THE PSYCHIATRIC PAPER-TRAIL:

A study of the continuity of psychiatric management from a community clinic perspective

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ABSTRACT

Mental health services in South Africa have historically been hospital-based and treatment focused. In 1997 the Department of Health committed itself to the transformation of mental health services in South Africa and adopted a District Health System model through which to shift the focus of mental health care from a hospital-based to a community-based service. This transition has been challenging on many levels, as attempts are made to develop the capacity of community mental health structures so as to render a comprehensive mental health service at the community clinic level. Given the infancy of this change, very little literature exists about the current struggles facing public community mental services, making the process of establishing an integrated mental health service at these sites all the more difficult. This study will explore the current mental health services offered at a community clinic, highlighting the limited capacity of this service site to offer a comprehensive psychiatric management service. After providing a historical overview outlining the context from which mental health services in South Africa have emerged, a situational analysis of a hospital-based and a community-based psychiatric service site is presented, highlighting some basic requirements of a psychiatric service and identifying shortfalls at the community clinic level in terms of these requirements. An audit of clinical work conducted at the community clinic is presented; illustrating that there is insufficient biopsychosocial information at the community clinic level in order to render an effective psychiatric service. A single-case study is then presented and used to substantiate the claim that psychiatric management constitutes a specialist mental health service and as such, requires a multi-disciplinary team approach. A possible model for community psychiatric management is presented based on the intervention strategy used in the single-case and an argument is developed for a potential role for clinical psychology in the development and management of an effective community-based psychiatric service.
DECLARATION

The author hereby declares that this whole thesis, unless specifically indicated to the contrary in the text, is his own original work.

signature removed

______________________________
Paul Haupt
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**LIST OF ABBREVIATIONS**

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>CMHN</td>
<td>Community Mental Health Nurse</td>
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<td>CMHS</td>
<td>Community Mental Health Service</td>
</tr>
<tr>
<td>DHS</td>
<td>District Health System</td>
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<td>GSH</td>
<td>Groote Schuur Hospital</td>
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<tr>
<td>MHCHCCM</td>
<td>Mental Health Community Hospital Coordinating Committee Meeting</td>
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<tr>
<td>MHS</td>
<td>Mental Health Service</td>
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<td>MO</td>
<td>Medical Officer</td>
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<td>NGO</td>
<td>Non Governmental Organisation</td>
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<td>OPD</td>
<td>Out-patient Department</td>
</tr>
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<td>VBH</td>
<td>Valkenberg Hospital</td>
</tr>
<tr>
<td>WAU</td>
<td>Woman's Admission Unit</td>
</tr>
</tbody>
</table>
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Chapter</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABSTRACT</td>
<td>I</td>
</tr>
<tr>
<td>DECLARATION</td>
<td>II</td>
</tr>
<tr>
<td>ACKNOWLEDGEMENTS</td>
<td>III</td>
</tr>
<tr>
<td>LIST OF ABBREVIATIONS</td>
<td>IV</td>
</tr>
<tr>
<td>TABLE OF CONTENTS</td>
<td>V</td>
</tr>
<tr>
<td>LIST OF TABLES &amp; FIGURES</td>
<td>VIII</td>
</tr>
<tr>
<td><strong>CHAPTER 1</strong></td>
<td></td>
</tr>
<tr>
<td><strong>INTRODUCTION</strong></td>
<td>1</td>
</tr>
<tr>
<td>1.1 INTRODUCTION TO THE STUDY</td>
<td>1</td>
</tr>
<tr>
<td>1.2 CONTENT</td>
<td>2</td>
</tr>
<tr>
<td>1.2.1 Historical overview</td>
<td>2</td>
</tr>
<tr>
<td>1.2.2 The current landscape</td>
<td>2</td>
</tr>
<tr>
<td>1.2.3 Auditing the clinical work</td>
<td>3</td>
</tr>
<tr>
<td>1.2.4 Conclusion</td>
<td>3</td>
</tr>
<tr>
<td><strong>CHAPTER 2</strong></td>
<td></td>
</tr>
<tr>
<td><strong>BACKGROUND HISTORY</strong></td>
<td>4</td>
</tr>
<tr>
<td>2.1 INTRODUCTION</td>
<td>4</td>
</tr>
<tr>
<td>2.2 A HISTORICAL OVERVIEW</td>
<td>4</td>
</tr>
<tr>
<td>2.3 THE CURRENT SITUATION, A NEW MILLENIUM</td>
<td>6</td>
</tr>
<tr>
<td>2.4 PROPOSED MENTAL HEALTH SERVICES FOR THE</td>
<td>7</td>
</tr>
<tr>
<td>WESTERN PROVINCE</td>
<td></td>
</tr>
</tbody>
</table>
2.4.1 Four primary service provision levels 7
2.4.2 The regional mental health support team 8
2.4.3 The regional hospital mental health services 8
2.4.4 Mental hospital and tertiary hospital units 8
2.4.5 Summary 8

2.5 CONCLUSION 9

CHAPTER 3 THE CURRENT LANDSCAPE 11

3.1 INTRODUCTION 11

3.2 AN OVERVIEW OF THE STRUCTURES OF THE PROPOSED MENTAL HEALTH SERVICES IN THE CAPE METROPOLE REGION OF THE WESTERN CAPE PROVINCE 11

3.3 THE WOMAN'S ADMISSION UNIT OF VALKENBERG PSYCHIATRIC HOSPITAL 12
  3.3.1 The staff compliment, the Woman's Admission Unit's (WAU) management team 12
  3.3.2 The WAU's primary task, the admission and discharge criteria 13
  3.3.3 The WAU's operational strategy 13
  3.3.4 Summary 14

3.4 MAITLAND COMMUNITY CLINIC, PRIMARY SERVICE LEVEL 3 15
  3.4.1 Staff compliment 15
  3.4.2 Maitland community clinic's primary task 15
  3.4.3 Maitland community clinic's operational strategy 16
  3.4.4 Summary 17

3.5 A GAP IN THE CURRENT SERVICE 18

3.6 CONCLUSION 18

CHAPTER 4 AUDITING CLINICAL WORK CONDUCTED AT MAITLAND COMMUNITY CLINIC 20

4.1 INTRODUCTION 20

4.2 AIM OF THIS RESEARCH: 20
  4.2.1 Hypothesis 20

4.3 SAMPLE SELECTION 21
  4.3.1 The selection of Maitland community clinic 21
  4.3.2 Referral procedure of cases 21
4.3.3 Selecting patients for this study

4.4 THE RESEARCH PROCEDURE
4.4.1 The research method
4.4.2 My position in the data gathering and analysis process
4.4.3 The data
4.4.4 Data gathering
4.4.5 Data analysis

4.5 RESEARCH RESULTS
4.5.1 Summary of all interventions conducted
4.5.2 The single-case

4.6 SINGLE-CASE SUMMARY
4.6.1 The case of S
4.6.2 Method and reason for referral
4.6.3 Presenting problem
4.6.4 Family history
4.6.5 Personal history
4.6.6 Mental state examination
4.6.7 Working diagnosis
4.6.8 Intervention plan

4.7 THE INTERVENTION PROCESS
4.7.1 Tracking the process
4.7.2 Summary

4.8 PROPOSING A MODEL FOR PSYCHIATRIC MANAGEMENT AT THE COMMUNITY CLINIC LEVEL
4.8.1 A model for community psychiatric management

4.9 CONCLUSION

CHAPTER 5 CONCLUSION

REFERENCES
<table>
<thead>
<tr>
<th>Table</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.1</td>
<td>Time spent on interventions at Maitland clinic</td>
<td>28</td>
</tr>
<tr>
<td>4.2</td>
<td>Time spent on interventions with S at Maitland clinic</td>
<td>28</td>
</tr>
<tr>
<td>4.1</td>
<td>Audit of interventions at Maitland clinic</td>
<td>29</td>
</tr>
<tr>
<td>4.2</td>
<td>Audit of interventions at Maitland clinic</td>
<td>29</td>
</tr>
<tr>
<td>4.3</td>
<td>Audit of the single-case, a psychiatric management Intervention</td>
<td>30</td>
</tr>
<tr>
<td>4.4</td>
<td>Audit of the single-case, a psychiatric management Intervention</td>
<td>30</td>
</tr>
</tbody>
</table>
CHAPTER 1
INTRODUCTION

1.1 INTRODUCTION TO THE STUDY

This study provides a microanalysis of two mental health service sites within a district of the Cape Metropole Region of the Western Cape Province. The findings of this study are based on research conducted by the author over the period February - December 1999, while working as an intern psychologist at these two sites. In focusing on mental health service provision at these two sites, this study explores the current state of mental health services offered at these two levels. As such, the study does not attempt to evaluate the mental health service policy underpinning these services, but rather focuses attention on the current mental health services generated by policy. The shift in focus over the last decade or so, from hospital-based to community-based mental health services, has proved to be a complex though necessary process; initiated by political change, this transformation process was undertaken in the face of enormous pressure generated in part, by the limitations of both staff and financial resources. The limited literature available in the field of the transformation of mental health services in South Africa and in particular, public mental health services, highlights the fact that this process is young and in need of research; so as to generate sufficient information about the needs of clients using these mental health services as well as the current limitations of these services to meet clients’ needs. From this basis, informed service development planning can occur whereby priority areas for development can be identified and focused, co-ordinated service development strategies can be implemented. It would appear that without such vigorous methodology, there is a risk of service development responding to the immediacy of service limitations and in so doing, spreading the already limited resources so thinly that it incapacitates the current mental health services. It is hoped that this study will raise relevant issues surrounding mental health service development at the community clinic level of the public health system and stimulate research interest in this field.
1.2 CONTENT

1.2.1 Historical overview
Chapter 2 provides a historical overview; tracking the history of mental health services in South Africa, from the 1800s to South Africa’s political change and resultant social transformation in the 1990s. This overview provides a backdrop against which the scope of the challenge of transforming South Africa’s mental health system is presented. Within this context, the commitment by the Department of Health, to transform mental health services from a predominantly hospital-based to a community-based service, is discussed. Attention is drawn to the proposed mental health service provision structures, for the Western Cape; the conceptual map against which health services in the Western Cape are currently being developed, so as to provide a structure against which the reader can conceptualise the focus and aim of the proposed mental health services at the community clinic level.

1.2.2 The current landscape
Chapter 3 presents a situational analysis of two sites at two distinct levels of the mental health service provision structures (i.e. the Woman’s Admission Unit of Valkenberg Hospital and Maitland community clinic). The analysis is conducted in terms of each site’s: staff compliment, primary task and operational strategy, delineating the current services offered at each site as well as describing the current operational strategy of a specialist psychiatric service. From this point an argument is developed suggesting that psychiatric management is a specialist mental health service, irrespective of where it is rendered. This discussion serves to locate the reader within the current landscape of these two functionally connected levels of the mental health service, in that both these levels offer a psychiatric management service. However, due to the fact that the community clinic level’s psychiatric service remains predominantly treatment-focused, a functional gap exists between these two levels, which limits the community clinic’s capacity to deliver an effective psychiatric management service. The argument is developed, by proposing that psychiatric management requires an interdisciplinary approach based on a thorough biopsychosocial assessment. It is further argued that biopsychosocial assessment is not currently offered at the community clinic level and that its absence presents a
fundamental obstacle to the development of an effective psychiatric management service at the primary level of mental health services in the Western Cape Province.

1.2.3 Auditing the clinic work
Chapter 4 sets out the research project, detailing the aim, hypothesis and research methodology. The research results are then presented and against this backdrop, a single-case study is presented. The single-case of S, is discussed in terms of the limited biopsychosocial information about S available to the intern on referral, a psychiatric patient known to the clinic services. For purposes of discussion the information available to the intern from S’s hospital and clinic file, is divided into two categories of information, i.e. “bio-information”, geared toward the treatment of S and psychosocial information geared more toward the understanding of the context in which S needs to be managed. On the basis of this simplistic division between these two categories of information, the point is made that both these sources of information are required if a patient is to be offered effective psychiatric treatment and management at this level of the mental health service. For this to be achieved, some resemblance of a specialist multi-disciplinary team needs to be brought to bear on psychiatric cases being managed at the community clinic level. By way of conclusion, the strategies employed in the case of S are distilled into a proposed model for the management of psychiatric patients at the clinic level of mental health services.

1.2.4 Conclusion
Chapter 5 draws the discussion to a close by concluding that more research in the area of mental health care at a community clinic level must be conducted so as to establish a body of information on which to assess the impact of the transformation of the mental health services on clients using the services. A point is made that the current challenge of mental health service provision at the community clinic level, appears to be that of identifying specific gaps in the current service and through focused, co-ordinated efforts, develop what is currently existing before attempting to extend the scope of service delivery.
CHAPTER 2

BACKGROUND HISTORY

2.1 INTRODUCTION

This chapter will track the historical development of mental health services in South Africa, contextualising the landscape from which mental health services in South Africa emerged and highlighting some of the present challenges confronting the transformation of these services. The proposed mental health plan for the Western Cape Province will then be presented by way of introducing the reader to the conceptual framework underlying the proposed structures through which mental health services will be delivered in this province.

2.2 A HISTORICAL OVERVIEW

South Africa has emerged from "... three centuries of imperialism and colonialism and a more recent history of internal colonialism under apartheid, ..." (Foster & Swartz 1997, p.2), this history has had a profound influence on the development of mental health services in this country. The 1800s and 1900s saw the emergence of legislation, which gave the medical profession control of the area of mental health, provided for the detention of lunatics and racialised madness, by segregating public facilities for lunatics and racialising treatment and diagnostic practices. “These features of medical and legislative control remain in place and while racialisation has been gradually undone in a formal sense since the 1990’s, its influence will be felt for many years to come.” (Foster & Swartz, 1997, p11).

Foster and Swartz point out that the notion of “mental health” emerged in South Africa after the establishment of Union in 1910, claiming that from 1910, a broader definition of the term "mental health" began to emerge and a host of specialised mental health areas developed as a consequence of this (1997). Freeman and Pillay highlight the fact that mental health legislation still remained focused on the treatment of the mentally ill and services continued to be institutionally based (Freeman & Pillay, 1997). It was not until the 1990s that government critically
assessed mental health services in terms of the mental health needs of service users. The result was an acknowledgement that mental health services were hospital centric and reflected little or no prevention and mental health promotion strategies (Foster & Swartz, 1997).

South Africa's political change in the 1990s generated a host of policy developments which culminated in the Department of Health's 1997, (White Paper for the Transformation of the Health System in South Africa). The paper's mission statement was “To provide leadership and guidance to the National Health System in its efforts to promote and monitor the health of all people in South Africa, and to provide caring and effective services through a primary health care approach.” (Department of Health, 1997, p13). In terms of Mental Health Care, this White Paper suggests that mental health services were fragmented and inappropriate for the majority of South Africans. In this White Paper the department of health set itself the task of “promoting the psychosocial well-being of all communities” (Department of Health, 1997, p. 135) and outlined its plans and implementation strategies for the establishment of a comprehensive community-based integrated health service. Amounting to a strategy aiming to transform Mental Health Services from an essentially institutionally based, racialised and fragmented service to a community-based service, responsive to the mental health needs of all South Africans, with the capacity to promote mental health and prevent mental illness; thus shifting emphasis from institutional to community care.

To achieve this task, a District Health System (DHS) model was adopted by the Department of Health, the aim of which "is to support people to lead healthy, productive lives ... The DHS which is based upon the primary health care model, is the reigning model of health care delivery in the world. It allows bottom-up and top-down planning, bringing health managers and communities together to deliver health care at the lowest possible service points." (Gilson, Balfour, & Goosen, 1997, p3). Freeman & Pillay describe a primary health care model as a health care approach that includes “goals such as intersectoral collaboration, empowerment of communities, emphasis on care in the community, promotion of healthy lifestyles and prevention of disorders, training of appropriate health workers and prioritising
vulnerable groups ...” (1997, p.36) and delivers comprehensive mental health services at the primary level of the Mental Health System. This District Health System based service “aims to provide an integrated, equitable service based upon local needs and participation, a valuable goal indeed for the racially segregated and fragmented South African health service.” (Muller, Ensink, & Leon, 1998, p19). However, given the deeply ingrained fragmentation of the health services, the success of its transformation will arguably lie in the extent to which the fundamental divisions within the services are challenged and addressed; rather than simply the adoption of a new model of health care delivery.

2.3 THE CURRENT SITUATION, A NEW MILLENNIUM

Substantial changes have occurred over the last decade and South Africa’s mental health service enters the year 2000 “characterised by two dominant features: first the almost overwhelming legacy of ... (its)... history in the form of a still deeply power-divided social formation and second, some very sound policy principles already in place.” (Foster & Swartz, 1997, p.2). This description marks the current terrain in the Mental Health System, reflecting its characteristic tension between the deeply ingrained feelings of disempowerment and hope on the part of those committed to the proposed changes.

Although much ground has been covered, an enormous amount of work is still clearly required in order to establish the fundamental parameters on which to base the new Mental Health Care Service. This shift from a hospital-based to an integrated community-based mental health service is a complex and tedious process, the repercussions of which are arguably reflected on every level of the current mental health service. As changes are introduced and implemented, institutionalised services are rationalised or closed and community based services are earmarked for development, often in the face of scarce resources.

Although implementation of the DHS is being co-ordinated at a national level, each provincial health department has the responsibility of facilitating intersectoral co-ordination at the provincial, district and community levels so as to ensure the
comprehensive integration of mental health services (Department of Health, 1997). Within the Western Cape Province the priorities for 2000s mental health planning are: co-ordination of Mental Health Services (both within the health sector and between Health and Social Services), the support and development of Mental Health Care at all levels of the health service and the promotion of community and consumer involvement in service development (Documentation from Mental Health Community Hospital Coordinating Committee Meeting, 2000, unpublished).

2.4 PROPOSED MENTAL HEALTH SERVICES FOR THE WESTERN PROVINCE

The department of health services of the Western Cape developed a provincial Mental Health Plan in 1996 - 1997. The plan delineates what mental health services will be provided at each level of the provincial public health system and ensures the presence of mental health services within an integrated community-based health system (Muller, Ensink, & Leon, 1998). By way of orientation to these service structures, a brief summary of the plan follows:

2.4.1 Four primary service provision levels

2.3.1.1 Level 1: Community service (e.g. mental health societies, community clinics)

FOCUS:
The promotion of mental health and prevention of mental illness through supportive community living.

2.4.1.2 Level 2: Community Health Centres (CHC) (e.g. Woodstock CHC)

FOCUS:
The provision of holistic health care with mental health care as a component of this holistic health care service.

2.4.1.3 Level 3: Community Mental Health Services (CMHS)

FOCUS:
To provide designated mental health services for community, including psychiatric services for the community.
2.4.1.4 Level 4: District Hospitals (e.g. Somerset Hospital)

FOCUS:
To provide acute in-patient care for patients in the catchment area.

2.4.2 The regional mental health support team

FOCUS:
The development, planning and support for these services is the task of the Regional Mental Health Support Team; which is comprised of a Psychiatrist, an Occupational Therapist, a Psychologist, a Social Worker and a Medical Officer.

SECONDARY LEVEL CARE

2.4.3 The regional hospital mental health services (e.g. Jooste Hospital)

FOCUS:
To provide holistic acute in-patient care to mentally ill patients in the catchment area.

TERTIARY LEVEL CARE

2.4.4 Mental hospitals and tertiary hospital units (e.g. Valkenberg Psychiatric Hospital):

FOCUS:
To provide specialised inpatient mental health care and rehabilitation for adults and children, with emphasis on rehabilitative rather than custodial care.

2.4.5 Summary

It is within the above proposed service provision structures, that comprehensive integrated community based mental health care in the Western Cape is currently being defined, developed and reviewed, a process aiming to establish a mental health service comprising of state, civic and community involvement and a service comprehensive enough to address the mental health needs of the population of the Western Cape.
2.5 CONCLUSION

South Africa’s long arduous political history has left a profound impact that continues to influence the task of social transformation. Mental health services in South Africa, have been characterised by legislation that has resulted in institutionally-based services as well as racialised treatment and diagnostic practices. It was only after South Africa’s political change in the 1990s that the government critically assessed mental health care services; and acknowledged the findings that mental health services were hospital centric and reflected little prevention and mental health promotion strategies. As a result, the Department of Health released a white paper, suggesting that mental health services were fragmented and inappropriate for the majority of South Africans; committing itself to the establishment of a comprehensive community-based integrated health care service. This commitment amounted to the transformation of mental health services in South Africa, which is currently evident in among other things, the implementation of the DHS model.

Although the DHS model is capable of establishing a service delivery infrastructure through which a comprehensive integrated health service can be delivered at the community level; the success of this DHS is likely to lie in both thorough preparation and implementation of this service provision model, as well as the degree to which the fundamental divisions within the health services (i.e. racial, political) are challenged and addressed. Given that the transformation of the health services is not yet a decade old, it is likely to take time for the necessary policy to be formulated around these issues. The infancy of this change is evidenced in the current lack of literature in the area of mental health policy. A recent book (Foster, Freeman & Pillay, 1997) entitled Mental Health Policy Issues for South Africa, eludes to the fact that very little writing has occurred in the area of mental health policy in South Africa. Although this book is arguably the most comprehensive current source on mental health policy issues and related mental health service provision in South Africa, it stops short of addressing the area of mental health service delivery within state service structures, at a community clinic level. The chapter in this book dealing with psychiatric service provision, provides a broad discussion of both the private and public sector facilities outlining the administrative structures in the health sector and
noting that, "Before psychiatric services can be incorporated into primary health care a needs assessment and an audit of services and facilities are essential." (Robertson, Zwi, Ensink, Malcolm, Milligan, Moutinho, Uys, Vitus, Watson & Wilson, 1997, p.76). The chapter on community mental health care presents a rather philosophical debate around community participation in primary health care and although this chapter makes policy proposals, it locates its discussion within the interface between state mental health services and community initiatives by focusing on two case studies of NGOs rendering community mental health services (Peterson, Parekh, Bhagwanjee, Gibson, Giles & Swartz, 1997). Very little literature about current mental health services and service delivery in state community structures exists and the little that does exist, is mostly in the form of service proposal documents, discussions documents and more localised situational analysis of the impact of DHS on various mental health services.

This transformation process is well underway and in need of constant monitoring and evaluation of the ongoing changes within the mental health system at both macro and micro levels, so as to inform and refine further implementation decisions. The following chapter presents a micro-level evaluation (in the form of a situational analysis), of two sites in the Mental Health System within the Cape Metropole region, of the Western Cape Province.
CHAPTER 3

THE CURRENT LANDSCAPE

3.1 INTRODUCTION

The following section presents a descriptive analysis (description of the current functioning of a service site according to fixed variables, e.g. staff compliment, primary task and operational strategy, deemed central to the delivery of service), of two distinct areas within the Cape Metropole Mental Health Service provision structures. The first is the Woman’s Admission Unit (WAU) of Valkenberg Psychiatric Hospital (VBH), the second is Maitland community clinic; representing two distinct levels of the mental health system (MHS) as outlined in the previous chapter, (i.e. Tertiary level Psychiatric Hospital care and level 3 of community based primary service structures respectively). These two sites have been selected because of their close functional relationship and because the author worked as an intern clinical psychologist in both of these sites as part of the internship training requirement, in the second year of a Masters degree in Clinical Psychology. The WAU was the first 4-month block (February - May ’99) of this internship, while the community clinic placement ran throughout the year, one day a week (February - December 1999, every Wednesday).

This descriptive analysis will locate the reader within the landscape of this particular facet of the MHS. This analysis is based on the author’s personal observations and work experience in each of these service sites. Each service site will be described in terms of its current staff compliment, its primary task and its operational strategy. By way of introduction, the section begins with a brief overview of the structures of the Cape Metropole health service.
3.2 AN OVERVIEW OF THE PROPOSED MENTAL HEALTH SERVICE
STRUCTURES FOR THE CAPE METROPOLE REGION OF THE WESTERN
CAPE PROVINCE

The Cape Metropole Region is sub-divided into 11 districts, each of which has a
number of community clinics and community health centres where outpatient mental
health services are provided; as well as district hospitals (Leon, 1998). Although it is
proposed that district hospitals provide acute in-patient care, it is unlikely to be
achieved at these sites given the specialised nature of acute mental health care, and
the fact that the staff at these hospitals, are not specialised mental health
practitioners. Finally, each district also has access to a mental hospital (e.g.
Valkenberg Hospital) and tertiary hospital units, (e.g. The Child and Family Unit),
which provide specialist care services.

An increasingly important relationship exists between the community clinic site and
the Mental Hospital site of the Mental Health Services in that these two sites
represent two levels of the psychiatric service and each forms an important part of
this service. Although there is a general shift towards community-based care, the
specialised requirements of psychiatric patients in community settings, necessitates
a sustained relationship between these two service levels. However, the nature of
the relationship between these service levels (i.e. tertiary hospital and the
community level) is in a state of flux and in need of being more clearly formulated.
The following section will describe the current functioning of these two levels
outlined above, and will identify a gap in the current functioning between these two
levels.

3.3 THE WOMAN’S ADMISSION UNIT OF VALKENBERG PSYCHIATRIC
HOSPITAL

3.3.1 The staff compliment, the Woman’s Admission Unit (WAU) management
team

The team is comprised of the unit consultant psychiatrist (the head of the team),
three registrars (trainee psychiatrists), the supervising psychologist, one intern
psychologist (trainee clinical psychologist), 5th and 6th year medical students
(trainee medical doctors), psychiatric nursing sisters (permanent staff in the unit) and student nurses.

3.3.2 The WAU's primary task, admission and discharge criteria
The primary task of the WAU is to provide specialist in-patient mental health care and rehabilitation to those who are in need of this service and cannot be managed at other levels in the Mental Health Care System (Muller, Ensink & Leon, 1998). As such, admission is reserved for acute psychotic patients who have come through other levels of the mental health services (e.g. ward C23, Groote Schuur Hospital's psychiatric emergency unit) or are brought directly into the hospital, typically by the police, as certified patients.

The WAU was comprised of a lock-up and an open ward but now, as of 2000, the WAU has an intermediate ward. Patients are admitted into the lock-up ward where they are assessed and a psychiatric history is taken. A diagnosis is made and treatment (medication) is started. Patients are then assigned to a case manager whose task it is to monitor the patients’ progress and management and to begin preparation for their discharge. Patients are transferred to the open ward of the unit, as soon as they are sufficiently settled on medication and their behaviour is manageable in an open ward. Treatment continues in the open ward and once an effective mediation regime is established and the patient is apsychotic, the patient is discharged (approximately 3-5 weeks after admission).

3.3.3 The WAU's operational strategy
Patients are usually transferred to the WAU with a file containing the clerking information (i.e. a psychiatric history surrounding the patients presenting illness). The individual patient's case manager (registrar, intern or medical student) then obtains more information about the patient (i.e. collateral from family, friends, previous hospital records) and presents the patient at the unit ward round. The ward round is facilitated by the consultant psychiatrist and attended by the management team, typically between eight to fourteen team members. The case manager presents a thorough biopsychosocial history of the patient, (i.e. the patent’s mental state, the presenting problem, family history, previous psychiatric history,
psychosocial stressors, precipitating factors, current functioning, premorbid functioning, behaviour on the ward, response to medication, a working diagnosis and a differential diagnosis). The patient is then brought into the ward round and interviewed by the consultant. After the patient has left the room, the consultant gives a second opinion and discusses the patient with the team. This discussion generates ideas about outstanding/further medical work-ups (blood tests), the patient’s medication (drugs of choice and dose) and results in a management plan for the patient, for which the case manager takes responsibility.

After presentation at a ward round, the remaining management takes the form of progress reports by the case manager to the consultant at the unit’s clinical management meetings. Results of tests requested are discussed, medication is altered and/or changed if indicated by test results and once the patient’s blood levels are safe on the medication, the discharge process begins. This typically entails notifying the family of the discharge plans and arranging a discharge date with the nursing staff. Finally, the case manager completes a discharge summary, a copy of which is sent to the community clinic where the patient’s treatment will be continued. The patient is then discharged into the care of the community psychiatric services and treatment continues under co-ordination of the clinic’s community mental health nurse (CMHN).

In cases where a patient’s diagnosis and management pose clinical difficulty for one reason or another, the patient may be discharged into the care of VBH’s Out-Patient Department and followed up by a registrar or the consultant of the unit to continue diagnostic investigation and ensure that she is effectively treated. From here, she is transferred to the community clinic where treatment continues as described above.

3.3.4 Summary
The WAU of VBH provides a specialist in-patient psychiatric service to patients suffering from acute psychiatric illnesses. The unit is managed by a consultant psychiatrist who is responsible for the effective and efficient psychiatric management of patients in the unit. The average duration of stay in the WAU is 3-5 weeks, placing enormous time constraints on the unit and limiting the possibilities of treatment and
rehabilitative services the unit is able to offer. Treatment begun in the WAU is continued by the Community Mental Health Services, however it is clear from the above that psychiatric diagnosis, treatment and management are interrelated services and specialised areas of mental health care. This is true no matter where in the mental health structure these services are offered (i.e. diagnosis, treatment and management). It can thus be argued that there are some basic prerequisites if a psychiatric service is to be offered; perhaps the most crucial of which is access to sound biopsychosocial information about the client being managed as seen from the operational strategy of the WAU. The following section provides a situational analysis of the Maitland community clinic, highlighting this level’s limitations to offer a comprehensive mental health service, as suggested in the mental health service proposal for the Western Province (see previous chapter).

3.4. MAITLAND COMMUNITY CLINIC, PRIMARY SERVICE LEVEL 3

3.4.1 The staff compliment
The Community Mental Health Nurse (CMHN) at the Maitland community clinic runs a psychiatric service once a week at the clinic. The clinic’s Medical Officer (MO) offers backup, general medical and routine psychiatric support. The recent addition (February ‘99) of an intern clinical psychologist for one day a week, has added a team member, bringing the mental health staff compliment at the clinic up to one permanent staff member and two support staff (MO & intern). Although general primary health nurses work at the clinic they are not involved in the “designated” mental health services offered at the clinic (i.e. the provision of a psychiatric “treatment” service).

3.4.2 Maitland community clinic’s primary tasks
The primary task of the mental health services offered at Maitland clinic is to provide clients with designated mental health services, currently amounting to psychiatric care for the clinic’s psychiatric patients. The clinic’s mental health services are thus largely limited to psychiatric patients discharged into the clinic’s care; as such services aimed at preventing mental illness and promoting mental health are currently underdeveloped at this clinic.
In terms of the proposed psychiatric services, this level of the primary service provision structure is expected to assess, diagnose and manage psychiatric illnesses as well as manage clients with complex psychiatric illnesses. In addition, it is proposed that this service level will ensure continuity of care for patients with psychiatric problems through liaison with community services, home visits, and facilitating links between the community and hospital services. Such a comprehensive service cannot be rendered by a staff compliment of three, working one day a week at this clinic.

3.4.3 Maitland community clinic’s operational strategy

Coordinated by the CMHN, this clinic offers a weekly psychiatric service comprised of dispensing monthly medication to patients, conducting routine blood tests for patients whose medication regime indicate this, offering a brief limited “counselling” service to clients who request it and referring patients in need of specialised counselling to the district psychological service. In addition, the CMHN is required to monitor patients’ treatments and access other services through referral where indicated.

In terms of this site offering a psychiatric management service, it appears that the current operational strategy of the mental health services at Maitland community clinic has a shortfall in terms of its capacity to gather, collate and synthesise biopsychosocial information of the clients. The reasons for this appear to be among other things, the lack of a multidisciplinary team approach as seen in the WAU, poor information capturing, evident in the lack of documented biopsychosocial information about the patient as well as a lack of patients’ treatment and management history.

The addition of an intern clinical psychologist into district 1 has made it possible to offer a psychological service within the district community clinics; extending the mental health services offered at the Maitland community clinic. However, in spite of this additional staff capacity the mental health services offered at this clinic were still oriented around the needs of the clinic’s psychiatric patient population. This suggests that the clinic’s capacity to offer mental health services to a broader range
of the Maitland population needs to be developed. However the pressing need is to improve the capacity of this community clinic to offer a psychiatric management service, which is now the task of this level of the mental health service and a matter of urgency for those in need of this service.

3.4.4 Summary
The Maitland community clinic’s mental health service is essentially coordinated and run by a CMHN. This service currently offers a predominantly treatment-focused psychiatric service to this community. The related services at the clinic include a routine psychiatric service offered by the clinic medical officer, and a specialist consultancy service rendered by the consultant psychiatrist of the district health team as well as the recent addition of an intern psychologist, adding limited psychological services to the clinic’s existing mental health services. However, these services did not extend beyond the clinic’s psychiatric patient population, a far cry from the proposed comprehensive mental health services for this level of mental health system. The psychiatric service offered at this clinic is severely limited in its current capacity to offer psychiatric services for both routine and more complex psychiatric cases. It can be argued, based on the WAU model, that the current services at this clinic do not have the infrastructure to offer a psychiatric management service, which requires specialist skills to conduct a biopsychosocial assessment of the patient, a multi-disciplinary team approach to synthesise the information and formulate a comprehensive treatment plan as well as a designated case manager to carefully monitor and evaluate the patient’s progress. It appears therefore, given the clinic’s mental health staff compliment, that every effort should be made to focus attention on the development of the psychiatric service at the clinic, which is currently limited in its capacity to provide a treatment and management service to its users; this service is likely to become further taxed as the DHS continues to divert more and more complex psychiatric patients away from institutional care to this level of the mental health services.
3.5 A GAP IN THE CURRENT SERVICE

In light of the overall plan to implement a DHS and hence shift service focus from hospital to community-based mental health care, the above situational analysis identifies an inherent gap between the tertiary hospital and community clinic levels of the mental health service. As outlined above, this gap amounts to the fact that there is insufficient biopsychosocial information about the patients using the service, for this service level to offer an effective psychiatric management service. This gap (i.e. lack of biopsychosocial information of service users) is currently limiting this mental health service level's ability to offer a psychiatric case management services, an essential component of the proposed overall plan for the transformation of mental health care, from an essentially institution based service to a community based service. This is arguably a gap requiring urgent, focused attention if psychiatric patients are to be adequately catered for in the DHS model of mental health services.

3.6 CONCLUSION

The situational analysis presented in this chapter illuminates the current functioning of two typical mental health services in District 1 of the Western Province, i.e. the WAU of Valkenberg Hospital and the Maitland community clinic; a tertiary level and a primary level mental health service respectively. The WAU currently offers a specialist inpatient service in the form of acute psychiatric care to patients suffering from psychiatric illnesses. The average stay of a patient in this unit is between three to five weeks, placing enormous time constraints on the unit and limiting the scope of this service to a predominantly treatment focused service, with limited interaction with the patient's family who are likely to have an ongoing role in the patients future management and treatment.

Treatment begun in the WAU is continued at community clinics, such as the Maitland community clinic. The proposed mental health services aims to shift psychiatric management of patients to the community level of the system. However, the situational analysis of Maitland community clinic highlights the fact that this
clinic's psychiatric services fall short of having the capacity to offer a psychiatric management service as a routine component of its service, instead this clinic's psychiatric services are currently treatment focused. The analysis also identified a gap in the link between these two levels of the current mental health service focusing on the lack of biopsychosocial information at the community clinic level, suggesting that the lack of biopsychosocial information at this level places limitations on this site's capacity to offer a psychiatric management service.

The following chapter provides an audit of the clinical work conducted at the Maitland community clinic, highlighting the nature of clinical work conducted at this clinic and the mental health needs of the client population seen at this site.
CHAPTER 4
AUDITING CLINICAL WORK CONDUCTED AT MAITLAND
COMMUNITY CLINIC

4.1 INTRODUCTION

This chapter will report on the research project, detailing the aim and hypothesis guiding the research, sample selection, research procedures and data gathering methods. The research results will then be presented and summarised in terms of the nature of interventions conducted at the Maitland clinic. This will provide a backdrop against which a single-case study will be presented.

4.2 AIM OF THIS RESEARCH

The aim of this research project is to critically explore the impact of the current transformation of the mental health system on the psychiatric management of patients at the community clinic level of the system. This will be achieved by; firstly providing an audit of the clinical interventions conducted by the author at a community clinic over the course of a year, thus reflecting the current needs of the clients and this community clinic; secondly, by focusing on a psychiatric management case study of a patient at this clinic so as to illustrate the impact the current transformation of the mental health system has on the Maitland community clinic's capacity to offer an effective psychiatric service.

4.2.1 Hypothesis
4.2.1.1 The central hypothesis
- There is insufficient biopsychosocial information about patients using the psychiatric services at primary service level 3 (i.e. Maitland community clinic).

4.2.1.2 Peripheral hypothesis
- This can be viewed as a gap between two essential levels of the psychiatric service, i.e. Mental Hospital level and Community Clinic level.
This lack of biopsychosocial information about patients using the psychiatric service at level 3, limits the capacity of the clinic to provide a psychiatric management service.

A distinction must be drawn between psychiatric treatment (routine continuation of treatment) and psychiatric management; the latter being an information gathering and processing procedure based on a specialist multidisciplinary team management approach, hence a specialist psychiatric service.

Biopsychosocial information is crucial to effective psychiatric management.

In order to manage psychiatric cases (complex and more straightforward) at the primary service level (level 3) some derivative of the multidisciplinary management team approach needs to be established.

The clinical assessment and case management skills of clinical psychology can make an important contribution to establishing such a service at the community clinic level by providing information about the system (family and organisational) in which management is conducted as well as accessing and managing resources at this level.

4.3 SAMPLE SELECTION

4.3.1 The selection of Maitland community clinic

Maitland community clinic is located in District 1 of the Cape Metropole Region, the district in which the author was placed as part of the internship-training requirement of a master's degree in Clinical Psychology. The initial orientation meeting for this "district placement" was held at Maitland community clinic; after general introductions and orientation to the district services, the mental health nurse of Maitland clinic immediately referred two cases. The result was that clinical work at Maitland community clinic began a week later and within three weeks the clinical caseload was sufficiently large to dedicate a full morning to this clinic, this continued throughout the year.

4.3.2 Referral procedure of cases

The placement supervisor regulated the referral of clients by the community mental health nurses to the district psychological services. Referrals were directed to the supervisor who perused the referral and if a case was considered to be in need of
psychological services, it was passed on to the intern for intervention. This screening of cases was intended to ensure appropriate referrals from the community mental health nurses and to regulate the caseload of the intern.

The referrals seen by the psychological services of the Maitland community clinic, can therefore be seen as an indication of both the clinic's specialist support needs (i.e. in the selection of these cases), as well as an indication of the clinical needs of the client group seen.

### 4.3.3 Selecting participants for this study
The four clients referred to in this study, are all the clients seen by the intern at the Maitland community clinic during the course of the year. A single case study, the case of S, was selected from these four clients because of the nature and duration of the clinical intervention conducted with this client over the course of the year. This intervention reflects some of the crucial issues surrounding the psychiatric management of psychiatric patients at the community clinic level of the mental health system. The case of S and his family illustrates the psychiatric career of a young man, who was not effectively treated nor managed by the community clinic's mental health service. The case material is rich, providing insights into both the limited capacity of the community clinic level to meet this client and family's needs as well as how these needs were met over the course of the intervention.

### 4.4 THE RESEARCH PROCEDURE
#### 4.4.1 The research method
This research is based on a mixed method approach grounded in a hermeneutic model of qualitative inquiry, based within phenomenological design and methodology as described by Moustakas (1994). Titelman (1979) argues, "the hermeneutic task is to find justifiable modes through which my experience and comprehension of the phenomenon being researched can serve as a bridge of access for elucidating and interpreting the meaning of the phenomenon." (cited in Moustakas, 1994, p.11). In this light, the modes used to elucidate and interpret the phenomenon of clinical management in the Maitland community clinic include: field research, clinical supervision, clinical interventions, reflective interpretation, clinical
decision making and review through follow-up, as well as auditing the clinical interventions, transcribing two family interventions and analysing these data for the purpose of reflecting these experiences, to substantiate the argument that there is currently insufficient biopsychosocial information at the community clinic level on which to base sound clinical management decision.

The methods used in this research include: participant-observation, semi-structured interviews, clinical therapeutic techniques and interventions, single-case study, document study as well as a summary analysis of data pertaining to the nature, number and duration of clinical contacts with clients at the Maitland community clinic.

4.4.2. My position in the data gathering and analysing process

My position as an intern clinical psychologist in the community mental health services punctuated my position during the data gathering process, as that of a participant-observer. The position I occupied was both a team member of the community mental health service and a learner. Due to the fact that I worked at the Maitland clinic one morning a week, I retained a position of an outsider with regard to the clinic structure (i.e. organisationally). On another level this experience left me feeling that the mental health service I was offering, was an adjunct to the other services offered at this clinic rather than integrated part of the overall public health services offered by the clinic.

The clients using the psychological services at the clinic appeared unaware of my outsider position within the clinic structure, treating me as an insider, able to access and offer services at the clinic. In spite of occupying an outsider position within the clinic structures, I remained a member of the community mental health team, giving me access to other members of the team e.g. the community mental health nurse and district consultant psychiatrist. Both engaged me in an honest and insightful critique of the public health care system from their perspectives and experiences. This position provided invaluable insights into the mental health services, assisting me to maintain a reflective, interpretative position during the time spent working in the system.
My personal bias of working in a mental health care system dominated by a medical treatment model, which was proving inadequate in the cases of the patients I was seeing at the clinic, became more and more pronounced over the course of the year. The realisation that the community level of the mental health system is central to the success of the transformation of the mental health service and establishment of a district health system, encouraged me to reflect on the experiences and insights I gained during this internship in the form of this mini-thesis.

4.4.3 The Data

The data used in this research is clinical-case-material derived from patient records including: clinical files of Valkenberg Hospital (VBH), clinical summaries and referral forms from VBH, clinical files and medication charts at the community clinic, as well as patients' records generated by the psychological intervention process. The latter includes the clinical case history, psychosocial formulation, management plan and detailed contact summaries of each patient seen at the clinic.

Patients and staff referred to in this study either directly or indirectly, gave their informed consent for the material to be used in the form of research material, which will be reproduced and made available for public consumption. Names of clients have been omitted to protect their privacy and confidentiality.

4.4.4 Data gathering

The data was captured over the course of the internship year, which constitutes the field study phase of the research. The data was gathered during the clinical intervention with clients in the following two contexts: appointments at Maitland clinic and home visits, in individual, family and/or joint sessions (i.e. sessions conducted in collaboration with the consultant psychiatrist of the district mental health team).

The clinical interventions with clients include; biopsychosocial assessment, cognitive behavioural therapy, family therapy, joint consultations with the consultant psychiatrist, consultations with the community mental health nurse (case
management regarding treatment options, updating the CMHN of the work I was
doing with her clients), telephone conversations with clients and psychoeducation.

Clinical supervision pertaining to the assessment, diagnosis, formulation,
intervention and management plan was received on a weekly basis from the district
placement supervisor. It was through this supervision that I retained a reflective
stance in light of the interpretations I made in the process of clinical interventions at
the Maitland community clinic. The supervision also served to advise me as to how
to access resources from other levels of the district health care system e.g. the
consultant psychiatrist, when such needs arose. Although the data in this research
does not refer directly to the content or process of this supervision, its influence on
management and intervention decisions is implicit.

4.4.5 Data analysis
4.4.5.1 Analytic procedures
The data was generated through a clinical intervention process, comprising of an
ongoing process of analysing the clinical data, in both a self reflective mode and in
clinical supervision; insights generated through this process informed hypotheses
and guided further clinical intervention; a reflective-interpretative cycle central to the
hermeneutic process, as described by Moustakas (1994). The clinical data was
analysed by conducting an audit of the clinical interventions offered to patients at the
clinic over the course of the year in terms of: the type of intervention, the intensity of
intervention over time and the total time spent on each intervention category. The
audit is based on the following eight intervention categories:
biopsychosocial assessment, cognitive behavioural therapy, family therapy,
consultation with the consultant psychiatrist, joint consultation with the psychiatrist,
consultation with community mental health nurse (CMHCN), teleconversations with
clients and psychoeducation.

4.5 RESEARCH RESULTS
4.5.1 Summary of interventions conducted
The audit conducted on all the interventions carried out at Maitland community clinic
from the period March 1999 - December 1999 reveals the following. Figure 4.1
shows that biopsychosocial assessment comprised the largest category of psychological services rendered to the clinic (33%), followed by consultations with the community mental health nurse (CMHN) (17%), family therapy (15%), cognitive behavioural therapy (11%), psychoeducation (9%), joint consultation with the psychiatrist (6%), teleconversations with patients (5%), and lastly consultation with psychiatrist (4%). Figure 4.2 depicts the intensity of these interventions over time, the peaks in biopsychosocial assessment in March, May, August, September and November are noteworthy; in that these peaks correlate the times of intake of new clients, which given the fact that all these clients were known to the psychiatric services suggests that there was little existing biopsychosocial information available at the clinic about these patients. As a result, a large proportion of time had to be spent on biopsychosocial assessment before a more focused clinical service could be offered to these patients.

Table 4.1, a summary of the time, in minutes, spent on each intervention at the clinic over the year reflects the following: biopsychosocial assessment (1445 minutes), consultations with the community mental health nurse (CMHN) (780 minutes), family therapy (675 minutes), cognitive behavioural therapy (480 minutes), psychoeducation (425 minutes), joint consultation with psychiatrist (270 minutes), teleconversations with clients (215 minutes) and lastly, consultation with psychiatrist (195 minutes). This information shows that although these interventions offered a wide range of psychological services to these four clients the average time spent on these interventions over the entire year, amounted to only 45 minutes a week over this ten month period.

4.5.2 The single-case
The audit conducted on the psychiatric management of the single-case over the period March 1999 – December 1999 reveals the following: Figure 4.3 shows that biopsychosocial assessment comprised the largest category of psychological services rendered to this single-case (44%), followed by consultations with the community mental health nurse (CMHN) (21%), psychoeducation (19%), joint consultation with the psychiatrist (7%), consultations with the psychiatrist (6%) and finally, teleconversations (3%). Figure 4.2 depicts the intensity of the intervention
process over time, highlighting the fact that almost all the clinical time in the first
month of intervention (March) was devoted to biopsychosocial assessment;
suggesting that biopsychosocial information about this patient, who was known to
this clinic’s psychiatric service, was not available to the intern. Discussions with the
mental health nurse at the clinic and experience with other patients at the clinic
revealed that this is not a unique case and that very little biopsychosocial information
exists about any of the patients using the mental health services at this level.
Instead, the psychiatric intervention revolves around the patients’ medication chart,
clearly a treatment focused source of information.

Table 4.2, a summary of the time, in minutes, spent on the clinical intervention of the
single case, a psychiatric management intervention, reveals the following:
biopsychosocial assessment (580 minutes), consultation with the community mental
health nurse (CMHN) (280 minutes), psychoeducation (255 minutes), joint
consultation with the psychiatrist (80 minutes), consultation with the psychiatrist (90
minutes) and lastly, teleconversations with the client’s mother (35 minutes). These
figures show that the time spent on both assessing S’s psychosocial context, as well
as engaging his family in his psychiatric management, constitutes a monthly average
of 132 minutes over the ten-month period of intervention, a substantially large
amount of time which cannot be routinely offered to psychiatric patients like S using
these services. This implies that the psychiatric service rendered at this site will need
to be reviewed and made more efficient, if the mental health needs of psychiatric
patients in this community are to be met.
Table 4.1
Time spent on interventions at Maitland clinic
(March '99- December '99)

<table>
<thead>
<tr>
<th>INTERVENTION</th>
<th>TOTAL TIME SPENT IN MINUTES</th>
<th>MONTHLY AVERAGE</th>
<th>PERCENTAGE OF TOTAL INTERVENTION TIME</th>
</tr>
</thead>
<tbody>
<tr>
<td>BIOPSYCHOSOCIAL ASSESSMENT</td>
<td>1445</td>
<td>144.5</td>
<td>33%</td>
</tr>
<tr>
<td>COGNITIVE BEHAVIOURAL THERAPY</td>
<td>480</td>
<td>48</td>
<td>11%</td>
</tr>
<tr>
<td>FAMILY THERAPY</td>
<td>675</td>
<td>67.5</td>
<td>15%</td>
</tr>
<tr>
<td>CONSULTATION WITH PSYCHIATRIST</td>
<td>195</td>
<td>19.5</td>
<td>4%</td>
</tr>
<tr>
<td>JOINT CONSULTATION WITH PSYCHIATRIST</td>
<td>270</td>
<td>27</td>
<td>6%</td>
</tr>
<tr>
<td>CONSULTATION WITH CMHN</td>
<td>780</td>
<td>78</td>
<td>17%</td>
</tr>
<tr>
<td>TELECONS WITH CLIENTS</td>
<td>215</td>
<td>21.5</td>
<td>5%</td>
</tr>
<tr>
<td>PSYCHOEDUCATION</td>
<td>425</td>
<td>42.5</td>
<td>9%</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>4435</strong></td>
<td><strong>448.5</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

Table 4.2
Time spent on interventions with S, at Maitland clinic
(March '99 - December '99)

<table>
<thead>
<tr>
<th>INTERVENTION</th>
<th>TOTAL TIME SPENT IN MINUTES</th>
<th>MONTHLY AVERAGE</th>
<th>PERCENTAGE OF TOTAL AVERAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>BIOPSYCHOSOCIAL ASSESSMENT</td>
<td>580</td>
<td>58</td>
<td>44%</td>
</tr>
<tr>
<td>CONSULTATION WITH PSYCHIATRIST</td>
<td>80</td>
<td>8</td>
<td>6%</td>
</tr>
<tr>
<td>JOINT CONSULTATION WITH PSYCHIATRIST</td>
<td>90</td>
<td>9</td>
<td>7%</td>
</tr>
<tr>
<td>CONSULTATION WITH CMHN</td>
<td>280</td>
<td>28</td>
<td>21%</td>
</tr>
<tr>
<td>TELECONS WITH CLIENTS</td>
<td>35</td>
<td>3.5</td>
<td>3%</td>
</tr>
<tr>
<td>PSYCHOEDUCATION</td>
<td>255</td>
<td>25.5</td>
<td>19%</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>1320</strong></td>
<td><strong>132</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>
FIGURE 4.1
Audit of interventions at Maitland Clinic
(March '99 - December '99)

FIGURE 4.2
Audit of interventions at Maitland Clinic
(March '99 - December '99)
FIGURE 4.3
Audit of the single-case, a psychiatric management intervention
(March '99 - December '99)

FIGURE 4.4
Audit of the single-case, a psychiatric management intervention
(March '99 - December '99)
4.6 A SINGLE-CASE SUMMARY

4.6.1 The case of S

The following information was gathered in the initial assessment interviews with S and his family, held at Maitland community clinic and at the family’s home in Maitland. S’s clinic file contained the following information, a referral note to Groote Schuur Hospital’s psychiatric emergency unit from the Doctor at the Maitland day hospital dated (23/01/97), one discharge summary (11/07/97), clinical contact notes and a prescription chart. No patient history was available nor any record of S’s functioning on discharge from hospital, making it difficult to establish S’s optimal functioning on medication.

4.6.2 Method and reason for referral

S (20, male) was referred by the community mental health nurse (CMHN) of Maitland community clinic, to the psychological services (the clinic intern) for assessment and management recommendations. The CMHN reported that she had noted that S had not collected his medication for three months and on investigation (a home visit) was told by S’s mother that S had become increasingly withdrawn, he hardly spoke to anyone and he did not listen to mother’s requests nor did he obey her orders. Mother added that S had not been taking his medication (Trifluoperazine 7mg) for about 8 months. The CMHN reported that S was mute, his self-care was neglected and he made no attempts to engage with her.

4.6.3 Presenting problem

S was brought to the clinic for his first appointment with the intern, by his mother who reported that he was withdrawn, he had been neglecting his self-care, he didn’t listen to mother, he was impulsive, (e.g. walked to his sister in Kensington at night), he hardly spoke to anyone and he was not taking his medication. Mother reported that S was a normal, healthy young boy until about the age of 16 when “he got caught up with the wrong crowd”.

4.6.4 Family history

S lives with his mother, father, brother and a boarder in a two-bedroom house in Maitland. His mother is a domestic worker for a large company, his father a chronic
alcoholic, was made redundant in 1980s and was unemployed until May 1999 when he got a job as a security guard. Mother reports that father has always been verbally and occasionally physically abusive toward herself and the children, especially S. The family moved to Maitland three years ago from a house in Mitchell’s Plain, where mother and father had lived since they married, 27 years ago.

4.6.5 Personal history
4.6.5.1 Birth and milestones
Mother reports a natural birth with no complications and remembers S’s developmental milestones being normal.

4.6.5.2 Substances
S began abusing marijuana and mandrax at the age of 15 and continued until his first admission to Valkenberg Hospital (VBH) when he was 18.

4.6.5.3 Life events/recent stressors
- Chronic history of physical and verbal abuse by father
- Father chronic alcohol abuse
- Gang involvement in his early teens
- Started abusing drugs 15 years old, marijuana, mandrax, alcohol, noticeable changes in mood (“moody”) and behaviour (“violent”), reported by mother
- Family moved from Mitchell’s Plain to Maitland August ’96
- Attacked and stabbed by gang “friends”, ? gang raped
- Two admissions to VBH February and May of ’97

4.6.5.4 Past psychiatric history
2 Admissions to VBH, below are the discharge summary diagnosis and management plans.

28/02/97 Axis I: Query, Major Depressive Episode, Query, Post Traumatic Disorder (Suspected gang rape)
Query, Schizophrenia (no psychotic features observed)
Discharged 6/03/97, no medication

22/05/97 History suggests psychotic disorder
Axis I: Query, Schizophrenia  
Axis II: Query, Mild mental handicap  
Discharged 11/07/97, medication management, Trifluoperazine 12mg, Orphenadrine 50mg PRN (when needed, for the treatment of side-effects from the neuroleptic medication)

4.6.6 Mental state examination
S is a medium framed young man of average height. He was neatly dressed in a pair of baggy jeans and a checked shirt although his personal hygiene was neglected. He was unshaved, his hair was dirty and he had dandruff. His face was acne scared and he had pimples on his jaw line, which he picked at throughout the interview. His eyes are green-brown and he has an engaging smile. S made little eye contact and had a poor rapport with the clinician. He spent most of the session swinging his legs and looking at the floor and occasionally at the wall ahead of him.

Speech
Selectively mute, spoke only when asked questions about his brother, monosyllables.

Affect
Restricted, inappropriate, appeared anxious/depressed

Mood
Could not be assessed

Thoughts
Form - concrete  
Flow - slow
Query of Hallucinations, S smiled and laughed to himself during the interview for no apparent reason.

Cognitive functioning
Could not be assessed, due to his selective mutism.

4.6.7 WORKING DIAGNOSIS
AXIS I: Major depression with psychosis  
Query Post Traumatic Stress Disorder  
Query Schizophrenia, although no bizarre behaviour to date
P-C relational problem

AXIS II: Query Borderline Mental Handicap, although S completed Std7 at school

AXIS III: Nil

AXIS IV: Problems with primary support group

AXIS V: Global assessment functioning = poor

4.6.8 INTERVENTION PLAN

• Establish a trusting relationship with S and his family

• Assess family’s overall functioning and dynamics especially with regard to S’s non-compliance

• Look at VBH file to establish previous diagnosis, most effective medication management

• Work toward compliance, treat psychotic features

• Conduct a thorough assessment of family functioning and S’s cognitive capacity (current and premorbid) so as to plan long term management within this context

4.7 THE INTERVENTION PROCESS

4.7.1 Tracking the process

A trusting relationship was established with S and his family through the initial psychiatric history taking process, (i.e. the “bio” information component of a biopsychosocial assessment). This information together with information about S’s previous psychiatric treatment from his hospital file, gave sufficient data to establish that S was suffering from a mild psychosis for which he required medication. The clinic files showed that S had been prescribed 7mg of Trifluoperazine daily, (a 2mg tablet in the morning and a 5mg tablet at night). This dose was consistent with the recorded therapeutic dose in S’s hospital file. Based on this information, the plan was to reintroduce medication and monitor S’s progress, paying specific attention to possible side effects, as S’s hospital records showed that he was extremely sensitive to this medication and he experienced sided-effects in hospital on low doses of Trifluoperazine, such as this one.
In the next session with S and his mother (a home visit), mother expressed surprise at the suggestion by the intern, that S's behaviour is likely to be linked to the fact that he was not taking his medication saying, "Do you think it could be that? That that's because of that? Oh..." By the end of that session an agreement was reached that mother would assist S to take his medication, as his mental functioning at that time was very poor and he could not be expected to administer his own medication.

Weekly home visits revealed that S was not taking his medication regularly and mother confessed that the logistics of administering his medication were stressful and no one else in the home could assist. Mother explained that she left home each morning before S woke up, she returned home at lunch time for 45 minutes, to make lunch for S and her husband and begin to cook supper, when she finished her day’s work at 16:30, she had to rush home to finish supper so that she could feed her other son by 17:30, when he had to leave home for work (working night duty in a factory). With this in mind, a consultation was set up with the district psychiatrist where a case summary was presented. Following this consultation, S was prescribed 4mg Trifluperazine nightly (i.e. two 2mg tablets at night), for the first two weeks so as to accommodate mother’s logistical constraints.

However, it was clear from follow-up visits that S had still not been taking his medication regularly and he remained psychotic. A family meeting was held at the family’s home in June and was attended by all the family members, mother, father, sister, brother and S. The aim of this meeting was to understand how S’s family were experiencing his behaviour, to establish the family’s expectation of the clinic’s mental health services, to clarify the responsibility of both the family and the mental health service in S’s psychiatric treatment and management, and lastly, to identify the family’s motivation to play a role in S’s psychiatric management. The meeting provided key psychosocial information including the following:

- Father and S had a longstanding conflictual history, father assumed that S was being obnoxious and that if S got a job and did something useful with his life things would be fine.
- The children feared father because his abusive history and the fact that he was strict. Brother, "We were brought up very scared of my father, man. My mother
always used to say, go in, go in, here comes your father! That used to work on us all the time, because we developed this fear for my father, we didn’t talk to my father, we didn’t talk to my father, you know? Like, like when we go out you see other children how they speak of their father, we didn’t speak about our father.” (First family meeting).

- As a result of this dynamic, father never took an active role in his children’s lives, holding a distant position in the family. Father, “No I just treated them like my father treated me, he just greeted me in the mornings, greeted me in the evenings and my time was my time to come in.” (First family meeting) Mother, “... But it was the way he was brought up also, his father was a very cold man. I remember him asking his father once, ‘Papa why didn’t you ever pick me up when I was a child?’ He never showed them love when they were small.” (First family meeting).

- Mother assumed the position of the protector, protecting her children from their father’s abuse. Father, “No, she (mother) always take their part.” (First family meeting)

- Although mother assumed a very involved position in S’s life, she had little understanding of S’s mental state, even though she frequently visited him in hospital and always accompanied him to hospital for follow-up visits.

- Mother is illiterate and had a lot of difficulty understanding how the medication should be taken. It is like likely that mother would not have been able to discriminate between the potencies of the tablets dispensed to S, i.e. 2mg and 5mg tablets.

- Mother knew at an intuitive level that S was not the same as he used to be, but put this down to his past drug abuse and the fact that he made the “wrong friends” when he was younger. Mother did not consider S to be mentally ill.

- Sister was deeply concerned about S and represented the voice of reason in the family, with regard to the fact that S was mentally ill and that they (the family) had to do something to help him.

- Brother was also deeply concerned about S, with whom he has a very close relationship. He insisted that S was “normal” and that if S was not shouted at and spoken to as though he was a child, S would be fine.
• S sat quietly throughout the sessions when there was a family member present, communicating from time to time with a smile or a glance. On his own S did speak in mono-symbols but his verbal communication was tedious and frustrating.

• A pattern of communication had been established in the family, whereby S was shouted at and prompted to respond by further shouts, resulting in a stressful interaction between S and his family, except S’s brother who would speak to S “normally” and would not mind if S did not answer him.

A psychiatric management plan was formulated in collaboration with S’s family and a commitment was reached whereby mother would administer S’s medication nightly, until he was well enough to assume responsibility for this himself. The management plan was implemented and S made a dramatic improvement over the following months. After further biopsychosocial assessment and consultations with the district psychiatrist a joint session was held with S, the psychiatrist and the intern. Due to S’s vastly improved mental state, he was able to give an account of himself. As a result, a more comprehensive assessment could be made which suggested that there was a strong mood component to S’s presentation, after which a decision was made to begin treatment for depression and an anti-depressant was prescribed.

Approximately two months later, in the second family interview (November), after further improvement on his medication, S reported that he was feeling happier, he had more energy and he was able to focus his attention on tasks and complete them, saying “I’m alright now, I can do things, I feel better” (Second family meeting). Collateral from his family confirmed his reports; mother, “Paul, there has been a big improvement in S, really there has. S is able to do things. Now I can just ask him once, S will you clean the kitchen please and S do it” (Second family meeting) and father, “Yes for me too, there has been a big improvement, S helps in the garden, he comes down to the work and asks me if there are any cars to wash, he helps me wash the cars” (Second family meeting).

This improvement continued and was supported by his parents, brother and sister. S was attending individual sessions at the Maitland community clinic in the last three months of the Intervention. S used these sessions to talk about his daily life and his
ambition to find work and live a more independent life one day. He expressed the wish to work with his hands and began to enquire about places he could go to for training. The last month was used to terminate the intervention and discuss the possibilities of a referral to an organisation for mentally ill people, where they are assessed for work opportunities and placed in a suitable working environment. During the last session with S the final arrangements were made for this referral.

4.7.2 Summary
This clinical case material clearly reflects the need for thorough understanding of the patient's psychosocial context as well as information pertaining to the patient's treatment and management history if an effective psychiatric management service is to be offered at the community clinic level of the mental health system. For purposes of discussion, this case material can be seen to reflect two distinct components of biopsychosocial information, i.e. bio-information and psychosocial-information. The bio information being information pertaining to diagnosis, medication, history of side effects, duration and nature of stays in hospital was found in S's hospital files. The information about the medication S received since his discharge from hospital was found in his file at Maitland clinic, however neither of these sources of information contained information about S's psychosocial context. The case of S suggests that both these bodies of information i.e. bio & psychosocial were crucial to the effective psychiatric management of S. Hospital information gave detailed accounts of the most therapeutic dose of Trifluoperazine for S as well as the fact that he remained sensitive to this medication and suffered unpleasant side-effects. The psychosocial information revealed a detailed understanding of the context in which S was being managed (i.e. his family), highlighting the limitations of this context (logistically and otherwise), crucial information that has been severely neglected in S's past psychiatric management.

This case also illustrates the important role a patient's family plays in his psychiatric management. In this light, the family can be seen to form an essential part of the psychiatric management team and every effort should be made to facilitate this role of the family by ensuring that the family is informed and involved in patient's psychiatric management.
4.8 PROPOSING A MODEL FOR PSYCHIATRIC MANAGEMENT AT THE COMMUNITY CLINIC LEVEL

The clinical intervention referred to above, flies in the face of claims that there are insufficient resources at the community clinic level to offer specialist mental health care at these sites. Furthermore, the implementation of the DHS model and subsequent shift of focus from hospital to community based mental health services, has made the need to offer specialist psychiatric services at the community clinic level a reality. In this light, there is no longer a choice of venue; hospital services will cater for the needs of the acutely ill patients, while community clinics will have to continue the treatment and management of patients. A multi-disciplinary team approach is needed at the community clinic level so as to offer a specialist service capable of treating and managing psychiatric patients. The case material above suggests one possible model for offering such a specialist psychiatric management service at the community clinic level.

4.8.1 A model for community psychiatric management

The team members in the case of S, included: the community mental health nurse, the supervising psychologist, the district consultant psychiatrist and the intern psychologist as well as S’s family (in particular his mother). Within this context, the role of the intern psychologist was:

- to conduct a biopsychosocial assessment
- feedback the findings to the community mental health nurse, and to be guided by her opinion and knowledge of the system at the community level
- to access specialist support for the case through supervision with the placement supervisor and through consultations with the district consultant psychiatrist
- to act as a case co-ordinator in collaboration with the community mental health nurse who remained the case manager
- to feedback clinic findings to S’s family, to plan a management strategy that would be practical for the family and effectively treat S’s psychiatric symptomatology

As the case coordinator, the intern psychologist’s task was essentially to conduct a biopsychosocial assessment and on the basis of this information, coordinate the
services of other team members (e.g. the district psychiatrist), so that these services could be offered to S and improve his psychiatric treatment and management. In this context, clinical psychology can play an important role in the establishment and management of a community based psychiatric service. The biopsychosocial assessment and case management skills of clinical psychologists, as well as their position in the mental health structure, (i.e. management) and resultant access to other specialist services, places this profession in a unique position and one that is increasingly important for the management of comprehensive mental health services outside of hospital structures.

4.9 CONCLUSION

Although the research results reflected in this chapter are based on a small sample size of clinical cases at one clinic site, some insights can be derived within the limitations of this study. The large amount of clinical time devoted to biopsychosocial assessment of patients seen by the intern at this clinic suggests the following: firstly, there is an insufficient flow of biopsychosocial information (in particular the bio-information component) from the Tertiary Hospital level to the community clinic level of the mental health system, resulting in unnecessary time being spent on accessing this information, which is essential for effective psychiatric management; secondly, the psychosocial context of the patient, the context in which psychiatric treatment and management occurs, needs to be fully understood if an effective psychiatric management service is to be offered at this level of the mental health system.

The needs of psychiatric patients at the community clinic level of the mental health services require a specialist multi-disciplinary team approach in order to establish an appropriate psychiatric management plan in collaboration with the patient and his/her family, based on a thorough biopsychosocial understanding of the patient. The current psychiatric service offered at Maitland community clinic falls short of offering such a service, not because of insufficient resources, but because of inadequate management of these resources. Within this light, clinical psychologists could play an important role in the development and management of community based psychiatric services because of their biopsychosocial assessment and clinical
case management skills. However since as the presence of clinical psychological services at the community clinic sites remains an exception rather than the norm, this will be left to the psychologists in the state services to change, by establishing a role for themselves at this level of the mental health system and claiming ownership of the specialised skills, unique to this profession.
CHAPTER 5
CONCLUSION

South Africa’s political history has left a legacy within mental health services, of racially divided, fragmented and hospital-centric services, reflecting little prevention and mental health promotional strategies. The commitment by the Department of Health in 1997, to the transformation of the mental health service, has had a dramatic effect on these services, from tertiary through to primary level. The national Department of Health has adopted a district health system (DHS) model, aimed at transforming the current health service delivery system to one committed to the provision of appropriate, comprehensive mental health care services within community-based service structures. Based on a primary health approach, this model aims to shift the focus of mental health service delivery away from hospital-based care, currently evident in Tertiary Mental Hospitals, which now offer a short-term (3-5 weeks) specialist service to patients suffering from acute psychiatric illnesses. Once patients are treated and settled on their medication, they are discharged into the care of the community mental health service (i.e. at the community clinic), where psychiatric treatment and management continues.

However, current psychiatric services at the community clinic level do not offer an effective psychiatric management service, leaving a gap in current psychiatric services between the Tertiary Mental Hospital level and the Community Clinic level. The psychiatric treatment focus at the Maitland community clinic was reflected in the fact that the available information at the clinic in the case of S, a patient known to the service, comprised of a mental hospital discharge summary, a referral note and a medication chart. No information existed in S’s clinic file about his psychosocial context, even though he had been managed in this context for the previous two years. In order to effectively manage S, 44% of clinical intervention time had to be devoted to generating adequate biopsychosocial information on which to base psychiatric management decisions. Furthermore, S needed access to the specialised skills of a psychiatrist in order for an assessment to be made and a diagnosis to be made. The psychiatric management model used in the case of S, a multi-disciplinary team approach, proved to be effective in terms of successfully
managing S. However, this intervention was intensive and time consuming, a monthly average of 132 minutes (Table 4.2), which would clearly not be possible to offer every psychiatric patient. The intensive nature of this intervention is arguably due to the fact that the mental health system at the community level is currently inefficient. If there was a more efficient means through which pertinent information pertaining to the patient’s psychiatric management could move from a patient’s tertiary hospital file to the patient’s community clinic file, as well as an effective note taking strategy at the community clinic, patients could receive a far more efficient psychiatric management service, reducing the time spent on biopsychosocial assessment (44% in the case of S, Figure 4.3) and hence the total intervention time.

The case of S also alerted the researcher to the degree to which specialist biopsychosocial assessment skills are needed at the community level if psychiatric services are to be offered at this level. The process of investigating why S was non-compliant on his medication raised a number of questions surrounding the implicit assumptions made by mental health practitioners, which in the case of S proved incorrect (e.g. that S understood that he had a mental illness, that he could administer his prescribed medication, that his non-compliance was due to either his or his family’s lack of motivation to take his medication). Although these issues are not directly related to this work, they are important and warrant focused attention and research. It was on the basis of the information generated by this clinical investigation that it became apparent to the author that without a clear understanding of the psychosocial context of a patient, it is not possible to ensure that a psychiatric management plan is even possible to implement.

In light of the above, it appears that there is a vast scope for clinical psychological skills at the community level of mental health care. However this profession has not yet made an impact at the community level of the public health care system. Given the changes underway in the public mental health system and resultant reformulation of the role of clinical psychology within these services, the opportunity for clinical psychology to develop itself within this new landscape is an exciting challenge. However, this will require that the psychological profession within the state service give up old established positions for largely undefined and potentially
liberating new positions. In light of the overall transformation of the mental health services in South Africa, it would appear that such a change is not only inevitable, but also essential if clinical psychology is to find a valued position in the response to the challenge to provide comprehensive mental health services to all South Africans in the state mental health system.
REFERENCES


