

Patient and social work factors related to successful placement of long-term psychiatric in-patients from a specialist psychiatric hospital in South Africa

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Abstract

Objective: The slow discharge of long-term psychiatry patients from Weskoppies Hospital into the community has not matched the national and international drive towards deinstitutionalisation. This article investigates patient and social work factors related to successful community placement, in the context of limited community care facilities. **Method:** Thirty-six long-term patients who were successfully placed outside of the hospital during a seven month period were compared to 235 unplaced long-term patients in terms of demographic and clinical variables. Social work services were analysed in terms of which patients received the most interventions, and the most common type of interventions. **Results:** The most significant patient factors associated with successful placement were: female patients; medium-to-high level of functioning; having involved relatives living far away; a low frequency of behavioural problems (especially of cannabis abuse, verbal or physical aggression, uncontrolled sexual activity), and agitation or restlessness. These patient factors were mirrored in the social work services rendered to the long-term patients during the study period: The recipients were mostly female, in open wards (higher-functioning); and the social services utilised were mostly related to planning for placement and patient support. **Conclusion:** The lack of community care facilities in the Pretoria area that are able to care for the more difficult long-term psychiatry patients, limits successful placement and increases the burden of hospital based social workers. The problem cannot be resolved at a hospital level and needs to be addressed in the context of provincial and national health departments.

Key words: Deinstitutionalisation; Social work; Mental health services; Hospitals, psychiatric; Long-term care; In-patients; Patient discharge; South Africa.

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Introduction

Until the middle of the 20th century the usual mode of treatment for severely mentally ill patients was to confine them to psychiatric hospitals for life. Thereafter, improved medications that enable patients to gain control over their symptoms, a new awareness of the devastating effects of lifelong isolation from society, as well as concerns about the costs associated with hospital-based care have led to changes in attitudes towards the management of psychiatric patients.¹ As a result, increasing numbers of patients

are now being discharged back into the general community.

This migration of psychiatric patients back to the community has been called by various names, depending on the country, for example: community placement and community care (United Kingdom)²⁻⁴, discharge into the community (Germany)⁵, community reintegration or decentralisation (Denmark)⁶, social reinsertion (Brazil)⁷, downsizing of psychiatric hospitals (Switzerland)⁸, and deinstitutionalisation (Canada, Australia, Japan, Netherlands, United States of America).⁹⁻¹⁸ Deinstitutionalisation as it will be called in this article has been a global phenomenon, serving as the topic of research studies in many countries over the last 10 years, including Australia¹¹⁻¹³, Canada^{9,10}, Denmark⁶, Germany⁵, Japan^{14,15}, Netherlands^{16,17}, Switzerland⁸, the United Kingdom²⁻⁴, the United States of America¹⁸, Israel¹⁹ and Italy.²⁰

Numerous studies have demonstrated the benefits and

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positive outcomes of deinstitutionalisation: Clinically, community living has been associated with a reduction in psychiatric symptoms, especially psychotic symptoms^{8,9,11,15,17}, increased clinical effectiveness¹¹, clinical stability^{12,21}, and a reduced need for medication.¹² On the social side, community living has been reported to lead to a higher level of social functioning, greater independence, better living skills, and increased employment.^{15,17} On the humanistic side, community living fosters patients' human rights¹⁸ and quality of life^{2,5,11-13,22}, fulfils more of their needs⁵, and patients prefer it.^{2,5,12-13,23} Although some studies have found that community living supported by out-patient psychiatric treatment is cheaper than hospital care^{1,9,24}, the opposite has been demonstrated more frequently by others.² Similarly, there have been conflicting findings on whether or not deinstitutionalisation is associated with an improvement in or worsening of maladaptive behaviour.²²

Following in the wake of international trends, there has been a national drive in South Africa for the deinstitutionalization of long-term psychiatric patients.²⁵ This drive is aligned with the new South African Mental Health Care Act (Act 17 of 2002) according to which psychiatric care should be given in the least restrictive environment possible.²⁶ This drive has been intensifying during the last few years, and has resulted in progressively more discharges or placements of long-term patients into community care that includes care by patients' relatives, non-government organisations (NGO's) and other community care facilities. For example, much progress has been made in the Eastern Cape, Western Cape and KwaZulu-Natal.²⁷⁻³²

The placement destination of choice is usually the patient's family. However, caring for a mentally ill family member, especially if it is someone who has spent years in hospital away from the family, brings additional financial, emotional and social burdens to a family.²⁷ Families have to cope with the extra responsibilities of ensuring the patient's medication compliance, keeping clinic appointments and supporting the patient financially (even when the patient receives a disability grant). Families also have to deal with the stigma associated with mental illness as well as new restrictions in their social lives, where for example, the patient's behaviour is too disruptive for them to accompany the rest of the family or to be left alone at home.^{27,33} Moreover, many long-term patients either have no relatives or the relatives are uninvolved in the lives of the patients, making it difficult to discharge these patients into the care of relatives. Such lack of involvement by relatives has been blamed on the prevalent medical model that excludes the family from the treatment process.³³

Alternatively, the placement destination in the developed world is usually a group home, community home, or community residence that accommodates between 2 and 28 patients.^{4,10,11} Supervised hostels and foster families are additional options.¹⁰

However, in the Northern Gauteng / Pretoria region, the luxury of small group homes for psychiatry patients is a scarce resource. The options are limited to a number of community care facilities or NGOs that are mostly intended for the non-psychiatrically ill homeless. Although these community care facilities are not specifically licensed to care for the mentally ill, the fact that the homeless population always contains a certain proportion of psychiatric patients has led to some facilities possibly unknowingly accommodating psychiatric patients.³⁴ This lack of integration between social services and mental health care is not unique to South Africa, and has been described in the Swedish context.^{25,35}

Among the Gauteng region's NGOs that accept psychiatric patients, the available number of beds in Pretoria is far less than the number in the neighbouring Southern Gauteng /Johannesburg region, as can be seen from the Gauteng Health Department address list of NGOs (available from the Mental Health Directorate, Gauteng Department of Health). This makes placement even more difficult, since relatives in Pretoria who maintain contact with long-term patients in Weskoppies Hospital often find the idea of the patient's placement outside of the Pretoria region unacceptable as it is less accessible. Moreover, the registered NGO's in the Pretoria region usually charge a monthly rate that is at least three times higher than the state disability grant. Even when subsidised, the rate is still two-and-a-half times higher than the state disability grant. These high fees effectively put these facilities out of reach of the majority of long-term psychiatric patients.

The local placement options are extended by a number of additional community care facilities that are not registered with the Health Department, some of which accept psychiatric patients. Whereas some of these facilities are ordinary old age homes that also accept psychiatric patients over the age of 55 years, others are intended primarily for patients with physical disability, epilepsy and mental retardation but also accept patients with psychiatric disorders.

A small minority of these facilities are subsidised by the National Department of Health and Social Development, which makes them more affordable to patients. In such cases, the monthly fees are only slightly higher than the state disability grant. Some facilities charge a certain percentage, for example, two-thirds of a patient's income, whereas others charge lower fees. Unfortunately the facilities that charge lower fees often cannot provide the level of expertise and services needed by psychiatric patients.

The number of community care facilities in the Pretoria region that are willing to accept psychiatric patients has been increasing, thanks to a community outreach project conducted by the Social Work Department at Weskoppies Hospital since 2005.³⁶ In that project the hospital-based social workers liaised with and paid visits to community care facilities, and held open days for the staff of the community care facilities to visit Weskoppies Hospital. Through these efforts the number of facilities that are willing to accept psychiatric patients has more than doubled between 2006 and 2008, from 17 to 47.³⁶ However in 2007 when this study was conducted there were only around 23 community care facilities available to psychiatric patients in the Pretoria region.

Apart from the availability of beds in community care facilities, another problem is that several of the facilities are owned and run by lay people who are not equipped to manage the kinds of problems that come with severe long-term mental illness. So a mismatch may occur between a particular psychiatric patient's needs and the expertise that is offered by the community care facility where the patient is placed. Such a mismatch may lead to a failure of the placement and a readmission to hospital.

Placement may also fail when a patient does not manage to readapt to the community. Some patients' behaviour may result in rejection by their peers and a drifting towards the subculture of the homeless or street-dwellers. In others the stresses associated with re-adapting to society or the rejection by peers may lead to relapses and readmissions to hospital.³⁷ Such relapses and readmissions not only have detrimental effects directly for the patient, but also result in a reputation of the patient as a "difficult to place individual". This in turn makes it more difficult subsequently

to find a suitable and willing placement facility.

The problems relating to the burden experienced by families, the limited number of community care facilities, their tariffs, a lack of community expertise in the management of psychiatric patients, and difficulties around placed long-term patients' readaptation in the community present special challenges to hospital-based social workers. Each individual patient needs to be assessed comprehensively, taking into account his/her age, social background, psychiatric diagnosis and current mental condition, insight, medication compliance, general medical conditions, care needs, level of functioning in all spheres, abilities (including ability to work and occupy oneself, as well as financial ability), behavioural problems, substance abuse, contact with family, and the geographical area where the family or visitors live, as well as his/her mobility and mode of transport.

These patient factors are then matched to every available community care facility, taking into account the services offered by the facility, its license, level of insight into mental illness and its associated problems among staff, preference for specific diagnostic conditions, age- and gender-related criteria for admission, tolerance of substance use or a history of previous substance abuse, degree of supervision, care and structure, access to employment and day programmes, management of patient behavioural problems, fees, physical environment, visiting conditions, and accessibility to various modes of transport.

The best match is the one where the community care facility fulfils the greatest number of patient needs, or the needs of the highest priority, depending on the case. However, despite such thorough and careful searching for an optimal fit between the patient and the facility, placement often still fails.

The aim of this article is to identify patient factors and social work service factors that might contribute to successful community placement of long-term psychiatric patients. The focus is on long-term psychiatric in-patients and on specialist psychiatric hospital based social work services. If a profile could be identified of patient factors that are associated with successful community placement, it might help to direct the efforts of hospital based social workers in pursuing community placement. Further, such a profile might influence decisions at an institutional level about the social work services offered to the long-term patients in Weskoppies Hospital specifically, and perhaps more generally at other psychiatric hospitals.

Although in the South African Mental Health Care Act psychiatry patients are referred to as 'mental health care users', the term 'patient' is used here in the interests of clarity when communicating effectively in an international forum.²⁶

Methods

Setting

Weskoppies Hospital in Pretoria in Northern Gauteng is a 1067-bed specialist psychiatric hospital that renders psychiatric services to a large geographical catchment area, and also offers child psychiatric services and forensic psychiatric services. Both in-patient and out-patient services are offered. In addition to the acute in-patient services, there are long-term in-patients who are either undergoing extended psychiatric rehabilitation or their problems are of such a nature that previous attempts at community placement have failed. Nevertheless, in accordance with the national drive towards deinstitutionalisation the number of long-term patients in Weskoppies Hospital has also been decreasing progressively.

Design

This was a quantitative, cross-sectional descriptive study combining placement statistics, clinical file data and social work service statistics relating to long-term in-patients in Weskoppies Hospital. This study formed a part of a larger multi-phased programme evaluation project aimed at improving clinical service delivery and quality of care to the long-term psychiatric patients in Weskoppies Hospital, developing multi-disciplinary expertise in long-term hospital-based psychiatric care, and pursuing appropriate placement of patients outside of the hospital where possible.

This particular cycle of the programme evaluation project was concerned with the monitoring of services after the creation and implementation of a multi-disciplinary team of 14 health care professionals dedicated to the care and treatment of the long-term patients in Weskoppies Hospital. The monitoring was done using quantitative data from existing records, patient clinical files and routine hospital statistics.

The primary research question in this study was to identify those factors that contribute towards the successful community placement of long-term psychiatric patients. More specifically, the sub-objectives were:

- To compile a profile of patient factors that are associated with successful community placement;
- To analyze whether successfully placed long-term psychiatry patients differ from their non-discharged counterparts with respect to:
 - Demographic variables;
 - Clinical characteristics; or
 - Habitual behavioural problems;
- To evaluate the patient characteristics in the context of utilised social work services to the long-term patients in Weskoppies Hospital and specifically to describe:
 - The long-term in-patients accounting for the most social work interventions; and
 - The type of social work interventions required;
 - The subjects were 271 long-term psychiatric in-patients at Weskoppies Hospital and the study occurred between 1 March and 30 September 2007. Data was collected from the 10 wards in which the long-term patients were accommodated: four open male wards, one semi-closed male ward, one closed male ward, three open female wards and one closed female ward.

Outcome measures

Discharge or placement statistics were collected for all long-term patients who were successfully placed outside the hospital during the seven-month study period. The variables included: the nature of the administrative procedure (for example, whether the procedure was a transfer to another institution, leave of absence, or formal discharge); the categorisation of the patient immediately following placement (for example, voluntary or involuntary out-patient or in-patient); the nature of the new accommodation (for example, relatives, friends, or a community care facility) and its geographical destination.

Demographic information and clinical data were recorded from the placed as well as the non placed patient clinical files. The demographic variables of interest included: age, gender, level of education, municipal area from which the patient was originally referred, number of admissions to Weskoppies Hospital, age at first hospital admission, total duration of hospital stay, current ward,

involvement by relatives or friends, where these relatives or friends live, and the frequency of their visits.

The clinical variables included: the current primary and comorbid DSM-IV psychiatric diagnoses; level of functioning and insight; severity of psychopathology; symptom stability; treatment resistance; comorbid general medical conditions; reasons for previous readmissions to the hospital; clinical evaluation of suitability for placement outside of the hospital; and the presence or absence of a series of habitual behavioural problems. Amongst the possible reasons for previous readmissions, the following were included: unsuitable accommodation, poor social support, aggression, other behavioural problems, acute psychosis, treatment resistant psychosis, poor compliance, psychiatric comorbidity, substance abuse or dependence, and a low general level of functioning.

Social work services rendered to the long-term patients in the hospital were monitored during the seven-month study period. Statistics were recorded of which types of social work interventions were performed, as well as the wards in which the recipients of these interventions were accommodated. The various types of interventions included, for example, placement enquiries and arrangements, patient support, psycho-education, liaison with the multi-disciplinary team and patients' relatives, preparation for team conferences, psychosocial reports, and assistance with patients' finances or jobs.

Data management and statistical analysis

The demographic and clinical data were integrated with the placement data for each patient. The relationship between placement on the one hand, and demographic and clinical characteristics on the other, was analysed statistically by comparing the patients who were successfully placed outside of the hospital with the patients who were not placed during the study period, in terms of the demographic and clinical variables. For these comparisons, two-way tables and Chi-Square or Fisher's Exact Tests were used. Cases with missing data were excluded from analyses.

The placed and non-placed patients were also compared with

respect to the reasons for their previous readmissions. Furthermore, the placed and non-placed patients were compared with respect to how many different types of behavioural problems they exhibited during the seven months study period, using t-tests.

Social work service statistics were analysed in two ways: First, social work service statistics were analysed by comparing different subgroups of long-term patients with respect to who received the most social work interventions. This was done by comparing the different long-term wards where social work services were rendered in terms of the mean monthly number of social work interventions per patient per ward, calculated over seven months. In particular, open wards were compared to closed wards, and male wards were compared to female wards. For the gender comparison, since the majority of long-term patients were accommodated in open wards and the number of patients in closed wards was small, only the data on social work interventions in open wards were used. Ninety-five percent conservative confidence intervals were calculated for the parameter of the Poisson distribution.

Second, in order to evaluate whether certain types of social work interventions occurred statistically significantly more frequently than others, the 95% confidence intervals were used to compare the means of the seven most frequent social work interventions simultaneously. Bonferroni corrections were made.

Ethical considerations

This study received ethics approval from the Research Ethics Committee of the Faculty of Health Sciences, University of Pretoria. A waiver of written informed consent was granted for this study that was exclusively records-based. Written consent was obtained from the Chief Executive Officer of Weskoppies Hospital to access clinical and hospital records for the purpose of this research.

Results

Table I describes the demographic characteristics of the study population. Thirty-six of a total of 271 long-term

Table I: Demographic characteristics of study population

<i>Present age, age at first hospital admission, and total duration of hospital stay:</i>				
	<i>N (%)</i>	<i>Variable</i>	<i>Mean (years)</i>	<i>Std Dev</i>
All long-term in-patients	271 (100%)	Present age Age at first hospital admission Duration of hospital stay	49.97 36.88 12.78	13.50 13.14 9.43
Patients successfully placed outside the hospital during the 7 months study period	36 (13%)	Present age Age at first hospital admission Duration of hospital stay	50.15 37.33 10.93	11.88 11.96 5.72
Patients who were not placed during the 7 months study period	235 (87%)	Present age Age at first hospital admission Duration of hospital stay	49.95 36.82 13.01	13.74 13.30 9.78
<i>Gender distribution:</i>				
	<i>N</i>	<i>Male:female ratio (%)</i>		
All long-term in-patients	271	65 : 35		
Successfully placed patients	36	42 : 58		
Patients who were not placed during the study period	235	69 : 31		

Table II: Details of the 36 placements

	No of patients	% of 36 placements (rounded) *
Nature of administrative procedure:		
Transfer to another institution	33	92%
Discharge	1	3%
Leave of absence	1	3%
Other	1	3%
Categorisation immediately following placement:		
Involuntary in-patient	33	92%
Involuntary out-patient	2	6%
Nature of new accommodation:		
Community care facility	34	94%
Relatives	2	6%
Geographical destination:		
Pretoria	1	3%
Town surrounding greater Pretoria	1	3%
Rest of Gauteng province	34	94%

* The percentages do not add up to 100% due to missing data.

psychiatric in-patients (13%) were placed from the hospital during the seven-month study period. These 36 patients were all in open wards at the time of their placement. Table II summarises the administrative details of these 36 patients' placements.

When the 36 successfully placed patients were compared to the remaining 235 patients in terms of demographic and clinical variables, a profile of statistically significant differences emerged (summarised in Table III): In terms of demographic characteristics, the successfully placed patients were, significantly more often female (Figure 1), and their relatives lived, significantly, more often farther away than those of the non-placed patients. In terms of clinical picture, the successfully placed patients, significantly more often demonstrated a higher level of functioning than the non-placed patients (Figure 2).

Figure 1: Differences in gender distribution between patients who were successfully placed outside the hospital and those who were not placed

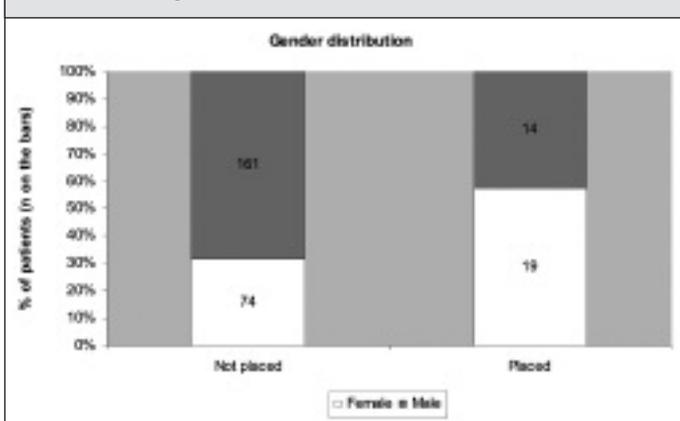


Table III: Profile of successfully placed patients

Patients who were successfully placed outside the hospital (n=36) were compared to the non-placed patients (n=235) in terms of demographic and clinical variables, using Chi-Square and Fisher's Exact Tests. (Variables are arranged according to p-values.)

In terms of demographics and hospital stay, placed patients demonstrated the following more often than non-placed patients:

1. Female gender p 0.0032 **
2. Involved relatives living farther away p 0.0454 *
3. Shorter total duration of hospital stay (≤ 9 years) p 0.1374
4. Less frequent contact with involved relatives p 0.1742
5. More admissions (>2) during total hospital stay p 0.1747
6. Having a greater number of involved relatives/friends p 0.2573
7. More often originally referred from outside Pretoria p 0.2608
8. First hospital admission after the age of 37 years p 0.3584
9. Older (present age >45 years) p 0.3894
10. Level of education (too many missing data)

In terms of clinical picture, placed patients demonstrated the following in comparison with non-placed patients:

1. Medium to high general level of functioning (more often) p 0.0026 **
2. Clinically evaluated as suitable for placement (more often) p 0.0167 *
3. Better insight (more often) p 0.0707
4. Comorbid personality disorder (more often) p 0.1738
5. Comorbid epilepsy (less often) p 0.2049
6. Comorbid hypertension (less often) p 0.2622
7. Lesser severity of symptoms (more often) p 0.3880
8. Comorbid substance related diagnosis (less often) p 0.3920
9. Primary psychiatric diagnosis of a psychotic disorder (more often) p 0.4583
10. Symptoms constant rather than episodic (more often) p 0.5105
11. Compliance with treatment (more often) p 0.5428
12. Comorbid mood disorder (less often) p 0.6174
13. Comorbid anxiety disorder (less often) p 0.6993
14. Treatment-resistant psychosis (more often) p 0.7077
15. Previous head injury (more often) p 0.7419
16. Comorbid diabetes mellitus (less often) p 0.9257

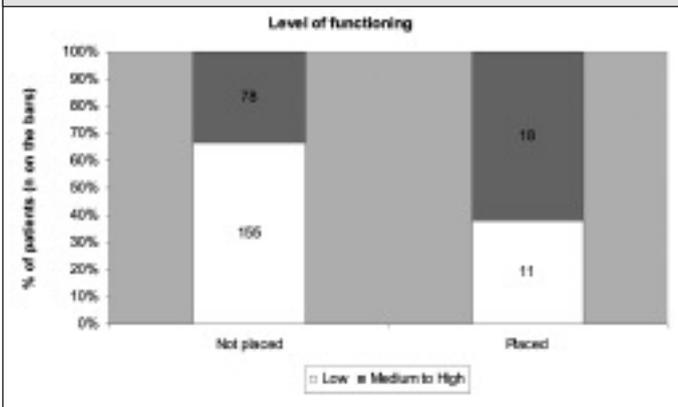
In terms of habitual behavioural problems, placed patients demonstrated the following in comparison with non-placed patients:

1. Cannabis abuse (less often) p 0.0026 **
2. Physical aggression (less often) p 0.0064 **
3. Verbal aggression (less often) p 0.0166 *
4. Uncontrolled sexual activity (less often) p 0.0193 *
5. Agitation or restlessness (less often) p 0.0477 *
6. Inappropriate behaviour (less often) p 0.0723
7. Suicide attempts (more often) p 0.2657
8. Oppositionality / non-compliance with hospital rules (less often) p 0.3736
9. Disorganised behaviour (less often) p 0.5308
10. Alcohol abuse (less often) p 0.5495
11. Harassment of fellow-patients (less often) p 0.5901
12. Theft (less often) p 0.7018
13. Self-harm (less often) p 0.7491
14. Absconding (less often) p 0.8112
15. Disinhibited behaviour (less often) p 0.8225
16. Hoarding (less often) p 1.0000
17. Trading in sex (less often) p 1.0000
18. Abuse of other substances, i.a. cigarettes and cough medicine (more often) p 1.0000

* = statistically significant at the 0.05 level

** = statistically significant at the 0.01 level

Figure 2: Comparison between successfully placed patients and non-placed patients with respect to level of functioning

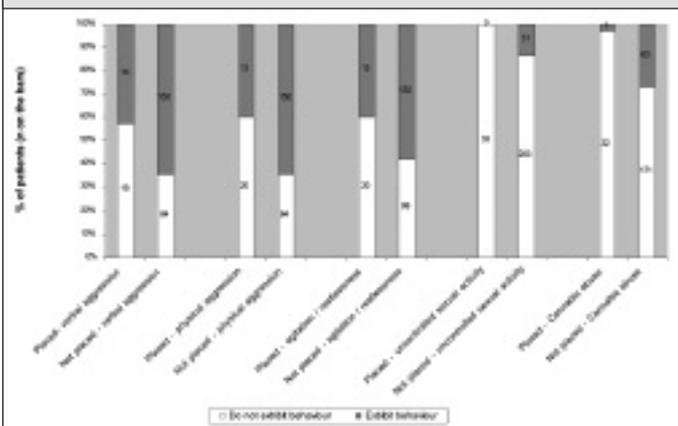


On the whole, psychiatric comorbidity and general medical comorbidity were less prevalent among the placed patients than among the non-placed patients. However, the placed patients did not differ statistically significantly from the non-placed patients in relation to psychiatric diagnosis or comorbid psychiatric or general medical conditions (Table III). In both groups, around two-thirds of the patients suffered from a psychotic disorder, including schizophrenia, schizoaffective disorder or a psychotic disorder due to a general medical condition.

With regard to possible reasons for readmissions, the placed patients exhibited fewer of nearly all the recorded reasons for readmissions, including aggression or other behavioural problems, acute or resistant psychosis, psychiatric comorbidity, substance abuse or dependence, a low level of functioning, poor compliance, and a lack of social support. Aggression was the only reason for readmission where the difference between the placed and non-placed patients tended towards significance ($p=0.1897$). Successfully placed patients had a less frequent history of previous readmissions for aggression. Unsuitable accommodation was more often a reason for previous readmissions among the placed patients than among the non-placed patients ($p=0.6446$), confirming that psychiatric morbidity and behavioural problems played a lesser role in previous readmissions of the successfully placed patients than of the non-placed patients.

When the placed and non-placed patients were compared with respect to the type of habitual behavioural problems they

Figure 3: Proportions of successfully placed and non-placed patients exhibiting habitual behavioural problems



exhibited during the seven-month study period, the placed patients exhibited significantly fewer types of behavioural problems than the non-placed patients: a count of 3.22 different kinds of behavioural problems per successfully placed patient (\pm standard deviation 3.15) versus a count of 5.01 per non-placed patient (\pm standard deviation 2.76) ($p=0.0005$).

In comparing the placed and non-placed patients with respect to their patterns of specific habitual behavioural problems, Table III confirms that on the whole the prevalence of the different types of behavioural problems was lower among the placed patients than among the non-placed patients. The placed patients, significantly less often exhibited cannabis abuse, verbal or physical aggression, uncontrolled sexual activity, and agitation or restlessness in comparison with the non-placed patients (Figure 3).

Given the total number of 910 social work interventions for the long-term patients over the seven month study period, the mean monthly number of social work interventions for all long-term patients was 130. Figure 4 compares the mean monthly number of social work interventions per patient among the different long-term wards. The open wards accounted for significantly more social work interventions (0.6 interventions per patient per month) than the closed wards (0.2 per patient per month) (Figure 5). The fact that the confidence intervals do not

Figure 4: Typical monthly number of social work interventions per long-term patient by ward

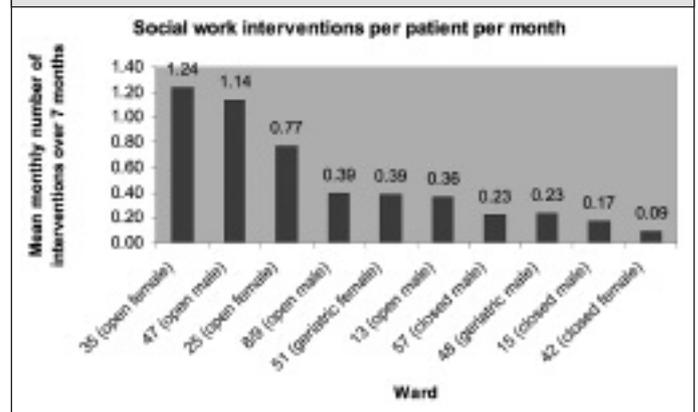


Figure 5: Comparison between open and closed long-term wards in terms of typical monthly number of social work interventions per patient

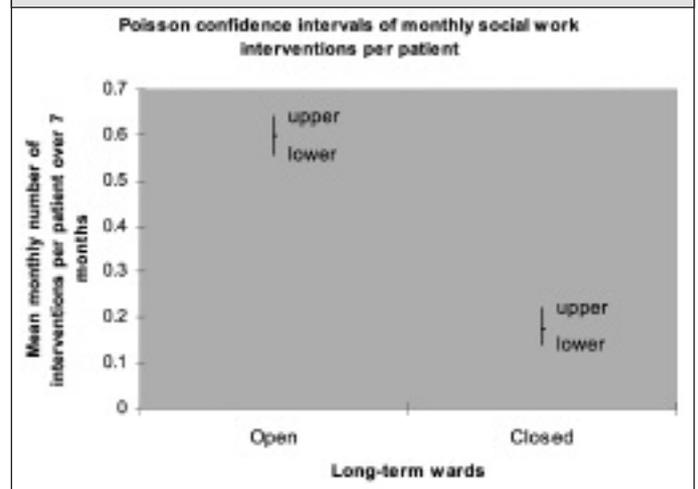


Figure 6: Comparison between male and female open long-term wards in terms of typical monthly number of social work interventions per patient

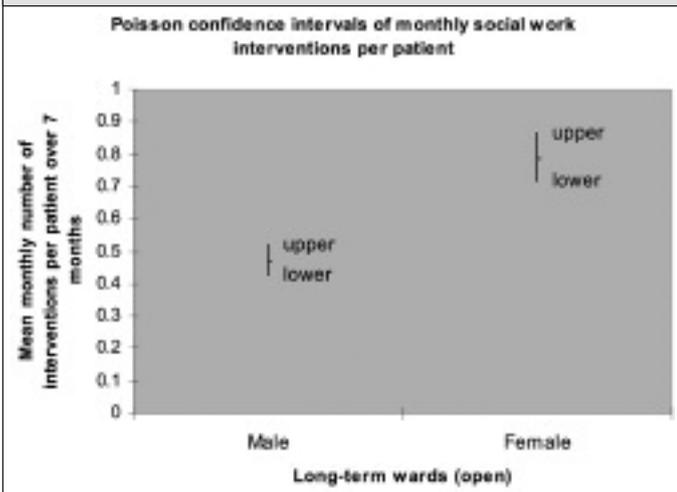
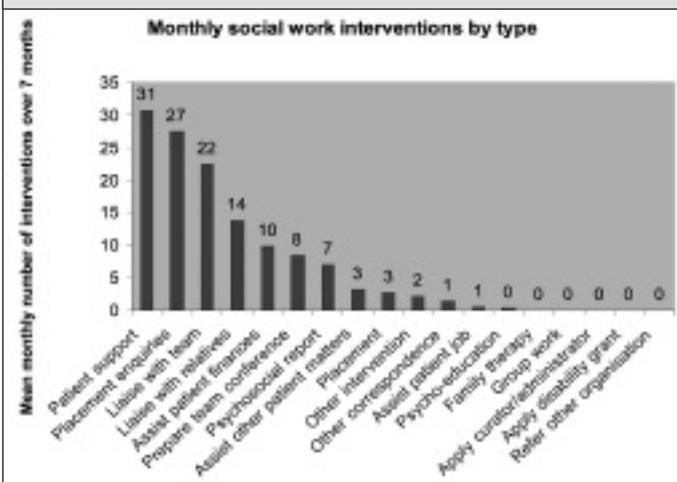


Figure 7: Typical monthly number of different types of social work interventions for long-term patients



overlap, indicates that the two subgroups' mean numbers of social work interventions are statistically significantly different at the 5% level. Similarly, female patients accounted for significantly more social work interventions (0.8 interventions per patient per month) than male patients (0.5 per patient per month) (Figure 6).

Figure 7 shows the typical monthly distribution of the different types of social work interventions. When the 95% confidence intervals were used to compare the means of the seven most frequent interventions simultaneously, the two most frequent interventions, patient support and placement enquiries, occurred significantly more frequently than the 4th to 7th interventions (Figure 7).

Discussion

The placement of the 36 long-term patients outside of Weskoppies Hospital coincided with the instruction by the Mental Health Directorate of the Gauteng Department of Health to transfer long-term patients to the Life Esidemeni facilities (that are run by a contracted private service provider) in order to reduce long-term care beds in Weskoppies Hospital. This may have biased the sample of

placed patients, due to their similar placement destination, as may the limited seven-month study period. If the study period had been longer, a greater variety of types of placements might have taken place, which might have yielded different results. Notwithstanding the similar placement destination though, this study does provide valuable insight into which long-term patients were the best candidates for placement.

The finding that the successfully placed patients' involved relatives lived farther away than those of the non-placed patients might best be explained as follows: Relatives who live near to the hospital might be the ones who would complain if the patient were placed at a far-away community care facility, since that would jeopardise their continued involvement in the patient's life. On the other hand, it might not make much of a difference to relatives who live far away, as to exactly where the patient is placed, since they have to travel anyway a long way to visit the patient.

The demographic characteristics and clinical profile of the patients in this study resembled those in other African studies, where the great majority of long-term patients were men with schizophrenia.^{28,38} In contrast, similar studies done in Brazil demonstrated a more equal distribution between men and women, as well as between schizophrenia and mental retardation.^{7,39}

What was surprising in this study was the lack of association between successful placement and the following clinical variables: psychiatric diagnosis, comorbid psychiatric or general medical conditions, and a file diagnosis of substance related disorders. However, this study population was too small to allow for the statistical analyses required to determine proper predictors of placement. Nevertheless, the lack of association between placement and psychiatric diagnosis found here has also been reported previously.⁴ Note that whereas a diagnosis of substance related disorders did not yield a statistically significant difference between placed and non-placed patients, cannabis abuse as a recorded behavioural problem (that did not make its way into the diagnosis) did yield a statistically significant difference between placed and non-placed patients.

With regard to behavioural problems, the finding that the placed patients less often exhibited certain behavioural problems than the non-placed patients is in line with earlier studies.⁴ Despite the lower prevalence of behavioural problems among the placed patients, most of the placed patients in this study could only be accommodated in another psychiatric facility, as opposed to family care or lay care. In this regard, Trieman and Leff, in a prospective cohort study with follow-ups at 1 year and 5 years concluded that there is a subgroup of psychiatric patients who are too disturbed or disturbing to be managed in standard community homes.⁴

From a clinical perspective, the analysis of the reasons for previous readmissions under "Results" above gives further support for the finding that the successfully placed patients are the ones with fewer behavioural problems and a higher level of functioning. Whereas Smith found that violence and other high risk behaviours were common reasons for readmission, in this study that was only valid for the non-placed patients.⁴² The successfully placed patients'

previous discharges were more likely to have failed because of a lack of suitable community care facilities, than because of their own clinical conditions, as has also been suggested by Breen et al.²⁷

The patient-related factors associated with successful placement in this study tell us something about where the gaps lie in the available community mental health services. The fact that mostly higher-functioning female patients were successfully placed suggests that there is a lack of suitable community care facilities that are able to manage the more difficult psychiatric patients with: more frequent behavioural problems, a lower level of functioning, poor insight into their illness and accompanying level of functioning, and possibly male patients. Indeed, many of the existing available community care facilities have an exclusion criterion that prospective clients should not have a history of aggressive behaviour. Moreover, several of the available facilities require that patients should have the level of self-care that makes independent living possible. Furthermore, a few of these facilities restrict their availability to female patients.

In pointing out the gaps in the existing community mental health services, this study supports previous studies that have expressed concerns about the poor state of community mental health services in South Africa and that emphasised the importance of first developing those services properly before hastily discharging long-term patients into the community.^{23,28,40-43} In this regard, see also Uys who demonstrated that all three of the South African provinces studied (Gauteng, the Eastern Cape and KwaZulu-Natal) fared poorly with respect to psychosocial rehabilitation at the clinic level.⁴⁴

From a social work perspective these findings confirm how labour-intensive the process of community placement is.⁴⁰ Figure 7 illustrates that 27 out of a mean monthly number of 130 social work interventions (that is, a number of 192 out of a total of 910 interventions during the seven-month study period) were needed to secure community placement for the 36 patients. These included only the realistic placement enquiries and discussions, and did not account for any of the unrealistic expectations by patients for whom the social workers also had to provide support.

Institutional constraints in the deinstitutionalisation of low-functioning psychiatry patients with behavioural problems are having a ripple effect on the social work services rendered to the long-term patients in Weskoppies Hospital. An already overburdened hospital based social worker corps has to work even harder to try and place out the long-term patients at the limited number of available community care facilities. And no matter how much effort is put in by the social workers, it remains impossible to place out a sizeable proportion of long-term patients because of the admission criteria of the facilities and the lack of expertise at many of the facilities to care for the more difficult long-term psychiatry patients. Furthermore, the lack of community expertise in the management of the more difficult psychiatry patients eventually contributes to a skewed service focus within the hospital on the higher-functioning female patients with fewer behavioural problems who are potential candidates for placement at the existing community care facilities.

The main contribution of this study lies in its relevance

for evaluating the role of hospital based social work services in facilitating deinstitutionalisation of long-term psychiatry patients in our context. Whether or not the national drive towards deinstitutionalisation might be implemented successfully, does not depend on the effort put in by hospital based social workers. Rather, both the problem and the solution lie mostly outside of the psychiatric hospitals.^{45,46}

Since the future development of community mental health services in South Africa falls outside of the scope of this article, suffice it to mention that it might occur by channeling new funds into community care (in addition to hospital care)²³, moving funds from hospital care and reallocating it to community care^{1,41}, or improving the quality of accommodation for long-term patients in the hospital context, such as has been done in the Netherlands where most long-term psychiatry patients are accommodated in ordinary housing on or around the premises of psychiatric hospitals.¹⁷ An example of the latter approach has also been implemented locally at Weskoppies Hospital in the form of an independent living unit on the hospital premises, where the occupants (although classified as out-patients) use in-patient accommodation, linen and food supplies that they prepare themselves.

The limitations of this study concern mostly the small size of the study population. The small size precludes proper analyses to determine statistical predictors of placement. This limits the potential clinical implications. A further limitation is that certain clinical aspects were not measured in detail, for example, the severity of psychosis. In addition, details of placed patients' forensic history and convictions were not recorded.

Notwithstanding its limitations, this study has a number of strengths. First, comparing the placed patients to a control group of non-placed patients facilitated more meaningful analyses than would have been possible without such a control group. Moreover, this study is the first scientifically sound investigation of its kind at a state psychiatric hospital in Gauteng province – a hospital that serves not only one of the most densely populated regions of South Africa but also its neighbouring provinces.

Second, the fact that the results of this study are mostly in line with previous international studies suggests that these findings are generalisable to an extent. For future research, a follow-up study of the placed patients in this study might be worthwhile, or further placement data recorded over a longer period might yield a larger variety of placement destinations that might provide new insights into the factors contributing to community placement.

Conclusions

The patient and social work service factors identified in this study tell us something about the profile of the currently available community care facilities in the Pretoria region that are willing to accept psychiatry patients. The available facilities do not have the expertise to care for the more severely disabled and disturbed psychiatry patients. So given the limited number of successful placements there appears to be a dire need for community care facilities that are able to manage the more difficult patients in the Pretoria region. Although from this study the need is clear for the Northern Gauteng / Pretoria region, it may apply if these

findings are replicated also to the rest of Gauteng province and possibly even more widely in South Africa. This problem regarding suitable accommodation for low-functioning psychiatry patients with behavioural problems indicates one area in which the mental health services offered in the Pretoria region (and possibly in the rest of Gauteng) are not in line with the published standards for mental health services in South Africa, in particular standards 2.9.7 and 2.25.⁴⁷

Although the local lack of community expertise in the management of the more difficult psychiatry patients impacts on and increases the burden of Weskoppies Hospital, it is not something that can be solved at the hospital level. The problem needs to be addressed in the context of the provincial and national health departments.

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References

1. Shera W, Aviram U, Healy B, Ramon S. Mental health system reform: a multi country comparison. *Social Work in Health Care* 2002; 35(1-2):547-75.
2. Killaspy H. From the asylum to community care: learning from experience. *British Medical Bulletin* 2006; 79-80:245-58.
3. Mansell J. Deinstitutionalisation and community living: progress, problems and priorities. *Journal of Intellectual & Developmental Disability* 2006; 31(2):65-76.
4. Trieman N, Leff J. Long-term outcome of long-stay psychiatric in-patients considered unsuitable to live in the community: TAPS Project 44. [Erratum in *Br J Psychiatry* 2003; 183:80-1]. *British Journal of Psychiatry* 2002; 181:428-32.
5. Priebe S, Hoffmann K, Isermann M, Kaiser W. Do long-term hospitalised patients benefit from discharge into the community? *Social Psychiatry & Psychiatric Epidemiology* 2002; 37(8):387-92.
6. Munk-Jorgensen P. From psychiatric hospital to rehabilitation: the Nordic experience. *Encephale* 2000; 26 Spec No 1:3-6.
7. Wagner LC, Fleck MP, Wagner M, Dias MT. Autonomy of long-stay psychiatric in-patients. *Revista de Saude Publica* 2006; 40(4):699-705.
8. Lay B, Nordt C, Rossler W. Trends in psychiatric hospitalisation of people with schizophrenia: a register-based investigation over the last three decades. *Schizophrenia Research* 2007; 97(1-3):68-78.
9. Reinharz D, Lesage AD, Contandriopoulos AP. Cost-effectiveness analysis of psychiatric deinstitutionalization. *Canadian Journal of Psychiatry* 2000; 45(6):533-8.
10. Lesage AD, Morissette R, Fortier L, Reinharz D, Contandriopoulos AP. Downsizing psychiatric hospitals: needs for care and services of current and discharged long-stay in-patients. *Canadian Journal of Psychiatry* 2000; 45(6):526-32.
11. Hobbs C, Tennant C, Rosen A et al. Deinstitutionalisation for long-term mental illness: a 2-year clinical evaluation. *Australian & New Zealand Journal of Psychiatry* 2000; 34(3):476-83.
12. Hobbs C, Newton L, Tennant C, Rosen A, Tribe K. Deinstitutionalization for long-term mental illness: a 6-year evaluation. *Australian & New Zealand Journal of Psychiatry* 2002; 36(1):60-6.
13. Newton L, Rosen A, Tennant C, Hobbs C, Lapsley HM, Tribe K. Deinstitutionalisation for long-term mental illness: an ethnographic study. *Australian & New Zealand Journal of Psychiatry* 2000; 34(3):484-90.
14. Mizuno M, Sakuma K, Ryu Y et al. The Sasagawa project: a model for deinstitutionalisation in Japan. *Keio Journal of Medicine* 2005; 54(2):95-101.
15. Ryu Y, Mizuno M, Sakuma K, Munakata S, Takebayashi T, Murakami M. Deinstitutionalization of long-stay patients with schizophrenia: the 2-year social and clinical outcome of a comprehensive intervention program in Japan. *Australian & New Zealand Journal of Psychiatry* 2006; 40(5):462-70.
16. Pijl YJ, Sytma S. The effect of deinstitutionalization on the longitudinal continuity of mental health care in the Netherlands. *Social Psychiatry & Psychiatric Epidemiology* 2004; 39(3):244-8.
17. Duurkoop P, Van Dyck R. From a 'state mental hospital' to new homes in the city: longitudinal research into the use of intramural facilities by long-stay care-dependent psychiatric clients in Amsterdam. *Community Mental Health Journal* 2003; 39(1):77-92.
18. Hillman AA. Human rights and deinstitutionalization: a success story in the Americas. *Pan American Journal of Public Health* 2005; 18(4-5):374-9.
19. Grinshpoon A, Zilber N, Lerner Y, Ponizovsky AM. Impact of a rehabilitation legislation on the survival in the community of long-term patients discharged from psychiatric hospitals in Israel. *Social Psychiatry & Psychiatric Epidemiology*, 2006; 41(2):87-94.
20. Tansella M, Amaddeo F, Burti L, Lasalvia A, Ruggeri M. Evaluating a community-based mental health service focusing on severe mental illness. The Verona experience. *Acta Psychiatrica Scandinavica* 2006; 113 (Supplement 429):90-4.
21. McGonagle IM, Allan S. A comparison of behaviour in two differing psychiatric long-stay rehabilitation environments. *Journal of Psychiatric & Mental Health Nursing* 2002; 9(4):493-9.
22. Young L, Ashman AF. Deinstitutionalization for older adults with severe mental retardation: results from Australia. *American Journal on Mental Retardation* 2004; 109(5):397-412.
23. Lucas M, Stevenson D. Violence and abuse in psychiatric in-patient institutions: a South African perspective. *International Journal of Law and Psychiatry* 2006; 29(3):195-203.
24. Lapsley HM, Tribe K, Tennant C, Rosen A, Hobbs C, Newton L. Deinstitutionalisation for long-term mental illness: cost differences in hospital and community care. *Australian & New Zealand Journal of Psychiatry* 2000; 34(3):491-5.
25. Lazarus R. Managing de-institutionalisation in a context of change: the case of Gauteng, South Africa. *South African Psychiatry Review* 2005; 8(2): 65-69.
26. South African Mental Health Care Act, No. 17 of 2002. *Government Gazette* 6 November 2002; vol. 449, no. G24024.
27. Breen A, Swartz L, Flisher AJ et al. Experience of mental disorder in the context of basic service reforms: the impact on caregiving environments in South Africa. *International Journal of Environmental Health Research* 2007; 17(5):327-34.
28. Dartnall E, Modiba P, Porteus K, Lee T. Is deinstitutionalisation appropriate? Discharge potential and service needs of psychiatric in-patients in KwaZulu-Natal and the Eastern Cape, South Africa. Durban, South Africa: Health Systems Trust, 1999.
29. Dartnall E, Porteus K, Modiba P, Schneider H. Deinstitutionalisation in

- South Africa: discharge potential and service needs of psychiatric in-patients in KwaZulu-Natal and the Eastern Cape. *Health Systems Trust Update* 2000; 50:16-7.
30. Pillay AL, Lockhat MR. Developing community mental health services for children in South Africa. *Soc. Sci. Med.* 1997; 45(10):1493-1501.
31. Simon-Meyer J. SA feeling its way to community care. *Health Systems Trust Update* 1999; 41:15.
32. Strachan K. Deinstitutionalisation – a Cape Town case study. *Health Systems Trust Update* 2000; 50:9-11.
33. Mphelane ML. The role played by families in support of their mentally ill relatives in a rural community in Limpopo province. MA Dissertation. Pretoria: Unisa, 2006.
34. Nichols M. A national shame: the mentally ill homeless. *Anxiety, Panic & Health: Living with Health, Wellness and Wholeness* 2008; <http://anxietypanichealth.com/2008/10/15/a-national-shame-the-mentally-ill-homeless/>. (Accessed on 26 August 2009.)
35. Piippo J, Aaltonen J. Mental health: integrated network and family-oriented model for co-operation between mental health patients, adult mental health services and social services. *Journal of Clinical Nursing* 2004; 13(7):876-85.
36. Social Work Department, Weskoppies Hospital (Community Outreach Committee). Empowering community care facilities to provide appropriate care to mental health care users. Report for entry to Khanyisa Awards for Service Excellence. 2008. Pretoria: Gauteng Department of Health.
37. Partridge N. Factors behind 'revolving-door' behaviour in a psychiatric institution: a qualitative study. Psychology Honours Dissertation. Cape Town: University of Cape Town, 2000.
38. Taiwo H, Ladapo O, Aina OF et al. Long stay patients in a psychiatric hospital in Lagos, Nigeria. *African Journal of Psychiatry* 2008; 11(2):128-32.
39. Fleck MP, Wagner L, Wagner M, Dias M. Long-stay patients in a psychiatric hospital in Southern Brazil. *Revista de Saude Publica* 2007; 41(1):124-30.
40. Janse van Rensburg B. Community placement and reintegration of service users from long-term mental health care facilities. *South African Psychiatry Review* 2005; 8:100-3.
41. Lund C, Flisher AJ, Porteus K, Lee T. Bed/population ratios in South African public sector mental health services. *Social Psychiatry & Psychiatric Epidemiology* 2002; 37(7):346-9.
42. Smith HM. Factors leading to frequent readmission to Valkenberg Hospital for patients suffering from severe mental illness. Masters in Public Health dissertation. University of the Western Cape, 2005.
43. Stein DJ, Allwood C, Emsley RA. Community care of psychiatric disorders in South Africa - lessons from research on deinstitutionalization. *South African Medical Journal* 1999; 89(9):942-3.
44. Uys LR. The evaluation of public psychiatric services in three provinces of South Africa. *South African Medical Journal* 2000; 90(6):626-30.
45. Gantt AB, Cohen NL, Sainz A. Impediments to the discharge planning effort for psychiatric in-patients. *Social Work in Health Care* 1999; 29(1):1-14.
46. Iglesias C, Alonso Villa MJ. A system of patient classification in long-term psychiatric in-patients: Resource Utilization Groups T-18 (RUG T-18). *Journal of Psychiatric & Mental Health Nursing* 2005; 12(1):33-7.
47. Muller L, Flisher AJ. Standards for mental health services in South Africa. *South African Psychiatry Review* 2006; 9(1a):3-40.