

# Optimising outcomes for severe mental illness: a service prescription

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## The challenge

Severe mental illness (SMI) is consistently found to be among the most costly health problems in the world.<sup>1</sup> That these conditions are so burdensome is not surprising given that most begin in adolescence and early adulthood, often persist across the lifespan, and cause substantial disability. The significance of this burden is further heightened if one considers the impact of mental illness on physical well-being. Standardised mortality ratios of sufferers of schizophrenia and mood disorders are some three or four times above that of their peers, the vast majority of deaths attributable to preventable cardiovascular and respiratory disorders.<sup>2</sup> Put bluntly, people suffering from schizophrenia and other severe mental illnesses die 20 years earlier than the general population, and they do so from preventable conditions.

A mental breakdown is shattering, not only for the individual but also for his or her family, and not solely because of the direct consequence of the illness. Mental illnesses attract a degree of fear and opprobrium that has not been seen in developed countries since the decline in chronic contagious diseases, and so, even after the acute phase of the illness has subsided, sufferers are less likely to be employed, and more likely to live in material poverty, to reside in poor quality shared and subsidised accommodation, and to have profoundly restricted social networks. This social disconnectedness may be partly a feature of the illness, but it also has a lot to do with how the potential for recovery is viewed, not least by those delivering care, and so the investment in treatment and support.

Although we are still a long way off a definitive cure for any of these conditions, there is much that can be done to improve outcome, and several well-evidenced interventions are still inadequately implemented in routine care. The purpose of this short article is to outline how these elements have been brought together in the mental health services of one London borough.

## What treatments improve outcome?

When asked, most people recovering from a psychotic illness express the same desires as their healthy peers, including a wish for employment that will bring a decent standard of living. But sadly, this desire is all too easily snuffed out by the pessimistic or overprotective views of some clinicians, who discourage their clients on the erroneous belief that they will be incapable of managing the demands and stress of work and that this will lead to a relapse. In fact, returning to work or study is associated with fewer psychiatric hospitalisations and improved quality of life, a rise in self-esteem and reduced health care costs. But even where the positive benefit of employment is acknowledged, until recently the dominant rehabilitation approach has been based on the belief that

this can only be attained after a prolonged period of prevocational preparation and training in the generic skills of time-keeping, personal grooming and social skills. Movement through these programmes is usually slow, with relatively few participants achieving employment in ordinary, competitively obtained jobs. This is now beginning to turn around with the introduction of new methods of supported employment first trialled in North America. Referred to as 'supported employment', this intervention is based on a 'place then train' approach that helps the patient to find a job they would like to do in the open marketplace. It also assists with job applications and provides continued support once in the job. Key to the success is the fact that employment is in an ordinary job alongside healthy peers, and that the employment specialist is embedded within the early intervention team and so has immediate and unrestricted access to clinical advice and support where this is needed. The approach now has a solid evidence base in terms of achieving around three times better rates of open employment than comparison interventions based on prevocational training approaches, and does so with no apparent ill effects in terms of worsening mental health, relapse or rehospitalisation.<sup>3</sup>

Two other psychosocial interventions – Cognitive Behavioural Therapy for psychosis (CBTp) and Family Intervention (FI) – have even more extensive evidence of effectiveness.<sup>4</sup> The evidence comes from local and international research trials conducted over the past 20 years that have been remarkably consistent in their findings. Yet few mental health services deliver these interventions routinely. Several studies have looked at the reasons for the lack of implementation and found a depressingly consistent story of disbelief in research evidence, a lack of training and support, and the near absence of organisational support for these therapies.

Finally, although primary care in the UK willingly takes on the task of monitoring the physical health of people with SMI, the structure and resourcing of primary care means that active outreach is not provided to those who miss appointments or consistently fail to attend. This outreach service is more commonly provided by the mental health nurses, most of whom lack the skills to carry out any but the most basic health screening. The challenge, then, is to devise health promotion strategies to increase patients' uptake of the resources available in primary care.

One such strategy concerns tobacco smoking, which is the largest preventable cause of chronic physical illness and premature death in the UK. People suffering from severe mental illness account for nearly half of all the tobacco smoked. So it's a no brainer that helping this population to quit smoking would reap huge health benefits. And yet many mental health professionals do not offer this intervention, believing that people with severe mental illness are incapable of stopping smoking, or even that they should not



Picture: Scott Mackinnon/Commonwealth Photographic Awards

*'Healthy living' interventions combat isolation, stress, depression, weight gain and other physical health effects of admission/medication for psychosis*

stop because quitting is stressful and might result in deterioration in mental health. In fact, the opposite seems likely: stopping smoking reduces levels of anxiety and depression, and people feel better for having successfully given up a habit that in the UK may account for more than half their weekly earnings.

## Putting it together: a service model

### a. Early and sustained intervention

It has long been known that even the most severely affected individuals can achieve substantial improvements if supported by a comprehensive psychosocial rehabilitation programme. Research in the 1980s and 1990s showed that the outcome was also better in patients who had been treated early in the first episode of their illness, and this heralded the emergence of specialist early intervention teams focused on rapid and sustained treatment of psychosis. The Lambeth Early Onset (LEO) team was one of the earlier examples in the UK. It prioritised the delivery of the evidence-based interventions described above, and this may well explain why, compared to standard care in a randomised clinical trial, it achieved better recovery, reduced relapse and superior patient and carer satisfaction, as well as lower suicide rates and greater cost-effectiveness.<sup>5-7</sup>

The idea of offering support earlier in the course of illness has been extended to identifying young people who are at particularly high

risk of a psychotic disorder and intervening with the aim of preventing onset. These approaches target people who are seeking help for mental distress and who also experience brief and transient psychotic symptoms. Studies have suggested that these people are at high risk of developing a full-blown psychotic illness and, by implication, that early treatment could avert onset. The evidence is slowly accumulating that this approach may bear fruit. A recent analytic overview of the existing studies concludes that cognitive behavioural therapy can prevent transition to psychosis in a 12-month follow-up of young people at particularly high risk.<sup>8</sup> Most of these studies are relatively small scale, and it is too early to declare truly preventive effects, though there may be benefits in reduction in the severity of the disorder among those who do go on to develop a psychosis and this itself would be a good reason for advocating the approach.

### b. Increasing the availability of evidence-based interventions

One of the most common obstacles to implementing evidence-based interventions is a lack of critical mass, the few trained specialists being scattered around the wider service where they have no protected time to deliver therapy. LEO managed to secure some dedicated time for specialist staff, but this was not sufficient to address the wider dearth in provision. One way forward may be to pool resources rather than distributing the resource across dispersed sites. The Social Inclusion Hope and Recovery Project

(SHARP) was set up in light of the experience with LEO to ensure wider delivery of evidence-based treatments. The focus was on the provision of CBTp, FI, supported employment and 'healthy living' interventions (including nicotine-smoking cessation and a range of dietary and exercise interventions targeted at patients on medication that places them at risk of obesity and related health concerns).

Hope and optimism are at the heart of the approach that emphasises the possibility of success rather than of failure, of looking forward not back, and of encouraging the taking of those risks where success would boost confidence and self-esteem. Therapists are projected as coaches with skills to help individuals achieve personal goals and all outcomes are assessed using standardised outcome scales. A steering group for the service includes patient and carer representatives as well as senior health and social service management. Since its launch in 2008, SHARP has tripled the delivery of all three evidence-based therapies, and has demonstrated symptomatic and functional outcomes comparable to those observed in clinical research trials of these interventions. Because all interventions are made through one team, it is usual to provide these in parallel so that, for example, a client can benefit from a course of CBTp while also attending a weekly support group for weight management.

### c. A place to belong

Both LEO and SHARP are focused on delivering relatively brief, time-limited treatments. But an equally, if not more, important aspect of a good quality of life is the fulfilment of the need to feel part of a social group, to be appreciated and loved. Good quality social support contributes to better recovery and continued good health, but stigma and discrimination are real obstacles to community integration. As a result, many of those who find intimate companionship do so with others with shared experiences of mental health disorders. One interesting way of facilitating social support is the Clubhouse model. First developed in the 1950s in New York, the approach is founded on the importance of personal relationships and participation in a common task. Mosaic Clubhouse was one of a small number of clubhouses set up in the UK in the 1990s, and continues to thrive in the London borough. People who attend are members of a club, not patients or clients of a care system, and as members have responsibilities for the running of the organisation. This means that their presence is not just essential but wanted. This 'importance to others' is reinforced through the fact that members play an active part at all levels of the organisation, working alongside a small number of staff to undertake everything that is essential for the running of the clubhouse, and in so doing provide a supportive network of peers, encourage skill development and reciprocity in relationships, which in turn nurtures self-esteem and self-confidence. Clubhouse provides a supported employment intervention, but membership is retained even when people have moved on to full-time jobs, frequently returning to renew friendships or seek straightforward non-professional support and encouragement from their peers. The model has a substantial evidence base, particularly for employment outcomes but also in terms of measures of 'belonging', 'mattering' and shared identity, all of which are important components of recovery.

## Conclusion

While progress in the treatment of SMI sometimes seems desperately slow and frustratingly inadequate, it could be substantially improved if more consistent attention is given to implementing what we already know to be effective. This is not without financial cost, but the actual sums involved are modest, however, as much of the work involves reorganisation rather than the creation of new services. What is needed by way of specialist therapy resources is easily matched by the returns they would bring.

## Endnotes

- 1 Ormel, J. et al. (2008). 'Disability and Treatment of Specific Mental and Physical Disorders Across the World'. *British Journal of Psychiatry* 192:368-75.
- 2 Brown, S. et al. (2000). 'Causes of Excess Mortality of Schizophrenia'. *British Journal of Psychiatry* 177:212-17.
- 3 Bond, G. R. et al. (2008). 'An Update on Randomised Controlled Trials of Evidence Based Supported Employment'. *Psychiatric Rehabilitation Journal* 31:280-90.
- 4 National Institute for Clinical Excellence (2009). *Core Interventions in the Treatment and Management of Schizophrenia in Primary and Secondary Care* (update). London.
- 5 Craig, T. K. J. et al. (2004). 'The Lambeth Early Onset (LEO) Team: Randomised controlled trial of the effectiveness of specialised care for early psychosis'. *British Medical Journal* 329:1067-68.
- 6 Garety, P. A. et al. (2006). 'A Randomised Controlled Trial of Specialised Care for Early Psychosis: Symptoms social functioning and satisfaction at 18 months'. *British Journal of Psychiatry* 188:37-45.
- 7 McCrone, P. et al. (2010). 'Cost-Effectiveness of an Early Intervention Service for People with Psychosis in South London: The LEO study'. *British Journal of Psychiatry* 96:377-382.
- 8 Stafford, M. et al. (2013). 'Early Intervention to Prevent Psychosis: Systematic review and meta-analysis'. *British Medical Journal* 346: f185.

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