Assertive community treatment in the South African context

U Botha[1], L Koen[1], P Oosthuizen[1], J Joska[2], L Hering[3]
[1]Department of Psychiatry, University of Stellenbosch, Stellenbosch, South Africa
[2]Department of Psychiatry, University of Cape Town, Cape Town, South Africa
[3]Associated Psychiatric Hospitals, Western Cape, South Africa

Abstract
Although the integration of psychiatric services into the community has potentially been beneficial to many patients, this transition has not been without problems. A major obstacle to establishing successful community-based treatment in South Africa has been that the reduction in number of inpatients beds did not coincide with the development of adequate community resources. This, in combination with our patients' poor socio-economic circumstances, has contributed to a substantial increase in the so-called ''revolving door'' or high frequency use phenomenon in state psychiatric facilities. Clearly, there is need for a renewed approach to address this problem in our setting. With this in mind the APH in the Western Cape appointed three community treatment teams in January 2007. This publication serves to give an overview of the Stikland Psychiatric Hospital team's experiences in the first 12 months since establishment. To date, we have been confronted by several challenges that complicate the successful implementation of an ''assertive'' outreach service in the South African context. However, there seems to be some hope as early findings demonstrate a reduction in number of admissions as well as inpatient days. Furthermore there has been a very positive response from service users, their families and other staff members leaving us to conclude that this initiative seems to be a much needed step in the right direction.

Keywords: Community psychiatry; South Africa; Therapeutics

Received: 30-11-2007
Accepted: 28-02-2008

Introduction

The face of psychiatry has changed considerably over the last twenty years. Perhaps the most significant change has been the shift to community-based services. Though the integration of services into the community has potentially given many patients the opportunity to live more functional and happy lives, this transition has not been without problems.[1-5]

The provision of community-based care depends heavily on the availability of resources in the community. Such services include group homes, day centers, home-based care and clinics with staff trained in managing mental disorders. Although South Africa is not unique with regard to the difficulties experienced when setting up such services, it certainly has a unique combination of factors that affect and complicate the implementation thereof.[6] Though attempts have been made worldwide - including South Africa - to streamline the setting up of such services, tremendous challenges remain. Singh et al highlighted some of these issues in a recent publication about community services in Australia. They concluded that although the principles of deinstitutionalization are sound, the implementation has been more troublesome than expected and the initial promise is yet to be realized.[5]

Correspondence:
Dr UA Botha
PO Box 19063, Tygerberg, 7505, South Africa
email: ulla@sun.ac.za

One of the major obstacles to successful community-based treatment in South Africa is the paucity of residential and day-care services.[4,7,8] Patients are more often than not discharged into the care of family members who are themselves overwhelmed by socio-economic difficulties. Even though many patients in South Africa with severe and enduring mental illness do receive disability support in the form of a grant, this is most often not enough to alleviate the financial pressure on families. In fact, in many households the grant is the only regular form of cash income.

While families and communities are strained by the burden of managing individuals who are far from well with limited support, hospital staff battle with increased pressure on inpatient beds due to the dramatic reduction in number of beds that coincided with the shift to community-based care.[7,8] In most facilities, there are now very few or no long term beds and only a small number of so-called medium term beds, which are often used for rehabilitation of patients who require longer hospital stay. The combination of these factors along with other socio-economic aspects, have contributed to the so-called ''revolving door'' phenomenon.[9,10] This term refers to individuals who are frequently admitted to psychiatric institutions and remain well for only short periods of time.

The effect of revolving door patients on the acute inpatient system has repercussions for community care as well. Community mental health workers are left to try and stabilize these patients under difficult circumstances. Unfortunately this is often unsuccessful, resulting in readmission and further perpetuation of

the revolving door pattern. Families are left feeling unsupported and are often expected to deal with mentally ill individuals who pose potential risks to themselves and others. Although the magnitude of the problem may vary between settings, this is a worldwide phenomenon.[2,3,11] In some countries initiatives such as crisis resolution and assertive outreach were born out of the desperate need for additional support. The term assertive outreach is often used interchangeably with assertive community treatment and intensive case management, though small differences exist in the implementation of these services.[2,12]

It is commonly accepted that assertive community treatment was initiated in its current form by Stein and Test in the1980's.[11,13] Their pilot project started as a temporary program known as Training in Community Living and attempted to offer additional support to patients with severe mental illness. However, it soon became clear that the positive outcomes initially experienced could not be sustained if the support was not continued. Since then, assertive outreach teams have been established in many centres in the United Kingdom, Australia and the US.[2,13,14] According to Burns et al. assertive outreach should be an intensive, community-based program, which offers frequent and comprehensive support to patients in an attempt to primarily improve their quality of life.[12] Such teams follow a multi-disciplinary approach and typically share caseloads of 8-15 patients. Though the reduction of inpatient days is undoubtedly the most attractive outcome from a manager's perspective, available literature supports the notion that patients' quality of life may also improve, which in turn impacts dramatically on the morbidity associated with the illness.[14]

Clearly, there is need for a renewed approach to address the revolving door phenomenon facing many psychiatric hospitals in South Africa. However, the service models used in the developed world may not be realistic or feasible in our setting. With limited funds and strained resources, the key would be to find a more cost-effective way to provide a similar service to as many patients as possible, without compromising the quality of the service being delivered.

With this in mind, in January 2007, the Associated Psychiatric Hospitals in the Western Cape introduced a community treatment team for each of the three psychiatric hospitals' (Valkenberg, Lentegeur and Stikland) catchment areas. Each team comprises a principal medical officer (PMO), a chief professional nurse (CPN) and a senior social worker (SSW). The purpose of the service is to provide a follow-up program for patients identified as being high frequency (revolving door) users of the acute inpatient system. Such a follow-up is aimed to be more comprehensive in comparison to standard care, facilitating existing services rather than duplicating them.

Service structure

The teams for the different catchment areas follow similar protocols. However, as each area has unique needs and constraints the teams have adapted their methods of working to accommodate these.

Generally, patients are identified on admission (using a modified version of Weiden's criteria) (see Tables I & II) and initial engagement of family and patient occurs during the inpatient stay.[9] Once patients are discharged, they are actively followed up by the team. Although visit frequency is tailored according to patients' needs, the majority of patients are visited at least once every two weeks. About half of these contacts are in the form of home visits whilst other contacts are either at the Community Mental Health Facility or at the Psychiatric Hospital, where medication is dispensed. Most contacts are performed by a designated key worker (SSW/CPN) whilst the PMO has monthly contacts during the first three months after which the frequency of visits is tapered to once every three months if the patient is stable. Contact between visits is maintained by means of telephone calls and family members are provided with contact numbers for the key workers during office hours. A crisis plan is made available for after hours' emergencies. If crises occur after hours, patients in the program bypass community services and are assessed directly via the existing after-hours service at the psychiatric facility.

In order to objectively evaluate the effectiveness of the service a concurrent research project was initiated recruiting control groups of both low and high frequency users. For these control groups demographic and clinical data are collected but no intervention is done and the groups receive treatment as usual. The research project is currently being run across all three sites and where patients are included all three teams follow the same structured approach.

Table I: Weiden's modified HFU criteria used to identify patients for inclusion in concurrent research component

General criteria
1) Schizophrenia or Schizo-affective Disorder 2) Age 18-59 years (extremes included) 3) Needs current treatment with antipsychotic
Must meet General Criteria PLUS either (A) or (B) or (C) to be included
(A) ≥3 admissions in 18 months/≥ 5 in 36 months (B) ≥2 admissions in 12 months AND treated with clozapine (C) ≥2 admissions in 12 months AND ≥120 days in hospital

Table II: Weiden's original criteria for identifying revolving door patients[9]

Primary diagnosis of schizophrenia or schizoaffective disorder AND 1) two hospitalizations in the last year, OR 2) three hospitalizations in the last three years

Impressions and findings

Results from the formal research will only be available towards the end of 2008. However, the service has been running for 12 months now, enabling the Stikland team to report some preliminary impressions and results. At the time of writing this, 63 patients were actively being followed-up by this team. Of these, 42 were male and 21 female; 61 were unemployed at the time of inclusion and the majority were receiving disability grants. See table III for details about days spent in hospital prior to inclusion and post inclusion. To date, 16 patients have had readmissions. Without exception, all admissions have been shorter than previous admissions, leading to a clear reduction in the number of days spent in hospital compared to the 12 months prior to inclusion. Four patients who were previously unemployed are currently employed and one patient was placed in residential care. The other

62 patients all live with family or friends. Of the 63 patients, 36 readily admit to almost daily substance abuse and 11 have problematic metamphetamine abuse. Four patients have completed 12 months in the service, with only one of these being readmitted. Collectively, these four had 980 days spent in hospital (DIH) in the 12 months prior to inclusion and only 50 days in the 12 months after inclusion. As the other patients have been in the service for varying periods, DIH for this group should be viewed in this context. (see Table III)

As previously suspected we have been confronted by several challenges that complicate the successful implementation of this type of service in the South African context. Some of the most prominent impressions formed are:

Social circumstances:

The majority of the ''revolving door'' patients making use of public mental health services live in adverse social circumstances. Although the severity of adversity may vary, virtually all are unemployed and receive disability grants as their only form of income. Some live in informal settlements and many have overcrowded, chaotic environments. These impact on their illness and their ability to maintain compliance on medication and attend appointments. Financial difficulties are sometimes so severe that patients do not have regular meals or funds to travel to the clinics. Many patients do not have phone numbers and are therefore difficult to reach. In some cases there are safety concerns for staff when performing home visits, due to gangsterism and drug activity which are rife in many urban communities. Breen et al. recently commented on the relationship between mental disorders and social factors. They highlighted again the particular hardships facing mentally ill individuals in poor urban communities.[10]3

Multicultural environment:

In a unique society such as South Africa, where there are eleven official languages, we strive to deliver the best quality of care humanly possible and acknowledge that each individual has the right to receive care in his/her first language. Yet, this is a promise that is virtually impossible to keep even within the larger context of health services. Our team does not have access to any official translators and is therefore often dependant on individuals with little or no training to help with translations. There is no doubt that subtle manifestations of psychiatric illness may therefore be missed. This affects the team's ability to successfully engage patients and family members. Therefore in a small team that serves a multi-cultural grouping it is imperative to acknowledge the ways in which cultural differences may impact on: (1) the individuals' ability to engage with the service as well as (2) the key workers ability to provide the quality of care required to keep the individual well.

Structure of primary health facilities:

Unlike other countries, such as the UK, Community Mental Health facilities in South Africa form part of the general primary health clinics in communities. These clinics are often understaffed and very busy, resulting in long queues at pharmacies, chaotic waiting rooms and, for mental health service users, stigmatization by other patients. Also, consultation space in these clinics is often limited and not readily accessible teams. As may be imagined, these factors have a detrimental effect on patients' ability to attend appointments and remain compliant.[3,15] General staff at times seem intolerant of the specific needs of mentally ill patients attending appointments. Patients are sometimes turned away without medication when forgetting their appointment cards at home and on one occasion a patient was asked to return a week later because his medication was out of stock, leaving him without medication.

Availability of medication:

In South Africa, not all medications are readily available in the public sector. Budget constraints affect the availability of atypical anti-psychotics (specifically in the Western Cape) other than Clozapine and there is no atypical depot available in the public health sector. Practitioners are therefore often limited in treatment choices for difficult-to-treat patients and in cases where compliance is an ongoing concern, patients are invariably placed on depot typical anti-psychotics, which can lead to unpleasant and even intolerable side-effects. Some medication may not be available at Community Clinics, or in some instances only specific strengths of a tablet may be available, leading to unnecessary large numbers of tablets being prescribed to maintain a therapeutic dose.

Transport difficulties:

When giving the choice many patients prefer to collect their medication directly from the psychiatric facility (i.e. one of the large psychiatric hospitals), due to stigmatizing, negative attitudes and long queues at the primary health facilities. However, few patients are able to afford these visits on a regular basis and they often need help to fund their transport. In many cases the ACT team has preferred to continue providing medication to patients to facilitate compliance. Occasionally patients reported attending clinic appointments, but on follow-up the team established that although the appointments were attended, medication was not issued. For patients with recurrent non-compliance, we have found that the only way to effectively assure compliance is if the team remains involved with the dispensing of medication.

Substance Abuse:

The Western Cape currently finds itself amidst an epidemic of metamphetamine abuse and all-in-all more than 60% of patients in

Table III: Summary data reflecting time patients have been included in service and days in hospital (DIH) in 12 months prior to inclusion as well as post inclusion

Period in service	*Number of patients*	*Number of readmissions*	*Total DIH 12 months pre- service*	*Total DIH since inclusion*
< 3 months	4	0	506	0
3-5 months	15	3	2037	71
6-8 months	25	7	3809	437
9-12 months	15	5	1830	270
>12 months	4	1	980	50

the service abuse substances. Many patients live in areas where gangsterism and drug use are part of daily life. Not only are these patients more difficult to engage, but they are invariably the individuals that require the most input from the team, have the most crises and the poorest adherence to treatment plans. Substance rehabilitation services have been difficult to access and often do not cater for the unique needs of dual diagnosis patients.

Quality vs Quantity:

It has been extremely difficult to establish what the optimal caseload would be to which an effective service can be provided. Clearly, it would be unrealistic to expect caseloads of 15 per key worker (as seen overseas) to be cost-effective and significantly impact on bed-pressure, yet large caseloads may undermine the quality required to significantly impact on patients' morbidity and may make the service obsolete. Therefore we have opted for 30-40 patients per key worker, with caseloads being shared by team members and visits being tailored according to patients' needs.

Community resources:

From our experience with this service, it is clear that a lack of community resources remains a major obstacle. There is a tremendous shortage of residential placement facilities for patients with severe mental illness and limited occupational therapy input at this level. Access to vocational rehabilitation programs is practically non-existent and substance rehabilitation units do not provide programs from which patients with severe mental illness can benefit. Also, as previously described, existing primary care centres do not facilitate streamlined access to mental health services. In short, though the deinstitutionalization of individuals with chronic mental illness may have been successful, serious reconsideration needs to be given to the structure of community facilities and the development of resources for individuals with chronic mental disorders. This opinion was shared by Singh et al.who highlighted some of the simplified premises under which deinstitutionalization was implemented worldwide.[5]

There is no doubt that a combination of these shortcomings contributes greatly to the pattern of recurrent relapses and readmissions, which some may argue, has been even more harmful to our patients than the chronic institutionalization that preceded this era.

Conclusion

One could ask whether this model is the most appropriate deployment of resources in South Africa. Traditionally Community Mental Health Services have been very understaffed (proportionally even more so than the general level of understaffing). Redress for such does not happen overnight and a team that can therefore be deployed across facilities has a greater overall impact. Furthermore, as reported preliminary results indicate reduced number of admissions and shorter stays in hospital. Early indicators of social functioning also show improvement in occupational status for some patients. Feedback from carers and community mental health workers has indicated that teams reduce pressure on existing services and families.

Clearly, in spite of the issues that still exist, the initiative seems to be a much needed step in the right direction. Interestingly, current literature seems to support the view that assertive treatment approaches are more likely to succeed in under-resourced settings where standard community services are less comprehensive.[16] When one looks at the key elements of the ACT model as set out by Burns et al[2] (Table IV), local teams follow more or less the same modus operandi, deviating primarily in the size of caseloads and continuity of care. Wider implementation of the principles of assertive outreach, with more teams in more areas should be considered in the planning of future services.

Table IV: Key Elements of ACT model (Adapted from Test 1992 by Burns et al[2])

- A core service team provides bulk of clinical care.
- Primary goal is improvement in patients' functioning.
- Patient is assisted directly in symptom management.
- Ratio of staff to patient should be small (no greater than 10-15:1).
- Each patient is assigned a key worker responsible for comprehensive care.
- Treatment is individualized between patients and over time.
- Patients are engaged and followed up over time.
- Treatment is provided in community settings.
- Care is continuous over time and across functional areas.

References

1. *Arboleda-Florez J. On the evolution of mental health systems.Curr Opin Psychiatry 2004;17;377-380.*
2. *Burns T, Firn M. Assertive Outreach in Mental Health; a manual for practitioners. Oxford university press 2002.*
3. *Breen A, Swartz L, Flisher AJ, Joska JA, Corrigal J, Plaatjies L et al. Experience of mental disorder in the context of basic service reforms: The impact on caregiving environments in South Africa. Int J Environ Health Res 2007; 17(5):327-334.*
4. *Lazarus R. Managing de-institutionalization in a context of change: The case of Gauteng, South Africa. S Afr Psychiatry Rev 2005;8:65-69.*
5. *Singh BS, Castle DJ. Why are community psychiatry services in Australia doing it so hard? Med J Aust 2007;187(7):410-2.*
6. *Stein DJ, Allwood C, Emsley RA. Community care of psychiatric disorders in South Africa – lessons from research on deinstitutionalization. SAMJ 1999; 89(9):942-943.*
7. *Lund C, Flisher AJ (2003) Community/hospital indicators in South African public sector mental health services. J Ment Health Policy Econ 2003;6(4):181-187.*
8. *Lund C, Flisher AJ. Norms for mental health services in South Africa.Soc Psychiatry Psychiatr Epidemiol 2006;41(7):587-94.*
9. *Weiden P, Glazer W. Assessment and treatment selection for ,,revolving door'' inpatients with schizophrenia. Psychiatr Q 1997;68:377-392.*
10. *Gastal FL, Andreoli SB, Quintana MIS, Gameiro MA, Leite SO, McGrath J. Predicting the revolving door phenomenon among patients with schizophrenic, affective disorders and non-organic psychoses. J Public Health 2000;34(3):280-5.*
11. *Lamb RH, Bachrach L. Some perspectives on Deinstitutionalization. Psychiatr Serv 2001; 52 (8):1039-1045.*
12. *Smith L, Newton R. Systematic Review of case management. Aust N Z J Psychiatry 2007;41(1)2-9.*
13. *Dixon L. Assertive Community Treatment: twenty-five years of gold. Psychiatr Serv 2000; 51(6):759-765.*
14. *Marshall M, Lockwood A. Assertive Community Treatment for people with severe mental disorders. Cochrane Database Syst Rev 2000;(2):CD001089.*
15. *Breen A, Swartz L, Joska JA, Flisher AJ, Corrigal J. Adherence to treatment in poorer countries: A new research direction? Psychiatr Serv 2007; 58(4):567-568.*
16. *Tyrer P. The future of specialist community teams in the care of those with severe mental illness. Epidemiol Psychiatr Soc 2007: 16(3):225-30.*