term effective care and treatment. Where medication compulsion is necessary this must be enforced in compliance with the Key Principles of the MHA Code of Practice.	CQC Monitoring the Mental Health Act in 2012/13 NICE Clinical Guidance: Service user experience in adult mental health. (CG136).
28	hqt-diagnostics	Before talking therapies and drugs are used for schizophrenia, physical tests should be done These include: Fatty Acids Vitamin D	Many mental problems have an underlying physical cause	Major improvements in mental health have been seen within 3 months of supplementing levels of Omega-3 Fatty Acids and Vitamin D	Fatty Acids: www.expertomega3.com/omega-3-study.asp?id=38 Vitamin D: http://vitamindwiki.com/tiki-index.php?page_id=2985
29	Royal College of General	Key area for quality improvement 1	Weight gain and obesity is a common problem for people with	Regular exercise and physical activity is thought to improve both physical and	Cochrane review shows small weight loss is possible with

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	Practitioners	All patients with schizophrenia should receive regular and systematic assessment of physical health and monitoring for adverse treatment and appropriate action taken using the HE LESTER UK ADAPTATION – Positive Cardiometabolic Health Resource: an intervention framework for patients with psychosis on antipsychotic medication	schizophrenia and both pharmacological (medication) and non- pharmacological (diet/exercise) interventions have been tried to treat this problem including targeted weight management interventions. People with serious mental illness tend to have poorer physical health than the general population with a greater risk of contracting diseases and often die at an early age. In schizophrenia, for example, life expectancy is reduced by about 10 years. People with mental health problems have higher rates of heart problems (cardiovascular disease), infectious diseases diabetes, breathing and respiratory disease, and cancer. Advising people on ways to improve their physical health is not without problems since there is often a perception, that advice offered is ineffective and will be ignored but it has been shown that healthcare professional advice can have a positive impact on behaviour. Advice can often motivate people to seek further support and treatment.	mental health. Although only three studies are included in this review, the overall results show that regular exercise can help some individuals with schizophrenia improve their physical and mental health and well-being. There are few programmes, however that Primary Care Physicians can access and refer to that are specialised or tailored to this particular patient group. Until recently BMI was a QOF indicator. However, now this has been removed it is less likely that this be done in primary care. There is an increased demand for preventative health services that involve the provision of advice and which may also reduce costs to health services. Health advice could improve the quality and duration of life of people with serious mental illness. There is currently much focus on general physical health advice for people with serious mental illness with increasing pressure for health services to take responsibility for providing better advice and information. NAS report identified that only 29% of this population received a fully	selective pharmacological or non-pharmacological interventions See more at: http://summaries.cochrane.org/CD005148/interventions-to-reduce-weight-gain-in-schizophrenia#sthash.osFV2dO6.dpuf AND http://summaries.cochrane.org/CD004412/exercise-therapy-for-schizophrenia#sthash.dIoc566Q.dpuf http://summaries.cochrane.org/CD008567/general-physical-health-care-advice-for-people-with-serious-mental-illness#sthash.ELJ7UtVL.dpuf http://summaries.cochrane.org/CD008298/physical-health-care-monitoring-for-people-with-serious-mental-illness#sthash.Pxf0J7Tb.dpuf Bailey S, Gerada C, Lester H, Shiers D. The cardiovascular health of young people with severe mental illness: addressing an epidemic within an epidemic. *The Psychiatrist* 2012;36:375-378. Gordon E, Hulatt I, Shiers D. Protecting hearts and minds. *Mental Health Practice* 2012;16:20-

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				comprehensive assessment of important cardiometabolic risk factors. In particular, only 56% of service users were reported to have been weighed during the previous 12 months. For those service users with evidence of physical health problems, for example high blood pressure and high cholesterol levels, there is frequently no evidence that they have had further appropriate investigation or treatment for these problems. At even a simple level, for those with elevated BMI there was only evidence of advice being given about diet and exercise in 76% of cases.	21. Patel MX, Bishara D, Jayakumar SN, Zalewska K, Crawford MJ. Quality of prescribing for schizophrenia: Evidence from a national audit in England and Wales. *European Neuropsychopharmacology* 2014;24:499-509. Shiers D, Holt R, Lester H, Rafi I. Fact file 13: Protecting the cardiometabolic health of people with severe mental illness. *Diabetes Update* 2012;Winter. Report of the National Audit of Schizophrenia (NAS) 2012
30	Royal College of General Practitioners	Key area for quality improvement 2 All people with schizophrenia should be offered focused or tailored smoking cessation programmes in primary care/ community settings	People with schizophrenia are very often heavy smokers.	Needs a tailored programmed approach as it is uncertain whether treatments that have been shown to help other groups of people to quit smoking are also effective for people with schizophrenia. Again required to deliver smoking cessation therapy to general population but not this population. Bupropion (an antidepressant medication previously shown to be effective for smoking cessation) helps patients with schizophrenia to quit smoking. The effect was clear at the end of the treatment and it may also be maintained after six months. Another	http://summaries.cochrane.org/CD007253/are-there-any-effective-interventions-to-help-individuals-with-schizophrenia-to-quit-or-to-reduce-smoking#sthash.bfs70Tts.dpuf

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				medication, varenicline (a nicotine partial agonist which has been shown to be an effective intervention for smoking cessation in smokers without schizophrenia), also helps individuals with schizophrenia to quit smoking at the end of the treatment. There was too little evidence to show whether other treatments like nicotine replacement therapy and psychosocial interventions are helpful.	
31	Royal College of General Practitioners	Key area for quality improvement 3 All patients should be offered Case management approach delivered using Collaborative care model for people with SMI	Collaborative care aims to improve the physical and mental health of people with severe mental illness (SMI). Common to all definitions is that collaborative care aims to develop closer working relationships between primary care (family doctors or GPs and practice nurses) and specialist health care (such as Community Mental Health Teams). nurses, pharmacists, psychologists). This is meant to provide a person with severe mental illness with better care, based in the community, which is often a less stigmatised setting than hospital, and that promotion of good practice helps consumers maintain contact with services. A major issue is that many GPs still feel that physical health problems (such as diabetes, heart disease, smoking cessation) are more their concern (but not the physical health of people with SMI) and see	Currently a lack of evidence to support the CMHT approach alone. There is some evidence to support an intensive case management approach. ICM When ICM was compared to standard care, those in the ICM group were significantly more likely to stay with the service, have improved general functioning, get a job, not be homeless and have shorter stays in hospital (especially when they had had very long stays in hospital previously). There was also a suggestion that it reduced the risk of death and suicide. People with mental health problems may not have networks of support such as family, friends and carers. They often have no one they know personally to help them when they go home. To complicate matters, people with SMI can have critical downturns in their mental health creating a revolving-door of care, where service	http://summaries.cochrane.org/CD000270/community-mental-health-teams-for-people-with-severe-mental-illnesses-and-disordered-personality#sthash.HeslPTlL.dpuf http://summaries.cochrane.org/CD001087/crisis-intervention-for-people-with-severe-mental-illnesses#sthash.VsWkEWJE.dpuf http://summaries.cochrane.org/CD000453/supported-housing-for-people-with-severe-mental-disorders#sthash.RkcnsmYu.dpuf http://summaries.cochrane.org/CD009531/collaborative-care-approaches-for-people-with-severe-mental-illness#sthash.IpIQbtSH.dpuf http://summaries.cochrane.org/CD007906/intensive-case-management-for-people-with-severe-mental-

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			treatment of severe mental illness as the job of psychiatrists and other mental health professionals. Collaborative care aims to improve overall quality of care by ensuring that healthcare professionals work together, trying to meet the physical and mental health needs of people above and beyond the role of the CMHT. An appropriate reasonable adjustment which should be introduced is the use of care plans, perhaps in a similar way to Health Checks for people with learning disabilities. Care plans are completed routinely in secondary care as part of the Care Plan Approach but are not generally shared with primary care. The 2014/15 DES introduces case management for vulnerable patients (both those with physical and mental health conditions) proactively through developing, sharing and regularly reviewing personalised care plans, including identifying a named accountable GP and care coordinator. This potentially re-focus's primary care's intentions on physical health care management using a case management approach for people with severe mental illness. CCGs are responsible for commissioning	users are discharged from hospital when considered stable and well, only to go back into hospital again when their mental health becomes worse during an acute episode or crisis. Crisis intervention and home-care packages have been developed as a possible solution to these problems. Can be facilitated by use of the Integrated Physical Health Pathway, recently developed by Rethink Mental Illness. Integrating or joining-up primary care and mental health services, so that they work better together, is intended to increase communication and joint working between health professionals (e.g. GPs, psychiatrists, CPNs, Psychology, nursing staff).collaborative care may be effective in reducing going into hospital (less psychiatric admissions and other admissions). It also helps improve people's quality of life and mental health.	illness#sthash.TqblxHYT.dpuf

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			this service		
32	Royal College of General Practitioners	Key area for quality improvement 4 All individuals with SMI should have access to IPS for vocational training	A majority of severely mentally ill people would like to work and there are compelling ethical, social and clinical reasons for helping them to achieve this goal. Supported Employment is that placement in competitive employment should occur as quickly as possible, followed by support and training on the job. Individual placement and support (IPS) is a more specified scheme that includes: finding local jobs; a rapid job search; customer choice in what they want from the employment service; close working between employment and mental health teams; attention to people's preferred job, their strengths and work experience; ongoing and, if necessary, long-term individual support; and the benefits of counselling.	Systematic review found that people who received Supported Employment and IPS were significantly more likely to be in competitive employment than those who received Pre-vocational Training. Supported employment and IPS are superior approaches.	http://summaries.cochrane.org/CD008297/supported-employment-for-adults-with-severe-mental-illness#sthash.HLqScTDD.dpuf http://summaries.cochrane.org/CD003080/vocational-rehabilitation-for-people-with-severe-mental-illness#sthash.nQR13aQY.dpuf
33	SANE	Employment support for people with psychosis and schizophrenia	For most people, work is a normal part of everyday life. More than this, a job is the central hub from which many of our other areas of functioning emanate. For this reason, employment can be considered to be one of the most important factors in promoting recovery and social inclusion. It not only promotes financial independence but also provides structure and purpose, opportunities for socialising and	Employment support is recommended in NICE guidance Recently published NICE Guidance (CG178) on psychosis and schizophrenia recommends that supported employment is offered to people with psychosis or schizophrenia who wish to find or return to work. (Recommendation 1.5.8.1) There is a strong evidence base around the effectiveness of	SANE has been involved in setting up the Mental Illness and Employment Task and Finish Group, which is chaired by Rt Hon Paul Burstow MP and Marjorie Wallace, Chief Executive of SANE. The group has been set up to support the development of key health policy levers to incentivise local health services to improve employment outcomes for people with severe mental illness.

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			developing new relationships, a sense of identity, self-worth and meaning in life. Work enables people who have experienced mental health conditions to take on a stigma-free social role that in most societies is associated with positive identity, status as an employed person and a contributing member of society. Repeatedly, people with a diagnosis of psychosis and or schizophrenia identify obtaining employment as one of their most frequently nominated goals and see the ability to return to work as a yardstick to their recovery.	employment support Cochrane systematic reviews (Crowther et al, 2001, Kinoshita et al, 2013) show that there are two main types of vocational rehabilitation for people with severe mental illness: Pre-vocational Training and Supported Employment (Individual Placement and Support (IPS) approach). The key principle of pre-vocational training is a 'train and place' approach where a period of preparation is necessary before entering competitive employment. In contrast, the key principle of IPS (supported employment) is a 'place and train' approach where placement in competitive employment should occur as quickly as possible, followed by support and training on the job. The systematic reviews find that people who received IPS were significantly more likely to be in competitive employment at 12 months (34%) than those who received pre-vocational training (12%). For young people with a first episode of psychosis, supported employment (IPS) adapted to include support to fulfil educational goals, has demonstrated that a mean of 69% of young people can gain and retain education and employment compared to 35% (Rinaldi et al, 2010). Employment is associated with	On 6 May 2014, the Mental Illness and Employment Task and Finish Group held a workshop to consider a 'Quality Statement' on employment support for people with psychosis and schizophrenia based on the recently published NICE guidance (CG178). The aim of the workshop was to review the evidence around employment and psychosis/schizophrenia and agree the content and key measurements that could be included in a Quality Statement on the area. The workshop was chaired by Dr Jed Boardman and Margaret Edwards, and the activity in developing a draft 'Quality Statement' has been led by Miles Rinaldi. Members of this group would welcome the opportunity to engage further with NICE to talk through our findings in relation to the technical detail for this key area of quality improvement. For more information on the Task and Finish Group, see here. Secretariat services to the Mental

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				improved clinical outcomes Being in paid employment is associated with improved clinical outcomes, reduced bed usage and overall health service usage (Burns et al, 2009, Kilan et al, 2012). There is consistent evidence that supported employment (IPS) is cost-effective compared to traditional train and place approaches (Knapp et al, 2013; Greig et al, 2014). Demand for employment support is high The CQC Community mental health survey (2013) showed that almost a third (32%) of respondents on CPA and over half of respondents not on CPA (52%) said they did not receive support from someone in the NHS mental health services in getting help with finding or keeping work but would have liked it (CQC, 2013). Provision of employment support and rates of employment among this group are measurable There are existing national datasets which would enable the recording and measurement of both the provision of employment support services (through the CQC Community Mental Health Survey and local feedback mechanisms) and the overall rates of employment of people with psychosis	Illness and Employment Task and Finish Group are provided by Munro and Forster Communications, funded by Janssen-Cilag Ltd. Editorial control of all materials rests with membership of the Mental Illness and Employment Task and Finish Group. The following references give additional detail in support of the issues outlined in this consultation responses: Burns T, Catty J, White S, Becker T, et al (2009). The impact of supported employment and working on clinical and social functioning: results of an international study of individual placement and support. *Schizophrenia Bulletin* 35: 949-958. Care Quality Commission (2013) *Community Mental Health Survey 2013*. London: Care Quality Commission. Crowther R, Marshall M, Bond GR, Huxley P. (2001) *Vocational rehabilitation for people with severe mental illness*. Cochrane Database of Systematic Reviews 2001, Issue 2. Art. No.: CD003080. DOI: 10.1002/14651858.CD003080

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				and schizophrenia (through the Mental Health Minimum Dataset (MHMDS).	Greig, R., Chapman, P., Eley, A., Watts, R. et al (2014) *The cost effectiveness of employment support for people with disabilities.* Bath: National Development Team for Inclusion. Kilian R, Lauber C, Kalkan R, Dorn W, et al (2012). The relationships between employment, clinical status, and psychiatric hospitalisation in patients with schizophrenia receiving either IPS or a conventional vocational rehabilitation programme. *Social Psychiatry and Psychiatric Epidemiology* 47(9): 1381-1389. Kinoshita Y, Furukawa TA, Kinoshita K, Honyashiki M, Omori IM, Marshall M, Bond GR, Huxley P, Amano N, Kingdon D. (2013) *Supported employment for adults with severe mental illness*. Cochrane Database of Systematic Reviews 2013, Issue 9. Art. No.: CD008297. DOI: 10.1002/14651858.CD008297.pub2 Knapp M, Patel A, Curran C, Latimer E, et al (2013) Supported employment: cost-effectiveness across six European sites. *World Psychiatry* 12: 60-68. Rinaldi, M., Killackey, E., Smith, J.,

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					Shepherd, G., Singh, S.P., Craig, T. (2010) First episode psychosis and employment: A review. *International Review of Psychiatry* 22, 2, 148-162. Centre for Mental Health, *'Turning evidence into outcomes in Sussex: an accelerated county-wide IPS implementation programme'*. Accessible online at: http://www.centreformentalhealth.org.uk/pdfs/IPS_development_post_sussex.pdf
34	The Royal College of Nursing	Key area for quality improvement 1	Reduction in numbers of people with combined antipsychotic medications or with high dose antipsychotic medication	This is known to have a negative impact on physical health and mental health recovery in terms of re-engagement with the community and fulfilling goals around employment. It can also mask other symptoms of ill-health. Side effects are often increased which also increases chance of non-concordance with medication. NICE guidance only recommends short term use if absolutely necessary.	
35	The Royal College of Nursing	Key area for quality improvement 2	Percentage of people in education, training or employment, or other occupational activities	This is key to recovery and re-engagement with the community. It also provides an indicator of issues around stigma and social exclusion. NICE guidance recommends this as an important factor for recovery.	
36	The Royal College of Psychiatrists	Key area for quality improvement 1 To provide intensive case management for patients	Intensive case management has been shown to be more effective than standard care for a number of important outcomes including; reduced inpatient bed use,	Currently there is much variability in provision of specialist intensive community rehabilitation services for people with severe and enduring complex mental health conditions.	1. Killaspy, H & Meier, R.A. (2010) Fair Deal for Mental Health Rehabilitation Services. The Psychiatrist, 34, 265-267.

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		with psychosis who are likely to disengage from treatment.	improved engagement with services, improved quality of life, higher levels of functioning, increased satisfaction with services and reduced levels of criminal victimisation The 2014 NICE Guideline for Psychosis and Schizophrenia in Adults considers that the costs associated with intensive case management are offset by the savings made through reduced use of inpatient services, improved engagement and increased social inclusion.	Outcomes are clearly improved using this model of working including sustaining community living (reference 5 and 6). This is a “low volume, high needs” group, comprised largely of service users with psychosis who have a multitude of difficulties including high levels of treatment resistance, negative symptoms, co-morbidities, severe functional impairments (reference 8) and increased criminal victimisation, such as domestic and sexual violence (reference 7). This highly vulnerable group of service users comprises only 1% of inpatient beds, yet absorbs 25-50% of the total mental health budget (reference 4)(DH, 2010). The Rehabilitation and Social Psychiatry Faculty of the Royal College of Psychiatrists, argues that disinvestment in intensive support risks marginalising people with complex mental health needs. (reference 8) They highlight that, in areas where there is no local provision of specialist rehabilitation services, people with complex mental health needs do not receive appropriate treatment and support and become stuck on acute admission wards, in lengthy hospital and residential placements, sometimes many miles from home and that the	2. National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH) (2013). Patient suicide: the impact of service changes. A UK wide study. Manchester: University of Manchester 3. Rethink (2012). Schizophrenia Commission. The Abandoned Illness: A Report by the Schizophrenia Commission. Rethink Mental Illness, 2012 4. Department of Health (2010). Strategies MH. The 2009/10 National Survey of Investment in Mental Health Services. London: Department of Health; 2010. 5. Killaspy H and Zis P (2012). Predictors of outcomes of mental health rehabilitation services: A 5 year retrospective cohort study in inner London, UK. Social Psychiatry and Psychiatrist Epidemiology. 6. Lavelle E, Ijaz A, Killaspy H et al. (2011). Mental health rehabilitation and recovery services in Ireland: a multicentre study of current service provision, characteristics of service users and outcomes for those with and without access to these

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				use of expensive out-of-area placements increases substantially (reference 1). Residential placements are commonly funded by Local Authorities rather health care providers - these costs are relevant when considering overall cost to the public purse. The 2012 report from the UK Schizophrenia Commission (Rethink, 2012 – reference 3) emphasises the need for investment in 'high-quality services to deliver evidence- based treatment for people with long-term psychosis' and specifically states the case for extending the effective aspects of early intervention work to those with multiple episodes of psychosis. The recently published National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH, 2013) detailed the provision of specialist community services as one of the top five changes mental health service providers could make to reduce suicide (reference 2).	services. Final report for the Mental Health Commission of Ireland 2011. 7. At risk, yet dismissed: the criminal victimisation of people with mental health problems. Full report http://www.victimsupport.org.uk/sites/default/files/At%20risk%20full.pdf 8. Joint Commissioning Panel for Mental Health: Guidence for commissioners of rehabilitation services for people with complex health needs.
37	The Royal College of Psychiatrists	Key area for quality improvement 2 Monitoring physical health of patients with schizophrenia	There is considerable evidence of increased mortality and morbidity in patients with schizophrenia and other SMI. This group of patients do not make proactive use of care services, have poor diets, don't exercise, use substances and have	Reduction in co- morbidity and premature mortality.	

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			the iatrogenic effects of their treatment to contend with.		
38	The Royal College of Psychiatrists	Key area for quality improvement 3 Better use of Clozapine	Clozapine is the gold standard treatment for treatment resistant schizophrenia. There is often a lengthy delay in its introduction. This should be addressed.	Earlier and better outcomes for patients and for symptom control.	
39	College of Occupational Therapists	Key area for quality improvement 1: VOCATIONAL REHABILITATION	There is strong evidence that employment has a positive impact on mental health. It can promote recovery from mental illness, leading to better health, improved quality of life and reduced social exclusion and poverty. Occupational therapists are highly skilled at grading, facilitating and supporting vocational rehabilitation for service users with schizophrenia.	Although there have been some positive developments within vocational rehabilitation services, mental health service users are at a significant disadvantage when trying to access training, skills development opportunities and jobs. Personal and social barriers such as lack of confidence, substance misuse problems and a lack of relevant skills and qualifications make gaining work or employment much harder. Issues in relation to stigma, disclosure of history of offending and mental health problems can cause difficulties for mental health service users looking to access work, further education or vocational activities. Our members report variability in employment support services and that employment is still not routinely addressed in care and support plans.	Occupational therapists' use of occupational focused practice in secure hospitals *Practice Guideline* College of Occupational Therapists.2012 McQueen J (2011) Towards work in forensic mental health: national guidance for allied health professionals. A review to government by Jean McQueen. The Forensic Network. Amith A, Petty M, Oughton I, Alexander RT (2010) Establishing a work – based learning programme: vocational rehabilitation in a forensic learning disability setting. British Journal of Occupational Therapy (BJOT) 70 (10), 416-425 National Social Inclusion Programme (2006) *Vocational Services for people with severe mental health problems*: Commissioning Guidance. London: Department of Health Dunn C, Seymour A (2008) Forensic Psychiatry & Vocational

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					Rehabilitation: Where are we at? BJOT 71(10) 448 – 450 The College of Occupational Therapists & National Social Inclusion Programme (2007) *Work Matters – Vocational Navigation for Occupational Therapy Staff.* **Realising Potential. An Action Plan for Allied Health Professions in Mental Health: http://www.Scotland.gov.uk/Publications/2010/06/15133341/0** Waddell G., & Burton, K. (2006) *Is Work Good for your Health & Wellbeing?* London: Stationary Office Sainsbury centre for mental health (2009) Briefing 37: Doing what works, London, Sainsbury centre for Mental Health
40	College of Occupational Therapists	Key area for quality improvement 2: OCCUPATION, & SOCIAL INCLUSION	Occupation and occupational performance skills are vital for accomplished daily living. Many service users with schizophrenia due to their illness or disorder, may not have the required performance skills to support successful community integration. Social inclusion is high on the agenda for mental health services users.	"*The social inclusion agenda, with the requirement of reducing discrimination and social exclusion for mental health service users, has been dominant in mental health provision in the UK*" (Fitzgerald 2011). Although high on the agenda, mental health service users continue to face barriers to social inclusion due to stigma, the lack of availability of resources, community opportunities to support their recovery and successful integration.	Occupational therapists' use of occupational focused practice in secure hospitals *Practice Guideline* College of Occupational Therapists.2012 National Social Inclusion Programme (2006) *Vocational Services for people with severe mental health problems*: Commissioning Guidance. London: Department of Health

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				Our members report that many statutory services are reverting to medically orientated, risk adverse services that focus on symptom management rather than life goals that service users often want help with –a home of their own, supportive social contact and meaningful everyday activities.	The College of Occupational Therapy & National Social Inclusion Programme (2007) *Work Matters – Vocational Navigation for Occupational Therapy Staff.* Fitzgerald M (2011) An evaluation of the impact of a social inclusion programme on occupational functioning for forensic services users. BJOT, 74 (10), 465- 472 Realising Potential. An Action Plan for Allied Health Professions in Mental Health: http://www.Scotland.gov.uk/Publications/2010/06/15133341/0
41	College of Occupational Therapists	Key area for quality improvement 3: EARLY INTERVENTION	Experience across a range of health settings suggest that for some people, early access to services results in better outcomes. Allied health profession services need to facilitate better early intervention. (Allied health professionals are the second largest staff group after nurses and doctors and include for example, occupational therapists, speech and language therapists and arts therapists.)	Service user and carers focus groups have suggested that allied health profession (AHP) services in mental health are difficult to access, particularly as an early intervention. It is suggested that AHPs should strive to facilitate access to deliver early interventions as close as possible to people's homes to promote recovery and enable the individuals to self-manage their conditions. This should be done with an integrated approach to team working with all mental health professionals. Our members report that some Early Intervention Psychosis services initially allowed occupational therapists to	Realising Potential. An Action Plan for Allied Health Professions in Mental Health: http://www.Scotland.gov.uk/Publications/2010/06/15133341/0

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				focus on occupational and social inclusion (see above point) but are now under pressure to deliver crisis management rather than focus on early intervention for meaningful occupational goals. Our members also report that early intervention needs to better include education on the relationship between psychosis and substance misuse.	
42	College of Occupational Therapists	Key area for quality improvement 4: PHYSICAL ACTIVITY	There is strong evidence that physical activity, healthy living programmes and exercise are of benefit to the general health & wellbeing of individuals with schizophrenia. OTs are dual trained in both physical and mental health and can support service users to make the links between their physical health and mental well being, using clinical skills to enable people to engage with opportunities for physical activity that are meaningful and appropriate for the individual.	Service users with severe mental illness have disproportionately high levels of physical health problems such as diabetes, hypertension & coronary heart disease (Brown et al 2007, SIGN guidelines 2010). Evidence of the benefit of physical activities for the treatment and management of schizophrenia appears in the NICE Guidance 2009. Physical activities can also aid social inclusion and improve low mood. Our members report that levels of physical activity and related obesity problems are not routinely addressed in statutory services. Excessive weight gain while on anti-psychotic medication is generally accepted in return for the reduction in positive symptoms, despite the resulting physical health problems. In particular, the weight gain can reduce people's confidence which inhibits their motivation to search for employment or engage in other sociable activities.	Occupational therapists' use of occupational focused practice in secure hospitals *Practice Guideline* College of Occupational Therapists.2012 Tetlie T, Heimsnes MC, Almivik R (2009) Using exercise to treat patients with severe mental illness: how and why? Journal of Psychosocial Nursing & Mental Health services, 47 (2) 32 – 40 Teychenne M, Ball K, Salmon J (2010) Sedentary behaviour and depression among adults: a review. International Journal of Behavioural Medicine, 17 (4) 246-254 Brown, S, Inskip H, Barrowclough B (2007) Causes of excess mortality in schizophrenia. British Journal of Psychiatry, 177, 212 217. Coglan R et al. (2001) Duty of care: physical illness in people with

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					mental illness. Perth. Western Australia, DOH. Johnstone etal (2009) Barriers to uptake of physical activity in community-based patients with Schizophrenia. Journal of mental health, 18 (6) 523-532
43	NHS England	Thank you for the opportunity to comment on the engagement exercise for the above Quality Standard. I wish to confirm that NHS England has no substantive comments to make regarding this consultation.			
44	Janssen Cilag UK	Employment: People diagnosed with Serious Mental Illness (SMI) who are stabilised on their medication are supported to gain paid employment	This is in line with Improving Recovery from Mental Health Conditions. There should be a focus on employment for patients with serious mental health conditions.	"The current system of care and support for people with schizophrenia and psychosis, and their families, is failing both them and the taxpayer" (Prof Sir Robin Murray).	It is a part of the NOF/MH Strategy and already in the CCG indicator set for mental health but not SMI specifically. The Abandoned Illness, A report by the Schizophrenia Commission. 2012
45	Janssen Cilag UK	Shared Care/Physical Health: In line with reducing premature death in people with SMI there should be a defined shared care and physical health protocol for patients with Serious mental health conditions	People diagnosed with SMI should receive regular physical health checks from their MH care coordinator. Patients with SMI who are stabilised on their medication should be transferred to their GP for continued prescribing and receive physical health checks in primary care through an agreed shared care protocol between the Mental Health Trust and CCG.	Shared care in mental health is now a policy imperative in England and Wales, yet its meaning, form and function are still unclear. Offers opportunities for addressing long-standing issues regarding the morbidity and mortality of people with serious mental illness. Shared care trials report improved mental and physical health outcomes in some clinical settings with improved social function, self-management skills, service acceptability and reduced	Shared care- captured in NICE current Guidelines (2014). Physical health captured in NOF (inc CCGOIS), CQUIN. *Brugha, T. S., Wing, J. K. & Smith, B. L. (*1989*) Physical health of the long term mentally ill in the community. Is there unmet need?* British Journal of Psychiatry*,* 155*,* 777*–781.* *Singleton, N., Bumpstead, R., O'Brien, M., et al (*2001*) Psychiatric Morbidity among Adults Living in Private Households, 2000. London:*

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				hospitalisation. Other benefits include improved access to specialist care, better engagement with and acceptability of mental health services. Limited economic evaluation shows significant set up costs, reduced patient costs and service savings often realised by other providers. Nevertheless, these findings are not evident across all clinical groups. Gains require substantial cross-organisational commitment, carefully designed and consistently delivered interventions, with attention to staff selection, training and supervision. Effective models incorporated linkages across various service levels, clinical monitoring within agreed treatment protocols, improved continuity and comprehensiveness of services. People with severe mental illness are at increased risk of developing chronic physical health problems. As covered elsewhere in the report by the Schizophrenia Commission, we must have preventative programmes tackling cigarette smoking, screening programmes, and use of practice nurse-led interventions to promote healthy lifestyles, including exercise programmes. These must build upon a collaborative care model addressing the interface between secondary and primary care	*Stationery Office* Kelly, BJ**,** Perkins, DA**,** Fuller, JD, Parker, SM. (2001). Shared care in mental illness: A rapid review to inform implementation. The Abandoned Illness, A report by the Schizophrenia Commission. 2012
46	Janssen Cilag	The use of long acting	By improving adherence and	The Schizophrenia Commission report	Avoiding unplanned admissions is a

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	UK	injectable antipsychotics (LAIs) early in patients diagnosed with schizophrenia	ensuring continuous treatment, there is good evidence to suggest that use of LAIs for treatment of schizophrenia can prevent relapses and hospitalisations as well as reduce the number of days spent in hospital which can lead to better long-term outcomes. LAIs have also been shown to significantly improve clinical symptoms as well as improve patient functioning which can enable patients to reintegrate into society early in their illness. Poor insight and poor adherence is common early in the illness which can lead to unstable antipsychotic treatment resulting in a greater loss of cerebral grey matter and poorer prognosis. It is widely accepted that the first few years of schizophrenia is a critical period during which there is the greatest opportunity for secondary prevention. Given the evidence, LAIs can be a valuable option for treatment in this critical period.	(The Abandoned Illness) 2012 stated that early intervention is crucial to improving outcomes. Long acting injectables are generally not considered or offered to patients as a choice for first-line treatment early in the course of the illness. The National Audit for Schizophrenia (2012) found that in almost a third of patients' records, it was not clear whether patients were involved in decisions regarding their treatment or not. By not discussing the option of a LAI as first-line treatment in this early period, the patient may potentially lose the benefit of achieving sustained remission, leading to poorer long-term outcomes. Informed patient choice can also help reduce the stigma associated with LAIs. Authors have also argued that patient' attitudes towards and perceptions of LAIs and depot clinics are generally positive, thus choice of treatment should be provided early in the course of the illness and not reserved for patients who are reluctant to adhere to treatment.	core enhanced service outlined by the NHS Employers and General Practitioners Committee. The Abandoned Illness, A report by the Schizophrenia Commission. 2012 Rethink Mental Illness report 2014;Investing in recovery: Making the business case for effective interventions for people with schizophrenia and psychosis This report concludes that early intervention services for people experiencing first episode of psychosis can help improve clinical outcomes, avoid substantial costs to health and social care system, greater rates of participation in employment as well as lower rates of suicide and homicide. A-La Park et al, Early Intervention in Psychiatry 2014: Early intervention for first-episode psychosis: broadening the scope of economic estimates This paper used three decision analytical models to compare treatment by early intervention for first-episode psychosis with standard care. It demonstrated that investment in early intervention can help reduce suicide and homicide rates, improve employment and education and generate more substantial cost savings for the economy.

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					Emsley R et al, J Clin Psychopharmacol 2008; 28(2): 201 -213 Long-Acting Injectable Risperidone in the Treatment of Subjects With Recent-Onset Psychosis Patients in this study showed good improvements in terms of symptom reduction and health-related quality of life and functional outcome when treated with Risperidone long acting injection. Birchwood M et al. Br J Psychiatry Suppl 1998; 172(33):53-59 Early intervention in psychosis: The critical period hypothesis This paper outlines the important opportunities for secondary prevention in the early phase of schizophrenia. Walburn J, Gray R, Gournay K, Quraishi S, David AS. Systematic review of patient and nurse attitudes to depot antipsychotic medication. *Br J Psychiatry* 2001; **179**: 300-7 Waddell L, Taylor M. Attitudes of patients and mental health staff to antipsychotic long-acting injections: systematic review. *Br J Psychiatry*2009; **195** (suppl 52): s43-50 The above two papers argue that attitudes of patients and nurses towards long acting injectable antipsychotics are positive.

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					Taylor & Olofinjana , International Clinical Psychopharmacology 2014: Long acting paliperidone palmitate – interim results of an observational study of its effect on hospitalisation. This paper demonstrated a significant reduction in admissions to hospital and bed days in a 12 month period following the introduction of a long acting injectable antipsychotic, paliperidone palmitate, in patients with a serious mental illness compared to the 12 months before it was initiated. These patients were treated in the South London and Maudsley NHS Foundation Trust. Attard et al, Acta Psychiatrica Scandinavica 2013: Paliperidone palmitate long acting injection – prospective year-long follow-up of use in clinical practice This paper demonstrated high continuation rates in a cohort of patients in the South London and Maudsley Trust with serious mental illness that were treated with a long-acting injectable antipsychotic paliperidone palmitate. Schreiner et al: A randomized, active-controlled rater-blinded 2-year study of paliperidone palmitate versus investigators' choice of oral antipsychotic monotherapy in patients with schizophrenia (PROSIPAL); Poster presented at

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					the EPA, 2014; March 1-4, Munich, Germany This poster demonstrates that time to relapse was significantly longer for patients treated with a long acting injectable antipsychotic, paliperidone palmitate, compared to oral antipsychotics. It also noted significant improvements in patient treatment satisfaction and physician satisfaction with medication in those treated with the long acting injectable. Schreiner et al, World J Biol Psychiatry 2014; Long-acting injectable risperidone and oral antipsychotics in patients with schizophrenia: results from a prospective, 1-year, non-interventional study (InORS) Conclusions: Hospitalizations and symptomatic and functional outcomes were better with RLAT vs. oAP; frequent medication switches were associated with less favourable outcomes Kishimoto et al, J Clin Psychiatry 2013 Oct;74(10):957-65; Long-acting injectable versus oral antipsychotics in schizophrenia: a systematic review and meta-analysis of mirror-image studies. This paper showed that results from mirror-image studies in patients eligible for clinical use of LAIs showed strong superiority of LAIs

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					compared to oral antipsychotics in preventing hospitalization. Kaplan G et al, Patient Prefer Adherence. 2013 Nov 13;7:1171-80; Impact of long-acting injectable antipsychotics on medication adherence and clinical, functional, and economic outcomes of schizophrenia This paper discusses significant improvements in adherence with LAIs compared with oral drugs, and this is accompanied by lower rates of discontinuation, relapse, and hospitalization. In addition, LAIs are associated with better functioning, quality of life, and patient satisfaction. M.X Patel et al, BJPsych 2009 195:S1-S4; Antipsychotic long-acting injections: mind the gap
47	Janssen Cilag UK	The training of mental health nurses on administration of intramuscular injections, physical health in SMI and the use of objective tools to measure change. The training of primary care nurses to be able to recognise relapse indicators in patients with SMI.	The Schizophrenia Commission report 2012 highlighted the need to place a greater emphasis on physical health training of all those involved in the care of patients with serious mental health illness (including doctors and nurses in primary and secondary care). Mental health practitioners, especially nurses, should be able to demonstrate competence in providing physical health care and should have regular training updates to ensure they are aware	Mental health nurses are the largest group of registered practitioners working in the mental health setting and therefore have an opportunity to make a positive contribution to the improvement of the physical health status of patients with a serious mental illness. However, they receive insufficient training on monitoring physical health and being able to make basic interpretations of the physical health checks they perform. This leads to a lack of confidence and a lost opportunity to improve physical health.	South Staffordshire and Shropshire Healthcare NHS Foundation Trust: A study exploring mental health nurses confidence and practice caring for the physical health needs of people with serious mental illness within a forensic mental health setting. This study showed that forensic nurses recognised that they play an important role in the physical health care of a patient with SMI but acknowledged that a significant barrier to providing physical health

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			of current best practice. They should also be able to use objective tools to measure change (e.g. Lester UK Adaptation – Positive Cardiometabolic Health Resource) and document that physical health checks lead to action. The "Closing the gap: Priorities for essential change in mental health" document (2014) proposed the development of training programmes to increase awareness of physical health problems in those with mental illness and the importance of integration of care. Conversely, primary care nurses have very little training and experience in recognising signs and symptoms of serious mental illness despite regularly seeing these patients when assessing and treating their co-morbidities. This can lead to potential missed opportunities to avoiding relapse at early stages and often treatment plans for physical health problems are not adapted to reflect mental health needs. Side-effects of antipsychotic medication are often wrongly attributed to symptoms of mental illness and as nurses tend to see patients more frequently; this can lead to non-adherence and be missed as an opportunity to modify treatment plans if they are not fully trained on discerning one from the	They would also benefit from being trained to use tools that can monitor patients' health status and enable nurses to ensure appropriate interventions are initiated by a responsible health care professional. Successful integrated care critically depends on the understanding of symptoms of mental illness and the physical health needs of SMI patients by staff working in both primary and secondary care. If primary care nurses are expected to demonstrate some basic competence in understanding mental illness, it would not only help remove the stigma within the healthcare system but also help ensure holistic care is delivered by all practitioners involved in the patient's care, thereby improving patient experience and outcomes. Nurses and student nurses have few opportunities for administration, practice and demonstration of skills, to the point where some students do not get the opportunity to administer an injection until the third year of their course. There is a need for regular injection update training for registered nurses and to find ways to better prepare students for safe practice.	care was a lack of training. Hemingway et al, Journal of Nursing Management, Volume 22, Issue 3, 383-393, April 2014: Facilitating knowledge of mental health nurses to undertake physical health interventions: a pre-test/post-test evaluation Hippisley-Cox J and Pringle M (2005) Health inequalities experienced by people with schizophrenia and manic depression: analysis of general practice data in England and Wales. Mental Health Foundation, Crossing Boundaries: Improving integrated care for people with mental health problems 2013 DOH Closing the Gap: Priorities for essential change in mental health 2014 Leucht et al, Acta Psychiatrica Scandinavica 2007 116(5): 317-33, Physical illness and schizophrenia: a review of the literature Cornwall J (2011) Are nursing students safe when choosing gluteal intramuscular injection locations? Australas Med J 4(6): 315-21 London C & Saxton, L (2012) Depot and long-acting intramuscular injection training: an evaluation. Canadian Journal of Community

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			other. The technical competency of administering a long acting injectable antipsychotic is essential in ensuring that the optimal outcomes for that patient can be achieved when undergoing treatment. It is as important as the choice of treatment prescribed. Newer long acting injectable antipsychotics can be administered into the deltoid muscle which is not a site frequently injected into by mental health nurses, highlighting a need for training particularly in this area.		Mental Health 31, (3) 8-21
48	Janssen Cilag UK	Implement measures which ensure the different types of non-adherence are explored in SMI patients and that they are incorporated into patient discussions on treatment options	Non-adherence can take many different forms. The patient may simply fail to fill the prescription. If the prescription is filled, the patient may incorrectly time the medication or take the wrong dose because he or she misunderstood, or forgot, the health professional's instructions. Patients may also forget a dose completely or prematurely terminate the medication. Moreover, patients may self-adjust their regimen because of side-effects and toxicity or personal beliefs. According to systematic reviews, approximately 40-60% of patients with schizophrenia are known to be partially or totally non-adherent to oral antipsychotic medication.	Through a number of rigorous reviews, the World Health Organisation estimates that adherence among patients suffering from chronic diseases averages only 50%. The magnitude and impact of poor adherence on patient outcomes, healthcare costs and personal and social relationships highlights the critical need to implement measures that ensure non-adherence is actively incorporated into decisions made on management plans and that patients are fully aware of the treatment choices available to them. Psychiatrists underestimate the numbers of their own patients who are non-adherent and may not think to consider discussing with their patient the option of prescribing an LAI. A	NICE clinical guideline 178 (2014) WHO: Adherence to Long-Term Therapies - Evidence for Action 2003 M.X Patel et al, BJPsych 2009 195:S1-S4; Antipsychotic long-acting injections: mind the gap M.Patel & David: APT 2005, 11:203-211; Why aren't depot antipsychotics prescribed more often and what can be done about it? Heres S, Hamann J, Kissling W, Leucht S. Attitudes of psychiatrists toward antipsychotic depot medication. J Clin Psychiatry 2006; 67: 1948–53. Kane et al. World Psychiatry Oct 2013: 12(3): 216-226 Non-adherence to medication in patients

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			However, non-adherence is often only acknowledged once a patient has relapsed. The consequences of non-adherence, especially relapse, are so important for long-term outcomes, it is key that psychiatrists and pharmacists openly discuss the consequences of the different types of non-adherence and document patient understanding. The NICE guidelines (2014) state that an LAI should be considered when preventing covert non-adherence is a clinical priority, i.e. the guidance does not specify that non-adherence has to have occurred or led to negative consequences before an LAI is considered. It is also important to recognize that adherence can vary across the multiple medications that a patient might be taking.	particular problem among early phase patients and those who have had a generally good response to treatment is the belief that treatment is no longer necessary. The treatment of asymptomatic disease is always a challenge, but in psychotic disorders this is a particular problem which needs to be addressed by the healthcare professionals who may overlook these patients if unprompted.	with psychotic disorders: epidemiology, contributing factors and management strategies
49	Rethink Mental Illness	Key area for quality improvement 1 Physical health	People affected by mental illness die, on average, 20 years earlier than the general population. A number of national initiatives have recently highlighted the specific health challenges faced by this group. These include the *Living Well For Longer* strategy[22] and the 2014/15 physical health CQUIN for mental health services.[23]	The 2012 National Audit of Schizophrenia found that just 29% of people using community mental health services are receiving all the recommended physical health checks.[24] Where problems are identified, there are very low follow up rates. For example only 25% of people who were identified as having high blood pressure received an	The report of the National Audit of Schizophrenia showing low levels of physical health monitoring and follow up http://www.rcpsych.ac.uk/pdf/NAS%20National%20report%20FINAL.pdf Integrated Physical Health Pathway from Rethink Mental Illness and the

[22] Department of Health (2014) *Living Well For Longer*
[23] NHS England (2014) *Commissioning for Quality and Innovation (CQUIN); 2014/15 guidance*

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			Key barriers include a lack of clarity around the role of mental health services in supporting physical health, inaccessible physical health services and poor integration between primary and secondary care. We support the strengthened recommendations around physical health in the updated NICE guidance on psychosis and schizophrenia in adults.	intervention.[25] The new national CQUIN offers a significant opportunity to improve the physical health outcomes of people using mental health services, particularly in inpatient care. However it is essential that all health services, including primary care, understand their role in supporting the physical health of people affected by mental illness. This includes ensuring routine monitoring takes place and that problems are flagged and followed up on appropriately.	Royal Colleges of Nursing, General Practitioners and Psychiatrists https://www.rethink.org/media/304426/integrated_physical_health_pathway1.pdf CQUIN 2014/15 guidance for commissioners http://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2013/09/CQUIN-Guidance-2014-15-PDF-751KB.pdf *Lethal Discrimination* – a report from Rethink Mental Illness highlighting the health inequalities faced by people affected by mental illness http://www.rethink.org/media/810988/Rethink%20Mental%20Illness%20-%20Lethal%20Discrimination.pdf Department of Health's *Living Well For Longer* strategy https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/307703/LW4L.pdf
50	Rethink Mental Illness	Key area for quality improvement 2 Early Intervention in Psychosis	Early Intervention in Psychosis (EIP) services make a significant difference to people experiencing a first episode of psychosis. There is a wealth of evidence about the	In spite of this strong evidence, EIP provision across the country is currently under threat. A report from Rethink Mental Illness shows that 50% of EIP services have had budget cuts	Lost Generation – report from Rethink Mental Illness including data from national EIP survey http://www.rethink.org/media/973932/LOST%20GENERATION%20-

[24] Royal College of Psychiatrists (2012). *Report of the National Audit of Schizophrenia (NAS) 2012*. London: Healthcare Quality Improvement Partnership.
[25] Royal College of Psychiatrists (2012). *Report of the National Audit of Schizophrenia (NAS) 2012*. London: Healthcare Quality Improvement Partnership.

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			clinical- and cost-effectiveness of EIP. People who receive EIP care have better employment outcomes, reduced suicide rates, lower rates of detention under the Mental Health Act and better experiences of care.[26] Timely access to these services is crucial – research shows that if someone receives EIP support within two months, their prospects of recovery are significantly improved. However a delay of longer than six months leads to poorer outcomes and reduces their chances of recovery.[27] Research has also shown that progress 14 months into a person's illness will dictate their trajectory over 7.5 years.[28] It is therefore essential that these services are available as early as possible to anyone who needs them.	in the last year. 53% of services believe the quality of their service has decreased due to staff shortages, loss of specialist support and high caseloads.[29] There is also a business case for improving EIP access and provision. Recent economic analysis from the LSE suggests that for every £1 invested in EIP services, £15 costs are avoided.[30]	%20Rethink%20Mental%20Illness%20report.pdf *Investing in Recovery - m*aking the business case for effective interventions for people with schizophrenia and psychosis http://www.rethink.org/media/1030280/investing_in_recovery.pdf
51	Rethink Mental Illness	Key area for quality improvement 3 Employment	Employment can be a very important part of a person's recovery. However employment rates amongst people affected by	The Schizophrenia Commission's *The Abandoned Illness* report found that only 8% of people with schizophrenia are in employment.[32] A recent Care	The Schizophrenia Commission (2012) *The Abandoned Illness* *http://www.rethink.org/media/514093/TSC_main_report_14_nov.pdf*

[26] Rethink Mental Illness (2014) *Lost Generation*
[27] Prof. MBirchwood et al, 2013. *Reducing duration of untreated psychosis: care pathways to early intervention in psychosis services.* British Journal of Psychiatry.
[28] Alvarez-Jiminez, M. Et al, 2012. *Road to full recovery: longitudinal relationship between symptomatic remission and psychosocial recovery in first episode psychosis over 7.5.* Psychological Medicine.
[29] Rethink Mental Illness (2014) *Lost Generation*
[30] Knapp, M. et al (2014) *Investing in Recovery*

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			mental illness are lower than most other health conditions.[31] Many more people would like to work but face considerable barriers in doing so. As with physical health, mental health services do not always understand their role in supporting people's employment outcomes. Health professionals may avoid talking about it, concerned that a person is not yet ready or that it might be detrimental to their health.	Quality Commission survey showed that nearly a third of people (32%) on the Care Programme Approach (CPA) had not received the support they wanted around employment.[33] This rose to 52% for people not being supported through CPA. Employment in people with mental health problems has been identified as an outcome for inclusion in the CCG Outcome Indicator Set, which signals the national priority given this recovery area. However, implementation support for providers and commissioners would be valuable given the low take up of good practice models.	Care Quality Commission - National Summary of the Results for the 2013 Community Mental Health Survey http://www.cqc.org.uk/sites/default/files/media/documents/20130911_mh13_national_summary_final.pdf The Work Foundation (Feb 2013) Working with Schizophrenia: Pathways to Employment, Recovery & Inclusion http://www.theworkfoundation.com/DownloadPublication/Report/330_Working_with_Schizophrenia.pdf
52	Rethink Mental Illness	Key area for quality improvement 4 Crisis care	Too often, people experiencing a mental health crisis come into contact with the police and other emergency services, rather than mental health services. The Health and Social Care Information Centre has shown that people affected by mental illness disproportionately access acute and emergency services, approximately twice as often as people not affected by mental illness.[34]	The number of people being detained under the Mental Health Act is increasing – it has risen 12% in the past five years.[37] This points towards a system where people are not getting the necessary support until they reach the point of crisis and hospitalisation. We also know that people in touch with mental health services are twice as likely to access Accident and Emergency services, indicating a lack of dedicated crisis care	Quality standard for service user experience in adult mental health (QS14) http://publications.nice.org.uk/quality-standard-for-service-user-experience-in-adult-mental-health-qs14 Mental Health Crisis Care Concordat https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/281242/36353_Mental_Heal

[32] The Schizophrenia Commission (2012) *The Abandoned Illness*
[31] Department for Work and Pensions (2013) *The disability and health employment strategy: the discussion so far*
[33] Care Quality Commission (2013) *National Summary of the Results for the 2013 Community Mental Health Survey*
[34] Health and Social Care Information Centre (2014) *HES-MHMDS Data Linkage Report: Provisional Summary Statistics, April 2013 to November 2013 (Experimental)*
[37] Care Quality Commission (2014) *Monitoring the Mental Health Act in 2012/13*

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			Appropriate, community-based crisis care and support needs to be incentivised so that people can access support earlier, avoiding detention under the Mental Health Act and inpatient care. Economic analysis shows that this is more cost-effective than inpatient care – crisis resolution and home treatment teams could lead to a 30% reduction in costs for people with psychosis and schizophrenia.[35] The crisis house model as an alternative to admission also shows cost-savings and is viewed more favourably by people affected by mental illness.[36]	(http://www.hscic.gov.uk/catalogue/PUB11514/hes_mhmds_link_add_stat_1112_update.pdf) People are also not being given the necessary support and information to access appropriate services in a crisis. Crisis planning is one of the quality statements in NICE's Service User Experience in Adult Mental Health Services quality standard.[38] However just 58% people on CPA say that their NHS care plan 'definitely' covers what to do in a crisis. This drops to 49% for people not on CPA.[39] The Mental Health Crisis Care Concordat has been created to drive improvement in crisis care across the country, [40] This signals the urgency of this issue for prioritisation, and there is considerable need for implementation support for local health services.	th_Crisis_accessible.pdf *Investing in Recovery - m*aking the business case for effective interventions for people with schizophrenia and psychosis http://www.rethink.org/media/1030280/investing_in_recovery.pdf Care Quality Commission - National Summary of the Results for the 2013 Community Mental Health Survey http://www.cqc.org.uk/sites/default/files/media/documents/20130911_mh13_national_summary_final.pdf *Monitoring the Mental Health Act in 2012/13* http://www.cqc.org.uk/sites/default/files/media/documents/cqc_mentalhealth_2012_13_07_update.pdf
53	Rethink Mental Illness	Key area for quality improvement 5 Psychological therapies	Psychological therapies are widely recognised as effective treatments for a range of mental health problems. The NICE guidelines recommend talking therapy, both for people with psychosis or schizophrenia and people at risk of developing these conditions. A	Recently Rethink Mental Illness published a report on access to talking therapies as part of a coalition of mental health organisations. There has been investment made in recent years to improve access to psychological therapies for mild-moderate anxiety and depression (IAPT). However two-	*We Still Need to Talk* – a report from the We Need to Talk on access to talking therapies http://www.rethink.org/media/869903/We_still_need_to_talk.pdf *Investing in Recovery - m*aking the business case for effective

[35] Knapp, M. et al (2014) *Investing in Recovery*
[36] Knapp, M. et al (2014) *Investing in Recovery*
[38] NICE (2011) *Service user experience in adult mental health (QS14)*
[39] Care Quality Commission (2013) *National Summary of the Results for the 2013 Community Mental Health Survey*
[40] HM Government (2014) *The Mental Health Crisis Care Concordat*

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			recent review of evidence of the effectiveness of Cognitive Behavioural Therapy (CBT) for people with schizophrenia concluded that CBT can reduce the severity of psychiatric symptoms.[41]	thirds of people with severe mental illness wait more than three months, and one in five wait for more than a year to access these therapies.[42] There is a national programme to develop an implementation model for IAPT for severe mental illness, including psychosis. However, there is no guarantee on completion of this work that roll out across the country will be supported. Access to talking therapies across the country is also inconsistent. The National Audit of Schizophrenia found that 34% of people currently under the care of community mental health teams had not been offered any form of psychological therapy.[43] This is despite it being a NICE-recommended intervention.	interventions for people with schizophrenia and psychosis http://www.rethink.org/media/1030280/investing_in_recovery.pdf
54	Lundbeck / Otsuka (joint response)	1. Access to Early Intervention in Psychosis Services and getting help in a crisis	It is vital that people with schizophrenia receive the necessary support as early as possible and are given a choice from a full range of treatments or interventions to allow them to best able to manage their condition. Getting effective treatments to people with schizophrenia or psychosis earlier can help them to avoid relapses and thereby improve	In a survey recently undertaken by Lundbeck and Otsuka in partnership with SANE (to be published in May 2014) 63% of respondents (n=32) stated that they had seen a healthcare professional five or more times about their symptoms before receiving a diagnosis of schizophrenia. It is vital that delayed diagnosis does not act as a barrier to people receiving the support and treatment that they need.	SANE, Lundbeck and Otsuka, *Living with schizophrenia*, to be published on SANE's website by the end of May 2014 – http://www.sane.org.uk/ The Schizophrenia Commission, *The Abandoned Illness: A report by the Schizophrenia Commission*, November 2012, available at: http://www.rethink.org/media/51409

[41] Knapp, M. et al (2014) *Investing in Recovery*
[42] Rethink Mental Illness, Mind et al. (2014) *We Still Need To Talk*
[43] Royal College of Psychiatrists (2012). *Report of the National Audit of Schizophrenia (NAS) 2012*. London: Healthcare Quality Improvement Partnership.

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			their quality of life. NICE clinical guideline 178 recognises the importance of early intervention services being accessible to all people with a first episode or first presentation of psychosis and maintaining the benefits of early intervention once service users are discharged. It is equally important that people with schizophrenia or psychosis, at all times, have access to an appropriate crisis resolution and home treatment team, or equivalent.	The 2012 Schizophrenia Commission report, *The Abandoned Illness*, highlighted concerns that Early Intervention in Psychosis (EIP) services are currently being cut. The Commission named EIP services as "the most positive development in mental health services since the beginning of community care". It is therefore vital that access to EIP services is a key element of the quality standard in order to ensure that all people are able to access these services. The latest NHS Mandate highlights the importance of access to appropriate support and services during a mental health crisis. The Mandate notes that recent reports have highlighted a particular challenge around mental health crisis intervention, and notes the development of liaison and diversion services to address this challenge. It is important that the success of these new services is examined as part of the quality standard development process.	3/TSC_main_report_14_nov.pdf Department of Health, *The Mandate: A mandate from the Government to NHS England: April 2014 to March 2015*, November 2013, available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/256406/Mandate_14_15.pdf
55	Lundbeck / Otsuka (joint response)	2. Provision of accessible care plans	The Government's principle of 'no decision about me, without me' should be a key priority for mental health services. In practice this can be achieved by ensuring people with schizophrenia and their carers are informed about the full range of	The Schizophrenia Commission highlighted significant concerns about the quality of care planning for people with schizophrenia. The Commission recommended that all care plans should give people an element of choice as to where they are treated	The Schizophrenia Commission, *The Abandoned Illness: A report by the Schizophrenia Commission*, November 2012, available at: http://www.rethink.org/media/514093/TSC_main_report_14_nov.pdf

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			treatment options, are involved in care planning and can, therefore, exercise informed choice. It is crucial that effective care planning is undertaken in collaboration with healthcare professionals and produced following a holistic assessment, which promotes recovery and sets out long-term outcomes. The need to write a care plan in collaboration with the service user as soon as possible following assessment is recommended in NICE clinical guideline 178 as a key element of high quality care.	and by whom and include goals which have been agreed by the person. Care plans must reflect the full spectrum of needs, ie psychological, pharmacological and physical, as well as social needs such as housing and education, as these have an impact on people's ability to achieve their recovery goals. The necessity of care plans being accessible must also be reflected in the quality standard. This will help to ensure that care plans remain understandable and user-friendly for healthcare professionals, people with schizophrenia and their carers.	
56	Lundbeck / Otsuka (joint response)	3. Provision of information about the condition, treatment options	Aligned with high quality care planning and ensuring the principle of 'no decision about me, without me' is a reality for people with schizophrenia, is the need to ensure that all those affected by the condition are given accessible information about the illness and available treatment and care. The provision of high quality information underpins the principle of patient choice, which is enshrined in the NHS Constitution. Information should cover the condition itself, the different treatment options available, including all the benefits and any risks, and how to get help in a	One of the key findings of the 2012 National Audit of Schizophrenia was that there are differences between the information that healthcare professionals think they have given to service users and service users' perceptions of the accessibility of that information. This was something also reflected in relation to carers. The evidence in the Audit indicated that many service users felt they were not provided with information about their medication in an adequately understandable form. Only 62% of service users surveyed reported that the information was in a form they could properly understand.	NHS, The NHS Constitution, March 2013, available at: http://www.nhs.uk/choiceintheNHS/Rightsandpledges/NHSConstitution/Documents/2013/the-nhs-constitution-for-england-2013.pdf National Audit of Schizophrenia, Report of the National Audit of Schizophrenia 2012, December 2012, available at: http://www.rcpsych.ac.uk/pdf/NAS%20National%20report%20FINAL.pdf SANE, Lundbeck and Otsuka, *Living with schizophrenia*, to be published on SANE's website by the end of May 2014 –

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			crisis. Information should be provided and discussed as early as possible in the pathway and presented in an accessible format. In addition, and where appropriate, carers and family members should be part of the discussion and have information made available to them.	These findings were reflected in the survey recently undertaken by Lundbeck, Otsuka and SANE, which found that over half of people with schizophrenia who responded to the survey (58%, n=30) received no information at diagnosis. Similar findings were seen when looking at responses from carers and family members of those with schizophrenia. Just over half (51%, n=28) stated that they had received no information at all at diagnosis of the person they cared for/their family member.	http://www.sane.org.uk/
57	Lundbeck / Otsuka (joint response)	4. Shared decision-making and support for carers	The provision of information and effective care planning underpins shared decision-making. Timely and accurate information on treatment and care options is vital to supporting people and enable them to be in control and empowered to make informed decisions about their treatment. Shared decision-making should be based on shared information and agreeing jointly the best treatment plan to enable people with schizophrenia to achieve their personal recovery goals. Healthcare professional have a vital role in supporting people with schizophrenia to be involved actively in shared decision making to make fully informed choices	There is evidence to demonstrate that, when patients and clinicians make a joint decision, both are more likely to adhere to their treatment plan (Gray 2009). As non-adherence to medication is the most common cause of relapse for people with schizophrenia (as reported in the National Audit of Schizophrenia), ensuring that everything is done to support patients to adhere to their treatment is vital. The National Audit of Schizophrenia found that people with schizophrenia do not always feel sufficiently involved in the final decision about which medication they should take. While clinical staff reported that they thought they had involved service users in the choice of medication in 62% of cases, only 41% of service users felt their	Gray R et al 'Antipsychotic long-acting injections in clinical practice: medication management and patient choice', *British Journal of Psychiatry*, 195: 51-S56, 2009 National Audit of Schizophrenia Report of the National Audit of Schizophrenia 2012, December 2012, available at: http://www.rcpsych.ac.uk/pdf/NAS%20National%20report%20FINAL.pdf SANE, Lundbeck and Otsuka, *Living with schizophrenia*, to be published on SANE's website by the end of May 2014 – http://www.sane.org.uk/

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			about their treatment and care that reflects what is important to them. The importance of people with schizophrenia having the opportunity to make informed decisions about their care and treatment, in partnership with their healthcare professionals, is recognised in NICE clinical guideline 178. Furthermore carers have a vital role to play in shared decision-making and it is important that they too are supported to fulfil this role with provision of the necessary information and advice at every stage.	views were taken into account. Lundbeck, Otsuka and SANE's recent survey found that the large majority of respondents reported that they felt completely uninvolved, or only partly involved (86%, n=41) in their choice of treatment. Many respondents also reported that the full range of treatment options was not discussed with them at diagnosis. Carers and families have always played an important role in the management of schizophrenia and, with the increasing emphasis on supporting people to manage their condition in the community, this has assumed even greater significance. Many people with the illness require regular support from family members and carers. Families who are carers save the public purse £1.24 billion per year but are not receiving sufficient support. Evidence suggests that families are often <u>not</u> treated as partners in schizophrenia care, and regularly have to battle for basic services. This is contrary to existing NICE guidance (CG178), which emphasises the need to support carers and the benefits this has for people with the condition. If health professionals and carers work in partnership, the care of people with	

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				schizophrenia is likely to be optimised.	
58	Lundbeck / Otsuka (joint response)	5. Assessment and treatment of physical health	It is essential that people with schizophrenia have their physical health thoroughly assessed when first in contact with healthcare professionals and regularly monitored, at least annually, by GPs and other healthcare professionals. Subsequent treatment to address any physical health needs that have been identified is then vital, in addition to ongoing assessment and treatment. In this context regular, annual, medicines reviews are important to ensure the right treatment at the right time to avoid unnecessary adverse events which may have detrimental effect on an individual's physical health.	The Schizophrenia Commission report highlighted that people with schizophrenia have significantly worse physical health outcomes than the rest of the population. They are also three times more likely to die from cancer than the general population. Prevalence of type 2 diabetes is 2-3 times higher for people with schizophrenia than in the general population. In addition, people with severe mental illness are twice as likely to die from heart disease as the general population. The National Audit of Schizophrenia also reported major concerns about the poor physical health of people with schizophrenia. The audit illustrated that many people are not getting the assessments they need to detect and treat physical health problems. This contributes to the significantly worse physical health outcomes that people with schizophrenia experience compared to the rest of the population. Lundbeck, Otsuka and SANE's recent survey found that physical health monitoring remains a problem and the majority of people are not satisfied with the support received. Our survey assessed whether people were satisfied with the support they, or	The Schizophrenia Commission, *The Abandoned Illness: A report by the Schizophrenia Commission*, November 2012, available at: http://www.rethink.org/media/514093/TSC_main_report_14_nov.pdf National Audit of Schizophrenia, *Report of the National Audit of Schizophrenia 2012*, December 2012, available at: http://www.rcpsych.ac.uk/pdf/NAS%20National%20report%20FINAL.pdf SANE, Lundbeck and Otsuka, *Living with schizophrenia*, to be published on SANE's website by the end of May 2014 – http://www.sane.org.uk/

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				the person they cared for/their family member, received from their doctor in monitoring their physical health. Looking at the combined responses across the two groups, just over half (51%, n=49) of people stated that they were dissatisfied with the support provided.	
59	Lundbeck / Otsuka (joint response)	Additional developmental areas of emergent practice: Use of the Lester tool in identifying and treating physical health problems	In order to support the key area for quality improvement set out above in relation to assessment and treatment of physical health, it would be helpful to examine the use of the 'Lester tool'. This is a clinical resource which provides a simple framework for identifying and treating cardiovascular and type 2 diabetes risks in patients with psychosis receiving antipsychotic medication.	The Lester tool is designed to support collaborative practice across professional disciplines and service settings. It would therefore be helpful to examine its success in helping clinicians to assess and treat physical health problems in people with schizophrenia with a view to including a reference to it in the quality standard.	Royal College of Psychiatrists, *The Lester UK Adaption: Positive Cardiometabolic Health Resource: an intervention framework for patients with psychosis on antipsychotic medication*, adapted for use by the RCGP/RCPsych with permission from Curtis J, Newall H, Samaras K, 2011, available at: http://rcpsych.ac.uk/pdf/RCP_11049_Positive%20Cardiometabolic%20Health%20chart-%20website.pdf
60	Pharmaceutical Mental Health Initiative	Paid employment for people living with schizophrenia.	Being in paid employment is associated with improved clinical outcomes, reduced bed usage and overall health service usage.	People with a diagnosis of psychosis and or schizophrenia identify obtaining employment as one of their most frequently nominated goals and see the ability to return to work as a yardstick to their recovery.	Kilian R, Lauber C, Kalkan R, Dorn W, et al (2012). The relationships between employment, clinical status, and psychiatric hospitalisation in patients with schizophrenia receiving either IPS or a conventional vocational rehabilitation programme. *Social Psychiatry and Psychiatric Epidemiology* 47(9): 1381-1389. Knapp M, Patel A, Curran C, Latimer E, et al (2013) Supported employment: cost-effectiveness across six European sites. *World*

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					Psychiatry 12: 60-68.
61	Pharmaceutical Mental Health Initiative	Information provision for people with schizophrenia and their carers	Information should be provided to people with schizophrenia and their families/carers in an easy to understand and accessible format. EXAMPLE: The principle of patient choice relies on high quality information. Information should be given early in the patient's pathway and cover the condition, the different treatment options available, and their benefits and any risks, and how to get help in a crisis.	EXAMPLE: It has been shown that healthcare professionals have different views on how understandable information is when compared to people with schizophrenia. This was something also reflected in relation to carers. Furthermore, service users have been shown to feel that they are not provided with information about their medication in an adequate form.	EXAMPLE: Please see the NHS Constitution for the principle of patient choice. http://www.nhs.uk/choiceintheNHS/Rightsandpledges/NHSConstitution/Documents/2013/the-nhs-constitution-for-england-2013.pdf EXAMPLE: Please see the National Audit of Schizophrenia which highlights the differences between healthcare professionals'/service users' views on information and service users concerns over adequate information provision. http://www.rcpsych.ac.uk/pdf/NAS%20National%20report%20FINAL.pdf
62	Pharmaceutical Mental Health Initiative	Shared decision-making and support for carers	People with schizophrenia should be actively involved in shared decision-making and supported by healthcare professionals to make informed choices; agreeing jointly the best treatment plan to enable patients to achieve their personal goals. Carers also have a vital role to play in shared decision-making and it is important that they are supported to fulfil this role with provision of the necessary information and advice.	Non-adherence to medication is the most common cause of relapse for people with schizophrenia. Patients should be supported to adhere to their treatment and if clinicians make a joint decision with the service user, both are more likely to adhere to the agreed upon treatment plan. Carers and families have always played an important role in the management of schizophrenia. There is a need to support carers and the benefits this has for people with the condition. If health professionals and carers work in partnership, the care of people with schizophrenia is likely to	Gray R et al (2009) Antipsychotic long-acting injections in clinical practice: medication management and patient choice. *British Journal of Psychiatry* 195: S51-S56. National Audit of Schizophrenia (2012) Report of the National Audit of Schizophrenia. http://www.rcpsych.ac.uk/pdf/NAS%20National%20report%20FINAL.pdf NICE (2014) Psychosis and schizophrenia in adults: treatment and management. *CCG178* http://guidance.nice.org.uk/CG178

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				be optimised.	