

THE DEVELOPMENT OF COMMUNITY TREATMENT IN SLOVENIA - FIRST OUTCOMES

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SUMMARY

This paper describes how a team who would work in the community with patients from the rehabilitation unit of Ljubljana psychiatric hospital was developed and what the results of treatment of a group of these patients were in terms of admission and relapse rate. The admission and relapse rate of these patients was markedly reduced by working assertively with them in the community.

Key words: community psychiatry - assertive community treatment - schizophrenia

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Aim

The aim of this pilot project was to demonstrate that it was possible, by working with patients in the community, to reduce hospital admissions and bed days spent in hospital.

Introduction

In 2005, a team of six staff from the rehabilitation unit of Ljubljana University Psychiatric Hospital visited the Bedfordshire and Luton Partnership NHS Trust, to experience for themselves how community psychiatry works. The process of learning which they underwent has been published (Agius 2006). At the end of this visit the participants devised a pilot project for treatment of patients with serious mental illness in the community which began in January 2006.

The pilot is based on combining methods of Assertive Community Treatment with intensive psychiatric rehabilitation. The first patients were included in January 2006.

By June 2007 first 20 patients were included and first evaluation attempted (at the moment cca. 30 patients are included).

The community psychiatric team comprises 2 psychiatrists, 3 psychiatric nurses, 3 Occupational

therapists, 2 social workers, and 1 clinical psychologist.

All the staff are also working on the inpatient wards which the patients are admitted from.

The table demonstrates the average age of patients, as well as the age range. It also demonstrates the average number of hospital admissions and bed days used, with the range of number of admissions and bed days, and the number of patients included in the project at any one time.

Table 1. Patients included, including mean age and age range, and average number of hospital admissions and bed days used, with the range of number of admissions and bed days

	M	Min	Max
Age	37.9	24	63
No. Of prior admissions	17.6	44	1
Days in hospital/year of treatment	97.9	12	252
Inclusion in project	10	2	18

The Main causes for recurrent admissions of these patients in the past were; Poor compliance with medication (13), concurrent substance abuse (8), poor living conditions, family disputes or poor social network (6), and Symptoms resistant to treatment (20).

This paper is an update of the paper read by Dr Mark Agius at the Meeting of ISPS Slovenia at Bled in February 2006. In that Paper, Dr Agius had reported on how a team from Ljubljana had been trained in Community Psychiatry, however he had not had the opportunity to report on the outcome of that training. The original paper was published as 'The development of a Leonardo Program for teaching Community Psychiatry. Psychiatria Danubina 2006; 18; 193-199', and so cannot be re-published. In this updated version, Dr Agius and colleagues describe the outcomes for community psychiatry in Slovenia of the training which had been reported on.

There were 9 male and eleven female patients.

One patient was in employment and two were in education. Three were registered unemployed, and twelve were retired.

In terms of diagnosis, 14 patients had Schizophrenia F20, four had Schizoaffective disorder F25, One had organic delusional schizophreniform disorder F06.2.

Five patients lived independently, eleven lived with their parents, and three in supported living accommodation.

Methods

The interventions utilised were; At the discharge, a care plan was developed, and a care co-ordinator was appointed from among the team members. Home visits were organized by the care coordinators, who worked in pairs: The visits ranged in length from twenty minutes to one hour, and their frequency ranged from once a week to once a month. The care co-ordinators worked in cooperation with NGOs and other services, as well as working with the outpatient psychiatrist of the patient.

Based on a needs assessment, the objectives in the care plan included: Improvement in daily living skills (13 patients), maintaining daily structure (15 patients), Continuing formal education (3 patients), providing better social inclusion (16 patients) and maintaining the actual level of functioning (4 patients). In all patients, prevention of admission to hospital was a key objective.

Within the home visits, a number of interventions were carried out; they included; general follow up of the symptoms, as well as the use of medication and the level of functioning, teaching daily and social skills, continuous psycho education, working with family, by providing it with education about mental disorder, relationship problem solving, enabling improvement in communication, and organizing care for aging parents. In a similar way, the team worked with neighbors and friends of patients without family and with staff of supported living units. The team also delivered depot medication.

Results

Over the first 16 months, the first reported outcomes include the following. Sixteen patients have followed up the care plan. Fourteen patients have demonstrated Improved daily living functioning, domestic skills. However, social inclusion has only marginally improved.

Partial relapse in symptoms and functioning occurred with 13 patients, without need for readmission. This was because relapse was detected early and support was intensified. No avtoagresive or heteroagresive behavior occurred, and substance abuse was controlled.

There were two re-admissions to the in-patient wards. These were:

CASE 1: A female patient with a prior history of 44 admissions and altogether 1560 days spent in hospital was admitted to inpatient unit for 3 days and attended our day care unit for another three weeks. As in the many times she had required admission before, she relapsed after she had refused medication.

CASE 2: A male patient was readmitted for 44 days after relapsing after refusing medication and abusing alcohol. Hospitalization was prolonged because of his requiring placement in supported living.

In both the cases where readmission was necessary, it was not necessary to employ secure wards or involuntary admission to hospital.

Discussion

This team is the first modern community mental health team in Slovenia. It works using principles derived from both rehabilitation practice and assertive community treatment. Furlan has described the concept of assertive outreach in an ISPS Slovenia meeting.

Key to the assertive outreach model is the appointment of a care co-ordinator.

The care co-ordinator is a person who becomes the central point of referral who will work with the patient and his/ her family to identify the needs of the patient and to work out a plan to provide them. The care co-ordinator may work in a number of ways, the two most well known of which are 'Brokerage case management', (where the co-ordinator is essentially office based, and acts to refer the client's needs to appropriate agencies, who in turn respond) and 'assertive case management' (where the care co-ordinator himself takes the responsibility to ensure that the needs are met, by acting in a more pro-active fashion). This team preferred the model of Assertive case Management.

The IRIS guidelines for the treatment of young patients with Psychosis state; 'A key worker should be allocated early following referral of the case in order to develop engagement and rapport and to 'stay with' the client and family/friends

preferably within an assertive outreach model' (IRIS 1999).

It would appear that the lack of a care-coordinator to work with the patient and family will inevitably lead to sub-standard care. The original Stein and Test study compared assertive case management as first conceived to a situation where patients had been discharged from hospital with no case management in place. The superiority of case management was evident (Stein 1980). English studies have attempted to compare brokerage case management in Community Mental Health Teams. These include studies by Tom Burns (Burns 1999) and by the UK700 group (UK 700 1999). Assertive case management (ACT) appears to have the advantage, but not such a great advantage as observed in Stein and Test. This may be because of the care the patients in the brokerage (CMHT) group were receiving. Samele and Murray (2001) suggest that the reason ACT is effective is; 'a single point of accountability (that is, a key worker), the case manager/ patient relationship and continuity of care, compliance with medication, good multidisciplinary team, a psychiatrist integrated to the team, and applying the ACT model' (Samele and Murray 2001). A very recent study by Craig et al. (Craig 2004) reports that an assertive team treating young persons with psychosis had better outcome results than those in a CMHT. Craig comments 'The work of the LEO community team differed from community sector teams mostly in terms of intensity. Patients in LEO were seen more frequently- an average of 13 visits in the first three months out of hospital compared with 5 for standard care' (Craig 2004).

The present study is the first of its kind in the region of the Balkans, and follows guidance published recently (Agius 2005). Its results were first presented in a conference held in Cambridge in 2007 (Furlan 2007).

One final comment must be, however that the success of community psychiatry must depend on the availability of adequate staff who are appropriately trained.

Conclusions

It would appear that this attempt to deliver community treatment to patients with serious

mental illness is delivering good results. However, it is clear that regardless of the delivery of intensive care, relapses do occur particularly if medication is refused.

Continuous community care provides the conditions to monitor closely and intervene early. As a consequence, admissions are prevented and relapses are expeditiously dealt with, so that the prior level of functioning is returned to rapidly.

However when admissions occur, they are short, and secure wards and involuntary admissions do not seem to have been necessary in this cohort of patients.

REFERENCES

1. Agius M, Furlan M, Bulic I, Zmuc L, Zajelda B, Susnik V, Jeric A. (2006) *The development of a Leonardo Program for teaching Community Psychiatry. Psychiatria Danubina* 2006; 18:193-199.
2. Agius M, Martic-Biocina S, Alptekin K, Rotstein V, Morselli P, Persaud A *Basic Standards for Management of Patients with Serious Mental Illness in the Community Psychiatria Danubina* 2005; 17(1-2);42-57.
3. Burns T et al. *Intensive versus standard case management for severe psychotic illness; a randomised trial Lancet* 1999; 353:2185-9.
4. Craig T et al *The Lambeth early onset team; randomised controlled trial of the effectiveness of specialised care for early psychosis British Medical Journal* 2004; 329:1067-9.
5. Craig T *Author's reply British Medical Journal* 2004; 330:197.
6. Furlan M *Assertive outreach – the meaning of the intervention, Proceedings of ISPS Slovenia meeting Bled.* 2006.
7. Furlan M, Jeric A, Bulic Vidnjevic I, Agius M, Švab V. *The development of Community Treatment and first outcomes in Slovenia. Psychiatria Danubina* 2007; 19 supp p41.
8. *IRIS Guidelines North Birmingham Mental Health Trust* 1999.
9. Samele C, Murray R *Case Management of patients with Schizophrenia in Comprehensive care of Schizophrenia Martin Dunitz* p133-140. 2001.
10. Stein L, Test M *Alternative to mental hospital treatment .1. Conceptual Model, treatment program, and clinical evaluation Archives of General Psychiatry* 1980; 37:392-7.
11. UK700 Group *Comparison of intensive and standard case management for patients with psychosis. Rationale of the trial British Journal of Psychiatry* 1999; 174:74-8.

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