

The RANZCP guidelines for Schizophrenia: Why is our practice so far short of our recommendations, and what can we do about it?

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Abstract

The new RANZCP guidelines for the treatment of schizophrenia and related disorders highlights what we know works. In this paper, we examine why patients so often fail to benefit from this knowledge and why clinical practice falls so far short of the recommended standard. Instead of the continuous improvement that we expect of health care in general, in psychiatry we face an accelerating decline in systems of care. There has been a sustained underinvestment in public mental health care and a shared failure by State and Federal governments to construct and commit to a governance and funding model that can deliver the standard of care that is available in other major non-communicable diseases, and which we know is equally possible for severe mental illness. This paper sets out some of the reasons for the poor quality of care received by many people with schizophrenia and related disorders in Australia, and describes ways that care could be improved. In particular, we recommend an explicit statement of what constitutes an adequate standard of care, for people at all stages of these illnesses. This would help provide transparency about whether the care provided by mental health services achieves these benchmarks, and enable publication of results comparing the performance of different states and regional services. Patients and families, as well as professional, consumer and carer organizations would then be able to see clearly where the deficits are and demand resources and care that match the recommendations.

Keywords

Psychiatry, schizophrenia, services, guidelines, mental health

The parlous state of public mental health services

The publication of updated Royal Australian and New Zealand College of Psychiatrists (RANZCP) guidelines for the treatment of schizophrenia and related disorders (Galletly et al., 2016) raises the question: Why is our treatment of these disorders so far short of the recommendations contained in the guidelines? Patients, families and health professionals are all too aware that people either cannot access expert care at all, or receive delayed, time pressured and inadequate expert care for serious mental illness. Many become dangerously ill before receiving treatment, and the

care they then receive is usually short term, provided by over-stretched staff and often does little to address long-term disability. A walk through the centre of any one of our large cities at night reveals many people sleeping in the open who are obviously affected by psychotic disorders. A conversation about the mental health system with any policeman or magistrate quickly turns to the frustration of having to deal repeatedly with untreated mentally ill offenders. Trainee psychiatrists in our public hospital system live with the stress of having to find beds for patients who cannot be turned away, which often requires gambling on the discharge of an incompletely recovered patient, and hoping that the outcome is not a

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disaster for the patient and for the service. Making rapid decisions about the risk of an adverse outcome, based on very limited information and with few safe options, is part of the working life of psychiatrists and trainees in acute services. There are regular preventable tragedies from deficiencies in our mental health system. How have we come to this sorry state of affairs?

Errors of history

The situation in Australia mirrors the 'perfect storm' described in 'American Psychosis', Fuller Torrey's dystopic history of the treatment of severe mental illness in the United States (Torrey, 2013). We had the same decay of the Victorian era asylums, with overcrowding, long-term loss of liberty and abuse of patients. We had the same hasty deinstitutionalization to an unprepared and under-resourced community based system of care. We had the same tragic experiment with mental health laws that required patients to be dangerous to themselves or to others before they could receive involuntary treatment, effectively raising the threshold for receiving care for many patients. We have witnessed the same struggle between the fiscally dominant national government, responsible for much of the non-hospital care, and state governments, responsible for hospitals and related community services, which has created a vacuum, leaving people with severe forms of mental illness without access to consistent expert care. State governments in particular have seriously underinvested in public mental health services, and failed to meet rising demand from population growth (Duckett et al., 2016).

A series of National Mental Health Plans and other reports have been exercises in rhetoric and restructuring, the latest of which embraces the ideal of stepped care, but with vital steps to provide comprehensive care unfunded and missing. Large investments in non-government organizations (NGOs) at

the expense of public mental health services has led to further fragmentation of roles and responsibilities. Furthermore, the ongoing lack of synergies at a policy, governance and clinical level between drug and alcohol services and mental health services has resulted in a lack of coordinated longitudinal care for people with these complex comorbidities. Finally, we have the impasse of trying to improve the human rights and choices of people with mental illness, while operating in a system that continually raises the bar for access. Most of those who receive acute treatment have passed the stage of having the insight and capacity to recognize the need for treatment, to the extent that involuntary treatment is the only option. Chronic underinvestment in services makes late intervention the only option, despite all the rhetoric and evidence demonstrating that early intervention is cost-effective.

'Bending the Curve'

The former Director of the US National Institutes of Mental Health (NIMH), Dr. Thomas Insel, during his term of office, repeatedly pointed to the examples of cancer and cardiovascular disease, where he highlighted the success in 'bending the curve' in mortality and morbidity. He came to see that the failure to achieve similar successes in mental health was not due to the failure to discover new mechanisms of illness and new treatments, but to a comprehensive failure to implement what we already know. In cancer and cardiovascular disease, there has been a balanced effort in prevention, early diagnosis and sustained delivery of evidence-based care, including palliative care, for as long as it is needed. In the treatment of schizophrenia, while the evidence exists to support the same set of strategies, none of them are routinely applied. Prevention is weak, early intervention remains piecemeal, and consistent guideline-adherent care over the long term is unusual. To use Dr Insel's analogy, the curve remains unbent, with

employment rates in the basement and a gap in life expectancy of about 15 years (Hjorthøj et al., 2017).

Early intervention

There is considerable evidence supporting the value of reducing the duration of untreated psychosis (DUP) and guaranteeing comprehensive, multidisciplinary treatment for first episode psychosis (FEP) and the 'critical period' of the first 2 years of illness (Kane et al., 2016; Nordentoft et al., 2014). There has been some disagreement about the extent of the advantage conferred by specialized FEP care, but given that it is clearly better in the short to medium term (Nordentoft et al., 2014) and also more cost-effective (McDaid et al., 2016), it should be universally available across Australia.

A further challenge is to maintain the initial beachhead that early intervention has established in the substantial subset of patients who need more than sparse, intermittent and reactive care. For those who do benefit from specialized early psychosis care, transition to standard community mental health care often means that the same level of psychological and social intervention is no longer available, one reason that many of the gains achieved through specialized FEP treatment may be lost (Nordentoft, 2014).

Treatment delay, especially in the early stages of illness, entrenches abnormal beliefs, hampers recovery and increases the risks to the patient and to others (Nielsen et al., 2012). Yet despite the fact that reducing the DUP can double the rate of recovery over the first 10 years (Hegelstad et al., 2012), DUP has yet to be adopted as a performance indicator in Australian mental health services, as it has been in the United Kingdom and in Norway. Building on the Norwegian TIPS data (Hegelstad et al., 2012), the major US NIMH-funded RAISE study has shown that specialized early psychosis care is only more effective than standard care if the DUP is under 74

weeks (Kane et al., 2016). We would not be so complacent about treatment delay in young patients with cancer, and there is no way a young person with cancer would be discharged from care and lost to follow-up before they had received optimal care for the necessary period, however long that might take.

Overcoming therapeutic nihilism and extending therapeutic optimism

Schizophrenia can be a frustrating condition to treat in under-staffed and distressed services. Dismay over the lack of insight and cooperation, continued substance use and the severe disability of the chronic forms of schizophrenia can create a 'clinician's illusion' of poor outcomes. The early intervention and recovery movements have sought to challenge therapeutic nihilism, backed by outcome data, but wider application of those models of care has been limited by poor service design and lack of comprehensive rehabilitation services. Even simple interventions, such as assistance finding secure supported housing and continuous integrated treatment, might lead to substantial improvements in the course of illness and in the ability to benefit from other services over time. A related source of neglect is the continuation of treatment as usual in patients who are 'settled' in their behaviour, with minimal immediate risk and not demanding much from services, even if they are lonely, disabled, with declining physical health and a low level of social function. There is pressure to discharge such patients from community services, rather than to undertake a comprehensive review, implement more effective management and maximize recovery. Reducing the variability of care and extending the therapeutic optimism and comprehensive recovery-oriented treatment seen in our best services, which are usually teaching hospitals in higher

socio-economic areas, to all services is a major challenge.

Discontinuity and fragmentation of care

Community mental health services are increasingly discharging patients with enduring illness once they are 'stable', even though the management of chronic schizophrenia relies very much on an ongoing therapeutic relationship and the development of a habit of adherence to treatment. Refusing to accept or retain patients rated as mild to moderately unwell, usually means they come back later more severely unwell. Long-term care of stable patients is relatively inexpensive in comparison to dealing with the costs of acute relapse. Many patients will not seek treatment of their own volition, especially if services are unwelcoming, passive, preoccupied with more acute cases, and have a high turnover of staff.

Discontinuity and fragmentation are apparent in the lack of coordination of physical and psychiatric care, and the continuing division between mental health and substance use services. Self-defeating substance abuse by people with schizophrenia is a major source of therapeutic nihilism and a common cause of treatment failure. The use of alcohol, cannabis, stimulants and tobacco as self-medication for distressing symptoms is so ubiquitous as to be almost ignored in many therapeutic settings. Research into the treatment of comorbid substance use has been given a low priority and addiction medicine services have been run down or replaced by NGOs that often do not have the expertise to manage comorbid schizophrenia and substance abuse.

The rise and rise of forensic psychiatry: the default option

The sight of shiny new forensic wards set in the grounds of crumbling

Victorian era asylums has become common throughout the western world. The irony is that those units contain the 'lucky' few, who often receive state-of-the-art rehabilitation, and in many cases never have another episode of psychosis and never re-offend (Hayes et al., 2014). In a classic '*ambulances at the bottom of the cliff*' scenario, forensic hospitals receive an ever-increasing share of the mental health budget. Even so, most mentally ill offenders do not get the benefit of such sustained and comprehensive rehabilitation, and are instead crowded into our new asylums, the prisons, where the prevalence of schizophrenia is at least 10 times that of the wider community (Nielssen and Misrachi, 2005). Many of the offences that resulted in imprisonment might have been prevented by community care, and continuous care reduces recidivism and saves money (Lin et al., 2015); these savings could then be invested in better preventive care.

Lack of meaningful occupation and employment

The RANZCP guidelines for the treatment of schizophrenia and related disorders (Galletly et al., 2016) emphasizes the importance of vocational rehabilitation, and people with schizophrenia themselves say that one of their most pressing goals is to continue to work or return to work (Waghorn et al., 2012). Yet, the rates of unemployment for people with psychotic disorders are extremely high, even when the employment market is relatively favourable. Individual Placement and Support (IPS) is an evidence-based strategy which enables up to 90% of early psychosis patients and 30–40% of patients with later stage illness to find and maintain employment (Killackey et al., 2006). However, it is simply not available to the vast majority of patients, a failure of public policy and of the translation of clear evidence into routine care that verges on negligence.

Lack of supported accommodation

In some busy inner city services, the 'recovery model' means restoring the patient's autonomy by returning them to the street, often within hours of arrival and after a change in diagnosis from schizophrenia to antisocial personality disorder and drug induced psychosis. There is a severe shortage of affordable accommodation with the kind of supports that help patients recover, which might in turn break the cycle of readmission or re-offending. 'Housing first' programmes have been shown to improve adherence to treatment and reduce hospital admissions, yet are not routinely available (Rezansoff et al., 2016).

Leadership in psychiatry

Craddock et al. (2008) describe a creeping devaluation of medicine and psychiatry in mental health services in the United Kingdom, with focus on costs and risks that has seriously eroded quality of care and service morale. The tendency of managers to 'manage up', to disguise neglect and to make services look good to those above them, rather than to 'manage down', to ensure that services are actually running well, means that outspoken and non-conformist psychiatrists are particularly unwelcome. Loss or down-grading of clinical leadership has led to learned helplessness or flight of experienced psychiatrists into the relative autonomy of private practice. The lack of clinical leadership has contributed to the low productivity of many services, from delays in arranging expert assessments and initiating treatment plans to low morale in general.

Towards an adequate standard of care

Where do we start in encouraging the implementation of our new guidelines to provide better treatment for all patients with schizophrenia? A good start would be a clearer statement

about what constitutes an adequate standard of care, with reference to the evidence-based recommendations for each stage of illness. Systematically auditing the performance of services against the recommendations in the guidelines, and perhaps publishing the results in the same way that surgical waiting lists are published, would be one way of measuring the unmet need in mental health services. It would also tell us where and why the gaps exist and what we could do about them. Auditing our practice could help establish a culture of measurement of outcome and the harnessing of data to improve patient care, rather than for risk management and organizational goals. We know that the routine care of people with schizophrenia falls well short of the recommended standards, but we do not know precisely how far or how often, because we do not routinely audit our care against established standards and outcome measures. Data such as levels of clozapine use, and the proportion of people with schizophrenia receiving cognitive behaviour therapy, family therapy or psychoeducation, can be relatively easily collected and compared. Improvement in the clinical usefulness and accessibility of electronic record systems including information sharing with other services, could improve the efficiency of care and the productivity of services.

There is an urgent need for a funding model that provides for a spectrum of inpatient and other residential services and especially community mental health care, which takes into account the growth in Australia's population and other measures of demand for services. The lack of a robust financial model for integrated community mental health care has allowed services to recede back into a defensive posture, in which all new referrals are unwelcome and inadequate care can be justified by the needs of other patients. The missing middle steps of stepped care need to be built into the funding model, with a clearer statement of

the responsibilities of the states and the Commonwealth.

A greater supply of purpose built supported housing is crucial to help overcome the physical danger and neglect of homelessness, and the loss of continuity of care that goes with not having a fixed place of abode. Most homeless patients come indoors when suitable accommodation is available (Tulloch et al., 2012), and the requirement of pre-payment of rent would reduce the diversion of income to fund substance use (David et al., 2016).

There is also a clear need to attract experienced psychiatrists back into the public system, to oversee treatment decisions, use their authority and influence to secure the best outcome for each patient, and to set an example for the next generation of clinicians. Re-engaging senior psychiatrists in community care might improve the continuity of care for long-term patients, who see a different trainee every few visits and rarely meet a senior psychiatrist.

Leadership in psychiatry, fully supported by professional organizations and with academic independence, is crucial to overcoming therapeutic nihilism. Psychiatric leaders in mainstreamed health systems need to organize themselves to advocate collectively for a greater share of resources for their patients, who often miss out when there are other priorities in the health system. Academic clinicians have a particular role to play in enhancing service delivery. This group is threatened with extinction through lack of security of tenure, erosion of university funding, poor pay, the obsession of universities with their international rankings often to the detriment of clinically focused research and a consequent failure to develop the next generation of clinical academics (Henderson et al., 2015).

The right of patients to an adequate standard of care needs to be championed by all our professional organizations and peak bodies, who can be fairly accused of viewing their

responsibility to be to act in the interests of providers, rather than patients. We should insist the RANZCP explicitly states that a key duty is to advocate for patients, as well as looking after the interests of psychiatry as a profession. The standard of care set out by the guidelines could help consumers and carers identify where treatment falls short of the recommended standard, and allow them to demand comprehensive care.

Declaration of Conflicting Interests

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