EVALUATION OF MENTAL HEALTH SERVICES IN THE FREE STATE

PART III. SOCIAL OUTCOME AND PATIENT PERCEPTIONS

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Objective. To assess patient functioning in the community, attitudes to the service and living and care preferences.

Design, setting and subjects. Semi-structured interviews were conducted with 114 patients attending selected psychiatric outpatient clinics and with 22 'defaulting' patients traced from these clinics into the community.

Results and conclusion. Social adjustment, community behaviour and psychiatric functioning were within reasonable limits compared with those reported for discharged patients in international studies. Functioning was found to be poor in a small minority. Patients expressed their satisfaction with the mental health service, for example 96% of patients said that coming to the clinic helped them. However, they identified a number of problems, including insufficient time spent with nurses and problems in receiving and paying for medication. Racial inequities in service provision were noted, for example in rates of hospital admission, attendance at community clinics, and time spent in queues. Fifty-four black patients (63%) and 6 white patients (21%) reported a preference for long-stay hospital over community care. The expressed need for day care was high, with 61 black patients (72%) and 16 white patients (55%) requesting this facility. Almost half of the patients interviewed had consulted a traditional healer regarding their illness and 25% continued to do so. Differences between clinic attenders and 'defaulters' were not significant. Recommendations include the need for additional inpatient beds as well as more community facilities and services.

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Most outcome studies of community mental health interventions have been service-based and do not provide information regarding the experience of patients in the community.[1] According to Thornicroft and Breakey[2] service utilisation has often been wrongly identified as the main outcome variable, whereas in their view clinical, social and quality-of-life information are the main outcome variables. Furthermore, when considering outcome, the attitudes of long-term psychiatric patients are often not assessed with regard to living and care preferences.[3,4]

The aim of this study was, therefore, to determine patient functioning in the community, attitudes to the service, and living and care preferences. Patient variables that were measured include social adjustment and community behaviour,[1,5,6] views and attitudes towards the service,[1] living and care preferences[4] and control of psychiatric symptomatology.[7]

There is a distinct danger in community-orientated mental health services that patients will lose contact with the service, while remaining symptomatic or socially disabled.[8] The Free State mental health service (MHS) has fewer hospital beds (especially for chronic cases) than is recommended in most community care studies;[9] it is also an embryonic community service largely reliant on psychiatric medical care (see Part I). In the light of these factors, tracing patients who have been lost to the service was seen to be especially important. Hence, though this is not an evaluation of a 'classic' hospital discharge programme, it has followed the lead of more comprehensive evaluations[10] in assessing both those patients who have defaulted from the service and those who continue to receive ongoing care.

METHOD

Subjects

Sixteen psychiatric outpatient clinics were selected to form part of this study (see Part I). Convenience samples of patients who attended these clinics as part of their routine visits were interviewed. One hundred and fourteen patients were interviewed (85 black, 29 white).

Patients who had at some point attended the clinic but who had not done so for 4 months prior to this research were regarded as having defaulted from the service. Only those patients who had defaulted while the decentralised system had been in place for at least 6 months were included. Where possible, defaulters were contacted by telephone and appointments for interviews were set up. Those without telephones were contacted via their last available address. If a subject could not be reached or refused to be interviewed, the next subject was traced. A sample of 22 defaulting patients was interviewed (16 black, 6 white).

Research instrument

No patient-based studies of patients in a community-based psychiatric service in developing countries could be found.[11] A number of validated instruments, which have been used in

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developed countries to evaluate patients in the community, were reviewed.[12] Following a thorough examination of these instruments with regard to their cultural applicability, length and goals, it was decided to develop an interview schedule for this study. However, most of the questions incorporated were based on one or other available instrument. Additional questions relating specifically to the Free State context were included. After an initial piloting the interview schedule finally consisted of 70 questions. The interview was conducted in the patient's language of choice, i.e. English, Afrikaans or Southern Sotho.

Empirical measures of psychiatric symptomatology are highly time-consuming and usually require professional administration.[13] As this was not possible with the constraints of this study, only a proxy measure was attained. Social science students assessed gross malfunctioning, for example they ranked ability to comprehend questions and assessed space and time orientation on 5-point scales. It is accepted that this measure provides only rough indications of psychiatric functioning.

Analysis of results

Results were analysed in terms of race, grade of clinic and district. Analyses consisted of chi-square tests, or Fisher's exact tests (when any expected value in a cell was less than 5). Statistical significance was accepted at $P < 0.05$. As race and grade of clinic were highly associated (see Part I), and as analysis by district mainly reflected differences of local management interest, the following results are reported by race.

RESULTS

Community functioning

Twenty-three black (28%) and 13 white (46%) patients attending the community service had (at some point) been admitted to hospital following a relapse. The higher rate of white admissions was despite the fact that more community services were available to and utilised by white than black patients. For example, 12 white patients (43%) attended a community clinic more than once a month compared with 10 black patients (11%).

Nine black (11%) and 6 white attending patients (21%) were employed. Ratios were similar for defaulting patients, with 2 black (13%) and 1 white (17%) patients found to be employed. Eighty-three patients (80%) said that they had been employed at some point in their lives.

The vast majority of all interviewees lived with immediate family members. However, patients who attended clinics were more likely to live with their families than those who had defaulted from the service (73 black (86%) and 23 white (79%) attenders compared with 11 (69%) and 4 (66%) defaulters, respectively).

Table I. Social functioning of psychiatric patients in the community

	Black attenders (N = 85)		White attenders (N =29)		Black defaulters (N = 16)		White defaulters (N = 6)	
	N	%	N	%	N	%	N	%
Shopping alone	65	76	19	65	10	69	3	50
Visiting out of home	56	66	20	69	9	63	4	67
Being visited	48	58	16	55	5	31	1	17
Church attendance	74	87	23	82	9	63	5	83
Dresses self	82	96	27	96	14	88	5	83
Washes self	81	95	28	100	14	88	5	83
Feeds self	83	98	27	96	15	94	5	83

Social functioning in the community was also measured using the criteria indicated in Table I.

Police contact and court appearances were also assessed. Twenty-nine black (35%) and 5 white (18%) attending patients said that they had had police contact. This resulted in court appearances for 11 black (15%) and 1 white (4%) patients. Fifteen (53%) of the black patients who had had police contact said they did not know the reason for the contact. Only 1 patient said that vagrancy was the cause. Among defaulting patients, 4 (25%) black and no white patients said that they had had police contact.

Patient reports of and attitudes towards the service

One hundred and six attending patients (96%) expressed satisfaction with the service they received at the clinic. However, further questioning revealed that notable problems were in fact experienced with the service provided. For example, 15 patients (13%) said that at times they had difficulty obtaining medication or care when needed. Payment for services and time spent in queues were further difficulties encountered. Thirteen patients (11%) said they only attended the service because they were forced to do so by a family member. Moreover, defaulting patients often reported having left the service as a result of experiencing difficulties with the care provided (see Fig. 1).

After leaving the service 6 defaulting patients (all races) (25%) experienced a recurrence of symptoms. Significantly, however, a similar number (5 black patients (31%) and 3 white patients (50%)) said that they felt better after stopping psychiatric treatment.

Ten white patients (35%), compared with only 1 (1%) black patients, stated that part of the service they received at the clinic was 'to talk about problems' ($P < 0.05$). However, a high proportion of both white and black patients felt that they needed more time with the sister than they received (12 white (41%) and 46 black (54%) attending patients). Of the defaulting patients, 4 white (no black) patients reported that they had received counselling. A significant racial difference was found

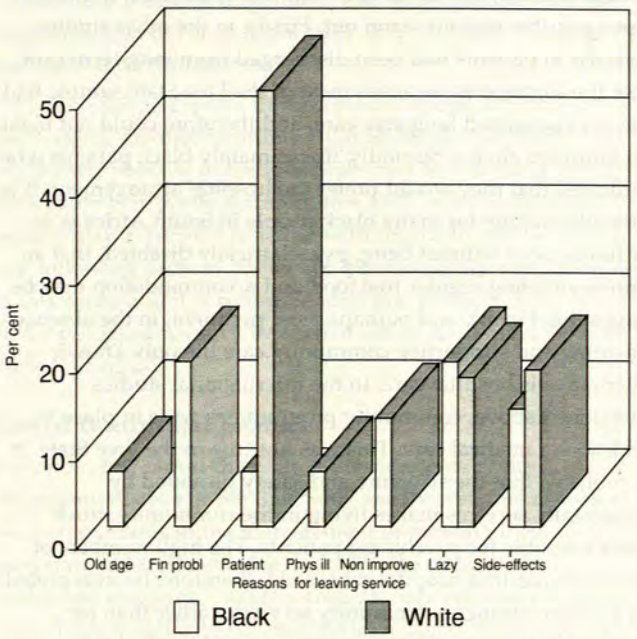

Fig. 1. Reasons why defaulting patients left the service (N = 22) *(Old age = old age; Fin probl = financial problems; Patient well = patient well; Phys ill = physically ill; No improve = no improvement; Lazy = lazy to go; Side-effects = side-effects of medication).*

with regard to time spent in queues before consultation ($P = 0.011$). This was due to the fact that while most white patients were given appointments, black patients were merely given a day to attend the clinic. One-third of black patients waited longer than 30 minutes to be seen. Also, more white attending patients received home visits than black patients (16 (52%) compared with 17 (37%)). Of the defaulting patients, 6 black (38%) and 2 white (33%) patients had received home visits after it was found that they had defaulted from the service.

More black patients than white patients paid for the services received (44 (54%) and 11 (41%)). Where payment was made, the range for black patients was lower than for white patients (R6 - R13 for blacks and R8 - R26 for whites). More than double the proportion of blacks received disability grants than was the case with white patients (57 (67%) compared with 9 (31%)).

The vast majority of patients saw the clinic sister/psychiatric nurse on their routine visits. However, in the central Bloemfontein region one-fifth of patients (almost all of whom were white) routinely saw a doctor. Forty-six patients (all races) (40%) reported that they had never been attended to by a doctor at the clinic.

Living and care preferences

Forty-five black (53%) and 3 white (11%) attenders said that they would rather be in hospital in (central) Bloemfontein where people with psychiatric problems were treated and where they could live, than in their current community arrangement. If long-stay hospital care was available in the district, 54 black (63%) and 6 white (21%) patients reported a preference for hospital care.

Patients expressed a need for daily support and structure. Sixty-one black (72%) and 16 white (55%) patients said that they would want to attend day care in their town/township if given the opportunity to do so.

Twenty-two black patients (26%) were consulting a traditional healer while simultaneously receiving treatment at the clinic, and 32 black patients (45%) had consulted with a traditional healer at some point for their mental health problem.

Psychiatric symptomatology

Table II indicates the psychiatric symptomatology of attenders and defaulters. The proxy nature of measures (see 'Research instrument' section) should be taken into account here.

Discussion

Given the well-accepted principle (in the developed world at least) that community care is likely to fail as an alternative to hospital care unless the service provided is full and

Table II. Psychiatric symptomatology of attending and defaulting patients

	Attenders (N = 114)						Defaulters (N = 22)					
	Poor		Fair		Good		Poor		Fair		Good	
	N	%	N	%	N	%	N	%	N	%	N	%
Ability to comprehend questions	14	12	30	26	62	54	2	9	2	9	18	82
Communication ability	8	7	30	26	68	60	1	5	2	9	18	82
Ability to answer questions	11	10	26	23	69	61	3	14	4	18	11	50
Orientation for space and time	3	3	8	7	95	83	3	14	1	5	18	82

Per cents in each row do not add up to 100% as symptomatology of some patients was not assessed.

comprehensive,[8,14] and given that the community service in the Free State is limited, a central issue for this evaluation was how well patients in the Free State were functioning — mentally and socially.

For a number of reasons comparison of psychiatric patients in the Free State with those in other areas is limited. Some reasons are that health service and community responses to psychiatric patients differ, research instruments have not been internationally standardised, and patient profiles *vis-à-vis* diagnosis, age and gender vary from study to study and are often not made explicit. Nonetheless, international data provide some context for our results.

In this investigation 2% of patients were found to be housebound and 8% left their homes only 'very seldom'. In a major study of outcome of discharged schizophrenics in London, Leary *et al.*[5] report that 4% of patients were housebound for the 6 months before being interviewed and 11% for the month before interview. In the Free State, 74% of attending patients had only been out to go shopping in the 2 weeks before being interviewed, compared with 75% in the abovementioned study; and 57% had been visited compared with Leary *et al.*'s finding of 49%. Eighty-six per cent of patients in the Free State reported having attended church compared with 45% in a similar study by MacGilp *et al.* in Scotland.[1]

In the Free State 13% of attenders and 14% of defaulters were employed. Following a discharge and community-orientated programme in London, Melzer found 14% employment,[15] while MacGilp found a 7% employment rate among discharged patients in Scotland.[1] In a country such as South Africa with high unemployment, the Free State figures appear favourable.

Thirty per cent of patients in the Free State had had contact with the police. In approximately half of these cases the patient did not know the reason for contact. In 12% of cases patients were brought to court. In the UK Johnstone[16] found that a similar proportion of discharged patients had had police contact and that a similar number had been discharged without being brought to court. The number of patients involved in cases of assault was substantially higher in the Free State — one-third compared with 1% in the UK. However this may well reflect generally higher levels of community violence in South Africa and may not reveal problems specific to psychiatric patients at all.

A startling difference between the Free State study and other studies is the number of patients who requested hospital care in preference to community care. Johnstone and her colleagues[10] found that only 1% of patients who had been discharged from hospital into community care did not prefer the community arrangement, while in MacGilp's study not a single patient wanted to return to long-term hospital care after community discharge.[1] In this study 45 black (53%) and 3 white (11%) patients wanted long-term hospital care. Further research would be needed to determine why this is the case, although three possible reasons stand out. Firstly, in the other studies referred to patients had been discharged from long-term care into the community whereas most of the Free State sample had never experienced long-stay care, and therefore could not make an informed choice. Secondly, it was mainly black patients who indicated that they would prefer the hospital arrangement. It is possible that life for many black people in South Africa is so arduous, even without being psychiatrically disabled, that an option entailing regular free food and accommodation may be appealing. Finally, and perhaps most pertinent, in the absence of strong and supportive community care the only known alternative is hospital care. In the international studies mentioned above, community programmes were in place in addition to medical care. This was not true in the Free State. It is probable that the structure and safety provided by community services makes living in the community much more tolerable for psychiatric patients. The high numbers of people requesting hospital care could, therefore, be interpreted as a call for stronger community services, rather than for inpatient care *per se*. This view is supported by the high number of patients wanting to attend day care.

There is also evidence to suggest that additional hospital care is needed. For example, 4 patients (out of 114) reported being unable to dress or wash themselves and 3 patients could not feed themselves. Psychiatric functioning was also assessed to be poor among a minority of patients. The number of long-stay beds in the Free State is low by recommended standards (outside of Italy).[12] Moreover, it has been found that around 10% of all schizophrenics will remain severely ill and will not respond to treatment.[17] Hospital care should be made available to certain severely disturbed patients in the Free State.

A high percentage of patients (96%) expressed satisfaction with the service. This may be partially attributable to the frequently reported finding that in surveys there is a tendency towards acquiescence and socially desirable responses due to fear of having the service withdrawn.[18] This is supported by the finding that despite their expressed satisfaction, patients wanted more time with the nurse, experienced difficulty with receiving and paying for medication and wanted hospital and/or day care. It is also possible that black patients were more undemanding of the service (see Part IV).

The finding that 9 defaulters (40%) reported feeling better after discharging themselves indicates that there are problems with regard to ongoing assessment and willingness to discharge patients from the service (see Part I).

Racial differences

Until recently the Free State MHS was racially based. As such it is not surprising that racial differences were found with regard to services such as referral, counselling, time spent in queues and home visits. However, despite preferential

treatment, it was generally found that white patients did not perform any better than black patients with regard to social and psychiatric functioning.

Hypotheses to explain the latter may be that African populations are more community-orientated, that black psychiatric patients in the Free State may be less stigmatised than patients in white communities, and/or that traditional healers play a decisive function with regard to mental illness (see following section). However the reasons were not assessed in this study and it is recommended that in-depth anthropological research be carried out to clarify and explain these findings.

Use of traditional healers

Pretorius *et al.* report that 9.2% of respondents in the Manguang district of the Free State used traditional as well as modern methods in the management of mental illness, 78% used only modern medicine and 3% used exclusively traditional medicine.[19] Results from the current study indicate much higher utilisation of traditional healers. Nearly half of all black respondents had consulted a healer at some point for their illness and 25% continued to do so in conjunction with modern care. Given that the interviews were conducted at a modern health care clinic and given the secrecy that often surrounds traditional care, it can be assumed that even the above figures are underestimations of true utilisation. The role that traditional healers currently play in the control of mental illness in the Free State (and elsewhere) should not be overlooked. For example, inpatient bed numbers and the range of modern community interventions may indeed be mediated by the existence of traditional methods of care. In any event co-operation between traditional and modern sectors needs to be developed.

CONCLUSION

In view of the political constraints existent at the time of the study it is not surprising that the Free State decentralised MHS has had mixed results. On the positive side most patients appear to be socially functional, and while some patients have had relapses, contact with police and levels of violence are lower than might have been expected in a service where community care is limited. Similar findings in developed countries have been considered to be within reasonable limits.

Of concern are service problems, for example availability of medication, defaulting due to financial problems, lack of home visits, long queues and inadequate discharge procedures. Moreover, the fact that over half of the black patients interviewed would have wanted to be in inpatient care is a finding that requires careful consideration. Addressing this want may involve more than simply providing additional beds, though this may indeed be necessary for some patients; it should probably also involve the provision of better community services. The importance of working closely with traditional healers is highlighted by the number of patients seeking indigenous solutions to mental health problems.

For full acknowledgments, see Part I.

References

1. MacGilp D. A quality of life study of discharged long-term psychiatric patients. *J Adv Nurs* 1991; **16:** 1206-1215.
2. Thornicroft G, Breakey WR. The COSTAR Programme. 1: Improving social networks of the long-term mentally ill. *BMJ* 1991; **159:** 245-249.
3. Thornicroft G, Gooch C, O'Driscoll C, Reda S. The TAPS Project. 9: The reliability of the patient attitude questionnaire. *Br J Psychiatry* 1993; **162**(19): 25-29.
4. Anderson J, Dayson D, Wills W, *et al.* The TAPS Project. 13: Clinical and social outcomes of long-stay psychiatric patients after one year in the community. *Br J Psychiatry* 1993; **162**(19): 45-56.
5. Leary J, Johnstone EC, Owens DGC. Social outcome. *Br J Psychiatry* 1991; **159**(13): 13-20.
6. Warner R, Huxley P. Psychopathology and quality of life among mentally ill patients in the community. British and US samples compared. *Br J Psychiatry* 1993; **163:** 505-509.
7. Hazel KL, Herman SE, Mowbray CT. Characteristics of seriously mentally ill adults in a public mental health system. *Hospital and Community Psychiatry* 1991; **42**(5): 518-525.
8. Thornicroft G, Bebbington P. Deinstitutionalisation — from hospital closure to service development. *Br J Psychiatry* 1989; **155:** 739-753.
9. Andrews G. *A Description of a Model Mental Health Service.* The Tolkien Report, 1991. Sydney: Clinical Research Unit for Anxiety Disorders, 1991.
10. Johnstone EC, Frith CD, Leary J, Owens DGC. IX. Concluding remarks. *Br J Psychiatry* 1991; **159**(13): 43-46.
11. Appleby L, Araya R, eds. *Mental Health Services in the Global Village.* Gaskell: Royal College of Psychiatrists, 1991.
12. Freeman M, Lee T, Vivian W. *Evaluation of Mental Health Services in the Orange Free State.* Johannesburg: Centre for Health Policy, 1994.
13. Wing JK. Use and misuse of the PSE. *Br J Psychiatry* 1983; **143:** 111-117.
14. Mechanic D, Rochefort DA. A policy of inclusion for the mentally ill. *Health Aff* 1992; **11**(1): 128-150.
15. Melzer D, Hale AS, Malik SJ, Hogman GA, Wood S. Community care for patients with schizophrenia one year after hospital discharge. *BMJ* 1991; **303:** 1023-1026.
16. Johnstone EC. Disabilities and circumstances of schizophrenic patients: a follow up study. *Br J Pschiatry* 1991; **159:** suppl 13, 40-42, 44-46.
17. Horder E. Care for patients discharged from psychiatric hospital. *Br J Gen Pract* 1991; **41:** 339-400.
18. Lebow J. Consumer satisfaction with mental health treatment. *Psychol Bull* 1982; **91**(2): 244-259.
19. Pretorius E, de Klerk GW, van Rensburg HCJ. *The Traditional Healer in South African Health Care.* Co-operative HSRC Programme: Affordable Social Provision. Pretoria: HSRC, 1991.

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