

Involuntary First Admissions to a Tertiary Psychiatric Hospital in Cape Town: A Five Year Review of Family Referrals to Psychology

Abstract

Background: Valkenberg Hospital is one of three tertiary psychiatric hospitals in Cape Town – and has a catchment area population of over one million. It is an acute admissions hospital for adults (18-59 years).

Objectives: This article aimed to determine the psychosocial history of male patients involuntarily admitted to a high care psychiatric unit for the first time, and the needs and concerns of their families, to allow for the development of more appropriate services.

Method: The psychology family clerking interviews (June 2007 – June 2012) of the Male High Care Unit (MHCU) of Valkenberg Psychiatric Hospital's first admission families (FAF) were reviewed. All of the patients in the chart review were severely psychotic and had not been able to be managed at a secondary hospital level, which had necessitated their referral to Valkenberg. Each clerking interview with the family lasted 1.5 to 2 hours, and was conducted by the Intern Clinical Psychologist placed at Male Admissions. All 225 available folders were reviewed and coded.

Results: The majority of the patients were young (mode = 21), still living at home (80%), single (90%) and unemployed (65%). More than 80% of the men were given a working diagnosis of either Substance Induced Psychotic Disorder (SIPD: 46%), Schizophrenia (27%) or Bipolar (11%). There was a strong family history of severe mental illness (SMI: 49%), psychiatric admissions (30%), depression (26%), suicide (18%), substance use (SUD in parent/s: 45%, siblings: 36%) and domestic violence (30%). Most families suspected that the patient had used drugs and police had had to be involved in at least 40% of the admissions. Despite nearly half of the patients expressing regret at their substance use, more than half the families reported that the patient had become aggressive and that at some stage they had feared them. The families most identified the patients' admission as their greatest stressor. The second most identified greatest stressor was finances, with 40% of the families being in debt and more than a third of the families being either unable to or financially struggling to visit the patient while he was admitted.

Conclusion: For many patients and their families, the times before and during the admission had been long and traumatic. Family intervention was necessary to provide more effective help-seeking methods, and to provide services that simultaneously looked at co-morbid substance use, depression and anxiety, suicidal thinking, social isolation and domestic violence, often in the background of poverty. It was highly recommended that the development of services aimed at treating dual diagnosis (severe mental illness or the risk thereof, and substance use disorder) be developed and prioritised.

Keywords: First episode psychosis; Substance use disorders; Dual diagnosis; Impact on families

Abbreviations: FA: First Admission; FEP: First Episode Psychosis; FHCU: Female High Care Unit; HIV: Human Immunodeficiency Virus; ICP: Intern Clinical Psychologist; MHCU : Male High Care Unit; PTSD: Post Traumatic Stress Disorder; SIPD: Substance Induced Psychotic Disorder; SMI: Severe Mental Illness; SUD: Substance Used Disorder; UCT: University of Cape Town

Introduction

It is well documented that for families of people being admitted for the first time, the pathway to care can be long and traumatic [1]. For first episode psychosis (FEP), most people have had active psychotic symptoms for 1-2 years before treatment [2,3], and research suggests that the longer the duration of untreated psychosis, the more the associated long-term disability

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[4]. Comorbid substance use, depression, suicidal thinking, social avoidance and anxiety are common [5]. These can also potentially lead to ineffective and demoralising help-seeking and a variety of traumatic events - one of which being the involuntary hospital admission [1,2].

The prevalence rate of aggression in mental illness, is typically found to be more than half [6]. This is against a suggested background of higher levels of the patients' premorbid exposure to violence [7] - between 34% and 81% of patients with severe mental illness (SMI), reported premorbid childhood and sexual abuse, and between 43% and 81% of patients with SMI had had exposure to physical and sexual violence [8,9]. It is also known that the risk of violent behaviour increases with substance use problems [10] and that half of FEP admissions have comorbid substance diagnoses [11,12]. It is also known that the greater exposure to violence by a family member is associated with greater levels of trauma (including PTSD) for the families [13]. Risk for violence also increases with nonadherence with medication, poor levels of insight [10], dual diagnosis (SMI and substance use), and if there was a family history of substance use and family history of mental illness [6].

Most people presenting with FEP are young, and still living with their family of origin. Especially at the time of the onset of a mental disorder, and at the time of the diagnosis of the mental disorder, family members often experience strong emotional reactions such as guilt, fear, disappointment, anger and relief [14].

Aim and Objectives

Cape Town has a population exceeding 3.5 million [15], and Valkenberg Hospital is one of the three tertiary psychiatric hospitals that serve this population (each hospital therefore covers more than a million people.) It is predominantly an acute admissions hospital for adults (18-59 years) and its Male High Care Unit has a waiting list for admission of up to 50 men at any given time. The resultant bed pressure means the great majority of people being admitted are very ill and involuntary. Intern Clinical Psychologists (ICPs) working on the MHCU, concentrate their services on the families of psychotic patients who were being admitted for the first time-these were referred to as the First Admission (FA) families.

The study reviewed the family clerking interviews conducted by the Intern Clinical Psychologists of the MHCU. The objectives were to explore the patient's psychosocial history, to examine the needs and concerns facing FA families, and to identify common needs that may suggest more appropriate services and allocation of resources.

Methodology

In 2006, members of the multidisciplinary teams (psychologists, social workers, occupational therapists, doctors and nurses) of the High Care Admission Units met together to discuss an auxiliary clerking document that could be used with families to gain further collateral regarding the patient, and to record what the families were experiencing and needing. From this, emerged what was to become the clerking document used by the Intern Clinical Psychologists (ICPs). All information was confidential and permission from UCT's Ethics Committee and the research committee of Valkenberg Hospital was first gained. Between June

2007 and June 2012, the Intern Clinical Psychologists had clerked 225 FA families.

Results

Patient demographics generally followed that of the catchment population, except that patients were substantially under employed for their age. The majority of patients were young (mode = 21 years, 38% were between 18-25, and nearly 75% were in their teens or twenties), 90% were single, 80% had no dependants and 80% still lived with their family of origin. Sixty five percent were unemployed despite 60% having 10-12 years of education (30% had Grade 12). Over 90% of all patients admitted, spoke a home language common to the Western Cape (English: 38%, Afrikaans: 27%, Xhosa: 26%), and the majority of the families reported to follow the Christian (71%) or Islamic (12%) faiths, or had "no religion" (11%).

Nearly a quarter of the families felt that finances were their biggest stress, despite 60% of the families owning their own home. Forty percent of families reported that they were in debt, 75% reported that they were struggling financially, and more than a third of families either struggled to or could not afford to visit the patient. While almost all had access to piped water, 30% only had cold water, and 5% of families used outside toilets. Generally, the families despite their financial difficulties, had access to electricity (96%), had access to public transport (99%), and over 97% had access to a local clinic. On average, each accommodation had 2.47 bedrooms, and an average of 4.54 people stayed in each family home. Most patients (55%) did not share their bedroom with someone else. Those that did share mostly shared with their siblings (18%), their mother (9%), or close family members (5%).

Nearly two-thirds of FA families (60%) reported the index admission to be their "biggest stress", with nearly 40% needing the police to be involved. Nearly three quarters of the FA families (73%), suspected the patient had used drugs. On direct questioning (n = 119 families), daily use of cannabis (51%), methamphetamines (45%), and alcohol (32%) was reported. More than half the families (56%) reported that the patient had been aggressive, and 29% reported that the patient had become "dangerously violent" or had made death threats, and nearly a third reported the patient to have been a perpetrator of domestic violence. While 95% of the families believed that the patient was not a risk to the family when well, more than half reported the patient to be a risk to them when he was ill, and more than half of the families (53%) reported that they had at some stage feared the patient. However, more than half of the patients (55%) had told their families that they wanted to give up or regretted their substance use.

There was a significant level of psychiatric illness within FA families. Almost half the FA family histories were positive for severe mental illness (SMI: 49%) and nearly one fifth of families reported a family history of successful suicide (18%). Psychiatric family histories also showed psychiatric admissions (30%), anxiety (29%) and maternal depression (23%), and substance use disorders (SUD in parent/s: 45%, siblings: 36%).

FA families also reported high levels of domestic and community violence. Nearly a third of the FA families (30%, n=168), reported that the patient had premorbidly witnessed domestic violence, and nearly a quarter of FA families reported that the patient had

premorbidly been a victim of domestic violence (24%, n=170). Most families reported living in dangerous communities, and said that the patient had often been a victim of community violence (41%, n=167), or had witnessed it (44%, n=154).

More than 80% of admissions had had one of the following working diagnoses: Substance Induced Psychotic Disorder (SIPD: 46%), Schizophrenia (27%) or Bipolar I (11%). Most families expected the patient to improve by 85% (n=150), and that this would take one week to a month (48%). Many families believed that it would take the patient 1 day to improve (6%), 1 day to 1 week to improve (6%), while alternatively, some felt it would take 1 month to 1 year to improve (37%) or more than a year to improve (5%). More than three quarters (77%) of the FAF families believed that the patient would never need another admission. More than a quarter of the families felt that they wanted to have another session, although 11% of families explained that they would phone later to ask for one, and 60% of families felt that the clerking session (averaging 1.5 hours), had been sufficient.

Generally, the families looked forward (59%) to the patient's return. A further 18% of FA families felt that they would conditionally accept the patient back (e.g., if they gave up drugs / if they were no longer violent), and 13% of FA families were ambivalent about the patient's return.

Even prior to the patient's admission, many of the FA families had already accessed some level of help (39%), including accessing mental health organisations / experts (20%), and substance use organisations / experts (17%). Other areas identified by the FA families as providing support, were from friends and neighbours (64%) and religious support (61%). More than 72% of the families, believed that it was the mother who had been the most negatively affected / stressed, by the patient's admission, and 56% the FA families identified that it would be the mother who would be the person responsible to help the patient with their medication.

Discussion

It was noteworthy that despite the male population being admitted for the first time to Valkenberg Hospital being relatively better educated, they were nonetheless significantly underemployed [15]. Otherwise, their demographic variables tended to be consistent with the Cape Town population, and the admission profile for first episode psychosis, also tended to be similar to the current reported literature. It was possible that the high levels of comorbid substance use, the high incidence of reported domestic and community violence, and significant poverty, may have made the Cape Town FEP community particularly vulnerable. Despite South Africa having a generalised HIV epidemic which has stabilised over the past several years at a national antenatal prevalence of about 30% [16], the great majority of families (97%) denied that the patient (or any family member) had HIV.

Conclusion

Family work was necessary to provide more effective help-seeking methods, and to provide services that simultaneously looked at co-morbid substance use, depression and anxiety, suicidal thinking, social isolation and domestic violence, often in the background of poverty. Services focusing on dual diagnosis (severe mental illness and substance use disorder) need to be

provided and prioritised, and the treatment teams for the dual diagnosis should be coalesced. This may reduce the occurrence of a SMI developing or worsening, and reduce the risk for violence. These services must not simply offered to the patient, but also be available for the family.

Future Research

Based on these initial findings, several clinical directives are suggested. Psychology clerking interviews should provide more direction for psycho-education (e.g. risk for future admissions and how to avoid them). Family members (especially the mothers), where there was a high risk for depression and anxiety, should be offered ongoing psychology services. More realistic interventions regarding the patient's substance use, especially if there was a high comorbidity of substance use by the patient's parents, siblings, neighbours and or friends, must be sought. It would be of help to list and liaise with the organisations and experts that the families had already contacted regarding the patient, prior to their admission.

In 2013, the chart review was completed, detailing the first 5 years of the ICP family clerking interviews. Future research should include extending the chart review to the FAF families where no appointment had been offered. Usually this would have been because of lack of contactable numbers for the family, or that the family lived too far away, or if the psychology services were overstretched and unable to provide cover. It may suggest a bias against the families that were not contactable (possibly less resourced than those accessing the services). Resources are limited, but it would be useful to compare FAF families of male patients, to the experiences of the Female High Care Unit (FHCU) families. It was assumed that later comparative chart reviews would reflect a greater identified concern regarding HIV prevalence.

It is necessary that psychiatric health care professionals take the initiative and responsibility for psycho-education and support of family members [14]. Loss, guilt, confusion and high levels of emotional distress make the need the early intervention programmes focusing on psychosocial and familial interventions crucial [17,18]. It is possible that family intervention in the early stages of psychosis may prevent the development of a critical family atmosphere and the onset of the associated expressed emotion, and effectively postpone the onset of later relapses [19-20]. Care-giver burden may be somewhat alleviated with improved community-based services for preventative long-term care, including medication adherence (rather than multiple hospitalizations) [10].

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