Psychiatric Home Care and Family Therapy: A Window of Opportunity for the Psychiatric Clinical Nurse Specialist

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This article discusses use of the Developmental-Interactional Model of family therapy by a Psychiatric Clinical Nurse Specialist (CNS) for selected patients receiving psychiatric home care services. This form of family therapy is an integrative approach to working with individuals, couples, and families that combines elements of structural-strategic family therapy with life cycle and intergenerational approaches. Applied to patients and families in a home care setting, this model permits the CNS to assess relational dynamics over time, determining how these transitions relate to a family's problem-solving capability. Case studies are provided to show the application of this model for desired outcomes.

PSYCHIATRIC HOME care services continue to grow as the result of efforts to contain increasing hospital costs, creating a home health environment that offers increased opportunity for the Psychiatric Clinical Nurse Specialist (CNS). As institutions downsize their work forces, many CNS positions are being eliminated or reduced causing the CNS to seek employment opportunities in the community. Psychiatric CNSs are now finding challenging positions in certified home health care agencies, which receive Medicare, Medicaid, health maintenance organization (HMO), and preferred provider organization (PPO) reimbursement for a psychiatric nurse's visit if the client is under the care of a psychiatrist, has a psychiatric diagnosis, and is homebound secondary to his/her psychological or medical status. Psychiatric home care presents a great opportunity for the CNS to provide family therapy interventions based on assessment of complex clinical problems presented by patients living with their families.

Between 1980 and 1996, the number of patients receiving Medicare-sponsored home care increased by more than 400% and the number of agencies delivering that care increased by more than 200% (Montauk, 1999). Individuals most appropriate for home care services include those patients diagnosed with schizophrenia, bipolar disorder, major depression, and anxiety disorder discharged early from inpatient services, those with increasing levels of acuity, and the elderly who are vulnerable to psychosocial crises as well as chronic physical conditions (Iglesias, 1998). Trimbath and Brestensky (1990) report 50% to 70% of elderly patients receiving home care services have affective and/or behavioral disorders. Services may also be initiated for a homebound patient who has not been hospitalized, but has been referred by a psychiatrist in the community for interventions to prevent further decompensation.

There is a paucity of nursing literature on home-based family therapy on which to base effective intervention strategies to assist patients and families in coping with problems of caring for

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a mentally ill family member living at home. This article discusses application of the Developmental-Interactional Model (DIM) (Hanna, 1997) of family therapy used by the Psychiatric CNS in providing psychiatric home care. Case studies are provided to show the application of this model for desired outcomes.

LITERATURE REVIEW

Home-Based Family Therapy

Home-based family therapy has its origin in the 1980 passage of Public Law 96-272. This legislation, also known as the Adoption Assistance and Child Welfare Act, encouraged efforts to keep children in their natural homes by establishing programs designed to provide intensive family intervention for at-risk children and adolescents (Christensen, 1995). Home-based programs are regarded as an alternative to the placement of children in group or foster homes and general or psychiatric hospitals. The underlying philosophy of these programs is that to make significant changes within an individual child, the family system must be considered. Therefore, the family-at-risk is emphasized rather than the individual-at-risk (Zarski, Pastore, Way, & Shepler, 1988).

Home-based service has been reported to be an effective strategy for engaging involuntary clients in treatment (Balgopal, Patchner, & Henderson, 1988); for use with the religious, abusive patient and family who are highly resistant to outside intervention (Dixon & Kixmiller, 1992); and for situations where traditional family therapy models have yielded poor results, such as with lower-income, multiproblem families (Woods, 1988). Woods (1988) found that home-based service can be a less resistant avenue to confront family patterns. A two-tier model for work with high-risk families has been presented by Aponte, Zarski, Bixen, and Cibik (1991), which combines multiple family groups in the community with home-based family therapy for individual families. Cottrell (1994) proposes home-based therapy for families to gain insight into the living conditions of clients to enhance the ability to work with all families.

Psychiatric Home Care

Psychiatric home care has been defined as the provision of psychiatric services in the home on an intermittent basis to individuals who are homebound secondary to their psychological or medical status (Blazek, 1993) with an RN acting as the case manager. The role of the RN includes ongoing assessment of: mental status, the environment, medication compliance, family dynamics, and home safety. The provision of supportive therapy to the patient and family is provided according to the educational preparation of the nurse. Psychoeducation, coordination of all services delivered by other home care staff, and communication of clinical issues to the patient's psychiatrist are also major areas of focus. Patients are usually seen 1 to 3 times a week for 4 to 8 weeks. Maximization of the patient's potential to remain home by stabilizing the course of psychiatric illness is the goal of home healthcare services (Ward-Miller, 1996).

It is during this assessment that the CNS can directly observe the patient and the family in the natural environment of the home and may encounter situations that have evolved as a result of the anger, guilt, burden, embarrassment, and ambivalence involved in the daily care of the mentally ill person. The family of a mentally ill person is frequently the primary caregiver (Anderson, Hogarty, & Reiss, 1981; Anderson, Reiss, & Hogarty, 1986; Marley, 1992; Chafetz & Barnes, 1989). For elderly patients, chronic illnesses can become a major factor influencing their ability to live independently, often signaling the onset of major caregiving roles for the family. Bradley and Alpers (1996) report caregivers may have more unmet needs than the family member receiving home healthcare services. Information about family functioning, which may not have been apparent at the time of referral may be obtained during this assessment. Direct observation of a family in the natural environment of their home quickly brings into focus significant family dynamics and can effectively guide CNS interventions

THE ROLE OF THE CNS

Iglesias (1998) advocates the use of the CNS as an expert practitioner and agent of change in the provision of home healthcare in the next decade as increasing numbers of clients, often elderly, and more acutely ill individuals, require quality care at a lower cost. Use of the community health CNS to enhance illness prevention, health promotion, and wellness has been proposed by Zwanziger et al. (1996). Nursing's Agenda for Health Care Reform (American Nurses Association, 1992) supports the need for community-based CNSs who: (1) en-