THE READINESS OF PROFESSIONAL NURSES IN THE
KHAYELITSHA HEALTH SUB-DISTRICT TO RENDER
MENTAL HEALTH CARE SERVICES AS STIPULATED IN
THE HEALTHCARE 2010 PLANS FOR THE
WESTERN CAPE

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the Western Cape.

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The readiness of professional nurses in the Khayelitsha health sub-district to

render mental health care services as stipulated in the Healthcare 2010 Plans for the Western Cape

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KEY WORDS:

- Mental health nurse

- Mental health care user

- Professional nurse

- Primary health care

- Readiness

- De-institutionalization

- Healthcare 2010 Plans

- Sub-district

- Psychosocial rehabilitation

ABSTRACT

The readiness of professional nurses in the Khayelitsha health sub-district to render mental health care services as stipulated in the Healthcare 2010 Plans for the Western Cape

F.O. Molopo

Throughout the years management of mentally ill persons was mostly rendered in psychiatric hospitals with prolonged admission faraway from place of origin, leading to stigma, fear, marginalization, and reduced access by people that would benefit from the service. Now the focus is on de-institutionalization of mental health care users in an attempt to treat people closest to their homes, de-stigmatizing mental illness, as well as improving accessibility of care.

Integration of mental health into primary health care has been one of the most important ways in which mental health policy has shifted. Presently, community mental health is a nurse-driven service with one professional nurse rendering the service in each health care facility. Undoubtedly, integration of mental health care users into the community will be challenging to both health providers and users.

This study aims to assess the readiness of professional nurses in the Khayelitsha health sub-district to render mental health care services as stipulated in the Healthcare 2010 Plans for the Western Cape. The main objectives are: to assess the readiness of professional nurses in the Khayelitsha health sub-district to render mental health care services after de-institutionalization of mentally ill persons in terms of skills and resources, as well as to explore feelings and perceptions of professional nurses regarding the Healthcare 2010 Plans for the Western Cape with specific reference to mental health.

Phenomenological approach, an approach of conducting qualitative research was used to meet the objectives of this study. Semi-structured, individual interviews were conducted with a purposive sample whereby, with consent of the participants, a tape recorder was used to collect data. This data was then analyzed using thematic analysis, however single statements that had an effect on the study were also presented narratively.

In terms of skills, all participants believed that they are well equipped with skills

that will enable them to render efficient mental health care services (MHCS). Out of eight participants, six participants has accepted the Healthcare 2010 Plan for the Western Cape, seeing it as a vehicle to render effective community mental health care services. Out of five participants currently not rendering the Mental Health Care Services (MHCS), four participants showed high levels of readiness. All participants identified resources required for effective implementation of the plan. When looking at ingredients of change, which are 'importance' and 'confidence', participants showed high levels in both aspects, and rated high on five aspects of change used as a tool to measure readiness in this study.

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DECLARATION

I declare that *The readiness of professional nurses in the Khayelitsha health sub-district to deliver mental health care services as stipulated in the Healthcare 2010 Plans for the Western Cape* is my own work, that it has not been submitted for any degree or examination in any other university, and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references.

Molopo Fundiswa Olivia   15/11/2007
    Full name   Date

Signed:..........................

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ACKNOWLEDGEMENT:

I give glory to my God for the love, strength, and guidance He granted me. I truly believe that before I was born, He assigned this achievement on my name. To my supervisor, Mrs Julie, I appreciate your efforts in helping me complete this mini-thesis. When I felt despondent you constantly reminded me that I can make it, may God bless you.

To my dear husband for all the time you sacrificed during my studies, your understanding, and encouragement. You played a role of a father to me and our children. I thank my sons, Thabang, Sechaba, and Thato for loving me unconditionally even when I failed to dedicate myself during my studies. To my mother Thembeka and my sisters Ncebakazi and Andisiwe for looking after our children to give me a break when I felt like throwing in the towel.

ABBREVIATIONS

CHC   - Community Health Centers

CNS   - Central Nervous System

FP   - Family Planning

HIV   - Human Immunodeficiency Virus

IDP   - Individual Developmental Plan

INH   - Isoniazid

MHCS   - Mental Health Care Service

MHCU - Mental Health Care User

MO   - Medical Officer

PGWC - Provincial Government of the Western Cape

PHC   - Primary Health Care

PPHC   - Personal Primary Health Care

PMTCT - Prevention of Mother To Child Transmission

PN   - Professional Nurse

PSR   - Psychosocial Rehabilitation

SANC   - South African Nursing Council

STI   - Sexually Transmitted Infections

TB   - Tuberculosis

TOP   -Termination of Pregnancy

VCT   - Voluntary Counselling and Testing

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CHAPTER 1: ORIENTATION TO THE STUDY

1.1. INTRODUCTION

This chapter provides the background and rationale of the study by giving geographic information about area where the study was conducted, elaborating on health service delivery in the Khayelitsha health sub-district as well as service agreement guiding service delivery at the community level. An overview of Healthcare 2010 Plan is given. Research aim, objectives, and problem statement are stated. Definition of key words used in the study is provided, limitations of the study are stated and finally the outline of the study is provided.

1.2. BACKGROUND AND RATIONALE

Khayelitsha is a health sub-district about 35km from Cape Town, with a population of 400 000 (census 2001). However, based on an area photograph, Eskom estimated the population in this sub-district at about 800 000 to 1000 000. It was estimated that 42% of the population is below 16 years of age and 57% between 16 and 65 years of age (Malan & Nyewe, 1999:5) .
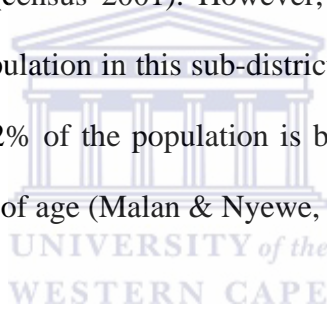
Khayelitsha consists of privately owned houses, formal settlements, and informal settlements. The latter is further divided into free standing plots with proper sanitation, groups of households sharing communal toilets and taps, and those who use open fields as their toilet facility.

Health needs of residents in Khayelitsha health sub-district are rendered by different health providers. Primary curative services, mental health and obstetric services are rendered by the Provincial Government of the Western Cape (PGWC) in three community Health Centers (CHCs). On the other hand, through the district health system, City Health has a statutory responsibility for rendering

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environmental health services and renders Personal Primary Health Care (PPHC) on sub-contract for PGWC in eight clinics and one CHC.

The clinics render HIV/AIDS treatment and care programs, Tuberculosis (TB) control programs, treatment of Sexually Transmitted Infections (STIs), promotive and preventative services for women and children, curative services for children below 13 years of age, and comprehensive primary health care which includes adult curative services at the CHCs.

Lack of integration of key role players in provision of health care services is regarded as "the source of fragmentation of health services with consequent problems such as inaccessible and poor health services" (Mtwazi, 2000:5). Zwi and Saunders (cited in Zimba, 2002:15) argues that fragmentation has resulted in a rigid structure, which gradually became resistant to change. Lund and Flisher (2006:587) argue that "in the aftermath of apartheid, South Africa has inherited a fragmented, under sourced and inequitable public sector mental health services".

The Healthcare 2010 Plans for the Western Cape is an initiative based on primary health approach. The plan aims to improve the quality of care of the health services and simultaneously bringing expenditure within budgetary limitations. This initiative is the continuation of plans that began in 1994, and it was approved by the Cabinet in March 2003 after different stakeholders were consulted (Healthcare Western Cape, 2003:10-12).

The plan for the Western Cape specifies that "90% of health patient contacts should occur at primary level, 8% at secondary level and 2% at tertiary level" (Healthcare Western Cape, 2003:18). In the area of mental health, although de-institutionalization is welcomed, it has raised some concerns and the agreed-upon challenge is to put community based support systems in place (Healthcare Western Cape, 2003:48).

UNICITY (a term that was previously used when referring to City Health, consisting of eight health sub-districts in the Western Cape) was one of the stakeholders consulted even though it has not provided written feedback during the publication of the plan (Healthcare Western Cape, 2003:42). The plan has raised some concerns, such as how can the Province make decisions for the local government, and the argument was that "while financial responsibility for Metro health services will lie with the Metro local government, we are confident that colleagues will co-operate fully with the provincial department to ensure seamless and integrated quality services" (Healthcare Western Cape, 2003:47).

As the City Health clinics are not rendering mental health services at present, the question is whether mental health services will still be the exclusive responsibility of the CHCs after de-institutionalization of Mental Health Care Users (MHCUs) in the Khayelitsha health sub-district or a shared responsibility by all health care service providers. If there is equal interest to render services to MHCUs, do Professional Nurses (PNs) perceive themselves as being ready to render services in terms of skills and resources?

1.2.1. Health service delivery in the Khayelitsha health sub-district

The most recent expansion of this type of service rendering is that Michael Mapongwana CHC be re-opened for Tuberculosis (TB) services. SiteB CHC has combined facility with services being provided by both City Health and PGWC, taking over from City Health child health for children below 13 years of age, taking of pap smears, Family Planning (FP), Voluntary Counselling and Testing (VCT) for Human Immunodeficiency Virus (HIV), basic HIV care, comprehensive management of STIs, and Prevention of Mother To Child Transmission (PMTCT) program. Nurses from City Health provides extended services at SiteB CHC (from 16H30-21H00 during the week and 08H00-12H00 on week-ends) because PGWC does not have many people with pediatric curative skills. Nolungile CHC has recently commenced with basic antenatal care.

Of the four CHCs, a Medical Officer (MO) is present 24 hourly at SiteB CHC and during office hours at Michael Mapongwana CHC, Matthew Goniwe CHC and Nolungile CHC as they render doctor-based services. In contrast to that, City Health offers a nurse-based approach with the MO visiting weekly for TB services. Therefore PNs from the clinics refers the complicated cases to the CHCs or Red Cross Children's Hospital based on guidelines for service delivery in the district (National Health Act no.61of 2003, 2003:40). Unfortunately having to turn away health care users based on delimitation of services to be rendered by each facility provides tension between staff and the users as there is still lack of understanding.

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Separate responsibilities regarding health care delivery between CHCs and City Health clinics dates back to the colonial and republican days when local authority had the responsibility to focus on control of infectious diseases and environmental sanitation (Mtwazi, 2000:5). Although integration of health services in the district between City Health clinics and CHCs could ensure greater comprehensiveness and sustainability, Mtwazi (2000:40) states that the absence of enabling legislation addressing the integration of these services will disable its success. The presence of an 'enabling legislation' is also supported by Zimba (2002:67) arguing that "... an enabling legislation to facilitate the integration process is of paramount importance".

1.2.2. Service Agreement

According to the National health Act no.61 of 2003 (2003:40), there should be an agreement of contribution between the relevant members of the Executive Council and the Municipal Council of the metropolitan or District Municipality with regard to matters of health or health services in the health district. The agreement will ensure open referral systems and smooth functioning in the district health system. The mental health Act no.17 of 2002 (2002:14) states that:

- Health establishment must provide any person requiring mental health care, treatment, and rehabilitation services with the appropriate level of mental health care, treatment, and rehabilitation services within its professional scope of practice, **or**

- Refer such persons, according to established referral and admission routes, to a health establishment that provides the appropriate level of mental care,

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treatment, and rehabilitation services.

"One of the biggest obstacles to a unified mental health policy in South Africa is the fact that services are provided by a number of different role players who rarely plan together toward common goals and objectives" (Foster, Freeman, & Pillay, 1997:42). These authors argue that there should be an intersectoral collaboration between various government departments, non-governmental sectors, consumers of services, and professional organizations.

1.3. HEALTHCARE 2010 PLAN

Healthcare 2010 is the Western Cape's long-term strategic plan that envisages reshaping the services to focus on primary level services, community based care and preventative care (Healthcare Western Cape, 2003:4). "Healthcare 2010 is built on the restructuring plans that were begun in 1994" (Healthcare Western Cape, 2003:10). It is argued that the aim of Healthcare 2010 Plan is to "provide equal access to quality health care by reshaping the health services and optimally utilizing allocated resources" (Department of Health, 2006:1).

There are underlying principles of Healthcare 2010 that were widely supported by stakeholders consulted (Healthcare Western Cape, 2003:14), which are:

- Quality care at all levels

- Accessibility of care

- Efficiency

- Cost effectiveness

- Primary health care approach

- Collaboration between all levels of care

- De-institutionalization of chronic care

"A fundamental assumption of Healthcare 2010 is that the number of patient contacts would not be reduced but that patients would be treated at the level of care that is most appropriate to their need within a seamless service (Department of Health, 2006:1). As stated in Healthcare Western Cape (2003:17-18),implementation of Healthcare 2010 was aimed at executing four inter-related plans, namely:

- Healthcare 2010 Service delivery plan,

- Healthcare 2010 Infrastructure plan,

- Healthcare 2010 Human resource plan, and

- Healthcare 2010 Financial implementation plan
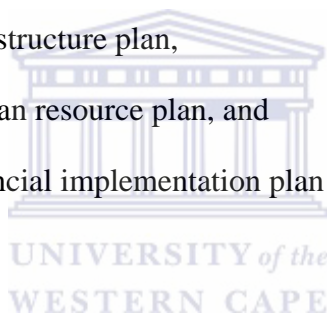
1.4. RESEARCH AIM

The main aim of this study is to assess the readiness of professional nurses in the Khayelitsha health sub-district to render mental health care services as stipulated in the Healthcare 2010 Plan for the Western Cape.

1.4.1. Objectives

The research objectives of this study are to:

- Assess the readiness of professional nurses in the Khayelitsha health sub-district to render mental health care services after de-institutionalization of mentally ill persons in terms of skills and resources.

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- Explore the feelings and perceptions of professional nurses regarding the Healthcare 2010 Plan for the Western Cape, with specific reference to mental health care services.

- Make recommendations in order to improve the quality of community mental health care nursing rendered at the Khayelitsha health sub-district.

1.4.2. Problem statement

People residing in Khayelitsha health sub-district faces social issues that may contribute to mental health problems. Most people moved in from rural areas to seek job opportunities, health services, and education. Urbanization alone may be stressful as people must adapt to new environment away from their place of origin. According to Flisher and Chalton (2001:244), "rapid urbanization is frequently accompanied by housing difficulties, crime, poverty, unemployment, and separation from extended families. Such adverse social circumstances limit behavioral choices that impact on wellbeing".Unemployment and high level of people living below the poverty line contributes to extremely high levels of domestic violence. All these factors together with HIV/AIDS may precipitate mental health problems.

Three CHCs that serves the population in the Khayelitsha health sub-district are the only mental health care service providers. This immediately raises the issue of accessibility especially as City Health clinics are more accessible to the

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population geographically. Accessibility in PHC is defined as "the continuing and organized supply of an equitable level of health care that is within reach of all citizens geographically, functionally, and culturally" (Dreyer, Hattingh, & Lock, 1997:132). Although some of the PNs working at the City Health clinics qualified in mental health care nursing, they are not utilizing their mental nursing skills.

According to Swanson and Nies (1997:243), "nurses practicing in community health settings should be aware of the signs and symptoms of depression and identify referral sources for professional help within the community", this will mean that nurses at the City Health clinics will refer to nurses at the CHCs (with same qualifications) as they lack expertise, guidelines, protocols, and access to psychotropic drugs.

"Attempts are being made to reform mental health services, in keeping with new health policy, which proposes the downscaling of psychiatric institutions and the development of community based services" (Lund,& Flisher, 2006:587).

The question is whether PNs at the CHCs will be able to cope with the increased workload due to de-institutionalization of mentally ill persons. In addition to this, it impacts negatively on the skills utilization and development of mental health prepared nurses placed in the clinics. These limitations also impact negatively on student nurses placed in these facilities given our current limited available training sites.

1.5. DEFINITION OF TERMS

Mental health care nurse: (psychiatric nurse) A registered nurse qualified in the nursing care of the mentally ill (Blackwell's dictionary of nursing, 1997:459).

Mental health care user: A person receiving care, treatment, and rehabilitation services or using a health service at a health establishment aimed at enhancing the mental health status of a user (Mental Health Act, no.17 of 2002:10).

Professional nurse: A professionally trained and registered nurse who is legally empowered by the nursing Act, no.50 of 1978, to carry joint responsibility with the doctor for patient care and who is fully accountable for her own acts and omissions (Vlok, 1991:47)

Primary health care: Care the person receives at his first point of contact with the health care system usually within the community (Blackwell's dictionary of nursing, 1997:539).

Readiness: A state of mind which reflects the outcome of quite a lot of psychological activity" (Rollnick, Mason, & Butler, 1999:18).

De-institutionalization: The movement to place institutionalized persons in the community and provide the necessary supportive services (Blackwell's dictionary of nursing, 1997:193).

Healthcare 2010 Plan : A strategic plan for the reshaping of public health services in the Western Cape (Health Western Cape, 2003:7).

Health District: geographic area that is small enough to allow maximal involvement of the community so that local health needs are met, but also large enough to effect economies of scale (Government gazette 1997:224).

Psychosocial rehabilitation: A process that aims to facilitate the optimal functioning of ill and disabled people (Robertson, Allwood, & Gagiano,

2001:422).

Multidisciplinary mental health care team: A team which provides a forum where psychiatrists, social workers, psychologists, nurses, and others can democratically share their professional expertise and develop comprehensive therapeutic plans for clients (Valfre, 2001:17).

1.6. LIMITATIONS OF THE STUDY

Although the Healthcare 2010 Plan for the Western Cape is designed to cater for all health services, this study focused only on mental health care services. Healthcare 2010 Plan states that " patients with mental illness will be largely managed in the community" (Healthcare Western Cape, 2003:19). Due to time constraints, there was only one interaction with participants, and therefore data saturation was not achieved.

Data collection was influenced by the following factors: personal primary health care at SiteB CHC was taken over by PGWC; the merging of Mayenzeke and Luvuyo clinics took place shortly before commencement of data collection; and Zakhele clinic was excluded because there was no qualified mental health care nurse. Therefore the number of participants dropped from eleven (11) to eight (8).

1.7. OUTLINE OF THE STUDY

In addition to chapter one, which has provided the background for this study, there are four more chapters as stated in the following table:

CHAPTER	*CONTENT*

CHAPTER	CONTENT
Chapter two	Literature review
Chapter three	Research design and methodology
Chapter four	Data presentation
Chapter five	Findings conclusion and recommendations

1.8. CONCLUSION

This chapter discussed background and rationale of the study. Information with regard to geographic area, health services, and service agreement governing health care service delivery was discussed. Healthcare 2010 Plan was discussed. The aim, objectives as well as problem statement of the study were discussed. Definition of key words was provided and limitations of the study were stated.
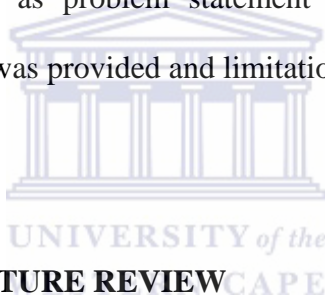
CHAPTER 2: LITERATURE REVIEW

2.1. INTRODUCTION

This chapter will discuss the evolvement of psychiatry in order to demonstrate the changes that resulted into new trends in mental health nursing. Differences between institutionalization and de-institutionalization of MHCUs will be discussed. The change of focus in presentation of mental health conditions will be demonstrated under 'new trends' in mental health care nursing. Then community mental health nursing, its challenges in terms of roles and qualifications as well as emergence of psychosocial rehabilitation will also be discussed. Current job descriptions of mental health care nurses will be looked at.

2.1.1. Evolvement of psychiatric nursing

Psychiatric books mention that mental illness has always been present even before 'psychiatry' was created. Mental illnesses were traditionally defined differently over time. Robertson, Allwood, and Gigiano (2001:1-2) argue that medical documents describing mental illnesses were written before Christ was born, stating that there has been primitive, humanistic, and scientific stages in which the history of psychiatry has followed both in Africa and Western cultures. However, mental illnesses were attributed to demons (being possessed), supernatural powers and witchcraft.

Traditional healers and priests had control over the management of people with mental illnesses until the early years of colonial rule in Africa whereby the traditional healers and relatives were overpowered and the people with mental illness were cared for in institutions by nurses and doctors. It was in 1793 when Pinel was dismayed by the condition of mentally ill people stating that, "they were abandoned to the incompetence of a calous director and to the cold brutality of servants who opposed a premeditated force of their own to impetuous acts of blind and seemingly automatic violence" (Weiner cited in Keltner, Schwecke, & Bostrom, 1999:4).

It was Pinel who started treating them with kindness unchained the shackled, clothed the naked, fed the hungry, and abolished the whips and other instruments of cruel treatment (Keltner et al, 1999:5). Pinel stressed the importance of empirical observations as he introduced psychotherapy (Robertson et al, 2001:2-3), hence 'psychiatry' was created as it was discovered that many patients suffered

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from mental illness and they presented with special needs and challenges.

In South Africa, Searle (cited in Mtwazi, 2000:8) argues that, "psychiatric hospitals were administered by the department of Interior which kept them out of the mainstream of health care. Later these were handed over to the minister of health in 1943 to be part of mainstream health care".

Public health is focusing on preventative measures to improve health status of the populations, this has been the case for mental illness too. According to Foster et al (1997:44), integration of mental health into primary health care has been one of the most important ways in which mental health policy has shifted. According to Zimba (2002:66), "the major obstacles delaying the implementation of PHC at the district level are multifold, namely the lack of goals, the absence of consensus on what PHC is, and the lack of a proper information system".
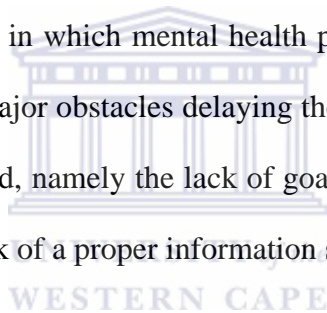
For a long time psychiatric illness has been managed through 'curative' means and preventative measures were not of importance. Albee and Gullotta (1997:11) argue that it was during the early years of the 20th century that Adolf Mayer raised the view that mental and emotional disorders results from lifelong social issues, thus arguing that, "prevention was a matter of ensuring more adequate child rearing under conditions that placed less stress on parents".

Preventative services is the focus of PHC, hence the clinics mainly render 'child and maternal' health services. In terms of mental health, the main aim of primary

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prevention is to decrease incidence of psychiatric morbidity in the community (Uys & Middleton, 1997:44).

2.1.2. Institutionalization

"Institutionalization usually refers to placement of persons who can no longer care for themselves in a nursing home or care facility from which they are not expected to return to an independent life in the community" (Swanson & Nies, 1997:362).Martin (cited in Crouch, 1992:4-1) used the term institutionalization "to denote the syndrome of submissiveness, apathy, and loss of individuality encountered in many patients who have been for some time in mental hospitals".

According to Crouch (1992:4-5), institutionalization is more debilitating than psychiatric illness. Institutionalization (for mentally ill persons) is recommended for suicidal, homicidal, or those who cannot care for themselves to the point of self-harm (Kaplan & Sadock, 1998:178).
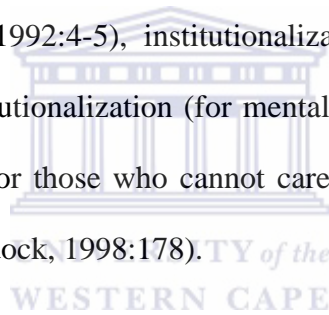
Although long-term hospitalization was the dominant type of care provided for psychiatric patients from the late 19th to the middle of the 20th century, it has drawn negative effects as patients were stripped off their personal identity. Van Rensburg (2004:487) believes that hospitalization is disadvantageous as the patient's care is taken over entirely by the specialist, and therefore creates dependency. Crouch (1992:4-5) believes that institutionalization is more debilitating than psychiatric illness.

According to Barton (cited in Crouch, 1992:4-1), factors contributing to the

totality of institutionalization are:

- Loss of contact with the outside world

- Enforced idleness

- Bossiness of medical and nursing staff

- Loss of personal friends, possession, and personal events

- Medication

- Ward atmosphere

- Loss of prospects outside of the hospital

In Cape Town specialized in- and outpatient mental health care is rendered in four psychiatric hospitals, namely: Valkenberg, Stikland, Lentegeur and Alexander hospital. However Alexander hospital renders services only to people with intellectual disabilities, while Lentegeur renders services to both people with mental illness and intellectual disabilities (Cape Gateway, 2006:1).

Mental health care services for children and adolescents are rendered at the following institutions: the Red Cross child and family unit (have in-patient specialized services for children under 12 years), William Slater (for adolescents between 13 and 18 years), Tygerberg child and family unit, as well as Lentegeur child and family unit (Cape Gateway, 2006:1).

Some selected mental disorders are also managed as in- and outpatient services at Groote Schuur hospital, University of Cape Town's psychiatric department, Stellenbosch University's psychiatric department, and Tygerberg hospital (Cape

Gateway, 2006:1).

"Healthcare 2010 Plan aims to shift the primary site of mental health services from institutions to communities and to promote a more comprehensive and integrated approach to mental health delivery (Department of health, 2006:15).

2.1.3. De-institutionalization

Throughout the years the management of mentally ill persons was mostly rendered in psychiatric hospitals. The history of de-institutionalization is traced back in the 1950s where in America large numbers of patients were discharged from public psychiatric hospitals back into the community to be treated and be rehabilitated on an out-patient basis (Keltner et al, 1999:9). "In South Africa the process of de-institutionalization has only just begun, but some centers seem to be moving towards the idea of day hospital treatment" (Crouch, 1992:18-1).

De-institutionalization is advantageous because at the PHC facilities individuals, families, and communities are enabled to care for themselves (van Rensburg, 2004:487). In a comprehensive review of projects designed to assist with the de-institutionalization of chronic psychiatric patients, Braun and his colleagues (cited in Butler & Pritchard, 1983:63) reported that through community-care programs re-admission rates and length of hospital stay can be reduced, and patient's social as well as psychological functioning can improve.

According to Foster et al (1997:42), full involvement of the welfare sector and the transfer of some resources across departments is essential for successful de-

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institutionalization of patients to the community. Foster et al (1997:74) identified the following tasks as some of those related to the provision of psychiatric services at the district and community level:

- Rendering promotive, preventive, curative, and rehabilitative services for all psychiatric disorders, for all ages, in hospital, clinic, school, and other district and community settings

- Rendering emergency psychiatric services

- Ensuring equity in service provision, community participation in service development and intersectoral collaboration

- Providing for human resource development, and managing a health information system
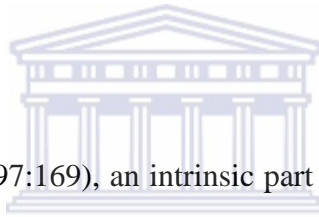
According to Mason (1997:169), an intrinsic part of de-institutionalization was to render care in a layered fashion with the community being a starting point rather than the hospital, as shown below:

LAYER ONE
(community, as close as possible to the doorstep of the patient)

LAYER TWO
(range of day-care facilities, residential care, and short-stay hostels)

LAYER THREE
(the psychiatric unit of the local general district hospital)

LAYER FOUR
(long-term psychiatric care, although the number of beds will be reduced)

The Healthcare 2010 Plan continues the process of downsizing of services which commenced in 1997 to reduce number of beds in psychiatric hospitals from 3500, to 1568 by the year 2010 (Department of health, 2006:15). However, Lund,

Flisher, Porteus, and Lee (2004:1) argue that "before a fashion of de-institutionalization is followed blindly in South Africa, effective community services should be in place and sufficient psychiatric beds should remain in hospitals for those who cannot be cared for in the community".

2.1.4. New trends in mental health

"Issues which require consideration includes stigma against psychiatry and the poor knowledge base and awareness of mental health needs among the public and professionals, the lack of rehabilitative services, ... the lack of mental health services for priority areas such as children and youth, violence, substance abuse, physical and sexual abuse ..." (Foster et al, 1997:75).

According to Albee and Gullotta (1997:41), many children and parents are facing 'pervasive, intractable, and costly problems' which are consequences of factors such as drinking and drug use during pregnancy, dysfunctional infant care giving, and stressful environmental conditions which interferes with parental and family functioning. These factors, together with HIV/AIDS epidemic, and teenage pregnancy calls for new trends in provision of mental health care services.

"The mental health problems in children as a result of Aids epidemics are enormous, range from bereavement, loss of parents and siblings" (Robertson et al, 2001:409). Individual and family support is important in helping people deal with mental health problems associated with HIV/AIDS infections. Robertson et al (2001:407) argue that HIV/AIDS has replaced syphilis as the great imitator in the

central nervous system (CNS), and almost any psychiatric or neurological presentation is possible. According to Kaplan and Sadock (1998:365), HIV/AIDS allows the body to be susceptible to a broad array of medical conditions and neuropsychiatric syndromes.

Robertson et al (2001:273) state that, in their lives women are exposed to gender specific stressors and mental health risks. These authors argue that pregnancy, childbirth, and peurperium are significant periods for the women and their families requiring major adjustment. Different circumstances determines the severity of these adjustments. Emotional disturbance or cognitive dysfunction is reported by about 20% to 40% of mothers in the postpartum period (Kaplan & Sadock, 1998:27), with one in five mothers being affected by a major mental disorder in the first twelve months following childbirth and up to two years after the birth of a baby.
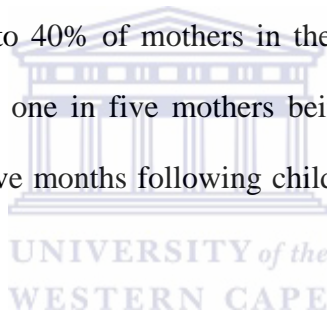
Robertson et al (2001:278) state the following as a variety of mechanisms through which HIV/AIDS infection can result in psychiatric disorders:

- the stress of the diagnosis may precipitate a psychiatric illness such as major depressive episode or an adjustment disorder,
- complications of the immune-compromised state may have psychiatric consequences, and
- anti-retrovirals (ARVs) has many psychiatric side effects such as mania and depression, for an example, INH used as prophylaxis for TB in HIV/AIDS positive people may cause psychosis.

According to Albee and Gullotta (1997:11), "the beginning of the effort at the prevention of mental and emotional disorders were laid down with attempts at teaching poor mothers to be better parents in the hope that their children could avoid the temptations and dangers of their crime-ridden and poverty-stricken environments".

Despite a number of techniques implemented in an attempt to empower the youth such as programs rendered by organizations like Love life, the presence of free Family Planning (FP) services, and the right to Termination Of Pregnancy (TOP), there is a growing number of teenage pregnancies especially in poverty stricken communities. One cannot deny that teenage pregnancies have an impact on emotional health of an individual which is worse in poverty stricken communities.

Despite the absence of national studies, it is reasonably assumed that 15% of young people in South Africa suffer from mental health problems warranting a psychiatric diagnosis, of which the majority of them would benefit from mental health services (Department of health, 2000:43). A situational analysis showed that 19% of high school students in Cape Town had thought about committing suicide in the past year, while 8% had made an actual attempt in this time period (Department of health, 2000:43).

Policy guidelines for youth and adolescent health states that despite large service needs, there are only six provincially supported child and family units. Only a

handful of specialist adolescents units, which are linked to academic complexes, thus making them relatively inaccessible to many young people especially for those in disadvantaged and rural communities (Department of health, 2000:43-45). the guidelines highlights the following as some of the means to ensure accessibility as part of intervention strategies:

- mobilize additional resources to improve mental health services for adolescents and youth
- conduct research in which the magnitude of mental health needs of adolescents and youth in South Africa are documented
- ensure that comprehensive integration of youth and adolescent mental health services with other services takes place
- where appropriate, involve communities (including disadvantaged and rural communities) in the planning and implementation of adolescent and youth mental health care at all tiers.

Flisher and Chalton (2001:244) argue that "although there is evidence of an association between urbanization and poor mental health in South Africa and other developing countries, the association between urbanization and adolescent risk behavior has received little research attention".

The following table shows the primary level of adolescent and youth mental health services as adapted from Dawes et al (Department of health, 2000:46):

Table 1:Primary level of adolescents and youth mental health services.

Tier	Level	Site	Personnel	Services
Primary	District	Clinics Schools District hospitals Maternity services Courts Penal system Children's homes Families Private practices NGO's	Generally not mental health specialists Lay counsellors Trained volunteers	Parental and youth education about mental health issues Screening for mental health disorders (including suicidality) Identification of young people at risk of abuse Short-term counselling services for young people and their families Basic management of behavioral disorders Maintainance Management of young people with chronic conditions

Desjarlais, Eisenbergh, Good, and Kleinman (cited in Foster et al, 1997:195) believe that if problems are detected early and managed appropriately in under developed communities, many children may be assisted. In support of this view, Cross and Rimmer (2002:292) argue that early diagnosis is highly significant to determine prognosis as well as the impact of the mental health problem to the patients and their whole family system.

Although the problems discussed above are basically non-psychiatric mental health problems, they however form the majority of mental health problems

presented at primary health level. At times people with such problems present at health establishments with physical complaints. Foster et al (1997:80) argues that services for people who are affected by violence, substance abuse, and for children, youth, and women were traditionally left to Non Governmental Organizations (NGOs), specialists, or non-health sectors. It therefore becomes difficult for the nursing staff to manage these clients appropriately.

However, it is important to note that intervention does not lie only in health care workers but families, community, and schools could play a major role. For an example, in the following table, Newton (cited in Uys & Middleton, 1997:47) illustrated the following factors to be targeted in primary prevention programs when dealing with adolescents:

Table 2: factors to be targeted in primary prevention programs

Antecedent	*Disorder*	*Strategy*
• Children who have had many different carers • Poor planners • Act helpless • Poor participation in extracurricular activities	• Early pregnancy • Poor parenting • Child abuse • Anxiety • Depression	• Encourage extracurricular activity • Life skills training programs in high schools to improve planning and self-esteem

2.1.5. Community mental health nursing

"Primary health care refers to community based provision of essential health care that is accessible to all members of the community" (World Health Organization[WHO] in Swanson & Nies, 1997:145). According to Uys and Middleton (1997:12), it was in 1978 in Alma-Ata whereby the WHO adopted a

declaration which stated primary health care as the way to go to ensure health for all by the year 2000. However, these authors state that at the time, mental health care services were not included under primary health care, assuming that oversight of mental health services stems from two factors, namely:

- the historic position of psychiatry as the stepchild of health services, coupled with the fact that the declaration was adopted before the enormous growth in the science of neurology which has occurred over the past two decades, and

- an underestimation of the seriousness and extent of mental illness.

"In a time of rapid social and political transformation, a set of guidelines or norms were thought to be necessary to assist in the development of an appropriate, community-based mental health services" (Lund & Flisher, 2006:588). Swanson and Nies (1997:145) argue that community psychiatry is advantageous in that it acknowledges the importance of managing patients within the context of community values, norms, and agencies. According to Cross and Rimmer (2002:16), much primary care work concerns people with mental health problems, however they believe that many of these people remain unassisted as they remain undiagnosed.

According to Van Rensburg (2004:427), primary health care workers have a role to play in mental health, saying that "preventive measures for mental disability are included in all services such as antenatal, infant, child, reproductive health, and curative care". However, van Rensburg ascertain that treatment of as many people as possible in the community through integration is one of the broad goals of the

mental health, but cautions that integration is only possible if PHC workers are trained in mental health before the integration takes place.

According to Cross and Rimmer (2002:283), nurses in the primary health care must assess and then make management decisions with regard to their mental health patients. Although managing patients in the community is welcomed, Foster et al (1997:80) argues that factors such as the shortage of PHC personnel, their current lack of psychiatric knowledge and skills, and frequently negative attitude towards psychiatric patients will make transformation from institutional and specialist-oriented psychiatric services to primary health care services difficult.
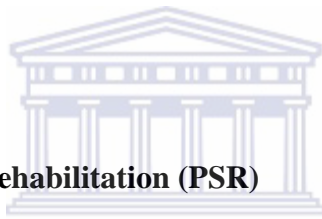
2.1.6. Psychosocial rehabilitation (PSR)

Uys and Middleton (1997:12) state that "two major health care movements currently exert an influence on mental health nursing. The first is a move towards primary health care and the second is a greater focus on psychosocial rehabilitation in community psychiatric care". As it became apparent that de-institutionalizing MHCUs does not necessarily improve the quality of life for them, a new trend had to be introduced. Anthony, Cohen, and Farkas (in Foster et al, 1997:76) refers to this trend as the 'third era', the rehabilitation era.

Foster et al (1997:76) state that rehabilitation has always been a neglected aspect of health care in the community as it was considered a 'tertiary' prevention which was aimed at providing greatest measure of social and economic participation and

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independence to people with disabilities irrespective of the nature and origin of their illness. "The aim of rehabilitation should be the successful return to the life and social activities which society and the client himself expect, through reintegration into the community as independent and productive members of society (Whiteneck cited in Smith & Middleton, 1999:2).
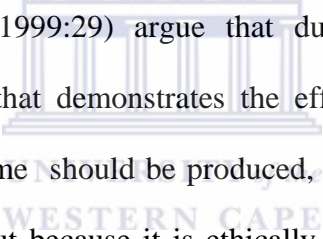
According to Booyens (1996:209), "psychosocial intervention is supportive in nature and is indicative of the professional consciousness of the nurse to support the patient in the treatment of non-physical reactions to illness and treatment". This strategy works only if people are involved in their own required regimen of health care planned to provide them with functional, restoration, improvement or compensation achievement.
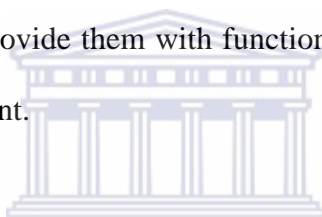
Butler and Pritchard (1983:58) argue that "... there is good evidence to indicate that when drugs are used appropriately and backed up with adequate and purposive social and psychological treatment, the results are better than if these interventions are made singly". Foster et al (1997:77-78) suggest that there are five basic elements of rehabilitation as follows:

- Psychoeducation
- Case management
- Skills training
- Vocational rehabilitation
- Appropriate housing

Eysenck (cited in Butler & Pritchard, 1983:14) believes that neurotic illness results from an inability to adapt and cope with everyday life rather than a pathology resulting from physical lesions, therefore argues that some form of intensive social education is required instead of medication. At present the number of PNs trained on psychosocial rehabilitation is extremely low in South Africa with only two nurses in the Western Cape regarded as expects in this field (class presentation by Sr Matthews). "Healthcare 2010 Plan provides the opportunity to develop a service plan for rehabilitation services across all levels of the service platform, encompassing both facility and community-based services" (Department of health, 2006:13).
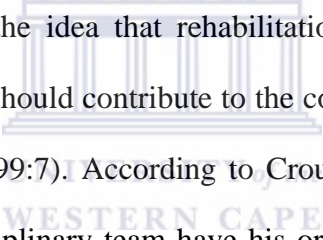
Smith and Middleton (1999:29) argue that due to financial constraints on rehabilitation, evidence that demonstrates the effectiveness of rehabilitation in achieving positive outcome should be produced, not only to ensure viability of rehabilitation services, but because it is ethically bounding through professional duty to provide such evidence.

While arguing that new health patterns are needed, Zimba (2002:67) identified resistance to change by many professionals and managers as the root cause of the delay to implement the PHC model thus calling for implementation of a 'one stop approach' whereby baby clinics, antenatal and postnatal clinics, family planning, and adult curative services are rendered on a daily basis.

2.1.7. Multidisciplinary team

"The achievement of health results for individuals is based in large part on the capabilities and motivation of health service personnel and their willingness and ability to cooperate and to coordinate their efforts" (Orem, 2001:389). In mental health, the health personnel that is required to assist patients is referred to as a "multidisciplinary team". This team consists of members of different health services, working together collectively. According to Orem (2001:390), a team only exist if its members have common goals, co-operate with each other, and co-ordinate their activities. The multidisciplinary team mostly consists of: Psychiatrist/Consultant or Registrar, Clinical psychologist, Psychiatric nurse, a Social worker, and an Occupational therapist.

"It is right to promote the idea that rehabilitation requires the skills of many disciplines, all of which should contribute to the concept of a holistic approach..." (Smith & Middleton, 1999:7). According to Crouch (1992:19-1), although each member of the multidisciplinary team have his or her own particular role within the team, sometimes these roles overlap, effectively emphasizing that this overlapping of roles is desirable in order to treat patients.

According to the Department of health (cited in Mtwazi, 2000:25), "health teams and workers at all levels should develop a caring ethos and commit themselves to the improvement of the health status of their communities".

2.2. SPECIFIC QUALIFICATIONS
Fortinash and Holoday-Warret (1996:24) argue that there is an educational demand for psychiatric nurses to add additional components in their education as

they are faced with new educational and clinical challenges. Psychiatric nurses "will integrate biologic content for safe and effective care, while still forging the proven basis for optimum client wellness-the art and science of the nurse-client relationship".

According to Davis (cited in Smith & Middleton, 1999:257), post-registration courses are essential part of future quality assurance initiatives as they set the benchmark for achievable criteria in standards of care. Specialization is noted to enhance professionalism as nurses are enabled to communicate and discuss with other disciplines on an equal level of knowledge, skill and understanding.

Wilson and Kneisl (1996:15-18) stipulate the following functions for a certified clinical specialist:

- Psychotherapy: this means that the specialist is expected to conduct individual, group, and family therapy that will address psychiatric needs of the clients.

- Additional psychobiological intervention: here the nurse is expected to know the appropriate medication to prescribe according to the regulation. The specialist is expected to order the appropriate diagnostic and laboratory test required for clients.

- Clinical supervision/consultation: the specialist is expected to act as an example, a consultant to both the clients and colleagues as well as an educator. The education role can be fulfilled by being familiar with the constitution, understanding the client's rights, accepting the beliefs and values of both the clients and the nursing staff, as well as take part in research programs that are aimed at updating the specialist's knowledge and developing the staff (colleagues and student nurses).

- Consultation-liaison: the specialist must liaise and intervene with the client and his family. Also other health providers must see her as a consultant. Making psychosocial diagnoses and intervening is another expected function. Referring the client for disability grant if she identifies the need to do so is also an

important task.

Spross and Baggerley (cited in Humphris, 1994:10) talks about sub-roles of a specialist which are divided into:
-Direct functions (expert practitioner, role model, and patient advocate), and
-Indirect functions (innovator, change agent, consultant or resource person, supervisor, teacher, researcher/liaison).

Fortinash and Holoday-Warret (1996:40) argue that in the case of an emergency commitment of a psychiatric client, the advanced practice nurse is required (by the state) to see the client before admission and is expected to take responsibility for his or her actions as he or she might be expected to justify his or her actions as the first person who saw the patient before admission. These authors also distinguished Psychotherapy, Prescription of pharmacological agents, Consultation, and Evaluation, as four main roles of a specialist, arguing that these interventions "may be employed only by clinical specialists who are certified in advanced psychiatric-mental health nursing".

Although the above specific functions are to be performed by the specialist, they do not prevent the specialist from doing basic roles of the generalist such as:
Health promotion and health maintenance, intake screening and evaluation,
case management, provision of a therapeutic environment, health teaching,
facilitating self-care activities, crisis intervention, counseling, home visits,
administering and monitoring psychobiological treatment regimens, advocacy,
and community action (Wilson & Kneisl, 1996:15).

To determine competency of mental health nurses, apart from the above discussed essential qualifications, performance plan of mental health care nurses stipulates the following requirements:
1. Registered nurse with qualification and experience in mental health (registered with South African Nursing Council)
2. Supervisory skills

3. Labour relations training

4. Communication skills

5. PSR training

6. Counselling skills

2.3. JOB DESCRIPTION OF MENTAL HEALTH CARE NURSE

To render a community mental health care service in the district, the following key performance areas and performance outputs are included in the job description of mental health care nurses by PGWC. Firstly, an employee must ensure effective and efficient mental health service at CHC by:

1. Monitoring and evaluating service delivery at facility level to the individual, family and community

2. Monitoring quality of care in terms of records of clinical care, support and follow up of mental health clients

3. Monitoring and evaluating the need for research on community level with regards to mental health issues.

4. Facilitating integration of mental health into the system by devolvement of stable clients into the general PHC system.

5. Referring clients to community based services for follow-up by home based care nurses.

Secondly the mental health care nurse is expected to monitor the implementation of the Mental Health Care Act (MHCA) at facility level by:

1. Monitoring and evaluating skills of personnel in terms of the application of the MHCA.

2. Providing training at facility level.

3. Reporting areas of concern in terms of compliance with the MHCA.

Thirdly the mental health care nurse is expected to ensure effective and efficient

training of colleagues, self, and students by:

1. Monitoring and evaluating training needs as per Individual Developmental Plan (IDP).

2. Monitoring and evaluating training needs of students and colleagues at facility level.

Lastly the mental health nurse is responsible for strengthening of PSR at community level by:

1. Monitoring and evaluating PSR implementation in the community.

2. Referring stable clients to PSR groups run by non governmental organizations.

2.4. THEORETICAL FRAMEWORK

This study was guided by Neuman's health systems model. Neuman was a pioneer in the community health movement and she adopted a 'whole person approach' (George, 1990:259-267). This theory is based on the philosophy that the person is a composite of physiological, psychological, socio-cultural, developmental, and spiritual variables.

Neuman argues that "we must now empathetically refuse to deal with single composites, but instead relate to the concept of wholeness. We need to think and act systematically. Systems thinking enables us to effectively handle all parts of a system simultaneously in an interrelated manner, thus avoiding the fragmented and isolated nature of past functioning in nursing" (George 1990:265).

According to Neuman, maintaining, retaining, and attaining client system stability is the primary goal of nursing and it can begin at any point at which a stressor is either suspected or identified. In support of this theory, the study attempts to look

at the means of managing health clients holistically, not only taking care of their biological or physiological needs but also their psychological, socio-cultural and developmental needs too. Presently, the provision of spiritual needs is limited to the short prayer performed in some of the health establishments before resuming work in the mornings (personal observation).

2.5. CONCLUSION

This chapter has looked at the evolvement of psychiatry and discussed the trends in mental health nursing. It has shown that a different angle had to be used in looking at mental health problems as issues like drug abuse, teenage pregnancy, and HIV/AIDS are posing as challenges. A need to employ different strategies in management of MHCUs such as psychosocial rehabilitation is indeed apparent. Chapter three will be discussing the research design and methodology employed in obtaining data for this study.
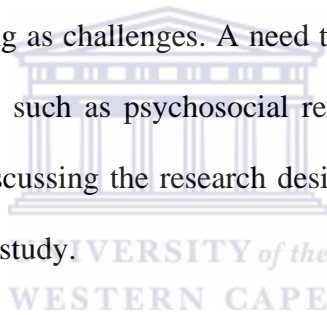
CHAPTER 3: RESEARCH DESIGN AND METHODOLOGY

3.1. INTRODUCTION

This chapter discusses the process through which the data was obtained for this study. The research methods used in the study, participants from which the data was obtained, the data collection techniques, trustworthiness, data analysis technique, and ethical considerations are also discussed.

3.2. RESEARCH METHOD

Unlike other methods such as quantitative research method which uses a

standardized measure as data-gathering methods (De Vos, Strydom, Fouche, & Delport, 2002:291) in qualitative method, everyday life is it's laboratory as it cannot be contained in the test tube or manipulated (Morse, 1999:1). Although quantitative research provides a broad generalizable set of findings as it measures the reactions of many people to a limited set of questions (Patton, 1987:38),researchers who intend promoting understanding of human experiences would find it difficult to quantify (Brink, 2001:119). Qualitative research method was therefore used in this study.

"Qualitative research methodology has been referred to as holistic, inductive, dynamic, subjective, humanistic, exploratory, and process oriented (Cook and Reichadt cited in Baumgartner, Strong and Hensley, 2002:209). According to Brink (2001:119), qualitative research studies human experiences in the context in which action takes place, focusing on aspects such as meaning, experience, and understanding. Phenomenology, which is one of the mostly used research design for conducting qualitative research was selected for this study. De Vos et al (2002:268) describe phenomenological study as "a study that attempts to understand people's perceptions, perspectives, and understanding of a particular situation". The main goal of the phenomenological study is to find common themes that illustrates the wide range of meanings of a certain phenomenon, thus placing more emphasis on the participant's perspective and description of events, beliefs, and behaviors (Struwig & Stead, 2001:16).

Brink (2001:119) argues that phenomenological approach can help nurses to

understand the meaning of 'health' or 'caring' in patient's point of view as it examines human experiences by focusing on descriptions provided by the people involved in a particular situation. Phenomenological approach is therefore suitable for this study as its aim is to obtain an in-depth understanding of the perceptions and readiness of professional nurses in the Khayelitsha health sub-district to render mental health care services after de-institutionalization of MHCUs.

3.2.1. Participants

Purposive sampling technique was used to select the participants for this study. "Qualitative research focuses primarily on the depth or richness of the data and therefore qualitative researchers generally select samples purposefully rather than randomly" (Struwig & Stead, 2001:121). According to Brink (2001:141), purposive sampling "is based on the judgment of a researcher regarding subjects or objects that are typical or representative of the phenomenon being studied, or who are especially knowledgeable about the question at issue". Purposive sampling, was used because of awareness on the existence of specific characteristics in a certain segment of a population (Baumgartner et al, 2002:133) who are the nurses who render care for mentally ill clients.

Only professional nurses who have been trained on mental health care nursing during their undergraduate level and currently working in the Khayelitsha health sub-district at the time of data collection has been included as participants in this study. Struwig and Stead (2001:111) refer to this as 'Judgment sampling' as it was believed that only nurses who have basic training on mental health nursing will

have fruitful responses. One professional nurse per facility was interviewed. Informed consent was obtained before conducting the study to ensure that participants agreed to participate voluntarily (Struwig & Stead, 2000:67).

3.2.2. Data collection techniques

"When the researcher's objective is to find out what people believe, think, or know, the easiest and most effective method is to ask questions directly of the person involved" (Brink, 2001:153). Hence only nurses currently rendering mental health services at the CHCs were included in the study. According to Brink (2001:153), this is known as 'self-report technique' as the questions asked provides facts about what is going on in the minds of the interviewees using either semistructured or unstructured interview guides to collect data.

Although according to Carey (in De Vos et al 2002:291), "focus groups could be meaningful in the case of a new topic, or when one is trying to take a new topic to a population, or if one wants to explore thoughts and feelings and not just behavior". In this study, semi-standardized individual interviews were conducted with the participants, based on the premise that true reflection of each participant's views will be obtained.

According to Berg (cited in Struwig & Stead, 2001:98), semi-standardized questions are predetermined questions that are posed to each participant in a systematic and consistent manner, giving participants the opportunity to discuss issues beyond the question's confines.

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Individual interview as the method to collect data was selected for this study because it is viewed as an effective and useful way of obtaining depth in data (De Vos, 2002:305). According to Patton (1987:108), in-depth interviewing provides a holistic understanding of the interviewee's point of view. Interviews are also advantageous because questions may be clarified or rephrased to the interviewee (Brink, 2001:153).

A tape-recorder was used with the informed consent of the participants. According to Patton (1987:137), tape recording increases accuracy of data collection and gives the researcher the opportunity to listen attentively to the interviewee. De Vos et al (2002:304) assert that the use of the tape recorder provides the researcher with time to concentrate on proceedings of the interview and the awareness of where to go next instead of spending extra time on jotting down the entire communication. Sometimes interview may trigger anxiety to some participants (Brink, 2001:153). Participants were therefore re-assured and given time to relax before commencing the recordings.

A set of questions was designed with room for minimal adjustment as the participants' present working environment differed. Therefore the questions were phrased differently for participants already rendering mental health care services than those not rendering the service yet.

To the participants from the CHCs, the questions were:
As you are already rendering services to MHCUs:

1. What are your feelings and perceptions with regard to the proposed Healthcare 2010 Plan for the Western Cape with specific reference to mental health care services?

2. What are the anticipated challenges that you believe would influence the effectiveness of rendering a comprehensive mental health care services?

On the other hand, questions to the participants working at the clinics were:

As you are not rendering mental health services at your clinic at the present moment,

1. What are your feelings and perceptions with regard to the proposed Healthcare 2010 Plan for the Western Cape with specific reference to mental health care services?

2. What challenges would you anticipate if you were to render mental health services at your clinic?

Data was collected during lunch time to avoid interfering with daily duties of both the interviewees and the researcher, on days chosen by the interviewee, at the work place of the interviewee. The researcher personally collected data using the tape recorder and noting down some important points that needed further exploration.

3.3. ENSURING TRUSTWORTHINESS

"Validity in qualitative research has to do with description and explanation and whether or not the explanation fits the description" (Denzin & Lincoln, 2003:69). According to Bollen (1989:184) to ensure validity, the variable should measure what it is suppose to measure. In this study validity was maintained by assigning meaning to variables before the interviews took place. Bollen (1989:185) refers to this as content validity which is defined as "the qualitative type of validity where the domain of a concept is made clear and the analyst judges whether the

measures fully represent the domain".

Trustworthiness was also ensured in this study. "Being trustworthy as a qualitative researcher means at least that the processes of the research are carried out fairly, that the products represent as closely as possible the experiences of the people who are studied" (Ely, 1991:93). To accomplish this, questions that were used to collect data were used in a manner that provided relevant response to meet the research objectives.

Data collection tools were designed as the data to be collected from the City Health's PNs differed from the one collected from CHC's PNs. To ensure reliability, no new meanings or assumptions were attached to individual statements. According to Selltiz et al (cited in Brink, 1996:124), "reliability is concerned with investigator's ability to collect and record information accurately".
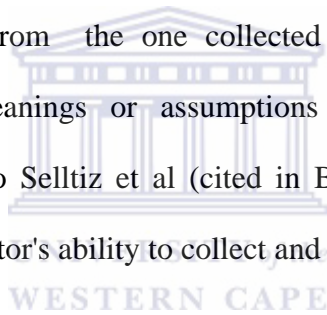
Neutrality was achieved through bracketing. "Bracketing is the process of identifying and setting aside any preconceived beliefs and opinions one might have about a phenomenon under investigation" (Brink, 1996:120). The researcher assumed a neutral stand when interpreting research findings, using only the information from the tapes.

3.4. DATA ANALYSIS

"Analysis is the process of bringing order to data, organizing what is there into patterns, categories, and basic descriptive units" (Patton, 1987:144). According to

Mouton (2001:108), analysis provides the researcher with understanding of 'various constitutive elements' of the data that will enable the recognition of patterns and trends establishing themes in the data.

"Coding is seen as a key process since it serves to organize the copious notes, transcripts or documents that have been collected and it also represents the first step in the conceptualization of the data" (Bryman & Burgess, 1994:218). To conceptualize data was reviewed again and again until there was a common understanding of the responses from interviewees. Responses were then contrasted and compared to determine emerging themes (Brink, 1996:120). Data was broken up into manageable themes, patterns, trends, and relationships (Mouton 2001:108). Verbatim transcriptions and analysis of data was done immediately after the interviews (Baumgartner et al, 2002:219). These transcripts were then read repeatedly to conceptualize emerging themes. Ely (1991:150) describes themes as either statements that appears throughout the data or single statements that carries factual impact. Thematic analysis was done, however single statements that had an effect on the study were also presented.

As suggested by Seaman (1987:289) responses were transcribed and presented as they were spoken without grammatic changes.

3.5. ETHICAL CONSIDERATIONS

The research ethics committee at the faculty of Health Sciences (University of the Western Cape) approved the study. Permission was obtained from the City Health

and PGWC's ethical committees to conduct the study at the health facilities. Participants were informed that information will not be divulged and only the researcher will have access to the tapes recorded (Baumgartner et al, 2002:115). No participant was requested to disclose personal identification on tape when responding to the topic. Voluntary participation was encouraged after the importance of the research has been explained to participants before coming to the interview sessions.

Informed consent

Although voluntary participation was encouraged, participants were informed that they may withdraw from taking part at any stage during interview sessions and were free to stop participating should they feel uncomfortable to answer questions. Participants had access to the tapes as tapes were played back to individual participants immediately after the recordings to allow participants an opportunity to add, withdraw, or rephrase any of their statements if they needed to do so (Bell, 1993:96).

Confidentiality and anonymity

Participants were informed that tapes would be destroyed after verbatim transcriptions and the issues raised during the interview sessions were not to be communicated with participant's colleagues. No names or even place of employment would be revealed during data presentation to avoid the possibility of linking participants to responses.

3.6. CONCLUSION

The process of data collection, data analysis, ensuring trustworthiness and ethical considerations was discussed. The obtained and analyzed data is presented in the following chapter.

CHAPTER 4: DATA PRESENTATION

4.1. INTRODUCTION

In this chapter verbatim presentation of raw data is presented focusing on the common views that emerged from the participant's responses. However, even single statements that have a strong effect on the research are presented. Although there were two questions on the data collection tool, some of the raw data that is presented in this chapter was obtained by means of the probing questions. Participant's responses are presented without specifying whether the participant is from the City Health clinics or CHCs.

To demonstrate that comments are from different participants, responses are numbered like participant 1, participant 2, and so forth (except for the single statements). However, for confidentiality reasons, participants will be kept anonymously, therefore participant 1 will not actually mean the first participant interviewed but rather that the participant's comment is quoted before the others.

Raw data is presented in major categories, themes and sub-themes without any discussion, explanation, or interpretation (Baumgartner, Strong & Hensley

2002:151).

4.2. FINDINGS

4.2.1. Feelings and perceptions about readiness to render MHCS according to Healthcare 2010 Plan:

Personal feelings:

Participant 1: "Personally I don't have a problem with rendering the service".

Participant 2: "I don't have a problem at all ... I think its a good idea because
clinics are more close to the community".

Participant 3: "As far as I'm concerned its something that should have been started
many years ago ... and therefore the question is not what I feel about
it but is when do we finally start implementing what we've been
trained to do ... so how I feel about it really is its about time that
we put into action ...".

Participant 4: "It is a very good idea ...".

Participant 5: "I think its a very good move, its very good for mental health"
"And also it will help devolving clients with mental illness, so in
general I think it is good".
"The move in principle and in theory is right but let us put what is
in theory into practice thats what I want to say".

Participant 6: "I'm very positive about the move".

Participant 7: "the idea of directing the patients to the community is good but it

seems to be impractical ...".

Participant 8: "...what I feel is that if they can employ more staff to render the

service at primary level then there won't be a problem ... and my

perceptions about 2010 Plan I don't think it will work ...".

<u>Conflicting ideas</u>:

Participant 1: "... one of ways to improve de-institutionalization has been started

already for instance from Lentegeur we have a doctor working with

one of registered nurse they keep a regular contact with families in

terms of educating the family these patients six months every six

months they used to be institutionalized but now they are coping

now because there is regular follow up".

Participant 2: "... its even worse now with this 2010 Plan because patients are

going to be discharged whether the patient is not 100% stable as

they

are doing right now ...".

<u>Needed Support</u>:

<u>Support (from the employer)</u>:

Participant 1: "... I'm sure the authorities will equip the nurses with such, em, with

such skills just to update them in terms of the current practices, ja".

Participant 2: "... then it's up to the department to fulfill those requests and then

we will know we are ready when they offer us whatever we are

asking as means of equipment".

Support from the facility level:

Participant 1: "There is no support system ...".

"... maybe its because the managers some of them are not

psychiatric trained, or they never worked in psychiatry, they don't

take it seriously, that's how I feel, they don't take it seriously...

seemingly they don't want to know".

Participant 2: "... I'm talking about other people, other health care professionals,

other nurses, the clerks, the managers of the hospitals, the doctors, I

don't think people are taking this seriously".

Support from other disciplines:

Participant 1: "I'm talking about a multidisciplinary team, there will have to be a

nurse who will be the driving force for that team, there will have to

be a doctor, psychiatric doctor, social worker, psychologists,

occupational therapists, you name it the whole team".

Participant 2: "Hand in hand with the doctors and social workers ... so there must

be the whole team actually and the psychologists".

Participant 3: "Ja well I mentioned personnel I mentioned nurses, doctors, and the

police but what about the social workers ...".

Dissatisfaction:

Participant 1: "For an example you sit in a clinic with patients who when you look

at close, you would find that their problem would need psychiatric

intervention ... or you find yourself having to manage that person,

mismanage the person ...".

Participant 2: "... its even worse now with this 2010 Plan because patients are

going to be discharged whether the patient is not 100% stable as

they

are doing right now ...".

Participant 3: "... and another thing they are not right when they are discharged at

the hospital ... thus they become sick and they go back to the

hospital ...".

"I don't think, those people do not belong to the hospitals, they

belong to the communities and they need to be rehabilitated at their

communities".

Participant 4: "Well I don't think for now, there is no one ready now even if the

person is working in the psychiatric hospital ... I will definitely

refuse to take this service now because if I do take it that means I'm

putting my life at risk as well as the community at risk".

Learning gaps:

Participant 1: "What I'm not sure of now is whether I would be able to handle

clinic without prio probably some updates or some workshops of

some kind just to update one as to what are the current practices as

you know that nursing is evolving all the time".

Participant 2: "... but yes there is a need for sort of increased training by in-

service training".

4.2.2. Anticipated challenges in terms of skills and resources:

Workforce:

Participant 1: "... first of all it will be the workload as it is we are very short

staffed ... in my belief we will need a very effective team to

manage that clinic".

Participant 2: "... it will mean that we'll have to do extra work".

Participant 3: "... how do you sufficiently deal with the problems if you don't

have enough human resource and how do you get enough or well

motivated staff".

Participant 4: "Ja, the first one is about the personnel ...".

Participant 5: "Its like one is going to have extra work now ... so that's extra

work for you".

Participant 6: "... then the challenges will be more about the workforce".

Resources:

Participant 1: "The main challenge as I can see now, I anticipate to be more on

resource allocation ... to actually give the kind of quality care that

we require if you do not have sufficient financial resources ...".

Participant 2: "As well as the resources the community resources we also need

that also a challenge ...".

Environment:

Participant 1: "ja, the other one is the environment itself is not conducive ... we

have small rooms and small clinics around, I mean the structure not

the personnel quantity but the structure quality".

Participant 2: "Also we have to think about the space, because mostly mental

health is in small rooms, so then there should be plans to enlarge the

space so that to prepare for the large number of people".

Concern about success:

Participant 1: "And then the second challenge that I'm thinking of is the

defaulting ... so I'm worried what would then happen if they start

defaulting ... would we have a plan in place when for what would we

do when people start to default ...".

Participant 2: "Like firstly I think its non-compliance that I'm definitely sure, the

non-compliance of the unstable patient ... that patient will default

his or her treatment".

Participant 3: "... there must be psychiatric doctors to assess these patients

especially those that are not responding to treatment...".

Participant 4: "... I think they are being abused and they are being mistreated at

the communities, thus they go back to the hospital, so I think those

are problems that I'd experience if I were to go back to mental

services many of them are not taking treatment".

Stigma:

Participant 1: "... because its actually kind of sensitive seeing that, well mental

illness has been a stigma for the community ... so we wouldn't

like to make them feel uncomfortable ... then the stigma comes in

the people get uncomfortable and just stop coming for treatment ...".

Participant 2: "You need to integrate those clients to the larger community thus

de-stigmatizing the way people are seeing mental health illness ...".

"Well because of the stigma, I think its still a problem ...".

Participant 3: "... because we are all aware of the stigma by health professionals

as well to MHCUs ...".

4.2.3. Confidence in ability to meet the Healthcare 2010 Plan

Educational background:

Participant 1: "I think we would be able with the knowledge that we acquired at

the undergraduate level and some who did at varsity at that basic

level ...".

"... So I'm answering your question I do believe the skills that we

acquired at general training will be enough".

Participant 2: "At basic level yes, I think at basic level with the kind of nursing

that we trained [cannot hear] we come out with sufficient training ..."

Participant 3: "Yes I should say yes because adding the experience that we have I

think we are adequately skilled to handle the patients in the

community".

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Action plans:

Participant 1: "Well we can never begin to undermine the effect of talking about it, exposing people to mental illness, talking about itself because as we talk more about it people are empowered, they get to understand that we need not necessarily be a stigma so we have to embark vigorously on using media to inform people ...".

Participant 2: "... I mean going as far a mile informing people informing them about this change".

"The role that we can play its like educating them, its like the mass education ...".

Participant 3: "I think we need to talk about it, train people, clerks, cleaners, everybody ...".

"Ok, I think people need to be educated about the diseases including

health care workers".

4.3. CONCLUSION

This chapter has presented the raw data obtained from the interviews under three major categories and sub-categories. The next chapter will discuss the findings supporting with available literature in order to draw conclusion of the study.

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CHAPTER 5: FINDINGS, CONCLUSION AND RECOMMENDATIONS

5.1. INTRODUCTION

This chapter provides findings of the research study. It is important to point out that implementation of the Healthcare 2010 Plan for the Western Cape will bring about change in the present way in which services are rendered. In order for the PNs to be ready to meet the principles of Healthcare 2010 Plan, they need to be ready to change. Therefore, this chapter discusses change and readiness (supporting with participant's responses) to show the relationship between the two. Thereafter continuum of readiness will be used to measure readiness in order to show findings of the study. Recommendations will then be made.

5.2. WHAT IS CHANGE?

Sullivan and Decker (1992:428) views change as being necessary for growth, however acknowledging that it often produces anxiety. According to Keltner et al (1999:130) growth, self satisfaction, improved relationships, and a healthier self-esteem are potential benefits of change. "Change is often planned to close a performance gap, a discrepancy between the desired and actual state of affairs" (Sullivan & Decker, 1999:435).
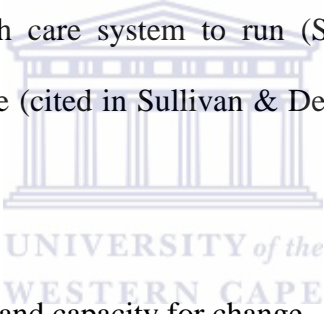
Understanding that in health care services change does not only affect health care providers, but health care users too. Keltner et al (1999:130) provide 'time tested approaches' that are likely to bring successful change. These approaches state that:

- Carefully considered, rational decisions are more likely to result in healthy changes than decisions that are hasty and emotional.

- Patient initiated change seems to be more successful than change imposed by others.

- Practicing or rehearsing change with the nurse builds confidence for trying new behaviors with others and increase success.

- Support and acceptance of change by patients, friends, and families help.

- Support groups can reinforce new behaviors.

- Patients are more likely to change when they are ready and motivated.

- Pushing for change too quickly is frustrating for all concerned.

Nurses are regarded as agents of change, bringing about change by using concrete ideas to make the health care system to run (Sullivan & Decker, 1992:429). Lippitt's phases of change (cited in Sullivan & Decker, 1992:433) states the need to:

- Diagnose the problem

- Assess the motivation and capacity for change

- Assess the change object's motivation and resources

- Select progressive change objects

- Choose a change agent role.

- Maintain the change.

- Terminate the helping relationship.

To achieve goals and system viability, integrative processes are required, however arguing that "one's commitment to change, energy level, future ambitions, and power bases must be considered" (Sullivan & Decker, 1992:430-433).

5.3. WHAT IS READINESS?

Readiness is a state of mind which reflects the outcome of quite a lot of psychological activity" (Rollnick, Mason, & Butler, 1999:18). These authors identified two ingredients of readiness, namely, 'importance' and 'confidence'. Importance refers to personal values and expectations of the importance of change where an agent of change would ask 'why should I change'? On the other side confidence refers to self efficacy with an agent of change asking 'how will I do it'? (Rollnick et al, 1999:22).

5.4. DISCUSSION OF FINDINGS

Although Cohen, Farkas, and Cohen, (1992:38) in their study were relating to readiness of clients to engage in psychosocial rehabilitation, the readiness assessment tool they have used could be employed in assessment of readiness in the workplace. These authors argue that to assess whether an individual is ready to change, he or she should rate high in the following aspects:

- Need for change
- Commitment to change
- Environmental awareness
- Self awareness
- Personal closeness

5.4.1. Need for change

The need for change is seen as being determined by the individual's dissatisfaction

by his or her current environment to the extent that he or she expresses an urgent need to change the environment (Cohen et al, 1992:6). Participants voiced out that there is indeed a need for change, when asked about their feelings and perceptions about the fact that 90% of mentally ill clients will be managed at the primary level, responses were as follows:

"As far as I'm concerned its something that should have been started many years ago and to the extent that we already face problems that points to the need for it to have been implemented many years ago, we sit here a lot of times we sit with problems that eh that points to the need for integrated primary health care services which at this point is not fully operational".

While the above response showed dissatisfaction with the current method of rendering the services (which was based on the need for job satisfaction), also referring to the same question, some participants' responses were:

"I think its a very good move, its very good for mental health, one of the reasons you need to integrate those clients to the larger community thus de-stigmatizing the way people are seeing the mental health illness and also it will help to diagnose, and assess and treat mental illness at the community level thus reducing the risks associated with the illness and it will help with devolving clients with mental illness so in general its good"

"I think its a good idea because the clinics are more close to the community. What I mean is the most of the time hospitals are far so it will be easy for the clients to reach the clinics more accessible in other words"

It is interesting to see that the need for change does not only stem from the need to be personally comfortable, but the need to render efficient and more accessible service to the members of the community, which in turn leads to job satisfaction. Locke (cited in Pinder, 1984:93) defines job satisfaction as "an emotional reaction that results from the perception that one's job fulfills or allows fulfillment of one's important job values and to the degree that those values are congruent with one's needs".

What is more interesting is the fact that three participants' responses that were narrated above are from participants working for the City Health clinics. Clinics are rendering adolescent services, although mental health services are absent at present. Robertson et al (2001:318) argue that "HIV- infected and Aids present a major challenge to those concerned with the mental well-being of children today, especially in the Southern African context".
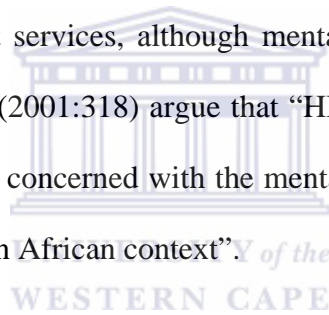
Considering the fact that children are put on anti-retroviral drugs which prolongs their lives, the possibility of these children beginning sexual activity is high. Robertson et al (2001:319) ascertain that "another issue that needs careful consideration is when and how to discuss the diagnosis with the child or adolescent, who may be beginning sexual activity", thus arguing that in the case of children in Southern Africa psychosocial aspects are the major concern. Priority in this case is to train general practitioners and other primary health care workers to identify as well as manage psychological and psychiatric aspects of physical disease (Robertson et al, 2001:370). This means that nurses working at

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the clinics need to be skilled, but what would be the good of training them if they will not use the skills?

5.4.2. Commitment to change

According to Cohen et al (1992:38), high level of commitment to change is characterized by the belief that a need exist, belief that change is positive, belief that change is possible, and belief that support for change exists. "If a change feels important to you and you have confidence to achieve it, you will feel more ready to have a go, and more likely to achieve" (Rollnick et al 1999:18).

Some participants believed that <u>need exists</u>. When asked about their feelings and perceptions regarding managing majority of mentally ill clients at community level, some of the responses were :

"...so how I feel about it really is its about time that we put it into action because we've talked about it, trained for it, even in other areas we talk about problems such as political willingness and we do not have such problems so its just the question of implementation and really gearing or re-arranging the system to suit that model because that model has been agreed upon had been in papers but its just the matter of implementing".

This statement shows that the respondent is psychologically prepared to render services after de-institutionalization of mentally ill clients. The respondent does not only look at self efficacy but at other factors that may influence delivery of services at PHC level.

Some participants also felt the need exists for the well-being of MHCUs. This is evident in responses such as:

"*I do not think those people, they do not belong to the hospitals, they belong to the communities, and they need to be rehabilitated at their communities, I mean rehabilitation involves many things, the hospital, the home where you live, where the client leaves, so I think in general it will help rehabilitate those kinds of clients and it is not going to create any problems*".

Participants also had a belief that <u>change is positive</u>. This is demonstrated on the following responses:

"*I think its a good move, its very good on mental health, one of the reasons you need to integrate those clients to the larger community thus de-stigmatizing the way people are seeing the mental health illness ... and also it will help with devolving clients with mental illnesses so in general its good*".

"*It's positive and at the same time its positive in many ways because to institutionalize a patient is very costly ...*".

Sullivan and Decker (1992:428) state that because change is the process of making something different from what it was, it can be threatening even when planned. When the situation is threatening, people may be resistant to change. According to Sullivan and Decker (1992:443), "a generalized resistance stems from fear of loosing the comfort of familiar, no matter how inadequate it is".

Booyens (1998:486) states that "some people fear anything which is unfamiliar to them. However, most employees resist change not because they fear anything

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unfamiliar but because they fear that certain contemplated changes will make it more difficult for them to get to something worthwhile accomplished in their jobs in the available time span".

While other participants thought the move to PHC is wise and good, some participants felt it will not be effective, as shown on the following responses:

"I don't think it will work this thing of 2010 ..."

"I will definitely refuse to take this service now because if I do take it that means I'm putting myself at risk as well as the community at risk".

Sullivan and Decker (1992:443) argue that resistance have positive and negative aspects. Positive aspect of resistance is that "it helps the change object to clarify information, keep the interest level high, and answer the question why is the change necessary". On the other hand an individual may withdraw due to being de-satisfied. Pinder (1984:98) refers to tardiness, absenteeism, and turn over as three most commonly acknowledged forms of withdrawal.

Participants also had a belief that change is possible. Interestingly, the possibility of change was based on what participants felt would assist them in executing change as well as what they intended doing to facilitate change. While all participants reported that the knowledge and skills they acquired during basic training is enough for them to render efficient mental health services at primary level, participants not rendering MHCS felt that there is a need for some training to keep them in par with mental health needs.

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When asked whether they can be able to render mental health services efficiently, their responses were:

"*... I have the basic knowledge, what I'm not sure of now is whether I would be able to handle the clinic without prio probably some updates or some workshops of some kind just to update one as to what are the current practices now as you know nursing is evolving all the time*"

"*... but yes there is a need for sort of increased training by in-service training*"

"*... of course one will have to go for updates and things like that*"

Participants also intends assuming responsibility to make change possible. This is regarded as one of the ingredients of readiness to change, referred to as 'confidence', where an individual asks how will I do it? (Rollnick et al, 1999:22). Participants argued that talking about mental illness, teaching or informing the community about mental illness could make management of MHCUs at PHC level possible. This is evident on the following responses:

"*Well we can never begin to undermine the effect of talking about it, exposing people to mental illness, talking about itself because as we talk more about it people are empowered ...*"

"*... it will mean that we'll have to do extra work, by extra work I mean going as far a mile informing people, educating them about this change*"

"*I think we need to talk about it, train people clerks, cleaners, everybody about the illness ...*"

Again it was interesting to note that the above responses were of participants working at the City Health clinics. They already saw themselves as being responsible for educating the community members about the change. Booyens (1996:302) argues that in health care provision, accessibility involves supplying patients with necessary information to encourage them in becoming involved in decision making regarding their treatment program and follow up care.

Pinder (1984:96) identified the following factors as some of blockages of change:

- Organizational policies that prevents individuals from being effective in spite of their best efforts.

- Fellow employees who don't cooperate

- Too much work to be done in the time permitted

- Shoddy machinery or supplies

- A supervisor who doesn't listen, or who fails to provide assistance when it is needed

- An organizational structure that prohibits rapid advancement promotion.

Participants identified some of these blockages as challenges that they anticipate in implementation of de-institutionalization. In fact participants working at CHCs are already experiencing some of these blockages.

Participants were divided in belief that support for change exists. Those not rendering MHCS at present are hoping that authorities will support them during implementation of Healthcare 2010 Plan , while those rendering the service has lost hope especially with regard to being supported by their facility managers.

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Hopes that support will be available was indicated in responses such as:

"*I'm sure the authorities will equip the nurses with such em with such skills just to update them in terms of the current practices*".

"*Ok my responsibility is to check what I really need in terms of the equipment and forms or whatever then its up to the department to fulfill those requests*".

However, participants voiced strongly the lack of support by managers at facility level. It is clear that participants felt let down by managers on the following responses:

"*... there is no support system for mental health nurses especially in the facilities like here there is no support system, so hence I say this 2010 Plan will not be effective at primary level*".

"*... but seemingly this service, psychiatric, I don't know how they, how to put it, maybe its because the managers some of them are not psychiatric trained or they never worked in psychiatry, then they don't take it seriously, that's how I feel, they don't take it seriously ... seemingly they don't want to know*"

The same notion was supported by another participant who said:

"*I remember when I started the clinic at [name of CHC], I was called in and nobody had a clue as to what was to go on, the managers, they didn't know, the doctors, nobody knew anything, so there is no support structure, its like an isolated illness, see what to do with it, its not my problem its your problem*".

Mason (1997:66) states that if an organization does not support and value its staff there is a likelihood of high turn over and or sickness resulting in loss of valuable

skilled staff.

Being short staffed is associated with turnover as one participant stated that:
"*there is high turnover at primary level of people that are working in psychiatry because most of them they feel its not safe to run this service, and its even worse now with this 2010 Plan because patients are going to be discharged whether the patient is not 100% stable as they are doing right now ...*".

Pinder (1984:98) shows that there are advantages and disadvantages of turnover of staff. The advantage is that new blood introduced may bring in new ideas and the potential for change as well as adaptation of the organization involved. On the other hand it is disadvantageous in the sense that it can be very costly in terms of recruitment, training, and supporting new employees, and may disrupt work processes.

According to Sullivan and Decker (1992:22), organizational structure is mostly influenced by the environment, which is defined as people, objects, and ideas outside the organization. "Physical facilities are important. Optimum conditions of lighting, layout of the working area, comfort of the workers, and the necessary tools and equipment must be supplied" (Booyens 1996:133).

5.4.3. Environmental awareness

According to Cohen et al (1992:38), high ratings of environmental awareness is characterized by being very aware, talking about past and future environments in detail:people, places, and activities. When talking about people, participants

raised issues of stigma towards mental illness, both by health care providers and community members.

When discussing anticipated challenges, some of their responses were:

"*... its actually kind of sensitive seeing that mental illness has been a stigma for the community and people suffering from the illness so we wouldn't like to make them feel uncomfortable ... then the stigma comes in and people get* uncomfortable *and just stop coming for treatment...*"

"*Well I think because of the stigma I think its still a problem ...*"

"*... because we are all aware of the stigma by health professionals as well as to mental health care users*".

With regard to places, participants referred to consultation rooms in which they are working. Mason (1997:66) argues that "*...* readily accessible supplies of materials, equipment, and sufficient privacy both to undertake the intervention and inform, educate, and counsel the patient are required". In mental health nursing conducive environment is essential for therapeutic milieu.

Participants voiced out dissatisfaction with their clinical environments, this is evident in comments such as: "*... the environment itself is not conducive... we have small rooms and small clinics around, I mean the structure not the personnel quantity but the structure quality*"

"*also we have to think about the space because mostly mental health is in small rooms so then there should be plans to enlarge space so that to prepare for the*

large number of people".

Sullivan and Decker (1992:23) state that to avoid dehumanizing the patient which may lead to lower quality of care, each health care facility should be designed to treat each individual patient in an individual way.

Dreyer et al (1997:37) argue that the responsibility of the community nurse is increased by the growing informal settlements. This task seem to be difficult as these areas are under dangerous and difficult circumstances. One participant has highlighted this difficulty by alleging that: "due to high rate of crime sometimes it becomes difficult to visit families of patients".

Participants talked into detail about activities involved in their practice. These activities can be divided into those that participants felt they need to do to serve clients effectively, means by which service rendering can be facilitated, as well as the things they encounter during their practice. Smith and Middleton (1999:78-79) argue that nowadays clients are hospitalized for shorter period of time, and families become more involved and more at the forefront of patient health care needs. Suggesting that it is therefore important to offer these families support and counselling if the need is perceived so.

Apart from educating MHCUs, which was discussed earlier, participants felt the need to involve families to achieve success in maintaining good results in community mental health services. Some of the responses confirming this statement are:

"... I should say we should start now preparing the communities, the families involved..."

"You know one of the challenges of de-institutionalization is actually regular contact with the families because trying to deal with patients alone, educating the patient is seemingly not enough, you know you need to educate the family ...".

Resources were identified as some of the challenges that are essential for service rendering. In terms of human resources, participants felt that there is a need for additional work force to ensure efficient service provision. Participants argued: *"first of all it will be the work load as it is we are short staffed in fact its a universal problem ... because in my belief we will need a very effective team to be able to manage that clinic ..."*

"... how do you sufficiently deal with the problems if you don't have enough human resources ..."

"... if you are still understaffed because now we are going to have more clients its going to be a disaster ..."

Technology has also appeared as a needed resource. Technology is defined as "tools, equipment, or materials, knowledge, and skills to use them, and coordinative mechanisms and patterns of activity utilized to accomplish the organization's work" (cited in Sullivan & Decker, 1992:23).

Participants showed that they are very much aware of their activities as they discussed in detail about their daily experiences. For different reasons, they

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showed a high level of dissatisfaction both in participants rendering and those not rendering MHCS. One participant showed an urgent need for rendering of MHCS at the City Health clinic saying:

"*For an example you sit in a clinic with patients who when you really look at close you would find that their problem would need psychiatric intervention but because the program is not fully integrated you will find yourself having to transfer that patient ... I'm saying that a lot of time we mismanage, misdiagnose ... you would treat and treat and the person comes back you treat again why because you are focusing on biological aspect of the problem and not the full picture ...*".

This concern is supported by Uys and Middleton (1997:48) arguing that patients repeatedly come to general medical services with no positive results as the psychiatric condition is often concealed under the cover of ill-defined somatic conditions. George and Cristiani (1995:175) state that "depression is the most common symptom experienced by sexual abuse survivors, their distress can result in sleep and eating disturbances, phobias, anxiety attacks, and physical ailments, such as gastrointestinal problems, headaches, and backaches".

Considering the fact that management of STI is one of the major services provided at the City Health clinics, and that mostly women complains of lower abdominal pain, the above participant's response may be true as Robertson et al (2001:366) argue that although it is not clear but the aetiology of chronic pelvic pain are thought to be both physical and psychological.

A three step model to improve the ability of general practitioners to identify and manage psychiatric disorders that present with physical symptoms has been proposed by Gask (cited in Robertson et al, 2001:370). It is called a 're attribution model', requiring the practitioner to:

- Acknowledge the symptoms or make the patient feel understood - involves taking full history, identifying emotional cues, considering social and family factors, the patient's health beliefs and performing a brief but focused examination.

- Broadening the agenda - informing the patient of the results of the assessment again acknowledging the reality of the symptoms and then reframing the symptoms by drawing in psychological and social stresses and linking these to the physical complaints.

- Making the links between life events and the onset of the complaint- explanation of how emotional states can lead through physiological mechanisms and to physical symptoms.

Another participant's dissatisfaction stems from inability to render efficient service due to overworking that hampers quality care for MHCUs, expressed as follows: "... *its just that one tend to know your patients and then you develop that relationship with them but then comes the time when you feel that you are sick and tired because you are all alone and you must see to all these patients you know then you become fed-up and then you just want to get out you see ...*".

Although both participants are dissatisfied about their current working situations,

they have different levels, where one would love to render the MHCS and the other one would love having a second hand (as currently only one mental health nurse is rendering the service in each facility).

5.4.4. Self awareness

Self awareness is determined by the individual being able to describe interests, values, and experiences without prompts (Cohen et al, 1992:38). Bennis (cited in Booyens, 1998:445) states four self-knowledge lessons which are:

- You are your best teacher,

- Accept responsibility, blame no one,

- You can learn anything you want to learn, and

- True understanding comes from reflecting on your experience.
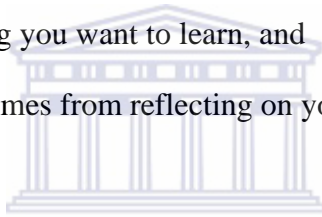
The participants demonstrated self awareness in terms of being equipped with skills to render mental health services. When asked whether they (participants) feel that skills they gained during basic training is adequate for them to render the service effectively, the responses were similar to both professional nurses already rendering mental health care services and those not rendering the service, which were:

"*Yes I should say yes because adding the experiences that we have, I think we are adequately skilled to handle the patients in the community*".

"*At basic level yes, I think at basic level with the kind of nursing that we trained we come out with sufficient training, but yes there is a need for sort of increased training by in-service training*".

5.4.5. Personal closeness

Participants showed a need for personal closeness. Level of closeness is characterized by being not isolated, liking closeness, and being positive about practitioners (Cohen et al, 1992:38). They showed a need for closeness by highlighting the need for existence of the multidisciplinary team. Participants acknowledged that contribution of other disciplines is crucial in rendering mental health care effectively. Some of their responses were:

"*I'm talking about a multidisciplinary team there will have to be a nurse who will be the driving force for that team there will have to be a doctor psychiatric doctor, social worker, psychologist, occupational therapist you name it the whole lot*"

"*Hand in hand with the doctors and social workers because some of the clients have social problems that's why they are that's why they become mentally depressed at times and eh so there must be the whole team actually and the psychologists*".
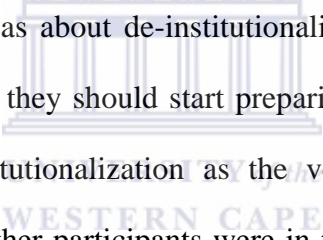
According to Booyens (1996:134) "Team work and good interpersonal relationships are important in an organization for productivity and effectiveness". The need for support (which demonstrate need for closeness) has also been discussed earlier where participants voiced the lack of support by their facility managers.

5.5. CONCLUSION ON THE FINDINGS

The data obtained from the participants has been discussed above, the need is to reach a conclusion, by showing whether the study shows any evidence whether the participants are ready or not to render MHCS integrated in the PHC level. Although six participants in this study has accepted the Healthcare 2010 Plan for the Western Cape, seeing it as a vehicle to render effective community mental health services, two participants felt otherwise. However, only one participant argued that the plan will not work at all (*"I don't think it will work this thing of 2010 ..."*), while the other one felt that it is good but resources should be in place before implementation ("...*there is no one ready now even if the person is working in the psychiatric hospital because urgently what is needed is personnel ...*").

There are conflicting ideas about de-institutionalization of mentally ill patients. One participant felt that they should start preparing the community and nursing personnel about de-institutionalization as the vehicle for service delivery at community level. Two other participants were in two different spheres regarding effectiveness of de-institutionalization. One felt that the de-institutionalization is very good saying that there is a positive change as patients who used to be admitted every six months are now coping because of regular follow ups, the other one felt that it can never work.

Participants understands well that as much as nursing is a nurse-driven service at the community level, they can never do it alone. They voiced out that they need support from other people such as the employer, facility managers, other health care providers, as well as colleagues. To measure readiness of participants to

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render MHCS, the following readiness rule (cited in Rollnick et al, 1999:69) was used.

Continuum of readiness:

Not ready			Unsure			Ready

Out of five participants not rendering MHCS, four of them are on the 'ready' side of the continuum while one participant on the 'not ready' side, saying: "... I will definitely refuse to take this service ...".

In terms of training, all participants are on the 'ready' side as they felt that they are well equipped at undergraduate level. However, participants that are not rendering MHCS have identified a need for some in-service training and workshops to update them with current issues around mental health nursing.

Interestingly even those who felt not quite ready, had insight on what needs to be done for this plan to work. This is good in the sense that those with doubt are not actually resistant to change but with support, transparency, good communication, and being involved in planning, they might be confident to render MHCS with minimal resistance.
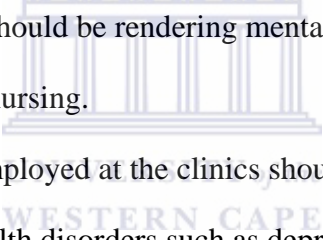
When looking at the ingredients of change which are 'importance' and 'confidence', collectively participants has showed high levels on both aspects. They have rated high on five aspects of change (adapted from Cohen et al, 1992:38) and has proved to be confident on how to do it (feeling well equipped in terms of skills required).

Although the participants employed by City Health feels ready to render mental

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health services, it is important to highlight that qualifications alone do not really mean the person can perform effectively. There are other factors such as exposure to the problems of mental health as well as to the tools of the trade. Therefore, protocols and guidelines need to be in place and PNs need to be exposed to psychotropic drugs and mental health problems before they can start implementing the proposed integrated model of care.

5.6. RECOMMENDATIONS

Considering the responses from both City Health and PGWC participants, it is evident that mental health service is vital at all levels of health care services, thus the following recommendations are made:

- Mental health nurses should be rendering mental health care services at all tiers of community health nursing.
- Professional nurses employed at the clinics should be skilled at screening and diagnosing mental health disorders such as depression at an early stage in all children as part of preventative services.
- There should be an open line of communication between different health care providers, such as, referral of women who have suffered from post-partum depression for regular follow up at the well baby clinic to ensure well being of both mother and child.
- School nurses should refer pupils for assessment at local clinics before referring them to tertiary institutions.
- Each clinic should render psychosocial rehabilitation to adolescents in order to decrease incidents as well as effects of teenage pregnancy, TOP, drug

dependency, truancy, gangsterism, and so forth (working hand in hand with schools).

- Provision of mental health care services should be regarded as a team effort by ensuring that there is more than one professional nurse rendering mental health care services in each facility and regular contact with other stakeholders like Non Governmental Organizations (NGOs).

- Community based research projects should be encouraged to determine current mental health problems, their effect in the entire community, as well as the means of proper intervention.

- There should be regular case presentations and discussions of mental health problems at the sub-district level.

- There should be resources such as rehabilitation centers and workshops in the sub-district to enable psychosocial rehabilitation of MHCU closest to their homes.

- Nursing staff as well as facility managers should be trained by means of in-service education about Healthcare 2010 protocols and guidelines.

5.7. CONCLUSION

This chapter has shown the relationship between change and readiness. Findings of the study has been shown using the continuum of readiness. Finally recommendations were made.

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APPENDIX A.1

I NTERVIEW GUIDE

FOR

PROFESSIONAL NURSES

RENDEREING SERVICES TO MENTAL HEALTH CARE USERS

Interventions that determines effective psychiatric nursing includes: "the continuous and comprehensive primary mental health care services necessary for the promotion of optimal health, the prevention of mental illness, rehabilitation from mental disorders and health maintenance" (preventative, promotive, curative, and rehabilitative health care services). Presently de-institutionalization of mentally ill persons is in the process, and according to the Healthcare 2010 Plans for the Western Cape, patients with mental illness will be largely managed in the community.

As you are already rendering services to mental health care users:

1. What are your feelings and perceptions with regard to the proposed Healthcare 2010 Plan for the Western Cape?

2. What are the anticipated challenges that you believe would influence the effectiveness of rendering a comprehensive mental health care services?
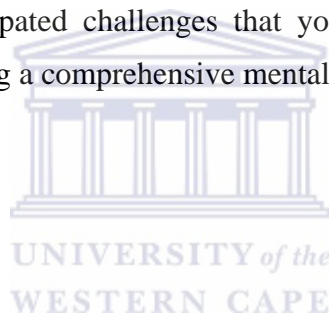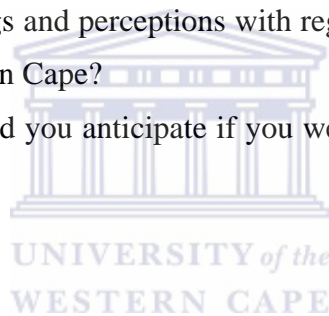
APPENDIX A.2

INTERVIEW GUIDE

FOR

PROFESSIONAL NURSES

NOT RENDERING MENTAL HEALTH CARE SERVICES

Van Rensburg (2004:427), argues that primary health care workers have a role to play in mental health by providing preventative measures for mental disability in services such as antenatal, infant, child, reproductive health, and curative care. Presently de-institutionalization of mentally ill persons is in the process, and according to the Healthcare 2010 Plans for the Western Cape, patients with mental illness will be largely managed in the community. Provincial department is hoping that local authority (as colleagues) will co-operate fully to ensure seamless and integrated quality services.

As you are not rendering mental health services at your clinic at the present moment,

1. What are your feelings and perceptions with regard to the proposed Healthcare 2010 Plan for the Western Cape?
2. What challenges would you anticipate if you were to render mental health care services at your clinic?

APPENDIX B.
CONSENT FORM

The readiness of professional Nurses in the Khayelitsha health sub-district to deliver mental health care services as stipulated in the Healthcare 2010 Plans for the Western Cape.

Your permission to participate in a research study is requested. The research study will require you to describe your feelings and perceptions with regard to the proposed Healthcare 2010 Plan for the Western Cape, and the challenges that may

be brought by implementation of the proposed plan.

The study will consists of interviews that will last approximately 20-35 minutes. You will be asked to respond to questions pertaining to mental health care. With your consent, the interview will be tape recorded and the tapes will be erased after the information required has been transcribed. At your request, tape recording will be terminated anytime during the interview.

There are no anticipated physical risks involved by participating in this study. However, should you feel uncomfortable during the interview, feel free to end the interview.

There is no direct benefit to you for participating in this research study. The outcome of the study will help in making recommendations for effective planning for the implementation of the Healthcare 2010 Plan for the Western Cape.

Your name will remain anonymous when reporting the outcomes of the study. All the information gained from you will be confidential.

Your voluntary participation will be greatly appreciated.

CONSENT

I have read the information contained in this consent form and hereby give my consent to participate in this study.

Signature of Supervisor:.................................... Date:....................
Signature of researcher:.................................... Date:....................

Signature of participant:.................................... Date:...................