A case study of a client with schizophrenia in a community care unit in Melbourne, Australia

Dr. Tan Kan Ku[1], Mercy Henry[2], Dr. Marylin Shinde[3]

[1]Ph.D. (Public Health), Sessional Academic, Deakin University, Melbourne, Australia
[2]Ph.D. Scholar, Lecturer, Victoria University, Melbourne, Australia
[3]Ph.D. (Nursing), Associate Professor, MGM Mother Teresa College of Nursing, Aurangabad, Maharashtra, India

Corresponding Author: Dr. Marylin Shinde

Abstract

Victoria's Mental Health Services provides a variety of treatment options for clients with special needs. The individual rehabilitation program is specifically related to residential services which provide community-oriented mental health initiatives. Since 1995, several Community Care Units (CCUs) were built in various regional areas in residential settings to replace the long-term rehabilitation wards of a psychiatric hospital. This case study aims to provide a model sample for international mental health workers to present at a Case Conference. This paper presents a case study of a 30-year-old single woman of Italian background. A pseudonym, Maria, is used to ensure anonymity. Maria was referred to the CCU by the Community Treatment Team. The case study was formulated for the purpose of arranging a Case Conference by Maria's Case Manager with the Multi-disciplinary Team Members (MDT). Maria was discharged after three months to return home to live with her family. The rehabilitation program for Maria aimed to promote early recovery by reducing the stigma attached to mental illness which has been an international concern and a long-standing challenge for research on rehabilitation to understand its basis, mechanisms, and consequences in order to formulate means by which stigma and its impact may be ameliorated.

Keywords: Community care, rehabilitation, stigma, mental illness

Introduction

The framework of a CCU is based on the concept of deinstitutionalization which forms part of the mainstreaming of mental health services within the wider health reform (Health & Community Services 1994) [1]. Mainstreaming means integrating mental health with general health care, based on the framework of the discussion paper Victoria's Health Reforms: Psychiatric Services (Health & Community

Services 1995) [2]. In terms of the impact on symptoms and consumers' quality of life, a CCU provides clinical treatment and care by the public mental health sector to individuals with chronic mental illness who are not acutely psychotic, but persistent symptoms prevent them from living independently in the community. A CCU prepares clients ready to live by themselves in rented accommodation or supported residential settings.

A CCU provides a supported residential service to treat and rehabilitate consumers/clients recovering from significant mental illness. A rehabilitation program not only focuses on symptom alleviation but also addresses each client's multiple residential, social, vocational and educational needs as they work their way through the recovery phase with the case manager (Farkas *et al*., 1998; Young & Ensing 1999) [3, 4].

Recovery is described as a deeply personal, unique process of changing one's attitudes, values, feelings, and goal, skills, and/or roles. It is a way of living a satisfying, hopeful, and contributing life e with the limitations caused by illness. Recovery involves the development of new meaning and purpose in one's life (Anthony, 1993) [5].

Objective: The intended outcome of this case study is to provide a sample template in case management for undergraduate mental health workers in nursing, social work and public health. A specialist health care worker/clinical educator can utilize this case study format as a framework to integrate theory and practice-based skills development in the process of becoming a competent mental health worker/educator/therapist in the therapeutic process (Ku, 2007; Ku & Minas, 2010; Ku & Ha, 2020; [6, 7, 8]. Data (background demographics and ethnicity of Maria) had been changed for privacy purposes.

Maria's admission profile for psychiatric care

Maria, aged 35, a single woman, was first diagnosed with schizophrenia when aged 15 and since then, she had about 20 admissions to psychiatric hospitals in Metropolitan Melbourne covering the period of 20 years. Her length of stay in hospitals ranged from one day, one week, one month to one year. Maria was initially admitted to the Extended Care Unit (ECU) at the Psychiatric Department of a local Melbourne General Hospital due to non-compliance with medication when living at home, which resulted in the deterioration of her mental state. She was transferred to the Rehabilitation Program at the CCU as a voluntary client for monitoring of medication compliance and assessment of living skills. The treatment team felt that Miss X needed a short to medium stay (2 to 3 months) in the CCU to improve some of her living skills. Indeed, two months afterwards, she was discharged from the CCU and returned home to live with her mother and two sisters in a small suburb. She was followed up by the Mobile Support Team (MST) attached to a local Community Clinic. The MST visited her four times weekly for monitoring of medication and daily living skills. She had never lived independently.

Family History-Data Were Changed for Privacy Purposes

Maria, an Italian, immigrated from Yugoslavia with her family in the 70s when she was six. Her father died in the 80s. She lived with her family in the outer suburban area. She was the fifth of 10 children. Bilingual, Maria spoke Italian at home. Her family seemed to have accepted her illness and had supported her throughout the years. There was a family history of schizophrenia. Her mother attended mass every Sunday to seek God's grace, aiming that one day a miracle could happen and that all the 'mental people' (exact word spoken by her mother) in the family could be cured. Mental health workers who knew Maria well felt that her family situation, especially her mother, contributed to her relapse. Yet Maria spent more time at home than in the hospital.

Personal History

Maria was of medium height, slim build with dark shoulder length curly black hair. She dressed casually in blue jeans, boots jumper and jacket. Her favorite color was purple. Some days she would change her clothes three or four times to have something purple on and throw the discarded ones on the floor in her bedroom. She carried her personal possessions in a navy handbag, slung over her head and shoulders. Maria practiced Catholicism intermittently. She wore a crucifix for protection. She left school at an early age after being diagnosed with mental illness. She had never held down a job.

Mental/Physical Status Examination

On admission to the CCU, a mental state examination showed Maria to be animated with pressured speech. Her affect was blunted. She was orientated to place, time and person. Her memory was good. She denied auditory hallucinations but had somatic hallucinations regarding 'being pregnant'. Her thoughts were disorganized at times and contents delusional, e.g., pregnant, raped by a neighbor, co-residents and staff at the CCU. She had numerous somatic complaints including abdominal pain and stated that the baby was moving around inside her. She was noted to have nocturnal incontinence. Physical examination and urinalysis revealed nothing abnormal detected (NAD).

Mood/Affect

Maria's mood was labile. You could be greeted with silence and a scowl, a big smile and a profuse welcome, or a very worried look and mutterings that you could not decipher. She could also become tearful and distressed at times and preferred to be left alone when being approached by staff. She was a late riser and when she was being called for the third time to go for medication, she would shout at you to "bugger off and leave me alone" and who could blame her. She had a low concentration span.

Analysis of Maria's Mental Health Problems and Impact

Maria's past history revealed that over time, her simple schizophrenia had developed into paranoid schizophrenia with fixed delusions including people talking about her,

expecting a baby, being raped, and those co-residents and "others" were injecting her with Heroin. These symptom-pathologies continued while she was at the CCU. She expressed these concerns on a one-to-one basis with staff. She did not, however, show fear when interacting with male staff members or with co-residents. She had a history of being disorganized, intrusive, irritable, and unpredictable with impulsive behavior. She had partial insight into her illness. Maria, a very generous person, was gentle with children. She had a good sense of humor once she knew you well, and when she was in a good mood. She cooked well. Her behavior has improved since her transfer to the CCU. There had only been one verbal outburst. The onset of Maria's illness dates back when she was 12, when she witnessed her five-year-old brother being run over by a truck. This had a devastating effect on her. This crisis came at an important developmental stage when she was seeking independence. Two years later, she had her first admission to a psychiatric hospital. Since 1987, Maria could hardly hold down a job due to her mental condition. Thus, she had been receiving a Disability Pension. She needed to improve her living skills before pursuing other goals.

Maria's poor social skills impacted her life deeply. She was unable to maintain relationships with friends, due to her delusional ideations about people, her inability to sit still, and her speedy "talk" and "walk", which most people found hard to tolerate. All mental health workers encouraged Maria to talk about her problems. Once a therapeutic relationship was established, Maria felt free to talk about her various concerns of being "raped", and laughed at by men. Her "phantom" pregnancy must have taken a toll on both her mind and body. She frequently complained of abdominal pain and stated that the baby was moving around inside her. These "pregnancies" might be related to two previous terminations of pregnancy (TOP). She did not appear to have counselling at the time. She frequently talked about these experiences and liked to think that she miscarried twins as her sister had twin girls. Realistically she had said "I don't think I would have been able to look after them", but one caught a sense of grief also. Maria's numerous delusional beliefs, poor social skills and low concentration span could result in distress and limit her social functioning and role performance. These problems were not life-threatening risks. However, medication compliance was paramount in the prevention of relapse of her mental illness. Hence, a Case Conference was initiated by her Case Manager.

Short Term Goals

Identify what needs to change for Maria before she can move out of the CCU. Present Maria with a choice of plans, and encourage her to help to formulate, that is, to begin with improving basic skills in cleaning, shopping and tidying with staff's supervision, then proceed with doing these independently, without shouting to passers- by. To assess her ability to go on weekend leave on public transport. If incontinence is not due to Clozapine [1], then what investigations should be done? In the meantime, encourage her to use the toilet before bedtime and review situations with staff daily. If Maria agreed, counselling would be arranged for her to see a grief counsellor re-history of Termination of Pregnancy (TOP) and "rape".

Long Term Goals

Maria is to be followed up by MST after being discharged from CCU to prevent relapse. Maria and her family to recognize the signs and symptoms of relapse and the need for medication compliance. This was an area that had been neglected in the past. They were encouraged to attend Psycho-education sessions at the local Community Clinic. What would be the best living environment for Maria? Should she be with her family to maintain kinships or break away eventually, as realistically her family might not be able to support her permanently? What consultative elements are to be incorporated for the family during the rehabilitative process?

Evaluation of the Assessment Process

The rehabilitation program in the CCU utilized a broad spectrum of approaches in relation to assessment, which accounted for Maria's symptoms impairments, psychosocial functions and environmental supports. The assessment was a continuous process using the Life Skills Profile (LSP) and the Health of the Nation Scales (HoNoS) which were clinician rating measures.

The LSP is a 39-item scale measuring psychosocial function designed specifically for people with schizophrenia. The LSP comprises five subscales (self-care, non-turbulence, social contact, communication and responsibility) with individual items rated on a 1-4-point scale. The time frame for rating is generally the previous three months and completing the scale takes approximately 20 minutes. The LSP is fairly brief easy to use and demonstrated a broad range of content specifically relevant to community 'survival', which was a suitable assessment scale for Maria. Research completed by Andrews *et al*., (1994) [9] showed that the LSP had good psychometric properties with good inter-rater reliability and adequate criterion validity.

The HoNoS-version 4 was developed by the Royal College of Psychiatrists in London (Wing *et al*., 1998) [10]. It comprises a set of 12 clinician-rated items covering four key areas of functioning (behavior, impairment, symptoms and social functioning), each rated on a 0-4 point scale. An experienced clinician rates the resident's last two weeks on the basis of all available information, and completing the scale takes about 10 minutes. Research completed by Wing *et al*., (1998) [10] commented that the HoNoS is a structured instrument, brief and easy for routine use by mental health workers covering common problems and social functioning. A recurring theme emerged in the recovery literature commented that the clients needed to have the capacity to be aware is conceptualized as a series of stages that are characterized by moments of clarity and insight into one's psychopathology' (Young & Ensing 1999, p. 220) [4]

[1]Incontinence is a common side effect of this atypical anti-psychotic medication, which will slowly be resolved. Monthly hematological monitoring is need for clients on Clozapine.

The psychiatric interviewing and case management review indicated that by listening actively to Maria and being non-judgmental about her delusional beliefs, she could gain a sense of efficacy. When a therapeutic relationship was established between the client and the Case Manager, who contemplated being a therapist utilizing three

attributional attitudes (genuineness, unconditional positive regard and empathy), Maria looked forward to participating in the CCU program (Ku & Ha, 2020) [8].

Community Rehabilitation Program and Recovery

Maria's program initially focused on achieving living skills independently, and engaging her on a one-to-one psycho-education session with the Case Manager to develop a sense of empowerment in recognizing her symptoms, understanding medication adherence need, and self-management of her illness Maria said she could improve her living skills; was happy to learn stress management when faced with tension provoking situations. The Case Manager advised her to engage in small group discussions because the other residents might help her to self-manage her illness through their own experience. The recovery literature reported that many clients have strong desire to self-manage their disability (Young & Ensing 1999) [4]. The Case Manager ensured Maria that she would refer her to non-government agencies (Boomerang Club, Job Co and Cross Road) for community social support, so that she would not need to rely on her family all the time. Maria agreed that this was a good idea.

While recognizing Maria's delusions were her perceptions of the environment, the Case Manager would never try to convince her that her beliefs were false. The interaction was on a one-to-one basis of real things, that is, by doing shopping lists and working out her roster of daily tasks at the CCU. As Maria did not like attending group sessions, she was encouraged to attend the small women's group which consisted of four residents who went on shopping and sightseeing with staff. By engaging Maria in the same gender group lessened her delusional belief of being raped; and felt safe. She seldom showed signs of anxiety since joining the women's group. Lessening of anxiety could partly be the effect of medication.

While aiming to help Maria to recognize her delusions, the Case Manager was never judgmental about her beliefs or showed any acceptance of her delusions as realities. For instance, Maria stated that after one weekend's leave at home, someone had injected her with Heroin; the Case Manager showed her that no injection marks were found and that her urine drug screen was negative. She responded with an "okay" and walked away.

The Case Manager discussed with Maria the implementation of a wellness plan which included the needs to increase coping mechanism with symptom triggers (Moller & Murphy 1997) [9] and to improve social and living skills, Maria agreed and said that she would like to go home eventually. The CM emphasized that rehabilitation could take time and the community program aimed to provide a comprehensive service that addressed residential, social and vocational needs and ultimately emerging towards a recovery vision.

Conclusion

The case study provides a comprehensive assessment of a client and continuous supervision during the two months at the CCU. The case study critically discussed the use of two standardized rating scales in the review process towards the wellness of the

client. It is hopeful that data identifying subjective improvement observed improvement and subjective expression of concerns in relation to how the client's adaptation to the rehabilitation program would eventuate towards the recovery vision of her living semi-independently with optimal support from the Community Mental Health Team. It is hoped that Maria will eventually be able to live in the least restrictive environment. It is anticipated that the case study will provide international mental health workers with a positive perspective to specialize in mental health settings.

Conflict of Interest Statement

The authors approve the final version of the manuscript and declare no competing interest.

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