



PRISM: Promoting Resilience, Independence and Self Management—A strategy to manage chronic mental illnesses

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ABSTRACT

Many transformations in how mental health care is delivered have required the development of new ways of providing care, treatment and support to mental health consumers. In the recent past, to support consumers and their carers adequately and appropriately, there has been emphasis on case management and care coordination.

There is a need to consider whether over-emphasis on case management should be limited to the minority of mental health consumers who are unable to make competent decisions, whereas majority of consumers should take complete charge of their own treatment.

PRISM (Promoting Resilience, Independence and Self Management) is a conceptual framework that potentially offers an opportunity to empower consumers to take charge of their own treatment by using specific tools, including a PRISM Pack, Take Charge Sheet, Protocol for Appropriate Care and use of methods that ensure that the mental health consumer does become a key decision maker with regard to their own care and treatment.

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1. Introduction

Over the last 200–300 years, the mental health system has experienced several dramatic transformations. These have included a move from hospital to the community, greater recognition of human rights and self determination, focus on equality, introduction of the concept of recovery and rehabilitation, and so on.

The move from the hospital to the community in particular necessitated consideration of different options to meet consumer needs that could previously be met within the walls of the institutions. For consumers, living independently meant a need to make more choices and decisions without institutional support structures previously available within hospitals. For services, consumer and the family (or carer), engagement become incredibly important. Without this support and assistance it was no longer possible to promote their well being. Concepts of recovery, rehabilitation and self management not only become acceptable and popular, but also necessary. All of the above required the sector to incorporate models of care coordination and case management, to be able to provide holistic supportive care to people with mental illness (Butler, 1969; Crow, 1971; Hafford,

1980; Hicks et al., 1970; Jones, 1970; Mound et al., 1991; Pittman, 1991; Pyke et al., 1991).

1.1. The 'mental health ship' is still turning

If one reviews the shift over at least the last century, it is not difficult to understand the reasons why the sector has made such shifts to meet needs of people with chronic mental illnesses.

Clearly, availability of more effective medications, changing societal expectations and availability of resources for health care provision has influenced where care is delivered, by whom, why and also how care is delivered. For example, at the turn of the twentieth century, there was a realisation that well intentioned mental institutions had deteriorated and had become a dumping ground for people with mental illness (Freeman, 1999). There were concerns that people admitted to these institutions were locked away and forgotten (Issac and Armat, 1990; Lamb, 1981). Institutions had become regimented, inadequately resourced and had become back wards for people who were perceived by wider society to have "deviant" behaviour (Brothers, 1962; Garton, 1988). Therefore there were political, societal and ethical imperatives to close these mental institutions (Goffman, 1961). The economic arguments may have also sounded appealing as mental institutions were also rather expensive to run.

However, closure of large mental institutions meant that people had to be treated in the community, at outpatient centres, day centres and in the community health facilities. It did not take long for

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the sector to realise that many people with chronic mental illness needed a huge amount of assistance to cope with the requirements of community living, including housing, activities of daily living and developing other social skills needed to participate as active members in the community. Many people with chronic mental illness found themselves on the streets, homeless (Herrman et al., 1990; Doutney et al., 1985). Because of a lack of understanding and awareness in the general community, there was fear in the mind of lay public about the potential dangerousness of people with mental illness attributed to erratic and unpredictable behaviour (Appelbaum et al., 2000). This also resulted in stigma and discrimination as they attempted to integrate in the community.

Having noted the above, even though treatment in the community was full of challenges, it was seen to be the right thing to do. To respond to this large scale experiment of deinstitutionalisation and also to manage this chronic health condition characterised by remissions and relapses, it was acknowledged that an army of community mental health clinicians was required (Australian Health Ministers, 1992). Trained mental health nurses, psychologists, social workers, occupational therapists and psychiatrists endeavoured to provide care and treatment in the community. There was also a realisation that a singular focus on health care and treatment was inadequate, as without social intervention, it was not possible to meet health care needs of the mentally ill in the community. The model of care coordination or case management borrowed from social services appeared to be an appropriate model to implement. It seemed quite sensible for a provider (either of health or social care) to be identified as coordinator or manager of care to ensure that not only the diverse health and social care needs of people with mental illness were identified, but that care was delivered (Cesta et al., 1998). Moreover, since these very diverse health and social needs now had to be met by a variety of community providers and government departments, need for coordination was essential (Simpson, 2005; Wallace et al., 2005). For people who were severely incapacitated by their mental illness, assertive community treatment and intensive case management appeared to be necessary (McGrew and Bond, 1995).

1.2. *The transition continues*

The current model of mental health care provision is to support people with mental illness in the community. Inherent in this model is a belief and understanding that people with mental illness can live independently, participate in society and can contribute effectively as equal members of the community. Yet, for some reason the system orientation appears to be struggling to make a change.

Even though people with a mental disorder are living independently and receiving treatment in the community, the mental health care system sometimes continues to operate as if people with mental illness are unable to manage their own affairs, unable to make decisions that are in their best interest and are unable to understand and accept their illness. Therefore, at times, the mental health system appears to hold a belief that dependence of patients with mental illness on the healthcare system needs to be ongoing and continuous. Surely, that must be the reason why almost everyone receiving care from the public mental health services is “case managed”. This does appear to be a slight contradiction in our philosophy (supporting independence) and system orientation (enabling recovery).

2. Challenges for service providers

2.1. *Search for new models of care must continue*

Care in the community has seen the need for the mental health services to engage with other services and departments to meet

health and social care needs. It has also seen the need for development of structures for effective coordination of care and communication. The community mental health provision framework has emphasised care coordination and/or case management. Indeed, the society's expectation from mental health clinicians has been to take de-facto responsibility for care of people with mental illness to ensure needs of people with mental illness (and their carers) are comprehensively assessed; potential risks people with mental illness pose are managed; and the needs and demands of people with mental illness and their families are responded to.

It is true that the case management model has been an effective model and has enabled many people with mental illness who would have struggled to survive in the community to seek assistance from caring (health and social welfare) services (Weil and Karls, 1985; Schilling et al., 1988; Hall et al., 2002). Care coordinators and care managers have been able to negotiate assistance on behalf of mental health consumers, have endeavoured to ensure that provision of all aspects of care are coordinated and non-health care needs are not neglected. However, even though this model has been quite effective for some mental health consumers, the mental health sector has not always been able to strike the right balance between providing case management and enabling self management.

Many people who are able to self manage and make independent decisions are still ‘case managed’. In fact the healthcare standards require a case manager or contact person to be appointed for all mental health consumers receiving care, treatment and support from specialist mental health services. This has not only meant an unnecessary high cost resource investment, but also interference with people's autonomy, independence and decision making.

The sector's orientation has always been to serve, care, assist and support, however, perhaps because of over-zealous intervention and intrusion, the sector has sometimes lost sight of this goal and become over-involved in the lives of many, when it is not really necessary. This may also be the reason why some advocates have suggested that the sector needs to learn, understand and accept the concept of recovery (Corrigan et al., 1999). It is not that this concept is new or novel for health care professionals; perhaps it is necessary for the sector to be reminded again.

3. Introducing PRISM

Promoting Resilience, Independence and Self Management is a concept for all mental health consumers. Integral to this concept is the principle that consumers who are voluntary and considered to be competent decision makers should be allowed to take complete charge of their treatment decisions. On the other hand, consumers who are not considered to be competent decision makers should be given as much responsibility and independence in making decisions about their own care and treatment, as is considered clinically appropriate.

As the name suggests, the key concept PRISM promotes is that of Promoting Resilience, Independence and Self Management. However, this requires a change in attitudes, culture, environment, practice and also systems and processes. The concept is driven from a simple starting point: “I must manage my own care.”

The focus in PRISM is on changing attitudes and development of a shared culture and understanding, carefully understanding environmental contributors that interfere with the systems' ability to promote resilience and independence; developing tools and methods that promote self management; and system redesign of clinical care practice and provision. The underlying concept being that even though service providers may be clear about what needs to be done, until the principles of care are clear to consumers and carers, and applied consistently, the environment is conducive and

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