VIEWS OF SOCIAL WORKERS ON THEIR ROLE IN MENTAL HEALTH OUTPATIENT AND COMMUNITY-BASED SERVICES

BY

ABIGAIL ORNELLAS

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SUPERVISOR: PROF LK ENGELBRECHT

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DECLARATION

I declare that the entirety of the work contained in this document is my own original work, that I am the owner of the copyright thereof (unless to the extent explicitly stated otherwise) and I have not previously in its entirety or in part submitted it for obtaining any qualification.

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SUMMARY

Mental health is a fundamental aspect of social functioning which affects a significant portion of the population. The movement toward deinstitutionalization became the core focus of mental health policies such as the White Paper (1997) and the Mental Health Care Act (17 of 2002) post-apartheid. However, this process was implemented at a rapid rate, with poor corresponding development of necessary outpatient and community-based facilities and services. Social, cultural, and economic conditions have significant and measurable effects on both individual health status and the delivery of health care. As a result, there is a growing recognition of the need for social work services within the mental health outpatient and community-based care context. Research regarding the role of the social worker within mental health care, particularly within a South African context is poor and therefore a research gap with regard to examining the views of social workers on their role in mental health outpatient and community-based services exists. The overall objective of the study was to, in light of the above, examine the views of social workers on their role in mental health outpatient and community-based care.

A combination of both qualitative and quantitative research approaches was employed for the study, with a stronger emphasis on the use of qualitative data. A combination of exploratory and descriptive research designs was utilized as the framework for the implementation of the research approach. This was appropriate for the utilization of both quantitative and qualitative design elements.

A purposive sample of twenty social workers was compiled, and data was collected through the means of semi-structured interviews; a pilot study was implemented to test the measurement instrument with two social work participants.

Two literature chapters are presented, focusing on the topic of mental health and its related policy, as well as expanding on mental health care and service rendering according to an ecological perspective. These chapters served to achieve established objectives of the study.

Chapter four is a presentation of the empirical study. Data which was collected was both relayed and analyzed, in accordance also with the literature study. Data was analyzed, through both quantitative and qualitative analysis and was presented according to identified themes, sub-

themes and categories. Relevant tables, figures and participant narratives were used to further substantiate the analysis of data.

Chapter five gives an overview of relevant conclusions and recommendations, in terms specifically of the role of the social worker in mental health outpatient and community-based care, in light of the empirical study and data analysis. Five specific roles were identified as being significant for the social worker in mental health care, with regard to their role in therapeutic intervention, working with clients and families in a one-on-one, counseling capacity; supportive services, through linking of clients to necessary resources; advocacy, through fighting for, and protecting the rights of clients and related vulnerable groups within mental health; relational role, recognizing the importance of social and interpersonal aspects on the functioning of mentally ill clients; and finally their role as a holistic worker within a multidisciplinary team, incorporating key aspects of the ecological perspective into assessments and interventions.

OPSOMMING

Geestesgesondheid is ŉ fundamentele aspek van maatskaplikefunksionering wat ŉ beduidende gedeelte van die bevolking affekteer. Die beweging na deïnstitusionalisering het die kern fokus van verwysings na geestesgesondheidsbeleide soos vervat in die Witskrif (1997) en die Wet op Geestesgesondheidsorg (17 van 2002) geword. Hierdie proses is teen ŉ vinnige tempo geïmplementeer, wat die ooreenstemmende ontwikkeling tussen dienste aan buitepasiënte en gemeenskapsgebaseerde fasiliteite en dienste benadeel het. Maatskaplike, kulturele en ekonomiese toestande het ŉ groot en meetbare uitwerking op beide individue se gesondheidstatus en die lewering van gesondheidsorg. As gevolg hiervan, is daar ŉ groeiende erkenning van die behoefte aan maatskaplike dienste in die geestesgesondheidsorg van buitepasiënte en binne ŉ gemeenskapsgebaseerde konteks. Navorsing oor die rol van die maatskaplike werker in die geestesgesondheidsorg, veral binne ŉ Suid-Afrikaanse konteks is onvoldoende. ŉ Gaping bestaan veral in navorsing oormaatskaplike werkers se rol in geestesgesondheidsorg met betrekking tot buitepasiënte en die gemeenskapsgebaseerde dienste. Die oorkoepelende doel van die studie was om, in die lig van die bogenoemde, ondersoek te doen oor die sienings van maatskaplike werkers met betrekking tot hul rol in geestesgesondheidsorg van buitepasiënte en gemeenskapsgebaseerde dienste.

ŉ Kombinasie van beide kwalitatiewe en kwantitatiewe navorsingsbenaderings is gebruik vir die studie, met ŉ sterker klem op kwalitatiewe navorsing. ŉ Kombinasie van verkennende en beskrywende navorsingsontwerpe is gebruik as ŉ raamwerk vir die implementering van die navorsing benadering.

'n Doelgerigte steekproef, bestaande uit twintig maatskaplike werkers is saamgestel, en data is ingesamel deur middel van semi-gestruktureerde onderhoude met behulp van ŉ onderhoudskedule. Loodsonderhoude met twee deelnemende maatskaplike werkers is gevoer ten einde die onderhoudskedule te toets.

Twee literatuurhoofstukke word aangebied, wat fokus op die onderwerp van geestesgesondheid en verwante beleide, sowel as geestesgesondheidsorg en -dienslewering volgens ŉ ekologiese perspektief. Hierdie hoofstukke dien as fondasie om die doelwitte van die studie te bereik.

Hoofstuk vier dien as ŉ verslag oor die empiriese studie. Die data wat ingesamel is, is op grond van die literatuurstudie ontleed. Data is geanaliseer deur middel van beide kwantitatiewe en kwalitatiewe analise en is aangebied volgens geïdentifiseerde temas, sub-temas en kategorieë. Toepaslike tabelle, figure en narratiewe is gebruik om die analisering van data te substansieer.

Hoofstuk vyf bied relevante gevolgtrekkings en aanbevelings aan in terme van spesifiek die rol van die maatskaplike werker in geestesgesondheidsorg met betrekking tot buitepasiënte en gemeenskapsgebaseerde dienste. Vyf spesifieke rolle is geïdentifiseer as belangrik vir die maatskaplike werker in geestesgesondheidsorg: maatskaplike werkers se rol in die terapeutiese intervensie met betrekking totberading van individue en gesinne; ŉ ondersteunende rol wat kliënte met die nodige hulpbronne in verbinding bring; ŉ voorspraakrol, deur te beding vir die beskerming van die regte van kliënte en verwante kwesbare groepe in geestesgesondheidsorg; ŉ verhoudingsrol in die erkenning van die belangrikheid van sosiale en interpersoonlike aspekte in die funksionering van geestesgesondheidskliënte; en die rol as ŉ holistiese werker binne ŉ multidissiplinêre span, waarin belangrike aspekte van die ekologiese perspektief in assessering en intervensie geïnkorporeer word.

Dedicated to the year "I overcame"

2010-2011

"Love, like life, is much stranger and far more complicated than one is brought up to believe."

– Kay Redfield Jamison, *An Unquiet Mind: A Memoir of Moods and Madness*

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CHAPTER ONE

INTRODUCTION

1.1 MOTIVATION FOR THE STUDY

The World Health Organization estimates that up to 450 million people are affected by mental, neurological and behavioral disorders worldwide (Patel, Woodward, Feigin, Heggenhougen & Quah, 2010). Recent surveys have shown that between 25-50% of adults will develop one mental disorder in their lifetime (Patel et al., 2010). Mental illness alone accounts for up to 20% of disability adjusted life years lost. Within the South African context, mental illness is ranked third in the contribution to the burden of disease, outweighed only by HIV/AIDS and other infectious diseases (Bradshaw, Norman & Schneider, 2007).

Mental health care has been established as a priority programme within South African national health policy and there is a growing recognition of mental health being a significant public health issue (Lund & Petersen, 2011). This is clearly demonstrated in relevant policy documents such as the White Paper on health service transformation (1997) and the Mental Health Care Act (17 of 2002) (Lund & Petersen, 2011). Under the previous apartheid government, the mental health care system in South Africa was strongly focused on institutionalized care. However, a policy shift to universal primary health care in post-apartheid South Africa resulted in a process of deinstitutionalization, whereby relevant policy documents, as mentioned above, established the grounds for the decentralization of mental health services (Petersen, Bhana, Campbell-Hall, Mjadu, Lund, Kleintjies, Hosegood & Fisher, 2009). This was largely influenced by international movements in terms of issues of human rights and dignity through the leadership of groups such as the World Health Organization (2001; 2005).

Despite some significant developments in South African mental health policy, studies have found that the process of decentralization and deinstitutionalization have had a negative impact on service rendering and service availability for the mentally ill individual (Lund, Kleintjies, Campbell-Hall, Mjadu, Petersen, Bhana, Kakuma, Mlanjeni, Bird, Drew, Faydi, Funk, Green, Omar & Flisher, 2008; Petersen et al., 2009). According to Petersen et al. (2009), the end product

of deinstitutionalization was more of a cost-saving exercise without the simultaneous development of sufficient and appropriate outpatient and community support structures and systems. This process was implemented at a rapid rate, with poor understanding and management of the implications of such a transition (Lund, C., Flisher, A.J., Lee, T. & Porteus, K.A. 2002; Lund et al., 2008). Therefore, in this regard, the adoption of the policy of deinstitutionalization has resulted in a fragmentation of specialized mental health services and poor quality of care available to the mentally ill patient as a whole. Studies concluded that a wide number of adverse effects of the implementation of deinstitutionalization and poor service availability could be found, including that of an increase in psychiatric patient suicide rates, an increase in the number of criminal offenders within the mentally ill group, the increasing rate of bed occupancy within psychiatric units and wards, the increase in emergency admissions, as well as a high increase in relapse and readmissions within a year period (Salize, Schanda & Dressing, 2008). Recent studies suggest that deinstitutionalization may also be responsible for an increase in forensic mental health and prison admissions (Salize et al., 2008).

In reflecting upon mental health services, a significant gap between mental health needs and the availability of quality services toward appropriately addressing those needs can be seen at both a local and international level (Faydi, Flisher, Funk, Kim, Kleintjies & Mwanza, 2011). It is estimated that in low- and middle-income countries, between 76-99% of individuals with serious mental disorders do not have access to the necessary treatment (Faydi et al., 2011). Within the South African context, a definite treatment gap with regard to mental health services at a district level has been identified, and studies from various researchers have concluded a particular problem with mental health service accessibility (Garland, Haine-Schlagel, Brookman-Frazee, Baker-Ericzen, Trask & Fawley-King, 2013; Petersen et al., 2009; Petersen, Ssebunnya, Bhana & Baillie, 2011). Studies found that 16.5% of South African's presented with common mental disorders within a period of 12 months; within that group it was estimated that only 1 in 4 individuals received treatment (Lund & Petersen, 2011; Petersen et al., 2009).

Against this backdrop expounded above, it is important to have an understanding of the current context of services availability and rendering within mental health care in South Africa. In the implementation of deinstitutionalization, the South African Mental Health Care Act (17 of 2002) established legislation for a 72 hour emergency referral and observation period for the mentally

ill patient within a district general hospital setting; this was seen to be the initial phase of mental health service delivery before the patient would be referred to a mental health hospital at an in-patient level, if such space was available, or relevant community-based care at an outpatient level (Lund & Petersen, 2011; Mental Health Care Act, 17 of 2002). However, due to the closing down of mental health institutions as part of the deinstitutionalization process, and the poor development of community-based initiatives and NGOs focused on service rendering for the mentally ill, the availability of adequate services and care dropped significantly (Lund et al., 2008; Lund & Petersen, 2011). As a result, general district hospitals, of which only some are actually allocated for 72 hour observational care, and all of which do not have the capacity for long-term treatment of such individuals, are being overwhelmed with a high influx of patients in need of overall treatment and care. Therefore, patients are often being treated within a general health care setting by practitioners who are not specialized in mental health care, and where there is very little quality service and support available (Lund et al., 2008; Lund & Petersen, 2011; Petersen et al., 2009). This has resulted in what Lund & Petersen (2011) refer to as the "revolving-door phenomenon" where patients continue to relapse on their treatment. Studies have shown that post-deinstitutionalization, statistics of relapse and re-admission at the general hospital setting have increased significantly (Salize et al., 2008). This phenomenon has placed a large amount of pressure on outpatient and community-based care facilities for the mentally ill, of which there is also very little specialized or appropriate services available (Lund et al., 2008; Lund & Petersen, 2011). Outpatient and community-based care facilities, through NGO's, community support structures, and local clinics are now faced with the challenge of meeting the high demand for the care and stabilization of the mentally ill, in place of the previous institutionalized system.

The effects of deinstitutionalization have also reached that of the social work profession and the role of the social worker within mental health care. The number of clinical social workers specialized in mental health care has diminished due to the closing down of institutions and a shift to community-focused care (Lund et al., 2008; Lund, Fisher, Lee &Porteus, 2002). This has resulted in a poor understanding regarding the role of social workers within mental health care, particularly generalist social workers today working within the context of health care despite insufficient knowledge or training.

The traditional role of social workers in health care included working with patients and families to facilitate effective communication between patients, families, and health care teams (Gehlert & Browne, 2012) in ways that will mitigate barriers caused by low health literacy. This is still a significant activity which needs to be undertaken by the social worker, however, their role has expanded to include many activities such as case management, within both in- and outpatient care, supported employment, residential care, psychosocial support, family therapy and support, and assistance in basic reintegration into society and the needs associated with this (Barlow & Durand, 2012; Johnson & Yanca, 2007). According to Gehlert & Browne (2012), based on a comprehensive psychosocial assessment, social work interventions also need to include helping patients and families to obtain and understand health information and to apply that information to better their health after discharge; this is a service which is not rendered by any other mental health professional in both the in- and outpatient, and community-based, setting. With regard to case management specifically, the social worker can be found to have an important role to play in rendering services of assessment, planning, coordination of services, and crisis intervention. According to Johnson & Yanca (2007:431), services such as these are vital to advancing the quality of life of mentally ill individuals and ensuring that their basic needs are being met. Case managers are also required to monitor a patients needs with regard to medication and symptomatic display, linking patients to the relevant services and treatment where necessary (Johnson & Yanca, 2007). With the increased focus being on outpatient and community-based services, and a poor availability of specialized social workers, general social workers are now being faced with the task of reaching out to this vulnerable group. The high influx of mentally ill individuals into local communities, a lot of whom are unstable and untreated, is also having an effect on general social work practice, impacting areas of crime, family structure and functioning, child abuse, domestic violence, family violence and unemployment.

There is increasing evidence which suggests that mental illness is strongly correlated with poverty and social deprivation, particularly within low- and middle-income countries (Skeen, Kleintjes, Lund, Petersen, Bhana & Flisher, 2010). Studies by Skeen et al. (2010) suggest that social factors such as stigma and discrimination attached to mental illness tend to have negative effects on the functioning and recovery of the mentally ill individual, leading to a decrease in desire to make adequate use of the services available to them and to adhere to the established treatment regimes. Factors of poverty, poor home circumstances and experiences of crisis and

emotional trauma, can also be viewed as being both stimulants for the onset of a mental illness, as well as barriers to recovery (Barlow & Durand, 2012; Skeen et al., 2010). For this reason, support, in terms of psychosocial rehabilitation, working with the family, and assisting in adequate reintegration of the patient into society, over and above clinical services, is incredibly important and should be taken into account when reflecting on the need for social work services within mental health care (Barlow & Durand, 2012;Brown, Smith, Ewalt & Walker, 1996; Johnson & Yanca, 2007). Social, cultural, and economic conditions have significant and measurable effects on both individual health status and the delivery of health care. According to Brown et al. (1996), one result of this growing awareness of the social context of health has been increased demands for social work services within the health care setting.

However, despite the extensive knowledge and skills that social workers can bring, there is an existing gap with regard to the availability of social work services within the mental health context. The process of deinstitutionalization has made very little room for the practice of clinical social workers within mental health; recent research found that within a population of 100 000 mentally ill patients, data recorded a capacity of only 0.40 social workers (Lund et al. 2008). Therefore, general social workers within outpatient and community-based contexts are required to be able to work with mentally ill individuals and their families, in order to ensure that their needs are being adequately met. Poor research and furthered education also reflects missed opportunities for social workers to contribute their expertise to the evolving field of health literacy and to strategically align their work with organizational and national priorities (Liechty, 2011). Within the context if deinstitutionalization and policy change, it may be time for the social worker to relook at their role within mental health services and care, particularly at an outpatient and community-based level.

In attempting to understand the views of social workers on their role in mental health outpatient and community-based services, it was considered beneficial to the study to develop this understanding according to an ecological perspective. The definition provided for by Germain & Gitterman (1980:1), as primary authors in social work in the ecological perspective, states that the ecological paradigm is made up of the perception that human needs and problems are generated by the transactions between people and their environments. The ecological perspective

is of great value within the health care setting specifically; in fact, this is where it was initially implemented.

Germain (1979) conceptualized the ecological perspective on social work practice in health care, reflecting this perspective conceptualized the social work 'case' as the patient and relevant features of his/her life space; this, according to Germain, included the health organization itself. Thus, this perspective requires a simultaneous focus on the coping tasks of patients and families, as well as the coping supports that must be provided by the health organization. More recently, it has been suggested that ecological models in health care lead to the explicit consideration of multiple levels of influence, which results in the development of more comprehensive interventions (Glanz, Rimer & Viswanath, 2008). Therefore, toward assessing the role of social workers in mental health outpatient and community-based service rendering, the ecological perspective will serve as the lens through which the importance of, availability of and need for social work services is assessed.

Finally, according to Lund et al (2008), information systems within mental health settings are generally weak and that there is no established routine service delivery system for the assessment of mental health care within the South African context. This was supported by Petersen et al. (2011), who concluded that mechanisms for the monitoring of service delivery within the mental health context were weak, thus indicating a need for the assessment of mental health services. This is even more significant with regard to social work specific services and their role in mental health, as research regarding this is poor within South Africa (Brown, 1996; Liechty, 2011; Lund, Kleintjies, Kakuma & Flisher, 2010). This can therefore be considered to be a research gap which was addressed through this study.

Due to limited research and literature available in the local context, the work of C. Lund and colleagues has been utilized as the primary source for the local mental health South African context. Specific focus has been given to his work with Petersen on the overview of mental health service delivery in South Africa (2011); his paper on norms for mental health services in South Africa with Flisher (2006); looking at roles for intersectoral approaches in South Africa with researchers Skeen et al. (2010); planning for district mental health services in South Africa with Petersen, Bhana, Campbell-Hall, Mjadu, Kleintjies, Hosegood & Flisher (2009); and finally, the country report on mental health policy development and implementation for South

Africa, which was compiled with primary researchers Kleintjes, Campbell-Hall, Mjadu, Petersen, Bhana, Kakuma, Mlanjeni, Bird, Drew, Faydi, Green, Omar & Flisher (2008).

1.2 PROBLEM STATEMENT

Mental health is a fundamental aspect of social functioning which cannot be ignored; it affects up to 450 million people worldwide, with studies indicating that between 25-50% of adults will develop one mental disorder in their lifetime (Patel et al., 2010). The movement toward deinstitutionalization became the core focus of mental health policies such as the White Paper (1997) and the Mental Health Care Act (17 of 2002) post-apartheid, followed by the human rights movement as promoted by groups such as the World Health Organization (2001; 2005).

However, this process was implemented at a rapid rate, with poor understanding and management of the implications of such a transition (Lund et al., 2008).Within the South African context, research has shown that post deinstitutionalization, a large treatment gap exists for mental health disorders in South Africa (Petersen et al.,2009).Services are poor and sparely available, with unspecialized care being rendered through local hospitals and particularly that of community-based initiatives. Social, cultural, and economic conditions have significant and measurable effects on both individual health status and the delivery of health care. As a result, there is a growing recognition of the need for social work services within the mental health outpatient and community-based care context (Barlow & Durand, 2012; Brown, 1996). However, despite the extensive knowledge and skills that social workers can bring, there is an existing gap with regard to the availability of social work services within the mental health context, with studies showing a capacity of 0.40 social workers within a population of 100 mentally ill individuals (Lund et al., 2008; Lund et al., 2002). Research regarding the role of the social worker within mental health care, particularly within a South African context is poor (Brown, 1996; Liechty, 2011; Lund et al., 2010). Thus, there is a definite research gap with regard to examining the views of social workers on their role in mental health outpatient and community-based services.

1.3 AIMS AND OBJECTIVES

The primary goal of the research study is to gain an understanding of the views of social workers on their role within mental health outpatient and community-based services. This goal is achieved through the implementation of various research objectives.

The following objectives were devised:

1. To provide an overview of the mental health context at both an international and local level, toward the understanding of the rendering of mental health services, particularly at an outpatient and community level.

2. To expand on the ecological perspective within a mental health context as a basis for critical analysis of the rendering of mental health outpatient services and the social worker's role in this regard.

3. To investigate the views of social workers on their role in mental health outpatient and community-based services, according to an ecological perspective.

4. To make recommendations regarding the role of social workers in outpatient and community-based mental health services in order to better meet the needs of this vulnerable group.

1.4 CLARIFICATION OF KEY CONCEPTS

In this section of the chapter, selected key concepts within the study have been further discussed and clarified, in order to ensure that they are understood, particularly within the context of this study.

1.4.1 Mental health

The World Health Organization defines mental health as "a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stressors of life, can work productively and fruitfully, and is able to make a contribution to his or her community" (World

Health Organization, 2001). However, an understanding of mental health is subject to the cultural and social context of the individual, and thus one cannot establish a concrete definition for mental health which makes allowances for all respective cultural, social and religious aspects; competing psychological theories also further influence how mental health is defined (World Health Organization, 2001). Therefore, mental health is often viewed as an unstable continuum where an individual's mental health status may have different possible values.

Mental health can also be viewed as being a branch of medicine which focuses on the achievement and maintenance of mental, psychological and emotional wellbeing. A holistic understanding of mental health as a field of study includes concepts based upon anthropological, educational, psychological, religious, sociological and theoretical perspectives; such concepts may further stem from a theoretical study and understanding of personality, social, clinical, health and developmental psychology (Barlow & Durand, 2012).

1.4.2 Mental illness

The Mental Health Act (17 of 2002) defines mental illness as "a positive diagnosis of a mental health related illness in terms of accepted diagnostic criteria made by a mental health care practitioner authorized to make such a diagnosis". Mental illness is further defined as being "a severe or emotional thought disturbances that negatively affect an individual's health and safety" (Barlow & Durand, 2012:539). Mental health disorders include that of unipolar depression, bipolar affective disorder, schizophrenia, alcohol and drug use disorders, posttraumatic disorder, panic disorder, Alzheimer's disease and other dementias, and primary insomnia (Patel et al., 2010). The recognition and understanding of mental illness has changed over time and across cultures, and although variations in the definition and classification of mental illnesses still exist, there are specific criteria which have been established as a uniformed means of assessment and diagnosis in the field of mental health and in the defining of a mental illness (Diagnostic and Statistical Manual, DSM-IV-TR).

1.4.3 Mental health services

Mental Health services and support refer to the various means of treatment and care for the mentally ill provided through mental health professionals within public and private settings,

institutions, district and provincial hospitals, as well as community-based care initiatives (Lund et al., 2010). There are two levels at which service rendering takes place: at the in-patient level, and at the outpatient and community-based level. This include services such as assessment of patients, diagnosis, pharmacological treatment and medication adherence monitoring, educating the patient and family members regarding the diagnosis, sufficient information provision in terms of the individual's diagnosis, symptom management and medication adherence, assistance in the reintegration of the patient into society, employment support and overall psychosocial support (Barlow & Durand, 2012; Petersen et al., 2009).

1.4.4 Outpatient and community based care

An outpatient is an individual who receives medical and/or therapeutic care within a clinical setting, but is not necessarily admitted or hospitalized for 24 hours or more. Instead, services are rendered through a day clinic, or associated facility. Outpatients are often referred for community-based care as a means of long-term sustainable intervention. Community-based care refers to services that are rendered through community structures and organizations, which are locally based and established within the patient's closely related physical and social environments (Lund et al., 2010). Outpatient and community-based care allow for intervention, treatment and service-delivery outside of the in-patient setting.

1.4.5 Deinstitutionalization

Deinstitutionalization first emerged in the 1950s as a mental health policy which aimed at accommodating the needs of diverse groups within society, and allowed for a greater promotion and protection of the rights and dignity of the mentally ill individual (Shadish, 1984). Social critics and human rights activists stirred up concern regarding the dependence which was fostered in mentally ill patients within institutionalized care, and proposed that this served to hinder their return into and development within society (Shadish, 1984). It is a complicated process whereby a focus shifts on reducing institutionalized care, and in turn developing community-based treatment, care and rehabilitation, toward effectively reintegrating the mentally ill patient into society in an attempt to prevent stigmatization and discrimination against such individuals (Lund et al., 2010; Patel et al., 2010; Petersen et al., 2009).

1.4.6 The ecological perspective

The ecological perspective, as presented by Carel. B. Germain in 1979, proposes that human needs and problems are generated by the transaction between people and their environments. It is a combination of ecology and the general systems theory, and formulates a perspective which integrates and systemizes knowledge about the interrelationships of people with one another and their environment (Nicholas, Rautenbach & Maistry, 2010). The ecological perspective was first used within the context of social work practice in health care and services by Gittermain (1977); ecological models of health behavior emphasis the environmental and policy contexts of behavior, while incorporating social and psychological influences (Glanz et al., 2008).

1.5 RESEARCH METHODOLOGY

In this section, the research methodology which was utilized for the study will be presented and discussed in further detail, with regard specifically to the research approach, research design, research method and data management and statistical analysis.

1.5.1 Research approach

A combination of both qualitative and quantitative research approaches was employed for the study, with a stronger emphasis on the use of qualitative data (Alasuutair, Bickman & Brannen. 2008:15). Quantitative research relies on measurement to compare and analyze different variables (Bless, Higson-Smith & Kagee, 2006:43). It focuses upon identifying the existing relationships among measured variables, in order to explain, predict and control specified phenomena, and thereby develops generalizations through the use of statistical inference (De Vos,Strydom, Fouche & Delport, 2012).

The Qualitative approach, on the other hand, aims to understand social life and the meaning people attach to everyday phenomena (De Vos et al., 2012). Therefore, this particular research approach is focused upon obtaining in-depth accounts of meaning, experience and perceptions exhibited by individuals, in order to form what is referred to as descriptive data (Bless et al., 2006). Although strong distinctions between the two paradigms do exist, most researchers would suggest that within the study of real life social and human sciences, both approaches should be utilized. Thus, with regard to a combined methods approach, various elements of the quantitative

and qualitative approaches were utilized in such a way so as to complement one another in order to allow for a more complete and in-depth assessment and understanding of the research problem (De Vos et al., 2012).

According to De Vos et al. (2012), there are a number of valid benefits which result from the utilization of a combination of quantitative and qualitative research approaches:

- It enables the researcher to both verify and generate theory.
- It allows for the overall strengths of both approaches to offset the identified weaknesses.
- It provides the opportunity for a broader scope of views and perspectives regarding the particular phenomenon being studied, therefore implementing a multifaceted approach.
- It is more practical in nature, providing further freedom for the researcher with regard to the use of methods, paradigms, data collection and analysis.
- The combined methods approach eliminates the various kinds of bias which often exist in research, and provides a holistic and true interpretation of the specified phenomenon.

1.5.2 Research design

A combination of exploratory and descriptive research designs was utilized as the framework for the implementation of the research approach. This enabled the utilization of both quantitative and qualitative design elements within the study.

Exploratory research can be defined as social research that explores a specific phenomenon with the primary aim being that of formulating more specific research questions/hypotheses related to the phenomenon (Bless et al., 2006). It is conducted in order to gain further insight into a phenomenon or community, and arises out of a lack of information within a particular field or area of interest (De Vos et al., 2012). Exploratory research is generally associated with a qualitative approach. As the intention of the study is to explore the policy movement toward deinstitutionalization and the views and opinions of social workers on the management thereof, the essence of ‘exploring a phenomenon’ in order to gain a more in-depth understanding is highlighted here, and therefore this research design was considered as being appropriate to the implementation of this study.

A descriptive research design is defined as social research which has the primary aim of describing, rather than explaining, the particular phenomenon (Bless et al., 2006). Descriptive research presents a picture of the specified details of the area of interest, focusing on 'how' and 'why', as opposed to 'what' (De Vos et al., 2012). It is utilized for both qualitative and quantitative approaches, differing with regard to the nature of the description. According to De Vos et al. (2012), a description which is qualitative is more likely to refer to an intensive examination of a phenomenon and its deeper meanings, whereas a description which is quantitative will more typically include the characteristics of a population. In being that this study will be utilizing both quantitative and qualitative approaches, both given natures of description will be implemented.

1.5.3 Research method

The research method is made up of aspects such as the literature study, population and sampling, method of data collection and the pilot study. These will be explored in greater detail below.

1.5.3.1 Literature study

According to De Vos et al. (2012), a literature review offers a clearer understanding of the nature and meaning of the identified problem, thus allowing for sufficient theoretical knowledge from which an established research problem/need and related data analysis will stem. The literature study is comprised of two chapters, in terms of an overview and mental health care and service rendering according to an ecological perspective. This study was conducted through the use of relevant journals, articles and books from both international and local sources.

1.5.3.2 Population and sampling

The population is the total set out of which individuals for the study are chosen (De Vos et al., 2012). With regards to this particular study, the population was that of all social work professionals who have in some way worked with mentally ill individuals, within the outpatient and community-based context in the Western Cape. According to Sarantakos (2000), a complete average of the total population is seldom possible, and therefore a sample is utilized in order to achieve better feasibility. The specific sampling method which was utilized is that of purposive sampling techniques. This refers to the purposive selection by the researcher of participants most

directly linked to the research area. Therefore, a sample is formatted that contains the most characteristics or typical attributes of the population that best serves the purpose of the study (De Vos et al., 2012).

The sample size is of particular importance. According to De Vos et al. (2012), it is generally stated that with a larger population, a smaller sample percentage is required. This will prevent the development of oversensitivity with regard to the phenomenon or problem presented. Therefore, due to the fact that the focal population can be considered to be quite large, the sample group itself was made up of 20 respondents, all of whom were social workers.

The criteria for inclusion within the sample group were as follows:

1. Participants must be registered, practicing social workers within the Western Cape area.
2. Participants must be social work professionals either working within a mental health care context, or within a community-based context with some experience of mental health in their generic social work practice

1.5.3.3 Method of data collection

The instrument for data collection which was used throughout the study was that of a semi-structured interview schedule, conducted during interviews with relevant social workers. A semi-structured interview schedule is one where the need for specific information that can facilitate comparison of reactions and details relayed is recognized. Therefore the interviewer has a precise goal in mind when conducting the interview, and types of questions are fixed in order to implement some form of control over the data gained through the interview process (Bless et al., 2006). However, the interviewer is also free to formulate other questions as judged appropriate within the given situation. Participants are not necessarily confronted with an already existing definition or answer to the problem being addressed, but instead are given the freedom to choose their own definitions and motivate their own views within the focal area (Bless et al., 2006). Semi-structured interviews are often used to gain a more detailed description of individual's perceptions of a particular topic and it allows for more flexibility within the interview process (De Vos et al., 2012).

A set of predetermined questions on an interview schedule were established, based on the literature study and in line with the presented research problems and objectives. However, the interview was guided rather than dictated by this schedule, according to the outlines provided for by De Vos et al. (2012). The interview was conducted in the home language of the participant and the appropriate climate-setting techniques will be implemented in order to ensure that the participant is comfortable and able to share freely (De Vos et al., 2012). The data was captured through means of audio-recording of participants and the transcribing of discourse by the researcher after each interview. This allowed for the capturing of in-depth qualitative data.

1.5.3.4 Pilot study

A pilot study refers to a trial run whereby the data collection method is implemented with a smaller group of participants, in order to test the established method and ensure that it is both efficient and effective. According to the De Vos et al. (2012:73), it is "a dress rehearsal for the main investigation". Thus, in order to clarify the determined measurement instrument, a purposive selection of two respondents was utilized to test the data collection process, and necessary changes which were identified were dealt with accordingly, to ensure a valid and effective study.

1.5.4 Data management and statistical analysis

Data management and statistical analysis is compiled through clarifying the method of data analysis, and the method of data verification, in terms of validity and credibility, and reflexivity. These factors will be discussed in further detail below.

1.5.4.1 Method of data analysis

Data analysis refers to the process whereby order, structure and meaning are brought about to the data which has been collected (De Vos et al., 2012). Marshall & Rossman (1995) highlight the necessary steps involved in the data analysis process which were utilized in this study, toward ensuring an effective structure, organization and understanding of the data collected through the interviews. These necessary steps involved that of organizing the data by means of becoming aware with the existing content, and from this understanding, generating relevant categories, patterns and themes. The third step in the data analysis process involved the act of linking

patterns, providing appropriate explanations for such patterns or themes, as well as searching for possible alternatives. Finally, the data was presented in the fourth chapter, using both qualitative and quantitative scientific means of presentation. The quantitative data is presented through means of tables and figures, while the qualitative data is discussed according to established categories and themes, and the use of direct respondent discourse. According to De Vos et al. (2012), the results, both qualitative and quantitative, must be verified against the literature presented in the literature study, and it must be further embedded in larger perspectives/paradigms.

1.5.4.2 Method of data verification

Established criteria for the verification of quality data include that of validity, which refers to the extent to which an empirical measurement adequately reflects the real/true meaning of the concept being studied (De Vos et al., 2012). Validity refers to truthfulness, accuracy, authenticity and genuineness, or "the extent to which an instrument measures what it is supposed to" and that this measurement is done so accurately (De Vos et al., 2012).

Data must also be determined to be reliable, in the sense that the same results will be brought about in future endeavors or tests, as in the past (De Vos et al., 2012). Thus, reliability is dependent upon the data measurement instrument, in ensuring that in measuring the same two things twice, it will yield the same results. In qualitative research, it is also important to incorporate principles such as credibility, transferability and dependability when determining the quality of data.

- Credibility

Credibility demonstrates that the inquiry was conducted in such a manner so as to ensure that the subject was accurately identified and described (De Vos et al., 2012). The researcher achieved this by means of utilizing various interview techniques, such as paraphrasing, probing, summarizing, clarifying and focusing in order to ensure that the subject was clearly and accurately presented to the participant in the semi-structured interview. This was further achieved through the recording all interviews in order to establish that all interviews were conducted under the necessary and correct circumstances.

- Transferability

Transferability looks at whether the findings of the research can be transferred from one specific case to another, which is often referred to as external validity in quantitative data verification (De Vos et al., 2012). The researcher achieved this through reporting all findings in a well-structured research document and made use of similar research, such as that of Lund et al. (2008, 2010, 2011). Further still, an accurate and clear description of the research methodology was also presented, thus allowing for a high level of transferability of research findings.

- Dependability

Finally, dependability was determined through establishing that the research process was logical, well documented and audited (De Vos et al., 2012). The researcher ensured that all data was presented in a logical, systematic and organized way, all findings were documented accordingly, and the chapters were externally edited and audited to further ensure dependability. Both local and international research on similar subject matter and contexts was utilized which allowed for a constant and sound research context.

1.6 REFLEXIVITY

Although a combined approach of quantitative and qualitative data was used in this study, a stronger emphasis was placed on the use of qualitative data. Therefore, the researcher understands that in using qualitative data, the researcher is a primary instrument in the analysis of the findings, and thus it is important that the researcher is aware of their feelings toward the subject area of their study. This is significant toward ensuring that the researcher is able to recognize, separate and prevent their own bias, feelings and opinions from influencing the overall research process (De Vos et al., 2012).

The researcher shared a similar professional background with the participants in the study, as both the participants and the researcher are social workers. Although the researcher is not yet a practicing social worker, she was aware of the fact that she had previous experience in implementing social work intervention within contexts of mental health and therefore did hold personal understandings and feelings regarding social work within mental health care. However, that being said, the researcher has limited experience and knowledge in this field of practice and

therefore was able to recognize this and set aside any feelings of bias in order to receive participant qualitative data without predetermined judgments or assumptions.

The researcher is further aware that her particular interest in social work within the mental health context is as a result of personal experience and predetermined ideas about the role of the social worker in this regard, however the researcher had not yet established any stereotypes with regard to the social worker within the community-based mental health context, due to limited experience in this specific area and felt that the research would serve to clarify a deepened understanding of this.

The researcher engaged in continuous and regular personal reflection, as well as supervision with her thesis supervisor. This served to ensure that personal bias, feelings and opinions did not influence the research process or findings in any way.

1.7 ETHICAL CONSIDERATIONS

As a registered social worker, the research is bound by the general ethical code of the South African Council for Social Service Professions (SACSSP, 2011) and therefore, although there are no specific ethical establishments for social work research, the values and principles of social work practice should always be applied when interacting with respondents (De Vos et al., 2012). There are also existing established rules and behavioral expectations regarding the most correct conduct towards experimental subjects and participants, employers, sponsors, other researchers, assistants and students within general research practice which must be upheld throughout the research process (De Vos et al., 2012). The following ethical procedures were implemented:

- Appropriate provision was made for informed consent from participants. These consent forms have been attached as appendices.
- Participants received copies of signed informed consent documents. The original informed consent forms have been kept in a secured research file.
- Participants were informed, inter alia, that they have the right to refuse to answer questions and to withdraw from participation at any time.
- Steps were taken to ensure that personal data of participants is secured from improper access.

- Confidentiality of information was maintained and the identity of participants was not be disclosed.
- Participants were asked to participate in the study within their personal capacity and therefore institutional permission was not be required.

In light of ethical considerations within social work practice and policy regarding vulnerable groups, participants of the research remained within the established boundary of social work professionals. Ethical clearance for the study was granted by the Department of Social Work Ethical Screening Committee (DESC) before conducting the empirical study.

1.8 LIMITATIONS OF THE STUDY

According to De Vos et al. (2012), limitations in research studies are important elements which the researcher needs to be aware of, recognize, acknowledge and present clearly. There were two primary limitations which existed within this particular study. Firstly, although local research on the social worker within the mental health context does exist, this was limited to a few set researchers and authors. This meant that the researcher had to draw from international research and research from other contexts in order to further explore literature on the subject matter. However, the primary research authors utilized within the local context produced a rich set of literature which was both appropriate and beneficial for the study. Literature from international and alternative contexts allowed for a more broad and in-depth study of the subject.

The second limitation can be found in terms of the number of participants being limited. This could serve to affect the ability of the research findings to be generalized within the context of the role of the social worker in mental health community-based care. However, the use of purposive sampling allowed the researcher to ensure that a broad and varied sample of participants was used from a number of social work contexts, ensuring access to a wider scope of data.

1.9 PRESENTATION

This research report is made of up several chapters; the first chapter serves as an introduction, identifying the necessary motivation, aims, objectives, and use of methodology for the research study. The two chapters which follow present a literature review according to relevant titles and

focal discussions, focusing on the topic of mental health and its related policy, as well as expanding mental health care and service rendering according to an ecological perspective. These chapters have achieved objectives one and two of the study.

Chapter four is focused on the empirical study which was conducted, in terms of the semi-structured interview. Data which was collected was both relayed and analyzed, in accordance also with the literature study as provided in the previous two chapters; the third objective was achieved through the composition of this chapter. Chapter five achieved the final objective, presenting relevant conclusions and recommendations in light of the empirical study results and related data analysis.

CHAPTER TWO

MENTAL HEALTH AND ITS RELATED POLICY: AN OVERVIEW

2.1 INTRODUCTION

Mental health is fast becoming an incredibly significant public health issue, both within a global and local context. Toward understanding the role of the social worker in mental health services and care, this chapter will provide a basic overview of the concept of mental health. Factors such as the nature of mental illness, policy development and implementation in mental health care, and the effect thereof on mental health service delivery, need to be utilized as a backdrop against which social work service rendering for the mentally ill patient is evaluated. To this end, an overview of the mental health context will be provided, with regard to the defining of mental illness, as well as that of mental health, and a basic overview of the nature, causation, onset and treatment of mental disorders, will be discussed. A reflection on policy development within the mental health field, both internationally and locally, and the adaptation of deinstitutionalization and community-based care will be presented and the effects thereof on service rendering will be further discussed, with a basic overview of social work within mental health care. This chapter will serve as the foundation for the critical analysis of mental health care, and the role of the social worker in this regard, which will be then further discussed in chapter three.

2.2 THE MENTAL HEALTH CONTEXT

The context of mental health involves understanding mental illness and mental health in terms of their concrete definitions, the theories and models which form a basis for understanding, the nature, course, onset and treatment of mental disorders, and policy and legislation regarding mental health related services and care within international and local settings.

2.2.1 Defining mental illness

A concrete understanding of mental illness is still being debated amongst various scholars and professionals; there are many different existing theories regarding the cause, nature and onset of

such disorders. More specifically, the "what" of mental illness is dependent on different variables, and thus it can be difficult to find complete agreement on concrete terms and definitions.

However, although varying definitions do exist, there are certain basic understandings which are more broadly accepted, such as those presented in The World Health Organization's *International Classification of Diseases* (ICD) and the American Psychiatric Association's *Diagnostic and Statistical Manual* (DSM). The most recent edition of the ICD, the ICD-10, does not necessarily draw a distinction between physical and mental disorders, but instead refers to mental illness as another branch of disease; the DSM-IV serves to provide a definition of mental illness by offering an overview of respective classifications of the disorders seen and treated by American psychiatrists and clinical psychologists. Both systems adopt a primary inclination toward that of medical concepts and references and therefore can often be viewed as being representative of the biomedical model, which will be discussed later in the text (Coppock & Dunn, 2010).

That being said, it needs to be noted that the presence of psychological disorders has not yet been able to be confirmed by laboratory tests (First, 2010; Seligman & Rosenham, 1998) and therefore is reliant instead on the experience and clinical training of mental health professionals, with the DCM and ICD acting as guidelines based on research and common findings within the mental health professional community; symptomatic association is then also largely based on impressions formed during unstructured interviews to arrive at diagnoses (Westen, 1997). In light of this, therefore, the reliability and validity of these documents suffer due to the fact that the disorders listed are often abstract concepts that are not necessarily directly observable. Kleinman (1988:7-9), refers to psychiatric diagnosis as "an interpretation of a person's experience" and "a culturally constrained activity". This can be viewed as serving to minimize social causes and solutions for mental illness, which can in turn affect treatment efforts at the individual level (Austrian, 2005; Healy, 2002).

For the purpose of this study, a concrete understanding for mental illness will be based upon both international and local definitions which constitute as "legal definitions" for mental illness

(Barlow & Durand, 2012). There is an international definition of mental illness provided for in the New York Mental Hygiene Law (1992):
"Mental illness is an affliction with a mental disease or mental condition which is manifested by a disorder or disturbance in behavior, feeling, thinking, or judgment to such an extent that the person afflicted requires care, treatment and rehabilitation."

The South African mental health act (17 of 2002) defines mental illness as "a positive diagnosis of a mental health related illness in terms of accepted diagnostic criteria made by a mental health care practitioner authorized to make such a diagnosis".

It is critical in reflecting on these definitions to understand the meaning of terms such as "mental health" and "illness" in order to properly grasp the concept of mental illness, as both a legal disorder, as well as a field of study. It is broadly accepted that the word "illness" concretely refers to that of "a disease or period of sickness affecting the body or mind" (*the free dictionary*), as opposed to the concept of "health" which refers to "a person's mental or physical condition", that being "free from illness or injury" (*the free dictionary*).

2.2.2 Mental health versus mental illness

Every individual possesses mental health needs, regardless of their mental health status, and thus it is vital that one does not focus on defining mental illness without also having a sufficient understanding of what constitutes mental health. Mental health is more than merely that of the absence of symptoms of a mental illness or distress, as the earlier defined understanding of "health" implied. According to Lester and Glasby (2010:2-3), positive mental health includes the ability to be able to understand and make sense of our surroundings, to be able to cope with change, and to communicate effectively with others. Other definitions of mental health include that of culturally acceptable behavior and thoughts which can be classified as falling into the society's category of "normal", that being the "conforming to a standard" which is "usual, typical or expected" (*the free dictionary*).

Both mental health and mental illness are determined by various interacting factors, such as that of psychological, social and biological elements (Patel et al., 2010). According to the Mental Health Act (17 of 2002), mental health status is defined as being a "level of mental well-being of

an individual as affected by physical, social and psychological factors and which may result in a psychiatric diagnosis". According to the WHO (2001), the term "mental health" is seen as being all encompassing of the well-being of an individual, with regard to their mental, emotional and psychological functioning. An individual who is considered to have mental health would therefore be someone who is viewed as possessing a state of holistic well-being. It is within this context, therefore, that an understanding of mental illness is then derived, with regard to being the absence of that which constitutes mental health (WHO, 2001).

2.2.3 Theoretical approaches and models

In defining and understanding mental illness, it is important to have a basic knowledge of the various approaches, theories and models that have influenced mental health classification and treatment within practice. Different understandings can be grouped into respective categories, according to their standpoint on aspects such as the cause of mental illness, the onset, the nature and the treatment of mental disease. Such categories include that of the biological approach, physiological approaches and social theories.

2.2.3.1 The biological approach

The biological approach is most strongly represented through that of the biomedical model. This model, in essence, believes that there is no such thing as mental illness, but rather mental illness is merely the grouping of symptomatic responses to physical conditions; biological treatments, as a result, combat mental illness through the use of medication, focusing on the treatment of the biological and neurological symptoms of the so-called 'disease' (Barlow & Durand, 2012:12-13). This biomedical approach stemmed originally from the work of physicians Hippocrates (460-377 B.C.) and Galen (129-198 A.D.) who promoted the idea that psychological disorders were caused by brain pathology and genetics. Theoretical knowledge based on this approach extended well into the 19th century and a biomedical approach to mental illness influenced the medical understanding and treatment of these disorders for a long period of time (Barlow & Durand, 2012:10). These views were further promoted by one of the most influential American psychiatrists, John P. Grey (Barlow & Durand, 2012:11). He re-affirmed the fact that all mental disorders were physical in their causation, and the patient should thus be treated as an individual who is physically ill, as opposed to mentally ill. Although medical practitioners and scientists

have moved away from viewing mental health as a solely biological condition, the biomedical approach is still very much influential in the medical field today, and often forms the basis for understanding, diagnosing and treating mental disorders in patients. This is seen in key reference and evaluative tools such as the DSM-IV-TR and the ISDM-10.

2.2.3.2 Physiological approaches

Physiological approaches have birthed models such as the cognitive-behavioral model and the psychoanalytic theory; these approaches take a different standpoint to that of the biomedical model in that mental illness is viewed as being rooted in mental cognitions and adaptations. The psychoanalytical theory, for example, focuses on aspects of the mind, in terms of its structure with regard to the existence and nature of the id, ego and superego, as well as the aspects and functions of the minds personality and the various influences of such on the cognitive and behavioral functioning of an individual; the stages of psychosocial development are also stressed here as being of great significance in terms of having a profound and lasting impact on one's mental development (Barlow & Durand, 2012:16-17; Freud, 1923). Mental illness, in this regard therefore, is either viewed as stemming from poor psychosocial development, or as being an adaptation to clashes between the id, ego and superego's desires and behaviors (Barlow & Durand, 2012). The cognitive-behavioral model, strongly influenced by Watson's behavioral theory (Watson, 1913), and the work of B. F. Skinner (1948), focuses predominantly on the interactions between the mind and behavior, and how these two parts serve to influence one another (Barlow & Durand, 2012). Disorders are viewed as being reactive of inappropriate and poor thought processes which serve to influence ones understanding of self and the then reactive behavior of such understandings. Treatment of mental illness, according to this approach, focuses on an individual's mental constructs and understandings of self and the world around them, toward the promotion of behavioral changes and positive development (Barlow & Durand, 2012; Skinner, 1948; Watson, 1913).

2.2.3.3 Social approaches

Social approaches are those which advocate alternatives to medicine, leaning toward the understanding that social aspects can give rise to the onset and nature of mental illness (Johnson, Meyer, Winett& Small, 2000). It is being increasingly recognized that the bringing about of

positive changes in mental health status requires more than a solely medical approach (Braveman & Gruskin, 2003; Skeen et al., 2010). This is based on the understanding that socio-economic factors play a large role in determining one's health status; in fact, poverty and social deprivation can be directly linked to the onset of mental disorders (Barlow & Durand, 2012; Johnson et al., 2000; Lund et al., 2010; Skeen et al., 2010). Therefore, within approaches such as these, there is a strong focus on environmental factors and social stressors which can lead to mental breakdowns and the subsequent onset of mental disorders. Understanding the history and upbringing of the patient, the influence of stressor factors and coping mechanisms at the time of the onset of a mental disorder, and the existing social support which is available for the patient are key areas which are observed and analyzed toward implementing appropriate intervention for the individual. Research also demonstrates that social support and healthy social functioning has a direct impact on the nature of the recovery of the patient, and their chances of relapsing (Barlow & Durand, 2012; Johnson et al., 2000; Lund et al., 2010).

2.2.3.4 The integrated approach

In mental health practice today, the average mental health practitioner works according to an integrated approach, incorporating aspects of biological, physiological and social understandings (Barlow & Durand, 2012:23). Each theoretical approach has both strengths and limitations, and therefore integration of these diverse lenses through which mental health is viewed will allow for a holistic understanding and a more encompassing treatment for the mentally ill individual. Thus, in diagnosing and treating a mental disorder, the practitioner needs to assess the individual according to the biological, behavioral, social, emotional and cognitive influences and causes which could together have triggered the onset of mental illness (Barlow & Durand, 2012:30).

2.2.4 The onset, nature, course and treatment of mental illness

There are a wide range of mental disorders differing according to the symptomatic features, causality, onset, duration, intensity and treatment. These disorders are generally classified into eight specific categories, namely: anxiety disorders, somatoform and dissociative disorders, mood disorders, eating and sleeping disorders, sexual and gender identity disorders, substance-related and impulse-control disorders, personality disorders and psychotic disorders. These will be briefly discussed in order to generate a basic overview of mental illness.

2.2.4.1 Anxiety disorders

In understanding *Anxiety disorders*, one needs to be able to accurately conceptualize the emotion 'anxiety' and its symptomatic effect on an individual. Anxiety can be defined as being a negative mood state which is characterized by unease, fear, worry and poor perception. This is coupled with a set of specific behaviors, physical tension and a physiological response which is reflected in elevated heart rate and muscle tension (Barlow & Durand, 2012:123). Anxiety disorders include that of generalized anxiety disorder, panic disorder, agoraphobia, social anxiety disorder, post-traumatic stress disorder and obsessive compulsive disorder. All of these disorders exhibit some form of anxiety, panic or the need to be in control. They are both hereditary in nature, as well as resulting from environmental, psychological and social aspects and are treated through both the use of medication and psychotherapeutic means (Barlow & Durand, 2012:123-124).

2.2.4.2 Somatoform and dissociative disorders

Somatoform Disorders are those which involve an unhealthy and unrealistic obsession with one's health or appearance. Disorders within this category include that of hypochondriasis, somatization disorder, pain disorder, conversion disorder and body dysmorphic disorder; all of which involve an overly obsessive concern with the one's physical body (Barlow & Durand, 2012:171). *Dissociative disorders* are associated with symptomatic behaviors of detachment from reality. An individual with dissociation will either feel detachment from themselves, to the extreme point where they will lose all identity, or they will experience a detachment from the environment around them, resulting in a break from reality (Barlow & Durand, 2012:171). Disorders of dissociation include depersonalization disorder, dissociative amnesia, dissociative fugue and dissociative trance disorder.

These two categories of disorders are linked together due to the fact that they share many common features, and were previously viewed as being one mental disorder referred to as "hysterical neurosis" (Barlow & Durand, 2012:171). They are both classified as being more psychological and cognitive in nature and causation then they are biological; generally childhood trauma is a leading factor in the onset of a disorder of this nature (Barlow & Durand, 2012). Treatment for a somatoform or dissociative disorder differs, however both are primarily focused upon psychotherapeutic aspects over and above the use of medication; although medication is

viewed as being useful and somewhat necessary, depending on the severity and chronic nature of the disorder onset.

2.2.4.3 Mood disorders

Mood disorders are probably the most well-known mental disorders within society today, in terms specifically of clinical depression and manic-depressive bipolar mood disorder. These disorders are characterized by extreme mood swings in the form of depressive lows, manic highs and strong suicide ideation (Barlow & Durand, 2012:205). Depression and bipolar disorder are viewed as being as a result of a genetic vulnerability coupled with a form of trauma or stressful life events which then serve to trigger the dormant gene (Barlow & Durand, 2012; Lund et al., 2010). Disorders such as these often occur in late adolescent or early adulthood and can be extremely chronic in nature and onset. Treatment of mood disorders involves a well-balanced combination of pharmacological and psychotherapeutic methods (Barlow & Durand, 2012).

2.2.4.4 Eating and sleeping disorders

Eating and sleeping disorders are often not viewed by the public as falling into the sphere of mental illness; however, they are most definitely disorders of the mind and thus need to be treated with the same understanding and severity. Eating disorders, namely anorexia nervosa, bulimia nervosa, binge-eating disorder and obesity, are all rooted in incredibly unhealthy and erratic eating behaviors which are ultimately detrimental to the health of the individual and stem from poor cognitive processes and constructs regarding the conception of self. Although studies have determined that eating disorders do exhibit some form of hereditary cause, the primary contributing factor to the onset of these disorders is external social and cultural factors coupled with internal cognitive processes and developments (Barlow & Durand, 2012). Treatment of eating disorders involves a strong focus on psychotherapy methods toward alerting cognitive perceptions. Sleeping disorders are neurological in nature, with physiological bases that then interact with psychological factors (Barlow & Durand, 2012:283). Sleep disorders are divided into two differentiating categories: parasomnias and dyssomnias. Parasomnias refer to disorders which result in symptoms of abnormality during sleep, such as excessive nightmares and sleepwalking; dyssomnias refer to sleep disorders characterized by difficulties in falling asleep (Barlow & Durand, 2012). Dyssomnias can include primary insomnia, primary hyposomnia,

narcolepsy, breathing-related sleep disorder and circadian rhythm sleep disorder; parasomnia disorders are made up nightmare disorder, sleep terror disorder and sleepwalking disorder. A combination of biological and psychological interacting forces can be found in the etiology of sleeping disorders, and thus treatment is also a combined effort of medication and psychological methods of therapy and intervention (Barlow & Durand, 2012).

2.2.4.5 Sexual and gender identity disorder

Sexual and gender identity disorders can at times be quite difficult to classify, as it is dependent on what constitutes 'normal' sexual behavior. According to Barlow & Durand (2012:337), "Current views tend to be quite tolerant of a variety of sexual expressions, even if they are unusual, unless the behavior is associated with a substantial impairment in functioning or involves non-consenting individuals". There are three identified disorders within this category, namely that of gender identity disorder, sexual dysfunction and paraphilia, a form of sexual deviation. These disorders are primarily, if not completely, rooted in psychological etiology, although sexual dysfunction can at times be as a result of physiological problems. Treatment falls primarily to the appropriate use of psychotherapy techniques, with some medication involvement if deemed necessary.

2.2.4.6 Substance-related and impulse-control disorders

Substance-related and impulse-control disorders both have to do with the display of symptoms and 'disorder' as a result of being controlled by a specific desire and/or need. Substance-related disorders are those where individuals display psychotic symptoms, referred to as drug-induced psychosis, as a result of excessive use of drugs and/or alcohol (Barlow & Durand, 2012). Impulse-control disorders represent a number of problems centered on an inability to resist a specific desire or temptation. Examples of this include intermittent explosive disorder, kleptomania, pyromania, pathological gambling and trichotillomania. Due to the fact that these disorders are about self-control and the influence of external factors, treatment generally involves some form of rehabilitation with the assistance of medication use and psychotherapy. Studies have shown that both substance-related disorders and impulse-control disorders can have a genetic component which leaves an individual vulnerable to developing a disorder from this category; however, environmental factors do play a large determining role.

2.2.4.7 Personality disorders

Personality disorders are divided into three clusters: cluster A is made up of paranoid personality disorder, schizoid personality disorder and schizotypal personality disorder; cluster B consists of antisocial personality disorder, borderline personality disorder, histrionic personality disorder and narcissistic personality disorder; and cluster C includes avoidant personality disorder, dependent personality disorder and obsessive-compulsive personality disorder. According to the DSM-VI-TR, personality disorders are "enduring patterns of perceiving, relating to, and thinking about the environment and oneself that are exhibited in a wide range of social and personal contexts" and "are inflexible and maladaptive, and cause significant functional impairment or subjective distress" (American Psychiatric Association, 2000:686). Cluster A is made up of odd or eccentric disorders, cluster B, dramatic, emotional or erratic disorders, and cluster C consists of anxious or fearful disorders (DSM-VI-TR, 2000). Personality disorders, much like mood disorders, result from a combination of genetic vulnerability and stressful life events/trauma in childhood and adolescent years (Barlow & Durand, 2012). Treatment, however, is often more pharmacological in nature, then psychotherapeutic, especially when compared to mood disorders.

2.2.4.8 Psychotic disorders

The final category, *psychotic disorders,* focuses primarily on schizophrenia and its different forms; this is considered to be one of the most difficult psychiatric diseases, as well as the disease which leads to the highest level of disability (Waghorn, Chant & Jaeger, 2007). Schizophrenia is genetic in nature, and therefore can be inherited through family members; however, environmental aspects can also trigger the onset of this disease, as well as substance abuse and traumatic experiences as a child (Barlow & Durand, 2012). Different forms of schizophrenia include the paranoid type, disorganized type, catatonic type, undifferentiated type and residual type. These forms differ from one another in terms of the severity of positive and negative symptoms, with regard to delusions, hallucinations, disorganized speech, catatonic behavior, affective flattening, alogia and avolition. Other psychotic diseases include schizophreniform, delusional disorder, brief psychotic disorder and shared psychotic disorder. Psychotic disorders have a need for high levels of medical treatment and care, particularly within

the beginning stages of psychosis. That being said, psychotherapeutic care is also of vital importance.

2.2.5 Mental health policy and services

Mental health policy development has a long history, with various influencing factors such as developments in medical and pharmaceutical knowledge, human rights movements, religious views and expectations and a developing understanding of mental health care needs. In order to provide an overview which is relevant for this particular study, the focus of the discussion will remain based on mental health policy development which had the most significant impact on mental health care today, with regard to the movement from institutionalization to that of deinstitutionalized care, both at an international and local level.

2.2.5.1 An international context

The concept of deinstitutionalization first emerged in the 1950s as a form of mental health policy, as a means to accommodate for the needs of diverse groups within American society at the time (Shadish, 1984). Before being based on the principles of human rights, deinstitutionalization was primarily introduced as a cheaper alternative to the financial upkeep of and increasing demand for mental health services through institutions and mental hospitals (Bloom, 1973). However, the cause for human rights quickly became an incredibly important contributing factor, and social critiques began to question the level of dependence that mental health patients were developing which they believed was hindering their ability to function adequately in society (Goffman, 1961; Shadish, 1984). Thus, advocacies were made for the development of a policy that allowed for, and encouraged, more personalized care closer to the environment of the patient, minimizing institutional dependence (Shadish, 1984). Developments in medical care and pharmaceutical drugs allowed for the implementation of this movement, with care being more easily administrated in non-institutional settings (Crider, 1979).

In the years post the initial introduction of this policy change, developments in mental health care reformation, both in terms of legislation, as well as practices for implementation and the structuring of non-institutional care grew largely; benefits were definitely visible for both the patient and the field of mental health overall (Kiesler, 1982; Shadish, 1984). As observed by

Kramer (1977), “major shifts in the location of mental health did occur”, enabling patients to live in non-institutional care and community settings; to this day there is continued optimism regarding the potential that lies within the utilization of community care structures and policies. However, there were many issues which arose post deinstitutionalization, hindering positive results, more with regard to the actual implementation of policy, as opposed to its theoretical content.

In reflecting on the “discrepancies between the intentions and the consequences of deinstitutionalization”, Kiesler (1980, 1982) noticed that instead of shifting mental health care to that of community-based services, inpatient care within general hospitals that did not have allocated psychiatric units were fast becoming the single largest source of mental health care episodes. In fact, researchers such as Kiesler (1980) and Bardach (1977) went as far as to claim that deinstitutionalization, despite its noble intentions, did more harm than good through removing existing care for patients, with a severe lack of alternative developments. This is still relevant today. Some modern researchers believe that mental health care is in fact moving back toward institutional procedures, due to poor efforts to develop adequate public health and community-based care procedures (Lund & Petersen, 2011; Salize et al., 2008).

Today, mental health services and policy with regard to the structuring and development of efficient care for the mentally ill is still being globally debated and discussed. Although there continues to be a strong pull toward staying away from forms of institutionalized care, the essence of community care and the integration of mental health services into public health care is being re-evaluated and critiqued (Salize et al., 2008).

2.2.5.2 The local context

Under the apartheid government, the focus of mental health services was on institutionalized and centralized care (Petersen et al., 2009). Post-apartheid, South Africa adopted a policy shift in their approach toward mental health service implementation by purposefully downscaling psychiatric institutions and implementing a community-focused public health model influenced highly by international policy developments and growing human rights movements, as discussed above (Lund &Flisher, 2006). In the last decade, there have been significant policy and legislative developments, primarily through three important documents: the White Paper for the

transformation of the health system (1997), the National Health Policy Guidelines for improved mental health in South Africa (1997) and the more recently revised Mental Health Care Act (17 of 2002), which was promulgated in 2004, consistent with international human rights standards (WHO, 2005).

In the early developing stages of this policy shift, the Department of Health commissioned a study of mental health care in 1997, toward establishing concrete norms for service rendering; this was the first thorough national survey of public mental health services to have been conducted in South Africa (Lund &Flisher, 2006). The data generated through this study then directed the practical implications of policies such as the White Paper and the National Health Policy Guidelines (1997). The focus of these documents initially was limited to that of de-hospitalization and the psychopharmacological management of chronic patients within the public health care setting (Petersen et al., 2009).

The vision for the reformation of mental health services is clearly articulated in the White Paper for the transformation of the health system (1997), where it states, "A comprehensive and community-based mental health service should be planned and coordinated at the national, provincial, district and community levels, and integrated with other health services" (White Paper, 1997:136). This policy shift, therefore, called for the integration of mental health care into primary care and the then related development of community-based services, in keeping in step with recommendations at an international level through bodies such as the World Health Organization (Lund &Flisher, 2006; WHO, 1984).

The National Directorate: Mental Health and Substance Abuse, in the Department of Health acts as the authority which provides advice to the government on mental health policy and legislation; the directorate comprises of a director, three deputy officers, assistant directors and administrative staff (Lund et al., 2010). The national mental health authority then provides direction for the provincial mental health authorities toward service planning, management and coordination, as well as monitoring and quality assessment (Lund et al., 2010). Each province has a specific structure which is then responsible for mental health and substance abuse, controlled either by a directorate or sub-directorate; mental health services are organized in catchment areas within all provinces (Lund et al., 2010). The Directorate's operational plan for

mental health is then devolved to the provinces; these plans tend to be integrated within the general health plan for the province.

In 2000, a further systematic review of mental health services in South Africa was conducted through the work of researcher Rita Thorn. This review supported the shift from centralized institutional care toward decentralized, integrated and community-based services (Lund & Petersen, 2011; Thorn, 2000). Thorn also encouraged the use of trained non-specialists in providing mental healthcare in order to increase access in the context of a shortage of mental health specialists (Thorn, 2000). Further policy reformation was then implemented through the revised Mental Health Care Act 17 of 2002 with a continued focus on decentralized and community-based care, establishing standards such as the allocation of 72-hour observation services within specific district hospitals for assessment and referral purposes (Mental Health Care Act, 2002).

Service delivery and care for the mentally ill group is thus primarily provided through 72-hour observation services at allocated district hospitals, the remaining few institutions which have been set aside for longer-term treatment of the chronically ill (this however no longer allows for permanent residence by patients, and thus can still be considered to be short-term in nature), and the then sustainable care provided by community-based and public health structures. However, due to the fact that the end product of deinstitutionalization within South Africa was more of a cost-saving exercise without the simultaneous development of sufficient and appropriate outpatient and community support structures and systems, deinstitutionalization has been evaluated as being poorly implemented and having a negative impact on mental health care overall (Lund, 2008; Petersen et al., 2009).

In terms of the financing of mental health service rendering, public sector mental health care is covered through national tax revenue, and expenditure is determined by the National Department of Health. Thus the allocation of finances and resources specifically for the area of mental health is at the discretion of the department within each province (Lund et al., 2010). This can often result in poor allocation of resources for mental health, with a greater focus on other areas of public health. This is beginning to change, however, due to increasing recognition of the high importance of mental health and the related necessary services and care (Petersen et al., 2009).

2.2.5.3 A critical evaluation of deinstitutionalization

Although the transformation of the mental health care system has enabled the improvement of certain aspects of healthcare services and policy development, there have been significant adverse effects which need to be taken into account. As early as the 1960s, adverse effects of deinstitutionalization were recorded, at an international level, in the United States, with an example being provided through the homeless crisis in America in 1963, where the introduction of deinstitutionalization as a law through enactment of the Mental Retardation Facilities and Community Mental Health Centers Act resulted in hundreds of thousands of disabled patients with schizophrenia, affective disorders, alcoholism, and severe personality disorders being released from large institutions directly onto the streets. This resulted in what J. London (1992) refers to as "the former residents of structured institutions became the homeless". In reflecting upon the local South African context, similarities in terms of negative consequences resulting from the implantation of deinstitutionalization can be found. These will be discussed in further detail below.

According to Salize et al. (2008), in order to determine the success of the deinstitutionalization process, one needs to analyze aspects such as that of the interaction among various health and social functioning sectors, the extent of the patient shift between these sectors, and "whether potential shifts indeed correspond to the actual needs of the persons concerned, or whether referral patterns seem inappropriate, or there seems to be a potential systematic misuse of the referral or receiving sector" (2008:533). In light of this within the South African context, despite the bringing in of policy reformation post-apartheid, the actual implementation of deinstitutionalization was poorly done. The process was largely focused on the emergency management of patients, through 72-hour observation facilities, with very little corresponding development of long-term, sustainable community services toward the rehabilitation and reintegration of the mentally ill individual into society (Lund et al., 2010; Petersen et al., 2009). According to Lund et al (2008), this process was implemented at a rapid rate, with poor understanding and management of the implications of such a transition, as it was primarily introduced as a cost-saving exercise based on international movements (Petersen et al., 2009).

Therefore, in this regard, the adoption of the policy of deinstitutionalization, in terms of that which is outlined in the White Paper for the transformation of the health system, the National

Health Policy Guidelines for improved mental health in South Africa (1997) and the more recently revised Mental Health Care Act (17 of 2002), has resulted in a fragmentation of specialized mental health services and poor quality of care available to the mentally ill patient as a whole within the South African context, with the process of decentralization and deinstitutionalization having a negative impact on service rendering and service availability for the mentally ill individual (Lund et al., 2008; Petersen et al., 2009). According to research conducted by Lund et al. (2008), deinstitutionalized care is actually not considered to be the cheaper option, when taking into account the resources required for the effective establishment of tertiary and community-based care (Lund & Petersen, 2011; Lund et al., 2008). Their studies stressed the need to utilize the finances saved from reduced spending on psychiatric institutions on creating adequate community services (Lund et al., 2008).

According to Petersen et al. (2009:2), deinstitutionalization is a much broader process which should be primarily focused on the structuring and implementation of community-based rehabilitation and reintegration services. However, this was not the case within the South African context. Research found that within South Africa, of the recorded 16, 5% of adults suffering from a common mental disorder, only one in four had received treatment (Williams, Herman & Stein, 2008). Research also found that there was a significant lack of specialized mental health practitioners, with specific reference to psychologists and psychiatrists (Lund et al., 2010; Petersen et al., 2009). Petersen et al. (2009) further concludes that, a decade after the reformation of policy, even with the implementation of the new Mental Health Care Act (17 of 2002), the process of deinstitutionalization is still strongly focused on and limited to the emergency management and screening of chronically ill patients; sustainable rehabilitation programmes are few and far in between. Further adverse effects of the poor implementation of deinstitutionalization includes the fragmentation of specialized services and care, the lack of quality assurance procedures and assessments, the decreased access to mental health services and care, an increase in the suicide rate of mentally ill patients, as well as an increase in acute emergency admissions and readmission relapse (Salize et al., 2008).

Thus, in reflecting upon the above, it can be seen that deinstitutionalization, though perhaps ethical in theory, has not necessarily been as effective in practice. Although these adverse effects are only being recognized in South Africa more recently, due to its implementation in the 1970s,

the consequences of this policy reform at an international level has been recognized from its beginning stages. Professor Richard Titmuss, a pioneering British social researcher and teacher who founded the academic discipline of Social Administration, now largely known in universities as Social Policy, when reflecting on deinstitutionalization, stated:

"We may feel righteous because we have a civilized mental act on the statute groups; but unless we are prepared to examine it…at the level of concrete reality, what we mean by community care is simply indulging in wishful thinking… We are transferring the care of the mentally ill from trained staff to untrained or ill equipped staff or no staff at all" (Titmuss, 1968:106-107).

It is within this context, that the significance of social work within mental health care, particularly now at the community-based level, is more clearly recognized.

2.3 SOCIAL WORK IN MENTAL HEALTH: A BASIC OVERVIEW

The aim of the research study is to examine the role of the social worker within mental health outpatient and community-based services, and therefore, it is necessary to have an understanding of social work within the overall mental health context. This will be discussed below. The social worker within the outpatient and community-based mental health context will be explored in chapter three of the study.

According to Volgeman (1990:503), the establishment of a national health service, within the context of deinstitutionalization in particular, calls for the participation of particular mental health professionals, in terms of psychologists, psychiatrists and social workers. He stipulates that in order to render adequate services, mental health professionals will need to begin to work together more closely, and states the possibility of a developing conflict between mental health policy changes and the previous training of professionals, thereby encouraging further education and academic development across professions interacting with this group. In line with this, Volgeman then advocates for the training and utilization of non-professionals, in terms of the mental health field, toward service rendering in order to ensure adequate service access and availability and the success of the primary health care approach (1990:503). Within the context of deinstitutionalization, the call for social work participation in mental health patient care has never been more needed.

Social work as a profession has always been acknowledged to be render services that aid and empower the downtrodden, assessing and incorporating debilitating environmental factors that can contribute to human problems. The International definition of social work, as adopted by the IFSW and the IASSW in 2001, states that:

"The social work profession promotes social change, problem solving in human relationships and the empowerment and liberation of people to enhance well-being. Utilizing theories of human behavior and social systems, social work intervenes at the points where people interact with their environments. Principles of human rights and social justice are fundamental to social work." (IFSW-IASSW, 2001).

It can be noted here, that the ecological perspective in social work practice and understanding the needs of vulnerable groups is highlighted in this definition, and that the empowerment of individuals toward their well-being is a key focus. Mental health needs to begin to be recognized as a vulnerable group which requires intervention through the social work profession, in keeping with such definitions as provided above. Social work intervention within the context of mental health care thus needs to be at all four levels: prevention needs to be implemented through educative means within communities, teaching groups about mental health, the incorrect stigma of this illness, and how to properly administrate care for the mentally ill; early intervention needs to take place through the rendering of services such as family counseling and awareness regarding mental illness, working closely with clinic and hospital settings to ensure assessment and early diagnosis; statutory intervention through the means of outpatient and community based services that offer group support, therapy, caregiver and family support, medication administration and monitoring, assistance toward job and resource access; and finally, reconstruction and after care, which is primarily through the assisting in the reintegration of mentally ill patients into society, post-diagnosis or institutional care – this is probably one of the most important aspects required within the context of social work intervention in mental health care (Lund et al., 2010; Lund et al., 2002).

In this regard, the need for social work services within mental health can be clearly recognized and advocated for. According to research conducted by Rose (1998), the discursive practices of

mental health care influences individuals to regulate their behavior in accordance with normative social expectations, and thus social workers, psychiatrists and psychologists are there to provide "expert" knowledge to guide practice and service rendering in this regard. Medical interventions, although helping to alleviate painful symptoms that individuals experience, more often than not are implemented regardless of the existence of social origins of the distress. So much so, that the fact that problems are understood as existing within individuals makes it less likely that contributing social factors will be addressed at all (Austrian, 2005; Conrad, 2007; Corcoran & Walsh, 2010; Kleinman, 1988).

At a time of much change to professional roles and organizational structures, where concerns have been expressed about the distinctive role that social workers have to play in the broader provision of health and social services within the field of mental health, it is worth noting and reflecting on the role and contribution of social work in community mental health provision in statutory community mental health teams, integrated or multidisciplinary teams, and assertive outreach and crisis intervention teams. With the increased focus being on outpatient services, and a poor availability of specialized clinical social workers (Lund et al., 2010; Lund et al., 2002) general social workers are now being faced with the task of reaching out to the mentally ill. The increasingly high influx of mentally ill individuals into local communities that have little, if any, structured public health and community-based care systems, has an effect on general social work practice, impacting areas of crime, family structure and functioning, child abuse, domestic violence, family violence and unemployment (Lund et al., 2010) and thus the generic social worker can no longer remain isolated from mental health care practices.

However, the exact role of social workers in the rendering of mental health care is still being debated and developed, and serves as the basis for this study. The role of social workers in the rendering of mental health care services will be further evaluated and discussed through the reflection on mental health care within an ecological context, the empirical study and the analysis of data presented in chapters three and four.

2.4 CONCLUSION

Mental health, in its definition, policy implementation and care, is an ongoing debate with much room for further understanding and development. The implementation of deinstitutionalization and community-based care, although defined in theory and policy can be viewed as still being in its early stages of successful integration into public health care models which have a positive and sustainable impact on the functioning of the mentally ill individual. In this regard, the role and position of the social worker in the rendering of care for this vulnerable group is a topic which needs to be reviewed and discussed, particularly within a local context, in order to generate an understanding of the current mental health needs, toward equipping the social worker with effective tools for intervention.

CHAPTER THREE

MENTAL HEALTH CARE AND SERVICE RENDERING ACCORDING TO AN ECOLOGICAL PERSPECTIVE

3.1 INTRODUCTION

The movement toward deinstitutionalization and community-based and outpatient care has had a significant impact on the nature, availability and quality of service rendering for the mentally ill patient within the South African context. An understanding of mental health care and service rendering in this regard requires a multi-dimensional overview that encompasses and considers all possible influential factors with regard to the needs of the mentally ill, as well as the nature of related service rendering initiatives; this is best done within the ecological framework. Therefore, the ecological perspective will be discussed, with regard to a theoretical understanding, its specific role within health care, and the relevant models which have been developed, focusing on core aspects such as individuality, social and physical environments and the policy context, and the needs of the mentally ill patient in this regard. An overview of the current context of outpatient and community-based services within South Africa will then be reflected upon, as well as a discussion regarding the role of the social worker within this spectrum.

3.2 THE ECOLOGICAL PERSPECTIVE

In order to better understand the ecological perspective, and its influence as the theoretical framework and underpinning of the study, a theoretical overview will be provided, with a then more focused reflection on the models as presented by Bronfenbrenner (1979), Fisher (2005), McLeroy, Bibeau, Steckler and Glanz(1988) and Flay and Petriatis (1994), as key frameworks through which mental health care, and the role of the social worker in this regard is understood and assessed.

3.2.1 A theoretical overview

Ecology, in broad terms, refers to the biological science that studies the organism–environment interactions and relations (Glanz et al., 2008). The Ecological Perspective, derived from this field of biological science, often referred to as the Social Ecology Model, is a framework which serves to examine and explore the multiple effects and interrelatedness of social elements in an environment (Oetzel, Ting-Toomey & Rinderle, 2006). It is the study of people in an environment, and the influences which are exerted on the individual within their particular eco-system (Hawley, 1950; Oetzel et al., 2006). This perspective allowed for the conceptual development of such relations that were then less abstract than those provided by systems theories, and thus offered reflections that were closer to the common human experience. Therefore, this approach allowed for the integration of multiple levels and contexts to establish the "big picture" in terms of conflict, health and social interactions. According to Rousseau & House (1994), research that tended to focus on only one level of the ecosystem actually undermined and underestimated the effects of other contexts and could not serve as a true assessment of the overall functioning and development of an individual.

There are many different derivatives of this perspective which have been developed and implemented across fields of study. Lewin (1951), however, was one of the first individuals to conceptualize this with his *Ecological Psychology*, which studied the influence of the outside environment on the person, within social and behavioral contexts, moving away from the solely biological approach. This was later further developed by R. Barker (1968) into what he referred to as *Environmental Psychology*, establishing that all behavior settings are social and physical situations in which behavior then takes place. Behaviors could thus be predicted more accurately from the situations people are in than from their individual characteristics.

The initial concept of systems embedded in the ecological perspective was founded by Urie Bronfenbrenner in the late 1970's with his well-known *Systems Theory* (1979). This model was an extension of Kurt Lewin's equation (1951), demonstrating that behavior is deemed to be as a function of the person and the environment; Bronfenbrenner extended this further through recognizing the layers which exist and serve to have an impact on each other. Later, in the 1980's, Rudolph Moos identified four categories of the *Social Ecology model* through which

behavior and environmental influence could be assessed, in terms of the physical settings, which included features of the natural and built environment; the organizational settings, with regard to size and functions of worksites and schools; the human aggregate, sociocultural characteristics of individuals in an environment; and the social climate, referring to the existing supportiveness within a social setting of a certain behavior or action. The models above where later classified as being those which are designed and focused upon explaining and understanding behavior (Glanz et al., 2008).

Further expressions and developments of the ecological perspective were conceptualized toward not only understanding behavior, but also guiding behavior interventions. Skinner (1948) introduced his *Operant Learning Theory* with his primary model being that of the person-in-environment concept, where he believed that there were specific reinforces and cues in the environment which directly controlled behavior. Bandura (1973) came up with the concept of *Social Learning* and developed *social cognitive theories*, which proposed environmental and personal influences on behavior. However, Bandura focused on social environments, with very little reference to physical, community or organizational influences. McLeory, Bibeau, Steckler and Glanz(1988), introduced these influences in their *Ecological Model for Health Promotion*, where five key sources of influence on health behaviors were identified, being that of intrapersonal factors, interpersonal processes, primary groups, institutional factors, community factors and public policy. A similar concept was presented by Stokols and others (1992 and 2003), with their *Social Ecology Model for Health Promotion*, with the four key assumptions of the model being: health behavior is influenced by physical environments, social environments and personal attributes; environments are multi-dimensional; human-environment interactions occur at varying levels of aggregation; and people influence their settings, and these changed settings then influence health behaviors.

Another important theory for the health context was introduced by Flay and Petriatis (1994) with their *Theory of Triadic Influence* which proposed the view that genes and the environment are assumed to affect all behaviors and the three streams of influence on behavior are then intrapersonal, social and sociocultural. Later, theorists Cohen, Farley and others (2000) came up with the *Structural-Ecological Model* which identified four categories of structural influences, in terms of the availability of protective and/or harmful products, physical structures, social

structures and policies, and media and cultural messages. Flisher (2005) took concepts of the ecological perspective and established the *Resources and skills for self-management model*, which was based on the integration of individuals' skills and choices, with the support they received from the social environment, as well as physical and policy environments of communities.

All of the above mentioned theories and models were derived from the concept of the ecological framework and it's implication for behavior, whether it is toward understanding behavior, or guiding interventions in this regard. When reflecting on these models within a health context specifically, there are four primary principles which serve as a core baseline. Firstly, there are multiple levels of factors which influence behaviors, and health behaviors in particular; secondly, these influences interact across levels; thirdly, multi-level interventions should be most effective in changing behavior; and finally, ecological models are most powerful when they are behavior specific (Glanz et al., 2008).

When used metaphorically, these concepts could enable a practitioner and a client to keep a simultaneous focus on the person as well as their environment, and on the reciprocal relationship which exists between the two. As a result, certain concepts have been singled out as being particularly appropriate for social work interventions (Germain, 1979; Germain & Gitterman, 1980).Germain (1979) introduced an ecological metaphor as a perspective for practice in social casework in the 1970s. According to Germain's findings (1979), as important as social provision is, the physical and social environments of an individual also need to be understood and worked with as people interact with them (Germain & Gitterman, 1980). As time passed, and these concepts developed and were increasingly implemented within social work interventions, it became clear that the capacity of ecological concepts was helpful not only in practice with individuals, families, groups, and organizations but also with communities and in political advocacy (Germain & Gitterman, 1980).

Another aspect of the ecological perspective is "ecological thinking". This refers to a mode of thought that differs markedly from linear thinking, in that ecological thinking examines exchanges between A and B, for example, that shape, influence, or change both over time. Event A acts, which then leads to a change in result B, whereupon the change in result B then elicits a

change in event A that in turn changes result B, which then changes or otherwise influences event A, and so on. The process is further complicated by the fact that other variables are usually operating at the same time (Germain & Gitterman, 1980). This concept becomes highly influential when looking at factors such as adaptations, life stressors, stress in general, coping measures, relatedness, competence, self-esteem, self-direction, habitat, niche and power (Glanz et al., 2008). This became increasingly relevant to, and important for, social work interventions and practice.

3.3 THE ECOLOGICAL APPROACH WITHIN THE HEALTH SECTOR

The ecological approach has been central to health promotion for several decades now. Health policy groups have been found to increasingly depend on multi-level interventions to solve challenging health problems. A key strength of ecological models, as presented above is the focus on multiple levels of influence; this allows for a broadened view of interventions options. Policy and environmental changes are expected to affect entire populations, in contrast to some interventions that would reach only those individuals who chose to participate (Glanz and Mullis, 1988). Interventions which take into account policy and environmental influences, therefore, serve to establish settings and incentives that can be highly effective in maintaining behavior changes, helping to solve the problem of sustainability and frequent relapse. That being said, a weakness of many general ecological models of health behavior is the lack of specificity regarding the most important conceptualized influences, which results in professionals having to identify critical factors for each behavioral application. The lack of information regarding how broader levels of influence operate, or how variables interact across levels, can also be viewed as being a weakness of this framework approach, as the models within this perspective tend to broaden perspectives without simultaneously identifying specific variables; this can sometimes result in practitioners struggling to understand how to directly apply such models in intervention. Therefore, as influential and helpful such models are to health care, there is a need to develop more sophisticated operational models that can lead to more testable hypotheses and useful guidance for interventions (Glanz et al., 2008).

However, despite these limitations, according to Glanz et al. (2008), there has been a dramatic increase in interest in the use of ecological models in both areas of research and practice within

the healthcare setting, primarily due to the fact that they offer guidance for a more comprehensive and population wide approach to changing behaviors that will serve to reduce serious and prevalent health problems, as ecological models are believed to provide comprehensive frameworks for understanding the multiple and interacting factors and determinants of health behaviors. Even more so, ecological models can also be used to develop comprehensive intervention approaches that serve to systematically target mechanisms of change at each individual and specific level of influence (Glanz et al., 2008).

According to this perspective, behavior change is viewed as being maximized when environments and policies together support healthful choices, as well as when social norms and social support for healthful choices exist, and when individuals are then through such support systems motivated and educated to make choices which result in improved health behavior and functioning. Therefore, a central conclusion of utilizing ecological models within healthcare is the fact that the combination of both individual-level and environmental/policy-level interventions are needed in order to achieve substantial and sustainable changes in health behaviors (Germain & Gitterman, 1980; Glanz et al., 2008). Therefore, with this in mind, the needs of and related service rendering for mentally ill individuals will be examined according to this framework, with a specific focus on the models of Bronfenbrenner (1979), McLeroyet al. (1988), Flay & Petriatis (1994) and Fisher (2005).

3.4 MENTAL HEALTH NEEDS AND SERVICE RENDERING ACCORDING TO AN ECOLOGICAL FRAMEWORK

The scope and nature of mental health needs is broad, and is therefore best examined through the lens of the ecological perspective; service rendering, as a response to identified needs must also, therefore, be considered in this light. Four key models for the adoption of the ecological perspective within health care, and mental health in particular, will be utilized as a framework through which the needs of mentally ill patients, and the necessary service rendering as a response, will be examined and extrapolated. These four models include that of the *Systems Theory* (Bronfenbrenner, 1979), and it's breakdown into the micro, meso, and macro levels, the *Ecological Model for Health Promotion* (McLeroy et al., 1988),with its focus on intrapersonal, interpersonal, primary groups, institutional, community and policy factors, the *Theory of Triadic*

Influence (Flay & Petriatis, 1994), reflecting on the three primary streams of influence of intrapersonal, social and sociocultural aspects, and the *Resources and Skills for Self-Management Model* (Fisher, 2005), which looks at individuals skills and choices with the support received from the social, physical and policy environments.

In looking at these four models, there are four key areas that the researchers have identified as being most influential on behavior development and functioning: Individual, social environment, physical environment and policy, These areas will be discussed according to the integrated notions presented in the highlighted models as mentioned above. However, first the key assumptions of these models will be discussed in more detail.

3.4.1 Key assumptions

Bronfenbrenner(1979),developed the systems theory based on the notion that the ecosystem in which an individual is embedded is made up of three core layers which have a direct impact on each other and the overall functioning of the individual. These layers, or systems, tend to describe the influences existing within an eco-system as being intercultural, community-based, organizational, interpersonal and individual (Bronfenbrenner, 1979; Johnson & Yanca, 2007). According to this perspective, human beings are a part of a sub-system within a hierarchy of larger systems such as the family and community. Thus, Bronfenbrenner's perspective is based on the principles of the person, the environment, and the continuous interaction between the two. According to this model, these interactions are constantly evolving, and serve to develop the two existing components (Nicholas et al., 2010). The three core systems within this model are that of the micro-system, the meso-system and the macro-system. The needs of the mentally ill individual and the related service rendering interventions required will be discussed within these three system approaches.

The Ecological Model for Health Promotion identifies the influence of the ecological perspective on the behavior of an individual through five core areas of functioning, in terms of intrapersonal factors, interpersonal factors and primary groups, institutional factors, community factors and public policy (Glanz et al., 2008; McLeroy et al., 1988). These factors are very similar to the systems as laid out by Bronfenbrenner (1979), however, they focus on the categories as more like entities on their own, as opposed to interacting systems; although the influence of each level

on the other is recognized, the power and influence is exerted equally between categories, with the category exerting such influence as a stand-alone, separate environment per say (McLeroy et al., 1988).

The Theory of Triadic Influence as established by Flay & Petriatis (1994) is the only ecological model that incorporates the influence of an individual's genetic make-up as a significant factors in behavior determination and development within the field of mental health (Glanz et al., 2008). This model assumes that it is the interactions between genes and the environment which then in turn affect behavior. In light of this, three streams of influence are highlighted as being of particular significance, in terms of intrapersonal, social and sociocultural factors (Flay & Petriatis, 1994). These are very much like the categories mentioned by Bronfenbrenner (1979) and McLeroy et al. (1988); the social and sociocultural categories would fall into Bronfenbrenner's meso system of influence.

Finally, the Resources and Skills for Self-Management Model as presented by Fisher (2005), looks at an individual's skills and choices, thus their strengths and their personal pathways that have resulted in certain experiences and adaptations, and how this is then integrated with the support available to them through their social environments. Therefore, social support is considered to be highly influential at this level; however, it is viewed as only being as significant and influential as the skills, coping mechanisms and personal choices that are made at the individual level (Fisher, 2005; Glanz et al., 2008). Secondary to this integration, or interaction between the individual and their social environment, is that of the physical and policy environments of the communities within which the individual is embedded (Fisher, 2005).

3.4.2 The four core areas

When looking at all four models as mentioned above, the individual is established as being at the center each time. According to the various researchers, strategies which serve to bring about change at this individual level tend to be focused on the changing of an individual's knowledge, their attitudes, behavior and skill set. Therefore, service rendering includes aspects of education and mentoring programs (Glanz et al., 2008; Jamner & Stokols, 2000). Surrounding the individual, within each model, is the social environment. The social environment comprises of the relationships and interpersonal interactions within an individual's immediate environment, as

well as the culture and the society with which the individual interacts (Barlow & Durand, 2012; Johnson & Yanca, 2007; Nicholas et al., 2010). Interventions which can bring about change at the social environment level include various forms of community education, support groups, peer programs, workplace incentives and social marketing campaigns. These services can then be used to promote positive community attitudes and awareness (Glanz et al., 2008; Jamner & Stokols, 2000).

Physical environments, on the other hand, include a combination of the natural and the human-made environment (Glanz et al., 2008). Interventions at this level focus on aspects of the physical environment which should be put in place before educational or community awareness initiatives are able to be attempted, in terms of resource availability and accessibility (Jamner & Stokols, 2000). Sometimes educational initiatives encourage impossible or unrealistic behavior that cannot necessarily be implemented or successfully achieved in certain physical environments; such limitations need to be addressed before adequate social interventions can take place. In this scenario, education and awareness programs are more likely to be effective when preceded by programs for the development of community facilities and promoting community safety and sustainable development. The final category, policy, generally refers to formal legal actions taken by local, provincial, or national governments. It can, however, also refer to informal local policies or rules in settings such as schools or workplaces which then serve to influence and govern certain behaviors and interventions (Bronfenbrenner, 1979; Johnson & Yanca, 2007; Glanz et al., 2008).

3.4.2.1 Individual

In breaking down the suggested levels of an eco-system, the individual level reflects upon individualistic attributes, characteristics, conflicts and behaviors. Within the paradigm of Bronfenbrenner's Systems theory, Gregson (2001) describes the micro-system as consisting of those aspects of groups that compromise the social identity. These intrapersonal attributes, as discussed by McLeroy et al. (1988) and Flay and Petriatis (1994) are important with regard to how an individual perceives themselves. The individual system is constantly being shaped by an individual's interactions with their surrounding environment, and thus can also include systems such as the family, friends and social clubs with which one interacts regularly (Bronfenbrenner,

1979; 2012; Glanz et al., 2008; Johnson &Yanca, 2007; McLeroy et al., 1988); this is however, more strongly considered in the social environment.

Primary needs identified in mentally ill patients at the individual level tend to be centered on aspects of individual cognitive functioning, development and feelings of self-worth. The stigma which is so often attached to living with a mental disorder can result in poor self-esteem development in sufferers of mental illness; this then only adds to an individual's poor sense of self-worth which already exists as a symptomatic response to most mental disorders, particularly those with a tendency toward depressive episodes (Barlow & Durand, 2012). Individuals living with a mental illness therefore tend to require a stronger support system at the individual, both in terms of intrapersonal support toward a positive self-knowledge and acceptance, as well as interpersonal interactions and support networks through close family and friendship groups (Barlow & Durand, 2012). In reflecting upon the fact that the individual level consists of those aspects that compromise the social identity (Gregson, 2001), the primary needs, therefore, of individuals at this level would be those individualistic and interpersonal attributes which serve to develop a positive and healthy identify of self (Bronfenbrenner, 1979; Fisher, 2005; Glanz et al., 2008; McLeroy et al., 1988).

The needs expressed at this level can be met through personal and intimate relationships, whether it be through family, friendships or romantic relations. Social work service rendering, when taking into consideration the needs presented at this level, can be seen to require a more personal and intimate relationship of care and support (Barlow & Durand, 2012; Johnson & Yanca, 2007). This is predominantly provided through family and friends, however the help of a mental health practitioner, particularly that of a social worker can be of great significance toward developing the individual's inner sense of self, promote healthy and positive intrapersonal attributes and thought patterns, as well as the motivate continued development and growth toward optimal functioning (Nicholas et al., 2010).

At the individual level, according to McLeroy et al. (1988) and Fisher (2005), stressors are what most negatively impact individual behavior and functioning. Stressors, according to these theorists, are those day-to-day aspects and demands made by the internal or external environment that upset balance or homeostasis, thus affecting physical and psychological well-being and requiring a restoration of balance or equilibrium (Lazarus, 1980). Stress can contribute to illness

through its direct physiological effects or indirect effects via maladaptive health behaviors, and are proven in research to even be the primary factor contributing to the onset of mental illness (Barlow & Durand, 2012; Lund et al., 2010). Stress does not affect all people equally; some people live through terribly threatening experiences, yet manage to cope well and do not get ill (Lund et al., 2010). Further, many people experience growth and find positive lessons from stressful experiences, as studies of cancer survivors demonstrate. Thus, coping mechanisms can be important influences on psychological and physical health outcomes. Support from friends, family, and health care providers in the face of stress can also have profound effects on psychological and physical outcomes. The illness experience, medical treatment, a diagnosis of illness, and fear of developing an illness can also serve to provoke stressful reactions. This includes aspects regarding how an individual may experience and cope with stress, as well as how well they adhere to health professionals' advice. Reactions to stressors can both promote or inhibit healthful practices. A better understanding of theory and the empirical literature on stress and coping is essential to developing effective strategies and programs for individuals to improve coping and enhance psychological and physical well-being. Coping with stress thus needs to be a primary focus in intervention activities at the individual level (Barlow &Durand, 2012; Glanz et al., 2008; Lund et al., 2010).

3.4.2.2 Social environment

The social environment is viewed as being one of the most significant influences on an individual's behavior. This is particularly true with regard to mental health related problems, as although individual cognitive functioning is critical in the onset and development of mental illness, an individual's social support system shapes the nature and course of this illness, with regard to the individual's ability to recover, the sustainability of this recovery, their reintegration into society and their ability to adapt to, and cope with their illness (Altamura, Lietti, Dobrea, Benatti, Arici & Dell'aOsso, 2011; Barlow & Durand, 2012; Glanz et al., 2008; Lund et al., 2010).

Primary needs presented by mentally ill patients at this level would include that of relational interactions and support networks, social participation and inclusion and community affiliation.

Support groups are a significant aspect of functioning and resource provision at this level (Altamura et al., 2011; Barlow & Durand, 2012; Nicholas et al., 2010). This is a form of service delivery which is at a minimum in South Africa, despite it being stipulated in the new Mental Health Act as a primary action for community-based services and support (Mental Health Act, 17 of 2002).

Respondents of a study conducted on mental health service delivery in South Africa in 2010 (Lund et al., 2008) generally felt that existing stigma against mental illness was something highly problematic within South African societies. The consequences of this are that individuals suffering from mental disabilities are often feared, ridiculed, exploited, neglected, isolated and even rejected by family members and peers. This can then be seen to have a negative impact on the individual's ability to obtain employment, access social security and health care, as well as maintaining housing and security (Lund et al., 2008:52-53). Respondents in this study further identified that stigma by health care practitioners also seemed to play a part in a mentally ill patient's ability to access adequate care and support in terms of there still being an existing fear regarding violent behavior of patients with mental illness, along with a lack of professional expertise and experience (Lund et al., 2008).

The stigma which is so often attached to living with a mental disorder can result in poor self-esteem development in sufferers of mental illness; this then only adds to an individual's poor sense of self-worth which already exists as a symptomatic response to most mental disorders, particularly those with a tendency toward depressive episodes (Barlow & Durand, 2012).

According to the definition provided by Germain & Gitterman (1980:1), the ecological paradigm is made up of the perception that human needs and problems are generated by the transactions between people and their environments. This can be seen as being particularly true with regard to the social aspects which serve to influence the onset of mental illness and the consequential recovery of the mentally ill individual, with regard to risk of relapse and symptomatic breakdown. Aspects such as adaptation, reciprocity, mutuality, stress and coping can be reflected upon in order to generate a better understanding of the impact that the environment has an individual functioning (Johnson & Yanca, 2007:406).

However, the effectiveness of this level is strongly dependent on the individual themselves. Core characteristics and strengths can be developed through the use of support groups, positive relationships and psychotherapy. The cognitive-behavioral approach discussed in chapter two is a treatment which can be significantly effective in strengthening an individual's functioning at the individual level, and thus in turn influence their functioning in their social environments also (Barlow & Durand, 2012). Medication can have a direct influence on the mental capacities and intrapersonal functioning of an individual living with this illness, also then positively influencing their ability to interact with others and function effectively in society (Altamura et al., 2011; Barlow & Durand, 2012).

In terms of service rendering at this level, the most effective action would be that of social network support groups within communities. The term social network refers to the web of social relationships that surround individuals. The provision of social support is one of the important functions of social relationships, and of interventions implemented by a social worker within an outpatient context (Barlow & Durand, 2012; Glanz et al., 2008; Johnson & Yanca, 2007). More recently, the term social capital has been used to describe certain resources and norms that arise from social networks (Ferlander, 2007). Social networks give rise to various social functions: social influence, social control, social undermining, social comparison, companionship, and social support (Jamner & Stokols, 2000; Glanz et al., 2008). The primary goal of support groups is to help individuals cope with stressful life events, toward re-vitalizing and enhancing one's coping mechanisms; this promotes optimal functioning and development and can be extremely valuable for the mentally ill patient. Such support groups can be offered through both formal and informal institutions and organizations (Barlow & Durand, 2012).

3.4.2.3 Physical environment

The physical environment can be viewed as being made up of aspects of the meso-system, as identified by Bronfenbrenner (1979), in terms of organizational or institutional structures that shape the environment in which the individual and interpersonal interactions occur (Gregson, 2001; Johnson & Yanca, 2007). An individual's workplace and organizational involvements are located within this system. Examples can also be found in structures such as schools, companies and working environments, churches and sport teams. According to Bronfenbrenner (1979), the richer the medium for communication in this particular system, the more influential it is on the

microsystem. The physical environment is identified by theorists McLeroy et al. (1988) and Fisher (2005) as being of great influential significance with regard to serving as the overall framework in which all other interactions and functioning takes place.

Therefore, with regard to the meeting of exhibited needs at this level, aspects which create a positive physical environment are important. Such aspects can include a stable and secure employment status, a degree of job satisfaction, religious affiliation, such as church group involvement, and access to appropriate medical care (Barlow & Durand, 2012). It is important here to note that although medical care falls under the meso-system in terms of direct contact and interaction with local clinics and hospitals, the overall operating of the public health sector and its broader influence on individual functioning is viewed as being found at the policy development level.

Other aspects which are significant within the physical environment include housing, security, access to public and private services, income status, transport services and community structure (Bronfenbrenner, 1979; Johnson & Yanca, 2007; McLeroy et al., 1988). In the study conducted on mental health services in South Africa in 2008, twenty percent of respondents participating in the study identified poverty as a central issue for mental well-being. Poverty was seen as a force which serves to erode the mental wellbeing of the national psyche, and thus limits the availability of resources and support, in terms of physical, social and economic resources, that communities are then able to invest in individuals with mental disabilities (Lund et al., 2008:49). Within a South African context, poverty is most likely the highest influencing factor in the onset, course, nature and recovery of mental illness within the physical environment. Ensuring equitable access to necessary resources and tangible, physical support for mentally ill patients is a key role for mental health practitioners, and particularly social workers, at this level. The benefit of optimal intrapersonal functioning and strong social support systems cannot be fully realized or maximized if the physical environment in which it operates is limiting in this regard (McLeroy et al., 1988; Fisher, 2005). According to Lund et al. (2008:49):

“Individuals with mental illness may be further impoverished by the exclusionary impact of stigma, and obstacles that prevent them from accessing the already scarce existing resources in poorer communities; this includes work privileges.”

This serves to further highlight the significance of social work service rendering and overall support at this ecological level.

3.4.2.4 Policy

Finally, the policy context encompasses all aspects of individuality, social support and physical environments; at this level, the legislative documents such as the White Paper for the transformation of the health system (1997), the National Health Policy Guidelines for improved mental health in South Africa (1997) and the more recently revised Mental Health Care Act (17 of 2002), which was promulgated in 2004, consistent with international human rights standards (WHO, 2005), have direct influence on how an individual experiences mental health services, care and support, as well as how communities and society overall views and deals with the issue of mental health (Bronfenbrenner, 1979; Johnson & Yanca, 2007; McLeroy et al., 1988). Other applicable policies include policy which dictates the provision of social grants and security for the mentally ill. The issues of stigma, however, seem to reach as far as policy and legislation. The gap that exists between the burden of mental illness and the related lack of mental health resources and services in South Africa can be considered to be a human rights issue (Burns, 2011). Psychiatric hospitals remain outdated, and community mental health psychosocial rehabilitation services remain underdeveloped. In this regard, the need for the physical and social environments to match that which is theoretically outlined within the policy context is key to creating an overall environment which supports the mentally ill patient. Although appropriate legislation does exist, and a revised mental health care act was approved in 2002, this policy has not necessarily been widely published or implemented. There is no established national mental health plan, outside of the Mental Health Act (17 of 2002),nor an outlined budget specific for mental health (Burns, 2011). Instead, health services are funded through general health budgets, and often do not receive the necessary resources which are often required (Burns, 2011). Concrete and emotional support for the mentally ill is an area within social service delivery which requires increased focus and policy amendment. The state has an obligation to provide services for the health needs of its people (Bill of Rights, 2006), however, services for the mentally ill are mostly inadequate and inaccessible (Barlow & Durand, 2012; Burns, 2011).

Needs presented at this level are slightly harder to identify and to assess than those of the other three levels. This is due to the fact that the policy environment comprises of a broader cultural,

political and ideological framework which serves to influence the functioning of the three previously discussed systems (Bronfenbrenner, 1979; Fisher, 2005; Johnson & Yanca, 2007; McLeroy et al., 1988). The functioning of the various governmental and NGO sectors, in terms of policy and procedure, would be influenced by larger and more broad legislative actions. Therefore, services rendered through NGO's and government organizations which serve to meet both the medical and psychosocial needs of the mental health community would be directly impacted and developed at this level. Services such as treatment facilities for the mentally ill, the public health sector, policy regarding the provision of medication to clinics and local hospitals, as well as the establishment and running of organizations which provide services mentioned at the individual, social and physical levels can thus be considered to be significant in this category. These services and organizational resources do not necessarily involve direct participation from the individual, but rather serve to influence policy and a broader framework within which individual functioning and interaction takes place (Bronfenbrenner, 1979; Johnson & Yanca, 2007).

Aspects such as cultural contexts which surround an individual should also be considered at this level; such contexts are not always geographical or physical, but can also include emotional and ideological aspects. Examples can include that of Western culture, religion, and the broader political climate (Johnson & Yanca, 2007). The way in which a country is governed and run can have a strong impact on the lower micro and meso levels; thus, the macro system is often considered to be the most influential of the three systems.

Social stigma and prejudice, though affecting the individual at the individual and social level, largely develops and is directly influenced through cultural and social attitudes regarding the norm, which is often as a direct result of legislative policy. Media influence also plays a large role here (Bronfenbrenner, 1979; Johnson & Yanca, 2007).

Key service rendering at this level would require social policy advocacy by mental health practitioners, toward establishing a sound policy format that provides the necessary boundaries and spaces for optimal individual, social functioning within a resource-rich and readily accessible physical environment.

3.5 OUTPATIENT AND COMMUNITY-BASED CARE

In reflecting upon the above identified needs and nature of service rendering, according to an ecological framework, it can thus be understood that the aspect of outpatient and community-based care is of crucial importance toward the overall functioning, support and recovery of the mentally ill patient. This is particularly significant when considering policy actions which have limited the availability of institutional care. A basic definition of such care, as well as its current status within the South African context will be reflected on below.

3.5.1 A definition of outpatient and community-based care

The Mental Health Care Act (17 of 2002) clearly legislates for less restrictive care, and advocates for service rendering that is offered as close to the patient's community as possible. The Act states that only when outpatient services are considered to be insufficient to address treatment needs, should institutional care then be implemented in order to provide safe treatment and stabilization services; this should, however, be for as short a period as is needed for the individual to return to community life. That being said, according to such legislation, inpatient mental health care should preferably be offered in a general hospital setting, with specialized hospital care available for only more intensive mental health care, if required. Patients who have lived in an institutional care setting for longer periods are identified as needing access to rehabilitation services post release, in order to prepare them for a return to community life. All patients who require short term or long-term support for work, study, and family and community life should have full access to necessary psychosocial support services. To this end, the Act stipulates the development of community based services and support systems that promote the mentally ill individuals recovery and reintegration into society (Lund et al., 2010).

Simply defined, an outpatient is an individual who receives medical and/or therapeutic care, but is not hospitalized for 24 hours or more. Instead, services are rendered through a day clinic, or associated non-governmental and/or non-institutional facility. Community-based care refers to services that are rendered through community structures and organizations, which are locally based and established within the patient's closely related physical and social environments (Lund et al., 2010).

3.5.2 The present structure of outpatient and community-based service rendering within the South African context

In 2008, a study was conducted on the overall service provision and availability within the mental health sector in South Africa; this was the last extensive research conducted on mental health services which will be utilized as a baseline for understanding the current context of mental health outpatient and community-based service rendering in the South African context (Lund et al., 2008:48). The country report for South Africa found that 50% of respondents participating in the study highlighted the fact that mental health remained a low priority, despite the seemingly progressive policy framework. Research through this study found that mental health is not necessarily at the forefront of policy development and implementation, and little integration exists with regard to that of mental health and other key sectors.

According to this study, there are 3,460 outpatient mental health facilities available in the country, of which 1, 4% are for children and adolescents only. These facilities treat 1,660 users per 100,000 general population annually. In the Western Cape, data on the average number of contacts per year was 1.7, while data on the percentage of outpatient facilities that provided follow up care in the community as a mean result for all four provinces as 44%.

There are 80 day treatment facilities in the country; these facilities treat on average 3.4 users per 100,000 general population. There are 41 psychiatric inpatient units in general hospitals available in the country with a total of 2.8 beds per 100,000 population, with 3, 8% of these beds in community-based inpatients units being reserved for children and adolescents only. These facilities are provided for and run by provincial health authorities. In addition to this, the National Department of Health officials reported that 53% of all hospitals have been listed to provide 72 hour assessments of psychiatric emergencies, in keeping with the provisions of the Mental Health Act (17 of 2002). This includes 131 of 251 district hospitals, 28 of 59 secondary hospitals, and 14 of 33 tertiary hospitals. However, despite such written establishments, there are major concerns regarding the capacity of staff and facilities to provide adequate mental health care in these hospitals (Lund et al., 2008:100-102).

There are 63 community residential facilities available in the country, of which 47% are provided for by the SA federation for Mental Health. These facilities provide a total of 3.6 beds per 100, 000 population.

There are then 23 remaining mental health hospitals in the country, providing a total of 18 beds per 100,000 population; 79% of these facilities are organizationally integrated with mental health outpatient facilities. The number of mental health hospitals has decreased by 7, 7% in the last five years; the Western Cape showed a dramatic 21% drop rate (Lund et al., 2008). The average number of days spent in mental hospitals in the Western Cape was 32 days. No other provinces were able to provide this data.

Respondents who were interviewed in the study of Lund et al. (2008) on the current issues which existed in mental health service delivery stated that the policy of deinstitutionalization, intended to support user access to services and continued integration into community life, had at that point in service development primarily resulted in "de-hospitalization": a cost saving exercise without the simultaneous development of the necessary community based supports to assist users and their support systems to cope with psychosocial disabilities within a community setting. Consequences of poorly planned deinstitutionalization were identified as: frequent relapses –and consequently frequent re-admissions to over-burdened services – family strain, and decreased support of users. These resulted in mental health service users being exposed to violence, abuse and neglect, impoverishment and adverse living conditions. The issue of support to families was a discussion strand with the overall issue of increased reliance on community care without increased development of supports, which spontaneously emerged as an area of concern for respondents (Lund et al., 2008:66-67).

Key issues were identified by respondents in the study of Lund et al. (2008) during semi-structured interviews at the national and provincial level, two of which were the integration of mental health within general health, and deinstitutionalization and the need for community-based mental health services. With regard to the integration of mental health into general health care practices, the core principles of the policy, as laid out relevant policy documents such as the Mental Health Care Act (17 of 2002), were supported, however respondents felt that human resource constraints existed at the primary health care level which then impacted significantly on

the primary health care worker's ability and willingness to treat mental health care users (Lund et al., 2008:166).

In terms of deinstitutionalization and the need for community-based mental health services, respondents felt that in practice, deinstitutionalization has often been used to motivate for the downsizing of large institutions without the corresponding development of community residential, general hospital, and outpatient mental health care services (Lund et al., 2008:170). The need for the development of a community based mental health policy and services, adequately funded service level agreements with NGOs to set up and manage these services, within an intersectoral framework of service development, was among the strongest themes which repeatedly emerged during the interviews across stakeholder groups. Respondents within the study of Lund et al. (2008)were also concerned about the increased burden of care on families and the negative impact on user wellbeing which results from hastily reduced hospital services in the absence of community based treatment and support services. The lack of community-based mental health services was also viewed to burden facility based health centers, putting additional pressure on already stretched primary health services and hospital beds, with then adverse consequences for quality care provision (Lund et al., 2008).

3.5.3 The role of the social worker in outpatient and community-based care

As discussed in chapter one, the traditional role of social workers in mental health care primarily involved working with patients and families to facilitate effective communication between patients, families, and health care teams (Gehlert & Browne, 2012) in ways that would then decrease barriers caused by issues such as low health literacy. This is still a significant activity which needs to be undertaken by the social worker. However, their role has expanded to include many activities such as case management, within both in- and outpatient and community-based care, supported employment, residential care, psychosocial support, family therapy and support, and assistance in basic reintegration into society and the needs associated with this (Barlow & Durand, 2012; Johnson & Yanca, 2007). According to Gehlert & Browne (2012), based on a comprehensive psychosocial assessment, social work interventions also need to include helping patients and families to obtain and understand health information and to apply that information to better their health after discharge. This is a service which is not rendered by any other mental health professional in both the in- and outpatient and community-based setting. With regard to

case management specifically, the social worker can be found to have an important role to play in rendering services of assessment, planning, coordination of services, and crisis intervention. According to Johnson & Yanca (2007:431), services such as these are vital to advancing the quality of life of mentally ill individuals and ensuring that their basic needs are being met. Case managers are also required to monitor a patient's needs with regard to medication and symptomatic display, linking patients to the relevant services and treatment where necessary (Johnson & Yanca, 2007).

Individuals who utilize services have been shown to value the non-stigmatizing help and access to services which provided specifically by social workers as a result of the core values of social work practice which directly supports the principles underpinning self-directed support and the independent living movement, thus keeping in step with the theme of deinstitutionalization as stipulated by relevant legislation and policy (Glanz et al., 2008).

The significant role of social work in promoting the direct involvement of individuals who make use of such services, and developing systemic approaches to practice with families and groups has also been identified as being of particular importance by Glanz et al. (2008). Joint-working initiatives between social services and child and adolescent mental health teams was identified as having positive effects; this encompassed an extended therapeutic role for social work practitioners that included family therapy. Through service rendering such as this, positive outcomes including quicker response times, more effective prioritization, improved multidisciplinary work and a more positive experience for children and families have been identified (Glanz et al., 2008).

That being said, it is important, in reflecting on the current context of social work within mental health, to recognize that, at the time of the study conducted by Lund et al (2008), the total number of human resources working in the Department of Health or NGO mental health facilities per 100,000 population country wide was 11.95, and of this, only 0.4 were recorded as being social workers. Therefore, with the increased focus being on outpatient services, and a poor availability of specialized social workers, general social workers are now being faced with the task of rendering intervention services to such individuals (Lund et al., 2010). The high influx of mentally ill individuals into local communities, a lot of whom are unstable and untreated, is also having an effect on general social work practice, impacting areas of crime,

family structure and functioning, child abuse, domestic violence, family violence and unemployment (Lund et al., 2010).

Recently mental health experts have recommended new methods of mental health care in low middle income countries (LMICs) that are adapted to the local needs and resources, e.g. involvement of non-psychiatric staff, non-medical staff (e.g. nurses), and low dose neuroleptic treatment in the community(Barlow & Durand, 2012; Glanz et al., 2008; Lund et al., 2010). This calls directly for the increased involvement of the generic social worker in mental health care and service rendering.

Several typologies of social network and social support interventions have been suggested (McLeroy, Gottlieb & Heaney, 2001). This includes interventions which serve to enhance existing social network linkages, as well as developing new social network linkages, thus both maintaining and further developing the social environment and context of the mentally ill individual. Further suggestions include enhancing networks through the use of indigenous natural helpers, and enhancing networks at the community level through participatory problem-solving processes(Jamner & Stokols, 2000).

Self-management and quality clinical care are dependent on each other. Without sound clinical care, the individual's efforts may be misdirected. Without self-management, clinical care will fall short of its potential, through failure to achieve healthful behavior patterns. The social worker can be viewed as being the mediator between the two, working with the patient at a personal and individual level in the form of therapeutic interventions; working with families toward improved social support; implementing community development schemes toward in order to develop a more positive physical environment and increased resource access; as well as advocating for improved mental health legislation and policy that is beneficial for the patient and their optimal functioning, treatment and recovery, according to an ecological perspective (Glanz et al., 2008; Jamner & Stokols, 2000).

The exact role of the generic social worker in mental health service rendering, particularly in light of movements such as deinstitutionalization, is an issue which needs to continue to be adequately researched and debated, both in theory and in practice.

3.6 CONCLUSION

Mental health care is strongly based on outpatient and community-based initiatives, as stipulated by policy acts such as the revised Mental Health Care Act (17 of 2002). The significance of such services is evident when reflecting on the needs of the mentally ill individual according to an ecological framework and the models of socio-ecological behavior development and interventions as presented by theorists Bronfenbrenner (1979), McLeroy et al. (1988), Flay and Petriatis (1994) and Fisher (2005). However, despite this, the current context of such services within South Africa is poor and in need of further development. The role of the social worker in this regard is becoming increasingly apparent and recognized (Glanz et al., 2008; Lund et al., 2010), although the exact nature of this role is still uncertain and poorly researched. Thus, the views of generic social workers on their role in mental health outpatient and community-based services is important and necessary to examine, in order to work toward a more optimal service delivery system within mental health care.

The views of social workers on their role in mental health outpatient and community-based care was explored in further detail through the means of an empirical study and semi-structured interviews. The resultant data has been analyzed and presented in chapter four, with relevant reference to the correlation of this data according to the literature as presented in chapters two and three.

CHAPTER FOUR

EMPIRICAL INVESTIGATION OF THE VIEWS OF SOCIAL WORKERS ON THEIR ROLE IN MENTAL HEALTH OUTPATIENT AND COMMUNITY-BASED SERVICES

4.1 INTRODUCTION

The following chapter aims to meet objectives three of the research, as established in chapter one. In doing so, the views of social workers on their role in mental health outpatient and community-based services will be discussed according to the implementation of an empirical study.

The resultant data of the study will be analyzed according to both quantitative and qualitative analysis, thus adopting a combined approach, as indicated with regard to the established research methodology; however, qualitative data analysis will be the primary focus for the empirical study. Therefore, both statistical analyses of the numerical data through the utilization of tables and figures, as well as interpretations of narratives provided by participants will be presented. This data was collected through the use of semi-structured interviews and the data wasanalyzed according to an exploratory and descriptive research design. Reference to the literature study as provided in chapters two and three, and discussions regarding its correlation with the presented data, will also be provided toward appropriate deductions regarding the identified themes, sub-themes and related categories.

SECTION A: RESEARCH METHOD

In this section, an overview of the research method employed for the gathering of data toward the interpretation and analysis of the empirical findings will be presented.

4.2 PREPARATION FOR THE INVESTIGATION

4.2.1 Pilot study

A pilot study, as a means of a trial run, was conducted whereby the data collection method was implemented with a smaller group of participants, in order to test the established method and ensure that it is both efficient and effective. According to De Vos et al. (2012:73), the pilot study is "a dress rehearsal for the main investigation". In this study, a purposive selection of two respondents was utilized to test the data collection process, and necessary changes which were identified during these interviews were then implemented accordingly, thus ensuring a valid and effective study.

4.2.2 Research sample

The sample group was made up of 20 social workers; all participants had some experience in mental health, having worked with or had experience with mentally ill clients in some capacity. A wide scope of social work contexts and organizations were utilized, including social workers from government departments, community NGOs, private organizations, clinics and rehabilitation centers, as well as state hospitals and institutions.

The criteria for inclusion within the sample group were as follows:

1. Participants must be registered, practicing social workers within the Western Cape area.
2. Participants must be social workers either working within a mental health care context, or within an outpatient and/or community-based context with some experience of mental health in their generic social work practice.

4.2.3 Research approach, design and instrument

A combination of both qualitative and quantitative research approaches was employed (Alasuutair et al., 2008:15). Quantitative research relies on measurement to compare and analyze different variables (Bless et al., 2006:43). This was done through the use of relevant tables and figures. The qualitative data was analyzed through the discourse and narratives of participants, with excerpts according to identified themes, sub-themes and categories.

A combination of exploratory and descriptive research designs was utilized as the framework for the research approach, in order to allow for the utilization of both quantitative and qualitative design elements.

The instrument for data collection was a semi-structured interview schedule, conducted during interviews with social work professionals. A set of predetermined questions were established, in line with the presented research problems, aims and hypothesized themes. The interview was not strictly dictated by this schedule, but was rather guided by the overall structure of the interview schedule, according to the outlines provided for by De Vos et al. (2012:351-352). Appropriate climate-setting techniques were implemented in order to ensure that the participant was comfortable and able to share freely during the interview (De Vos et al., 2012:353).

4.2.4 Data gathering and analysis

In this section of the chapter, the data obtained through the study will be evaluated through both a quantitative and qualitative analysis. The information provided by the twenty participants who participated in the study will be organized within the distinctive themes of biographical information of participants, training and knowledge in mental health, the mental health care context in terms of services at the outpatient level, the mental health act (17 of 2002), social work in mental health, the mentally ill service user and finally, referral and co-operation. These themes were established in the semi-structured interview schedule and the resultant data as presented by respondents will then be discussed according to the predominant sub-themes and categories which were identified; the existing relationship between the data and that of the literature study presented in the previous two chapters will also be evaluated.

Data analysis refers to the process whereby order, structure and meaning are brought about to the data which has been collected (De Vos et al., 2012). Marshall and Rossman (1995:113) highlight the necessary steps involved in the data analysis process which were utilized in this study, toward ensuring an effective structure, organization and understanding of the data collected through the interviews. These necessary steps involved that of organizing the data by means of being aware of the existing content, and from this understanding, generating relevant categories, patterns and themes. The third step in the data analysis process involved the act of linking patterns, providing appropriate explanations for such patterns or themes, as well as searching for

possible alternatives. Finally, the data will now be presented in this chapter, using both qualitative and quantitative scientific means of presentation. The quantitative data is presented through means of tables and figures, while the qualitative data will be discussed according to established categories and themes, and the use of direct respondent discourse. According to De Vos et al. (2012:402), the results, both qualitative and quantitative, must be verified against the literature presented in the literature study, and it must be further embedded in larger perspectives/paradigms.

SECTION B: BIOGRAPHICAL INFORMATION OF PARTICIPANTS

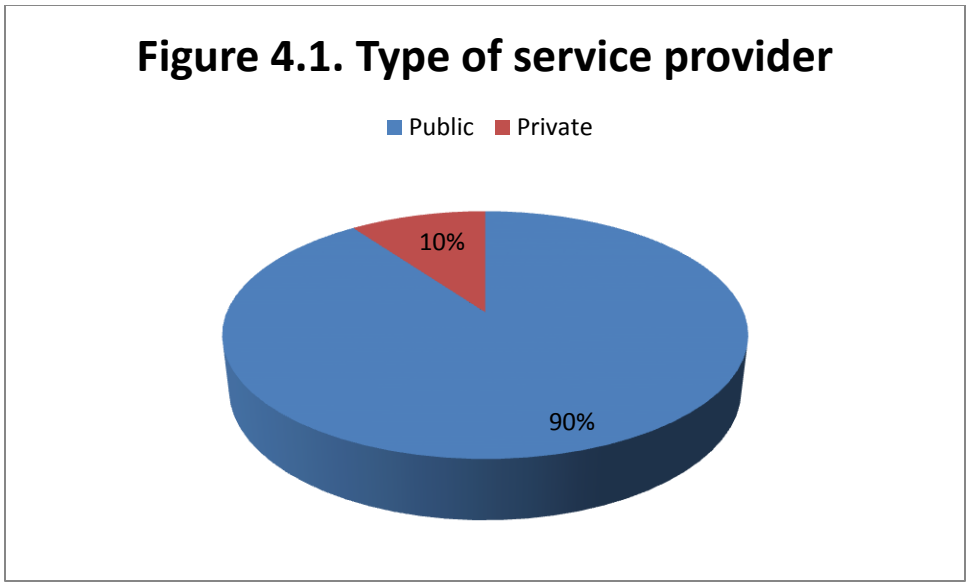
In this section, the biographical information of the participants will be discussed, according to the predetermined set of questions on the semi-structured interview schedule. This will be done by means of quantitative data analysis and the use of various figures and tables.

4.3 BIOGRAPHICAL INFORMATION OF PARTICIPANTS

The biographical information of participants will be presented in terms of the type of service provider, the core business of the participants, their position within the organization, their years of experience, the average caseload per month, and the percentage of clients within this caseload that present with or are affected by mental illness.

4.3.1 Type of service provider

Participants were asked to give an indication of the type of service provision that they render, in terms of being a public or private organization. The resultant data is displayed in Figure 4.1. below:



N = 20

Eighteen of the participants (90%) indicated that they were public service providers, with only two participants (10%) classifying themselves as being within the private sector.

The term 'service provider' refers to individuals who are either, through a professional capacity or as a volunteer, rendering services to those in need within a particular field (Hepworth, Rooney, Rooney, Strom-Gottfried & Larsen, 2006).

4.3.2 Core business

The participants of the study were asked to give an indication of their core business at the various organizations within which they were practicing as social work professionals. The information they provided has been organized below in table 4.1.

Table 4.1: Core business of service providers

Core Business	**F**
Casework	8 (40%)
Family therapy	7 (35%)
Psychiatric illness	4 (20%)
Emotional adjustment	3 (15%)
Group work	6 (30%)
Referral	4 (20%)
Assessment	3 (15%)
Intellectual disability	3 (15%)
Psycho-education	3 (15%)
Crisis intervention	2 (10%)
Home visits	2 (10%)
Rehabilitation	2 (10%)
Screening	2 (10%)
Therapeutic counseling	2 (10%)
Addiction counseling	1 (5%)
Child Protection services	1 (5%)
Community work	1 (5%)
Corporate social work	1 (5%)
Geriatrics	1 (5%)
Maternity services	1 (5%)
Pregnancy counseling	1 (5%)
Reintegration	1 (5%)
S Social work management	1 (5%)
Statutory intervention	1 (5%)
Substance Abuse	1 (5%)
Trauma counseling	1 (5%)

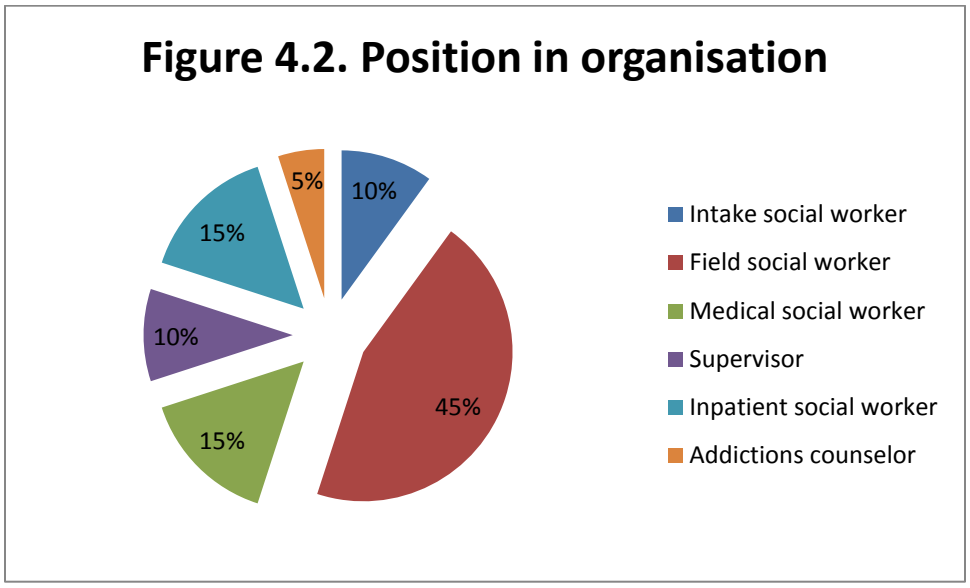
N = 20 *Participants could give more than one answer

The core business of the service providers can serve to reflect the core needs of mentally ill clients and service users. According to Waghorn et al. (2007), one cannot overlook the psychosocial areas which need to be addressed by relevant social work professionals through the rendering of welfare services. There exists a key role for social work professionals in order to develop optimal and holistic recovery. The broad scope of service provision by the participants also gives an indication of the wide knowledge and expertise base exhibited within the social work profession.

The researcher found it significant that, within the percentage of participants who were within the public sector, service providers who were more specialized in mental health services, in terms particularly of outpatient and community-based care, were predominantly that of the nongovernmental organizations over and above government facilities and structures.

4.3.3 Position in organization

Participants in the study operated at various positions within their organizations; these positions have been displayed in figure 4.2 below:

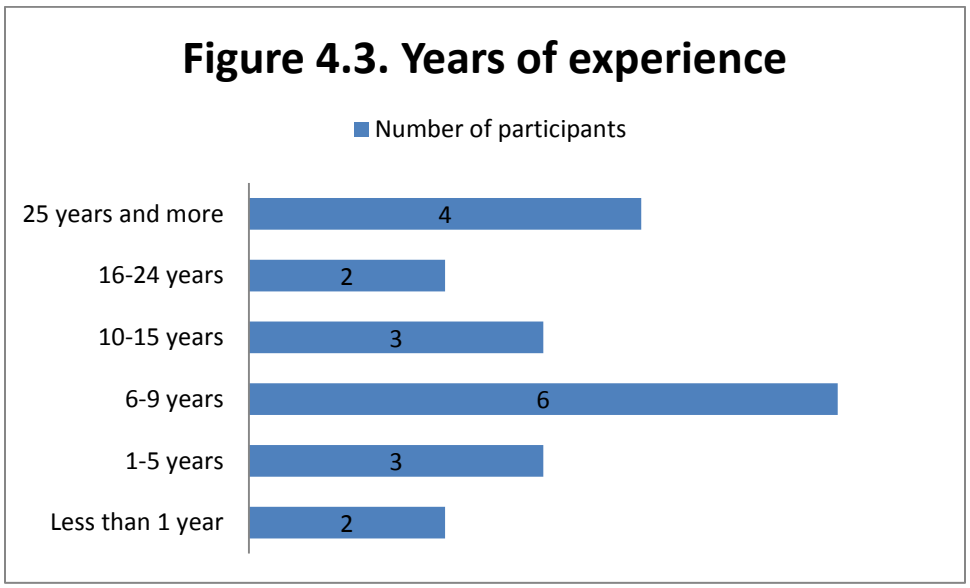


N = 20

Within the study, the nine participants (45%) were field social workers within their various areas of service delivery, be it generic social work or specialized. There were three (15%) medical social workers and three (15%) inpatient social workers. Following this were the positions of intake social worker and supervisor, with two participants (10%) within each category; one participant (5%) indicated their position as being an addictions counselor.

4.3.4 Years of experience

Participants were asked to give an indication of the number of years of experience that they had acquired working as a social worker. The resultant data is given below in the form of Figure 4.3.



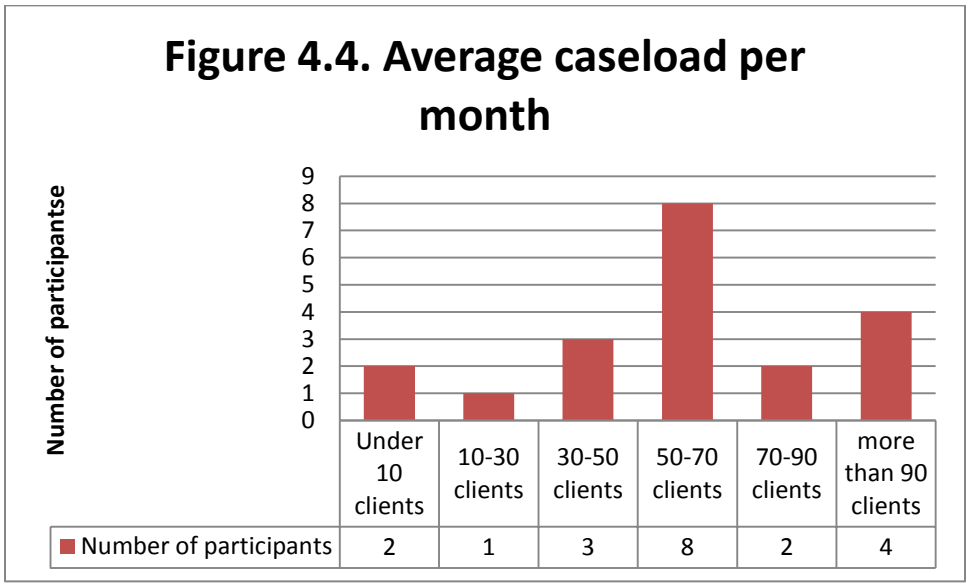
N = 20

It is evident, when analyzing figure 4.4., that the average participant, in terms of years of experience, is within the six to nine years category; however, based on the total value in terms of years of experience, and taking into account the number of participants, the mean value is sitting at 12, 3 years, despite the majority of participants (55%) being under this. Two participants (10%) had been working as a social worker for less than a year, three (15%) had been working for more than a year, but under, or equal to, five years, and six participants (30%) had six to nine years work experience. In other words, years of experience was on an average relatively high and

thus indicates significant experience within the field of social work practice, and for some, the field of mental health specifically.

Within the category of 10-15 years of experience, there were three participants (15%), with two participants (10%) falling into the category of 16-24 years, and finally, four participants (20%) had over twenty five years of experience as social work professionals. These two participants were also in the position of supervisor within their organization, at a grade two and grade three levels, based on their years of experience within the field.

4.3.5 Average caseload per month



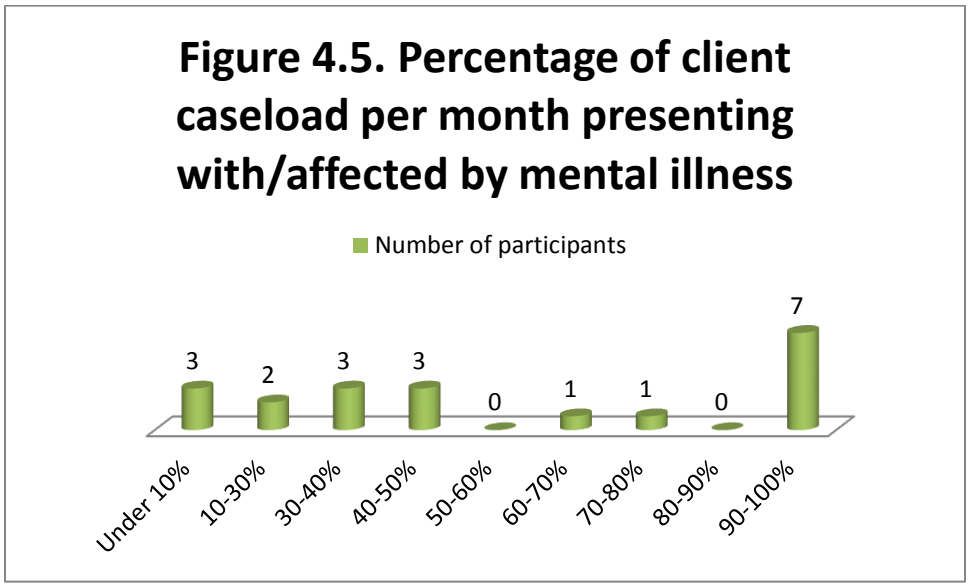
N = 20

The participants were asked to give an indication of their average caseload per month. Two participants (10%) said to see under ten clients per month, with one respondent acting as social work manager and thus only being brought in on more serious cases within the organization; the second respondent worked for a private rehabilitation clinic and thus worked only with four clients per month. Only one participant (5%) indicated that their caseload was within the category of 10-30 clients per month, and three participants (15%) were found to be working with 30-50 clients per month.

The predominant category was that of 50-70 clients per month, with eight participants (40%) indicating their caseload to be in this specified area. This matched up with the fact that the median average, in terms of the caseload quantity of the respondents participating in the study, was 60 clients per month. Two participants (10%) indicated that their caseload was higher than that of the 60-70 monthly categories, however not exceeding 90 clients per month. It needs to be noted that the second highest score as demonstrated on figure 4.5., was within the category of 90 plus clients per month, with four participants (20%) indicating their caseload average to be within this area; the highest caseload out of the pool of participants was at 160 clients per month.

4.3.6 Percentage of client caseload presenting with/affected by mental illness

Participants were requested to give an estimate of the percentage of their monthly caseload that involved clients who presented with, or where affected by in some way, mental illness. These estimates are displayed below in figure 4.5.



N = 20

The percentages provided above in figure 4.5 looks specifically at clients who made up the average caseload of the social worker per month that were in some way related to mental illness, either presenting with a mental health condition themselves or being in some way affected by mental illness which led to the need for social work intervention. The data shows that at the

minimum, three participants (15%) had under 10% of their caseload affected by/presenting with mental illness, whereas seven participants (35%) indicated that up to 90-100% of their clients per month were affected by mental illness in some way; in fact, six of these participants (30%) clarified that 100% of their client-base were affected by mental illness -these were participants who were practicing specifically within the field of social work and mental health.

Eight participants (40%) viewed their client caseload affected by mental illness as being between 10-50%, with the highest levels being between 30-50% of the client-base. Only two participants (10%) indicated their client percentage that can be linked to mental illness as being greater than 60% but under 80%, one in each category. Many participants in these categories, from 10-90% worked in either an NGO or hospital setting, and discussed the fact that their caseload was split between mental illness, intellectual disability, emotional adjustment disorders, which primarily was as the result of a traumatic experience as opposed to the onset of a mental illness, and substance abuse, of which drug-induced psychosis often would be a factor.

SECTION C: EXPOSITION OF EMPIRICAL FINDINGS

This section of the chapter will involve an exposition of the various themes, sub-themes and categories which were identified through the data collected in the semi-structured interviews. This will be done by means of an established process whereby each theme will be broken down into respective sub-themes. These sub-themes will then be analyzed according to identified categories; the categories for each sub-theme will be presented by means of a table, whereby the frequency of participant indication of this category, as well as representatives of participant narratives, will be presented. Following this, the categories will be analyzed using further participant dialog, tables and figures, as well as relevant literature and deductions of the researcher. Key words which indicate key findings will be made bold, in order to allow the reader to recognize that which the researcher has highlighted as key patterns.

All themes, sub-themes and categories are presented by the use of a table; this is identified as being important in the exposition of empirical findings within a study according to Bless and Higson-Smith (2004:140).

4.4 THEMES, SUB-THEMES AND CATEGORIES

Six themes were identified in the semi-structured interview schedule, which were then broken down into related sub-themes and categories according the data provided by respondents. These themes, subthemes and categories are presented in table 4.2. below:

Table 4.2. Themes, sub-themes and categories

THEMES	SUB-THEMES	CATEGORIES
1. Training and Knowledge in Mental Health	1.1. Undergraduate Training	• Poor training received by respondents at the undergraduate level • The need for increased training of undergraduate students in mental health
	1.2. Further training and knowledge development	• Postgraduate training • In-service training& CPD points • Personal professional development
	1.3. The generic social workers knowledge and understanding of social work	• Generic social workers are ill-equipped& don't view mental health as part of their service-rendering focus
2. Mental Health Context	2.1. Nature of community-based services	• Mental health community-based services viewed as being predominantly poor • Lack of resources for adequate service implementation
	2.2. Community-based services within an ecological framework	• Individual • Family • Community • Policy
	2.3. Service Accessibility	• Services are available but not always accessible • Traveling distance for clients to access resources • Scarce resources in rural areas
	2.4 Hospitals and clinics	• Hospitals overpopulated • Clinics have a lack of professional capacity

THEMES	SUB-THEMES	CATEGORIES
	2.5. Mental health as a priority issue	• Mental health not recognized as important by government • Poor government provision of necessary funding and resources for mental health care
	2.6. Caregivers and communities	• Caregivers of mentally ill patients recognized as a vulnerable group • Abuse of mentally ill patients by families and communities • Need for increased psycho-education in communities
3. The Mental Health Act 17 of 2002	3.1. Knowledge of the mental health act	• Poor knowledge of the new mental health act in the social work profession • Community knowledge of the mental health act
	3.2. Effect and implementation of the Mental Health Act	• Accommodation and homelessness • The need for institutionalization • Assisted living/half-way homes • Police co-operation
4. The mentally ill service user	4.1. Profile of the mentally ill client	• Prevalence of schizophrenia • Comorbidity • The elderly • Lack of services available for teenagers affected by mental illness
5. Referral and Co-operation	5.1. Multi-disciplinary team approach	• The importance of the multidisciplinary team in outpatient care
6. Social Work in Mental Health	6.1. Experiences of social workers	• Positive experiences • Challenges
	6.2. Need for social work in mental health	• Shortage of social workers • Importance of the social work profession in mental health • Integration of mental health

THEMES	SUB-THEMES	CATEGORIES
		into generic social work
	6.3. Role of the social worker in mental health	• Therapeutic intervention • Empowerment and Support • Advocacy • Psycho-education • Relational role • Seeing the patient holistically

N = 20

SECTION D: KNOWLEDGE AND TRAINING

In this section, knowledge and training will be explored in terms of the training received by participants at the undergraduate, postgraduate, professional, and personal level, as well their views on the nature and development of such knowledge, according to established sub-themes and categories as presented in table 4.2 above.

4.5 THEME 1: KNOWLEDGE AND TRAINING IN MENTAL HEALTH

The theme of knowledge and training in mental health will be discussed according to three sub-themes which were identified, in terms of undergraduate training, further training and knowledge development outside of the undergraduate curriculum, and the generic social workers knowledge and understanding of mental health. These sub-themes will be discussed according to eight respective categories as presented in table 4.2.

4.5.1 Sub-theme 1.1: Undergraduate training

Participants were asked to give an indication of the nature of their undergraduate training, in terms of the scope of theoretical and practical knowledge on mental health which was provided within their undergraduate curriculum. The categories that emerged within this sub-theme were as a result of predominant data patterns highlighting poor training received by participants in mental health at the undergraduate level, and the need, according to the views of the participants, for increased training of undergraduate students in mental health. These categories are outlined in table 4.3 below, with an indication of the frequency within the different category patterns, and

representative participant narratives. The respective categories will be explored in more depth with further participantdiscourse and a comparison with relevant literature.

Table 4.3: Sub-theme 1.1. Undergraduate training

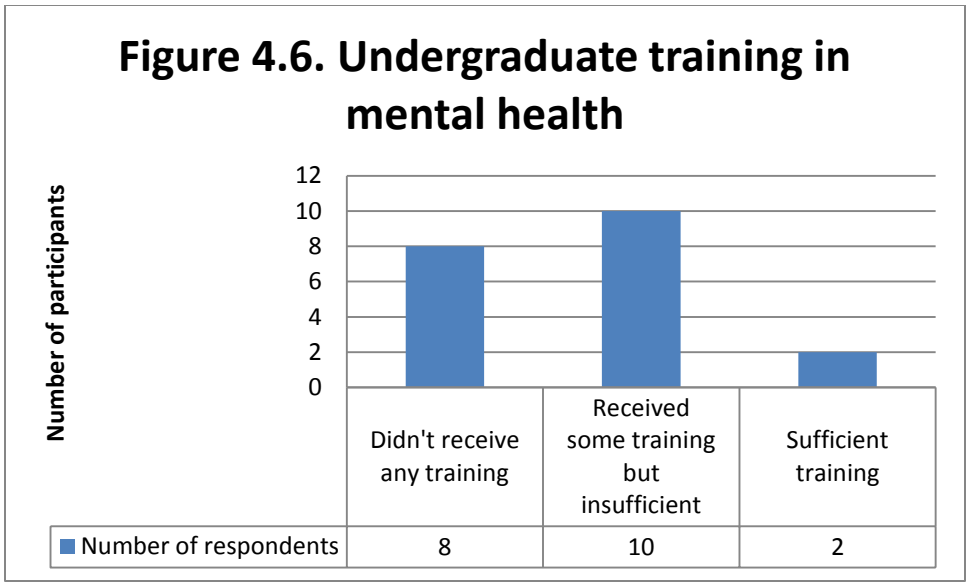
Category	**F**	**Representative participant excerpt**
Poor training received by participantsin mental health at the undergraduate level	• 8 (40%) No training • 10 (50%) Some training but insufficient • 2 (10%) Sufficient training	*"**Undergrad wasn't adequate enough**. I think with generic social work, it becomes very difficult to work in a psychiatric setting. I didn't feel like I had the skills that I needed to facilitate the groups or to do, like, building a therapeutic relationship and really work therapeutically with a client."* (Participant C)
The need for increased training of undergraduate students in mental health	• 20 (100%)	*"...the core **gap** at the moment is undergraduate"* (Participant E)

N = 20

This sub-theme will now be discussed and analyzed in more detail with regard to each identified category, with the aid of relevant tables, figures and participant discourse.

4.5.1.1 Category: Extent of training in mental health at the undergraduate level

Participants were asked to give an indication of the nature of the training that they received at the undergraduate level within the area of mental health. The resultant data, in terms of this identified category is provided in figure 4.6 below:



N = 20

In reflecting on the training of participants at the undergraduate level, it was found that very few had received sufficient training in the field of mental health in their undergraduate curriculums. Eight (40%) participants stated that they had received absolutely **no training** whatsoever in the subject of mental health and mental illness, while ten (50%)participants indicated that although they had received **some training** and theoretical understanding, it had been **insufficient** for the practical needs of working with mental illness in terms of social work service delivery. This is evident in the narrative provided by participant C in table 4.3 above.

The feeling of not being adequately equipped with skills to effectively implement intervention services within the mental health setting is further acknowledged by respondent Q:

*"No, **not equipped**. I was thrown into the deep end, just with my degree. I had to learn to swim"*(Participant Q)

This is also expressed by respondent O, where she discusses the fact that she did not even have sufficient knowledge regarding the different types of mental illnesses which existed, nor an understanding of the **terminology** utilized within this field:

*"Nothing, nothing at all. Even these big words like **schizophrenia**, I was like 'what, what, what?' Not at all"* (Participant O)

The predominant of the participants within this 50% category, where training had been received but was insufficient, attributed the training to the **psychology courses** which were a requirement within an undergraduate social work degree, however theory that was social work specific, in terms of mental health, was not provided and the knowledge developed within the psychology stream was **minimal and insufficient**, as expressed below by respondent P:

*"I think we touched on it – **we did psychology**, and then I did research psychology, but it was very broad. I think I left varsity feeling, ok, I have all this theoretical knowledge, but **no knowledge on how to actually implement**."*(Participant P)

Only two (10%)participants felt that the training they had received in mental health, within the undergraduate setting was indeed sufficient and had **adequately prepared and equipped them** for working within the field of mental illness. Of these two participants, one had started as a social auxiliary worker and had completed their studies while working at a non-governmental organization that was mental health focused in terms of service rendering, and so they felt that they had therefore received more specialized training and exposure then other students; this is demonstrated in their discourse:

*"Yes I think so, **it was enough to equip me** , was very generic, so we did everything from substance abuse, to mental health, to child protection, to criminal cases, we did everything"*(Participant R)

The second participant within this 10% category had completed her undergraduate studies in the older curriculum where fourth year was specialized and she had chosen to move into the clinical stream and thus received detailed training in mental health in this final year of her studies.

The notion that social workers do not receive sufficient training regarding mental health is identified in a study conducted by Olckers in 2013, in his analysis of the practicing social worker in clinical settings, "Social workers do not receive sufficient training in mental health diagnostic systems in undergraduate training" (Olckers, 2013:1).

According to Aviram (2002), mental health is considered to be a fundamental area within the social work profession, and thus training in this regard should be a requirement at the

undergraduate level; however, it is evident, from the data above, that mental health is not necessarily highlighted as a priority area within social work training.

As a result, the generic social worker, and the mental health professional have vast differences in terms of their knowledge base regarding mental disorders and the treatment thereof (Aviram, 2002; Olckers, 2013), and this results in graduate social workers being ill-equipped in this field.

4.5.1.2 Category: Need for further equipping of undergraduate students in mental health

In discussing the training that respondents had received in their undergraduate studies, the topic of further training for future undergraduate students in terms of theory regarding mental illness and mental health practice arose, and all twenty participants (100%) indicated that they felt that this was something that needed to be introduced. The views of participants on the exact nature and intensity of this training varied, however all were in agreement that it was a definite need and could serve to further enhance the role of the generic social worker in the field of mental health, through equipping them with the basic knowledge and skills. All participants (100%) indicated that, although also important in terms of follow-up knowledge development through postgraduate and professional training, this primary **equipping of the social work professional in mental health** expertise **needed to take place within the undergraduate context** first and foremost. This is evident when reflecting on the narrative of participant E, as partially provided in table 4.3 above and presented in full discourse below:

*"…so that's one of the big things that I do in my training is to re-iterate that **social workers need to understand that the act says they are mental health care practitioners**, and they know enough, **they should know enough about mental illness** to be able to say I think this person is ill and these are the symptoms I am seeing, and that is the reason why I agree, and I put my hand on paper to day please admit this patient against their will. **And I don't think a social worker stepping out of university understands that well enough to be able to be in that position**, but now its in the act and that's the way it works. That's the core need at the moment, in my opinion. I mean obviously we will carry on with postgrad and we'll always need to check up and continued professional development and things change in treatment and in understanding the illnesses, **but the core gap at the moment is undergraduate**."*(Participant E)

The reference to social workers being recognized as **mental health professionals** in the new mental health act will be discussed in greater detail later in this chapter under the themes of the mental health act and social workers and mental health care, as indicated in table 4.2.

The need for training of undergraduate students is further echoed by the following narrative from participant B:

*"**I think it really should be built into your undergraduate training**, because again, you know, I think social workers, I read somewhere, you know, we get to talk to magistrates, doctors, all of these things, but, our degree, a four year social worker, not everybody really takes their hat off to you, and **people don't think we know what we're talking about**, and yet we do have a lot of knowledge and training, but again, **because of the way the degree is structured**, we focusing on social policies and issues, and yes that is important, but **how many of us end up working in a clinical setting, or you come across it whether you want to or not**, if you working with a child , the mother could have a major depressive episode, are you going to run and phone another organization, yes I believe it should work like that, but you should also know the **basic steps**, 'this is what I need to identify with this mother, this is where I should be referring', at least get the process started, otherwise the poor person is running from pillar to post, again I get phone calls about, 'I have been here, I have been there', where as you could just take it in one go, and know where to refer. I genuinely get the sense some **social workers don't always feel equipped** to deal with certain situations, they don't get the right instruction… Obviously, you gonna get to speak to a psychologist and so on, you do get intimated if you don't know the **terminology** or what you're talking about."*(Participant B)

And further by participant C:

*"I think it should be introduced, if the focus now is not just, if we're moving away from just social worker just being about giving food parcels to individuals, which I think was what the generic social worker, or the field social worker, used to be in the past. If we're moving away from that, and we're wanting **more community-based services**, then I think it should be **introduced at undergrad level**, because it was **a huge gap for me** to go from having not done psychiatry, to doing psychiatry in honors, it was very difficult to start thinking in that way. If they can already start introducing it, it would be great."*(Participant C)

The narrative of participant B correlates with what was said by participant O in the earlier category of undergraduate training received by participants, where she acknowledged that she had graduated with almost no understanding or knowledge of the **terminology** utilized in the mental health field. Participants B and C also recognize the fact that there was a **large gap** that existed at the undergraduate level, in terms of the understanding and knowledge levels in mental health.

The need for an understanding of, and training in mental health within the social work profession is expressed in literature (Aviram, 2002; Olckers, 2013; Wilson, 2008). According to Aviram (2002) and Olckers (2013), in order to sufficiently support and assist social workers to deal with mentally ill clients even more efficiently, awareness of and training in mental health needs to be implemented. Researcher Aviram (2002) believes that training particularly in the utilization of a mental health diagnostic system, such as the DSM-IV-TR, could serve to empower not only the individual social work professional, but also the entire profession as a whole. However, according to Wilson (2008:589), it seems that the role of social workers in mental health, and related training in this regard, is being questioned. Many researchers, such as Aviram (2002), Olckers (2013) and Wilson (2008)state that the generic social worker needs to have a good working knowledge of psychiatric classifications of mental distress, and how to work effectively with this.

It is thus evident that there is not only a lack of sufficient training of undergraduate social work students in mental health, but also a need for such training in order to better render social work services within this field. This need for further training, as expressed by participants within the study, serves also to motivate the importance and role of the social work profession in the area of mental health care.

4.5.2 Sub-theme 1.2: Further knowledge and training development

In the semi-structured interview, participants within the study were asked to discuss any further training that they had received after their graduation as social work professionals, and whether this training had been mental health specific in anyway. The respective patterns that emerged where than classified into four categories, in terms of trends in postgraduate training of social workers, in-service training and CPD points, personal professional development and personal

experience as a form of knowledge and expertise. These categories are presented in table 4.4 below, with respective percentage descriptions and appropriate participant narratives.

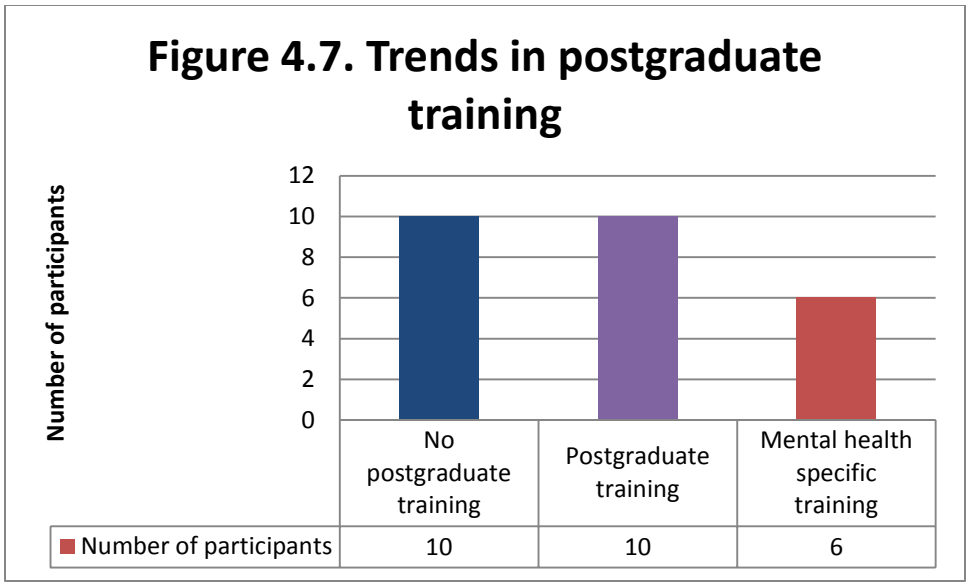
Table 4.4: Sub-theme 1.2. Further knowledge and training development

Category	**F**	**Representative participant excerpt**
Trends in postgraduate training of social workers	• 10 (50%) did not complete any postgraduate training • 10 (50%) completed some form of postgraduate studies –of this: - 6 (30%) trainingspecifically in mental health related subjects.	*Not relevant to the analysis of this data.
In-service training and CPD points	• 16 (80%) received in-service training through their organizations – the majority of this training was linked to the generation of CPD points. Of this: - 12(60%) received in-service training specific to mental health.	*"This goes for most NGO's out there; they do **provide a lot of training,** particularly [mental health NGOs] focus on training. Training and development is one of the pillars of the organization, and so we experienced some kind of training at least once a month, sometimes twice a month."*(Participant J)
Personal professional development	• 9 (45%) had undergone personal professional development within the field of mental health	*"Also that reassurance that your own **personal self-growth** is important, I don't think enough emphasis is placed on that"* (Participant B)

N = 20

4.5.2.1 Category: Trends in postgraduate training of social workers

In the exploration of further knowledge development of participants of the study, certain trends in postgraduate training were recognized, as highlighted in table 4.4 above. These trends are also demonstrated in figure 4.7 below:



N = 20

Of the twenty participants, exactly half (50%) had undergone some form of **postgraduate studies**, be this through short causes at the university in addictions, HIV/AIDS and counseling, or honor and master degree levels of training in a wide variety of topics. However, it was interesting to note that of these ten participants (50%) who had completed some form of postgraduate training; only six (30%) of them had specialized or further developed their postgraduate knowledge within the field of mental health specifically. The remaining 10 participants (50%) had received **no postgraduate training** at all; two (10%) had only been working as social work professionals for a few months, having graduated the previous year. Others spoke of areas that they would like to study further in, however expressed that they just didn't have the time to pursue this further.

It can be deduced, based on the trends and patterns demonstrated above, that postgraduate training, though perhaps considered to be significant within the social work profession, as indicated by those participants who did pursue this and those who expressed the desire to do so; however capacity in terms of the time to study further is not always available for the practicing social worker.

4.5.2.2 Category: In-service training and CPD points

In discussing further training after graduating as social work professionals, sixteen (80%) of the participants indicated that they had been adequately equipped in mental health knowledge and understanding through the in-service training that they had received within the organizations/departments/institutions in which they practiced social work service delivery.

Twelve participants (60%) indicated that this training was mental health specific, particularly those participants that worked in specialized mental health NGO groups, as well as those within the clinical and institutional setting. This training was also **CPD registered**, and all participants (100%) identified in-service training, CPD courses, and professional development within the working context to be at a good level, allowing for adequate equipping of the professional, as is confirmed by participant E below:

"It's a monthly, it's a one-two hours monthly academic program that you can voluntarily participate in, it's all ***CPD registered academic training****. And that is, that* ***includes everything in psychiatry****, bio-psychosocial model, disease model, the intervention from all different sides, you know, so sometimes its illness and treatment specific, you know, medication specific, and other times it would be bio-psychosocial specific. So that includes psycho-educational programmes, outreach programmes, lifestyle management recovery process, as well as illness or diagnostic specific training."*(Participant E)

According to relevant literature (Hepworth et al., 2006; Johnson & Yanca, 2007; Nicholas et al.,2010), **in-service training** within social service agencies is recognized as being a key means through which social work professionals are provided with the necessary knowledge and skills to improve overall agency performance and service rendering within their organizations, and is thus considered to be an important factor in **continued professional development** and growth. Through the analysis of data above, it can be deduced that while undergraduate training in mental health is poor, and postgraduate training is not always pursued, in-service training is implemented and effective in equipping practicing social workers within the field of mental health care.

4.5.2.3 Category: Personal professional development

Through looking at in-service and professional training with respondents, the theme regarding personal professional development emerged, where respondents indicated the importance of taking charge of one's own development and growth as a professional through personal endeavors. Respondents discussed the fact that they set aside personal time to read, increase their knowledge and understanding of mental illness and learn what they felt they lacked in terms of expertise in this area. Although respondents did highlight the fact that this form of knowledge development was provided through in-service training, 45% of respondents also recognized and stressed the fact that personal development was necessary. This is expressed through the narrative of participant B, as presented in table 4.4 and is echoed by participant Q below:

"I equipped myself because I bought myself books, I did a lot of reading" (Participant Q)

This is relevant when reflecting on the outlines provided by Johnson & Yanca (2007:289) for professional development. According to the authors, social workers must increase their professional knowledge and skills, and should work toward further contributing to the knowledge base of the profession. This therefore implies that social work professionals must be committed tocontinuing education and knowledge development throughout their careers. Although authors agree that this takes place primarily through in-service training (Hepworth et al., 2006; Johnson &Yanca, 2007; Nicholas et al., 2010), they also advocate for personal knowledge development through the reading of professional literature (Johnson & Yanca, 2007:289).

Within this category, it was further highlighted that **personal experience** in dealing with mental illness was a common factor for those participants who were actively equipping themselves in knowledge regarding this field. Nine participants (45%) indicated that they had been interested in mental health, and developed knowledge regarding mental illness, through personal experience with family members, friends, neighbors and communities. This personal experience had resulted in a desire to **increase their understanding** of this phenomenon, and this had then furthered the knowledge development process. This is addressed by participant J below:

"I was interested in mental health because I had a lot of ***neighbors and people that I knew that were experiencing mental health problems*** *and I wanted to* ***understand*** *them better and help them in the process."* (Respondent J)

This can be related to the social work principle of personal experiences impacting on professional practice and development, as outlined by Johnson & Yanca (2007) and Hepworth et al. (2006), where the principle of personal impact on service rendering is recognized as having an influential impact on the nature of service provision and client interaction of the social work professional.

4.5.3 Sub-theme 1.3: Social workers knowledge and understanding of mental health

Table 4.5: Sub-theme 1.3. Social workers knowledge and understanding of mental health

Category	F	Representative participant excerpt
Generic social workers are ill-equipped and don't view mental health as being part of their service-rendering focus	• 16 (80%) indicated that they felt generic social workers did not feel equipped to work with mentally ill clients • 14 (70%) raised the issue of social workers feeling this was a specialized field and not part of their focus	*"You know social workers are desperate for work, so people that just graduate apply for posts at psychiatric hospitals and then after six months to a year they leave and they go and work in a different system for less money perhaps because they just feel they* ***not equipped*** *and they not ready and it's too much and it's* ***too difficult*** *and its emotionally too tiring and draining and then we lose good people in the service, because they not well equipped."* (Participant E)

N = 20

4.5.3.1 Category: Generic social workers are ill-equipped and don't view mental health as being part of their service-rendering focus

In the data analysis process, it became evident that there was sufficient data regarding the pattern of participants expressing the view that generic social workers were ill-equipped to work with

mental illness. Sixteen (80%) participants raised this as an issue, particularly those who worked within specialized mental health non-governmental organizations, as well as government institutions. These participants expressed concern regarding the fact that many **social workers did not feel comfortable** working in such settings or with clients who were in some way affected by mental illness, due to being ill-equipped. This is demonstrated through the narrative of participant B below:

*"…as part of my role at intake I do get calls from other social workers, where immediately you can pick up the **anxiety**, 'I don't know anything about this person here', or they using incorrect terminology…I literally got to break it down for them and take them through it, you know, so what is the patient doing, and some of the questions are basic social work questions that any social worker, I believe, should be asking when you meet with the family, **not immediately wanting to run for the hills because the mother or somebody said, 'oh they were at [mental health institution]'**, or wherever the case may be in the past. I think **every social worker should feel comfortable** to explore with someone, 'ok so you're saying that you sons talking to himself or your family members doing x y and z,' to know the relevant questions to ask and not wanting to run when somebody says 'I want to commit suicide', and immediately pick up the phone and say 'oh I must phone the **specialist social worker** or which hospital do I refer, because **they don't feel equipped**."*(Participant B)

Further than this, fourteen (70%) of participants also raised the concern that generic social workers did not make the effort to equip themselves in this area because they did not feel that mental health was necessarily a focus in their service delivery, and instead felt that this was **a specialized task** that they needed to **refer** for. This was evident in the narratives above and is expressed directly by participant K below:

*"Definitely, I think it would definitely help. Because that is exactly what's happening, if, you know social workers will pick up the phone and say well you know this is somebody with intellectual disability, **it's not our field of expertise**, we do child protection, **we're shipping them off to you**, that is just what's happening."*(Participant K)

According to literature(Lund et al., 2010; Lund et al., 2002; Olckers, 2013) at a time of much change to professional roles and organizational structures, concerns have been expressed about

the distinctive role that social workers have to play in the broader provision of mental health services, and in this debate, the role and contribution of social work in community mental health provision has been reflected upon. With the increased focus being on community-based services, and a poor availability of specialized clinical social workers (Lund et al., 2010; Lund et al., 2002) general social workers are being relied upon to render their services within the area of mental health.

According to the data provided above, and the views of participants, it is evident that despite the need for the generic social worker within community-based mental health care, the feeling of being ill-equipped is preventing social work professionals from stepping into this role. This can be traced back to the poor level of undergraduate training of social work students as discussed earlier in the text.

According to Lund et al. (2008), the shutting down of institutions with poor corresponding development of adequate public health and community-based care systems, impacts on generic social work practice, specifically in the areas of crime, family structure and functioning, child abuse, domestic violence, family violence and unemployment, and thus the generic social worker can no longer remain isolated from mental health care practices (Aviram, 2002; Olckers, 2013). Therefore, it can be deduced that the need for the social worker in mental health care, and the corresponding equipping of social workers for such a task is of significant importance.

SECTION E: THE MENTAL HEALTH CONTEXT

In this section, the mental health context will be explored in terms of looking at mental health care and services, reflecting on the nature and availability of services, within an outpatient context specifically, and according to an ecological framework, discussing service availability, hospitals and clinics involved in service rendering, the view of mental health as a priority issue in health care, and the challenges faced by caregivers and communities, working with established sub-themes and categories as presented in table 4.2 above.

4.6 THEME 2: MENTAL HEALTH CARE AND SERVICES

The theme of mental health care and services will be discussed according to six sub-themes which were identified, in terms of the nature of community-based mental health services, exploring the views of participants regarding the nature and availability of such services, and the existence of resources and funding for adequate service implementation; looking at mental health community-based services within an ecological framework, exploring in further detail services rendered for the individual, the family, the community and the nature of mental health policy in this regard; discussing service availability and the accessibility of services at the community level, with regard to aspects such as the impact of traveling distances and scarce resource availability in rural areas; exploring hospitals and clinics, specifically in terms of overpopulation, bed space availability and professional capacity; reviewing the notion that mental health is not a priority issue, both in terms of government recognition, as well as funding and resource allocation; and finally, reflecting on the roles and experiences of caregivers and communities in the care of mentally ill patients. These sub-themes will be discussed according to six respective categories as presented in table 4.2.

4.6.1 Sub-theme 2.1: Nature of outpatient and community-based services

Participants were asked to share their opinions regarding the overall nature of outpatient and community-based services for the mentally ill population group within a South African context. The resultant patterns which emerged will be looked at according to two predominant categories, as outlined in table 4.6 below:

Table 4.6: Sub-theme 2.1. Nature of outpatient and community-based services

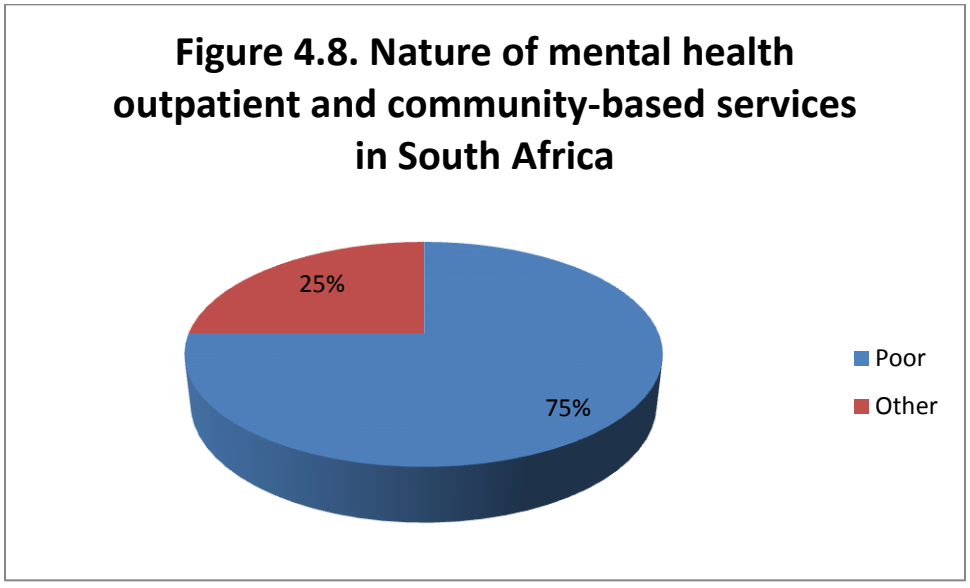
Category	**F**	**Representative participant excerpt**
Mental health outpatient and community-based services viewed as being predominantly poor	• 15 (75%) felt that mental health outpatient and community-based services were poor • 5 (25%) indicated that services weren't necessarily poor in nature, but were insufficient/inaccessible	*"…it doesn't hit the mark yet, but we are a developing country, so I don't think one can say its completely poor, it doesn't target what it should and we fall far short of the mark, but we do have something in place."*(Participant B)

Category	F	Representative participant excerpt
Lack of resources for adequate service implementation	• 14 (70%) indicated that there were insufficient resources made available for the adequate implementation of services for the mentally ill at the community level	*"But I think if we had the resources, if we had the money, we would try to move away from the whole one on one kind of thing and work more toward groups and reaching the masses and empowering families and not get bogged down with this kind of things like it is here, because this is the big challenge, the admin and the files"*(Participant K)

N = 20

4.6.1.1 Category: Mental health outpatient and community-based services viewed as being predominantly poor

In the study, participants were asked to give an indication of their opinion regarding the nature of mental health outpatient and community-based services in South Africa. The data is presented in figure 4.8 below:



N = 20

Fifteen of the participants (75%) felt that mental health outpatient and community-based services were essentially **poor in nature**; the remaining five (25%) felt that the services weren't

necessarily poor in terms of quality and existence, but rather they were **insufficient and inaccessible** in nature and thus still led to a poor outcome with regard to service rendering within the field of mental health. This is highlighted by the narrative of participant E:

*"I don't think they're poor**, I just don't think that it's enough**. That the **availability is not sufficient** for, the amount of staff, number one, for the amount of people that needs community follow up is not enough, that's the one. And number two, apart from the government treatment facilities in the community, there's no other drop-in centers, lifestyle management kind of programmes for people with mental illness in the community. I'm not talking about work rehab, I'm specifically talking, you know, drop-in crisis center management for patients and families, the only place that they can go to is the day hospital and to the clinic, and if it's a day clinic then after hours they have to start running around to secondary hospitals."*(Respondent E)

Here participant E felt that services were insufficient with regard particularly to that of **drop-in crisis centers**. This will be discussed in further detail later in the chapter where the themes of the mental health context and the effect of the new mental health act are explored, as demonstrated in table 4.2. However, in terms of the **insufficiency of community-based services** and facilities, this is expressed in literature(Lund et al., 2008), where a study conducted on the overall service provision and availability of mental health services within South Africa found service availability to be particularly poor. A definite treatment gap with regard to mental health service availability was identified (Garland et al.,2013; Petersen et al., 2009 and Petersen et al.,, 2011) and studies found that of the 16.5% of South African's presenting with common mental disorders within a period of 12 months, it was estimated that only 1 in 4 actually received treatment (Lund et al., 2010; Petersen et al., 2009).

Participants, who felt that services weren't necessarily poor in nature, elaborated that although the services were perhaps insufficient, there were at least **some services in place** and that to therefore label services within this field as completely poor would be an unfair assessment. However, these participants expressed concerns that although not necessarily poor, these services were mostly **insufficient** and **inaccessible**. This is summarized clearly by the narrative of participant B in table 4.6 above.

This is echoed by researchers Salize et al. (2008), where they indicate that despite good policy development, the actual **implementation** of community-based care was poorly done. The process was largely focused on the emergency management of patients, with very little corresponding development of long-term, sustainable community services toward the rehabilitation and reintegration of the mentally ill individual into society (Lund, Kleintjies, Kakuma & Flisher, 2010; Petersen et al., 2009).

Therefore, from the above, it can be deduced that an increase in the availability and sufficiency of community-based services within the field of mental health is specifically required, and that, according to the views of participants, the overall nature of such services is predominantly poor, although it is recognized that there are some services in place.

4.6.1.2 Category: Lack of resources for adequate service implementation

In reflecting on the nature of outpatient and community-based services within the mental health context, fourteen (70%) of participants indicated that services were poor in nature due to a lack of adequate resources for the implementation of necessary services within this field. Respondents felt that the **lack of resources hindered service rendering ability** in terms of its scope, nature, focus and impact and this then resulted in poor service rendering.

According to the narrative of participant K as presented in table 4.6 above, and many other participants, the lack of resources resulted in social work professionals having to spend most of their time on administrative and tedious tasks for resource development and service implementation, taking away from the time they had to give to the communities and clients in need. Participants also felt that **one on one intervention** was all that resources allowed for, and that **larger scale community projects** and outreach initiatives were just not possible with the resources available to social workers. This will be discussed in further detail later in the chapter, in reflecting on services at the ecological level as expressed in table 4.2. The lack of resources, in terms of facilities and financial support was further expressed by participant G below:

*"Government needs to start building **more hospitals**, maybe we also need those places, if the client can go and stay with professionals who will assist them to take their medication. We need **facilities** where we can place them with government, where they can use their own grant, don't need extra money, where **government will fund**."*(Participant G)

Here the theme of increased facilities for live-in purposes was raised as an issue; this was expressed by many participants in the study and therefore will be discussed as a separate category later in the chapter. However, the need for increased resources is evidently expressed. This correlates with literature (Lund et al., 2008), in that research has found that services for the mentally ill outpatient are particularly poor due to a lack of resource provision and development within this field. Studies have claimed that the movement toward predominant community-based based care has often been used to motivate for the downsizing of large institutions **without the corresponding development** of community-based mental health care services and has been deemed a cost saving exercise without the simultaneous development of the necessary support and resources to assist users and their support systems to cope with psychosocial disabilities within a community setting (Lund et al., 2008:170).

In understanding the nature of service rendering for the mentally ill within the community-based context, it is evident that community-based care is considered to be predominantly poor, unavailable and insufficient, and that hindrances in effective care include poor development and allocation of necessary resources and funding.

4.6.2 Sub-theme 2.2: Outpatient and community-based services within an ecological framework

In the semi-structured interview, participants were asked to share their opinion regarding the nature and availability of outpatient and community-based services within the mental health field according to an ecological framework, focusing on services for the individual, the family, and the community, as well as the nature of mental health policies and the implementation of this in terms of service rendering. This sub-theme was broken down into four categories, following the pattern of the ecological perspective.

The use of the ecological framework for assessing outpatient and community-based services correlates with literature (Bronfenbrenner, 1979;Fisher, 2005; Flay & Petriatis, 1994; McLeroy et al., 1988), in that the ecological perspective in both social work practice and the health care setting, serves to foster an understanding of the needs of vulnerable groups holistically, and thus the effective empowerment of individuals toward their well-being. The use of these four

particular categories, in terms of the individual, family, community and policy is based on the collaboration of four important ecological models within healthcare, based on the work of the *Systems Theory* (Bronfenbrenner, 1979), the *Ecological Model for Health Promotion* (McLeroy et al., 1988),the *Theory of Triadic Influence* (Flay & Petriatis, 1994), and the *Resources and Skills for Self-Management Model* (Fisher, 2005), as presented in chapter three.

Each category will be explored in greater detail. Participants were asked to rate each section, in terms of service quality and availability on a scale of one to five, with one meaning that services at that particular ecological level are incredibly poor, and five indicating that services are excellent. The resultant data for each category is presented in table 4.7 below.

Table 4.7: Sub-theme 2.2. Outpatient and community-based services within an ecological framework

Category	**F(rating 1-5: one = poor; five = excellent)**	**Representative participant excerpt**
Individual	One: 5 (25%) Two: 8 (40%) Three: 3 (15%) Four: 1(5%) Five: 3 (15%)	*"On an individual level, I think if you look at people who have the means to access services, so your upper class for instance, then I think there's enough social workers who are in private practice that are able to provide the services, but if you look at your lower income people, then there isn't enough services. Then I would rate it at a one."*(Participant C)
Family	One: 2 (10%) Two: 4 (20%) Three: 11 (55%) Four: 1 (5%) Five: 2 (10%)	*"The thing is I think where services are available, you know what they try and assist the family with is good, but once again it's limited, and the availability is limited. Whatever is, they are trying, it's just the availability."* (Participant E)
Community	One: 5 (25%) Two: 6 (30%) Three: 4 (20%) Four: 2 (10%) Five: 2 (10%) Unsure: 1 (5%)	*"Quite poor. When you look at our communities, yoh it's bad, seriously it's bad."*(Participant I)

Category	F(rating 1-5: one = poor; five = excellent)	Representative participant excerpt
Policy	One: 3 (15%) Two: 8 (40%) Three: 3 (15%) Four: 3 (15%) Five: 3 (15%)	*"I mean policy is trying to implement that. They try, they've changed the act and it's a good act, but the implementation is a problem. So the intention is there."*(Participant E)

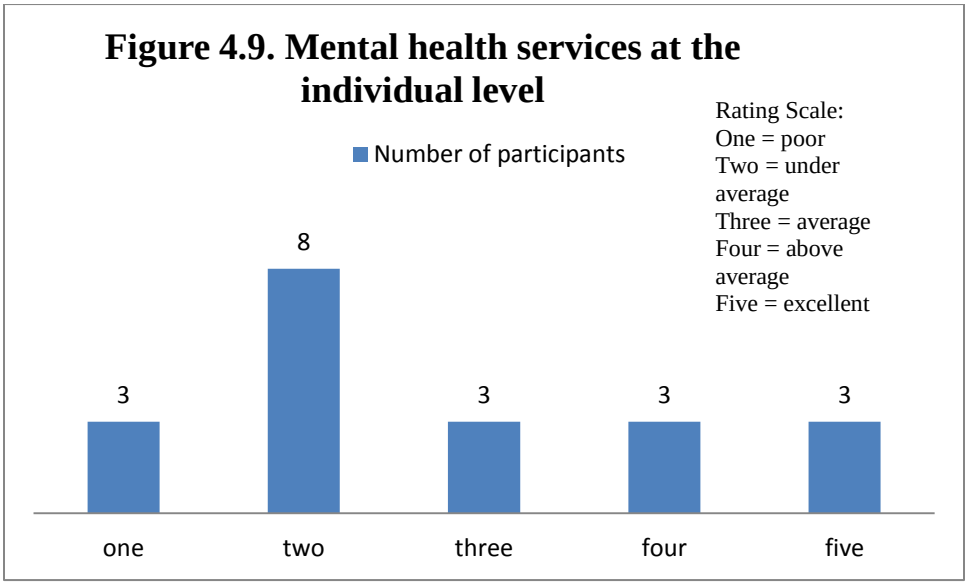
N = 20

Each category will be discussed in further detail below with the use of figures, more relevant participant narratives and corresponding literature.

4.6.2.1 Category: Individual

Participants were asked to indicate their views regarding the nature of outpatient and community-based mental health services that are available for clients at the individual level, with regard specifically to one-on-one therapeutic intervention services, counseling, assessment and overall assistance for the individual. The participants were required to rate the services at the individual level on a scale of one to five, with one indicating services to be extremely poor, and five implying services to be at an excellent level. The resultant data is represented in figure 4.9 below:

Figure 4.9. Mental health services at the individual level



N = 20

In reflecting on mental health community-based services within the ecological context, participants predominantly felt that mental health community-based services at the individual level were **poor**, with thirteen (65%) of participants indicating that services at this level were between one and two on the scale, with one and two both representing a poor rating. Participants who indicated this, felt that **services were poor overall**, and therefore were not necessarily any better at the individual level than they were overall. It was identified, however, that services for the individual were particularly worse within poorer communities. This is explained by participants L and C below:

"You know the illness itself, you are left so vulnerable, ***if you not going to get family assistance, then you not going to get what you need at a day hospital****. No-one's going to bother about you. And very often if you go to the day hospital, the first thing they're going to ask you, ok so when last did you have your medication, when last did you have your injection, you know, so you could have had it like six months ago, no-one follows up on that, that is how bad it is, whereas before, had there been no community health center involvement and you fall directly under [mental health institution] or so, they would be out there scouting for you, you know? That type of thing."* (Participant L)

"On an ***individual level****, I think if you look at people who have the means to access services, so your upper class for instance, then I think there's enough social workers who are in private practice that are able to provide the services,* ***but if you look at your lower income people, then there isn't enough services.*** *Then I would rate it at a one."*(Participant C)

Only three (15%)participants felt that services at the individual level were of an excellent standard. These participants indicated the rating of community-based services for the individual to be high due to the fact that they felt that NGOs and community-based organizations were focusing largely on the individual and therefore these services were of a higher availability and quality then services at the other ecological levels. This is evident in the narrative of participant G provided below:

"Well I think with NGOs, ***we are doing our best in terms of trying to deal with our clients,*** *I think we are doing well, some of our clients are doing well, we try to get them involved.* ***I am not***

sure how to rate them when it comes to government or whatever. *There are some things that are needed…"* (Participant G)

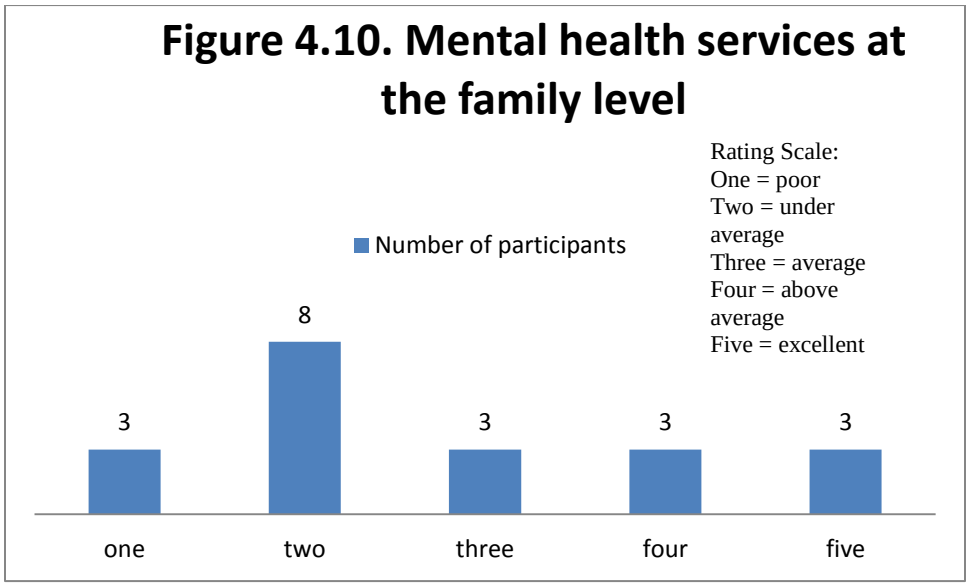
One participant (5%) rated services at the individual level as a four, advocating that **services were improving** and better at this level than most, however this was also, in their opinion, the nature of services that are rendered through nongovernmental organizations such as the one in which they worked, and could not necessarily be applied to other governmental sectors. The remaining three participants (15%) rated services to be at a three, indicating they were of an **average standard**, neither poor, nor excellent; participants acknowledged that there was definite **room for improvement**, but there were **services in place** that could be accessed by clients.

The importance of service provision at the individual level is highlighted in literature (Glanz et al., 2008; Jamner & Stokols, 2000).According to the various researchers, strategies which serve to bring about change at this individual level tend to be focused on the changing of an individual's knowledge, their attitudes, behavior and skill set. Individuals living with a mental illness therefore tend to require a stronger support system at the individual level (Barlow & Durand, 2012). Service rendering, when taking into consideration the needs presented at this level, can be seen to require a more personal and intimate relationship of care and support (Barlow & Durand, 2012; Johnson & Yanca, 2007). Although this should be predominantly provided through family and friends, this is not always the case, and therefore the help of a mental health practitioner, particularly that of a psychologist and/or social worker can be of great significance toward developing the individual's inner sense of self, promote healthy and positive intrapersonal attributes and thought patterns, as well as the motivate continued development and growth toward optimal functioning (Nicholas et al., 2010).

Although the literature above advocates for service rendering at the individual level, it is evident that this is predominantly poor in nature and availability within the mental health setting. This can be linked to the view of mental health community-based services being assessed as being predominantly poor overall by participants within the study; however, NGOs seem to be more effective in this form of service rendering than that of other groups.

4.6.2.2 Category: Family

Participants were asked to give an indication of the nature of services that were rendered for the family within the context of mental health, rating these services on a scale of one to five, with one being poor and five being excellent in terms of the overall quality and availability of such services within the community-based context. The resultant data is illustrated below in figure 4.10.



N = 20

Within the pool of participants, six (30%) viewed mental health community-based services for the family to be under three in terms of rating, thus viewing them to be predominantly poor in nature. This is expressed by participant C below:

"Because if the patients don't receive the services, than it ***affects the families****."*(Participant C)

However, eleven (55%)participants viewed the services rendered to the family to be on an **average level**, neither poor nor excellent, stating that while such services were not necessarily rendered as they should be and could be improved, they were available and **the family was identified as a key target group within the field of mental health** and social work in general. Therefore, it was deemed that provision for services in this context was readily made available by organizations. This is expressed in the narrative by participant E below:

"The thing is I think, ***where services are available,*** *you know what they* ***try and assist the family*** *with is good****,*** *but once again it's limited,* ***the availability is limited****. Whatever is, they are trying, it's just the availability."*(Participant E)

Services that were rendered to the family, according to participants were predominantly focused on **family counseling sessions**, in order to assist families in dealing and coping with a mentally ill family member, offering **psycho-education** for caregivers of such individuals, as well as rendering **support** for families and caregivers through the implementation of family support groups within communities and through outpatient organizations and facilities.

These types of services will be discussed in further detail later in this chapter. However, according to relevant literature (Lund et al., 2008; SANE, 2010), services for families in terms of psycho-education and support are key intervention priorities within the mental health setting.

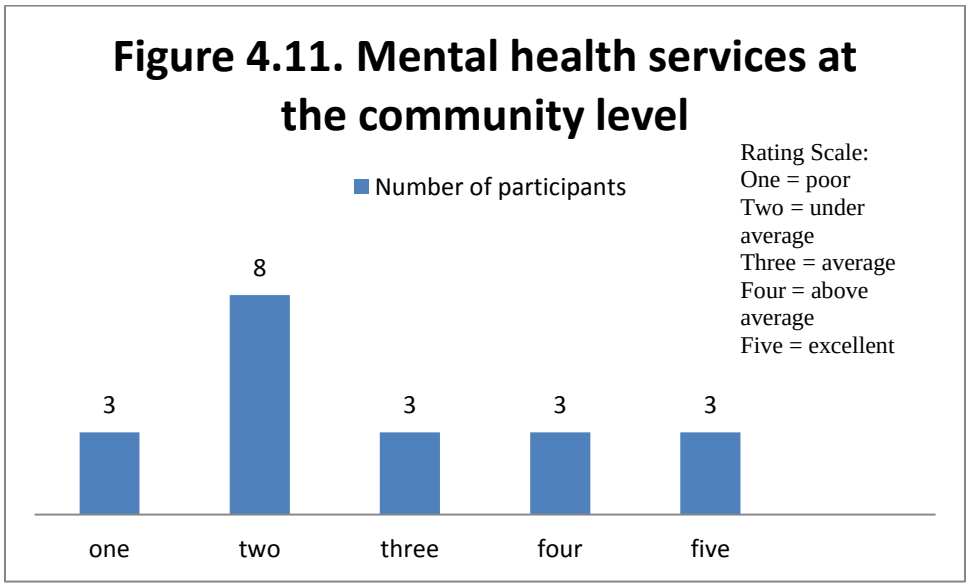
One participant (5%) viewed services at the family level as being on a scale of four, which implies that such services are not necessarily excellent, but they are **above average**; this participant felt that services rendered through **community-based contexts were particularly targeted at the family** and therefore were essentially good in terms of quality and availability. Interestingly enough, two (10%)participants felt that services for the family were **excellent in nature**; however, these participants specified, much like in the category of individual services, that the services they considered to be excellent in nature where rendered through that of **community-based non-governmental organizations**, more than that of governmental facilities and institutions.

According to relevant literature(SANE factsheet report, 2010), services for the family are incredibly important within the field of mental health, as mental illness tends to have a 'ripple effect' on families, creating tension, uncertainty, high levels of stress and anxiety. Such effects on the family are sometimes not acknowledged by health professionals and thus services in this regard are of incredible significance. Literature (Barlow & Durand, 2012; Lund et al., 2008; SANE factsheet report, 2010) further acknowledges that families are often the main support for people affected by mental illness, and thus have a right to be treated as 'partners in care'. They need information about the illness and treatment provided, and about training and support to help themselves as well as the person who is ill.

It is evident from the data provided above that services are viewed as being more sufficient at the family level than that of the individual level; however, these services are still not predominantly viewed as being above average in nature. It is significant to recognize that, as with services at the individual level, ratings for services rendered through community-based organizations were viewed as being higher than that of government-based groups.

4.6.2.3 Category: Community

Participants were asked to share their views regarding the nature and availability of community-based mental health services at the community level, according to a rating scale of one to five, with one representing services that are essentially poor in nature and five being services that are viewed as being excellent. The data is presented in figure 4.11 below:



N = 20

Within the scale categories of one and two, eleven (55%)participants felt that community-based mental health services aimed at the larger community fell within these two levels, therefore expressing the view that such services were **poor in nature and availability**, with five (25%) of participants rating community services as being as low as a one, and six (30%) indicating that they were a two in terms of rating. Participants felt that these services were poor due to the fact that there were **limited professional and facility capacities** for communities and therefore service rendering was hindered through this **lack of resources** necessary for its implementation;

these concepts and issues will be dealt with in greater detail later in this chapter as is indicated in table 4.2, however the notion that service quality and availability was hindered due to a lack of resources was expressed earlier in the analysis of sub-theme 2.1.

Four participants (20%) indicated that services at the family level were **average** in nature, being neither poor nor excellent; again this was justified by the fact that although services weren't necessarily 'hitting the mark', **such services were available** and means were being put into place to ensure an increase in the rendering of such services.

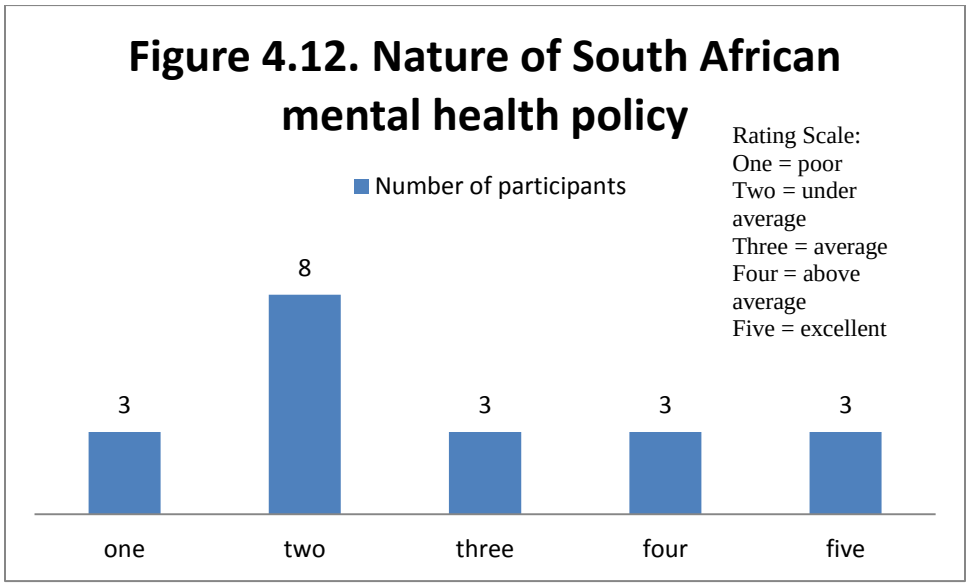
Two respondents (10%), within each category, indicated that services were at a four, being relatively good, or at a five implying that they were of an **excellent standard**; these views were expressed based on their assessment of services that they themselves were rendering through their specific organizations, as **community-based nongovernmental organizations** and therefore may not necessarily reflect the nature of community services as a whole within the mental health context.

One participant (5%) indicated that they were unable to rate the nature and availability of community services as they worked within a primarily institutional and inpatient setting and therefore **did not have sufficient awareness and understanding to comment** on the standard of services rendered at the community level.

Literature(Lund et al., 2008), confirms that current issues which exist in mental health service delivery in South Africa are centered on the need to increase support user access to services and continued integration into community life. The need for the development of a community based mental health policy and services, adequately funded service level agreements with NGOs to set up and manage these services, within an intersectoral framework of service development, was among the strongest themes which repeatedly emerged during research conducted on a country report of mental health community services in South Africa by Lund et al.(2011).

4.6.2.4 Category: Policy

The participants of the study were asked to discuss their views regarding the nature of the present mental health policies which existed in South Africa, and whether these were sufficient overall, as well as whether they were well or poorly executed and implemented; this rating was based on a scale of one to five, with one being poor and five being excellent. The resultant data is illustrated in figure 4.12 below:



N = 20

According to the data collected from the pool of respondents, eleven (55%) of the participants felt that the overall **nature of mental health policies within South Africa was primarily poor**, falling in between a rating of one and two. The reasons for this lay within the fact that, although all participants felt policies were **essentially good on paper** and in theory, they were **poorly implemented** and the effect of such policy documents such as the new Mental Health Act (17 of 2002) were in fact more detrimental then positive, due to the poor development and availability of services as expressed earlier in this sub-theme section, with regard to services rendered at the individual, family and community levels. This is expressed by participant T below:

*"A lot of documents in place and a **brilliant constitution** but **we don't have the resources and the man power to support the ideas.** We do have a policy in place but it's **not always effective**. And people may not be utilizing the policy in the correct manner."*(Participant T)

Three respondents (15%) felt that policies were **average in nature**, neither excellent nor poor, again indicating the reasons for this as being that the **policies were good, just poorly executed**; six (30%) of participants felt that the policies that were in place were very good overall, and even excellent in nature. However, **not one respondent indicated that they found the policies as being efficiently executed** and implemented into adequate service provision.

The policy context encompasses all aspects of individuality, social support and physical environments; at this level, the legislative documents such as the White Paper for the transformation of the health system (1997), the National Health Policy Guidelines for improved mental health in South Africa (1997) and the more recently revised Mental Health Care Act (17 of 2002), have direct influence on how an individual experiences mental health services, care and support, as well as how communities and society overall views and deals with the issue of mental health (Bronfenbrenner, 1979; Johnson &Yanca, 2007; McLeroy et al., 1988).

Literature(Lund et al., 2008; Lund et al., 2011) confirms that policy development and deinstitutionalization, though perhaps ethical in theory, has not necessarily been as effective in practice. This is further expressed by Professor Richard Titmuss (1968), a pioneering British social researcher and teacher where he expressed the fact that although one may feel righteous and justified in having a civilized mental health act, if we are not willing to examine this act and its implementation, then what we mean by community care is simply wishful thinking.

It is evident that policy is viewed as being good in theory, yet poorly examined and implemented in practice. According to participants, this has resulted in ineffective and insufficient mental health services at the community level, and thus policies such as the Mental Health Act (17 of 2002) need to be further reviewed and developed.

4.6.3 Sub-theme 2.3: Service accessibility

In exploring the theme of the mental health context, the sub-theme regarding service availability quickly arose as a key issue affecting the rendering of sufficient community-based services for the mentally ill client group. Core patterns which emerged were that services were available but not necessarily always accessible, traveling distances for clients in order to access services and resources were a challenging factor, and there was a scarcity of resource and service availability

within rural areas in South Africa. These categories will be explained in greater detail and are presented in table 4.8 below.

Table 4.8.Sub-theme 2.3. Service accessibility

Category	**F**	**Representative respondent excerpt**
Services are available but not always accessible	12 (60%)	*"I just want to pose the question – I don't think it's an issue of 'are the services available', the services are there, but do people know about the services –is there enough information about these services. Secondly, are these services accessible to everybody."*(Participant J)
Traveling distance for clients to access resources	5 (25%)	*"Not so much the services, we have a lot, I think it's the fact that some people live far away from the services."* (Participant M)
Scarce community services in rural areas	18 (90%)	*"we only look at what is happening in urban areas, but you find in rural areas its worse off than it is in the urban area, so the need is out there, social workers needs to be available and accessible."*(Participant D)

N = 20

4.6.3.1 Category: Services are available but not always accessible

Participants were asked to discuss the nature of mental health community-based services within South Africa, and in doing so, raised the issue that although services were available for the mentally ill individual, families and communities, they were not necessarily always easily accessible. Twelve(60%) participants expressed that services within the mental health community-based context were **difficult to access** and thus hindered the ability of social workers and other mental health professionals to sufficiently implement intervention and mental health care. According to the narrative of respondent J as presented in table 4.8 above, when asked about his view regarding service availability for community-based mental health care, **availability was not the core challenge,** but rather a lack of awareness and knowledge

regarding services which were available, and then following this, **poor accessibility** was a pressing issue.

This is further echoed by the discourse of participant E:

*"The thing is I think, where services are available, you know what they try and assist the family with is good, **but once again it's limited, the availability is limited**. Whatever is, they are trying, it's just the availability."*(Participant E)

The issue of availability of such services was linked to many other **contributing factors**, such as resources, facilities, funding, poverty, and traveling distance and so on; some of these concepts will be explored in further detail in this chapter as is outlined in table 4.2. However, some participants felt that **services were in fact available**, and that the ability of patients, groups, families and communities to **access these resources was a contributing factor** to the poor nature of community-based service rendering that needed to be addressed.

This corresponds with literature (Salize et al., 2008), where it is found that despite the movement toward predominantly community-based mental health care, since the implementation of deinstitutionalization, there has been a marked decrease in access to mental health services and care. Research (Lund et al., 2008) found that within South Africa, of the recorded 16, 5% of adults suffering from a common mental disorder, only one in four had received treatment. It is evident from the discourse provided above, that service accessibility is a key issue in the rendering and availability of community-based mental health care. It is clear that the issue of accessibility, along with poor resources and funding, as well as inadequate policy implementation and examination, have resulted in predominantly poor community-based service rendering with the mental health field.

4.6.3.2 Category: Traveling distance for clients to access resource

One of the key contributing factors that affected service availability, as well as service accessibility as discussed above, was the **traveling distance** that many clients and families had to undergo in order to come into contact with the services and resources which were being made available. Five participants (25%) raised this as being a challenge for many clients and groups,

stating that **individuals had to travel far distances**, through the use of public transport, in order to attend appointments at community clinics or social work intervention sessions.

Further still, participants discussed how the traveling distance also meant that patients and families had to spend large amounts of finance on **traveling expenses** in order to receive necessary treatment and intervention, and that for many individuals from impoverished settings, this was just not a possibility. Secondly, participants highlighted the fact that this distance meant that clients were required to take **longer periods of time off from work** in order to incorporate traveling time and this was again not always a possibility for many clients and families. All of these factors resulted in a serious **lack of motivation** of clients to attend clinics, groups and follow-up intervention sessions with social workers and other mental health professionals. Therefore, although services were somewhat available, this did not necessarily mean that they were adequately and sufficiently put into place in such a way where they were **accessible and beneficial** for this vulnerable group. This is expressed by participants B and R below:

"…but somebody that doesn't have access to private medical care, first of all ***has to travel quite far*** *to get to the local community health center"*(Participant B)

"People don't arrive for appointments, ***reasons distance involved****. But then actually that's* ***not convenient for the client****, because they've got to travel so far or* ***take time off from work****."* (Participant R)

Over and above this, participants highlighted that **waiting periods** for health care services, particularly through community health centers and hospitals were incredibly long and this then added to the time required for individuals to set aside in order to access the necessary services they required. According to some participants, **many patients would wait for an entire day and have to leave without being seen**, only to then have to repeat the process the following day. This again **added to poor motivation** to make use of the services that were put in place for this vulnerable population group. This is identified as being a particular problem for the mentally ill client, as expressed by participant H below:

*"****It's not that they are not accessible, its maybe waiting periods*** *and our clients have,* ***their threshold for waiting****, some of this just can't, at the end of the day, being realistic sitting there,*

hearing voices the entire time, voices telling you whatever, you're not going to sit there till whenever the doctor decides to come or the sister, some of our clients sits there from what four o clock, five o clock, half of them will sleep outside just in order to get their number, because by the time we pass there, at ten o clock pass there then the queue is right outside the gate"(Participant H)

Literature (Lund et al., 2008; Salize et al., 2008)states that within South African mental health care, there is a fragmentation of specialized services, and a lack of quality assurance procedures and assessments toward ensuring that there is equal distribution of access to mental health care. In a study conducted by Lund et al.(2008), it was found that services in rural, more impoverished areas were poorly distributed, and this would mean that patients would need to travel far distances in order to access appropriate services and care. The lack of sufficient community health care centers and services also contributes to waiting periods and a poor capacity of professionals to meet the need of this vulnerable group, with a noted absence of community based treatment and support services.(Lund et al., 2008).

This issue of traveling distance, cost and time for mentally ill patients and family members to access necessary resources only serves to further add to the already recognized poor availability and accessibility of community-based services, and can be attributed to the lack of sufficient resources and funding toward the development of further services and care within communities.

4.6.3.3 Category: Scarce community services in rural areas

The third factor which was raised in looking at and exploring the availability of mental health community-based services within the larger theme of the mental health community-based care context, was the fact that rural areas were particularly under-resourced and had a lack of services that were available within these areas. Eighteen participants (90%) felt that this was an influential issue when assessing services within the community context.

This then ties in with the challenge of **traveling distance**, as clients and mentally ill service users living in rural areas then had to travel far distances into urban and populated contexts in order to access resources and services for intervention, treatment and care. According to the new Health Law (Lund et al., 2008; Mental health act, 17 of 2002),**individuals are supposed to be**

able to access medical and health care resources in their own communities and areas where they reside; however this is not the case. Participants expressed the fact that assessing mental health community-based services, as was explored earlier in this chapter, was often at times an unfair assessment as it **predominantly focused on urban areas** where organizations, clinics and professionals were in a greater capacity, however such **resources and services were incredibly scarce in rural areas** and this was not necessarily being addressed by government. This is confirmed in the narrative of participant J below:

*"These programmes that I have mentioned, only cater for the areas in the cape peninsula**,** which means that **nothing is being done for those living in rural areas** and on the outer skirts of cape town. I'm actually saying both –the rural areas **there are no rehab services** for people coming from a mental health hospital –that is a big problem. The person goes to a mental health hospital –when they come back to the community, there is no rehab program for them in the rural area. They attend counseling services with the psychiatric sister/psychiatrist at the day hospital- they have to wait the whole day to see the person – so **there is nobody there in the rural area to make sure that these clients take their medications, receive psychosocial interventions, receive rehab**, when we talk about rehab in this sense, it is where we help the person to cope and function normally in society again."*(Participant J)

According to a study conducted by Lund et al (2008:34), advocacy was made for an increase in rural development and service implementation within these areas, as this was also raised as a priority issue in the assessment of mental health care within the South African context in the 2008 country report; poverty, which is high in rural areas, was further recognized as being a primary developmental challenge, and the alleviation of which was seen as being key to impacting on all other development priorities, including that of mental health.

4.6.4 Sub-theme 2.4: Hospitals and clinics

In the exploration of the theme of the mental health context, hospitals and clinics were common themes which were frequently raised and addressed. Key focus areas in this context were the fact that hospitals were overpopulated and that clinics lacked a professional capacity. These categories will be explored in greater detail and have been presented in table 4.9 below:

Table 4.9.Sub-theme 2.4. Hospitals and clinics

Category	**F**	**Representative participant excerpt**
Hospitals overpopulated	14 (70%)	*"Is there enough man power in [government hospitals] to cater for all these areas? The issue, these places they become over populated and there's not going to be enough consultation."*(Participant N)
Clinics have a lack of professional capacity	13 (65%)	*"they are not available – the availability of the doctors and nurses and so, it's not as if the patients see the doctor every month…they will see the doctor once in 6 months"* (Participant I)

N = 20

4.6.4.1 Category: Hospitals overpopulated

Within the pool of twenty participants, fourteen (70%)expressed the fact that hospitals were incredibly overpopulated and could not accommodate the majority of clients and vulnerable individuals who were in need of admission, assessment and intervention within a hospital setting. This is expressed by respondent N in table 4.9 above.

According to participants, there is a **server lack of bed space in hospitals** to accommodate the large population group in need of health care services, and particularly that of mental health care services. This is discussed in detail by participant B below, where she highlights that this lack of space and capacity within state hospitals is actually serving to **dehumanize** the rights and needs of the client base:

*"**there's not enough beds**, in some of the hospitals I've heard of clients sleeping in chairs, I certainly don't sleep in a chair in my own house, why on earth must I go lay in a hospital and sleep in a chair there so that's the sort of thing that still needs to be improved, lack of beds, sometimes even putting mattresses on floors, yes we can argue that social circumstances for many clients, some of them live in shacks, sometimes in their own house they sleep on a mattress **but why should you have to do that in a state institution in a hospital,** so that's the kind of thing that people find challenging."*(Participant B)

According to the New Mental Health policy (Mental health act, 17 of 2002), hospitals are allocated as 72-hour observation wards where initial assessment and screening needs to take place before referral to either an institution or community-based services. Clinics are made available for this kind of assessment, but is often as an initial diagnosis, and the individual still needs to be referred to a district hospital in order to be assessed and diagnosed(Lund et al., 2008; Mental Health Act, 17 of 2002).Therefore, that being understood, the overcrowding of hospitals means that this initial assessment and diagnoses is not taking place with all vulnerable individuals. This then is recognized as having an effect on all other services. According to participants, due to the overpopulation of hospitals, only emergency cases were being admitted, where extreme cases of psychosis or suicidal risk were identified. Other cases were just not being attended to adequately and patients were being discharged from hospitals with the notion that they were stable and able to return to normal functioning in society, when in fact this was far from the truth. This is expressed in the narratives by participants G and I below:

"Most of the hospitals, they are full. ***Even though the client needs to be admitted, because there is no space, they will just turn them away****. They will say that the patient is stabilized. But they are not stabilized; when they go home they will start again. But also the hospitals, they are full. There are no beds available. So a lot of advocating needs to be done by social workers, but its limited when government is not doing anything. Doctors will also say, what can we do, when its full its full."*(Participant G)

"It's either a case of, like the general hospitals, like, psychiatric hospitals, it's always full. It's always over, there's no beds available, and even if you had to do involuntary admission, ***they'll always send the person back, they won't even stay for the 72 hours of observation****, so it's bad."*(Participant I)

In exploring this category, participants also raised the fact that this overpopulation in hospitals resulted in services which were rendered within this context being poor and insufficient, where very **little professional-patient relationship was able to be built** or sustained:

"You know and also, I mean, a lot of my clients complain about not being able to form a relationship, cause I think nine times out of ten, it's not the psychiatrist, it's the registrar, and the registrar has moved on and then there is another one, so ***they don't really build up a***

relationship with any actual professional *besides the psychiatrist nurse. And also people burn out, professionals' burn out, they move on."*(Participant B)

This echoed by participant K below:

"Look at your day hospitals; ***they don't have time to sit with people*** *on, like one on one."* (Participant K)

According to stipulations made by the Mental Health Act (17 of 2002),service delivery and care for the mentally ill group is primarily provided through 72-hour observation services at allocated district hospitals, as well as through community-based and public health structures. However, due to the fact that there was poor development of sufficient and appropriate community-based support structures and systems, deinstitutionalization has been evaluated as having a negative impact on mental health care overall (Lund et al., 2008; Petersen et al., 2009). In an assessment of mental health services in South Africa, as was presented in chapter two, it was found that there are only 41 psychiatric inpatient units in general hospitals available in the country with a total of 2.8 beds per 100, 000 population; this does not allow for sufficient capacity for the growing vulnerable population group of mentally ill patients.

In a study conducted by Lund et al. (2008:100-102), there are major concerns regarding the capacity of staff and facilities to provide adequate mental health care in these hospitals. Research by Petersen et al. (2009) further concludes that the process of deinstitutionalization is still strongly focused on and limited to the emergency management and screening of chronically ill patients; sustainable rehabilitation programmes are few and far in between.

This serves to correlate with the views of participants, in terms of the fact that hospitals are largely overpopulated and unable to cater for the entire mentally ill population group. As a result, emergency management stipulations are implemented, hindering the majority of patients in need from receiving adequate treatment and rehabilitative care. In assessing the phenomenon of the "revolving door patient" and the high statistics regarding patient relapse (Barlow & Durand, 2012; Lund et al., 2008), this then can be seen as being a high priority issue which would serve to impact on the community-based context of mental health care.

4.6.4.2 Category: Clinics have a lack of professional capacity

In correspondence with hospitals being overpopulated, community clinics and health care centers are tasked with the heavy burden of rendering the predominant of health services to communities; this includes mental health care. According to thirteen (65%)participants, there is a lack of professional capacity in clinics to sufficiently undertake such a task. In referring to professional capacity, respondents were implying a lack of overall professionals within clinic settings, which included doctors, psychiatrists, psychologists, nurses and social workers. This lack of professional capacity meant, that although such clinics were available within many communities, the actual capacity of clinics to implement effective health care was hindered by the fact that there simply were not enough professional staff to render the services necessary for adequate care and treatment. This is expressed in the narratives by participants R and B below:

The accessibility –we have these community health centers, but there is ***one social worker covering about four different clinics****, she is seeing everybody for all their problems, and definitely will ignore the mental health problems because it just feels like something that can be ignored.* (Participant R)

"There is day clinics, yes ***there isn't a psychiatrist there everyday clinic****, or you don't get to see a psychiatrist as often as one should, you know obviously if you're in private practice, or you go to someone in private practice, you see the person quite often, but I mean* ***here patients are not being seen as regularly as they should****. The psychiatric nurse might only be there for two days a week, the psychiatrist might not be there, there's one psychiatrist for how many community health centers, yes there might be a GP on call, but a GP is not an expert"* (Participant B)

According to relevant literature(Lund et al., 2008; Petersen et al., 2009), the adoption of the policy of deinstitutionalization, in terms of that which is outlined in the more recently revised Mental Health Care Act (17 of 2002), has resulted in a fragmentation of specialized mental health services and poor quality of care available to the mentally ill patient as a whole within the South African context. The process of decentralization and deinstitutionalization has been assessed as having a negative impact on service rendering and service availability for the mentally ill individual overall (Lund et al., 2008; Petersen et al., 2009). The lack of community-based mental health services was also viewed to burden facility based health centers, putting

additional pressure on already stretched primary health services and hospital beds, with then adverse consequences for quality care provision (Lund et al., 2008). Research further supports the views of participants in terms of there being a significant lack of specialized mental health practitioners, with specific reference to psychologists and psychiatrists (Lund et al., 2010; Petersen et al., 2009).

4.6.5 Sub-theme 2.5: Mental health as a priority issue

In reflecting on the mental health context, fourteen (70%) participants felt that mental health was not recognized as a priority issue, within both the sectors of health care and that of social work. Participants in particular, felt that mental health not being recognized as a priority issue was evident in the attitudes of government departments toward mental health, as well as the inadequate provision of necessary funding and resources for mental health care practices. These categories are explored in greater detail and have been laid out in table 4.10 below:

Table 4.10: Sub-theme 2.5. Mental health as a priority issue

Category	**F**	**Representative participant excerpt**
Mental health not recognized as important by government	14 (70%)	*"but we don't always hit the mark as a country, so if we can't even supply that, where the heck does mental health come into the bigger picture of South Africa and yes statistics shows right around the world that mental health takes the bottom end of the medical pie or the finances"* (Participant B)
Inadequate provision of funding and resources for mental health care	20 (100%)	*"but how do we advocate if government just closes their ears, you know, are we meant to build the community health centers"*(Participant B)

N = 20

4.6.5.1 Category: Mental health not recognized as important by government

Fourteen participants (70%) within this study indicated that, in their opinion, mental health was not recognized as something of importance by government. They felt this to be reflective in

terms of **resources and finances** which were allocated to this sector of health care, which they deemed to be significantly less than that of other health and social issues.

This lack of recognition by state regarding the importance of mental health affected the standard, availability and nature of mental health services, particularly at the community-based level, as insufficient funding was provided for the implementation of effective services for this population group. This was keenly expressed by many participants within the study and the narratives of participants have been provided below, in the form of table 4.11:

Table 4.11: Narratives regarding mental health not being recognized as important by government

Narrative
"I don't think it's something that the health sector is putting a lot of effort on. ***What the government did, they shrunked social workers****, and I think its failing the patients, mental health in a way is ignored in that sense"*(Participant D)
"There is enough facilities that help patients and treat the patient and ***there's a lot of resources in the community for other stuff****, there's a lot of resources for substances and HIV, and people don't necessarily use it, but they're there, and for child abuse,* ***but they don't specifically address the mental illness side."*** ***(***Participant E)
*"****From the government's viewpoint, the department of health and the department of social development does not see mental health as a priority****, this is evident when we look at representation at mental health meetings, at forum meetings, at NGO directory meetings and all that,* ***it's clear that the government is not particularly interested in mental health****. I stand to be corrected, but I'm basing this on government involvement, I'm basing this on stats, I'm basing this on the fact that [mental health nongovernmental organizations]* ***receives very little funding from government departments."***(Participant J)
*"Policy, not really good. Sometimes it seems as the mental whatever****,*** *we are not recognized there, understand? Because we have* ***lack of resources*** *to place our patients. Social development is having lots of resources, food parcels, money from government, but I mean, us…****I mean it seems like we are not recognized."*** (Participant O)
*"****Our country nationally, provincially and locally, does not see mental health as an issue.*** *I also want to add to that and say we have a big mental health problem in our country, one out of every 5 people will at some point in their life experience a psychiatric/mental health problem, which means that our likely hood of developing depression, etc. is very high.* ***The government needs to step up a little bit –see it as a priority.*** *For example, you cannot divorce mental health and drug abuse, alcohol abuse, couples going through a divorce, loss, disappointment – you are going to have some or other mental health problem. It is a reality in our society and we need to start facing it –****not evident when we look at funding"*** (Participant J)

N = 20

It is evident, when reflecting on these narratives, that this was a particularly strong issue raised by participants within the study. Fourteen participants(70%) felt that mental health not being recognized by government was the **core reason behind poor resources and service rendering**

capacities of mental health organizations and institutions. As indicated by participant J, mental health is a very pressing and concerning issue within society, with one in every five individuals developing a mental illness at some point in their lives. This is supported by literature (Barlow & Durand, 2012).

In terms of bodies which are responsible for mental health policy, advocacy and priority planning, the National Directorate: Mental Health and Substance Abuse, in the Department of Health, acts as the authority which provides advice to the government on mental health policy and legislation (Lund, Kleintjies, Kakuma & Flisher, 2010). It is significant to note that plans regarding mental health, as established nationally and provincially by such bodies, tend to be integrated within the general health plan for the province, and that there isn't a dedicated budget for mental health services specifically (Lund et al., 2008; Lund et al., 2010).

According to a country report conducted on mental health services in South Africa (Lund et al., 2008), research found that mental health remained a low priority, despite the seemingly progressive policy framework. Research through this study found that mental health is not necessarily at the forefront of policy development and implementation, and little integration exists with regard to that of mental health and other key sectors, thus supporting the views of participants in the idea that mental health is not necessarily viewed as being a priority issue. It is significant to note here that participants felt that this lack of concern and **recognition** by government was the predominant cause for poor services at the community-based level. This is the core behind that which has already been identified in terms of lack of resources and funding, lack of professional capacity, overpopulation of hospitals, under-resourced rural areas and poor implementation and re-assessment of mental health policy.

4.6.5.2 Category: Inadequate provision of funding and resources for mental health care

According to participants within the study, mental health not being recognized as a priority issue was evident in the poor provision of funding and resources for mental health care within communities. All participants (100%) indicated this to be a concern, advocating that service provision was not possible if limited by poor resources and funding. This is indicated by participant O below:

*"We need more support in terms of **resources**, ja, in terms of resources."*(Participant O)

The lack of sufficient resources and funding for mental health is supported by relevant literature (Lund et al., 2008; Petersen et al., 2009),in terms of the financing of mental health service rendering, public sector mental health care is covered through national tax revenue, and expenditure is determined by the National Department of Health. Thus the allocation of finances and resources specifically for the area of mental health is at the discretion of the department within each province (Lund et al., 2010). This can often result in poor allocation of resources for mental health, with a greater focus on other areas of public health.

Further than this, participants raised the fact that it was **the responsibility of government** to make provision for increased resources toward improved service rendering for vulnerable patients within this field of mental health care. Participant G expressed this below, also clarifying that such services needed to be **government funded** and not add to the patients and families already existing financial struggles:

*"**Government needs to start building more hospitals**, maybe we also need those places, if the client can go and stay with professionals who will assist them to take their medication. We need facilities where we can place them with government; where they can use their own grant, don't need extra money, **where government will fund**."* (Participant G)

The need for increased facilities toward professional care is a separate category which will be dealt with in greater detail later in this chapter, as indicated in table 4.2 earlier.

However, the lack of funding and resources for mental health care, and this being as a result of mental health not being recognized as a priority issue, is recognized in literature (Lund et al., 2008; Lund et al., 2010)

According to relevant research (Lund et al., 2008:66-67), 'de-hospitalization' was deemed as being primarily a cost saving exercise by government, without the simultaneous development of the necessary community based supports to assist users and their support systems to cope with psychosocial disabilities within a community setting; this again confirmed the low priority given to mental health in terms of funding and resource allocation.

4.6.6 Sub-theme 2.6: Caregivers and communities

A sixth sub-theme that was evident when assessing the patterns of data and discourse that emerged from the semi-structured interviews, was the fact that caregivers and communities were key factors in understanding the mental health context, its insufficiencies, needs and challenges. According to participants, categorical issues were raised such as the fact that caregivers of mentally ill patients were recognized as being a vulnerable group, as well as the fact that abuse of mentally ill patients by family members and caregivers was an issue. The need for increased psycho-education in communities with regard to mental health and mental illness overall was also raised. These categories will be explored in greater detail and are extrapolated in table 4.12 below:

Table 4.12: Sub-theme 2.6. Caregivers and communities

Category	**F**	**Representative participant excerpt**
Caregivers of mentally ill patients recognized as a vulnerable group	11 (55%)	*"And then there's other people with mental illness who cannot be with families, because, I mean, we see horrific things, families that cannot cope with people that are very ill, and we struggle with that on a daily basis, because families come to us and we see the desperation, we see how families are torn apart and then there's nothing you can do"*(Participant K)
Abuse of mentally ill patients by families and communities	8 (40%)	*"For number one, the families just don't care, so they do become victims of sexual abuse, of exploitation, of so many things, so those kind of people who are just not able to, you know, where families just don't care, they shouldn't be out there, they should be a place where other people can look after them."* (Participant K)
Need for increased psycho-education in communities	20 (100%)	*"There are some services that are available outside, but most of our families, the carers, they not aware, even the social workers at the clinic, they were asking me, where to refer, what must we do. I think, in terms of awareness, I think we need to lots and lots of awareness outside there. We need more workshops and awareness."*(Participant O)

N = 20

4.6.6.1 Category: Caregivers of mentally ill patients recognized as a vulnerable group

In exploring the sub-theme of caregivers and communities, participants indicated that caregivers of the mentally ill were actually considered to be vulnerable group in its own that needed to be recognized by mental health professionals and services. According to eleven (55%)participants, the **caregivers within the mental health context were in need of increased support and recognition as being vulnerable to risk** and abuse by mentally ill patients, and were under extreme stress in attempting to care for these individuals.

Participants in the study indicated that the movement to increased focus on community-based care added **increased pressure on caregivers** to look after mentally ill family members who were often **violent and abusive in nature**; participants stressed that **families were simply not coping** with this task and that there were **insufficient resources and services available to support this vulnerable group**. Participants F and I echo this viewpoint below:

*"That's a huge problem, because **families can't cope with the service**, with clients and there's nowhere to go because the **government doesn't provide any services**."* (Participant F)

*"We were at a family session, now, one Sunday, caregivers or the parents or whatever were generally concerned about that, because their children or husbands or whatever were in the hospital for a period of time and now its time to, to just come visit or so, or be released or whatever, and **they couldn't cope with it, with their family members.**"*(Participant I)

Participants felt that the core issue in this category was the fact that, due to policy shifts and implementations, **patients were having to live with families in communities**, as opposed to institutionalized care, and this was a very heavy task to place on the shoulders of caregivers, especially **without sufficient community support services** in place; the issue of accommodation and institutionalization will be addressed in greater detail later in the chapter as indicated in table 4.2.

In the view of participants, families are considered to actually be **at risk of harm** in having to accommodate some mentally ill individuals who were not necessarily stable or **ready for reintegration into society**. The narratives of the following participants are evident of this being a priority issue:

"And then there's other ***people with mental illness who cannot be with families****, because, I mean,* ***we see horrific things,*** *families that cannot cope with people that are very ill, and we struggle with that on a daily basis, because families come to us and* ***we see the desperation, we*** *see how families are torn apart and then* ***there's nothing you can do.****"*(Participant K)

"And because this guy had strange behavior, he sees things at home, some of them they hallucinate, ***some of them become aggressive,*** *and now the parents, they will force you, want you to admit the person so they can relieved at home, but this guy, his behavior at home, they're afraid, and sometimes you end up fighting a losing battle, because that person, when it comes to trauma,* ***if he is not sick, he is going to be discharged, that is the problem****.* ***What happens now is very very bad, of very emotional,*** *because you find the mother pulling you 'don't go, there's nothing I can do, can you speak to the doctor and convince the doctor that this person needs to be admitted', but the doctor has the final say."*(Participant N)

It is significant to note here that participants were expressing not only concern for the caregivers as a vulnerable group at risk of harm and under extreme pressure, but were also expressing their lack of ability to adequately support the vulnerable caregiver as practicing professionals. Participants highlighted the fact that there was nothing they were able to do and this proved to be incredibly challenging and emotionally difficult for social workers within the field of mental health. As such, this vulnerable group, is not being supported within the mental health care context, and in fact, is being further isolated through new mental health policy. In fact, one could go as far as to say that the Mental Health Act (17 of 2002) and the movement toward deinstitutionalization served to create a new vulnerable group, in the attempt to care for the first one. This group needs to be recognized in policy and service implementation.

According to relevant research and literature (Lund et al., 2008), consequences of poorly planned deinstitutionalization and community service provision were identified in terms of frequent relapses –and consequently frequent re-admissions to over-burdened services – **family strain**, and decreased support of users (Lund et al., 2008:66-67). The issue of support to families was a key theme in the research findings of Lund et al (2008), with the overall issue of increased reliance on community care without the corresponding increased development of support.

4.6.6.2 Category: Abuse of mentally ill patients by families and communities

Interestingly enough, despite raising the fact that caregivers were a vulnerable group in regard to having to care for mentally ill patients, participants also acknowledge that many **mentally ill patients were themselves at risk** of being victims of abuse by their family members and caregivers. Eight participants(40%) indicated this to be an issue, and spoke of abuse of mentally ill patients in terms of physical and sexual abuse, emotional abuse and neglect, as well as financial abuse and exploitation. The narrative of participant J expresses these concerns of mentally ill patients being particularly at risk of being mistreated and harmed:

"The other challenge that we have on a primary level the ***families members of those people often ostracize them, abuse them, beat them****, put them out of the house"*(Respondent J)

This concern, as raised by participants within the study, again was then followed by advocating for **increased facilities and accommodation services** for the mentally ill patient, where they could be properly cared for and protected.

In relevant research (Lund et al., 2008), participants of a country report conducted on mental health service delivery in South Africa generally felt that existing stigma against mental illness was something highly problematic within South African societies. The consequences of this are that individuals suffering from mental illness are often feared, ridiculed, exploited, neglected, isolated and even rejected by family members and peers. This then results in mental health service users being exposed to violence, abuse and neglect, impoverishment and adverse living conditions (Barlow & Durand, 2012; Lund et al., 2008).

Both the risk of caregivers and the abuse of mentally ill patients were factors that supported the advocacy of many participants for institutionalized care – a factor which will be further explored later in the text.

4.6.6.3 Category: Need for increased psycho-education in communities

In discussing the challenges that arose within the context of caregivers and communities having to care for the mentally ill individuals, all participants (100%)shared the need for an **increase in**

psycho-education services for communities, in order to generate a more appropriate understanding of mental health and how to care for individuals suffering with mental illness. Participants felt that if communities were being allocated this task of caring for the mentally ill and if community-based care was becoming an increasing focus, than it was necessary to **further educate communities on the topic of mental illness**. This is expressed by participant E below:

*"Because what should be available there would definitely be the crisis management and the **continued psycho-educational kind of programmes** and support programmes for families and that is **non-existing**, they do not have the staff to do that, so if we don't do it here than there is nothing available."*(Participant E)

The lack of understanding and awareness in communities also lead to **cultural assumptions and fear** around mental illness, which, in the view of participants, was common in communities and needed to be addressed through increased education, as expressed by participant N below:

*"We see those things and sometimes you think you can understand what is happening, sometimes you want to understand, and **if you don't have much insight, you will be like the other members of the community that discriminate**. Some people think that you are being cursed, that's why you like that. It's how we are brought up in the communities. **We are all afraid to be like that**, and no one wants to be like that."*(Participant N)

According to relevant literature (Glanz et al., 2008; Jamner & Stokols, 2000), interventions which can bring about key changes at the social environment level include various forms of community education, support groups, peer programs, workplace incentives and social marketing campaigns. These services can then be used to promote positive community attitudes and awareness. However, literature (Jamner & Stokols, 2000) also stipulates that interventions at this level focus on aspects of the physical environment which should be put in place before educational or community awareness initiatives are able to be attempted, in terms of resource availability and accessibility. Jamner & Stokols (2000) found that sometimes educational initiatives encourage impossible or unrealistic behavior that cannot necessarily be implemented or successfully achieved in certain physical environments; such limitations need to be addressed before adequate social interventions can take place. In this scenario, education and awareness

programs are more likely to be effective when preceded by programs for the development of community facilities and promoting community safety and sustainable development.

This is relevant when reflecting on the summaries and analysis presented earlier in the text, in that there needs to be a simultaneous development of community structures and services, and an increase in access thereof, as well as professional capacity, in order for the psycho-education of communities to render any kind of effective impact on mental health care. Thus, education and development of the environment of care need to go hand in hand toward improved overall service rendering for the mentally ill group.

SECTION F: THE MENTAL HEALTH ACT (17 OF 2002)

The Mental Health Act (17 of 2002) will be reflected upon in this section, according to two key sub-themes, which serve to explore knowledge surrounding the new act, both in terms of professional and community understanding, as well as the effect of the mental health in terms of service rendering and key challenge areas raised by social work professionals.

Post-apartheid, advocacies were made for the development of a policy that allowed for, and encouraged, more personalized care closer to the environment of the patient, minimizing institutional dependence (Shadish, 1984). South Africa adopted a policy shift in their approach toward mental health service implementation by purposefully downscaling psychiatric institutions and implementing a community-focused public health model influenced highly by international policy developments and growing human rights movements, as discussed in chapter's two and three (Lund & Flisher, 2006). In the last decade, there have been significant policy and legislative developments, primarily through three important documents: the White Paper for the transformation of the health system, the National Health Policy Guidelines for improved mental health in South Africa (1997) and the more recently revised Mental Health Care Act (17 of 2002), which will be the focus of this section.

4.7 THEME 3: THE MENTAL HEALTH ACT (17 OF 2002)

The new mental health act (17 of 20020 was a strong theme that emerged in the analysis of the discourse and data in the semi-structured interviews. Participants were asked to share their opinions regarding policies in mental health care, and all participants raised the new mental

health act as a key policy document which needed to be assessed and looked at in terms of its implications for mental health care within the South African context, and most particularly that of community-based care.

The following sub-themes emerged as key issues and factors related to the mental health act, in terms of knowledge of the act, in terms of both social work professionals and communities, and the effect of the implementation of the act on service rendering and mental health patient care, in terms of accommodation and homelessness, the need for institutionalization, and assisted living and police co-operation. These sub-themes and categories will be discussed in greater detail below.

4.7.1 Sub-theme 3.1: Knowledge of the mental health act

In exploring the new mental health act (17 of 2002), knowledge surrounding the actual act emerged as a prominent theme, with poor knowledge being demonstrated specifically by social work professionals and communities on the content and implications of this act. These categories will be explored further and are presented in table 4.13 below:

Table 4.13.Sub-theme 3.1. Knowledge of the mental health act

Category	**F**	**Representative participant excerpt**
Poor knowledge of the new mental health act (17 of 2002) in the social work profession	11 (55%) didn't have sufficient knowledge of the mental health act	*"I haven't read the mental health act, so I am not sure, you know, what it does"*(Participant C)
Community knowledge of the mental health act	12 (60%) communities had poor knowledge of the mental health act	*"Well we've got a new Mental Health care Act, and I spend a lot time, cause a lot of clients that have mental illnesses for years, families came through the old mental health process, so you still need to do a lot of psychosocial around that in explaining the new mental health care act"* (Participant B)

N = 20

4.7.1.1 Category: Poor knowledge of the new mental health act (17 of 2002) in the social work profession

Within the pool of twenty **social work professionals** who participated within the study, eleven (55%) indicated that they **didn't have much knowledge** of the mental health act (17 of 2002) and its exact details. This was confirmed through participants clarifying that they hadn't read through the act; this included social workers who were rendering services that were specific to that of mental health, much like the narrative of participant C provided above in table 4.13.

That being said, all participants (100%) indicated that they were aware that there were issues and concerns surrounding the act, despite not having personal knowledge regarding this.

This correlates with literature (Olckers, 2013) presented earlier in this chapter that confirms that social workers were implementing mental health service rendering without the sufficient training and knowledge required, and this was considered to be a serious issue. Poor knowledge regarding the mental health act can also be linked to earlier analysis in the chapter which explored the fact that participants felt generic social workers did not view mental health as being part of their service rendering focus and were thus not attempting to adequately equip themselves with the necessary knowledge and skills required to practice within this field. This can serve to further support the notion that mental health is not viewed as a priority issue within the larger South African context.

4.7.1.2 Category: Community knowledge of the mental health act

Much like the poor knowledge exhibited by social work professionals, it was also expressed by participants that average **community members did not possess adequate knowledge** of this act, and that part of the role of social workers and other mental health professionals was to **educate communities on the stipulations and implications of the new act** on mental health care and service rendering. According to twelve participants (60%), knowledge surrounding the mental health act in communities was poor; many community members had an understanding of the **older system of institutionalization** and did not have sufficient understanding or awareness of the changes in policy and the movement toward increased **deinstitutionalized care**. This was viewed as being particularly problematic. This is expressed by participant B in table 4.13 above.

The need for increased education of communities was recognized as a key priority issue in a country report conducted by Lund et al (2008), as well as a key function of social work professionals within the mental health context (Johnson & Yanca, 2007; Nicholas et al., 2010).

4.7.2 Sub-theme 3.2: Effect and implementation of the Mental Health Act (17 of 2002)

In reflecting on the new Mental Health Act (17 of 2002), the implications of the act on service rendering and mental health care were of high concern by participants of the study, particularly with regard to its implications for accommodation and homelessness, the need for institutionalized care, as well as assisted living and half-way homes, and finally the co-operation of key role players in the act, with specific attention to that of the police and their participation. These categories will be discussed in further detail below and have been laid out in table 4.14:

Table 4.14: Sub-theme 3.2. Effect and implementation of the Mental Health Act (17 of 2002)

Category	F	Representative participant excerpt
Accommodation and homelessness	12 (60%)	*"I'm at the stage where I say 'you go find your own accommodation', there isn't, there really isn't, accommodation is one of the things that is, it's like gold."* (Participant L)
The need for institutionalization	10 (50%)	*"If I now think of some of our clients that's walked through the door, they've been, they were in hospitals or in the institutions in the time when it was still in effect and then those people were discharged years later and they were just not thriving, they were just not thriving."*(Participant H)
Assisted Living / Half-way homes	14 (70%)	*"There is a minor portion of the population that cannot live on their own, so we don't have that kind of facility, you know, I think everything really needs to be assessed. I'm definitely all for community living and not institutionalizing people, but as I said there are people with certain genetic conditions that just cannot live on their own or be with family"* (Participant B)
Police co-operation	5 (25%)	*"... there's not enough cooperation from state, the police and other role players"* (Participant F)

N = 20

4.7.2.1 Category: Accommodation and homelessness

A key issue that was raised by twelve participants (60%),when discussing the mental health act (17 of 2002) and its implications was the fact that the act had resulted in **poor accommodation availability** for the mentally ill and **high levels of homelessness**. Due to the fact that institutions were being shut down as a result of the movement toward deinstitutionalization, as stipulated by the new act, long-term inpatient care was scarcely available. As was discussed earlier, hospitals are overpopulated and unable to accommodate the high level of mentally ill individuals, and families were struggling to cope with having to care for these individuals. As expressed by participant L in table 4.13 above, **accommodation has become as precious and valuable as gold** in the practices of social work service rendering for this vulnerable group:

This is a burden that is particularly relevant for **social workers**, as no other mental health professionals have the task of finding accommodation and placement for patients, and this task can become incredibly overwhelming when accommodation space is simply not available. This is further exasperated by the fact that **many homes and accommodation settings refuse to take on mentally ill individuals**, as they feel this is challenging or they are not sufficiently equipped, and thus already limited resources are made even scarcer within this particular context. This is expressed in the narratives of participants J and M below:

*"…because **our role is to find a place for that client to stay**, if they don't have family that is willing to take them in. **it's my job to find that accommodation for that person –there is not really accommodation for people with psychiatric disorders** –our mental hospitals have limited beds, hospitals are full –that's part of the problem. I think the government needs to construct more hospitals and accommodation needs to be made for people that have been evicted by the family members."*(Participant J)

*"I don't think it's good, because you know what, sometimes there's no body at home to look after somebody who's mentally ill, and **these places they don't want to take these people, they usually say no they can't take a person, especially whose schizophrenic**, can't take the person unless the person is really really out, otherwise if he's just mild, they can't, and **the homes, they are very nonexistent, I struggle to find a place for a person who's schizophrenic,** the minute I*

mention that they're schizophrenic, they say no they don't have the resources to deal with that." (Participant M)

This lack of necessary accommodation for patients, coupled with the struggle of families and communities to adequately care for such individuals, has resulted in an increasing number of mentally ill individuals living on the streets, where there is very little care and support for them, and where they can also be a danger to society if unstable:

"But what I can say is I think ***we are going to have a lot homeless people*** *but all patients want to go to an institution, or go to a place or make use of outpatient, or be with other people or be like a lus,* ***so they prefer staying on the streets, and they can be dangerous to the community, and they can be dangerous to themselves as well.*** *So I think more places, these things needs to come in place, more places like this, where they can have treatments, where they can feel comfortable, the staff know their case, knows how to help them and understand the,, the clinics are only dealing with crisis intervention****, buts there's not long terms places that I am aware of that can accommodate these people with their condition****."*(Participant Q)

Respondents also indicated that even with accommodation spaces where stigma was not necessarily a factor, there was just not enough space to accommodate this vulnerable group, and particularly within **homeless and night shelters**, as expressed by participant R below:

"We can't find a place for her to stay, and that's ***not necessarily the stigma*** *against mental illness, could just be there* ***aren't sufficient resources****, similarly with accommodation, we get a list everyday of what place is available in night shelters for the whole f the western cape.* ***Very seldom that there's actually a vacancy in one of the homes****."*(Participant R)

According to relevant literature(Lund et al., 2008), although the transformation of the mental health care system has enabled the improvement of certain aspects of healthcare services and policy development, there have been significant adverse effects which need to be taken into account. The notion that deinstitutionalization has led to increased homelessness was echoed by J. London (1992) in his statement: "the former residents of structured institutions became the homeless".

The task of social workers to find accommodation for client groups is supported by Johnson &Yanca (2007) and Hepworth et al. (2006). However, it is significant to notice that this has become a burden for social workers within the mental health context and is made even more challenging by the stigma of mental illness. Social workers, practicing with mental health care, seem to lack sufficient support by other community groups, and even other social workers, and this can prove to be extremely emotionally straining and stressful. It can also be deduced that the lack of sufficient accommodation and care for mentally ill patients gives credit once again to the notion of participants that mental health is not considered to be a priority issue and is thus under-resourced and under-financed, with the poor examination of policy implementation leading to such difficult circumstances that the social worker is now tasked with alone.

4.7.2.2 Category: The need for institutionalization

In keeping in step with the pattern of negative effects of the new mental health act on patient care, and the movement toward deinstitutionalization and increased community and outpatient-based care, ten participants (50%) advocated for the fact that **institutionalized care was actually necessary** for particularly ill individuals within the mentally ill group, and that the act of doing away with institutions and facilities which allowed for the institutionalized care of patients was **detrimental to the patients themselves, as well as families and communities at large**. This is advocated for in the following narratives presented in table 4.15 below:

Table 4.15: Narratives of participants regarding the need for institutionalization

Narratives
"There is a minor portion of the population that cannot live on their own, so we don't have that kind of facility, you know, I think everything really needs to be assessed. ***I'm definitely all for community living and not institutionalizing people, but as I said there are people with certain genetic conditions that just cannot live on their own or be with family****"* (Participant B)
"Because the mental health institutions, ***they built a huge hospital that was hardly used****, it was used, but then they closed soon after that, and now its being used for other things, not necessarily what it was initially built for****.*** *Other hospital, there are a lot of wards that were closed.* ***But when you look outside, there are lots of mentally ill people roaming the streets.*** *And you find that, there are* ***families who don't want to take in the people, because maybe they are overburdened,*** *we don't have enough time to sit with families to ask them how they feel, what it means for them to be having that mentally ill person, because some of them* ***they are very violent and it affects the person****."* (Participant t D)
"If the state, if they make more services available, or spend more money where it is supposed to be spent. Like, I disagree with the fact that… ***there are some clients that need supervised care, not in the community****,* [you mean institutions?] *yes, there are some people that just needs that."* (Participant F)
"Its poor, very poor. ***Parents are struggling out there and the government, I don't think they understand what's going on in these houses****, I mean those people are struggling with their children who are maybe mentally ill, its hard –****some parents would tell you I wish this person could die so that at least I will rest,*** *or even this person could rest also, there are cases like that really, the government, I think we need to have some sort of those* ***houses where we could place them and be taken care of****. I mean, they can visit their homes, but I don't think we have to force to let them stay, because some of the patients are very difficult,* ***they can be violent, beating them up, some of them stay for 3 months and when they come out, they are still not one, and the government will say, no they are stabilized****, and then they come out and they hurt their parents or caregivers,* ***I mean caregivers have been stabbed.****"* (Participant G)
"… if I now think of some of our clients that's walked through the door, they've been, they were in hospitals or in the institutions in the time when it was still in effect and then those people were discharged years later and ***they were just not thriving,*** *they were just not thriving."* (Participant H)
"I think it's, it was better, let me put it to you that way, ***it definitely was better previously, but since the whole system has changed now, where you can't just have people admitted****, you know things like that, when they're not well and they're ill, you can just take them to hospital, you've got to do a whole certification which is a traumatic experience in itself.* ***I think the policy makers don't consider the people with the disease.*** *They don't know enough to make the policy of, ok fine so we will clear this ward and we will put all this people out on the street, and this is what they said in the very beginning when I remember, I clearly remember them* ***putting*** *people out who's been in hospital for fifteen to thirty five years,* ***society must take care of them, but they never identified who society is****, you know."* (Participant L)
"…so I think that maybe, like most of the things, our government had a, ***it looked good on paper type of thing, but in essence it's just not working. Some of our clients have to be in institutions,*** *and families don't understand, and there is no amount of or times that we have try and explain to them, that* ***the government has brought in deinstitutionalization, there's nothing that we can do****, it's like you must take this person, and you must put them wherever, yesterday again, phones was slammed in my face, whatever, because you don't live with this person, but what they don't understand is I might not live with the person but I am living, I am sitting with 150 of them and it's not just sitting, there's walk ins, phone calls, having to go out and all those types of things.* [Do you feel like the act has tied your hands a little bit in terms of what you are capable of doing?]***It think it has****."* (Participant H)

N = 20

The heavy emotion of the participants in the discourse provided above is clearly evident; social work professionals are struggling in the rendering of care to mentally ill individuals and caregivers. This is seen as being particular true with regard to the vulnerability of family members and their inability to cope with the violent behavior and abuse by mentally ill individuals. This ties in with other categories, such as that of families and **caregivers being vulnerable groups**, a phenomenon that has essentially been created by the movement toward deinstitutionalization without corresponding development of efficient community-based facilities and resources to support families and mentally ill individuals. It is evident through the narratives provided above that respondents feel strongly about the fact that **some individuals need to be institutionalized for both their well-being**, as well as that of families and communities. The issue of creating an **increased level of homeless individuals** through this policy shift is also apparent, as well as the fact that **social workers feel like they are hindered with regard to what they are able to do** to meet the needs of such individuals and family groups, with a **limit in resources and accommodation.**

In reflecting on the "discrepancies between the intentions and the consequences of deinstitutionalization", Kiesler (1980, 1982) and Bardach (1977) claim that deinstitutionalization, despite its noble intentions, did more harm than good through removing existing care for patients, with a severe lack of alternative developments. Some modern researchers(Lund & Petersen, 2011; Salize et al., 2008) believe that mental health care should in fact be moving back toward institutional procedures, due to poor efforts to develop adequate public health and community-based care procedures.

Thus, in reflecting upon the above, it can be seen that deinstitutionalization, though perhaps ethical in theory, has not necessarily been as effective in practice. It is of significance to recognize here that the social work profession is one that supports the protection and care of vulnerable groups, the promotion of human rights and dignity and the development and maintenance of strong family relationships (Hepworth et al., 2006; Johnson & Yanca, 2007) and therefore if participants, as social work professionals, are strongly urging for the need for institutionalization, then this should be taken into definite consideration.

4.7.2.3 Category: Assisted living/half-way homes

In exploring the negative impact of the new mental health act on community-based mental health care, participants who didn't necessarily advocate for institutionalization, did state that they felt it was necessary to introduce community facilities, such as **assisted living care and halfway homes** as a means of combatting the growing need for placement and inpatient care for such individuals. Fourteen participants (70%)felt that this was something that government needed to begin to focus on and work toward introducing in community settings. Their opinions regarding **certain patients requiring more assisted care** was much like that of the participants above, however they also **recognized the value in deinstitutionalization** in terms of **reducing stigma** and **reintegration into society**, and thus felt a halfway home would be more appropriate and necessary. This is expressed through the narratives of participants K and B provided below:

"I think it's almost like a 50/50 type of thing, you know, ***because its good, the whole deinstitutionalization thing*** *is good because people with intellectual disability, psychiatric disability, they need to be out there, they need to be part of the community, and family, and all that kind of thing,* ***but in reality, and this is what we see at a community level, is that sometimes there's just people that shouldn't be in the communities that we work in****."*(Participant K)

"Obviously the impact of the new mental health care act meaning deinstitutionalization, cause parents and families still want their family members institutionalized and having to explain that, so yes our policy is excellent because we do no longer lock up the mentally ill, lock up being in inverted commas, so I would say, ***yes we've got a good policy but we didn't put anything adequately in place for the deinstitutionalization process****, I mean a lot of group homes or assisted living environments and so on, we don't have enough of that and you know… yes you can partially take care of yourself, but* ***you still need some sort of support or assistance****, so you know where does the fifty year old gentleman who was unfortunately treated like a child by their parents and their parents are looking at death, where does he go, and siblings are living their own life.* ***So obviously we're lacking in that regard. I mean, obviously assisted living is not institutionalized care****… I think it's definitely the lack of more resources out there, if you come back to the whole deinstitutionalization process, waiting lists at a hospital, if a patient is mentally ill and they need an admission, they land at a psychiatric ward in your main tertiary hospital, waiting for a bed at Valkenburg, and now being in a psych ward in a main hospital is*

not an ideal place, not that we want identified psychiatric hospitals, I think if we could have a decent psychiatric unit in a main hospital, it would be quite nice because we don't want the whole stigmatization around having a psychiatric hospital." (Participant B)

The notion that in theory, the movement toward deinstitutionalization was valuable is reflected in literature (Goffman, 1961; Shadish, 1984), in that in initial assessment of the deinstitutionalization process, the cause for human rights quickly became an incredibly important contributing factor, and social critiques questioned the level of dependence that mental health patients were developing which they believed was hindering their ability to function adequately in society. Thus, advocacies were made for the development of a policy that allowed for, and encouraged, more personalized care closer to the environment of the patient, minimizing institutional dependence (Shadish, 1984).

Literature (Kiesler, 1982; Kramer, 1977; Shadish, 1984) also confirms that in the years post the initial introduction of this policy change, benefits were definitely visible for both the patient and the field of mental health overall and there is continued optimism regarding the potential that lies within the utilization of community care structures and policies. However, there were many issues which arose post deinstitutionalization, hindering positive results, more with regard to the actual implementation of policy, as opposed to its theoretical content. This has been echoed by participants in the study over and over again: the policy is efficient in theory, but was simply not implemented or reviewed effectively in practice, and poor simultaneous development of community support structures and facilities has resulted in a detrimental effect on the mentally ill population.

4.7.2.4 Category: Police cooperation

The final theme which emerged when discussing the implications of the mental health act was that of the cooperation and participation of key role players as outlined in the act stipulations for the mental health care, screening, assessment and involuntary admission processes. An important group that was recognized by participants as being particularly challenging within this area was that of the police in communities'. Five participants (25%)felt that police cooperation was incredibly insufficient and challenging, despite the fact that the new act stipulates their core responsibility in assisting social workers and other mental health professionals in tasks such as

involuntary admission as in Form 22, safety, transport, and overall support. This is evident in the discourse of participants as presented below:

"So, in terms of, if you've got a schizophrenic on the streets for example, ***it says the police are meant to pick up that person and take them to a psychiatric hospital****, but because the police have so much more going on,* ***they won't necessarily follow that protocol****. So I don't know about adherence to the mental act or if there is enough knowledge of the mental health act."*(Participant C)

*"I think the policies are good, its maybe difficult to implement them –****even with the police, they know what they are supposed to do, but they don't want to act****, they will say why are you calling us, even though they know they are supposed to take this person to the nearest clinic,* ***so we have to enforce them,*** *we try educate the caregivers on from 4 that they can take to the police station, because then they will be forced to act. So the act is there, just some people trying to ignore it.* ***So the act is good, it is just not being implemented by other stakeholders."***(Participant G)

"The police has this perception of, ah is it the same people again that's calling you, they have to go to the same people again, then it's almost like they don't go anymore, even if its an involuntary admission, ***so even the police is not really helping us****. The police, if you do an* ***involuntary admission****, after, say here, round about 2 or 3, than you have to literally go with the police to the person, go with the police to the day hospital and you stay there, maybe, because you know the police, that specific shift ends at six which means that six o clock they leave, it doesn't matter if your client is booked in or whatever, they just leave because their shift is over and* ***its not their problem anymore*** *so you have to literally stand there and wait, just kind of get them to, just allow the doctor or whoever to book the client in, stuff like that."*(Participant I)

*"****And there's a clear section in the mental health care act that I've now, I rely on that, I have to sort of make sure that I make a point of it, according to section 22 you have to assist****, because it's a case of why must we take him, you's have a car, why don't you take him, why don't you put him in the back, not thinking that this person might be aggressive, might choke, do whatever, and they have to take this client. There's incidents where I, you know how difficult the process is already and* ***just to get the van out there, it's like a one of those hallelujah moments.****"* (Participant H)

"There is another point coming, in terms of stigma. Police stations. When, one of our family phone us early in the morning, patient is starting to relapse, as a family I call the police station to come and assist, to help us to assist in terms of readmission. ***But the police they are very difficult outside there.*** *And I am talking now in terms of my experience. We have to ask the family, how is the patient, is he aggressive. If he is aggressive, we have to start at the police station, so they can assist us to go there, because we also scared.* ***Now the police, no we can't, we have to remind them of our job, I mean they have to assist on that, but they very difficult. The police services, they are not helpful at all. At those police stations, I think we also need to do awareness.*** *"*(Participant N)

According to the Mental Health Act (17 of 2002), police are requested to assist with any involuntary admissions of patients, in accordance with Form 22, as well as assisting mental health professionals in the transport of patients to hospitals and clinics for admission, particularly when they are considered to be violent and a danger to the health professionals. The lack of support by stakeholders in mental health care is reflected earlier in the chapter, in terms of generic social workers not viewing mental health as a focus in their service rendering, the department of social development not sufficiently incorporating mental health training into the undergraduate curriculum, and the government not recognizing mental health as an overall priority issue which needs to be addressed. A small group of devoted mental health care practitioners and social workers seem to be carrying this incredibly large and heavy load, and it is resulting in burn-out, frustration and high levels of strain within this area of professional practice and care.

SECTION G: THE MENTALLY ILL SERVICE USER

The Mentally ill service user will be discussed according to one primary sub-theme which was identified, in terms of the profile of the mentally ill client, according to the views of respondents in the study. This sub-theme will be discussed according to four respective categories as presented in table 4.2.

4.8 THEME 4: THE MENTALLY ILL SERVICE USER

The theme of the mentally ill service user will be explored within the established sub-theme of the profile of the mentally ill client, according to four distinctive categories. This sub-theme and

the associated categories will be discussed in further detail in this section, and are demonstrated in table 4.2 above, as well as table 4.16 below.

4.8.1 Sub-theme 4.1: Profile of the mentally ill service user

In exploring the mentally ill service user, the predominant patterns which emerged were centered on that of the profile of the mentally ill client, according to the views of social work professionals working within the mental health context. These patterns were broken down into four respective categories, in terms of the prevalence of schizophrenia, comorbidity, the elderly, and the lack of services for teenagers affected by mental illness. These are demonstrated in table 4.16 below.

Table 4.16: Sub-theme 4.1. Profile of the mentally ill service-user

Category	**F**	**Representative participant excerpt**
Prevalence of schizophrenia	8 (40%)	*"mostly schizophrenia"* (Participant O)
Comorbidity	17 (85%)	*"90% of our patients, they are using substances –substance abuse. Imagine substances, plus mental health, they can't work together"*(Participant O)
The elderly service user	6 (30%)	*"We have certain gaps, where we, or age groups, like the one between, I'd say 50 and old age, there is absolutely nothing for these people, there's no facilities for them, we can't put them into an old age home, they won't get a subsidy there for them, so if there isn't accommodation for them, then they are also just out in the streets, you know?"*(Participant L)
Lack of services available for teenagers affected by mental illness	6 (30%)	*"so hence me saying the government does not make provision for teenagers in this age bracket. There is no provisions made for them."*(Participant J)

N = 20

4.8.1.1 Category: Prevalence of schizophrenia

In exploring the concept of the profile of the mentally ill client, participants were asked to give an indication of the primary mental illness with which they came into contact in terms of working with mentally ill clients and families affected by mental illness; **schizophrenia** was a strong category that emerged in this regard. Eight participants (40%)indicated the schizophrenic individual to be one of the primary client profiles with which they interacted. According to these respondents, the schizophrenic client was also considered to be **the most challenging** of all mentally ill individuals, due to the strong play **of psychosis** in this diagnosis, hallucinations and delusions, episodes of **violence and aggression**, as well as **frequent relapse and instability**.

In discussing the violence and abuse of mentally ill patients toward their caregivers and family members, participants were often referring to their schizophrenic patients as such individuals, if not stabilized on medication, can exhibit strong symptoms of aggression and inappropriate behavior.

In literature(Waghorn et al., 2007),schizophrenia is considered to be one of the most difficult psychiatric diseases, as well as the disease which leads to the highest level of disability. Psychotic disorders, such as schizophrenia, have a need for high levels of medical treatment and care, particularly within the beginning stages of psychosis. That being said, psychotherapeutic care is also of vital importance and thus the need for social work intervention in this regard is recognized (Barlow & Durand, 2012).

4.8.1.2 Category: Comorbidity

The second primary client profile with which participants came into contact with in their experiences within the mental health context was that of the **comorbid client**. According to seventeen participants (85%), the majority of their clients had a **dual diagnosis**, suffering from both a mental illness and a substance addiction; often, the mental illness was as a result of substance abuse through the onset of **substance-induced psychosis**. This proved to be **incredibly challenging**, in that the social worker was required to take into account both the need for stabilization with regard to mental illness and symptoms of psychosis, while also working through the **addiction process** with the client and ensuring that the substance abuse was no longer an influential factor in the functioning of the client system. Participants also indicated that

the use of substances made **medication adherence** incredibly difficult and further demotivated clients from participating in rehabilitation activities, toward full recovery. This is evident in the narratives of participants C and O as presented below:

"It's definitely been challenging, especially when I worked here, then there is, if it's a ***co-morbidity****, then it's* ***definitely more difficult to treat the substance, the addiction****, if there is a psychiatric illness and condition there."*(Participant C)

*"****A lot of substance-induced psychosis****. It's a big one. Although, there are some symptoms of schizophrenia, but query substance use.* ***90% of our patients, they are using substances*** *– substance abuse.* ***Imagine substances, plus mental health, they can't work together****, plus treatment."*(Participant O)

According to literature (Barlow & Durand, 2012), due to the fact that disorders such as substance-induced psychosis are about self-control and the influence of external factors, treatment generally involves some form of rehabilitation with the assistance of medication use and psychotherapy. The lack of inpatient facilities for such rehabilitation and long-term care prove to make treatment for individuals suffering with a dual diagnosis incredibly challenging, particularly for that of the social worker, as very little can be done to intervene for the patient without the assistance of rehabilitative services.

4.8.1.3 Category: The elderly service user

In further exploring the profile of the mentally ill service user, participants raised the issue of the **elderly** in terms of being a **particularly vulnerable group** within the mental health context. According to six participants (30%), there were particular challenges working with the elderly, specifically with regard to **resource availability, accommodation placement and care**. Participants indicated that, due to their age and the presence of a mental illness, elderly clients are incredibly difficult to find placement for and there are a high number of elderly mentally ill individuals living on the streets simply because homes won't accept them and caregivers and family members have all passed on; they are unable to retain employment and cannot adequately look after themselves. Participants feel that there is need for an increase in facilities and resources for this particular group. This is demonstrated in the narrative of participant L below:

***"We have certain gaps**, where we, or age groups, like the one between, **I'd say 50 and old age, there is absolutely nothing for these people**, **there's no facilities for them, we can't put them into an old age home, they won't get a subsidy there for them, so if there isn't accommodation for them, then they are also just out in the streets,** you know? I think the one thing that can really make a real difference is having something like halfway homes; that type of thing. I think in general."*(Participant L)

The elderly as a particularly vulnerable group is recognized in literature (Barlow & Durand, 2012:62), with the effect of social and interpersonal factors on the expression of physical and psychological disorders having a significant impact on elderly individuals. According to Barlow & Durand (2012), understanding and treating the disorders experienced by the elderly is deemed as both necessary and important, as this group is viewed as being particularly vulnerable.

The fact that the elderly have not been signaled out by government as a particularly vulnerable group within the context of mental health, and as being determinately affected by the movement toward deinstitutionalization, demonstrates the level of poor assessment and review regarding mental health policy and the implementation thereof. The elderly are the primary responsibility of the government, due to the fact that it is a growing population, with the impact of HIV/AIDS and poverty, and thus there is very little community and family support available for this group. These stressors and vulnerabilities alone are hugely significant, and when coupled with the challenges and stigma of mental illness, the need for intervention with this age group rises dramatically and needs to desperately be addressed by government.

4.8.1.4 Category: Lack of services available for children affected by mental illness

The second vulnerable group which was raised when exploring the profile of the mentally ill client with participants was that **of children who are affected by mental illness**. Six participants (30%)identified this as a primary area for concern; this was raised by participants in terms of two core concepts. Firstly, participants indicated that there were very **few resources and facilities** available that specifically targeted the needs of children presenting with mental illness; over and above this, **very few facilities are willing to take in children** if they are not child specific in terms of the nature of their service rendering and target group, and this is even more so when the child is presenting with a mental illness. This has resulted in **children being a**

vulnerable and neglected group within the mental health context. According to the narrative of participant J below, the **age bracket of 15-18** is particularly neglected:

"So what I am trying to say is ***there are absolutely no rehab services or aftercare services or intervention programmes for children in between the age of 15 and 18****. That becomes somewhat worrisome when you at the same time consider all the kids that are standing on the streets during the day, the high school dropout rate we have in our high schools, the absconding rate, the rate of children having behavioral challenges and all that, so hence me saying* ***the government does not make provision for teenagers in this age bracket. There is no provisions made for them****."*(Participant J)

According to the narrative of participant C as presented below, children very quickly **get lost in the system** due to the fact that there are **limited resources and facilities** available for them, and those that are available have incredibly **long waiting lists:**

"I'd say that on average the services are poor. I think there is room for improvement. Because even when I was working at [a child and family welfare organization], there were children that had behavioral problems who definitely needed psychiatric help. ***But if you referred them to [a] hospital, the waiting list is like 6 months to a year*** *and because something isn't suicidal and is not an emergency,* ***that child just gets lost in the system****. So there wasn't enough access in terms.. I got really frustrated."*(Participant C)

The second issue regarding children in mental health which was raised in the discourses with participants was the fact that there are very **scarce resources available for children who have parents or family members with mental illnesses**. This was particularly raised by participant E who felt that this was a core issue in the context of mental health that was not being addressed, and according to this respondent, and others, school social workers were ill equipped to deal with mental illness and adequately support these children:

"I do not know of one service, and ***it's a big big gap****,* ***where children that grow up in households where a parent has a mental illness*** *gets supported, that does not exist. And the school social workers, they come to my training and they would say that they are so unequipped,* ***teachers are so unequipped****, they do not know how to work with these children, what to tell them, how to explain these illness, how to be the constant link. And that would be one of the big*

things that the social worker, well obviously with crisis management and assistance with admission and readmission and you know with managing their lifestyle and with managing compliance, we all know that those are big issues, ***but being able to help a family and to help children that grow up in a house where there is somebody with a mental illness, and that has to see the illness pathology****, that has to understand,, moms coming back after she's done all these weird things, what must I now think about this, or what shouldn't I think about it,* ***that's important. I would love to see that happen.****"*(Respondent E)

According to literature (Lund et al., 2008:86), a child and adolescent mental health policy guideline has been developed at the national level. However, research has indicated that technical support is needed to develop mental health plans and strategies in order to implement this national guideline. It would also be considered that perhaps if mental health was recognized as a priority issue by government, vulnerable groups such as children, the elderly and caregivers would then also begin to be recognized and take priority in terms of service and policy development toward their protection and support. The fact that child and adolescent mental health policy has been developed, however, does indicate that there is some recognition of its importance.

That being said, the narrative of participant E raised an issue which has not yet been addressed by policy in any way. Services are not available for children whose family members and/or caregivers have been affected by mental illness. Experiences of mental illness for a child can be extremely traumatic (Barlow & Durand, 2012) and if not dealt with adequately, can have a permanent impact on the development of the child, emotionally and psychologically, as well as in terms of basic care and stability in their upbringing. It can be noted here that generic social workers are again recognized as being ill-equipped for a task that, in essence, involves child protection, a core function of the generic social worker. This advocates for the need to equip social workers in mental health from the undergraduate level.

SECTION I: REFERRAL AND CO-OPERATION

The concept of referral and cooperation will be explored in this section of the chapter, looking at this theme within the context of the multi-disciplinary team as a core sub-theme, along with one relevant category, as presented in table 4.2. According to Volgeman (1990:503), the

establishment of a national health service, within the context of deinstitutionalization in particular, calls for the participation of particular mental health professionals, in terms of psychologists, psychiatrists and social workers. He stipulates that in order to render adequate services, mental health professionals will need to begin to work together more closely. This idea of the multi-disciplinary team approach will be explored further in this section.

4.9 THEME 5: REFERRAL AND CO-OPERATION

The theme of referral and cooperation will be discussed in light of the core pattern which emerged in the study, in terms of the multidisciplinary team approach within the mental health context. This sub-theme will be further explored through the analysis of one specific category, namely the importance of the multi-disciplinary team within community-based care in mental health.

4.9.1 Sub-theme 5.1: The multidisciplinary team approach

In exploring the theme of referral and cooperation, the sub-theme of the multidisciplinary team approach emerged as a pattern in the narratives and discourses of participants. This will be discussed in further detail according to the established category, as presented in table 4.17 below:

Table 4.17: Sub-theme 5.1. Multi-disciplinary team approach

Category	**F**	**Representative participant excerpt**
The importance of the multi-disciplinary team within outpatient care	12 (60%)	*"So I think if we can get to the stage where people can work together as a team. I'd love to see that happening"* (Respondent L)

N = 20

4.9.1.1 Category: The importance of the multi-disciplinary team within outpatient care

In discussing the theme of referral and cooperation in the semi-structured interview with participants, and that of the multidisciplinary team approach, it became evident that there was a strong theme regarding the **importance of the multidisciplinary team in community-based care in mental health services**. According to twelve participants (60%), the participation of key

role players and mental health professionals within mental health care was incredibly important for adequate service rendering and each participant was quick to point out where the assistance of other professionals was needed above and beyond that of social work, in order to render sufficient care for the mentally ill service user. According to participants, there was a particular need for **more psychologists and psychiatrists** in the public and community health setting, and participant B strongly advocated for the participation of private practice professionals in community care and service rendering, as is presented below:

*"I think obviously **if we had more psychiatrists at community level**. **We've got a whole lot of psychiatrists sitting in private practice**, private psychiatrists as far as I know, you're going to pay 5, 6, 7, 800 rand to see somebody for a 50 minute session for someone to tell you ' yes you're taking the right dosage of medication' etc., do some basic counseling maybe, and maybe that person could be lucky enough to go to a clinical psychologist or social worker or whatever. And **I definitely think that whole distance between private and public, it really needs some sort of integration** and so on, I mean it would be, this is pie in the sky, you know you get lawyers that have to do pro bono work, **maybe one or two doctors, or it would be wonderful if one of the psychiatrists could do it, you know they could do additional service** or the **persons can give a couple of hours at the community health sector**, maybe that's one way of doing it, instead of going to stand on the golf course."*(Respondent B)

Participants were strong advocates of the **team approach** in mental health care, in terms of **cooperation together** and **support for one another**, and different professionals within different settings taking up **different roles**, all of which complimented the overall work being done within this field. This is evident in the narratives of participants L, C and M below:

*"So I think **if we can get to the stage where people can work together as a team.** I think if you can find, like they say, society, **then identify people in society who are prepared to assist**, you know, and not just I'm talking accommodation, because we have certain places where people can stay, but then others do it for the money, its purely for the money, and community day hospitals, the nurses there, **the psych nurses there, if they work their areas, they can do follow up on a monthly basis**. If the client didn't come in for a hospital appointment, where is he? **Pick up the phone to the social worker**, have you seen this person perhaps, do you know if there's a problem or something? I don't know. I'd love to see that happening."*(Participant L)

*"But **I'm a strong thing in outpatient care**. I think more in outpatient there is a need for social workers., because in inpatient facilities, you also find that, you know, there's a lot of psychologists here already and that, **but in the outpatient, then you really need social workers there,** because the person is coming, you know, there's also the social problems that need to be attended to, so a person isn't just an individual not on their own, but you often find that even in the home there is need for intervention and people can't always take off work for, to come into an inpatient programme."*(Participant C)

*"So we are doing a portion of that work, **there must be somebody who is going to be there full-time, who is going to be able to go out and assist** the home circumstances of these patients, and make plans of how, where to place, what to do."*(Participant M)

Finally, participants particularly from nongovernmental organizations expressed the fact that they felt at times that they were **carrying the heaviest load** in terms of cases and service rendering and that **institutions and government departments were very quick to refer cases to them**, without offering any form of support or even sufficient understanding of the role and capacity of the organization. Participants expressed the fact that increased support and assistance from other groups would be beneficial, as "there is only so much that we can do". This is expressed by participant K below:

*"I think its **long sort of standing relationship** that we have, but I think what also sometimes happens, because everybody feels the weight, so sending Peter to* [mental health outpatient organization] *is a way of passing the buck, you know that kind of thing, so if you are not very proactive in terms of what it is that you're taking on, **because what we have found here sometimes is that** **[mental health institution]** **wants to park everything at** **[mental health outpatient organization]**, so you need to be very careful what the message is that you take out there in terms of what you can do, because the big thing is always accommodation, so when* [mental health institution] *sends the referral down to say well Peter is looking for accommodation, it goes right back because accommodation is not our baby. And that is what we try, because people think when they send people to* [mental health outpatient organization], *this is where they are coming to stay, it's a place for them to stay, and **sometimes the community health centers and hospitals don't tell people when they refer patients here, this is actually why you going there, for support and for counseling and that, they tell you, go here and***

they're going to sort you out with another place to stay, *because many of our clients are not happy with here they stay, so we would be saddled with that kind of thing from family and from our clients, so I think in terms of our management and people who sort of capture files and register, they are quite good in terms of what we accept, what we can take and what we cannot* ***because we can only do so much****."*(Participant K)

The need for a multi-disciplinary team approach in community-based service rendering is supported by literature (Barlow & Durand, 2012:23). In mental health practice today, the average mental health practitioner works according to an integrated approach, incorporating aspects of biological, physiological and social understandings. Thus, in diagnosing and treating a mental disorder, the practitioner needs to assess the individual according to the biological, behavioral, social, emotional and cognitive influences and causes which could together have triggered the onset of mental illness (Barlow & Durand, 2012:30). This requires professional expertise from different areas of professional operation, including that of the social worker, doctor, psychiatrist, and psychologist and nursing staff.

The need for a multidisciplinary team in community-based services also advocates for the social approach in mental health care, understanding that social aspects can give rise to the onset and nature of mental illness (Johnson, Meyer, Winett & Small. 2000). It is being increasingly recognized that the bringing about of positive changes in mental health status requires more than a solely medical approach (Braveman & Gruskin, 2003; Skeen et al., 2010). This is based on the understanding that socio-economic factors play a large role in determining one's health status; in fact, poverty and social deprivation can be directly linked to the onset of mental disorders (Barlow & Durand, 2012; Johnson et al., 2000; Lund et al., 2010; Skeen et al., 2010). Therefore, the need for varied professional expertise is made evident.

SECTION I: SOCIAL WORK IN MENTAL HEALTH

Social work within the context of mental health will be focused on in this section according to three sub-themes which were identified, in terms of the experiences of social workers implementing intervention within the mental health context, the need for the social work professional in mental health care, and the role of the social worker in mental health care. According to Volgeman (1990:503), the establishment of a national health service, within the context of deinstitutionalization in particular, calls for the participation of particular mental

health professionals, in terms of psychologists, psychiatrists and social workers. Within the context of deinstitutionalization, the call for social work participation in mental health has never been more needed.

4.10 THEME 6: THE SOCIAL WORK PROFESSIONAL IN MENTAL HEALTH CARE

The theme of social work professional in mental health care will be discussed, according to the sub-themes of experiences of social workers, reflecting on both positive experiences and challenges, the need for social work in mental health care with regard specifically to the shortage of social workers, the importance of the social work profession in mental health care, and the integration of mental health into generic social work, as well as the role of the social worker, with predominant roles such as therapeutic intervention, support, advocacy, the relational role, and seeing the patient holistically.

4.10.1 Sub-theme 6.1: Experiences of social workers in mental health service rendering

In exploring the theme of social work in mental health care, participants expressed their experiences in working with the mentally ill population group, both in terms of their positive experiences and the challenges they had been confronted with. These will be discussed in greater detail and are provided in table 4.18 below:

Table 4.18: Sub-theme 6.1. Experiences of social workers in mental health service rendering

Category	F	Representative participant excerpt
Positive experiences	5 (25%)	*"...seeing the gratitude, you know I need gratitude, you know, I don't need that from somebody, but just that acknowledgement, you know it wasn't small to them, it did help them. I suppose that's the good side of being a social worker as well so despite the challenges there are positives to it as well."* (Participant B)
Challenges	12 (60%)	*"However, part of the challenge in this role is the lack of safety. Social workers are probably the most vulnerable professionals when it comes to safety, these mental health clients some of them become violent."* (Participant J)

N = 20

4.10.1.1 Category: Positive experiences

Five participants (25%), in exploring their experiences in working within the mental health context, shared positive experiences in working with this vulnerable group, which were centered predominantly on experiences of gratitude from patients and clients with whom they worked, as well as the fact that recognizing that their work did in fact assist clients and make a difference, as expressed by participant G below:

*"…**its good when you know that you are helping people** –the way they **appreciate** the support, especially with the caregivers, even if you just visit there, they will be thankful, 'at least I know I am not alone, there are people trying to assist me with my child'. So at least **it is fulfilling** in that way."*(Participant G)

Positive affirmation is recognized in literature(Johnson & Yanca, 2007) as being significant within social work practice in order to encourage and motivate the social work professional in their work. Recognizing the motivation for working within the field of mental health, both in terms of the passion for this particular vulnerable group, as well as the affirmation received by clients that their work is having a positive impact, are key to understanding the social worker within the mental health context.

4.10.1.2 Category: Challenges

Despite the acknowledgment that there were rewards and positive experiences in working with this vulnerable population group, twelve participants (60%)expressed the fact that it was particularly challenging working within the mental health context, in terms predominantly of **issues of safety**. This was raised as a concern especially in light of the fact that social work professionals within the community context are required to conduct **home visits**, which can prove to be risky; this is described by participants J and G below:

*"However, **part of the challenge in this role is the lack of safety**. **Social workers are probably the most vulnerable professionals when it comes to safety**, these mental health clients some of them become violent."*(Participant J)

*"There are a lot of challenges –only been here for8 months – I did find it difficult – you go there, this client has just been discharged –how are you going to find this person – **is he going to be***

aggressive towards you, you are always scared*, you don't know how this person is going to react –find a person is psychotic, maybe try do something to you –****so there are challenges where you are afraid to do home visits.****"* (Participant G)

Some participants also expressed the fact that working with the mentally ill could be challenging in terms of needing to go **above and beyond what is normally expected** of professionals working with such groups, with regard to areas of needing to find **housing and accommodation placement**, ensuring that patients get the adequate care when needed, partaking in **involuntary admission** of psychotic patients and having to **work with families**, where there is very little that can be done in terms of limitations presented through mental health policy, as discussed earlier in this chapter. These challenges are expressed by participant H below:

"…now you get to your community health center and ***the client decides to run****, trust me whether you wearing heels or whatever* ***you run after that client, you catch that client and you make sure he gets into trauma.*** *So that is the extent of the things we have to do."*(Respondent H)

Safety as a challenging area within the practice of social work is not necessarily specific to the field of mental health (Johnson & Yanca, 2007), however, it can be noted that social workers are particularly at risk when working with violent or aggressive patients who are unstable and irrational. This can be particularly true in the case of a dual diagnosis, where drug-related aggression and symptoms of psychosis can result in very challenging interactions with patients (Barlow & Durand, 2012). Thus, the safety of social workers within this context can be deemed as a priority issue which needs to be further explored and assessed.

4.10.2 Sub-theme 6.2: The need for the social work profession in mental health care

The need for the social work profession was one of the core focuses of the semi-structured interview and emerged as a strong sub-theme under the banner of social work within the mental health care context. All participants (100%) felt that there was a specific need for social workers within mental health care and that the social work profession was particularly important for the rendering of services to this vulnerable group. The categories that emerged within this sub-theme were focused on the shortage of social workers within the mental health context, the importance

of the social work profession in mental health care, and the need for the integration of mental health care into generic social work. These categories will be further explored in this section and are outlined in table 4.19 below:

Table 4.19: Sub-theme 6.2. The need for social work in mental health care

Category	**F**	**Representative participant excerpt**
Shortage of social workers	11 (55%)	*"there isn't a lot of social workers and then sometimes you are working with a caseload of 300 if you are in an NGO, you can't give specialized one on one care for that individual. So the problem just feeds into each other because there is a shortage of social workers and a lack of access to resources"* (Participant C)
The importance of the social work profession in mental health care	20 (100%)	*"I feel like the whole world need social workers. There is never a situation in which a social worker cannot utilize their skills. Therefore any facility or institution that deals with mental illness can and should utilize the specific skills of a social worker"* (Participant T)
Integration of mental health into generic social work	20 (100%)	*"All social workers, they do need to know about mental health."* (Respondent G)

N = 20

4.10.2.1 Category: Shortage of social work capacity

In reflecting on the theme of social workers within the mental health context, and more specifically, the need for social workers in mental health care, eleven participants (55%)discussed the core issue being a significant **shortage of social workers** within the mental health field. It was felt that this shortage was spread across the mental health context, in terms of inpatient care, community-based care, nongovernmental organizations and government departments. The viewpoints of participants are illustrated through relative narratives below, describing the shortage of social workers and the particular impact of this on the field of mental health, in terms of a **lack of capacity for specialized, focused and one-on-one therapeutic**

care, the **capacity for effective community outreach** and **poor social work service delivery within the day clinic and community health center** settings:

"We also have community outreach and training as part of our brief, and we do that, but we don't do that large scale, smaller item, ***we don't really have the capacity****, I don't have the time to do all this,* ***if we had a department of 20 social workers instead of 10 then it would make a huge difference.*** *What's the point of employing double the amount of social workers without resources, but if* ***we did have double the amount of social workers we would be involved in resource creation, being catalysis for self-advocacy****. Then we would be able to comply with our outreach and training support mandate."*(Participant R)

"Its poor. And ***half of the day hospitals and clinics do not even have social workers in their service.****"*(Participant E)

The shortage of social workers in mental health care is reflected in literature (Lund et al., 2008),where studies on the current context of social work within mental health, found the total number of human resources working in the Department of Health or NGO mental health facilities per 100, 000 population country wide to be 11.95, and of this, only 0.4 were recorded as being social workers. Therefore, with the increased focus being on community-based services, and a poor availability of specialized social workers, generic social workers are now being faced with the task of rendering intervention services to such individuals (Lund et al., 2010). This shortage can also be linked to the fact that generic social workers do not feel equipped to work within the field of mental health, and do not necessarily view mental health as being a core part of service focus, as discussed earlier in this chapter.

4.10.2.2 Category: Importance of social work in mental health care

All participants (100%), in discussing social work within the mental health context, advocated for the fact that there was a **particular need for and importance of the social work profession within the mental health care context.** Participants expressed the fact that social workers possessed a **unique skill, knowledge and ability to interact** with individuals, families and communities, adopting the ecological perspective; rendering a level of care that was not undertaken by other health professionals and was incredibly important for meeting the holistic needs of the mentally ill group, as described by participants C and D below:

"so I think there is definitely a need for more resources and I think ***there is a need for more training of social workers*** *to be able to work with that kind of clientele. I think there is* ***a real strong need for social work, because, social workers are able to intervene at a community level and to work with the families*** *and to be part of the community, where it's not always accessible, you know, for someone to jump on two or three taxis to be able to get those services."*(Participant C)

"Yes. I think they are needed because as I am a social worker, ***understanding how much those patients need u****s, the social workers, to deal with them and their families, to support not only the patient plus their families also,* ***so it's important to have more social workers out there.*** *Community services – it isn't enough."*(Participant D)

Participants also advocated for the importance of the social work profession with regard to the notion that social workers were the only professionals able to **"do the dirty work"**, tasks such as accommodation placement, disability grant applications, administration, home visits, family therapeutic services, psycho-education and so forth where very rarely undertaken by other professionals, and thus the need for social work within this setting was evident in this regard. This notion is expressed in the narratives of respondents K and T below:

"…that if you work in a multidisciplinary team, and especially if you work in the field of health, I'm not talking about mental health, but health, ***the social worker is always the one who gets parked with the baby****. Once the doctors seen, once the psychiatrist the psychologist, the nurse, the OT, here comes,* ***everybody leaves the stuff that nobody wants at the social workers door****, That is just how it is., because the doctor is not going to have a family conference and go sort out the accommodation and the disability grant,* ***we do the dirty work****. Is there a need for social worker?* ***There will always be a need for social workers. We are a scarce skill*** *kind of thing, even though we don't get the recognition, we don't get the same money, you know that story,* ***there will always be a need for social workers.****"* (Participant K)

*"****I absolutely believe that there is a need for social workers in mental health*** *because so often we view a mental illness as the service scope of health professionals, where as* ***a social worker plays a specific role in the journey of a patient's life****. I feel that there is a need for social workers in a private or outpatient facility; I feel that there is a need for those facilities in itself.* ***I***

feel like the whole world need social workers. There is never a situation in which a social worker cannot utilize their skills. *Therefore any facility or institution that deals with mental illness can and should utilize the specific skills of a social worker and even better a clinical social worker."*(Participant T)

The social work as a profession has always been acknowledged to be render services that aid and empower the downtrodden, assessing and incorporating debilitating environmental factors that can contribute to human problems. This is evident in the definitions of social work as provided by the NASW (1999) and that of the joint definition of the IFSW and IASSW (2001).

Literature (Glanz et al., 2008) also indicates that individuals who utilize services have been shown to value the non-stigmatizing help and access to services which provided specifically by social workers as a result of the core values of social work practice which directly supports the principles underpinning self-directed support and the independent living movement.

The need for social workers in mental health practice is further advocated by the themes and sub-themes that emerged in this chapter, such as that of vulnerable groups and service rendering tasks which are only effectively implemented by the social work professional, much like that of accommodation, placement, support of caregivers and families, psycho-education of communities, and linking individuals to necessary resources for adequate recovery.

4.10.2.3 Category: Integration of mental health into generic social work

Based on the understanding that there was both a shortage of, and the importance for, the involvement of the social work profession in the mental health care context, all participants (100%) raised the fact that mental health care should be an aspect that is incorporated into generic social work. This is much like the need for the training of students at the undergraduate level in mental health knowledge and practice, but more than this, respondents felt that the generic social worker needed to not only have sufficient knowledge of mental health, but also needed to take on the **role and responsibility** of working with mentally ill clients without always feeling the need to refer this to a more specialized organization. Over and above this, all participants (100%)indicated that generic social workers should at least **be trained and**

sufficiently equipped to recognize, screen, assess and appropriately refer mentally ill clients. This is outlined in the narratives of participants B and C below:

"Again, I think it's ***one social worker at every day hospital****, as far as I know, and obviously, social workers I have found at the community level, yes,* ***do understand about mental health care, but*** *they know about [mental health nongovernmental organization], so* ***if its specific social issues, or whatever the case may be, or the person needs to be referred to a psychosocial group, they will refer*** *it to [mental health nongovernmental organization]."*(Participant B)

"I think ***if social workers could be trained****, because they work and have that initial contact and* ***if they can pick up the problems that are there and have the proper training or the proper referral facilities*** *to be able to do that, then it already helps."* (Participant C)

According to certain studies and research, concerns have been expressed about the distinctive role that social workers have to play in the broader provision of health and social services within the field of mental health. With the increased focus being on community-based services, and a poor availability of specialized clinical social workers (Lund et al., 2010; Lund et al., 2002), generic social workers are now being faced with the task of reaching out to the mentally ill.

This is expressed by participant E below, where the fact that **all** social workers are considered to be mental health professionals according to the new mental health act (17 of 2002) and should therefore be sufficiently equipped to act on this responsibility accordingly:

"The other thing is, ***social workers at the child and welfare organizations and social development need to stand in court and make a recommendation about children*** *that would be better off not being in the care of their parents, because of a lot of different reasons,* ***but sometimes it's because there is a mental illness involved. Now if I am the social worker, I have got no knowledge of mental illness,*** *and my patient says she's a [institution] patient so now I write to [said institution] and I say, look please furnish me with a report about this patients treatment because there is now a children's court procedure and the hospital sends me a report and says she's been here 10 times, and she's got a 5 axis diagnosis and she's got a borderline disorder and now I say to court, oh [said institution] says she's got a borderline personality disorder so she's very ill,* ***but I don't know what do we expect, what is the profile of somebody with a borderline personality disorder, what kind of behavior, how to they attach with their***

children, what's the kind of behavior that they display in their relationships with their children, because I need to know something like that before I make a recommendation, *but we don't."* (Participant E)

Finally, all twenty participants (100%) expressed the fact that the generic social worker was going to come across mental health cases, regardless of their area of operation or expertise and thus couldn't avoid it, but instead needed to adequately equip themselves to deal with these situations, as in the narrative of Respondent Q below:

"Some ***social workers feel uncomfortable with psychiatry*** *or the depth of problems, people that have been sexually abused, substance abuse, they feel comfortable with it,* ***so they will try to fit themselves into a field of social work where they feel comfortable****, wherever they will be going,* ***you still won't be able to escape from it, because you will get it everywhere****, a condition is combined with another problem, everywhere you will get it, if you do a proper assessment, you will realize, eg, a family history of alcohol abuse."* (Respondent Q)

The increasingly high influx of mentally ill individuals into local communities that have little, if any, structured public health and community-based care systems, has an effect on general social work practice, impacting areas of crime, family structure and functioning, child abuse, domestic violence, family violence and unemployment (Lund et al., 2010) and thus the generic social worker can no longer remain isolated from mental health care practices.

Literature (Lund et al., 2008; Lund et al., 2010) in the assessment of community-based services, reflects that mental health would infiltrate into generic social work, and in keeping in step with the International definition of social work, as adopted by the IFSW and the IASSW (IFSW-IASSW, 2001), in being a profession that protects vulnerable groups, it can be advocated that there is a distinct call for and requirement of generic social work in the mental health sector.

It can be noted here, that the ecological perspective in social work practice and understanding the needs of vulnerable groups is highlighted in this definition, and that the empowerment of individuals toward their well-being is a key focus. Mental health needs to begin to be recognized

as a vulnerable group which requires intervention through the social work profession, in keeping with such definitions as provided above.

4.10.3 Sub-theme 6.3: Role of the social worker in mental health care

Through the analysis of data and qualitative discourses as provided in the semi-structured interviews, predominant roles for the social worker in mental care emerged, in terms of therapeutic intervention, support, advocacy, relational role, and seeing the patient holistically.

Literature (Glanz et al., 2008; Jamner & Stokols, 2000)advocates, that in terms of the role of the social worker, the social worker should be viewed as being a mediator, working with the patient at a personal and individual level in the form of therapeutic interventions, working with families toward improved social support, implementing community development schemes toward in order to develop a more positive physical environment and increased resource access, as well as advocating for improved mental health legislation and policy that is beneficial for the patient and their optimal functioning, treatment and recovery, according to an ecological perspective.

These roles will be discussed in more detail below as individual categories and are outlined in table 4.20 below:

Table 4.20: Sub-theme 6.3. Role of the social worker in mental health care

Category	**F**	**Representative participant excerpt**
Support	18 (90%)	*"I think the social worker has got a huge role, in terms of supporting the individual… gathering of collateral and making sure the client is discharged in the environment that is going to be healthy and that's going to promote their mental wellbeing. So I definitely think social workers have a role to play in outpatient care on multiple levels. But I think as a strong supportive service – primary role"* (Participant C)
Relational role	14 (70%)	*"If one were to clearly define the role of the social worker here – our role is also to foster good family relationships. To help the client to have healthy relationships with other people. Our expertise is interpersonal;*

Category	F	Representative participant excerpt
		relationships." (Participant J)
Advocacy	12 (60%)	*"Advocating for clients – so that they could get better treatments or whatever, with the police or courts, they will understand what is going on, even at hospitals, there is a lot we can do there for our clients."*(Participant G)
Holistic assessment of the service-user	11 (55%)	*"we are different, we are different to the doctors and to the nurses and to the everybody else because we see the person differently. We just don't see that his leg is broken and he needs to take his medication or whatever, we see the person as a whole, and that is where the difference is, so there will always be a need for us."*(Participant K)
Therapeutic intervention	8 (40%)	*"definitely they can provide therapeutic intervention – in terms of working with the family also, then the social worker definitely has a supportive role in that way"*(Participant C)

N = 20

4.10.3.1 Category: Therapeutic intervention

Eight participants (40%) indicated that a primary role for the social work professional within mental health care is that of **therapeutic intervention**, in terms of **one-on-one counseling services**. Participants indicated that this was considered to be a primary need of mentally ill clients, as well as their caregivers, and this therefore was of high importance in terms of service rendering. This is demonstrated in the narrative of participant C in table 4.19 above.

However, it needs also to be noted that it was primarily the nongovernmental organizations and private organizations that gave the indication that they had the **time and capacity** for the rendering of such services, many government departments, hospitals and institutions concerted that although they felt therapeutic intervention should be a core role of the social worker, this kind of one-on-one time with clients was not always possible, due to high caseloads, and administrative tasks which took priority. For those participants that were able to render therapeutic services, only the private sectors indicated sufficient time for this form of intervention; nongovernmental organizations, although they were implementing therapeutic

intervention as much as possible, did struggle to do this at the level of intensity they felt was required.

Social approaches within mental health advocate alternatives to medicine, leaning toward the understanding that social aspects can give rise to the onset and nature of mental illness (Johnson et al., 2000). It is being increasingly recognized that the bringing about of positive changes in mental health status requires more than a solely medical approach (Braveman & Gruskin, 2003; Skeen et al., 2010). This is based on the understanding that socio-economic factors play a large role in determining one's health status; in fact, poverty and social deprivation can be directly linked to the onset of mental disorders (Barlow & Durand, 2012; Johnson et al., 2000; Lund et al., 2010; Skeen et al., 2010). Therefore, understanding the history and upbringing of the patient, the influence of stressor factors and coping mechanisms at the time of the onset of a mental disorder, and the existing social support which is available for the patient are key areas which are observed and analyzed toward implementing appropriate intervention for the individual. Research also demonstrates that social support and healthy social functioning has a direct impact on the nature of the recovery of the patient, and their chances of relapsing (Barlow & Durand, 2012; Johnson et al 2000; Lund et al., 2010).

Therefore, a central conclusion of utilizing ecological models within healthcare is the fact that the combination of both individual-level and environmental/policy-level interventions are needed in order to achieve substantial and sustainable changes in health behaviors (Germain & Gitterman, 1980; Glanz et al., 2008).

4.10.3.2 Category: Support

According to eighteen participants (90%), the second important role of the social worker is that of **support**. This concept of support is geared at all four levels of individual, family, community and policy contexts and is an indication, according to the viewpoints of participants, of the larger scale role of the social worker in terms of offering support in as many areas of need as is possible, **supporting through the process of reintegration into normal societal functioning, emotional and administrative support, building collateral, and facilitating resource access**. This is demonstrated in the narrative of participant E below:

"Well, mental health is, we work from the bio-psychosocial model, and it's a disease, and a ***disease impacts on the persons own life****, and it impacts on their life with their family or* ***with their support systems****, you have to look at it in the same way that you look at an addiction. There's no way that a person with a mental illness only gets affected themselves, as the individual, it just doesn't work that way and* ***there's also no way that in their recovery, that they do that without the necessary support, they need to have support along the way****. So that recovery process in mental health is the most important thing, patients need to be equipped around disability management and illness management."*(Participant E)

According to literature (Glanz & Mullis, 1988), behavior change is viewed as being maximized when environments and policies together support healthful choices, as well as when social norms and social support for healthful choices exist, and when individuals are then through such support systems motivated and educated to make choices which result in improved health behavior and functioning.

4.10.3.3 Category: Advocacy

Participants within the study largely promoted the idea of the **role of the social worker as an advocate** for the client. Twelve participants (60%) indicated this to be a primary function of the social worker. According to the views of participants, **social workers should be advocating on behalf of their clients in all areas of functioning** and service rendering, with regard to financial access, such as through the disability grant, service access through clinics and hospitals, professional support and understanding, policy development and implementation, court procedures and particularly in light of community awareness regarding mental illness and the stigma attached to this. Participants also felt that advocacy was needed with certain community role players, such as the police and medical staff, ensuring that individuals were protected and treated fairly. And finally, participants saw **advocacy for caregivers and family members** of the mentally ill as an incredibly important function and role of the social work professional within the mental health context. These views are demonstrated in the narratives of participants J and L below:

"I think the ***biggest difference between social workers and other professionals is advocacy****,* ***our role is to be advocates for our clients****, to represent them when they cannot represent themselves.*

*And to be the **enabler and the broker to link them to the resources that they should have**. We don't necessarily have to keep them on a caseload – we should link them. The role of the social worker should be a link to resources, **an advocate to represent those persons right legally, not in court, but with their family and community at large**"*(Participant J)

*"Yes – huge. Look, I think for us, these people, **by the time that they come to us, they have no voices.** And I can't think that there is anything worse than having your whole life taken away from you, you know, that drastic change, so you need **somebody to act on your behalf**. That's the one thing, the other thing is, out there our clients are no-one. Unless they have the support of their families and that, but out there they have no one and they are nothing."* (Participant L)

This correlates with literature (Johnson & Yanca, 2007:226), in that one of the primary roles of the social worker is that of the advocate, helping clients to obtain services in situations in which they may be rejected or find challenges in terms of access to relevant resources and services; in other words, expand services to clients with a particular need. It can also be recognized that the role of advocate is extremely important when reviewing the high level of vulnerability which exists within this field of mental health, both in terms of the patients, as well as the caregivers and family members. Being a "voice to the voiceless" is the grand call of the social worker and nowhere has there been more of a need for this practice then in the area of mental health within South Africa. The failure of government to recognize mental health as a priority issue further calls for the social worker to adopt the role of advocate and to demand the provision of necessary resources and funding for this vulnerable group. However, it can also be added that without sufficient understanding and knowledge of the mental health act (17 of 2002), the social worker will fail to effectively take a stand and thus social workers needs to equip themselves in knowledge and skill within this field in order to better advocate for their clients.

4.10.3.4 Category: The relational role

In exploring the role of the social worker in mental health care, it was found that one of the key functions and skills of the social worker that could be effectively utilized in the mental health context was that of the focus on the **relation role between the worker and the client**. According to fourteen participants (70%), the relational**, interpersonal function** and role of the social worker was incredibly important when working with the mentally ill population group and

was something that was **not readily availablethrough** interactions with and service rendering of **other mental health professionals**; this was seen to be a **unique social work skill**. According to the views of participants, therefore, it was the role of the social worker within mental health to understand and **foster healthy relationships** between clients and their caregivers/family members, individuals within communities, partnerships, between the client and other mental health professionals, and so forth. This is demonstrated in the narrative of participantE as provided below:

"Well I think, you know what we are well-trained in is assessing ***where a person are with their life and with their lifestyle*** *and* ***how impacted they feel****, about what's going on in their life. We are well-trained to* ***understand where relationships go wrong****, what people would need to have to be able to get back into setting boundaries and* ***to support and to be able to be a part of a recovery process****. I think we well equipped with that."*(Participant E)

According to relevant literature(Gehlert& Browne, 2012), the traditional role of social workers in mental health care primarily involved working with patients and families to facilitate effective communication between patients, families, and health care teams. This is further echoed by Johnson &Yanca (2007), where the role of caregiver is recognized in terms of social work intervention functions, providing support and care to persons. The relational role can be considered to be particularly important when considering aspects such as the difficulty and strain in relationships between mentally ill patients and their caregivers, as well as when reflecting upon the existing stigma regarding mental health which is still active in communities today.

4.10.3.5 Category: Holistic assessment of the service-user

The final key role of the social worker that was identified by participants within the course of the semi-structured interview was that of the **ecological role**, in terms of the ability of the social work professional to **view the client holistically** within an ecological framework. According to eleven participants (55%), this was a unique skill that social workers possessed, and was what primarily separated them from other health professionals –the notion of **holistic assessment and intervention.** This is evident in the narrative of respondent K provided in table 4.19 above.

This correlates with literature (Patel et al., 2010), in that both mental health and mental illness are determined by various interacting factors, such as that of psychological, social and biological

elements. According to the Mental Health Act (17 of 2002), mental health status is defined as being a "level of mental well-being of an individual as affected by physical, social and psychological factors and which may result in a psychiatric diagnosis". According to the WHO (2001), the term 'mental health' is seen as being all encompassing of the well-being of an individual, with regard to their mental, emotional and psychological functioning.

When used metaphorically, these concepts could enable a practitioner and a client to keep a simultaneous focus on the person as well as their environment, and on the reciprocal relationship which exists between the two.

In this regard, the need for social work services within mental health can be clearly recognized and advocated for. According to research conducted by Rose (1998), the discursive practices of mental health care influences individuals to regulate their behavior in accordance with normative social expectations, and thus social workers, psychiatrists and psychologists are there to provide "expert" knowledge to guide practice and service rendering in this regard. Medical interventions, although helping to alleviate painful symptoms that individuals experience, more often than not are implemented regardless of the existence of social origins of the distress. So much so, that the fact that problems are understood as existing within individuals makes it less likely that contributing social factors will be addressed at all (Austrian, 2005; Conrad, 2007; Corcoran & Walsh, 2010; Kleinman, 1988).

This is further highlighted within the ecological paradigm, through the four key models, in terms of the *Systems Theory* (Bronfenbrenner, 1979), the *Ecological Model for Health Promotion* (McLeroy et al., 1988),the *Theory of Triadic Influence* (Flay & Petriatis, 1994), and the *Resources and Skills for Self-Management Model* (Fisher, 2005), where the aspects of the individual, the social environment, the physical environment and policy are recognized as being significant for understanding and rendering services within the mental health context.

4.11 CONCLUSION

Analysis of the empirical findings as gathered through the semi-structured interview were presented in this chapter according to, firstly, the biographical information of the participants, in terms of factors such as type of service provider, core business, position in organization, years of experience, average caseload per month, and percentage of clients presenting with/affected by

mental illness. Secondly, six themes were explored, with regard to training and knowledge in mental health, the mental health context, the Mental Health Act (17 of 2002), social work in mental health, the mentally ill service user, and referral and cooperation. These themes were explored within respective sub-themes and categories accordingly, reflecting on respondent narratives and correlation of findings with relevant literature.

CHAPTER FIVE

CONCLUSIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

The purpose of the study was to gain an understanding of the views of social workers on their role within mental health outpatient and community-based services. This goal was achieved through the implementation of four primary research aims/objectives, as outlined in the relevant chapters:

- **Chapter One**: An introduction and motivation for the study was provided;
- **Chapter Two**: An overview of the mental health context at both an international and local level, toward the understanding of the rendering of mental health services, particularly at the community-based level, was discussed;
- **Chapter Three:** An expansion of the ecological perspective within a mental health context as a basis for critical analysis of the rendering of mental health outpatient and community-based services and the social workers role in this regard was executed;
- **Chapter Four**: An investigation of the views of social workers on their role in mental health outpatient and community-based services, according to an empirical data, was executed.

This chapter will serve as an achievement of the final research objective, toward offering relevant conclusions and recommendations regarding the role of social workers in outpatient and community-based mental health services in order to better meet the needs of this vulnerable group.

5.2 CONCLUSIONS

The following conclusions will be structured according to the empirical study and the structure as presented in chapter four with regard to structural layout and format. The empirical findings in terms of the established themes will be outlined with relevant conclusions. Thus, conclusions will be given with regard specifically to biographical information of participants, training and

knowledge in mental health, the mental health context, the Mental Health Act (17 of 2002), the mentally ill service-user, referral and cooperation and social work in mental health.

5.2.1 Biographical information of participants

In the presentation of the biographical information of participants, the predominant service provider was within the public field, in terms of government departments, hospitals and institutions, as well as community-based nongovernmental organizations. Based on the data provided, it can be concluded that the predominant of community-based services are provided through nongovernmental organizations specialized in mental health. This is significant, in that despite the fact that government implemented policy which advocated the move toward deinstitutionalization and community-based care, they failed to provide the corresponding community support structures and facilities, over and above hospitals and community clinics, and this task has thus been taken up by NGOs and community groups without sufficient resources and financial support from the state.

The core business of participants was varied, allowing for the conclusion that there are a number of roles and functions required within the mental health field. That being said, the predominant position of participants in the study was that of the field social worker, who is also the predominant provider of community-based services. Caseloads were averagely quite high, especially for nongovernmental organizations, enforcing the conclusion that NGOs act as primary service renderers of community services within the field of mental health. Percentages of clients within participant's monthly caseloads presenting with/affected by mental illness were also predominantly quite high, and thus it can be concluded that mental health is a predominant theme within the field of social work practice.

5.2.2 Training and knowledge in mental health

Based on the data provided within the theme of training and knowledge development, it can be concluded that there is a high need for the training of undergraduate social work students in mental health, both with regard to theory and practice. Students at the undergraduate level do not presently receive sufficient training in this field within the social work curriculum, and this was

identified by all participants as being incredibly important and something that needs to be implemented at the tertiary level, particularly within the fourth year of the social work course.

It can be further concluded that in-service training within organizations is of equal importance and is being effectively implemented within both the public and private sectors, thus adequately equipping social workers with sufficient knowledge and skills in mental health, particularly within specialized community organizations and government hospitals and institutions. Based on participant narratives, it can also be concluded that personal experience and interest in the subject of mental health is a predominant prerequisite to the motivation of social workers to expand and develop their knowledge and skills regarding mental illness and working effectively with clients within this field.

Finally, conclusions regarding the generic social worker's knowledge of mental health are that the generic social worker is ill-equipped in knowledge regarding mental health and does not feel adequate or comfortable to be working with clients presenting with problems associated with mental illness. Further still, generic social workers do not strive to equip themselves with sufficient knowledge as a result of the assumption and belief that mental health is not a core focus of their service provision, but rather is a specialized field for which they need only to refer; this is an incorrect assumption and needs to be examined further.

5.2.3 The mental health context

Within the mental health context, based on participant data, it can be concluded that mental health community-based services are predominantly poor overall; this conclusion can be extended to all four ecological levels of the individual, family, community and policy. In terms of policy specifically, the conclusion can be made that policy in itself is not necessarily poor, and in fact the majority of participants viewed the theory behind mental health policy as being good; however, the implementation of policy is insufficient and needs to be further evaluated and assessed regarding its limitations and further developments required for effective implementation at the community level.

In concluding the primary reasons for mental health community-based services being predominantly poor in nature and availability, there are three core underlying themes that can be deduced. Firstly, policy, as mentioned above, is poorly evaluated and implemented and thus,

service structures and facilities are either unavailable or insufficient in nature. Secondly, accessibility of services is extremely limited. Accessibility is a high priority issue in terms of traveling distance for clients to and from services, costs in traveling expenses, time required to attend service activities, in terms of traveling distance, long waiting periods and difficulty in clients finding time off from employment. Further accessibility difficulties can be found with regard to scarce resources in rural areas, the overpopulation of hospitals, which results in primarily emergency-management focused treatment, thus adding to the increasing "revolving door" phenomenon in terms of patient relapse, and the lack of sufficient professional capacity in community health centers and clinics. The third and final reason for mental health services being poor in nature can be concluded to be as a result of mental health not being recognized as a priority issue by government, both in terms of policy and focus, but primarily in terms of resource allocation and funding; a lack of resources for the sufficient rendering of services is a major challenge within the field of mental health.

Final conclusions within the theme of the mental health context can be made with regard to caregivers of the mentally ill patient; two conclusions can be made in this regard. Firstly, the caregiver is recognized as a newly emerging vulnerable group within the field of mental health, in that the movement to community-based services has resulted in caregivers taking up primary responsibility for the care of mentally ill individuals; this is incredibly stressful and can be seen as actually putting caregivers at risk of physical harm. Services to support this vulnerable group are scarce and needs to be addressed by government. Support for caregivers can also be seen as being an emotionally taxing role for social workers, particularly in light of the fact that very little is able to done within the constraints of deinstitutionalization and the lack of sufficient resources and government support. The second conclusion is that mentally ill patients are also at risk of abuse, physical, emotional and sexual, from caregivers and family members when being reintegrated into communities and this is a further issue which needs to be addressed.

5.2.4 The Mental Health Act (17 of 2002)

Within the theme of the Mental Health Act (17 of 2002), three primary conclusions can be made. Firstly, knowledge surrounding the mental health act is sufficiently poor, in terms of both social workers and the general community. Although social work professionals are aware of the deinstitutionalization process which was brought about through mental health policy, the exact

details of the mental health act (17 of 2002) are not as well known by social work professionals, and many of the participants acknowledged having not even read the act. Further still, the general community is ill-informed regarding the act, and even that of deinstitutionalization stipulations; thus, it can be concluded that increased education on the mental health act (17 of 2002) is needed on a broad scale, for both social work professionals and communities at large.

The second conclusion that can be made regarding the mental health act (17 of 2002), is that it's advocation for deinstitutionalization, and subsequent more corresponding development of community structures and facilities has had two core detrimental effects on the mental health community: it has resulted in extreme difficulties regarding accommodation for individuals with mental illness, in that there is a lack of sufficient inpatient placements for such individuals, and scare placement facilities, coupled with residing stigma regarding mental illness has resulted in social workers struggling to find accommodation for clients presenting with mental illness. This has further exacerbated the issue of caregivers being vulnerable and at risk of harm as they are being forced to take in family members who are still mentally unstable and often aggressive and dangerous. This has led to the second core negative effect of the mental health act (17 of 2002), in terms of the rise in homeless individuals with mental illness, and the lack of capacity of shelters to deal with this increasing problem.

Through the data presented in the empirical study, two means of combatting these above mentioned negative effects of the act were identified. The first option, which was strongly supported by a large percentage of participants, was for the re-introduction of facilities which allowed for the institutionalization of certain patients, particularly those that are very unstable and can be considered to either be at risk of harming others, or at risk of experiencing harm and maltreatment themselves. Secondly, participants who believed in the concept of deinstitutionalization and community-based care, advocated for the implementation of halfway houses and assisted living for vulnerable or at risk individuals, thus remaining away from institutionalized care, yet combatting the accommodation and homelessness issues which deinstitutionalization brought about.

The final and third conclusion which can be made regarding the mental health act (17 of 2002) is that police are failing to follow through on their role and function as key stakeholders in the mental health community service context, in terms of supporting and assisting social workers in

areas of involuntary admission, safety and transport. This is found to be a particular challenge with regard to social work service rendering and practice in the field of mental health.

5.2.5 The mentally ill service user

In exploring the theme of the mentally ill service user, it can be concluded that there are two dominant client profiles which are met by social workers within the field of mental health, and two vulnerable groups, over and above that of caregivers, that are not recognized by mental health professionals.

In terms of predominant profiles, data concludes that schizophrenic and comorbid patients are primarily seen by the social worker in the practice within the field of mental health. In light of this, and data provided regarding these two profiles, it can be concluded that these are the two most challenging client types to work within the context of mental health and prove difficult for social workers to effectively implement intervention. They can also be regarded as being the most needy in terms of difficulties in recovery and reintegration into society, thus requiring increased social work intervention than other mentally ill patients.

With regard to the primary vulnerable groups which are not recognized within this field, it can be concluded that the elderly, and children are were strongly advocated as being in need of increased service rendering with regard to both social work and mental health specific services. The elderly are most vulnerable with regard to accommodation and permanent placement needs, as a result of poor family support, inability to retain employment, and the lack of support from old age homes for elderly clients presenting with mental illness. Children are viewed as being in one of two vulnerable groups. Children presenting with mental illness are viewed as being a group that is not offered sufficient resources and funding, in terms of rehabilitation, intervention and support, particularly that of teenagers. Secondly, children with family members presenting with mental illness are seen as having minimal, if any, services available to them for support, therapeutic intervention, protection and care and this was recognized by participants as being a high priority issue.

5.2.6 Referral and cooperation

In the theme of referral and cooperation, two primary conclusions can be made. Firstly, there is a serious lack of professionals within community-based mental health care, particularly in terms of psychologists, psychiatrists and social workers. In light of this, it can thus be concluded that intervention and therapeutic services which are relational in nature are minimal in terms of availability, due to a lack of professional capacity.

Secondly, it can be concluded that, in light of the multidisciplinary team approach, there is an incredibly important role to be played by nongovernmental and community-based organizations in assisting government departments, institutions and hospitals, in that field social workers within these organizations are able to conduct home visits and build more of a long-term therapeutic working relationship with clients and families.

5.2.7 Social work in mental health

Within the framework of social work in mental health, four main conclusions can be made. Firstly, social workers within the field of mental health are experiencing particular challenges with regard to safety, specifically in terms of home visits with mentally ill clients. This is an issue which is not being addressed adequately.

The second conclusion within this theme is that there is a significant shortage of social workers within mental health, particularly at the community NGO level and in community clinics. Thirdly, there is a definite need for, and importance of, the social work profession in mental health care. Based on data provided by participants, it is evident that social workers possess a unique knowledge and skill set which is not rendered through other mental health professionals and thus social work can be recognized as being a unique mental health profession. Based on the above two conclusions, it can therefore be deduced that there is a strong need to incorporate mental health care into generic social work practice, in order to effectively render services to this vulnerable population group. In order for this to take place, increased knowledge and training of generic social workers in mental health needs to take place, and social workers need to accept responsibility as recognized mental health professionals as stipulated in the mental health act (17 of 2002).

Finally, in this section it was concluded that there are five primary roles which need to be executed by the social worker within mental health service rendering and care. Firstly, there is that of therapeutic intervention, whereby one-on-one and family counselling sessions are deemed as being of high significance within mental health care. The social aspect of mental illness, in terms of onset, treatment and recovery, is recognized by literature and thus the need for therapeutic intervention in order to render services that deal with the social aspects of mental illness are seen as being incredibly significant. Secondly, the role of support is highly important, for both individuals and families, in terms particularly of offering support through linking patients and families to necessary resources and services, offering emotional support and understanding, and facilitating administrative tasks and the collection of collateral. Thirdly, the role of advocate is necessary within mental health practice, as social workers are seen as having a responsibility to speak out for the vulnerable groups within the mental health context, protect their rights within communities and in policy developments, and to ensure sufficient availability of and access to resources and funding. Fourthly, the relational role is seen of being unique to the social work profession, in terms of working with interpersonal relationships between mentally ill clients, caregivers, families, professionals and communities. Finally, seeing the patient holistically is deemed as being incredibly important for mental health practice and also a specifically unique social work skill that allows for ecological assessment and understanding of client functioning, development and recovery, which is more sustainable and effective in nature. This role is further highlighted by the ecological models as set out by Bronfenbrenner (1979), McLeroy et al. (1988),Flay & Petriatis (1994), and Fisher (2005) and the four key aspects outlined for holistic assessment and intervention, in terms of the individual, the social environment, the physical environment and policy.

5.3 RECOMMENDATIONS

In light of the above conclusions, and in terms of the overall aim of the study, with regard to exploring the views of social workers on their role in mental health community-based services, the following recommendations can be made for social workers, government, policy-makers and other mental health professionals and key role players:

5.3.1 The social worker

- **The therapeutic role**

The social worker needs to focus on increased therapeutic intervention services for identified vulnerable groups in terms of caregivers of the mentally ill, the elderly mentally ill and children presenting with/affected by mental illness.

- **The supportive role**

The social worker needs to render support services to individuals and families within the mental health context through creating increased awareness of and access to resources and services in communities.

It is in the opinion of the researcher that, based on the conclusions provided above, the generic social worker needs to adopt a supportive role within an inter- and intra-professional context through demonstrating support for social workers in specialized community organizations. The social worker can do so by equipping themselves with necessary knowledge and skills in mental health in order to be effective in implementing basic assessment, screening, counselling and linking to resources for mentally ill clients, before deciding to refer to specialized social workers. This will serve to lighten the burden experienced by social workers in the field of mental health.

The social worker needs to further offer support for social workers in institutions and hospital settings, by recognizing and accepting their role as field social workers. Thus, essentially, the generalist social worker needs to take up their role as "feet on the ground" for inpatient social workers who are unable to conduct home visits and follow up in a long-term capacity. The social worker needs to offer support and cooperation in this regard in order to assist in the rendering of more effective and sustainable services.

- **The advocate role**

The social worker needs to be prepared to advocate for the following:

1. Increased resource and funding allocation for mental health services and facilities from government departments;
2. Increased recognition and protection of vulnerable children presenting with and/or affected by mental illness, toward adequate provision of resources, care, and safety;

3. Increased recognition of mental health within the social work field as a high priority, and generic social work issue;
4. Protection and increased service provision for the elderly mentally ill client;
5. Protection and increased service provision for the caregivers of mentally ill individuals;
6. Increased development of facilities and resources for accommodation and placement provision for mentally ill clients, through halfway homes, assisted care, and de-stigmatization of existing accommodation facilities; special accommodation provision needs to be advocated for, for the elderly, children and the homeless;
7. Compulsory training of undergraduate students in mental health and inclusion of mental health as part of the BSW Qualification's exit level outcomes.
8. Increased recognition of the risk in home-visits with mentally ill clients and for resources to be implemented toward combatting / offering support for this.

- **The relational role**

The social worker needs to facilitate improved working relationships between mentally ill clients, policy-makers and government departments toward increased and improved service provision, resource allocation and funding;

The social worker needs to place stronger emphasis on the facilitation of long-term group family sessions, toward improved communication and functioning between caregivers, family members and mentally ill patients;

The social worker needs to work together with other social work professionals toward facilitating a positive, empowering working relationship between NGOs, government departments, private sector, hospitals, institutions and clinics, toward establishing a united front for the combatting of challenges and issues facing mental illness community-based service rendering, and to effectively collaborate in sharing the workload in order to ensure the rendering of more effective services for mentally ill clients and families.

- **The holistic role**

The social worker needs to recognize the significance of the ecological perspective in effectively assessing and implementing intervention with clients; this needs to be understood as being a unique social work skill. The social worker needs to work toward effectively implementing the

ecological framework in all interventions with mentally ill groups, in light of the understanding that mental health needs holistic service rendering and thus the social worker has a unique and significant role to play within the multidisciplinary mental health care team.

5.3.2 Other role players

- **Government**

It is recommended that the Department of Social Development recognizes mental health as a key social services issue, and allocates resources, professional capacity and funding accordingly.

Provision should be made for government funded transport to and from hospitals and community clinics for patients with appointments with a mental health professional; this should be free of charge and run at regular hours.

Increased accommodation services need to be developed, including halfway homes for long-term rehabilitation and holistic intervention, and assisted living care for individuals who cannot cope on their own or with families.

Services need to be implemented for children affected by mental illness in their family groups. These services need to be government funded and provided in schools, hospitals and community clinics.

Implications of the Mental Health Act (17 of 2002) need to be reviewed and reassessed; limitations and negative impacts needs to be recognized and dealt with accordingly, incorporating all key role players.

Increased mental health community services need to be made available in rural areas, particularly with regard to clinics and rehabilitative services.

- **Police**

Increased communication between social workers and police departments within communities needs to be created; increased support from police services needs to be facilitated, and mutual understanding needs to be generated in terms of what is possible, needed and challenging for both parties in the implementation of the stipulations of the Mental health act (17 of 2002). The role of the social worker as advocate is significant in this regard, as the social worker needs to

advocate for the cooperation and support of key role players in communities, toward more effective service rendering.

5.3.3 Social work education

Mental health needs to be incorporated into undergraduate training of social work students, toward the sufficient development of knowledge and skill and toward acting as mental health professionals as is stipulated by government policy. Training and knowledge development around these particular areas needs to be incorporated:

- The Mental Health Act (17 of 2002) and policies;
- The roles of the social worker in mental health as therapeutic workers, offering support, advocates, the relational role, and their role within the multidisciplinary team;
- The onset, nature, symptoms, and treatment of specific mental illnesses;
- Working with vulnerable groups within the mental health context, such as children, the elderly and caregivers;
- Recognizing and being able to effectively utilise resources in mental health care for intervention with clients;
- The nature of inpatient, outpatient and community-based care in mental health service rendering, and the role of the social worker within these contexts.

The promotion of mental health CPD registered courses needs be further focused upon, in collaboration with Schools of Social Work and relevant practice institutions. These courses should allow for the facilitation of collaboration and feedback regarding mental health care between different sectors.

5.4 FURTHER RESEARCH

In light of the lack of adequate research on the topic of social work within mental health care, and more particularly that of the role of the social worker in mental health community-based care, the following recommendations are made:

- The field of mental health should be focused upon more readily within social work research activities, thus acknowledging and identifying the key relationship between

mental health and social work service delivery and support on the recovery of mentally ill patients, as opposed to only that of clinical treatment and care.

- The rendering of social work services to the mentally ill client should be particularly further examined and researched, in order to better determine and correlate the existing services against unmet needs.
- Specific functions of social workers in mental health practice needs to be further researched, in light of the established roles, toward an even more in-depth and concrete understanding of social work in mental health care.

5.5 KEY FINDINGS AND MAIN CONCLUSIONS

In offering a final conclusion for this study, it is evident that there are significant roles for the social worker in mental health community-based care. This is primarily in termsof the therapeutic role, the supportive role, the advocate role, the relational role and the holistic role. Within these specified role categories are key functions and significant intervention activities for the social worker within community-based service rendering in the field of mental health. However, there are many challenges facing the social worker, in terms of lack of recognition of the importance of mental health, poor resource allocation and funding provision, exclusion of vulnerable groups from necessary resources, lack of professional capacity and role player cooperation, and ill-equipped training of generic social work professionals in mental health care. Therefore, it can be concluded that although there is a significant role for social work in mental health outpatient and community-based services, much development needs to take place in order for this role to be executed effectively. In order for these developments to take place, it is time that social workers accept their established position as mental health professionals, as stipulated in the Mental Health Act (17 of 2002) and begin to advocate more loudly for this vulnerable group.

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APPENDIX A

UNIVERSITY OF STELLENBOSCH

DEPARTMENT OF SOCIAL WORK

The Views of Social Workers on their role in Mental Health Outpatient Services: An Ecological Perspective

Researcher: A. Ornellas

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1. Identifying particulars of respondent

1.1. Type of service provider

Public	Private

1.2. Clarify your core business:

1.3.Position in organization/institution (eg. Frontline, middle management, supervisor):

1.4.Years of experience as a social worker:

1.5.What is your average caseload per month:

1.6.Of this caseload, what would you say is the percentage of clients presenting with/affected by mental illness?

2. Training and Knowledge in Mental Health

2.1. Training in mental health:

Did you get any training regarding mental health within the following contexts?

Undergraduate	Postgraduate	Other
x		Specify…… ……

2.1.Describe the content of the training:

2.2.Was it sufficient to enable you to work with mental health users now in your work? Motivate.

3. The Mental Health Context

3.1. How would you view the current status of mental health outpatient and community-based services, from a social work perspective, in South Africa:

Good	Poor

3.2. Motivate:

3.3. In terms of the following need areas, where, in your professional opinion, are the predominant of social work services available and rendered for the mentally ill service user:

Need Area	**Rate (1-5)** 1-hardly at all 5 – high service rendering	**Motivate**
Individual		
Family		
Community		
Policy		

4. Social Work

4.1. What is the predominant profile of the mentally ill client with which you work/have worked?

4.2. What is the nature of your primary experience in working with the mentally ill in social work intervention initiatives? Discuss

4.3. What type of intervention services do you primarily render when dealing with mental illness? Give a brief description:

4.4. Discuss your referral process (do you have strong professional support base, is the referral process sufficient, to whom do you primarily refer with regard particularly to mental illness, etc)

4.5. Do you feel that there is a need for social work in mental health? (Particularly in terms of outpatient care). Motivate your answer

4.6. If so, what do you feel that role should look like?

4.7. Do you feel adequately equipped to be working with clients affected by mental illness? Motivate your answer:

4.8. Based on your answer above, do you feel there is a need for more training of social workers in mental health, and what should this training look like?

4.9. How else can social workers be further supported in this area?

In your experiences and professional expertise, is there anything particular in the area of social work and mental health that you feel needs to be addressed, that hasn't necessarily been discussed in this interview?

APPENDIX B

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STELLENBOSCH UNIVERSITY
CONSENT TO PARTICIPATE IN RESEARCH

THE VIEWS OF SOCIAL WORKERS ON THEIR ROLE IN MENTAL HEALTH OUTPATIENT AND COMMUNITY-BASED SERVICES

You are asked to participate in a research study conducted by A. Ornellas, a doctoral student from the Social Work Department at the University of Stellenbosch. The results of this study will become part of a research report. You were selected as a possible participant in this study because you are a social worker.

1. PURPOSE OF THE STUDY

The aim of the study is to explore the views of social workers on their role in mental health outpatient and community-based services.

2. PROCEDURES

If you volunteer to participate in this study, we would ask you to do the following:

A semi-structured interview will be utilized to gather information confidentially. You need not indicate your name or any particulars on the interview schedule. The schedule will be completed during an interview conducted by a student-researcher.

3. POTENTIAL RISKS AND DISCOMFORTS

Any uncertainties on any of the aspects of the schedule you may experience during the interview can be discussed and clarified at any time.

4. POTENTIAL BENEFITS TO SUBJECTS AND / OR TO SOCIETY

The results of this study will inform welfare organisations on the role of the social worker in mental health outpatient and community-based services. This information could be used by welfare organisations for further planning in service delivery.

5. PAYMENT FOR PARTICIPATION

No payment in any form will be received for participating in this study.

6. CONFIDENTIALITY

Any information that is obtained in connection with this study and that can be identified with you will remain confidential and will be disclosed only with your permission or as required by law. Confidentiality will be maintained by means of coding where each questionnaire is numbered. All questionnaires will be managed, analysed and processed by the researcher and will be kept in a safe place.

7. PARTICIPATION AND WITHDRAWAL

You can choose whether to be in this study or not. If you volunteer to be in this study, you may withdraw at any time without consequences of any kind. You may also refuse to answer any questions you don't want to answer and still remain in the study. The researcher may withdraw you from this research if circumstances arise which warrant doing so, eg should you influence other participants in the completion of their questionnaires.

8. IDENTIFICATION OF STUDENT-RESEARCHER

If you have any questions or concerns about the research, please feel free to contact:

Proffessor LK Engelbrecht(Supervisor), Department of Social Work, University of Stellenbosch,

Tel. 021-808 2070, E-Mail: lke@sun.ac.za

9. RIGHTS OF RESEARCH SUBJECTS

You may withdraw your consent at any time and discontinue participation without penalty. You are not waiving any legal claims, rights or remedies because of your participation in this research study. If you have questions regarding your rights as a research subject, contact MsMaléneFouché [mfouche@sun.ac.za; 021 808 4622] at the Division for Research Development.

SIGNATURE OF RESEARCH SUBJECT OR LEGAL REPRESENTATIVE

The information above was described to me the participant by _____ in English and the participant is in command of this language or it was satisfactorily translated to him / her. The participant was given the opportunity to ask questions and these questions were answered to his / her satisfaction.

I hereby consent voluntarily to participate in this study.

_____

Name of Participant

_____ _____

Signature of Participant **Date**

SIGNATURE OF INVESTIGATOR

I declare that I explained the information given in this document to _____[name of subject/participant]. [He / She] was encouraged and given ample time to ask me any questions. This conversation was conducted in English and no translator was used.

_____ _____

Signature of Investigator **Date**

APPENDIX C

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Approval Notice
Stipulated documents/requirements

23-Aug-2013

Ornellas, Abigail A

Dear Ms Abigail Ornellas,

Your **Stipulated documents/requirements** received on **22-Aug-2013**, was reviewed by members of the **Research Ethics Committee: Human Research(Humanities)** via Expedited review procedures on **22-Aug-2013** and was approved.

Sincerely,
SusaraOberholzer
REC Coordinator
Research Ethics Committee: Human Research (Humanities)

Proposal #: DESC_Ornellas 2013

Title: The views of social workers on their role in mental health outpatient and community-based services: An ecological perspective

Investigator Responsibilities
Protection of Human Research Participants

Some of the general responsibilities investigators have when conducting research involving human participants are listed below:

1. Conducting the Research. You are responsible for making sure that the research is conducted according to the REC approved research protocol. You are also responsible for the actions of all your co-investigators and research staff involved with this research. You must also ensure that the research is conducted within the standards of your field of research.
2. Participant Enrollment. You may not recruit or enroll participants prior to the REC approval date or after the expiration date of REC approval. All recruitment materials for any form of media must be approved by the REC prior to their use. If you need to recruit more participants than was noted in your REC approval letter, you must submit an amendment requesting an increase in the number of participants.

3. Informed Consent. You are responsible for obtaining and documenting effective informed consent using **only** the REC-approved consent documents, and for ensuring that no human participants are involved in research prior to obtaining their informed consent. Please give all participants copies of the signed informed consent documents. Keep the originals in your secured research files for at least five (5) years.
4. Continuing Review. The REC must review and approve all REC-approved research proposals at intervals appropriate to the degree of risk but not less than once per year. There is **no grace period.** Prior to the date on which the REC approval of the research expires, **it is your responsibility to submit the continuing review report in a timely fashion to ensure a lapse in REC approval does not occur.** If REC approval of your research lapses, you must stop new participant enrollment, and contact the REC office immediately.
5. Amendments and Changes. If you wish to amend or change any aspect of your research (such as research design, interventions or procedures, number of participants, participant population, informed consent document, instruments, surveys or recruiting material), you must submit the amendment to the REC for review using the current Amendment Form. You **may not initiate** any amendments or changes to your research without first obtaining written REC review and approval. The **only exception** is when it is necessary to eliminate apparent immediate hazards to participants and the REC should be immediately informed of this necessity.
6. Adverse or Unanticipated Events. Any serious adverse events, participant complaints, and all unanticipated problems that involve risks to participants or others, as well as any research related injuries, occurring at this institution or at other performance sites must be reported to Malene Fouché within **five (5) days** of discovery of the incident. You must also report any instances of serious or continuing problems, or non-compliance with the RECs requirements for protecting human research participants. The only exception to this policy is that the death of a research participant must be reported in accordance with the Stellenbosch University Research Ethics Committee Standard Operating Procedures. All reportable events should be submitted to the REC using the Serious Adverse Event Report Form.
7. Research Record Keeping. You must keep the following research related records, at a minimum, in a secure location for a minimum of five years: the REC approved research proposal and all amendments; all informed consent documents; recruiting materials; continuing review reports; adverse or unanticipated events; and all correspondence from the REC.
8. Provision of Counselling or emergency support. When a dedicated counsellor or psychologist provides support to a participant without prior REC review and approval, to the extent permitted by law, such activities will not be recognised as research nor the data used in support of research. Such cases should be indicated in the progress report or final report.
9. Final reports. When you have completed (no further participant enrollment, interactions, interventions or data analysis) or stopped work on your research, you must submit a Final Report to the REC.
10. On-Site Evaluations, Inspections, or Audits. If you are notified that your research will be reviewed or audited by the sponsor or any other external agency or any internal group, you must inform the REC immediately of the impending audit/evaluation.