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Is deinstitutionalisation appropriate? Discharge potential and service needs of psychiatric inpatients in KwaZulu Natal and the Eastern Cape, South Africa

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IS DEINSTITUTIONALISATION APPROPRIATE?

Discharge potential and service needs of psychiatric inpatients in KwaZulu Natal and the Eastern Cape, South Africa

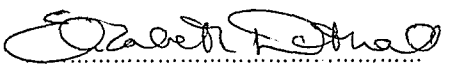
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Dissertation submitted to the Faculty of Health Sciences, University of the Witwatersrand, in fulfilment of the requirements for the degree of Masters of Science in Medicine

Johannesburg
1999

DECLARATION

I, Elizabeth Dartnall, declare that this dissertation is my own work. It is submitted for the degree of Master of Science in Medicine in the University of the Witwatersrand, Johannesburg. It has not been submitted for any degree or examination at this or any other University.



.....4.....day of November 1999

DEDICATION

This work is dedicated to all people living with mental illness and their carers.

EXECUTIVE SUMMARY

Deinstitutionalisation - the movement of psychiatric inpatients out of hospital - has been promoted internationally on the precept that care in the community leads to better treatment outcomes and a better quality of life for people with mental illness. It currently forms a key element of proposals to transform the provision of mental health care in South Africa.

Experiences with deinstitutionalisation in other countries have, however, been mixed and while some efforts have demonstrated positive results, others have resulted in a worse state of affairs for patients and their families. In too hasty deinstitutionalisation processes, hospitals have been closed and people moved into the community in an ad hoc and random manner. With scarce or inadequate community services, many patients have been left to wander the streets, joining the ranks of the homeless (Krupinski 1995) and are often abused by unprepared and prejudiced communities. Further, the assumption that all patients with mental illness respond favourably to deinstitutionalised care may not be justified, with some patients achieving better outcomes within institutional settings (Lawrence et al 1990). Moreover, cost savings, a major motivation for deinstitutionalised care for the mentally ill, have not materialised. There is a clear understanding that community services need to be developed either ahead of or in conjunction with patient discharge, necessitating additional resources.

These are the challenges facing mental health services in South Africa, which are currently highly institutionalised and based on an outdated, custodial model of care. It is made more complex by a context of limited community mental health care resources, restricted health budgets and competing community development needs.

A comparison between the existing levels of provincial psychiatric services against recommended national norms for psychiatric care (Flisher et al 1995) suggests that there is no over provision of psychiatric beds or staff, but rather a need to transfer long term bed resources to acute and residential beds, over time. The implication is that additional resources will have to be found if community services for people with a mental illness are to be developed.

In a review of existing non-governmental services conducted in KwaZulu-Natal, McClaren and Philpott (1998) found that community based services were poorly developed and where they existed, were threatened by the lack of emphasis given to mental health in the overall health agenda, inadequate financial assistance and limited communication between government and non-government sectors. The absence of a guiding framework for mental health services in these

provinces served to further perpetuate the apparent ad hoc and fragmented nature of the development of these services.

In light of these findings, it seems that a decrease in bed numbers – a traditional focus of a deinstitutionalisation thrust – would serve to further deplete an already under resourced service. Using deinstitutionalisation as a vehicle for transformation of the mental health services in these provinces may put the services at risk of losing what little resources they do possess.

A more considered approach to a discharge oriented policy is needed. To better guide mental health sector transformation, a study of psychiatric institutions in the Eastern Cape and KwaZulu Natal Provinces was conducted in order to answer the following questions: Who is actually being cared for in these institutions, what is their discharge potential and what services might they need in the community if they were to be discharged?

The study was funded through a research grant from the Health Systems Trust.

Study Aim

This study aimed to provide a profile of currently hospitalised patients both to inform the emerging deinstitutionalisation debate, and to serve as a baseline for future evaluations of deinstitutionalisation policy initiatives.

Study Objectives

The objectives of this study were:

- To develop and document a Care Needs Assessment Protocol (CNAP) for inpatients of public mental health institutions in two provinces – the Eastern Cape and KwaZulu Natal. The purpose of this tool was to:
  - describe the demographic, diagnostic and social profile of psychiatric inpatients in Eastern Cape and KwaZulu Natal psychiatric hospitals
  - assess the broad parameters of potential care needs of current inpatients of Eastern Cape and KwaZulu Natal psychiatric hospitals
- To make recommendations to national and provincial government on future deinstitutionalisation policies for public mental health services.

Methods

A cross sectional survey was conducted at all government psychiatric hospitals (n=8) in two South African provinces: The Eastern Cape and KwaZulu Natal. A systematic sample of 737 patients was studied, and an attempt made to obtain a representative sample from each hospital. In pooling the data across all hospitals, samples were adjusted according to inpatient population, giving a final sample size of 557. Table A outlines the sampling methodologies, the weighted sample sizes and precision measures achieved for each hospital visited.

Table A. Sampling and Representivity Measures at Hospitals Surveyed

Province	Hospital	Total Number Psychiatric Patients	Sampling	Actual N	Weighted N	Representivity
Eastern Cape						
	Elizabeth Donkin	104*	All	104	8	100%
	Tower	421	1:6	71	82	CI:95%; 10% margin error
	Fort England	291	1:3	85	59	CI:95%; 9% margin error
	Komani	492	1:5	91	112	CI:95%; 9% margin error
	Umzimkulu	182	1:2	89	36	CI:95%; 8% margin error
KwaZulu Natal						
	Madadeni	352	1:3	120	64	CI:95%; 8% margin error
	Fort Napier	445	1:4	104	99	CI:95%; 9% margin error
	Town Hill	387	1:5	73	97	CI:95%; 10% margin error
	Total	2674		737	557	CI:95%; 7% margin error

(*This includes inpatients of Dora Ward, Port Elizabeth Hospital.)

Data for this study were gathered via two tools: the Institutional Profile which has been designed to collect hospital wide data on patients and staff and the Care Needs Assessment Protocol (CNAP). The CNAP uses a combination of functional and family support criteria to categorise patients into broad levels of care needs, thus placing them on a continuum of discharge potential. For each of the categories it attempts to define specific service needs. particularly in the light of deinstitutionalisation processes.

Key Findings

To what extent are patients in psychiatric hospitals dischargeable, and if they were discharged what might their service needs be? The CNAP framework developed by the study categorised 425 patients of whom there was a complete set of information into 4 levels of mental and rehabilitative care needs (Table B).

Table B: Levels of Care and Discharge Potential of Current Inpatients (n=425)

HIGH DISCHARGE POTENTIAL

Level of Care	N (%)
Low Support Needs	140 (33%)
Low Support Needs, No Recovery Environment	27 (6%)
High Support Needs	132 (31%)
High Support Needs, No Recovery Environment	126 (30%)
Total	**425 (100%)**

LOW DISCHARGE POTENTIAL

One third of patients assessed through the CNAP framework was found to have low support needs and high discharge potential. This means they were able to perform basic functions of daily independent living and had somewhere to go if discharged, and hence had high discharge potential. However, when this group was looked at in terms of admission status, it was found that the majority of them were either "certified" or "state" patients. These patients were admitted without their consent because they were deemed to pose a risk either to themselves or to others, or were serving prison sentences, and thus faced bureaucratic or legal barriers to discharge. However, at the time of the study very few were assessed by nurses as posing either a risk to themselves or others. These findings thus highlight the need to review hospital certification processes and patient admission status on a regular basis.

An additional, smaller group of patients possessed important basic community living skills but lacked non-hospital accommodation alternatives ("no recovery environment"). Like the low care needs group, these patients reportedly did not pose a risk to either themselves or others. However, the lack of residential community options in both provinces compromises the discharge potential of these patients. As with patients in the low support needs category, the discharge potential of these patients is hampered by their admission status. Just under half of this patient group were certified. Lack of residential options and certification status are thus important issues to address if discharge of these patients is to be promoted.

Nearly two-thirds (61%) of patients in this study were assessed as having high support needs and therefore lower discharge potential. These patients were reportedly unable to carry out some of the most basic functions of daily life and had features which made community living difficult, such as not being medication compliant, incontinence or an inability to feed or bathe themselves.

Half of this group (31% of total patient sample), however, reportedly had a family willing to take care of them if they were to be discharged. On this basis, the discharge potential of this group of patients is increased. Families of these patients will require training to properly care and support them in the home environment. A quarter of this group of patients were also assessed as being at risk to themselves, whilst just under a third were reported as being a danger to others. If such patients are to be discharged, mechanisms to monitor and manage such risk would need to be put into place.

The remaining group of patients with high support needs group (30% of total sample) had both low functioning and lac ced places to stay if discharged. Risk potential and the need for all types of services was highest for this group of patients. Interestingly, nurses assessed the majority (71%) of this patient group as not dischargeable, correlating well with functional status established through the CNAP.

The need for financial assistance was high across all categories of support needs.

In sum, the CNAP framework has shown that the majority of patients currently in psychiatric hospitals in the Eastern Cape and KwaZulu are not easily dischargeable. The reasons range from barriers posed by their admission status and risk potential, to low functional ability and the lack of a recovery environment.

The study has highlighted the complex nature of assessing discharge and the need for the provision of a mix of services and facilities in order to maintain patients successfully in the community. The CNAP has also shown that there is a group of vulnerable patients who may require ongoing hospitalisation.

The findings of this study motivate against an isolated process of deinstitutionalisation, but call for a more comprehensive approach to the planning and transformation of mental health services based on the following three broad principles:

1. Ensuring ba' ,ce and integration of mental health services
2. Establishme . of quality assurance processes
3. Placing mer al health on the policy agenda

1. Ensuring balance and integration of mental health services

Starting points for achieving a balance and integrated system of mental health care are to:

- Maintain the current numbers of hospital beds, but transform a certain proportion of chronic beds into acute beds, over time
- Build community based services and link them to hospital services
- Transform spare capacity in hospitals into community based services
- Promote community and family involvement
- Promote volunteerism and community health workers
- Forge links with traditional forms of health care
- Promote intersectoral discussion and provision of services

2. Establishment of quality assurance processes

Moving toward an integrated system of care must be underscored by a quality approach that includes:

- Hospital quality improvement programmes
- Improved admission and discharge procedures
- Evidence Based Service Development

3. Placing mental health on the policy agenda

Promotion of improved services for people with a mental illness by service providers, particularly NGOs, the development of consumerism in service users and improved information systems can all play an important role in the move to greater equity within the mental health care system. The following therefore need to be developed:

- Advocacy
- Service User Empowerment
- Improved information systems

ACKNOWLEDGEMENTS

This report is dedicated to those people living with a mental illness and their carers. Unfortunately, due to issues of confidentiality I am not able to personally name the patients and their carers who, through their involvement in this project have made it a success.

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In a similar vein I would like to thank the provincial mental health representatives of the Eastern Cape and KwaZulu Natal, Dr Walker and Mr Mbulawa. These people gave me access to their provinces, without which project would not have even begun.

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Chapter 1

INTRODUCTION

Mental illness impacts on a great many members of our society and represents one of the world's most serious contemporary public health issues. It has been estimated that between 20-40% of all attenders at primary care facilities in developing countries are experiencing a mental health problem (WHO 1990). For most, this experience is likely to be transitory. For approximately a third of this group the experience will be so severe and persistent that they will require professional help (Smith et al 1996). The burden of mental health problems on our society is unlikely to diminish. By 2020 it is estimated that depression will be the second major cause of disability in developing countries (WHO 1996).

Current service provision is inadequate in South Africa (Lee & Zwi 1997) particularly in the face of this growing need. Much of South Africa's mental health care resources are poured into large institutions, inaccessible to the majority of the population. Internationally, psychiatric care has been undergoing a paradigm shift. It is increasingly recognised that it is no longer therapeutic to care for people in large institutions, away from family and community. There is a shift in emphasis from hospitals to community. Linked to this shift in care focus is the policy of deinstitutionalisation.

Deinstitutionalisation has traditionally meant the combined movement of patients from hospitals to less custodial / restrictive environments, and ideally the redistribution of hospital resources from the mental health institutions to more community oriented care for people with a mental illness. Theoretically therefore, deinstitutionalisation means the reduction of hospital psychiatric inpatients in conjunction with the development of more appropriate forms of care in the community (Markson 1984). In practice, however, deinstitutionalisation has most often meant a reduction in hospital beds with minimal changes in community services, rather than achieving an optimum balance between the two.

Thus international experience has shown that deinstitutionalisation may have negative rather than positive effects on quality of care for people with a mental illness (Leff 1997). With the haste to improve psychiatric care and deinstitutionalise, hospitals have been closed and people moved into the community in an ad hoc and random manner. Stories of patients' suffering are common. With scarce or inadequate community services, many patients are left to wander the streets, joining the ranks of the homeless (Krupinski 1995), and reports of patient abuse by unprepared and prejudiced communities are common. Further, there is evidence that the assumption that all patients with mental illness respond favourably to deinstitutionalised care may not be justified, with some patients achieving better outcomes within institutionalised settings (Lawrence et al 1990).

with some patients achieving better outcomes within institutionalised settings (Lawrence et al 1990).

Deinstitutionalisation has been identified as a policy priority by the new democratic government of South Africa. While the new government considers this new policy, the lack of data on types of patients currently receiving inpatient psychiatric care has become apparent. Who are these patients? To what extent do they have families who support or oppose their discharge? To what extent do they impose a threat to themselves or others? To what extent could they function in community life? These questions – vital in the broad understanding of the shift from institutional to community care for patients – are not understood by the services themselves. There are no data across hospitals to inform future service planning and ensure a considered approach to deinstitutionalisation. Baseline data on the needs of psychiatric patients in public mental health institutions in South Africa has therefore been recognised as a priority.

Through a grant from the Health Systems Trust, a survey of current psychiatric inpatients in public sector psychiatric hospitals in two provinces, Eastern Cape and KwaZulu Natal, was conducted. The aim of this study is to provide a profile of currently hospitalised patients, both to inform the emerging deinstitutionalisation debate, and as a baseline for future evaluations of deinstitutionalisation projects.

Public sector psychiatric hospitals in the Eastern Cape and KwaZulu Natal were selected in order to inform government deinstitutionalisation initiatives in these two provinces. The National Department of Health has selected two hospitals, one in the Eastern Cape and one in KwaZulu Natal as pilot sites for a deinstitutionalisation project. It is hoped that the findings from this study will inform these processes.

Chapter 2

DEINSTITUTIONALISATION: The International Experience

2.1 Institutionalisation: A historical overview

The tradition of institutional care for the mentally ill was established internationally in the late 18th century. People with a mental illness were cared for in large institutions, typified by large wards filled wall to wall with beds. Containment was a fundamental underlying principle, with the central belief being that people with a mental illness needed to be removed from broader society – to protect "us" from "them" and "them" from "us" (Bootzin and Acoccella 1998). Institutionalisation was also used as a form of social control for non-conforming mentally ill persons who presented a threat to the broader community (Foster & Swartz 1998). Lastly, the aim was to provide low cost hospital care. A philosophy of custodial care permeated these institutions, with little focus on rehabilitation.

Today, in many countries, it is recognised that it is no longer therapeutic to conceal people with mental health problems in large institutions, and it is generally agreed that people with psychiatric problems should be retained and supported within the community (Smith et al 1996; WHO 1987). The failure of hospitals to provide a therapeutic milieu (Solomon 1958 *cited in* Braun 1981), coupled with the perceived potential cost-savings of moving care to the community (Hafner & van der Heiden 1989), breakthroughs in pharmacotherapy and changing concepts of mental illness all gave impetus to the contemporary drive to deinstitutionalise mental health care.

A description of the UK and USA experiences of deinstitutionalisation provides an understanding of the underlying factors behind the move away from institutionalised care.

2.2 The downfall of the psychiatric institution: The UK and USA

In the USA, pressure from the lobby groups played a significant role in facilitating change in social policies geared towards the care of persons with psychiatric illness (Carrier and Kendal 1997). During the 1950's, the civil rights movement advocated for the eradication of the social inequalities with regard to minority groups such as, blacks, women and people with disabilities (Shepherd 1989). The movement also upheld the rights of persons suffering from psychiatric illness and criticised the social control function of mental institutions (Shepherd 1989). This criticism was based on the contention that mental institutions deprived patients of individual rights and freedom (Shepherd 1989, Raftery 1992).

As with the US, in the UK humanitarian concerns regarding the ill-treatment of psychiatric patients and stories of malpractice emanating from mental institutions, provided an arena for the critical evaluation of these institutior s (Thornicroft and Bebbington, 1989). For example, between 1969-1980, fourteen investigations were made in Britain with regard to the ill treatment of patients in mental hospitals. The investigations found gross abuse of patients (Ekdawi and Conning 1987).

Such investigations began to confirm the limitations of institutional care such as, lack of patient support, ineffective administration, inadequate financial resources, poor staff training, poor reporting procedures and isolation of the institutions (Thornicroft and Bebbington 1989). The reportedly miserable existence experienced by many psychiatric inpatients of this time added to both the humanitarian concern for psychiatric inpatients and to the belief that community care would be far more humane and therapeutic than institutional care (Bacharach 1997).

An unlikely bed partner joined this humanitarian force for deinstitutionalisation – those who motivated for deinstitutionalisation on the basis of presumed cost savings. This force was fiscally conservative and primarily criticised the ineffective administration and the high costs associated with long-term institutional care. In the US for example, it was argued, that the transfer of the patients from hospitals to their own communities would result in less expensive care (Durham and La fond 1996). Whilst, in the UK, underlying the moves to deinstitutionalise were decreases in public expenditure generally and on psychiatric services specifically (Thornicroft and Bebbington 1989). As in the USA, deinstitutionalisation was seen as a cost saving mechanism (Thornicroft and Bebbington 1989). The alliance between the humanitarians and the fiscally conservative made for complex underpinnings of the deinstitutionalisation movement.

The advances in pharmacotherapy in the 1950's also facilitated the move from institutional care towards community oriented services for persons with mental illness (Shepherd 1989, Durham and La fond 1996, Mechanic and Rochert 1990). Access to new medications enable psychotic behaviour to be controlled, thus enabling patients to be retained in their own communities (Bootzin and Acoccella 1988, Carrier and Kendal 1997 and Shepherd 1989).

Such advancements, together with the other factors already discussed, contributed to the steady decline in the number of inpatients in the US and the UK from the mid 1950's (Raftery 1992, Shepherd 1989), and affirmed the policy of deinstitutionalisation (Durham and La fond 1996).

2.3 The impact of deinstitutionalisation

> *"....the policy of deinstitutionalisation of chronic patients assumed that the community will provide the necessary resources, housing, jobs, support and supervision. But the second part of the equation never happened." (Krupinski 1995:577)*

According to Bacharach (1997:25), "the original intention when deinstitutionalisation began .... was that three separate processes would play a critical part in the movement: patients would leave hospitals; new admissions would be blocked or restricted; and accessible, relevant new services would be developed in the community." The extent to which this has happened is debatable and Bacharach argues that the first two have happened at a much faster pace than the third. What then has the implications or such a policy been to mental health services and their users?

Firstly, as already noted, this movement has dramatically impacted on the numbers of dedicated hospital beds for the care of the mentally ill in the US. Between 1950-1983 there was an 80% drop in bed numbers in the mental hospitals (Raftery 1992) and a corresponding reduction in the number of inpatients from 559 000 in 1955 to 150 000 in 1980 (Krupinski 1995). Britain has also, over the last 45 years, experienced a drastic reduction in the number of beds in mental hospitals from 150,000 to 64,000 in 1985 (Thornicroft *Personal communication* 1998 and Carrier & Kendall 1997).

While successful in reducing beds in both countries, the experience of initial deinstitutionalisation efforts was that of unplanned and ad hoc discharge of patients to unprepared and under-resourced communities. Little thought was given to the lives of patients after discharge. For example, the British Mental Health Act of 1959, although promoting the policy of deinstitutionalisation, did not include concrete plans for the level of community services to be developed for discharged psychiatric patients (Carrier and Kendall 1997). This criticism was reinforced by a British government review of 1987, which reported that community based psychiatric care, was developed without any planned or well managed approach (Thornicroft and Bebbington 1989).

Unfortunately a reduction of hospital beds without a corresponding increase in community services meant that the care needs of many mentally ill patients were not met (Raftery 1992, Carrier and Kendall 1997). It has therefore been argued that the release of chronic mentally ill patients without any proper facilities was equal to their 'total abandonment' (Krupinski 1995).

Numerous cases have been documented of psychiatric patients being discharged from the hospital with no families to care for them or any form of alternative accommodation (Durham and La fond, 1996). Many discharged patients became homeless (Appleby & Desai 1985; Krupinski, 1995). A shortage in the provision of low-income housing reportedly resulted in persons with a mental illness being relegated to circumstances which became known as "psychiatric ghettos" (Durham and La Fond, 1996).

To meet the shortage of accommodation, alternative services sprung up, but without standards or norms to guide them, they were difficult to regulate. Stories of low quality accommodation services are common in the literature. Jones (1975) describes the following scenario, which to him was a common feature of the time:

> *"Many of those patients have gone to live in boarding and nursing homes, most of whose operators have not had much experience with chronic mental patients. With few exceptions, there is no planned program of activities for them and they sit about aimlessly watching television or remain isolated in their bedrooms. That such conditions are an improvement on the back wards of state hospitals is debatable." (Jones 1975:95)*

It seemed that the alternative accommodation services provided for discharged chronic patients were in fact mini custodial institutions in the community. The predicted improvement in quality of life and individual freedoms for these patients did not materialise. Lack of planning, limited resources and economic and political considerations were the major reasons given for the apparent failure of boarding houses to provide a therapeutic milieu for psychiatric patients (Jones 1975).

Deinstitutionalisation of patients to unsupportive communities resulted in people becoming marginalised. Reports from US studies found that discharged inpatients lacked social power, were unemployed or occupied low paid jobs, and were unable to participate in stable employment (Durham and La fond 1996). High rates of unemployment resulted in many of them living in poverty with some ending up in prison (Bootzin and Acocella 1988). Lack of public education programmes aimed at dealing with communities' fears and insecurities of the mentally ill also contributed to their isolation. Greater access to alcohol among the psychiatrically ill population further aggravated their situation (Carrier and Kendal 1997; Durham and La Fond 1996).

Critics of deinstitutionalisation in the US also argued that policy makers did not consider the burden of care to be placed on families who have to care of the mentally ill (Krupinski 1995).

Outcomes of this heavy burden included a profound financial impact (Hamber 1997), the breakdown of many families and the compromised health of family members (Krupinski 1995).

A further social consequence, particularly relevant to countries with a strong union movement is the impact of hospital closures on employees. In the US there was resistance on the part of the unions against the move to close mental hospitals due to the potential for job loss (Durham 1989; Durham and La Fond 1996).

Thus the "humanitarian" mandate has been less than fully realised, leaving many in this camp to question both the pace and concept of a massive deinstitutionalisation effort. Moreover, as already noted, the policy was also motivated by a perceived cost savings. There are many hidden costs in community care which cannot be easily factored in cost effectiveness research (Bacharach 1997). Bacharach (1997) believes that this has been very detrimental to the credibility of mental health service planners, particularly as the promise of financial savings has not been and may not ever be realised (Thornicroft & Bebbington 1989). Moreover, the emphasis on unattainable cost savings could promote cost cutting to the detriment of quality of care.

The most recent criticisms of deinstitutionalisation focus on community calls for protection and fear of the mentally ill (Durham 1989). This perception of society has grown with a correspondent increase of mentally ill in the streets. As Mechanic & Aiken (1987:1636) write, "Community tolerance has diminished in the absence of decent services."

For a variety of reasons, thus, communities, families, the police and mental health professionals in the US are apparently calling for the return of the institution (Durham 1989). Reasons cited for this shift range from public safety to humanitarian concern (Durham 1989).

2.4 Why then community care?

Durham (1989:129) argues, however that deinstitutionalisation, "... was never given a chance to succeed. The present call to return to the asylum holds no greater guarantees of success than earlier reform movements and many of the same recipes for failure", and whilst the impacts have been serious, the deinstitutionalisation experience has not all been negative. As he further highlights, a return to hospital based care will not necessarily be a panacea to the ills of deinstitutionalisation. Moreover, research on psychiatric patients' perceptions of hospitalisation reflects overall dissatisfaction and a sense of "permanently being set apart from "normal" people, an identity based on deficiency..." (Letendre 1997).

There is a large body of research which shows that community alternatives improve function and quality of life when compared to hospital based care (Kiesler & Sibulkin 1987 *cited in* Mechanic & Rochefort 1990; Bacharach 1997; Okin 1995). In a review of outcomes studies conducted in the US, Bacharach (1997:25) concludes that, "...the basic idea of community care appears to be valid for many persons who would formerly have resided in psychiatric hospitals." However, he is cautious to note that these achievements only apply to some patients once discharged from hospitals. Reference is given to those small group of patients increasingly being recognised as "difficult to place patients" who continue to require ongoing hospitalisation even with the provision of a comprehensive array of community care services.

2.5 Models of Care

International mental health care providers have had a number of years to reflect on the lessons of deinstitutionalisation and to review mental health care models. A number of developed countries have moved towards a multi-disciplinary, "case management" model of care (Stroul 1988), whereby programmes of care are designed on an individual basis by teams of professionals (Bacharach 1997; Mechanic & Aiken 1987).

There has been a large amount of research undertaken on the efficacy of models based on the concept of case management. One model which apparently has had some success is that known as "Program Assertive Community Treatment" (PACT) (Burns & Santos 1995). This model was motivated by a need to address the problem of the "revolving door patient", and "calls for provision of a full range of medical, psychosocial and rehabilitation services by a community based team that operates seven days a week, 24 hours a day" (Burns & Santos 1995:669).

This form of care has been found to be more effective than conventional treatments in, controlling symptoms (Olfson 1990; McFarlane et al 1992 cited in Burns & Santo 1995), promoting social functioning (Olfson 1990; Thompson, Griffith, Leaf 1990), encouraging and supporting independent living (Test 1992 cited in Burns & Santos 1995), reducing hospital use (Marks et al cited in Burns & Santos 1995), improving work performance (Olfson 1990; Audini et al 1994 cited in Burns & Santos 1995) and ensuring greater life satisfaction (National Advisory Mental Health Council 1993).

Despite the favourable reviews, the extent to which such a programme is applicable and relevant to South Africa is questionable – especially in a context of limited resources and few skilled practitioners. The experiences of developing countries may be more relevant to the South African context.

2.6 Developing Countries Care Models

Developing country psychiatric care is beset with problems of limited resources, low priority, stigma, a medical model orientation and institutional care (Abiodun 1991, Chikara & Manley 1991; Deva 1988; Deva 1995a&b; Deva 1998; Freeman 1988; Donald et al 1981; Murphy 1998).

Following the world wide trend towards community psychiatric care, many developing countries are moving away from institutional care and have begun to develop more creative ways to care for the mentally ill. Limited resources, enabling socio-political climates and changing notions of mental illness have been major stimulants behind these shifts (Deva 1982; Deva 1985; Donald et al 1981; Jegede 1981).

Unfortunately, the literature provides few examples of successful and sustainable community mental health services in the developing world from which to draw lessons. Community services in developing countries appear to be based primarily on a volunteer and family model (Erinhosho 1977, Jegede et al 1985, Deva 1995a). They are often in rural areas and intricately rooted in local customs, cultures and socio-economies. These models however have been challenged and often found unsustainable in the context of the new social, cultural and economic environment of urban living.

For example, in Malaysia the family is the central role player in the management and care of the mentally ill (Deva 1995b). This emphasis appears to have emerged from traditional practices of care. Deva (1995b:47) writes, "Long before the advent of western type of psychiatric hospitals, the care of the mentally ill was done in the community and most of the time within the family itself." However, rapid urbanisation has resulted in the breakdown of the extended family system of care. Lack of family alternatives has seen the development of urban "homes" for the mentally ill (Deva 1995b). Profit seems to be a major motivating force for these "mini-institutions" rather than rehabilitation (Deva 1995b).

In Nigeria, a village based psychiatric system, once viewed as a promising model, has also proved unsustainable (Jegede, Williams & Sijuwola 1985). Again this model required a strong commitment on the behalf of the family and community. Dr Lambo, the innovator behind this project once observed, "Such a scheme can operate in non-industrial agrarian communities ..... where the threshold of community tolerance is high .... with the advent of social change difficulties may ensue" (Leighton et al *cited in* Desjarlais 1995:61). Social change has occurred -

urbanisation, diminishing community involvement and family participation impacting on the sustainability of the programme.

In countries, such as South Africa, which has a dual care system of traditional and allopathic notions of mental illness, there is also need to establish a proper role in the formal care system for traditional health care providers. However, Desjarlais et al (1995) are quick to point out that most projects which have tried to fully integrate traditional and professional mental health services have mostly failed. "Neither glorification, nor control of traditional healers has benefited mental health services" (Desjarlais et al 1995:54). Despite this, there is a recognised need for greater understanding of traditional caregivers on the side of the professional mental health services. Understanding traditional notions of mental illness can help in the treatment and rehabilitation of patients. Moreover, improved communication with and a clearer understanding of the roles of traditional healers in the care of the mentally ill at the grassroots level will most likely assist in overcoming the fragmentation of mental health services.

Developing countries' experiences have also highlighted the importance of both political and legal commitment to human rights and the redistribution of resources for the care of all people with a mental illness if reforms are to occur in a sustainable quality way (Desjarlais et al 1995).

2.7 Summary

In sum then, deinstitutionalisation, although found to be successful in some instances does not appear to have solved the problems linked to institutional care as initially predicted. The pace of hospital downsizing and closure has far surpassed that of community services development, whilst hospital resources have not followed patients to the community. With the haste to discharge, little thought was given to the service needs of patients. Ad hoc and unplanned release of patients has had many negative outcomes for patients. This does not mean a call for the return to institutionalised care. Community care is the preferred option for many people with a mental illness. It is clear however, that successful tenure of mentally ill patients in the community is dependent upon the appropriate development of community based services and the maintenance of existing hospitals to ensure a system of care exists which can provide both hospital and community based services to the mentally ill. Developing country experience has also highlighted the importance of an enabling political environment to underscore mental health sector transformation and provides a ward of caution regarding models which depend heavily on family and community commitment.

Chapter 3

SOUTH AFRICAN MENTAL HEALTH CARE: An Overview

3.1 Introduction

Inequities pervade all spheres of South African life, and are profoundly demonstrated in the psychiatric services. Care in the past has, to some extent mirrored the international experience of institutional and custodial care, with the mentally ill being cared for in large institutions, away from society. This philosophy of care agreed well with an authoritarian and repressive apartheid society which also promoted separateness and inequities by establishing racially segregated facilities (Foster & Swartz, 1997).

Vogelman (1986) notes that advances in mental health treatments were generally confined to white* South Africans, whilst services for black* South Africans continued to be inaccessible, inadequate, and under-funded. Moreover, formal mental health services in South Africa have never reached, nor were designed to reach the entire South African population. While white patients had relatively greater access to formal care, formal care for black patients was confined to either profoundly low functioning, disruptive or dangerous patients. As Foster & Swartz (1997:5) note, "Within the state sector, gross racial disparities in treatment and service have been apparent. For instance black patients were required to labour on asylum estates (it was regarded as therapeutic) while white patients were not. The state sector largely restricted itself to more serious disorders of "madness" or "mental retardation", leaving many wider reaches of mental health to the private or semi-private sphere".#

During the 1960's the South African government began to contract out psychiatric services to private organisations. Although this was aimed at providing a much needed psychiatric service, in practice it entrenched racial division and promoted a policy of privatisation (Vogelman, 1986). Mental health services provided for blacks by private institutions was very poor and lacked any rehabilitative approach (Vogelman, 1986). Moreover, the contracting out of mental health institutional care by the government did not solve the massive shortage of mental health care

* Racial-based terminology has been used in this report where white refers to those who received historical privilege during the apartheid regime, whilst black refers to individuals who were disadvantaged by law during apartheid, including black, coloured and indian peoples. This terminology has been used to measure the negative impact of the past on this country and to enable changes to be monitored overtime as more equitable policies are implemented.

Given the bio-social nature of mental health and mental illness, it is likely that apartheid has not only been detrimental to service provision, but has also impacted negatively on health overall, through, oppression, adversity and discriminatory practices. This negative impact continues in South Africa as its residents continue to face enormous developmental challenges such as poverty, alcohol and drug abuse, rapid urbanisation and other similar problems. The need for mental health services and the government overall to address this vulnerability is paramount.

services, particularly at a community level. A non-profit, private/NGO sector has emerged in an attempt to partially fill this gap (Foster and Swartz, 1997).

In the late 1970's and early 1980's primary health care and community health centres were established in some parts of the country, mainly in the urban areas. Psychiatric units were established within the community health centres and offered a vertical service. The introduction of the South Africa Health Care Act of 1977 and the Health Plan of 1980 facilitated these developments (Foster and Swartz, 1997). The creation of community psychiatric services has however been extremely slow and still today psychiatric care remains mostly institutional based with little cognisance of traditional notions of mental illness (Bhengu 1989, Porteus et al 1998).

The advent of democracy has brought a new movement of human rights for all in South Africa, and in parallel with international concerns, there has been a closer look at conditions in psychiatric institutions. In 1995 the National Department of Health formed a committee on mental health and substance abuse to investigate reports of malpractice and patient abuse (Mental Health and Substance Abuse Report, 1995). The committee reported to parliament on gross violations of patient rights in psychiatric institutions and recommended a review of the Mental Health Act of 1973 (Robertson, et al 1997). More recently, a study examining quality of care in institutions revealed alarmingly low levels of quality in historically black institutions, with no move toward the development of community services and a continued discrepancy of quality in terms of historical racial privilege (Porteus et al 1998).

In response, the National Department of Health has developed an action plan aimed at improving the conditions of persons with mental illness and entitled the "Proposed National Health Policy Guidelines for the Improved Mental Health in South Africa" (National Directorate of Mental Health and Substance Abuse, 1997). Emphasis in the document is on priorities for caring for persons with mental illness in their communities, including:

1. Developing community care for persons with mental illness, in order to increase access to services, reduce long periods of stay in psychiatric hospitals, encourage patient rehabilitation, and dealing with stigma through integration of the persons with mental illness within their own communities.
2. Integration of mental health services within the broader primary health and general district health services, so as to detect mental health problems at an early stage and reduce the isolation and stigmatisation of people with mental illness as well as the services more generally.

3. Developing public awareness programmes to promote mental health and emphasise the prevention of mental ill-health.

One of the proposed implementation engines underlying these objectives is the policy of deinstitutionalisation (Freeman, *personal communication*, 1998).

3.2 The Study Provinces: An Overview

Basic socio-demographic indicators for the two study provinces are provided in Table 3.2.1 below. Together the two provinces contain 35% of the total South African population. Each has a large metropolitan area, although more than half the population in both provinces lives in the rural areas. Unemployment rates, as with the rest of South Africa, are high. In various indicators of socio-economic status, the Eastern Cape consistently features as the poorest and least developed province. KwaZulu-Natal ranks fourth amongst the provinces in terms of unemployment rates.

Table 3.2.1 Socio-Demographic Indicators for the Eastern Cape and Kwazulu-Natal Provinces

Indicator	Eastern Cape	KwaZulu-Natal	All Provinces
Population size (1998)*	6,302,525	8,417,021	42,130,500
% of total population	15%	20%	-
Population urbanised	37%	43%	43%
Unemployment rate**	41%	33%	29.3%

* Source: StatisticsSA (1998)
** Source: Central Statistics (1996)

3.3 Mental Health Services in the Eastern Cape and KwaZulu Natal

A number of stakeholders are involved in the provision of mental health services in the provinces. These include:

3.3.1 The public health sector
3.3.2 Private providers
3.3.3 Non-governmental organisations
3.3.4 Other government departments
3.3.5 Traditional healers

3.3.1 Public Sector Mental Health Services:

In both provinces mental health services continue to remain a vertical and hospital-based service. There are 5 public sector psychiatric institutions in the Eastern Cape and 3 in KwaZulu Natal. Services in these hospitals are complemented to a varying degree by the provision of acute beds in district hospitals.

In KwaZulu Natal, since the 1970's there have been moves towards the development of a more comprehensive community based mental health service, which has reportedly resulted in a corresponding decrease in inpatient beds (Walker 1996). There have also been moves in the Eastern Cape to address the historical inequities entrenched in current day mental health services (Petse, Holmes & O'Bose 1998). Such efforts appear to have made little impact on the institutionalised nature of care in the provinces. A comparison of Eastern Cape and KwaZulu Natal mental health services against proposed national norms and standards for mental health care in South Africa (Flisher et al 1998), shows that:

- Community based services in both provinces are virtually non-existent.
- There is an excess of long term beds over acute, community-based beds.
- Professional mental health staff are hospital based with a resultant lack of staff located within community services.
- The hospital based services are typified by relatively long length of stays and low admission rates (Appendix A).

Flisher et al (Ibid) recommend not a reduction in total beds, but rather for long term beds to be transferred over time to acute and community based beds. This seems to promote caution against the too hasty closure of long term beds before the establishment of complementary services at district level, both within community and hospital services.

Moreover, public sector community mental health services are still poorly developed and where they exist, provide a very limited service mainly dedicated to the provision and maintenance of medications (Walker 1996; Petse, Holmes & O'Bose 1998). A KwaZulu Natal study highlighted the following problems in the provision of community mental health care: Fragmented services, staff shortages, medication shortages, lack of clerical assistance, inadequate transport, clinic accommodation, security, and training, poor community participation, lack of services for groups with special needs, and difficulty getting patients into hospital (Walker 1996). Although the integration of mental health into primary care services is widely advocated, in practice mental health services remain vertical and separate, and primary care workers lack the skills to identify and manage mental health problems.

3.3.2 Private Sector

In addition to public sector provision of services, the state has since the 1960s (Broomberg *cited in* Porteus et al 1998) contracted with a private-for-profit companies, to provide long term, chronic hospital based psychiatric care. There are 3 such institutions in the study provinces, all currently managed by one company. Recent research showed that patients in these institutions remain predominantly black (Porteus et al 1998) and recommended a revision of the contractual arrangements in order to promote the provision of better quality of care.

3.3.3 Non-Government Organisations

In a rapid assessment of services, McClaren & Philpott (1998) discovered a range of NGOs providing community care for people with mental illness in KwaZulu Natal. These included support and self help groups, group homes, counseling services and day care centres (see Appendix B for a detailed summary of the types of services provided in each province). However, these are limited in scale and appear to be ad hoc and unplanned.

Other problems included:

- Lack of funding
- Lack of information
- Lack of appropriate training
- Poor co-ordination and lack of communication with government structures
- Lack of awareness of mental health
- Inaccessible public transport for people with disabilities

In response, the authors have proposed a number of strategies to address these barriers. These include: Securing sustainable funding through partnerships with the state, improved co-ordination in service provision, the formation of a provincial mental health lobby group and the establishment of a provincial Disability Desk (McLaren & Philpott 1998). These are concrete steps that the province can take in order to expand and improve the role of the NGO sector in the provision of mental health services.

3.3.4 Other Government Departments

Other government departments, such as labour, welfare, correctional services, safety and security and defence also provide services. Intersectoral collaboration between departments is lacking and needs to be promoted.

3.3.5 Traditional Healers

"It is commonly believed that mental illness is caused by bewitchment and evil spirits and as a result, for many the first point of help is traditional healers" (McClaren & Philpott 1998:36). The important role played by traditional healers in mental health care is slowly being recognised and closer links are being forged between them and the health services (Freeman 1992). There is little documentation of the impact of this emerging recognition and partnership, although anecdotal evidence suggests that little has been achieved and much more is yet to be done.

3.4 Summary

Public sector mental health patients are cared for mainly in large institutions, away from their families and communities. Although hospital care is not the ideal treatment environment for a person with a mental illness, there appear to be few alternatives to institutional care in the provinces of the Eastern Cape and KwaZulu Natal. Some of the major barriers to the provision of community services include the lack of priority given to mental health and mental health services, lack of integration into primary health care and district level services, lack of adequate financial assistance and lack of partnerships between the government and non-government sectors (McClaren & Philpott 1998). The services that do exist in the community appear to be ad hoc and unplanned, lacking a guiding framework for service provision. There is a clear need for mental health sector transformation, starting with better policy frameworks.

Chapter 4

CONCEPTUALISING A COMPREHENSIVE MENTAL HEALTH SYSTEM OF CARE

If there is a move towards less institutional and more community based models of mental health care in South Africa, an important first step in the planning process is to establish the service needs of patients currently institutionalised (Lubostsky Levin 1997; Kazarian et al 1997; Phelan et al 1996; Foster & Swartz 1997). South African Policy makers and service planners need to be able to answer questions such as: Who is currently using our hospitals, what are their functioning levels, and what services would they require if they were discharged?

Service need may be viewed as the extent to which an individual has "access to appropriate forms of care or to an adequate level of service" (Hansson et al 1995:286) in order to achieve a meaningful existence in the community. Clearly then mental health treatment alone is not enough (Stroul 1988). A range of basic community services and supports are needed to enable people with a mental illness to live a good quality of life in the community and to realise their own potential (Desjarlais et al 1995). This chapter outlines a conceptual model for a comprehensive mental health system of care, against which service needs can be assessed.

This conceptual outline is underpinned by a definition of mental ill-health as a grouping of illnesses whose causes lie in complex interactions of social, environmental and biological factors (Desjarlais et al 1995). This emphasises a broader understanding of mental illness, moving away from the medical model and the view that mental health lies on a continuum of health to ill-health. Broader social conditions such as poverty, lack of security, violence, trauma and loss are major role players in the causation of mental illness (Ibid).

4.1 A Mental Health System of Care

A mental health system of care is a wide range of mental health and related services and supports organised to work together to provide care. The underlying principles of which should include: Empowerment, involvement, accessibility, continuity, equity, flexibility, respect, cultural appropriateness, co-ordination, quality, effectiveness and efficiency (Stroul 1988; Tippet et al 1994; Robertson et al 1997).

The system of care should emphasise community living but not to the exclusion of hospital services. The following diagram proposes the types of services a mental health system will need to provide to enable patients to live successfully in the community.

Figure 4.3.1 A Mental Health System of Care for Persons with a Mental Illness and their Carers



A description of each of these components of the mental health system of care is provided below.

4.1.1 Mental Health Treatment

The clinical management and care of mental illness should form the basis of any mental health care system. Mental health care should include the diagnostic evaluation and ongoing assessment and monitoring of psychiatric conditions as well as the provision of basic psychotropic medications (Stroul 1988). Other essential components of mental health treatment are counselling and therapy, and psychosocial rehabilitation.

In South Africa, greater integration of mental health services into general health care is needed to make mental health treatment accessible to people with a mental illness living in the community. Integration particularly needs to begin at the primary care level. Proposals are being drawn up to train primary health care workers at the primary care level in the care and management of chronic and stable mental health problems as well as to detect mental health problems and deal with mental health emergencies. This expanded role for primary health care workers requires both training and support. The primary health care practitioner must also have 24 hour access to a mental health care specialist for guidance and the referral of more complex cases. The extent to which such integration is feasible in terms of staffing requirements is something that still requires further research.

Services need to be available for secondary and tertiary level referrals. For example, if the mental health problem is not manageable at the primary care level, it needs to be referred to a higher level including community health centres and district hospitals. These facilities should provide services to patients requiring short stay admissions (Flisher et al 1998). The extent to which primary and secondary level health care workers are actually providing a psychiatric service is extremely limited (Robertson et al 1997). This needs to be addressed in order to make services more equitable, accessible and less institution based.

Specialised psychiatric care is also needed. As Flisher et al (1998:35) note, "Users with severe psychiatric conditions cannot be managed and assisted in the community without adequate hospital support". Tertiary level services need to be available for more severe and enduring mental illnesses, i.e. those illnesses that are so severe that they cannot be treated at a primary or secondary facility (Robertson et al 1997, Flisher et al 1998). Moreover, specialised hospital services must also be available to care for patients requiring hospital care under the Mental Health Act 1973, including "State President Patients" and mentally ill prisoners.

If a patient does require hospital admission, every effort should be made to discharge patients at the earliest possible time and to care for people as close to their communities and families as possible. Shorter lengths of stays will only occur if there is a shift away from the more curative care approach current in South Africa psychiatric institutions to a more rehabilitative care focus (Robertson et al 1997).

Efforts within the mental health system of care need to be made to provide access to psychiatric services to people with special needs including: People living in rural areas, people affected by violence, physical and sexual abuse and for children, young people and women.

4.3.2 Psychosocial Rehabilitation

The Integrated National Disability Strategy (1997:26) describes rehabilitation as, "...ways of helping people with disabilities to become fully participating members of society, with access to all the benefits and opportunities of that society." It proposes that community based rehabilitation should form the basis of any national rehabilitation strategy. Elements of psychosocial rehabilitation include:

- **Psychosocial education:** The aim of psychosocial education is to empower patient's through increasing their knowledge of and control over their illness, and enhancing coping skills through: Symptom and illness management; medication teaching; coping skills and communication skills.

- **Social Rehabilitation:** Stroul (1988:17) defines social rehabilitation as services that are, "directed at helping the client to gain or regain the practical skills needed to live and socialise in the community. Services should include activities that teach daily and community living skills and address diet, personal hygiene, cooking, shopping, budgeting, housekeeping, use of transportation and other community resources in the natural settings where clients live, learn, work and socialise". Social rehabilitation also works to improving interpersonal skills and should address attitudes towards community living and discharge. A willingness to be discharged will work in a patient's favour when hospital discharge is being proposed.

- **Vocational Rehabilitation:** The aim of vocational rehabilitation is to assist patients to, "prepare for, obtain and maintain employment" (Stroul 1988:18). Services such as supported employment programmes and sheltered workshops are included in this category, with preference given to *supported*, over *sheltered* programmes. Ideally, "employment should be integrated and competitive, which means that the person works for at least minimum wages, or better, with non-disabled co-workers, at a job which provides room for advancement in settings that produce goods and services" (Robertson et al 1997:78).

Within a mental health system of care it is essential that rehabilitation services provide continuity of service, graded opportunities and expectations both in the community and in hospital settings (Robertson et al 1997).

4.3.3 Family and Community Support

Discharge of patients from institutional settings, will in many instances transfer the responsibility of care to the family. Up to two thirds of patients are estimated to return to their families on hospital discharge (Goldman 1982). As community resources in the Eastern Cape and KwaZulu Natal are virtually non-existent, it is likely that in a first phase of a discharge programme, the responsibility of care will fall to the family. There is a real need to acknowledge the importance of the family within formal care systems. International thinkers have begun to advocate for the development of policies that embrace families and caregivers and formally integrate them into the health service (Backlar 1997).

It is therefore imperative that families and / or caregivers are involved in any treatment planning and treated as an equal partner in the care of the patient. A mental health system of care needs to equip families with the skills needed to better cope with their mentally ill family member (Guarnaccia & Parra 1996).

Policy makers and service providers must however be cautious when promoting the family as the central role-player in the management and care of a person with a mental illness in the community. The Malaysian experience referred to in Section 2.6 of this report, shows that rapid urbanisation often results in the breakdown of the extended family. In terms of mental health care in Malaysia, this breakdown has resulted in the development of "urban" homes, the focus of which are profit rather than care and support (Deva 1995b). South Africa, with its rapid urbanisation and enormous developmental challenges, must recognise the limitations of families and be extremely cautious of over-romanticising the role of the family in the care of people with a mental illness.

A mental health care system also has responsibility to promote community acceptance and work closely with other agencies that come in contact with people with a mental illness. Such efforts will make it easier to care for and live with a person with a mental illness.

4.3.4 Income Support

Psychiatric disability impacts on a person's ability to secure and maintain stable jobs (Stroul 1988). This coupled with the high rates of unemployment and poverty experienced in South Africa means that securing work to buy food, clothing and shelter might be an unrealistic goal. Financial support is likely to be essential for many psychiatric inpatients, particularly in the period immediately post discharge.

4.3.5 Housing

Personal well-being is inextricably linked to adequate housing. Lack of housing options is a major barrier to discharge of patients in South Africa (Dartnall & Porteus 1998). The provision of long term stable housing options is integral to the successful treatment and tenure of a person with a mental illness in the community (Stroul 1988). Housing options should suit a persons, "own needs and lifestyles and optimise social and vocational functioning" (Robertson et al 1998:78). A mental health system of care must strive to provide an array of housing options, from group homes to single room accommodation.

However, in resource poor areas like the Eastern Cape and KwaZulu Natal, the extent to which provinces can provide an array of housing options in the first instance is limited. The literature therefore promotes the use of existing capital when deciding on alternatives to hospital accommodation such as in the development of hospital based group homes (Wing et al 1997). Hospital based group homes are hospital wards converted to group homes. They are on the hospital grounds, and are serviced by the hospital. They are a transitional home for patients, with patients moving from supervised to less supervised living environments. Work is encouraged and patients are assisted to manage their own lives with day supervision from health care workers. Although on hospital grounds, this is not a hospital service.

The advantage of this form of care as a starting point for developing community based residential services is that it ensures resources follow the tient. As noted in the literature, a major failure of international efforts to move patients from hospitals to the community was the inability of service planners and managers to ensure resources flowed in the same direction. Utilising the existing capital resources affords community care some protection from loss of resources. The major disadvantage however is that hospital based group homes are not that far removed from hospitals. They are however one step on from pre-discharge wards, which in previous studies have been shown to be no different to other hospital wards (Porteus et al 1998). Moreover, hospital based group homes are useful in the transition phase between hospital and community care, particularly in the absence of services elsewhere.

4.3.6 Substance Abuse Services

Substance abuse is an ever increasing problem in South Africa (Parry 1997). Anecdotal evidence seems to suggest that substance abuse is also an extensive problem among people with a mental illness. On its own, substance abuse is a difficult problem to treat and when coupled with a mental illness will most likely necessitate specialised treatment services. Appropriate treatment, rehabilitation and prevention services need to be established to address issues of substance abuse amongst people with a mental illness.

4.3.7 Risk Monitoring and Management

In South Africa, recent media coverage of mental illness has highlighted violent acts such as murder and rape committed by people with a mental illness (Duffy 1998). Unfortunately such reporting is often over simplistic and misleading, not providing the complex history behind these incidents (Trieman 1997).

Research from the UK estimates that only around 0.01% of all people with a mental illness engage in violence (Thornicroft, *personal communication*, 1998). Unfortunately, sensationalised reporting, stigma and fear, means that blame for such acts tend to be placed firmly on the shoulders of community care. Community care in Treiman's (1997:177), words "..... is desirable yet is bound to expose the public to some of the unpleasant aspects of mental illness." Although there are some clear behavioural indicators for these patient types, Trieman (1997) highlights that, "...not all violence by psychiatrically ill people is predictable and therefore avoidable. The alternative is to lock up large numbers of people to secure a very small minority who cannot be identified with any certainty. The choice between these alternatives is a societal one." (Treiman 1997:185).

The issue for mental health care in South Africa is how to deal with people at risk of committing violent acts. United Kingdom researchers have begun studying this area and have identi .d what they call

"difficult to place" patients (Treiman 1997). These patients are defined by staff as, "being offensive to the public and potentially dangerous" (Treiman 1997:177). It has been suggested that these patients require specialised care.

Within services there is also a duty to protect those patients who pose a risk to themselves such as those patients displaying suicidal tendencies, self-mutilation and/or extreme carelessness (Treiman 1997).

A mental health system of care must strive to identify patients who are likely to be harmful to others or to themselves and ensure that responsible services are developed which promote swift intervention and relapse prevention.

Finally, this is an area where more public debate is needed, particularly with regards the constitutional rights of the individual versus the constitutional rights of the public, and finally where difficult and complex public health choices must be taken.

4.3.8 Health Services

It is important not to overlook the general health care needs of people with a mental illness. Research has shown that people with a mental illness have significantly higher rates of physical illness than the general population (Stroul 1988). Services need to be aware of this potential comorbidity. Moreover, a patient with severe or chronic physical illness or disability will require additional supports in the community and pose an additional care burden to the families and / or caregivers. In such cases, service providers will need to be able to provide assistance to the families and / or caregivers with education, support and appropriate referrals as required.

4.3.9 Support and Self Help Groups

Self help or support groups provide consumers with a forum to share experiences and provide mutual support. A mental health system of care should encourage the development of such groups. Appendix B of this report provides a more detailed discussion of this type of service.

4.3.10 Advocacy

The protection of the rights of people with a mental illness should be a fundamental principle which underlies a mental health system of care. Policies and guidelines within services need to be developed. The recently developed National Norms and Standards can be used to assist with the development of such guidelines (Flisher et al 1998). Positions within the civil service should be developed for mental

health advocates who can promote improvements in service provision and to ensure protection of the rights of the mentally ill. Finally, improved information systems and better data on mental health epidemiology and the mental health services will all serve to empower advocacy movements in South Africa.

4.4 Summary

While establishing a broad wish list, all of which is clearly unattainable in the short term, the services described in this chapter provide a conceptual framework for a mental health system of care that could lead to successful community living for mentally ill people. The extent to which the provinces are able to provide the total package of services is dependent on local realities and needs. Service planning needs to proceed on the basis of existing reality and in an incremental manner. Consultation with service providers, users, families and the community is of vital importance. A broad understanding of current inpatient discharge potential and service needs is a good starting point to begin the development of a mental health system of care that strives to enable people with a mental illness to realise their potential and be meaningful participants in their communities.

Chapter 5

METHODS

5.1 Study Aim:

This study aimed to provide a profile of currently hospitalised patients, both to inform the emerging deinstitutionalisation debate, and to serve as a baseline for future evaluations of deinstitutionalisation policy initiatives.

5.2 Study Objectives

The objectives of this study were to:

- develop and document a Care Needs Assessment Protocol (CNAP) for inpatients of public mental health institutions in two provinces – the Eastern Cape and KwaZulu Natal. The purpose of this tool is to:
  - describe the demographic, diagnostic and social profile of psychiatric inpatients in Eastern Cape and KwaZulu Natal psychiatric hospitals
  - assess the broad parameters of potential care needs of current inpatients of Eastern Cape and KwaZulu Natal psychiatric hospitals
- make recommendations to national and provincial government on future deinstitutionalisation policies for public mental health services.

5.3 Study Design

A cross sectional descriptive study was conducted in all government psychiatric hospitals (n=8) in two South African provinces: The Eastern Cape and KwaZulu Natal. Data collection occurred over a three (3) week period in July 1998.

5.4 Study Population

Only psychiatric inpatients were assessed by this study. This refers to patients whose main reason for being in hospital is psychiatric in nature and excluded mental handicap (learning disabilities) and other physical illnesses. Mental illness and mental handicap are two separate sets of conditions often implying a different set of services, as Molteno (1997:115) writes, "Mental handicap is not an illness, although people with a mental handicap, like anyone else, can become ill and the condition could have originated from an illness". As such, mental handicap was excluded from the study.[1]

[1] It is however recommended that a similar study be undertaken looking at mental handicap, particularly as deinstitutionalisation is also

5.5 Sampling

A systematic sample of patients was taken at each hospital. Sample sizes were calculated to achieve a representative sample from each hospital. A total of 737 patients were included in the study. In combining the data across hospitals a weighted sample of 557 people was obtained. Patients in Eastern Cape hospitals made up 60% of patients and the remaining 40% were in KwaZulu Natal hospitals. Table 5.5.1 outlines the sampling, weighted sample size and precision measures achieved for each hospital.

Table 5.5.1 Sampling and Representivity Measures at Hospitals Surveyed

Province	Hospital	Total Number Psychiatric Patients	Sampling	Actual N	Weighted N	Representivity
Eastern Cape						
	Elizabeth Donkin	104*	All	104	8	100%
	Tower	421	1:6	71	82	CI:95%; 10% margin error
	Fort England	291	1:3	85	59	CI:95%; 9% margin error
	Komani	492	1:5	91	112	CI:95%; 9% margin error
	Umzimkulu	182	1:2	89	36	CI:95%; 8% margin error
KwaZulu Natal						
	Madadeni	352	1:3	120	64	CI:95%; 8% margin error
	Fort Napier	445	1:4	104	99	CI:95%; 9% margin error
	Town Hill	387	1:5	73	97	CI:95%; 10% margin error
	Total	2674		737	557	CI:95%; 7% margin error

(*This includes inpatients of Dora Ward, Port Elizabeth Hospital.)

5.6 Development of the Data Collection Tools

Data for this study were gathered via two tools: The institutional profile which has been designed to collect hospital wide data on patients and staff and the Care Needs Assessment Protocol (CNAP) which aims to broadly assess care needs of current psychiatric inpatients.

5.6.1 Institutional Profile

The institutional profile provides hospital wide data such as patient numbers, bed occupancy rates and staffing levels. This tool was developed in co-ordination with the National Directorate of Mental Health and Substance Abuse. This ensured that the information collected was relevant at a national level. Development of the institutional profile incorporated feedback via a workshop with the Director of Mental Health, feedback from researchers working in hospital based survey work and drew from lessons learnt through a recent quality of care study (Porteus et al 1998) and a study conducted at an Eastern Cape

debated and discussed in the context of people with a mental handicap.

hospital (Dartnall & Porteus 1998). Changes arising from these processes included the inclusion of data definitions, inclusion of more detailed hospital admission and discharge items and minor changes to the staff categories. The institutional profile was also sent to senior management at a Gauteng based psychiatric institution for comments and feedback. Staff feedback was positive and no changes were made to the form (Appendix D).

5.6.2 Care Needs Assessment Protocol (CNAP)

The Care Needs Assessment Protocol (CNAP) was developed to provide a gross indicator of the discharge potential and service needs of current inpatients in KwaZulu Natal and Eastern Cape psychiatric hospitals.

The CNAP has a number of functions. Firstly it aims to gather baseline data on current inpatients, secondly it sorts patients into levels of care and places them on a continuum of discharge potential, and finally it broadly assess patients' service needs. A later section of this chapter describes this framework in more detail. A copy of the CNAP can be found in Appendix E.

A draft version of the CNAP was developed using a variety of sources, including international assessment tools and advice from national and international mental health experts.

5.6.2.1 International Assessment Tools

While no gold standard exists for the assessment of service needs for people with a mental illness (Leicester & Pollock 1996; American Association of Community Psychiatrists 1998), there are some research programmes which have begun to develop tools to assess needs for service planning.

Unfortunately, direct applications of international tools to a South African context is often problematic (Parry 1996; Oduwole & Ogunyemi 1989). Reasons for this include issues of the language and tone of the tool and the relevance of the items to the daily socio-economic realities of South African psychiatric inpatients. Such differences strongly motivated for the development of a locally relevant tool.

This does not mean that international experience was not useful for local assessment efforts even though their direct applicability is questionable. International tools were therefore be used to guide the development of the CNAP in combination with local expertise and experience. This project reviewed a number of instruments developed internationally from which relevant items were adapted to suit a South African context (Table 5.6.2.1.1).

Table 5.6.2.1.1 Tools Reviewed and Their Major Characteristics

Tools*	Areas Assessed	Time Frame	Main Features
Camberwell Assessment of Need – CAN[a] (Phelan and colleagues 1995)	22 Domains[a]	Last month	• Snapshot assessment • Key-worker interviews patient • No training required[b] • Administration takes 25 minutes • Two versions: Clinical & Research[c]
Camberwell Assessment of Need Short Appraisal Schedule – CANSAS[a] (Thornicroft & McCrone 1998, personal communication, 1998)	22 Domains (same as CAN)	Last month	• Snapshot assessment • Key-worker interviews patient • No training required
Global Assessment of Functioning Scale (GAF) (PRiSM 1992 adapted from DSM III-R (1987))	Rates patients' psychological, social and occupational functioning on a continuum fro 0-100	Last month	• Completed by trained professional

*These were not the only instruments reviewed. A number of other instruments were "eyeballed" for items and topic but not in as much detail as the above-mentioned tools.
[b] The interviewer needs to be a professional with experience in assessment interviews.
[c] The research version is used as a service evaluation instrument (Phelan and colleagues 1994 a & b).
[a] The CAN/CANSAS measures 22 domains of need in recognition of "the complex mix of health and social needs" of people with mental illness (Phelan and colleagues 1996). The CAN/CANSAS has begun to enjoy a wide dissemination and review and much work has been completed on the validity and reliability of the tool in different settings and in different countries (Slade et al 1996; Hansson et al 1995). There are also currently 13 translations in preparation (Phelan et al 1996). Areas assessed by the CAN = accommodation, food, household skills, self care, occupation, physical health, psychotic symptoms, information about condition and treatment, psychological distress, safety to self, safety to others, alcohol, drugs, company, intimate relationships, sexual expression, child care, basic education, telephone, transport, money, welfare benefits.

Using these tools in combination with local experience, a draft version of the CNAP was developed.

5.6.2.2 Mental Health Experts

A consensus building method was used to develop the Care Needs Assessment Protocol further. A draft version of the protocol was sent to a panel of mental health experts, both locally and internationally. These researchers were asked to review the tools in terms of comprehensiveness, credibility and sense. This was done in an effort to ensure the validity of the tool given there was no "gold standard" against which criterion related validity could be measured. The experts were also asked to suggest other people to whom the protocol should be sent. Eight people in total received copies of the CNAP and / or were communicated with regarding specific areas of the CNAP. See Appendix F for a list of informants who commented on the CNAP. Detailed comments on the tool were received and focused mainly on the inclusion of items on the estimated time patients have spent in hospital, items concerning medications compliance and family interventions, history of violence and minor points on the categories used and layout of the tool.

5.7 Pilot of the measurement tools

The institutional profile and CNAP were piloted over a period of one day (17 June 1998) at Sterkfontein Hospital, Gauteng. Sterkfontein was selected as the pilot site because it is both accessible to the researchers and represents a specialist public mental health institution, similar to the ones in the study. The purpose of the pilot was to both gather information on the reliability of the CNAP tool as well as to receive feedback on the user-friendliness and comprehensiveness of the tool. A three pronged approach was therefore adopted and included:

- Key Stakeholder interview
- Inter-rater reliability measures
- Group discussions

5.7.1 Key Stakeholder Interview

The nursing service manager was asked to gather feedback from management on both the Institutional Profile and the CNAP tool. The tools were sent to the nursing service manager in advance of the pilot. On arrival at the hospital, a one on one interview was conducted with the nursing services manager to gather feedback on the tools. All comments were positive and no changes were made on the basis of this interview.

5.7.2 Inter-rater reliability

Repeat measures were taken on a small number of the sample to test repeatability. This involved two groups of two professional nurses of two different wards: One acute ward and one chronic ward. Each group was asked to abstract the first 10 files from the filling cabinet and complete the CNAP questionnaire on those patients. The responses of nurses from the same ward were then compared. Due to lack of time and staff not being made clear about the purpose of the researchers' visit, staff based at the chronic ward completed only five questionnaires each on the same five patients. Only a brief introduction was given to nurses. No formalised training was provided. Reasons for this decision were to see if the tool was indeed simple and self-explanatory, and to minimise the time spent with already over-worked nurses.

5.7.3 Results of the pilot

Due to small samples, the Kappa statistic could not be calculated. As such only the level of agreement between variables could be calculated. Agreement measures for a small selection of CNAP variables were calculated (Table 5.7.3.1). Good agreement is defined as 90% or above.

Table 5.7.3.1 Summary Results of Pilot

VARIABLE	LEVEL OF AGREEMENT	
	ACUTE (length of stay is less than 6 mths) n=10	CHRONIC (Length of stay greater than 6 mths) n=5
This patient has a problem with alcohol and / or drugs	90%	100%
This patients behaviour is appropriate for community living	60%	Sample size too small
This patient can be discharged given existing community services	80%	Sample size too small
This patient should remain in hospital, either temporarily or permanently	60%	Sample size too small
This patient is co-operative about taking his/her medications	60%	100%
Is there someone in the patient's family who is prepared to take the patient if discharged	90%	Sample size too small
This patient is violent and disruptive and is a danger to others	90%	100%

Findings from the pilot reflect good agreement in responses on only 3 variables for the acute ward and only 4 variables for the chronic ward. The small sample taken in the chronic ward meant that agreement could not be calculated for 4 of the variables. These outcomes may have been a result of nurses not having received any training prior to completing the CNAP. Staff motivation may have also played a role. As mentioned earlier, staff were not informed of the researchers' visit until the researchers arrived at the ward. This was in spite of numerous telephone calls and letters to the hospital prior to the visit. The wards were understaffed that day and the pressures of work may have taken precedence to the pilot study. The value of the pilot lay in the lessons of process that arose out of the experience. Lessons learnt included recognition of the importance of training, the need to ensure nurses are informed of the study prior to the hospital visit, and the need to recognise the demanding context in which nurses are working.

5.7.4 Group Discussion

Finally, once the forms had been completed, group discussions were held with staff at each ward. Individual feedback on each item was requested regarding clarity, wording, and relevance of items. Feedback was generally positive. Nurses found the form clear and easy to complete. However, they felt it important to exclude the section for nurses' names on the forms – preferring anonymity. They also

identified some questions that were unclear and provided recommendations for alternative wordings, which were thought to be more appropriate to the nursing profession. The acute ward staff, in particular highlighted items that were irrelevant to acute patients. All comments were discussed and, where appropriate were incorporated into the CNAP.

5.8 Data Collection

Approval for the study and letters of support were sought from the National Director of Mental Health and Provincial Mental Health Co-ordinators. A detailed letter was sent to the superintendent of each hospital appended with letters of support from provincial and national departments of health. The letter outlined the purpose and process of the study and proposed dates for data collection. The data collection tools were also sent to all the hospitals approximately three weeks before the researchers' field visits. Each letter was followed up with phone calls.

Data were gathered during the period from 7 to 22 July 1998. Each hospital was visited by 2 researchers who spent an average of two days at each hospital. These site visits were undertaken in order to promote good data quality and high returns.

5.8.1 Institutional Profile

The superintendent of each hospital was asked to identify appropriate administrative staff to complete the institutional profile and in most instances, a researcher worked alongside the administrative staff in the completion of this tool. One institutional profile was completed per institution visited.

5.8.2 Care Needs Assessment Protocol (CNAP)

The CNAP was completed by ward-based nursing staff. A brief introduction to the study and the CNAP was provided. This introduction took a different form at each hospital, ranging from mass meetings with all nursing staff to one on one meetings with nurses at the ward level. Only minimal training was given, as the assessment falls short of a detailed psychiatric examination. A brief introduction to every item of the CNAP was however provided.

Ward-based nursing staff who best know the particular psychiatric patient completed the CNAP. Nurses were instructed to complete the CNAP using their knowledge of the patient, information contained in patient files and in interview with the patient. Nurses were asked to draw a sample of files as outlined in Table 5.5.1. Researchers worked along side the nurses, providing assistance as required. It took approximately 10 minutes per patient to complete the CNAP.

5.9 The CNAP Framework

The CNAP has an internal scoring system that enables the researcher to assess patients in relation to a number of parameters. As mentioned, these parameters were identified as important factors for assessing service needs of inpatients drawing from the local realities and the experience of international and national literature and mental health experts. Parameters identified as important starting points for the prediction of service need are:

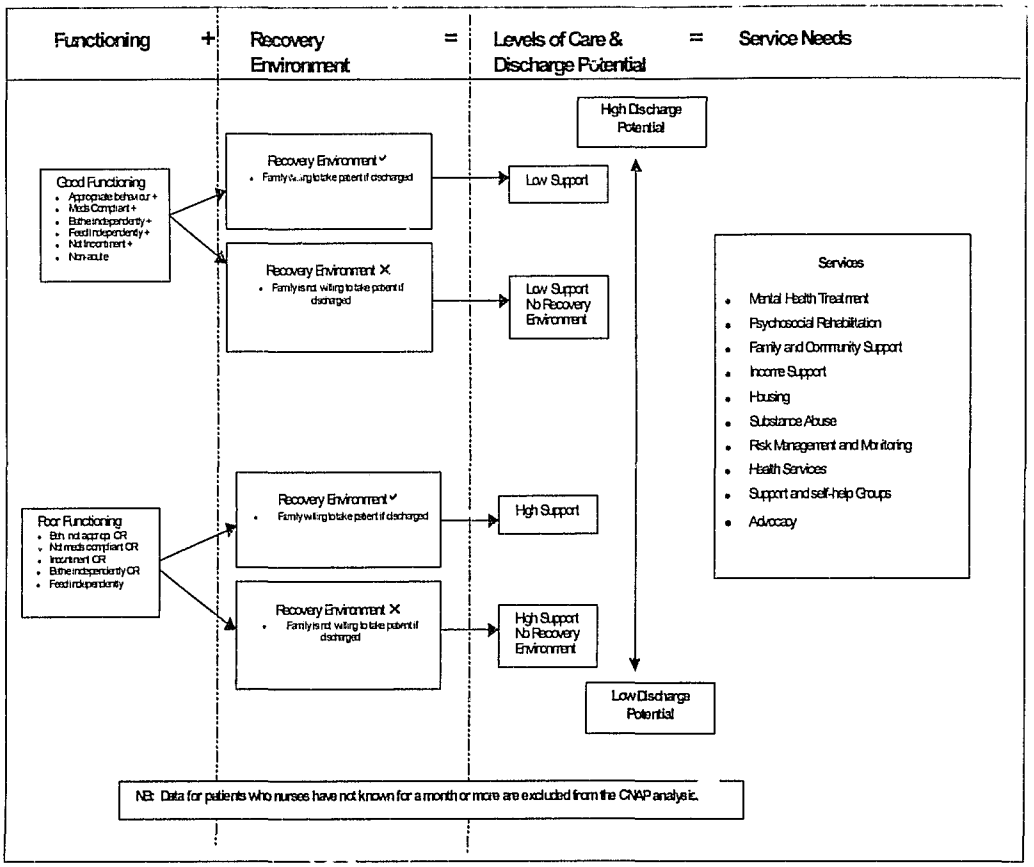
- Functioning
- Availability of Recovery Environment

Using these parameters, patients are further grouped into levels of care, placing them on a continuum of discharge potential. These levels of care are:

1. Low Support
2. Low Support / No recovery environment
3. High Support
4. High Support / No recovery environment

This framework is diagrammatically presented in Figure 5.9.1. The next section provides a commentary on these levels of care and discharge potential and the parameters used to define them.

Figure 5.9.1 Defining Service Needs of Current Psychiatric Inpatients



5.10 Parameters for Assessing Service Need

5.10.1 Functioning

A very simplistic approach to functioning has been adopted by this study. Functioning of the sample is spilt up into "good" and "poor" functioning and relates only to basic living skills. The arbitrary nature of functioning must also be highlighted. Functioning is not static, rather it is something which changes over time. Moreover, the working definitions proposed by this study are only starting points for further discussion around what constitutes "good" and "poor" functioning. With this in mind, working definitions of these categories are as follows:

"Good" functioning

Patients falling into this category have the basic skills and ability to live independently in the community. They are in a non-acute phases of their illness, and are absent of any symptomatology of their illness.[2] They have little or slight impairment in social and living skills. Their behaviour is appropriate for community living, they can bathe and feed independently, and they are not incontinent. The patient is medication compliant.[▾] The following table provides a summary of how a good functioning patient is defined by this study.

Table 5.10.1.1 Good Functioning Patients Scoring

Must score true on all of the following:	**Must score false on all of the following:**
This patient's behaviour is appropriate for community living (Question 31)	This patient is incontinent (cannot control his/her bladder) (Question 26)
This patient is co-operative about taking his/her medications (Question 32)	This patient experiences hallucinations and / or delusions (Question 29)
This patient can bathe independently (Question 33)	
This patient can feed independently (Question 34)	

"Poor" Functioning

These patients' behaviour and functioning level is such that they would require close supervision and / or support to live in the community. They are currently unable to carry out some of the most basic living skills. Their behaviour is not appropriate for community living or they are not medication compliant, or they are incontinent or they cannot feed or bathe themselves (Table 5.10.1.2).

Table 5.10.1.2 Low Functioning Patients Scoring

Must score true on the following:	**Must score false on anyone of the following:**
This patient is incontinent (cannot control his/her bladder) (Question 26)	This patient's behaviour is appropriate for community living (Question 31)
	This patient is co-operative about taking his/her medications (Question 32)
	This patient can bathe independently (Question 33)
	This patient can feed independently (Question 34)

[2]Drawn from the Global Assessment of Functioning Scale (GAF Scr .)

[▾]Medications Compliance is apparently is one of the most critical issue in preventing relapse (Burns, personal communication, 1998).

5.10.2 Availability of a Recovery Environment

A recovery environment is important as it contributes, "to the onset or maintenance of addiction or mental illness, and factors which may support a person's efforts to achieve or maintain mental health and/or abstinence" (American Association of Community Psychiatrists 1998:12) as well as providing the basic infrastructure needed for the discharge of patients to the community. Only limited non-familial alternatives are available in the Eastern Cape and KwaZulu. The family will therefore most likely have to provide the patients' recovery environment. In attempting to identify who and who should not be discharged, a families' willingness to accept the patient back after discharge is therefore an important parameter for identifying the discharge potential of current inpatients (Question 47/48/53).

5.11 Levels of Care and Discharge Potential

Functioning and the availability of a care recovery environment have been identified as important predictors of discharge potential and service needs. Four levels of care emerge from this process. These levels enable the plotting of groups of patients along a discharge continuum.[3]

The definitions of the different levels of care and their position on a discharge continuum are outlined below:

[3] This framework should be seen as a guide to service planning only and not as a tool for assessing discharge potential of individuals. A more detailed, multi-disciplinary team assessment is needed to determine the discharge status of individual patients.

HIGH DISCHARGE POTENTIAL



Low Support: These patients are experiencing good functioning and have access to a recovery environment. They require minimal community services to be discharged.

Low Support, No Recovery Environment: These patients are experiencing good functioning but do not have access to a recovery environment. Although these patients require very few supports in the community to be discharged, the lack of family supports may work as a barrier to discharge given the current lack of alternative residential options in the provinces.

High Support: These patients are experiencing poor functioning but do have access to a supportive recovery environment. The availability of a recovery environment in the community may overcome the difficulties associated with the poor functioning of these patients.

High Support, No Recovery Environment: These patients are experiencing poor functioning and do not have access to a recovery environment. For this patient grouping, community living may be a long way off, particularly in the absence of any community facilities to support patients with high care needs.

LOW DISCHARGE POTENTIAL

These level of care groupings only serve as a guide to discharge potential – a more detailed understanding of what each group of patients may require by way of services is also required. The following section begins to define in more detail the service needs of each group.

5.12 Identifying Service Needs

Indicators and the associated CNAP item used to assess service needs of the inpatients according to their levels of care is provided in Table 5.12.1. The model for a mental health system of care proposed in Chapter 4 is used to guide this discussion.

It is important to note that **all** of the services proposed in Chapter 4 are important to successful community living, however some may be more important than others to the patients assessed in this study at their respective levels of care, or to the provinces. Decisions on what are important priorities for the provinces have to be made at a local level with good knowledge of resources and in consultation with patients, the caregivers and the communities.

Table 5.12.1 Indicators for Assessing Service Needs

Services	CNAP Items	Indicator
Mental Health Treatment	% Admission Status (Question 20)	Extent to which inpatients are required to be in hospital by law
Vocational Rehab Services[▼]	% Working prior to admission (Question 9)	Potential to take up employment on discharge
	% Hold down a job (Question 40)	Extent to which patients may succeed in the open job market
	% Patients who would benefit from a sheltered workshop (Question 48)	Extent to which sheltered workshops may be useful
Social Rehab Services	% Public transport (Question 37)	Extent to which patients need assistance in using public transport
	% Keep neat and clean (Question 35)	Extent to which patients need education in personal hygiene
	% Budget money (Question 38)	Extent to which budgeting skills are required
	% Willingness of patient to be discharged (Question 55)	Extent to which psychosocial counselling is needed
	% Length of time in hospital (Question 17)	Extent to which the impact of social disablement caused by long term hospital care may need to be addressed
Psychoeducation	% Patients remember to take medications (Question 36)	Extent to which supervised pharmacotherapy is needed
Risk Management	% Patients at risk to others (Question 24)	Extent to which patients require risk management and monitoring in the community
	% Patients at risk to self (Question 25)	
Housing[▲]	% Patients requiring assistance with finding accommodation (Question 41)	Need for housing options
Income Support	% Patients who will benefit from financial assistance (Question 42)	Need to assist patient with obtaining disability grant before discharge.

[▼] Functioning levels are also linked to the need for rehabilitation. As such poor functioning may also be used as an indicator of the need for more intensive rehabilitation services.

[▲] This option is also measured by the main parameters of discharge potential by way of the availability of a recovery environment.

Substance Abuse Services	% patients who have a problem with drugs and / or alcohol (Question 25)	Need for substance abuse services
Health Services	% Chronic physical illness (Question 27)	Extent to which access to general health care is required and the extent to which there may be an added care burden.
	% Severe Physical disability (Question 28)	
Family & Community Support*	No measure available	
Self Help Groups	No measure available	
Advocacy	No measure available	

5.13 Data Analysis

Data was analysed using SAS, SPPS and Epi Info. The Centre for Epidemiological Research in Southern Africa, Medical Research Council provided assistance with the data analysis. As already mentioned, the sample taken at each hospital was weighted proportionally to the total sample in order to make the data representative of the total patient population sampled. The data are combined across hospitals and across both provinces. Where significant differences were found between provinces these are reported.

5.14 Study Limitations

5.14.1 Not a Discharge Tool

The CNAP is not designed to identify individual patients who should or should not be discharged. Rather it's purpose is to act as a planning tool for policy makers and planners alike in order to have a more in-depth understanding of the gross service needs of current psychiatric inpatients. Individual discharge decisions should be made by a local multi-disciplinary team considering the diverse factors that reach beyond the scope of this planning model.

* This service need is however measured through the main parameters of the CNAP framework.

5.14.2 Cross-sectional study design

The limitations of cross-sectional studies are well known in that secular and other trends are not reflected (Youngleson & Joubert 1991). However, the large sample size and the chronic nature of severe and persistent mental illness will serve to diminish the limitations of cross-sectional studies. It is also recognised that patients' needs and functioning levels change over time. Follow-up cross-sectional studies are therefore recommended in order to monitor trends over time.

5.14.3 Measurement Bias

The CNAP is a new care needs assessment tool. As no "gold standard" of this measure exists, an investigation of the criterion validity of the measure is not possible (Botha & Yach 1987). As such content validity was assessed and the protocol was sent to other local and international researchers. However, there is still a need to test the tool further, particularly in the light of poor inter-rater reliability results arising from the pilot. Further research in different settings is also recommended.

In general, nurses could fill in three responses to questions: yes, no or don't know. To categorise patients into levels of care needed, it was necessary to exclude all patients who had "don't know" responses against the key variables. The result was that 132 patients were excluded in the categorisation process, which may have biased the distribution across categories or the service needs within categories.

In order to diminish measurement bias in future studies, it is recommended that more opportunity for objectivity is created, by testing nurses assessments further. For example, measuring their assessments of discharge potential and the availability of a care recovery environment and by getting an independent researcher to investigate the don't know categories in more detail.

5.14.4 Data-Quality

As highlighted in the pilot study, limited resources, immense change and high amounts of uncertainty describe the environment experienced by hospital staff. There was also fear expressed at some hospitals that the policy of deinstitutionalisation may result in staff reductions. Such fears and concerns undeniably impacts on nurses' motivation to undertake added work. The methodology developed through this study involved the nurse in gathering data. Given this context it was not surprising that researchers were met with some resistance. Such resistance may have to some extent impacted on the quality of data gathered. However, as researchers were on site during the time of data gathering they were able to address problems and concerns of staff as they arose.

5.14.5 Who Assesses?

The tool itself involves the use of nurses as the experts in the assessment of patient functioning. Nurses who best know the patient complete the assessment. Reports from nurses completing the tools were that it is simple, brief and relevant to their work as psychiatric nurses. The fact that we were able to complete 767 assessments at 8 psychiatric hospitals over a period of only 10 working days attests to the simplicity and brevity of the tool.

A point to consider when interpreting the results, is the question around the appropriateness of nurses in assessing inpatients. This methodology was based on the assumption and the knowledge that nurses are the best suited to assess patients in a broad way. They have spent most time with the patients, it is often their role to bring a person who is discharge ready to the attention of the medical officer, and they should be able, in terms of clinical skills, to undertake such assessments. However, the extent to which nurses who assessed patients in the study were skilled to do so was not measured by this study. As such, a more detailed assessment of the CNAP and the extent to which nurses across hospitals applied the CNAP tool with a common understanding of operational definitions is recommended.

5.14.6 Service Needs Indicators

These indicators have been developed through this study. They have not been subjected to any formal validity or reliability checks. Such testing is recommended.

5.14.7 Omissions

The three private, contractor hospitals were excluded due to the time-consuming process necessary to negotiate access to such facilities. It is recommended that a similar study be undertaken in these institutions to ascertain possible differences in patient profiles, if any.

5.15 Ethical Considerations

Ethical approval for the project was obtained from the Committee for Research on Human Subjects of the University of the Witwatersrand[4]. Participation in the project was voluntary, and informed consent was obtained from all respondents prior to each interview. Names of interviewees do not appear on interview schedules.

[4]Reference R14/49 Dartnall; Clearance number: M980512

Chapter 6

RESULTS: PROFILE OF INSTITUTIONS

6.1 Location:

Four of the 8 hospitals were situated in urban centres. Three were located in rural towns. One hospital was peri-urban and situated in a "township"*.

6.2 "Historically White" and "Historically Black":

As South Africa's history is deeply rooted in racial discrimination, an important defining characteristic of hospitals is their recent history in terms of racial differences. Of the sample of hospitals, three were "historically white", four were "historically black" and one historically cared for both white and black patients on the same grounds but in different wards.

There has been little change in the racial breakdowns of patients within these hospitals with "historically black" hospitals being home to a majority black patients and vice versa. In one province in particular, racial integration of care was still a distant "goal". White patients from a small town in which the only psychiatric institution is "historically black" were transported about 300km to a "historically white" hospital. As Porteus et al (1998:188) found, "While the formal policy is one of equal access to any institution, "historically black hospitals" are almost exclusively black, while "historically white" hospitals remain with a majority of white patients". Perceived access barriers to "historically white" institutions faced by black patients include clinical bias, family expectations and knowledge and communication barriers (Porteus et al 1998:188).

These findings highlight a slowness of some institutions to embrace the changes happening within the country. Lack of a guiding framework or coherent vision for mental health sector reforms may, to some extent, explain the slow pace at which change is happening in some of these institutions.

6.3 Institutional / Custodial Care:

All hospitals in the sample are large, representing the era of custodial / institutional care, both in terms of bed numbers and ward size. Wards are large, hostel like, and filled wall to wall with rows of beds. Across hospitals there was a mean of 42 beds per ward (Table 6.3.1).

Table 6.3.1 Numbers of Authorised Beds Across Hospitals

Province	Hospital	Number Authorised Beds	Beds per Ward
Eastern Cape			
	Elizabeth Donkin	163	27
	Tower	600	33
	Fort England	470	52
	Komani	968	44
	Umzimkulu	440	49
KwaZulu Natal			
	Madadeni	812	62
	Fort Napier	458	33
	Town Hill	586	34

Informal observations done during site visits found very little individualisation of wards. Care in each of the institutions mostly emphasised drug treatment with little focus on rehabilitative care across hospitals. Large patient numbers and large wards do little to promote a rehabilitative ethos of care. This observation is supported by other studies (Mental Health Directorate 1998; Porteus et al 1998).

6.4 Medications Profile

The "medical model" still drives the care provided in the hospitals in South Africa (Foster & Swartz 1997) of which medication management is the key aspect. Arguably, patients' treatment in these hospitals is often little more than medication management, particularly in the absence of counseling and rehabilitation services (Porteus et al 1998).

Proper medication management and compliance is however linked to successful discharge. Compliance is made more likely if side effects of medications are minimal. Minimisation of side effects can be achieved in most instances through proper and regular medication review and monitoring. Table 6.4.1 below provides a summary of medication and diagnoses of patients in this current study. The top five medications according to the top three diagnoses are displayed below.

It was beyond the scope of this study to analyse the correctness of the medications being provided in the hospitals visited. Recent research in 6 psychiatric institutions in South Africa however has looked at the quality of medication management for psychiatric patients and found no evidence of extensive polypharmacy and over-medication across hospitals (Porteus et al 1998).

* Township refers to locations where black, coloured and Indian South Africans were forced to live during the apartheid era.

Table 6.4.1 Common Medications and Diagnosis Profile

	Top 3 Diagnoses		
Top 4/5 Meds	**Schizophrenia**	**Substance Abuse**	**Epilepsy**
	Chlopromazine	Chlopromazine	Carbamazepine
	Haloperidol	Fluphenazine	Phenobarb
	Thioridazine	Haloperidol	Thioridazine
	Fluphenazine	Thioridazine	Trifluoperazine
	Trifluoperazine	Trifluoperazine	

6.5 Admission Status

Some patients, during the course of their illness may pose a risk to themselves and/or others. These patients, although unwell during such phases, may refuse treatment. The psychiatric services have the responsibility to manage the risk these patients may pose and achieve this through certification, whereby a patient is placed under psychiatric care through legal processes. Being certified may however serve as a major barrier to discharge. Anecdotal evidence suggests that decertification is often a time consuming and overly bureaucratic process (Dartnall et al 1998).

Similarly, the discharge of "State" patients (i.e. those patients found to have committed a crime whilst mentally ill and serve their jail term within a psychiatric institution) is also difficult, even when they are no longer required to be there by law (Robertson et al 1997). As such the admission status of patients is an important issue to review when thinking about deinstitutionalisation.

Table 6.5.1 below provides brief descriptions of the different Articles of the Mental Health Act 1973, under which patients are most commonly admitted.

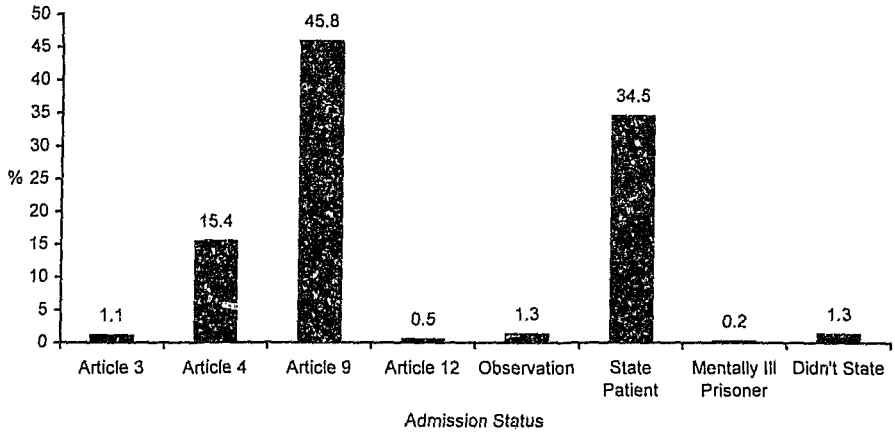
Table 6.5.1 Hospital Admission Types

ARTICLE / TYPE	DESCRIPTION
3	Voluntary admission
4	Admission by consent
9 & 12	This patient type is either putting themselves or others at risk and is refusing treatment. Admission to hospital requires a reception order which is obtained through the magistrates court
Observation	A patient is sent by the courts for 30 days observation in a psychiatric hospital. This happens in the event where an accused person is suspected of having a major psychiatric disorder.
State President's Patient	Patient has been referred by the courts for detention in a psychiatric institution (i.e. patient has been found guilty of committing a crime whilst mentally ill)
Mentally ill prisoner	Patient transferred from a prison for psychiatric treatment

Table adapted from a recent study on Mental Health Information Systems in Gauteng (Dartnall et al 1998)

Figure 6.5.1 provides a breakdown of the admission status of patients across the hospitals.

Figure 6.5.1 Breakdown of Admission Status of Inpatients (n=557)



A large number of the patients in the hospitals surveyed are required to be there under the Mental Health Act of 1973. This poses certain bureaucratic barriers to discharge.

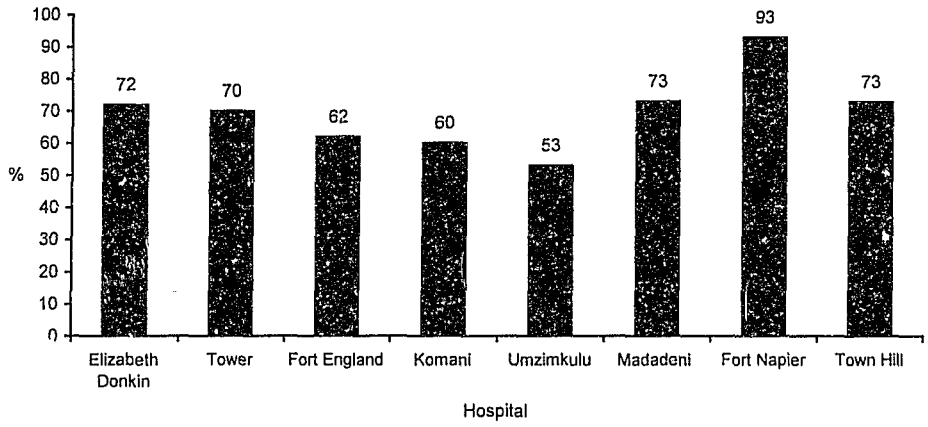
6.6 Bed Occupancy

The bed occupancy is calculated by dividing the total number of occupied beds by the total number of available beds x 100 (Hospital Strategy Project 1995). It is a gross measure of bed use for an inpatient facility (Hospital Strategy Project 1995).

The Hospital Strategy Project (1996) recommends an optimum occupancy rate for hospitals of between 70 and 80%, whereas Flisher et al (1998) propose a bed occupancy rate of 85% for acute beds and 95% for long term beds. Total Bed occupancy rates were 73% for the Eastern Cape and 86% for KwaZulu Natal (Flisher et al 1998).[1]

Bed occupancy rates per hospital found in this study are shown in Figure 6.6.1 below. These figures seem to suggest that many of the hospitals are not working at optimum efficiency and may reflect a need for better management of resources. For example, in comparing the occupancy rates with those recommended through the Hospital Strategy Project, a number of hospitals are working below the recommended rate of 70-80%. However, if we assume that these hospitals house predominantly chronic beds, then all are working below optimum efficiency levels.

Figure 6.6.1 Bed Occupancy rates for 8 Psychiatric Institutions in Eastern Cape and KwaZulu Natal, 1995



[1] This figure includes private sector facilities and has been drawn from the national norms and standards study (Flisher et al 1998)

6.7 Staff:Bed Ratios

Staff:bed ratios by staff categories are provided in Table 6.7.1 below.

Table 6.7.1 Staff:Bed Ratios by Staff Type by Hospital

Hospital	No. Beds	Professional Nurse* / per Occupied Bed	Non-Professional Nurse♣ / per Occupied Bed	Number of psychiatrists and medical officers / per Occupied Bed	MDT ♦ / per Occupied Bed
Town Hill	586	0.19	0.38	0.002	0.01
Madadeni	812	0.25	1.62	0.03	0.02
Fort Napier	458	0.24	0.31	0.04	0.03
Fort England	470	0.09	0.21	0.01	0.02
Komani	968	0.11	0.27	0.002	0.01
Tower	600	0.14	0.24	0.003	0.02
Elizabeth Donkin	163	0.16	0.29	0.03	0.02
Umzimkulu	440	0.25	0.57	0.005	0.01
Mean		*0.15*	*0.48*	*0.02*	*0.02*

On average, across hospitals there are 0.15 professional nurses, 0.48 non-professional staff, 0.02 psychiatrists or medical officers and 0.02 multi-disciplinary team members per bed. Base norms of 0.25 nursing staff per bed, and 0.01 and 0.02 psychiatrists and medical officers per bed, respectively, have been proposed (Flisher et al 1998). While there is large variation between hospitals, the overall the means suggest a reasonable nursing staff complement, and under staffing by medical personnel. These findings have also to be considered in the light of relatively low bed occupancy rates, which suggest that there may be spare capacity within hospitals that could be used for alternative purposes.

However, a word of caution is advised. As Flisher et al (1998:131) note, "...bed occupancy rates are only meaningful if supplemented by information on standards or quality of care, level of staff experience and expertise, practice guidelines, clinical policy and the kind of available facilities within the inpatient setting". Gathering such information is beyond the scope of this study, although recent research suggests that care currently provided in South African psychiatric institutions is often of low quality (Porteus et al 1998).

* Includes Chief, senior and professional nurses
♣ Includes Senior enrolled nurses, Enrolled nurses, ENA and ENA's
♦ Includes Dentists, Clinical Psychologists, Social Worker, Occupational Therapists, Occupational Therapists Assistants, Physiotherapist, and Physiotherapy assistants.

6.8 Summary

The psychiatric hospitals in the Eastern Cape and KwaZulu Natal are mostly located in urban areas, which in turn pose access problems to people living in rural and peri-urban areas.

Contrary to the constitution, many psychiatric institutions continue to reflect the racial divisions of the past. The lack of an overall vision for mental health care at provincial level may in some way explain this slow pace of change. Any new policy, such as deinstitutionalisation, must therefore be underscored by a coherent vision of a mental health system of care so to expedite implementation.

Specific issues to be considered include:

- The impact of long term institutionalisation on the social skills and functioning of inpatients.

- There are major bureaucratic barriers to the discharge of many patients as many are admitted under the Mental Health Act, 1973. To decertify and / or discharge "State Patients" is a time consuming and overly bureaucratic process (Dartnall et al 1998).

- Bed occupancy rates were below suggested norms, and with existing staff complements suggest that there may be spare capacity in some psychiatric hospitals that could be used for alternative purposes. However, it is unclear to what extent the particular skills mix and level of qualifications would allow for any flexibility and redefinition of functions.

Chapter 7

RESULTS: A PROFILE OF PATIENTS IN PSYCHIATRIC INSTITUTIONS

7.1 Demographic profile

7.1.1 Gender

Table 7.1.1.1 below reports on the gender breakdown of the sample.

Table 7.1.1.1 Gender Breakdown of Psychiatric Inpatients

Gender	N	%
Male	418	75.1
Female	139	24.9
Total	557	100.0

The majority of the psychiatric inpatients are male (75.1%). Only 24.9% of patients across hospitals are females.

7.1.2 Age Group

Just under half (46.3%) the patients sampled fell into the 30 to 49 agegroup (Table 7.1.2.1).

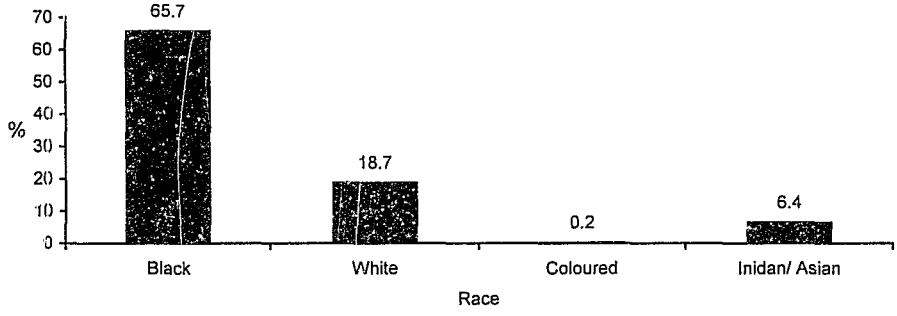
Table 7.1.2.1 Age groupings of Sample (Missing = 47)

	Age group						
	0-14	**15-19**	**20-29**	**30-49**	**50-59**	**60 + over**	**Total**
N	4	10	94	236	78	88	510
%	0.7	1.9	18.4	46.3	15.3	17.3	100.0

7.1.3 "Population Group"

Two thirds (65.7%) of patients were African (Figure 7.1.3.1). These proportions were similar across both provinces.

Figure 7.1.3.1 Population Breakdown of Psychiatric Inpatients (n=557)



7.1.4 Marital Status

The majority of patients (72.8%) were reportedly single (Figure 7.1.4.1).

Figure 7.1.4.1 Marital Status (n=557)



7.1.5 Number of Children

Just under half (40.4%) of the patients reportedly had children, with 7.8% having four or more children. (n=531)

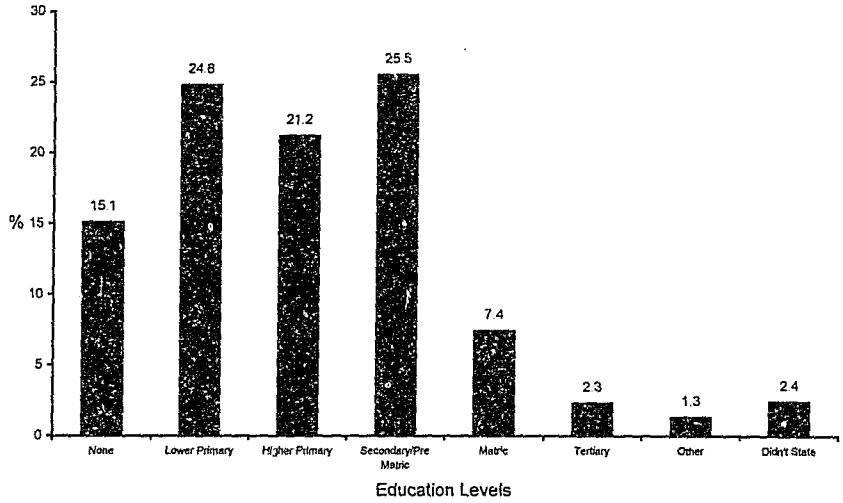
7.1.6 Financial Contribution to Household

The nurses were asked to establish whether or not the patient contributed financially to the family income prior to hospital admission, either through a disability grant or through a wage. Just under half of the sample of patients reportedly contributed to the family income (45.5%, n=253), with 39% (n=218) having not contributed and 15.4% (n=86) providing no response.

7.1.7 Education Levels

Overall, the patients surveyed had low levels of education (Figure 7.1.7.1). Fifteen percent had had no formal education.

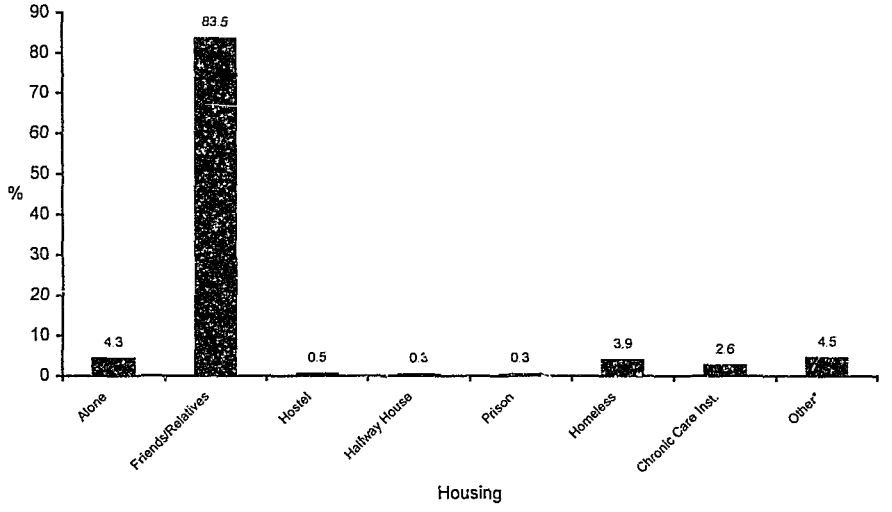
Figure 7.1.7.1 Education Levels (n=557)



7.1.8 Living Arrangements

The majority (83.5%) of patients lived in a household prior to admission, either with relatives or friends (Figure 7.1.8.1). These households have a crucial role to play in any discharge programme.

Figure 7.1.8.1 Patients' living circumstances prior to hospital admission (n=557)

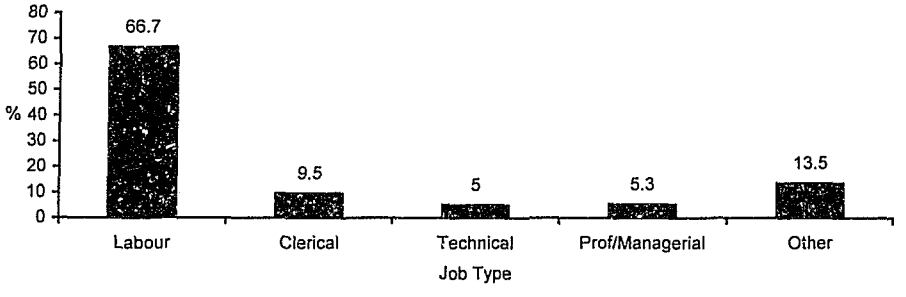


Other* refers to missing/don't know responses

7.1.9 Work Status

Just under half (49.1%; n=273) of the patients sampled were reportedly working prior to their hospital admission. A breakdown of the type of work patients engaged in prior to their admission is provided in Figure 7.1.9.1 below.

Figure 7.1.9.1 Work Type of Patients (n=277)*



(*Some respondents ticked more than one category. E.g. Clerical and other)

Of the patients working, just over two-thirds (66.7%) of the sample had been employed in unskilled positions. Only 10.3% of the sample fell into the technical or professional categories. Similar trends were observed across both provinces.

7.2 Diagnostic and Admissions Profiles

7.2.1 Patient's Behaviour Prior To Admission

Of the patients (n=476) on whom information was available, 63.6% were reportedly violent or disruptive in the community prior to admission.

7.2.2 Prior admissions

Just under two-thirds (59.9%) of the patients sampled had had previous hospital admissions, with only 34.2% being first admissions.[1] The same trends were observed in each province.

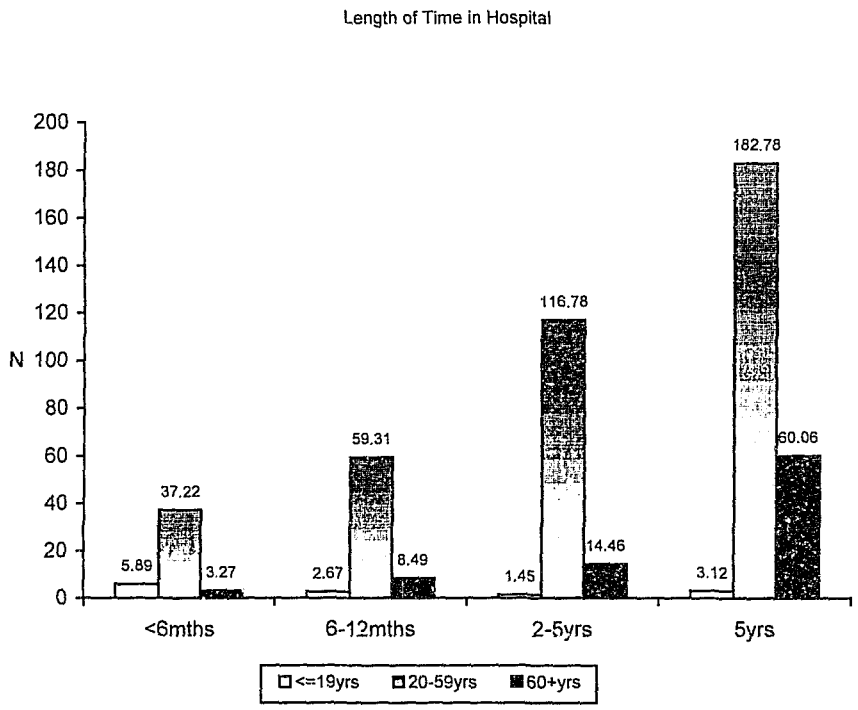
7.2.3 Length of Time in Hospital over a Patient's Lifespan

Nurses were asked to estimate the length of time a patient had spent in hospitals over his or her lifetime. The majority (87.7%) had spent more than 6 months in hospital.

The relationship between length of time in hospital and age group was assessed (Figure 7.2.3.1).

[1] Current admission data, as opposed to data on the total number of admissions, were collected, as new files are created for every new admission, even if the patient has a long history at the hospital.

Figure 7.2.3.1 Estimated Length of Time in Hospital over a Patient's Lifespan by Age group (n=496)



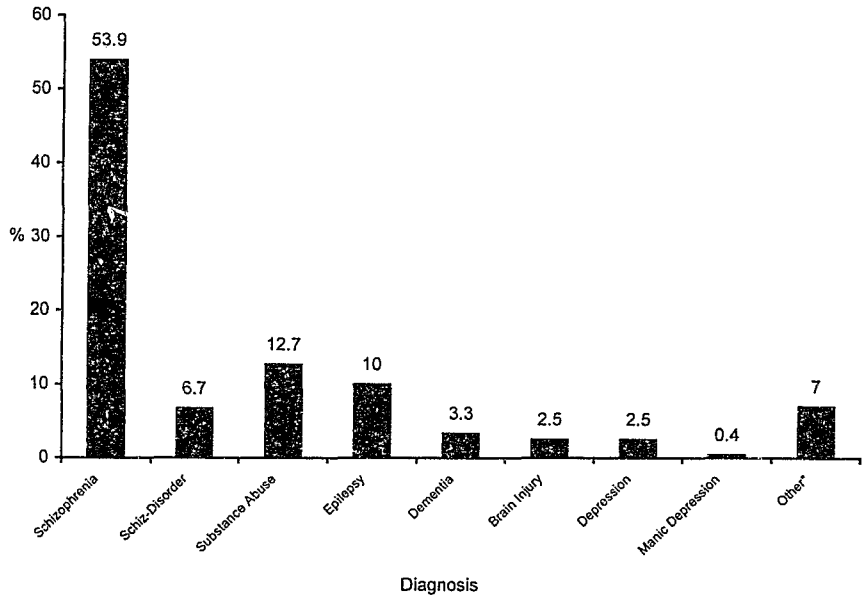
There was a statistically significant relationship between age and length of time spent in hospital (χ^2=37.4, p<0.001, df=6).[4]

7.2.4 Diagnosis[2]

Schizophrenia was the most commonly recorded diagnosis (Figure 7.2.4.1). Eighty-two patients (15%) were recorded as having more than one diagnosis, and 1 patient had 3 diagnoses. Twenty *five patients had no diagnosis or unclear information recorded on their files.*

[4] On chi-squared analysis 25% of the cells had expected counts of less than 5.
[2] *Diagnosis was collected from patient records via the CNAP using a check box item. Common diagnoses were* ascertained through findings of previous studies (Dartnall & Porteus 1998, Porteus et al 1998, Zwi, Dartnall & Lee 1997, Mental Health Directorate 1998). Respondents could give more than one diagnosis.

Figure 7.2.4.1 Diagnostic Profile of Patients (n=599)



*Other = mentally disturbed, diabetic, reactive psychosis, psychosis, acute confused state, personality disorder, paranoid delusional disorder, mentally ill

The relationship between gender and diagnosis was analysed (Table 7.2.4.1).

Table 7.2.4.1 Gender by Diagnosis

Current Diagnosis		Gender			
		Male N(%)	Female N(%)	Total N(%)	P Values
	Schizophrenia	243(54.3)	80(53.0)	323(53.9)	NS*
	Schizophreniform Disorders	30(6.7)	10(6.6)	40(6.7)	NS
	Substance Abuse	65(14.3)	11(7.3)	76(12.7)	χ^2=5.273,df=1,p=0.022
	Epilepsy	49(10.9)	11(7.3)	60(10.0)	NS
	Dementia	9(2.0)	11(7.3)	20(3.3)	χ^2=10.173,df=1,p<0.001
	Brain Injury	11(2.4)	4(2.6)	15(2.5)	NS
	Depression	8(1.8)	7(4.6)	15(2.5)	χ^2=4.978,df=1,p=0.026
	Manic Depression	3(0.7)	5(3.3)	8(1.4)	χ^2=4.368,df=1,p=0.037
	Other (misc)	30(6.7)	12(8.0)	42(7.0)	NS
Total		448(100.0)	151(100.0)	599(100.0)	

*NS=Not significant

Men had significantly higher rates of substance abuse than women did, whilst women had higher rates of dementia, depression and manic depression.

7.3 Patient Skills and Functioning

Nurses, using their clinical skills and knowledge of the patient, were asked to check "true" or "false" against a number of statements relating to the patients' social skills and functioning levels.

7.3.1 Social Functioning

Nearly a quarter of the patients assessed was viewed as either being a danger to themselves or to others (Table 7.3.1.1). Just under half of all patients were assessed as currently experiencing hallucinations and/or delusions, whilst, two-thirds of the patients were assessed as having behaviour appropriate to community living.

Table 7.3.1.1 Summary of Selected Social Functioning Measures for Inpatients as Assessed by Nurses

	TRUE	FALSE	MISSING	TOTAL
	N (%)	N(%)	N(%)	N(%)
This patient is in danger of hurting him / herself (e.g. suicidal tendencies)	123 (22.1%)	426 (76.4%)	8 (1.5%)	557 (100%)
This patient is violent and disruptive and is a danger to others.	128 (23.0%)	423 (75.9%)	6 (1.1%)	557 (100%)
This patient [currently] experiences hallucinations and / or delusions	233 (41.9%)	318 (57.1%)	6 (1.0%)	557 (100%)
This patient has lasting friendships	321 (57.5%)	231 (41.5%)	5 (0.9%)	557 (100%)
This patient's speech is incoherent (e.g. muddled, illogical, irrelevant, confused)	135 (24.2%)	414 (74.4%)	8 (1.4%)	557 (100%)
This patient's behaviour is appropriate -- that is, it would be considered acceptable for community living.	350 (62.9%)	203 (36.4%)	4 (0.7%)	557 (100%)

7.3.2 Life Skills

Successful community living requires being able to engage in a number of activities (Table 7.3.2.1). As expected, a higher percentage of patients managed lower order life skills (e.g. bathing, eating) than the more complex tasks (e.g. taking public transport, working).

Table 7.3.2.1 Summary of Selected Social Skill Measures for Inpatients as Assessed by Nurses

	TRUE	FALSE	MISSING	TOTAL
	N (%)	N(%)	N(%)	N(%)
This patient can bathe independently	439 (78.9%)	113 (20.2%)	5 (1.0%)	557 (100%)
This patient can feed independently	500 (89.8%)	53 (9.5%)	4 (0.7%)	557 (100%)
This patient can make his / her bed without assistance	397 (71.3%)	145 (26.1%)	15 (2.6%)	557 (100%)
This patient can keep him/herself neat and clean	388 (69.6%)	151 (27.2%)	17 (3.2%)	557 (100%)
This patient can use public transport	297 (53.3%)	178 (32.0%)	82 (14.7%)	557 (100%)
This patient can budget his/her money	239 (43%)	246 (44.2%)	72 (12.9%)	557 (100%)
This patient can hold down a job	211 (37.8%)	255 (45.8%)	91 (16.4%)	557 (100%)

7.3.3 Physical health

Severe or chronic physical problems on top of a mental illness may increase the care burden of families. As such, data on physical illness and disability were gathered, along with information on

urinary incontinence of the patient. Overall, patients with physical problems were reportedly few (Table 7.3.3.1).

Table 7.3.3.1 Summary of Selected Physical Measures for Inpatients as Assessed by Nurses

	TRUE	FALSE	MISSING	TOTAL
	N (%)	N(%)	N(%)	N(%)
This patient is incontinent (cannot control his/her bladder)	49 (8.8%)	505 (90.7%)	3 (0.6%)	557 (100%)
This patient has a chronic physical illness (e.g. TB, hypertension)	75 (13.5%)	481 (86.3%)	1 (0.3%)	557 (100%)
This patient has a severe physical disability (e.g. in a wheel chair)	36 (6.5%)	519 (93.1%)	2 (0.4%)	557 (100%)

7.3.4 Medication Compliance

Medication compliance is also important for the care and sustainability of patients in the community. Just over 80% of all patients were assessed as co-operative with taking their medications, however it is striking that nearly 40% of all the patients would not remember to take their medications if not supervised. This suggests the need for monitoring of medications, particularly in relapse prevention.

Table 7.3.4.1 Medication Compliance of Inpatients as Assessed by Nurses

	TRUE	FALSE	MISSING	TOTAL
	N (%)	N(%)	N(%)	N(%)
This patient is co-operative about taking his/her medications.	456 (81.9%)	96 (17.2%)	5 (0.9%)	557 (100%)
This patient can remember to take his/her medications	325 (58.3%)	203 (36.4%)	29 (5.3%)	557 (100%)

7.3.5 Alcohol and Substance Abuse

Alcohol and drug problems were reported in 32.3% of the sample (Table 19.5.1).

Table 7.3.5.1 Alcohol and Substance Abuse Problems of Inpatients as Assessed by Nurses

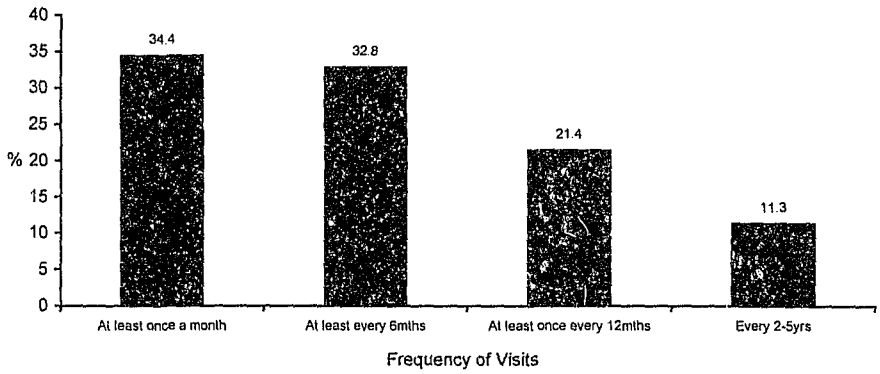
	TRUE	FALSE	MISSING	TOTAL
	N (%)	N(%)	N(%)	N(%)
This patient has a problem with alcohol and / or drugs	180 (32.3%)	369 (66.2%)	8 (1.5%)	557 (100%)

7.3.6 Family / Friends Involvement

Family / friends involvement was looked at both in terms of hospital visits and their estimated frequency, and indirectly in terms of periods of leave of absence* from hospital, receipt of letters and telephone contact.

Fifty three percent (53.1%) of the patients received visits from friends or family. Of those who received visits, around a third received visits at least once a month (Figure 7.3.6.1).

Figure 7.3.6.1 Frequency of Visits (n=315)



Nurses were also asked if the patient had contact with family / friends in ways other than physical visits e.g. post / telephone / leave of absence. Just under half did have contact with families in other ways (49.3%)*. Thirty eight percent had contact with their family via the telephone, whilst 28.8% had received written correspondence. Only 20% had been on leave of absence.

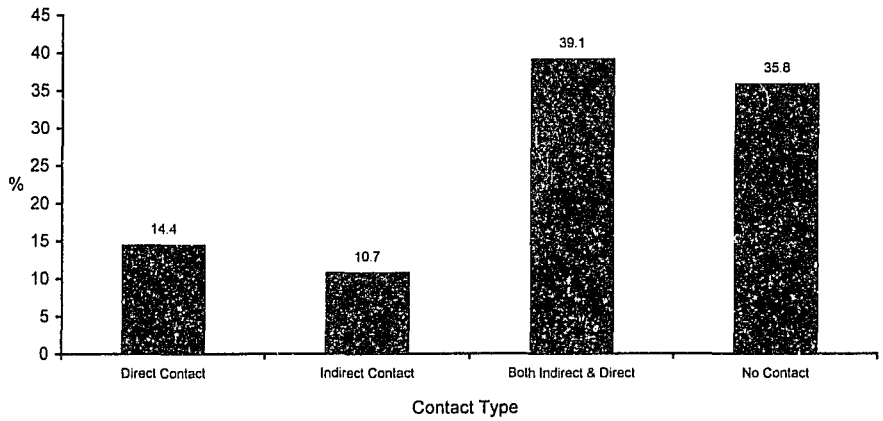
* Leave of absence refers to times when the patient leaves the hospital for fixed periods of time, often to stay with friends or family. Such leaves are important stepping stones to reintegration into the community.

* This figure also includes those patients who receive face to face visits in hospital by family. Of those who did not receive family visits, only 20% were in contact with the family in other ways.

A summary of the various direct and indirect contacts made with family and friends is provided in Figure 7.3.6.2 below.

The lack of contact by approximately 35% of patients is of concern given the importance of familial relationships in potential discharge.

Figure 7.3.6.2 Contacts with Family and Friends (n=550)

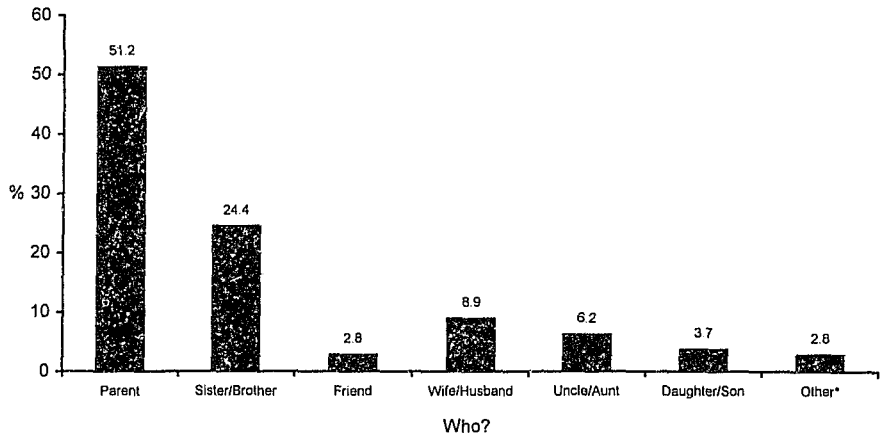


7.3.7 Discharge and The Family

The willingness of family and friends to take patients if discharged is an important contributor to discharge potential of a patient population. As such, nurses were asked whether or not they knew if there was someone in the patient's family willing to take responsibility for the patient if discharged. While this information would be more meaningful if elicited direct from the families, such an investigation was beyond the scope of this current study.

Nurses reported that 49.1% of the patients sampled had family / friends who were prepared to take the patient, with 27.9% having no relatives and friends willing to take them. The remaining 23% nurses were not sure. A question on who was prepared to take the patient was also posed. Respondents could give more than one answer (Figure 7.3.7.1).

Figure 7.3.7.1 Who will take the patient if discharged? (N=291)



(*Other = Girlfriend / boyfriend, Cousin)

7.3.8 Patients' Willingness to be Discharged

Perceptions of discharge are also an important contributing factor in community living hence the question was asked: Does the patient want to be discharged? Nearly 80% responded in the positive (75.7%;N=422), 15.3% (N=85) said no and 9% (N=50) did not respond either way. The nurse also asked the patient if he/she wanted to be discharged back their family. The majority stated they did (61.3%, N=341), with only 36 stating they did not (6.5%). A relatively large number did not respond to this question (32.3%; N=180).

7.3.9 Service Needs

Nurses were asked to give their opinion on what types of assistance the patient might require if he/she were discharged. The most important service as reported by nurses appears to be the need for family support and financial assistance. Access to day care centers and sheltered workshops were also frequently considered to be required. Around 50% of the patients assessed were said to require assistance with accommodation and 20% were reported to require frail care / aged services (Table 7.3.9.1).

Table 7.3.9.1 Service Needs of Inpatients as Assessed by Nurses

If discharged, this patient would require.....	TRUE N (%)	FALSE N(%)	MISSING N(%)	TOTAL N(%)
. Financial assistance	468 (84.0%)	73 (13.0%)	16 (3.0%)	557 (100%)
. Assistance with finding accommodation	287 (51.5%)	235 (42.2%)	35 (6.3%)	557 (100%)
. Access to a day centre	363 (65.2%)	158 (28.4%)	36 (6.4%)	557 (100%)
. Family support and assistance	486 (87.2%)	44 (7.9%)	27 (4.9%)	557 (100%)
. Frail care or hospice services	112 (20.1%)	400 (71.8%)	45 (8.2%)	557 (100%)
. Access to a sheltered workshop	354 (63.5%)	153 (27.6%)	50 (8.9%)	557 (100%)

7.3.10 Nurses Perceptions of Discharge Potential

Nurses were asked three questions relating to their assessment of discharge potential:

- In your opinion, do you think this patient can be discharged given existing community services?
- Do you think this patient should remain in hospital, either temporarily or permanently?
- Do you think, given good or better community services this patient could be discharged?

Table 7.3.10.1 Nurses Perceptions of Discharge Potential

	Yes(%)	No(%)	Don't Know (%)
Discharge Now	373 (67%)	155(27.8%)	29(5.2%)
Ongoing Hospitalisation	186(33%)	326(58.6%)	45(8.0%)
Discharge when better services	419(75%)	98(17.5%)	40(7.2%)

The favored option among nurses is to discharge patients when better or good community services are developed. However 67% of nurses also felt that patients could be discharge now, with nurses supporting ongoing hospitalization, either temporarily or permanently, in 33% of patients.

7.4 Summary

The patients as described by this study were typically male, black, adults and unmarried with no children and low levels of education. This profile is consistent with findings from other South African studies (Zwi et al 1997, Mental Health Directorate 1998, Dartnall & Porteus 1998, Porteus et al 1998).

The data however seems to suggest a gender bias in the provision of mental health care services, with the majority of inpatients being male. This finding is consistent with other work conducted on admission patterns to psychiatric institutions in non-Western cultures (Al-Issa cited in de la Rey & Eagle 1997). For example, studies conducted in Africa have found that men have much higher rates of admissions to psychiatric institutions than women (Kisekka in Rothbum & Cole, 1990 *cited in* de la Ray & Eagle 1997).

According to Kisekka there are a number of structural issues that may account for male predominance in psychiatric hospitals. Firstly men have greater access to medical care given their increased likelihood to be employed in formal sector employment. Secondly, men tend to be more physically aggressive than females which in many instances will result in greater exposure to state authorities, including referrals to psychiatric hospitals. Finally it is suggested that women have a greater tendency to access the traditional health sector for psychological support and care. Such gender inequities in terms of access require further research.

In terms of living status, most patients lived with their friends / or relatives prior to their current hospital admission. This attests to the primacy of the family in the care of people with a mental illness in the community and reinforces the need to involve families in the care of their mentally ill relations.

Almost half of all patients had worked in some capacity prior to hospital admission, mostly in the labour, contractual market. This is a positive finding for vocational rehabilitation initiatives, in that patients in the past had held down jobs in the open labour market.

A high proportion of the patients was reportedly violent or disruptive in the community prior to hospital admission. This supports anecdotal evidence which seems to suggest that patients who gain admittance to psychiatric institutions are more likely to be those who are disruptive and violent in the community and hence bringing themselves to the attention of the "authorities". The long-term care institutions of today, continue to serve as instruments of the state for the control of "deviant" behaviour, despite efforts to the contrary (Foster & Swartz 1997).

For most patients this was not their first hospital admission with a vast majority having spent over six months or more in psychiatric hospitals over their lifetime. Lengthy hospital stays can have a negative impact on an individuals social functioning and skills. This potential impact needs to be recognised and addressed when discharge plans are being drawn up.

Patients' most common diagnosis was schizophrenia. Again this finding is consistent with other South African studies (Zwi et al 1997, Mental Health Directorate 1998, Dartnall & Porteus 1998, Porteus et al 1998). Gender differences in diagnosis were also found to be significant with males reporting higher rates of substance abuse and females presenting more frequently with dementia, depression and manic depression. The gender differences around dementia may to some extent be explained by the differences in age between men and women. The other findings are consistent with research on gender differences in diagnosis, with women reporting more depression and somatisation disorders, and males having higher rates of substance abuse disorders (Tippet et al 1994, Desjarlais et al 1995).

In terms of skills and functioning, nearly a quarter of all patients assessed were reportedly a risk to themselves or others. Although, over half were thought to display behaviour that was appropriate for community living.

Most patients were assessed as being able to feed and bathe themselves and keep themselves and their living environments neat and clean. A smaller proportion of patients was assessed as being able to budget or use public transport – skills also very important for successful independent community living. Just under half of all patients could remember to take their medications unsupervised. Few patients had concomitant physical illness or disabilities. Involvement of family and friends was present in half of patients, with 35% of patients receiving no contact at all. This is disturbing given the importance of the family in the tenure of people with mental illness in the community. Also of concern is the small number of patients reported as going on leave of absence from the hospital. Leave of absence, where appropriate, should be encouraged.

Almost half of the sample had family/friends prepared to take them if discharged, with an overwhelming majority of the nurses having assessed patients as wanting to be discharged. Of course, the extent to which this is a true reflection of a family's' willingness to take the patient if discharged needs further investigation. Nor does this measure the quality of care the patient would receive if discharged. Cognisance of this is needed when interpreting the findings.

Finally, nurses were asked about their perceptions for discharge for individual patients. Three quarters of all nurses sampled stated they felt discharge would be preferable when better or more community services are developed and almost 70% motivated for immediate discharge.

CHAPTER 8

APPLYING THE CNAP FRAMEWORK

Using the weighted data (n=557), the framework described in Chapter 5 is used to broadly assess discharge potential and service needs of patients. Firstly patient data are grouped according to levels of care using patients' functioning levels and the availability of a recovery environment on discharge. These levels of care then enable the placement of patient groups onto a discharge continuum.

Data from a total of 425 patient assessments were used in this analysis, with 132 assessments not meeting the criteria for either one of the 4 levels of care. The analysis excluded all "don't know" responses as invalid. Patient data are first grouped into four categories, according to levels of care. The potential care needs of each group is then assessed using a series of indicators (see Figure 5.9.2, Table 5.12.1).

In order to ascertain what may be, if any, the implications of the exclusion of the 132 patients not included in the CNAP analysis a description of their characterises is provided in Table 8.1.1 below.

Table 8.1 Demographic data on patients excluded from the CNAP analysis

Gender		
	N	**%**
Male	92	70
Female	40	30
Total	**132**	**100**
Population Group		
Black	86	65
White	23	18
Coloured	13	9
Indian / Asian	10	8
Total	**132**	**100**
Age-group		
<=19yrs old	3	2
20-59yrs old	80	61
60+	32	24
Missing	17	13
Total	**132**	**100**

Diagnostic Profile[1]		
	N	%
Schizophrenia	82	56
Schizophreniform Dis	11	8
Substance Abuse	14	10
Epilepsy	19	13
Dementia	4	3
Brain Injury	4	3
Depression	3	2
Manic Depression	-	-
Other	8	5
Total	**145**	**100**

The demographic profile provided in Table 8.1, is similar to the profile of patients included in the CNAP analysis (Table 8.2.1.1 refers).

8.1 Levels of Care and Discharge Potential:

Patients were grouped into 4 levels of care and placed on discharge continuum from high to low discharge potential using the CNAP framework. The results of which are outlined in Table 8.1.1 below.

Table 8.1.1 Levels of Care and Discharge Potential of Current Inpatients (n=425)

HIGH DISCHARGE POTENTIAL



Level of Care	N (%)
Low Support Needs	140 (33%)
Low Support Needs, No Recovery Environment	27 (6%)
High Support Needs	132 (31%)
High Support Needs, No Recovery Environment	126 (30%)
Total	**425 (100%)**

LOW DISCHARGE POTENTIAL

[1] Please note, that DSMIV diagnosis are not used in this report, as diagnosis has been take from patient records.

Using the CNAP framework, 33% of the patients were assessed as having low level support needs and hence fell at the top end of the CNAP discharge continuum. By definition, this group of patients had basic social skills and a family who was willing to provide them with a place to stay if they were discharged.

In addition to this group, there was a smaller group of patients (6%) who, although possessed the basic skills most likely needed for community living, they had no recovery environment available to them outside of the hospital. This lack of a recovery environment placed them lower down on the CNAP continuum of discharge.

Nearly two-thirds of the patients (61%) fell somewhere along the bottom half of the discharge continuum as they did not posses some of the most basic functioning skills. Their behaviour was not appropriate for community living nor could they feed or bathe themselves. For these patients to live successfully in the community a variety of community supports would need to be established prior to their discharge. For half of these patients however, there was a family willing to take them if discharged. The availability of the family served to increase the discharge potential of this group. Of course, the measure used to assess the availability of the family may be an overestimate of the reality. This reality needs to be assess in future studies. The final 30% of patients sampled were found to be both low functioning and without a recovery environment. The combination of both these variables placed this group of patients at the bottom of the CNAP discharge continuum.

In sum then, around 33% of the sample are discharge ready, whilst the remainder require various services to varying degrees to be developed prior to their discharge. To what extent then do these different groups of patients require services, and what type of services are needed? The CNAP framework, using a number of service need indicators developed through the course of this study, begins to try and answer this question. The Mental Health System of Care model described in Chapter 4 of this report is used to guide this discussion.

8.2 Defining Service Need

8.2.1 Demographics

Before embarking on a more detailed assessment of the service requirements of each patient grouping, a closer look at the demographics of each group was undertaken. Each grouping was looked at in terms of gender, race, agegroup and diagnosis. Overall, the profile of patients across levels of care was similar: most were African, adult, and male with a diagnosis of schizophrenia. The only exception to this trend were those patients falling into the "high support, no recovery environment" grouping. In this grouping, the ratio of male to female was lower, a higher proportion fell into the 60 years and older age group and

whites outnumbered other population categories (Table 8.2.1.1).Schizophrenia was the most common diagnosis across all categories.

Table 8.2.1.1 Demographic data of Patients by Level of Care

Levels of Care				
	Low Support	Low Support, No Recovery Environment	High Support	High Support, No Recovery Environment
Gender				
Male	125(89.3%)	20(76.7%)	105(19.5%)	75(60%)
Female	15(10.7%)	6(23.3%)	27(20.5%)	50(40%)
Total	140(100%)	26(100%)	132(100%)	125(100%)
Population Group				
Black	112(80.4%)	15(55.7%)	105(79.5%)	47(37.6%)
White	6(4.3%)	5(17.7%)	11(8.1%)	59(47.2%)
Coloured	14(10.1%)	4(15.5%)	11(8.2%)	9(7.5%)
Indian / Asian	7(3.2%)	3(11.1%)	5(4.2%)	11(7.7%)
Total	140(100%)	27(100%)	132(100%)	125(100%)
Age				
<=19yrs old	2(2%)	-	4(3.3%)	4(3.4%)
20-59yrs old	122(95%)	15(59.7%)	113(91.4%)	78(66.9%)
60+	5(3%)	10(40.3%)	7(5.3%)	34(29.7%)
Total	129(100%)	25(100%)	124(100%)	116(100%)
Diagnostic Profile				
Schizophrenia	79(54.9%)	15(53.5%)	73(52.9%)	74(51%)
Schizophreniform Dis	11(7.6%)	1(3.6%)	5(3.6%)	12(8.3%)
Substance Abuse	13(9.0%)	6(21.4%)	25(18.1%)	19(13.1%)
Epilepsy	18(12.5%)	3(10.7%)	12(8.7%)	9(6.2%)
Dementia	1(0.7%)	1(3.6%)	3(2.2%)	10(6.9%)
Brain Injury	3(2.1%)	-	4(2.9%)	3(2.05%)
Depression	4(2.8%)	1(3.6%)	3(2.2%)	4(2.8%)
Manic Depression	1(0.7%)	1(3.6%)	3(2.2%)	3(2.05%)
Other	14(9.7%)	-	10(7.2%)	11(7.6%)
Total	144(100%)	28(100%)	138(100%)	145(100%)

8.2.2 Mental Health Treatment

As already mentioned in an earlier chapter, psychiatric hospitals are required by law to take responsibility for patients posing a risk to themselves or others. This is done through a legal process and patients are either certified or classified as a State President's Patient. Being either certified or a State President's Patient means discharge is not a given. Admission status is therefore an important variable to consider when thinking about a deinstitutionalisation programme. The admission status of patients by levels of care is provided in Table 8.2.2.1 below.

Table 8.2.2.1 Admission status of patients by levels of care.

	Levels of Care				
Admission Status*	Low Support	Low Support, No Recovery Environment	High Support	High Support, No Recovery Environment	Total
Voluntary* (Art 3 & 4)	16 (11.8%)	8 (30%)	36 (27.3%)	16 (12.5%)	76 (18.1%)
Certification** (Art 9 & 1'	24 (17.6%)	12 (44.1%)	52 (39.6%)	94 (76.6%)	182 (43.4%)
Observation	-	-	4 (2.7%)	1 (1.0%)	5 (1.2%)
State Patients	98 (71.1%)	7 (25.9%)	39 (29.7%)	12 (9.9%)	156 (37.1%)
Mentally Ill Prisoner	-		1 (0.7%)	-	1 (0.2%)
Total	138 (100%)	27 (100%)	132 (100%)	123 (100%)	420 (100%)

(*Includes patients admitted to hospital under Articles 3 or 4 of the Mental Health Act, 1973)

(**Includes patients admitted to hospital under Articles 9 or 12 of the Mental Health Act, 1973)

A high proportion (71%, n=98) of patients in the "low support" category were "State" patients and therefore could only be discharged if they have completed their prison sentence. However, given appropriate community supports care for state patients could not be conducted in the community. This of course would require the development of a comprehensive array of community services to ensure that society continues to be protected. Given the current levels of community services in the provinces, community care for state patients is most likely to be a long-term goal.

Furthermore, 17.9% of the low support patients are certified. As mental illness is episodic, the need for certification needs to be constantly reviewed. The bureaucracy should not serve as a barrier to the discharge of these patients. Patients should be, "decertified, certified or discharged as and when appropriate. Patients should not remain [unnecessarily] certified for convenience or any other reason" (Robertson et al 1997:92).

* Please refer to Chapter 6 for a description of each of these categories.

Finally, only 11.6% (n=16) of the low support group were either voluntary or voluntary by consent admissions. These patients face no major bureaucratic obstacles to their discharge.

8.2.3 Psycho-social Rehabilitation Services

The simple movement of patients from hospitals to the community without appropriate rehabilitation services will not necessarily improve the quality of life of patients or be more therapeutic than hospital care (Robertson et al 1997). The provision of rehabilitation services both within and outside hospital walls should therefore be a central component of a good mental health care system. This section begins to look at what types of rehabilitation services are needed within each patient grouping. Rehabilitation services are broken up into three components:

- Vocational
- Social
- Psycho-educational

Vocational Rehabilitation Services:

Vocational rehabilitation skills and service needs are assessed across levels of care, in terms of the following indicators: The extent to which the patient had worked prior to hospital admission, the extent to which patients may succeed in the open job market and finally the extent to which patients may benefit from a sheltered workshop (Table 8.2.3.1).

Table 8.2.3.1 Vocational Rehabilitation Indicators by Levels of Care

Vocational Rehabilitation Indicators	Levels of Care							
	Low Support		Low Support, No Recovery Environment		High Support		High Support, No Recovery Environment	
	Yes (%)	No (%)	Yes (%)	No (%)	Yes (%)	No (%)	Yes (%)	No (%)
Was the patient working prior to admission	86 (62.6%)	51 (37.2%)	13 (47.7%)	14 (52.3%)	67 (51.2%)	63 (48.8%)	50 (40.2%)	74 (59.8%)
Could the patient hold down a job if discharged	99 (79.5%)	26 (20.5%)	12 (56.7%)	10 (43.3%)	60 (56.2%)	47 (43.8%)	12 (10.9%)	99 (89.1%)
Would the patients benefit from a sheltered workshop	103 (75.5%)	34 (24.5%)	20 (76.0%)	7 (24.0%)	83 (71.9%)	32 28.1%)	65 (54.7%)	54 (45.3%)

Findings in Table 8.2.3.1 seem to reflect an increasing need for vocational services as need for support increases. For example, a comparison between high and low support groups and whether the patient would benefit from a sheltered workshop was found to be significant. (χ^2=11.84 p=0.0005795).

Social Rehabilitation Services:

A number of basic social and living skills were reviewed in relation to levels of care in order to assess the degree to which social rehabilitation services may be required (Table 8.2.3.3).

Table 8.2.3.3 Social Rehabilitation Indicators by Levels of Care

	Levels of Care							
Social Rehabilitation Indicators	Low Support		Low Support, No Recovery Environment		High Support		High Support, No Recovery Environment	
This patient can ...	Yes (%)	No (%)	Yes (%)	No (%)	Yes (%)	No (%)	Yes (%)	No (%)
use public transport	127 (93.4%)	9 (6.6%)	14 (67.9%)	6.35 (32.1%)	83 (71.8%)	32.4 (28.2%)	37 (35.4%)	67 (64.6%)
keep neat and clean	135 (96.4%)	5 (3.6%)	22 (81.3%)	5 (18.7%)	100 (77.6%)	29 (22.4%)	60 (48.4%)	64 (51.6%)
can budget money	115 (87.5%)	17 (12.5%)	11 (55.1%)	9 (44.9%)	57 (50.3%)	56 (49.7%)	22 (19.7%)	90 (80.3%)
This patient can remember to take their medications	140 (100%)	-	27 (100%)	-	107 (81.9%)	24 (18.1%)	77 (61.7%)	48 (38.3%)

Again, there appears to be a trend across levels of care with low support needs patients scoring positively more frequently on all social rehabilitation indicators than high support patients (Table 8.2.3.3).

The length of time patients had spent in hospital over their lifetimes by levels of care was also assessed in order to determine the extent to which the impact of social disablement caused by long term hospital care might need to be addressed (Table 8.2.3.4).

Table 8.2.3.4 Estimated length of time patients have spent in hospitals over their lifetime by levels of care

Length of Time in Hospital over Lifetime	Levels of Care							
	Low Support		Low Support, No Recovery Environment		High Support		High Support, No Recovery Environment	
	N	%	N	%	N	%	N	%
<6mths	16	12.0	1	5.9	27	21.2	2	1.7
6-12mths	18	13.8	4	14.1	23	17.7	12	9.7
2-5yrs	42	30.5	5	19.9	43	33.5	33	26.4
>5yrs	60	43.7	15	60.1	35	27.6	77	62.2
Total	136	100.0	25	10.0	128	100.0	124	100.0

Across all levels of care, most patients have spent over 2 years in psychiatric hospitals across their lifetime. Addressing the potentially disabling impact of long term institutionalisation on a person's functioning is therefore important when creating a rehabilitative approach to care in these institutions.

Psycho-education:

Finally, psycho-education skills and service needs were reviewed in terms of patients' willingness to be discharged (Table 8.2.3.5). Across levels of care the majority of patients reported a positive 'attitude' to discharge. The only exception were patients with high support needs and no recovery environment. In this grouping only 55% patients reported a willingness to be discharged. This difference was found to be significant when compared with other groupings (χ^2=111.26 p=0.000).

Table 8.2.3.5 Psycho-education Indicator by Levels of Care

Psycho-education Indicators	Levels of Care							
	Low Support		Low Support, No Recovery Environment		High Support		High Support, No Recovery Environment	
	Yes (%)	No (%)	Yes (%)	No (%)	Yes (%)	No (%)	Yes (%)	No (%)
This patient wants to be discharged	136 (98.7%)	2 (1.3%)	21 (87.6%)	3 (12.4%)	126 (97.0%)	4 (3.0%)	61 (55.4%)	49 (44.6%)

8.2.4 Risk Management

The extent to which a patient poses either a risk to themselves or others is an important indicator of the need for the development of services in the community. Such patients need good community based monitoring systems in place prior to their discharge to ensure that any potential relapse is picked up swiftly so as to minimise the risk of harm either to themselves or others (Table 8.2.4.1).

Table 8.2.4.1 Risk Indicators by Levels of Care

Risk Indicators	Levels of Care							
	Low Support		Low Support, No Recovery Environment		High Support		High Support, No Recovery Environment	
	Yes (%)	No (%)	Yes (%)	No (%)	Yes (%)	No (%)	Yes (%)	No (%)
This patient is at risk to themselves	6 (4.2%)	134 (95.8%)	1 (4.9%)	24 (95.1%)	33 (25.4%)	97 (74.6%)	53 (42.7%)	71 (57.3%)
This patient is violent and disruptive and is a danger to others	11 (7.8%)	127 (92.2%)	2 (9.2%)	24 (90.8%)	39 (29.4%)	93 (70.6%)	47 (38.2%)	76 (61.8%)

Findings in Table 8.2.4.1 show a gradual increase in levels of risk to either themselves or others as the need for care increases. Very few low support patients appeared to require risk-monitoring services in the community. Chi-square tests comparing low support and high support groups with risk, both in terms of risk to self and risk to others were found to be significant (i.e. χ^2=13.19 p=0.0002819 and χ^2=51.10 p=0.000 respectively).

8.2.5 Housing

The need for accommodation services over and above the availability a recovery environment was also assessed (Table 8.2.5.1).

Table 8.2.5.1 Housing Indicators by Levels of Care

Housing Indicators	Levels of Care							
	Low Support		Low Support, No Recovery Environment		High Support		High Support, No Recovery Environment	
	Yes (%)	No (%)	Yes (%)	No (%)	Yes (%)	No (%)	Yes (%)	No (%)
If discharged, this patient would need assistance with finding accommodation	42 (30.5%)	96 (69.5%)	21 (78.2%)	6 (21.8%)	35 (30.8%)	78 (69.2%)	100 (80.1%)	25 (19.9%)

Findings in Table 8.2.5.1 show that even with the availability of a recovery environment there are some patients who will still required assistance with finding accommodation. Not surprisingly, however the need for accommodation services increased markedly for those patients who did not have access to family supports. This difference was found to be significant when a comparison between those patients without a care recovery environment and those patients who had a care recovery environment was conducted (χ^2=90.68 p=0.000).

8.2.6 Income Support

Income support has been measured by the item in the CNAP that asks whether or not the patient would benefit from financial support if discharged. Informal discussions at hospitals visited highlighted that financial support was fundamentally important to patients when moving from the hospital to the community.

Table 8.2.6.1 shows that the majority of patients across levels of care reported requiring some type of financial support on discharge from the hospital.

Table 8.2.6.1 Financial Support Indicators by Levels of Care

Financial Support Indicators	Levels of Care							
	Low Support		Low Support, No Recovery Environment		High Support		High Support, No Recovery Environment	
	Yes (%)	No (%)	Yes (%)	No (%)	Yes (%)	No (%)	Yes (%)	No (%)
If discharged, this patient would require financial support	114 (84.1%)	22 (15.9%)	24 (90.9%)	3 (9.1%)	105 (82.3%)	23 (17.7%)	112 (91.6%)	10 (8.4%)

Table 8.2.5.1 Housing Indicators by Levels of Care

Housing Indicators	Levels of Care							
	Low Support		Low Support, No Recovery Environment		High Support		High Support, No Recovery Environment	
	Yes (%)	No (%)	Yes (%)	No (%)	Yes (%)	No (%)	Yes (%)	No (%)
If discharged, this patient would need assistance with finding accommodation	42 (30.5%)	96 (69.5%)	21 (78.2%)	6 (21.8%)	35 (30.8%)	78 (69.2%)	100 (80.1%)	25 (19.9%)

Findings in Table 8.2.5.1 show that even with the availability of a recovery environment there are some patients who will still required assistance with finding accommodation. Not surprisingly, however the need for accommodation services increased markedly for those patients who did not have access to family supports. This difference was found to be significant when a comparison between those patients without a care recovery environment and those patients who had a care recovery environment was conducted (χ^2=90.68 p=0.000).

8.2.6 Income Support

Income support has been measured by the item in the CNAP that asks whether or not the patient would benefit from financial support if discharged. Informal discussions at hospitals visited highlighted that financial support was fundamentally important to patients when moving from the hospital to the community.

Table 8.2.6.1 shows that the majority of patients across levels of care reported requiring some type of financial support on discharge from the hospital.

Table 8.2.6.1 Financial Support Indicators by Levels of Care

Financial Support Indicators	Levels of Care							
	Low Support		Low Support, No Recovery Environment		High Support		High Support, No Recovery Environment	
	Yes (%)	No (%)	Yes (%)	No (%)	Yes (%)	No (%)	Yes (%)	No (%)
If discharged, this patient would require financial support	114 (84.1%)	22 (15.9%)	24 (90.9%)	3 (9.1%)	105 (82.3%)	23 (17.7%)	112 (91.6%)	10 (8.4%)

8.2.7 Substance Abuse Services

KwaZulu Natal and the Eastern Cape are said to have the highest proportion of heavy drinkers in South Africa, with rates of 1.45% and 1.21% respectively (Rocah-Silva, 1995 *cited in* McLaren & Philpott 1998). Unfortunately there is little data available on the extent of illicit drug problems in the provinces however it probably is safe to assume that drug use is a growing problem. The extent to which substance abuse is a problem for current inpatients by levels of care is represented in Table 8.2.7.1 below.

Table 8.2.7.1 Substance Abuse Indicators by Levels of Care

	Levels of Care							
Substance Abuse Indicators	Low Support		Low Support, No Recovery Environment		High Support		High Support, No Recovery Environment	
	Yes (%)	No (%)	Yes (%)	No (%)	Yes (%)	No (%)	Yes (%)	No (%)
This patient has a problem with drugs and / or alcohol	41 (29.6%)	98 (70.4%)	6 (22%)	21 (78%)	70 (53.4%)	61 (46.6%)	33 (27.1%)	88 (72.9%)

Across care levels the extent of substance abuse problems varies. On average, a third of each patient grouping (33%) reported having a substance abuse problem.

8.2.8 Health Services

Patients who have either chronic physical illnesses or disabilities will most likely require extra supports in the community. The extent to which patients by their levels of care, had such concerns is represented in Table 8.2.8.1 below. A significant difference was found when this group was compared with all other groups (χ^2=13.19 p=0.0002819).

Table 8.2.8.1 Health Services Indicators by Levels of Care

	Levels of Care							
Health Services Indicators	Low Support		Low Support, No Recovery Environment		High Support		High Support, No Recovery Environment	
	Yes (%)	No (%)	Yes (%)	No (%)	Yes (%)	No (%)	Yes (%)	No (%)
This patient has a chronic physical illness	11 (7.5%)	129 (92.5%)	5 (16.6%)	22 (83.4%)	8 (5.7%)	125 (94.3%)	25 (20%)	97 (80%))
This patient has a severe physical disability	3 (1.8%)	137 (98.2%)	3 (8.7%)	24 (91.3%)	8 (5.7%)	125 (94.3%)	16 (13.1%)	109 (86.9%)

Across all levels of care severe physical illness and disability is minimal. There does however appear to be a slightly higher proportion of patients who reported such concerns in the high support and no recovery environment group.

8.2.9 Other Services

Other services that were proposed in Chapter 4 as important for people living in the community, but for which no indicators were developed, are family supports, self-help groups and advocacy services. These services do not directly relate to patient behaviour and functioning. However, where a family is willing to take a patient if discharged, it may be assumed that family involvement and psycho-education is fundamentally important. Moreover, advocacy and self-help all serve to instill an ethos of consumer empowerment into the services, all of which are fundamental to a dynamic mental health system of care and successful community tenure of once institutionalised patients.

8.3 Nursing Staff Perceptions of Discharge Potential

Finally, the perceptions of nursing staff around discharge of patients was compared with the levels of care created through the CNAP framework (Table 8.3.1).

Table 8.3.1 Nursing Staff Perceptions of Discharge Potential by Levels of Care

	Levels of Care							
Nursing Staff Perceptions	Low Support		Low Support, No Recovery Environment		High Support		High Support, No Recovery Environment	
	Yes (%)	No (%)	Yes (%)	No (%)	Yes (%)	No (%)	Yes (%)	No (%)
This patient can be discharged given existing community services	137 (98.1%)	3 (1.9%)	20 (80.1%)	5 (19.9%)	109 (86.3%)	17 (13.7%)	35 (28.9%)	87 (71.1%)
This patient can be discharged given good or better community services	133 (98.9%)	1 (1.1%)	24 (95.3%)	1 (4.7%)	116 (91.8%)	11 (8.2%)	63 (54.2%)	53 (45.8%)

Interestingly, nurses promoted discharge for the majority of patients across care categories, except for patients falling into the high support, no recovery environment grouping (Table 11.3.1). Comparisons between this group and other groups for both discharge now and discharge when better community services were found to be significant (χ^2=171.09 p=0.000 and χ^2=101.81 p=0.000 respectively). This finding is resonant with the CNAP framework, which classifies this grouping as having low discharge potential.

8.4 Summary

The CNAP framework has shown that approximately 33% of the sample were assessed as having low support needs and high discharge potential. The major barrier to discharge for the majority of this group was their admission status. Thirty seven per cent of patients fell into the middle of the CNAP discharge continuum and were assessed as having either low support needs but no recovery environment, , high support needs with a recovery environment. A final 30% of inpatients were found to have very low discharge potential, probably requiring ongoing hospitalisation in the first instance, given their high level of care needs.

In terms of service need, there appeared to be a consistent trend for most of the service areas assessed, with the need for services increasing across levels of care. For example, patients in the low support needs groups were more frequently assessed as having worked prior to hospital admission and being able to hold down a job if discharged than those patients falling into the high support needs groups. Moreover, low support needs patients were reportedly more socially able than patients in the high support categories. Conversely, patients in the high support categories more frequently required psycho-education services particularly around medication compliance than low support patients. The need for risk management and monitoring services also increased across levels of care.

There appeared to be no apparent trend when looking at substance abuse across levels of care, whilst the need to address issues of severe / chronic physical illness and disability was minimal across all levels of care.

The majority of patients, across all levels of care, reported the need for financial assistance if they were to be discharged.

Finally, nurses promoted discharge for patients falling into all levels of care except for those patients who were high level care needs, and lacked a care recovery environment.

CHAPTER 9

DEBATING DEINSTITUTIONALISATION

9.1 Thinking about the international experience

The international literature has shown that deinstitutionalisation is not a new policy thrust. The deinstitutionalisation experience of the UK and USA for example, which began in both countries in the early 50s, provides South African policy makers and planners with a number of useful lessons. The shifting of patients out of hospital beds in these two countries saw a dramatic drop in bed and inpatient numbers without a corresponding increase in community services (Krupinski 1995). Resources once used for the institutionalised patient did not follow the patient into the community resulting in community care facilities and services being under-resourced (Braun et al 198, Smith et al 1996, Carrier and Kendall 1997). The literature also records an ad hoc approach to the process of discharge in these countries, often without planning or preparation for patients once they left the hospitals (Thornicroft and Bebbington 1989). In many cases this resulted in homelessness, marginalisation and abuse of patients (Durham and La fond 1996, Krupinski 1995, Bootzin and Acoccella 1988, Appleby & Desai 1985).

More importantly, the assumption that community care would be cost saving has been heavily disputed, with an emerging realisation that community care is more costly than institutional care in at least the setting up phases of community mental health care models (Hafner & van der Heiden 1989). Finally, the international experience has shown that there are some patients who, despite therapeutic interventions and strong models of community care, will remain chronic and require continued hospitalisation (Raftery 1992; Bachrach 1997).

9.2 Models of Care for South Africa

Given the problems of deinstitutionalisation highlighted internationally a search for alternative care models applicable to South Africa was initiated through a review of developing country experience of mental health care. Unfortunately, the literature reviewed uncovered very few examples of successful and sustainable community based mental health service models. The community services models reviewed were primarily based on a volunteer and family model (Erinhosho 1977, Jegede et al 1985, Deva 1995a), all of which were intricately rooted in the customs, cultures and local socio-economies of the country reviewed. Such models although successful on a small-scale, were not sustainable with the advent of social change (Jegede, Williams & Sijuwola 1985; Deva 1995b; Leighton et al *cited in* Desjarlais 1995:61). Rapid urbanisation, lack of community and family / patient participation have all worked towards the

collapse of such initiatives. The applicability of such models to South Africa, being over 60% urbanised and facing immense social change is therefore questionable.

Finally, the experiences of developing countries' highlighted the importance of involving traditional healers in the formal health care system, and ensuring both a political and legal commitment to human rights and the redistribution of resources to the care of people with a mental illness (Desjarlais et al 1995). According to Desjarlais et al (1995) such commitments must underscore any future mental health policy initiatives else reforms will continue to struggle and flounder.

Looking to developed countries for answers, where the deinstitutionalisation debate has raged for many years, mental health service planners have begun to promote a comprehensive system of care, underscored by case-management. This involves the provision of an array of services, both in the community and in the hospital with patient care being the responsibility of an individual or a small team. Of course, such comprehensive models, although found to be effective (Burns & Santos 1995) are costly and require skilled practitioners . There is need for research into the cost-effectiveness and feasibility of such programmes to South African mental health care.

The introduction of such models to South Africa would necessitate a complete overhaul of the current service model. The custodial approach to care currently permeating the services would need to be reversed involving the retraining of all health professionals, restructuring of services, the development of new and different facilities and more. Although not impossible and, in most instances desirable, it does not provide a short-term solution to current South African mental health service needs. One would argue however that deinstitutionalisation is not a medium-term solution either, particularly given the current nature of the mental health services.

9.3 Mental Health Care in the Provinces

For the two provinces studied, containment appears to be a major principle of care. The mentally ill are cared for in large institutions, with minimal community services. There is however little scope to utilise hospital resources for the development of community services. Findings from the recent national norms and standards study shows that in the provinces there is no oversupply of beds or staff, but rather a need for long term beds to be transferred over time to acute and residential beds. Alternative resources need to be found for the development of community based services.

When a patient is discharged from hospital they are mostly referred to a local community psychiatric for follow-up. These clinics provide little more than medications and are constrained by a custodial ethic of care and lack of resources (Walker 1996; Petse, Holmes & O'Bose 1998). A small number of non-governmental services do however exist in both provinces. Unfortunately the growth and expansion of these services are hampered by the lack of priority given to mental health and mental health services, inadequate financial assistance and the limited interaction between government and non-government sectors (McClaren & Philpott 1998).

The lack of a guiding framework for service provision means that existing community services appear to be ad hoc, fragmented and unplanned. There is a need for a clear policy framework to guide mental health sector transformation

Both the literature reviewed and the existing levels of mental health services in the provinces call for a cautionary approach to any policy that talks to deinstitutionalisation. To further support this cautionary attitude are the findings arising from the CNAP assessment of the services needs and discharge potential of current psychiatric inpatients in KwaZulu Natal and Eastern Cape public sector psychiatric hospitals.

9.4 Who is currently institutionalised?

Box 9.4.1 provides a summary of the typical patient as described by this study. This profile is consistent with profiles described in other South African based studies (Dartnall & Porteus 1998, Mental Health Directorate 1998, Porteus et al 1998, Zwi et al 1997).

Box 9.4.1 The Typical Patient

The typical KwaZulu Natal and Eastern Cape psychiatric patient is a black, male, unmarried with no children. He is an adult aged between 30 to 49 and has a low level of formal education. This is not his first hospital admission. He has spent between 6 months and 5 years in hospital over his lifetime. Before entering hospital, he lived with family or friends and contributed to the family income via a disability grant. If employed, he most likely worked as a contract / unskilled labourer. Admission was most often stimulated through some form of violence or disruption in the community. He is a certified patient with a diagnosis of schizophrenia.

His behaviour is most likely to be appropriate for community living, although the potential for him to be either a danger to himself or the community needs to be assessed before he is discharged. He is able to feed and bathe himself. He experiences difficulties with using public transport and handling money. He does not have any physical disabilities or diseases. Although he is co-operative with taking medications he is likely to forget to take them unless supervised. He may have a drug or alcohol problem.

He may or may not have contact with his family. If his family does visit, they do so at least once a month. He rarely goes on leave of absence. If discharged, his parents are willing to take him, and he is willing to be discharged back to them. It is preferable that community services are improved before he can be successfully discharged to the community. For successful community living, nurses propose that he require assistance in the areas of family intervention and education, day activities and respite services for the family, employment services, medications monitoring, and financial support.

The patient described in Box 9.4.1 is someone who could be cared for in the community. His behaviour is acceptable for community living, he has acquired basic social and living skills and he has a place to stay if he was to be discharged. (Refer to Section 7.4 of this report for a more detailed discussion on the demographic profile of current inpatients in KwaZulu Natal and Eastern Cape psychiatric institutions.)

The current ethic of custodial care combined with the lack of community based services serve to perpetuate institutional care for people with a mental illness. Such a simple analysis, however, does not provide details on the extent to which patients are, in reality, dischargeable.

9.5 Applying the CNAP Framework

To what extent are patents in these hospitals d hargeable, and if they were discharged what might their service needs be? The CNAP framework was developed in order to answer these questions.

Using the CNAP framework, a third of all patients assessed were found to have low support needs and high discharge potential. By definition, this means they were high functioning and had somewhere to go if discharged. Unfortunately, a large majority of this group was certified or state patients. Only 16 patients faced no bureaucratic barriers to discharge. These findings beg the question - if a patient functions well and has a place to stay, why then are they certified? Very few of this high discharge potential grouping were assessed as posing a risk to themselves or others. This poses a great challenge to the mental health services – to assess the appropriateness of psychiatric patients' admission status across provinces and to streamline existing de-certification processes.

An additional group of patients were assessed as high functioning but had no care recovery environment. These patients possessed important basic community living skills but lacked non-hospital accommodation alternatives. Moreover, in the majority of cases they did not pose a risk to either themselves or others. Given the lack of residential community options in both provinces, the discharge potential of these patients is therefore compromised. Furthermore, as with the low support needs patients, the discharge potential of a vast majority of these patients is further reduced by their admission status. Just under half (44%) of this patient grouping were certified. Lacks of residential options and certification status are important issues to address if discharge of these patients is to be promoted.

Finally, 61% of patients were assessed as having high care needs. These patients' were assessed as having poor functioning and needing supervision and / or support to live in the community. They were unable to carry out some of the most basic living skills. They either displayed behaviour that was inappropriate for community living, were not medication compliant, incontinent or could not feed or bathe themselves.

Half of this group (31%) however reportedly had access to a care recovery environment, i.e. they had a family willing to take them if they were to be discharged. On this basis, the discha ge potential of this group of patients is increased. Families of these patients will require training to properly care and support these patients in the family home. This indicates the need for services to involve families more in the care of these patients. A quarter of this group of patients were however assessed as being at risk to themselves, whilst just under a third were reported as being

a danger to others. The risk these patients may pose either to themselves and / or society will need to be continuously assessed if they are discharged.

The remaining half of this high support needs group (30%) was both low functioning and lacked a place to stay if discharged. The need for all types of services and risk potential was highest for this group of patients. Interestingly, nurses assessed the vast majority of this patient group as not dischargeable given current existing community services (71%). It appears the CNAP model has been sensitive enough to identify this most vulnerable group of patients, for whom discharge is most likely to be a distant goal. Across all patients the need for financial assistance was imperative.

In sum, the CNAP framework has shown that the majority of patients currently in psychiatric hospitals in the Eastern Cape and KwaZulu Natal cannot be discharged easily. The reasons include lack of care recovery environment, admissions status, level of functioning and issues of risk. It has highlighted the complex nature of assessing discharge and the need for the provision of a mix of services and facilities in the community in order to sustain patients successfully in the community. The CNAP has also shown that there is a group of vulnerable patients who may require ongoing hospitalisation, particularly in the absence of community systems in both provinces.

9.6 To deinstitutionalise or not to deinstitutionalise?

As mentioned, the international literature is replete with cautionary tales around deinstitutionalisation. Moreover, the debate in these countries has moved away from deinstitutionalisation to focusing more on the development of different models of community care and how best to meet the needs of patients both in community and hospital settings. The hope of potential cost savings of deinstitutionalisation has not materialised, and there is a clear recognition of the need to ensure that development of community care services occur in conjunction with or ahead of patient discharge. In more wealthy nations, individually tailored solutions are provided to patients before discharge.

In the context of South Africa, these challenges are even more daunting. With limited national resources, restrictive national economic policies and massive community development challenges, the extent to which resources will be channeled into community based support services for the mentally ill, in the short term, is at most, limited. More likely, with provincial health departments dealing with budget deficits combined with the current low bed occupancy in psychiatric hospitals, it will be difficult to maintain the current levels of expenditure. The difficulty

of ensuring resources follow patients from hospital to community services warn against simplistic assumptions that funds currently dedicated to hospital beds could be channeled into community services should bed numbers be decreased.

Further, these provinces are not overly resourced in terms of beds. A review of national norms for psychiatric care in South Africa (Flisher et al 1998) suggests that current beds should be maintained and over time transformed into more acute beds and more residential facilities. A decrease in hospital bed numbers – the traditional focus of deinstitutionalisation - should not be a short or medium term service transformation objective.

Finally, this study has shown that only a very small number of patients can be discharged immediately, with the vast majority requiring either their admission status to be reviewed or, to varying degrees, require the development of a variety of community based services to be successfully tenured in the community.

In so saying, this study motivates against the implementation of a simplistic deinstitutionalisation programme in these provinces.

9.7 Transforming the Mental Health Care System

The findings of this study suggest that deinstitutionalisation as the focus for mental health transformation, on its own, is inappropriate. A comprehensive approach is required, based on the following three elements:

9.7.1 Balance and integration of mental health services
9.7.2 Establishing quality assurance processes
9.7.3 Placing Mental Health on the Policy Agenda

9.7.1 Balance and Integration of Mental Health Services

A broader vision of the mental health care system is needed. Primary health care and hospital services, the family, the community, the traditional healer and the patient all need to be viewed as part of a dynamic system of care whereby each part has an important and significant role to play in the provision of good quality mental health care. The goal of this dynamic system of care should be to provide a flexible service for people, providing them with appropriate services, as is their need, one objective of which should be to explicitly counter long-term institutionalisation of an episodic illness wherever possible. The episodic nature of mental illness does however dictate the need of the provision of hospital beds at times of relapse.

Mental health policy makers and service planners need to begin to work towards achieving an optimum balance between these role players. Therefore in light of the findings arising from this study the following are recommended as starting points for obtaining this balance:

- **Maintain current hospital beds:** Current norms suggest that there is no over-provision of beds in the Eastern Cape and KwaZulu Natal but rather a need to shift resources from long term-beds to more acute and community residential facilities. In the light of international experience, it is imperative to protect resources, and a means created to ensure that the acute beds are established, while the numbers of chronic care beds are downscaled. An immediate option could be to transform existing spare capacity in chronic care institutions into residential facilities for people who had no household to be discharged to.

- **Build community based services overtime:** Given the current budgetary constraints faced by health service planners, an abundance of additional resources to develop a comprehensive array of community services is somewhat unlikely. Better use of resources and building on existing systems and models is therefore important. There are a number of dynamic community based services already running within the provinces, including support groups, day-care centres, and group homes. These initiatives need to be monitored and evaluated, and effective programmes supported. Makhale and Uys (1997) recommend that a central body be charged with the responsibility of registering such local initiatives to ensure people are aware of the existence of such services.

- **Transform Hospitals into Community Based Services:** Lack of accommodation was found to be a barrier to community discharge for psychiatric patients. A good starting point for the development of community based accommodation services in resource poor environments is to transform current hospital resources into community resources. Empty hospital wards, for example, could be transformed into halfway houses. This does not however resolve the problems of accessibility nor is it "community based" in the truest sense, but it does provide a short-term alternative to hospital care.

- **Promote Community and Family Involvement:** Important to the success of a dynamic system of mental heath care is the family and community. Previous studies have found family and community alienation as major barriers to patient discharge (Porteus et al 1998; Dartnall & Porteus 1998). Working closely with patients, families and community in developing care plans for individual patients is imperative. Of course, the promotion of the family and community involvement in the care of people with a mental illness must be done

with an awareness of their limitations and vulnerabilities. The role of communities and families must not be over-romanticised or abused.

- **Promote volunteerism and community health workers:** South Africa has a long history of local volunteerism and activism, which may be tapped into. For example, a recent study on providing home-based care for people with HIV/AIDS received an overwhelming response from members of a small Cape community wanting to volunteer to be trained in community health work (Doherty, Juby & Coetzee 1998). As with families and communities, the developing country literature provides a word of caution in promoting models of care that over-emphasise altruism, particularly in countries such as South Africa that are characterised by rapid urbanisation and social change. The use of community health workers and the sustainability of such models need to be investigated in the realm of mental health care.

- **Forge Links with Traditional Forms of Health Care:** The traditional health care providers are often over-looked in the development of models of care. It is of course a complex area, but ignoring a possibly invaluable resource is no solution. There is a need for the formal health sector to acknowledge traditional concepts of mental illness and the role traditional health care providers may play in the care of the mentally ill.

- **Promote intersectoral discussion and provision of services:** Mental illness is a cross-sectoral issue. Promoting mental health services in schools, provision of the disability grant in an expeditious manner, sensitive handling of mental illness by the police – these are all cross-sectoral concerns. There are of course great barriers to intersectoral work, such as lack of budgets and time commitments. This however, should not be a deterrent to initiating dialogue between the health sector and other government departments in order to address cross-sectoral issues.

9.7.2 Establishing quality assurance processes

Moving toward a dynamic system of care must be underscored by a quality assurance process that begins with improving hospital care. The following are some of the first stepping stones that must be traversed in order to being to address the poor quality inherent in South African mental health services.

- **Hospital quality improvement:** As noted earlier, psychiatric institutions in South Africa have been found to provide poor quality care. Patients have to endure an extremely low level of care, both in the public and semi-public psychiatric institutions. Porteus et al (1998) in their

assessment of quality in psychiatric institutions call for the transformation of hospitals into care centres which emphasise "rehabilitation" rather than "institutionalisation". The hospital itself, as promoted by the developing country literature, needs to be transformed into a community resource, which is open to families and communities. In the longer term, there needs to be a shift in services and facilities closer to families and communities.

The recent national norms and standards project (Flisher et al 1998) has developed indicators that may be used to guide and monitor this transformation.

- **Improve admission and discharge procedures:** Psychiatric institutions also need to review existing admission and discharge procedures, with a view to promoting rehabilitation and minimising long term stays. Central to this objective is the urgent need to review patients' certification status and to ensure such reviews are ongoing.

- **Evidence based service development:** There is a number of community based initiatives running in the provinces studied. The extent to which these services are effective and efficient and fit into the overall goals and objectives of a mental health system of care needs to be evaluated. Moreover, international literature promotes the use of case management in the care of people with a mental illness. Research on the appropriateness of case management models for community based mental health care in South Africa is also needed.

9.7.3 Placing mental health on the policy agenda

This study has highlighted the need for a legal and political commitment to mental health care reforms. However, in a context of competing needs and limited resources, keeping mental health on the health policy agenda is no easy task. Promotion of improved services for people with a mental illness by service providers, particularly NGOs, an inculcation of consumerism in service users and improved information systems can all play an important role in the move to greater equity within the mental health care system.

- **Advocacy and Service Providers:** Service providers, and in particular, non-government organisations are important role players in the lobbying of government for improvements in the mental health services.

- **Service User Empowerment:** Underlying all these shifts is the need to promote an ethic of service user participation in the policy making process. People with a mental illness are rarely involved in policy-making processes, despite the fact that these processes impact on

them and their life quality (Tarlton 1997). Development of sustainable, appropriate, flexible and relevant mental health services by necessity should involve service users. The lack of end-user involvement in the mental health arena is distressing. Encouraging service user participation in the policy process should be a priority for all mental health service providers and developers alike. The Department of Health must therefore begin to develop links and formalise partnerships with service users in order to ensure services developed respond to their needs and preferences.

- **Improve information systems:** The lack of information on mental health and health care makes it difficult for role players to motivate for better services or more resources. Provincial and national information systems need to be expanded to ensure that mental health information needs are addressed.

9.8 Developing the CNAP Further

The CNAP and the underlying CNAP framework are only in a developmental phase. There is a need to promote further discussion around the CNAP, its utility and the appropriateness of the framework amongst policy makers and service planners. In so saying, the researchers have also learnt a number of lessons around mechanical and theoretical aspects of the tool. If the tool is to be used in future studies, the following changes should be made:

- **Further tests of validity and reliability:** Further studies are needed on the reliability and validity of the CNAP tool.

- **Reworking of the CNAP Framework:** The CNAP framework and its associated service need indicators were developed through the course of this study. Neither the framework nor the indicators have been subject to any external validity or reliability checks. More research is needed in this area. It is also important to reiterate that this tool is not meant to identify individuals for discharge but rather provide service planners and policy makers with an overall planning tool. A more qualitative, multidisciplinary approach is needed for individual discharge decisions.

- **Application of the CNAP Model in Different Settings:** This study has focused solely on hospital based patients. This is, in some way, a limitation. Also of interest are the needs and wants of ambulatory patients. This study therefore promotes the adaptation of the CNAP for use in other settings.

- **Removal of "don't know" categories:** In certain sections of the CNAP, respondents were given a "don't know" option. In retrospect, the "don't know" category does not provide any useful information to the researcher. One cannot discern whether the persons completing the form actually do not know the answer, simply does not want to complete the question or if it is truly a "missing" category. Removal of the don't know category will work to clarifying these issues.

- **Breaking down the question on hospitalisation:** The tool asks the assessor to state whether or not, in their opinion, the patient should remain in hospital, either temporarily or long term. This question needs to be broken up into two separate questions.

- **Exclude observation patients**: This tool is not useful in the assessment of observation patients - they have not been in hospital for a month, nor has their psychiatric status been determined.

- **Provide Proper Introduction:** The results arising from the pilot has highlighted the need for a proper introduction of the CNAP and its contents to the staff who will be responsible for completing the CNAP. Working through each item, supplying definitions the nurses with definitions of each item will prove important in the quest to improve data quality.

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APPENDIX A

TO WHAT EXTENT IS CARE DEINSTITUTIONALISED: A REVIEW OF THE NATIONAL NORMS FOR MENTAL HEALTH CARE.

Actual levels of service provision and the balance between hospital and community services can be examined by reviewing the recently developed national mental health service norms (Flisher et al 1998). Flisher et al (1998) provides national guidelines for levels of service provision. Norms which talk specifically to the balance of hospital and community beds as well as provide guidelines for quality are therefore examined with reference to the Eastern Cape and KwaZulu Natal.

The following norms are reported and discussed:

- Bed/population
- Community / Hospital
- Admission Rates
- Average Length of Stay

Flisher et al's (1998) study provides recommended national norms at both a baseline and a target level. The baseline level reflects a minimal level for service delivery. It is considered unacceptable for service provision to fall below this value. The target level norms are calculated on an estimation of meeting 100% service need in any given population. Please refer to the study for a detailed description of the methodology used to develop each norm.

Bed/Population Norm

A bed / population norm is a measure of the number of beds required for the care of people with a severe psychiatric condition per 100,000 population. The recent national study conducted on norms and standards for psychiatric care in South Africa found that both KwaZulu Natal and the Eastern Cape had 40 beds per 100,000 population[1]. Tables A and B provide a summary of these norms by bed type.

[1] Private sector facilities are included in these figures

Table A Existing bed/population ratios per 100 000 population in KwaZulu Natal and Eastern Cape.

	Pop (x1000)	Acute beds	Ratio	Medium / long stay beds	Ratio	Lifecare	Ratio	Commu nity Beds	Ratio	Total	Ratio
EC	5,856	832	14	1690	29			0	0	2330	40
KZN	7,672	1029	13	1238	16	819	19	0	0	3086	40

Table A Recommended National bed/population norms.

National norms (per 100,000)	Acute beds		Medium / long stay beds		Community beds		Total	
	Baseline	*Target*	*Baseline*	*Target*	*Baseline*	*Target*	*Baseline*	*Target*
	13	**28**	**3**	**10**	**3**	**10**	**19**	**48**

In comparing the national bed population norms outlined in Table B, with current bed population norms in the two provinces there is clear under-provision, of community based residential beds. There appears to be a relative over provision of medium-long term beds. Figures also show that the existing level of acute beds are only just meeting baseline norms and hence need to be protected and built up over time in order to meet target norms. This distribution points to two conclusions. Firstly, the dramatic need to develop community residential beds and secondly, the need to shift long term beds to shorter term / community residential beds overtime.

Community / Hospital Norms

A community/hospital ratio describes the use of hospitals as compared to community services within a certain population grouping. It can be calculated in two ways: Staff distribution or patient service utilisation. Flisher et al (1998:118-119) defines staff distribution as, "the ratio of staff employed in community settings to all staff". Whilst patient service utilisation is defined as "the ratio of the ambulatory care attendance rate per 100 000 population to the sum of this rate and the annual hospital admission rate per 100,000".

Flisher et al (1998:117) lists a number of advantages in reporting existing community / hospital ratios. They include:

- It provides a broad description of the relative utilisation of hospital and community services
- It provides some information on the input requirements of each

- It can be used to document the progress of deinstitutionalisation over time.
- Hospital / community ratios can be compared across provinces providing a summary of the relative emphasis a provincial service places on hospital or community services.

Each of these points is important in determining the extent to which care is deinstitutionalised in each of the provinces. Flisher et al (1998) notes however that there is little evidence in the literature to suggest an optimal community / hospital ratio. The value of this ratio therefore lies in the monitoring of service development over time.

Tables C and D, again drawing from Flisher et al (1998) provide existing staff distribution community / hospitals ratios in each of the provinces under investigation and the recommended national norms.

Table C Existing community / hospital ratios for staff in Eastern Cape and KwaZulu Natal mental health services.

	No. Staff			No. Staff		
	Community (Hosp OPD + Clinics + CHCs)	Hospital (Inpatients only)	Ratio 1(%)	Community (Clinics + CHCs)	Hospital (Inpatients + OPD)	Ratio 2(%)
EC	170.2	926.1	16	22	1074.3	2
KZN	173.86	1401.8	11	66	1510.66	4

Table D Proposed national community / hospital norms for staff

	Baseline[2] (low community)	Target
Ratio 1	25%	40%
Ratio 2	15%	30%

The figures presented in the above Table C show low community / hospital ratios for both Eastern Cape and KwaZulu Natal (Flisher et al 1998). Low community / hospital ratios for patients are an indicator of high utilisation rates for hospitals as compared to community services. This in turn reflects the extent to which hospital services are more developed as compared to community services and highlights the well-established nature of the hospital services in these provinces. Care in these two provinces is currently institutionalised, particularly when compared to the recommended national community / hospital norms (Table D).

[2]In the original document two baseline figures were calculated, one for provinces which have high community/hospital ratios and one for those provinces, like KwaZulu Natal and the Eastern Cape which have low community / hospital ratios. Only low community/hospital baseline ratios are reported in this report.

Admission Rates

An admission rate is an indicator of bed usage in hospitals. It is a measure of the process of service delivery (Flisher et al 1998). It is however closely linked with availability of beds, service quality, staffing levels and other resources, as well the disease profile within a specific area (Hospital Strategy Project 1995). Hence interpretation of admission rates necessitates knowledge of the mental heath system overall (Flisher et al 1998). Existing admission rates per 100, 000 population in Eastern Cape and KwaZulu Natal has been calculated through the recent norms and standards study (Flisher et al 1998). These findings are found in Table E below

Table E Admission rates per 100,000 population by province as compared with recommended national norms

	Population (x1000)	No. admissions / year	Rate of admissions per 100,000
EC	5865	7242	123
KZN	7672	10037	131
Proposed baseline norms	-	-	150
Proposed target norm	-	-	180

Flisher et al (1998) predicts an increase in admission rates over time in South Africa. Admission rates for both provinces need to increase even to meet the baseline norms. Flisher et al (1998:142) provides the following reasons for this predicted increase:

- Improved services should result in increased detection rates;
- Lengths of stays are likely to be reduced if community care services are improved;
- An increased number of acute beds and a decreased number of chronic beds should lead to an increased number of admission; and
- Increased access to services by people previously denied access by informal and formal barriers.

Average Length of Stay

Average Length of Stay is the average length of time (in days) that patients spend at the hospital prior to discharge and is reportedly a good indicator of hospital resource use (Hospital Strategy Project 1995). According to Flisher et al (1998:143), reduced length of stays "as an indicator of

hospital resource utilisation,.....have been as much a benchmark of deinstitutionalisation as reduced bed/population ratios".

Internationally there have been moves in psychiatry towards shorter lengths of stays (Allen et al 1993 *cited in* Flisher et al 1998). Defining an optimal length of stay is however difficult. Length of stay is dependent on issues such as patient needs, the actual facility the patient is in, bed availability, staffing levels, admission, readmission and defaulter rates, existing hospitals discharge policies and an existing community service with which to discharge patient to (Flisher et al 1998). This complexity calls for caution when interpreting this indicator.

Average lengths of stays (in days) for each province by hospital type is provided in Table F below.

Table F Average length of stays in Eastern Cape and KwaZulu Natal as compared with recommended national norms

	Average Length of Stay (days)				
Provincial Figures					
	Psychiatric Hospital		General Hospital		District Hospital
EC	66		28		8.5
KZN	226		14		7
National Recommended Norms					
	Acute Psych Hospital	Med-long Psych Hospital	General Hospital Dedicated acute	General Hospital Non-ded acute	District Hospital
Proposed baseline norms	14	-	14	5	3
Proposed target norm	19	180	19	8	5

The above table reflects enormous variations in lengths of stays between the provinces, particularly in the psychiatric hospitals. In both provinces, especially in psychiatric hospitals current lengths of stays are dramatically longer than the suggested norms. Reasons for this variation are complex and require greater investigation but are most likely a product of hospital discharge and admission procedures, emphasis in the hospitals on custodial care rather than rehabilitation as well as the quality of care provided in hospitals.

APPENDIX B

COMMUNITY CARE - SOME FLASHPOINTS

There are some important community based initiatives running in the provinces which can be built upon and provide some hope. To follow then is a brief and selective overview of the types of community based services currently provided in the mental health sector in the Eastern Cape and KwaZulu Natal. Information on support groups, self help groups, group homes, counseling services, day care centres has been drawn from both the literature and key stakeholder interviews. Nine key informants in each of the 2 provinces were interviewed telephonically (Appendix C).

Support Groups / Self-Help Groups

Support and self help groups aim to assist persons with mental illness to cope with community living. They involve people with mental illness getting together as a group to share their experiences and coping strategies. South African research on support groups found they are an important community intervention for people with a mental illness living in the community (Makhale and Uys 1997). They reportedly assist in maintaining people in the community, thereby reducing hospital readmission rates, whilst the sharing aspect of the group serves to enhance coping abilities (Pogenpoel, 1993 and Makhale and Uys, 1997). A further advantage of support groups is the minimal setting up and running costs. Destigmatisation and advocacy are also other benefits. Makhale and Uys (1997) found however, very little involvement on the part of mental health professionals in these groups. This non-participation is reportedly a reflection of the "underestimation of the competence of consumers" by the medical establishment and "to the insufficient person power in the community services" (Makhale & Uys 1997:48). Support from government of consumers and support groups is a major recommendation arising from this study (Makhale & Uys 1997).

Home Visiting Programmes

Home visiting programmes involve the provision of psychosocial education to family members of patients with a mental illness, as well as preparing them for the patient's for discharge. Research on the effectiveness of home visiting programmes found they reduced the time patients spent in hospitals by up to 50% (Gillis, Koch and Joyi 1990).

Social clubs

Social clubs aim to assist members to develop social skills needed to cope with the demands of daily living, such as grooming, relationship building, communication skills, and confidence building. Family and community education are also important components of social clubs.

Social clubs are reportedly a viable method of providing community based care to the persons with mental illness. Firstly, there are minimal capital costs involved as existing community structures are utilised to run these clubs. Secondly, they provide a mechanism for the monitoring of medication compliance and behaviour of discharged patients. Thirdly, social clubs are accessible, as they are located within the members' communities. Finally, location within communities may help facilitate the integration of the persons with mental illness back into regular, everyday life.

Unfortunately, according to key informants, the sustainability of these clubs is threatened because of limited funding from government and the difficulty of procuring funding from the private sector for mental health oriented projects.

Group Homes

Group homes provide accommodation services to people discharged from hospitals. The programmes provided to the residents are geared towards assisting them to develop skills of daily living in order to assist them to readjust back into their own communities. A criterion for admission to a group home seems to relate to issues such as access to availability of alternative accommodation and the willingness of the family to receive the patient on discharge. Anecdotal evidence suggests that access to services such as group homes is mainly limited to white patients (*Key Informant, #A 1998*). Further investigation is required to determine the extent to which these services continue to be relegated to white patients.

Group homes, provide patients and service providers with an alternative source of accommodations in situations where a deep rift between a patient and his family has occurred. Group homes although successful in reorienting the psychiatric patients' back in to their own communities reportedly have some drawbacks. In particular, if not monitored properly, they are at risk of becoming mini-institutions and may in turn contribute to the further marginalisation of persons with mental illness from families and broader society.

Counselling Services

Mental health societies in both KwaZulu Natal and the Eastern Cape provide counselling services. These mainly involved social workers providing individual or group counselling to the

persons with mental illness and their families either through home visits or by appointment at the mental health societies' offices.

This form of intervention aims to assist discharged patients to develop coping mechanisms and to enhance their emotional functioning levels. According to provincial key informants, there are a number of barriers to providing adequate counselling services. Social workers struggle with the large distances needed to be travelled in order to provide services to people living in rural areas. The service users themselves often experience difficulty accessing more centrally located services due to the lack and / or cost of public transportation.

Day Care Centres

Day care centres provide respite to both families and patients from the burden of living with a mental illness. They provide daytime activities for people. One such centre was identified in Eshowe, Kwa Zulu-Natal province. This project provides daytime activity for people of various disabilities including persons who suffer from mental illness. People are provided with an opportunity to develop daily living skills, with an emphasis on developing income-generating skills. Participants of the day centre are engaged in activities such as, vegetable gardening, wiring, pottery and brick making. Items produced are sold within the local community. This enhances members' sense of meaningful contribution to the community's economy.

Participants are encouraged to comply with medication. Family education is directed towards assisting the members to accept and cope with caring for a mentally ill person. A problem of non-compliance has been noted. Patients and family members are provided with information and education on the importance of medication compliance. Some participants have not been able to access the service due to lack of transport. In order to deal with this problem the centre accommodates some of the participants during the week.

APPENDIX C

KEY INFORMANTS

KEY INFORMANT	ORGANISATION
Bridget Delport	KZN Mental Health
Phumi Msomi	KZN Mental Health
Nomsa Ntuli	KZN Mental Health
Cathrine Mbatjati	Tower Hospital
Veditha Sing	Pietermarizburg Mental Health Society
Mandy Roux	Cape Mental Health
Mrs V Dupreez	Elizabeth Donkin hospital

APPENDIX D

THE INSTITUTIONAL PROFILE

Institutional Profile Instructions

This form is designed to help us get necessary information about the patient population at your hospital.

Please use the following definitions when completing this form.

1. **An inpatient:** A patient admitted to a planned bed for continuous care, irrespective of the length of time the patient actually spends in his/her bed. The total should include those patients currently on Leave of Absence.
2. **An outpatient:** A patient visiting an outpatient clinic or a patient admitted as an outpatient to an outpatient care facility. This definition implies an outpatient admission procedure. Unless otherwise specified, the number of outpatients during a specific time period is equal to the number of attendances or contacts with the outpatient service. In other words 2 encounters with 2 different patients in the same day are counted as 2 outpatient visits. Whilst, if a patient visits 4 clinics on one day, the patient is counted as 4 outpatient visits.
3. **Psychiatric Patient:** A patient whose primary reason for being in hospital is psychiatric in nature. (e.g. schizophrenia, depression, dementia). This study excludes all patients whose first diagnosis is mental retardation or mental handicap.
4. **Chronic Patient:** A patient who has been in continuous institutional care for a year or more, either in your institution, or another institution. (Note: If your definition of 'chronic' differs from this definition, please contact us so that we can agree the best way forward.
5. **Acute Patient:** A patient who has not been in continuous institutional care for a year or more. See above.
6. **Community Services:** Refers to those community psychiatric services which are managed as a department or division of the hospital.
7. **Authorised Beds:** The number of approved beds for "continuous use". The case of provincial hospitals this is the number of beds for which funds are obtained on annual basis from the Department.
8. **Wards:** Actual wards in use
9. **Full Time Equivalent:** As services may be provided by part-time as well as full-time staff, an FTE refers to the time for which there are staff, rather than to the number of staff. E.g. 3 part-time staff members may equal to one FTE.

Please do not hesitate to contact one of the following at the Centre for Health Policy, University of the Witwatersrand if you have any questions.

Liz Dartnall Kim Porteus Precious Modiba Tennyson Lee

Phone: (011) 489 9936/8 Fax: (011) 489 9938 Email: lizmat@global.co.za

Many thanks for your hard work and co-operation in completing this questionnaire

A. INSTITUTIONAL / PATIENT PROFILE

This form asks you to provide information about your hospital. Write the appropriate numbers i the boxes.

Hospital Name: _____ Health District:_____

Year when started Operation:_____ Date completed form: _____

1. Total Patients: Please provide the total current patient population:

Total Inpatient Population		**Number persons visiting outpatients in last 3 months (not contacts)**	

2. Chronic vs. Acute Psychiatric Inpatients

Please provide the total number of chronic psychiatric patients and the total number of acute psychiatric patients currently at the hospital. Refer to page one for definitions of chronic and acute.

Outpatient facilities and community services refer to those services which are attached to the hospital. Only complete this section if you have outpatient or community services attached to your hospitals. (Note that these two totals should add up to the total provided in question 1 above)

Chronic Patients:		**Acute Patients:**	

Complete only if appropriate **Outpatients (Total number of contacts during 97/98 financial year)**		**Community Services (Total number of contacts during 97/98 financial year)**	

When a patient is discharged from your hospital, where do you refer them to? Please list in order of decreasing frequency:

1. _____
2. _____
3. _____
4. _____
5. _____

3. Total Chronic Inpatient Breakdown

Please provide the breakdown of chronic inpatients according to the following categories. Refer to page one for definitions chronic psychiatric, mental handicap. Note that these totals should add up to the total number of chronic patients at the hospital provided in question 2 above.

Chronic Psychiatric		Mental Handicap	
State Patients		Other (please specify)	

4. Chronic *Psychiatric* Inpatient Functioning

Please provide the breakdown of the functioning levels of your chronic psychiatric patients. Please use the functional rating system currently used at your hospital to organise your patients. E.g. High, middle, low or A. B. C. D. E. Please provide us with an explanation for this system in the space provided below. Note that these totals should add up to the total number of chronic psychiatric patients at the hospital provided in question 3 above.

FUNCTIONAL LEVEL (as defined by the hospital)	Number of patients
1	
2	
3	
4	
5	

DEFINITION:
Please write in spaces below definitions of each of these hospital defined categories

5. Hospital Information

This section requests information on hospital bed numbers, occupancy figures, average length of stays, number of deaths, and number of admissions and discharges for the 12 month period of the 1997/98 financial year. (I.e. 1 April 1997 to 31 March 1998)

Please provide the following figures for the last financial year	
Number of authorised beds	
Number of wards	
Average number available beds	
Average bed occupancy	
Number admissions for 97/98 financial year	
Number discharges for 97/98 financial year	
Number patient deaths for 97/98 financial year	

6. Discharge by length of stay:

In the table below, please provide a breakdown of the total number of discharges and deaths b an estimated length of stay.

Please complete the following sentence: Of those people who were discharged or died during the 1997/98 financial year how many had an approximate length of stay of:	
Less than 3 months	
3 to 6 months	
7 to 12 months	
More than a year	
TOTAL NUMBER OF DISCHARGES	

STAFF PROFILE

Please write the appropriate numbers in the boxes below.

Nursing Staff	Full Time Equivalents
Nursing service manager	
Chief Professional Nurse	
Senior Professional Nurse	
Professional Nurse	
Senior Enrolled Nurse	
Enrolled Nurse	
Snr Enrolled Nursing Asst.(ENA)	
Enrolled Nursing Asst (ENA)	
Other (please specify)	
Other (please specify)	

Practitioner Staff	Full Time Equivalents
Psychiatrist	
Medical Officer	
Dentist	
Clinical Psychologist	
Social Worker	
Occupational Therapist	
Occ. Therapist Asst. (OTA)	
Physiotherapist	
Physio Therapy Assistants	
Community Services	
Other (please specify)	

Technical / Maintenance / Administrative Staff: *Please write the appropriate numbers in the boxes below.*

Technical Staff:			
Pharmacist		Pharmacy Assistants)	
Lab Technician		Other (please specify)	

Administrative Staff

	Full Time Equivalents
Administrators	
Management	
Kitchen	
Security	
Other (please specify)	

Maintenance Staff

	Full Time Equivalents
Cleaners (housekeeping)	
Maintenance / Grounds	
Laundry	
Drivers	
Other (please specify)	

WARD PROFILE

Instructions: Please complete the following information about each ward in the hospital.

Name or Number of Ward	'A' / 'C' / 'M'	Description of Ward	Number Psychiatric	Number Acute Patients	Number Mentally Handicapped	Total Available Beds	Present Bed Occupancy	Leave of Absence	Day Shift Nursing Staff	Night Shift Nursing Staff
	A= acute ward C=chronic ward M=mixed (A&C)	For example, low functioning male; high functioning male and female etc.						How many patients are currently on leave?	How many nurses or other direct care givers are on duty during day shift?	How many nurses or other direct care givers are on duty during night shift?
1)										
2)										
3)										
4)										
5)										
6)										
7)										
8)										
9)										
10)										

APPENDIX E

THE CARE NEEDS ASSESSMENT PROTOCOL (CNAP)

Dear Ward Staff

This survey forms part of a study conducted by the Centre for Health Policy. The Centre for Health Policy is a research unit attached to the Department of Community Health, University of the Witwatersrand.

As you know, there is currently a national policy shift toward moving people out of long term hospital care into community care settings. This clearly a complicated objective. We must work carefully to achieve this objective, with an understanding of the barriers and opportunities to discharging patients to the community. The objective of this study is to provide baseline data about this hospital and other hospitals in this province and patients to contribute to future discussions and project aimed at gradually moving patients from hospital to community care.

The first step then is to obtain an understanding of the patients currently using our services, what is their diagnosis, do they have family support, what are their functioning levels. The purpose of the attached questionnaire is to attempt to gather this type of information.

HOW TO COMPLETE THE QUESTIONNAIRE:

1. You should complete this form for psychiatric patients **ONLY.** You do not have to complete the form for every psychiatric patient in your ward. Using patient files, select **EVERY _____ FILE** from the storage cabinet and complete the form for those patients only.

2. To properly complete the form you will have to talk with the patient, and consult their files. Please do not write any patient names on the forms.

3. Read each question carefully and take time before answering. It is very important that your answers, unless otherwise specified, refer to patients' behaviour **DURING THE PAST MONTH.**

4. Please cross or write the most appropriate answer in the spaces provided.

5. Please submit the completed form to the sister in charge of your ward.

Thank you for your time and patience in completing this questionnaire.

If you have any questions or queries about this study, please ask one of the researchers or contact one of us on the following numbers:

Liz Dartnall	Precious Modiba	Tennyson Lee	Kim Porteus
(011) 489 9938	(011) 489 9952	(011) 489 9954	(011) 489 9953

Care Needs Assessment Protocol

Date:_____ Hospital:_____ Ward No.:_____

Completed By:	Snr Prof Nurse	Prof Nurse	Enrolled Nurse	Enrolled Nursing Asst

A. Demographics / History

1. File No.:		2. Ward Type:	Chronic	Acute	Admissions	Child	Psychogeriatric	Mixed	Other

3. Gender:	M	F	4. Race:	Black	White	Coloured	Indian/Asian

5. Age Group:	0 to 14	15 to 19	20 to 29	30 to 49	50 to 59	60 and over

6. Marital Status: (formal or traditional)	Single (never married)	Married (formal or traditional)	Separated / divorced	Widowed	Other

7. No. children:	0	1	2	3	4	5 or more

8. Highest level of education achieved:	None	Lower Primary (Sub A - St 3)	Higher Primary (St 4 - St 5)	Secondary/ Pre matric (St6-St9)	Matric	Tertiary	Other

9. Was patient working prior to admission (formal/informal)	Yes	No	10. Job type:	Labourer (e.g. domestic, mine worker, sub-contractor)	Clerical / service sector (e.g. secretary)	Technical (e.g. mechanic, technician)	Professional / Manager	Other (please specify)

11. Housing: (What were the patient's living circumstances prior to admission?)	In household alone	In household with friends or relatives	Hostel	Halfway house	Prison
	No known residence (homeless)	In chronic care institution	Don't Know	Other (Please specify)	

12. Which province did the patient live in prior to hospital admission	Northern Province	Free State	Gauteng	Kwa Zulu Natal	Mpumalanga	
	Eastern Cape	Northern Cape	North West	Western Cape	Outside of SA	Don't know

13. In which province has the patient lived most of his / her life	Northern Province	Free State	Gauteng	Kwa Zulu Natal	Mpumalanga	
	Eastern Cape	Northern Cape	North West	Western Cape	Outside of SA	Don't know

B. Diagnostic Profile

14. Current Diagnosis: (tick more than one only if appropriate)	Schizophrenia	Schizophreniform Disorders	Substance Abuse	Epilepsy	Dementia
	Brain Injury	Depression	Manic Depression	Other (Please specify)_____	

15. Date of most recent admission:	d	d	•	m	m	•	y	y	16. Is this the patient's first admission to a psychiatric hospital?	Yes	No

17. Please estimate the total time the patient has spent in psychiatric hospitals over his/her lifetime?	Less than 6 mths	6 to 12 months	2-5 years	Over 5 years	Don't Know

18. Was the patient violent or disruptive in the community prior to hospital admission?	Yes	No	Don't Know

19. Did the patient contribute financially to the family income prior to admission, either through a disability grant or through working?	Yes	No	Don't Know

20. Section of the mental health act?	3 (Voluntary)	4 (Adm /consent)	9	12 Emergency	Obs (Observation)	28 (State pt)	Mentally Ill Prisoner

21. Current Medications: Please list patients current medications regimen (psychiatric drugs only)	
Drug	**Dosage**

C. Patient Functioning

Instructions: The following questions concern the patient's basic self-care capacity and social skills. Please cross the answer that **best** describes the patients' behaviour **DURING THE LAST MONTH.**

22.This patient has lasting friendships	TRUE	FALSE
23.This patient is at risk to themselves (I.e. suicidal tendencies, self-mutilation, extreme carelessness, e.g. when crossing the road)	TRUE	FALSE
24.This patient is violent and disruptive and is a danger to others.	TRUE	FALSE
25.This patient has a problem with alcohol and / or drugs	TRUE	FALSE
26.This patient is incontinent (cannot control his/her bladder)	TRUE	FALSE
27.This patient has a chronic physical illness (e.g. TB, chronic hypertension)	TRUE	FALSE
28.This patient has a severe physical disability (e.g. wheel chair, cannot use an arm)	TRUE	FALSE
29.This patient experiences hallucinations and / or delusions	TRUE	FALSE
30.This patient's speech is incoherent (e.g. muddled, illogical, irrelevant, confused)	TRUE	FALSE
31.This patient's behaviour is appropriate -- that is, it would be considered acceptable for community living.	TRUE	FALSE
32.This patient is co-operative about taking his/her medications.	TRUE	FALSE

D. Service Needs

Please complete the following sentence, choosing the option which best describes this patient.

If this patient were living outside of the hospital, he or she could.....

33.Bathe independently (without supervision)	TRUE	FALSE	DON'T KNOW
34.Feed independently (without supervision)	TRUE	FALSE	DON'T KNOW
35.Keep him / herself neat and clean (without supervision)	TRUE	FALSE	DON'T KNOW
36.Remember to take medications (without supervision)	TRUE	FALSE	DON'T KNOW
37.Use public transportation.	TRUE	FALSE	DON'T KNOW
38.Budget his/her money to buy food, clothing, rent	TRUE	FALSE	DON'T KNOW
39.Make his / her bed without assistance	TRUE	FALSE	DON'T KNOW
40.Hold down a job	TRUE	FALSE	DON'T KNOW

This patient, if discharged would .....

41.require assistance with finding accommodation	TRUE	FALSE	DON'T KNOW
42.require financial assistance e.g. disability grant	TRUE	FALSE	DON'T KNOW
43.benefit from a day centre where he/she could interact socially with others	TRUE	FALSE	DON'T KNOW
44.require family support and assistance	TRUE	FALSE	DON'T KNOW
45.require hospice or frail care services (e.g. old age home)	TRUE	FALSE	DON'T KNOW
46.benefit from participating in a sheltered workshop	TRUE	FALSE	DON'T KNOW

E. Family Involvement and Support

47. Does the patient receive visits from friends or family?	Yes	No

48. If yes, please estimate how often the patient receives visits from friends or family.	Often At least once a month	Sometimes At least once every 6 months	Seldom At least once every 12 months	Rarely Every 2 to 5 years

49. Does the patient have contact with friends or family in other ways?	Yes	No

50. If yes, How?	Phone	Letter	Leave of Absence	Other

51. Does the patient ever go on leave of absence (LOA)?	Yes	No

52. If yes, how often does the patient go on leave of absence?	Often At least once a month	Sometimes At least once every 6 months	Seldom At least once every 12 months	Rarely Every 2 to 5 years

53. Is there someone in the patient's family or friends who is prepared to take the patient home to live with if the patient was discharged?	Yes	No	Don't Know

54. If yes, who do you think will be responsible for the patient once discharged?	The patient's parent/s	Sister and / or brother	A Friend	Don't Know
	The patient's wife / husband	Uncle and / or aunt	Daughter and / or son	Other

55. Does the patient want to be discharged?	Yes	No	Don't Know
56. If yes, does the patient want to be discharged back to his/her family as defined in question 54 above.	Yes	No	Don't Know

F. Discharge Status

56. In your opinion, do you think this patient can be discharged given existing community services?	Yes	No	Don't Know
57. Do you think this patient should remain in hospital, either temporarily or permanently?	Yes	No	Don't Know
58. Do you think, given good or better community services this patient could be discharged?	Yes	No	Don't Know

59. How long have you worked with this patient?	Less than 1 month	1 to 3 months	4 to 6 months	7 to 12 months	2-5 yrs	5yrs+

60. Any further comments?

Many thanks for your time in completing this form.
Please hand completed forms to the sister in charge of the ward.

APPENDIX F

THE CNAP KEY INFORMANTS

International and National Key Informants For Developing the CNAP:

KEY INFORMANT	ORGANISATION
International	
Dr. Kenneth Lutterman	National Institute for Mental Health (NIMH), USA
Prof. Graham Thornicroft	PRiSM, Institute of Psychiatry, DeCrespigny Park, London SE5 8AF.
Dr Paul McCrone	PRiSM, Institute of Psychiatry, DeCrespigny Park, London SE5 8AF, UK
Prof. Barbara Burns	Dept of Psychiatry, Duke University Medical Centre, Durham, North Carolina, USA
National	
Melvyn Freeman	Director, National Directorate of Mental Health and Substance Abuse, Pretoria, South Africa
Dr Edith Madela-Mntla	Deputy Director, National Directorate of Mental Health and Substance Abuse, Pretoria, South Africa
Lorna Twomey	Deputy Director, National Directorate of Mental Health and Substance Abuse, Pretoria, South Africa
Debbie Bradshaw	CERSA, Burden of Disease, Medical Research Council, Cape Town, South Africa
Cathy Kahn	Department of Community Health, University of the Witwatersrand, Johannesburg, South Africa

Author Dartnall E
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