

The Need for a Complete Care Pathway in Schizophrenia

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Abstract.

We discuss the problems which have arisen because of the loss of the improvement in patients with psychosis which happens during the first three years after transfer of patient to community mental health teams. We recommend an ongoing psychosis service which will provide assertive treatment for patients as long as possible. Thus we recommend an assertive care pathway for schizophrenia based on the concept of staging in schizophrenia.

Keywords: care pathway, assertive treatment, schizophrenia, staging.

Early intervention services in psychotic illness has become an extremely important part of the Mental Health Services provided in the United Kingdom and other parts of the world. They were introduced as a result of the National Health Service plan about 10 years ago.

A number of studies have been carried out in order to assess the outcome of patients who have been treated within such services. These services operate when a patient has a first psychotic episode, is admitted to the service and is treated for a limited period of time, usually 3 years within the British system, before being discharged back to his General Practitioner or transferred to a Community Mental Health Team, should he continue to have mental health problems.

The majority of the studies on early Intervention have published findings based on follow up to three years. Notably, the LEO service published data over about 1½ - 2 years (1,2) and the OPUS study in Denmark has published data over 2 years (3). A study in Luton has published data over the full 3 year period; however, this was not actually a clinical trial but rather an audit in which the outcome of patients treated in the service was compared to the outcome of patients in a neighbouring area where there was no Early Intervention Team and instead care was delivered by the Community Mental Health Team (4).

The LEO (1,2), OPUS (3) and Luton studies (4) showed that there were improvements in the patient outcomes best demonstrated by the finding that patients were more able to return to work or education, more able to live with their families, more likely to continue to take medication and had fewer positive and negative symptoms of schizophrenia than patients who were treated in the usual way.

However, a problem arose when first OPUS (5) and then LEO (6) and even more recently the Luton Service (7) have published the data on how patients had progressed by the 5th or 6th years after the psychotic episodes. After patients are treated for three years in an Early Intervention Service, they are transferred to treatment in community mental health teams or indeed back to general practice. The improvement of the first three years appeared to have been lost once the transfer took place and the assertive nature of the intervention carried out in the Early Intervention Service ended.

Thus it has been reported by all of the studies that over 5 years, it appears that there is a loss of treatment outcomes. In the OPUS study, positive and negative symptoms increase by five years, although less patients were living in hospital and more patients were in accommodation such as hostels at the end of 5 years. The LEO study showed a loss of any improvement in admission rates at the end of five years, since both the group who had early intervention and the group that did not

appeared to have the same admission rates and the same number of bed days. It should be noted, however, that at least in this study there had clearly been a fall in the number of admissions in both groups over the years.

What also is of note is the fact that there is a fourth study which spans over 5 years. This is a Russian study in which patients were either treated assertively in an early intervention service with a great deal of psycho-education or were treated as usual both over the period of 5 years. It was clear that there were gains in the early intervention group in terms of continuing employment and education, continuing improvement and reduction in admissions to hospital which were maintained over the 5 years because of the assertive element had been continued (9).

All of this has led to reappraisal of the design of services for schizophrenia (10). It has been suggested that what is necessary is an ongoing service which continues to be assertive for as long as is necessary to keep the patient stable and maintain outcomes. This will mean that instead of transferring patients to community mental health teams at the end of 3 years, the early intervention service will continue to provide assertive treatment tailored to the needs of the individual over several years, thus becoming a continually assertive psychosis service which will treat patients with psychosis in the longer term. The study from Russia provides the first evidence for the development of such a long-term psychosis service.

Schizophrenia can be viewed as having a number of different stages; the prodrome, the first episode and then the ongoing illness (7,8,10). Each of these stages should be treated differently and has different expected outcomes. Treatment in the prodrome of psychosis would have as an expected outcome, the prevention of full psychosis. Treatment of the first episode would have as an expected outcome, the return of the patient to employment or education, whereas treatment of the ongoing "recovery or chronic phase" would have optimisation of employment and social inclusion of patient as the expected outcome. In order to achieve treatment of the phases as described above, the new psychosis service (10) would treat the patient throughout the course of the illness as described above, so that the service would provide a complete treatment pathway for the treatment of schizophrenia. Such a staging model for schizophrenia is supported by the anatomical changes described in another article in this journal issue.

Based on these factors, there is an argument for a care pathway for developing psychotic/schizophrenic illness with different interventions and different expected outcomes for each stage of the illness. This concept will be particularly helpful in directing resources to different points along the care pathway and also in terms of auditing the success of treatment at different points along the pathway against established expected outcomes for the appropriate stage of the illness. This is important for the treatment of both patients in the early stages of the illness, who need to be returned to work or education if at all possible, and of patients in the later stages of the illness, who are often otherwise left languishing at home with little social inclusion. A single care pathway as we have described will ensure that improvement in functioning and hence improved quality of life and 'recovery' will be a key focus in the treatment of patients with psychosis/schizophrenia.

Clearly, if such a care pathway was established as the model for treating psychotic illness, then there would have to be close cooperation between primary and secondary care, since primary care would carry out many of the key interventions in every stage of the illness, such as prescribing and physical health monitoring. General Practitioners and Commissioners would need to be aware of where each patient is on the pathway, what resources are needed, what the aims of treatment are, and what the expected outcomes should be.

GP comment

What have I learned from this paper?

1. Schizophrenia passes through various stages that need different interventions and have different expected outcomes.
2. A care pathway for schizophrenia can clarify what interventions are required at each stage and what the expected outcomes should be.

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