POINTERS IN PSYCHIATRY

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The current strategy worldwide is to encourage primary care doctors to play a bigger role in mental health care, from prevention to earlier diagnosis, and also more informed management and shared care of their psychiatric patients. In this family practice skills course, we focus on the key topics of insomnia, depression, suicide, and anxiety.

Insomnia

Insomnia is the most prevalent sleep complaint in the general population. It may be defined as the inability to obtain sleep that is sufficiently long or 'good enough' to result in feeling rested or restored the following day. Patients with insomnia often report difficulty in falling sleep, difficulty in maintaining sleep, such as having intermittent awakening during the night, or early morning awakening with inability to fall asleep again (Ng, 2010)[1].

Non-pharmacological and pharmacological approaches are used to manage insomnia. Non-pharmacological methods are effective and should be considered as first line treatment. Methods such as sleep hygiene, stimulus control therapy and relaxation techniques are discussed in this skills course (Lee, 2010)[2].

Pharmacological treatment of insomnia should focus on treating the underlying disorder. Pharmacological management should be used at the lowest dose for the shortest time possible. Consider referral to a psychiatrist if the patient is not responding or shows signs of dependence or tolerance to the hypnotics (Lee, 2010)[2].

To assist doctors in the appropriate use of the benzodiazepines and other hypnotics, the Ministry of Health has issued the Administrative Guidelines on benzodiazepine use which require the benzodiazepine prescriber to comply with three tasks – (1) Document & keep medical records, (2) Use benzodiazepines appropriately, and (3) Make specialist referrals when indicated (Goh, 2010)[3].

The MOH Clinical Practice Guidelines 2/2008 provide details that guide the approach and management of acute insomnia, chronic insomnia, depression, pain disorder, schizophrenia, the elderly with insomnia, benzodiazepine dependence and the need to consider benzodiazepine withdrawal in such a patient (MOH, 2008)[4].

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Depression

Depressive disorder affects the quality of life, increases the economic burden from cost of treatment or loss of employment, and may lead to suicidal tendency. Depressive disorder is the commonest psychiatric problem in primary care practice. However, it is often undetected and the under-diagnosis is partly because the depressed person is preoccupied with physical complaints of pain or aches and this could mislead the attending doctor. The early symptoms of depressive disorder are low mood, loss of energy, anhedonia, poor sleep, poor appetite and loss of interest in work or activities (Kua, 2010)[5].

Suicide Risk

Often it is not just one factor, but a combination of factors which triggers a person to commit suicide. It is through the understanding of these risk factors, that we can better assess the risk of suicide in our patients. Relationship problems are associated with one-third of all suicides, and are seen across the spectrum in all age groups. Financial (failed business, debt and legal issues) or employment problems are associated with a further one-third. Gradual physical disability and suffering (due to illness and advance age) are important risk factors in the elderly suicide, particularly if coupled with poor community and family support (Chia & Chia, 2010)[6].

Anxiety Disorders

Fear and anxiety are normal emotions felt when exposed to stressful situations. Anxiety disorders happen when the level of anxiety felt is out of proportion to the perceived threat and more importantly affects the person's ability to function. Generalized anxiety disorder and panic disorder are the 2 most common anxiety disorders encountered in Family Practice. A combined approach of psycho-education, relaxation training and medications give the best results. Anti-depressants are the mainstay of pharmacological treatment. Benzodiazepines when employed should be used at the lowest shortest possible dose for the shortest possible time. Patients with psychotic symptoms, those with significant suicide risk, and those who fail to improve with the initial treatment and follow-up should be reviewed by a psychiatrist (Lee, 2010)[7].

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