Managing mental health problems in a family and community setting: Reflections on the family physician approach and Re-imagining psychiatric education

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ABSTRACT

Family Medicine is unique in that it recognizes the central role of the patient’s context and the interplay of family dynamics, social relationships, cultural background, and economics in the causation and presentation of any illness and the response to any given treatment. While this is true across the board, it is particularly true of mental health. In this article, using a selection of stories from our daily practices as family physicians, we: (1) reflect on the role of family physicians in addressing mental health needs in the community; (2) contrast between a disease-oriented (specialist approach) and a person-oriented (family physician approach); and (3) suggest a course correction to the existing model of mental health education for both generalists (such a family physicians) and specialists (such as psychiatrists). We conclude that Family Physicians have an extremely important role to play in the promotion of mental well-being and the management of mental illness in the community. Additionally, we highlight several unique facets of the family physician approach that tends to be less disease oriented and more patient-centric. Lastly, we suggest the need for mental health training to occur in the family practice context in the community. Mandatory representation of practicing family physicians on the National Medical Commission (NMC) will facilitate the above.

Keywords: Community, family medicine, mental health, person centred care, primary health care

Introduction

Physical health and mental health are closely connected with each other and together constitute essential elements of wellbeing. The World Health Organization (WHO) aptly defines health as “a state of physical, mental, and social well-being and not merely the absence of disease or infirmity.” According to WHO, mental health problems are highly prevalent across the globe and nearly 1 in 10 people have a mental health disorder. However, only 1% of the global health work force provides mental health care.

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any given treatment. While this is true across the board, it is particularly true of mental health. A family physician (FP) who has already established a relationship with the patient and is aware of the family dynamics becomes an anchor for the family and the decision-making process. FPs who make home visits are especially privileged in this regard. Primary care being accessible, affordable and acceptable for individuals and their families has key advantages for delivering mental health and ensures continuity of care and promotes overall well-being by empowering and engaging individuals and families in shared decision making.

In this article, using a selection of stories from our daily practices as family physicians, we: (1) reflect on the role of family physicians in addressing mental health needs in the community; (2) contrast between a disease oriented (specialist approach) and a person oriented (family physician approach); and (3) suggest a course correction to the existing model of mental health education for both generalists (such family physicians) and specialists (such as psychiatrists).

Subjects and Methods
The three unique cases that we came across during our practice are discussed to help provide better understanding of the need and urgency of a new model or tweaking of the existing model for the smooth transition care within a multidisciplinary ecosystem in community-centred care approach. These stories were selected from our daily practice and discussed for internal learning and quality improvement project, it was not submitted to the Institutional Ethics Committee for approval but formal permission and support through written documentation from the individuals and primary care givers.

Results

Story 1: The Placing of Trust in the Family Physician A sensitive issue involving a teenage girl
Priya, a 12-year-old girl, was found to be stealing money over the past 2 years. Since the first incident, the family had tried several methods such as talking and explaining to Priya about the consequences of her behaviour, asking Priya to list out her wants, and offering pocket money. However, these attempts by the family and others who included a psychiatrist and a child psychologist did not prove to be of much benefit. Priya’s mother (Mrs Jaya) and Dr. RP, a family physician who makes house calls and is part of a team practice, have known each other for over a year. Dr. RP had taken care of Mrs Jaya’s aged parents.

Mrs. Jaya requested Dr. RP and his team to help her out in dealing with this situation. She mentioned that the whole family was distressed, worried, and confused about Priya’s behaviour and felt lost with regard to the way forward. Dr RP expressed his willingness to assist in whatever manner possible.

Subsequently, a home visit was made by Dr. RP and SB, a primary care psychologist who is part of the family practice team. In the beginning Priya was hesitant and would not appear in the drawing room where other members of the family were present. SB went to Priya’s room and had a one-to-one conversation. SB spoke in a comforting manner, expressed that they were not here to judge her and were here to be of help. She also expressed their commitment to maintain confidentiality. This made Priya feel comfortable and willing to open up to them and resulted in Priya joining the family meeting in the living room.

During the discussion, it was noted that Priya was aware of her behavioural problem. The family narrated multiple events related to Priya’s behaviour that had occurred over the preceding 2 years. Discussion involving Priya’s behaviour and family dynamics, particularly around the mother-daughter relationship, resulted in a better understanding between the teenager and the family.

Further visits revealed the reason for Priya’s truancy as being related to attention-seeking behaviour. It was suggested to the mother to devote more time and attention to Priya, especially her emotional needs. This behavioural change involving the family resulted in a visible improvement in the Priya’s attitude. She has not stolen since.

Another aspect noted was that the emotional distance between the mother and the girl improved to a great extent. Priya who was avoiding physical contact with the mother previously now even welcomes the mother hugging and cuddling her. Over the next few months, as the team followed the family, it became evident that the relationship and family dynamics had improved significantly.

Story 2: Managing a mental health crisis
Mr. Vincent and Mrs. Mary live close to Dr. AA’s home and are acquainted with her. Dr. AA, a family physician who leads a home care team, received a call from a distressed Mrs. Mary to see her husband who was behaving strangely. This was time of COVID-19 lockdown and hence Mr. Vincent was home bound with no social interaction with anyone other than members in his household. Also, Mr. Vincent, a smoker who drank regularly – had been drinking and smoking a lot more than usual during lockdown.

A house call was made. During the visit, Dr. AA accompanied by a PS (a clinical pharmacist) and SB (a primary care psychologist) found Mr. Vincent sitting with a dazed look. He was slow in his responses to questions. He was hallucinating as well. However, he was not aggressive. On further questioning, it emerged that he was being given risperidone clandestinely for the last 15 years. The details of the diagnosis were not available. Dr. AA counselled regarding alcohol and tobacco, continued his risperidone, and prescribed Librium twice a day.
A few days later, Dr. AA received another call to handle an emergency involving Mr. Vincent. He had not slept the whole night, was restless, and threatening to beat up a 5-year-old boy, a neighbour, as he said the boy was irritating him. Upon arrival, Dr. AA found that Mr. Vincent had locked himself up in his room. Only after a great deal of persuasion, did he agree to come out. His hallucinations had worsened since the last visit. This made Dr. AA decide to admit him to a psychiatric facility.

Once admitted, he was initiated on antipsychotic medications. Over the next few days, his restlessness and agitation decreased. Also, the situation became amenable. A family meeting was held in the psychiatric unit involving Mrs. Mary, Mr. Vincent, his sister, Dr. AA, and the psychiatrist. In a few more days, his condition improved further and he was discharged home under Dr. AA’s supervision.

Dr. AA’s visits to the family and her understanding of the situation resulted in timely and appropriate action. Multiple phone calls and home visits following his discharge helped in stabilizing Mr. Vincent’s psychiatric condition while also supporting the family. Currently, Mr. Vincent is improving, no longer aggressive and sleeping much better. He is also taking his medications regularly.

**Story 3: Anxiety in the Covid-19 lockdown – a family physician’s personal narrative**

Anxiety is a state of mind wherein there is a constant run of negative thoughts that does not allow the person to perform and live his routine life. I experienced this in the past few months. Two events contributed to this. One was the announcement of lockdown. This prevented normal social interactions at all levels. I am a person, who has lived the outdoor life 4 to 5 half days a week and enjoyed playing and being with friends, Lockdown was like a jail sentence. I was unable to do any constructive thinking or writing. I felt constantly restless and stressed. Tele-interactions with friends and patients were a poor substitute.

The second event that compounded the on-going simmering anxiety was the worsening of dementia in my 86-year-old sister-in-law. She was living alone with a helper. Her deteriorating condition made her unmanageable. We had to wind up her apartment in a hurry and shift her to our home. We had to do some frantic searching and luckily were able to admit her to a dedicated dementia home. All this took three weeks of intense tension for both me and my wife. One can imagine the logistical nightmare that we underwent with all the restrictions on vehicle movement during lockdown, with the dementia patient living 20 km away from our home and the dementia home 30 kms away in the opposite direction. This was the kind of situation when one realizes how important it is to have close friends. Many helped to see us through these tough months, including those with government-issued passes to move freely.

What were the signs and symptoms that I experienced during this hard time? The one constant was the feeling of mild sinking in the pit of my stomach. This would occasionally become worse, sometimes associated with nausea but no vomiting. Next were episodes of sweating, which worsened whenever there was a phone call or when thoughts of what was going to happen next came up. Third was a mild headache located at the temples. Sleep was hard to come by and when it did, it was disturbed and restricted to the wee hours of morning. All these are classical signs and symptoms of anxiety. I also experienced dry coughing bouts. On high-stress days such as when bringing her to our place or shifting her to the dementia home, the cough would be there all the time. On other days it was there only for some time in the mornings. In fact, if someone heard me coughing like I did they would presume that I had COVID-19 infection!

Once my sister-in-law got placed, the first symptom to disappear was the sinking feeling, followed by attacks of sweating and the coughing bouts. Sleep too improved. For the last 10 days my teleconsultations and seeing an occasional patient or friend in person has helped to calm me down. The prospect of restarting my outdoor activity too has helped me regain my sense of control.

My anxiety still shoots up when I start thinking about how my sister in law might be settling in the dementia home or when thinking about the plight of the millions of socioeconomically disadvantaged men and women of our country. But it has become bearable.

**Discussion**

Family Physicians have an extremely important role to play in the promotion of mental well-being and the management of mental illness in the community. Their role spans across detection, evaluation, management, facilitation of coping, and restoration of function. Mental, emotional, and social health issues are inseparable from physical health. The biopsychosocial (as opposed to a biomedical approach alone) is foundational to Family Medicine.

In this paper, we as a team comprising of 3 practicing family physicians, a primary care psychology fellow, and a clinical pharmacist with a focus on home-based primary care, have shared three stories from our daily practice. We use these stories to reflect on our own practice context and the context in which our patients experience mental health challenges. We highlight two crucial points namely: (a) The disease-oriented approach and the person-centred (family practice) approach differ significantly; and (b) Mental Health Training should occur in the family practice context in the community. It is hoped that reading this article will facilitate reflection and reflective practice.

**The disease-oriented approach versus the person-centred (family practice) approach: A field of differences**

Substantial differences exist between the disease-oriented approach (usually informed by practice and research in
tertiary care settings) and the family practice approach (usually informed by practice in the community setting). The disease-oriented approach is based on reductionist thinking and consequent action based on the biomedical model which is the root cause of this dichotomy. The reductionist approach tends to keep subdividing illnesses and this has resulted in the emergence of many new psychiatric names. However, classification systems over-rely on symptoms scores but ignore the context of the patient. This results in misdiagnosis and suboptimal outcomes.

Classification of any illness based on certain criteria which are given to change is always risky. What might be consistently observable in a physical condition, such as the characteristic murmur in aortic regurgitation, may not apply to mental illness. A patient with depression based on symptom count today may come with a symptom count tomorrow suggestive of anxiety or a mixture of both.

There is often an assumption (typically by specialists) that general practitioners (GPs) are ill-trained and not confident of treating mental illness. However the truth is, as family physicians living and working in the community, we often have deep relationships (sometimes lasting decades) and understanding of the patient and family context. We also have the luxury of being able to follow-up and reconsider our decision-making iteratively. This results in the great advantage that the patient often recognizes us as his or her confidant (sometimes even friend) and might be more amenable to our suggestions including the willingness to take medications.

Consequently, the statement by two accomplished specialist psychiatrists (Drs Kuruvilla and Jacob)⁵ that “all psychiatric syndromes are heterogeneous in etiology, pathology, clinical features, treatment response, course outcome and the currently available psychiatric treatments are essentially symptomatic is a good start to navigate the complex issues of managing psychiatric presentations in general medical practice”⁵⁹ is most welcome and is essentially how experienced family physicians approach emotional/psychiatric presentations in practice. We believe that several differences between the diagnoses made by Family Physicians and Psychiatrists are due to different ways of recognizing the same illness and also different ways of management of a given patient and not necessarily due to defects in training. Box 1 lists a number of unique elements in the approach of family physicians to mental health in the community.

**Box 1: The Family Physician’s Approach: Unique features**

1. Utilizes an integrated/undifferentiated/holistic approach to understanding patient’s context and interplay of family dynamics, social relationships, cultural background, and economics in the causation and presentation of illness and the response to treatment.
2. Builds on existing trust between the doctor-patient and family.
3. Harnesses the power of the continuity relationship.
4. Associated with lower stigma for patients and families.
5. Professional boundaries are more fluid and less defined.
6. The principal therapeutic methods used are: Active listening, being non-judgmental, and empathy.
7. Family Physicians do not hesitate to visit patients’ home - this provides better insights and a fuller picture of the context and underlying dynamics.
8. Labels and formal diagnoses are deemed less important, contextual understanding given greater importance.
9. Shared decision making and preservation of autonomy at the heart of the approach.
10. Involves the family in care planning (rather than the patient alone).
11. The focus is on supporting and helping the patient and family cope.
12. More accepting of cultural norms.
13. Less eager to use medications, and if used, used in much lower doses.
14. Often use a team-based approach drawing on the expertise of other family physicians, organ system specialists, clinical pharmacists, psychologists, and psychiatrists.
15. More time spent especially longitudinally and often as micro-conversations (including over phone etc.).
16. Escalation to institutional admission/legal recourse used only as intervention of last resort.

In our experience too, educational programs by specialists for primary care practitioners tend to primarily focus on transfer of specialist knowledge rather than facilitating reflective learning and enhancing practical skills and confidence to manage psychiatric problems themselves in the community by general practitioners/primary care physicians. Psychiatric training must take into consideration the fact that the presentation and treatment of mental illness differs significantly between tertiary care/institutionalized settings and the context of primary care. Importantly, the goals of psychiatric education (for both psychiatrists and family physicians) should result in a sense of partnership between psychiatrists and family physicians that results in: (a) integration of the richness of context (that FPs have) and the expertise of the psychiatrist; (b) reduced stigma; (c) bidirectional learning; (d) significantly greater support for the patient and family; and ultimately, better outcomes for the patient.

To accomplish the above, peer-learning approaches where-in a mix of community-based family physician practitioners/
faculty and institution-based psychiatrists collaborate to facilitate cross-learning are required. A collaborative practice-based learning approach might also reveal valuable insights on how family doctors handle psychiatric illness in the community setting (often with much less use of medication and support). See Box 2.

Lastly, while we welcome the new MCI competency-based curriculum that shifts the focus from knowledge to competencies, the lack of inclusion of the practicing family physician perspective and the complete omission of “general practice” or “family medicine” is misguided. This is not only short-sighted but also utterly and dangerously fails to recognize that the real need of the country lies in strengthening primary care as an integrated platform into which specialist capacity can be weaved in rather than the creation and perpetuation of a fragmented landscape of specialist silos which compromises community health. This needs urgent remediation through the mandatory representation of practicing family physicians on the National Medical Commission (NMC).

### Key Messages

The Family Physician approach is patient-centric. Family Physicians play an important role in the promotion of well-being and the management of mental illness in the community. We suggest that mental health training should occur in the family practice context in the community.

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### Conflicts of interest

There are no conflicts of interest.

### References

1. Preamble to the Constitution of WHO as adopted by the International Health Conference, New York, 19 June-22 July 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of WHO, no. 2, p. 100) and entered into force on 7 April 1948. https://www.who.int/bulletin/archives/80(12)981.pdf.
2. MhGAP humanitarian intervention guide (mhGAP-HIG). 2015. Available from: https://www.who.int/mental_health/publications/mhgap_hig/en/.
3. Rao BC, Prasad R. Principles of family medicine practice: Lessons gleaned over a lifetime in practice. J Family Med Prim Care 2018;7;303‑8.
4. Mental health in primary care: Illusion or inclusion? World Health Organisation. Technical Series on Primary Health Care. 2018. Available from: https://www.who.int/docs/default-source/primary-health-care-conference/mental-health.pdf?sfvrsn=8c4621d2_2.
5. Jacob KS, Kuruvilla A, Zachariah A. Psychiatric curriculum for training physicians. Natl Med J India 2019;32;32‑7.
6. Rao BC. Doctor's club: An experiment in education. Natl Med J India 2019;32:242.
7. Clinical Guidelines Level 2-Kcpphc. KC Patty CF Primary Health Centre. Sites.google.com. 2014. Available from: https://sites.google.com/site/kcpphc/home/clinical-guidelines. [Last accessed on 2020 Mar 08].
8. Basavarajappa C, Chand PK. Digital platforms for mental health-care delivery. Indian J Psychol Med 2017;39:703‑6.
9. Kumar R. Call for mandatory representation of practicing family physicians on the National Medical Commission (NMC): Leaving behind the monopolistic barriers in medical education regulation. J Family Med Prim Care 2020;9:453-5.