

# A neurobehavioural-informed approach to the use of clinical competencies in supporting the community-based care of individuals with multi-axial diagnoses

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## Abstract

*Individuals with multiple diagnoses most often present with social difficulties, with either aggressive or withdrawn behaviour predominating. In individuals with behaviours that represent changes at a neural level, and in those with comorbid psychiatric diagnoses, these behaviours often represent obstacles to rehabilitation. Consequently there is little consensus as to how such patients can be assessed, treated and interacted with, and so too there is little potential to improve outcomes with guided training. When multiple agencies are involved, such patients may 'fall between the cracks' and undergo prolonged and disempowering interventions with poor outcomes in the absence of individual programmes. This article addresses the core issue of empowerment in the assessment and community-based rehabilitation of patients with multiple mental health issues, and utilises a case report format to illustrate the methodology.*

## Introduction

Community empowerment is a concept that is difficult to apply and measure within the context of the assessment and treatment of patients with complex and interacting disabilities (Laverack & Wallerstein 2001). Intentional non-compliance is an issue that arises in such patients, as they struggle with their perceptions of the bona fides of treating teams (Webb, Horne & Pinching 2001). Social withdrawal following illness (Sugarman 1999), following on difficulties in the acute and post-acute settings, demands a more patient-centred inpatient and outpatient approach (Scheil 2001).

There is a need to adopt an ecological approach that addresses empowerment issues at varying levels of abstraction, takes into account the variety of agencies in the community, and involves longitudinal rather than cross-sectional assessment and treatment plans, especially in Australia's transcultural settings (Sugarman 2001, in press; Tsey & Every 2000). At the same time, approaches to patients with complex and interacting mental health problems have been teacher-driven and focussed on diagnostic issues, and this needs to move to learner-driven and health-focussed, moving from impairment issues to disability issues in order to allow for consumer empowerment (Condeluci 1997; Schofield 1998).

There appear to be at least two valid constructs in such an approach: firstly, a self-orientation to empowerment is significantly associated with quality of life, social support, self-esteem and psychiatric symptoms overall, and secondly, community orientation is correlated with self-esteem, resources, verbal intelligence and ethnicity

(Corrigan, Faber, Rashid & Leary 1999). Any programme designed around patients with special needs should take these constructs into account by assessing the deficit, determining needs, establishing strategies, activating the best strategies, and then evaluating the outcomes (Condeluci 1997)

This article proposes a grouping of core clinical competencies that “place more emphasis on preferences and performance expectations of diverse groups and stakeholders.....and reflect the need for performance in typical community settings” as proposed by Young, Forquer, Tran, Starzynski and Shatkin (2000, p 322) as applied to other areas of severe mental illness.

A related concept, namely community empowerment, has become a central theme in the discourse surrounding health promotion, especially in Adelaide (Laverack & Wallerstein 2001). It is used here to drive a neurobehavioural approach to assessment and intervention in the context of organisational domains.

## **Case example**

A young woman from a non-western background was referred for assessment. She was under a detention order, and a community treatment order, but spent little time out of acute care. A brief attempt at formal assessment by the neuropsychologists came unstuck as she was verbally abusive and uncooperative. Following a team meeting, she was discharged into the care of the public advocate who was then forced to detain her to a non-treatment facility: the treating team asserting there was no way to effectively diagnose or treat any Axis-I or II condition. This team then contacted the author with instructions to deliver a health care plan for this patient.

A neurobehavioural approach was thus adopted (Nell 2000; Prigatano 1994) by the consultant team in order to provide a more flexible and dynamic approach (Sugarman 2001: in press) to diagnosis and community intervention. A series of stages was decided upon in this regard, based on existing principles of rehabilitation (Finlayson and Garner 1994) and the need to measure outcome effectively (Bond 1990; Harris 1997). Outcome was defined as obviating the need for acute admissions.

### **Stage One: Information gathering (assessing the deficit).**

The key worker was contacted and the complete clinical notes perused. On the basis of neurobehavioural information, it was determined that the patient had a multitude of physical and psychiatric difficulties. She was cerebral palsied and hemiplegic from birth, epileptic, of limited intellect according to testing on formal instruments, and was diabetic. Multiple examinations by medical and psychological experts had illuminated precisely on all of these conditions, but no co-ordinated approach had been designed, and no measurement of outcome was mooted.

### **Stage Two: Individual Programme Planning (IPP - determining needs)**

A series of meetings with involved agencies was conducted, part information gathering and part goal setting, in keeping with the principle dialectic proposed by Margret Scheil (2001). It was decided to target the patient's disabilities rather than attempt further psychiatric diagnosis/ treatment of some supposed impairment, although an integrated approach to this was discussed (Wilson 1997). This series of meetings also involved several phone calls and meetings to clarify and develop a series of hypotheses aimed at deciding on the core issues that should be addressed in her rehabilitation.

### **Stage Three: Identifying core clinical competencies (establishing strategies)**

The IPP process identified several areas of concern that would have to be addressed in order to provide a neurorehabilitation milieu that would support a process of empowerment for the patient (Prigatano 1997). These issues were clustered into groupings that in themselves defined key areas around which the various agencies involved would have to constitute clinical competencies. Clinical competencies are critically important interventions that encompass divergent treatment modalities while focussing on domains that result in the greatest improvement in patient outcomes (Young et al. 2000 op cit). Using this approach, the following key areas emerged, and clinical competencies developed to deal with them strategically.

### **Stage Four: Activating the best strategies**

1. Cluster one: Client-clinician relationships. Issues of respect, positivity, communication, financial supervision, accessibility, style of health-care delivery were all addressed and focussed. Strategies for invariant approaches to her attempts to access acute care agencies were developed and co-ordinated.
2. Cluster two: Initial and ongoing assessment. Critical stresses proved to be related to issues of family, hygiene, hemiplegia, uninformed crisis intervention and admission, lack of a holistic view to diagnosis and treatment, failure to implement assessment recommendations, poor integration of care agencies, concern around self-efficacy related to cultural and political issues especially the control of her finances and the removal of her children from her care, and the choice of caregivers, and other client preferences. Steps were taken to co-ordinate responsibility of the various agencies in addressing these critical issues.
3. Cluster Three: Rehabilitation and empowerment. Optimism was low, and affected all areas of competency. A holistic approach was adopted with clear-set goals and lines of responsibility. Her world view and personal experience were taken into account. A premium was set on education, rehabilitation of disability, client self-advocacy and natural supports. Attempts to be negative about outcome and institutionalise her were thwarted.
4. Cluster Four: Family and support system. Clear and irrevocable problems were revealed, and the non-treatment support centre made extensive allowances to provide respite, asylum and outreach available to her, which the treatment centre had not achieved.
5. Cluster Five: Social and cultural factors. Her cultural and socio-economic status proved critical in the aetiology of her violent behaviour. Her key worker then undertook active interventions to redress the balances and reduce paradox and inequity in these areas with good outcome.
6. Cluster Six: Resources and co-ordination of care. A series of entitlements, with resultant co-ordination of care around the integration of community resources and ongoing medical and social support were identified, and various agencies then took responsibility for their own resource management in this regard. Fragmentation of care and resources diminished.

### **Stage Five: Evaluating outcome**

As a result of these meetings and discussions around core competencies, the patient's contacts with acute care diminished despite a lifetime of extensive previous contact with such agencies since childhood. Over a short period of time she returned to her home, but she later adapted her lifestyle to move away from unsupported accommodation, as she more readily began to identify her needs and specify what competencies suited her needs in the community. Her level of aggression and the number of aggressive acts dropped to nil. A total of 25 hours were required of the consultant overall.

## **Discussion**

Rehabilitation involves several core issues which must be addressed if patients are to be successfully integrated into the community care venue or milieu, and are not to return to the expensive and overcrowded acute care venue. It is proposed that a combination of individual patient programming and the subsequent identification of core competencies around the provision of services is feasible and cost effective, despite the presence of multiple impairment and severe interlocking mental health issues. Rehabilitation as a philosophy targets disability rather than impairment, is client-centred and transparent, and focuses on issues of empowerment and outcome measurement in order to be goal-driven (Wilson 1997).

Despite psychiatric, cultural and neurological concerns, the co-ordination of care around such patients need not become a quagmire, and fraught with negativity and despair. The identification of relevant, personal key issues and their resolution is part of an individual programme approach, and this responsibility passes on to the community upon discharge, who must then develop the informed clinical competencies to co-ordinate and ensure continuity of care. By its nature, such a process is dynamic and collaborative, driven by optimism and a desire to empower the patient and caregivers through the processing of information.

It is clear that patients have to recover, not just from the effects of impairment of mental function, but from internalised stigma, low expectations and negativity of self and treating team, as well as dehumanising clinical practices (Deegan 1997).

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