

Schizophrenia as a Lifelong Illness: Implications for Care

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The management of schizophrenia has advanced considerably since the term was first coined in 1911, with Kraepelin's early pessimism tempered by more recent evidence examining outcome.¹ The discovery of antipsychotics represented a major breakthrough in the treatment of schizophrenia, while more recently we have witnessed promising initiatives such as the early intervention and recovery movements.

The early intervention initiative began in the 1990s, premised on the notion that reducing duration of untreated psychosis (DUP) through early intervention would translate to better long-term outcomes. There was evidence already in place to support this rationale; for example, the International Study of Schizophrenia (ISoS) had reported that initial 2-year course patterns were the strongest predictor of 15-year functional outcomes.² Evidence since has, indeed, confirmed that early intervention leads to improved 1- and 2-year clinical and functional outcomes,³ as well as cost-effectiveness in the first 18 months.⁴ However, recent reports on longer term follow-up of the early intervention cohorts paint a different picture, noting no differences in course of illness or a diminution of early gains compared to those who did not receive early intervention.^{5,6}

Further to this point, when we compare studies examining the clinical course of schizophrenia before and after the adoption of early intervention, the proportion remaining symptomatic appears similar (Table 1). Results from the OPUS trial, a landmark trial comparing early intervention versus treatment as usual in Denmark, showed that 3 years after a 2-year early intervention programme, there were no significant differences in the symptomatic proportion between early intervention and treatment as usual groups (59% vs 57% respectively).⁷ In a follow-up study of the same cohort, stable rates of symptom remission and recovery were reported at 2-, 5- and 10-years, again with no differences between early intervention and treatment as

usual groups.⁵ When we examine recovery rates between ISoS, EPPIC (Early Psychosis Prevention and Intervention Centre in Melbourne, Australia), and OPUS, results are similar; 16.3% vs 14.9% vs 14%, respectively.^{2,5,8} Despite perceived advances in the care of schizophrenia, a recent meta-analysis reported no significant increase in rates of recovery for schizophrenia over the past 60 years.⁹

As important as it is to be optimistic, it is also essential that we remain realistic and these findings cannot be ignored. Antipsychotics and early intervention have fundamentally changed the way we manage schizophrenia, but they are by no means panaceas.^{6,10} Evidence indicates that the illness has varied outcomes ranging from a single episode with full recovery to a chronic deteriorating illness course; however, for the large majority, schizophrenia is a chronic and lifelong condition^{11,12} exacting significant burden beyond the initial years following diagnosis.¹³

Also arising from the early intervention work has been the notion of 'clinical staging' for schizophrenia, with 3 major categories (at-risk; first-episode; incomplete response), each with specialised care services.¹⁴ While such an approach has advantages in understanding the illness, its progression, and need for different treatments, it also runs the risk of fostering a silo approach to care that belies the illness' chronicity. Challenging management issues (e.g. continued service engagement, treatment adherence, medication side effects, suicide and comorbid psychiatric disorders) persist for schizophrenia's duration, with new challenges such as treatment resistance and chronic medical conditions frequently arising over time.^{15,16}

The World Health Organisation (WHO) defines a chronic disease as one that is of long duration and generally slow progression (e.g. diabetes mellitus). Arguably, labeling schizophrenia as "chronic" connotes pessimism and ignores that subgroup who demonstrates a good outcome;¹ however, for many this is not the case and for others they move in and

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Table 1. Comparison of Course Types and Recovery Rates for Studies on Schizophrenia in the Pre-early Intervention (ISoS) Cohort, the Early Intervention Cohort (EPPIC) and in a Randomised Trial of Early Intervention Versus Standard Treatment (OPUS)

	Psychotic Illness Course, %			Recovery, %	Duration of Follow-up, Years
	Episodic	Continuous	Never Psychotic		
ISoS*	16.6	33.6	42.8	16.3	15 and 25 years
EPPIC†	18.8	40.7	40.4	14.9	7
OPUS‡					5
Early intervention programme	14	45	41	16	
Standard treatment	13	44	43		

*International Study of Schizophrenia: rates from incident schizophrenia cohort, n = 502

†Early Psychosis Prevention and Intervention Centre in Melbourne, Australia. Includes schizophrenia and schizophreniform, n = 276

‡Intervention in the OPUS trial lasts for 2 years. Illness course data reported here is for the 3 years post OPUS trial. Recovery rates are for combined early intervention and standard treatment arms. Early intervention programme, n = 151; standard treatment, n = 150.

out of recovery over the illness' course.⁵ In reality, the vast majority is afflicted with recurrent or persistent symptoms,¹² and framing schizophrenia as a chronic condition may offer advantages in terms of management strategies.

As an example of this, diabetes is an illness where outcomes have improved over time after the implementation of a chronic disease management framework.¹⁷ Early detection and intervention strategies have certainly been promulgated in diabetes care, but its persistence is both acknowledged and embraced in establishing longer term care from the outset. So too is its complexity, with aspects of care ranging from regular monitoring of blood sugar to diabetic complications, dietary and lifestyle advice. The management strategy is one of prevention and health promotion built upon close and collaborative care coordination between the different treatment components, an over-arching philosophy for all chronic conditions.

Adopting a chronic care model (CCM) in the management of schizophrenia is not new,¹⁸ but an approach that we perhaps have lost sight of based on shifts in treatment that have not necessarily lived up to expectations. Current clinical care is often administered in an ad hoc, time-limited approach that is not appropriate for a chronic illness. Components of the CCM remain evident in established early intervention programmes, examples including self-management and support through psychoeducation, implementation of treatment algorithms as decision support tools, and assertive community treatment to enhance community integration.¹⁹ Unfortunately, though, these services may be tied to the programme and withdrawn when the individual is no longer deemed to be 'first-episode'. The early intervention model of care should be extended and adapted to as long as the individual requires psychiatric care, and expanded to integrate with medical care. Clinicians need to find ways to hold on to and build upon the early gains from early intervention.

The stark reality remains that schizophrenia is a chronic illness that for most individuals waxes and wanes over the years. However, chronic illness and poor outcome are not inextricably linked. As noted for diabetes, gains can be made in embracing chronicity and integrating a multifaceted, long-term approach to care delivery that fosters optimal outcomes.²⁰ Identifying schizophrenia as a chronic illness acknowledges clinical reality, does not preclude good outcome, and in shaping service delivery accordingly should actually enhance this possibility. Therefore, just as healthcare and research resources have been increasingly allocated to early intervention and to the understanding of pre-psychotic phases of the illness, we argue that the research and development of a feasible CCM for schizophrenia is an equally important need.

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