2013

Somerset Hospital

South Africa – Cape Town

Internship assignment part 1:
Description of the organisation.

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New Somerset Hospital:

Financial, political and legal frames

New Somerset Hospital (NSH) is a state hospital and a subsection of the Department of Health. The political and legal frames are set by the Government and the hospital is therefore obliged to follow certain procedures and take on projects set by the state. All state employed personal work according to the Batho Pele law that can be compared to "Forvaltningsloven". The Social Work Department works under legislations like for example The Human Rights, Childrens Act, Domestic Violence Act and Mental Healthcare Act. NSH is financed by the Government and The Social Work Department is a part of the hospital budget. Only 3 social workers have been budgeted and there are no money left for social projects, development etc. within the department. When projects are made, a part of the social work is to find sponsors and funds that can cover the expenses of the project.

Visions, missions and values

As mentioned above NSH falls under the Department of Health and the overall visions, missions and values are therefore set by them. The vision of the Social Work Department is to enhance the quality of health for the patients and in order to do so they try to revile the patients´ socioeconomic conditions to find out how it affects their health. Their mission is to provide equal access to quality health services for all patients. The overall values are set by the Provincial Government of the Western Cape and are as listed below:

- Caring
- Competence
- Accountability
- Integrity
- Responsiveness

Structure

The Social Work Department consists of 3 social workers and one of them is Head of Department. Together they cover all the wards of the hospital, but have responsibility for different wards since they have diverse qualifications and interests. There are also quite a few students from the University working as part of their study and there is also a receptionist.

Cooperation

The Social Work Department is in close cooperation with the other employees at the hospital and work in multidisciplinary teams with doctors, nurses, occupational therapists etc. Shipley Maternity Clinic is one of the units at the hospital that the Social Work Department works closely with. It is from this unit, the department receives referrals regarding women who want to terminate their pregnancy. The social worker prepares the women, in group sessions, for the procedure both practical and emotional. The close cooperation between nurses, doctors and social workers are essential so that all information given to the women are aliened.

The Social Work Department also cooperates with external social workers, offices and organizations. Since NSH both receive and refer patients they are in cooperation with other hospitals and regarding children they cooperate with Child Welfare. We also refer patients to shelters, crisis centers, safe houses and other placements. In cases where further investigation is required we refer the patients to Social Development. To give an example: If we think a child must be taken away from his/her current environment, it is up to us a write a thorough assessment and sent it to Social Development so they can do further investigation and take action.

NSH also cooperates with The South African Social Security Agency (SASSA) who provides social grants. SASSA disburses different grants to for example disabled people, children support, care dependency, old people etc. Our part in this is to provide the patients with an application form and send it to SASSA for payout.

Ethical dilemmas

Homelessness

Some of the ethical dilemmas we have experienced so far are concerning homeless people who are taking up beds in the hospital.

Homeless patients are taken in to counseling before being discharged to make sure that they have someone to care for them. We always call the family or friends to make sure that the patient can stay with them and to let them know that the patient will be discharged.

If the patient has nowhere to go, we try to look for placement in different shelters. Since it is winter they are all fully booked, it can be difficult and the dilemma is now what to do. On one side we

cannot discharge a patient to homelessness, but on the other side we need the bed for other sick patients. The homeless patient is no longer sick and therefore cannot have the bed.

Teenage pregnancies

Another area with lots of ethical dilemmas is teenage pregnancies. One of our first days we had counseling with a pregnant, 16 year old girl. She was confused and felt pressured from both her own family and her ex-boyfriends family. She did not know how she felt herself. During the counseling we found that she was afraid of getting an abortion, both because the Bible that says you should pressure life and the fact that she was afraid of her own health and she questioned if she would ever be able to have kids.

The ethical dilemma here was for us to stay neutral and supportive for whatever choice she made, despite the fact that we could see that her socioeconomic situation and the support she would need if having a child did not exist. Also that the chance of this child ending up in foster care was high and this would mean another damaged child bouncing back and forth in the system.

Target groups and social problems

The target group is very broad since the hospital is public and covers all sorts of medical problems. Doctors and nurses from all wards refer patients to The Social Work Department if they are concerned about the patient's social circumstances. Patients often referred to the department are:

- Pregnant women that need guidance in making the decision on whether to proceed with their pregnancy or terminate it.
- Pregnant women and mothers that consider adoption and foster care.
- Patients that have tried to commit suicide and patients that show suicidal behavior.
- Children suffering from malnutrition.
- Parents (mainly mothers) that needs education and guidance in her responsibilities as a parent.
- Patients with substance abuse.
- Psychiatric patients. These patients often also have problems with substance abuse and/or homelessness.
- Homeless patients that needs placement after they are discharged.

- Patients that need to apply for grants. Mainly disability grants.
- Patients that are having problems with their family relationships. This often links back to mental illness and/or substance abuse.
- Abused and assaulted patients. Mainly women abused by their husbands.

Since NSH is a public hospital there are a lot of poor people coming for treatment. Poverty and unemployment is almost always a factor when talking to patients and it has a huge impact the patients' health, wellbeing and on the decisions that they make in life. Patients also have a lot of worries and emotional problems due to the fact that they are struggling financially.

Theoretical approach, tools and methods used

With every patient referred to the social work comes a doctor's note on a pink slip, roughly explaining the social problem/problems that the patient has. Once the patient is in our hands we do counseling from a holistic approach. The holistic approach means that you need to take all aspect of the patient's life into consideration – Mentally, physically and spiritually. Based on the counseling we make an assessment on the patient's social circumstances. If necessary we refer the patient to other organizations, shelters etc. for more help and/or investigation.

Suicidal cases

In suicidal cases we do risk assessments. This means that we try to find out if it really was the patient's intention to kill him/herself or if it was an act of attention seeking behavior, or if they still are suicidal and will try to take their own life again once discharged. In the assessment we try to focus on factors that may higher the risks for suicide and the resources within the patient that lower the risks. The resources uncover the patients coping skills and could be a supportive family or friend. The patient's own sense of responsibility towards her own and others life for example responsibility for her children. In general we look for all positive aspects within patient's circumstances that can help prevent them from trying to commit suicide again. When looking for the factors that increase the risks of committing suicide we ask the patient weather they have a plan for how, when and where they will commit suicide. We also need to find out if the patient is a substance user, physically or mentally ill, has a history of abuse and/or recently have had a life crisis of any sort. Based on our assessment we will make recommendations to the doctors either to discharge the patient once clinically stable or keep the patient for further care. We always tell the patients that it is important to talk about their problems with someone before they get out of hand.

We offer them to come back to see us if they need someone to talk to. There are also cases where the patient has a history of suicidal attempts then we refer the case to a psychiatrist.

Group work

Another method used at the hospital is group work. There are groups for the mentally ill patients, substance abusers and for women referred from Shipley Maternity Clinic that wants to terminate their pregnancies. We are mainly working with the last mentioned target group. The purpose of the group work is for the women to talk to others in the same situation as themselves and share feelings, thoughts and experiences. There is also a lot of information that needs to be given to the women. During the session we need to prepare and tell them how the abortion procedure is working.

Minors

If we are counseling a minor regarding any issues, we always contact his or her parents before discharging the patient. This is to make sure that the parents live up to their role and responsibility as a parent. If necessary the parents/parent needs to come and see us at the office.

Disabled patients

At the hospital it is up to the doctors to assess whether a patient can or cannot go back to work once discharged. If the patient cannot work anymore we help them apply for disability grants. We consult the patient and help them fill out the form that needs to be sent to SASSA for pay out.

In general

Generally the intentions of helping people with their difficult social circumstances are good. The methods and theoretical practice are in place; however the lack of financial resources makes the relation between the social worker and the patient seem very hard and inflexible seen from a Danish perspective. The social worker needs to be selective in the choice of which cases he/she can invest time and money. Nevertheless; after getting to know more about the social work in South Africa and the extent of the poor living conditions and lack of resources I begin to get more insight and understanding for the decisions made.

Internship assignment part 2: The profession in practice

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CONTENT:

Introduction:

My assignment will be based on the social work intervention done when a patient is admitted to Somerset Hospital after attempting suicide. About 5-15 patients are referred weekly from the Trauma unit and the purpose of the referral is to determine if the patient is still suicidal. The main methods that are used when assessing and counseling the patient is suicide risk assessment done from a holistic perspective with an awareness of context. The code of ethics for social workers in South Africa (South African Council for social service professions, 2006) is also an important document to help make sure that the assessment is done in an ethical way. The code of ethics has some similar components as the Danish ethical code for social work professionals (Dansk socialrådgiverforening, 2011).

Local, National and Global perspective on suicide and suicide attempts:

Globally one suicide attempt is made every one to three second. Around the world about one million people die from suicide every year making suicide and suicide attempts a big health issue. (Schlebusch, 2012)

There are no records on how many people attempt suicide in South Africa. Some studies on suicide attempts in South Africa show that there are at least 137 860 – 160 000 suicide attempts made every year. (Web 5: Calitz, F J W, 2008) Furthermore other studies show that 9.5 % of non-natural deaths amongst young people are caused by suicide and for adults the ratio is 11 % (Schlebusch, 2012).

According to a study made during one year (2005-2006) at Pelonomi Hospital more women than men attempt suicide. The average age of all patients was 25. The patients had lots of different social stressors or risk factors leading to the suicide attempt. The most common factor was relationship problems followed by financial problems and psychiatric problems. The most common ways of attempting suicide was overdose with medication or self-poisoning with paraffin.

(Calitz, F.J.W et al, 2008)

The above findings at Pelonomi Hospital correspond with the patients that I see for suicide risk assessment at Somerset hospital. In the light of the findings it underlines the importance of context awareness and a holistic perspective when doing assessments. Even if there are general factors that are frequently seen with patients that have tried to commit suicide, it is important not to make assumptions about the patient's feelings, the patient's reasons behind

the suicide attempt and the outcome of the assessment beforehand.

Theoretical perspective on the suicide risk assessment:

To prevent myself from making assumptions about the patient and in order to create a holistic approach I have used the arena method. (Bo, K. A. & Guldager, J., et al, 2011) When I start a session I try to uncover what different arenas the patient is a part of and what different social stressors and resources there might be connected to a specific arena. It is especially vital to uncover what support mechanisms the patient has in place, because when working at a hospital the main focus is how the patient's social circumstances effects their health. Support and resources is therefore key elements.

When I move along in the assessment I have used different elements from the Chronological Assessment of Suicide Events - The CASE Approach (Shea, 2009)

The Chronological Assessment of Suicide Events - The CASE Approach is a technique used to make sure that patients stated intent[1] on committing suicide is accurate. It explores the patients reflected intent[2] and its withheld intent[3] making sure that all information necessary is compiled before the social worker makes his or her decision on further intervention. (Shea, 2009) In general it is important to be systematic during the assessment and it helps to follow a chronological path.

When starting to talk about the patient's suicide attempt it is important how the suicidal topic is introduced to the patient and it sometimes helps to normalize the topic (Shea 2009:3). Suicide is for some a taboo and very shameful. Sometimes patient's starts off saying that they do not want to talk about what happened and that they just want to forget what they did and move on. I normalize the situation by saying that a lot of other patients in the same situation feel the same way and that for others it has helped to talk about what happened. They then know that for me it is nothing shameful to talk about and that lots of other patients have spoken to me about their thoughts on suicide.

When having entered the topic it is important to uncover what actually happened. It helps me understand the real extent of the suicide attempt – How close was the patient actually on committing suicide. I try to explore with my questions and to get as detailed a picture as possible: How did you attempt suicide?

What triggered the attempt?

Where you under the

~~influence?~~

[1] The information that the patient present to the social worker about his/her intent.
[2] The amount of thinking, planning and action taken on the suicidal ideation.
[3] The suicidal intent that is unconsciously or purposefully held from the social worker.

What were your thoughts?

What emotional state was you in and what feelings were present?

What happened after you attempted? Who took you to the hospital, who found you? Did you call someone before attempting?

How do you feel about being alive today?

After talking about the recent suicide attempt I ask about previous attempts. If there's other suicide attempts ask some of the above questions again to find out how serious the attempt/s was.

Among other questioning techniques, the questions asked, are often behavioral incident-questions (Shea 2009:4) where I ask for specific facts. When it is suitable I sometimes also make gentle assumptions (Shea 2009:5). It is helpful when I sense that the patient is holding something back. That could be a question like: What other ways have you tried to commit suicide? Or what other things did you do before attempting?

Non-verbal communication is also a big factor to take into account. I have had some patient that has had so much anger and frustration in them that they were shaking at the same time they kept saying that they were fine and just need some rest.

In the end of the session I will try to find out the real suicide intent based on the knowledge gained on the patients corresponding to questions about the future. The patient and I will also discuss how the he/she is planning on handling a situation where he/she thinks about committing suicide again. (Shea, 2009)

In South Africa there are many different cultures and traditions and for me it has been important to have some cultural sensitivity (Antczak & Johansen 2010). However I feel that it has not been something that has played a major role when doing suicide risk assessment - As long as I have looked on every patient as a unique individual with different perspective on life and death.

Ethics and ethical dilemmas:

The main ethical dilemma for me is that based on the outcome of the suicide risk assessment it is our job as social workers at the hospital to determine whether the patient is suicidal or not at present. Of course there are a lot of theories, methods and studies to help you make that decision, but they are all based on the general picture and not on that exact person sitting in front of you. No matter what decision you make, you can never be sure that what you

decide is 100 % correct.

If I come to the wrong conclusion it will without any doubt have negative consequences for the patient. It is unfair and it can have negative effects to put non suicidal patients through in debt psychological evaluations. Patients that actually are suicidal are wrongly sent home without the necessary treatment and intervention. Worst case they attempt suicide again or succeed committing suicide.

The therapeutic relationship is of great importance and actually the treatment already starts during the assessment. The outcome all depends on the skills of the social worker, how she communicates and builds a relationship with the patient. (Granello, 2010:367) After all it is the inner thoughts of the patient the social worker tries to reach. At a hospital there is little time to prepare and execute the assessments and sometimes it feels very unethical to make decisions based on the not very in debt assessment made.

Another ethical dilemma was that I felt that I could do so little. At a hospital you only see patients once and if necessary you refer them for further intervention at the psychologist or psychiatric team. Often the patients have numerous social stressors that contribute to the decision of attempting suicide such as unemployment, family problems, relationship problems, substance abuse etc. Things that is very hard to work on together with the patient in only one visit. Once the patient is referred you can only hope that he or she finds the strength to go for the appointments made.

All values in the code of ethics are essential in any assessment. However when dealing with patients that have attempted suicide it's important to inform the patient that everything that he or she discloses during the assessment is confidential and that you treat the patient with respect and dignity. (South African Council for social service professions, 2006:6) Some patients feel shameful after attempting suicide and because of that they have a hard time to open up and talk about the reasons behind their attempt. In some cultures it is shameful to attempt suicide and they are afraid that they now will be judged as a bad person by family, friends or even the social worker.

Reflection on gained knowledge, Personal Challenges and future learning objectives:

I think what I have learned from doing suicide risk assessments is the importance of asking the right questions and being able to connect with the patient sitting in front of you. People skills are undeniably the best tool that you as a social worker have, and it constantly needs to be an aim for reflection. The verbal and non-verbal communication between the patient

and the social worker is not to be underestimated since that is where the professional relationship is built.

The most challenging for me was to trust that I was making the right decision on whether the patient was suicidal or not at present. However I have learned to be more confident in the professional decisions that I make. When I'm in doubt I need to turn to the knowledge I have gained from the literature and methods on the Para-suicidal area. Additionally I have also learned the importance to turn to my colleagues for help and bring the professional arguments based in literature into the discussion/supervision on my cases to make my decisions more well-founded.

I feel that my communication skill has developed. I'm more confident in what I say and how I say it, not only to clients but also when I'm communicating with colleagues and other professions in the multidisciplinary team. For the future I will practice on how be more systematic in my conversation. It's difficult not to be carried away and when a patient has something on their mind they tend to just let it all out at once. I think I will try to use the Arena method to work my way around the issues the patient presents to me. On a smaller scale I will reflect more about my communication, how I choose my words, how I respond and my non-verbal communication when making conversations on a daily basis.

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