







History of the Treatment of Patients with Schizophrenia

- Up to the 18th century
 - Families without support, care in local community unless ostracised
- 18th – 19th century
 - Shift of care to large institutions / asylums
 - Increasingly overcrowded and deterioration in conditions



1900's



- 1949 – Lithium: First modern psychopharmaceutical agent discovered by John Cade in Melbourne

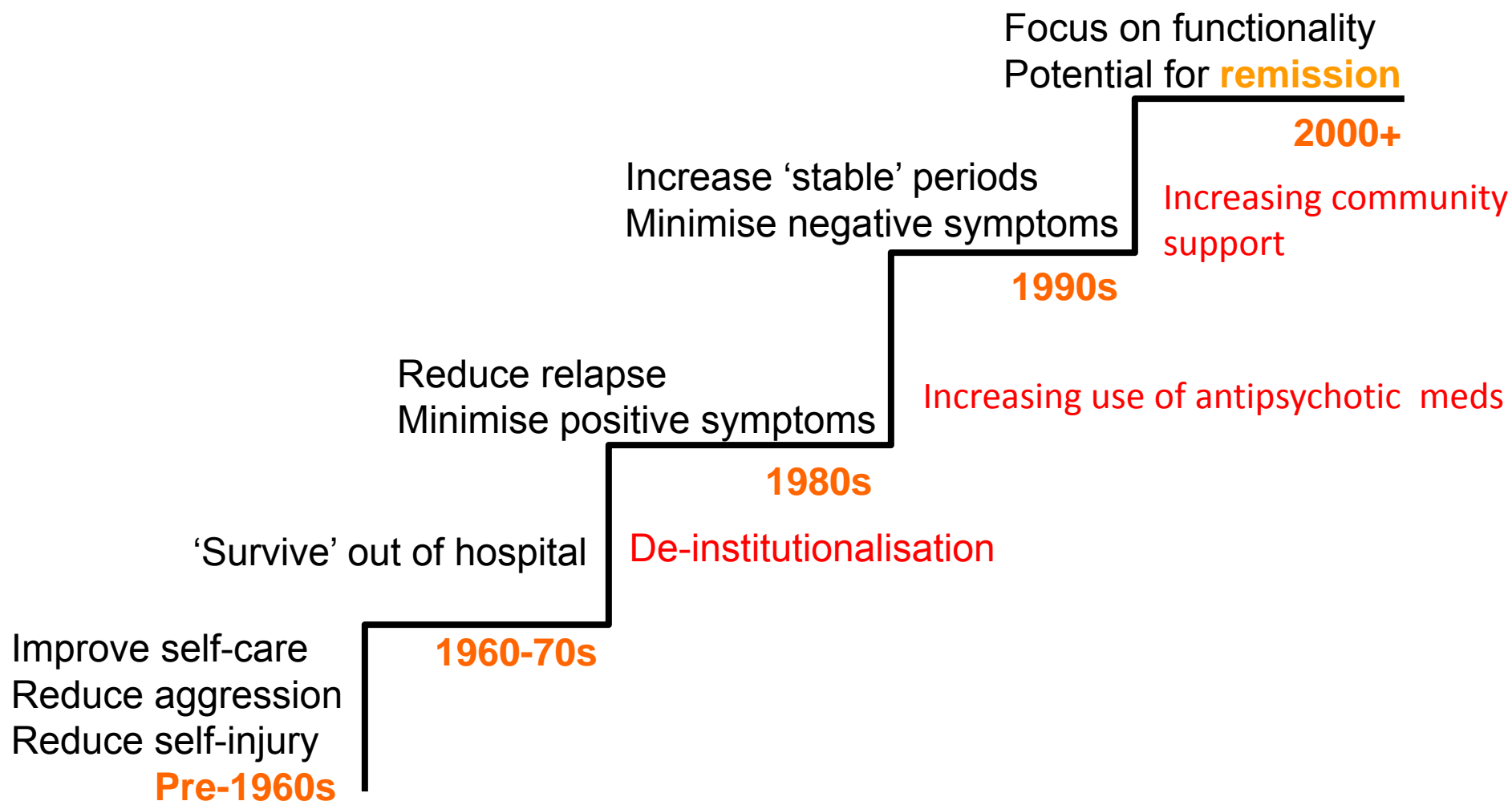


- 1950s – First antipsychotic and antidepressant drugs introduced
- Deinstitutionalization from late 1950's

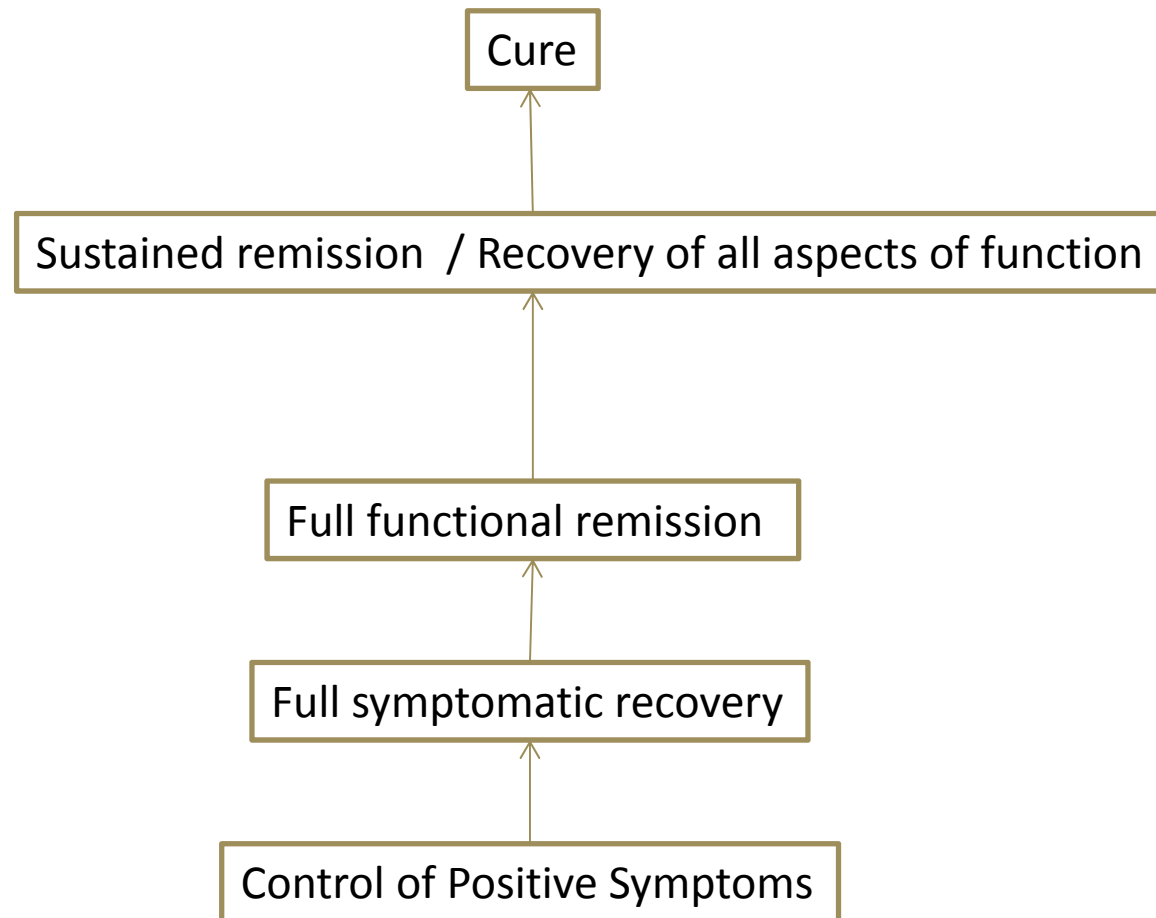
Impacts of Deinstitutionalization

- Increase in respect for patients rights but...
 - Frequently a failure to respect the rights of patients to access adequate treatment and support
 - Lack of support for families and carers
 - Inadequate shift of resources from institution to community based treatment

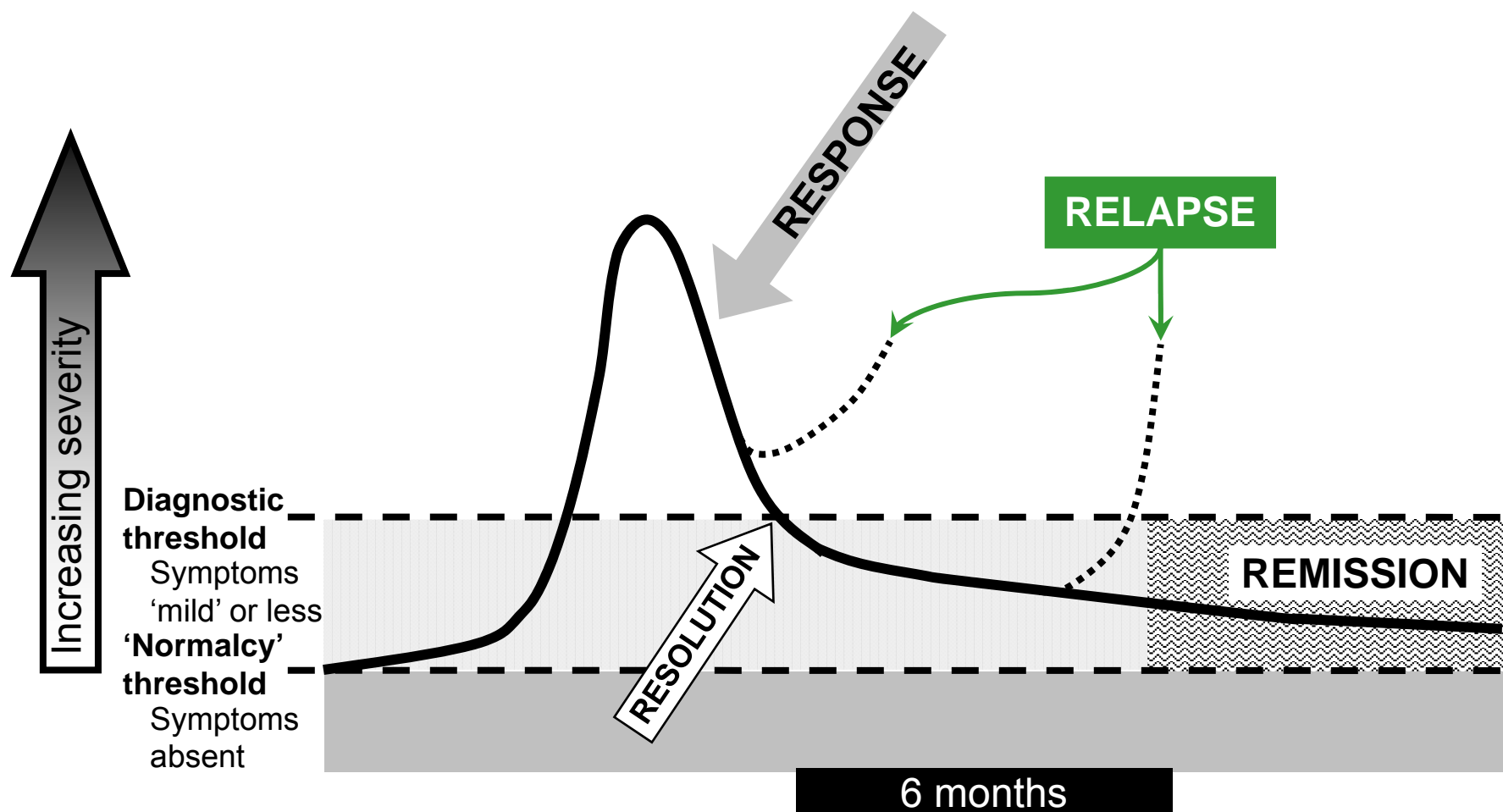
Historical Focus of Care



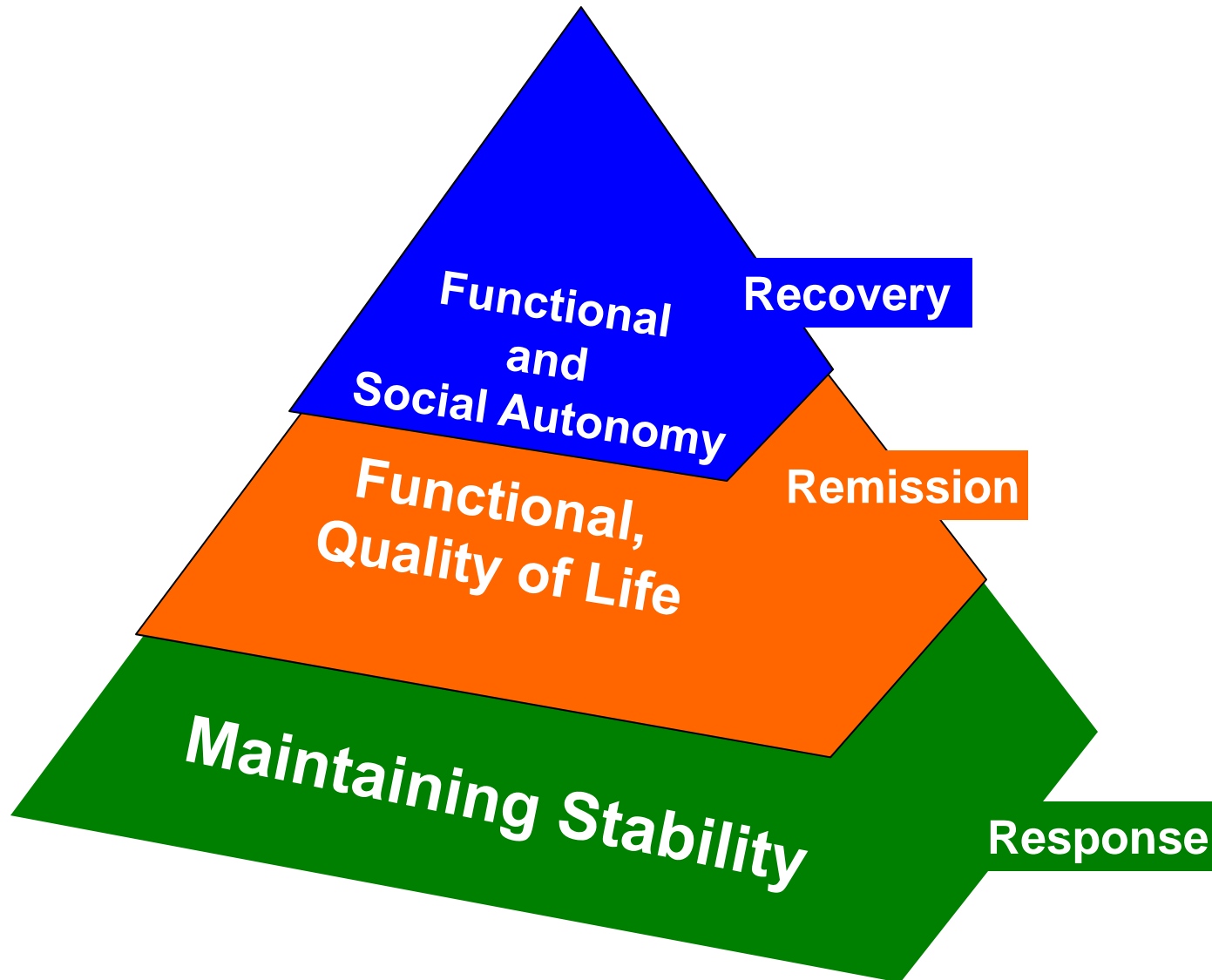
What should the goals of care be?



Remission in schizophrenia



Remission in Schizophrenia



How do we help achieve optimal outcomes?

- Early identification and intervention
 - Minimise accumulation of biological, psychological and social disability early in illness course
- Broad based individualised medical and psychological treatment
- Proactive family support (and family based intervention)
- Early supported employment reintegration

Treatment Challenges

- Illness related limitations to insight
- Stigma and discrimination
- Comorbid illness
 - Substance abuse
 - Depression
- Direct and indirect medical complications of illness and medications
 - Cardiovascular disease, NIDDM

Optimal medical management

- Availability of a wide range of first and second generation antipsychotic medications
 - Efficacy differences limited
 - Large differences in side effects – often most appropriate guide for choice of treatment
- Low dose, slow dose escalation strategies
- Active screening for and management of cardiac disease risk factors and diabetes
- Appropriate and early use of clozapine for treatment resistance

Psychosocial Treatment

- Social-skills training involves teaching behaviours to interact successfully with others
- Family therapy aims to reduced expressed emotion (hostility, overly critical)
- Vocational interventions
- Cognitive-behavioral therapy demonstrates that maladaptive behaviors and beliefs of some patients can be changed, can target treatment resistant positive symptoms

Families and Carers

- Families as a cause of psychosis –DISCREDITED
- The burden of care on families
- Families as a resource
- Families as a place for treatment
- Families as a focus for treatment

The Burden of Care

- Increased worry and strain.
- Emotional upset.
- Reduces social networks.
- Isolation, stigma & shame.
- Financial problems.
- Worry about the future.
- Loss.
- Anger.
- Guilt.
- Denial.

The Burden of Care

- Some symptoms particularly difficult for carers to cope with;
 - disruptive behaviour,
 - social withdrawal,
- Often a poor understanding of difference between illness behaviour and personality.

Cross cultural issues in EE research:

- Some evidence of cultural specificity
- High EE predicted relapse only if caucasian
 - (Kopelowicz et al (2002) & Lopez et al (2004))
- Negative behaviour must be seen in context: may be perceived as a sign of caring and concern in some families

Importance of early occupational re-integration

Patients with schizophrenia have high rates of

- Unemployment
- Homelessness
- Incarceration
- Experience of victim hood
- Poor physical health

Employment

- Critical component of:
 - Self identity
 - Social connection
 - Financial security
 - Physical health
 - Avoidance of involvement in crime (as perpetrator or victim)

Employment

- 75 - 90% unemployment among persons with serious mental illness in the U.S.
- 70 -84% unemployment rate for persons with schizophrenia in Australia: SANE (2002)

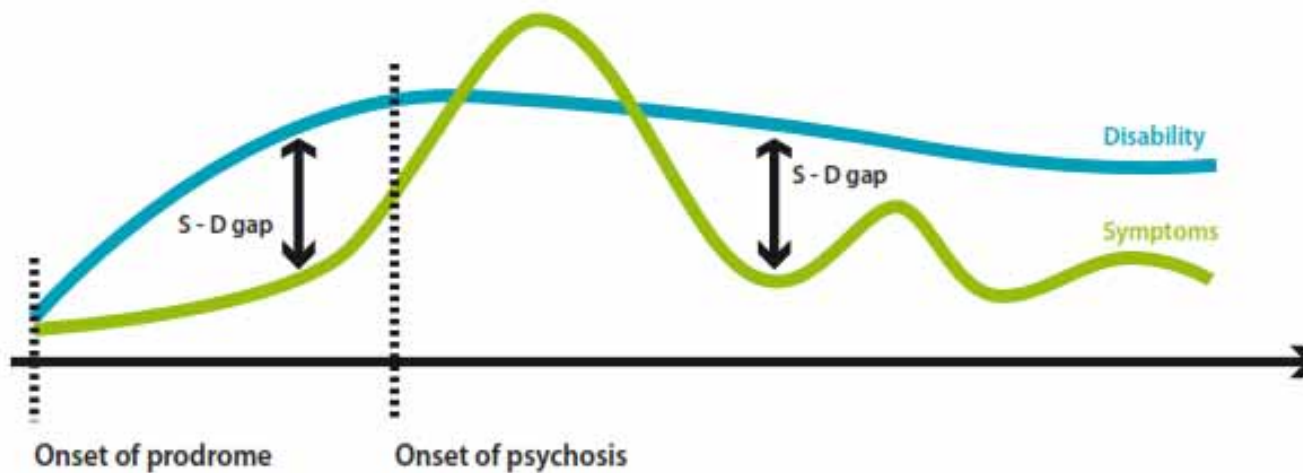
Employment

Supported employment approaches: Place and train / support

- job searching commences directly on entry into the program
- integrated with the mental health treatment team;
- jobs are chosen based on consumer preference;
- support unlimited in time – continues after employment is obtained and adapted over time
- Do this early
 - Young people more likely to be on a vocational pathway
 - At a stage where skill acquisition is age appropriate
 - Have less accumulated disability

Focus on Youth /early intervention

- Peak incidence of schizophrenia onset is in young people
- Disability accumulates progressively over time



Improving outcomes early

- Identify patients early
 - reduce duration of untreated symptoms
 - Reduce psychological, social and possibly biological impacts of persistent psychosis
- Provide age and illness stage specific models of care
- Explore possibilities for PREVENTION

Prodromal schizophrenia

- Pre-psychotic phase¹
 - Prodromal period
 - Change in thinking and feeling
 - Unspecific anxiety, depression; attenuated psychotic symptoms (late)
 - Social withdrawal
 - Impaired function
- Problem
 - Prodrome can only be diagnosed in retrospect
 - Can define an AT RISK MENTAL STATE (Yung et al)
 - Transition risk for At Risk Mental State not 100%²
 - 18% after 6 months
 - 22% after 1 year
 - 29% after 2 years

¹Klosterkoetter et al. Dtsch Arztebl Int 2008;105:532.

²Fusar-Poli P. Arch Gen Psychiatry 2012;69:220.

Reducing Duration of Untreated Psychosis (DUP)

- Social toxicity of being psychotic
 - Stigmatization
 - Loss of job
 - Interrupted schooling
 - Loss of friendships
 - Loss of family support
 - Criminal record
 - Accidental death
 - Accidental homicide
- Depression, demoralization

Reducing Duration of Untreated Psychosis (DUP)

- Prolonged DUP
 - Poorer response to initial treatment
 - Worse longer term outcome
- However:
 - DUP can be reduced (e.g. TIPS program)
 - Reduced DUP results in improved clinical outcomes at baseline, 2-year and 5-year follow up
 - *Sustained* information campaign is key

Stage specific treatment: Clinical staging

STAGE	DEFINITION
0	Increased risk, no symptoms
1a	Mild/unspecific symptoms
1b	Moderate but subthreshold symptoms
2	First episode of illness
3a	Incomplete remission
3b	Recurrence
3c	Multiple relapses
4	Unremitting illness

McGorry 2006, McGorry 2009



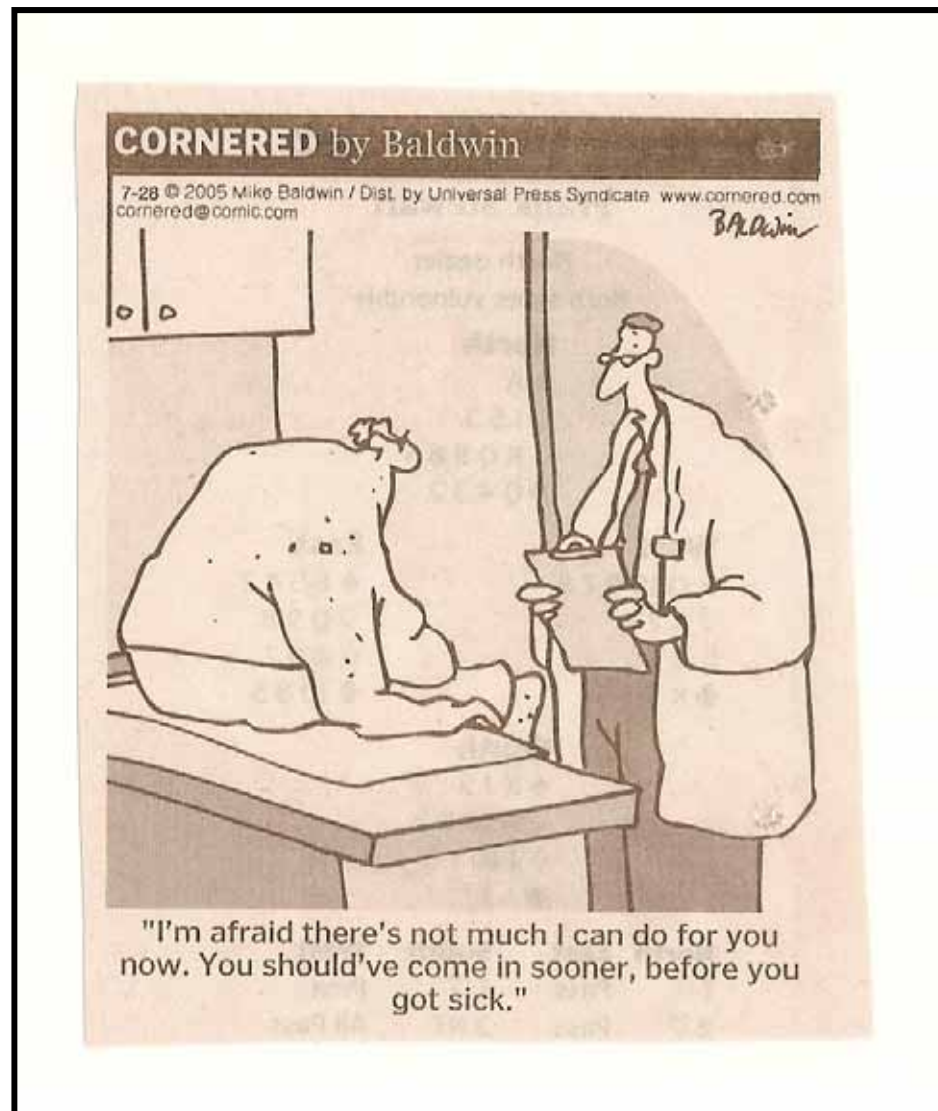
Age and illness stage specific services

- EPPIC model
 - 24 hour home based care and assessment
 - community education and awareness programs
 - easy access to acute and sub-acute services
 - continuing care case management
 - mobile outreach
 - medical and psychological interventions
 - functional recovery, group, family and peer support programs
 - workforce development
 - youth participation

Aims of an Early Intervention service

- Reduce delays (& DUP) by:
 - promoting early detection and collaborative engagement in the community
- Optimise assessment & diagnosis by:
 - Comprehensive Bio/psycho/social assessment
- Maximise recovery by:
 - providing integrated bio/psycho/social community Rx
 - focus on *functional* as well as symptomatic factors
 - addressing co-morbidity and treatment resistance early
- Prevent relapse by:
 - ensuring assertive follow up and psychoeducation during critical period

Prevention



Indicated prevention trial

12 weeks

700 mg EPA

480 mg DHA

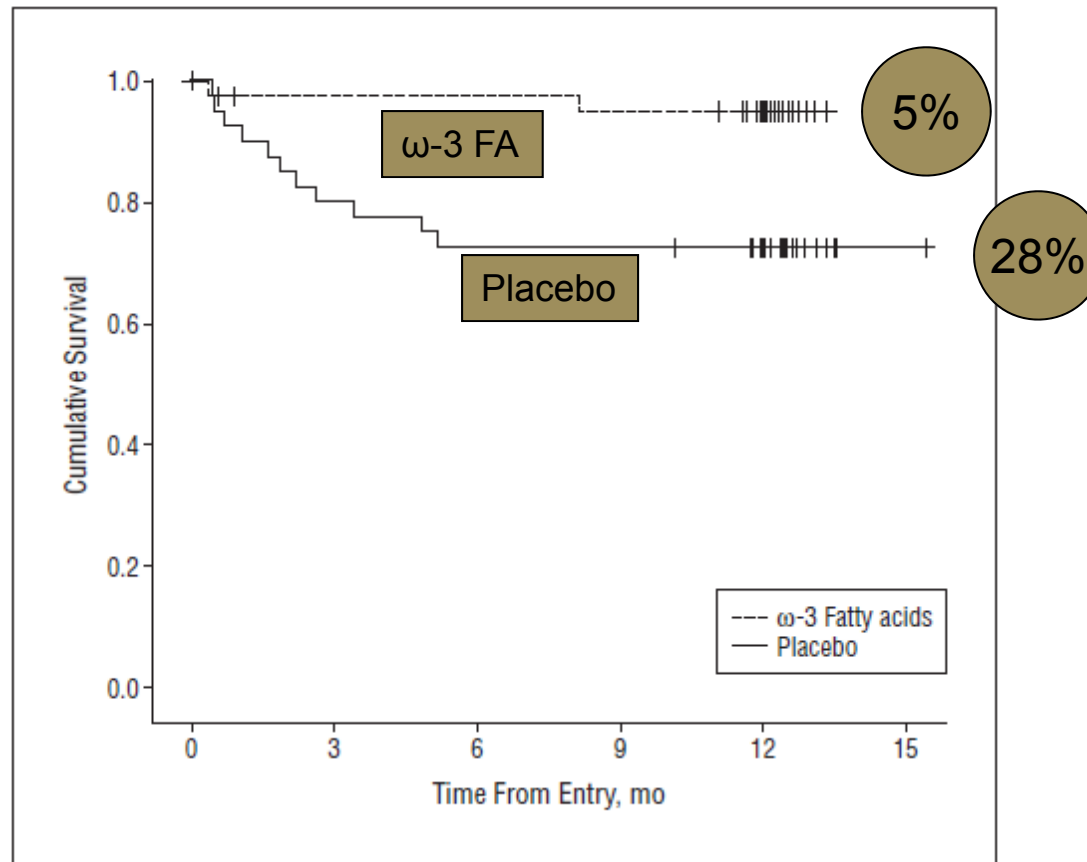
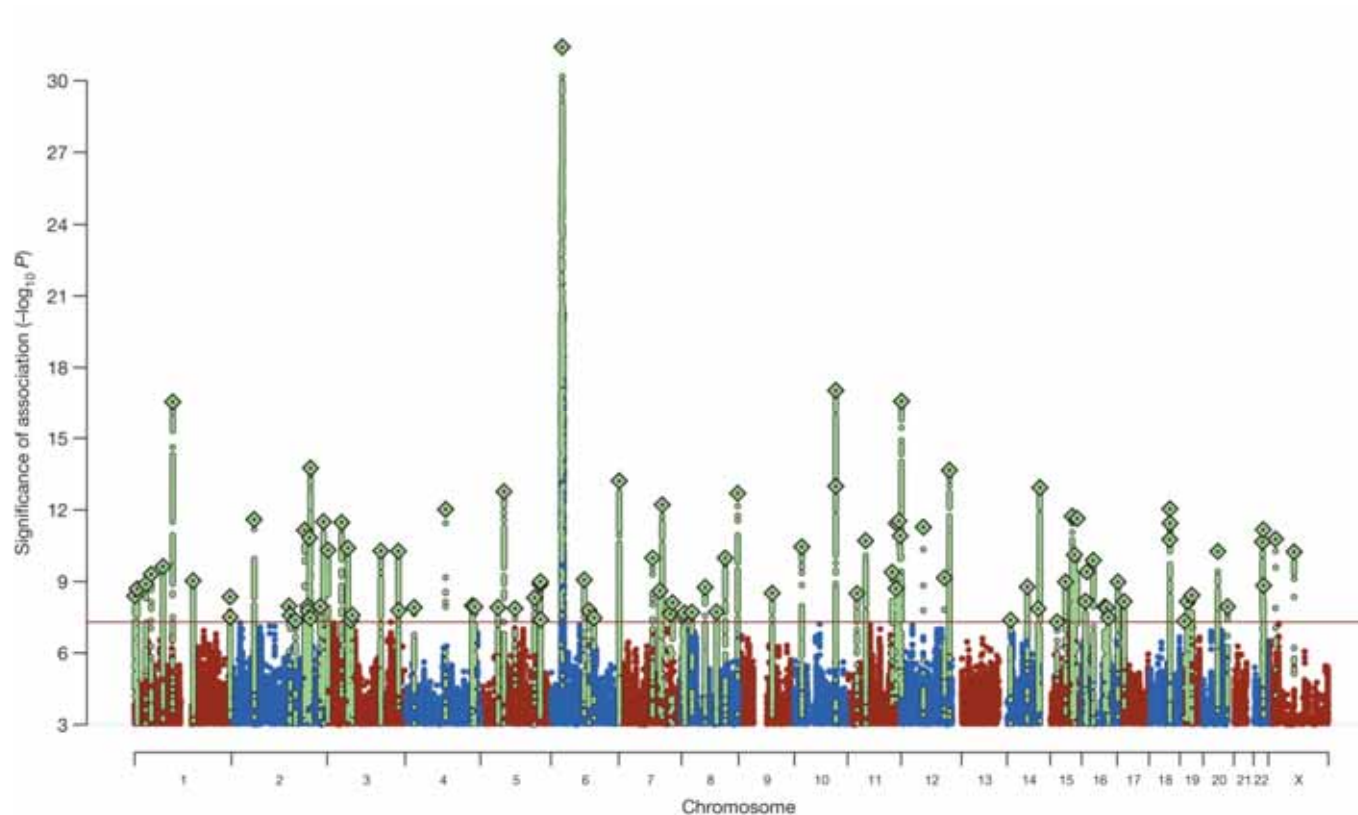


Figure 2. Kaplan-Meier estimates of the risk of transition from the at-risk state to psychotic disorder in patients assigned to ω -3 fatty acids or placebo ($P=.007$ by log-rank test).

Prevention might be possible, what about cure?



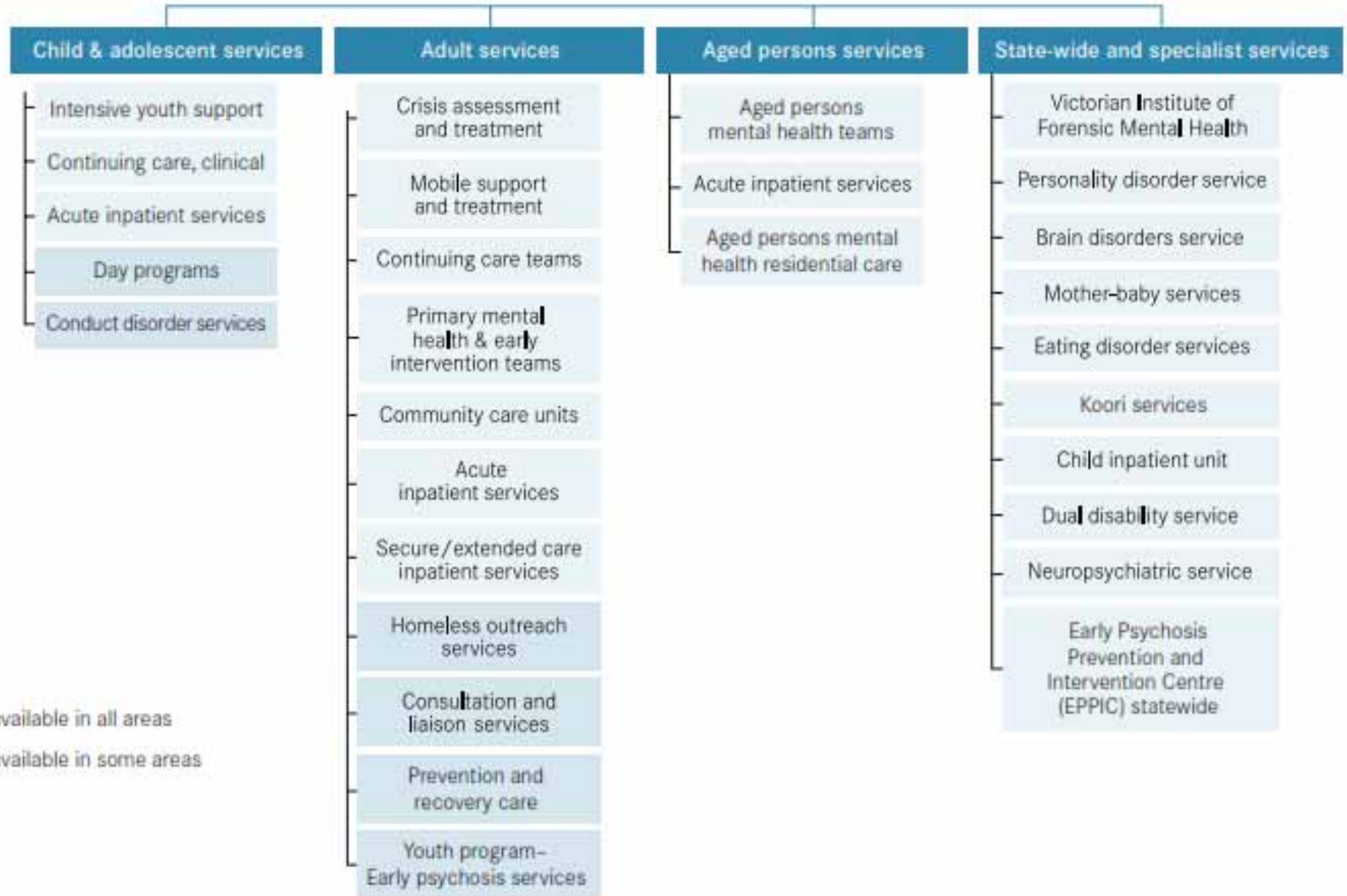
36,989 cases and 113,075 controls. 128 independent associations spanning 108 loci

S Ripke *et al. Nature* **000**, 1-7 (2014) doi:10.1038/nature13595

What should a Mental Health System
look like in 2014?

Clinical

The Victorian System 2014



Psychiatric disability rehabilitation and support services



Victorian MH System: Core components

- All services
 - Mainstreamed
 - Located with and managed by general hospital services
 - Universal
 - Geographical boundaries

Victorian MH System: Core components

- Inpatient beds
- Crisis assessment – community assessment and assertive acute management
- Low intensity and high intensity case management
- Community care (residential) units – 24 hour staffing

Victorian MH System: Recent Innovations

- Primary mental health teams
- Step up / step down units

Victorian MH System: Recent Innovations

- EPPIC / ORYGEN
- Headspace



Components of Early Intervention

- Public campaign to reduce stigma, increase mental health literacy and illness awareness
- Responsive and youth friendly front end of services – non stigmatised environment
- Treat symptomatically – psychosocial focus

Challenges

- Maintaining funding of core services whilst developing specialist programs
- Balancing provision of care for”
 - Early intervention – early stage illness
 - Provision of long term care and rehabilitation for patients with established illness
- Ensuring service developments are supported by adequate evaluations

Conclusions

- Schizophrenia can be a debilitating disorder with profound effects on patients and their families and carers
- There are ways to optimise care for patients with schizophrenia in 2014 that go well beyond established service models
 - These require comprehensive specialised programs to optimise biological, psychological and social treatments
 - We should also focus on the potential for early intervention and services based on a better understanding on the needs to patients at various life stages

Conclusions

- Service innovation need to occur without comprising established services for patients
- Service innovation should target both
 - Early intervention *AND*
 - Enhanced rehabilitation – community reintegration (*no patient left behind...*)

The Challenge...

- To design a mental health service for 2030
- To leap frog the 'best of the rest'
- To be culturally informed, universal and age / developmentally specific

The Gaps in Mauritius / Where to Start?

- Community based outreach
 - Early intervention and family based assessment and treatment
 - Support for continuing care / treatment
- Services for children and youth
 - Child and adolescent psychiatrists
 - Youth friendly mental health programs
 - Across departmental child welfare agency
- Population mental health literacy / stigma reduction (as a role of government as well as NGO organisations)
- Residential slow stream rehabilitation and supported accommodation services
- Further public health measures to reduce alcohol availability
- Develop and support academic departments in psychiatry and other mental health disciplines – development of clinician researchers