Community perspective on management of psychosis

Early identification of signs and symptoms is an essential part of managing psychosis, particularly schizophrenia, writes Stephen McWilliams

PSYCHIATRY HAS RECENTLY experienced a change of emphasis. While admission to hospital was once regarded as a virtual panacea for numerous mental illnesses, recent consensus has focused more on the merits of care in the community.

This approach naturally brings its own burdens, as many family members and caregivers will testify. So how is serious mental illness – such as schizophrenia and other forms of psychosis – best managed in the community setting?

Schizophrenia is defined in the ICD-10 as a severe, non-organic psychotic illness that occurs in clear consciousness, continuously or episodically over a period of at least one month. Typical symptoms include persecutory delusions, ideas of reference, auditory hallucinations, passivity phenomena, catatonic behaviour, and negative symptoms such as lack of motivation, social isolation, poverty of speech and blunted affect.

Schizophrenia is more common than many people realise. While psychosis affects 3% of the Irish population (some 75,000 individuals and hence almost sufficient to fill Croke Park to capacity), schizophrenia accounts for approximately half of that number, which in itself would easily fill Lansdowne Road.

Psychosis, therefore, places a considerable personal and economic burden on the individual, their family and caregivers, and the community.

The management of schizophrenia from a community perspective is not confined merely to treatment; it begins at the point of diagnosis. Schizophrenia usually presents in adolescence or early adulthood (a time at which we are, perhaps, least vigilant for illness) and therefore education is crucial.

Research has found that the duration of untreated psychosis (DUP) – namely the time from manifestation of the first psychotic symptom to initiation of adequate treatment – is typically one to two years worldwide. Ireland is no different, given that Clarke et al found the mean DUP in southeast Dublin to be 23 months. Furthermore, a recent prospective study by Clarke et al showed that a longer DUP was closely associated with a decrease in global functioning and an increase in positive symptoms at four-year follow up. The role of community education about signs and symptoms cannot, therefore, be stressed too highly.

In practice, the treatment of a first episode of psychosis (or a significant relapse) usually involves hospitalisation. The decision to admit takes into account a risk assessment, the level of insight, the mental state examination, and the likelihood of adherence.

While admission naturally provides a safe environment in which to initiate and monitor appropriate treatment, it also allows for a multidisciplinary approach, involving social work, community psychiatric nursing, psychology, occupational therapy and other disciplines. This approach helps to build the bridge between the hospital and the community.

The medications used to treat psychosis in the community are often those initiated prior to discharge, allowing for changes such as dosage in the outpatient setting. The prescription of antipsychotics should take into account the principles outlined in The Maudsley Prescribing Guidelines 2005-2006 and in the guidelines issued by the Royal College of Psychiatrists and the National Institute for Health and Clinical Excellence.

According to the Maudsley guidelines, the first-line medication used should usually be an atypical antipsychotic, titrated upwards to an optimal (and preferably single) daily dosage. Assessment should be ongoing, with sufficient time allowed before any given dosage is increased.

Where first-line medication is not tolerated, or where it fails to ameliorate symptoms within six to eight weeks despite an adequate dosage and good adherence, the trial of a second antipsychotic is indicated.

Where adherence is questionable, a depot formulation may be tried and, once again, assessed over six to eight weeks. In the community setting, administration of a regular depot usually involves the patient attending a depot clinic or allowing a community psychiatric nurse to call to their home.

Meanwhile, third-line medications include classical...
antipsychotics and clozapine, although it is important to rule out inadequate dosage, non-adherence, misdiagnosis and comorbidity before asserting treatment resistance.

Once a patient has been discharged to their own home; a caregiver’s home, a relative’s home, or a hostel – be it low, medium or high support – the emphasis of management switches to relapse prevention.

This naturally involves promoting good adherence to treatment; avoidance of illicit substances; learning of the early signs of relapse; good family support; structuring daily living; and regular attendance at the outpatient department or GP surgery. In addition, psychological measures such as cognitive behavioural therapy (CBT) have been shown to improve symptomatology, adherence and social functioning.

Finally, caregiver education plays a key role in the management of schizophrenia in the community. Indeed, as early as 1987, Smith and Birchwood reported on the specific and non-specific benefits of brief educational interventions for families living with a relative who has schizophrenia.5 Education was found to lead to considerable knowledge gains and a reduction both in relatives’ stress symptoms and their fear of the patient. Relatives also reported more optimism regarding their role in treatment.

Furthermore, at six-month follow up, relatives’ gains in knowledge were found to be maintained, while their perceptions of family burden were significantly reduced.

So, are these findings maintained in the longer term? Sellwood et al performed a 12-month follow-up study of needs-based cognitive behavioural family intervention for outpatients with schizophrenia and their caregivers.6 The intervention proved advantageous in terms of reduced caregiver needs, relapse and other clinical measures.

Meanwhile, poor adherence to medication was listed among the significant independent predictors of relapse. The study concluded: “family intervention directed at carer needs within a standard mental health service can produce benefits for patients beyond the term of intervention”.

Overall, intervention to target psychosis in the community requires a multidisciplinary and multimodal approach. This includes early identification of signs and symptoms to help reduce DUP, coupled with appropriate pharmacological treatment and comprehensive follow-up.

Meanwhile, measures to prevent relapse should ideally include appropriate CBT and caregiver education. Alas, it all contributes to psychiatry’s change of emphasis!

References
1. ICD-10 Classification of Mental and Behavioural Disorders (WHO, 1993)
5. Smith et al. Specific and non-specific effects of educational intervention with families living with a schizophrenic relative. British Journal of Psychiatry 1987; 150: 645-52

Stephen McWilliams is clinical fellow with DETECT Early Intervention Service for Psychosis in Dublin