

Community rehabilitation for schizophrenia patients: Is it feasible in South Africa?

The 16th National Congress of the South African Society of Psychiatrists has opened its doors to various branches and fields of psychiatry for consideration, including the areas of community psychiatry and psychosocial rehabilitation.

The effectiveness and importance of community-based rehabilitation programmes for patients suffering from schizophrenia and other chronic psychotic disorders have been well documented in the literature under various names and approaches. The objective of this editorial is briefly to look at current knowledge of the topic and reflect on its importance for South Africa.

Six basic types of community-based treatments have been examined in several controlled studies:

- the assertive community treatment model (ACT) of case management
- family interventions
- supported employment
- skills training and illness self-management
- cognitive interventions (cognitive therapy and cognitive rehabilitation)
- integrated treatment of substance use disorders and severe mental illness.¹

The ACT of case management is by far the most comprehensive and may incorporate some aspects of the others into its approach. It is worth considering how it could be adapted to the South African context.

Assertive community treatment

Case management is a general term used to describe the assessment, co-ordination and provision of different components of treatment for a person with chronic severe mental illness (SMI). The ACT model emanated from the observation that many clients with SMI are non-compliant with treatment or do not use clinic-based mental health services for other reasons. These clients are at risk of increased utilisation of particularly costly psychiatric services, such as inpatient hospitalisation and emergency department treatment.

In early 1970s Mary Anne Test² and her team decided to shift the focus from hospital to community rehabilitation, and ACT was

born as part of the de-institutionalisation of psychiatry. Since then this model has been utilised worldwide in improved forms.

Characteristics of the ACT model

The original ACT model is characterised by a multidisciplinary team, working with a low client/case manager ratio. The caseloads are shared among clinicians, and services are provided directly by the same team rather than brokering services to other providers. Usually this ACT team offers a 24-hour coverage which takes care of emergencies as well. This model pays close attention to illness management, and most services are provided in the community rather than at the clinic. Frequent contact with clients and practical assistance with daily living problems are offered.

Common features of different models of community rehabilitation programmes

Family intervention programmes follow a relatively long-term approach (from 6 months to 2 years). They focus on improving adherence to prescribed medication, improving relationships among family members, and helping the family to understand the patient's disorder better.

Supported employment traditionally uses a brokered approach to vocational rehabilitation, but literature reviews show it to be disappointingly ineffective in a labour market where even people without disabilities struggle to find jobs.

Cognitive interventions in this context focus on treating the cognitive deficits of schizophrenia, in particular those associated with social functioning, work skills and capacity for independent living.³

Substance use disorders with co-occurring SMI (i.e. 'dual diagnosis') are associated with a wide range of negative outcomes, including relapse and re-hospitalisation, housing instability, financial problems, violence, suicidality, increased service utilisation, family conflict and legal problems. These co-morbidities are highly prevalent in South Africa, which means that there is a critical need to provide for them in psychosocial rehabilitation.

One of the problems researchers have found in community rehabilitation programmes is that, although they take place in the community, they do not involve the community. Essential characteristics of a proper community rehabilitation programme⁵ should include:

- functional assessment in relation to environmental demands
- client involvement in the assessment and intervention phases of rehabilitation⁶
- systematic individual client rehabilitation plans
- direct teaching of skills to clients
- environmental assessment and modification
- follow-up of clients in the real-life environment
- rehabilitation team approach
- rehabilitation referrals
- evaluation of observable outcomes and utilisation of evaluation results
- consumer involvement in policy and planning.

The South African situation

In the present South African situation, community psychiatry services either do not exist in most places or are poorly developed, yet the intention is that mental health services in the country should progress from a hospital- to a community-based approach.⁷ As it will still be some years before South Africa has the minimum number of psychiatrists required for this approach, the question at this point in time is: What should be done right now?

One proposal may be to reshape the current functions of psychiatric hospitals and organise hospital-based community psychiatry services as the standard for psychiatric care in the country.⁸ It is likely that all psychiatric hospitals in South Africa have a formal and well-organised outreach programme, which may be the point of departure for a real community psychiatry approach that takes on board the collaborative work of physicians in primary health care, psychiatric nurses, clinical associates and the community component: families, community leaders, enthusiastic NGOs, religious institutions and business people. They would then form

the ACT team. Some South African colleagues already follow such an approach, even if only partially.⁹

There will be many challenges to overcome in this task, ranging from design of institutional organograms to managing the internal resistance among colleagues that can be expected when old patterns of care are changed to new. However, there are also many potential rewards as well. The same team that cares for the patient at the hospital will be in charge of the psychosocial rehabilitation needed by that same patient. An added advantage will therefore be that at least some faces will be familiar to the patient, whether from the primary care setting or from the tertiary institution. For mental health workers, the work satisfaction generated by this type of approach will serve as an incentive for South African specialists to stay in their posts, and in the country.

Orlando Alonso Betancourt

Head, *Department of Psychiatry*
Walter Sisulu University
Mthatha, E Cape

Maricela Morales Herrera

Senior Lecturer, *Department of Psychiatry*
Walter Sisulu University

1. Psychosocial rehabilitation – assertive community treatment. *International Journal of Psychosocial Rehabilitation*, Vol. 15, July 2010 - June 2011. <http://www.psychosocial.com/index.htm> (accessed 21 July 2010).
2. Assertive Community Treatment Association (ACTA). ACT history and origins. <http://www.actassociation.org> (accessed 15 July 2010).
3. Brekke J, Long DJ. Community-based psychosocial rehabilitation and perspective changes in functional, clinical and subjective experienced variables in schizophrenia. <http://schizophreniabulletin.oxfordjournals.org> (accessed 20 July 2010).
4. Van Deventer C, Couper I, Wright A, Tumbo J, Kyeyune C. Evaluation of primary mental health care in North West province – a qualitative view. *South African Journal of Psychiatry* 2008;14(4):136-140.
5. Anthony W A, Cohen M, Farkas M. A psychiatric rehabilitation treatment program: Can I recognize one if I see one? *Community Ment Health J* 1982;18(2):83-96.
6. Marshall SL, Crowe TP, Oades LG, Deane FF, Kavanagh DJ. A review of consumer involvement in evaluations of case management: Consistency with a recovery paradigm. *Psychiatr Serv* 2007; 58(3). <http://www.psychiatryonline.org> (accessed 21 July 2010).
7. Hering I, Dean C, Stein D. Providing psychiatric services in general medical settings in South Africa: Mental health-friendly services in mental health-friendly hospitals. *South African Journal of Psychiatry* 2008;14(1):4-6.
8. Moosa MYH, Jeenah FY. Community psychiatry: an audit of services in southern Gauteng. *South African Journal of Psychiatry* 2008;14(2):36-43.
9. Szabo CP. Should state sector community psychiatry be hospital based? A local, and personal, perspective. *African Journal of Psychiatry* 2010;13(1):1-2.