DOI: 10.5455/msm.2022.34.296-300
Received: Nov 12 2022; Accepted: Dec 04, 2022

ORIGINAL PAPER Mater Sociomed. 2022 Dec; 34(4): 296-300

The Impact of the Community Psychiatric Treatment Program on the User's Quality of Life - experience of the Study Participants

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ABSTRACT

Background: Community psychiatric treatment (CPT) is a novelty in the primary health care system for the people with mental health problems. The service operates according to the Flexible Assertive Community Treatment (FACT) model. FACT is a rehabilitation-oriented clinical case management model based on the ACT model (Assertive Community Treatment). **Objective:** This study aimed to assess how involvement in a community psychiatry program affects the quality of life of program participants. **Methods:** Between December 2020 and March 2021 we conducted a qualitative study. To obtain information, semi-structured interviews with twelve patients treated in the Community Psychiatric Treatment program were conducted. All restriction regarding COVID pandemic were considered at the research. Content analysis of the text was used for data analysis, which means that we interpreted the analysed text and determine the meaning of individual parts of the text. **Results:** Twelve persons participated in the interviews, six of which were women (50%) and six men (50%). All the participants were of Slovenian nationality. They were from 28 to 80 years old, with a mean age of 47 years. We identified twelve categories and four themes: treatment problems, principles of operating of CPT program, satisfaction with inclusion in the CPT and improvement of quality of life through inclusion in the program. **Conclusion:** Quality of life is essential for every individual, as well as for people with mental health problems. In our study we have proved that the Community psychiatric programs could significantly impact the quality of life of people with mental health problems.

Keywords: Community psychiatric treatment program, quality of life, mental health, primary health care.

1. BACKGROUND

Quality of life is an important aspect of mental health and has been a concern for centuries at patient population group with mental health problems. The assessment of the quality of life of the mentally ill is based primarily on the patient's self-assessment regarding the impact of his illness on his life (1). Various approaches have been developed involving patients and their relatives to improve the quality of life of people with mental illness. One of them is the model of community psychiatry that encompasses the use of methods, theories, and techniques to identify mental health needs at the community (2, 3). Community service is supposed to respond to the needs of individuals in a functional manner in and a geographically limited area (2). Patient treatment provides interdisciplinary working groups composed of psychiatrists, psychologists, nurses, social workers, and occupational therapists (2-4). In the program are mainly included people with severe and recurrent mental disorders with a high risk due to suicide and frequent psychiatric re-hospitalisations (4).

In 2013, pilot projects of Community Psychiatric Treatment (CPT) were introduced in Slovenia to treat and assist people with severe and recurrent mental health problems, such as depression, bipolar disorder, schizophrenia, and other sever mental health problems (2). According to the individual plan, the treatment is carried out in the home environment or in the community: it can include the learning of everyday activities (e.g., cooking, personal hygiene, use of public transport, etc.), planning of daily

activities for people with a broken structure of days, help with the inclusion in the community (e.g., in a day centre, other non-governmental organizations, etc.), assistance with inclusion in social life, encouragement of participation of relatives in the treatment and informing on the illness, relief, psychosocial counselling, etc (2,4).

The CPT service operates according to the Flexible Assertive Community Treatment (FACT) model (5). FACT is a rehabilitation-oriented clinical case management model based on the ACT model (Assertive Community Treatment), it is flexible and include a broader range of people with severe mental illness (3) and is increasingly applied to people with mild intellectual disability (6). One of the important competences in Family medicine is community-oriented approaches (7). For this reason, it makes sense for family medicine and community mental health centres to work together in the community. Both provide an easily accessible care for a patient population that otherwise finds it difficult to contact with the health system.

2. OBJECTIVE

Community psychiatric treatment is a novelty in the primary health care system, and as thus it is more accessible for the people with mental health problems and better connected to other professionals working in the community regarding to the promotion and mental health prevention. This study aimed to assess how involvement in a community psychiatry program affects the quality of life of program participants.

3. MATERIAL AND METHODS

We conducted a qualitative study. To obtain information, semi-structured interviews were conducted with patients treated in the Community Psychiatric Treatment (CPT) of the Health Center Murska Sobota (ZD MS) from December 2020 to Mach 2021. The sample was explicitly selected; 12 users of CPT were included. We wanted to get in-depth information about the community psychiatry program. The inclusion criteria were participation in the program at least three months, willingness to participate in the study and allowed the recording of the interview. Exclusion criteria were age below 18. The interviews were conducted in the patients' home environments or in ZD MS under strict COVID rules. We opted for the home environment because patients are thus more relaxed, and the possibility of obtaining accurate and objective results is greater. The questions in the interview were related to the quality of life, with an emphasis on the impact of inclusion or treatment in the Community psychiatric treatment on the quality of life, experience of treatment and advantages of treatment in the Community psychiatric treatment program. All interviews were recorded. Before conducting the interviews, we obtained the written consent of the participants for their participation in the research and recording. The ongoing analysis allowed us to detect data saturation and thus complete the interviewing of persons. The interviews were audio-recorded, and a literal transcript was made. The transcript includes the participants' answers and their non-verbal messages. Thirty-nine typed pages were written, i.e., 13,849 words, in Times New Roman font, size 12 pt. The interviewees were marked with a variable "I" - the interviewee and the serial number of the conducted interview from 1 to 12 was added. Content analysis of the text was used for data analysis, which means interpreting the analysed text or determining the meaning of individual parts of the text (8). After repeated reading, we assigned codes to individual parts of the text. Furthermore, we grouped the codes related to similar phenomena into categories and topics, thus defining the connections between the individual codes. The method to ensure the credibility of the research process was used. Two external researchers coded the interviews separately to improve the reliability of the research. Thus, triangulation in text analysis was also performed.

4. RESULTS

Twelve persons participated in the interviews, six of which were women (50%) and six men (50%). All the participants were of Slovenian nationality. They were from 28 to 80 years old, with a mean age of 47 years. The table 1 represent the demographic data of the interviewees.

	Participants	
	n = 12	%
Gender		
Male	6	50
Female	6	50
Marital Status		
Single	11	91.7
Divorced	1	8.3
Education		
Elementary school	4	33.3
Vocational School	5	38.7
Secondary school	1	8.3
University	2	16.7
Employment		
Employees	3	25
Homemaker	1	8.3
Retired	3	25
Unemployed	1	8.3
Social Inclusion	2	16.7
Vocational rehabilitation	2	16.7
Accomodation		
House	8	66.6
Apartment building	2	16.7
Housing group	2	16.7

Table 1. Socio-demographic data of the participants in the qualitative part of the research

As part of the text analysis, we created 4 themes and 12 categories. Each category also has subcategories. The themes and categories are presented in Table 2 and supported by citations below.

Theme: Treatment problems

Participants had many problems at the onset of their mental health problems, including accepting the mental

illness. They reported about exacerbation, periods of crisis and impact of mental illness on the quality of life. Some have experience with hospitalizations in a psychiatric hospital. They described the beginnings of their mental health problems and lack of knowledge, denial, ignorance of mental health problems and the impact of past events.

"I got hallucinations, I drank a lot of alcohol, and I had visions and heard voices, I saw how gypsies kidnapped my father and mother and blackmailed them."

"My problems began at the age of 14; I started purging, purging regularly, I had PTSD, and then I was treated in psychiatry, and then I stopped and was without treatment until I was 20. Then I started again when the symptoms hit again during my studies as it was too stressful."

Theme	Category	Number of codes
Treatment problems	problems at the beginning of treatment, difficulties in accepting the disease, the emergence of crisis periods and deteriorations, the impact of mental illness on the quality of life, hospitalizations in a psychiatric hospital.	30
Principles of operation of CPT	mental illness as a reason for inclusion, help in life, desires for change in life.	17
Satisfaction wit inclusion in the CPT	a sense of belonging when included in the CPT, therapeutic relationship.	8
Improving the quality of life through inclusion	the influence of the CPT service on various areas of users, the importance of quality of life.	12

Table 2. Summary of content analysis with themes, categories, and codes

The participants described the process of accepting the difficulties and the mental illness and stated that they faced feelings of helplessness and distress.

"Sometimes you're really angry because you can't be like others, but it feels easier. At first, I thought I would get over it in three months, and I would be healthy."

The participants stated that accepting the disease takes time; it is necessary to learn to live with the disease. At this point, the CPT service also plays an important role. They accepted the disease as a part of life.

"But now, when I go to the CPT, all the members of the team alleviate my problems; I accept it more easily. I get help from everyone. Then it's easier for me."

Exacerbations are part of mental illness, which the participants in our study also reported.

"I get terrified of these symptoms. I talk to my parents, tell them what's going on with me, and tell them to pay attention, list the signs, and tell them how to react. I begin to panic. I call the CPT."

Most of the participants perceived a significant impact of the disease on the quality of life.

"No, I don't live well enough, but I live a lot better than I did two years ago. I'm slowly climbing upward."

Theme: Principles of operation of CPT

The participants described how the treatments in the CPT work and cited various reasons for inclusion.

"I couldn't help myself anymore; I thought I had to seek some help; I needed help, advice..."

Some stated that they sought and wanted help and changes in life. A few said they were referred to the CPT by professionals. The participants pointed out that their involvement in the CPT helps them in various areas of life.

"For the structure of the day, to not just lie around. Walks, I go for walks with my occupational therapist, I get various tasks to boost my memory. We have connected with the Centre for Health Strengthening, which helps me lose weight and exercise."

The participants described how the work and inclusion in the CPT work. Inclusion in the CPT helps them achieve life changes that affect their quality of life.

"At the psychiatrist's, I first tell if I am paranoid, resentful, if I have fears, how my well-being is, such stuff, at what stage my schizophrenia is. With the occupational therapist, we touch some topics, which helps me. When I'm in better shape, we cook together; we go to the store because I have problems with that; I have fears of going to the store; we also went cycling because I have problems in this area as well. It helps me to get involved in daily activities more easily."

The participants described the accessibility of the CPT service, they express how essential it is the accessibility of the professionals for them. They notice how the impact of teamwork made changes in their lives.

"Because we started working on several areas. Teamwork. Because here I was helped in different areas. For example, the occupational therapist helped me be more integrated into society and be more active. The work here is really teamwork and touches areas that couldn't be touched before. Also, in a more practical sense."

The participants stated their wishes for the future, which relate mainly to social relations, financial situation, physical and mental health.

"I would like to be more open; I have a big fear of contacts, that's why I have so few friends and I don't go out at all. I would like to be more open so that I am no longer afraid of interpersonal contact with another person."

The findings show that they want a better quality of life in various areas, but face difficulties in achieving change in life, as outlined in the quotes below.

"I'm already 30 years old, and I'm starting to think maybe I could have a baby. Because somehow, the image in my head is: quality of life, a partner, a family, a job... And you want to have that quality of life."

Theme: Satisfaction with inclusion in the CPT

We find that the participants are satisfied with the inclusion which has added a significant contribution to their life. The participants experience a sense of belonging when included in the CPT; they expressed feelings of security, support, receiving help and feeling satisfied with being treated in a home environment.

"Some kind of security, I can say, I have support."

We find that the therapeutic relationship is of great importance to the participants. In the CPT, they are treated by various professional profiles; they participate in the treat-

ment, contributing to greater independence and autonomy.

"It's worth the most when you know someone comes because of you, and you see them stand up for you and ask you how you are."

Theme: Improving the quality of life through inclusion

The user quality of life has improved due to the inclusion and participation in the CPT. They are more active in their daily functioning, daily routine. The social and employment areas have also improved as well as their coping with problems or hardships.

"It has changed all the areas, I can say. Alcohol first... The fact that you kept helping me and such... Lately, we have been reducing the involvement of the psychiatrist who prescribed this and that."

Most of them said that they had changed their attitude towards themselves in dealing with hardships.

"I'm not so hard-working anymore, I allow myself more, I'm not so strict with myself anymore. There's still that voice in my head that says I'm a worthless creature and I don't deserve anything good, but it's not that loud anymore."

The participants defined what it means to them or how they understand the importance of quality of life.

"The quality of life means that you eat a healthy diet, that you do sports."

"That your head is straightened out. Finances, family, relatives, friends... That you are at peace, peace of mind, good job."

5. DISCUSSION

Our results show that participants of our study understand the quality of life very holistic, what includes physical, mental, and social well-being. Participation in the CPT, enable them achieve changes in their life in various fields, like social, educational, employment status and in relation to themselves when dealing with problems or hardships. Satisfaction with the inclusion in the CPT includes treatment in home environment, a team and comprehensive treatment approach. The results show that the therapeutic relationship is important for the participants, as it contributes to better adherence and achievement of set individual treatment goals. Ådnanes and co-authors say that continuity of care and good therapeutic relationships with healthcare professionals are essential for mental health services and indicate the quality of care (9). The ACT program contributes to strengthening the relationship between people with severe mental illness and health care staff (10). Clausen, and co-authors found that targeted interventions aimed at improving patient functioning could positively impact the patients' quality of life (11). Fewer hospitalizations, participation in antipsychotic treatment, improved social performance, and higher user satisfaction were found in subjects included in the community treatment (10). In the study of Andrade, the users' satisfaction with community-based mental illness treatment was assessed and the participants reported feelings of respect and dignity, understanding, problem-solving, and satisfaction with the community treatment program (12). Important role of the services are also crisis interventions. When the condition worsens, a team can respond quickly and act, which is an advantage of the CPT service. The CPT service is well accessible to users in the event of worsening conditions or crisis periods. Through such organization model, the participants reported about feelings of support, security, and acceptance. Murphy and co-authors observed that people with mental health problems often experience periods of crisis and worsening of their condition, and they need to return to the psychiatric hospital, but treatment in the home environment still has many advantages (13). Community-based mental health services are designed to act in the event of an exacerbation, to avoid re-hospitalization and help to improve the mental state of users (13) by the interprofessional team. Trane and colleagues conducted a study to observe the functioning of FACT participants three years after inclusion in FACT (14). Similarly, as in our study, they observed fewer crises and more accessible help in the event of exacerbation for the participants (14). Marshall & Lockwood compared the ACT program and standard community program regarding hospitalizations in a psychiatric hospital and concluded that the participants of ACT needed fewer hospital stays than people enrolled in standard community care (15). In our study participants reported about difficulties in achieving whished changes in their life, that mental illness and related problems affect their quality of life. Barnes and co-authors examined three aspects of subjective perceptions of quality of life in people with severe and recurrent mental disorders: general life satisfaction, physical and mental health (16). They pointed out that for recovering and improving well-being of people with mental health problem, attention should be paid to various factors, such as general health, psychiatric, and psychosocial wellbeing (16). The reported quality of life of our participants has, namely improved, in various areas: social, employment, financial, educational, as well as in dealing with problems or hardships, improving physical health, attitude towards oneself and improving daily functioning. Clausen and colleagues emphasize that the subjective quality of life of patients is positively related to their practical and social functioning (11). Persons enrolled in the ACT program have changed their living conditions and employment; patient satisfaction and the likelihood of independent living have increased (15). Nugter and colleagues investigated the extent to which the fully used FACT model allows for improvement of clinical and social outcomes and patient satisfaction with care (17). Three FACT-performing teams and 298 patients were included. There were statistically significant improvements in patient participation in treatment, reduction of unmet needs and improvement in the quality of life. The findings show that FACT is a successful model in adapting care to patient needs. They found that quality improvement was related to the duration of FACT (17). Cooperation between CPT teams and primary health teams could importantly ease the implementation of the program in the community and some weaknesses in the eHealth infrastructure could be a barrier for an easy implementation of FACT teams (18). In Slovenia, little research has been done on the quality of life of people with mental illness, we believe that our research is an important starting point for further research into the quality of life of people with mental illness and for the further work of the CTP.

Research limitations

A limitation in the research could be the participants' relationship with the leading researcher; the participants may have wanted to answer the questions in a pleasant way (19). An additional limitation may be the relatively short involvement of the program users in the program and the limitations in its implementation due to pandemic measures.

6. CONCLUSION

Quality of life is essential for every individual, as well as for people with mental health problems. We believe that the development and operation of Community psychiatric programs will significantly impact the lives and quality of life of people with mental health problems. However, more extended monitoring of the work and implementation of the program will be needed to assess the long-term effects on the course of treatment and the quality of life of the persons involved in a CPT program.

- **Author's contribution:** .Both authors were involved in all steps of preparation this article including final proofreading.
- **Conflict of Interest:** The author declares no conflict of interest.
- **Financial support and sponsorship:** This research received no external funding.

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