CASE REPORT

Modified Assertive Community Treatment (ACT) in the Management of Comorbid Mental and Physical Illnesses: A Case Report

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Abstract

The holistic approach of assertive community treatment (ACT) may provide better care and lead to better outcomes in populations with difficult-to-treat comorbid mental and physical illnesses. This paper describes the complex issues in managing a person with multiple chronic medical illnesses who also had comorbid treatment-resistant depression and poor social support. The patient achieved improvement after the implementation of the therapeutic ingredients of ACT.

Keywords: Assertive Community Treatment, Comorbid Physical and Mental Illness, Treatment-resistant Depression

Introduction

Comorbidity rates between depression and physical illnesses are in excess¹. The presence of depression in people with physical illness contributes to poorer prognosis through direct biological factors (e.g. immune suppression) and indirect psychosocial factors (e.g. noncompliance to treatment)². The underlying physical illness can also exacerbate the co-existing depression to the extent of the condition becoming refractory to treatment³ resulting in the increase of medical service utilization and treatment costs⁴.

While the holistic approach of ACT has been proven to be effective in providing services to people with severe mental illness (SMI)⁵, there has been a dearth of research in assessing the impact of ACT on clients with chronic medical illness with comorbid psychiatric conditions. In developing countries, modified ACT, mainly due to inadequate resources, has also been shown to be similarly effective in improving outcomes in people with SMIs⁶. This case report illustrates the complex issues in managing a person with multiple chronic medical illnesses who also had comorbid treatment-resistant depression and poor social support. The impact of modified ACT on this patient and its therapeutic ingredients are discussed.
Case Report

Miss ZA is a 42-year-old single unemployed lady who has been bed-bound since she had a fall and sustained left neck of femur fracture 5 years ago. One year later, she developed major depressive disorder. She had long standing medical illnesses, namely mixed connective tissue disease (rheumatoid arthritis and systemic lupus erythematosus) with atlantoaxial subluxation, iatrogenic Cushing’s syndrome with bilateral hip avascular necrosis, history of recurrent stroke and T4 to T6 spinal compression fracture (treated as spinal tuberculosis) with neurogenic bladder. She had been unemployed for many years and lived in poverty with her old parents. She had transportation problem to come for follow up and was not compliant with all her medications resulting in poor control of her illnesses and frequent hospitalizations.

She clearly had not overcome her grief for the loss of her physical health and the accompanying disabilities. She was constantly feeling angry and had unrealistic expectations on her recovery. She had multiple episodes of drug overdose as either suicide attempt or a way of expressing her frustration. The family was afflicted with increasing burdens, physically, emotionally and financially, with the patient’s increasing disabilities and frustration and the parents’ increasing age and their own medical problems. This manifested in the parents as high Expressed Emotion, resulting in verbal and sometimes physical aggression targeted to the patient which became a vicious cycle as she also directed her anger towards her parents by scolding them with vulgar words whenever they did not attend to her needs promptly.

She was referred to the community psychiatric team of Universiti Kebangsaan Medical Centre (UKMMC) 3 years ago. The team initially had difficulties in optimizing her medications as she coped by taking extra doses of her psychotropic medications whenever she was distressed by either insomnia, joints pain or mother’s critical comments. This problem improved after the community nurse prepared pill boxes for her and engaged her father to supervise her medications. She was planned for regular grief counseling, supportive psychotherapy, behavioural modification and monitoring of her medication intake. The community team visited her weekly to fortnightly to implement these treatment strategies with additional visits upon request whenever they were in crisis. Transportation was provided to send her to the rheumatology clinic for follow-ups. Steroid was given in minimum effective dose just enough to treat her arthritis and avoid exacerbation of her depression. The treating team network was also expanded to include a medical officer from the rheumatology team who would be consulted when she had a flare of arthritis and a counselor to provide more frequent grief counseling. A social worker was included to help renovate her room and create a bath and toilet area to ease her with these basic needs. She was also given a wheelchair to help her be more independent in her daily activities. Furthermore, financial aids from the relevant social agencies were secured to reduce the family’s financial burden.

In this case, apart from optimizing medications, large amount of time was spent in addressing the patient and her family’s emotional and social needs. This has helped the patient and her parents to accept her illnesses and remained engaged in treatment. She was taught adaptive skills such as distraction and prayers in dealing with her feeling of loneliness and worthlessness. Her perception on illnesses was also modified
that she and her family could view them as a challenge in life to strengthen their faith in religion. Thus, they could learn to cope with more forgiveness and love to each other as a family. One of the turning points in her arduous journey in reaching to a meaningful life was when her previous hobby in knitting was highlighted. With the help of an occupational therapist, she was provided with materials for knitting and encouraged to resume this hobby. Despite having severely deformed bilateral hand joints, she amazingly could still knit table runners that generated some income and helped combat her sense of hopelessness and worthlessness. She found satisfaction and meaning to continue living. Subsequently, her joints pain became less. The family situation was less chaotic and her parents were happier. The companionship and assertive treatment which were provided by the community team had instilled hope in this family; a hope that was lost in the midst of constant struggle with poverty, physical and mental illnesses on top of suffering from marginalization by the society. After 2 years of receiving a modified ACT, her admission was significantly reduced from 13 admissions in two years to none admission in the subsequent year.

Discussion

Mental and physical health are two inextricable entities that should be addressed concurrently in providing care for people suffering from Comorbid medical and mental illnesses\(^5\). A fragmented health care system may demoralize the patients with this condition and their caregivers. Multidisciplinary approach, integration of services, medication management and psychosocial rehabilitation in ACT model is useful in addressing the significant physical and mental health disparities as well as social difficulties in those with severe comorbidities\(^5\). The therapeutic ingredients of ACT such as assertive outreach, individualized services, building trusting relationship, solving day to day living problems and providing families with psychoeducation and support restore the clients’ dignity and make life more bearable and meaningful for them\(^5\).

Despite the challenges faced in implementing ACT in Malaysia, especially lack of resources, that made ACT have to be modified from the standardized western version, comprehensive services could still be delivered to the clients with most complex conditions when available resources are explored and utilized optimally. Innovation, adequate skills, perseverance and team spirit in the community staffs in dealing with the complexities in this reported client as well as utilization of resources from outside the team have proven to be useful in helping the client improve her life. Apart from the innovative quality in health care staffs in making ACT a success for individual patients, governmental commitment in changing mental health policy and legislation in support of this evidence-based clinical intervention is also crucial in bringing the implementation of this intervention to another height.

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References


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