Critical Social Work Practice

Working in a South African psychiatric ward

Estelle Silence

My name is Estelle. My surname is Silence. I am a Social Worker. At the moment I am employed at Lentegeur psychiatric hospital. I work in the Adolescent Psychosis Recovery Unit. It's basically a unit that provides mental health services to adolescents, who have had a psychiatric breakdown. And who basically need to remain in hospital for a longer period to recover.

I worked at Child and Family Welfare before. Which is basically an organisation that does child protection work and community development work etc. And I needed to move into a different field of practice.

I wanted to make a difference in people's lives. I felt that becoming a social worker was a good way to do that. It was a good starting point.

I applied at various places. But in South Africa as a social worker, the salaries aren't always particularly good if you're working in non-governmental organisations. So you want to get into a government department really, a state facility. I didn't plan to stay long. I remember when they interviewed me for the post, they asked me how long I would be staying, and I said 'Look, this is just a stepping stone. Give me two years and I am out of here'. And that's how many years later, I am there almost eight years now.

I don't want to end my life as a social worker. But I would like to believe that I was able to make a difference. And that I impacted on people's lives. And that is what I wanted to do.

I basically function as a Social Worker. I work as part of a multi disciplinary team. Which means that we have a psychiatrist, a registrar, nursing staff, occupational therapist etc. all involved in basically managing our patient. My work is to provide a social work service, and then I also do case management. So basically that means that I would take primary responsibility for providing a service to a particular adolescent. I would present the adolescent to the team and also ensure that all the work that we need to do on a particular adolescent, that actually does get done. And then I also act as a consultant to the rest of the team. In terms of ensuring that all the adolescents in our Unit do get an appropriate social work service.

Some of the adolescents come from socially disadvantages areas. And these adolescents have been exposed, some of them to trauma. Others have been exposed to the social evils that we have in South Africa. In terms of gangsterism and drugs etc. So the adolescent would end up in our unit with a diagnosis of let's say schizophrenia. He would maybe have a drug history. Meaning that he may have used drugs recreationally. or he may have been abusing drugs. And we will them have to treat the adolescent in terms of the schizophrenia. But we also need to treat him in terms of his social circumstances.

When someone comes into a health facility, then obviously the priority is to get the person healthy, if the person is ill.

It's a psychiatric unit, so first and foremost we want to get our patents psychiatrically stable. That means we want to get them symptom free. Or at least if they are going to have some residual symptoms, sometimes we want to be able to know that we have treated them optimally in terms of the medical aspects.

And I think for us, what we want to be looking at is, we want to see our clients holistically. We don't just want to see the illness. We want to see what are the other factors in this person's life that we can also help to improve on.

Part of our rehabilitation programme is actually to send out patients out on weekend leave etc. If it goes well, extended leaves. And during that process, we will engage with the family. They will have to come in for sessions with the individual case manager etc. But the role of social work seldom ends. Because often with our adolescents we have to refer them to community based resources, like your local welfare agencies. Or even a drug rehabilitation facilities. We always link them with a follow up service. We cannot just discharge them from

our unit and let them get medication. Because often what we realise is that our children don't become psychiatrically ill just because they have a genetic family history in terms of psychiatric illness. What we find in our unit, is that the age of onset is so much earlier now. And also the severity of the psychiatric illness, that in fact it is because of psycho social stresses. And that is why we need to address that.
We are a provincial unit. We admit adolescents from all over the Western Cape. So all adolescents within the Western Cape who become psychiatrically ill could be admitted into their nearest general hospital, transferred to Tygerburg and eventually be transferred to us. We don't take referrals. We just work directly with Tygerburg. And our psychiatrist, that we have in our unit, he is basically the link between us and Tygerburg. Because he works at both units.
When we have a new adolescent that is admitted into our unit, he would be referred to one of the case managers. Which would either be myself, a psychologist, the doctor or one of the nursing staff. And what will then happen, is that we would then do a full assessment of the adolescent of their mental illness, based on the family functioning, social, economic, political situation, everything.
When the case gets presented, my function is basically to be able to give some input in terms of what I feel we should be focussing on with regards to those aspects. So it would be looking at issues pertaining to family. Issues pertaining to relationships. Issues pertaining to educational aspects around the patient. And also just issues pertaining to the patients function within the community. For example if a patient has a drug history, then my concern would be that we need to determined whether this is drug use, or whether it's been abuse. And we need to look at whether the patient needs rehabilitation. Specific drug rehabilitation then.
We will then do a full presentation to the team in the unit basically on the adolescent. And as a team we then look at designing an intervention plan for a particular adolescent then. And that intervention plan gets reviewed on a weekly basis.
I am not able to always effect rehabilitation with a particular client in it's fullest form. Because of limitations due to community resources etc. For as long as the client is within our unit, we can only do so much. And we need to rely on community resources to continue with the rehabilitation. And often that isn't there. So you often feel when a client is being discharged, that you can identify the ones who you know will probably end up back in the system rather quickly.
One that sort of comes for mind for me is of a young man, I think he was about 16 or 17. He had been in Tygerburg hospital for a few months already. He came into our unit, basically was diagnosed with a schizoid-affective disorder. And really we struggled medically to treat him. And a lot of the struggle really in terms of him, was around the psycho-social factors. Because I think in his case, there was very poor family support. The parents were basically in the process of getting divorced. There was lots of fighting. They had been using this child really as a pawn in their marital conflict. And eventually he ended up using drugs basically as a way of dealing with the home situation. And also just as a way of not having to face his stresses specifically. And he ended up becoming ill.
And he stayed in our unit for probably six to nine months. And during that time, the work with the family was done intensively. And we as a team, we went out and we did home visits ourselves. Although they were divorced, we still worked with them as a unit. Because we realised that they haven't really dealt with the issues in terms of their divorce and separation. So a lot of our work focussed on just supporting them. But at the end of the day we felt that the child needed to be placed in an alternative facility. Because we realised that the parent who was going to take care of him, wasn't really in a position to do that. And although we had made that assessment as a team, we are also limited in the sense that as a social worker, working in the department of health, I don't have-the statutory powers to place a child. So all the work we can do beforehand. But we so dependant on our social work colleagues in the community then. And eventually after lots of consultation they don't necessarily agree with our plan of action. That he must be placed in a children's home.
Our plans fell through basically. We had to discharge him into his parents care. A few months later, we got a call from the social workers in the community saying 'you know he's busy getting sick. Can we readmit him, and can this time keep him very long?' Basically. So we are not in favour of doing that at all. We feel that adolescents with psychiatric illness must be treated in the community. And not necessarily institutionalised. We still offered him support, but we didn't re-admit him.