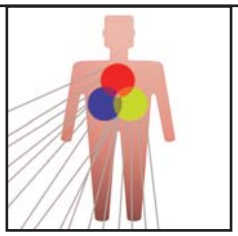

Psychiatric comorbidity in general practice

BACKGROUND Much of teaching and research has concentrated on single disease entities. In general practice, however, many patients suffer from a number of interacting illnesses at the same time. It is unlikely we will ever have randomised controlled trials to guide the management of such patients.

OBJECTIVE This article aims to develop a framework that will assist general practitioners in day-to-day clinical work with patients presenting with concurrent multiple physical and mental health problems.

DISCUSSION A positive, caring, patient centred approach is required and multiple diagnoses need to be managed within an integrated treatment plan. The quality of the therapeutic relationship is central to patient outcomes. Assessing and managing risk issues is a priority and coordinating care with other health professionals is essential. Set realistic goals, don't make changes too quickly or all at once, and don't assume that because a patient is taking a particular medication the associated diagnosis is correct.

Case history – Marietta

Marietta is a 32 year old woman who has just moved into your area. She presents for the first time seeking repeat prescriptions of her medications: risperidone, paroxetine and Panadeine Forte. On further questioning, Marietta reveals she has had schizophrenia since the age of 17 years, interspersed with bouts of severe depression. She has had chronic back pain since falling off a balcony 8 years ago while drunk, and she continues to drink heavily. She had a casual sexual encounter 4 months ago and has not had a period since. Her urinary pregnancy test is positive.

We all know life was not meant to be easy, but in general practice, we sometimes ask ourselves if it really was meant to be this hard. When we are faced with the care of a patient who has multiple diagnoses, especially if one or more is a psychiatric diagnosis (as illustrated in the *Case history*), all our skills, patience and experience are needed to achieve a good outcome.

While much teaching and research has concentrated on single disease entities; in general practice this is frequently the exception, with many of our patients suffering from a number of interacting illnesses at the same time. General practitioners have recently been referred to as 'specialists in multiple morbidity'.[1] Our patients often present with concurrent

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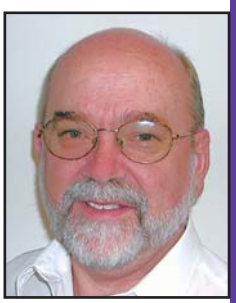

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multiple illnesses – physical and mental – and their presenting symptom patterns with mental illness are frequently somatic rather than psychological. This is perhaps a significant factor in the much discussed under recognition and under treatment of psychological disorders in general practice.[2] The increased health burden - both on the individual and the community - of those with coexisting physical and mental illness has been well established and researched.[3] As we move from a single diagnosis, through dual diagnoses to the multiple morbidities seen in general practice, we move away from the depth of evidence to guide such management. Perhaps it is unlikely we will ever have randomised controlled trials to guide the management of such patients.[4]

Marietta's problem list

A number of significant issues arise at the first consultation:

- How was the diagnosis of schizophrenia made and is risperidone still the appropriate treatment?
- Is the diagnosis of depression correct, and if so, is paroxetine the appropriate treatment? Patients with schizophrenia may manifest depression, but if the psychosis is active the appropriate treatment is to increase the dose of antipsychotic medication rather than prescribe antidepressant medication. If the patient's psychosis is under control then antidepressants are appropriate
- Is she receiving appropriate treatment for her back injury?
- What supports – community, family and mental health services does she have?
- What is her attitude to the pregnancy? If she is to continue with the pregnancy, she will need antenatal care and support
- Is her level of alcohol consumption such that it will affect the fetus?
- What is the effect of medication on the fetus? (Risperidone is classed as B3 and paroxetine as class C in pregnancy)
- Paroxetine blocks the metabolism of risperidone and changes in medication will need to be carried out carefully
- Children raised by parents with severe mental health problems have significantly poorer mental health outcomes than the general population. What does Marietta plan to do in relation to raising her child?

It is obvious that very few of these questions will be discussed during the first consultation. The main focus should be on establishing a trusting relationship so that Marietta will come back for a second (longer) appointment during which these issues can be explored. Working with Marietta will be difficult and ongoing care will be dependent on a strong therapeutic relationship, working slowly through the problems and dealing with crises as they arise. It is important not to try and change everything at once, but to set priorities and deal with the highest priority issue first. For Marietta this will mean dealing with the pregnancy first, before moving onto other issues of her care. It will also be helpful (with Marietta's permission) to seek previous medical records to clarify the issues referred to above.

Common mental illness comorbidities

Dual diagnosis, commonly used to describe a patient with both mental illness and a substance abuse problem, has received significant community publicity recently[5] with efforts being made to provide suitable management for these patients. Dual diagnosis is not a homogenous term. High prevalence and adverse outcomes mean we need to recognise the impact on our patients with a range of mental illnesses and coexisting alcohol, cannabis and/or heroin use.[6]

General practitioners will not be surprised to learn research has confirmed the frequent comorbidity of depression and anxiety,[7] but what about personality disorder? Research from United Kingdom[8] general practice suggests a prevalence of more than 20% with some of the most difficult patients to manage being those who have a personality disorder as one of their comorbid diagnoses.[9] This is an area of management that is worthy of more attention.

In the case of Marietta, the patient presents taking both an antipsychotic and an antidepressant, raising a further comorbidity issue. Schizophrenia with depression is not the same as depression with psychotic features. This complex situation may be clarified by following the patient over the course of their illness.[10]

The increased association of physical illness with mental illness is not confined to a few conditions, but appears to apply to most disease categories.[3] Chronic pain syndromes are a further common psychiatric comorbidity. The temptation to place such patients in the 'too hard basket' and perpetuate an often undesirable existing therapeutic environment may arise. Although an active response on our part may take more time, it is essential for optimal patient care.

Management

Establishing the diagnosis in patients with comorbid mental illnesses is difficult; determining the best management approach is frequently even more problematic (*Table 1*). When we see a patient with multiple comorbid diagnoses (including mental illness) the diagnostic picture may only be clarified after one of the diagnosis is treated.[11] Often however, the dilemma is to decide with which problem to start.

Prioritising

If issues of immediate risk are present, such as harm to self or another person, this must be an urgent management priority. If a patient presents with chest pain and acute schizophrenia, the assessment of the chest pain is an urgent starting point, ensuring we do no harm as a priority. Our approach to the patient's symptom of chest pain should be done in such a way as to avoid exacerbation of the patient's mental illness, especially anxiety features. When the patient is in our consulting room is not the time to develop a risk management strategy; we need to have thought about this beforehand and feel comfortable asking appropriate questions.

Revising current management

When patients with multiple comorbid diagnoses present to GPs, other practitioners will often have been involved in their care and it is important to review current management. Confirming accurate diagnoses is essential, avoiding the temptation to assume diagnoses based on current medications. Layer upon layer of treatment may have been added for each diagnosis, increasing the risk of medication interactions and reduced compliance.

A team approach

For this group of patients there will often be a number of other health care professionals involved; our management role will therefore include being a coordinator, facilitator and advocate. When complex patients present, we need to ensure we obtain previous medical information as a priority. Dual diagnosis involving mental illness and substance misuse issues are routinely managed at specialist level by different agencies in Australia – with consequent difficulties of continuity and coordination.[12] Too often, complex patients – who deal with a number of health care providers – feel 'lost in the system'. If we and our patients recognise our role as more than gate keepers, and act as the pivotal manager of their illnesses, we have a chance of preventing this feeling of being 'lost'.

Table 1. Management of patients with psychiatric comorbidity

Management approach

- positive, caring, patient centred
- assess risk issues as a priority
- treat multiple diagnoses within an integrated treatment plan
- treat patient as a whole person in their social context
- coordinate care with other health professional
- set realistic goals

Traps to avoid

- not establishing a relationship first
- missing risk issues by not asking questions
- treating each problem as independent
- making changes too quickly or all at once
- forgetting the patient's social context
- assuming medication always indicates diagnosis

The family

The interaction between patients with comorbid psychiatric illnesses, their medical carer and their 'family' frequently has a significant impact on outcomes. Families are often affected by the occurrence of severe mental illness[13] and may exert a positive or negative effect on the patient with the illness. It is also important to recognise that children raised by parents with mental illness have an increased risk of adverse long term outcomes.[14]

The therapeutic relationship

Finally, central to the outcomes of the care we provide will be the quality of the therapeutic relationship we form with the patient.[15] Having realistic goals, recognising that both full assessment and management may take a number of consultations, will reduce the sense of being overwhelmed by the complexity of many of these patients' problems.

Conclusion

Patients with comorbid mental illness are one of the most complex challenges we face in general practice. Our role often involves understanding and dealing with both a number of individual illnesses in the one patient and treating that patient as a whole person who lives in a social context at the same time. A central factor in the success of both these endeavours will be the therapeutic relationship we are able to form with these challenging patients.

Summary of important points

- Establishing a trusting relationship is a priority.
- Work slowly through the problems.
- Set priorities and deal with the highest priority first.
- A team approach is essential to optimal care.

Conflict of interest: none declared.

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