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April 2012

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Recommended Citation

Tharani, A., Farooq, S., Naveed, A. (2012). Community mental health services: a way forward to rehabilitate chronic mentally ill client.. *Journal of Ayub Medical College*, 24(2), 140-143.

Available at: http://ecommons.aku.edu/pakistan_fhs_son/121

ORIGINAL ARTICLE

COMMUNITY MENTAL HEALTH SERVICES: A WAY FORWARD TO REHABILITATE CHRONIC MENTALLY ILL CLIENT

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Schizophrenia and other mental illnesses produce devastating effects on a clients' personal and psychosocial wellbeing. Besides the sufferer, it has irrevocable impacts on the lives of their loved ones. With advancement in the treatment modalities, researches have proven that hospital based care and psychotropic drugs are not the sole solution in managing the client symptoms. Deinstitutionalization is the paradigm shift from hospital based to community based care model that allows client/s to spend rest of their lives in the community setting. A well-structured community care based programme that focuses on psychosocial interventions has significant contribution in treatment and rehabilitation of client/s. This article is aimed to provide the evidence of the effective use of community mental health care for management and prevention of relapse of a client with chronic schizophrenia. The substantial evidence of rehabilitation is represented through this case study of a chronic schizophrenic client who received these psychosocial interventions in his own community setting.

Keywords: Schizophrenia, community mental health care, psychosocial interventions, rehabilitation

INTRODUCTION

Mental health has an indispensable connection with the human life, for maintenance of healthy relationships and performance of daily activities independently. However, poor attention is been given to this significant part of health. The rise in global burden of mental illnesses has become a vitally important concern for the nations as it impacts on morbidity, mortality and economy;¹ reaching to the stage of 'global epidemic'.² According to a WHO³ report, 450 million people in the world are suffering from a mental or behavioural disorder. Opting for a treatment of mental illness has remained the least important area in relation to the attached cost and stigma. In developing world, 90% of the people suffering from mental illness do not receive treatment.³ Likewise, mental health care has been one of the most neglected areas in Pakistan considering the lack of awareness and health services,² and its attached stigma to seek appropriate treatment.¹

The population of Pakistan is estimated to be 187,342,721 in 2011.⁴ Whereas, the magnitude of mental illness in Pakistan is reported to be 6% Depression, 1.5% Schizophrenia and 1% Alzheimer's disease,⁵ which does not reflect the true picture. Though the number of psychiatrists have risen from 250-400^{6,7} over decade, it is still inadequate considering the ever growing population and burden of mental illness in Pakistan². In the same line, there are 480 psychologists and 600 social workers, but their utilization is almost negligible.⁶ Though the hospital based care and psychotropic drugs are used in the management of mental illnesses; however, there is always an unfilled gap after hospital discharge that leads to relapse.

In the management of mental illnesses, deinstitutionalization has shifted the focus of care from hospital to community based care model to manage

mentally ill clients.⁸ However, its accessibility particularly in a developing country like Pakistan is very much a far cry; where the struggle is still on to serve the mentally ill patients in hospital settings with the trained mental health care providers.⁷ Once the acute symptoms are managed in the hospital, the maintenance and prevention of relapse remain unsupported with the poor availability of the care providers in the home setting.⁹ Community based care can play a vital role in management of symptoms and prevention of relapse. According to the findings of the study conducted by Muijen, Marks, Connolly and Audini¹⁰ at South Southwark, London revealed that the home based care provided to mentally ill client brings remarkable improvement in clinical symptoms and social functioning with the reduction of hospital admission up to 80%. Another study done in Sydney, suggested better clinical outcome in community based intervention as compared to care in the hospital setting of mentally ill clients⁹ as symptoms are picked in acute phase and non-compliance is identified earlier to prevent relapse.

In view of the available literature, community based home care was implemented on following case, to address client's social functioning and prevention of relapse. To the authors' best knowledge, this is the first reported case study in Pakistan where home based mental health care has been implemented on a client with chronic mental illness, through trained mental health care providers in collaboration with a non-profit non-government social organization (NGO).

CASE

This was a 23-year-old young man with tall height, thin built and blunted facial expressions. He was in his usual state of health till 2008, when family started noticing changes in his behaviour. He had several somatic complains including weakness, that resulted in difficulty

in performing activities of daily living, difficulty in swallowing, nausea and indigestion. Parent consulted several physicians for a year but all proved in vain as no improvement was observed. Soon after this, he started to keep himself confined to home, became apathetic, and developed suspicious behaviour and poverty of speech. His academic performance started declining resulting from his inability to concentrate. Moreover, his social interaction, self-care and interest in activities of daily routine also decreased. His family consulted a psychiatrist considering these surfacing issues. He was diagnosed with schizophrenia and was placed on psychotropic medications. However, the condition did not improve. Parents were worried and they consulted the psychiatrist again who this time strongly recommended that along with the medications, he needs persistent psychosocial interventions at home in order to improve his clinical symptoms and social functioning. In collaboration with locally working NGO, parents struggled hard to improve his mental condition but it remained the same. The organization approached the trained mental health care providers to work collaboratively in order to improve the psychosocial functioning of this client.

This scenario raises several important questions for us to answer:

- Can psychotropic medication solely manage such symptoms?
- How psychosocial interventions can assist in improving clients' symptoms?
- What is the role of home based community mental health care in clients' recovery and prevention of relapse?

The focus of this paper would be to explore the effectiveness of home based community mental health care to improve the mental health and to prevent the relapse in chronic mentally ill clients.

DISCUSSION

Schizophrenia is a serious and persistent brain disease that results in disturbances of thought, perception, mood and behavior.¹¹ This disease of disconnected mind¹² deeply affects clients' interpersonal relationships and problem solving abilities⁸. It is one of the six leading neuro-psychiatric disabling cause that affects around 25 million people worldwide.³ This chronic mental health condition has a wide impact that not only affect client but serves as a huge burden on care givers too.¹³ The stigma attached to the mental illness adds to the sufferings of the clients when the disease is associated with their sins and supernatural powers.¹⁴

Introduction of psychotropic medication, as revolution in the treatment of psychiatric disorders,^{15,16} has shifted the paradigm contributing in de-stigmatisation and humane treatment of clients. Antipsychotic medications in schizophrenic patient

reduce the negative (social isolation, self care deficit, affective flattening, and attention impairment) as well as positive (hallucinations, illusion, delusions, bizarre behaviour and other disordered thought and reality testing) symptoms of the disease.^{15,17} However, the compliance with the antipsychotic medications remains a major concern due to absence of client's insight to the disease, unpleasant,¹⁶ disabling and life threatening side effects¹⁵. The relapse rate of 20–30% is reported during the first two years of drug treatment to antipsychotic drugs.¹⁸ Hence, long term or possible life-long support is required, considering the multiple relapses and residual impairment that are resulting,^{13,15} to improve quality of lives of the clients¹¹. Though this psychotropic medication contributes in symptomatic management of clients, it doesn't cure the mental illness.¹⁹ So, the management of the symptoms solely with the medications is uncertain. This uncertain management evoked the process of community based care with its available social support to manage client's symptoms. Various 'talking interventions' were started being used in conjunction of medications since 1970's to address the symptoms of schizophrenia and termed as 'psychosocial interventions'.¹⁷

Considering that the majority of clients suffering from schizophrenia are home based, literature suggests a structured cost effective community based care that focuses on psychosocial interventions and early identification of relapse symptoms, as part of treatment and rehabilitation plan/program.^{13,17,20} In schizophrenia, social skills training is considered as important attribute while implementing psychosocial interventions. Kopelowicz, Liberman and Zarate²¹ have referred social skills as:

'Social skills' training consists of learning activities utilizing behavioural techniques that enable persons with schizophrenia and other disabling mental disorders to acquire interpersonal disease management and independent living skills for improved functioning in their communities.'

Although, the available literature suggests the integration of psychosocial interventions as part of treatment and rehabilitation plan, it is usually not considered by the families/clients, viewing the drug therapy as a 'miracle pill' or 'quick fix' for the psychiatric disorders.¹⁵ As a result of this, personal, social and environmental conflicts remain unresolved,¹⁵ and eventually people with chronic mental illness are not successfully engaged by available mental health services and are at greater risk of repeated hospital admissions, isolation and social exclusion.²²

Schizophrenia is a chronic illness that affects all aspect of client as well as family life. Therefore, the heterogeneous rehabilitation plan for the above mentioned client was initiated by the mental health care providers in collaboration with patient and family

focusing on 3 major goals: a) Developing therapeutic relationship and promote treatment adherence, b) Providing psycho education to client and family, and c) Maximizing quality of life and adaptive functioning. The plan of care was implemented over a period of one year from the time of reporting this case.

It is essential for the mental health care provider to establish and maintain supportive therapeutic relationship to gain the essential information about the client, to gain their full participation in all aspect of plan of care and to achieve the set goals.⁸ Considering disability effect of schizophrenia on social, interpersonal and academic functioning of clients, the plan of care was meant to be based on thorough assessment of these areas of functioning. The thorough assessment of client further revealed that his academic performance was outstanding and it started declining with poor concentration since 2004. Aggravation of the symptoms was reported when the client was spending more time in his studies. Though, the family modified the burden of his education from Cambridge to intermediate education system, but never looked for professional help until 2008.

Ensuring treatment adherence with medications is vital in managing the acute symptoms of illness but can not completely cure the illness. This client was receiving atypical (new generation) anti psychotic medications: Aripiprazole 15 mg and Olanzapine 5 mg since 2008. The compliance with the medication and follow-up was ensured by the family as care provider. However, the persistent deterioration in the psychosocial functioning remained a concern for the psychiatrist and family throughout. Poor attention span, motivation, decision making, sense of pleasure, disability in self care and social relatedness were the major psychosocial concerns. These symptoms concur with the literature that indicates struggle with the management of these lingering deficits and disability though the compliance with the medication is maintained.^{16,21}

The client's deteriorating symptoms were attempted to manage through a comprehensive treatment plan that focuses psychotherapeutic drug and psychosocial intervention. Literature suggests that when the client is aware about the reliable use of medication, they become more responsible for their treatment, achieve greater insight and have more control over their illness.²³ Therefore, to ensure the adherence to the medication, client and family education was considered as apart of the comprehensive treatment plan. Client was encouraged to report the side effects and concerns associated with its use. Along with that, client and family were explained about the importance of medication compliance and timely follow-up in stable phase for the prevention of relapse. Similarly, educating about the nature of the illness and coping strategies can

markedly diminish the relapse and can improve the client's quality of life.²⁴ The relapse rate is reported to be reduced up to 50% when psycho education is used in combination with medication in the management of clients' symptoms.²⁵ Therefore, the patient education material related to the disease process was shared with the client and family, and their misinterpretations related to the disease were addressed. Besides providing the education, family was provided with the guidance and support to optimize their care taking role and improve their own well-being.

Early identification of symptoms of stress and coping mechanisms was the integral part of the therapeutic assessment plan to promote client functioning. Client was taught and encouraged to practice relaxation techniques such as exercise, deep breathing, progressive muscle relaxation, listening music and watching TV. Symptoms were reported to be reduced with the gradual increase in the utilisation of these relaxation techniques over the period of a year. Communication and social skills training was focused to build social connectedness and maximise the client's quality of life. As part of communication and social skills, the behaviour modification was focused on maintaining eye contact, voice, volume, posture and distance, and emphasis of perceiving and interpretation of signal and cues accurately. Improvement in the communication pattern was also evident over the same period of time as client was now responding in detail and was attempting to clarify the care providers misunderstanding, if any. Client appeared more confident and comfortable in discussing general topics and 'homework assignments' were also given to motivate the patient to implement the learnt communication in real-life situations. Client was encouraged to make social connectedness through attending religious place for prayers almost daily with father and he also started participating in voluntary services there for 15 minutes in a week.

Training to address the practical issues of daily living was also focused to improve the client's quality of life over the period of a year. These individual every day practical issues were addressed to meet his needs for independent living²² that includes clothing, bathing, shopping, grooming and using transport. The client was assisted to identify the barriers and difficulties that he was facing in carrying out these activities of daily living. Lack of confidence and negative perception of self were identified as barriers to carry out daily activities and social interaction by the client. Step-wise tasks were formulated to achieve the simple daily living activities over the period of several months with 'homework assignments.' Therefore, separate sub goals were formed to increase his individual functioning. Positive reinforcement was provided in each session based on the client's initiatives and progress since last session.

Participation of family, as the first line care provider, was given significance for successful implementation of treatment plan. Therefore, family was involved throughout in planning of client's care that focuses on family competencies rather than deficits.²⁶ Hence, the psychosocial family interventions included the psycho education about the disease and medications, lessening of adverse family atmosphere, enhancing the capacity of mother to anticipate and solve problem, reduction of expression of guilt and sadness, expecting reasonable performance from client, and setting limits to reduce dependency.²⁷ Family was assisted to manage their stressors associated with the care giver role strain. They were encouraged to use effective coping mechanisms and diversional activities to improve their own mental health and well-being.

CONCLUSION

Community based mental health programme can improve clients' functioning that can represent a meaningful change in their quality of life and their family. Implementation of psychosocial intervention with trained mental health care providers has shown significant improvement in the client's performance as mentioned in this case. The mental health care providers are still working with this client to further improve his psychosocial functioning and quality of life. Viewing the successful rehabilitation benefits of the community based psychosocial interventions; a sustainable approach needs to be taken into account with trained mental health care providers who can provide psychosocial interventions at their door step. Moreover, it can monitor the clients' progress, prevent the relapse and reduce the cost of re-hospitalisation. Therefore, collecting further evidences of implementation of effective community based mental healthcare programme is recommended. It is the high time to move the centre of care for chronic mental illness from hospital to client's community setting.

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