THE FREQUENCY OF RE-HOSPITALISATION OF PSYCHIATRIC PATIENTS IN NAMIBIA: HERALDING THE NEED FOR A NEW CARE MODEL

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MENTAL HEALTH CARE CENTRE, WINDHOEK CENTRAL HOSPITAL , WINDHOEK NAMIBIA

Content

- Environments
- Methodology
- Results
- Discussion
- Recommendations

ENVIRONMENTS: Physical, economic, demographical, attitudinal, and institutional

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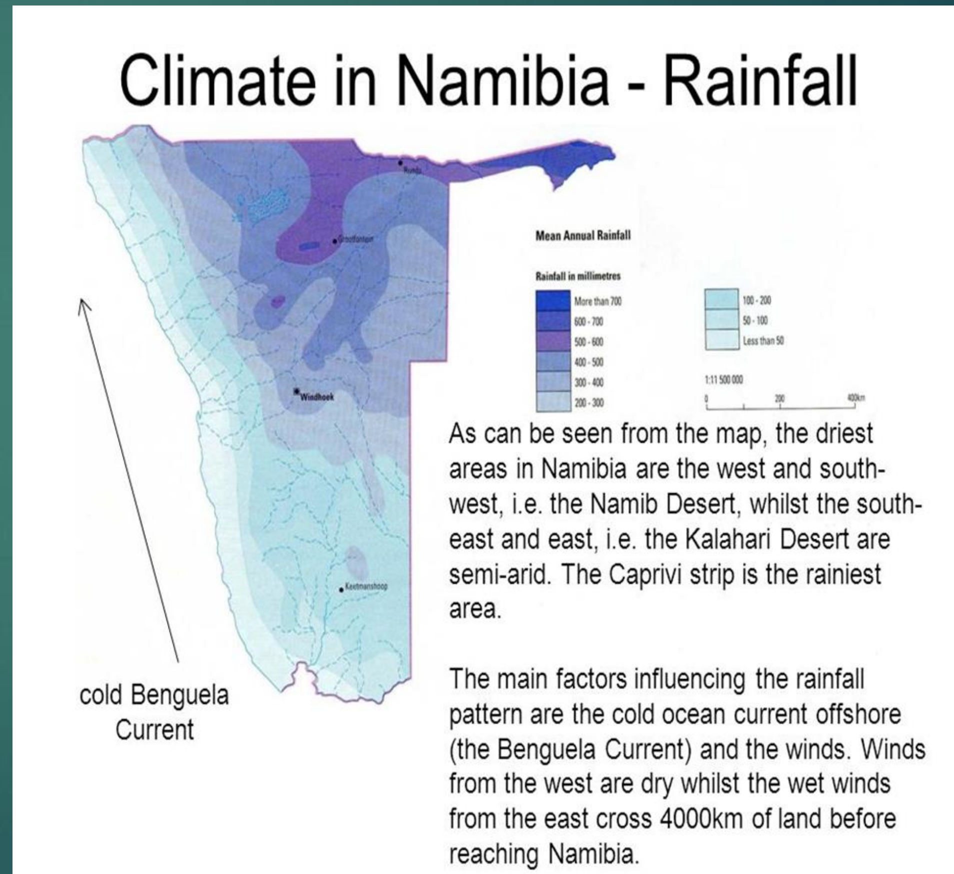
CLIMATE AND GEOPHYSICAL ENVIRONMENT

- Namibia is the most arid country south of the Sahara, with scarce rainfall and perennial rivers only at its borders; 80% of the area relies solely on groundwater.
- (Schneider & Sorensen, 201400



CLIMATE AND NAMIBIA'S ECONOMY

- Water scarcity has a devastating economic effect on the Namibian development, limiting opportunities for sustainable rural livelihoods that keep the population majority living below the World Bank poverty line (IFAD, 2013).

DEMOGRAPHIC INFORMATION OF NAMIBIA

- The current population of **Namibia** is **2,580,207** as of Monday, May 14, 2018, based on the latest United Nations estimates.
- Namibia population is equivalent to **0.03%** of the total world population.
- Namibia ranks number **228 (of 233)** in the list of countries by population.
- **The population density in Namibia is 3 per Km^2 (8 people per mi^2).**
- The total **land** area is 823,290 Km2 (317,874 sq. miles)
- **48.2 %** of the population is **urban** (1,248,506 people in 2018)
- The **median age** in Namibia is **21.2 years**.
- Population growth at 2% per year.

(World meters, 2018)

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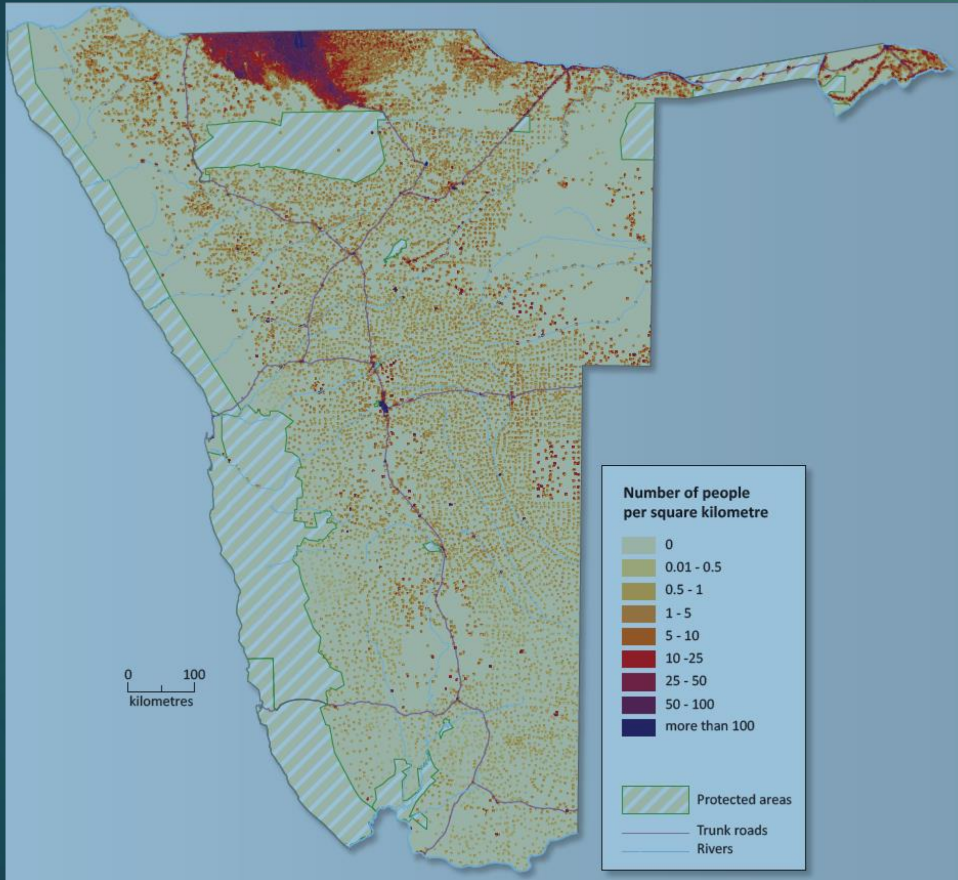
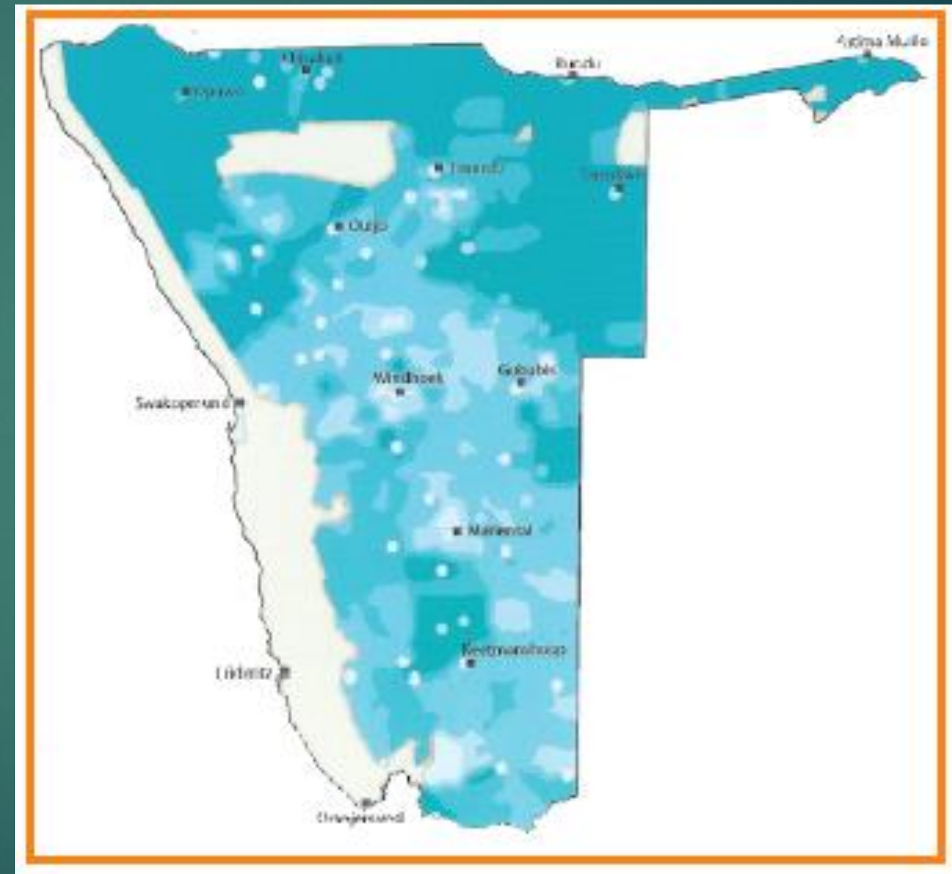
POPULATION DENSITY & CLINICS





STIGMA AND MENTAL ILLNESS

- Omananamwengu is seen as entirely problematic. Those who experience this madness are identified and separated from the broader cultural group because they are different. This stigmatization is in stark contrast to what has been observed generally in sub-Saharan Africa. (Bartholomeus, 2015)

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STIGMA continued

- New Era, Apr 12, 2016 - Windhoek.

"At least 8 527 people were treated for mental illnesses at various health facilities countrywide in 2016…. Our patients do not even get flowers like other patients. Some families request the centre to keep the patients forever."

She attributed the situation to beliefs that the causes of mental disorders are due to witchcraft and evil spirits. To make matters worse, some staff working at the mental centres label patients, said Paulus

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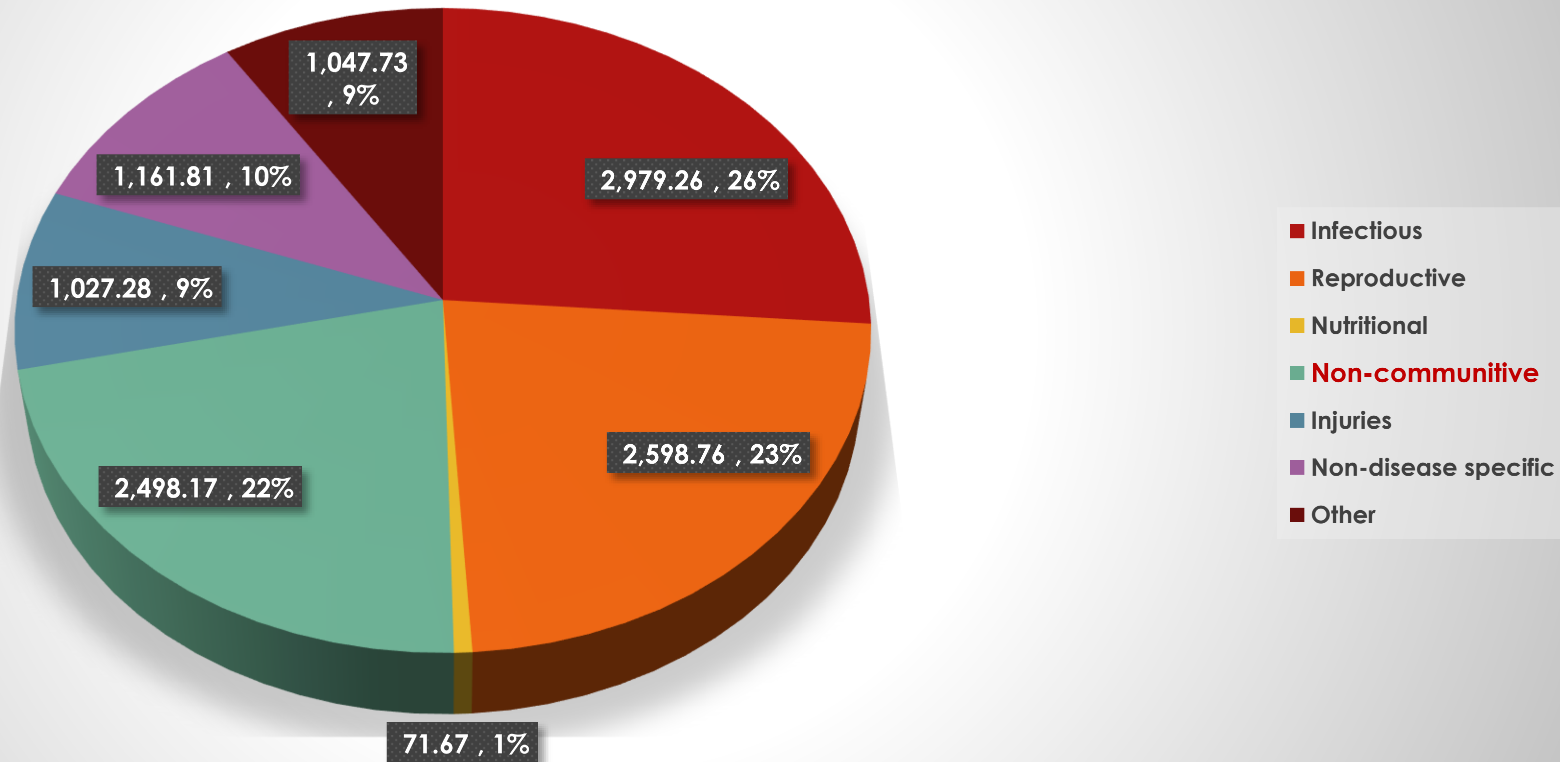
MENTAL HEALTH SPENDING

- Namibia Health Accounts Statistical Report 2014/2015 Pg. 20 (Sept 2017)



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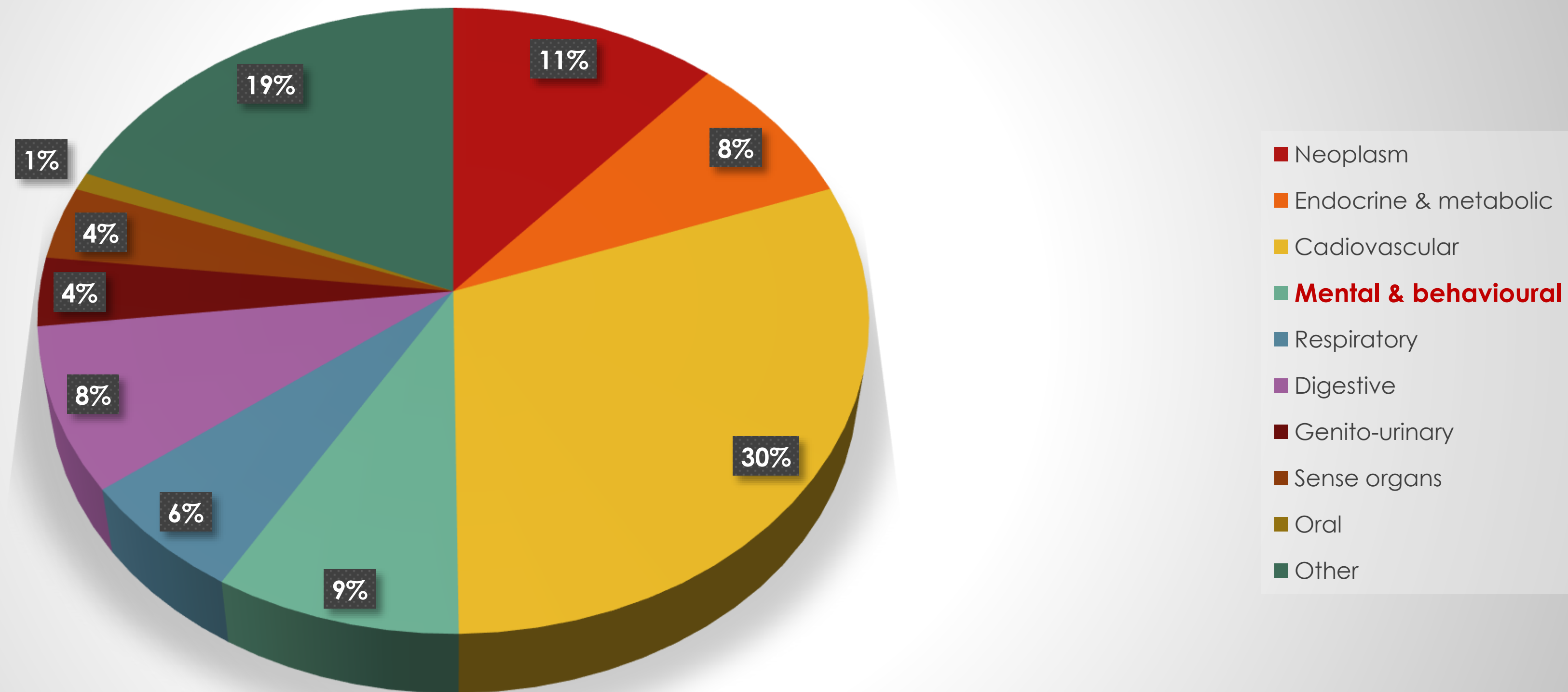

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MENTAL HEALTH SPENDING

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Mental Health Care Expenditure

Category	Expenditure
Inpatient curative care	128.05
Day care curative	-
Outpatient curative	40.76
Home-based care	-
Ancillary services	30.35
Rehabilitation	-

JUSTIFICATION TO EMBARK ON THE RESEARCH

- Mental health care is provided only at health care facilities, particular hospitals
- Medication (LIMITED) can be obtained at clinics
- No step down facilities, respite homes, or half way houses exist in Namibia for mental health care users, (neither people with physical disabilities)
- Rehabilitation services are limited to hospitals only
- It appeared that % of re-hospitalization of patients is high (revolving door syndrome)

RESEARCH: Methodology, participants and data collection, analysis of data

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DESCRIPTION OF THE RESEARCH

- Research: quantitative research design
- Population: all patients admitted to the hospital
- Pre-designed forms were completed during the presentation of all admitted patients by the occupational therapists of the Mental Health Care Centre (MHCC), Civil Psychiatry.
- Data analysis: Excel

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RESULTS, ANALYSIS OF DATA, FINDINGS

DEMOGRAPHIC INFORMATION OF THE RESEARCH PARTICIPANTS

Frequency by Gender

	Frequency
Male	111
Female	87

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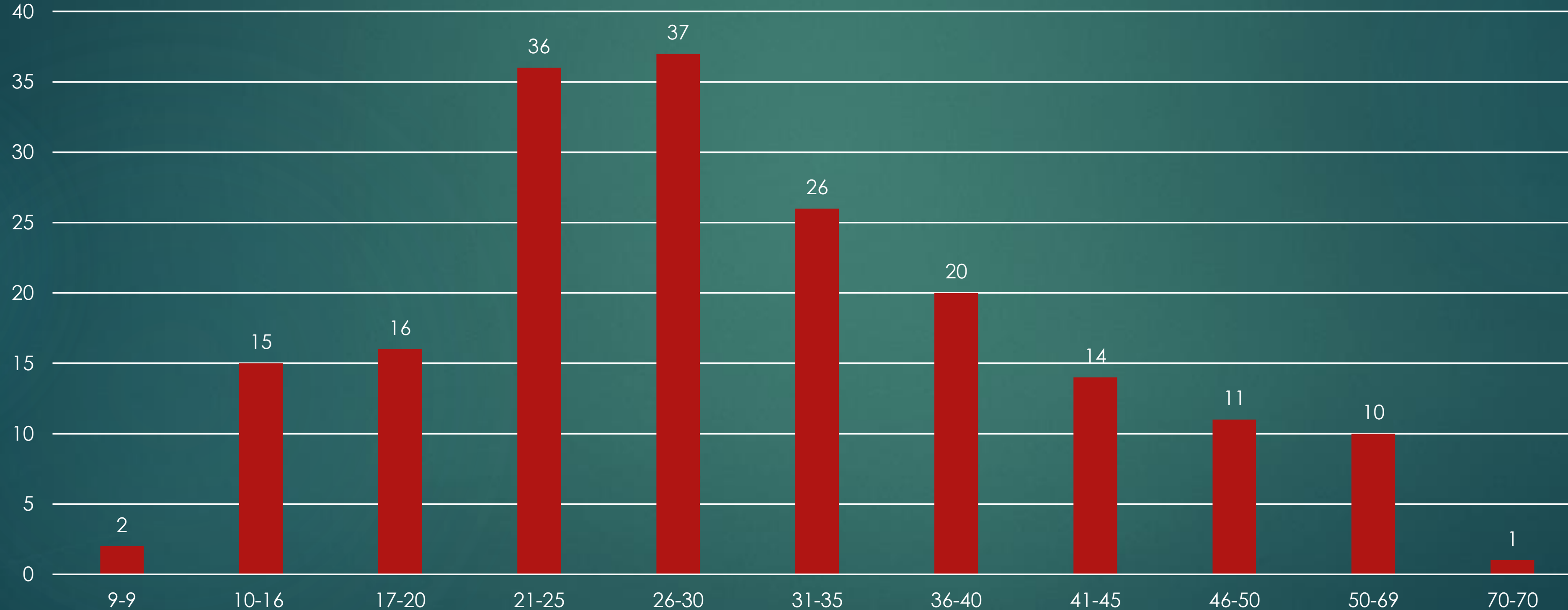
DEMOGRAPHIC INFORMATION OF THE RESEARCH PARTICIPANTS



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DEMOGRAPHIC INFORMATION OF THE RESEARCH PARTICIPANTS

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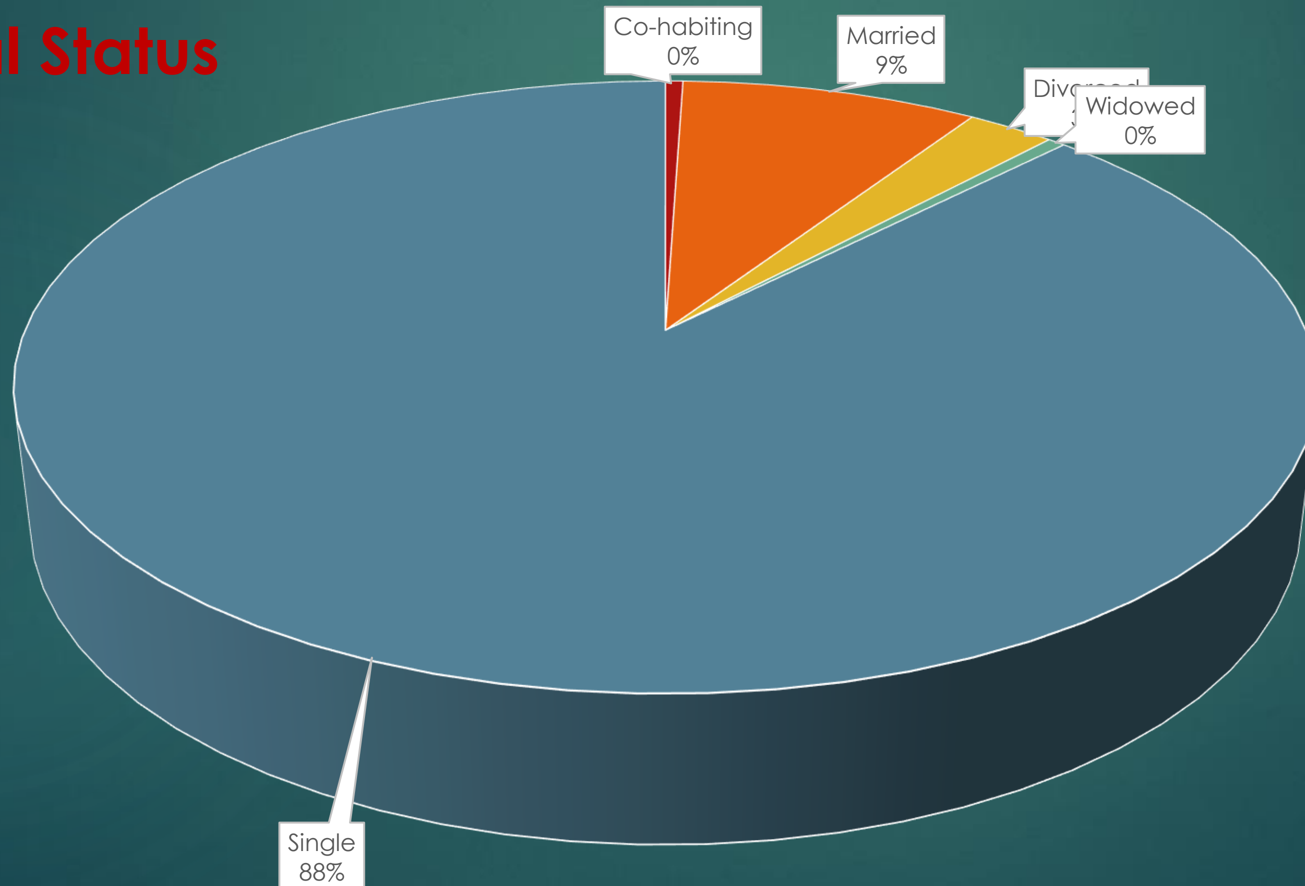
Marital Status



FREQUENCY BY DIAGNOSIS

Diagnosis	Frequency
Adjustment disorder	4
Autism Spectrum disorder	1
BMD	18
BMD with psychotic features	3
Brief psychotic disorder	3
Conduct disorder	1
Conduct disorder comorbid ADHD	1
Conversion disorder	1
Epilepsy	1
Frontal Lobe Neurocognitive Disorder	1
Learning disability	2
MDD	14
MDD with anxiety symptoms	1
MDD with catatonia	1
MDD with psychotic features	6
Neurocognitive disorder secondary trauma	1
Nocturnal Enuresis	1
Parasuicide	1
PDD	2
Post partum psychosis	1
Psychosis secondary to GMC	7
Schizoaffective disorder	14
Schizophrenia	35
Schizophrenia comorbid substance use	1
Substance Use Disorder	47

Y-axis: 0, 5, 10, 15, 20, 25, 30, 35, 40, 45, 50

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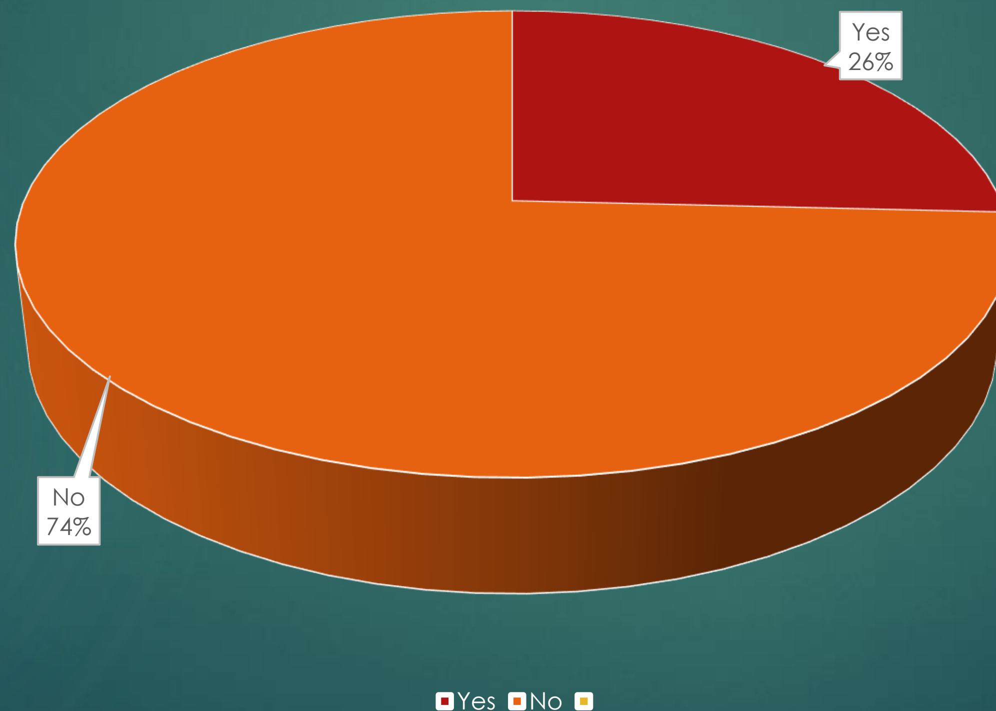
SUICIDAL AT ADMISSION



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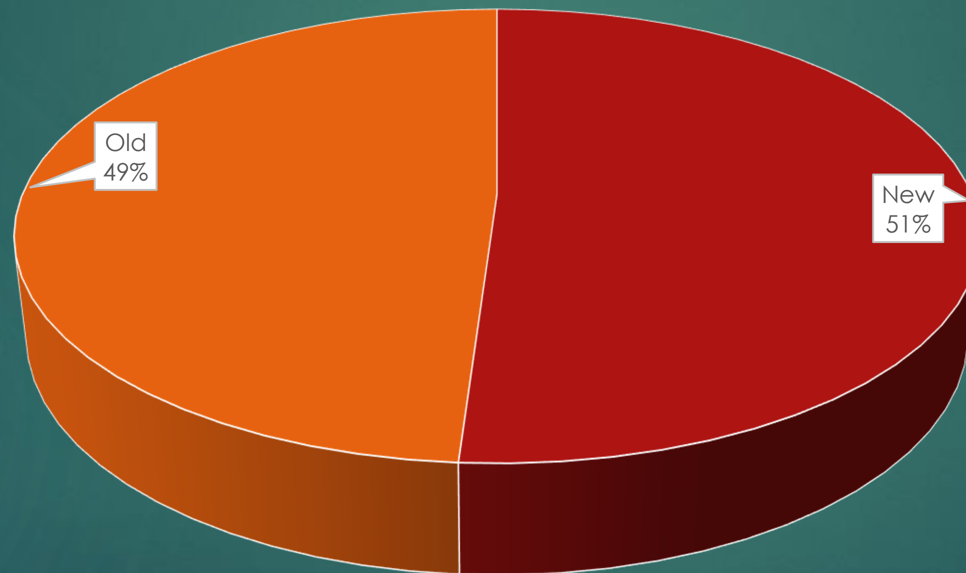
GLOBAL ASSESSMENT OF FUNCTIONING SCORE

GAF Score at admission

GAF Score	Count
11 - 20.	14
21 - 30	46
31 - 40	47
41 - 50	25
61 - 70	15
71 - 80	0
81 - 90	5
91 - 100	2

HOSPITALISATION & REHOSPITALISATION



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RE-ADMISSIONS

% of Total of Re-hospitalisation

Last 3 months 16%

12 months ago or longer 29%

Last 3-6 months 21%

Last 9-12 months 11%

Last 6-9 months 23%

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DISCUSSION

CURRENT CARE MODEL AT THE MHCA

- Heavy bias towards Medical model – particularly bio chemistry based
- Occupational therapy for all patients – care often restricted to one or two sessions before discharge
- No GAP evaluation at discharge.
- No follow-up in the community possible from an occupational therapy point of view
- Medication is available at the MHCC WCH or at various clinics (limited)

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LITERATURE: RE-HOSPITALISATION

- Neta & Da Silva (2008): 39,6% of hospitalisation were readmissions (over 21 months) Average of re-admissions 2,6 times over the time
- Jaramillo-Gonzalez, Sanchez-Pedraza & Herazo (2014): 60% of the cohort in the study were re-hospitalised during the year that followed the index event – variables associated with re-hospitalisation include separation, divorce and single status, diagnosis of substance abuse, schizophrenia, bipolar disorder, or major depressive disorder
- Dean (2017): rapid increase in socio-economic inequality has lead to poorer outcomes and rising mortality rates (schizophrenia, anxiety and depression)
- Morken, Widen & Grawe (2008): Non-adherence of taking medication was associated with relapse, hospital admissions and having persistent psychotic symptoms. Interventions to increase adherence needed

LITERATURE: EFFCTIVE CARE MODELS

- Glick, Sharfstein, &Schwartz (2011):
  - Driven by financial pressures, the sole focus of psychiatric inpatient treatment has become safety and crisis stabilisation.
  - Data are lacking on outcomes of ultra- short hospitalisation; however, such says may diminish opportunities for sustained recovery.
  - Focus on the need of reconsidering the current model of inpatient hospitalisation in order to maximise positive outcomes and emphasize appropriate transition into the community and less intensive levels of care,

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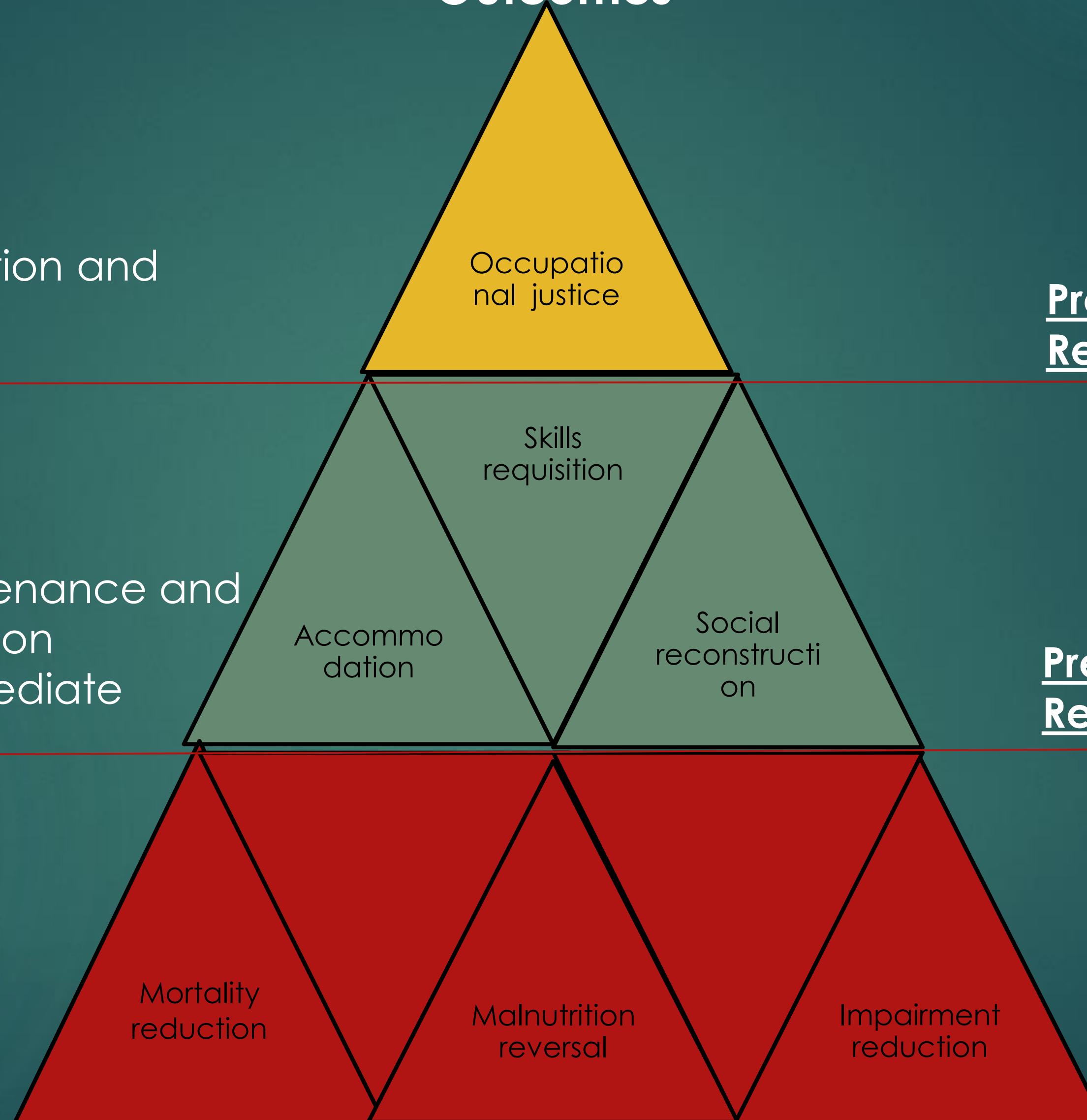
CURRENT OCCUPATIONAL THERAPY CARE MODEL AT MHCC, WCH

Medical Rehabilitation Levels

Occupational Therapy Outcomes

Intervention Programmes



Level 4+5 Community integration and productive activity (Advanced Rehabilitation)

Preventative/Restorative/ **Rehabilitative/Promotive**

Level 2+3 Physiological maintenance and home or residential reintegration (Moderate Acuity and Intermediate Rehabilitation)

Preventative/Restorative/ Rehabilitative/Promotive

Level 0+1 Physiological instability and physiological stability (High Acuity)

Preventative/Restorative/ Rehabilitative/Promotive

ALIGNING OCCUPATIONAL THERAPY OUTCOMES TO MEDICAL REHABILITATION LEVELS AND INTERVENTION PROGRAMMES IN HOSPITAL SETTINGS

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"DREAM" OCCUPATIONAL THERAPY CARE MODEL

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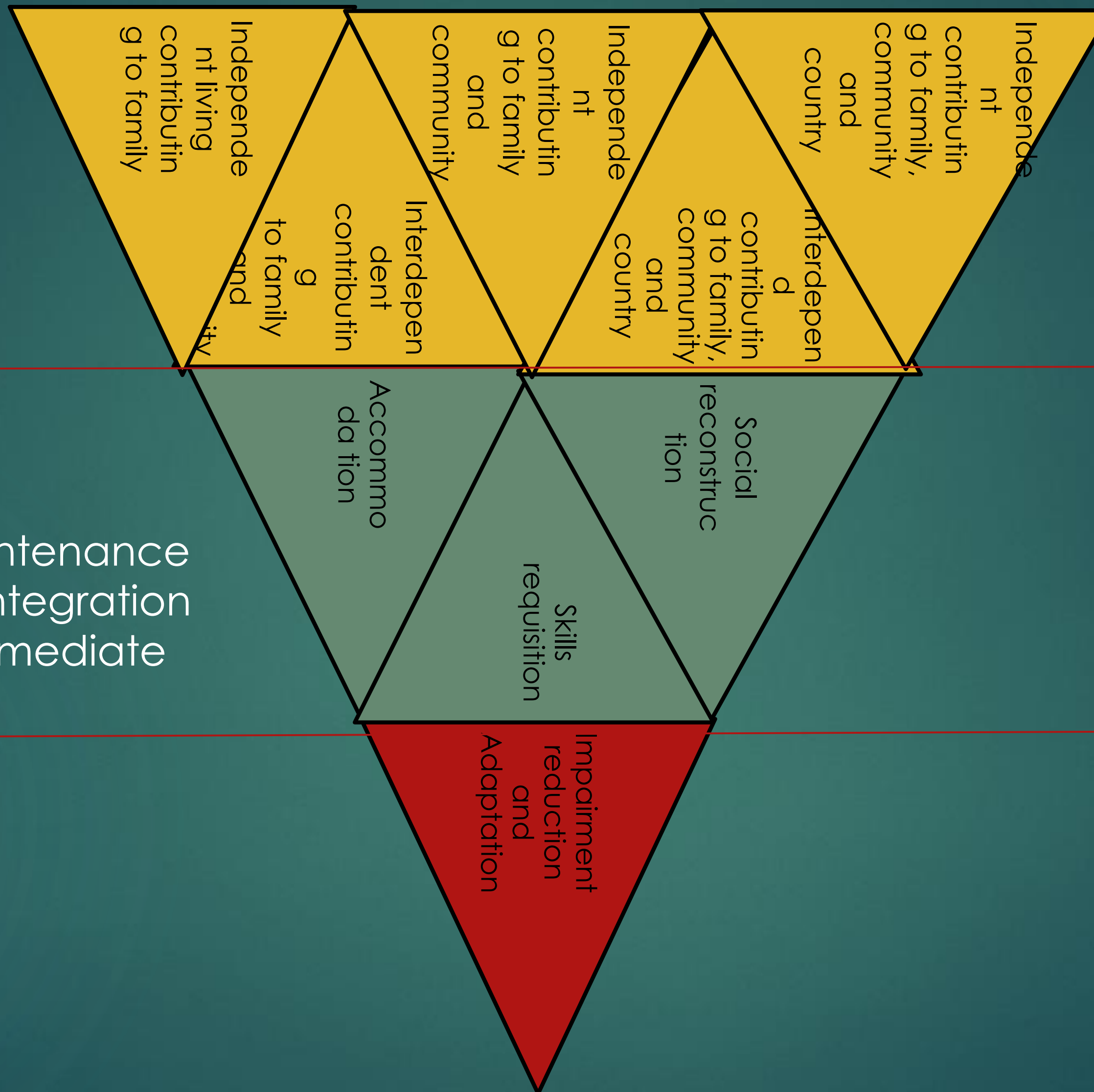
Medical Rehabilitation Levels

Occupational Therapy Outcomes

Intervention Programmes



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ALIGNING OCCUPATIONAL THERAPY OUTCOMES TO MEDICAL REHABILITATION LEVELS AND INTERVENTION PROGRAMMES IN <u>COMMUNITY SETTINGS</u>

RECOMMENDATIONS- THE WAY FORWARD

FUTURE STUDIES APPROACH

- HOW TO MOVE FORWARD
  - Using aspirations and dreams (The blue sky)
  - Assessment
    - PULL of the future/ PUSH of the future/ WEIGHT of the future
  - Leadership, action learning, context education, participatory planning, evaluation, alternate futures
  - Scenario development to moral futures

QUESTIONS

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