

Improving care, reducing the burden

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The conclusion from a meta-analysis of studies of the economic burden of schizophrenia was that the enormous burden is suggestive of the inadequate provision of healthcare services to patients with schizophrenia.¹ Better resource allocation and policy-orientated research is seen as a solution to this problem. The article in this *New Zealand Medical Journal*² provides an excellent summary of current state of play in New Zealand. It highlights the health, social and economic outcomes for those with the disorder.

Recent exploration of what matters for people with schizophrenia highlighted the need to feel safe, the opportunity for employment, access to good healthcare support and having meaningful social relationships.³ These factors were very similar to findings of a local (unpublished) review of the long-term outcomes for people who have been through our anti-psychotic treatment trials.

The age of the institution may have passed but the messages emerging from work such as that of Sheree Gibb et al² might be that we still have a long way to go to deliver healthcare, social and occupational supports to people with schizophrenia that does not disadvantage them or stigmatise them.

There are good guidelines for the treatment of schizophrenia.⁴ I suspect the problem is that we do not deliver according to these best evidence-guided recommendations.

The time between onset of symptoms and beginning treatment remains disappointingly high. We are used to strong pushes for the early identification of cancer because there is strong evidence that early detection and appropriate evidence-based interventions significantly alter the disease course. We do not see such initiatives for psychosis. An elegant Scandinavian study which was set up to examine differences with true early

detection of psychosis showed that early treatment for first psychosis had positive effects on clinical and functional outcomes.⁵

Reasons for delay include the stigma attached to any diagnosis of a mental illness, and especially to that of schizophrenia. It is also well recognised⁶ that the disorder itself causes a lack of awareness of the symptoms (anosognosia), such that an individual experiencing psychotic symptom will not have awareness of these. We have a long way to go the shift public attitude towards mental illness and to create safe environments where the young people experiencing their first episode of a psychotic disorder (illness onset is typically late adolescence to early adulthood) can present. They will often be reliant on family or close friends to assist them recognise a problem and seek help for it; thus the point of care needs to be user friendly for these support people also.

Though I do not have the data to support my clinical impression, it is likely that many presentations with schizophrenia are in crisis situations where there are concerns about the risk of the person with the disorder. They do not get seen in primary health settings, where one would ideally want an illness like this to be assessed and treated. By the time they present there is usually considerable disruption in their lives; relationships are challenged or disrupted; usual occupation or education and recreational pursuits have ceased. This loss of the usual social supports will coincide with a time of immense personal angst; the traumatic experience of identity dissolution, boundary loss and the like should not be underestimated. One only has to consider what it must be like to have some sinister voice that continues to berate you or threaten you; then, if you are brave enough to mention it to others, you then get told they cannot hear the voice—how do you assimilate that?

For my goal of dedicated public health campaigns that target early identification of and rapid interventions for those at risk of schizophrenia, it will be necessary to address the pervasive public prejudice and discrimination. This is no simple task and the available worldwide evidence of success for anti-stigma campaigns for mental illness is not reassuring.^{7,8} Strategies are generally described as contact with consumers, education campaigns and social activism and protest. Both contact approaches and education campaigns do have small to medium effect sizes. There is no study of social activism approaches.

I am hopeful that dissemination of the costs of schizophrenia, both to the people who experience it and to the population as a

whole, might stimulate people in influence to take the challenge to address the public health importance of reducing stigma, thereby enhancing the possibility of early access to best evidenced treatments.

Why we want to treat early and maintain good treatment is because it not only produces better outcomes regarding illness experience and function, but because it is also linked to arresting (and perhaps improving) loss of cortical matter⁹ and decreasing the effect of schizophrenia on reducing life expectancy.¹⁰ A German study¹¹ carefully reviewed the achievement of remission (using well defined criteria¹²) and suggests there is good reason for expectation of positive outcome from good treatment.

Competing interests:

Nil.

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