Comprehensive care for people with schizophrenia living in the community

David J Castle and Christos Pantelis

IN AUSTRALIA there continue to be significant barriers to care and gaps in service provision for people with schizophrenia. The extent of these shortcomings is echoed in the National Survey of Mental Health and Wellbeing study on low-prevalence (psychotic) disorders.[1] Of the 998 people with psychotic disorders surveyed, 84% were single, separated, divorced or widowed; 85% were reliant on welfare benefits; 72% did not have a regular occupation; and 45% were living in some form of hostel or supported accommodation, or were homeless. These unacceptable psychosocial outcomes were evident despite the fact that 91% of the people surveyed were currently receiving psychotropic medication. Furthermore, only 19% of patients had used any form of rehabilitation service over the previous year. It was not that they did not *want* to access such services; indeed, 47% of the survey cohort perceived the need for a particular type of service that was not accessible to them, either because it was unavailable or they could not afford it.

The service provider with whom the majority of survey respondents did have regular contact was their general practioner: 81% had seen their GP in the previous year, and the average number of visits was 12 per year.[1] Clearly, not all of these contacts were for mental health reasons, but the extent and regularity of contact with GPs by people with schizophrenia highlights the potentially crucial role GPs can play in their overall health. GPs are likely to have increasing involvement with managing medical comorbidity in patients with schizophrenia, especially now that newer "atypical" antipsychotic drugs are available. Thus, this Supplement, highlighting the latest developments in managing schizophrenia and delivering comprehensive care, is particularly relevant for GPs.

Hocking (*page S47*)[2] underlines the place of the community in schizophrenia management — highly pertinent in these "post-institutionalisation" days, when the vast majority of people with schizophrenia are resident in the community. It is important that GPs understand the functioning of the modern mental healthcare system, know what resources are available to assist in managing patients with schizophrenia, and have the information required to negotiate potential barriers to accessing support services. These issues are detailed by Harvey and Fielding (*page S49*).[3] A model for GP participation in managing people with schizophrenia is outlined by Meadows (*page S53*),[4] in the hope that the principles can be adapted more broadly.

There have been substantial recent developments in pharmacological treatments for schizophrenia. No longer are treatments for psychosis inevitably associated with unpleasant and potentially debilitating extrapyramidal side effects such as parkinsonism, akathisia and tardive dyskinesia. The newer "atypical" antipsychotics are much less likely to have these disabling side effects, and are now first-line treatment for schizophrenia. However, the atypicals have been associated with other medical problems, including weight gain,[5] diabetes[6] and hyperlipidaemia.[7] The decision about which drug to use for any individual patient requires a careful weighing of the side effects against potential therapeutic effects. An overview of the atypical antipsychotics is provided by Lambert and Castle (*page S57*).[8] Despite pharmacological advances, some patients remain "resistant" to conventional treatments. However, we are increasingly able to offer such patients newer treatments that more effectively reduce psychotic symptoms and enhance quality of life. Indeed, the newer agents can have benefits in a number of domains, including those of behaviour, depressive and suicidal thoughts, and cognitive functioning, as well as improving social and vocational outcomes. The management of "treatment resistance" in schizophrenia is reviewed by Pantelis and Lambert (*page S62*).[9]

The physical health of people with schizophrenia is often suboptimal, and general medical conditions may either be missed, through inadequate screening, or treated suboptimally. The GP has a crucial role to play here. Lambert et al (*page S67*)[10] outline the main medical problems encountered in people with schizophrenia and the barriers to detection and treatment. Many of the interventions for general medical conditions such as obesity and hypertension require educating the patient about "healthy living", including regular exercise, attention to diet, and stopping smoking.

A common problem among people with schizophrenia is the misuse of alcohol and illicit substances. Substance misuse impairs the overall health of the individual, resulting in more severe symptoms, greater chance of relapse and rehospitalisation and, in some instances, increased risk of crime and violence. Again, the GP has an important role to play in detection and management of comorbid substance misuse. Lubman and Sundram (*page S71*)[11] provide practical guidance for GPs in dealing with this complex issue.

Finally, Crosse (*page S76*)[12] suggests ways in which people with schizophrenia can be helped to participate fully in society so that each day is full and meaningful. This should be the aim of all of us involved in the care of people with schizophrenia.

Mental Health Research Institute, Parkville, VIC.
David J Castle, MD, MRCPsych, FRANZCP, Professorial Fellow; and Consultant Psychiatrist, Royal Melbourne Hospital.
Cognitive Neuropsychiatry Research and Academic Unit, Department of Psychiatry, University of Melbourne, Parkville, VIC.
Christos Pantelis, MRCPsych, FRANZCP, Associate Professor, and Head, Applied Schizophrenia Division, Mental Health Research Institute, Parkville, VIC.
Reprints will not be available from the authors. Correspondence: Professor David J Castle, Mental Health Research Institute, 155 Oak Street, Parkville, VIC 3052. dcastle@mhri.edu.au

References

1. Jablensky A, McGrath J, Herrman H, et al. People living with psychotic illness: an Australian study 1997–98. Canberra: Commonwealth Department of Health and Aged Care, 1999. Available at: http://www.health.gov.au/hsdd/mentalhe/resources/reports/pdf/psychot.pdf (accessed Mar 2003).
2. Hocking B. Reducing mental illness stigma and discrimination — everybody's business. *Med J Aust* 2003; 178 Suppl May 5: S47-S48.
3. Harvey CA, Fielding JM. The configuration of mental health services to facilitate care for people with schizophrenia. *Med J Aust* 2003; 178 Suppl May 5: S49-S52.
4. Meadows GN. Overcoming barriers to reintegration of patients with schizophrenia: developing a best-practice model for discharge from specialist care. *Med J Aust* 2003; 178 Suppl May 5: S53-S56.
5. Taylor D, McAskill R. Atypical antipsychotics and weight gain: a systematic review. *Acta Psychiatr Scand* 2000; 101: 416-432.
6. Sernyak M, Leslie D, Alarcon R, et al. Association of diabetes mellitus with use of atypical neuroleptics in the treatment of schizophrenia. *Am J Psychiatry* 2002; 159: 561-566.
7. Meyer JM. A retrospective comparison of weight, lipid, and glucose changes between risperidone- and olanzapine-treated inpatients: metabolic outcomes after 1 year. *J Clin Psychiatry* 2002; 63: 425-433.
8. Lambert TJR, Castle DJ. Pharmacological approaches to the management of schizophrenia. *Med J Aust* 2003; 178 Suppl May 5: S57-S61.
9. Pantelis C, Lambert TJR. Managing patients with "treatment-resistant" schizophrenia. *Med J Aust* 2003; 178 Suppl May 5: S62-S66.
10. Lambert TJR, Velakoulis D, Pantelis C. Medical comorbidity in schizophrenia. *Med J Aust* 2003; 178 Suppl May 5: S67-S70.
11. Lubman DI, Sundram S. Substance misuse in patients with schizophrenia: a primary care guide. *Med J Aust* 2003; 178 Suppl May 5: S71-S75.
12. Crosse C. A meaningful day: integrating psychosocial rehabilitation into community treatment of schizophrenia. *Med J Aust* 2003; 178 Suppl May 5: S76-S78. ❑