Commentary

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Title: Re-medicalizing the care of patients with schizophrenia

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Guy M. Goodwin FMedSci

University of Oxford Department of Psychiatry
Warneford Hospital
Oxford OX3 7JX
Tel: +44 1865 226451
guy.goodwin@psych.ox.ac.uk

Disclosures

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No one would want their child to develop schizophrenia. Its early onset entails debilitating effects on personal and social development and its high mortality is well described. Its management remains contested. Traditionally, patients with schizophrenia have been seen as often requiring hospital admission, where necessary against their wishes, and the use of dopamine antagonist drugs to reduce the intensity of the delusions and hallucinations that are causing problems. These problems often represent a conflict between the individual patient's beliefs and desires and societal norms. It is possible to take the view, popularized by the antipsychiatry movement, that the conflict between individual and society arises because society is wrong. While most psychiatrists would argue that this is just a debating point and does not survive real life experience of what happens in a psychotic breakdown, psychiatrists themselves have long accepted that long term institutional care became demeaning and required reform, with more emphasis on community care and less emphasis on hospitals.

In addition, schizophrenia, as defined by psychiatrists, is a severe condition at the extreme of end of psychosis proneness. Psychotic experience is much more common in the population at

large and carries less threatening implications(Henderson and Malhi, 2014). The treatment of milder psychotic states requires much less emphasis on the traditional themes of coercion, incarceration and medication and much more naturally suggest a less medicalized approach to treatment.

Frank *de-medicalization* of psychiatric services has become a policy in many developed countries. In the UK, for example, a 'National Framework for Mental health' was published in 1999, which marginalized the views of most psychiatrists. It has led to the development of highly generic mental health teams where assessment and diagnosis have been diminished at the price of a more social model of severe illness(Craddock et al., 2008). This approach has been heavily pushed by the WHO's 'Special Rapporteur on the right to health' recently, in what is essentially a political argument to ignore the biological basis of severe psychiatric disorder (http://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=21689).

One consequence of de-medicalizing patient services has been to reduce the expertise of the doctors who do see patients with schizophrenia. In part this relates to training, but more often it is a consequence of reduced experience and the distribution of responsibility across multi-disciplinary teams. The most predictable outcome of this development has been a failure to address the physical health needs of patients with severe mental illness.

The creation of expert centres in France has swum against this unhappy tide of neglect. They were created by Marion Leboyer and colleagues 10 years ago and a review of their experience is given in this volume by Schürhoff et al. There is a lot to be said for careful observation of real world patients in a systematic way. Their main observations relate to the metabolic syndrome, which is twice as frequent in schizophrenia as the general population, but is neither properly assessed or treated, the prevalence of chronic low-grade peripheral inflammation and major depressive disorder (MDD) as a common current comorbid condition in patients with schizophrenia. As they reflect, improving depression and negative symptoms may be the most effective strategies to improve quality of life in schizophrenia.

The studies to date concern cross-sectional findings 'at baseline' so to speak. The challenge is to maintain observation at long term follow up. Psychiatry as a specialty has been poor at capturing long term outcomes that matter. The present study of over 600 patients is a good start but we are a long way from generating big data sets from really large numbers of cases with adequate clinical detail as exhibited here. The true potential of naturalistic studies is illustrated both by the Expert centres and the studies on much larger, if less detailed databases

in Scandinavia. In the case of schizophrenia, for example, linking reasonably verified cases with pharmacological treatment on the one hand and admission or offending on the other has yielded simple but very powerful results. Within subject designs mean patient behavior can be compared on and off medication and the many potential confounds of between group case/control designs can be avoided. Violent offending is a particularly important risk for patients with schizophrenia, especially those with co-morbid substance misuse(Fazel et al., 2009). Treatment with dopamine antagonists reduced the risk of violent offending by 45% (Fazel et al., 2014). Interestingly lithium, which is also sometimes used in patients with schizophrenia judged to be at risk of violence was without benefit in patients with schizophrenia but had a major impact in bipolar disorder.

In conclusion, schizophrenia remains a major burden for patients, their families and the services that care for them. Re-naming it or appreciating its boundary with less severe conditions puts symbol before substance. Neglect of medical care will lead to further suffering. The modernization of services is not incompatible with a renewed effort to provide good medical care to patients with sever psychotic disorder. Collecting naturalistic data, alongside the evidence from clinical trials, is the best way to provide the evidence base on which to plan it.

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