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

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HELGA BURGER, MUNYARADZI CHIMARA, CHIEDZA MAVINDIDZE, CHARLES MABULAWA, JACKSON NOWA, RIVKAH WESSELS
MENTAL HEALTH CARE CENTRE, WINDHOEK CENTRAL HOSPITAL , WINDHOEK NAMIBIA
Content

- Environments
- Methodology
- Results
- Discussion
- Recommendations
ENVIRONMENTS: Physical, economic, demographical, attitudinal, and institutional
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, 2014)

![Climate in Namibia - Rainfall](image.png)

As can be seen from the map, the driest areas in Namibia are the west and south-west, i.e. the Namib Desert, whilst the south-east and east, i.e. the Kalahari Desert are semi-arid. The Caprivi strip is the rainiest area.

The main factors influencing the rainfall pattern are the cold ocean current offshore (the Benguela Current) and the winds. Winds from the west are dry whilst the wet winds from the east cross 4000km of land before reaching Namibia.
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).
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 Km² (8 people per mi²). 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)
POPULATION DENSITY & CLINICS
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)
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
MENTAL HEALTH SPENDING

Expenditure per classification of disease in Million (11,384.68 NAD)

- Infectious: 2,979.26 (26%)
- Reproductive: 2,598.76 (23%)
- Nutritional: 71.67 (1%)
- Non-communitive: 2,498.17 (22%)
- Injuries: 1,161.81 (10%)
- Non-disease specific: 1,047.73 (9%)
- Other: 1,127.28 (9%)

Total: 11,384.68 NAD
MENTAL HEALTH SPENDING

Expenditure Non-Communicable diseases

- Neoplasm: 19%
- Endocrine & metabolic: 8%
- Cardiovascular: 11%
- Mental & behavioural: 8%
- Respiratory: 4%
- Digestive: 4%
- Genito-urinary: 6%
- Sense organs: 9%
- Oral: 1%
- Other: 30%
Mental Health Care Expenditure

- Inpatient curative care: 128.05
- Day care curative: 40.76
- Outpatient curative: 30.35
- Home-based care
- Ancillary services
- Rehabilitation
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
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
RESULTS, ANALYSIS OF DATA, FINDINGS
DEMOGRAPHIC INFORMATION OF THE RESEARCH PARTICIPANTS

Frequency by Gender

- Male: 111
- Female: 87
DEMOGRAPHIC INFORMATION OF THE RESEARCH PARTICIPANTS

Marital Status

- Single: 88%
- Married: 9%
- Divorced: 3%
- Widowed: 0%
- Co-habiting: 0%
FREQUENCY BY DIAGNOSIS

[Bar chart showing frequency of various diagnoses with specific numbers for each]
SUICIDAL AT ADMISSION

Patients that Presented Suicidal at Admission

- Yes: 26%
- No: 74%
GLOBAL ASSESSMENT OF FUNCTIONING SCORE

GAF Score at admission

- 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

Hospital Admissions

New: 51%
Old: 49%
% of Total of Re-hospitalisation

- 12 months ago or longer: 29%
- Last 9-12 months: 11%
- Last 6-9 months: 23%
- Last 3-6 months: 21%
- Last 3 months: 16%
- Last 1-2 months: 11%
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)
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: EFFECTIVE 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 emphasise appropriate transition into the community and less intensive levels of care.
CURRENT OCCUPATIONAL THERAPY CARE MODEL AT MHCC, WCH
ALIGNING OCCUPATIONAL THERAPY OUTCOMES TO MEDICAL REHABILITATION LEVELS AND INTERVENTION PROGRAMMES IN HOSPITAL SETTINGS

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

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

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

Medical Rehabilitation Levels

Occupational Therapy Outcomes

Intervention Programmes

Preventative/Restorative/Rehabilitative/Promotive

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Preventative/Restorative/Rehabilitative/Promotive
“DREAM” OCCUPATIONAL THERAPY CARE MODEL
## Medical Rehabilitation Levels

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

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

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

## Intervention Programmes

- **Preventative/Restorative/Rehabilitative/Promotive**
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## Occupational Therapy Outcomes

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## Aligning Occupational Therapy Outcomes to Medical Rehabilitation Levels and Intervention Programmes in Community Settings

### Medical Rehabilitation Levels

- **Preventative/Restorative/Rehabilitative/Promotive**
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### Intervention Programmes

- **Preventative/Restorative/Rehabilitative/Promotive**
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**Aligning Occupational Therapy Outcomes to Medical Rehabilitation Levels and Intervention Programmes in Community Settings**
RECOMMENDATIONS - THE WAY FORWARD
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