

Costing statement: Schizophrenia (update)

The updated guideline on Schizophrenia: core interventions in the treatment and management of schizophrenia in adults in primary and secondary care (update) (NICE clinical guideline 82) is unlikely to result in a significant change in resource use in the NHS.

This clinical guideline updates and replaces:

- Schizophrenia: core interventions in the treatment and management of schizophrenia in primary and secondary care. NICE clinical guideline 1 (2002).
- Guidance on the use of newer (atypical) antipsychotic drugs for the treatment of schizophrenia. NICE technology appraisal guidance 43 (2002).

The guideline covers the treatment and management of schizophrenia and related disorders in adults (aged 18 and over) with an established diagnosis of schizophrenia (with onset before age 60). The guideline does not address the specific treatment of young people under the age of 18, except those who are receiving treatment and support from early intervention services.

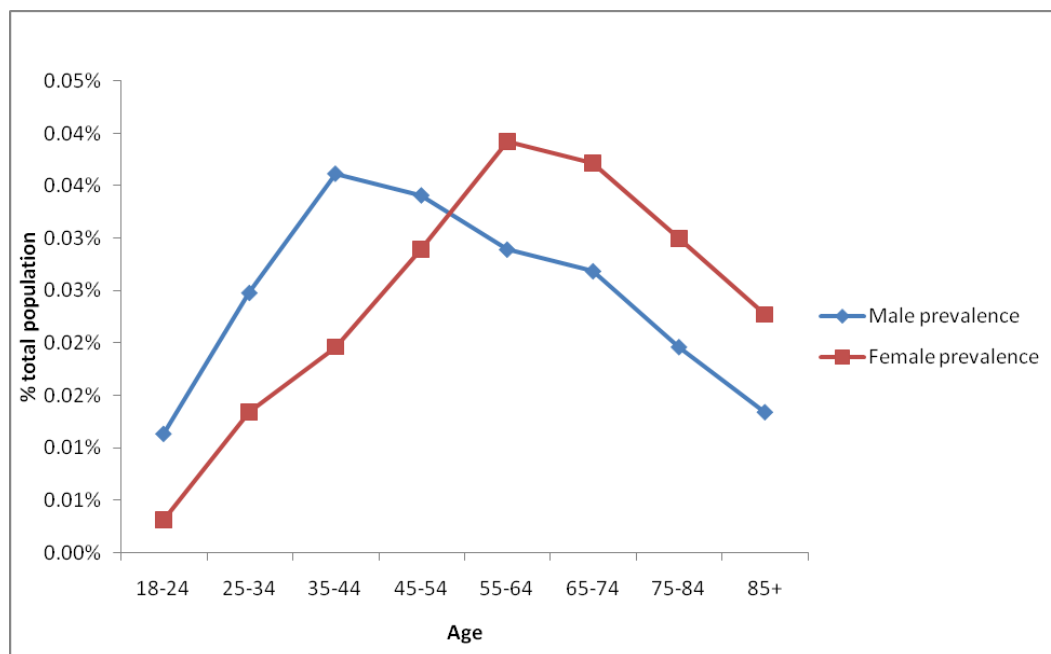
Schizophrenia is a major psychiatric disorder, or cluster of disorders, and is characterised by psychotic symptoms that alter a person's perception, thoughts and behaviour. Each person with the disorder will have a unique combination of symptoms and experiences.

Schizophrenia is commonly associated with a number of other conditions, such as depression, anxiety, post-traumatic stress disorder, personality disorder and substance misuse. This guideline does not cover these conditions. NICE has produced separate guidance on the management of these conditions.

Patient numbers affected

Schizophrenia is estimated to affect around 400,000 people in England (Office of National Statistics 2000), while the national annual incidence is estimated to be around 10,000 (Sham et al. 1994). Rates for men and women are similar; however the age of onset tends to be lower in men. This is confirmed by examining the psychiatric morbidity survey produced by the Office of National Statistics (2000) (figure 1).

Figure 1 Prevalence of schizophrenia by age and sex (Office of National Statistics 2000)



The causes of schizophrenia are thought to be determined by a number of factors. There is also increased incidence among black and ethnic minority groups (Sharpley et al, 2001).

Resource impact

Recommendations that have not changed from the original guideline have not been considered when estimating the resource impact. The recommendations that have changed and are most likely to have a local resource impact (depending on local circumstances such as BME population and current prescribing patterns) relate to:

- race, culture and ethnicity
- pharmacological interventions
- psychological and psychosocial interventions.

Recommendations

Race, culture and ethnicity (recommendations 1.1.2.1–1.1.2.4)

These recommendations apply to all people with schizophrenia and their carers, but particularly address the needs of people from BME groups.

They recommend that healthcare professionals are competent in assessing and communicating with people from diverse ethnic and cultural backgrounds. If necessary, they should seek advice from healthcare professionals experienced in working with these groups.

These recommendations will ensure that all BME groups receive culturally appropriate psychological and psychosocial treatment. This is particularly important as it is estimated that some ethnic groups are around six times more likely to develop the disorder.

The costs will mostly relate to training existing healthcare professionals to ensure they are competent in working with people from BME groups. There will be some recurrent costs, although these will be much lower and will mainly relate to training new staff. The training requirements between care sectors may vary a little, however a wide range of healthcare professionals receive training as part of their qualifications.

Cost impact

We have estimated that these recommendations will not have a significant resource impact. Staff working in early intervention services have already been trained in working with people from BME groups as detailed in the Mental Health Policy Implementation Guide (Department of Health 2000). We assume that no further training will be required.

Some training may be required for healthcare professionals working in secondary care. This could be in a range of areas, such as ensuring that all

staff understand the cultural and ethnic differences in treatment expectations and adherence. This will mainly involve training new staff, and the continued development of current staff across all sections of patient care.

Pharmacological interventions (recommendations 1.2.4.1–1.2.4.9)

These recommendations relate to pharmacological interventions. They give advice on methods of drug choice, the physical health of the service user, the information that must be discussed with the service user before starting treatment, and the technical aspects of pharmacological therapy.

Pharmacological treatment for schizophrenia is given in the form of first and second generation antipsychotic drugs. First generation antipsychotics were originally developed in the 1950s and are relatively inexpensive, but are considered to put users at greater risk of neurological side effects. Second generation antipsychotics were developed more recently and are significantly more expensive. They have differing side effect profiles to the first generation drugs, with the use of some drugs being linked to problems including weight gain.

Current prescribing levels in primary care (based on information provided by the Information Centre) suggest that around 60% of people with schizophrenia are prescribed second generation drugs and 30% are prescribed first generation drugs. (The remaining 10% are not taking any medication; this may be for a number of reasons, such as adverse reactions to drugs in the past.)

The original guideline recommended that oral second generation antipsychotic drugs should be offered as first-line treatment to people with schizophrenia. The choice of drug should be made by the service user (and carer if appropriate) and the healthcare professional.

In the updated guideline, no distinction is made between first generation and second generation drugs when deciding which oral antipsychotics to prescribe to people with newly diagnosed schizophrenia. As before, the choice of drug

should be made by the service user (and carer if appropriate) and the healthcare professional.

Response to treatment and any side effects should be recorded carefully because a key message of the guideline is that treatment with antipsychotic medication should be considered an explicit individual therapeutic trial.

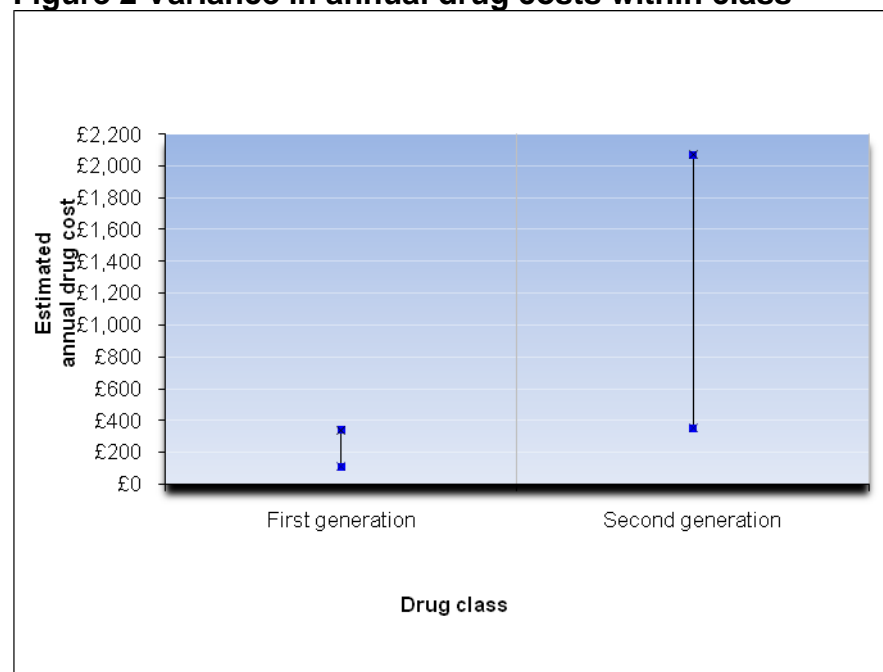
Cost impact

These recommendations contain a significant element of choice, so it is not possible to predict the change in costs.

The updated guideline encourages greater medication adherence by increasing people's understanding and involvement in the choice of drugs. Studies (Knapp et al) have shown that increased adherence reduces healthcare costs through a reduction in relapse/acute episodes, and subsequent hospitalisation rates. These cost savings may be offset against any increases in drug costs.

To help estimate the local cost impact, we have produced a costing tool which is available to download from the NICE website (www.nice.org.uk/CG82)

Figure 2 Variance in annual drug costs within class



Psychological and psychosocial interventions (recommendations 1.3.4.1–1.3.4.14)

The original guideline recommended that cognitive behavioural therapy (CBT) should be made available to all people with schizophrenia, and this recommendation has been continued in the update.

Evidence suggests however that resource limitations and a shortage of trained psychological therapists have been important factors in limiting implementation of this recommendation. According to figures produced by the Healthcare Commission, in 2006 only 46% of people who had been diagnosed with schizophrenia had been offered CBT. Therefore, there is still a huge gap in provision to meet the recommendations.

The number of people receiving CBT will therefore increase as a result of improved implementation. It is hoped that the cost of providing this treatment will be outweighed by the cost savings resulting from lower hospital admittance rates and mean number of days admitted.

The cost of providing one night's inpatient care for a person with schizophrenia is approximately £256 (based on figures provided by the Dept of Health). As CBT costs approx £1,072 per person, the average length of stay (currently 111 nights) would need to be reduced by 4 days in order for CBT to be cost neutral. CBT could also reduce readmissions in the future.

Family therapy has also been recommended for use in both versions of the guidance, however the implementation of it has also struggled due to a lack of resource. The Healthcare commission survey revealed that only 53% of people who were eligible for this type of therapy had received it in the 12 months to the end of March 2006. For this therapy to be cost neutral, the average inpatient stay would need to be reduced by approximately 10 days.

Arts therapy has been recommended for use in the treatment of negative symptoms, and has shown benefits in both inpatient and outpatient settings. It

should be provided by a clinical psychologist, and has been shown to be effective when carried out individually or in small groups.

Cost impact

We have not estimated the cost of additional CBT as it was recommended in the original guidance. However, we have included it in the costing tool for those local areas that may still be working towards implementing it. It is difficult to estimate the additional cost of providing CBT because we do not have actual patient numbers. As an example, however, the cost of CBT for one person has been estimated to be £1,072, based on a 16 week course being carried out by a clinical psychologist.

It is also important to note that for people with schizophrenia, any CBT that may be received as part of treatment for a comorbid condition will not be suitable for the treatment of their psychosis.

Conclusion

We do not consider that the new or revised recommendations in this update will have a significant cost impact. However, we recognise that local areas may have local impact as discussed above and changes in working practice on a local level may be required.

The costs of this guideline will fall under programme budgeting category 205C (Mental health disorders – psychotic disorders).

Appendix A. References

Department of Health (2000) Mental health policy implementation guide

Office of National Statistics (2000) Psychiatric morbidity among adults living in private households. London

Sharpley M, Hutchinson G, McKenzie K, Murray RM (2001) Understanding the excess of psychosis among the African–Caribbean population in England. Review of current hypotheses. *British Journal of Psychiatry Supplement* 40: s60–8

Sham PC, MacLean CJ, Kendler KS (1994) A typological model of schizophrenia based on age at onset, sex and familial morbidity. *Acta Psychiatrica Scandinavica* 89: 135–41

Knapp et al. (2004) Non-adherence to antipsychotic medication regimens: associations with resource use and costs. *British Journal of Psychiatry* , 184, 509-516.

Healthcare Commission (2007) No voice, no choice. A joint review of adult community mental health services in England