1. What is the prevalence of schizophrenia within the cultures of London and how does it compare to the rest of the UK?

Schizophrenia is a psychotic condition in which there is a functional disorder of the brain. The condition disables the ability for the patient to have clear thoughts and distinguishes fantasy from reality.

It is a lifelong condition that may arise gradually. Schizophrenia can be chronic or the illness may have episodes of remission. Patients most commonly exhibit symptoms of auditory hallucinations, paranoid or bizarre delusions, or disorganized speech and thinking. As a result there is substantial social or occupational dysfunction. The onset is most notably occurs in young adulthood. The condition is clinically diagnosed.

No true cause of schizophrenia has been found. However, it is thought that it is multi-factorial, involving genetic, environmental and social aspects of a person.

Studies have shown that acute (short-lived) symptoms mimicking paranoid schizophrenia are linked to cocaine, amphetamine and cannabis use. The latter in particular involved in establishing and increasing risk of developing psychosis.

The treatment involves antipsychotic medication. Psychotherapy and vocational and social rehabilitation are also important in treatment. In cases where the patient is a risk to one self and others, involuntary hospitalisation may be required.

The condition affect cognition, however it is a factor that contributes to chronic problems with behaviour and emotion. Schizophrenic patients have a higher risk of getting other conditions. These include major depression, anxiety disorders and substance abuse. There are other issue such as long-term unemployment, poverty and homelessness are common. The average life expectancy of a patient diagnosed with schizophrenia is reduced 12 to 15 years.

No true value of prevalence of London as a whole has been investigated. However studies have taken place in regions of London. One study includes The Camden schizophrenia survey II. This found a high point prevalence of schizophrenia (5.3 per 1000 resident population). Case distribution showed a marked and significant variation associated with socio-demographic factors.[1]

A study carried out in Denis Hill Unit in Bethlem Royal hospital in London during 1980-1994 looked in to admission rates. Although this study only looked at admission rates it showed that 1.7 per 100000 where white and of this 80%[2] was diagnosed as schizophrenic. Furthermore, 7.7 black patients per 100000 were admitted and 81% had schizophrenia[2]. The reason for the proportions to differ could lie in the demographic of the catchment area. There is a high Afro-Caribbean population in the area associated in with Denis Hill Unit.

Along with the Denis Hill study, other research that look in to the cultural rates of schizophrenia within London shows that there is a higher incidence of schizophrenia in ethnic minorities in particular black population[2,3].

Another study in London in particular South-East London showed a prevalence of 7.2 per 1000[3]. The rates of prevalence within London are higher than in the UK which shows a prevalence of 1%[4]. A study done on GP lists show an average of 8 per 2000 (4 per1000) in the UK are diagnosed with schizophrenia[5,6]. The general trend in the UK within the ethnic groups follows the trend is seen in London, that is there is a higher incidence of schizophrenia within the Afro-Caribbean population[5,7,8,9].

2. How are forensics services organised and delivered in the UK and how does it compare to another multicultural country such as Australia

Once a person has remanded or sentence for a crime and is thought to have a mental disorder, a forensic psychiatrist sees the individual to assess. If there is a possibility that the patient has an illness it is scrutinised to formally diagnose it. The patient is initially placed in a secure mental health centre. At this stage the patient is treated and continuously assessed. If the patient is deemed to be of no significant threat to him/herself or others, and after further assessments and if satisfied by doctors the patient is considered and possibly transferred to a lower secure setting. After further rehabilitation and with the patient's wishes a transfer to a lower security or a forensics hostel is considered. This stage of the process involves presenting the patient's progress to a tribunal. The patient's care team gives evidence of good progress to a panel of senior judge, doctor and a lay person. Once the panel is satisfied the patient can progress to the next stage.

In Australia, forensics services are centred upon the cities. The set up of hospitals and community teams is largely similar to the UK with a few esoteric differences. For instance in Melbourne, professor Mullen's service operates on a concentric model of security, whereby the most risky are treated in the centre of the hospital and those closer to rehabilitation and leave are on the perimeter of the site.

3. Describe the role of the MDT in the recovery and management of a schizophrenic patient within the community in London

Social and community support is very important. The key worker or case coordinator plays an essential role. However, families, friends and local support groups can also be major sources of help.

The management of a schizophrenic patient is a combined effort between secondary or tertiary care and primary practice. Multidisciplinary approach is crucial to ensure support and early recognition of problems. A mixture of in and outpatient care, hospital consultant, community psychiatric nurses, GPs, crisis support, day care, home treatment teams, assertive outreach, early intervention, social workers, voluntary organisations and involvement of carers is essential. These health care professionals assess use of anti-psychotic drugs which may cause additional problems e.g. weight gain and increased incidence of type II diabetes mellitus. The members of the team check the patients' awareness of healthy lifestyle such as efficient diet, smoking cessation and need to screen for other diseases. The GP or nurse carry out regular blood checks and monitor possible side effects which would improve compliance.

4. Develop skill required to treat schizophrenic patients and appreciate the role of MDT care of schizophrenic patients.

As mentioned earlier the diagnosis of schizophrenia is clinical. It is important to talk to the patent and form a rapport. The history is essential. As a junior doctor what is required is to ask a general psychiatric history which would include birth and childhood experience. It is however necessary to ask questions which would direct towards the likely diagnosis of schizophrenia. It may be required to speak to the family to get a collateral history. With all the information obtained including blood results, the referral to the senior members of the team is essential, followed by informing the general practitioner involved with the patient. A further referral to secondary care would be sought after to complete the patients care and wellbeing. A complete management plan is formulated by talking to the various healthcare professional teams available. This may be chaired by the GP or the consultant in the secondary care. Social and community support is very important. The key worker plays an essential role. However, families, friends and local support groups can also be major sources of help.

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