Current Practice

PRACTICAL PSYCHIATRY

Management of Schizophrenia in the Community

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Schizophrenia is a disease affecting about 1% of the population. This means that no general practitioner is likely to have very many patients of this kind on his list, but the ones he does have may present some of the most difficult problems in the practice. Schizophrenia is not a single clinical syndrome but a group of related conditions with certain features in common. The diagnosis may sometimes be a matter for disagreement, even among experts, and the schizophrenic label is certainly applied more widely in American medicine, for instance, than in Britain. Dropping the use of sub-categories such as paranoia or paraphrenia has helped to simplify the situation, but on the other hand it must be appreciated that the prognosis in different types of case will be very different. One would consider much more seriously a young adult who has become progressively more withdrawn and then shown disturbances of thought and mood than a middle-aged person developing an acute onset of paranoid delusions. Such a broad clinical rubric makes it difficult to generalize about management, but nevertheless there is now general agreement among British psychiatrists about basic principles.

The aetiology of schizophrenia is unknown, and primary prevention is therefore still something far beyond the limits of our present knowledge. But secondary prevention, in the form of minimizing handicaps and avoiding relapses, is both possible and supremely important, particularly in the community setting. A previous article in this series (October 26, p. 232) has dealt with the initial diagnosis of schizophrenia, and under present circumstances it is extremely likely that this identification will have been followed by admission to hospital. Though conditions still vary a good deal between different areas it is equally likely that this admission will not be for very long. The overwhelming majority of patients (particularly first admissions) are now discharged within two months, and in many cases the period in hospital will have been only a few weeks. Even before discharge the patient is likely to have been home for weekend leaves, or he may have resumed his job while still living in the hospital. So the general practitioner who has been involved in the admission of a case of schizophrenia may well find that the patient is back home in a surprisingly short time—but the responsibility should now be a shared one, and not for the family doctor alone.

Aftercare

It has become something of a truism that psychiatric after-care should begin before the patient leaves hospital. Efforts made at this time can have very valuable long-term results. If the psychiatric unit is (as it should be) close to the patient's home, the general practitioner may be able to visit the patient in hospital and discuss the problem of future management with the clinical team responsible there. At this point it is most

important to emphasize that schizophrenia calls throughout for a team approach, often very different from the traditional doctor-patient relationship that the general practitioner will be used to.

The old hierarchical structure of psychiatric hospitals is now fast disappearing, and in most of them responsibility has been decentralized among a number of clinical "firms." The best arrangement (and the one favoured by the Ministry of Health) is for each team to be responsible for a defined area. Then every general practitioner can establish a continuing working relationship with one or more consultants heading the team for his area. At the same time the arrangement should not be so rigid that the general practitioner loses his freedom to choose among consultants for his patient. It will also be best if his personal contact includes other members of the team, such as social workers and senior nurses. In many cases a general practitioner may then be able to handle a problem most effectively by dealing directly with one of these other workers in the first instance. If the lines of communication are always kept open this information will soon reach everyone in the team who is concerned.

Integrated arrangements of this kind are particularly important in the case of schizophrenia because of the nature of the condition. Acute episodes of disturbance may cause great distress to both patient and relatives and require rapid hospital admission. The general practitioner then will often be the one who has to assess that family care is breaking down. In these circumstances hospital care should be available at all times without administrative barriers or difficulty of communication between different services. But having a bed always open for the acute case requires an efficient use of the hospital, so that patients do not remain there without a real need to do so. This is where the hospital's relationship with community services and general practitioners is again essential.

Relapses

Another important aspect of schizophrenia is its tendency to run a relapsing course. Because of this management must always be thought of on a long-term basis, with a continuous plan of treatment, rather than merely reacting to events. This is very difficult to arrange with our present tripartite structure of health services, and in the long run something in the nature of a continuous care register will be essential for vulnerable cases in each area. By recording all contacts of the patient with medical and social services and all information about his condition it would then be possible to ensure that the plan of treatment and care was actually being followed. We have still a very long way to go before this kind of co-ordination is achieved, and until such a time general practitioners and other services have to keep a regular eye on known schizophrenic patients as well as they can. This is more important than ever now that medication can so often be effective in preventing relapses.

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Rehabilitation

The third important clinical feature is the likelihood of chronic disability and the need for rehabilitation. The most recent information available shows that five years after first admission for schizophrenia half the patients will be well to a greater or lesser extent and the other half will be handicapped to some extent. (It is quite likely, though, that patients first admitted in the last few years will in fact show rather better results.) Particularly when it begins in adolescence or early adulthood, the disease may have a crippling effect on educational achievement, earning power, and social relationships. In general the patient's life-history is likely to be one of unfulfilled promise. Since schizophrenics on the whole do not spend very long periods in hospital now, as they used to, the burden of caring for them when they are handicapped but not acutely ill will mostly fall on their relatives. A few who lack or refuse such care may drift into the central, doss-house areas of cities, where they are likely to be involved in alcoholism or petty crime and may experience the "revolving-door cycle" of prison and mental hospital. When they occur, these latter cases are a great trial to every service involved, but they do represent only a small proportion of schizophrenics.

Family care of the disabled schizophrenic has become more difficult with the tendency to smaller families and with the breaking-up of wider kinship groups that comes from rehousing. Any efforts that can help to keep relatives near to each other are certainly most important from this point of view. But chronic schizophrenia in a husband or wife may have serious results in terms of loss of earnings or inadequate care of home and children. The general practitioner may then have the duty of mobilizing help from public services, particularly when local authority social work is inadequate or when the hospital takes relatively little part in the aftercare of its patients. (Unfortunately, both these situations are still all too common.)

Help may be needed mainly as rehabilitation for work or to keep up the domestic structure of the home. In the first case the disablement resettlement officer should be consulted at the local office of the Department of Employment. He may be able to arrange for the patient to attend an industrial rehabilitation unit or (rather rarely) to learn a trade at a Government training centre. These facilities are not ideal for schizophrenics, but a proportion do certainly benefit from them. There may be more specifically psychiatric rehabilitation in some areas, such as hospital industrial therapy units—open to day patients—or local authority day centres or sheltered workshops. On the whole all such services are grossly inadequate for the size of the problem; the comprehensive industrial therapy organization at Bristol is scarcely matched anywhere else in the country. In this field progress is usually slow and often disappointing; only sustained, long-term effort and interest can obtain results. Under present conditions research has shown that those patients who resettle successfully in work usually find their own jobs—but it should be possible to help more handicapped patients to do the same.

On the domestic side the family may need advice in obtaining financial help from the Ministry of Social Security, and if housework has been neglected the services of a home help can be valuable. Unofficially these excellent ladies often have an important supportive role to the family also. Where there are young children, placing them in a day nursery or nursery class (or early entry to school) may help both children and parents, but unfortunately it is impossible in many areas to obtain these things. High emotional involvement between family members is known to have a bad effect on schizophrenics in general, and where this seems to be happening trouble may be avoided by taking the patient into a psychiatric hostel or supervised lodgings for a period. But, again, many areas lack these services.

If a psychiatric social worker is not available to supervise the family situation the general practitioner may be able to get this

kind of assistance from a health visitor or district nurse. Here the regular attachment of ancillary workers to the practice will obviously make such assistance much more effective. In Salford there are community health teams in which doctors have regular meetings with their attached workers, and problems such as these can be systematically reviewed.

Drug Therapy

The detailed drug treatment of schizophrenia is not discussed here, but it is important to consider the general question of therapy in community care. There is no doubt about the effectiveness of phenothiazine and similar drugs in controlling the acute phases of schizophrenic illness. In the periods of remission some patients will remain perfectly well for years without any treatment, while others will relapse quickly unless they have continuous medication. (The latter group would probably never have left mental hospital before the last 15 years or so.) At present there is absolutely no way of knowing in advance which category a particular patient is likely to belong to, or even whether he will continue to follow the same pattern over a long period. What is clear from statistical studies is that, when large groups of schizophrenics are compared, those who stay on continuous medication show far fewer relapses than those who do not. Therefore, under present conditions, every case of schizophrenia should be on long-term medication with regular supervision; this should be reduced only gradually and stopped only after very careful consideration.

Unfortunately, as we know already from conditions such as tuberculosis and diabetes, it is very difficult to get people to take continuous medication when they start feeling generally well. This difficulty becomes immeasurably greater when we are dealing with patients who have personality damage, disturbed family relationships, or very bad social conditions. Nevertheless both general practitioner and mental health service must do their utmost to keep as many patients as possible on regular drug treatment. Here it must be stated quite frankly that many problems arise from failure of co-operation between different services over this matter. Most psychiatrists know of cases where schizophrenic patients have had their dosages reduced by family doctors to an ineffective level, where the drug has been changed to an inappropriate one, or even when the general practitioner's advice has been "not to get used to taking tablets." All too often the result of this is disastrous. It cannot be emphasized too strongly that long-term medication in schizophrenia is a matter for specialized experience, and that any change should be carefully considered. If a general practitioner feels that there may be indications for a change, this should be discussed with the psychiatrist (whenever possible), but a social worker or nurse can often be helpful in facilitating the discussions.

However, even when all professional parties are agreed on their policy there remains the problem that a high proportion of psychiatric patients fail to take their medication regularly. Those who are most likely to be unreliable (and to be poor attenders at outpatient clinics) are often those with a history of frequent relapses. In some cases relatives will supervise the taking of tablets, but even then it cannot always be assumed that the tablets are actually swallowed. A very significant contribution to the solution of this problem has come from the introduction of a long-acting phenothiazine, given by intramuscular injection. This is fluphenazine enanthate, which has an action averaging 14 days. Patients are usually started on this regimen while in hospital and then continue to receive fortnightly injections after discharge. If progress is satisfactory, and if it seems that oral medication is also being taken, injections may then be spaced to three or four weeks and possibly reduced in dose from the standard 25 mg.

In the Salford comprehensive community mental health service vulnerable cases of schizophrenia have been treated with this preparation for nearly two years and experience has been gained in over 100 cases. This confirms results from elsewhere that it represents an important step forward in the community management of schizophrenia. The injections may be given in hospital clinics, at general practitioners' surgeries, or by nurses at the patients' homes. An interested family doctor can certainly make a big contribution to the community care of his schizophrenic patients by undertaking these injections, since it is possible to do a rapid check on the mental state at the same time, or perhaps receive a report from an accompanying relative. It may also be necessary to issue regular prescriptions for antiparkinsonian drugs, since side-effects are fairly common, at least in the early stages of the regimen.

The community care of schizophrenia is still in its infancy, but there is no doubt that the family doctor has a vital role to play in it, and it is likely that this role can only become more significant as time goes on.

FURTHER READING

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MEDICINE TODAY

Audiometry

"Medicine Today" is the television series for doctors produced by the B.B.C. Advice on the preparation of the programme is given by the Association for the Study of Medical Education.

The programme on B.B.C. 2 on 5 November was on the subject of investigation of adult deafness. Printed below is an article prepared with the help of expert contributors to complement the television programme, which will be repeated on B.B.C. 1 on 12 November at 11.27 p.m. approximately.

Audiometry has developed from a simple technique for the quantitative assessment of deafness into a versatile procedure for the investigation of various auditory phenomena. Ideally, audiometric examinations should be carried out in a soundproof room or booth so that background noise is effectively eliminated, and most modern ear, nose, and throat departments are equipped with such facilities.

Pure-tone audiometry provides the simplest method for the measurement of hearing loss. Sound impulses are generated by the audiometer at various frequencies and conveyed to the patient at an amplitude which he can hear via a head-set or a bone conductor placed on the mastoid process. The sound intensity is gradually reduced to a level which he can only just hear, and this is recorded graphically as the threshold of hearing

for that particular frequency (Fig. 1). In this way a reasonably accurate assessment can be made of the patient's hearing loss, and this serves as a source of comparison for any future measurements. By performing preoperative and postoperative audiograms the surgeon is able, for instance, to gauge the success of procedures which are carried out for the relief of deafness.

Pure tone audiometry, like any other investigation, is subject to the introduction of errors. The patient's concentration may wander, so that his threshold level may not be entirely precise, and this is particularly likely to happen in the young and the old. Results may vary if the tests are carried out by different persons or if regular recalibration of the apparatus is neglected. Errors in the interpretation of audiograms may also arise, and perhaps the best example of this is the "shadow curve." This occurs in patients with normal hearing in one ear and a severe or total perceptive hearing loss in the opposite ear. Clinical testing indicates very poor or absent hearing on the affected side when the "good" ear is masked, but the audiogram apparently reveals only a moderate deafness of mixed conduction-perception type. This is an illusion which is created by the "good" ear overhearing the signals conveyed to the deaf ear, often in spite of appropriate masking.

Differential Tests

The phenomenon of phonophobia is a useful one to investigate in differentiating cochlear from purely neural lesions. Damage to the outer hair cells of the organ of Corti is responsible for intolerance of loud sounds, the mechanism being attributed to the so-called "recruitment phenomenon." When this condition is present the deafened ear is found to be progressively more sensitive to sounds of increasing loudness in a way which the normal ear is not. For instance, in a patient with normal hearing on one side and a cochlear deafness on the other, increasing the amplitude of a tone presented alternately to both ears to a level when it is equally loud in both requires a smaller increment on the deaf than on the normal side. This phenomenon, which is seen typically in Ménière's Disease, is made use of in Fowler's alternate binaural loudness balance test. Its absence in a case of perceptive deafness signifies that

FIG. 1.—A typical audiogram showing a bilateral, conductive deafness due to otosclerosis.