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## Health professionals' views of services for schizophrenia – fragmentation and inequality

There has been much debate about effective treatments, service configurations and costs within Britain's mental health care system, but it has largely taken place in academic and management circles. We were interested in the views of those providing care. We organised a meeting of community psychiatric nurses, general practitioners and consultant psychiatrists (funded with an educational grant from Zeneca Pharmaceuticals). Participants worked in various parts of Great Britain, including rural and inner city areas. The authors facilitated the discussion, the emphasis of which was on participants' clinical experience.

Although much of the discussion related to the full range of serious mental illnesses, the primary focus was schizophrenia, the associated costs of which are wide-ranging and high (Knapp, 1997). Not only are there costs to the NHS, but other public sector agencies are regularly involved (housing, social services, criminal justice), as are the voluntary and private sectors. There are additionally the more indirect costs of lost productivity due to unemployment, impaired work performance, sick leave, premature mortality and family burden, and together these could outweigh the direct costs (Davies & Drummond, 1994). Economic costs apart, schizophrenia is associated with considerable intangible costs in terms of suffering and impaired quality of life.

The high and enduring costs of schizophrenia have attracted growing attention from policy-makers, care professionals and others. Evaluations have been commissioned to discover whether costs can be reduced or contained while maintaining or (better still) improving patient and other outcomes. Although there are still comparatively few completed economic evaluations of schizophrenia treatment, they nevertheless offer numerous pointers to cost-effectiveness improvements (Knapp *et al*, 1999). That is, there are proven ways to use existing resources to greater effect. One of the themes running through the discussion at our meeting was whether these cost-effectiveness gains could be realised in everyday practice, rather than in the 'experimental' environment of the research setting.

Two key issues emerged from this part of the discussion. First, care for schizophrenia can be worryingly 'fragmented' due to the involvement of multiple agencies and professionals, each with their own objectives, constraints, performance requirements and values. Second, there are major inequalities in services and in the needs of populations. Both factors were seen as contributing to variations in standards of care and clinical problems, hampering the pursuit of greater effectiveness and cost-effectiveness, but also reminding us that these two criteria are by no means the only objectives of a publicly-funded care system.

### Multiple agencies and fragmentation

#### Sources of support

Individuals with schizophrenia are often supported by professionals from a number of agencies, including health, social services and the voluntary sector. Some live permanently with their spouses, families or other caregivers, while others may temporarily stay with friends/relatives at a time of crisis. Many, of course, have no such contact at all. There are well-known variations in the nature and quality of family support (Magliano *et al*, 1998), with potential consequences for patient outcomes related to levels of expressed emotion (Vaughn & Leff, 1976).

#### Opportunities and challenges

Multi-agency work undoubtedly offers many potential advantages. Schizophrenia is an illness that needs skilled health care inputs, whether at primary or secondary care level. But people with schizophrenia are also often 'socially excluded': unemployed, out of contact with their families and with low incomes. Many feel socially marginalised. To address these non-medical needs requires support from non-health agencies. Multi-agency systems thus bring specialised skills to each case without 'medicalising' every need.

Every multi-agency system has the potential for an informed consensus of views to shape care plans tailored to individual needs, but it is a potential that often goes unrealised. Problems particularly arise when inter-agency working is poorly coordinated. Although participants in the meeting appreciated the benefits of working with different agencies, they identified the following problems:

#### *Incomplete knowledge*

The professional in charge of arranging a care plan (usually the consultant psychiatrist) must be aware of the services available in their sector. Unless there is a 'catalogue' of services this can be difficult, especially as services can develop and change quite rapidly. The remit of different agencies and their availability may also vary across a locality. As one participant observed, "partly the disparity within an area is due to ignorance of the services provided".

#### *Poor service coordination*

Coordinating the involvement of multiple professionals and agencies can be enormously time-consuming. Simply arranging joint meetings was cited as a common problem, and getting full attendance at Care Programme Approach



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(CPA) reviews in some localities was a rarity. There are also confidentiality issues to be overcome: what information can and should be shared between agencies? Problems can be most serious when professionals have different views and belong to different organisations, each with their own lines of management and accountability. We must make sure we are all singing from the same song book. A patient can see their consultant and go through the pros and cons of a medication. They go away and think about it and then go to the CPN for some advice or their GP, so we need to be sure we are giving them consistent information.

### Time constraints

Effective inter-agency coordination requires time to discuss issues, attend meetings, read reports and generally to provide and to receive shared information. Unfortunately the work pressures and timetables of many professionals make little allowance for the time needed for such liaison.

### Funding issues

Budgetary constraints, increasingly emphasised but in fact a perennial feature, can be a source of disagreement about responsibility for services. One example is when a social services department and health authority disagree about who should fund a specialised placement. Another example is when hospital pharmacies and general practitioners disagree about who should fund the cost of medication. The introduction of the atypical antipsychotics has brought this issue into sharp focus, although of course it has parallels in other clinical areas.

### Narrow perspectives

With performance monitoring becoming increasingly common and its results increasingly widely known, each care agency may be encouraged to focus narrowly on its own remit without considering the effects on other agencies or being able to address the overall needs of the patient. Funding issues often exacerbate this problem. This is particularly pertinent to schizophrenia given its chronic nature and its sizeable indirect costs. 'The costs are very varied and shared with many different agencies; it's very easy to lose sight of the big picture'.

These problems – incomplete information, poor coordination of services, time and funding constraints and narrow perspectives – can place quite formidable barriers in the way of effective and cost-effective care. The seriousness of their consequences in various domains was reported by participants at the meeting. For example, coordination is particularly difficult when bed shortages lead to patients being admitted outside the district. Multi-agency involvement can also make it difficult to design a long-term strategy for service development. Lack of effective communication has been highlighted in several confidential enquiries following suicide or homicide.

## Health inequalities

Although the UK has recently celebrated more than 50 years of a tax-funded, national health service, complete with in-built resource allocation formulae to redistribute resources from better to less well-provided areas, a great many inequalities persist. Participants in the discussion were concerned by local inequalities. They emphasised how service availability and quality can vary quite markedly even within small areas:

"We have a variation within our district. At our end we have got absolutely no problems, but the hospital down the road is short of psychiatrists, their community mental health teams are not well staffed and their access is poor. Whereas down our end, just four miles down the road, we have an excellent relationship and if necessary access on the day."

"The provision for sheltered accommodation is lacking and it is not in the right areas. In my district, there is a lot in one locality but there isn't any in my patch."

Often services were described as woefully inadequate:

"There isn't a bed, there isn't a place in the day hospital, there is no drop-in, you just come up against a lack of resources".

Some participants were having to 'borrow beds' from other districts:

"It can be very difficult to place patients locally and they can end up miles away. There seems to be a lack of local provision".

Participants working in inner cities appeared to experience particular problems, as has been noted elsewhere (Johnson *et al*, 1997). In-patient admission rates are highest in inner city areas (Faris & Dunham, 1939; Giggs & Cooper, 1987), largely reflecting social drift, although being born in a city confers a slightly higher risk of developing schizophrenia (Lewis *et al*, 1992).

Inequalities in health provision partly reflect differences in morbidity within populations, as well as differences in the accessibility of services. In Western countries the prevalence of schizophrenia is 2–3 times greater among those of low socio-economic status compared with the general population. Areas of high residential mobility are associated with higher rates of schizophrenia (Dear & Wolch, 1987). Most studies of ethnicity in Britain report higher prevalence rates for schizophrenia among African–Caribbean people compared with other groups, and admission rates have been reported to be 3–5 times higher (Harrison, 1988).

Ethnic minority groups face particular problems in accessing services. In some communities psychiatric illness carries great stigma, and people in need may avoid psychiatric services, perhaps under family pressure. Some find services unacceptable (Parkman *et al*, 1997). Mixed gender wards can be a particular source of difficulty. When African–Caribbean and Asian people do consult they are less likely than White people to have their mental health problems diagnosed by their general practitioner, and referral rates from primary to secondary care are also lower. This may partly explain why African–Caribbean people are over-represented in hospital admissions and are more likely to be detained under the Mental Health Act (Davies *et al*, 1996) and admitted to intensive care facilities. In one study the proportion of African–Caribbean people with a poor outcome of schizophrenia at one year was 2.5 times greater than for White people (Bhugra *et al*, 1997).



The consequences of health and health care inequalities should be self-evident. When people with psychiatric illness cannot or will not access the volume or standard of care that their symptoms and needs suggest they require, their quality of life may be impaired and their prognosis worsened. Poorly resourced services may find it difficult to recruit staff, potentially setting up a vicious circle.

## Ways forward

The views of health professionals have a place in assessing services, and in this paper we have sought to summarise some of their concerns. The views in this paper came from a small group of doctors and nurses; other stakeholders, including patients, relatives and voluntary agencies, were not represented. Nevertheless, the views of this group appear congruent with those expressed more widely and find support in the research literature (Mauthner *et al*, 1998).

Participants' concerns about our current mental health care system centred mainly around the themes of fragmentation and inequalities. Their criticisms were not of multi-agency work *per se* but of poor coordination without adequate time being allocated for working in this way. How can this be overcome? The formation of community mental health teams (CMHTs) can facilitate working between different professions and improve patient care, although it is not a panacea (Mauthner *et al*, 1998). Where separate agencies still operate, each needs to be clear about the services it provides, how referrals are accepted and how to communicate with other agencies. Better use of information technology can facilitate communication and improve time and resource management. Regularly updated directories of local services are essential. An increase in the number of psychiatrists and other health professionals would allow higher quality care and could be cost-effective. However, funding issues apart, there are currently insufficient trainees to fill existing consultant psychiatry posts let alone fill additional ones, a situation that also applies to psychiatric nurses (Storer, 1998).

The CPA should in principle enable better coordination but in many areas has proved difficult to implement. A common criticism is that the CPA was not targeted at those who would benefit most (i.e. those with severe and enduring mental illness) but was applied to all those coming into contact with secondary services. Furthermore, inadequate allowance has often been made either for the financial support needed to set systems up or professionals' time needed to run the system.

Joint training can improve understanding and cooperation between agencies. It has been suggested that there should be a clearer policy framework to provide greater incentives for inter-agency working. There has been talk of amalgamating health and social services budgets for mental health, and of course there is at least as much opposition to it. But even such amalgamation would not remove the gulf between agencies and individuals incurring the direct and indirect costs of schizophrenia. The widespread lack of awareness of, and

responsibility for the overall economic consequences of schizophrenia and its treatment has arguably been most influential in the worryingly myopic emphasis on short-term, narrowly-conceived economic concerns.

Health professionals need to be more aware of the influence of socio-economic factors on morbidity levels, and also of the problems faced by ethnic minority groups in obtaining access to services. National guidelines should be available on how to research and assess commissioning needs. The allocation of central funding across the country needs to take better account than heretofore of the wide variations in morbidity and provision.

The 1997 White Paper, *The New NHS* (Secretary of State for Health, 1997), heralded wide-ranging changes in health provision with important implications for psychiatry. Setting service standards through National Service Frameworks and clinical guidelines through the National Institute for Clinical Excellence (NICE) may reduce some problems highlighted in this paper. These developments may also widen the availability of treatments for which there is robust evidence of both effectiveness and cost-effectiveness. In schizophrenia this includes family interventions and atypical antipsychotics both of which (broad) treatment modes have been restricted for apparently non-clinical reasons (Knapp *et al*, 1999). Negative aspects of the reforms include a failure to provide incentives for primary care to become more involved in psychiatric care and the potential for primary care groups to undermine clinical freedom.

Schizophrenia has many deleterious consequences, but there are treatment and support modalities available which can reduce symptoms, improve personal functioning, raise quality of life and lessen the burden on families. Research shows that many of these are also cost-effective. But there are barriers in the way of achieving these desirable interventions – notably those associated with fragmentation and inequalities – which national policy attention and local action urgently need to address.

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