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69 – Continuity of Care for Patients with Mental Illness in General Practice

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Vulnerability, stress and coping behaviour

Stress in the everyday living environment as well as discrete stressful events appear to be associated with an increased risk of florid episodes of psychotic and affective disorders (Leff and Vaughn, 1985). However, not every person who is subjected to major stress develops a mental disorder. It is hypothesized that those most likely to succumb possess aspecific biological vulnerability that develops into an abnormal physiological reaction under the influence of stress, in much the same way that a person with a vulnerability to peptic ulceration produces excess stomach acid when stressed (Falloon *et al.,* 1992). The precise nature of these metabolic predispositions are poorly understood, but genetic factors, hormonal imbalance, brain injury and psychoactive drugs have all been implicated in major disorders. Psychological factors such as personality, preparedness and past experiences undoubtedly influence this process, possibly by deter- mining the effectiveness of coping processes in moderating the impact of stress. Highly efficient coping behaviour may render a person relatively invulnerable to the impact of major stress factors, even when that person is very prone to a pathophysiological reaction (Falloon,1985). Specific drugs and other biomedical interventions (e.g. respiratory control to correct blood gases) may have a similar impact in modifying the risk of pathogenesis. This vulnerability-stress formulation assists the clinician to integrate biomedical and psychosocial interventions in a similar manner to that employed in most fields of physical medicine. In addition it provides a rationale for preventive interventions for people with high vulnerability factors who present with stress reactions, as well as for intervention to minimize the risk of recurrence for people with established disorders. The first contact is usually made with the family practice team, who provides the initial phase of early intervention strategies.

The integrated care approach

The integrated care approach aimed to provide day treatment within the context of the patient's existing community resources, rather than in a group-oriented centre. This approach, has focused on people living in distressed family relationships, rather than providing assistance to all families who are caring for a person with a major mental disorder. The implications that may be drawn from these studies are clear.

First, it is not feasible to provide specialist care for all people who are suffering from mental disorders, particularly if that service is planned along traditional hospital-

based lines. Huge increases in the provision of hospital beds, day hospitals and outpatient services would be needed merely to cope with the severest cases in the community. Secondly, any effective service to meet the community needs for effective mental health care should involve close collaboration with family carers and primary care services. It is possible that efficient consultation and effective support for families and primary care services might reduce the need for many of the interventions currently undertaken by mental health services.

Continuity of care and Family psycho-education

Family psycho-education is an evidence-based practice that has been shown to reduce relapse rates and facilitate recovery of persons who have mental illness. A core set of characteristics of effective family psycho-education programs has been developed, including the provision of emotional support, education, resources during periods of crisis, and problem-solving skills. Unfortunately, the use of family psycho-education in routine practice has been limited. Barriers at the level of the consumer and his or her family members, the clinician and the administrator, and the mental health authority reflect the existence of attitudinal, knowledge-based, practical, and systemic obstacles to implementation. Family psycho-education dissemination efforts that have been successful to date have built consensus at all levels, including among consumers and their family members; have provided ample training, technical assistance, and supervision to clinical staff; and have maintained a long-term perspective.

Several models have evolved to address the needs of families of persons with mental illness: individual consultation and family psycho-education conducted by a mental health professional , various forms of more traditional family therapy , and a range of professionally led short-term family education programs , sometimes referred to as therapeutic education. Also available are family-led information and support classes or groups, such as those provided by the National Alliance for the Mentally Ill (NAMI) . Family psycho-education has a deep enough research and dissemination base to be considered an evidenced-based practice. However, the term "psycho-education" can be misleading: family psycho-education includes many therapeutic elements, often uses a consultative framework, and shares characteristics with other types of family interventions.

A variety of family psycho-education programs last nine months to five years, are usually diagnosis specific, and focus primarily on consumer outcomes, although the well-being of the family is an essential intermediate outcome. Family psycho-education models differ in their format—for example, multiple-family, single-family, or mixed sessions—the duration of treatment, consumer participation, location—for example, clinic based, home, family practice, or other community settings—and the degree of emphasis on didactic, cognitive-behavioural, and systemic techniques.

Although the existing models of family intervention appear to differ from one another, a strong consensus about the critical elements of family intervention emerged in 1999 under the encouragement of the leaders of the World Schizophrenia Fellowship .

Treatment models that have been supported by evidence of effectiveness have required clinicians to adhere to 15 principles in working with families of persons who have mental illness:

• Coordinate all elements of treatment and rehabilitation to ensure that everyone is working toward the same goals in a collaborative, supportive relationship.

- Pay attention to both the social and the clinical needs of the consumer.
- Provide optimum medication management.
- Listen to families' concerns and involve them as equal partners in the planning and delivery of treatment.
- Explore family members' expectations of the treatment program and expectations for the consumer.
- Assess the strengths and limitations of the family's ability to support the consumer.
- Help resolve family conflict by responding sensitively to emotional distress.
- Address feelings of loss.
- Provide relevant information for the consumer and his or her family at appropriate times.

• Provide an explicit crisis plan and professional response.

• Help improve communication among family members.

• Provide training for the family in structured problem-solving techniques

• Encourage family members to expand their social support networks—for example, to participate in family support organizations such as NAMI.

• Be flexible in meeting the needs of the family.

• Provide the family with easy access to another professional in the event that the current work with the family ceases.

Discussion

It may be concluded that it is feasible to provide comprehensive mental health services for adults in a community-based setting. The approach we have piloted employ strategies that have proven effectiveness, applied in the same home-based manner in which they have demonstrated advantages over hospital-based methods. This has involved extensive integration with the caring efforts of family members and other informal carers. Their efforts, as well as those of family practitioners and community nurses, have facilitated the early application of effective treatment, support through crises, and long- term rehabilitation. The continued development of the integrated approach has changed the role of the hospital in the care of adult mental disorders. Rather than being the first port of call, the hospital has become a small, but important, component of an extensive network of community-based care. Such as approach is remarkably similar to that provided in child and adolescent mental health care, where the focus of interventions has been the home and the family.

Take Home Message

- The main advantage of such an approach appears to be the ability to provide continuity of care that aims not merely to avoid major crises, but to provide full and lasting recovery from all forms of mental disorders.
- Once the index patient and family have been integrated into the care team, and trained in the specific strategies that have been shown to help with their specific problems, they are able to provide a continuing health-enhancing resource that is unrivalled by even the most intensive hospital programmes.

Original Abstract

http://www.woncaeurope.org/content/continuity-care-patients-mental-illness-general-practice

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