

# Translating advances in schizophrenia treatment: a glass ceiling

## *Reforms to the management of schizophrenia in Australia have stalled*

A DECADE AGO, the management of schizophrenia languished in medicine's backwaters. Treatment still occurred in asylums, using drug therapies serendipitously discovered decades earlier. Even these had proved ultimately disappointing and were used in excessive doses, with inevitable serious adverse effects, a great deal of suffering and only modest benefit. Psychosocial treatments were similarly obsolete or simplistic, with a weak evidence base. Therapeutic nihilism was pervasive and stigma profound. The public knew little about schizophrenia and gave little thought to it unless they happened to be directly touched by the disorder in their own lives. The Burdekin Report graphically captured this bleak scenario.<sup>1</sup>

The situation 10 years on is much more promising. Spurred on by the reintroduction of clozapine, a new wave of drug discovery has produced a second generation of antipsychotic drugs. Because of their better tolerability, and boosted by potent marketing campaigns, these "atypical" drugs have now become the first-line treatment in Australia and have engendered greater optimism in managing schizophrenia. Psychosocial treatments have undergone a similar renaissance,<sup>2</sup> with the advent of evidence-based family interventions, cognitive behaviour therapy for persistent psychotic symptoms, and vocational rehabilitation models. The first National Mental Health Strategy catalysed an overdue reform process and created a real sense of progress. Early intervention strategies, not seriously attempted previously in schizophrenia, were effectively developed in Australia, evaluated and exported.<sup>3</sup> The prospects for people with schizophrenia never seemed better.

However, the potential for greatly improved outcomes has not been realised in Australia. The daily reality for most people with schizophrenia is that quality of treatment and quality of life are relatively poor.<sup>4</sup> Many live in poverty in substandard housing, having little to occupy their time and

trying their best to cope, often with the aid of harmful amounts of legal and illegal substances. The plight of family members is also serious and all too often leads to frustration and despair. Despite the early intervention reform, which is being taken up enthusiastically overseas,<sup>3</sup> long delays in obtaining treatment for first episodes of schizophrenia are still common. Treatment is typically withheld until it can no longer be denied.<sup>5</sup>

In 2002, the Mental Health Council of Australia was contracted by the Federal Government to conduct a comprehensive review of the mental health system. The review concluded that, despite a decade of reform, Australia still does not have effective or accessible mental healthcare. Serious under-resourcing was identified as the fundamental cause. By the end of the 1990s, the devolved and mainstreamed mental healthcare system had developed a raft of problems. The reform process had stalled behind the complacent facade of a "mission accomplished".

A recent review of Victoria's mental health services by the State's Auditor General found evidence of unmet need, poor access to and continuity of care, and low levels of satisfaction with services — problems attributed primarily to under-resourcing.<sup>6</sup> Similar problems are likely to exist in other States. Furthermore, a substantial proportion of people with schizophrenia, whose management requires a team approach with specialist review, are being managed in minimalistic fashion by general practitioners with insufficient support from a beleaguered and reactive specialist system. As a result, despite significant advances in treatment efficacy, there is a vast gap between efficacy and effectiveness, which could be bridged if it were possible to implement optimal evidence-based treatment.

The Royal Australian and New Zealand College of Psychiatrists is poised to release new clinical practice guidelines for the treatment of schizophrenia.<sup>7</sup> The guidelines empha-

size the need for an optimistic therapeutic approach to treating schizophrenia, and stress that the social environment of people with schizophrenia needs to be improved (eg, through housing support, vocational rehabilitation and family support). The guidelines also endorse atypical antipsychotics as the first-line treatment for schizophrenia because they are better tolerated in the short term by the vast majority of patients.<sup>11</sup> Some have claimed that these outcomes could be achieved if the “typical” (first-generation) agents were used in lower doses,<sup>12</sup> but there is increasing evidence that this is not the case, and in practical terms such low-dose use of typicals is unlikely to be achievable. Used over longer periods, the atypical agents are showing a significant advantage in relapse prevention<sup>13</sup> and lower rates of tardive dyskinesia than the typical agents. However, this has to be balanced against the increased risk of adverse effects, such as weight gain and impaired glucose tolerance. Clozapine is clearly superior to other drugs for managing “treatment resistant” patients and reducing suicide risk.<sup>14</sup> Despite practical difficulties relating to its use (notably the need for routine blood monitoring), clozapine should be more widely used in Australia. Psychosocial treatments<sup>2</sup> are now solidly evidence-based, but are still only sparsely available in Australia.<sup>15</sup> This reflects a major failure of public policy and practice.

The failure to continue the reform process means that what is currently on offer is little more than acute-phase containment of risk in a reactive and rationed manner, with, at best, rapid disposal to minimal outpatient care. It has been claimed that much current funding for mental health services is not put to good use and that replacing some existing practice with evidence-based interventions is all that is required.<sup>13</sup> This is clearly desirable but a manifestly inadequate response, which also ignores the costs that would be involved in achieving such global change in clinical practice. Despite the much-emphasised high direct cost of treating schizophrenia,<sup>14</sup> treating it adequately, let alone optimally, will cost substantially more, and will require a much more professional and proactive approach, with widespread community support. For disorders that are treatable but not yet curable, achieving better outcomes is quite feasible but comes at a threshold price (my estimate of that threshold would be at least \$24 000, but further research is needed). Current direct costs are about \$18 000 per patient per year,<sup>14</sup> a figure that has been labelled high, yet which is clearly below this threshold. Indirect costs (eg, costs of social security, costs involved in reduced working capacity of family members and the patient, and prison costs) are very

substantial and could ultimately be diverted to proactive direct treatment. In fact, treatment in psychiatry is not intrinsically expensive in contrast to other complex medical disorders, yet Australia provides less funding per patient with schizophrenia than many other developed countries.

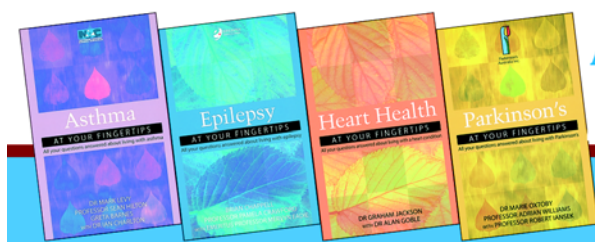
Sartorius claims that “there is enough money around to help those with mental illness, but it is not available because of the attitude of most decision makers and a large part of the general public towards mental illness and all that surrounds it”.<sup>15</sup> People with schizophrenia are most affected by the lack of funding. Members of the public do not discover this until a friend or relative develops the disorder, by which time it is too late. Australians need to consider the following question: “Are you willing to pay to make optimal treatment freely available? — you or your family may need it.”.

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