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A care pathway for schizophrenia

Swaran Singh has recently argued for a care pathway for psychosis or schizophrenia.[1] We have recently argued for a staging approach to schizophrenia.[2] Such an approach argues that there are different stages in the development of schizophrenia, and that therefore different stages of the illness will require different interventions to optimise treatment, be it pharmaceutical, social or psychological. Furthermore, logically, the different stages will require different goals of treatment and different expected outcome measures. Thus, for example, the aim of treatment in the first or 'at risk mental state' stage of psychosis is to prevent psychosis developing, while the aim of the second stage, or the first-episode stage, is to end the psychotic episode and return the patient to work and education.

Staging in schizophrenia also extends to the phase of chronic illness, and here the goal will be, depending on the severity of the illness, to limit the positive and negative symptoms of the illness, to prevent relapse, and to optimise social inclusion, promoting a return to work if possible. Such a staging approach to schizophrenia is underpinned by the neuroimaging evidence, since the loss of grey matter linked with schizophrenia does start in the prodromal 'at risk' phase, becomes more prominent in the first episode, and then becomes incrementally more severe in the later stages of the disease.[3–5] Furthermore, different stages of the illness appear to be mirrored in different patterns of change in such structures as the hippocampus and the amygdala,[6] as well as changes in pituitary volume.[7,8] Thus, a 'staging approach' to schizophrenia does provide a logical framework for the development of a care pathway for schizophrenia, with different stages or phases requiring the development of specialised teams with different expected outcomes, but who will always, in each phase of the illness, strive to optimise treatment in order to achieve the best results. Hence, such a pathway may include an 'at risk mental health' team, which will attempt to reduce the rate of transition to full psychosis in patients who are developing 'prodromal' symptoms. This would be followed in the pathway by a first-episode service which will work assertively with patients so as to deal with the first episode and return patients to work and education, and at the other end of the spectrum, assertive outreach teams will work with patients who are difficult to treat who have demonstrated the most serious deterioration in functioning.

What, however, is missing in this care pathway is the treatment of those patients who are returned to community mental health teams (CMHTs) after 3 years in an early intervention service and who are not deemed ill enough to require referral to the assertive outreach teams. These constitute the majority of patients with long-term schizophrenia. Unfortunately, since CMHTs have other priorities, and indeed are oriented to dealing with patients with relatively less severe forms of mental illness, many of these patients may receive suboptimal care, sometimes consisting of the simple delivery of medication within a depot or clozapine clinic, and without the systematic delivery of psychosocial interventions. As a result, in many cases, social inclusion is not optimised as a direct result of the loss of the assertive approach to care. It is therefore small wonder that both the Lambeth Early Onset (LEO)[9] and the OPUS[10] services report a loss of improvement in outcomes within 5 years of first treatment, after patients have been transferred from early intervention teams to the care of CMHTs.

It is of interest that a study in Russia,[11] where patients were followed up assertively for 5 years, has shown no such loss of improvement in outcomes. It is urgent that the development of ongoing assertive, specialised teams for psychosis, as suggested by Singh, should proceed in order to complete the schizophrenia care pathway. The CMHT cannot provide such an assertive service, since it is focused on other things. Seen in this perspective, recent suggestions that early intervention and assertive outreach teams should be amalgamated into CMHTs and provide elements of specialised care within the CMHTs must further confuse the focus of the CMHTs and constitute a serious misreading of the evidence.

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Author's reply: I am grateful for Dr Agius' comments and entirely agree that a staging approach allows the development of a comprehensive care pathway for psychotic disorders. With such an approach, the most efficacious and potentially less harmful interventions can be appropriately targeted at an earlier clinical stage of an emerging illness. Such a staging model is widely used in medicine and has recently been described as a heuristic framework for intervening early in all youth mental health problems.[1,2]

Half of all adult mental disorders begin in late adolescence, usually with an initial presentation of non-diagnostic symptoms. Mental health services, especially community mental health teams (CMHTs), offer interventions only when an illness is severe

enough to reach a diagnostic threshold. This is partly due to the reactive nature of CMHT care and partly because of concerns about treating 'false positives', benign and transient states that will not make a transition into a major mental disorder. An unfortunate consequence of this well-meaning caution is that young people are denied earlier and safer interventions, which are not only clinically appropriate at an early stage, but have the potential for altering the prognosis and preventing the emergence of more serious illness.

A staging approach also offers exciting possibilities for developing specific clinical and biological markers of mental illnesses and understanding the relationship between clinical states and neuropathological and neurophysiological changes that accompany illness progression.[3]

I also share Dr Agius' concern about the short-term financial pressures that may encourage managers to amalgamate early intervention services into CMHTs. This will simply dilute the well-established effectiveness of early intervention services in caring for vulnerable young people, while offering no improvement in CMHT functioning.

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Dilemma over antipsychotic use in dementia

The editorial by Treloar *et al*[1] has raised a controversial but justified issue regarding antipsychotic prescription in patients with dementia. We agree with the editorial supporting the cautious use of these drugs based on the ethical premise of reducing patient distress and palliation. However, we felt that there was a relatively quick and unchallenged submission to another important premise of the observed harm, which is intricately related to the topic in question. Our strong concern is that such unequivocal acceptance of the observed risks is likely only to enhance the ethical dilemma in a reader's mind. The decision to use these drugs, even for palliative purposes, is likely to be strongly governed by our safety and risk assessments. Are we not in a dilemma over the available safety evidence as well?

Is the observed harm specific to antipsychotic drugs, old age, dementia or behavioural and psychological symptoms of dementia (BPSD)? Is the observed association necessarily causation or are there certain limitations to a definite conclusion? For example, many a time the indication for which a drug is prescribed in dementia may be the cause of increased mortality rather than the drug *per se*. To quote the detailed Department of Health report,[2] 'people with dementia and BPSD may be more likely to die (and to be prescribed antipsychotic drugs) than people with dementia and no BPSD'. Safety concerns regarding the use of antipsychotic drugs in elderly populations are a valid consideration, but are the risks also specifically higher for elderly people with dementia? The landmark meta-analysis of randomised controlled trials (RCTs),[3] which concluded with a small increased risk for death with antipsychotics compared with placebo, also mentions that these results should be considered as hypothesis-generating. None of the individual drugs included in the 17 RCTs was sufficient to conclude for an increased risk, but a combined statistical effect was found. Does this call for a verification or should it be taken as conclusive?

Regarding efficacy studies, antipsychotic drugs have mostly been tested for treating BPSD. Behavioural and psychological symptoms of dementia is quite a heterogeneous term, used for an array of challenging behaviours such as restlessness, agitation, wandering, vocalisations, resisting help with dressing and personal hygiene, and verbal and physical aggression. Although the use of the term BPSD is quite appropriate in social dementia research (e.g. caregiver burden), is such a heterogeneous amalgamation of behaviours, which may or may not be of psychotic origin, a justified end-point to study clinical efficacy of drugs, or do we need more specific symptom clusters as indications of antipsychotic use in dementia? Further, is the number needed to treat (5–11) for antipsychotic drugs for behavioural improvement in dementia[2] any different from numbers needed to treat for antipsychotic drugs in schizophrenia?[4]

Undoubtedly, from a clinical perspective, extreme care and caution should be exercised in prescribing antipsychotics in old age, especially for those with an underlying organic illness (e.g. dementia). Regarding the dilemma whether they should 'ever or never' be prescribed for patients with dementia, our point of contention is: (a) we cannot focus the debate only on the ethical angle to resolve this dilemma, there are several unanswered medical questions; (b) we cannot close our eyes to the caveats in existing safety and efficacy studies; and (c) we need to resolve the ambiguity surrounding the available evidence to empower us for an ethical as well as informed decision. More than ever, the dilemma is to arrive at certain indications for which we can use antipsychotics with relative safety.

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I agree with the views expressed by Treloar *et al*[1] regarding antipsychotic use in dementia. This is not only an ethical dilemma, but an issue of medical prescribing practice that has entered public and political domains. The present widespread use of antipsychotics seems to be unjustified but the emphasis should be on more rational use of these medications rather than an either/or debate. Our focus should be to develop policies and protocols which can lead to justified use of antipsychotics, with continuing reviews of the need for these medications. Their editorial is a step in right direction.

It seems that antipsychotic use in dementia is being demonised in the media.[2–4] Policy makers are also pushing for a decrease in their use. I have two issues with the direction this debate is taking us. First, I hope the pendulum does not swing