"Are you sure we're talking about the same person?"

DIFFERENT PROFESSIONAL PERSPECTIVES ON A SINGLE PATIENT:

CHALLENGES FOR AN INTEGRATIVE APPROACH WITHIN

THE PRIMARY MENTAL HEALTH CARE SYSTEM

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ABSTRACT

In 1999 a system of placing intern psychologists in primary health care centres was introduced by the Department of Psychiatry of the University of Cape Town. This allowed interns the opportunity of experiencing and evaluating psychiatric services in situ at clinic level within the primary mental health care system. My own experience as an intern working at a clinic served to highlight some areas of difficulty in offering an integrated approach at a primary level. They are in particular the different perspectives brought to the provision of mental health care by the professionals, and the inequalities in status and work conditions of the partners in mental health care service provision. The differing professional perspectives and their implications for case management are explored through a case study of a single patient and her experience of the service. The study illustrates the way in which effective service provision may be compromised by the inherent differences in the perspectives of the disciplines represented by the professionals, as well as by the failure to recognise the extent and importance of the role played by the psychiatric nursing personnel. It is suggested that the system could be significantly improved by the introduction of a system of consultation between all of the partners to coordinate the care of patients in order to maximise the benefits they derive.

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CHAPTER ONE: INTRODUCTION AND BACKGROUND

1.1 INTRODUCTION

The last decade has seen the development of a primary health care system in South Africa based on the principles formulated by the World Health Organisation (WHO) (1990). The WHO has emphasised the need for good quality health services to be delivered at community level to the population within the health centres' catchment areas. An important part of their conceptualisation has been the need for an integrated approach to treating the needs of patients[1]. Within this approach a community health centre should attend to the social and psychological needs of the patients as well as the various aspects of their physical wellbeing.

This kind of service implies the need for a team of professionals from various disciplines who work together on these different aspects of health care to provide patients with an holistic form of intervention. In the past patients have been treated for basic health problems at the community health level and referred to tertiary services for a range of 'specialist needs'. This has resulted in a service which has functioned with a variety of splits and divisions and which has not always been in the interests of the patients (WHO, 1997). The shift towards an integrated service that can combine the efforts of a range of professionals from different disciplines effectively has a number of challenges. Professional perceptions differ in accordance with training, worldviews and roles of mental health professionals working at different levels within the primary health care system. Professional hierarchies, racial divisions and differential remuneration scales present further challenges to the optimal functioning of an integrated system. The challenges of integration obviously affect the whole system of which mental health is only a small part. There are also important issues around integrating mental health into a predominantly physically oriented health system. However

[1] For uniformity of reference the term 'patient' has been used throughout to refer to users of health care services. It should be noted that this term is part of a particular construction within a medicalised approach to mental health care.

these are not the focus of this study. This research focuses on integration issues existing within the mental health system itself.

At community health level the mental health team traditionally consists of a psychiatrist and a psychiatric nurse or possibly a staff nurse. While psychologists have occasionally attended to the needs of a small part of the community, attempts have recently been made to integrate a psychologist into this team, which is collectively known as the community psychiatric team. Within this team, the variety of perspectives and problems of integration existing on a broader level, appear to be duplicated in microform. This research intends to look at some of the issues relating to an integrative professional approach to service delivery in community psychiatric services. It focuses on different perspectives of mental health professionals in psychiatric service provision. It attempts to explore the various approaches to mental health care within the psychiatric team and the implications of this for integration of professional services. It does this by tracking the work of a team of professionals with a single patient seen at a primary care community health centre. The study explores the priorities and experiences of each of the professionals in relation to a patient seen at the community health centre. The case study is constructed through the perspectives of those mental health professionals, including me, who are involved in the patient's treatment within the psychiatric services. It also looks at the patient's experiences. All this is used to construct an understanding of some of the challenges that affect the possibility of an integrative approach at the community health centre.

1.2 AIMS OF THE RESEARCH

According to Kohler Riessman (1994) studies are needed to compare actual collaborative experiences among health professionals. This study is intended to raise an awareness of issues pertaining to the implementation of an integrated, effective and efficient mental health service. The broad aim of the research is to examine the challenge of differing professional perspectives to an integrated approach to primary level mental health care, and in particular to psychiatric service provision.

It aims to do this by attempting to explore the following questions:

(i) What are some of the differences in the perspectives of mental health professionals in psychiatric services at a primary care community centre?

(ii) How do the differing perspectives affect psychiatric service delivery at the level of case management?

(iii) What are the implications of the differing perspectives for an integrated mental health care service delivery at primary health care level?

The thesis will explore these questions through a case study, which is constructed through the perspectives of different professionals within the psychiatric mental health 'team' involved in the management of a single case in psychiatric services at a community health centre.

As this study is a reflection of my personal experience of psychiatric services within a community health centre, the following section focuses on the reasons for my motivation and interest underlying the study.

1.3 INTERNSHIP

Previous to the new system of integration of mental health services introduced in 1996, psychologists had only intermittent contact with the community health centre. In attempting to address the possible use of psychologists at primary level health care, a pilot project allocating two intern psychologists to community health centres was introduced in the South Peninsula area of the Western Cape in February 1999. As one of two psychologist interns selected, I was allocated, on a once-weekly basis, to two community health centres in a district of the Southern Cape Metropole. My brief was to provide psychological services for the duration of my year's internship. My experience has been limited to this district on the

Cape Flats and any discussion is therefore of necessity limited to the primary care services within the confines of the Cape Flats and primarily in the so-called 'Coloured'[2] area.

During my internship in psychiatric services, I came to question aspects of service delivery. I became aware of a paucity of interdisciplinary contact and teamwork within the context of primary level mental health service provision. Professional collaboration appeared to take place in an ad hoc fashion, with little or no space given to the sharing and understanding of the differing perceptions and professional perspectives. Patients were referred to me by psychiatric registrars or psychiatric nurses with whom I had minimal contact. My interactions with the psychiatric nurses, who had some understanding of the patients' difficulties, especially in the context of their shared cultural and social background, were limited to chance encounters. (The psychiatric nurses working at community health centres in the Cape Flats are drawn primarily from the same population and area as the patient base.) Other than through patients' reports, I was unaware of the psychiatric registrars' perspectives on patients' illnesses and treatment plans. In the absence of adequate interdisciplinary interaction between the mental health professionals, my subjective experiences within and of the community health centre were shaped, given reality and interpreted in terms of my clinical training and cultural and sociological perspectives, i.e. in terms of my own explanatory model (Kleinman, 1980). My training had thus far included assessment and diagnostics, but for me there was a stronger focus on psychodynamic understanding of and psychotherapeutic approach to mental illness. My way of "seeing" the patient was determined and limited by my worldviews and assumptions about the patient's illness. My understanding of medical interventions was, at best, extremely limited. I had little more than a cursory understanding of the effects of medication. As the only psychologist working in the primary care setting, I felt myself to be working in a vacuum, providing a psychological service whilst in relative ignorance of the other professionals' interventions. My experience as psychologist intern at a community health centre led me to believe that a need exists for an integrated professional approach within the psychiatric services, in order to provide an appropriate and effective mental health care service.

For integration to be meaningful it has to be practiced. My experience suggests that there is a considerable difference between broad policy and what happens on the ground. This study

[2] The reference to different racial groups is used to clarify issues relating to race, and in no way reflects the attitude of the author.

therefore explores an integrative approach to mental health care service provision in community psychiatric services in South Africa.

1.4 BACKGROUND TO THE RESEARCH

This section provides a brief sketch of the integration into and development of the psychiatric services within the mental health services at primary level.

1.4.1 THE PRIMARY MENTAL HEALTH CARE SYSTEM

The World Health Organisation (WHO, 1990) maintains that in addition to the need for good mental health services, effective mental health care is "essential if primary health care is to be useful". A study of the Free State model for decentralised health care suggests that the above " implies that unless mental health services are adequate and integrated into the health care system the foundation of the new national health policy, i.e., comprehensive primary health care, will be undermined" (Landman et al., 1995).

Rendering mental health care services at the primary care level in an efficient, cost-effective and culturally acceptable way presupposes dialogue and a sharing of differing perspectives and coordination of skills by mental health professionals at primary level of intervention (Freeman, 1992). Respect for the patient and for other disciplines means that mental health professionals involved at the primary care level enter into dialogue and debate with each other and not merely go along with what the patient or other informants say (Swartz, 1998). The primary level mental health team is an important resource for improving efficiency and reducing the duplication of mental health care provision which should be identified and defined by the health centre (WHO, 1997). Frontline health facilities and services that are deliberately coordinated, may prove more efficient in addressing intra-disciplinary and intersectoral fragmentation, and will have the potential to increase health gains from a collection of inputs. The consequences of lack of communication between mental health care professionals include unnecessary duplication of effort, wasteful or inefficient use of resources, and other hidden costs (WHO, 1997). According to WHO primary mental health

care facilities and services that are deliberately coordinated and integrated should prove more efficient in addressing interdisciplinary fragmentation, more cost-effective and therefore more likely to reach larger numbers of people in spite of limited professional resources.

1.4.1.1Background to the development of the current primary mental health care system

In the 1950's contemporary mental health practices began to be developed with the unlocking of many psychiatric wards and the development of new psychotropic drugs, which had the affect of reducing overt emotional distress (Petersen, 1998). Within the broadly defined health sector mental health care was provided through private transactions and by the state. For those who could afford private services and who lived in urban areas mental health care services were readily available. By comparison services in the public sector were extremely poor (Freeman, 1992). While the devolution of mental health care to primary care services, except in the most extreme cases, meant that patients could be treated close to their places of domicile, mental health was hardly considered and mental health problems remained generally untreated (Freeman, 1992). When problems were identified, treatment was generally medical. Prior to 1996 the needs of psychiatric patients at primary level were attended to by mental health care professionals, who were based at tertiary health institutions. Psychiatric services were provided by specialists from psychiatric hospitals. Patients referred to community health centres with mental health problems, were attended to by psychiatric nurses during once weekly, twice monthly or monthly visits. The psychiatric nurses brought the prescription drugs with them. Few patients with emotional problems were seen by a psychologist.

According to Robertson, Zwi, Ensink, Malcolm, Milligan, Moutinho, Uys, Vitus, Watson and Wilson (1997) psychiatric services were characterised by overuse of institutional care while mental health services at community health centres were underdeveloped. Freeman (1992) noted that mental health services for the majority were "grossly inadequate" and that little attention was paid to the "psychological wellbeing" or the empathic care of people in the community. The sidelining of non-medical curative, preventative and rehabilitative mental health care services within the primary health care system has serious repercussions for

patients' health and well-being and for human and financial resources of the state (Freeman, 1992). Proposals for mental health care by the Department of Health (1995) suggest that personnel should be adequately trained to provide integrated and comprehensive mental health care, based on primary health care principles. Mental health services should be provided by an integrated multi-disciplinary mental health team consisting of community health workers, (clinical) social workers, occupational/ physio-therapists, (psychiatric) nurses, psychiatrists and psychologists (Swartz, 1998; Western Cape Ministry of Health and Social Services, 1994).

1.4.1.2 The current primary mental health care system

In 1996 the Department of National Health published a document suggesting that the solution to the problems of health development lay in strengthening local or district health systems based on community health centres. This coincides with the WHO position which argues that the community health centre, in all its forms and functions, is in fact the backbone of all the health services and health development in all countries, and a critical vehicle for pursuing the goal of health for all. A strong health centre-based system should effectively act as the first community contact or point of entry for an optimal use of health services, provided that competent clinical and other health-related activities are offered (WHO, 1997).

Within the primary health care system in South Africa the community health centre stands in the forefront of the fight for healthy and fulfilling lives for the communities it serves. At present it is even more difficult to maintain or improve the quality of service provided at the community health centres. At the primary level of mental health service provision South Africa still fares better when compared to the Sub-Saharan states in terms of patient-mental health service provider ratio, but is still under-resourced by First World standards (Freeman, 1992). 80% of South Africans depend on the public and welfare sector which is serviced by approximately only 10,3% (161) of the 1568 registered clinical psychologists while only 37,9% (162) of 427 registered psychiatrists are employed by the state (M. Freeman, personal communication, 1997). The ratio of community health nurse to patients was 1:5,400 and social worker to patients was 1:1,500 in 1992 (Freeman). "It is noted that (in South Africa) patients' attendance at the community health centres has increased from 1.5 million in 1996

to 2.9 million in 1998, while personnel numbers have decreased from 2100 to 1900 in the same period" (Metropolitan Budget Report, 1999). It is therefore likely that the 1992 ratios underestimate the resource difficulties.

The service at most community health centres is largely 'doctor-driven' with nursing staff providing auxiliary services such as preparation, dressings and injections. Some professional nurses have a so-called 'dedicated role', e.g. a trained nurse experienced in psychiatry, now known as the community health nurse, who does provide a general medical curative function, in terms of administering of drugs, application of various medical treatments, etc. These functions are now carried out by generalist nurses, which, in theory, should free the psychiatric nurses to provide non-medical curative services, such as counselling, preventative and rehabilitative work.

With the intention that mental health care now be integrated into the primary health care system, based on the mental health care philosophy laid down in the WHO constitution, psychiatric nurses are no longer based at tertiary institutions. They are stationed at the community health centres and supervise medication and counselling of patients and their families, make home visits and have a follow-up role within designated areas. They also refer patients to psychiatric registrars who now attend the centres on a sessional basis. As only larger centres have psychiatric nurses, staff nurses at smaller community health centres are expected to undertake the role of follow-ups and the supervision of psychiatric medication.

Psychiatric registrars continue to provide a consultation service at primary level on average one morning or afternoon a week, assessing patients, prescribing psychotropic medication and dealing with referrals to other mental health facilities. The placement of registrars at any primary level health centre is limited to a three year period of service as stipulated by the Health Professions Council.

Previous use of psychologists was limited to referrals to psychologists placed at regional hospitals and at secondary level services. Since 1999 the services of psychologist interns have been introduced into the mental health system. The psychologists assigned to psychiatric

services provide a limited psychological service of one day a week for the duration of one year as stipulated by the Health Professions Council.

Presently most psychiatric disorders, both major and minor, are seen by mental health professionals in psychiatric services at community health centres. Sources of referral are tertiary and secondary hospitals, GP's, Cape Mental Health Society, social workers and the community health centre medical officer (Community centre psychiatric nurse, personal communication, April, 2000; Provincial Administration, 1999).

Figure 1 provides a diagrammatic view of the referral pathways to primary level psychiatric services and includes referrals from within the community health centre, the community, social workers and Cape Mental Health and regional/ secondary and tertiary hospitals. It also indicates the current referral system functioning within the psychiatric services at the primary health level of service.

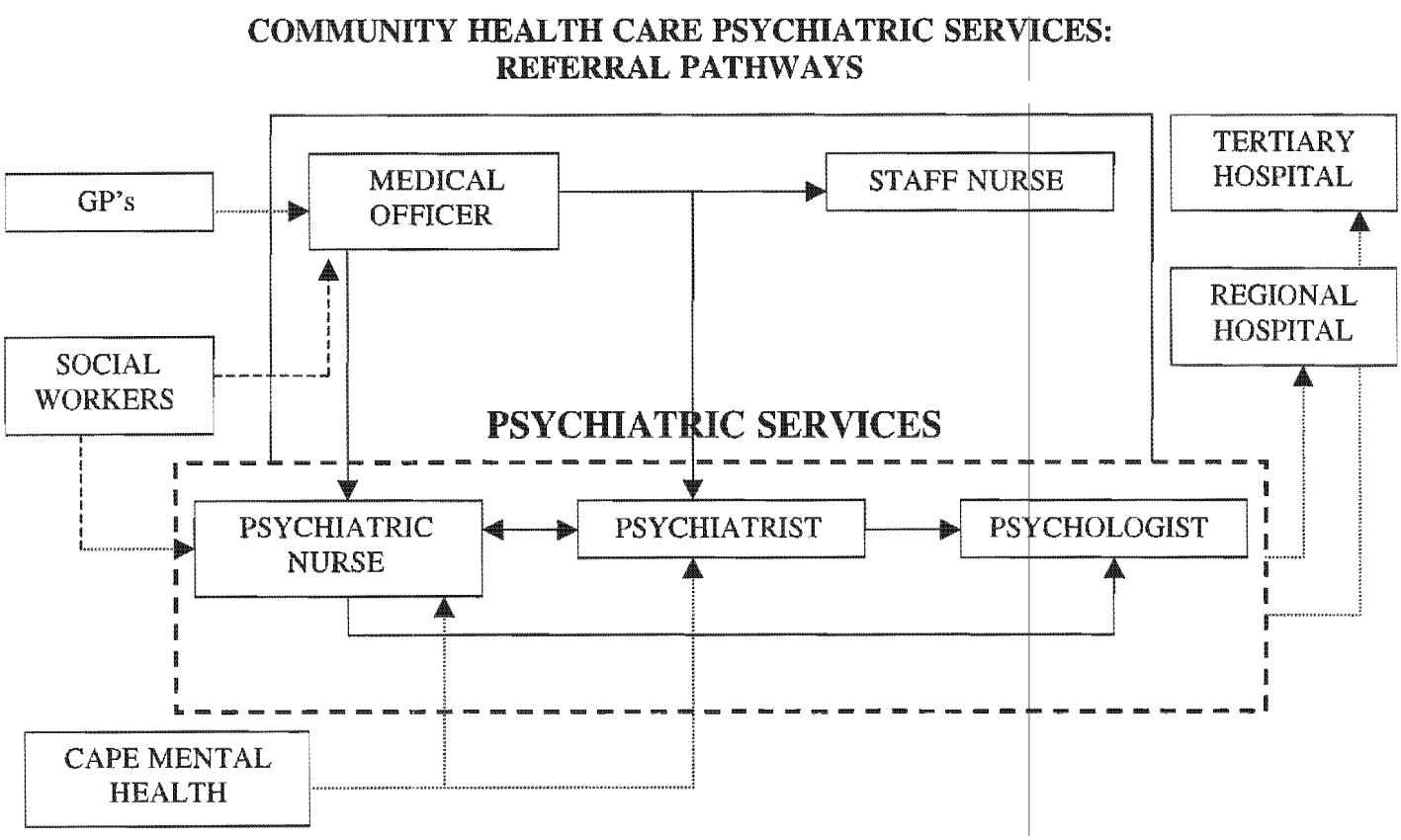

Figure 1.

The majority of 'mental' difficulties referred to and presented at psychiatric services at community health centres involve psychological, family and social dysfunction, in addition to a proportion having a mental illness component (Freeman & Pillay, 1997; WHO, 1990). The latter tend to be those 1-1.5% of the population with severe and disruptive tendencies and where the intervention tends rather towards symptom relief than to changing underlying dynamics, psychodynamic or psychosocial (South Peninsula Health District, 2000). In communities under stress the incidence of emotional disturbance can be as high as 65% of the population (Western Cape Ministry of Health and Social Welfare, 1994). More specifically, the most common disorders presenting at the community health centres' psychiatric services include personality disorders, schizophrenia and affective disorders.

The large number of patients attending primary health care centres with mental disorder is of key importance to mental health services (Tyrer et al., 1993). The growth of out-patients, discharged psychiatric patients and new patients attending clinic, presents many problems for the overburdened staff of the psychiatric services personnel. According to Landman (1995), estimates made in 1995 put the number of registered nurses qualified in psychiatry at 13%. The shortage of qualified personnel and other team members is problematic in terms of appropriate and efficient service delivery.

As mental health care can never be provided adequately by one person working in isolation (WHO, 1990), it can be assumed that contributions to mental health care should be interactive and develop horizontally across professionals working at primary care level in psychiatric service provision. When health centres are bypassed, and hospitals and specialist centres are used to provide treatment for simple ailments, the costs of care rise dramatically. Furthermore it is more difficult to coordinate vertical programmes where there is a marked lack of communication. This often results in inefficient use of resources, while service takers have to spend much time and money in procurement of services (WHO, 1997).

It has been widely acknowledged that new ways of making sense of mental illness, through an integrative and collaborative approach at the primary level of mental health care, are needed (Tyrer, 1993). Existing resources have to be used more efficiently if mental health services are to reach people more effectively (Freeman, 1991; Kriegler, 1993). With many

factors influencing differing perspectives, Holmes (1995) asks whether it is in fact possible for different approaches and perspectives in mental health care to usefully 'bed down' together or whether they need to retain separate identities. Holmes and Mitichson (1995) suggest that a 'hubs-and-spokes' model, in which psychologists make forays into psychiatric settings, while retaining a core psychotherapeutic identity, works well in National Health child psychiatric practice and could be 'usefully emulated in adult psychiatry in the National Health system'. Recent literature (Foster, Freeman & Pillay, 1997; Holmes, 1995, 1994; Lewis-Fernandez & Kleinman, 1995; WHO report, 1997) reflects that while strides have been made in the direction of an integrative professional approach to mental health service provision, much remains to be striven for. The WHO report suggests that all professionals, involved in primary mental health care, work towards common goals, allowing for flexibility in defining priorities and courses of action at health centre level. Attitudinal changes with regard to role definitions and power hierarchies need to be encouraged through explicit recognition of the importance of these changes for health centre objectives.

Until 1996 a 'top down' mental health care service was provided for patients presenting with mental illness at the community health centres. Psychiatric service professionals provided clinics at the community health centres on a sessional basis or patients were referred to tertiary institutions. This division and fragmentation of services meant that patients were often required to travel long distances at great expense to themselves in terms of time and money. It also meant that it was more difficult for professionals attending to patients to communicate and collaborate, with the result that many patients did not receive adequate attention (WHO, 1997).

Mental health services are now integrated into the primary system and patients are seen in what Gask, Sibbald and Creed (1997) refer to as the 'shifted' out-patient clinic at the community health centres closest to their habitation. Nonetheless it would appear that an integrated professional approach to psychiatric service delivery is still faced with difficulties, which have not been addressed by the relocation of psychiatric services to the community health centres. In this investigation the focus will be on the challenges to an integrative professional approach to mental health care service provision in psychiatric services at primary care level.

CHAPTER TWO: LITERATURE REVIEW

The literature review will begin with a broad overview of current literature on mental health issues relating to differing perspectives of mental health professionals in general. It also focuses on the effect of differing professional perspectives on primary level mental health care in psychiatric services in particular. The review looks at the effects of differing paradigms, and race and power relations inherent in professional hierarchies on the perspectives of mental health professionals within the primary mental health care system. The review also explores literature on how patients' perceptions of mental health service practitioners interact with those of the mental health practitioners themselves. Certain relevant aspects of training and clinical practice will be included in the review. Some of the challenges facing psychiatric services at the primary health care level in South Africa are also reviewed in order to provide a context for the case study.

2.1 INTRODUCTION

According to Swartz (1998) professionals working in institutional psychiatric care operate as a multidisciplinary team, with expertise from each profession being used collectively for the greater good of the patient. Arising from the above statement are the following questions, which underpin the literature review.

(i) What are the differing perspectives of mental health disciplines involved in mental health care and in community psychiatric services in particular?

(ii) What are the possible challenges to an integrative approach to service delivery inherent in the differing perspectives?

The following section deals with differing professional perspectives in terms of the variables determining and affecting these perspectives. These include different paradigms that inform the understanding of mental health problems and their treatment, race, power hierarchies and training. Within this I focus specifically on the perspectives of professionals who play a role within community psychiatric services: (a) psychiatric nurses, (b) psychiatrists and (c) psychologists.

(a) Psychiatric nurses

In South Africa and in terms of Regulation R425, 22nd February 1985, as amended, under the Nursing Act, 1978, nurses are required to be in possession of a Diploma or Degree in general and community nursing, psychiatry and midwifery, in order to register with the Nursing Council. Both Diploma and Degree require four years study at either a College of Nursing or a tertiary academic institution. The course in psychiatric nursing was incorporated into the nurses' training programme in 1988. While current qualifications allow all nurses to provide psychiatric services, it would appear that those placed in the community health centres since 1996 had previously chosen to work primarily in the area of psychiatry. According to Helman (1994) nursing education is primarily within the biomedical model. Service provision by nurses is largely treatment-based as opposed to interventions oriented to the patient as a mental, physical and socio-cultural entity. However, with the growth in the population of community health patients with psychological disorders (WHO, 1990), attention has been given to development of a psychological understanding of mental health problems and training of counselling skills in nursing training (Western Cape Ministry of Health and Social Welfare, 1995). Psychiatric nurses placed at community health centres are expected to make home visits, supervise medication, follow up defaulters, and counsel patients and their families.

(b) Psychiatrists

For South African psychiatrists to be admitted to the Faculty of Psychiatry requires a tertiary academic qualification (MBCHB) to practice medicine, which has been registered with the Health Professions Council (College of Medicine of South Africa). The degree of FF

Psychiatry (SA) requires a four year fulltime internship covering experience in child psychiatry, clinical responsibility for patients suffering from all kinds of psychiatric illnesses and experience in community psychiatric service, including a one year appointment in a psychiatric hospital or psychiatric department in a teaching hospital. Helman (1994) refers to doctors as products of medical schools; and traditionally perspectives of psychiatrists have been influenced by the biomedical model of treatment, referred to by Helman (1994) as a 'disease' perspective, which is based on tertiary care and institutionalisation of psychiatric patients. Psychiatrists primarily have a clinical responsibility for the assessment and diagnosis of patients, suffering from all main varieties of psychiatric illness. They are responsible for treatment, referrals and prescribing psychotropic medication, which is largely monitored and/ or administered by psychiatric nurses. While training has incorporated the discipline of psychology, the emphasis is not on the provision of psychological services.

(c) Psychologists

Clinical psychologists as health practitioners fall under the jurisdiction of the Health Professions Council of South Africa (HPCSA). In order to register with the HPCSA clinical psychologists are required, until 2004, to complete a two year Masters degree (by dissertation) at a tertiary academic institution (HPCSA, 2000). This includes a one year internship at several health care institutions, so as to gain as wide as possible a spectrum of experience in adult and child psychological services and psychometrics (Health Professions Act, 1974, Act 56 of 1974) (HPCSA, 1999). Psychologists are trained within the medical model in terms of assessment and diagnosis. The training in terms of treatment modality is non-medical, focusing on the psychosocial dynamics underlying psychiatric problems. Traditional skills of psychological therapy in individual and small group settings are emphasised (Koch, 1986). Freeman (1991) noted that by the time psychologists were trained, they were "indoctrinated" into a Euro-centric model of psychology, suggesting that there was a need "to forget much" in developing appropriate psychotherapeutic models in primary mental health care.

2.1.1 Differing perspectives as a function of training

Medical and psychological training and prejudicial attitudes (conscious and unconscious) inherent in the training, determine what the appropriate means of dealing with the patient might be (Acharyya, 1992). Training programmes of the various mental health disciplines involved in psychiatric services take place in isolation of each other, with each discipline developing and then working within its own explanatory model of mental ill health (Kleinman, 1988). Much difference of opinion comes from the variation in training given to the professionals involved in the psychiatric services which shows little evidence of integration (Tyrer et al., 1993). Tyrer et al. (1993) suggests that each discipline indicates a tendency to train within its own boundaries, thereby ensuring a territoriality of roles and interventions. Lack of unity of service is in part due to a rather narrow view of training by each profession. "In England, clinical psychologists know very little about social psychiatry and epidemiology; and (our) psychiatrists all too often adopt either a narrowly biological approach to their subject or an approach heavily emphasising dynamic psychiatry which is relatively uninfluenced by recent advances in either biological, or social psychiatry" (Goldberg & Huxley, 1992, pp.162-163). A study by Stones (1996) looking at differing perspectives of mental health care professionals, suggests the possibility that academic psychology, with its frequently critical approach towards biological psychiatric treatment, inadvertently influences the attitudes of students negatively towards psychiatry and other related disciplines. A local study by Mgoduso & Butchart (1992) similarily suggests that psychiatric nurses given training in psychological skills, were nonetheless limited in their ability to integrate these skills with internalised biomedical beliefs. Their findings are suggestive of a "schism" existing between perceptions of the traditional nurse role and that of the psychologist which depicts the biomedical and psychosocial models as disconnected and almost mutually exclusive rather than interactive and complementary.

2.1.2 Differing perspectives as a function of differing paradigms

Definitions of health are determined by the paradigms or conceptual frameworks within which they are formulated and/ or by whoever is asked to provide them. Within the medical paradigm it is assumed that diseases will always have the same cause, clinical picture and

treatment regardless of the society or culture in which it appears (Fabrega & Silver, cited in Helman, 1994). Although, as Helman (1994) points out, different interpretive models, e.g. the organic, the psychodynamic and the social models of illness, are all used in psychiatry, the predominant approach in clinical practice is still the symptomatic manifestation of 'illness' or dysfunction. The psychosocial model of illness which provides a conceptual framework for psychologists encompasses the social, psychological and cultural dimensions of ill-health and the context in which it appears. It focuses on meaning making of the illness for the patient in terms of individual experience. However, this interpretive approach, while offering an alternative paradigm for viewing illness, often fails to pay sufficient attention to the broader socio-economic issues and power relations (Petersen, 1998).

An integrative approach is impeded by differing professional socialisation processes in relation to values, patient care goals, the role and rights of the patient, teamwork and the structure of goals and processes of professional training (Roberts, 1989). There are fundamental differences in how professionals style their particular area of expertise and in how they relate to other professionals. Yet each discipline within the mental health profession can be seen as a healing sub-culture with its own particular worldview. If worldview is defined as the sum total of an individual's experience, assimilation and internalisation of the culture in which s/he matures, then "the worldview one adheres to determines the way one perceives, thinks and feels, and experiences the world" (Meyers, cited in Foster et al., 1997). Helman (1994) suggests that mental health professional education contributes to a form of "enculturation" whereby practitioners gradually acquire a perspective on ill health which lasts throughout their professional life. He further states that "doctors are not only the standardised products of medical schools and their disease perspective: their perceptions are personal, idiosyncratic and cultural, as well as professional" (Helman, 1994, p.143). It would appear that non-medical professionals such as psychologists and psychiatric nurses involved in the mental health care provision are not exempt. Given that most psychologists within the South African context are White and have been trained within the Western model of psychodynamic thinking their approach to mental health service provision will undoubtedly be influenced and shaped by the training and their status within a post-Apartheid society. Freeman (1991) has suggested that a large number of psychologists are not versed in the worldview of the majority in South Africa, are not from the same class nor share the same cultural point of view. When the differences are understood, it is usually from the point of

view of an anthropological "other" which carries the potential for patronising attitudes and the inability to form empowering therapeutic relationships. According to Seedat and Nell (1992) psychologists are often ambiguous about their roles and functions, as they work partially within the medical model in terms of assessments and diagnoses, yet have little medical training per se.

In a study examining conflicting value systems within primary mental health service provision, Seedat and Nell (cited in Mgoduso & Butchart, 1992) noted that psychological skills were viewed by nurses as "trivial in a context where biomedicine and the 'quick fix' are considered more efficient and so more important in the provision of primary health care". In the South African context the majority of nurses working in primary health care are drawn from the same population groups as the patients presenting at primary level. Given the above Littlewood (cited in Helman, 1994) suggests that nurses can have a major impact on the understanding of the "meaning" which patients give to their life and suffering and that this role needs to be acknowledged in mental health policy and by the involved professionals.

Kleinman (1993) refers to the monotheism of Western tradition as having a deterministic influence on Western medicine. He suggests that the idea of a single god legitimates the idea of a single underlying universal truth and unitary paradigm and as such underlies the medical approach to ill health. Universalism as practised by psychiatry tends to use the Western diagnostic systems as the standard by which to measure all forms of mental illness (Swartz, 1998). According to Petersen (1998), the universalist approach to mental illness promoted by psychiatry has its limitations in the treatment of patients in that it tends to neglect the subjectivity of the illness experience for the patient. Swartz (1998) suggests that this approach to mental illness leaves little room for taking into account the processes involved in shaping the illness which may have serious consequences for treatment. Freeman (1992) has argued that the ideology of the medical model in psychiatric service provision is so powerful that a comprehensive approach to the wellbeing of the patient as a whole is jeopardised. Psychosocial issues are not seen as 'real' and important objects of attention (Eisenberg, 1986). And failure of a patient to respond to biomedical interventions is ascribed to 'emotional' problems which need to be 'worked through' (Holdsworth, 1994). The patient is then referred to psychological services (Petersen, 1998). Kleinman (cited in Petersen, 1998) suggests that psychiatrists generally perceive psychosocial problems as being the

responsibility of psychologists and other related non-medical mental health professionals. According to Petersen, the ease with which non-medical mental health professionals such as clinical psychologists and psychiatric nurses are prepared to play a supportive role in psychiatry, is also reflective of the power dynamics within the primary health service provision. Nonetheless, given the dominance of the medical paradigm in the context of primary mental health care, Tyrer et al. (1993) and Freeman (1992) suggest that psychologists often feel that their special skills are not fully appreciated by their psychiatrist colleagues.

2.1.3 Differing perspectives as a function of hierarchy of power

In referring to the potential for conflict within the confines of a multi-disciplinary team Swartz (1998) suggests that some of the conflict will have its origins in power relationships and differences between professions and in confrontations relating to rival claims of disciplinary competence within delineated professional boundaries. The medical profession, by virtue of the power and status and authority it has achieved, ensures that psychiatrists are on top of the hierarchy of the professional groups involved in the care of the mentally ill. The psychiatrists have certain exclusive legal powers to prescribe drugs and to admit and discharge patients from hospital, even against their will. Their identity as doctors gives psychiatrists a key role in determining the content and character of mental health services (Busfield, 1996). According to Helman (1994) medical practitioners enjoy higher status and greater income and more clearly defined rights and obligations than other types of healers. Helman asserts that within the medical system most doctors are male and usually white and occupy more prestigious and powerful jobs than do female doctors and nurses. Although conceptually equal, the mental health profession is arranged in hierarchies of knowledge and power. Within the mental health profession there are specialised sub-professions which duplicate the medical hierarchical structure on a micro-scale. Busfield states that in the UK new mental health professionals, for example clinical psychologists and psychotherapeutic counsellors, pose a potential threat to the authority and status of the psychiatric profession. They have in many ways been contained as subordinate groups within the medical hierarchy. Holdsworth (1994) refers to the "marginalisation" of psychologists by the medical fraternity, suggesting that psychologists are not considered of equal status with psychiatrists. In South Africa the training of psychologists falls under the Department of Psychiatry and

psychologists are still under the control of the Health Professions Council (the renamed Medical and Dental Council). Tyrer et al., (1993) suggests that the opinions of psychologists are often disregarded in the planning of psychiatric services, whereas Holmes (1995) questions whether, if psychologists are integrated into primary health care systems, they do not loose the distance necessary for creative therapy. He asks the question, whether integration means that the special psychotherapeutic skills, which require years of training, will be devalued. According to Foster & Swartz (1997), psychologists in effect provide a "tier" of support to the hierarchically organised "multi-disciplinary" team which continues to be dominated by the medical model. Parker et al. (1995) suggests that the acceptance by non-medical professionals of a support role within the biomedical hegemony can be attributed to some attempt to "share" the power.

Occupational roles are an important part of the way in which individuals define themselves (McHugh & Vallis, 1986). Physicians such as consultants and doctors overall have more power and autonomy than nurses. According to Menzies Lyth (1991) nurses, as subordinates within the medical professional hierarchy, tend to feel dependent on their superiors. Seedat and Nell (1992) noted that nurse trainees often referred to the power they perceived to be inherent in the observational techniques of psychologists. In terms of the professional hierarchy within the psychiatric services the psychiatrists and psychologists are considered superior by virtue of their training. Menzies Lyth (cited in Van der Walt & Swartz, 1999) postulates that nurses split off those parts of themselves which they feel to be competent and powerful and project them onto those they consider to be superior and more powerful. While on the one hand alleviating some of the anxiety experienced by nurses in the face of stressful work, underestimation of the nurses' abilities may give rise to a concomitant sense of being undervalued and powerless (Tyrer et al., 1993; Van der Walt & Swartz, 1999).

2.1.4 Differing perspectives as a function of race

Medical anthropologists have pointed out that any society's health care system cannot be studied in isolation from other aspects of that society (Helman, 1994). Race and ethnicity are strong determinants in mental health considerations. Littlewood and Cross (cited in Kareem & Littlewood, 1992) suggest that, where there is racial and cultural divergence, a potential

exists for patients to be labeled as 'mentally ill' because mental health professionals have failed to interpret the patient's thoughts and behaviours and consequently make certain assumptions about the presenting problem. The issue of race is rarely absent from therapy, even when racial and ethnic identity are shared (Kareem & Littlewood, 1992). Swartz (1998) suggests that stereotypes about race interact, in mental health practice, with ideas about mental illness. Kareem & Littlewood similarly observe that 'non-European' patients are viewed as less verbally sophisticated and less 'psychological' and, by inference, less suitable as candidates for psychotherapy.

Mental health and mental health service provision have been seriously undermined by political determinism and social attitudes during the Apartheid era which Freeman (1992) suggests, have in turn severely inhibited the potential of the majority of South Africans to develop to psychologically optimal levels. Assumptions about the degree of psychological-mindedness of the different racial groups in South Africa are still underpinned by political ideologies of the Apartheid era (Swartz, 1998). While these assumptions are more obvious in the South African context, they are seen in a similar way in international psychiatric research, as cited in Kareem & Littlewood, (1992), Littlewood & Lipsedge, (1997) and Swartz, (1998).

According to Helman ethnic or cultural background and political affiliation will consciously or unconsciously affect perceptions in terms of the diagnosis and treatment of patients. The meanings attached to the political and socio-economic context in which diagnosis and treatment take place are important, (Helman, 1994, Freeman, 1992). Racial inequality and discrimination cannot but influence the differing perspectives of mental health care professionals (Freeman, 1992). Freeman and Pillay (1997) refer to an ideological framework in mental health care services in South Africa that has been a "combination of racial discrimination...and paternalism". As the majority of psychiatrists and psychologists involved in primary mental health care are White, and the patients seen at community health centres are very often Black or so-called 'Coloured', one cannot ignore the implications of racial issues for practitioner-patient power dynamics. "Psychiatrists themselves would deny that they consciously and selectively penalise black patients whilst agreeing that they are dealing with the casualties of disadvantage" (Littlewood & Lipsedge, 1997). The power imbalance in the patient-mental health professional relationship is inevitable and intensified by issues of

race, culture and gender. Kareem and Littlewood (1992) suggest that mental health professionals caught up in their own particular dynamics tend to exploit the imbalance, thus maintaining their patients in a powerless situation, while they point out that psychotherapy is perhaps even less innocent and less free of social and political ideologies than is biomedicine.

South Africa has a history of inequitable relations within professional areas, as well as the exploitation of women and black workers (Foster & Swartz, 1997). Within the mental health profession interconnected issues of race and power have also "bedeviled" the primary mental health care system. Political power relations of the previous Apartheid system are mirrored and have entrenched themselves within the system. Until recently most medical professionals and psychologists were Whites and the majority of psychiatric nurses in primary level care are still Blacks and so-called 'Coloureds'. The differential distribution of technical knowledge and expertise reinforces the existent stratified system in which psychiatrists and psychologists are seen to be superior to psychiatric nurses (Waitzkin & Waterman, cited in Seedat & Nell, 1992) and the nurses see themselves with little or no autonomy or power.

2.1.5 Professional perspectives as a function of patient perceptions and presentation

Mental health professionals have differing visions of their priorities, which determine their approach to their patients and colleagues. Miller and Swartz (cited in Swartz, 1998)) define the conflicts as relating partly to different ways of understanding patients. According to Landy (1977) the specified roles of doctor and patient fall into the socio-cultural aspect of relationships as do the rules governing these relationships and the specialised settings in which these interactions take place. According to Stones (1996) the perceptions of the patient are formed by and reinforce the perceptions of mental health professionals regarding the efficacy of the biomedical approach to mental illness. Research has indicated that the patient's perception of the psychiatrist as the mental health professional best able to deal with mental illness, concurs with the perceptions of other health professionals, e.g. general practitioners, in the health field (Stones, 1996, 1994, Albone, 1993). In both the doctor-patient interaction and the psychotherapeutic encounter, the power is vested in the expert, requiring the patient to relinquish control. Perceptions of patients are also formed by and in turn reinforce the perceptions of psychologists and the psychiatric nurses. According to

Seedat and Nell (1992) psychologists are viewed as super-skilled observers who possess skills to whom the patients 'surrender' their inner worlds or psyches. While referral and service depend to a certain extent on the characteristics of the patient, e.g. relative age and marital status (Fink, Shapiro & Goldensohn, 1970), patients presenting at primary care level are directly affected by and in turn affect differing professional perspectives. Kleinman (1988) suggests that patients are aware of the "demand characteristics" of different settings and that these demands lead to selective attention by professionals underpinned by the differing clinical viewpoints and paradigms. According to Helman, (1994) patients learn to display 'typical' clinical pictures that health professionals are looking for. Helman refers to the example of a patient who was mistakenly diagnosed as having angina from 'heart trouble". The patient developed psychosomatic chest pains, which came to closely resemble angina the more he had contact with clinicians, thus entrenching the original diagnosis. Helping to reveal and then shape the patient's 'illness' which in turn shapes the intervention is a characteristic of mental health care interventions (Kleinman, 1988).

Swartz (1998) has suggested that where resources are scarce, patients are processed more quickly and their illness experience attended to less than is desirable. Pillay and Lockhat (1997) noted a study on primary level mental health care in which it was established that the majority of patients with depressive or anxiety disorders, making frequent out-patient visits, were more likely to receive medication for chronic medical conditions such as hypertension or ulcers. Only the minority received any specific mental health treatment, either pharmacological or psychotherapeutic. The alarmingly low rate of detection of psychiatric morbidity at the primary level was found to be one of the major problems of primary health care occurring in the absence of sufficient mental health specialists.

2.1.6 Some concluding thoughts to challenges facing mental health care

According to Swartz (1998) the terms mental 'health' and 'illness' stem from a medicalised way of looking at problems which fails to take into account the impact of emotion and behaviour on health. He notes that although working primarily in the biomedical model, psychiatrists and psychiatric nurses work in the context of a broader society, which enables and constrains what may be done by them. The demand placed on few psychiatrists and

psychiatric nurses by many, compromises the quality of mental health care available. The biomedical model essentially keeps mental health in the biological context whereas the psychosocial model puts it in the context of culture and society. While an integrative approach by multiple disciplines allows a fuller understanding of illness than permitted by any one approach by itself (Good, 1994), the fact that biomedicine is an acknowledged, valued and entrenched 'cultural' system, with numerous economic and political factors promoting its maintenance, impedes change (McHugh & Vallis, 1986).

The perspectives of the various mental health professionals are based on very different premises and assess the appropriateness and efficacy of treatment in different ways (Helman, 1994). Therefore communication and an integrative approach between them require attention, in order to ensure comprehensive psychiatric services in the best interest of the patient which, it can be argued, in turn contribute to improving efficacy and reducing the duplication of essential activities (WHO, 1997).

Mental health dilemmas inevitably imply questions of value. The crisis of values between the mental health disciplines seems to be one in which the professional-patient aspect of healing competes with, rather than complements advances in the biomedical field (Tyrer et al, 1993). Psychological and psychiatric interventions should provide a complementary mental health care service, allowing for the provision of comprehensive services within the psychiatric services and ultimately in the primary mental health care system.

In conclusion, the literature on challenges to an integrative professional approach within primary mental health care in general, and psychiatric services in particular, provides evidence that differences in professional perspectives considerably limit an integrative approach, providing an inhibitory factor to a cohesive sense of team. In particular, literature suggests that factors which influence and affect an integrated service delivery within the primary mental health care system, are a function of a range of variables, which together constitute and are entrenched in the differing worldviews of the professionals. Authors in the field highlight a number of factors – training, differing paradigms, race, power hierarchies and others - which form and influence differing worldviews.

The above review considers the extent to which they affect service delivery and the patient. The implications are that integration of a variety of professional perspectives and approaches within psychiatric service provision is not automatically addressed by the integration of mental health services into primary care. It suggests that, given the complex interaction of factors affecting an holistic service delivery, it would be essential to consider if an integrated professional approach were to be achieved within psychiatric services.

According to Robertson et al. (1997) a new system of data collection in full consultation with service providers needs to be carefully designed. They suggest that "without this information, implementation and monitoring of service provision policy cannot proceed" (p.90). Case study method provides a useful tool to explore the influence and effects of differing professional perspectives on service delivery and the patient within the context of psychiatric services in a community health centre. However, it is unclear whether case study method provides an appropriate vehicle for studying the complexity of factors affecting an integrative professional approach. In order to explore this, I have included a brief section in which I examine the methodological approaches used by the authors cited in the literature review.

2.2 METHODOLOGICAL CONSIDERATIONS

From the literature on research in the field of primary mental health care service provision it would appear that a range of research approaches were used. Research into issues relating to an integrated service delivery within the National Health System in UK has focused primarily on outcome-based studies. While highlighting significant aspects of mental health care service provision, outcome-based studies allow for neither in-depth studies of the health system nor for situational analyses which take contextual implications into account.

In terms of local research integration of mental health care services within the primary care setting is a relatively recent innovation. Consequently, there has been relatively little research in South Africa focusing on the integration of the various disciplines within the community health centres themselves. The research in this field has been mostly anecdotal and carried out by the role players themselves or in the form of group reports on the status quo (Landman, 1995). The need for an in-depth study focusing on some of the challenges facing

mental health care providers in community health centres in South Africa within the current policy changes has motivated me to undertake a case study in this area.

Although not specifically used in the area of integration, case study method has been used extensively in international research to study micro-interactions. Helman (1994) introduces case studies from all over the world. The intention is to provide comparative cross-cultural perspectives in a wide range of issues of clinical significance, examining these within socio-cultural contexts. Littlewood and Lipsedge (1997) have drawn extensively on case studies to examine the links between racism, psychological ill health and inappropriate treatment. The WHO report (1997) has also made extensive use of case studies of primary health care institutions to investigate the efficacy of changes implemented in primary health care systems throughout the world.

Swartz (1998) has similarly made use of case studies to illustrate, amongst other issues, some of the challenges to mental health service provision related to culture. As health practices develop in settings, the settings need to be taken into account when studying the cognitions and service provision of role players. Case studies may allow the researcher to access the feelings and perceptions of role players in the settings or context framing the research in such a way as to give depth to the focus of the studies. Given the above it would appear that the case study method provides an appropriate methodology to investigate psychiatric services in situ. The following chapter focuses on the methodological approach used to explore issues relating to an integrated psychiatric service at primary level of mental health care.

CHAPTER THREE : METHODOLOGY

3.1 INTRODUCTION

In this research I intend to look at how four different health professionals, a psychiatric registrar, a senior psychologist, a psychiatric nurse and an intern psychologist (the researcher) viewed the same patient. This dissertation uses a case study to investigate the perspectives of different professionals involved in the treatment of a patient. A thematic analysis of the various perspectives is presented in the form of the case study. I built the case study on the basis of one patient attending a community health centre and recorded the views of the different professionals who saw her there over a period of time. I interviewed each of them in order to ascertain what they thought of her symptoms and their treatment of her and to establish their individual experiences of the psychiatric health services at a primary health care centre. In order to obtain a composite picture of psychiatric service provision, I also interviewed the patient so as to ascertain her experience of psychiatric services within the primary health care system. In addition I draw from my own experience of the patient and the psychiatric service as an intern. My research experience inadvertently commenced with my allocation as intern psychologist to the community health centre. As such I had access to psychiatric service providers and was personally involved in data gathering from the outset of my internship.

My research was intended to help me answer the questions inherent in my investigation of challenges to an integrative approach to mental health services presented by the differing perspectives of professionals.

3.2 METHODS

3.2.1 The case study method

"Case study is an umbrella term for a family of research methods having in common the decision to focus an enquiry round an instance" (Adelman et al, 1977). Bromley (1986) states that the object of a case study is the examination of any singular case or example or incident, the description or analysis of which is thought to contribute to our understanding of an area of enquiry. In keeping with Stake's assertion that "the case is an integrated system" (Stake, 1995, p.2), the psychiatric service within a community health centre was investigated in relation to its relevance to the research through the thematic analysis of the perspectives of professionals involved in the treatment of a patient. Whilst my interest in the patient who is at the core of the study was also intrinsic, the focus of the case study was in understanding something other than the particular patient: namely the nature of the multidisciplinary approach to this case in particular and psychiatric service provision in general - in other words, the system which comprised the professionals and the patient in interactions through the community health centre.

3.2.2 Strengths and weaknesses of the case study method

According to Stake (1995) case studies provide a seemingly poor basis for generalisations. This statement renders questionable the methodological consideration of using a single case study to generalise on issues relating to differing perspectives of mental health care professionals in primary mental health care. Eckstein (1975) considers that a single case study is unlikely to constitute more than a clue to a valid general model and therefore needs to be repeatedly tested against other cases, amended and improved, in order for conclusions to be generalised outside the case. Edwards (1990) however suggests that, while the individual case is not necessarily typical, key aspects, explicit or implicit in the case material, will be of value in the systematic investigation of a specific conceptualisation.

However, a major concern in individual case study research is the problem of overgeneralisation (Kvale, 1986). As counter-argument to the problem of overgeneralisation Yin (1984) suggests that validity can be established by the logical process of 'analytic generalisation'. 'Analytic generalisation' can be understood in the following terms: namely that the extrapolation is based on the validity of the analysis rather than on the representativeness of the case (Mitchell, 1983). It was hoped that the 'analytic generalisation' (Yin, 1984) of a single case study of psychiatric service provision in the context of the community health centre would serve to arrive at a preliminary understanding of the challenges for an integrative professional approach to service provision in psychiatric services.

The issues related to psychiatric service provision provided the conceptual structure for organising the study of the case as well as helping to understand some of the complexities of the case. While the limitations of the single case study method are obvious, it nonetheless provides a methodological framework to investigate issues relevant to an integrated and effective mental health service provision within psychiatric services.

3.2.3 Participants

The aim of the research was to explore the challenges presented by differing professional perspectives to an integrative approach to psychiatric services located within the primary health system. Sorenson and Hargreaves (1982) have suggested that more information would be elicited by using key informants rather than a random selection of health professionals providing primary mental health care services. While cognisant of this in identifying the so-called 'core' of mental health professionals, my choice was mainly limited by my circumscribed contact with mental health professionals in the clinic in question.

The group of participants with whom I had personal contact was made up of the psychiatric registrar, the psychiatric nurse and a senior psychologist attached to district service, each of whom represented one of the three organisational levels of mental health care services involved in primary health care. The participants (and I include myself here) were selected

on the basis of their involvement as mental health professionals in the management of the selected case in psychiatric services in the community health centre to which I was allocated.

The psychiatric registrar had, at the time of my allocation to the community health centre, attended to the patient at two to four monthly intervals since 1998. The psychiatric registrar was responsible for prescribing and monitoring the patient's drug therapy. The district psychologist, who supervised me throughout my contact with the patient, had attended to the patient for the duration of three sessions of supportive therapy at the time of her wedding in 1997. As one of the participants, I was caught up in my own perceptions. The perceptions of the district psychologist therefore provided a valuable check on the validity of my own perspective. The psychiatric nurse attached to psychiatric services had provided the patient with supportive counselling and administered the drug therapy prescribed by the psychiatric registrar since mid 1997.

In order to achieve as holistic a picture of psychiatric services as possible, the study included the patient's experiences of psychiatric services at the community health centre to which I had been allocated. The patient provided subjective material with regards to her direct experiences of psychiatric service provision.

The personal accounts of the mental health care professionals' perspectives on the case and psychiatric service delivery were elicited, as were the experiences and perspectives of the patient, by means of semi-structured interviews. Interviewing took place approximately four months after my internship had been terminated. As I no longer provided a service at the community health centre, appointments were set up by telephone and participants were interviewed within a few days of each other and at separate venues. The patient and the psychiatric nurse were interviewed individually at the community health centre. The psychiatric registrar was interviewed at Groote Schuur Hospital and the senior psychologist at the Avalon.

3.2.4 Methods of information gathering

The qualitative methods of participant observation and interviews, which rely on the subjective relationship between researcher and subjects (Terre Blanche & Durrheim, 1999), were considered appropriate for collecting data.

3.2.4.1 Participant observation

The intent of qualitative research is to promote a subjective research paradigm. While 'subjectivity' has been criticised as unscientific, Edwards (1990) suggests that the subjective research paradigm is not a failing to be eliminated, but provides an essential element of understanding which aims to explain the subjective reasons and meanings that lie behind social action.

In my capacity as intern psychologist I provided a service which involved me directly in psychiatric service provision. This gave me a unique opportunity to become a natural part of the context, observing the 'phenomenon' of interdisciplinary collaboration. As a member of the 'team' of professionals involved in psychiatric services, my dual role as participant observer gave me access to more material than if I had used only one-off structured interviews or questionnaires (Edwards, 1990). Immersed in the system, yet at the same time an outsider, in that I moved in and out of the community health centre, I had other perspectives, which enabled me to fill in the gaps. It enabled me access to a deeper level of interpretation in constructing explanations from my observations. As I was inevitably part of the 'living experience of the participants' in the research as well as a service provider in psychiatric services, my role as observer provided me with some space to distance myself from the service provision, so as to reflect on my role as researcher. However it was also an area of potential blindness to which I needed to remain continuously alert and which I will consider later.

3.2.4.2 Open-ended interviews

Stake (1995) suggests that while qualitative method is directed towards personal interpretation, the key interpretations to be pursued in a qualitative study are not the researcher's interpretations alone, but rather those of the people being studied. As the people 'being studied' were mental health professionals involved in psychiatric service provision to a patient, semi-structured interviews were conducted with the mental health professionals as well as the patient who was being treated. As one of the group of professionals involved in the treatment of the patient, I have included my own perspectives and experience of the patient and inter-professional collaboration within the psychiatric services.

This section contains a brief exploration of why semi-structured interviews were considered a methodological option in seeking to validate my conceptualisation and understanding of an integrated professional approach to psychiatric services.

Semi-structured interviews provide space for the complexities of individual subjective experience, facilitating access to in-depth information (Holdsworth, 1994). They allow the respondents to communicate their experiences or opinions about a specific issue in their own words and to "tell it like it is" (Terre Blanche & Kelly, 1999). While allowing for personal relevance, semi-structured interviews provide for comparability across respondents (Breakwell, 1995). The questionnaires were constructed to elicit information relevant to the research question: namely, the perceptions and experience of professional collaboration within the psychiatric services (See Appendix A, Section one). The participants' perspectives were also elicited in terms of their understanding of the patient and interventions (See Appendix A, Section two). The interviews focused on the following principle areas:

(i) professionals' perceptions of the patient

(ii) professionals' perceptions of interventions

(iii) psychiatric services in terms of service provision

The interview with the patient was structured to elicit her perceptions and experience of psychiatric service provision. While the utilisation of the same semi-structured interviews with all professionals involved in the case provided for comparability of their responses, my own comments as an involved professional were also considered, in that they filled in information gaps. The responses of the patient were elicited in order to give depth to the focus of the study. The data obtained through semi-structured interviews was gathered by means of audio-tapes ranging in length from 90 minutes to two sessions of 60 minutes each. The length of the interviews depended on factors such as participants' time constraints and the inclusiveness of their responses. The use of audio-tapes was intended to facilitate an easy flow of response without distractions or the need for interruptions. As researcher, my impressions of the interview were afterwards noted down. Relevant parts of the interviews were transcribed and used verbatim.

According to Terre Blanche and Kelly (1999) the quality of empathy has influenced the development of qualitative methodologies. As research interaction is construed as an open dialogue rather than an opportunity to 'mine' information (Terre Blanche & Durrheim, 1999), it was important that I worked at establishing relationships of mutual trust with the interviewees. Open-ended interviews allowed me to engage more freely and spontaneously and in an open and empathic manner with the interviewees.

3.3 ANALYSIS OF THE DATA

Firstly, relative familiarity with the interview material was achieved, through conducting the interviews, transcribing the tapes and reading the transcripts (Potter & Wetherell, 1987). Analysis of the data obtained from semi-structured interviews included looking at the interview material from a thematic perspective. The themes included the perspectives, values and ideas and experiences that were important in relation to the research issue. This stage required careful examination, making sense of and reducing the data contained in the thematic categories. Terre Blanche & Kelly (1999) speak of crystallisation styles, which involve becoming thoroughly familiar with the data in order to extract meaningful constructs linked through the themes in terms of the research question. The analysis of the material

allowed for the crystalisation of themes highlighting the differing perspectives to psychiatric service provision.

3.4 REFLEXIVITY

This section focuses on the need for reflexivity of the researcher in terms of the methodology and the effects of subjectivity in terms of the validity of the study.

A concern was that, as the case study was limited to the psychiatric services at one community health centre only, the validity and significance of the research for psychiatric services elsewhere was rendered questionable. In the light of Bromley's suggestion (1986) that a case study could contribute to the understanding of an area of enquiry, I considered the study justified in coming to an understanding of issues relevant to psychiatric service provision in a community health centre.

Case study method is subjective, rendering objectification of interpretations and analysis essential in order to ensure the validity of the study. Interviews and observation are likely to be influenced by subjective judgement or personal bias. The role of participant observer, of being personally involved, is difficult to reconcile with that of a detached neutral role of the conventional researcher. I therefore needed a heightened self-awareness in my involvement as participant observer, in the data collection process, analysis and interpretation of the research material (Helman, 1994). Valid interpretation of qualitative data required that I immerse myself in, yet reflect objectively on the data.

While direct observation may be more reliable than personal communications, the effect of participant researcher bias on data collection cannot be ignored (Terre Blanche & Durrheim, 1997). The needs, wishes and feelings of the researcher might affect the degree of objectivity required to obtain relevant information and distort the reality of the research situation. My involvement at the interface of service provision within the clinic influenced the degree to which I was able to be objective. As a newly trained intern, my enthusiasm for the profession no doubt biased my opinion of the importance of the role and the need for psychologists in

primary health care, and influenced my critical approach to the medicalised model of treatment. In this way too my own perspectives had bearing on my collaboration and approach to an integrated service delivery. My perspectives as a psychologist will have influenced the parameters of my relationship with the patient and my urge to 'do' something for the patient. Thus the ontological aspect of my observations was determined by and understood within the context of my worldview and training, whilst my demographic and personal characteristics no doubt played an important role in gathering the data and the interpretation of research material (Potter & Wetherell, 1987). It may well be assumed that my personal and social background, especially culture, economic status, education, experiences and prejudices (Helman, 1994) were reflected in my perceptions of psychiatric service provision per se. Regardless of any rapport with the staff, within the context of the community health centre situated on the Cape Flats I was, as a white university graduate, an outsider. I cannot rule out the part played by my status as a white professional and intern psychologist. My tertiary training carried with it the assumption that I 'know' what is wrong and hold the key to what the patient needs. Given the hierarchical nature of power relationships within mental health services, I was aware that my status as a psychologist might influence the responses of the interviewees. It is more than probable that the information and perspectives that I gleaned have been limited by my position as an outsider and the circumscribed nature of my contact with the community health centre and the permanent staff.

3.5 ETHICAL CONSIDERATIONS

This section highlights some ethical concerns I had in conducting a research on a service of which I was an integral part. An ethical concern was that I'd had limited experience of primary mental health care and psychiatric services and whether this limited experience allowed for, or indeed justified, a study on integrative professional approaches. Interpretations are limited in their validity by the fact that no one can ever 'know' what the other means. My position as intern, i.e. a psychologist in training, made it difficult for me to interpret with any confidence the perceptions and views expressed by the district psychologist who at the same time fulfilled the role of supervisor. I was also aware of my limited understanding of psychiatry and how this limitation could impact on my interpretation of the psychiatric registrar's and the psychiatric nurse's perceptions.

This raises a concern I have regarding the possible misrepresentation of the intent of the comments made by all the participants including the patient. However, my commitment to promote an equitable service within psychiatric services in primary health care, influenced my decision to embark upon the study nonetheless.

Throughout the research process I was aware of the need for sensitivity towards exposing the community health centre and the staff in this type of research. To this end the ethical consideration of confidentiality were taken into account. All participants including the patient were fully informed of the nature of the study and readily agreed to collaborate. Confidentiality of the personal identity of participants, including the patient, and the identity of the community health centre were assured with respect to all forms of reporting arising from the study. All the participants have been offered a copy of the dissertation for their perusal.

CHAPTER 4: BACKGROUND TO THE CASE STUDY

The case study, constructed through the perspectives of mental health professionals involved with the patient, and which include my perspectives, forms the core of the analysis. The analysis of the differing perspectives explores the challenge they present to an integrative approach to mental health service delivery. In order to orient the reader to the case study, I provide a background history of the patient. As psychiatric services are provided in the community health centre, the patient's experience of the clinics, subsequent to her discharge from the psychiatric hospital and prior to entry into the present community centre and description of the community health centre itself are included as background to the study.

In the following chapter the background to the case study in terms of its relevance to the research question is presented. The relevant case history of the patient is presented in the form of a psychologist's report in that it was constructed from my initial interviews with the patient. This report is therefore presented from my perspective as a psychologist. A background to the community health centre in which the psychiatric services is situated, is provided.

4.1 BACKGROUND INFORMATION

4.1.1 Relevant patient history

The patient was born in 1970, growing up as the youngest of eight children all of whom were born within a time span of fourteen years. Her parents, both of whom are still alive, live in the original family home. Her father, a retired fisherman, is 69 and her mother, a housewife, is 63. From a very early age she recalls being fearful of so much in her environment. Her father and only brother, her oldest sibling, would tease her by, amongst other things, pretending to throw her to the garbage collectors. Her fear of them was heightened by their

blackness, which was equated with evil. The patient reported that her mother did not protect her from the teasing, but that she stood by mutely observing her daughter's terror. She remembers that no one in the family comforted her and that her various fears were ridiculed and laughed at. She describes herself as feeling alone, unheard and unnoticed throughout her childhood and adolescence. She reports that these experiences caused her to feel invalidated, insecure and to suffer psychic and emotional pain. At home and at school she felt that she was always being watched and found wanting. She felt clumsy and incompetent and afraid to try anything new. She was reluctant to leave her mother, who, while not actively supporting her, at least did not tease her. She began to lose weight, eating very little and becoming increasingly more silent. Her distress appeared to go unnoticed.

When she was 17 she suffered a "nervous breakdown" and was taken for assessment to a unit specialising in children with emotional and psychiatric disorders. She was transferred to a psychiatric hospital for observation and diagnosed with Adjustment Disorder with Depressed Mood. She stayed for a week and reports feeling bewildered by the constant questioning of various psychiatric staff. It appears that her condition was not explained to her. Her confusion and anxiety grew along with a sense that no one listened to her or took her seriously. She asked to be discharged.

Eighteen months later she was readmitted to the psychiatric hospital. The reasons given for admittance were withdrawal from contact, confused thoughts and delusions. On admission she was considered to be psychotic, presenting with delusions of reference and persecution as well as overvalued religious ideation. She was treated with anti-psychotic drugs and her condition gradually stabilised. The patient was discharged after two months. The diagnosis on her discharge in 1990 was Schizophrenia (Paranoid Type). She had just turned 19.

She was instructed to see a psychologist intern for monthly follow-ups at the psychiatric hospital and to report to the local community health centre for medication. The patient now stayed at home on an almost continuous basis, rarely going out and never alone. She continued to see 'eyes' watching her in a 'mocking way' but seldom referred to them. She however attempted to make sense of the phenomenon in terms of her religious framework. As these 'eyes' caused her such anxiety and distress and appeared so harsh she ascribed them to

being the eyes of the 'Devil's angels' whose task it was to torment her. She reports feeling sure that one day she would meet someone who understood and who could explain to her what she was experiencing. She reports that the psychologist at the psychiatric hospital "only" asked how she was feeling and whether she had any specific concerns. She did not know what he wanted her to say, feeling as though she should produce some evidence of her wellbeing for him. After keeping four appointments at the psychiatric hospital she did not return.

During this time the patient was prescribed Clopixol[3] 200mg intramuscular injection (IMI) per month and Clozapine[4] 50mg per day. (It has been suggested that the patient was being treated with 2 anti-psychotic drugs simultaneously as issues of compliance might have surfaced previous to her referral to the community health centre at which she was currently receiving treatment.) The patient described herself as being unable to access feelings or of experiencing feelings through 'cottonwool'. The appearance of 'eyes' had increased in frequency. She attended a charismatic church in the hope that communal prayer would exorcise the 'eyes'. She reports that on two occasions she fell to the ground and spoke in 'tongues' but that the 'eyes' persisted in tormenting her. Her husband, whom she met in the charismatic church, also attempted to explain the 'eyes' in terms of his religious framework, ascribing them to the Devil and his attempts to gain power over her. While attempting to live with the 'eyes' watching her, she found herself increasingly unable to be alone, yet dreaded being in the company of people other than her husband and her mother.

She remained within the primary health care system. As the primary health care system requires that the patient attend a community health centre nearest to the place of domicile, she attended at four different centres in the interim ten years following her second admission to hospital. She has been seen at six to nine monthly intervals in order to have her medication reviewed or the IMI administered. She reports that sessions were kept to a minimum of three to five minutes, usually just long enough to elicit whether she was compliant with the medication and to inquire after her physical well-being. According to the patient, "every doctor has his own opinion". It appeared to her that the psychiatrists did not communicate with each other. She reports that one informed her that she might be taken off the medication

[3] Clopixol: Long-acting, injectable neuroleptic: 100 – 400 mg monthly, usually given as an anti-psychotic.
[4] Clozapine: Atypical neuroleptic: 50 – 600 mg daily dosage, usually given as an anti-psychotic.

while another changed the dose or brand of psychotropic drug. She felt that she would simply be ignored or given even stronger doses if she questioned them or the prescriptions.

Because of the large patient population presenting at community health centres and the lack of resources, patients have to wait long hours to be attended to. She expressed her sense of frustration to me saying:

> *I felt pressured to remember everything I had to say. I would have loved to talk about my anxieties but I knew that there wasn't enough time.*

During the intervening ten years several psychiatric nurses tested her blood and administered the IMI. She expressed her experience of service in the following way:

> *Sometimes the nurses weren't that friendly or if they were, they treated you just like a child, like you were just 5 years old. Seeing the nurses and sisters scared me because I did obey them, but I felt that they thought I did not take my medication. I would never dare to tell them that I didn't like how they were going about treating the patients. They tend to be arrogant, maybe they are just tired, but I don't think they should treat patients like that. They would take their frustrations out on the patients. I understand that some patients are just rude, but that is still not right.*

From the above quotes it would appear that the patient felt infantalised in some way by both psychiatrists and psychiatric nurses, who did not take the patient's individual needs into account. It is possible that, given the demands of a large patient population on a small number of health service providers, psychiatrists and nurses tend to treat patients in a way that leaves them feeling powerless. While it allows the psychiatric nurses to interact with the patients in a manner that encourages compliance, it simultaneously reinforces the implied hierarchical power structures in which the professionals are those 'who know' and the patients are those 'who do not'. Of greater significance to the study is however, that the patient was possibly indicating her recognition of my role as different to that of the other service providers and was attempting to reassure me that she saw my role as somehow better.

In the interview it became clear that the patient was of the opinion that psychologists take more time and are interested in the inner feelings of individuals. She commented:

> *"I feel that it is important to identify what the patient is going through and to see them as human beings who have feelings not as mechanical robots".*

By telling me that patients were not to be treated as robots, she was perhaps indicating that I treated her as a 'human being' and was able to identify what she was 'going through' while the other service providers ignored her individuality. The patient was possibly attempting to keep me involved by emphasising my humaneness.

Her perception of the differing roles of service providers may have been reinforced by the actual splits and fragmentation of roles within the psychiatric services, which she experienced and maintained in her relationships with the service providers. Her assumptions seemed to be that the psychiatrist provided the medical expertise and was therefore only responsible for the physical aspects, while the psychologist cared about the feelings and was more empathic. Hence the psychologist was kept informed of the experiences of anxiety underlying the manifestation of the eyes, while it is possible that questions which called on medical knowledge were kept back for the psychiatrist and the psychiatric nurse.

4.1.2 The Community Health Centre

In 1997, one year after psychiatric services were integrated into the primary health care service, the patient moved into the vicinity of the community health centre to which I was allocated in 1999. Both the psychiatric nurse and the psychiatric registrar, interviewed in the study, were assigned to the community health centre in mid 1997 and 1998 respectively. Initially the psychiatrist attended to the patient at two to four monthly intervals. With the institution of a gradual reduction in the psychotropic medication, the patient was seen on a fortnightly basis in order to monitor the reduction in medication. She was seen once a month for her depot injection and at various other occasions for support by the psychiatric nurse. In

May of 1999 the psychiatric nurse initiated a meeting between the patient and me. I continued to see the patient once a week on an hourly basis until the end of that year.

This community health centre, which the patient presently attends, is one of the smaller day hospitals falling within a southern district of the Western Cape Metropole. It serves a large area of mostly impoverished patients living on the Cape Flats. Services offered by the community health centre are: general curative care, daily psychiatric sessions and social work sessions once every second week. The staff compliment consists of 1 medical officer, 2 clinical nurse practitioners, 1 senior enrolled nursing assistant, 1 pharmacist and assistant. Psychiatric services itself is run primarily by the psychiatric nurse and is visited on a once weekly sessional basis by a psychiatric registrar and since 1999, an intern psychologist. Although the community health centre boasts a medical officer, it is primarily nurse-driven. The number of patients, on average 2400, is nonetheless reduced as the space is limited and staff is not available to see any additional patients. The waiting room in the building that houses the reception and consulting rooms, is small and mostly overcrowded. Access to all the buildings is difficult. The emergency room is at the back of the site which makes access for trolleys and stretchers problematic. The room, assigned to the psychiatrist and me, adjoined the room utilised by the psychiatric nurse and was situated in a dilapidated prefab building, which has since been demolished. The psychiatric service is now located in another building, which is situated alongside the main building.

In the following chapter case and interview material relevant to the research question are examined and analysed thematically.

CHAPTER FIVE: ANALYSIS AND DISCUSSION

5.1. INTRODUCTION

This chapter looks at the differing perspectives of mental health professionals working in psychiatric services at the community health centre. A thematic analysis of their perspectives on the patient, forms the basis of my case study. The analysis is aimed at raising some broad issues pertaining to contemporary practice in psychiatric services. Other than where indicated, the professionals' views, opinions and feelings are presented verbatim. I felt that this would bring the analysis into the arena of personal experience, thereby allowing for an authenticity absent in third person reporting (Terre Blanche & Kelly, 1999).

As "ill people are at the centres of therapeutic networks" (Helman, 1994, p.85), I considered the patient's experience and perceptions of service provision to play a vital role in any composite study of psychiatric service provision. The patient's views and personal experience are therefore introduced thematically and in conjunction with individual professionals' perspectives. My own professional understanding of the patient and of the psychiatric service at the health centre is likewise introduced thematically.

The analysis is divided into three sections:

(i) The differing professional perspectives on the patient

(ii) The professionals' sense of their role in understanding their perspectives on the patient

(iii) The professionals' suggestions for an approach to integrated psychiatric services

5.1.1 The professionals in psychiatric services

As service delivery is not only a function of differing professional perspectives but also of context, the participants were requested to indicate the nature of their relationship with the psychiatric services in the community health centre. The participants were asked to describe their training, the length of time and capacity in which they were involved and the nature of the service they provided. The mental health professionals involved in the case, while all providing services at the community centre, were attached to and represented at each of the three different levels of health care in South Africa. Each professional was trained at a different institution and, while paradigms overlapped to some extent, there was no sense of integrated training.

5.1.1.1 The psychiatric registrar:

The psychiatric registrar held a MBChB degree, which requires a six-year study in generalist medicine, a year's internship and one year's community service. She had had her own practice in general medicine for 7 years and had worked for 3 years in the trauma units of day hospitals. As a postgraduate student, she was currently in training to qualify for a MMed degree in psychiatry. Partial requirements for this specialist degree in psychiatric medicine were that she be appointed to the psychiatric department of a tertiary hospital and that she be assigned to a community health centre for a period of three years. She was expected to attend to psychiatric patients at the community health centre once a week on a sessional basis of between three to four hours. The psychiatrist felt that, while the training had equipped her to work at tertiary level i.e. in hospitals, she had to learn what the particular needs of patients in community psychiatry were by trial and error. Her patients were referred to her by the psychiatric nurse or the medical officer at the centre or by GP's and secondary and tertiary hospitals from which they had been discharged. She expressed some of the problems she experienced working in a community placement, which only allowed for minimal contact with patients with varying needs when she said:

> *It is quite difficult to manage that. I cannot run the clinic in a useful way for the patients and myself because it is so unpredictable. People arrive on the doorstep.*

Sometimes I see 15-18 patients. I spoke to the psychiatric nurse some weeks ago to limit the clinic to 6-8 patients but sometimes the clinic is bigger and this is unavoidable.

She expressed concern that time-constraints and the large numbers of patients attending the clinic adversely affected offering an adequate service. While most stable patients were seen only every 6 to 9 months for perhaps as little as 3 minutes, new admissions were given more time. Those patients who were follow-ups or whose medication was being reduced or changed, were seen every second week. She described the clinic as "*quite a hotch potch type of clinic*" in that she provided a medicalised curative service to relapsed, stable and new patients but was also required to provide non-medicalised services in the form of counselling of individual patients.

Then because we don't have psychological services, I think we are a bit thin on the ground here, I have to see people right at the end of my clinic for counselling.

The reference to 'no psychological services' is puzzling in the light of my allocation to the centre on a weekly basis and the availability of a district psychologist as a consultant at secondary level. On the one level it possibly reflects the psychiatrist's perception of the status quo within psychiatric service provision, in that she has no contact with the district psychologist and initially had none with me. On another level it is possible that psychological services are seen to be of little value within the primary health care setting and that she was primarily responsible for service provision. That the psychiatrist also makes no mention of the counselling service provided by the psychiatric nurse might similarily be attributed to the unintegrated nature of psychiatric services. While national health policy has instituted the integration of services, the nurses are peripheralised within the system. Failure to acknowledge the counselling done by the nurse can also be interpreted as devaluing her contribution, thus re-enforcing the hierarchy of power and status existing within the mental health care services.

5.1.1.2 The psychiatric nurse:

The psychiatric nurse was based at the primary level health centre. As the psychiatric nurse trained prior to 1988 her three-year initial training involved training in general nursing. Thereafter she completed three different courses in midwifery, public health and psychiatry. She also completed a BA in Nursing Science through UNISA and is currently registered with the Nursing Council as a specialist nurse in psychiatry. She described her training in psychiatry as more medical rather than focused on "*every day things*". She worked for seven years in tertiary level hospitals and for a further seven at child and welfare clinics. After training as a psychiatric nurse she worked at Valkenberg and visited clinics on a sessional basis in this capacity. She took up her present post one year after psychiatric services were integrated into the primary health system. While the psychiatric nurse felt that her training enabled her to do more in terms of prescribing medication than just handing out treatment, she expressed her reservations with respect to her competency to deal with emotional and psychological issues:

> *Initially one isn't confident and not really equipped especially for counselling. Now that I have done a basic counselling course I am better able to deal with patients. Luckily I now have an intern psychologist to whom I can refer the more difficult patients or ask for advice.*

It would appear that the psychiatric nurse prioritised her medical training, which she felt was better than the training in counselling. This possibly indicates the status accorded to the biomedical model within the nursing profession. On one level there is the realistic wish and the need for support when doing difficult work within psychiatric services. On another level her comment reproduces the hierarchical attitude within the mental health service.

Although the psychiatric nurse has received training, which enables her to counsel, the psychologist is perceived as the one who 'knows' in the field of psychotherapy. Therefore, regardless of her ability, she relinquishes her power and her role to the psychologist. It is possible too that the psychiatric nurse did not feel that counselling was her job and considered it to be the domain of the psychologist. Yet the district psychologist indicated the

reverse, suggesting that her role lay, not in providing psychological services at primary level, but in training and supporting the nurses in their counselling of patients.

The psychiatric nurse, like the psychiatrist, expressed the pressure she was under to deliver adequate services in the following way:

> *I don't have the time to see them adequately. I sometimes see up to 15 patients a day. When the psychiatrist is here it can be 30. Depending on what they present with they are given 5 or so minutes. If it takes too much time they get uneasy because others are waiting.*

She felt she was able to offer a more effective service since the integration of psychiatric services into community health centre, because she was now available on a daily basis.

5.1.1.3 The district psychologist:

The district psychologist trained at a tertiary institution and holds a Masters degree in clinical psychology. She worked as an intern psychologist at Valkenberg for 2 years and was employed in Community Health Services since 1995. She was attached to a second level hospital and was one of two psychologists responsible for the greater urban region of the Western Cape known as the Cape Metropole. She had a small private practice and provided supervision during my internship at the community health centre in 1999. She described her role at the community heath centre as providing support for the community psychiatric services and in promoting development of services at district level:

> *I take up issues at district level, train the psychiatric nurses and act as consultant to the community health centre. My role is to increase the capacity and skills of the nurses in every way to deal with mental health problems. Generally if a nurse called for advice the important aspect is not the case, but my relationship with the nurse. The case happens within that. We will talk about the case to ascertain what she is finding difficult, to try to get her to reflect on the case. But if she feels that she*

cannot work with the person I would go to the community health centre but only for a limited time. Nurses are the group with whom we as psychologists mostly work, whereas the psychiatrists have a much stronger link with the psychiatric registrars.

The district psychologist apparently has a clear sense of her role. While she appears not to see any role in relation to the psychiatrist, in terms of her own perspectives on the professional hierarchy, she is placed above the psychiatric nurse and provides the nurse with 'advice'. The word 'consultation' could be seen to be an expression of her perception of her role and professional relationship within the psychiatric service provision. In terms of patient service, consultation is more important than attending to the needs of the patient. Although able to provide a psychological service, the psychiatric nurse appears to share the district psychologist's set of assumptions that psychologists have more to offer in terms of psychotherapeutic interventions. It seems that the psychiatric nurse wants the district psychologist to provide the service, while the psychologist wants to advise. The psychiatric nurse, however, appeared to be successful in referring the patient to the latter when it came to providing the patient with more than just the routine chat.

5.1.1.4 The intern psychologist:

I had studied at a tertiary institution and was completing a year's internship as clinical psychologist under the Psychiatry Department of the institution at the time of my placement at the community health centre. In partial fulfillment of the requirements of my internship I provided a once weekly psychological service at primary level at two community health centres. I understood that my role as psychologist intern was to provide psychotherapy for patients who were to be referred to me by the psychiatric nurse via the district psychologist. The district psychologist screened the patients as to their suitability for therapy. I was also required to provide peer support to the psychiatric nurse. At the beginning of my internship I was introduced to the psychiatric nurses within the district, but did not make any contact with the psychiatrist. I received once weekly supervision, during which any new referrals were discussed. My understanding was that I should not accept patients who appeared to need 'only' counselling or those who could be 'adequately' attended to by the psychiatric nurse. Thus given the above, my initial assumptions about my role at the centre were that I would

work only with patients with affective and personality disorders and meet with the psychiatric nurse when the (her) need arose.

Each of the professionals involved in the case appeared to feel primarily responsible in different ways for aspects of the patient and the treatment. The psychiatrist, as medical practitioner, regarded her role as that of prime manager of the case. As psychologist I considered myself to have a specialised, psychodynamic understanding of the symptoms of psychosis. The psychiatric nurse considered psychiatric services to be primarily nurse-driven as she attended daily to the chronic patients, assessing them, administering medication prescribed by the psychiatrist or referring them elsewhere. She perceived the responsibility for the ongoing monitoring of this patient as primarily hers. The district psychologist perceived her role to be supportive of the psychiatric nurse rather than the patient. Thus each professional appeared to function separately within the parameters of the relevant discipline, mirroring the splits and fragmentation existing within mental health service provision.

5.2 Differing perspectives – initial contact with the patient

In this section I explore professional perspectives with regards to the referral, the presenting problem and role identification of the professionals involved in the case on initial contact with the patient. I examine and analyse the professionals' (including my own) understanding of the case in terms of training, different worldviews and the paradigms which shape the different perspectives and ultimately the service provided by the different disciplines. The patient's perspectives of the differing service providers within psychiatric services are examined and analysed in the light of her initial perception of the services provided.

5.2.1 The professionals

According to all the professionals interviewed and in terms of my own experience with the case, there appears to have been little or no contact with the referral source. This is problematic in terms of service delivery, as information on illness and treatment is therefore limited to the patient's file, which contains her medical history. The file, which originates

with the patient's initial contact with the primary level service, contains information regarding the discharge from any medical institution, illness, diagnoses and treatment. When the patient moves, the file is sent to the clinic nearest to the patient's domicile and which the patient is to attend. At each clinic attendance the file is updated by every professional attending to the patient. The patient accesses the file in the waiting room before each consultation. Folder notes are often illegible and for obvious reasons not confidential.

The psychiatric nurse constitutes first point of entry into psychiatric services. According to her some patients are referred by tertiary and secondary medical institutions, GP's and the local medical officer or patients "*just arrive*" at the centre. The comment with regards to the patient's entry into psychiatric services: "*I just found her in the clinic*" indicates that she was perceived as belonging to the latter group. She attended to the patient on a monthly basis, administering the IMI, and taking blood samples while counselling her for approximately ten minutes at a time. It is interesting to note that the psychiatric nurse reported not discussing the continued administration of the IMI and Clozapine with the psychiatrist, although she remarked that she considered the patient to be 'neurotic' rather than 'psychotic'. The psychiatric nurse's omission to communicate her perception of the patient's illness to the psychiatrist could be indicative of the pressure of so many patients requiring attention within the limited time available to the psychiatrist and therefore by inference not enough time available to discuss cases. Menzies Lyth (1988) has suggested that with little sense of the patient getting better through their efforts, nurses feel resentful about the lack of recognition accorded their contributions. It is possible that her sense of the role of the nurse as not being valued within the medical hierarchy, could have resulted in her preferring to not share her observations, as her observations might be ignored or dismissed, reinforcing the sense of unequal balance of power.

In partial fulfillment of the requirements of her registrarship the psychiatric registrar had been assigned to the centre for a limited period of only three years. The nature of the psychiatrist's initial contact with the patient was similar to that of the psychiatric nurse. The psychiatrist reported that she had "*inherited*" the patient from the previous psychiatrist. The role of the psychiatric nurse as referral agent within the psychiatric service appears to be of little import when seen in the context of the above definition. This could be indicative of the apparent separation and fragmentation of the functioning of the different disciplines in psychiatric

service delivery but also of the hierarchy of status within the medical field. The psychiatric hospital discharge summary provided her with limited information regarding the referral but not the nature or content of the psychotic episodes. The records of the previous psychiatrists attending to the patient made no reference to the anxiety states that the patient was experiencing. Only the medical treatment in the last ten years and the patient's responses in terms of physical effects, psychiatric stability and medical compliance were recorded. The psychiatrist reported that her diagnosis was in part informed by this document:

> *When I arrived I found her on this potent anti-psychotic drug Clozapine and in addition to that she was on the monthly depot Clopixol. I knew very little about her except what I saw on her notes. There was no detailed history of her psychotic episodes. She was sort of stable, meaning that she was not having psychotic episodes. She was a quiet one who came every six months for a repeat of her medication. Initially contact was between five to ten minutes.*

The psychiatrist reported that the patient always focused on her medication and medication-related symptomatology. It is possible that the patient's assumptions with regard to the role of the psychiatrist as 'the doctor' primarily interested in the effects of the medication, determined her focus on the medical aspect of the consultation. The patient had described her experience of doctors as not having enough time to talk about anxieties. The time restrictions imposed by the brevity of the consultation and the less frequent contact with the psychiatrist meant that the nurse carried more responsibility for monitoring the patient, while the psychiatrist had to rely on the psychiatric nurse's report and recommendations concerning the patient's mental state and treatment. It would appear that contrary to the psychiatrist's assertion that she was the case manager, the psychiatric nurse was primarily responsible for initial assessment, access to and possibly monitoring of the treatment prescribed by the psychiatrist. It is therefore hardly surprising that the psychiatric nurse sees psychiatric services as primarily nurse-driven and her role as service provider as undervalued.

At the end of 1997 the patient intended to get married and asked for help with her anxieties at being watched by 'eyes' and making a fool of herself during the wedding ceremony. The patient's referral to the district psychologist was made in the absence of psychological

services provided. While the district psychologist agreed to see the patient for three sessions of anxiety management, she saw the intervention in terms of support for the psychiatric nurse. The focus of the psychologist's intervention was limited to enabling the patient to cope with the emotional demands of her wedding. Any underlying issues were not investigated. The district psychologist indicated her response to the request:

> *I did not focus on the 'pathological aspect' and didn't question around the schizophrenia diagnosis. I used a cognitive behaviour approach and didn't explore how one could intervene in different ways.*

The split between the medicalised and psychologised perspectives of mental ill health is highlighted by the district psychologist's comment that she did not focus on the pathology but provided a cognitive therapy. The district psychologist's intervention from a psychological perspective, focused on the patient's feelings and while the psychiatric diagnosis of schizophrenia was acknowledged as significant, it appears not to have been taken into consideration. The district psychologist clearly defined herself as not relating to the domain of pathological illness, but opted instead for a focused therapy. Perhaps this reflects some of the ambivalence the psychologist felt about her therapeutic role versus the role of diagnosis as pathologising the patient and the illness. This reflects some of the values of the paradigm within which she has been trained.

The district psychologist made the comment that:

> *I would not have ignored certain aspects (of schizophrenia) but when she was referred the diagnosis was not her concern. I saw the 'eyes' in terms of anxiety and wondered about them, but she was not actively psychotic.*

It is possible that the patient's apparent lack of concern was in part a reponse to the fragmentation within the psychiatric service. She expected psychologists to deal with feelings and therefore did not express any anxiety with regard to the diagnosis. The patient's corresponding lack of concern with her diagnosis might have been as a consequence of the patient's own perceptions of what psychologists 'do'. That the psychiatrist was not contacted

and the district psychologist did not discuss any further psychological intervention with the psychiatric nurse, highlight the unintegrated nature of service delivery. It is ironic that, in this instance the district psychologist was playing a role that was closer to what the nurse wanted of her (with regard to her actually taking over), rather than what she envisaged for herself (a supportive, consultative role with regard to the psychiatric nurse).

At the time of my initial contact with her patient, she had been in the primary health care system for ten years. My first contact with the patient was when she wanted to discuss possible parenthood with the psychiatric nurse. The district psychologist, it appeared, had made it clear that, while she preferred to function in an advisory capacity, any further referrals would only be accommodated at the Avalon. As the patient appeared unable to travel, my allocation to the centre in February 1999 provided the psychiatric nurse with the possibility of referral to a psychologist in situ. Confronted with her continued feelings about her own incompetence in the face of supposed superiority of psychologists' training, she preferred to refer the patient. In spite of my relative lack of experience in relation to her own, she perceived me as being similarly competent to the district psychologist, namely that we were better able to deal with the domain of complicated feelings and underlying dynamics.

Holdsworth (1994) suggests that the unequal balance of power existing within the mental health service allows for the more powerful professions, in this instance psychology, to pose as, or to be seen as the 'expert', making it is more likely that the less powerful professions will accept their authority. The nurses are relegated to the periphery of professional services and rank low in the hierarchy of professional power. It would appear that this is both a function of their training, as well as of perceptions within the medical profession and of patients. The psychiatric nurse is subject to it but also perpetuates it herself. The relationship between the nurse and me in my role as psychologist, appeared to highlight once more the hierarchical nature and power imbalances of professional service delivery.

While I had access to the patient's medical file, the notes referring to psychiatric interventions, sessions with the psychiatric nurse and the district psychologist gave me only a thumbnail sketch of their perspectives on the case. As a newly appointed psychologist intern, my experience of schizophrenia was at best limited to observations of patients with this form of psychiatric disorder, and this left me feeling less than competent in this area. However, viewed from my perspective as a psychologist it seemed to me that her initial concerns

masked fears regarding the power of the 'eyes'. In the sessions we focused on the meaning of the 'eyes'. That she did not at first discuss the medication or the diagnosis with me possibly indicates the patient's perception of the separation of service provider roles existing within psychiatric services. Nor did I raise the topic initially. In this way I myself re-enforced and modelled for the patient the existing split between the medical and the psychological approach to mental ill health.

In terms of my perspective of the interventions of the other professionals, it appeared that each professional was attending to an aspect of the psychiatric and/ or emotional wellbeing of the patient in relative isolation from the other. Throughout the six-month period in which I saw her, the patient continued to attend the psychiatrist's clinic as one among 15 or more patients within a three hour session, one afternoon a week.

Given that the psychiatrist's role was defined in terms of medical expertise it is hardly surprising that the psychiatrist, with little time in hand, appeared to focus solely on the management of the symptomatology and the medication.

The psychiatric nurse continued to provide the patient with ongoing emotional support in the form of twice monthly 'chats' about the patient's concerns, and to monitor the medication. The patient was one of many requiring diverse services, to whom the nurse attended. This left her with little time for longer counselling sessions.

The district psychologist, who saw her role as service facilitator at secondary level, provided containment for only an aspect of the patient's anxiety and while available to see the patient elsewhere if there was an emergency, was prepared to provide support for the nurse in terms of advice.

My role as service provider to the patient was thus predetermined and delineated by the nature of the referral. My services were being enlisted to 'help' her in coping with having a baby, much in the way in which she had been helped to cope with anxiety with regard to the wedding ceremony. As the service of the more experienced district psychologist was not available, I was considered an available substitute. As I saw fewer patients, it was construed that I had more time to spend on each patient. Delivering psychological services to two clinics and an institution in the vicinity, I now saw the patient on a weekly basis which

enabled us to work at a more insight-oriented level and to focus on the meaning of the 'eyes'. However, from a psychologist's viewpoint I was reluctant to accept the diagnosis made ten years previously. In spite of this I identified to a certain extent with the patient in her dependence on the psychiatrist to provide a medicalised understanding of the diagnosis of schizophrenia. It would appear that our initial contact with the patient and our understanding of the presenting problem were defined by the varying paradigms and worldviews which were underpinned by our training and our experiences of the power hierarchies and splits inherent in the professional system.

5.2.2. The patient's initial experience of the psychiatric service

The patient felt that the psychiatric nurse was much more sympathetic and gave more of her time than other nurses had in the past. She reported that, while she could talk to the psychiatric nurse, her fears and paranoia were not being understood and that suggestions made by the psychiatric nurse were not always attuned to her needs. She added that the three sessions with the district psychologist had temporarily enabled her to cope but that she continued to see the 'eyes'. She wanted to understand her fear of being alone but found that the nurse would instead advise her on how to manage the anxiety. She commented to me that she had always known that she would find someone to understand her.

While one cannot imply from these statements that the psychologist had a better understanding of her, one could assume that the patient recognised a difference between the services and experienced them as being better or worse rather than complementary. The above comments together illustrate the experience of the patient, who must split the services in order to make sense of the splits in service provision. Thus, although the patient acknowledged the psychiatric nurse's willingness to give her 'more time', she still needed to communicate to me my assured superiority in the realm of being attuned to the patient. Her view of my superior competence is reinforced by the shared assumption of the psychiatric nurse, that the psychologist is the one who is possessed of the necessary expertise. However, had the patient been speaking to the nurse, there is a possibility that she would have expressed the view that she valued her advice as being more concrete and immediate. Perhaps the devaluing of the district psychologist's intervention was on one level an expression of the patient's anger at her perception of abandonment after three sessions and the importance of an ongoing supportive role for her. On another level she was possibly projecting her

experience of the existing fragmentation of the differing services within the psychiatric service onto the psychological service itself. I was staying and appeared involved with her while the district psychologist had left. In order to keep me longer, my efforts needed to be valued. The patient expressed her experience of the differing professional approaches in the following way:

> *Psychiatric nurses should be trained like the psychologists and they need to spend more time with psychologists and psychiatrists. When they all get together they should find time to discuss each patient.*

It could be assumed that the patient's above comments were a function of my interview with her. It is possible that, had the patient been interviewed by the psychiatric nurse or the psychiatrist, her responses might have differed in content. The patient's comment that nurses should have trained like psychologists can be understood in terms of her perception of nurses as being less valued within the professional hierarchy. The comment could also be understood in terms of the patient appearing to share in the nurse's assumption that psychologists were superior to the psychiatric nurses. It is also possible that the patient's perception of my services as more valuable than those of the other health professionals could have been influenced by the historically superior status of 'Whites' in this country. Within the community health centre I was continuously addressed as 'Doctor' by patients in passing. As a White, with a tertiary education and from outside the impoverished area of the Cape Flats, I was at times accorded greater status than even the psychiatrist and the district psychologist who, somewhat unusually, were both so-called 'Coloured'.

Literature suggests that patients are aware of the splits in service provision (Helman, 1994; Kleinman, 1988). The patient's perception of the fragmentation of the services can be seen as a reflection of the hierarchies of power, race and abilities within the mental health system, which in turn encourage alienation of service providers and reinforce a splitting of the services. It is this splitting of services and the professionals working in relative isolation from each other, which make it hard for the patient to integrate her differing experiences of service provision.

5.3 Ongoing interventions as a function of differing perspectives

This section examines the professionals' differing perceptions of the presenting problem. It explores the ongoing interventions as a function of the differing perspectives of the professionals. The perspectives of the professionals (including mine) are analysed in terms of differing worldviews and perceptions as a function of the different conceptual frameworks, which define the services provided to the patient by the different professionals. The patient's experience of the different treatment modalities is analysed in terms of her perceptions and understanding of the psychiatric services.

Although the patient had previously expressed her unhappiness with the medication to the psychiatric nurse she had not requested that the psychiatrist reduce the Clozapine 50mg and the Clopixal 200mg IMI until after several weekly therapy sessions. For the first six months of the registrar's placement at the community health centre, the patient had been seen at another clinic as she and her husband resided elsewhere. At the time of my initial contact with the patient, the psychiatrist had therefore attended to her on three occasions in the 11 months since the patient had presented at the community health centre. During this 11-month period the patient's medication was not reviewed. In the ten years since the patient's discharge from the psychiatric hospital, attending psychiatrists' and psychiatric nurses' comments on the phenomenon of watchful mocking 'eyes' recorded in the medical file were limited to medical interventions and related symptomatology. It appeared that the medication had not been reviewed in the five years preceding my placement , in part due to the irregular nature of the patient's contact with the primary care centres and the transient nature of the services provided by psychiatrists primarily based at tertiary level. Nor did it appear that any of the attending psychiatrists had questioned the fact that two different neuroleptics were prescribed simultaneously.

Her contact with psychologists had been limited to the four post-discharge sessions with a psychologist placed at the psychiatric hospital and the three sessions with the district psychologist prior to her wedding. According to the patient, the hospital psychologist appeared to have focused only on her physical state of wellbeing and the district psychologist only on containing the fears relating to the wedding. The patient had been referred to me as the psychiatric nurse felt unable to deal effectively with the patient's persistent and apparently deep-seated anxiety and reported delusions.

From the information in the file it appeared that the psychiatric nurses regularly administered the IMI and checked on the effects of the medication prescribed by the psychiatrists. According to the patient only the psychiatric nurse presently attending to her, appeared to show any real and continued interest in her emotional wellbeing.

5.3.1 The professionals

The psychiatrist reported that she had accepted the diagnosis of schizophrenia suggested by the psychiatric hospital, as two of the patient's family members were considered to have shown positive symptoms of schizophrenia. (Her sister, diagnosed with schizophrenia, had been in remission for some time, while a cousin currently displayed symptoms of psychosis.) The psychiatrist defined the way in which the patient presented at the clinic in terms of the diagnosis of schizophrenia.

She commented on her impression of the patient in the following way:

> *There was blandness about her affect, almost an emptiness that could also be a Depressed Mood or the negative aspects of schizophrenia. But there was no psychosis. She didn't volunteer the depressed mood. So there might have been a question on my mind why she has been on that medication so long, but I would not automatically have stopped it. I was going to wait another six months to a year before reviewing the medication, as I could only see her twice a year.*

Swartz (1998) suggests that psychiatric diagnosis represents one very particular way of interpreting the patient's experience. In the psychiatrist's view the patient appeared to indicate some of the negative symptoms of schizophrenia. From her comments it appeared that she focused primarily on the absence or presence of well-known symptoms of schizophrenia. Of significance in the above statement is that the psychiatrist needed to be cautious and monitor the patient for a period of time before she felt in a position to consider reviewing the medication. While the validity of this statement cannot be denied, the psychiatrist's comment that she would "*not automatically*" have stopped the medication, suggests that she viewed my encouragement of the patient to have her medication reviewed, as a challenge to her authority.

Within the conceptual framework underpinned by my training I also focused on 'very particular' aspects of the illness presentation. In the sessions with the patient I focused from my perspective as psychologist on the content rather than on the manifestation of the delusions and hallucinations. I tended to 'tune out' the psychiatric diagnosis. In terms of my training as a psychologist and my understanding of the psychodynamics underlying the manifestation, and immersed as I was in the discourse of the patient's continued reference to the negative effects of the medication, I questioned the continued prescription of psychotropic medications.

The psychiatrist and I attended on different days, rendering an ongoing dialogue with regards to the patient's progress or our understanding of the presenting problem, almost impossible. The two occasions on which we met to discuss the patient took place ironically outside the community health centre. As the psychiatric registrar was placed primarily at the Red Cross Child and Family Unit during the period of my contact with the patient, we agreed to meet there. The discussions revolved around the differing perspectives of the presenting problem and diagnosis and perceptions of the patient in consultative/ therapeutic interaction. The psychiatrist suggested a step-wise reduction in Clozapine from 50mg to 12.5mg and an immediate cessation of Clopixal. The intention was that I would monitor the patient's emotional state during our weekly sessions while the psychiatrist would increase the number of consultations with the patient from six-monthly to bi-monthly. The process of reduction of the medication proceeded without any further interactions that were more than just a cursory exchange of information between the professionals.

The psychiatric nurse was only intermittently available, thus reducing the communication with regards to the patient's state of mind and progress between the psychiatric nurse and me to informal exchanges. However, her interaction with the patient was of a more consistent nature. When I asked her whether she detected any changes in the patient's emotional wellbeing, she reported that she now saw her more often than other patients.

> *I let her ventilate and talk about her worries and her issues. To be honest, she is happy coming here. She is happy with the psychiatrist, but she will always want to see the psychologist. She knows it is something to cling to.*

The psychiatric nurse again appeared to need to attribute the patient's 'happiness' with psychiatric services firstly to my and secondly to the psychiatrist's interventions. Downplaying her role in containing the patient between my weekly sessions and the now twice-monthly consultations with the psychiatrist, could be understood as an expression of her sense of the position of the nurse within the hierarchy of mental health professionals. From the above it would appear that she devalues her role when compared with the contributions of mental health practitioners. It could be assumed that in the absence of any forum for communication the psychiatric nurse feels herself to be peripheralised. Of interest might be whether the psychiatric nurse might have juxtaposed the order of importance of professional contributions to the wellbeing of the patient, had the interviewer been the psychiatrist.

The coming to a working understanding given our differing worldviews and perceptions of the presenting problem and treatment, whilst feeling challenged in our professional capacity by the other professionals, was compounded by the difficulties experienced as the result of an absence of a structured and ongoing interaction.

The psychiatrist's question during our initial meeting, after I had described my experience of the patient in the therapeutic context, perhaps best illustrates the dilemma posed by differing perceptions and perspectives:

Are you sure that we're talking about the same person?

There are at least two ways to interpret the psychiatric registrar's response. It can be understood as a function of our different perspectives which are largely underpinned by the differing emphases in training. Miller and Swartz (cited in Holdsworth, 1994) have suggested that power relations and inter-professional conflicts within these relations "are likely to be waged directly through patient care". That the above comment represents an expression of incredulity at my presumed challenge of her diagnosis has validity, given that my viewpoint of the patient's presenting problem differed from the psychiatrist's. In considering the patient's perspectives of the differing roles of the psychiatrist, the psychologist and the psychiatric nurse, the difference in our perceptions might also have been reinforced by her selective illness presentations.

5.3.2 The patient

Throughout our sessions the patient continued to voice her sense of numbness. She ascribed the sensation of 'numbness' and of being "*doffed out*" to the effect of the anti-psychotic drugs. She expressed that her real emotions wanted to surface which could happen in therapy because I "*asked the right questions*" and that the medication was "*holding her down*". These comments could be construed as mirroring the separation in the patient's mind of the roles of psychiatrist and psychologist to which she gave credence by presenting to the different professionals in differing ways.

To the psychiatrist she presented with flattened affect and appeared to focus only on the medication:

> *Because she* (the psychiatrist) *only asks me questions about the medication, I talk about it. She doesn't explain what is going on. I want to come off the medication but when I'm there I'm not sure that I can say this. I'm not sure if it's the right thing to do, to come off.*

The patient's comment regarding her interaction with the psychiatrist could be interpreted as her sense of awe when confronted with the doctor, who is construed as the authority. Her reticence to communicate more than the physical aspects might then be in part due to her sense of intimidation by the psychiatrist's presence. The psychologist is the one she can tell that she wants to come off the medication because I will 'understand' and will listen. Congruent with her perception of the role of psychologists she showed me a range of emotion and insight into her condition in the therapy sessions.

It is interesting to note that the psychiatrist presented a differing perception of the patient's wish to 'come off' the medication:

> *Despite my efforts to explain to her that Clozapine is not something that she needs, she is stonewalling about coming off her medication and appears reluctant to do so when I suggest it. When she is with you* (the researcher) *she feels that she wants to come of the medication.*

The psychiatrist's comment could be seen as indicative of her view of the differing roles of the professionals in the patient's treatment and the patient's propensity to mirror these differing roles in her interactions. Individual professional perspectives appear to be influenced by perceptions of the patient which are underpinned by her experience of the services. It appears that the patient, by presenting differing aspects of herself to each role player, might be feeding into and maintaining the splits inherent in the service provision. Professional perspectives are also influenced by the perceptions of colleagues underpinned by the conceptual frameworks, which determine professionals' expectations of each other and the patients.

Given the time-limited nature of the registrarship and thus the need for caution, the medication might not have been reduced or changed by the psychiatrist during the time she had available at the community placement. It is conceivable that the patient might not have had the opportunity to express her sense of the 'cottonwool' effect of the drugs, nor given expression to her wish to reduce the medication, had a psychological service not been introduced into the already existing psychiatric services. While the introduction of a psychological service in itself would not have sufficed to bring about a change with regards to the patient's medical treatment, it is suggested that the once-weekly therapy sessions allowed for a sense of continuity and empathy to develop. And, as the number of patients assigned to me was restricted by my supervisor, I was able to see the patient far more frequently than the psychiatrist. It is possible that, had the psychiatrist been able to see the patient more often and for longer periods, the patient might have felt less pressurised to focus only on the biophysical aspects.of her illness and communicated sooner to the psychiatrist her concern regarding the side-effects of the neuroleptics.

From the above it would appear the reassessment of and reduction in the patient's medical treatment were brought about by a concerted effort on the part of the psychiatrist and me, as psychologist, to integrate our differing perspectives towards a common understanding of the patient and the treatment. Yet, in spite of the collaboration, the reduction in medication was still monitored and recorded separately by the professionals involved, thus maintaining the professional splits which are entrenched in primary mental health care provision.

5.4 Reflections on the service delivery within psychiatric services

This section attempts to provide some insight into professionals' understanding of their roles and interdisciplinary collaboration in the community health centre environment more generally. It also attempts to examine the effect of patient perspectives on professionals' perceptions of their role.

5.4.1 The professionals

The psychiatrist provided some important perspectives on her role in service delivery:

> *My role is to provide support from a psychiatric point of view. The historical situation is such that I'm responsible for the patient and should be informed if they see a psychologist. I mostly see those who need psychiatric input and far fewer of those needing psychological counselling. That's just the way that the clinic is constructed. For the psychologists and psychiatrists to work together towards a common goal, we need to make contact. I can't supervise the psychologist, but I want to be there as a colleague with equal status.*

The simultaneous perception of her premier responsibility for the patient and the wish to have the psychologist as a colleague of equal status, while possibly indicating an ambivalence to role and role responsibility, could also indicate a sense of the greater value of the discipline of psychiatry within psychiatric services. Her suggestion that she be informed denies the sense of collegiality intimated in the last sentence and re-enforces the hierarchical status quo within psychiatric services and the health profession in general. The common goal is clearly the patient's wellbeing, and to achieve that the psychiatrist sees herself as the primary provider, yet acknowledges the need for direct communication between professionals.

Tyrer et al. (1993) has suggested that a territoriality of roles and interventions exists among the differing mental health disciplines. It is possible that this sense of territoriality is reflected in the professionals' tendency to split and take responsibility for different aspects of the treatment of the patient. The psychiatrist described herself and other mental health professionals as "*compartmentalising*" the needs of the patients in spite of "*fantasies of breaking through that and of understanding people more in terms of themselves and how they*

function and of not breaking them up into physical and mental". Patients' needs appeared to be divided along similar lines thus re-enforcing the splits within the system: i.e. those requiring psychiatric interventions and those needing psychological interventions, highlighting the split between the disciplines.

It would appear that liaison between the psychiatric nurse and the psychiatrist was restricted to a once weekly interaction. The psychiatric nurse's comment provides an idea of her perceptions of psychiatric service provision:

> *We don't sit as a team (and) there is no time for a discussion. In an emergency the consultant does not respond to the beeper and we have to use our own initiative. We have to act independently in an emergency. I think that the psychiatric service is nurse-driven.*

Failure to operate as part of a team may mean that very valuable sources of information are lost in the management of a case, possibly resulting in unnecessary duplication of services. The perceived failure of the consultant to respond in an emergency engenders a sense of abandonment, which in turn reinforces a sense of self-reliance. This self-reliance entrenches the functioning in isolation of separate professional entities within an ostensibly integrated service.

The temporary nature of the appointments of psychiatrists to the community health centres, as well as large transient patient populations, have negative repercussions for in-depth and sustained engagement with the patients and on the development of an integrated professional service delivery within psychiatric services. These repercussions are illustrated by the psychiatrist's comment:

> *It was unfortunate that she moved from one clinic to the next. The way that the clinic operates and because everything is so transient, I could easily have seen the patient for a year and felt perfectly justified in leaving her on that medication. It is almost impossible to be attuned to a patient one sees every six to nine months for a few minutes only.*

The psychiatrist's comment that she felt "*perfectly justified*" in not reassessing the medication could be indicative of her sense of the appropriateness of the medical model of intervention. It is possible that she is simultaneously saying that psychology is not a 'perfect' service and that by extension, I was not providing the 'perfect' service.

The split in professional perceptions of what constitutes essential services is perhaps illustrated by the psychiatrist's comments that the patients enjoyed "*the luxury*" of seeing a psychologist:

> *The patient is one of the few who can see a psychologist. Others can't because of staff constraints.*

While the additional service of psychologists might be experienced as superfluous when compared with the need for psychiatric interventions within the psychiatric service, the above also appears to express a lack of awareness of the complementary role of psychological services.

The district psychologist highlighted another aspect which she considered to bear an influence on service provision, when she suggested that the concept of psychiatric services as a unit was erroneous, in that each professional was supervised by and reported to a different authority. Of the professionals working within the psychiatric services, only the psychiatric nurse was based at the clinic and had been so for a period of just over two years. The district psychologist presented an interesting point of view of the challenges facing the implementation of the current Ministry of Health policy of integrated services:

> *Challenges to an integrated system come from territorial divisions as well as from the actual practical problems of getting mental health workers from the same setting to sit down together. This requires practical coordination because all these people must be in the same place at the same time. Because the nature of psychiatric services is such that the majority of role players are not based at the community centre, it is difficult for mental health professionals to conceptualise a sense of team.*

The district psychologist acknowledges the role played by divisions and fragmentation of services and role differentiation, which are entrenched by training within different models

and the hierarchical infrastructures existing within the mental health care system. She suggests that a solution to the challenges presented by territorial divisions might be the coming together of involved professionals. However, being 'at the same place at the same time' does not guarantee integration of services or sense of 'team'.

My perceptions of 'team' were that consultation among the professionals involved in the case took place in a haphazard fashion and, for the most part, on an ad hoc basis. A case conference of the psychiatric nurse, the psychiatrist and me, to discuss the patient and the medication might have contributed to a more holistic and ultimately beneficial management of the case (Western Cape Ministry of Health and Social Services, 1994; WHO, 1990).

With each professional feeling individually responsible for an aspect of the patient's wellbeing and treating the patient within the parameters of different modalities, the patient was being treated in 'sections', reflecting the splits within the system. Inherent in different treatments offered without collaboration, was the possibility of duplication of services and neglect of important aspects of the patient's mental illness, as has suggested by the 1997 WHO report on studies investigating integrated services within primary mental health care.

5.4.2 The effect of the patient's perspectives on professionals' perceptions of their roles

The effect of the patient's perceptions on professional service delivery is highlighted by the psychiatrist's comment:

> *It is not that we might have a different perception and a different slant because of our training, but I believe that the patients come to us with different aspects of their problems.*

In the context of the patient's perceptions regarding differences in service delivery of the professionals involved, the psychiatrist's comment that patients present with different aspects of themselves has validity. Swartz (1998) suggests that the job of the professional is then to understand the explanatory model of the patient while negotiating between her/ his own explanatory model and that of the patient. This allows for the creation of common ground as a basis for treatment. The absence of negotiated professional explanatory models, allows for and maintains splits mirrored in the different ways in which the patient presents herself to the

different professionals. The psychiatrist's comment that the patient "*slots into different ways with each professional so easily*" serves to illustrate the effect on the patient of these splits in service provision.

The patient's initial comment that the psychiatrist appeared more concerned with medical aspects of her wellbeing, accords with and is maintained by the psychiatrist's perceptions of her role. The psychiatrist saw herself as the professional primarily responsible for the medical management of the patient's case. This perception of her role within the service was possibly echoed in her perceptions of her role as psychiatrist which she attributed to patients' perceptions in general, namely that psychiatrists were seen as people with status, with "*something special to offer*". The patient's reticence with regard to her needs was ascribed to the fact that "*she was definitely hamstrung and intimidated because I was the doctor*". This comment is perhaps an indication of her sense of the superiority of the medical profession, an assumption held not only by the medical fraternity but by other professionals as well and has been well documented in literature (Helman, 1994; Menzies Lyth, 1988; Stones, 1996).

My sense of the role of the psychologist in promoting mental health was perhaps reinforced by my own sense of the unique contribution of psychotherapy, as much as by the patient's perceptions that the psychologist is interested in emotional problems. I felt that I also had 'something special to offer' in terms of psychoanalytic input and understanding of the patient's dilemma with regards to communicating her wishes to the psychiatrist as the doctor in charge of prescriptions and diagnosis. I considered my contribution to the patient's emotional wellbeing to be important and felt sidelined by the psychiatrist's failure to contact me regarding the treatment of her patient. On this level I identified with the patient in that we were both not being consulted! In bringing the patient's concerns to the attention of the psychiatrist and giving informal feedback to the psychiatric nurse, I was attempting to assert the authority of my psychological training and explanatory model.

From the above it would appear that professionals' perceptions of their own roles and the perceptions of the patient affect the way in which they view each other's roles within the service and the way in which the patient is treated. In that the patient appears to present different aspects of herself to each professional, her perceptions of the professionals affect and reinforce the differing perceptions of these professionals.

5.5. Suggestions for improvements in psychiatric service provision

The following section briefly looks at the professionals' understanding of psychiatric service provision at primary level mental health care. It raises the question as to why, given the apparent awareness of the relevant role players of the benefits inherent in an integrated professional approach, it would appear so difficult to achieve this integration.

The district psychologist neatly encapsulates the effects of an integrated professional approach to psychiatric services:

> *The understanding between the three professionals* (the district psychologist, the intern psychologist and the psychiatric nurse) *allows the patient to feel that she matters. This has no doubt been containing, and has cut down on duplication, as well as on the professionals working against each other. Duplication is financially and medically expensive. Psychiatric registrars need to see themselves as part of the health team too.*

The district psychologist's opinion regarding the involvement of the psychiatrist might be understood in terms of her sense that psychiatrists, working within the medical model, are seen (and see themselves) as separate from other mental health professionals, whilst the three above-mentioned professionals work together within another model. However, the psychiatric nurse's claim that they have to use their own initiative in the absence of a response from the district psychologist, denies the psychologist's sense of team, and suggests that her comment should perhaps be seen in the nature of a wish rather than an actuality. It is possible that the disjunction between her perception of collaboration and the reality might have its origin in an ambivalence towards the role required of her by the nurse and her own sense of her supportive role to the nurses. Working in an advisory capacity has, in a sense, removed her from the horizontal level of collegiality within the psychiatric services at primary level and set her apart in a way which is similar to her perception of the psychiatrist's role.

The psychiatrist suggested a meeting between the psychiatric nurse, the intern psychologist and herself, if not once a month, then every second month. She envisaged cancelling a clinic

to accommodate such a meeting and considered it extremely useful for the professionals to exchange their points of view. She added:

> *If the mental health professionals could work as a team, it would take a lot of pressure off the patients. The patients become anxious when they have to talk to a lot of professionals about one problem. Then they're not quite sure how to feel about their problem. If we engaged jointly with the patients and we gave one message even if we did not all agree, it would reduce the burden.*

From the above comments it can be construed that the psychiatrist and district psychologist are aware of the implications of an integrated professional approach to service delivery. Both these professionals concurred that integration facilitates service provision while obviating duplication of psychiatric services. A further comment by the psychologist, "*the intention is always to strengthen the sense of team at primary care level*", indicates the intent to create a sense of team within the psychiatric services at primary care level.

While the professionals expressed the wish for a more integrated service, it appears that a sense of 'separateness' pervades the services which impedes the possibility of integration as defined by the policy implemented at ministerial, provincial and municipal levels in 1994 and 1996 (Department of National Health, 1996, Western Cape Ministry of Health and Social Service, 1994). It would appear that, while the professionals are aware of the benefits to the patient and themselves with regards to cooperation and collaboration, integration remains a mental health policy rather than a reality. It is possible that each professional, having previously functioned independently of the others, finds it difficult to relinquish authority and autonomy, thus maintaining the splits and fragmentation of the previous system. It would appear that, given the different conceptual frameworks of and training in the different disciplines, as well as the hierarchical power structures existing within the health services, it is difficult to develop a sense of team in service provision.

5.6 Summary of the central issues emerging from the analysis

The analysis indicates that the responsibilities and duties within the psychiatric services appear to be defined according to the occupationally defined titles of psychiatrist, clinical and intern psychologist and psychiatric nurse. The professionals' occupational roles are defined by their training, by the paradigms delimiting the professions and by the hierarchies and

power dynamics operating within the mental health system of service provision. All of which have bearing upon the perspectives of the professionals involved in the treatment of the patient. The perceptions of the patient also appear to have an important influence on the maintenance of traditional professional roles and splits. Each professional brought perspectives and perceptions about her role and the other professionals' roles in the case management, and the extent to which these clashed or intertwined, appears to have determined where an integration of services and professional collaboration 'happened'. It appeared that issues of power underlying race, hierarchy and differing professional viewpoints might have played themselves out through the approaches of the professionals to the patient, the treatment and each other. There were points at which the different health service providers met, but service provision was not structured to facilitate integration. Professionals met and shared information to a large extent on an ad hoc basis. While having the skills to counsel patients, the psychiatric nurse felt that the psychologist was better able to deal with the more complicated cases. There was no sense of either the intern psychologist or the district psychologist being called upon for assistance or containment. While the psychiatrist and psychiatric nurse met on a regular basis, the nature of their interaction was circumscribed by limited time allotted to the psychiatrist and by the nurse's sense of her position within the medical hierarchy. The psychological service component was perceived by the district psychologist and me, as well as by the 'psychiatric team', to be separate from psychiatry and to function within another paradigm. This perception was re-enforced by the lack of communication between the professionals. This was in part due to the limitations of service in terms of the timeframe of service provision imposed by the system and the location of the psychologists and psychiatrist outside the community health centre.

It would appear that the absence of an integrated approach to service provision has had repercussions for the treatment of the patient. When a form of contact and collaboration was established between the role players, albeit in a haphazard manner, it appeared that an holistic approach to treatment of the patient became possible.

CHAPTER SIX: IMPLICATIONS OF THE STUDY

The intention to make mental health care more readily available has led to the implementation of a process of integration of psychiatric services into the community health services. While a number of factors conspire against a successful integrative process, the focus of this study has been on the challenges of differing professional perspectives to an integrative approach to service delivery within the psychiatric services (Pillay & Lockhat, 1997). The analysis revealed a number of the implicit and explicit factors influencing holistic and integrated professional service provision in psychiatric services. The implications for an integrative and holistic service delivery were highlighted by the analysis. This section provides some thoughts and suggestions regarding these implications.

Holistic service provision which presupposes comprehensive mental health care requires the bringing together of various professionals in the form of a team to address the patient's needs. However, the analysis has highlighted various obstacles to the development of a sense of team. The study suggests that the 'top down' approach of the previous primary health care system, which generated splits and fragmentation of service provision, has been duplicated within the psychiatric services. The psychiatric nurse, now permanently placed at the community health centre, has more responsibility but the power structures appear not to have changed at all. She sees herself to be primarily responsible for carrying out the treatment prescribed by the psychiatrist and for monitoring the patient. The psychiatric registrar, primarily based at tertiary level, sees herself as the primary case manager, responsible for the diagnosis and prescription of treatment. The district psychologist based at secondary level of primary mental health service sees herself as primarily responsible for development of services and in a supportive role to the nurses. I, as intern psychologist, understand myself to be primarily responsible for the emotional wellbeing of the patient. As each discipline operating within the psychiatric services has been trained within a different paradigm and appears to subscribe to differing viewpoints and perspectives, the wellbeing of the patient as a whole is compromised.

Differing professional perspectives per se should perhaps not constitute a significant challenge to an integrated professional approach to service. The study however indicates potential obstacles which exacerbate and maintain the effects of differing perspectives on the diagnosis and treatment of the patient, thus affecting an integrated professional approach to psychiatric service delivery. The study suggests that the limited commitment allowed the professionals providing a time-limited service on a sessional basis, presents a stumbling block to an integrated service. The transitory nature of service provision makes it difficult for a sense of a mental health team to develop among the professionals. As the services of all professionals (other than the psychiatric nurse) involved in psychiatric services are rendered on a sessional basis, they are also not always readily available to support the psychiatric nurse who perceives them to be elitist and less involved. The unavailability of the other members of the psychiatric team provides an obstacle to the psychiatric nurse feeling part of the professional team. To manage these feelings of alienation Menzies Lyth (1988) suggests that the psychiatric nurse distances herself from involvement with the patient in her totality as well as from the psychiatric team. In the case of the patient, the psychiatric nurse, whilst continuing to work strictly within the medical model, refrained from communicating her perceptions of the patient to the psychiatrist, and avoided psychotherapeutic interventions in spite of having some training (Mgoduso & Butchart, 1992). Yet the psychiatric nurse provides a continuity of service at primary level which is both crucial as well as pivotal to holistic service provision. Given that she works on a daily basis at the patient-health professional interface, she is perhaps best able to negotiate between the goals of the mental health professionals on the one hand and the goals of the patient on the other (Helman, 1994).

The shortage of professional resources as an important factor affecting the successful implementation of an integrated professional approach to service delivery cannot be ignored. Psychologists and psychiatrists are primarily trained to work in the tertiary hospitals and psychiatric institutions, but the majority of psychiatric patients live outside these areas. While the psychiatric nurse feels that she is not sufficiently valued either through remuneration or recognition of status, she is faced with the brunt of the work and the responsibility for the wellbeing of the patients. Apparently overwhelmed by the large numbers of patients and faced with a lack of support owing to the transitory nature of the service provision by the other mental health professionals, the psychiatric nurse fails to treat the patient holistically. She appears to prefer instead, to split off and concentrate on "bits" which can be dealt with within the medical model (Mdgoduso & Butchart, 1992). The psychiatrist, under pressure of

time constraints and large numbers of patients requiring her attention, apparently prefers to pass the patients requiring psychotherapeutic interventions to available psychologists. Where psychologists remain unavailable, patients then receive little or no psychotherapy. Given the limited time allowed for psychotherapeutic interventions, the psychologist is thus forced to limit the number of patients who can be attended to on a sessional basis. As most patients presenting at community health centres do so because of emotional and psychological distress rather than obvious physical illness (WHO, 1990), but often present with physical complaints, it is vital that the mental health professionals are able to recognize and treat the patients accordingly. This requires that the professionals in the absence of shared perspectives literally find common ground whereby they can pool their perceptions and expertise. This case study suggests that, had the initial diagnosis in the case of the patient been continuously reviewed and the professionals involved given the opportunity to share their perspectives, treatment might have been of a more holistic and therefore more beneficial nature.

Given the South African political and social background, the issue of race should not to be ignored in the context of mental health services at primary level (Helman,, 1994; Kareem & Littlewood, 1992; Littlewood & Lipsedge, 1997). In this case, I, as the intern psychologist, was the only White attending to the patient. This might in part have accounted for the deference of the psychiatric nurse, a so-called 'Coloured', with regard to the service provided by me. The implied ambivalence of the psychiatrist, who, contrary to the norm, is also so-called 'Coloured', with regard to our collegial status might be have been a function of her perception of my intervention as that of a White attempting to undermine her authority. These issues need to be acknowledged and accommodated in a sensitive manner.

This case study also suggests that the patient's awareness of the differing viewpoints and perspectives of the mental health professionals feeds into and maintains the splits and fragmentation within service provision. This study highlights some of the effects of these differing perspectives on the treatment of the patient. The lack of an integrated professional approach is potentially perpetuated by and reflected in the manner in which patient presented selectively to the mental health professionals in apparent accordance with the professionals' perceived expectations of the patient and the patient's perceived expectations of the individual professionals. The patient's dependence on and sensitivity to the health services appeared to result in a responsiveness which also influenced the nature of the service

provision. Unless the professionals involved in psychiatric services find an integrative space, a fragmented approach continues to limit the formation of a composite picture of the patient which is mirrored by the patient's differing illness presentations and in the treatment by the different professionals of aspects of the patient in isolation. In order for the splits inherent in the psychiatric service provision, and which adversely affect the patient's responsiveness to be obviated, it requires that professionals communicate their perceptions and collaborate in the treatment.

The ad hoc form of interaction currently in place surely impinges on the quality of service provided. With no system in place for regular case discussions, there are poor information flows with the concomitant potential for patients' diagnoses and interventions to 'fall' between professionals. While broader recommendations would require a rethinking and reworking of policy with regards to training, supervision, equity in remuneration and status, the psychiatrist's suggestion that a time be set aside for case conference within psychiatric services can be instituted with little difficulty. It requires that the professionals providing a service on a sessional basis should be time-tabled for the same day and that twice monthly meetings be scheduled for the professionals to discuss cases at the community health centre.

The study suggests that inherently differing professional perspectives have implications for an integrated psychiatric service delivery. It furthermore suggests that the effect of differing perspectives on an integrated psychiatric service delivery is compounded by the absence of structures which facilitate a sharing of perspectives, an overburdening of psychiatric nurses, an increase in service takers and a lack of adequate resources.

Unless these factors are acknowledged and addressed, they are likely to continue to undermine an integrative professional approach to psychiatric service provision. While the policy implementing the integration of services in primary mental health care at primary level is intended to provide a better and more holistic service to patients, it might do so only on paper.

Since, as McHugh and Vallis (1986) noted, the whole of a patient's health care should amount to more than just the sum of separate professionals, the health professionals working within differing paradigms, should not operate in opposition to one another. Swartz (1998) refers to the power of medicine as the "dominant institution" which might account for the

perception of the psychiatrist of herself as the manager of the case and the psychiatric nurse's view of the service as primarily nurse-driven. Stones (1996) suggests that psychologists' perceptions of psychiatry as a treatment modality of mental illness are biased. Psychologists tend to fail to acknowledge that the psychosocial model/ view of mental illness and the patient is no more 'true' than the biomedical model/ view. It is interesting to note that both the district psychologist and I perceived ourselves also to be in charge of the patient's wellbeing, focusing almost exclusively on our area of expertise. With each discipline attempting to work only within its own paradigms, the responsibility of psychiatric services which lies in managing the mental illness in the context of the patients' lives, is lost sight of (Swartz, 1998; WHO, 1997).

6.1 CONCLUDING REMARKS

The case study illustrates how an integrative professional approach to the management of a case in psychiatric services is constrained by the differing professional perspectives which are underpinned by the training within definitive paradigms, the power dynamics and the racial issues affecting the professionals. The fact that the psychiatrist and the psychologist attend psychiatric services on different days and the psychiatric nurse is not always available has meant that collaboration and the exchange of information take place in an ad hoc manner, further exacerbating the challenge of differing perspectives to an integrative professional approach.

The case study highlights the way in which the patient is affected by the absence of an integrated approach to the management of her case. The patient finds herself receiving varied and at times conflicting advice and directions from the professionals involved in the case management. The splits within psychiatric service provision make it difficult for the patient to integrate her differing experiences of service provision, reinforcing the way in which the patient presents different aspects of herself to the different professionals.

Given the above constraints, the challenge becomes how to provide an holistic service in line with the primary health care principles as outlined by the WHO (1990). Of immediate benefit to the patient was the attempt by the professionals involved in psychiatric services to collaborate and share their expertise. This minimised the divisive effects of differing

professional perspectives on the treatment of the patient, the unnecessary duplication of services and allowed for a more holistic service provision.

Cross-disciplinary training to facilitate an integration of services would require expensive and major long-term restructuring of the training programmes. A simple shift in the differing time-tables to coordinate the times available for all professionals involved to discuss the case, would serve to begin to facilitate an integrated professional approach to service provision.

The study suggests that while psychiatric services are now integrated into primary level health care, the mental health professionals still tend to work in isolation from each other and within the narrow confines of the paradigms in which they have been trained. Working independently of other disciplines allows for speed of service delivery but leaves the patient without the holistic service to which s/he is entitled (WHO, 1997) and to cope with the splits inherent in this system of service delivery. However the dynamics of transient appointments of psychiatrists and psychologists as well as a sense of alienation of the psychiatric nurses who remain behind to deal with a large patient population, appear to play as important a role in hampering an integrative professional approach to service delivery. The psychiatrist's comment "*it's completely haphazard and unsatisfactory*" perhaps most closely describes the present quality of integration of disciplines within the psychiatric services.

The collective comments of the professionals, including mine, and of the patient, indicate that an integrative multidisciplinary approach to service provision is more likely to be successful in achieving a greater understanding and management of mental illness and illness behaviour. The review of the patient's medication and subsequent changes in both treatment and medication indicate what might be achieved by as small a shift in services as the meeting of involved professionals with the attendant increase in communication flow and subsequent collaboration. The study recommends that unless the various challenges facing the implementation of an integrated service at primary level are acknowledged and addressed, they are likely to undermine the success of the new policies of integration as envisaged by the Ministry of Health.

While the applicability of this study to other primary health care settings cannot be certain, it is hoped that it highlights some of the potential obstacles to an integrated and holistic mental health service at primary level. It is hoped that this study will lead to further investigations of

primary level mental health service provision drawing on the input of all involved role players.

In concluding, I would like to avail myself of a suggestion made by Tyrer et al. (1993) in the context of the provision of an integrated multi-professional mental health service. It could be hoped, that the ability of fellow professionals to deal with each other on an equal basis, recognizing the unique contributions that each discipline has to make and the gratifying response of the patient, would encourage an integrative approach.

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APPENDIX A:

PROFESSIONALS' INTERVIEW SCHEDULE

Section one: -

Demographic information:

Could you please state your name and your age.

What are your qualifications?

How long have you been involved as a professional in primary mental health care?

To what extent has your professional training equipped you to work in the clinic setting?

What is your role at the community health centre?

What are your priorities in terms of psychiatric service provision?

What are typical sources of referral?

How many patients consult with you during a session and what is the length of each consultation session?

To what extent are you able to attend to the patients' needs within the time available?

Resources in psychiatric services in primary mental health care:

What is your experience of the professional resources available to you?

What are the implications for you in terms of service delivery?

What form of contact do you have with other service providers in psychiatric services?

To what extent do you consider (a) your training and (b) your professional status to influence your relations with your colleagues in psychiatric services?

To what extent do you perceive yourself to be supported by the other professionals in psychiatric services?

What kinds of support or resources would enable you to function optimally within the community health care setting?

To what extent do you consider links between the different professionals at the primary level useful in terms of service provision in psychiatric services in a primary health setting?

To what extent do you consider the links between the different levels of service provision, namely primary, secondary and tertiary, useful in terms of service provision in a primary health setting?

Section two: -

Professional perspectives on the patient and intervention process:

How long have you known the patient?

Who or what was the source of referral and what has been your contact with the source to date?

Describe the nature of your contact with the patient in terms of number and length of consultations?

What information were you given regarding the patient's previous medical history?

Looking at the past psychiatric history of the patient, what kinds of treatment has the patient had in the past ten years and why do you think her treatment has taken that form?

What do you think is the patient's main problem?

Has your initial assessment of the patient changed? If at all, why?

What form has your intervention taken and why did you choose this?

What is your prognosis for the patient?

What do you consider to be your role in the outcome of this case?

How do you think the patient perceives your role?

To what extent have you been aware of the interventions of the other professionals involved in the treatment of the patient in psychiatric services?

What has been the extent of your collaboration with these professionals in the treatment of the patient?
Do you have any suggestions with regards to what might have facilitated and/ or improved service provision to this patient?

To what extent would a case discussion with other involved professionals have facilitated the intervention in this case? Why did no case conference take place?

What, in your experience, are the limitations of psychiatric service provision at primary level mental health care? In your view, is this patient typical of or different to the population attending psychiatric services?

Is the service rendered to this patient typical of psychiatric services in a community health centre? Explain.

APPENDIX B:

PATIENT INTERVIEW SCHEDULE

Describe your contact with the community health centres in the past ten years?

Describe psychiatric service provision you experienced at the different clinics?

Where there any differences between your previous experiences at other clinics and the service at the clinic which you now attend?

How do you understand (a) the role of the psychiatrist, (b) the psychologist and (c) the community health nurse?

How often do you meet with the psychiatrist

for how long and

for what reason?

How often do you see the psychiatric nurse,

for how long and

for what reason?

Why did you ask to see a psychologist in 1997 and again in1999?

What did you expect from the different professionals in the psychiatric service?

To what extent were your expectations met?

How did sessions with these professionals differ from each other?

What has your experience of the process of treatment been like?

Would like you like to add anything else?