SPECIAL PAPERS

Community mental health services in Al Ain Hospital, United Arab Emirates

Amir Mufaddel,[1] Mouza Al Sabousi,[2] Yahya Takriti,[3] Badr Dawoud,[4] Nora Coroza,[5] Habib Belhaj[5] and Nasser Al Hekmani[6]

[1]Psychiatrist, Community Mental Health Services, Behavioural Science Institute, Al Ain Hospital, United Arab Emirates

[2]Consultant Psychiatrist and Chairperson of the Behavioural Sciences Institute, Al Ain Hospital, United Arab Emirates

[3]Consultant Psychiatrist and Head of the Old Age Psychiatry Division, Behavioural Science Institute, Al Ain Hospital, United Arab Emirates, email ytakriti@alain-hospital.ae

[4]Consultant Psychiatrist, Community Mental Health Services, Behavioural Science Institute, Al Ain Hospital, United Arab Emirates

[5]Community Mental Health Nurse, Behavioural Science Institute, Al Ain Hospital, United Arab Emirates

[6]Psychologist, Community Mental Health Services, Al Ain Hospital , United Arab Emirates

This paper evaluates a model of community mental health service (CMHS) in Al Ain in the United Arab Emirates. The hospital records were reviewed and the total number of patient admissions and duration of in-patient care before and after enrolment in the CMHS were documented. Patient satisfaction with the CMHS was assessed using a questionnaire. The total number of admissions and the number of days that the patient spent in hospital per year were significantly reduced by the CMHS. Patients had high satisfaction rates with the information and advice they received, with their relationships with CMHS workers, with their access to mental health services and with their drug treatment.

Major changes have occurred in methods of delivering psychiatric care, particularly for those with severe and persistent mental illness such as schizophrenia, bipolar mood disorder and treatment-resistant depression. The trend is now directed towards community psychiatric services. Before the deinstitutionalisation movement, the majority of patients with severe mental illness spent most of their lives in psychiatric hospitals (Rosen *et al*, 2007).

Models for the delivery of community psychiatric services can be broadly divided into three types:

- standard case management
- rehabilitation-oriented community care
- intensive comprehensive care (assertive community treatment and intensive case management).

Countries adopt their own model according to population needs, health service structure and available resources (Hadley *et al*, 1997; Kim *et al*, 1998; Rosen *et al*, 2007; Ranasinghe Mendis & Hanwella, 2010; Flannery *et al*, 2011).

A Cochrane systematic review concluded that home treatment teams reduce days spent in hospital, particularly if the visits are regular and the teams have responsibility for both social care and healthcare. However, the review commented that most of the research evidence comes from the USA and the UK (Catty *et al*, 2002; see also Burns, 2007).

The current paper evaluates a community mental health service (CMHS) in Al Ain in the United Arab Emirates (UAE), and is offered as a comparison with studies done in other parts of the world. Such research can be useful for planning psychiatric services. The CMHS in Al Ain provides: psychiatric, physical and social assessment; assessment of activities of daily living; home administration of medication and medication supplies; social intervention; long-term follow-up; support and psychoeducation for patients and families; and community outreach involving repeated attempts to maintain contact with non-compliant and uncooperative patients and families.

The CMHS team at Al Ain Hospital consists of psychiatrists, community psychiatric nurses, a psychologist, a social worker and an occupational therapist. The team covers the Al Ain area. Al Ain is the second largest city in Abu Dhabi and has a population of around 570 000 (2010). The population covered by the service is mainly local citizens. The CMHS is continuously expanding, in terms of both patient number and organisation. It started in 1994, when it had 20 patients. The team now serves around 140 patients through 160 visits every month. An assessment of patient outcomes was a prerequisite for further development of the service.

The CMHS at Al Ain Hospital is guided by a comprehensive policy concerning the roles of the different team members, referral and admission, discharge, psychiatric assessment and doctors' case management, CMHS patient referral to hospital services, claim management, emergency action plans, transportation plans, management of patient records, medical waste, medication management, and patients' rights and responsibilities.

Methods

This descriptive study aimed to assess the outcome of Al Ain Hospital's CMHS. Hospital records were reviewed to obtain: demographic data; psychiatric and medical diagnoses; and duration of illness. Total numbers of admissions and duration of in-patient care before and after enrolment in the CMHS were documented. Frequency of admission and duration of hospital care (per year) were calculated for each patient. Patient satisfaction with the CMHS was assessed using a questionnaire modified from the user version of the Customers' and Users' Expectations of Health Services Questionnaire – Users (CUES-U), which has eight questions (four assessing quality of life and four assessing satisfaction with the CMHS), with three available responses ('satisfied', 'not satisfied' or 'unsure'). We used only the four questions assessing patient

https://doi.org/10.1192/S1749367600004239 Published online by Cambridge University Press

satisfaction with: information and advice offered by CMHS team members; access to the mental health service; relationships with CMHS team workers; and drug treatment.

Results

The characteristics of the 123 patients included in this study are shown in Table 1. About 60% had had symptoms for more than 10 years. The majority of patients were diagnosed with schizophrenia (32.5%). Other diagnoses are listed in Table 1.

The total number of admissions per year was significantly reduced, from 62 to 15, by enrolment in the CMHS ($t = 6.171$, d.f. = 122, $P<0.0001$). Similarly, the mean number of days spent in hospital per patient per year was reduced from 9.8 to 1.3, which was highly significant ($t = 5.678$, d.f. = 122, $P<0.0001$). About 15% of patients spent more than 20 days a year in hospital before they were enrolled in the CMHS, compared with less than 2% after enrolment. Table 2 compares the frequency and duration of hospital admissions before and after enrolment in the CMHS.

Patients' responses to the questionnaire indicated high satisfaction with the CMHS: 93.4% of patients were highly satisfied with the information and advice, 90.1% with their relationships with CMHS workers, 83.5% with the access to the mental health service, and 91.2% with their drug treatment.

Table 1
Characteristics of patients

	No.	%
Age (years)		
<20	11	8.9
20–29	32	26.0
30–39	24	19.5
40–49	16	13.0
50–59	8	6.5
>60	32	26.0
Gender		
Male	64	52.0
Female	59	48.0
Diagnosis		
Schizophrenia	40	32.5
Schizoaffective disorder	12	9.8
Bipolar disorder	13	10.6
Major depression	14	11.4
Dementia	9	7.3
Intellectual disability	24	19.5
Pervasive developmental disorder	6	4.9
Unspecified psychosis	5	4.1
Duration of illness (years)		
<5	24	19.5
5–9	25	20.3
10–14	35	28.5
15 and more	39	31.7

Table 2
Frequency and duration of hospital admissions for the 123 patients before and after enrolment in the community mental health services (CMHS)

	Total/ year	Mean	s.d.	Significance
Total number of admissions per year				
Before CMHS	62	0.50	0.77	$t = 6.171$, d.f. 122, $P<0.0001$
After CMHS	15	0.12	0.42	
Total duration of hospital stay (days/year)				
Before CMHS	1211	9.84	18.03	$t = 5.678$, d.f. 122, $P<0.0001$
After CMHS	166	1.35	5.73	

Discussion

Measures for the evaluation of services can cover a wide range of outcomes, including symptom control, social functioning and community stability, quality of life and risk reduction. However, the outcome most frequently reported is hospitalisation (Burns, 2007). This study has shown a significant reduction in the frequency and duration of hospitalisation after our patients started regular CMHS visits. This finding could be explained by the fact that CMHS patients are more likely to adhere to the treatment regime; also, relapse or worsening of the mental disorder was more likely to be detected earlier by the CMHS team, which results in early intervention (including admission, if indicated). It is important to consider that the team is currently providing a service to only a few patients of other nationalities. Therefore, the outcome may need to be investigated further when the service expands more to include more expatriates.

Comparisons with studies done in other areas of the world are limited by the fact that there are different models, tools and team structures. However, our findings are consistent with recent systematic reviews that have concluded that home treatment teams reduce days spent in hospital, particularly if the visits are regular and the teams have responsibility for both social care and healthcare (Catty *et al*, 2002). Hospitalisation is used as a research outcome mainly because of its assumed equivalence with relapse and its obvious utility to planners and service providers. It has, also, a powerful advantage in its face validity to clinicians. However, it gives little information about individual patient outcomes and can convey an impression that the researchers are more interested in services than in patients (Burns, 2007).

This study also found high patient satisfaction with the CMHS in terms of: information and advice; relationships with the CMHS team; access to mental health services; and drug treatment. Patient satisfaction with services is an important outcome variable that is increasingly used in mental health service evaluation (Ruggeri *et al*, 2003). Studies focusing on consumer views within community-based settings have identified the readiness of users to express their views. However, few studies have focused on CMHS users' satisfaction (Ralston *et al*, 1998).

Other benefits of treating psychiatric patients in the community have been documented in the literature. For example, a systematic review found that community mental health team management was effective, compared with standard care, in terms

https://doi.org/10.1192/S1749367600004239 Published online by Cambridge University Press

of acceptance of treatment, reduction of hospital admissions, maintaining care, reducing death by suicide and reducing costs. However, Simmonds *et al* (2001) found no significant differences in patient psychopathology between CMHT management and standard care.

Despite the advantages of the CMHS in reducing in-patient hospital care and patients' satisfaction with the service shown in our study, collaboration between the CMHS team and other mental health services is needed for crisis and relapse interventions, as many psychiatric illnesses are characterised by frequent relapses. In recent years there has been a debate between those who support the provision of mental health treatment and care in hospital, and those who support primarily, or even exclusively, the provision of community care. This dichotomy could be replaced by an approach that integrates community services with modern hospital care (Thornicroft & Tansella, 2004).

This study is limited by the fact that it examined only one CMHS team, and the findings cannot be generalised to the whole country.

Conclusion

The effectiveness of the Al Ain Hospital CMHS in minimising the need for hospitalisation as well as the length of stay for the enrolled patients has been demonstrated. Patients were highly satisfied with the CMHS. Further research is needed to assess the continued effectiveness of this service, assessing different outcome measures. Evaluations of CMHS in other regions are needed.

References

Burns, T. (2007) Hospitalisation as an outcome measure in schizophrenia. *British Journal of Psychiatry*, **191** (suppl. 50), s37–s41.

Catty, J., Burns, T., Knapp. M., *et al* (2002) Home treatment for mental health problems: a systematic review. *Psychological Medicine*, **32**, 383–401.

Flannery, F., Adams, D. & O'Connor, N. (2011) A community mental health service delivery model: integrating the evidence base within existing clinical models. *Australian Psychiatry*, **19**, 49–55.

Hadley, T. R., Turk, R. & McGurrin, M. (1997) Community treatment teams: an alternative to state hospitals. *Psychiatric Quarterly*, **68**, 77–90.

Kim, T., Mueser, K. T., Gary, R., *et al* (1998) Models of community care for severe mental illness: a review of research on case management. *Schizophrenia Bulletin*, **24**, 37–74.

Ralston, G., Beesley, S. & Bogue, J. (1998) Users' needs and satisfaction with a community-based mental health service. *Psychiatric Bulletin*, **22**, 473–476.

Ranasinghe Mendis, J. & Hanwella, R. (2010) Community psychiatry service in Sri Lanka: a successful model. *Sri Lankan Journal of Psychiatry*, **1**, 3–5.

Rosen, A., Mueser, K. T. & Teesson, M. (2007) Assertive community treatment – issues from scientific and clinical literature with implications for practice. *Journal of Rehabilitation Research and Development*, **44**, 813–825.

Ruggeri, M., Lasalvia, A. & Bisoffi, G. (2003) Satisfaction with mental health services among people with schizophrenia in five European sites: results from the EPSILON study. *Schizophrenia Bulletin*, **29**, 229–245.

Simmonds, S., Coid, J., Joseph, P., *et al* (2001) Community mental health team management in severe mental illness: a systematic review. *British Journal of Psychiatry*, **178**, 497–502.

Thornicroft, G. & Tansella, M. (2004) Components of a modern mental health service: a pragmatic balance of community and hospital care. Overview of systematic evidence. *British Journal of Psychiatry*, **185**, 283–290.

SPECIAL PAPER

Addressing the mental health needs of a rapidly growing megacity: the new Lagos Mental Health Initiative

Olufemi Oluwatayo,[1] Olufemi Olugbile[2] and Ayodele Coker[3]

[1]Consultant Psychiatrist, Wells Road Centre, Nottinghamshire Healthcare NHS Trust, Nottingham, UK, and Mental Health Advisor, Lagos State Ministry of Health, Ikeja, Lagos, Nigeria, email Olufemi@doctors.org.uk

[2]Consultant Psychiatrist and Permanent Secretary, Ministry of Health, Ikeja, Lagos, Nigeria

[3]Consultant Psychiatrist and Senior Lecturer, Department of Psychiatry, Lagos State University Teaching Hospital, Ikeja, Lagos, Nigeria

The Lagos State Government of Nigeria recently launched its Mental Health Policy and Work Plan aimed at addressing the mental health needs of Lagos, one of the world's fastest-growing megacities, and its nearby communities. This paper discusses the contextual basis of this initiative, its components and the challenges faced so far. It argues that urban centres deserve attention in the current push towards investing in mental health services in low- and middle-income countries.

There has recently been concerted global action to address the poor state of mental health services in low- and middle-income countries (Eaton *et al*, 2011) but the efforts seem to be based mainly in rural settings (WHO, 2011). The focus on rural areas mirrors past efforts, based on the assumption that access to mental health services in urban areas is better than in rural areas. In Nigeria, however, access is generally poor, regardless of location (Gureje *et al*, 2006) and a recent study from São Paulo indicated that the prevalence of

https://doi.org/10.1192/S1749367600004239 Published online by Cambridge University Press