

COMMENTARY

Moving Towards a New Model of Multidisciplinary Care of Schizophrenia and Other Psychoses. The Role of Primary Care

Ramon Ciurana Misol

Family Medicine, CAP La Mina, Sant Adrià de Besòs, Barcelona, Spain.

Primary care health professionals have been concerned for years to find out the prevalence and risk factors of diseases. To have information on a foreseeable workload is considered an essential prerequisite for adequately planning care dedicated to each disorder. The expected frequency of high blood pressure, diabetes, chronic obstructive pulmonary diseases, and many other health problems are fairly well known. However, little is known in our country on the real frequency of mental illnesses, particularly the most serious ones. The data available to the professional is normally provided by surveys carried out in the general population, some of them of doubtful accuracy and on many occasions they are carried out in countries with incidences and characteristics that do not necessarily extrapolate to ours. In this sense, the idea of Tizón et al, to establish an estimation of the reality from easily accessible primary care services is novel. Psychosis stops being a diagnosis mainly carried out in hospital on patients who had to be admitted, to being a mainly community diagnosis and, therefore more precise. The health centre or mental health team situated in primary care (primary care to mental health) must be able to follow up these cases. Only in this way will they be able to determine the special health care variables.

On many occasions, schizophrenia cases and other psychoses are detected by primary care doctors.

Depending on the characteristics of the prodromes of the disease, the diagnosis can be difficult, therefore it requires a careful follow-up, so the professional must be technically prepared. In these suspected clinical cases, generally identified from alarm signals in the clinic, an adequate system for the interchange of information with mental health professionals is necessary, by means of referrals or other alternative procedures. This interchange of information is crucial, and with it strategies have to be designed that may enable detected cases to be treated early.

Nowadays, the time interval from the first diagnosable symptoms of schizophrenia to time when the patient is

Key Points

- The prevalence of schizophrenia and other psychoses estimated from the data available from the situation in mental health centres may be nearer to the real data than that coming from population surveys.
- The linking of primary care professionals with those of mental health (in primary care) makes the follow up of cases easier and helps to ensure that treatment is started earlier.
- The provision of complementary active psychosocial resources enables cases to be followed up better and improves the links of patients and their families with the health system.

diagnosed generally varies between one and 2 years. The delay that occurs until treatment is started must be added to this time. That is why it is important that the non-psychiatric professional has the tools available that may ensure an early diagnosis and the first connection with the patient, which will make the referral to mental health easier and at the appropriate time.¹

There are two situations that might cloud the therapeutic success and they must be particularly borne in mind: the treatment gap and its lack of continuity.

The treatment gap may be defined as the absolute difference between the true prevalence of a disorder and the proportion of individuals with this disorder who receive

treatment.² According to World Health Organisation data,² this gap, in the case of schizophrenia, is estimated to be approximately 18% in the European region. This percentage is even higher in the other continents. In practice, this means that 1 in every 5 schizophrenics does not receive treatment from any health care service, specialised or not.

The lack of continuity of treatment in patients discharged from hospital due to schizophrenia is very high and it is estimated to be around 50% at 1 year and 75% at 2 years.³ This is closely associated with the risk of relapses. The question that arises, is not just how many patients have to follow pharmacological treatment, but how to connect those patients with the health services to avoid relapses. The experiences with follow ups nearer the patient that involve the family and provide suitable resources, over and above the exclusive pharmacological treatment, and with active psychosocial intervention, has been shown to be effective in reducing the number of admissions and improving the well-being of the patients.^{4,5}

The current outlook is not very encouraging. With the previous data, it seems that only 40% of schizophrenia patients, whether because they have not started treatment or because they have left treatment, follow appropriate pharmacological treatment at the end of the year in which they started and, most likely, few of them are given psychosocial treatment according to their individual needs.

The XXI century must eventually lead us to seriously rethink the treatment of psychosis. The step from systematic institutionalisation to the treatment of the patient in the community happened a few decades ago, but despite being an advance it has not given the desired results.

To know the real incidence of cases will enable them to be treated early and better “cared for,” if the follow-up of each patient is ensured and the mechanisms are drawn up for providing new therapeutic alternatives that give, added to the correct use of drugs, adequate psychosocial support.

References

1. The early diagnosis and management of psychosis. A booklet for general practitioners. Melbourne: ORYGEN. Youth Health; 2002.
2. Kohn R, Saxena S, Levav I, Saraceno B. The treatment gap in mental health care. *Bull WHO*. 2004;82:858-66.
3. Weiden PJ, Zygmunt A. Medication non-compliance in schizophrenia. Part I. Assessment. *J Pract Psych Behav Health*. 1997;98:106-10.
4. Power P, Elkins K, Adlard S, Curry C, McGorry P, Harrigan S. Analysis of the initial treatment phase in first-episode psychosis. *Br J Psychiatry Suppl*. 1998;172:71-6.
5. Linszen D, Lenior M, de Haan L, Dingemans P, Gersons B. Early intervention, untreated psychosis and the course of early schizophrenia. *Br J Psychiatry Suppl*. 1998;172:84-9.