A RECOVERY-ORIENTED SOCIAL WORK PROGRAMME FOR MENTAL HEALTH CARE IN A RURAL AREA IN SOUTH AFRICA

by

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A thesis submitted in partial fulfilment of the requirements for the degree:

DOCTOR OF PHILOSOPHY

IN SOCIAL WORK

Department of Social Work and Criminology

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UNIVERSITY OF PRETORIA

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June 2017

DEDICATION

I dedicate this work to:

To my parents, Shugeyi William and Feziwe Victoria Sineli, who planted the seed of education in me before they departed to be with our Lord.

To my husband, Khetani Solly Bila, and our children, Vangi, Khulu, Siya, and Bonga, your support and encouragement are what sustained me. I pray that you receive the good Lord's blessing in abundance.

ACKNOWLEDGEMENTS

First and foremost, I thank my Father in Heaven, God Almighty, for giving me the wisdom to complete this project. The journey was long, but Ebenezer the Lord was with me. I will forever remain grateful.

I wish to express my sincere gratitude to the following people who made the completion of this project possible:

Dr CL Carbonatto, my promoter, for your guidance, dedicated support, and encouragement, thank you.

Prof A Lombard, my mentor! Thank you for your constant support.

Prof R Prinsloo, for your assistance and support.

Dr L Le Roux, for your support and encouragement.

Dr I Van der Walt, for your assistance, support, and encouragement.

Dr M Spies-Coetzee, for your assistance and support.

Dr M Kekana, for your support and encouragement.

Dr Apostle Mandla and Pastor Sarah Chawane, for your support and prayers.

Ms Jacqui Sommerville, for your assistance with the quantitative data analysis and support throughout this project.

Ms Liona Bodenstein for the statistical analysis.

Mrs Tseleng Makganye for your assistance and support.

Mrs Merriam Malivha-Maluleke, for your support throughout the often difficult years. You were there to support me whenever I felt overwhelmed and in need of encourgement.

Ms Ruth Maluleke, for your support and assistance during this project.

Mrs Sarah Lamola, for your support and encouragement.

Zone 4 cell group, for your prayers.

My friend, Nigel Bougard, for your encouragement and support.

My friend, Joyce Ndzuta, for your encouragement.

Mrs Johanna Thabathi , Department of Social Development, Provincial Office, thank you for your assistance.

My friend, Betty Maluleke, Manager of the Malamulele Welfare office, thank you for your support.

Mr Shadrack Muthala, Manager of the Thohoyandou Welfare office, thank you for your support.

Mr Reggy Ngobeni, thank you for your assistance and support.

Mrs Peggy Mulaudzi, thank you for your assistance and support.

Ms Nilia Raphulu, thank you for your assistance.

Ms Sue Bell for editing this thesis.

The clinical manager of Evuxakeni Hospital, your assistance is highly appreciated.

All my family and friends for their encouragement.

All participants and respondents of this study, thank you for your participation.

(Photo: Pixabay.com)

There is **hope** for people living with schizophrenia, and this is made possible by recovery-oriented mental health care.

DECLARATION

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I declare that this thesis is my own original work. The sources that were used were acknowledged and referenced in line with university requirements. I understand what plagiarism is, and I am aware of the university's policy in this regard.

- Date: 30 June 2017

TITLE OF THESIS:	A recovery-oriented social work programme in mental health care in a rural area of South Africa
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ABSTRACT

In order to advance mental health care services, there has been a shift from the biomedical model to recovery-oriented care. Recovery has been steadily gaining ground as a guiding principle for mental health services, and has progressed from the lived experiences of people who use such services (Care Services Improvement Partnership [CSIP], 2007:iv). This is based on the premise that everyone should be involved in mental health services, and given the opportunity to work together and integrate various skills and experiences (CSIP, 2007:iv). Nationally and internationally, there is an increasing interest in the concept of “recovery,” particularly in the field of mental health and psychiatry. Consequently, professional bodies, health care agencies, and governments have become increasingly interested in focusing on recovery as the guiding principle for mental health policy, practice, and service (Osborn, 2012:8).

This empirical study was conducted in Limpopo Province. The research sites were the Departments of Health and Social Development - Capricorn, Vhembe and Mopani Districts for the first phase. The second phase was conducted in the Vhembe and Mopani districts. The study followed a mixed-methods approach (qualitative and quantitative). The first phase was based on a qualitative approach, and the second phase on a quantitative approach. For the first phase, the participants included thirteen mental health care users (MHCUs) from Evuxakeni, Shiluvana and Hayani Hospitals. Five caregivers from Mapapila Village in Malamulele. Fourteen social workers from Capricorn, Vhembe and Mopani Districts and sixteen social workers from Malamulele, Hayani, Nkhensani, Evuxakeni, Shiluvana, Polokwane, and Seshego Hospitals. Lastly, eight social work managers from Malamulele, Giyani, Polokwane, Thohoyandou and the DSD provincial

office. For the second phase, thirty-seven social workers were trained using a pre-test of a preliminary intervention programme, and subsequently the post-test was administered. A mixed-methods approach was employed using the exploratory sequential mixed-methods design. An intervention research was implemented. A collective case study design was selected for the first phase (qualitative) and a one-group pre-test post-test design (pre-experimental design) was implemented as a pilot study (quantitative).

The qualitative findings and the literature review contributed to the development of a Collaborative Recovery-oriented Mental Health Care Programme (CROCMEHC). It was evident from the findings that MHCUs and caregivers have unmet needs and that social workers lacked knowledge in mental health care. Therefore, the findings from the first phase determined the content of the preliminary intervention programme. From the quantitative findings, it was concluded that the CROCMEHC programme will need to be refined; however, the results were promising for future development of this intervention programme. It is therefore recommended that the CROCMEHC programme be refined and its effectiveness improved. The CROCMEHC programme has the potential to capacitate social workers in mental health care, especially in the rural areas of South Africa.

KEY WORDS

Mental health
Recovery
Recovery-oriented care
Recovery-focused approach
Social work
Programme
Intervention programme
Caregiver
Mental health care users
Schizophrenia
Rural area

List of acronyms/ abbreviations

AASW:	Australian Association of Social Workers
ACT:	Assertive Community Treatment
AHP:	Advocates for Human Potential
AMHP:	Approved Mental Health Professional
APA:	American Psychiatric Association
ASSW:	Australian Association of Social Work
BFT:	Behavioural Family Therapy
BMC:	Baylor College of Medicine
CASW:	Canadian Association of Social Work
CEOs:	Chief Executive Officers
CMHS:	Community mental health services
CPA:	Care Programme Approach
CPD:	Continuing Professional Development
CQC:	Care Quality Commission
CSI:	Consumer/Survivor Initiative
CSIP:	Care Services Improvement Partnership
CSWE:	Council on Social Work Education
CT:	Cognitive therapy
CT-R:	Care, Treatment, and Rehabilitation
CT-R:	Recovery-oriented Cognitive Therapy
DALY'S:	Disability-adjusted Life-years
DOH:	Department of Health
DSD:	Department of Social Development
DSM:	Diagnostic and Statistical Manual of Mental Disorders
ECT:	Electro-convulsive Therapy
EPB:	Evidence-based Practice
EPPIC:	Early Psychosis Prevention and Intervention Centre
EST:	Ecological Systems Theory
EU:	European Union
FET:	Further Education & Training

IASSW:	International Association of Schools of Social Work
ICD:	International Statistical Classification of Diseases and related Health Problems
IFSW:	International Federation of Social Workers
IMR:	Illness Management
INDS:	Integrated National Strategy
ISDM:	Integrated Service Delivery Model
KEC:	Knowledge Exchange Centre
MHaPP:	Mental Health and Poverty Research Project Consortium
MHCC:	Mental Health Coordinating Council
MHCUs:	Mental Health Care Users
NAMI:	National Alliance on Mental Illness
NASW:	National Association of Social Workers
NDP:	National Development Plan
NDRP:	National Disability Rights Policy
NICE:	National Institute for Health and Care Excellence
NIHR:	National Institute of Health Research
NSW CAG:	NSW Consumer Advisory Group
OECD:	Organisation for Economic Cooperation and Development
PIE:	Person-in-environment
PORT:	Patient Outcomes Research
PREEF:	Peer Recovery Employment and Resilience
RCPsych:	Royal College of Psychiatrists
RDF:	Rural Development Framework
RHCs:	Rural Health Clinics
SA:	South Africa
SACSSP:	South African Council of Social Services Professions
SADAG:	South African Depression Anxiety Group
SAMHSA:	Substance Abuse and Mental Health Services Administration
SBP:	Strengths-based Perspective
SCIE:	Social Care Institute for Excellence

SDM:	Shared Decision Meaning
SES:	Socio-economic Status
SMI:	Serious Mental Illness
SNRI:	Serotonin-norepinephrine Uptake Inhibitors
SSRI:	Selective Serotonin Reuptake Inhibitors
SST:	Social Skills Training
TPHs:	Traditional Health Practitioners
UK:	United Kingdom
UNHRC:	United Nations Human Rights Commission
USA:	United States of America
WFMH:	World Federation for Mental Health
WHO:	World Health Organisation
WONCA:	World Organisation and Association of Family Doctors
WRAP:	Wellness Recovery Action Plan

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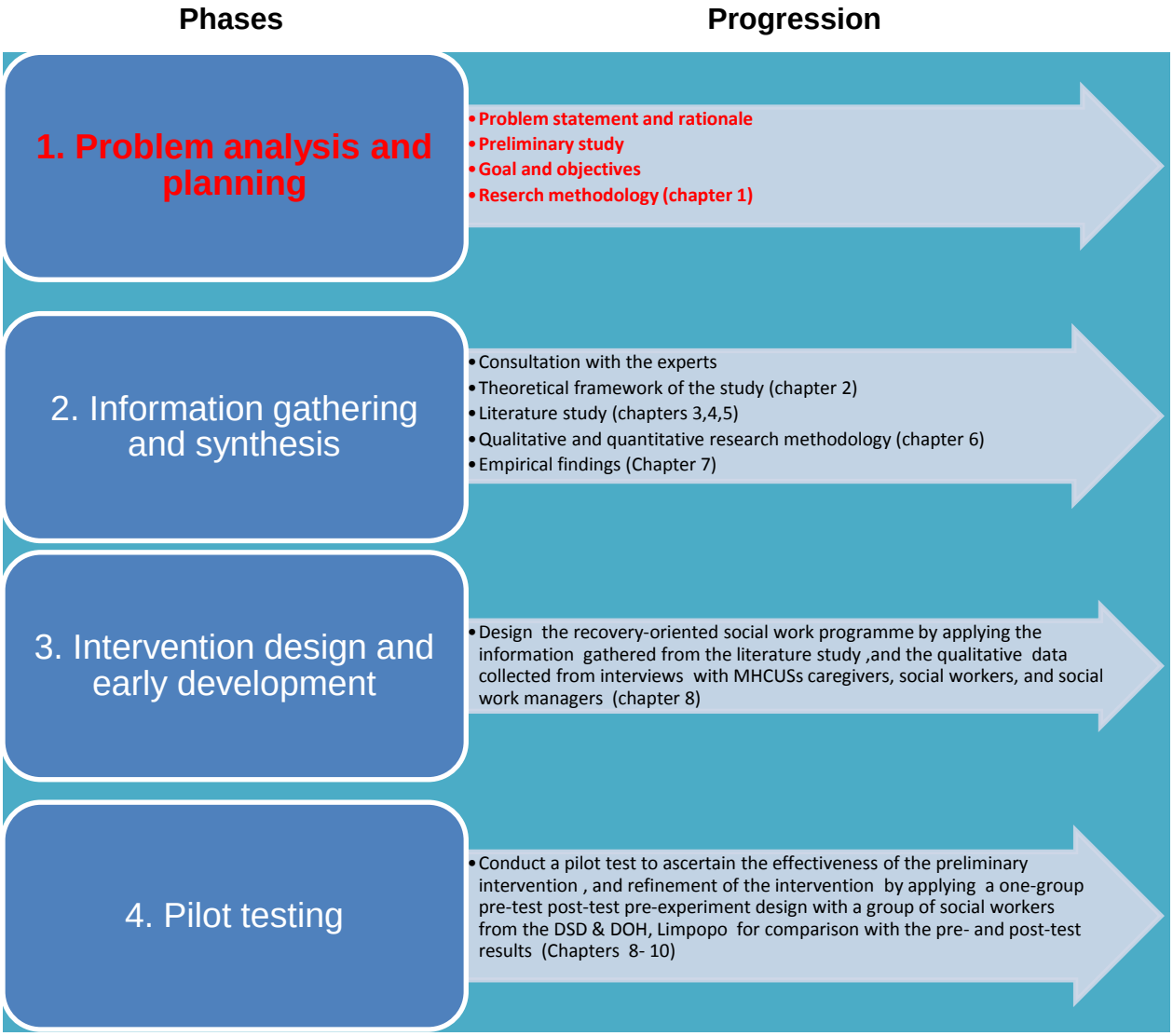
CHAPTER 1

BACKGROUND OF THE STUDY



Graphic representation of the phases of the intervention research: Adapted from Fraser and Galinsky (2010:463); De Vos (2011)

"I have recovered from schizophrenia. If that statement surprises you - if you think schizophrenia is a lifelong brain disease that cannot be escaped - you have been misled by a cultural misapprehension that needlessly imprisons millions under the label of mental illness" (Fisher, 2001).

1.1 Introduction

In recent years, the global context of mental health care has undergone significant transformation in recovery-oriented services, focusing on the wellbeing of mental health care users (MHCUs), and their families (Harrow, Grossman, Jobe & Herbener, 2005:723). Therefore, to meet this obligation many international state hospitals and community health centres have adopted recovery-oriented systems to guide their service delivery (Osborn, 2012:8). However, it is unclear whether these agencies (hospitals and community health centres) are creating new recovery-oriented treatment approaches or continuing with the existing traditional medical model approaches (Rogers, Norrell, Roll & Dyck, 2007:77). The definitions of traditional medical model, recovery, and recovery-oriented mental health practice are discussed below.

Traditional medical model approaches focus on the identification of symptoms, illnesses and pathologies, and the use of medicine (Osborn, 2012:9; Council on Social Work Education [CSWE], 2012; Substance Abuse and Mental Health Services Administration [SAMHSA], 2012:2), while recovery relates to "achieving a meaningful life in the midst (or absence) of illness, and encompasses the notions of purpose, taking responsibility, having a renewed sense of hope, having meaningful relationships, and making decisions about one's own treatment" (Randal, Stewart, Proverbs, Lampshire, Symes & Hamer, 2009:122). The following definition of recovery-oriented mental health practice was applied in the present study: "A recovery-orientation refers to a systemic approach to treatment, one that is embraced by clinicians, agencies, legislatures and clients. It necessitates a close relationship to empower clients toward goals of wellness and personal recovery beyond symptoms, illness and pathology. Programmes are person-centered and strengths-based by including the mental health care user in the design, plan, implementation, and evaluation of services; respecting the person's rights to make his or her own decisions about treatment goals and services, and acknowledging the

possibility of the person living a satisfying life beyond the disability" (Farkas, Gagne, Anthony & Chamberlin, 2005; Smith & Bartholomew, 2006).

It is interesting to note that there is no consensus on the definition of recovery and what constitutes recovery-oriented services (Liberman & Kopelowicz, 2005:739; Roe, Rudnick & Gill, 2007:171). However, several themes such as empowerment, hope, choice, self-defined goals, healing, wellbeing, and control of symptoms have emerged and offer clarity and insight into these phenomena (Osborn, 2012:9). Therefore, this chapter outlines the background of the study, rationale and problem statement, goal and objectives, overview of the research methodology, and content of the chapters.

1.2 Background

The recovery movement originated in the United States of America (USA) (Meehan, King, Beavis & Robinson, 2008:177) in the 1970s and 1980s when people suffering from mental illness began speaking and writing about their experiences of recovery (Ahern & Fisher, 2001:24; Carpenter, 2002:86). This can be traced to the psychiatric survivor movement (Deegan, 2003:373; Ellis & King, 2003:9) when people with psychiatric disabilities published their experiences of recovery (Mead & Copeland, 2000; Ridgway, 2001). However, those who had not experienced mental illness were excluded from consumer organisations, as consumers found that their radical views on mental illness were not shared by practitioners or the general public (Schiff, 2004:213).

Countries such as the USA, Australia, New Zealand, Canada, the United Kingdom (UK) and Ireland have implemented their recovery-oriented mental health practices (Shera & Ramon, 2013:17). These were deemed effective; however, a number of challenges were identified such as definitional clarity, stigma, availability of resources, policy and programme implementation, professional and consumer differences, and political will (Shera & Ramon, 2013:17). By contrast, countries such as South Africa (SA) have not yet implemented this practice. SA has been involved in the development of legislation and is a signatory to international treaties aimed at upholding and ensuring the human rights of people with mental illnesses. SA continues to fall short of meeting the needs of its citizens affected by mental illness (Burns, 2011:101). Mental health is not given the

priority it deserves; for example, Randfontein Life Esidimeni Psychiatric Hospital closed down in March 2016 due to a lack of funding and patients were transferred to Non-profit Organisations (NPOs). As a result, more than 100 MHCUs living with mental illness passed away while in the care of unlicensed non-governmental organisations in Gauteng Province (Thornycroft, 2016:1). The situation is worse in the rural areas of South Africa, where there is a severe lack of mental health services and human resources such as psychiatrists and psychologists.

The DSM-5 categorises different types of mental illness (APA, 2013). The present study focuses on schizophrenia as a category of severe mental illness (SMI). The researcher's motivation for studying this phenomenon was based on observation while working in the rural area of Limpopo Province where most referred cases of mental illness were MHCUs living with schizophrenia. Furthermore, literature indicates that people with schizophrenia can strive to achieve life goals similar to those of people without mental illness (Osborn, 2012:1).

Schizophrenia was initially characterised by Kraepelin as a progressively deteriorating illness with a poor outcome (Bellack, 2006:432). Nonetheless, this viewpoint was challenged by two perspectives, that people with schizophrenia could lead fulfilling lives by managing the symptoms of the illness (Rogers et al., 2007:77). The first was that personal stories of recovery provided initial evidence that people with schizophrenia can live productive lives despite their disabilities. The second was that recovery from mental illness was indeed possible. To validate these assertions, certain landmark studies were conducted in Vermont (Harding, Brooks, Ashikaga, Strauss & Breier, 1987:718-726; Harding et al., 1987:727-735). These studies revealed that 50% to 60% of people with schizophrenia significantly improved or recovered after an average of 32 years.

Historically, and currently in the global context, social work has been a major provider of mental health services, by some estimates delivering half the professional services provided to individuals with psychiatric conditions (CSWE, 2012:2). The social work profession "is a practice-based profession and an academic discipline that promotes social change and development, social cohesion, and the empowerment and liberation of people. Principles of social justice, human rights, collective responsibility and respect for

diversities are central to social work. Underpinned by theories of social work, social sciences, humanities and indigenous knowledge, social work engages people and structures to address life challenges and enhance wellbeing" (International Federation of Social Work (IFSW) & International Association of Schools of Social Work [IASSW], 2014).

Furthermore, Hyde, Bowles and Pawar (2014:11) assert that the profession has strong theoretical and historical ties to mental health recovery-oriented frameworks and it shares many of the same essential values, ethics, and practice perspectives. This, however, is not the case in SA. The findings of the present study revealed that some social workers were not involved in rendering services to MHCUs. In some instances, they reported that they were not capacitated to deal with cases of this nature. More details are captured in chapter 6.

Despite the strong alignment between recovery principles and those of the social work profession, social work voices have been noticeably absent from international recovery literature (Hyde et al., 2014:12). The absence of members of the social work profession during debates about recovery-oriented practice in mental health was brought to the fore by Slade, Amering, and Oades (2008:128).

Studies in the USA (Peebles, Mabe, Fenley, Buckley, Bruce, Narasimhan, Frinks & Williams, 2009:239-245) and Australia (Salgado, Dean, Crowe & Oades, 2010:243-248) provide some evidence that structured training in the critical components of recovery can increase both knowledge and pro-recovery attitudes. Training and implementation programmes may be more effective when integrating ideological and practical viewpoints to provide a comprehensive understanding of recovery and a basis for translating theory into practice (Gilburt, Slade, Bird, Oduola & Craig, 2013:8). Gilburt et al. (2013:6) assert that training can provide an important mechanism for instigating change and promoting recovery-orientated practice. Hence, appropriate programme development is illustrated in the present study.

The intention of the present study was to develop a programme on recovery-oriented mental health practice for social workers in the rural areas of SA. The programme

development was based on qualitative research conducted during the first phase, and literature review conducted in chapters 3, 4, and 5. The construct of the programme was based on the five developmental approach elements, namely rights of the individual, harmonising social and economic policies, participation and democracy, collaborative partnership, and bridging the micro/macro divide (Department of Social Development [DSD]), 2013). The researcher has adopted the stance that social work services should be based on social transformation, human emancipation, reconciliation and healing, and the reconstruction and development of society (DSD, 2013). Therefore, the title of the programme was abbreviated to CROCMEHC, meaning "Collaborative Recovery-Oriented Mental Health Care." It should be noted that CROCMEHC is not an acronym, it is a designated title of the programme. The programme details are captured in chapter 8. An intervention research was employed in the study at hand. Furthermore, ecological systems theory and the strengths-based perspective guided the present study. The theoretical stance is discussed in more depth in chapter 2 – the present study was conducted in Limpopo Province, a rural area of South Africa, from September 2015 to August 2016. The research sample was taken from social workers, managers, MHCUs, and caregivers for the qualitative approach and the preliminary programme developed was piloted with a group of social workers.

The researcher discusses the key concepts of the present study as follows:

1.3 Definitions of key concepts

- **Mental health:** "A state of well-being in which the individual realises his or her own abilities, can cope with normal stresses of life, can work productively and fruitfully and is able to make a contribution to his or her community" (WHO, 2001). For the purpose of this study mental health refers to the ability to function optimally, be able to manage stressful situations and make a valuable contribution to society.

- **Recovery:** It can firstly "be considered as a spontaneous and natural event. Some individuals who meet diagnostic criteria overcome their problems without intervention." Secondly, recovery "is the intended consequence of the skilful use of the full range of effective treatments." Thirdly, "the experience of personal

recovery can occur in the context of continuing symptoms or disabilities" (CSIP, 2007:2). The focus of the present study was on the third principle of recovery, which is fundamentally about the recovery of hope and ambition in order to live independently and purposefully despite mental health problems.

- **Recovery-oriented care:** The term is used interchangeably with the recovery-focused approach in the literature. The recovery-focused approach to mental health "aims at supporting people to build and maintain a self-defined and self-determined meaningful and satisfying life, regardless of whether or not there are ongoing symptoms of mental illness" (Shepherd, Boardman & Slade, 2008:3). Thus, a recovery-focused approach represents a movement away from a primary biomedical view of mental illness to a holistic approach to wellbeing focusing on individual strengths (Davidson, 2008:1). For the purpose of this study, recovery-oriented care refers to assistance of mental health care users (MHCUs) to take charge of their lives regardless of their mental health conditions.

- **Recovery-oriented mental health practice:** "A recovery-orientation refers to a systemic approach to treatment, one that is embraced by clinicians, agencies, legislatures and clients" (Farkas, Gagne, Anthony & Chamberlin, 2005:1). In this study, recovery-oriented mental health practice refers to facilitation of a collaborative systemic approach to the service provision of MHCUs. The MHCUs, caregivers, and mental health care practitioners work together in the provision of MHCUs treatment.

- **Rural areas:** Currently there is no formally agreed and accepted definition of "rural" within SA. The Rural Development Framework (RDF) (1997) defines rural areas as "sparsely populated areas in which people farm or depend on natural resources, including the villages and small towns that are dispersed throughout these areas". In this study rural areas is a remote area with limited resources.

- The **social work profession** "is a practice-based profession and an academic discipline that promotes social change and development, social cohesion, and the empowerment and liberation of people. Principles of social justice, human rights,

collective responsibility and respect for diversities are central to social work. Underpinned by theories of social work, social sciences, humanities and indigenous knowledge, social work engages people and structures to address life challenges and enhance wellbeing" (IFSW, 2014). For the purpose of this study, the social work profession refers to the caring profession that emancipate and empower the vulnerable groups and respecting the different values and beliefs of clients they serve.

- **Programme** is defined by Krysik and Finn (2013:112) "as a plan or guideline about what is to be done, it is a series of activities designed to reach precise objectives and to produce change at systems level." Programme in this study refers to the developed events with an aim to yield transformation in different dimensions of life.

- **Intervention programme** is described as a "service offered by social workers aiming on making a difference in the lives of service users" (Beckett, 2010:66). in this study, intervention programme refers to the involvement of social workers in changing service users' lives.

- **Caregiver**. The WHO (2003) defines a caregiver as "A person who provides support and assistance, formal or informal, with various activities to persons with disabilities or long-term conditions, or persons who are elderly. This person may provide emotional or financial support, as well as hands-on help with different tasks. Caregiving may also be done from long distance." Caregiver in this study is a person who assist people in need of care with different tasks that they cannot perform.

- **Mental health care user**. The Mental Health Care Act (No 17 of 2002) defines a mental health care user "as a person receiving care, treatment and rehabilitation services or using rehabilitation services or using health services at a health establishment aimed at enhancing status of a user." (Department of Health, 2002). MHCU in this study refers to a person who has been diagnosed with a mental illness and therefore receives treatment in a mental health facility.

- **Schizophrenia**. Mayo (2016) defines Schizophrenia as “a severe brain disorder in which people interpret reality abnormally. Schizophrenia may result in some combination of hallucinations, delusions, and extremely disordered thinking and behavior.” For the purpose of this study, schizophrenia is a mental health condition that affects the brain and the person does not think and function rationally. However, in this study, schizophrenia is viewed as having a positive outlook and recovery is possible if the person adheres to the treatment.

1.4 Rationale and problem statement

Although work has been done to outline the essential services needed in a recovery-oriented system (Anthony, 2000:50), there has been no systematic empirical inquiry assessing barriers to the development of recovery-oriented interventions (Slade & Longden, 2015:285). There is a lack of examples that take into account the professional experiences of social workers and managers regarding recovery-oriented mental health practice (Le Boutillier, Chevalier, Lawrence, Leamy, Bird, Macpherson, William & Slade, 2015:3). Internationally, scholars are on a quest to establish the challenges experienced to implement recovery-oriented practice. The following challenges have been identified (Frost, Tirupati, Johnston, Turrell, Lewin, Sly & Conrad, 2017:3):

- Definitional clarity.
- Stigma.
- Resources.
- Policy and programme implementation.
- Professional and consumer differences.
- Political will.

In South Africa, there is a dearth of literature relating to recovery-oriented mental health practice; however, the National Mental Health Policy and Strategic Plan (2013-2020) alludes to the fact that mental health services should incorporate recovery-oriented principles (Department of Health, 2013). Therefore, the researcher is of the opinion that the present study is pertinent as it will investigate how far South Africa has progressed in the implementation of recovery-oriented mental health services.

The researcher has noted that there is a problem in practice with regard to social work in mental health care. The effects of deinstitutionalisation have affected the role of social workers dealing with mental health care. The number of specialised mental health care social workers has diminished following the closing of specialised institutions and a shift to community care (Francis, La Rosa & Sankaran, 2014:23). Francis et al. (2014:23) state that this has resulted in a diminished understanding of the role of social workers who deliver mental health care, particularly generalist social workers who currently have to render mental health services despite insufficient knowledge and training. The researcher has noted that this is the case in the rural areas of South Africa. Moreover, literature indicates that participation of social workers in recovery-oriented debates are absent, and few articles have been authored by social workers in this regard (Hyde et al., 2014:12). The invisibility/absence of the social work profession during debates of recovery-oriented mental health practice was brought to the fore by Slade, Amering, and Oades (2008). Similarly, Ramon (2009:1620) acknowledges that fewer social workers are at the forefront of recovery work. The articles that the researcher obtained, authored by social workers, are:

- Literature review on recovery (NSW Consumer Advisory Group & Mental Health Coordination Council, 2009).
- Service providers' experiences and perspectives on recovery-oriented mental health system reform (Piat & Lal, 2012).
- Recovery-oriented mental health practice: A social work perspective (Khoury, 2015).

All these articles had been written in an international context. The researcher could not find any articles written by South African social workers and identified a gap in this field of research. Her interest in undertaking the present study was inspired by her experience working in a district hospital, which was located in a rural area of Limpopo Province. She was concerned about the quality of mental health services and how hospital staff, traditional healers, and society treated people with mental health problems (The National Rural Health Alliance, 2009:1). The researcher's motivation to undertake the present study was based on her exposure to recovery-oriented mental health literature, which she

accessed when preparing lectures for third year student social workers at a tertiary institution.

The researcher is currently employed at a tertiary institution as a lecturer. She has struggled to find literature based on rural social work and social work in mental health, especially on recovery-oriented practice in SA. The research that has been conducted is focused on mental health users' human rights (Burns, 2011:109). Another research project focused on people who were discharged from hospital into the care of their families, who had not received any supporting services, and the excessive burden this placed on these families (Kritzinger & Magaqa, 2000:296).

Moreover, a study conducted in Ireland on recovery was directed at theory development of the recovery approach (Kartalova-O'Doherty, 2010:10). Other studies that were also conducted in an international context are:

- Recovery-oriented mental health practice: a social work perspective (Khoury, 2015).
- Promoting recovery practice in mental health service: a quasi-experimental mixed-methods study (Gilburt et al., 2013).
- Service providers' experiences and perspectives on recovery-oriented mental health system reform (Piat, 2012).

Based on all these assertions, the present study is deemed pertinent because there are clearly gaps in the knowledge related to whether or not social work services in mental health care are rendered in a manner that promotes and supports the recovery process for individuals and families living with mental health disorders. Are social workers trained in mental health and do they have knowledge and an understanding of what recovery-oriented mental health practice entails? Therefore, the researcher holds the view that if a social work recovery-oriented programme is designed, this might benefit social workers in practice as well as student social workers. This programme might fill the gap in recovery-oriented practice in the field of social work in SA. The voices of social workers in recovery-oriented practice might be heard if the present study is published.

Furthermore, the study at hand might contribute to current debates on recovery-oriented mental health practice, focusing on the social work perspective.

1.5 Research question

The main research questions were formulated as follows:

- Will social workers trained in the recovery model of intervention be more empowered to render recovery-oriented intervention to MHCUs in rural areas?
- Can social workers make a paradigm shift in their intervention approach after undergoing training in recovery-oriented practice?

The following sub-questions informed the main research question:

- What is the state of mental health care services in rural SA?
- What are the current treatment practices utilised for MHCUs in rural SA?
- What are the current mental health care intervention practices used by social workers in rural areas?
- What is the nature of care that MHCUs receive in rural areas?
- What are the needs of MHCUs and their caregivers in rural areas regarding mental health care?

1.6 Hypothesis of the study

Hypothesis

- If social workers participate in a recovery-oriented intervention programme developed in this study, their level of knowledge will improve in rendering mental health services to mental health care users and their caregivers in rural areas of South Africa.

Sub-hypothesis

- A social work intervention programme based on recovery-oriented mental health will increase the knowledge of social workers in rendering mental health services to mental health care users and their caregivers in the rural areas of South Africa.

1.7 Aim and objectives of the study

1.7.1 Aim

The aim of the present study was to develop, implement, and evaluate a social work intervention programme aimed at recovery-oriented mental health practice in rural areas.

1.7.2 Objectives

Phase 1:

- To explore and discuss mental health services and policies from international, regional, and national perspectives.
- To explore the challenges of MHCUs regarding mental health care services in rural SA.
- To gather information from MHCUs and caregivers regarding their needs in mental health care in rural areas.
    - To gather information from social workers and social work managers in the districts, the hospitals and the provincial offices of the Departments of Health and Social Development about the current practice of mental health care in rural areas.

Phase 2:

- To design a recovery-oriented social work programme based on the needs identified in the first phase.
- To conduct a pre-test measurement with social workers regarding their knowledge of mental health and the recovery-oriented model.
- To implement the recovery-oriented social work programme through the training of social workers during a one-day training course.

- To conduct a post-test measurement with social workers regarding their knowledge of mental health and the recovery-oriented model after completion of the training.
- To analyse the effectiveness of the programme by comparing the pre-test and post-test results aimed at improving the knowledge of social workers based on mental health and the recovery-oriented model.
- To make practice recommendations for the broader utilisation of the recovery-oriented social work programme for MHCUs in rural areas.

1.8 Research methodology

Table 1.1 depicts a summary of the research methodology of this study.

Table 1.1: Research methodology – mixed methods

	Qualitative	Quantitative
Approach & purpose	- Problem analysis - Explorative - Need analysis - 1st component	- Analytical - 2nd component
Design	- Collective case study (hospitals in rural areas)	- One-group pre-test post-test pre-experimental
Type of research	- Applied - Intervention research (Rothman and Thomas steps)	- Applied
Sampling approach	- Non-probability	- Probability
Sampling method	- Purposive and snowball	- Simple random sampling
Data-gathering method	- Semi-structured interviews	- Group-administered questionnaire
Data-gathering instrument	- Interview schedule	- Questionnaire
Data analysis	- The multidimensionality of the qualitative data was reduced by using exploratory thematic analysis and narratives from interviews	- The quantitative data analysis consisted of the utilisation of descriptive statistical analysis and methods and inferential statistics using bivariate statistical formulas as suggested by the statistician, as well as applicable statistical tests

	Qualitative	Quantitative
Data presentation	- The display of qualitative data, involves describing pictorially the qualitative data. The researcher will utilise narratives, tables and literature to substantiate	- For the display of the quantitative data descriptive analysis of frequencies and percentages, as well as tables and graphs will be utilised

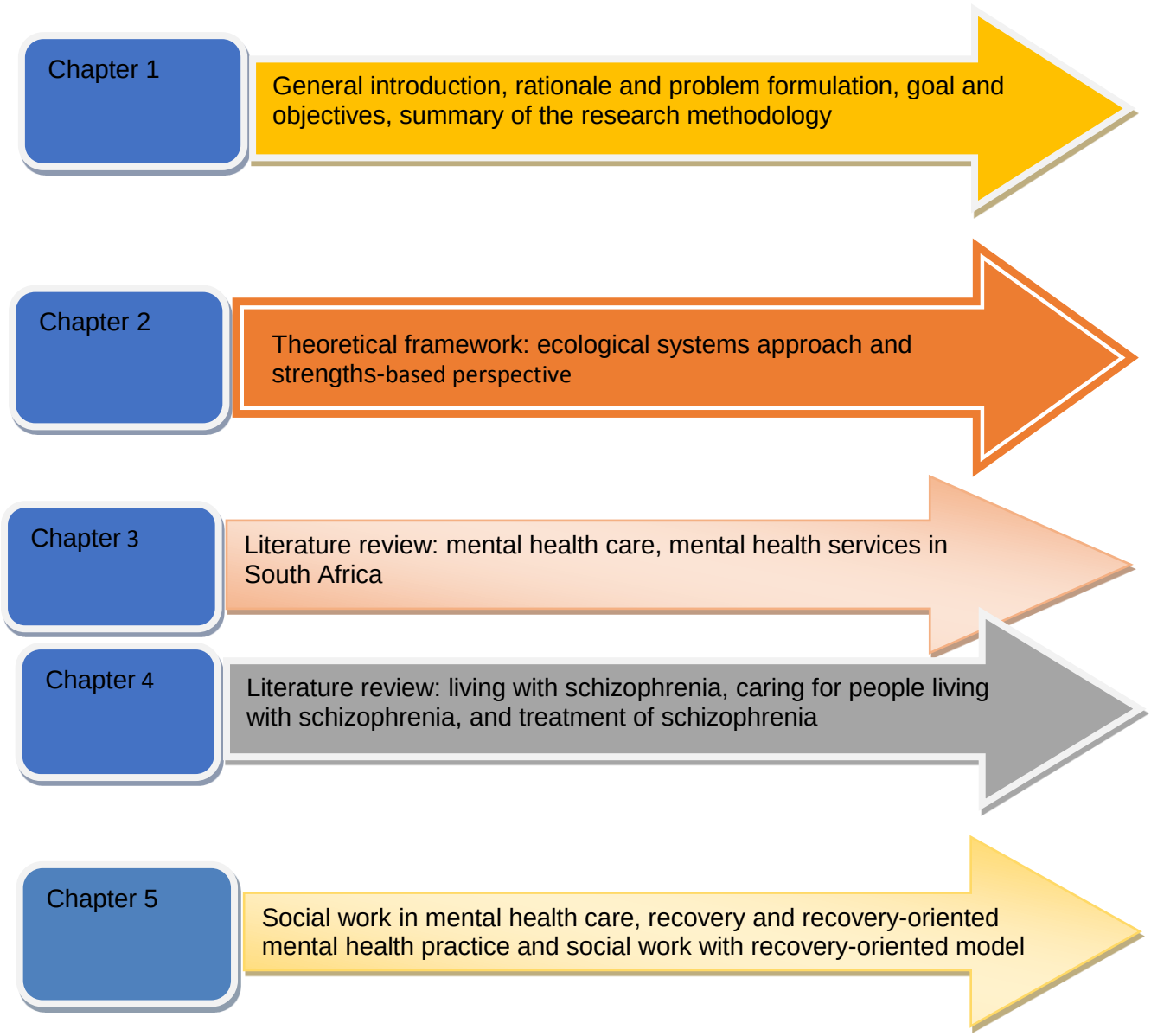
Adapted from Creswell (2013:266); Teddlie and Tashakkori (2010:1)

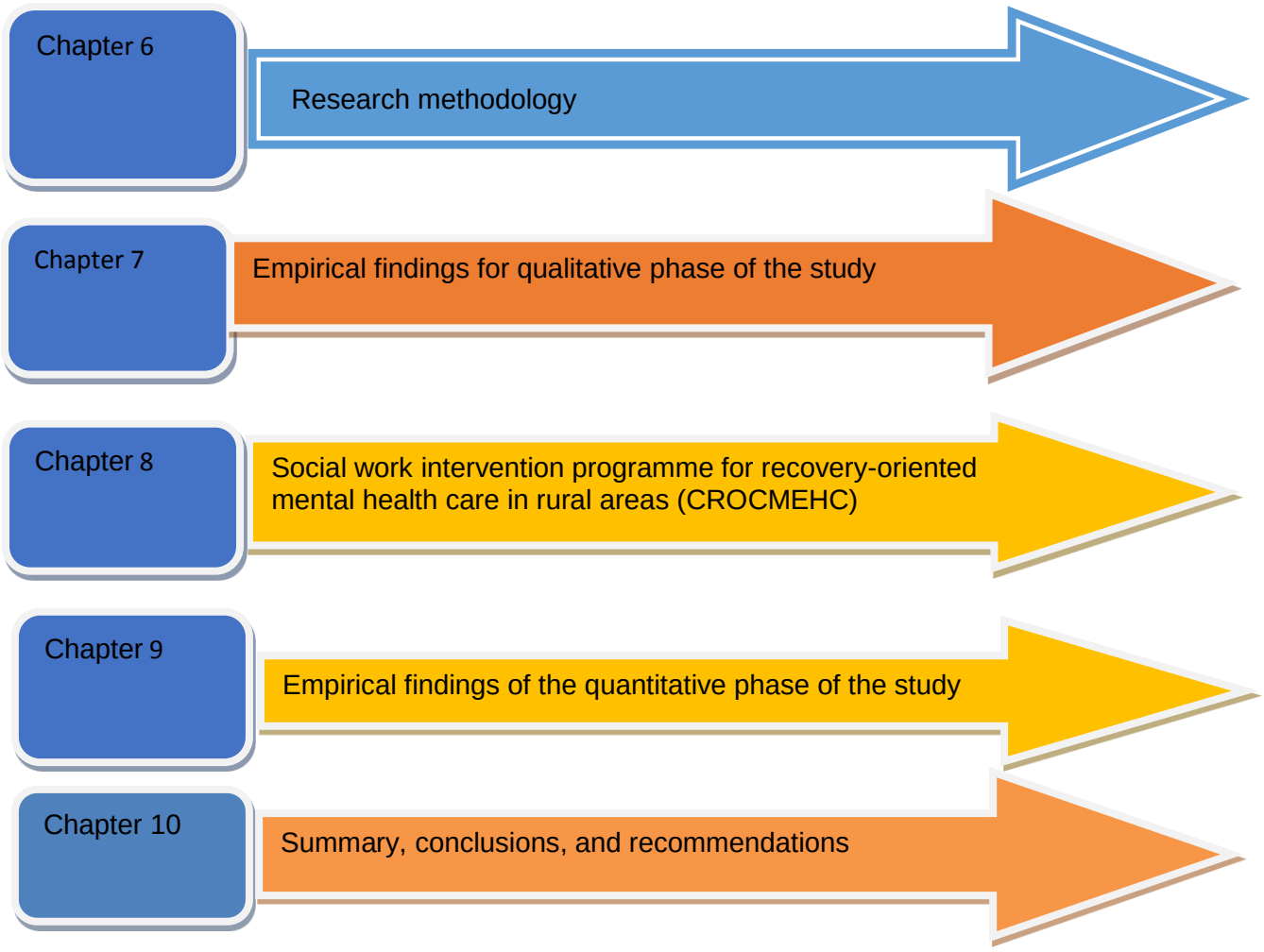
The researcher employed a mixed-methods approach (a combination of qualitative and quantitative) because this approach can concurrently address a range of confirmatory and exploratory questions, and provide the most viable explanations. The present study falls within the description of applied research. It was deemed appropriate as it dealt with problems in practice, namely a need for a social work recovery-oriented mental health programme for rural areas of South Africa. In the context of applied research, intervention research was appropriate for the study as it aimed to develop a programme for social workers in recovery-oriented metal health care practice for the rural areas of SA. An exploratory sequential mixed-methods design was utilised. For the first phase (qualitative approach), a collective case study research design was utilised which is a sub-type of a case study. The experimental design was employed as a quantitative research design in phase two of the study. In this case, a pre-experimental design was proposed and a one-group pre-test post-test design was deemed appropriate. The qualitative phase came first and this informed the second or quantitative phase.

The sample population in the first phase comprised five caregivers, thirteen mental health care users (MHCUs), fourteen social workers in the districts, sixteen social workers in the hospitals, and eight social work managers. The sample size in the first phase comprised fifty-six participants. Non-probability purposive sampling was used for social workers, social work managers, and mental health care users. Snowball sampling was used for caregivers. Semi-structured interviews were conducted as a data-collection method, using an interview schedule. Data for the first phase (qualitative) were analysed through thematic analysis. An independent coder was used to ensure trustworthiness of the data. A pilot study was conducted at Waterberg District where two participants were interviewed. The second phase was the quantitative approach, in Vhembe District accidental/convienient sampling was employed in order to supplement the number of the

attendees; some social workers who registered for the training and did not arrive. Thirty-seven respondents attended the one-day training at two separate districts, and completed the pre-and post-test questionnaires. The letters of informed consent were explained and signed; the pre-test was then administered before the training (intervention) commenced; the training was conducted and subsequently, the post-test was administered. The trustworthiness of the qualitative research was ensured, as were the validity and reliability of the quantitative research. The research methodology is discussed in detail in chapter 6.

1.9 Contents of the report

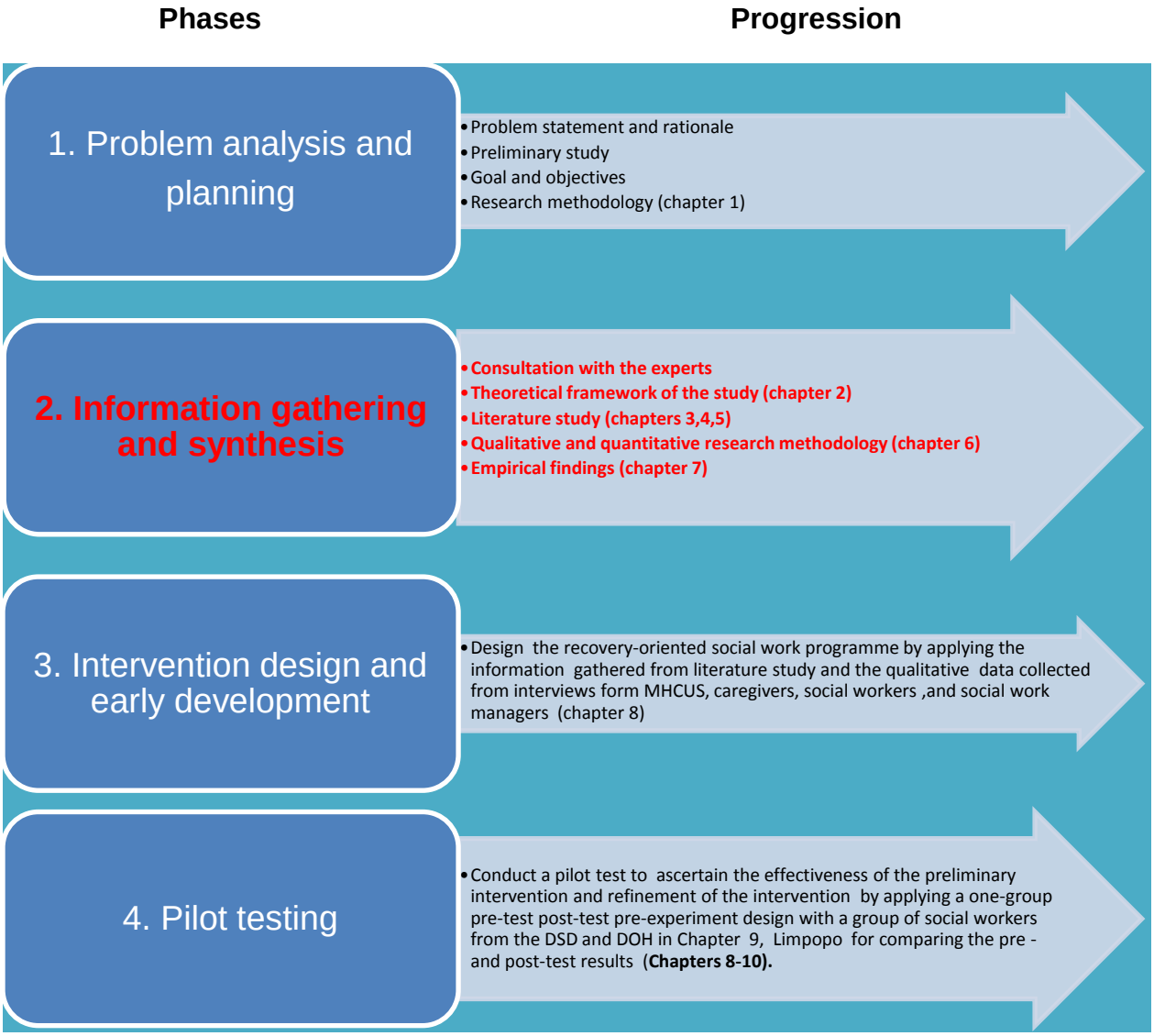




The next chapter focuses on the theoretical frameworks that guided this study.

CHAPTER 2

THEORETICAL FRAMEWORK FOR THE STUDY



Graphic representation of phases of the intervention research: Adapted from Fraser and Galinsky (2010:463); De Vos (2011)

2.1 Introduction

There are numerous theories which may be employed to underpin and explain recovery-oriented mental health care. In the present study, ecological systems theory (renamed bioecological model) will be utilised throughout. Ecological systems theory (EST) and the strengths-based perspective (SBP) were deemed appropriate for the study as they provided the analytical tools and a lens through which the study was approached, which the researcher could personally identify with. She is confident that MHCUs have the potential to recover and that they are competent to take full control of their lives provided they are empowered and capacitated to do so. The researcher believes that the environment can be adjusted to suit the needs of MHCUs.

Greene (2009:200) asserts that the core focus of ecological systems theory is "… how individuals adapt to environmental demands, it focuses on how an individual's needs, capacities and opportunities for both growth and the individual's ability to adapt to changing external demands are met, provided for and challenged by environment." It is assumed that "an individual human agency has a capacity to overcome external environmental obstacles when in reality the individuals may have little ability to exercise their will especially in response to institutional oppression" (Greene, 2009:206). This assertion is relevant to what is happening to mental health care users (MHCUs); most of the time they are viewed as incompetent and are not afforded an opportunity to make decisions about what they want in their lives.

Rangan (2006:2) states that "the strengths perspective attempts to understand MHCUs in terms of their strengths." This involves systematically examining survival skills, abilities, knowledge, resources and desires that can be used in some way to help meet client goals. The major focus in practice from a strengths-based perspective is collaboration between social workers and clients. This perspective has similar tenets to recovery-oriented mental health care that is to develop or strengthen independent thinking, problem solving and self-advocacy skills, and to assume responsibility for personal decisions of MHCUs (Gardner, 2000:6). This chapter presents each of these theories, focusing on the evolution, principles, and relevance to the study. The first theory to be discussed is the ecological systems theory; and subsequently the strengths-based perspective.

2.2 Ecological systems theory

Bronfenbrenner's ecological paradigm was first introduced in the 1970s (Bronfenbrenner, 1994). Bronfenbrenner (1994:1) and Turner (2005:111) argue that it is critical to gain a full understanding of human development and how growth happens, and that it is essential to focus on the ecological system in its entirety. Furthermore, Greene (2009:208) is of the opinion that the interface between an individual and the environment sometimes yields unfavourable life conditions. To Bronfenbrenner, people are active role players in their development, and the way they view their environment is often vital in understanding their environmental settings (Rogers, 2013:10). Härkönen (2007:1) asserts that "Bronfenbrenner did not create his theory out of nothing. He has transformed Kurt Lewin's human behaviour formula to suit straight development description needs."

Härkönen (2007:1) affirms that Bronfenbrenner is respected as one of the pioneers of the ecological systems theory in the field of developmental psychology; he has developed five interrelated systems, namely the micro-, messo-, exo-, macro-, and chronosystems. The author further highlights that Bronfenbrenner's ecological systems theory emphasises the value and setting of the person-in-environment. Paquette and Ryan (2001:1) concur with Bronfenbrenner that as human beings develop their interface with the environment occurs in a complex way as the physical and cognitive structures of an individual grow and mature. Moreover, Härkönen, (2007:1) perceives Brofenbrenner's theory as valuable in explaining human socialisation.

According to Pardeck (2015:133), Mary Richmond was the pioneer in the field of social work and realised the role that environment plays in the social functioning of human beings. Subsequently, in the early 1970s when social work theorists began stressing the importance of the person-in-environment perspective, little was actually being added to the traditional social work knowledge base. However, during this period, writers such as Germain (1973) and Hartman (1976), through the person-in-environment perspective, developed the groundwork for the ecological approach currently applied in the field of social work. However, their contribution had limitations as they did not provide the guidelines on how the approach could be applied in the assessment and treatment of MHCUs (Pardeck, 2015:133).

The researcher has observed in practice that living with schizophrenia is associated with stigma and discrimination, and that certain environmental factors do not facilitate the recovery process. Therefore, this theory proved to be very useful in the present study as it facilitated an understanding of how people living with schizophrenia are perceived and treated, and also how a recovery-oriented mental health practice can be applied in order to facilitate a perfect fit for mental health care users within their environment. Furthermore, the researcher has realised that rural areas and urban areas have different landscapes of mental health services and that environmental factors would consequently affect the MHCUs differently. The core assumption of the theory is that people are dependent on the environment (Bronfenbrenner, 1979:22). This theory has different levels and the interface is between these levels. Therefore, the researcher deemed the theory appropriate. The theory facilitated a better understanding of how the different levels interact and affect the lives of people living with schizophrenia.

Based on these levels, the researcher gained a better understanding of the roles that an individual, family, community, and culture play in facilitating and supporting the recovery process. Relevant information pertaining to its 10 guiding principles was drawn from the work of SAMHSA (2011): “Individuals, families, and communities have strengths and resources that serve as a foundation for recovery. In addition, individuals have a personal responsibility for their own self-care and journeys of recovery. Individuals should be supported in speaking for themselves. Families and significant others have responsibilities to support their loved ones, especially for children and youth in recovery. Communities have responsibilities to provide opportunities and resources to address discrimination and to foster social inclusion and recovery. Individuals in recovery also have a social responsibility and should have the ability to join with peers to speak collectively about their strengths, needs, wants, desires, and aspirations.” The discussion below focuses on the evolution of ecological systems theory (EST).

2.2.1 The evolution of ecological systems theory in social work

Historically, social work differentiated itself from other helping professions through its dependence on ecological systems theory and the representation of the person-in-environment (Gray & Webber, 2013:175). These authors state that several social work theorists began to develop philosophies from the field of ecology into social work theory. Furthermore, they assert that one of the most influential theorists was Urie Bronfenbrenner on social work ecological systems theory. Brofenbrenner's ecological systems theory posited five types of nested systems, which are in constant interaction with one another and which together powerfully shape human development (Gray & Webber, 2013:176, Brofenbrenner, 1979:37). Wakefield (2013:139) asserts that social work has adopted these systems into three broad practice categories consisting of micro, messo, and macro levels of intervention. However, Jeno (2014:16) states that the ecological model focuses on interventions that occur not only with individuals but also within the context of their environments that are interdependent upon one another. Furthermore, Wakefield (2013:139) asserts that the social worker not only works with the individual but also intervenes with the family, culture, and social factors that impair the individual's functioning.

While perusing a number of reviews emanating from the past decade, Gitterman and Heller (2011) in Gray and Webber (2013:176) "recognised the importance of goodness-of-fit between people and their environments, which allows both reciprocally respond and adapt to one another. Ecological systems theory has shaped the emergence of what many have come to commonly call ecological social work" (Gray & Webber, 2013:177). In addition, the authors state that ecological systems theory ushered in a new integrative paradigm for a profession that has struggled for decades to conceptualise its obligation to both person and environment.

Moreover, Nash, Munford, and O'Dononghue (2005:37) state that the synthesis of ecological systems emerged from two pathways:

- In response to criticisms of the systems theory.
- The pursuit of a unifying conceptual framework practice.

The researcher is of the opinion that the ecological systems theory provides a holistic theoretical base for social workers in order to render effective interventions when assisting mental health care users (MHCUs). Furthermore, this theory is vital as an intervention strategy to improve the social functioning of MHCUs. This implies that social workers have a fundamental role to play in recovery-oriented mental health practice. An important aspect in this theory is that the MHCU has a role to play in shaping the environment. For example, the MHCU should take ownership of his or her recovery. The researcher has noted in practice that social workers in the rural areas of Limpopo are not actively engaged in assisting people living with schizophrenia. The researcher is of the opinion that if social workers were trained in the EST and if they apply this knowledge in practice, this may facilitate the recovery process of people living with schizophrenia (MHCUs).

2.2.2 Interrelated systems of ecological systems theory

As mentioned in the evolution section of the ecological systems theory, Brofenbrenner posits five nested systems or interrelated elements, namely micro-, meso-, exo-, macro- and chronosystems. Each system is discussed separately.

2.2.2.1 Microsystem

The microsystem is defined by Bronfenbrenner as “a pattern of activities, rules, and interpersonal relations experienced by a mental health care user in a given face-to-face setting with particular physical and material features, and containing other persons with distinctive characteristics of temperament, personality, [and] systems of belief” (Brofenbrenner,1994:40; Rogers, 2009:10). Essentially, the essence of an individual comprises the various characteristics of family, home, school, peer group, workplace, and environment (Rogers, 2009:10). In addition, the microsystem comprises a pattern of activities, roles, and interpersonal face-to-face relations in the immediate setting, such as the family (Greene, 2009:218). Nash et al. (2005:37) state that the microsystem is the smallest and most direct system that a person experiences, for example household, classroom, or office.

In the context of recovery-oriented mental health practice, recovery is an ongoing dynamic interactional process that occurs between a person's strengths, vulnerabilities, resources, and the environment (Adam & Grieder, 2005:18). It involves a personal journey of actively self-managing a psychiatric disorder while reclaiming, gaining, and maintaining a positive sense of self, role, and life beyond the mental health system, in spite of the challenges posed by a psychiatric disability (Adam & Grieder, 2005:18). Recovery involves learning to approach each day's challenges, to overcome disabilities, live independently, and to contribute to society (Adam & Grieder, 2005:19). Recovery is underpinned by a foundation based on hope, belief, personal power, respect, connections, and self-determination. Successfully transforming the mental health service delivery system rests on two principles:

- Services and treatments must be consumer and family centred, set to provide consumers' real and meaningful choices about treatment options and providers, and not oriented to the requirements of bureaucracies.
- Care must focus on increasing the consumer's ability to successfully cope with life's challenges, on facilitating recovery, and on building resilience, and not just on managing symptoms (Adam & Grieder, 2005:20).

2.2.2.2 Mesosystem

The mesosystem comprises the "linkages and processes taking place between two or more settings containing the person in recovery process" (Rogers, 2009:18). For example, this relates to the relationships established with and interconnections between home and school, school and the workplace (Rogers, 2009:18). In addition, Nash et al. (2005:37) state that the links between two or more microsystems, for example the links between home and school or home and work, are described as the mesosystem. Greene (2009:218) also concurs with this assertion by stating that the mesosystem encompasses the linkages and processes occurring between two or more settings such as school and the family.

In the context of recovery-oriented mental health practice, family support plays a major role in facilitating recovery of mental health care users. Caregivers have a vital role to

play in supporting the recovery of mental health care users. Caregivers have to make decisions when mental health care users relapse. Most of a person's recovery occurs at home; so family, friends, neighbours, local community, church, clubs, school or workplace have an important role to play. Recovery-oriented services can facilitate and nurture these connections so that people can gain the maximum benefit from these support systems (Commonwealth, 2013).

2.2.2.3 Exosystem

The exosystem comprises settings "that do not involve the mental health care user as an active participant, but in which events occur that affect, or are affected by, what happens in the setting containing the developing person" (Rogers, 2009:18). The exosystem encompasses the linkages and processes that occur between two or more settings, at least one of which does not ordinarily contain the person (Greene, 2009:218). Furthermore, Nash et al. (2005:37) state that forces external to the person account for the concept exosystem, which involves one or more settings that do not involve the mental health care user as a direct participant, but nonetheless have an influence, for example, on the spouse's workplace.

There are currently policies in place to deal with mental health issues such as the Mental Health Act (No 17 of 2002) (Department of Health, 2002). Despite these policy developments, mental health care continues to be neglected. The situation is worse in rural areas where the present study was conducted. In the context of recovery-oriented mental health practice, these policies are geared toward enhancing the social functioning of mental health care users. A recovery orientation in mental health has largely been championed and driven by people with lived experience together with their families, friends, and peers as well as the non-governmental community mental health sector's assistance in facilitating the process. However, mental health practitioners and policymakers have increasingly supported the calls for cultural change (Commonwealth, 2013). Recovery-oriented mental health practitioners adopt a recovery lens through which they determine whether their policy practice is consistent with the needs of individuals with psychiatric conditions, while also encouraging their MHCUs to advocate for themselves (CSWE, 2011).

2.2.2.4 Macrosystem

The macrosystem consists of the overarching micro- meso-, and exosystem characteristics of a given culture or subculture, with particular reference to the belief systems of bodies of knowledge, material, resources, customs, lifestyle, opportunity structures, hazards, and life course options that are embedded in each broader system (Brofenbrenner, 1994:40). On the other hand, Nash et al. (2005:37) state that the macrosystem encapsulates the wider social policy and sociocultural setting, and includes ideological, customary, and legal norms. These authors further state that this system influences all other levels of the environment. In South Africa (SA), culture plays a major role in understanding the causes of mental illness, especially schizophrenia. Traditional healing takes precedence over Western allopathic medicine. In the context of recovery-oriented mental health practice, the practical tools and guidance for service practitioners on how to provide culturally sensitive and responsive recovery-oriented services are provided. Recovery-oriented social workers appreciate the complexities of identity and the myriad ways in which psychiatric conditions intersect with other factors of diversity (CSWE, 2011).

2.2.2.5 Chronosystem

Brofenbrenner (1994:40) states that “a chronosystem encompasses change or consistency over time not only in the characteristics of a person, but also of the environment in which that person lives for example over the life course in family structure, socioeconomic status, employment, place of residence and the ability in everyday life.” It is noted that mental health care users are mostly unemployed and live in low socio-economic conditions. The recovery-oriented mental health practice promotes mental health care users to become empowered and integrated into the labour market or in rehabilitation centres.

The levels of the EST proved to be valuable in the present study. The researcher realised that relationships in the microsystem are bidirectional, and that interaction has an effect on how mental health care users are treated by others who are on the same level. On the other hand, the mesosystem includes the interaction between the mental health care

users' caregivers and the health system. Caregivers and mental health care practitioners work together in order to facilitate the MHCUs' recovery. The exosystem does not impact the mental health care user directly because, for example, a spouse's workplace does not allow absences from work to see to the needs of the MHCU. The researcher has noted that the macrosystem involves social policies, such as the Mental Health Care Act (No 17 of 2002) (Department, 2002), that are essential in providing guidance as to how MHCUs should be treated. Lastly, the chronosystem denotes a level that portrays the experiences of the MHCU over time.

The theoretical framework assisted the researcher to interpret the empirical findings of the study. In the context of the recovery-oriented mental health care, EST assisted the researcher to have a better understanding of how the recovery principles can be applied in practice. Moreover, it provided the researcher with a better understanding of the MHCU as the master of his or her destiny and taking responsibility of changing the environment. Furthermore, family caregivers, the community, and service providers should create an enabling environment for the recovery process.

2.2.3 Aim of ecological systems theory

The aim of ecological systems theory is to facilitate the restoration of the adaptive balance between the person and environment by reducing stress, enhancing coping mechanisms, or establishing stability (Nash et al., 2005:33). The Department of Health (2011) states that the aim of a recovery-oriented approach to mental health service delivery is to support people to build and maintain a (self-defined and self-determined) meaningful and satisfying life and personal identity, regardless of the often unremitting symptoms of mental illness. Thus, a recovery-oriented approach represents a move away from a primarily biomedical view of mental illness to a holistic approach, to wellbeing that builds on an individual's strengths.

2.2.4 Vision of ecological systems theory

The vision of ecological systems theory is to help social workers customise their intervention to the person's environment or the interaction between the two (Nash et al., 2005:33). The Department of Health (2011) indicates that the orientation of service

delivery toward recovery involves the need to focus on strong partnerships in decision making between people and providers. It also requires partnerships with people's significant others. In order to forge genuine partnerships, practitioners must do the work of listening closely to the experiences of the mental health care users and their caregivers. This necessary work can be very challenging, especially when the act of listening amounts to acknowledging people's distress associated with accessing services.

2.2.5 Principles of ecological systems theory

The principles of ecological systems theory (EST) have been adapted over time based on the research of various authors, for example, Greene (2009:210) and Payne (2014:184):

2.2.5.1 Relatedness

The concept of relatedness is an idea central to an ecological view of development. Relatedness is the ability to form human relationships or to connect with other people (Greene, 2009:210; Payne, 2014:184). Greene (2009:210) states that relatedness occurs in intimate primary groups such as family, and in less personal exchanges such as those among members of civic groups. In addition, relatedness is a critical aspect of human development. With regard to recovery-oriented mental health care, Davidson (2008:1) indicates that people do not recover in isolation; recovery is closely associated with being able to take on meaningful and satisfying social roles and participating in local communities on a basis of equality.

2.2.5.2 Efficacy

Payne (2014:185) states that efficacy is the confidence in the ability to cope. Greene (2009:211) indicates that when a MHCU begins to actively transact with his or her environment, he or she experiences a feeling of efficacy or the power to be effective. The Council on Social Work Education (CSWE, 2011) indicates that recovery refers to the process in which people are able to live, work, learn, and participate fully in their communities. For some individuals, recovery is the ability to live a fulfilling and productive life, despite a disability. For others, recovery implies the reduction or complete remission

of symptoms. Science has shown that hope plays an integral role in an individual's recovery.

2.2.5.3 Competence

From an ecological perspective, Greene (2009:211) states that competence or the ability to be effective in one's environment is achieved through a history of successful transactions with the environment. Continued activity, combined with consistent mutual caretaking, results in a lifelong pattern of effective relationships, the ability to make confident decisions, to trust one's judgement to achieve self-confidence, and to produce the desired effects on the environment (Greene, 2009:211). Moreover, the availability and purposive use of environmental resources and social support are integral concepts (Greene, 2009:211). Commonwealth of Australia (2010) indicates that recovery means gaining and retaining an understanding of ones abilities and disabilities, engagement in an active life personal autonomy, social identity, meaning and purpose in life, and a positive sense of self. The researcher is confident that when MHCUs are capacitated with skills, they will be able to perform their day-to-day activities. The recovery-oriented mental health practice encourages MHCUs to be responsible and develop mastery in their lives. Furthermore, the researcher is convinced that the vocational rehabilitation and social skills training can fast-track the recovery process.

2.2.5.4 Role

Roles do not solely denote set patterns of expected behaviours, but a pattern of reciprocal claims and obligations (Greene, 2009:211). A role perspective offers an understanding of the social dimensions of development. Role performance encompasses not only expectations about how a person in a given social position is to act toward others, but also how others are to act (Greene, 2009:211). It is asserted that role performance or social participation is strongly related to one's sense of self and self-esteem (Greene, 2009:211). Gardner (2000:5) indicates that the process of personal recovery involves challenging assumptions, and undoing and moving beyond traditional MHCU roles. Assumptions underlying traditional professional roles also undergo scrutiny and re-tooling in recovery-focused organisations. Shared power, risk, decision making, mutual respect,

negotiated agreements, reciprocal personal accountability, and adult-to-adult interactions are recognised as important elements of healing relationships. Slade (2009:5) asserts that recovery-oriented mental health care involves the acquisition of previous, modified, or new valued social roles. This often involves social roles, which have nothing to do with mental illness. Valued social roles provide the scaffolding for the emerging identity of the recovering person.

2.2.5.5 Niche and habitat

Habitat refers to "the person's physical and social setting within a cultural context" (Greene, 2009:212; Hepworth, Rooney, Rooney, Strom-Gottfried & Larsen, 2010:15). Niche also refers to "the individual's immediate environment or statuses occupied by members of the community" (Greene, 2009:212; O'Donoghue & Maidment, 2005:40). Ecological niches are regions in the environment that are particularly favourable or unfavourable to the development of individuals with certain personal characteristics (Kirst-Ashman, 2011:6). A niche is a means of understanding a process that occurs in the person-environment unit associated with that niche (Greene, 2009:212; Ryke, Strydom & Botha, 2008:22). Commonwealth of Australia (2010) indicate that recovery-oriented mental health practice involves sensitivity and respect for each individual, particularly for their values, beliefs, and culture. It challenges discrimination and stigma wherever it exists within mental health services or the broader community.

2.2.5.6 Adaptiveness

Adaptiveness is viewed as "a process involving an active exchange between a person-and-environment unit" (Greene, 2009:213). It is asserted that the person and the environment influence and respond to each other to achieve the best possible match or goodness-of-fit (Gitterman & Germain, 2008:54). This occurs when the pervasiveness of person-environment transactions are successful or adaptive (Greene, 2009:213; Rothery, 2008:104). From an ecological point of view, adaptive problems are not defined as pathological states, but rather reconceptualised as a mismatching of needs and coping capacities with environmental resources and support (Greene, 2009:213; O'Donogue & Maidment, 2005:39). In terms of adaptiveness, an ecological social work approach

focuses on the extent to which the environment is supportive or whether it is stress-producing (Greene, 2009:213).

Sheperd, Bordman, and Slade (2008:1) indicate that recovery is about building a meaningful and satisfying life, as defined by the person him- or herself, whether or not there are ongoing or recurring symptoms or problems. Recovery represents a movement away from pathology, illness, and symptoms to health, strengths, and wellness. Hope is central to recovery and can be enhanced when individuals actively control their lives (agency), and by seeing how others have found a way forward. The researcher is of the opinion that recovery is possible if facilitated by the environment. People living with schizophrenia deserve to be treated with respect and dignity. The researcher is convinced that they can fulfil a productive role if they are afforded the opportunity. Therefore, the role of social work in recovery-oriented mental health practice is to enhance recovery by facilitating an enabling a conducive environment.

2.2.6 Relevance of ecological systems theory to the study

The basic ecological ideas for social work as stipulated by Payne (2014:185) are:

- Integration and connectedness.
- The wisdom of natural things.
- The importance of becoming, to see what realist theory calls emergent properties, rather than only what exists.
- Maintaining diversity.
- Relationship in the community.

These ideas have similar tenets based on recovery-oriented principles, for example, recognition that recovery is not necessarily about cure but about having opportunities for making appropriate choices and living a meaningful, satisfying, and purposeful life as well as being a valued member of the community. Payne (2014:185) also posits what social work practice should focus on in relation to ecological systems theory, namely:

- Developing caring communities.

- Identifying and developing activities that benefit the common good.
- Promoting active partnerships.
- Building capacity in individuals and communities.
- Promoting decentralised and localised decision making and helping it to work.
- Promoting community health and social resilience.
- Promoting environmental as well as social justice.
- Reducing human ecological stress.
- Focusing on natural methods of healing and spirituality (Payne, 2014:185).

The Department of Health (2011) asserts that recovery-oriented practice emphasises hope, social inclusion, community participation, personal goal setting, and self-management. Literature on recovery-oriented practice promotes a coaching or partnership relationship between people, accessing mental health services and mental health professionals, according to which people with lived experience are considered experts on their lives and experiences while mental health professionals are considered experts on available treatment services (Department, 2011). Table 2.1 provides a guideline on how to apply ecological systems theory (EST).

Table 2.1: Application of ecological systems theory in practice

Phase	Helping process	Actions
Initial beginnings	Auspice: create an accepting and supportive service environment	▪ Demonstrate empathy in engaging with MHCU to express wishes and choices ▪ Describe service, agency and worker's role clearly. ▪ Counteract effects of MHCU group's experience of oppression.
	Modalities	Select individual, family, group, community work to the MHCU choice and type of life stressor.
	Methods	Select episodic, emergency, short-term, time-limited, and open-ended service.

Phase	Helping process	Actions
	Skills	Assess person-environment-fit: ▪ Background: basic individual and family data. ▪ Define life stressors. ▪ Identify MHCU expectations of worker and agency. ▪ MHCU's strengths and limitations. ▪ Physical environment.
Ongoing	Helping with stressful life transactions and traumatic events	▪ Enable by demonstrating being alongside MHCU. ▪ Explore and clarify issues by giving focus, direction, specifying issues, seeing patterns, offering hypotheses, encouraging reflection, and feedback. ▪ Mobilise strengths by identifying capacity, reassuring, offering hope. ▪ Guide by providing and correcting information, offering advice and discussion, defining tasks. ▪ Facilitating by identifying avoidance patterns, challenging false engagement, confronting inconsistencies.
	Helping with environmental stressors	▪ Identify role and structure of relevant social welfare agencies. ▪ Identify supportive networks. ▪ Explore effect of physical environment: appropriate personal space, change semi-fixed space, mitigate effects of fixed space. ▪ Coordinate and connect MHCUs with organisational resources; collaborate with MHCUs, mediate with organisations. ▪ Directive, assertive and persuasive interactions with organisations. ▪ Adversarial or advocacy interactions.
	Helping with family processes	▪ Identify functions provided by family; procreation and socialisation of children; shelter or protection of members, nurturing acceptance and self-realisation, connections to outside world.

Phase	Helping process	Actions
		▪ Join the family group: affirm positives, track different life stories; create therapeutic contexts in which family can make progress; monitor family's paradigm (world view and structure). ▪ Interact with family: reframe perceptions, assign home works; work on rituals and patterns of behaviour, offer reflections.
	Helping with group processes	▪ Identify group focuses: education, problem-solving specific behavioural change, carry out tasks, social purposes. ▪ Identify internal stressors, problems in a group formation, structural, and value system. ▪ Form groups: gain organisational support; identify composition and structure, recruitment. ▪ Offer support, identity needs for being different and separate; mediate between members.
	Reducing interpersonal stress between worker and MHCU	▪ Identify sources of stress: agency authority and sanctions, worker authority and power, worker's professional socialisation, social differences, struggles for interpersonal control, taboo content. ▪ Prepare effectively for likely issues; explore with interpersonal barriers openly.
Termination: ending	Auspice: organisational time and methods factors	Identify factors leading to/ending in agency policy, timescale, and appropriate use of methods.
	Relational factors	Changing MHCU-worker relationships; differences in MHCU or social worker's background.
	Phases	▪ Identify and respond to negative feelings about ending and avoidance of ending. ▪ Acknowledge sadness or pleasure at success; acknowledge release from responsibility of work.

Adapted from Germain & Gitterman (2008) cited in Payne (2014:203)

The three main phases proposed by Germain and Gitterman (1996) as cited by Payne (2014:203) provide useful examples of practice and skills that can be applied by an ecological social worker. The main aim of ecological systems theory in practice is to improve the fit between people and their environment by alleviating life stressors, increasing people's personal and social resources to enable them to use more and better coping strategies, and influencing environmental forces so that they respond to people's needs (Payne, 2014:203). In recovery-oriented mental practice, the CSWE (2011:18) maintains that the recovery process is "a search for a unique and positive sense of who the person is." It highlights the individualised and person-centred element, focuses on the individual, and also manifests in the knowledge that there is more than one path to recovery, that there is "no assumption that all individuals described as having the same mental disorders are alike in all important ways." The Department of Health (2011) indicates that mental health services promote principles of hope, self-determination, personal agency, social inclusion, and choice. A service environment, supportive of people's recovery, is one that sustains and communicates a culture of hope and optimism, and actively encourages people's recovery efforts. The physical, social, and cultural service environment inspires hope, optimism, and humanistic practices for all who participate in service provision.

2.2.7 Ecological systems and social work

Social work has sought innovative ways to conceptualise the relationship between the individual and the environment (Gray & Webber, 2013:179). These authors further state that ecological systems theory is relevant to social work as it provides a comprehensive, multidisciplinary and holistic framework within which the complex and interrelation elements of peoples' lives can be connected and understood. The theory embodies meaningful attempts to integrate the psychological and sociological dimensions of social work practice, and supports a conceptual shift from a static to a dynamic view of the environment (Gray & Webber, 2013:179). It is further asserted that social workers have always been concerned with the situational determinants of human functioning, but until the evolution of ecological systems theory, the profession found it easier, and often more expedient, to address personal functioning (Gray & Webber, 2013:179).

2.3 The strengths-based perspective

2.3.1 Introduction

Hirst, Lane, and Le Navenec (2011:1) assert that strength-based perspective generally conceptualise strengths in two distinct ways, namely:

(a) Assets, resources, and abilities that can be used to assist in helping an adult to continue to develop.

(b) Strength can be developed or enhanced.

Strengths are therefore used as building blocks for service planning and programme development. Consequently, changes in the availability of various assets, resources, and abilities for an individual can be viewed as a service delivery outcome (Hirst et al., 2011:1). The strengths-based perspective is viewed as compatible with the developmental approach because people's strengths are actively utilised to the benefit of their development (Geyer & Strydom, 2007:79). The researcher supports the assertion of Peterson, Park, and Seligman (2006:17-26) that people have innate strengths that can contribute to recovery. Petersen et al. (2006) conducted a large-scale, web-based, retrospective study where 1008 participants considered themselves to have experienced serious psychological problems or emotional difficulties. The findings revealed that recovery from psychological disorders was associated with greater character strengths. Chopra, Hamilton, Castle, Smith, Mileshkin, Deans, Wynne, Priag, Toomey and Wilson (2009:203) state that there are six key principles related to recovery-oriented mental health practice, namely:

- People with psychiatric disabilities can continue to learn, grow, and change.
- The focus is on individual strengths rather than deficits.
- The community is viewed as an oasis of resources, not as an obstacle.
- Interventions are based on MHCUs' self-determination.
- The case manager-MHCU relationship is primary and essential.
- The primary setting for contacts is in the community.

Davidson, Shahar, Lawless, Sells, and Tondora (2006:151) assert that mental health care approaches in a community setting have moved in the direction of encouraging people to cultivate their interests, and identify and build their own strengths to pursue their goals. Furthermore, policies, practice methods, and strategies have been created that identify and draw upon the strengths of individuals. Practitioners believe that consumers have strengths that can be utilised for their recovery, and that they can work with MHCUs to facilitate the use of these strengths (Davidson et al., 2006:163). The researcher has noted that strengths play a major role in facilitating the recovery process, and are one of the principles of recovery.

2.3.2 Evolution of the strengths-based perspective

The strengths-based perspective is a dramatic departure from conventional social work practice (Saleebey, 2006:1). Social work, as is the case in other helping professions, has not been immune to the difficulties caused by mental disease and disorder-based thinking. Social work has constructed much of its theory and practice around the supposition that MHCUs are mentally ill because they have deficits, problems, pathologies, and diseases; that they are in some way flawed or weak (Miley, O'Melia & DuBois, 2011:86). This orientation arises from a past mired in the conviction among social workers that all MHCUs are morally defective, poor, despised, and deviant (Saleebey, 2006:2). In the past few years, there has been an increasing interest in developing strengths-based perspective to practice, case management in particular, with a variety of MHCU groups such as the elderly, youth in trouble, people with addictions, people with chronic mental illness, even communities and schools (Saleebey, 2006:1). In addition, rapidly developing literature, inquiry, and practice methods in a variety of fields bear a striking similarity to strengths-based perspective – developmental resilience, healing and wellness, solution-focused therapy, an asset-based community, and narrative and story therapy (Saleebey, 2006:1).

Practising from a strengths orientation means that everything you do as a social worker will be predictable in some way in the process of helping to discover and embellish, and explore and exploit MHCUs' strengths and resources in the process of assisting them to achieve their goals and realise their dreams (Saleebey, 2006:1). In addition, Rangan

(2006:127) asserts that the strengths-based perspective endeavours to understand MHCUs in terms of their strengths, and this involves methodologically investigating survival skills, abilities, knowledge, resources, and desires that can be used in some way to help MHCUs meet their goals. Recovery-oriented mental health practice focuses more on the strengths rather than pathology or deficit. One of the principles of the recovery is strengths based.

2.3.3 Goals of the strengths-based perspective

The strengths perspective encompasses the following principles, adapted from Saleebey, (2006:11):

2.3.3.1 Empowerment

Saleebey (2006:11) states that central to empowerment practice is an understanding of this practice as a relationship expression and not a technique or instrument. It is further stated that empowering and restoring meaning to relationships facilitate trust in and acknowledgement of the purpose of this practice. Interactions are explored to determine their links to social structures and their interests, and MHCUs' lives are seen as unique in terms of meaning, even though they are collective or population based. Empowerment encompasses five concepts, as stipulated by Saleebey (2006:9):

- Collaborative partnerships with MHCUs and constituents.
- An emphasis on the expansion of MHCUs' strengths and capacities.
- A focus on both the individual or family and the environment.
- Assuming that MHCUs are active subjects and agents.
- Directing one's energies to the historically disenfranchised and oppressed.

Pursuing an empowerment agenda requires a deep conviction of the necessity of democracy (Saleebey, 2006:12; Rapp & Goscha, 2012:33). It requires social workers to address the tensions and conflicts inherent in institutions and people that downplay and limit the help offered by social workers to people who endeavour to free themselves from the restrictions that impede their recovery (Teater & Baldwin, 2012:54). The strengths-based perspective imposes a different attitude and commitment; the strengths of

individuals and communities are renewable, and they expand resources. The assets of individuals mostly lie embedded in a community of interest and involvement (Saleebey, 2006:12). Empowerment is also central in recovery-oriented mental health care. Slade (2009:19) states that empowerment emerges from agency beliefs and involves behaviour that impacts positively on peoples' lives. The traditional approach has been to view the person as the problem. The fundamental shift in a recovery perspective is to see the person as part of the solution. A recovery-oriented approach assumes individuals have the capacity to take responsibility for their lives. The researcher is convinced that if MHCUs are empowered, they will be able to take charge of their lives. In the context of recovery-oriented mental health, the researcher is of the opinion that empowerment can be facilitated by vocational rehabilitation and social skills training.

2.3.3.2 Membership

People need to be responsible and valued members of a community (Saleebey, 2006:12). The strengths orientation recognises that all those whom we serve are like ourselves; that members of a species are entitled to the dignity, respect, and responsibility that come with such membership (Saleebey, 2006:12). Too often social worker assistance provides no comfortable place or sense of belonging (Saleebey, 2006:12). Another meaning of membership is that "people must often group together to make their voices heard; get their needs met, to redress inequities and to reach their dreams" (Saleebey, 2006:12).

Membership is very critical in recovery-oriented mental health care practice. Rangan and Sekar (2006:133) stipulate that "the strengths approach ascribes that people need to be citizens – responsible and valued members in a viable group or community." This is not the case for MHCUs as they are sometimes not valued as human beings and are treated as outcasts in their families and their communities. They are deprived of their rights of belonging as they are excluded from many activities. They are sometimes viewed as incapable of taking responsibility of deciding what is worthy in their lives.

In South Africa, deinstitutionalisation has not been implemented appropriately. Consequently, most MHCUs are still committed to institutions. The integration of MHCUs in the family and community setting continues to be a challenge. MHCUs are not regarded

as members of their families or communities, and are treated as outcasts. Therefore, the researcher recommends that social workers facilitate the reintegration of MHCUs into their families and communities. The district social workers can be of assistance in this regard by facilitating reunification services.

2.3.3.3 Resilience

A growing body of inquiry and practice makes it clear that the rule, not the exception, in human affairs is that people do rebound from serious trouble, and that individuals and communities do surmount and overcome serious and troubling adversity (Saleebey, 2006:13). Resilience is not the cheerful disregard of one's difficult and traumatic life experiences, neither is it the naïve discounting of life's pain (Saleebey, 2002:13). It is rather the ability to bear up in spite of these ordeals and the damage that has been done. Emotional and physical scars bear witness to that (Saleebey, 2006:13). In spite of adversity, however, many individuals recognise their trials and tribulations as instructive. Resilience is a process which continues through meeting the demands and challenges of one's world, however difficult. In recovery-oriented mental health care, human beings are viewed as resilient (Rangan, 2006:134) and carry on in spite of critical factors which impugn their lives. The researcher is of the view that resilience is a prerequisite for the recovery process. Recovery does not translate into a cure; some days the MHCU will relapse or experience setbacks. Resilience is therefore required so that the person can rebound and recover.

2.3.3.4 Healing and wholeness

Healing implies both wholeness and the capacity of mind and body to regenerate and resist when faced with disorder, disease, and disruption (Saleebey, 2006:13). Healing requires a beneficent relationship between the individual and the broader social and physical environment (Saleebey, 2006:14). All human beings have an innate capacity for healing. This evolutionary legacy can of course be compromised by trauma, environmental toxins, bodily or mental disorganisation and, one should not forget, by some of our professional intervention philosophies and systems (Saleebey, 2006:14). Nevertheless, the bottom line is this: "If spontaneous healing occurs miraculously in one

human being, you can expect it occurs in another and another. Healing occurs when the healer and an individual make an alliance with or instigates the power of the organism to restore it. Healing and self-regeneration are intrinsic life support systems, always working and for most of us, most of the time, on call" (Saleebey, 2006:15).

The strengths-based perspective encourages healing by focusing the attention on individuals' attributes that promote health, instead of focusing on symptoms and pathologies that induce sickness (Xie, 2013:5). Mental health recovery is a personal journey of gaining an increasingly meaningful life despite the presence of mental illness (Young & Ensing, 1999:219). To recover, however, MHCUs have to be confident in their ability to recover from mental health conditions. The strengths-based perspective aligns itself with mental health recovery by focusing on a person's ability to embark upon a journey of mental health recovery (Xie, 2013:6). Attention is placed on people's abilities rather than their shortcomings, symptoms, or difficulties. Mental health issues are seen as a normal part of life (Shanley & Jubb-Shanley, 2007:347). MHCUs' positive attributes, including assets, aspirations, hopes, and interests, are elicited and cultivated. Gable and Haidt (2005:103) provide an understanding of the strengths that can help prevent or lessen the damage of disease, stress, and disorder.

2.3.3.5 Dialogue and collaboration

An individual's humanity can only come to the fore through a creative and emergent relationship with others. Without such transactions there can be no discovery and testing of one's powers; no knowledge, heightened awareness, and internal strengths (Saleebey, 2006:20). Through dialogue, social workers advocate the importance of other people, and begin their own healing process by working toward eliminating the rift between self, others, and institutions (Rangan & Sekar, 2006:133). Dialogue requires empathy and the inclusion of other people. "Loving dialogue can surmount the barrier of mistrust built from years of paternalism and the extensive suppression of the knowledge and wisdom of the oppressed" (Saleebey, 2006:21). Rangan and Sekar (2006:134) assert that "humility and faith dialogue becomes a horizontal relationship of which mutual trust between the dialoguers is the logical consequence" (Rangan & Sekar, 2006:134).

The researcher is of the opinion that collaboration is critical in the recovery process. MHCUs are involved in decision making in collaboration with mental health practitioners. In such therapeutic relationships, practitioners and MHCUs are equal partners. The MHCU's autonomy is recognised. MHCUs possess the strengths that will put them on the road to recovery; they take control of their lives, and their preferences are incorporated into therapeutic relationships. The practitioner serves as a partner who has the professional and technical knowledge to facilitate consumers' identification and utilisation of their strengths to progress towards recovery. This is confirmed by Xie (2013:6) that as in all partnerships, every party has a vested interest in helping the other succeed. MHCUs depend on the practitioners for technical advice while the opinions of the MHCUs help practitioners understand them better. Xie (2013:6) contends that the recovery of the MHCU reaffirms the efforts of the practitioners. The entire family and community may also be involved in the partnership, and they could be potential resources to support the recovery of consumers.

2.3.3.6 Suspension of disbelief

Within a culture of professionalism, it would be difficult to take at face value MHCUs' bizarre accounts of their experiences, which may clearly lack plausibility. On the other hand, because of its enduring values, social work may see itself as less culpable in this regard compared to other professions. A little circumspection is therefore warranted (Saleebey, 2006:25). Although it is a primary source of information, MHCUs' verbal reports are susceptible to error because of possibly faulty recall, distorted perceptions, biases, and limited self-awareness. It is thus vital to avoid the tendency to summarily accept MHCUs' views, descriptions, and reports as valid representations of reality. It is important to recognise that feelings expressed by MHCUs may emanate from faulty perceptions or may be altogether irrational (Rangan & Sekar, 2006:136).

The researcher is of the opinion that training of social workers, and knowledge of the DSM-5 in recognising and understanding the symptoms of schizophrenia, are critical (APA, 2013). It should be noted that recovery does not mean that MHCUs are cured from mental illness, but that they might relapse at times. Social workers should be confident that recovery is possible even if there is a manifestation of symptoms of schizophrenia.

Substance Abuse and mental Health Services Administration(SAMHSA) (2011) postulates that the belief that recovery is real provides the essential and motivating message of a better future – that people can and do overcome the internal and external challenges, barriers, and obstacles that confront them. Hope is internalised and can be fostered by peers, families, providers, allies, and others. Hope is the catalyst of the recovery process.

2.3.4 Principles of the strengths-based perspective

The principles set out follow constitute the guiding assumptions and regulating understanding of strengths (Saleebey, 2006:16-20):

- **Every individual, group, family, and community has strengths**

It is essential that social workers bear in mind that individuals, their families, and communities possess assets, resources, wisdom, and knowledge that could be tapped into. The strengths perspective is about discerning those resources, and respecting them and the potential they may have for reversing misfortune, countering illness, easing pain, and reaching goals.

- **Trauma and abuse, illness, and struggle may also be injurious but they may also be sources of challenge and opportunity**

There is dignity to be drawn from having prevailed over obstacles to one's growth and maturity. This is viewed as survivor's pride. It is a deep sense of accomplishment in having met and overcome life's challenges, albeit not without fear, and certainly not without wounds. Individuals are more likely to continue development and growth when they are funded by the currency of their capacities, knowledge, and skills. People are more motivated to change when their strengths are supported. The tendency to view people as victims leads to discouragement, pessimism, and the victim-mind-set.

- **Assume that you do not know the upper limits of the capacity to grow and change and take individual, group, and community aspirations seriously**

Frequently, practitioners assume that a diagnosis or profile sets a parameter of possibilities for their MHCUs. From the schizophrenic MHCU's viewpoint, practitioners themselves cannot possibly imagine being on this journey to an unanticipated, often frightening destination. Practitioners must hold high the expectations of these MHCUs and believe in their hopes, visions, and values. Recovery-oriented mental health practice views recovery as possible, that hope can be inspired, and that there are opportunities for people to be involved in meaningful activities within their communities. All people have inborn wisdom, intelligence, and motivating emotions; and through education, support, and encouragement these can be achieved. Individuals clearly have the capacity for restoration and rebound.

- **We best serve by collaborating with them**

The role of the practitioner may not provide the best vantage point from which to appreciate MHCUs' strengths and assets. This means that practitioners should not approach individuals as experts, but instead as collaborators or consultants. It should be acknowledged that even if practitioners have specialised education and experience, they are not the only people who have the tools to resolve the myriad problems MHCUs have to contend with. MHCUs also have solutions as they are intimately involved in the situation. Therefore, it is vital to connect with their stories, narratives, their hopes, and fears rather than trying to confine them to a diagnostic treatment protocol. In this instance, the role of advocacy is vital.

- **Every environment is full of resources**

There are various opportunities in the community that individuals can be involved in, and they can make valuable contributions. It should be understood that in every environment there are individuals, associations, groups, and institutions that have resources and knowledge that can be valuable. In most instances, these resources are underexploited.

There are five critical assumptions relating to this aspect (Saleebey, 2006:17):

(a) The community has the will and resources to help itself.

(b) It knows what is best for itself.

(c) Ownership of the strategy rests within rather than outside the community.

(d) Partnerships involving organisations and communities are the preferred route for initiatives.

(e) The use of strengths in one area will translate into strengths in other areas, creating a ripple effect.

- **Caring, caretaking, and context**

Care is essential to human wellbeing. It is stated that there are three rights to care:

(a) All families must be assisted in caring for their relatives.

(b) All those paid caregivers need to be able to give the support and quality care that is commensurate with the highest ideals of care without subverting their own wellbeing.

(c) A right to care boils down to this: that all people who need care, should get it.

Social work is about caretaking. Social caretaking and related activities are the profession's hidden voice. Similar to social caretaking and social work, the strengths perspective is about the revolutionary possibility of hope, and the researcher has noted that this is similar to the principles of recovery.

2.3.5 Relevance of strengths-based perspective to the study

Recovery has put the MHCU back into the equation of success (Moran & Russo-Netzer, 2016:273). Recovery is also an interactive process within a supportive environmental context (Laudet, 2013:126). The process of recovery from serious and persistent mental illness is currently at a promising stage, yet few areas of inquiry in the field have drawn as much interest and enthusiasm among consumers and professionals alike (Saleebey, 2006:247). The strengths-based practice models are predicated on the central premise that all people should have access to social resources. Therefore, professional services guided by a strengths model, principles, and practices are ideally positioned to advance the process of recovery (Saleebey, 2006:247). Professionals often serve as a bridge for MHCUs to advance the process of recovery.

While hope may be the core ingredient to the recovery process, the next step is perhaps the most crucial – translating this renewed optimism into action (Saleebey, 2006:26; Moran & Russo-Netzer, 2016:273). A critical ingredient of recovery is purpose, but the critical task for professionals is to help facilitate this sense of purpose in the lives of MHCUs (Saleebey, 2006:27). When the mission of mental health services is shaped by the vision of recovery professional practice, at all levels, will be informed by the principles of the strengths model. Once the professional-MHCU relationship in the process of recovery has been established, this interchange has the potential to engender hope. A foundation principle requires that practitioners believe deeply that MCHUs can continue to transcend the impact of serious mental illness, and recover (Saleebey, 2006:28). The small steps taken by the mentally ill must be celebrated, and the professional at the very least should be consumer focused, empathic, steadfast, genuine, and trustworthy (Saleebey, 2006:29).

2.3.6 Guidelines for strengths assessment

Assessment is a process of helping people define their situations (Saleebey, 2006:102). The guidelines presented are based on the concept that the knowledge guiding the assessment process is based on a socially constructed reality (Saleebey, 2006:102).

Table 2.2: Strengths assessment

Assessment	Process
Document the story	Allows MHCUs' ideas, thoughts and memories to be expressed in their own words.
Support and validate the story	Individuals know the depth and reality of what they have experienced in their life journeys. If the social worker respects their ownership, the story will be more fully shared.
Honour self-determination	MHCUs are experts of their own situations or stories. They need to have control over what information they contribute as well as the direction of the treatment process.

Assessment	Process
Give pre-eminence to the story	MHCUs' knowledge and lived experiences need to be of central importance in guiding the assessment process.
Discover what is needed	Involves MHCU's goals and is concerned with what one perceives to be a successful resolution to the problem situation.
Move the assessment towards strengths	Practising from the strengths perspective means believing that the strengths and resources to resolve difficult situations lie within the individual's interpersonal skills, motivation, emotional strengths, and ability to think clearly.
Discover uniqueness	Assessment must be individualised to understand the unique situation each person is experiencing.
Reach mutual agreement on assessment	The worker's role is to inquire, listen and assist the MHCU in discovering, clarifying, and articulating. The MHCU gives direction to the content of assessment.
Assess but do not be caught up in the labels	Labelling accompanied by reinforcement of identified behaviour is a sufficient condition for chronic mental illness.

Adapted from Saleebey (2006:103-105)

The researcher believes that recovery-oriented social workers should assess MHCUs' strengths and limitations from a holistic perspective that considers context, culture, and community norms alongside a clinical comprehension of psychiatric diagnoses. Social workers should have a critical understanding of the epidemiology of psychiatric diagnoses, the biopsychosocial causes of psychiatric conditions, and the role of culture in defining psychiatric diagnoses and responses. Recovery-oriented social workers are aware of the established disparities in mental health diagnoses that have significant effects on service users' course of treatment and treatment outcome. They are knowledgeable about the differences between strengths assessment and problem assessment, and they recognise the importance of attending to trauma during assessment, and take the appropriate steps to mitigate or eliminate any retraumatisation during the assessment process.

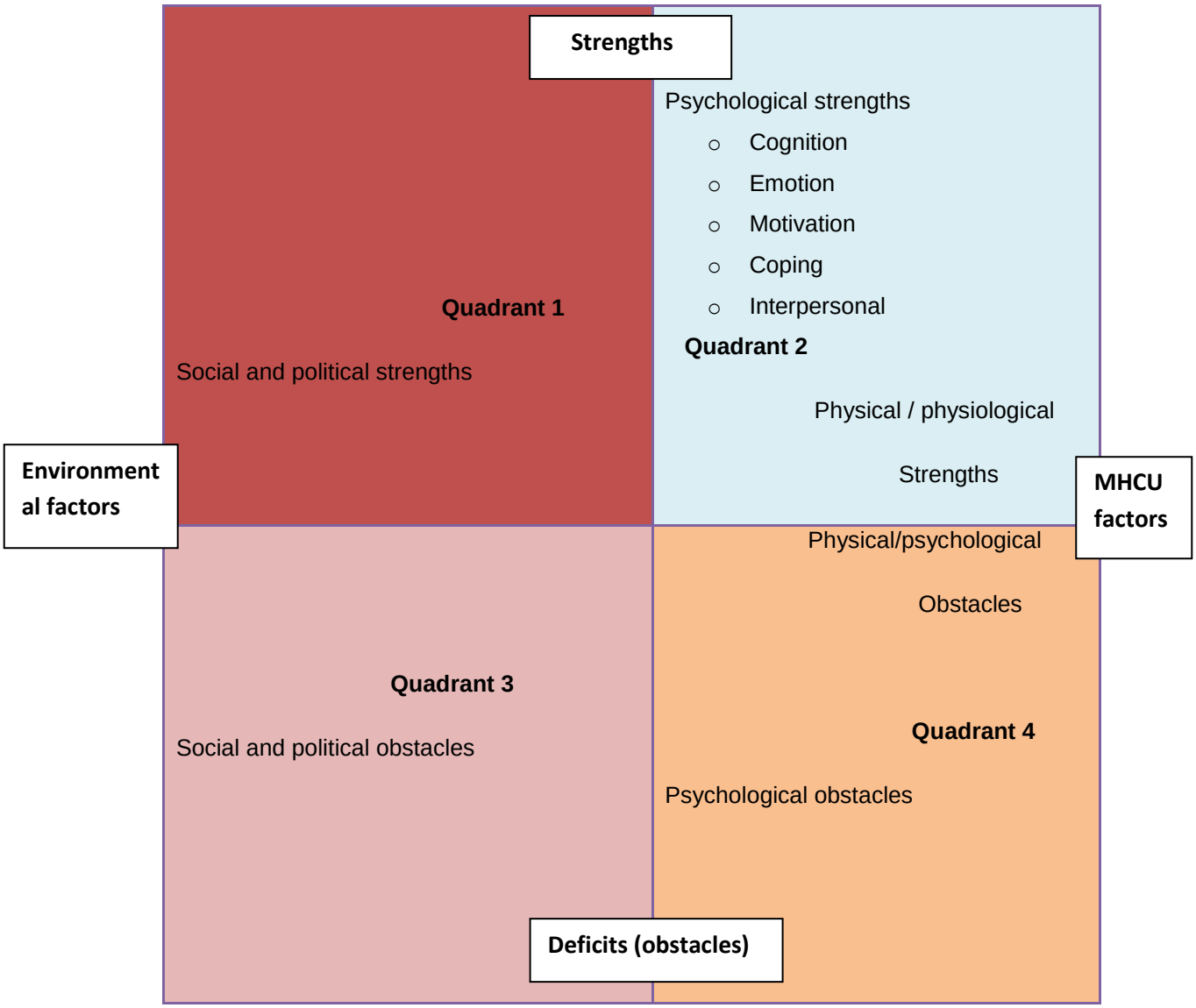


Figure 2.1: Framework for assessment: Adapted from Saleebey (2006:109)

The model proposed here revolves around two axes: the first axis is an environmental factor versus MHCU factors continuum; the second is the strengths versus deficits continuum. Each of the four quadrants represents important content of assessment (Saleebey, 2006:108). A comprehensive assessment would have something recorded in each quadrant. However, quadrants 1 and 2 are emphasised when practising within the strengths perspective. The framework and outline are proposed as a resource to assist social workers and MHCUs in considering those strengths and resilient capacities to be exploited in coping with the problem situation presented by individuals and families (Saleebey, 2006:110).

2.3.7 The strengths-based perspective and social work

The principle of the strengths-based perspective is a model largely hailed for its congruence with social work values (Saleebey, 2006:249). Empowerment can guide social workers as a concept, a way of thinking, a process, or a way of working. When social workers view their MHCUs from a strengths-based perspective so that they are able to see themselves beyond the masks of categorical grouping, they are able to suspend any negative judgement. They are able to discover and appreciate the unique and diverse possibilities that are inherent in all human beings (Saleebey, 2006:261). CSWE (2011:17) asserts that the social work strengths perspective itself is seen as an indicator of hope as it assumes the best of the consumer.

Individuals are experts on their lives: their strengths, resources, and capacities. The social worker, according to Saleebey (2006:250), helps to create the dialogue of strength. Intervention based on the strengths approach gives a perspective that individuals are already doing something to better their situation, and it is the social worker's responsibility to help the individual identify his or her strengths and continue working on their goals and visions (Rangan, 2006:128). Health care and human service professionals may employ a strength-based perspective in their work with MHCUs. While they do not clearly follow a particular model, they view and define MHCUs "by their values, strengths, hopes, aspirations, and capacities, regardless of the stressful or burdensome nature of the situation around them" (Peacock, Forbes, Markle-Reid, Hawranik, Morgan, Jansen, Leipert & Henderson, 2010:642).

This perspective directs social work services as they seek to balance problems with the strengths of MHCUs and their environments (Chapin & Cox, 2001:211; Rashid, 2009:23). This creates plans of care to fit individuals and families (Kivnick & Stoffel, 2005:345). Professionals may involve MHCUs in "strength chats" to identify their strengths, goals, and treatment plans. Thus, a strengths-based perspective is rooted in professionals' assessments, interventions, and evaluations of MHCUs' progress. In the context of the present study, strengths perspective is vitally important as recovery cannot occur if mental health care users' strengths are not assessed. The researcher assumes that the mental

health care users have talents, and social workers have to cultivate these talents in order to facilitate the mental health care users' recovery.

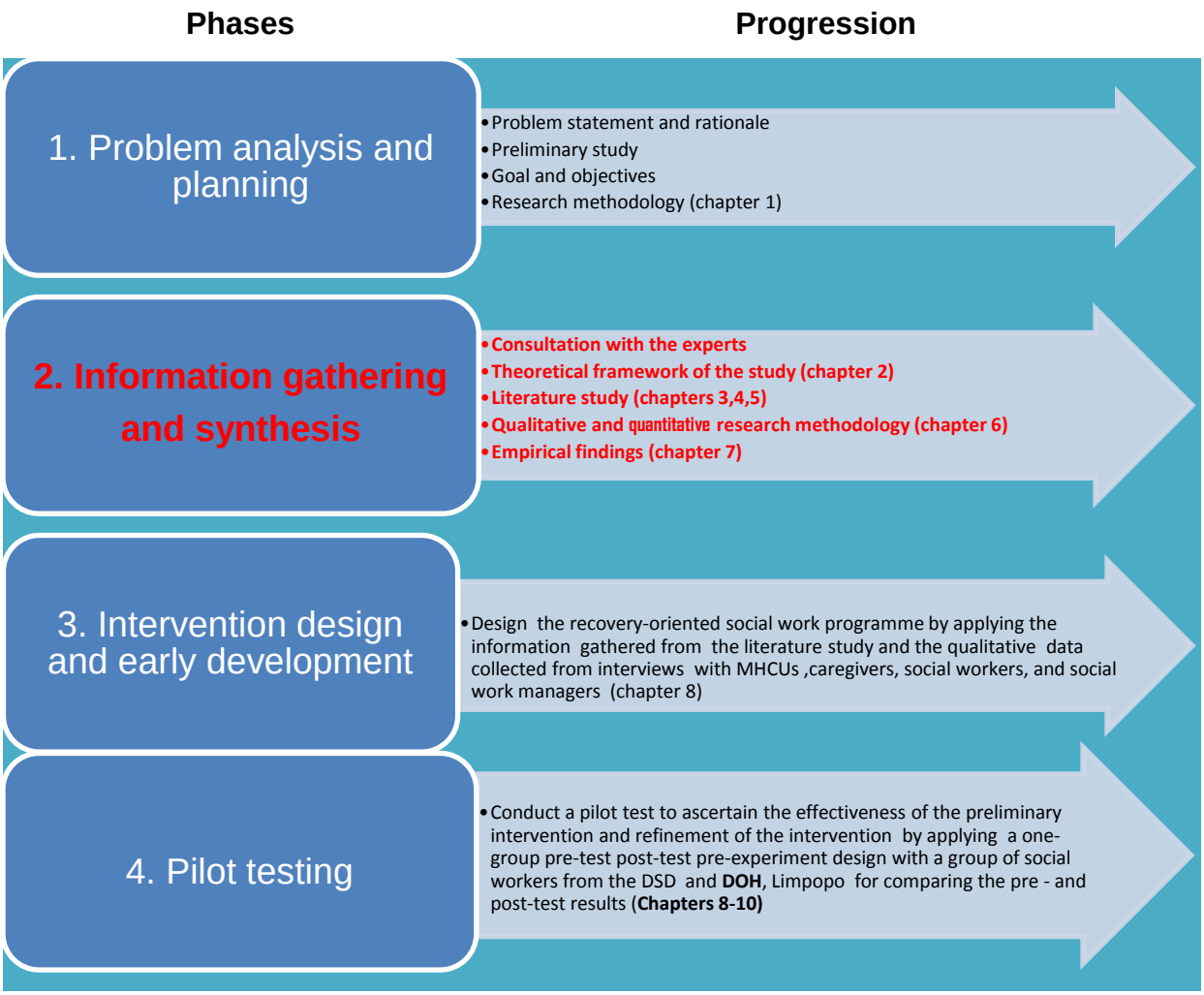
2.4 Summary

Ecological systems theory is applicable to the recovery-oriented mental health practice as confirmed by the interrelated systems that have been discussed in this chapter. These systems assisted the researcher in understanding the effect that the environment has on the lives of MHCUs. Ecological systems theory aims to restore the adaptive balance between the environment and further aims to reduce stress, enhance coping mechanisms, and establish stability. The theory frameworks that underpin the present study are appropriate and share tenets similar to those of the recovery-oriented approach that support people in building and maintaining meaningful and satisfying lives and personal identity.

The vision of ecological systems theory is to help social workers customise their interventions or interaction between the two. Ecological systems theory illustrates a meaningful way to mix the psychological and sociological dimensions of social work practice. The strengths perspective assumes that humans have the capacity for growth and change. The range of experiences, characteristics, and roles all contribute to the way in which MHCUs cope with setbacks in their lives. This perspective is relevant for recovery-oriented mental health practice as it enhances the empowerment and hope of MHCUs. Empowerment is central to recovery-oriented mental health care. Ecological systems theory and the strengths perspective are theoretical frameworks underpinning recovery-oriented mental health care practice, and these are appropriate in the present study. The discussion of these theories was based on their evolution, aim, vision, goals, principles, and their relevance; as well as their role in social work. Both theories have demonstrated their applicability in the exploration and clarification of social work recovery-oriented mental health care. The next chapter focuses on mental health care and mental health services in South Africa.

CHAPTER 3

MENTAL HEALTH CARE AND MENTAL HEALTH SERVICES



Graphic representation of phases of the intervention research: Adapted from Fraser and Galinsky (2010:463); De Vos (2011)

3.1 Introduction

Mental health disorders such as schizophrenia constitute an increasing burden globally, and the problem of inadequate resources and funding exacerbates the situation (World Health Organisation [WHO], 2003). The WHO maintains that "trends such as health sector restructuring and macroeconomic and political changes have important implications for mental health." However, at global level, the 194 member states of the WHO (including those from Africa) have adopted the Comprehensive Mental Health Action Plan (MHAP) with the objective of advancing the mental health agenda in the world (Daar, Jacobs, Groenewald, Eaton, Patel, dos Santos, Kagee, Gevers, Sunkel, Andrews, Daniels & Ndetei, 2014:24589). Based on the MHAP, Daar et al. (2014:1) assert that Africa has an opportunity to improve the mental health and wellbeing of its citizens, beginning with the provision of basic health services and the development of a national health strategic plan (roadmap). SA has progressed in the development of a national mental health policy framework and strategic plan; however, the implementation thereof is still lagging behind (Department of Health, 2013).

In this chapter, the focus is on the following mental health issues: contextualisation of mental health, history of mental health, values and principles, legislative framework, mental health, human rights and social justice, mental health in the context of culture, poverty and mental health, status of mental health and mental health care in rural areas, and mental health services.

3.2 Mental health

Mental Health is an area that has been underdeveloped, under-resourced and lacking in priority (Maruping, 2012:6). Maruping further states that "with the political transformation, mental health has been prioritised and there has been extensive policy development in the field of mental health." However, its execution is sluggish, and there are significant obstacles to effective implementation of mental health services (Thom, 2000:4).

3.2.1 Contextualisation of mental health

Currently, mental health denotes a substantial challenge which faces every country in the sub-Saharan African and European regions (Okasha, 2002:32, WHO, 2005:1). It is estimated that mental health problems affect at least one in four people at some stage in their lives (WHO, 2005:1). Moreover, the WHO concurs that the incidence of mental health disorders is particularly high in Europe. Additionally, “about 100 million people are estimated to suffer from anxiety and depression; over 21 million suffer from alcohol use disorders; about 4 million from schizophrenia; 4 million from bipolar affective disorder; and 4 million from panic disorders” (WHO, 2005:1).

Neuropsychiatric disorders are the second greatest cause of the mental health burden within the European region, after cardiovascular diseases (WHO, 2005:1). They account for 19.5% of all disability-adjusted life-years (DALYs – years lost to ill health and premature death) (WHO, 2005:1). Moreover, Burns (2012:2) asserts that in Africa the political socio-economic and cultural characteristics of the environment impact the epidemiology and natural history of psychotic illness and schizophrenia to a considerable degree. Burns (2012:2) further claims that “While the socio-economic environment is of course a feature of every society and undoubtedly impacts on the genesis and natural history of psychosis in every context, the African case is of particular interest in respect of the epidemiology of schizophrenia. This is because it is a continent that has, in a matter of less than a century, undergone (and continues to undergo) massive socio-economic, political and cultural transition from a predominantly rural, traditional, subsistence environment to an increasingly urbanized, industrialized and globalized region of the world.” Saayman (2010:12) maintains that literature pertaining to the current prevalence rate of schizophrenia in South Africa is lacking, but it is estimated that 1% of the South African population suffers from schizophrenia, amounting to a figure of roughly 500 000 people (following census estimates of population size) suffering from this disorder at any given time. On the other hand, the South African Depression and Anxiety Group (SADAG) (2017) asserts that schizophrenia is a mental condition that affects around one in every 100 people in South Africa. The researcher conducted the present study in the rural areas of SA, and the MHCUs targeted were those living with schizophrenia.

This section therefore focuses on mental health in general. The definition of mental health is discussed below.

The definition by WHO (2005:1) is that “Mental health can be conceptualised as a state of well-being in which the individual realizes his or her own abilities, can cope with normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community.”

The researcher is in agreement with this definition, and is of the opinion that MHCUs can function effectively and contribute within their communities only if capacitation takes place. Furthermore, she is of the view that if one member of the family is living with mental illness, this condition affects the whole family, especially the caregivers. Hence, the intention of the present study was to develop a programme that would capacitate social workers to facilitate improvement in the services provided to MHCUs and their caregivers. Therefore, it is essential to establish the origins of mental health care by perusing different legislative frameworks.

3.2.2 Legislative frameworks of mental health

Mental health policies indicate a government’s determination to address the mental health needs of its population (Omar, Green, Bird, Mirzoev, Flisher, Kigozi, Lund, Mwanza, Ofori-Atta & Mental Health and Poverty Research Project Consortium (MHaPP), 2010:2). However, many countries either lack a policy of any kind, or have a non-operational, inappropriate policy (WHO, 2005:15). For example, 53% of African countries do in fact have mental health policies, but many of these are outdated (WHO, 2005:15; Omar et al., 2010:2). In South Africa, mental health is acknowledged as a crucial public health issue; however, it is not given the priority it deserves on policy agendas (Draper, Lund, Kleintjes, Funk, Omar & MHapp Consortium, 2009:342). Cooper (2003:107) agrees with Draper, et al. (2009:342) that mental health is not given social priority, and there is generally a poor knowledge and understanding of mental disorders among different stakeholders.

The Mental Health Action Plan (2013-2020) has been adopted by member states, civil society, and international partners (WHO, 2013). The intention of the action plan is to

advance the mental health agenda. This plan recognises the essential role of mental health for all people (WHO, 2013). Four objectives are:

- More effective leadership and governance for mental health.
- The provision of comprehensive, integrated mental health and social care services in community-based settings.
- Implementation of strategies for promotion and prevention.
- Strengthened information systems evidence and research (WHO, 2013)

The researcher deems this approach a building block for the recovery-oriented mental health practice as it emphasises promotion, prevention, treatment, rehabilitation, care, and recovery (WHO, 2013). The recovery component is within the ambit of the present study. The focus will be on the South African constitutional mandate of mental health care.

3.2.2.1 South African constitutional mandate of mental health care

Mkhize and Kometsi (2008:104) postulate that there has been gross violation of human rights in South Africa and all these actions were fuelled by the policy of apartheid. These acts occurred before the advent of the new democratic dispensation in 1994. On the other hand, Lund, Petersen, Kleintjes and Bhana (2012:402) allude to the fact that the South African government is working hard to improve mental health services, since the demise of the apartheid system. In 1997, mental health was included in the White Paper for the transformation of the health system in South Africa, which stated that “a comprehensive and community-based mental health service should be planned and coordinated at the national, provincial, district and community levels, and integrated with other health services” (Lund et al., 2012:403).

Burke (2012:564) contends that when working with MHCUs, irrespective of the severity of their condition, the practitioner should take cognisance of and adhere to the principles of the Constitution of South Africa which protects MHCUs. The researcher is concerned by the manner in which MHCUs are treated. Burke (2012:565) maintains that “despite the increased focus on a rights-based approach, mistreatment of people with mental disorders continues, there have been media reports of abuse of MHCUs by state,

institutions, or individuals." The Constitution states clearly that all people should be treated with dignity and respect (Burke, 2012:564). Therefore, the researcher holds the view that the Constitution is essential in the provision of mental health services, and all mental health care practitioners should comply with these provisions. The intention of the present study is to create a platform for social workers to provide mental services aligned with the Constitution. Social workers should work collaboratively with MHCUs and their caregivers in order to improve their lives and functioning within society. The Mental Health Care Act (No 17 of 2002) is discussed in the next section.

3.2.2.2 Mental Health Care Act (No 17 of 2002)

Lund et al. (2012:404) contend that "the act was promulgated, which enshrined the human rights of people living with mental disorders, and set up mechanisms such as Mental Health Review Boards, to protect and uphold those rights." Burke (2012:566) argues that many past ethical abuses against people with mental disorders were corrected by the Act. The Act intends to bring synergy between mental health practices and World Health Organisation (WHO) principles, and promote the human rights of people living with mental illness in South Africa (Lund et al., 2012:404). The implementation of this Act took place in 2004.

The purpose of the act is to "provide for care, treatment and rehabilitation of persons who are mentally ill. To set out different procedures to be followed in the admission of such persons; to establish Review Boards in respect of every health establishment; to determine their powers and functions; to provide for care and administration of the property of people with mental illness; to repeal certain laws and to provide for matters connected therewith" (Department of Health, 2002). Burke (2012:564) claims that the Act applies in practice what the constitution stipulates pertaining to people with mental illness, and any person who acts contrary to the stipulated responsibility can be guilty of a crime. Furthermore, the Act clearly defines different mental health professionals, their roles, and responsibilities as well as the different types of admission requirements. In keeping with the Act, review boards have been established in each province and have been given the authority to review involuntary admission and discharge procedures, and review appeals associated with these processes (Department of Health, 2002). However, the review

boards do not have the authority to impose sanctions (for example, withdraw accreditation, impose penalties, or close facilities) that persistently violate human rights (Lund, Kleintjes, Campbell-Hall, Mjadu, Petersen, Bhana, Kakuma, Mlanjeni, Bird, Drew, Faydi, Funk, Green, Omar & Flisher, 2008:100).

The Act is a critical element in the present study; it governs the provision of services to mental health practice. Moreover, it promotes the rights and responsibilities of stakeholders in mental health. Consequently, the development and implementation of recovery-oriented mental health practice might respond to and address the purpose of the Act. These services are geared toward treating MHCUs with respect and dignity, and educating practitioners and caregivers about mental health. It is clear that the Act provides an excellent framework for mental health services, and that it actively seeks to protect the rights of people with mental health problems (Simpson & Chipps, 2012:54). In South Africa, there has clearly been an improvement in policy development. It is therefore appropriate that the researcher discusses the National Mental Health Policy Framework and Strategic Plan (2013-2020).

3.2.2.3 National Mental Health Policy Framework and Strategic Plan (2013-2020)

The National Mental Health Policy Framework and Strategic Plan (2013-2020) is a policy that is geared toward enhancing participation of mental health care users and their families (Department of Health, 2013). This is evident in the consultative process undertaken during the promulgation of the policy framework (Department of Health, 2013). All nine provinces held summits to review the state of mental health and mental health services in their provinces to identify best practices and to generate a road map for improving mental health. Data was gathered through interviews with key informants selected from the different spheres of government (Department of Health, 2013).

The international guidance materials by the World Health Organisation inform both the content and format of the National Mental Health Policy Framework and Strategic Plan (2013-2020). These consultations culminated in a national mental health summit where a draft of this policy framework was discussed (Department of Health, 2013). The policy framework advocates for the rights of mental health care users through the identification

of key activities that are considered catalytic to furthering transformation of mental health services, and ensures that quality mental health services are accessible, equitable, and comprehensive; and are integrated at all levels of the health system in line with World Health Organisation (WHO) recommendations (Department of Health, 2013). Furthermore, the policy is aligned with the current 10-point plan of the Department of Health (2009-2014). The policy further incorporates recovery and the recovery model and therefore paved the way for the present study. The policy emphasises that service development and delivery should aim to build user capacity to enable MHCUs to return to, participate in, and sustain a satisfying role of their choice in the community. Concisely put, this is recovery-oriented mental health. To sum up, the researcher has noted that there is information available regarding recovery; however, the implementation of this practice has been sluggish. Therefore, the researcher believes that the development of a recovery-oriented programme could contribute to the development of this practice in SA. The new National Disability Rights Policy (2015) is discussed in the next section.

3.2.2.4 National Disability Rights Policy (NDRP) (2015)

This policy was intended to update the White Paper on the Integrated National Disability Strategy (INDS) (1997). The vision of this policy is aligned with the National Development Plan (NDP) (2030) and the National Commission and Planning (2011:10). The plan states that SA is “an empowered and inclusive society that upholds the rights of persons with disabilities to equality, dignity and self-reliance” (National Commission and Planning, 2011). The researcher is of the view that the policy landscape of SA is changing and mental health is recognised; however, implementation is slow. The policy has good intentions to enhance the rights of people living with disabilities. The purpose of the policy is the following (Department of Social Development [DSD], 2015:31):

- Taking action to ensure that their rights as equal citizens are upheld.
- Removing discriminatory barriers to access and participation.
- Ensuring that universal design access informs the planning, budgeting, and service delivery value chain.
- Recognising the right to self-representation.

- Acknowledging that not all persons with disabilities are alike, and that personal circumstances such as gender, age, sexuality, cultural backgrounds, and geographical location require different responses.
- Embedding the obligations contained in the United Nations Convention on the Rights of Persons with Disabilities in legislation, policy and service delivery

This policy is relevant in the present study as its main intention is to promote the inclusion of people with mental illness in the decision-making processes which affect their wellbeing. The treatment of people with mental illness should be collaborative this implies that they should participate in the decisions about appropriate treatment. When referring to treatment in South Africa, we cannot ignore traditional medicine. Many black South Africans believe in indigenous medicine and practices to heal emotional problems. Traditional healers play a major role in providing services in mental health care. Hence, it is vital that the researcher discuss the Traditional Health Practitioners Act (No 22 of 2007).

3.2.2.5 Traditional Health Practitioners Act (No 22 of 2007)

Janse van Rensburg (2009:157) reported that this Act was promulgated in response to the political and social changes that have occurred in SA since 1994. Burke (2012:568) further asserts that “cross-cultural diagnosis and treatment present serious challenges; thus mental health professionals need to be trained to recognise and accommodate diverse customs and practices and to support people with a variety of needs.” The purpose of the Act is as follows:

- Establish the Interim Traditional Healers Council of SA.
- Provide for a regulatory framework to ensure the efficacy, safety, and quality of traditional health care services.
- Provide for management and control over the registration, training, and the conduct of practitioners, students and other specified categories in the traditional practitioners profession.

- Serve and protect the interests of the public who utilise the services of traditional health practitioners.

Tshehla (2015:279) states that the Act is an important development in the health sector of SA because the nonregulated traditional health sector created myriad problems in the past. This author further asserts that traditional healers are not held accountable for their actions. Street (2016:325) avers that traditional health practitioners (THPs) are an essential component in the history and culture of SA.

The researcher concurs with Street's assertion; she is of the view that traditional healing is the first point of call for MHCUs seeking help for their aberrant behaviour. As a result, in African countries this practice is highly regarded. The researcher is of the opinion that mental health care practitioners should be sensitive to cultural diversity. There should be collaboration between mental health care practitioners such as social workers and traditional healers in order to assist MHCUs in enhancing their recovery process. Mental health policies are deemed essential by the present study; if professionals do not treat MHCUs appropriately they may be guilty of a crime. Therefore, mental health policies should be at the fingertips of the mental health care practitioners-social workers. The researcher perceives the legislative framework of mental health care as rights-based in nature; hence the discussion in the following section is based on human rights and social justice.

3.2.3 Mental health, human rights, and social justice

Ife (2012:14) states that rights are seen as endorsed by God and are perceived as "self-evident". The United Nations Human Rights Commission (UNHRC) (2016) claims that "Human rights are rights inherent to all human beings, whatever our nationality, place of residence, sex, national or ethnic origin, colour, religion, language, or any other status. We are all equally entitled to our human rights without discrimination. These rights are all interrelated, interdependent and indivisible." The NASW (2014) defines social justice as "… the view that everyone deserves equal economic, political and social rights and opportunities." Karban (2011:3) concurs that mental health is an issue of human rights and social justice. Moreover, the International Federation of Social Workers (IFSW)

(2008) states that “human rights and social justice map the IFSW’s understanding that all people have an equal right to enjoy the social conditions that underpin human health and to access services and other resources to promote health and deal with illness.” Ife (2012:217) further asserts that “framing social work as a human rights profession has certain consequences for the way in which social work is conceptualised and practiced.” In addition, Ife claims that the human rights perspective supports social work and provides a strong foundation for assertive practice and recognition of social justice. In concurrence with this assertion, Allen (2014:13) states that the ethos of social work is to protect and safeguard the human rights of vulnerable people. Therefore, social workers who are recovery-oriented should collaborate with mental health care users to improve an often hostile environment, and further facilitate the promotion of human rights and social justice.

The researcher is of the view that social workers have a substantial task in educating communities about mental illness. Hence, the lack of knowledge about mental illness, its causes, symptoms, and recovery-oriented treatment options result in common but erroneous beliefs that it is caused by the individuals themselves or by supernatural forces, possession by evil spirits, or punishment by God (Lauber & Rossler, 2007:158). Misinterpretations often lead to the philosophy that mental illnesses are untreatable, and that affected people are not valued as members of their communities or entitled to resources allocated to provide social work services or support (Funk, Drew & Knapp, 2012:166). Equally, Kakuma (2010:116) asserts that people living with mental illnesses are abandoned for long periods in poorly resourced, unhygienic, abusive institutions. The WHO (2005) highlights that people with mental illness experience human rights violations in their daily lives in the community, with responsibilities handed to guardians who make decisions about place of residence, movements, personal and financial affairs, and medical treatment.

The researcher has observed that in many countries, people with mental illness are denied rights of citizenship and participation, such as the right to vote. In Thailand, no one “being of unsound mind or mental infirmity” can vote (Kingdom of Thailand, 2007). People under guardianship are denied the right to vote in many countries, as is the case in Hungary (Republic of Hungary) (Funk et al., 2012:167). This situation contributes to the

political marginalisation, disenfranchisement and invisibility of people with mental illness (Human Rights Watch, 2012). Participation means not only the right to vote and to stand for election, but to effectively and fully participate in the conduct of public life (Drew, Funk, Tang, Lamichhane, Chavez, Katontoka, Pathare, Lewis, Gostin & Saraceno, 2011:1665). Participation allows for the creation of an active civil society, able to give a voice to the poor and marginalised, and drive national reform (Funk, Minoletti, Drew, Taylor & Saraceno, 2006:70).

The United Nations General Assembly (2006) indicates that the UN Convention on the Rights of Persons with Disabilities is the key measure to promote and protect the rights of people living with schizophrenia. In addition, the WHO (2008) specifies that “the Convention sets obligations on governments and the international community to promote full inclusion and participation of people with mental disabilities in community life, including provisions aimed at preventing abuses in health care and community contexts. It also protects a full spectrum of rights, including the right to manage one's own financial affairs, marry and find a family, participate in political and public life, access education, work, have an adequate standard of living and social protection, and obtain health and rehabilitation services.” The WHO (2009) also states that the development and implementation of mental health policies and laws are essential architects for transformation. Based on these assertions, the researcher deemed the development of the recovery-oriented programme pertinent, and the tenets of the present study in alignment with the Convention’s obligations.

Human rights protection is a key issue in the delivery of care to people suffering from long-term mental disorders. In fact, the principles and standards set by international organisations such as Amnesty International, the United Nations Human Rights System, and the European Human Rights System have played a key role in driving the process of deinstitutionalisation across Europe (de Almeida & Killaspy, 2011:2). Human rights and social justice underpin the study at hand, also the principles of recovery-oriented mental health practice based on values related to human rights and dignity. Human rights and social justice promote the empowerment of MHCUs, their caregivers, and families. Jacobson and Greenley (2001:482) indicate that recovery is not tantamount to a cure.

The authors refer to recovery as both internal conditions experienced by persons who describe themselves as being in recovery – hope, healing, empowerment and connections. On the other hand, external conditions also facilitate recovery – implementation of human rights, positive culture of healing, and recovery-oriented services (Jacobson & Greenley, 2001:482). The researcher is in agreement with Jacobson and Greenley's assertion, and believes that hope, healing, empowerment, and social connections are the cornerstones of the programme that she developed. Furthermore, she believes that if the programme on recovery-orientation is implemented, a positive culture of human rights and recovery-oriented service can be instilled and fully realised. It is vitally important now to focus on culture and mental health. Culture plays a major role in mental health care.

3.2.4 Mental health in the context of culture

Amuyunzu-Nyamongo (2013:59) posits that mental health is a "socially constructed and defined concept, implying different societies, groups, cultures, [and] institutions". On the other hand, culture also refers to the "customs, habits, skills, technology, arts, values, ideology, science, and religious and political behaviour of a group of people in a specific time period" (Baker, 2003:105).

The World Federation for Mental Health (WFMH) (2007) suggests that "culture may have an impact in many facets of mental health and these include how people from a given culture convey and present their symptoms, their style of coping, their family and community supports and their willingness to seek treatment." Similarly, the cultures of the clinician and the service system can have an impact on the diagnosis, treatment, and service delivery (WFMH, 2007). This document further asserts that cultural and social influences are not the only causal factors of mental illness and patterns of service use, but they do play important roles (WFMH, 2007). In the mental health care setting, culture impacts people as follows:

- Label and communicate distress.
- Explain the causes of mental health problems.
- Perceive mental health providers.

- Utilise and respond to mental health treatment (World Federation for Mental Health, 2007).

The researcher is in agreement with the World Federation for Mental Health (2007) that culture plays a key role in mental illness interpretation in different societies and different cultural groups. This has a major bearing on the way MHCUs and their caregivers respond to mental illness. Culture also determines how MHCUs and their caregivers seek treatment. Local and international research consistently emphasises the importance of mental health literacy on the part of mental health practitioners and community members (Mohamed-Kaloo & Laher, 2014:350). These authors highlight that mental health literacy moves beyond the biopsychosocial sphere, and calls for a greater awareness of religious and cultural values that influence mental health practitioners and MHCUs.

Furthermore, Bulbulia and Laher (2013:52) claim that culture can influence mental illness in relation to subjective views and understanding; experience of the symptoms, classification, and treatment. This is the case in the South African context where supernatural, religious, witchcraft, and moralistic approaches to mental illness exist (Mohamed-Kaloo & Laher, 2013:350). The researcher grew up in a community where mental illness is ascribed to witchcraft and demon possession (abomofufunyana). She therefore fully agrees with Bulbulia and Laher's assertion that culture is all about how people perceive mental illness, its causes, and the way they solicit treatment. Lombo (2010) conducted a study in Komani, Eastern Cape, on mental health practitioners' perspectives on mental illness within the IsiXhosa cultural context. The findings revealed that the participants perceived mental illness as resulting from factors such as failure to observe cultural practices, or witchcraft, or failure to accept a calling for being a traditional healer (ukuthwasa). Furthermore, the participants in that study demonstrated that their knowledge and understanding of cultural factors paved the way and enabled them to treat mental illness.

Mental illness is treated in hospitals with the aid of mental health practitioners such as psychiatrists, psychiatric nurses, psychologists, and social workers. However, in African cultures treatment for mental illness is often sought from traditional healers because of their cultural belief that the illness is more spiritual than physical (Sehoana, 2015:13).

Concurring with this assertion, Mpofu, Peltzer, and Bojuwoje (2011:3) assert that the ways used to treat mental illness in African culture are through ritual enactment, dream interpretation, cleansing, scarification, aromatherapy, and fumigation. However, traditional healing is not the only service; African churches have become a modern development of the traditional care system of mental illness (Sehoana, 2015:14). The author highlights that the priest encourages faith in the supernatural and integrates Christian principles and African culture. Akrong (2000:1) is of the view that the Church encourages congregants to continue with their African rituals while simultaneously following the Christian faith. Therefore, the researcher is fully aware that recovery-oriented mental health practice encourages collaboration between MHCUs, services providers, and indigenous service providers. The researcher acknowledges that traditional and spiritual healings are the first point of entry in the help-seeking behaviour of sufferers of mental illness.

The researcher deems culture-bound syndromes essential to gain a better understanding of mental illness. Sumathipala, Siribaddana, and Bhugra (2010:200) define culture-bound syndrome as “episodic and dramatic reactions specific to a particular community – locally defined as discrete patterns of behavior.” In a study in West Africa, Niehaus, Oosthuizen, Lochner, Esmeley, and Jordan (2004) found that individuals with schizophrenia or other psychotic disorders were diagnosed with *ukuthwasa* (symptoms including social withdrawal) rather than *amafufunyana* (described as hysterical condition). The researcher has noted that culture-bound syndrome occurs in European states, for example in France *boufee delirented* is marked by transient psychosis. In Spain and Germany *involutional paraphrenia* refers to paranoid disorder (Versola-Russo, 2006:89). Versola-Russo further asserts that cultural-bound syndrome shares features of schizophrenia such as:

Amok – marked by sudden rampage.
Colera – marked by violent outburst, hallucinations, delusions, and temper tantrums.
Latah – marked by automatic obedience with reactions of echopraxia and echolalia.

This is also the case in South Africa. People living with mental illnesses are given different names, for example in Xitsonga – *xibengo* (meaning a person with a mental illness); *kupenga* (meaning madness); *kuhunw’ela* (demon possession). In all cultural groups,

mental illness is described in different ways. Therefore, social workers need to have a clear understanding of culture-bound syndrome in order to assist MHCUs in recovery. The syndrome is labelling in nature, and it is in contrast with recovery-oriented mental health practice. As cited in the Traditional Health Practitioners Act (No 35 of 2007) (Department of Health, 2007), the majority of black people have different views in responding to mental illness. The next section focuses on the relationship between poverty and mental health.

3.2.5 Poverty and mental health

The researcher has observed that poverty in rural areas is rife due to the lack of resources and mental health services. Lund et al. (2008:49) point out that "poverty erodes the mental wellbeing of the national psyche, reducing the available energies within communities to contribute to nation building, and influencing the proliferation of socially disruptive and disintegrating behaviour, such as those linked to the violence and crime in the country. Poverty also limits the amount of social and economic resources that struggling families and communities can invest in supporting people with mental disability as their energies are diverted to issues of daily survival."

Lund et al. (2008:50) contend that people with mental disabilities are further impoverished by the exclusionary impact of the stigma attached to their affliction, and the obstacles linked to poverty that prevent them from gaining access to already scarce resources, or to re-access family, community, and work privileges disrupted by mental ill health.

Swartz, Breen, Flisher, Joska, Corrigal, and Plaatjies (2006:1) provide some tentative evidence as to the link between poverty and mental wellbeing. They conducted a study in the Cape Town area to ascertain how a lack of basic services such as electricity and water affect the mental wellbeing of low-income households who have to cope with a family member diagnosed with a serious mental disorder such as schizophrenia. Their findings indicate that ineffective policies could also contribute to relapse. Families' social activities were also curtailed; for example, some families would not watch television in order to save on their electricity bill. As a result, some family members would get bored and turn to drugs. Generally, inadequate service provision was associated with stress

among caregivers, while social tension within the family was observed. This compounded the stigma associated with living with mental illness in the neighbourhood. The findings further show support for the work of Petersen (2000:321), who argues that the recognition of the material basis of poverty requires that initiatives falling outside the traditional boundaries of health care, such as (un)employment and (lack of) housing, be investigated (Petersen, 2000:321). She also cautioned that the market-oriented economic policy of the country, namely GEAR (Growth, Employment, and Redistribution), which emphasises deficit reduction and foreign debt repayment, could possibly undermine equity in service delivery (Petersen, 2000:322).

The WHO (2004) points out that poverty also exposes people to risk factors which could develop or worsen mental disorders. For example, limited educational and employment opportunities, exposure to adverse living environments (such as poor housing or homelessness), debt, substance abuse, and violence are all positively associated with poor mental health (De-Graft Atikins & Ofori-Atta, 2007:761). Similarly, Funk et al. (2012:167) argue that “People with untreated mental illness often have to rely on financial support from family members to meet basic living needs and to pay for any treatment.” These authors further state that family members or caregivers are compelled to relinquish personal time to provide care and support, curtailing opportunities for employment. This in turn affects their income, pension, and insurance entitlements, and further increases the risk of poverty.

A study conducted by Hudson (2005) in Massachusetts sheds light on the causal direction of poverty and mental health. The findings reveal a strong and consistent negative correlation between socioeconomic conditions and mental illness. The findings further reveal that the poorer the socioeconomic conditions, the higher the risk of developing a mental disability and psychiatric hospitalisation.

Heller and Gitterman (2011:44) point out that there are three elements of poverty that have been noted as increasing the risk of mental health disorders, namely:

a) The lack of resources often leads to poverty. This can also increase mental health problems in that people with mental illness cannot access health care, which in turn may aggravate the condition.

b) Stress resulting from trying to survive in a state of poverty intensifies the anxiety experienced in everyday life and in people's relationships. The daily struggle of having to juggle and balance expenses, for examples, places a stressful burden upon those living in poverty. Furthermore, various studies have revealed that stress adversely affects the quality of health among people living in poverty.

c) The environmental impact of living in impoverished neighbourhoods and a poor socioeconomic status strongly relate to overall environmental quality. The assertion is that those living in poverty are more likely to be exposed to a variety of environmental hazards.

The researcher is in agreement with the assertions of Heller and Gitterman (2011) that most MHCUs in South Africa are living in poverty. Moreover, most of them rely on disability grants, which are administered by their caregivers. These grants are often used as a source of income that has to support every family member in the household. MHCUs living in the rural areas of SA suffer severely in such an environment; hence the researcher's decision to focus on the rural areas of South Africa.

The researcher is in agreement with Swartz et al. (2006:1) and Funk et al. (2012:168) that poverty negatively affects the mental health of MHCUs, who are often economically marginalised due to unemployment resulting from inadequate education. If MHCUs are unemployed they will be deprived of basic amenities such as shelter, food, and access to health care facilities. The situation is worse in rural areas, which prompted the researcher to conduct her research in the rural areas of Limpopo. She believes that if social workers are capacitated with knowledge in mental health care practice, there could be an improvement in the lives of MHCUs, which would reduce the relentless conditions of poverty under which they have to survive. The National Development Plan (National Planning Commission, 2011) reports on this issue as follows:

> "SA has the potential and capacity to eliminate poverty and reduce inequality over the next decades. This requires a new apporach –

> one that moves apassive citizenry receiving services from the state to one that systematically includes the social and economically excluded, where people are active champions of their own development and where government works effectively to develop people's capabilities to lead the lives they desire."

3.3 Mental health services

Mental health services are defined as "assessment, diagnosis, treatment or counseling in a professional relationship to assist an individual or group in alleviating mental or emotional illness, symptoms, conditions or disorders" (Baylor College of Medicine [BCM], 2005:1). SA has relatively well-resourced mental health services as compared to many other African countries (Lund et al., 2008:12). Many services continue to operate within the institutional patterns of care, whereas in the global context community-based services have been introduced, and psychiatric institutions downscaled (Geller, 2000:42). In SA, deinstitutionalisation has been introduced as a cost-saving measure without being accompanied by the adequate development and implementation of community-based services (Lund & Flisher, 2003:157). This leads to a "revolving door" pattern of care in which service users are discharged from hospitals but are soon readmitted because adequate services are not in place to support them in their communities (Lund & Flisher, 2003:181). An example is the closure of the Randfontein Life Esidimeni Psychiatric Hospital. The purpose was to cut costs. Currently the Gauteng Department of Health is in a serious predicament due to this move, which led to the death of close to 100 MHCUs with mental illnesses.

3.3.1 State of mental health services

Mental health service implementation in SA takes place through national, provincial, and district structures (Jack-ide, Uys & Middleton, 2012:52). A national mental health authority – the National Directorate Mental Health and Substance Abuse – advises government on mental health policies and legislation (WHO-AIMS, 2007). Burke (2012:565) reports that there continues to be stumbling blocks to the financing of mental health services, in spite

of South Africa's progressive mental health legislation. As a result the following problems have been encountered:

a) Psychiatric hospitals remain outdated, are falling into disrepair, and are often unfit for human use.

b) Serious shortages of mental health professionals.

c) Inability to develop vitally important tertiary level psychiatric services.

Community mental health and psychosocial rehabilitation services remain undeveloped, and MHCUs end up institutionalised without hope of being rehabilitated back into their communities

3.3.2 Current state of service organisation, globally

The World Health Organisation (WHO, 2005) has entrenched the universal human right to quality health care (principles of primary health care) and social justice in all countries worldwide, reaffirming the holistic approach to attaining optimum primary health care. Therefore, integrating mental health services into primary care is the most practical way of closing the treatment gap for people with mental health problems, ensuring that they get the mental health care they need (World Organization and Association of Family Doctors [WONCA], 2008).

Developed countries such as the United States of America, Western European, and the United Kingdom rely less on mental hospitals to provide mental health care (WHO, 2003). The WHO further asserts that the process of deinstitutionalisation resulted in a reduced number of MHCUs committed to mental hospitals as some institutions were no longer operational. However, the deinstitutionalisation of mental health care resulted in challenges such as insufficient and inadequate provision of community-based residential and occupational facilities (Shen & Snowden, 2014:5). Jacob, Sharan, Mirza, Garrido-Cumbrera, Seedat, Mari, Sreenivas, and Saxena (2007:1061) argue that the objective of health care systems in developed and developing countries is equitable access to mental health care and the protection of rights. Olson (2006:7) is of the view that mental health systems should ensure that organisations, institutions, and resources improve service

provision. Furthermore, Olson (2006:7) highlights that mental health systems are generally subsystems of the health care system, and how these services are organised, delivered, and financed is significantly influenced by the way in which overall health services systems are run.

The WHO conceptualises optimal actions for improved service provision such as establishing national policies, programmes, and legislation on mental health and providing services for mental disorders in primary care, ensuring accessibility to essential psychotropic medication, developing human resources, promoting public education, and involving other sectors and promoting and supporting relevant research (WHO-AIMS, 2005). Therefore, the WHO service organisation pyramid for an optimal mix of services for mental health provides guidance to countries on how to organise services for mental health (WHO, 2009). As illustrated in figure 3.1 below, the preponderance of mental health care can be self-managed or managed by informal community mental health services such as community groups, religious organisations, and schools. Where additional expertise and support are needed, a more formalised network of services is required such as primary health care services, specialist community mental health services, psychiatric services based in general hospitals, and specialist long-stay mental health services (WHO, 2009).

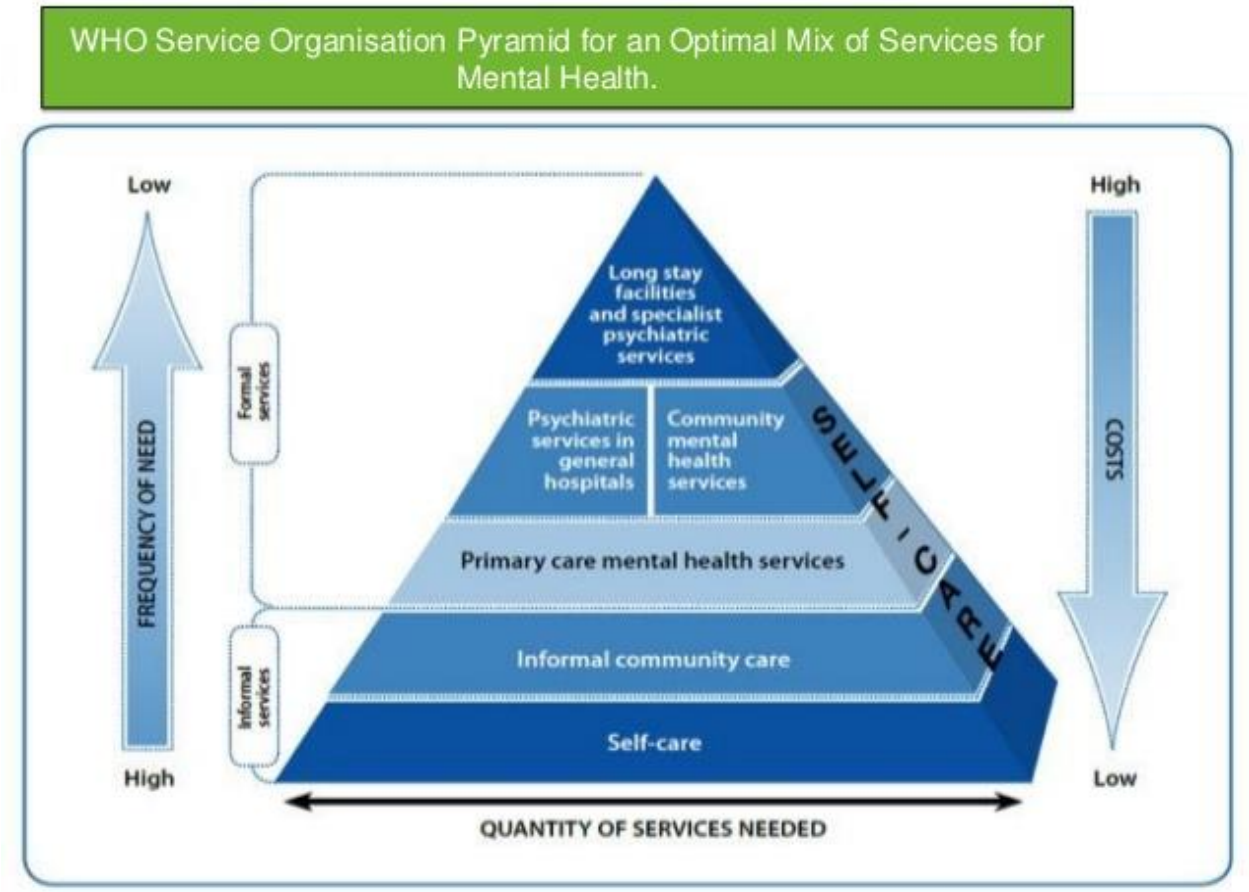


Figure 3.1: WHO Service Organisation Pyramid for an Optimal Mix Service for Mental Health (WHO, 2009)

Mental health systems in low- and middle-income sub-Saharan African countries face significant challenges in ensuring optimal mental health care services (Saraceno, Van Ommeren, Batniji, Cohen, Gureje, Mahoney, Sridhar & Underhill, 2007:1164). These challenges include a lack of mental health legislation, appropriately trained mental health personnel, and constraints caused by the prevailing public health priority agenda and its effect on funding. Other challenges include the complexity of and resistance to decentralisation of mental health services, scarce mental health resources, a mental health budget of less than 1% of the total health budget, stigma, and discrimination (Patel, Araya, Chatterjee, Chisholm, Cohen, De Silva, Hosman, McGuire, Rojas & Van Ommeren, 2007:991). It is possible that these challenges have contributed to the treatment gap of mental disorders in these countries (WHO, 2004). The WHO (2008)

asserts that it is important that mental health services within communities be enhanced in order to boost the impact of mental health service intervention in the larger population. The researcher is of the opinion that the WHO provides the guidance of how mental health services should be provided globally. Therefore, in Africa mental health services should be designed according to the WHO guidelines.

3.3.3 Mental health services in Africa

Africa is a large continent, prone to strife, especially south of the Sahara. Most African countries are characterised by low income, high prevalence of communicable diseases and malnutrition, low life expectancy, and poorly staffed services (United Nations Development, 1995; World Bank, 1998). In Africa, as in other third-world regions around the globe, there is an ongoing challenge as to the availability of resources and the political will to provide quality mental health services to people with mental illness (WHO, 2003). Sossou and Modie-Moroka (2016:vii) contend that in Africa, there is great concern regarding mental health services as a result of health disparities between geographical locations such as urban and rural communities. These authors further argue that there is evidence of disparity in the allocation of resources for health-related services, mental health services in particular. People in Africa are increasingly being affected by a host of psychological and mental health disorders and illnesses that go untreated for many years (Sossou & Modie-Moroka, 2016:vii).

In 1988 and 1990 the member states in the African Region of WHO adopted two resolutions, namely AFR/RC39/R1 and AFR/RC40/R9 to improve mental health services, and each state was expected to formulate its own mental health policies, programmes, and action plans (Gureje & Alem, 2000:475). A survey was conducted two years later to see if the countries (Egypt, Morocco, South Africa, Ethiopia, Uganda, Nigeria, Sudan, Zimbabwe, and Kenya) that had adopted these resolutions had done anything to implement them. Despite some doubtful achievements, the situation of mental health programmes in most countries was found to be unsatisfactory (Uznanski & Ross, 1997:1743). In addition, compelling evidence shows that a large proportion of the global health burden is due to mental disorders, and this proportion is projected to rise in many African countries (Gureje & Alem, 2000:475). The researcher is of the view that mental

health services are not accorded recognition in many African states. Despite mental health transformation, mental health services are neglected and not given priority in the developmental agenda.

3.3.4 Mental health services in South Africa

In South Africa, mental health services are organised in terms of catchment areas in all provinces (WHO, 2007). There are 3 460 MHCU mental health facilities in the country, of which 1.4% accommodate children and adolescents only. These facilities annually treat 1 660 per 100 000 users of the general population (WHO, 2007). Effective mental health intervention is delivered by means of mental health services (WHO, 2003). The WHO states that the organisation of services plays an important role in effectiveness and ultimate achievement of the aims and objectives of a mental health policy. The Department of Health (2013) has developed a National Mental Health Policy Framework and Strategic Plan (2013-2020) intended to transform mental health services and ensuring that quality services are accessible, equitable, comprehensive, and integrated at all levels of the health system, in line with the recommendations of the World Health Organisation (WHO).

Ramakgopa in Department of Health (2013) postulates that the policy framework and strategic plan intend to fill the critical gaps in the Mental Health Care Act (No 17 of 2002), which lays down the legal framework for a primary health care-based mental health system based on human rights. Since the demise of apartheid, there appears to be growing policy impetus to improve mental health services in South Africa. In 1997, mental health was included in the White Paper for the transformation of the health system in South Africa, which stated that “a comprehensive and community-based mental health service should be planned and coordinated at the national, provincial, district and community levels, and integrated with other health services” (Roestenburg, Carbonatto & Bila, 2016:170):

- The provision of mental health services in South Africa is in line with the WHO categorisation of mental health services. Therefore, the researcher will focus on

the WHO categorisation of mental health services: Mental health services integrated into general health services.

- Community-based mental health services.
- Institutional services provided by mental hospitals.

3.3.4.1 Mental health services integrated into general health services

Mental health services integrated into the general health system can be broadly grouped, similar to those in primary health care and those in general hospitals (WHO, 2003). Mental health services in primary care includes “treatment services and preventive and promotional activities delivered by primary care professionals. Among them, for example, are services provided by general practitioners, nurses, and other health staff based in primary care clinics. The provision of mental health care through primary care requires significant investment in training primary care professionals to detect and treat mental disorders. Such training should address the specific needs of different groups of primary care professionals such as doctors, nurses and community health workers” (WHO, 2003).

The South African government effected initiatives to align mental health services with international mandates such as integrating mental health into primary care centres, and deinstitutionalising care (WONCA, 2008). The endorsement of the Mental Health Care Act (No 17 of 2002) made primary mental health care accessible at district hospital levels and primary health care centres in the community, thereby enhancing the accessibility of mental health services (WHO-AIMS, 2007; Burns, 2008:46). In South Africa, general physicians (GPs) play active roles in offering primary mental health care services such as caring for MHCUs, screening, follow-ups, and referral. Secondary levels of mental health care are located in regional hospitals, and tertiary-level institutions provide specialised services at designated psychiatric hospitals (Burns, 2008:47; Mkize, Green-Thompson, Ramdass, Mhlaluka, Dlamini & Walker, 2004:8).

The researcher holds the view that the integration of mental health care into primary care is essential for recovery-oriented mental health practice, and that these services enhance the transition of people with mental health problems into general health. These services are accessible and less costly as MHCUs will not have to travel long distances to collect

their medication. These services promote respect for human rights and minimise stigma and discrimination (WHO, 2008). The best mental health care practices in South Africa are provided in the Enhlanzeni District in Mpumalanga, and the Mooreesburg District in the Western Cape (WHO, 2008).

Mental health services in general hospitals include certain services offered in district general hospitals and academic or central hospitals that form part of the general health system. Such services include psychiatric inpatient wards, psychiatric beds in general wards, emergency departments, and outpatient clinics. There may also be some specialist services, for example, for children, adolescents, and the elderly. Specialist mental health practitioners such as psychiatrists, psychiatric nurses, psychiatric social workers, psychologists, and physicians who have received special training in psychiatry provide these services. Clearly, the services require adequate numbers of trained specialist staff and adequate training facilities (WHO, 2003).

The Mental Health Act (No 17 of 2002) addresses provision for the integration of mental health services into the general health environment (Department of Health, 2002). Section 34 of the Act provides for involuntary and assisted mental health care users to be initially admitted for 72 hours' observation at a local general hospital (Department of Health, 2012). Burns (2008:47); Moosa and Jeenah (2010:125); Ramlall, Chipps, and Mars (2010:667) describe the reasons:

- Medical causes for behavioural or psychiatric disturbances can be ruled out and many mental health care users, especially those with acute trauma or substance abuse problems, can recover and be discharged within 72 hours – or at least improve sufficiently to give consent for voluntary treatment.
- Increasing access to care and the availability of local services, thus reducing the need for premature or unnecessary transfers to psychiatric hospitals.

Integrating mental health services into the general health service system has not been without its challenges (Simpsons & Chipps, 2014:47). In the context of the Western Cape, Van Heerden, Hering, Dean, and Stein et al. (2008:4) identified barriers that prevented managing mental health users in the general health system:

- The absence of safe observation facilities and the limited availability of psychotropic medicines hampered the effective care of mental health care users.
- Limited staff numbers, the lack of competency in existing staff, and staff prejudice toward the treatment of mental health users were additional challenges.

Similarly, Burns (2008:48) warned that most institutions were experiencing problems in providing 72-hour observations and that this was leading to suboptimal care. Mental health care users were often sedated making observation difficult, or were inadequately sedated making their management in a general ward very difficult. Inadequate facilities and poorly skilled health workers also contributed to the problems. A study by Ramlall et al. (2010) confirmed that many problems existed in respect of the 72-hour observation period in KwaZulu-Natal. Sixty-three percent of designated hospitals reported that they did not have appropriate or adequate facilities to provide the psychiatric services as required by the Act. Hospitals reported a lack of beds, staff, and appropriate private wards to accommodate mental health care users.

The researcher has noted that there are still serious challenges with regard to the provision of mental health service. The lack of resources, especially in rural areas, holds dire consequences in terms of the human rights of people with mental health problems, in particular the rights of mental health care users who have a right to the same standard of mental health care, treatment, and rehabilitation as that in other health care services in order to develop their full potential and facilitate their integration into community life. Recovery orientation requires that service models and practitioners favour collaborative practices in their everyday work. This involves supported approaches to decision making across the full spectrum of service provision, from assessment and acute treatment to therapeutic programmes, long-term rehabilitation, accommodation, and employment. This requires careful negotiation and collaboration (Department of Health, 2011).

3.3.4.2 Community-based mental health services

Community mental health services can be categorised as formal and informal. Formal community mental health services include community-based rehabilitation services, hospital diversion programmes, mobile crisis teams, therapeutic and residential supervised services, home help and support services, and community-based services for special populations such as trauma victims, children, adolescents, and the elderly. Community mental health services (CMHS) are not based in hospital settings but need close working links with general hospitals and mental hospitals (WHO, 2003). In South Africa, at policy level, the National Department of Health has committed itself to a comprehensive, community-based mental health service that is integrated into general health care (Department of Health, 1997). Regrettably, there has been limited implementation of this policy in service delivery, and CMHS are generally under-resourced and disproportionately distributed (Lund & Flisher 2003:181). Mental health staffing and service utilisation in South Africa tends to be concentrated in institutional urban settings. For example, 83% of public sector psychiatric staff are located in hospital settings, and 34% of psychiatric patient contacts with services are inpatient admissions (Lund & Flisher, 2003:182).

There are 41 community-based psychiatric inpatient units available in the country, with 2.8 beds per 100 000 of the population (WHO-AIMS, 2007). There are 80 day-treatment facilities available in the country, approximately half of which are provided by the SA Federation for Mental Health. These facilities treat 3.4 users per 100 000 of the general population (WHO-AIMS, 2007). Of all users treated in day-treatment facilities, the SA Federation for Mental Health (2014) reported that 41% are females, and none are children or adolescents.

Informal community mental health services may be provided by local community members other than general health professionals or dedicated mental health professionals and paraprofessionals (WHO, 2003). In South Africa, traditional healers are consulted for mental health problems. Several studies have shown that alternative practitioners may play an important role in addressing mental health care needs in South Africa by offering culturally appropriate treatment (Mbanga, Niehaus & Mzamo, 2002; Nattrass, 2005; Starkowitz, 2013). In many traditional African belief systems, mental

health problems are perceived as due to ancestors or witchcraft, and traditional healers and religious advisors are viewed as having expertise in these areas (Sorsdhal, Stein, Grimsrud, Seedat, Flisher, Williams & Myer, 2009:434). The present study advocates for the collaboration of mental health practitioners, traditional healers, MHCUs, and their caregivers. Recovery is a journey undertaken by MHCUs and mental health practitioners, and caregivers support MHCUs in this process. Therefore, the researcher advocates for mental health services that are collaborative.

3.3.4.3 Institutional services provided by mental hospitals

Institutional mental health services include specialist institutional services and mental hospitals. A key feature of these services is the independent stand-alone service style, although they may have some links with the rest of the health care system (WHO, 2003). Specialist institutional mental health services are provided by certain outpatient clinics and by certain public or private hospital-based facilities that offer various services in inpatient wards. Among the services are those provided by acute and high-security units, units for children and elderly people, and for forensic psychiatry. These services are not merely those of modernised mental hospitals, they meet very specific needs that require institutional settings and a large complement of specialist staff who have been properly trained (WHO, 2003). In South Africa, there are various private hospital-based facilities that provide mental health services such as Life Healthcare, Vista Clinic, and Denmar hospital.

Life Healthcare is a leading provider of private psychiatric services in South Africa, currently offering such services at six dedicated facilities in Gauteng, the Eastern Cape, and KwaZulu-Natal. Life Healthcare intends to widen access to, and meet the growing demand for, private acute mental healthcare. In 2016, it managed 2 424 beds (Life Healthcare, 2016). Furthermore, the mental health care services offered at the dedicated facilities include general psychiatry, treatment for substance dependence or other addictions associated with psychiatric disorders and, in certain cases, some psychiatric sub-specialities for high and medium acuity users. Post-discharge support is usually also offered. Treatments offered include evidence-based drug therapy, individual psychiatric consultations, psychotherapy, group therapy and, where needed, physical therapy. The

group sessions are supportive and educational and have been geared toward mental healthcare users' needs (Life Healthcare, 2016).

Vista Clinic in Centurion, Tshwane, Gauteng is a private psychiatric hospital that provides mental health services to people 16 years and older. The most frequent conditions treated are mood and anxiety disorders such as depression, bipolar disorder, and post-traumatic stress disorder (Vista Clinic, 2016). The hospital provides excellent person-focused services that are accessible and cost effective; they believe that people with mental health problems are entitled to the best treatment possible to ensure successful reintegration into the community, thereby achieving the highest level of functioning and quality of life (Vista Clinic, 2016).

Denmar Specialist Psychiatric Hospital was the first private psychiatric hospital in Gauteng, a dedicated healthcare facility specialising in the treatment of psychiatric illnesses, established and located in Pretoria. The hospital has grown from 18 to 170 beds with an electro-convulsive therapy theatre, and day clinic facilities (Denmar, 2016).

Dedicated mental hospitals mainly provide long-stay custodial services. In many parts of the world they are either the only mental health services or remain a secondary but substantial component of these services. In many countries, they consume most of the available human and financial resources allocated for mental health. This poses a serious barrier to the development of alternative community-based mental health services. Mental hospitals are frequently associated with poor outcomes, attributable to a combination of factors such as poor clinical care, violations of human rights, the nature of institutionalised care, and a lack of rehabilitative activities. They therefore represent the least desirable use of scarce financial resources available for mental health services (WHO, 2003). In South Africa, there are various public mental hospitals such as Weskoppies, Tara, and Sterkfontein in Gauteng; Hayani, Thabomoopo, Evuxakeni, and Shiluvana in Limpopo. These mental hospitals are public hospitals and fall under the auspices of the Department of Health.

Weskoppies Hospital is a specialised public sector psychiatric hospital situated in the western part of Tshwane (Pretoria), which serves the greater Tshwane area in Gauteng

Province. Metsweding and Tembisa Hospitals are also in Gauteng Province, and forensic facilities in North West Province and Mpumalanga. The hospital has 1 067 approved beds, with 715 beds operational. Some beds are temporarily closed due to infrastructure challenges (Gauteng Department of Health, 2016). Weskoppies is one of the biggest and oldest psychiatric institutions in South Africa. It has provided insightful information on the treatment of mental illness since the late 1800s. It is also the first hospital to be declared a national monument in South Africa, and even though only the 1 904 to1 907 additions to the site have official heritage status, there remain a large number of buildings on the site that should be declared heritage sites. The hospital also serves as a teaching hospital for students from the University of Pretoria (UP) as well as Sefako Makgatho University (SMU) (Geel, 2005).

Tara Hospital is a public sector psychiatric hospital situated in Hurlingham, Johannesburg, affiliated to WITS university.

Sterkfontein Hospital is a a specialised public sector psychiatric hospital situated in the surrounds of the Cradle of Humankind, just outside Mogale City's central business district. It serves a population of approximately 7.1 million people from Regions A and B in Gauteng. As a training institute, the hospital has links with the following universities: Witwatersrand, Johannesburg, North West, Pretoria, and KwaZulu-Natal; and the Ann Latsky and Chris Hani Barangwanath nursing training colleges: Some of the clinical personnel serve as joint appointees with the University of the Witwatersrand (Gauteng Department of Health, 2016).

Hayani Hospital is a public sector psychiatric hospital situated in Thohoyandou, Vhembe District, operated by Limpopo Department of Health. **Thabomoopo Hospital is** a public sector psychiatric hospital situated in Lebowakgomo, operated by Limpopo Department of Health. **Evuxakeni Hospital** is a public sector psychiatric hospital situated in Giyani, Mopani District, operated by Limpopo Department of Health. **Shiluvana Hospital** is a public sector psychiatric hospital situated in Tzaneen, Mopani District, operated by Limpopo Department of Health. The WHO (2003) asserts that mental hospitals are frequently associated with poor outcomes attributable to a combination of factors such as poor clinical care, violations of human rights, the nature of institutionalised care, and a

lack of rehabilitative activities. They therefore represent the least desirable use of scarce financial resources available for mental health services. The research settings for the present study were the Limpopo Department of Health, Hayani, Evuxakeni, and Shiluvana Mental Health (psychiatric) Hospitals.

The researcher has noted that the participants in the present study have been admitted for a longer period, and they do not enjoy good support from their families. She is of the opinion that the lack of community-based mental services might be the compounding factor leading to this predicament. Therefore, she is of the opinion that the implementation of her CROCMEHC programme might address this need. Furthermore, there is a lack of infrastructure with social workers sharing offices. This state of affairs compromises the right to confidentiality and the quality of mental health services rendered to MHCUs. Indeed, mental health is neglected in general, and the researcher is of the view that if community-based mental health services can be implemented and infrastructure improved, this issue can be addressed and the recovery of MHCUs can therefore be facilitated.

3.3.5 Strengths and weaknesses of the mental health system in South Africa

The strengths and weaknesses are as follows:

- **Strengths as stipulated in WHO-AIMS (2007)**

There are several strengths in the South African mental health system as compared to other African countries:

- South Africa has relatively well-resourced mental health services, including human resources, rehabilitation facilities, and psychotropic medication.
- There has been some reform in South Africa's mental health legislation with the promulgation of the Mental Health Care Act (No 17 of 2002), strategic plan, patient rights, and the Bill of Rights. This is in keeping with international human rights standards. Many of the reforms currently implemented in the country such as the introduction of mental health review boards and the establishment of 72-hour

assessment facilities in district general hospitals, are driven by the new Mental Health Care Act.

In spite of these strengths, there are several weaknesses in the current systems, which are presented below.

- **The weaknesses of mental health system adopted from WHO-AIMS (2007)**

- Related to the problem is a lack of nationally agreed-upon indicators for mental health information systems, with the result that information on current service resources (budgets, staff, and facilities) and provision (admissions, outpatient visits) is extremely sparse. Data, if and when collected, are seldom made available for planning; and if made available, are seldom reported on systematically.
- In general, mental health services continue to labour under the legacy of colonial mental health systems, with heavy reliance on mental hospitals. There are 23 mental hospitals in the country, and 56% of mental health hospital beds are located in these facilities. There is an urgent need to develop community-based mental health services (which include community-based residential care, day services, and outpatient services) in keeping with international best practice.
- There is also an urgent need for the training of general health care and public sector staff in mental health care as well as in a range of other sectors such as education, social development, criminal justice, housing, and employment. Evidence from the WHO-AIMS (2007) report indicates that while some training does occur, it is frequently not monitored and evaluated, and where training of PHC staff takes place, it is not supported by ongoing supervision and the establishment of referral pathways to and from specialist mental health care. There is currently a lack of clinical protocols at PHC level and standardised mental health training for health care providers.
- There is some evidence of the establishment of consumer and family associations, often with the support of NGOs, such as the SA Federation for Mental Health, but the role of these associations in the formulation of policy and planning of services is limited.

The researcher has observed that institutional care is predominantly practised in SA. There is therefore an urgent need to develop community-based mental health services, and the researcher is advocating for these services in this study. Furthermore, there is the urgent need of mental health training of general health staff and social development staff. This is in line with the present study's development of a recovery-oriented mental health care practice geared toward capacitating social workers in mental health. Lastly, the involvement of MHCUs and caregivers in policy formulation is reported to be limited. Hence, the first phase of the present study focuses on gathering information regarding mental health services for MHCUs and caregivers, and subsequently incorporating these in the recovery-oriented mental health programme to be implemented by social workers. Mental health services provision in rural areas is limited, and this issue is addressed in the next section.

3.4 Mental health care in rural areas

Globally, the health status of people in rural areas is generally worse than in urban areas (Strasser, 2003:457). The Rural Development Framework (RDF) (1997) defines rural areas as follows:

- Sparsely populated areas where people farm or depend on natural resources, including villages and small towns that are widely dispersed throughout these areas.
- Areas that typically have traditional land tenure systems, for example, large settlements in the former homelands, which depend on migratory labour and other remittances as well as government social grants for their survival.

Fifty-six percent of rural South Africans live five kilometres or more from a health facility; and 75% of South Africa's poor people live in rural areas (Gaede & Versteeg, 2011:100). South Africa has a population of 55.9 million people (Statistics South Africa, 2016), 35.20% of whom live in rural areas. There is a heavy burden of psychiatric disorders in all provinces; yet mental health services are in a state of neglect and deterioration from a lack of resources, including psychiatrists (Burns, 2011:99; WHO, 2005). Due to the

chronic shortages of mental health services, much of the burden of care for mental health issues in rural areas has shifted to the primary care sector (Gale & Lampert, 2006:66).

Other barriers to accessing mental health services include long travel distances, lack of transportation – particularly difficult for elderly rural residents, and poor or non-existent insurance coverage for mental health care among rural residents (National Advisory Committee on Rural Health and Human Services, 2004). Despite the substantial differences between developing and developed countries, the key themes in rural health care are the same around the world. Access is a major rural health issue, even in countries where the majority of the population lives in rural areas, as resources are mostly concentrated in the cities. All countries have difficulties with transport and communication, and they all face the challenge of shortages of doctors and other health professionals in rural and remote areas (Strasser, 2003:458).

An earlier study of rural health clinics (RHCs) in the United States of America (USA) found that few offered mental health services (0.12%) and employed one doctoral-level psychologist; 0.07% employed one clinical social worker (Gale & Coburn, 2003). This study examined changes in the delivery of mental health services by RHCs, operational characteristics of these services, barriers and challenges experienced by RHCs, and policy options to encourage more RHCs to deliver mental health services.

The health of persons living with mental health-related challenges has long been neglected by the public health care system in South Africa (The Rural Mental Health Campaign Report, 2015). Morgan (2015:v) asserts that “Services offered have largely been modelled on institutional care and have lacked elements that promote social inclusion, empowerment, hope and independence. Services have been centralized in tertiary hospitals in the main cities of South Africa, while most people living with mental health-related issues in smaller towns and rural settings are confronted with unsupportive and inadequate desert-like mental health care services. The lack of mental health care services in rural settings is dehumanising.”

In South Africa, there has never been any systematic tracking of expenditure on treating mental illness in either the public or private sectors, let alone in rural health care settings.

The most comprehensive data available is from 2004 and was reported on as part of the WHO's country report on the outcome of the SASH (WHO, 2005). In this instance, only four of the country's nine provinces could actually report on mental health expenditure. On average, the Gauteng, North West, Mpumalanga, and Northern Cape Provinces each spent approximately 5% of their total health budget allocations on mental health services (WHO, 2005). Mental health is not afforded priority; as a result, if there are budget cuts in the Department of Health, they do not hesitate to cut funds destined for mental health services; for example, the Life Esidemeni Hospital closure mentioned earlier.

3.5 Investing in rehabilitation is essential in addressing the gap in mental health care services in rural areas

The Rural Mental Health Campaign Report (2015) indicates that little or no rehabilitation is available to MHCUs in rural areas, and additional psychiatrists, psychologists, occupational therapists, and social workers are often only available at tertiary or district hospitals which are some distance away, incurring often unaffordable transport costs. Morgan (2015:17) highlights that rehabilitation services support MHCUs and their families in understanding their illness, and reintegrating them back into their communities. As outlined in the National Mental Health Policy Framework, "MHCUs should have access to care near to the places where they live and work" and "a recovery model, with an emphasis on psychosocial rehabilitation, should underpin all community-based services" (Department of Health, 2013). Therefore, the researcher concurs with Morgan and the Department of Health, and has developed a recovery-oriented mental health programme for social workers in rural areas. This programme is intended to contribute to the rehabilitation services already rendered to MHCUs and their families. Therefore, the tenets of the present study are similar to those which, for instance, capacitate social workers to support MHCUs on their journey to recovery.

The researcher has noted the lack of resources and facilities for mental health services in rural areas. Hence, her study aims at closing this gap by implementing her CROCMEHC programme that will capacitate social workers in contributing to the improvement of mental health services in the rural areas of South Africa. Furthermore,

the researcher found a gap in literature on mental health in SA rural areas, and this supports her view that the study at hand could contribute to the body of knowledge in the field of social work in mental health as well as in rural mental health.

3.6 Recovery-oriented mental health services

Recovery has been adopted as either a national policy or a guiding principle for reforming mental health services in many countries (Tse, Siu & Kan, 2011:155). The NSW Consumer Advisory Group (NSW CAG), Mental Health Inc., and the Mental Health Coordinating Council (MHCC) (2009) suggest that to make recovery a reality, the following should be undertaken:

- At system level, there should be a greater awareness of mental illness and the efforts to eliminate stigma and discrimination.
- MHCUs need to participate at every level of the mental health system.
- A greater awareness of human rights in the community.
- The language used to describe mental illness needs to shift from being deficit-based and be reframed to engender hope and empowerment.

Recovery-orientation to service provision facilitates a better understanding of how mental health services, community mental health sectors, organisations, and related sectors should provide care and treatment for people living with mental illness (NSW CAG & MHCC, 2009). Countries such as Australia, Scotland, Canada, and New Zealand developed policies that are in a recovery-orientation system (Commonwealth of Australia, 2003, 2009; Health Scotland, 2008; Mental Health Commission of Canada, 2009; Mental Health Commission of New Zealand, 2008; NSW Health, 2008). The following themes have been identified that should underpin recovery orientation in service delivery:

- Endorse person-centred services, which take into consideration a person's preferences, choices, and life goals aligned with their rights and responsibilities (Jacobson & Greenley, 2001:485).
- Promote a person's self-determination and individual responsibility (Kelly & Gamble, 2005:250).

- Treat the person with mental illness as an equal, and understand his or her life context and culture (Mead & Copeland, 2000:327; Western Australian Department of Health, 2004:13).
- Emphasise a person's strengths and capacity to grow, support integration, and provide links to meaningful activities (Mead & Copeland, 2000:327).
- With the person's consent, involve families and friends in the various stages of the recovery journey (Western Australian Department of Health, 2004:13).

Janse van Rensburg (2012:133) alludes to the adoption of a recovery framework for mental health care users (MHCUs), and this framework holds the potential for a radical transformation of mental health services in SA. Furthermore, the author holds the view that this will occur by empowering MHCUs through the adoption of a set of values that emphasises the principles of "person-centeredness, self-determination and self-management in a positive atmosphere of hope."

Janse van Rensburg (2012:133) asserts that the adoption and integration of a recovery framework should include the following essential steps:

- The promotion of recovery awareness in all aspects of services, such that personal recovery outcomes become the universal goal according to which service provision is measured.
- The introduction of active measures to combat discrimination against individuals with psychosocial disabilities within mental health care services and on a societal level.
- The introduction of progressive programmes in all services to establish and further develop consumer involvement in service feedback, planning, and delivery.
- Introduce steps to improve accessibility to the wide range of treatment and support services required for recovery.
- The strengthening of primary-level and community-based mental health services to improve prevention, rehabilitation, and restoration of social roles.

The researcher is therefore of the view that these themes are critical as they promote a paradigm shift to embrace self-directed care, and foster hope and empowerment during the recovery process. In South Africa, the Mental Health Strategy of 2013 has adopted a recovery-oriented stance; however, implementation is still lagging behind. Furthermore, Janse van Rensburg (2012) alludes to the adoption of a recovery framework. The researcher is of the opinion that the present study is pertinent as it introduces a recovery-oriented mental health practice to the social work fraternity.

3.7 Summary

From the available literature reviewed, the researcher has gained insight as to how mental health services are delivered. Various aspects were noted and are presented as follows:

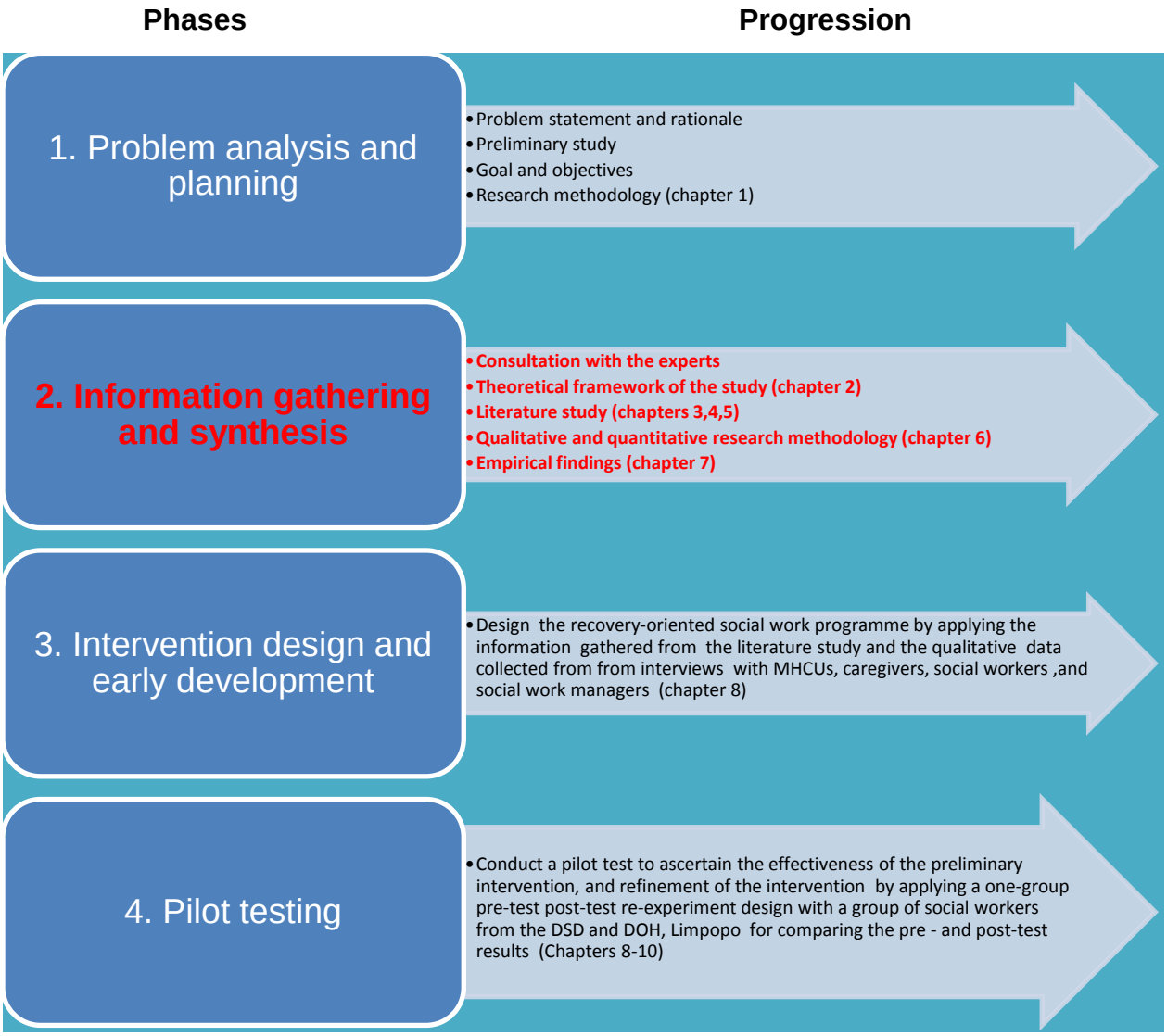
It has been noted that mental health poses a significant challenge faced by many countries world-wide. Mental health is clearly neglected in numerous instances, and it is evident that many people nationally and globally suffer from mental health problems. Advances have been made in improving mental health care, for example, legislation that is human rights based, and the integration of mental health care into general health services. Stigma and discrimination persist despite the progress in improving mental health services. Culture also plays a significant role in the way mental health problems are interpreted in SA communities. Furthermore, poverty is rife among families affected by mental illness, especially in rural areas. It has been noted that there is a relationship between poverty and mental health. Nevertheless, a national development plan has been put in place in an endeavour to eradicate, or at least minimise, poverty in SA.

It is acknowledged that the SA government has developed a national mental health policy framework and strategic plan geared toward improving and accelerating the provision of mental health services. The private and public sectors have the responsibility to provide these mental health services; furthermore, it has been noted that mental health services in rural areas are limited. These communities struggle with a critical lack of human and other resources. It is evident that access to mental health care in rural areas poses a major problem. Therefore, investing in rehabilitation is essential to address the gap in mental health care services in rural areas, in line with recovery-oriented mental health

practice. Recovery-oriented mental health services are person-centred, goal directed, instil hope, and facilitate empowerment to the individual's recovery journey. The following chapter focuses on living with schizophrenia, and the treatment and interventions for schizophrenia sufferers and their caregivers.

CHAPTER 4

LIVING WITH SCHIZOPHRENIA, CARING FOR PEOPLE LIVING WITH SCHIZOPHRENIA, AND THE TREATMENT THEREOF



Graphic representation of phases of the intervention research: Adapted from Fraser and Galinsky (2010:463); De Vos (2011)

4.1 Introduction

The global prevalence of lifetime schizophrenia is estimated to be between 14 and 55 people for every 10 000, and between 33 and 34 people for every 10 000 in terms of a one-year prevalence measurement of the disorder (Goldner, Hsu, Waraich & Somers, 2002:833; Saha, Chant, Welham & McGrath, 2005:0414). The serious implications of this disorder are clear, as it remains one of the major contributors to the worldwide burden of the disease (Saha et al., 2005:0414). Schizophrenia is a very complex disorder of the brain, believed to be caused by a chemical imbalance. But, with thorough assessment, careful treatment, and strong support for each individual the chances of successfully living with schizophrenia can be greatly improved (Canadian Psychiatric Association and Schizophrenia Society of Canada (2007:2). The World Health Organisation (WHO) (2004) estimates that more than 26 million people suffer from schizophrenia, making it one of the top 20 causes of disability, worldwide. Schizophrenia is also among the most financially costly illnesses in the world and, together with other psychotic illnesses, has been shown to account for 1.5% (UK), 2% (Netherlands, France) and 2.5% (US) of total national healthcare budgets (Rössler, Salize, van Os, Riecher- Rössler, 2005:399; Lindström, Eberhard, Neovius & Levander, 2007:33).

It has been estimated that between 4 and 5 million individuals afflicted by these severe psychiatric disorders such as schizophrenia live in African countries (Saha et al., 2005:0415). The 12-months survey found that 16.5% of South Africa's adult population suffered from some form of mental disorder (Chiumua & Van Wyk, 2014:1). The Sunday Times (2014) claimed that "more than 17 million people in South Africa are dealing with depression, substance abuse, anxiety, bipolar disorder and schizophrenia, that would account for around a third of South Africa's 51.8 million population." Baumann (2015:546) asserts that schizophrenia has been observed across all geographic, ethnic, racial, and socioeconomic groups.

Moreover, Baumann (2015:246) highlights that the peak incidence of onset is between 15 and 25 in men and about five years later in women. It should be noted that literature on the current prevalence rate of schizophrenia in South Africa is lacking, but it is estimated that 1% of the South African population suffers from schizophrenia, amounting

to a figure of roughly 500 000 people (following census estimates of population size) suffering from this disorder at any given time (Saayman, 2010:12). The presentation in this chapter will focus on schizophrenia, an overview of the history of schizophrenia, epidemiology of schizophrenia, diagnostic criteria, clinical symptoms and course of schizophrenia, treatment and challenges, and needs of those living with the disorder. The discussion also focuses on caring for people living with schizophrenia.

4.1.1 Overview of the history of schizophrenia

The definition of schizophrenic disorder was first coined in the early 1800s (Burke, 2012:560). John Haslam and Phillipe Pinel described some of the symptoms as part of what they termed “a form of insanity” (Burke, 2012:560). In addition, Berrios, Luque, and Villagran (2003:1) report that in 1860 Benedict Morel, a Belgian physician, used the French term *demence precoce* (early mental deterioration) which alludes to the age of onset of the condition, which is typically in adolescence. Burke (2012:561) further points out that “…by the end of the nineteenth century, a German psychiatrist, Emil Kraepelin, translated Morel’s term to *dementia praecox,* pointing out the characteristic cognitive aspects *(dementia)* and age onset *(praecox) of the condition.*” Cranco and Lehman (2000:1) assert that *dementia praecox* presents with distinctive, albeit disparate, signs of *catatonia* (immobility or agitation) and *hebephrenia* (apparent immaturity or “silliness” and paranoia) (persecutory or grandiose delusions).

Kuhn (2004:361) further state that in 1911 Eugen Bleuler, a Swiss psychiatrist, coined the term *schizophrenia*, which replaced the term *dementia praecox.* Bleuler introduced the concept of primary and secondary schizophrenic symptoms; his four primary symptoms (the four A’s) were abnormal associations, autistic behaviour and thinking, abnormal affect, and ambivalence (Ashok, Baugh & Yerangani, 2012:95). The central symptom of the illness is the loss of association between thought processes, emotion, and behaviour. In his view, depending on the individual's adaptive capacity and environmental circumstances, this fundamental process could lead to secondary disease manifestations such as hallucinations, delusions, social withdrawal, and diminished drive (Fusar-Poli & Politi, 2008:1407).

4.1.2 Epidemiology of schizophrenia

Schizophrenia can be described as a “severe mental disorder characterised by profound deficits in thinking, perception, affect, and social behaviour” (World Health Organization [WHO], 2014). It affects about seven per thousand of the adult population, especially those in the age group 15 to 35. Although its incidence is low (3 per 10,000), the prevalence is high due to the chronicity of the illness (WHO, 2014). The main clinical symptoms of this mental disorder are hallucinations, delusions, thought disorder, abnormal affect, and disturbance of motor behaviour. Although the most salient symptoms are hallucinations and delusions, for a significant portion of the course of the illness, the individual’s social and occupational functioning is markedly below the level achieved prior to onset (WHO, 2014).

One of the main features of schizophrenia is its impact on reducing the psychosocial functioning of the individual, including self-care skills, quality of social relationships, family life, and occupational performance (Ursano, Bell, Eth, Friedman, Norwood, Pfefferbaum, Pynoos, Zatzick, Benedek, MvIntyre, Charles, Altshuler, Cook, Cross, Mellman, Norquist, Wood & Yager, 2004:3). Antipsychotic medication is currently the basis of treatment for schizophrenia, significantly reducing the severity of positive symptoms (Lieberman & Kopelowicz, 2005:735). However, this medication has a very poor effect on the reduction of negative symptoms, cognitive impairment, and the overall functioning of the individual. The inclusion of psychosocial intervention in the treatment of people with schizophrenia is increasingly common and plays a key role in the recovery of the individual’s social functioning (Kopelowicz & Liberman, 2004:4).

An epidemiologic catchment area study in the United States reported a lifetime schizophrenia prevalence rate of 1.5% (Eaton & Kessler, 1985). A study of a representative community sample in the US, assessed by structured diagnostic interviews, yielded an estimate of the lifetime prevalence of schizophrenia of 0.7% (Kendler, Gallagher, Abelson & Kessler, 1996). Among persons aged 65 years and older, the prevalence is probably 1% (Gurland & Cross, 1982). The researcher has noted that schizophrenia has a good prognosis; hence, these individuals are good candidates for

the recovery process. A person with schizophrenia can continue living a satisfying life while the symptoms are still present but managed by antipsychotic medication.

4.1.3 Diagnostic criteria, clinical symptoms, and course of schizophrenia

There are no laboratory/physical examination findings or biomarkers that are useful in making the diagnosis, but the diagnostic criteria may be useful in excluding other medical causes of psychosis (Khamker, 2012:112). The author further asserts that family members provide the initial diagnostic and collateral information for the assessment of a person with schizophrenia. The clinical symptom domains of schizophrenia are grouped in the following clusters (table 4.1):

Table 4.1: DSM-5 diagnostic criteria for schizophrenia

A. **Two (or more) of the following, each presenting a significant portion of time during a one-month period (or less if successfully treated); at least one of these must be 1, 2 or 3:**

   1. Delusions
   2. Hallucinations
   3. Disorganised speech (that is frequent derailment or incoherence)
   4. Grossly disorganised or catatonic behaviour

   Negative symptoms

B. For a significant portion of the time since the onset of the disturbance, the level of functioning in one or more major areas such as work, interpersonal relations, or self-care, is markedly below the level achieved prior to onset (in childhood or adolescence), there is failure in achieving the expected level of interpersonal, academic, or occupation functioning.

C. Continuous signs of the disturbance persisting for at least six months. This six-month period must include at least one month of symptoms (or less if successfully treated) that meet criterion A (that is active-phase symptoms) and may include periods of prodromal or residual symptoms. During these prodromal or residual periods, the signs of the disturbance may be manifested by only negative symptoms or by two or more symptoms listed in criteria A present in an attenuated form (for example, odd beliefs, unusual perceptual experiences).

D. Schizoaffective disorder and depressive or bipolar disorder with psychotic features have been ruled out because either (1) no major depressive or manic episodes have occurred concurrently with the active-phase symptoms, or (2) if mood episodes have occurred during active-phase symptoms they have been present for a minority of the active and residual periods of the illness.

E. The disturbance is not attributable to the psychological effects of substance abuse (for example, drug abuse or medication), or another medical condition.

F. If there is a history of autism spectrum disorder or communication disorder of childhood onset, the additional diagnosis of schizophrenia is made only if prominent delusions or hallucinations in addition to the other required symptoms of schizophrenia have also been present for at least one month (or less if successfully treated).

Source: APA (2013)

The researcher is of the opinion that the DSM-5 is critical in the diagnosis of schizophrenia. Therefore, it is vital that social workers use this knowledge as a diagnostic tool. Olckers (2013) designed a DSM training programme for social workers and the diagnostic criteria prescribed as guidelines to be utilised and applied based on clinical judgement. The researcher therefore incorporated these diagnostic criteria in her recovery-oriented mental health programme. The criteria provide a clear classification or definition of schizophrenia, for example, in section A it is clearly articulated that a person is diagnosed with schizophrenia when he or she has two or more symptoms such as delusion, hallucination, disorganised speech – to mention but a few.

The clinical symptom domains of schizophrenia

The clinical symptom domains of schizophrenia are grouped in the following clusters (table 4.2).

Table 4.2: The clinical symptom of schizophrenia

Positive symptoms	Negative symptoms	Cognitive deficit	Mood symptoms	Neuromotor
Delusions	Affective blunting	Attention	Depression	Catatonia
Hallucinations	Alogia	Memory	Hopelessness	Stereotypic movements
Disorganised speech	Avolition	Executive function	Suicidality	Dystonia
Disorganised behaviour	Anhedonia		Anxiety	Hypokinesia

Positive symptoms	Negative symptoms	Cognitive deficit	Mood symptoms	Neuromotor
	Social withdrawal		Agitation	Dyskinesia
			Hostility	

Source: Khamker (2012:112)

Khamker (2012:112) provides more details regarding the clinical domains of schizophrenia as follows:

- **Positive symptoms** can be an exaggeration of a normal process and include hallucinations, which may be auditory, visual, tactile, or olfactory; and delusions, and which are fixed false beliefs that can be bizarre or non-bizarre, and are categorised according to the content, for example, paranoid, grandiose, and religious delusions. These symptoms are present in 80% of MHCUs. Other symptoms include disorganised speech and behaviour.
- **Negative symptoms** that are either the absence of or a decrease in normal processing. They can be primary or secondary in nature. Primary negative symptoms represent the core features of schizophrenia and include apathy, anhedonia, alogia, affective flattening, and avolition. Secondary negative symptoms can occur as a result of certain manifestations of the illness or due to treatment with antipsychotic medication.
- **Deficits in cognitive and executive functioning** are also observed in these MHCUs. The most affected areas are processing speed, attention, working memory, verbal and visual learning and memory, executive functioning, and social cognition.
- **Neuromotor symptoms** are also present, and include varying degrees of catatonia and stereotypic movements. Catatonia can present as extreme negativism, mutism, or excitement. Several neurological soft signs have been observed and encompass impairment in integration, motor coordination, and sequencing, but are unrelated to medication.

- **Mood and anxiety symptoms** are common in schizophrenia, and occur at a higher rate in these MHCUs. Substance use disorders also occur more frequently in these MHCUs.

Specifiers of course of illness in DSM-5

Tandon and Carpenter (2013:5) stipulate eight specifiers of the course of illness:

- First episode, currently in **acute episode**: This applies to the first manifestation of illness that meets all the diagnostic criteria of schizophrenia. An acute episode is a time period in which characteristic symptoms (criterion A) are present.
- First episode, currently in **partial remission**: Partial remission is a period during which an improvement after a previous episode is maintained, and in which the defining criteria of the disorder are only partially fulfilled.
- First episode, currently in **full remission**: Full remission is a period after a previous episode during which no disorder-specific symptoms are present.
- **Multiple episodes**, currently in acute episodes: Multiple episodes may be determined after a minimum of two episodes, i.e., after a first episode, a remission, and a minimum of one relapse. An acute episode is defined as above.
- **Multiple episodes**, currently in partial remission: Multiple episodes may be determined after a minimum of two episodes, i.e., after a first episode, a remission and a minimum of one relapse. Partial remission is defined as above.
- **Multiple episodes**, currently in full remission: Multiple episodes may be determined after a minimum of two episodes, i.e., after a first episode, a remission, and a minimum of one relapse.
- **Complete remission** is defined as above.
- **Continuous**. In order to categorise an individual as having a continuous course, symptoms fulfilling the diagnostic symptom criteria of the disorder must have been present for the greater part of the illness.
- **Unspecified**. Available information is too inadequate to characterise (APA, 2013).

The researcher has noted that the specifiers replaced the subtype of schizophrenia incorporated in the DSM-IV. Jager, Frasch, Lang, and Becker (2012:345) stipulate that the subtypes of schizophrenia provide a poor description of the heterogeneity of schizophrenia, has low diagnostic stability, does not exhibit distinctive patterns of treatment response or longitudinal course, and are not heritable. As a result, the subtypes of schizophrenia were eliminated from DSM-5. It is vitally important to have an understanding of the diagnostic criteria, clinical symptoms, and the course of schizophrenia; this will facilitate the appropriate application of recovery-oriented mental health practice. Mee-Lee (nd) asserts that "After assessment of diagnostic criteria, clinicians should consider the application of disorder specifiers as appropriate. Severity and course specifiers should be applied to denote individuals' current presentation, but only when full criteria [have been] met. Where applicable, specific criteria for defining severity (mild, moderate, severe, extreme), descriptive features (with good to fair insight in a controlled environment), and course (in partial remission, in full remission, recurrent) [are] provided with each diagnosis. Combination of: clinical interview, text descriptions, criteria, and clinical judgment – a diagnosis." The researcher is of the opinion that the course of schizophrenia is in line with recovery-oriented mental health practice. It assists with the treatment planning and treatment development. Furthermore, there is a category that focuses on full remission, and that is very critical to recovery-oriented mental health practice.

4.1.4 Treatment of schizophrenia

The *Medical Dictionary* (2017) defines treatment as "an action or manner of treating a MHCU medically or surgically." The APA (2010:9) identifies three goals of treatment planning:

- Reduce or eliminate symptoms.
- Maximise quality of life and adaptive functioning.
- Promote and maintain recovery from the debilitating effects of illness to the maximum extent possible.

Khamker (2012:113) asserts that comprehensive treatment entails a multimodal approach, including medication and psychosocial interventions; treatment objectives are to reduce the morbidity and mortality rates of the disorder.

4.1.4.1 Medication administered to MHCUs

As indicated by the APA (2010:9), medication or treatment reduces or eliminates symptoms. Furthermore, medication promotes and maintains recovery. The researcher is of the view that recovery cannot occur without medication, and that medication and recovery go hand in hand. Medication comprises typical and atypical antipsychotics.

4.1.4.1.1 Conventional or typical antipsychotics medication

Baumann (2015:772) claims that the typical antipsychotic is defined by dopamine-2 receptor activity. However, these first-generation medications have frequent and potentially significant neurological side effects, including the possibility of developing a movement disorder (tardive dyskinesia) that may or may not be reversible (APA, 2010:9). Table 4.3 provides more details about the medication.

Table 4.3: Typical antipsychotics medication

Drug	Proprietary name	Description
Chlorpromazine	Largactil	Used to treat psychotic disorders such as schizophrenia or manic-depression, and severe behavioural problems in children ages 1 to 12.
Fluphenazine	Moditen	An anti-psychotic medicine in a group of drugs called phenothiazines (FEEN-oh-THYE-a-zeens). It works by changing the actions of chemicals in the brain.
Haloperidol	Haldol (Serenace)	An antipsychotic medicine. It works by changing the actions of chemicals in the brain.
Perphenazine	Trilafon	An anti-psychotic medicine in a group of drugs called phenothiazines (FEEN-oh-THYE-a-zeens). It works by changing the actions of chemicals in the brain.

APA, 2010

These antipsychotics are often cheaper than the newer generation atypical antipsychotics, especially the generic versions that can be an important consideration when long-term treatment is necessary as it can take several weeks after first starting a medication to notice an improvement in symptoms. In general, the goal of treatment with antipsychotic medication is the effective control of signs and symptoms at the lowest possible dosage (Nolen-Hoeksema, 2014:241). On the other hand, the APA (2010:10) states that antipsychotic medication helps normalise the biochemical imbalances that cause schizophrenia, and is important in reducing the likelihood of relapse.

4.1.4.2 Atypical antipsychotics medication

Nolen-Hoeksema (2014:242) contends that atypical antipsychotics seem to be more effective in treating schizophrenia. These newer, second-generation medications are generally preferred because they pose a lower risk of serious side effects than do conventional medications (APA, 2010:11). These medications include the following (table 4.4):

Table 4.4: Atypical antipsychotics medication

Drug	Proprietary name	Description
Aripiprazole	Abilify	Used to treat the symptoms of psychotic conditions such as schizophrenia and bipolar disorder (manic depression).
Asenapine	Saphris	Used to treat the symptoms of psychotic conditions such as schizophrenia and bipolar disorder (manic depression) in adults, and for bipolar disorder in paediatric MHCUs (ages 10–17).
Clozapine	Clozaril, also known as leponex	Used to treat severe schizophrenia, or to reduce the risk of suicidal behaviour in people with schizophrenia or similar disorders.
Iloperidone	Fanapt	An antipsychotic medication used to treat schizophrenia. The recommended

Drug	Proprietary name	Description
		starting dose of Fanapt is 1 mg twice daily.
Lurasidone	Latuda	Used to treat schizophrenia in adults. Latuda is also used to treat episodes of depression in people with bipolar disorder (manic depression.
Olanzapine	Zyprexa	An atypical antipsychotic medication used to treat schizophrenia and manic episodes of bipolar disorder. Zyprexa is available in generic form known as olanzapine, and may be taken orally or by injection.
Paliperidone	Invega	Used to treat schizophrenia in adults and teenagers who are at least 12 years old. Invega may also be used for purposes not listed in this medication guide.
Quetiapine	Seroquel	A psychotropic medication used to treat schizophrenia in adults and children who are at least 13 years old. Also used in the treatment of major depression and bipolar disorder.
Risperidone	Risperdal	Used to treat schizophrenia and symptoms of bipolar disorder (manic depression). Risperdal is also used in autistic children to treat symptoms of irritability.
Ziprasidone	Geodon	Used to treat schizophrenia and the manic symptoms of bipolar disorder (manic depression) in adults and children who are at least 10 years old.
Diazepam	Benzodiazepine (ben-zoe-dye-AZE-eh-peen	Used to treat anxiety disorders, alcohol withdrawal symptoms, or muscle spasms.

APA, 2010

Nolen-Hoeksema (2014:241) further states that Clozapine has helped many people with schizophrenia who do not respond to phenothiazines, and it appears to reduce negative as well as positive symptoms. The researcher is of the opinion that this medication is critical and a cornerstone in the management of schizophrenia. However, the medication has side effects that are from mild to serious. Mild side effects: dry mouth, blurred vision, constipation, drowsiness, dizziness; these side effects usually disappear a few weeks after the person has started treatment (Grohol, 2016). More serious side effects: trouble with muscle control, muscle spasms or cramps in the head and neck, fidgeting or pacing, tremors and shuffling of the feet (similar to those affecting people with Parkinson's disease). Side effects are due to prolonged use of traditional antipsychotic medications: facial spasms, shoving and rolling of the tongue, lip licking, wheezing, and frowning (Grohol, 2016). It should be noted that antidepressants are also administered for the treatment of schizophrenia. The two most commonly used are selective serotonin reuptake inhibitors (SSRI) such as Sertraline (Zoloft) and serotonin and norepinephrinere re-uptake inhibitors (SNRI) such as Duloxetine (Cymbalta) (APA, 2010).

Electroconvulsive therapy (ECT): A controlled electric current is applied to the head while the MHCU is under anaesthesia in order to induce a grand mal seizure. This procedure can be effective, but is most often used for MHCUs who are nonresponsive to drug therapy. Severe long-term memory loss has been experienced by some MHCUs after the procedure, and constitutes a major risk of ECT (Mayo Clinic, 2016). The researcher believes that medication needs to be administered in conjunction with psychosocial interventions.

4.1.4.3 Psychosocial interventions in the treatment of schizophrenia

Karon (2003:90) is of the opinion that psychotherapy is not the sole treatment of choice for someone with schizophrenia but used as an adjunct to an effective medication plan; however, psychotherapy can help individuals maintain their medication, learn much-needed social skills, and support their goals and activities within their community. The author states that this may include advice, reassurance, education, modelling, limit setting, and reality testing with the therapist. Furthermore, the author states that people with schizophrenia often have a difficult time performing ordinary life skills such as

cooking and personal grooming as well as communicating with others in the family and at work. Therefore, therapy or rehabilitation therapy can help individuals regain their confidence to take care of themselves and live a fuller life. The treatment of schizophrenia has occupied a prominent position in the evolution of psychiatry and psychotherapy. Group therapy has come to play an important role in the treatment of schizophrenia. It is known that the best results are achieved with a combination of antipsychotic medication, psychotherapeutic treatment, family therapy, and a variety of social and rehabilitative interventions (Gabrovšek, 2009:67). The Mayo Clinic (2014) indicates that once psychosis is under control, psychological and social (psychosocial) interventions are important as an adjunct to medication. These may include:

- **Individual therapy (micro intervention)**: Learning to cope with stress and identify early warning signs of relapse can help people with schizophrenia manage their illness. In social work, this is coined micro intervention; individuals and their families are provided with mental health services (Garthwait, 2012:12). Family therapy (working with families): This provides support and education to families dealing with schizophrenia (Gabrovšek, 2009:67).
- **Group therapy (mezzo intervention)**: Combined with drugs, it produces somewhat better results than drug treatment alone, particularly in outpatient MHCUs living with schizophrenia. Positive results are more likely when group therapy focuses on real-life plans, problems, relationships, social and work roles, and interaction, in combination with drug therapy and dialogue about its side effects, or on practical recreational or work activity. This supportive group therapy can be especially helpful in decreasing social isolation, and increasing reality testing (Gabrovšek, 2009:67). Mezzo intervention focuses on groups that need mental health services (Garthwait, 2012:12).
- **Macro intervention**: Focuses on social policy and research in mental health (Garthwait, 2012:12).

Counselling

Counselling is another form of psychosocial intervention, and refers to professional guidance of the individual by utilising psychological methods, especially in using various techniques in collecting case history data (Lazarus & Freeman, 2009:14). Counselling denotes non-medical interventions that are limited in duration (generally not more than 6 to 8 sessions, but in some cases one session only) and scope (generally aimed at managing symptoms rather than more significant changes) (Lazarus & Freeman, 2009:15).

- **Informal counselling**

Informal counselling may occur in the context of a health consultation (Lazarus & Freeman, 2009:15). Health consultations generally "involve some communication between health worker and MHCU regarding health status and treatment (symptoms, duration, effect on functioning, expected or MHCU-reported effects of treatment, dosage, the importance of adherence) and related issues, for example life-style factors (diet, exercise, substance use, sources of stress and support)" (Lazarus & Freeman, 2009:15). In the case of MHCUs for whom psychotropic medication is prescribed, this communication could include (establishing the effect of the medication) an analysis of the MHCU's emotional state at home, at work, and under social circumstances (Lazarus & Herman, 2009:15). Problems in these areas could in turn invite useful responses by health workers, which may include emotional support, limited problem solving, advice, and referral to other resources (Lazarus & Freeman, 2009:15).

Da Rocha-Kustner (2009:1) is of the view that allowing problems to continue unabated will result in significant inconsistencies in focus, empathy, and effective communication. Communication may range from empty reassurances and inappropriate advice to what may amount to counselling to afford the MHCU an opportunity to articulate problems and express feelings so as to open the way to more effective problem solving (Da Rocha-Kustner, 2009:1). The author reiterates that there are a number of factors such as limited staffing, insufficient time available for consultation, lack of training, and the absence of a biomedical model that place significant restrictions on the level to which informal counselling can contribute to primary mental health care. Nevertheless, it does occur and may provide limited assistance where there are no alternative resources. In this regard,

Lazarus and Freeman (2009:15) suggest that the training of health personnel to make appropriate use of informal counselling opportunities, could improve its quality (Lazarus & Freeman, 2009:15).

- **Psycho-educational counselling**

Psycho-educational counselling is defined as "counselling which focuses primarily on providing relevant information (for example, regarding symptoms, the role of related factors such as stress, coping strategies) and helping MHCUs to apply the information in their own situation" (Conradi, De Jonge, Kluiter, Smit, Van der Meer & Jenner, 2007:849). Lazarus and Freeman (2009:15) are of the view that insufficient mental health professional resources and psycho-educational interventions may place undue pressure on general nurses and auxiliary workers who are not necessarily trained mental health professionals.

In the pilot study conducted by Chatterjee, Chowdhary, Pedneker, Cohen, Andrew and Araya (2008) in Goa, India, MHCUs described the psychoeducational component as useful; they could recall the content of the sessions, and they reported that they were making use of some of the stress-reduction techniques recommended in the sessions. However, the suggestions by Conradi et al. (2007:850), who conducted a three-year randomised controlled comparison of an individualised psycho-educational relapse prevention intervention, should be viewed with caution. The researcher holds the view that psycho-education is critical in recovery-oriented mental health practice as it is evidence-based, promotes recovery, improves adherence, and reduces relapse.

- **Referral**

Referral involves the transfer of responsibility of all or part of the care of a MHCU (Bower & Gilbody, 2005:839). Although it may occur within a primary care team, it usually involves referral to a specialist at primary care level or, where necessary, secondary or tertiary levels of care. Typical examples of referral within the health services would be referral to a psychologist for brief psychotherapy, or to an inpatient unit at a district hospital. Referral may also be made to services in other sectors, for example, social or employment services, for assistance necessary to support recovery. The referring service or health

worker, for example, may retain responsibility for certain aspects of care such as monitoring MHCUs' response to psychotropic medication (Lazarus & Freeman, 2009:20). The researcher is of the opinion that the mental health care practitioner should list the resources required by all community mental health services as MHCUs need to be referred after discharge from the hospital.

4.1.4.4 Recovery-oriented mental health treatment

Recovery-oriented mental health services promote active participation of MHCUs in selecting services and developing treatment plans while working toward recovery (Frost, Heinz & Bach, 2011:e22). Various forms of interventions that support recovery are discussed below such as recovery-oriented cognitive therapy for schizophrenia, skills training, vocational recovery/psychosocial rehabilitation, and assertive community treatment – to mention but a few.

Recovery-oriented cognitive therapy for schizophrenia

Cognitive therapy (CT) is referred to as a "treatment for people suffering from mental illnesses that try to change the way they think" (Mayo Clinic, 2016). Dr Aaron T. Beck pioneered the therapy in the 1960s (Beck, 1993:345). In the late 1990s, Beck and Grant (2009:1) developed recovery-oriented therapy for schizophrenia, focusing on treating negative symptoms (National Alliance on Mental illness [NAMI], 2016). Beck and Grant in NAMI (2016) discovered that therapy promoted recovery by targeting negative beliefs. They advocated energising engagement with the MHCU, eliciting meaningful aspirations, and planning action toward achieving these goals. Recovery-oriented cognitive therapy (CT-R) denotes a collaborative treatment approach that prioritises the attainment of personally set goals, removal of obstacles, and engagement of individuals in their own psychiatric rehabilitation (Grant & Beck, 2009:798). Kingdon (2006:1) indicates that cognitive therapy is now recognised as an effective intervention for schizophrenia in clinical guidelines developed in the United States and in Europe. The author further explains that this therapeutic technique has established a link between thoughts, feelings, and actions; and agendas comprising 12 to 20 sessions have been set and used more flexibly.

Social skills training (SST)

Social skills training (SST) is defined as “a type of psychotherapy that works to help people improve their social skills so they can be socially competent” (Kopelowicz, Liberman & Zarate, 2006:S12). Similarly, the WHO (1996) defines social skills training “as those methods that use the specific principles of learning theory to promote the acquisition, generalization and durability of the skills needed in social and interpersonal situations” (Rus-Calafell, Gutierrez-Maldonado, Ribas-Sabate & Lemos-Giraldez, 2014:464). Social skills training is an empirical-based strategy included in illness management programmes aimed at recovery (Mueser, Corrigan, Hilton, Tanzman, Schaub, Essock, Tarrier, Morey, Vogel-Scibilia & Herz, 2002:1272). Skills training occurs at different levels: it starts during primary mental illness treatment within an institution, and continues after discharge into the community. In line with self-help, empowerment, and prospects for recovery from schizophrenia, social skills training serves as a common denominator for becoming an active participant in controlling this illness, overcoming obstacles to achieving personal goals, and mobilising social support (Kopelowicz et al., 2006:S14).

Social skills training was integrated with a similar comprehensive treatment programme of evidence-based services for 547 young MHCUs in Aarhus and Copenhagen, Denmark after a first episode of psychotic illness. At the end of two years, MHCUs in the programme showed significantly fewer positive symptoms and negative symptoms, and significantly greater satisfaction with the treatment (Petersen, Nordentoft, Jeppesen, Ohlenschaeger, Thorup & Christensen, 2005:s98). The researcher is of the opinion that social skills training enhances the recovery process of MHCUs. She concurs with Baumeister, Campbell, Krueger, and Vohs (2003:1) that by incorporating empowerment, life satisfaction, and self-efficacy as outcome measures of social skills training, the subjective benefits of gaining competence will inspire improvement in the educational design of training goals and procedures, and would promote recovery.

Vocational rehabilitation/psychosocial rehabilitation

British Society of Rehabilitation Medicine (2010) defines vocational rehabilitation as a "process that enables people with functional, psychological, developmental, cognitive and emotional impairments or health conditions to overcome barriers to accessing, maintaining or returning to employment or other useful occupation." Pillay and Kramers-Olen (2013:277) refer to psychosocial rehabilitation as "a combination of occupational, social, educational, behavioural and cognitive interventions aimed at increasing the quality of those affected with serious and persistent mental illness." Simpson and Sambuko (2011:66) assert that psychosocial rehabilitation aims at long-term recovery and maximum self-sufficiency of MHCUs, fosters social interaction, and promotes independent living and vocational performance. The World Health Organisation mhGAP (2010) advocates that individuals who suffer from schizophrenia must be encouraged to continue their social occupational and educational activities as a way of enhancing social inclusion. Pillay and Kramers-Olen (2013:277) assert that the benefits of psychosocial rehabilitation coupled with treatment are widely accepted, and there is evidence that people with schizophrenia are benefitting from these programmes.

Research in the United States has enhanced the practice of psychosocial rehabilitation intervention (Anthony, Cohen, Farkas & Gagne, 2002). Notably, the needs of MHCUs and their family members have been considered in the refinement of psychosocial rehabilitation interventions and programmes (Rangaswamy and Sujit, 2012) as advocated in the recovery model; following empirical evidence that recovery is possible and desirable, and that rehabilitation outcomes facilitate the inclusion and wellbeing of people with schizophrenia (Farkas & Anthony, 2010). Hence, these authors are of the view that rehabilitation within the context of recovery aims at reducing symptoms and regaining vocational skills or social roles to increase self-sufficiency. Therefore, the researcher is of the view that in order for psychosocial rehabilitation to be effective, psychosocial rehabilitation interventions should be person-centred in order to improve the day-to-day functioning of an individual, with the emphasises on empowerment and quality of life. The psychosocial rehabilitation models are stipulated by Kramers-Olen (2014:503) as follows:

- **Psychosocial rehabilitation treatment model**

A model of inpatient psychosocial treatment provided to adults with severe mental illness. The Multi-Disciplinary Team provides rehabilitation services in centralised areas. This approach is premised on the idea that human resources can be more effectively utilised in this way, and that individualised treatment interventions can be facilitated since MHCUs can choose among the daily scheduled activities in order to maximise personal treatment goals, rather than among scheduled ward activities.

- **Choose-get-keep model**

The choose-get-keep model of psychiatric rehabilitation, developed by Anthony et al. (2002) in Kramers-Olen (2014:503) at the Centre for Psychiatric Rehabilitation in Boston, provides mental health professionals with guidelines and standards of care for persons with CMI as well as practical methods to record the rehabilitation goals of MHCUs, requirements of MDT team members, and timeframes. The choose-get-keep model has been applied in community housing settings in the Netherlands (de Heer-Wunderink, Visser, Caro-Nienhuis, van Weeghel, Systema & Wiersma, 2012:454) .

- **Assertive community treatment programme (ACT) models**

These models were developed in the 1970s by Stein and Test in Wisconsin (Stein & Test, 1980). ACT augments MHCU strengths in their adjustment to community life, and empirical research has consistently demonstrated improvements in MHCU health outcomes such as a decrease in psychiatric symptoms and substance abuse, reduced hospitalisation, or imprisonment (Dixon et al., 2010). Research indicates that adherence to ACT models results in maximal health outcomes (Dixon et al., 2010). ACT interventions have been applied to forensic mental health populations, managed by a probation officer and treatment teams, as well as residential housing and substance abuse treatment interventions. Research has yielded some evidence to suggest that recidivism rates were reduced, hospitalisation time lowered, and substance use decreased (Chandler & Spicer, 2006; Lamberti, Weisman & Faden, 2004).

- **Clubhouse models**

Models of psychosocial rehabilitation, established in the early 1980s, underscore the need for persons affected by Chronic Mental Illness (CMI) to move from "patienthood" to "personhood" (Beard, Propst & Malamud, 1982) emphasising autonomy and self-help (Jung & Kim, 2012). Clubhouse members make decisions regarding the extent to which they participate as well as the nature of such participation (Jung & Kim, 2012). The clubhouse model stresses the importance of parity between clubhouse staff and members; hence, clubhouse models are based on empowerment partnerships that allow members to develop meaningful interpersonal relationships that support employment, education, and housing opportunities. Clubhouses are peer-operated services managed collaboratively by staff and club members (Solomon, 2004). A study conducted in Massachusetts suggests that long-term clubhouse membership is associated with a higher rate of employment and higher paid jobs (McKay, Johnsen & Stein, 2005).

- **Case management, stepped care, and collaborative care**

Case management, stepped care, and collaborative care are overlapping and interlinked approaches to the treatment of schizophrenia. Increasingly, all the components are integrated, often referred to as stepped collaborative care, which includes a case-management component (Gilbody, Whitty, Grimshaw & Thomas, 2003:3145). In developing countries, these approaches may offer innovative alternatives where there are limited or no referral resources.

***Case management*:** Case management (sometimes also referred to as care management) involves assigning responsibility for overseeing and coordinating the care of MHCUs to a particular member of the health care team (Gilbody et al., 2003:3145). This is often someone who is responsible for providing a major aspect of the MHCU's care beyond the acute stage, for example, monitoring response to medication or providing counselling or psychotherapy (Gilbody et al., 2003:3145). These authors further point out that case management involves structured and systematic monitoring of the adherence to treatment and indicators of progress or relapses; follow-up in the case of treatment default; and liaison with other team members regarding treatment. The case manager may also facilitate access to resources such as health care for physical conditions, if necessary, or support from other sectors such as employment opportunities, grants or

other material assistance (Lazarus & Freeman, 2009:18). Case management is generally a central part of stepped care and collaborative care (Gilbody et al., 2003:3146).

***Stepped care*:** Stepped care has been developed as an approach to effective and cost-effective management and allocation of scarce resources. Needham (nd) in Lazarus and Freeman (2009:18) describes stepped care as involving provision of low intensity interventions to a significant proportion of MHCUs who derive significant benefit from these interventions; more intensive interventions (including referral for specialist care) are then restricted to MHCUs who have more severe disorders or who fail to improve. Successful stepped care is assumed to provide a filter that encourages appropriate care at the level of intensity required, with shorter waiting lists and easier access to more advanced care for those who really need these services (Lazarus & Freeman, 2009:19). Hence, case management is seen as essential for effective stepped care. Stepped care employs common sense logic in circumstances of limited resources, and where there is some evidence that it may improve MHCU outcomes.

***Collaborative care*:** Collaborative care is a way of organising care directed at more efficient resource utilisation and care that is more effective and beneficial to MHCUs. Bower, Gilbody, Richards, Fletcher and Sutton (2006:484) describe collaborative care as a multifaceted, multicomponent intervention, which includes case management and closer liaison between primary care generalist health workers and mental health specialists; it improves collaboration between staff working at the primary care level; and may also involve a stepped care approach in the use of interventions relating to resources or the addition of new categories, supplementing those that are more traditionally oriented. Collaborative care is shown to have some positive effects on outcomes such as depressive symptoms, medication adherence, and MHCU satisfaction (Bower & Gilbody, 2005:13).

- **The psychosocial rehabilitation model**

The researcher deemed the psychosocial rehabilitation model appropriate for the present study, and is advocating for the implementation of psychosocial rehabilitation programmes within the South African context. Furthermore, the National Mental Health Policy Framework and Strategic Plan (2013-2020) advocates for mental health services based on recovery models that facilitate the participation of consumers in determining their roles of choice in communities, with the emphasis on psychosocial rehabilitation (Department of Health, 2013). Therefore, the present study is geared toward furthering the knowledge of social workers as to their role in psychosocial rehabilitation. Traditional medicine plays a critical role when discussing the treatment of schizophrenia. The researcher has noted that the first point of entry or pathway to help-seeking behaviour for schizophrenia patients is traditional medicine. Hence, the researcher saw it fitting to discuss this phenomenon in the present study.

Cross-cultural treatments – traditional healing and spirituality

Traditional healing/medicine

Nolen-Hoeksema (2014:246) asserts that “in the developing countries and parts of industrialised countries, the symptoms of schizophrenia sometimes are treated by folk or religious healers, based on cultural beliefs about the meaning and causes of the symptoms.” Furthermore, this author provides four models that traditional healers tend to follow in treating schizophrenia:

- **The structural model** – interrelated levels of experience such as body, emotion and cognition of the person, society, and culture, and therefore the symptoms arise when the integration of these levels is lost. Healing involves reintegrating these levels through a change of diet or environment, the prescription of herbal medicines or rituals (Nolen-Hoeksema, 2014:246).
- **The social support model** – holds that symptoms arise from conflictual social relationships and healing, which involves mobilising a MHCU’s kin to support him

or her through the crisis and reintegrating the MHCU into a positive social support network (Nolen-Hoeksema, 2014:246).

- **The persuasive model** – suggests that rituals can transform the meaning of symptoms for MHCUs, diminishing their pain (Nolen-Hoeksema, 2014:246).
- **The clinical model** – denotes the faith the MHCU has in the traditional healer to provide a cure for his or her symptoms (Nolen-Hoeksema, 2014:246).

Nolen-Hoeksema (2014:246) is of the opinion that interventions for a person with schizophrenia also include his or her family. In South Africa, Sorsdahl, Flisher, Wilson, and Stein (2010) conducted a study in Mpumalanga, which consisted of in-depth interviews with Zulu traditional healers, the majority (60%) of whom asserted that psychosis is not necessarily a mental disorder. Some participants (traditional healers) in their study stated that their ancestors inflict these symptoms on people, summoning them to become traditional healers. For example, these healers reported that the voices these people were hearing were linked to the instructions to accept the calling to become healers (Sorsdahl, Flisher, Wilson & Stein, 2010). Moreover, healers in their study mentioned that there is more to the process of becoming a traditional healer than simply hearing voices (Sorsdahl, Flisher, Wilson & Stein, 2010). It is clear that traditional medicine plays a major role in treating schizophrenia, especially in SA rural areas. Due to limited mental health services in rural areas, some of the families consult traditional healers before they consider seeking assistance from medical facilities.

Spirituality

Mizock, Millner, and Russinova (2012:82) point out that the topics of spirituality and psychotherapy are often debated in literature with regard to schizophrenia treatment. However, literature alludes to the many possible benefits of incorporating issues of religion and spirituality into psychotherapy (Gottdiener, 2006:583). The integration of spirituality and religion into psychotherapy has been a relatively recent development (Post & Wade, 2009:247). During the twentieth century, mental health practitioners intentionally excluded issues of religion or spirituality from psychotherapy (Plante, 2007:891). However, the researcher has noted that spirituality is crucial in recovery-oriented mental

health practice. This assertion is supported by Lukoff (2007:646) that “the recovery and rehabilitation movement highlighted the integral role of spirituality for the holistic and overall functioning of individuals affected by the most disabling mental illnesses.” Furthermore, Starkowitz (2013:21) asserts that spirituality is an important component of African traditional medicine. The author holds the view that traditional medicine operates from “the indigenous a spiritual realm and aims to discover the spiritual tension or environmental disharmony.” There are benefits in integrating MHCUs’ spirituality into counselling; this enhances treatment results for individuals in general and holds implications for individuals with schizophrenia in particular (Gorush,& Miller, 1999:47). On the other hand, Walsh (2008:31) contends that spirituality contributes meaningfully to managing mechanisms and meaning-making systems when dealing with pain and suffering. Mizock et al. (2012:83) add that MHCUs regularly hold a diversity of spiritual beliefs and coping resources that range from private personal practices (such as prayer or meditation) to involvement in supportive religious communities. These authors further claim that “religious and spiritual practices, such as acceptance and forgiveness, prayer, meditation, and worship are areas of coping, which, developed in the context of psychotherapy, can enhance the ways in which people deal with adversity and people with schizophrenia in particular.”

Davidson, Drake, Schmutte, Dinzeo, and Andres-Hyman (2009:323) allege that the recovery model is an approach to mental illness that emphasises the process of living a satisfying life of wellbeing and autonomy, as opposed to the traditional treatment focus on symptom elimination. Lukoff (2007:646) further indicates that recovery from serious mental illness is presented as “a spiritual process in itself and a journey of facing spiritual questions about relationships to God, reasons for the illness, and finding a place in the world.” The researcher has noted that there are various forms of intervention in mental health care. She deems the present study pertinent, that when social workers are capacitated with different modes of intervention these could benefit MHCUs. She is of the opinion that these interventions can be applicable in South Africa’s rural areas.

4.2 The challenges and needs of living with schizophrenia

The researcher holds the view that living with schizophrenia is fraught with challenges. Furthermore, each person has a hierarchy of needs (Maslow, 1943).

4.2.1 The challenges of living with schizophrenia

People with the lowest socio-economic status (SES) have eight times the risk of developing schizophrenia compared to those of the highest SES (Funk et al., 2012:166). These authors state that people with schizophrenia are also four times more likely to be unemployed or partly employed. Cohen, Raja, Underhill, Yaro, De Silva and Patel (2012:1) asserts that "…one-third [are] more likely not to have graduated from high school and 3 times more likely to be divorced." The WHO (2013) describes the challenges experienced by MHCUs as follows:

Homelessness: Mental disorders frequently thrust individuals and families into poverty and homelessness; inappropriate incarceration is far more common among people with mental disorders than those in the general population. This exacerbates their marginalisation and vulnerability. Homelessness has been found to be relatively common among people with schizophrenia in rural China (Ran, Chan, Chen, Xiong, Caine & Cornwell, 2006:118). A ten-year study in China with a cohort of people with schizophrenia found that 7.8% had experienced homelessness compared to only 0.9% among the general population (Ran et al., 2006:119). In Nigeria, a 13-year follow-up of clinically stable outpatients found that 4% were homeless or had uncertain access to accommodation (Gureje & Bamidele, 1999:147). In a study conducted in 2014 by Skosana in Durban, South Africa, it was established that 50% of people with mental illnesses were homeless and living on the streets (Skosana, 2014).

Stigmatisation and discrimination: Persons with mental disorders often have their human rights violated and many are denied economic, social, and cultural rights; their rights to education and employment; their reproductive rights; and the right to the highest attainable standard of health is often curtailed. Studies in 21 European Union (EU) countries found that on average 26% of people with severe mental disorders and 20% of people with severe and moderate disorders abandoned full-time educational programmes

before the age of 15, compared with 14% of individuals without mental disorders (Organisation for Economic Cooperation and Development [OECD], 2012). Longitudinal data emanating from Australia and the United States suggest that approximately one-quarter of individuals with a severe or moderate mental disorder at age 18 had left school and had not earned a high school diploma by age 20 (OECD, 2012; Leach & Butterworth, 2012). While many young people who drop out of school eventually do further their education, this is not the case for those with emotional or behavioural disabilities (OECD, 2012). Consequently, many people fail to complete their education (Leach & Butterworth, 2012).

Discrimination against people with schizophrenia seeking employment is "high and consistent across countries" which affects their income levels (Thornicroft, Brohan, Rose, Sartotius & Leese, 2009:408). In a cross-sectional survey in 27 countries of 732 people with diagnosed schizophrenia, 70% of whom were unemployed, almost half reported experiencing discrimination in finding or keeping work (Thornicroft et al., 2009:408). A number of studies have indicated the reluctance of employers to hire people with mental illness (Stuart, 2006, McDaid, Knapp & Curan, 2005; McDaid, 2008). For example, a study in Uganda revealed that an important reason why people with mental illness are denied access to credit services, was that they are believed to have impaired functioning, unable to meaningfully engage in productive work, and are therefore incapable of paying back monetary loans. This discriminatory practice denied people the opportunity to escape poverty through income-generating activities (Thornicroft et al., 2009:408).

People living with schizophrenia may also be subjected to unhygienic and inhuman living conditions, physical and sexual abuse, neglect, and harmful and degrading treatment practices in health facilities (WHO, 2013). They are often denied their civil and political rights such as the right to marry and establish a family, personal liberty, the right to vote, participate effectively and fully in public life, and the right to exercise their legal capacity on other issues affecting them, including their treatment and care (WHO, 2013). As such, persons with mental disorders often live in hazardous situations and may be excluded and marginalised from society, which constitutes a significant impediment to the achievement of national and international developmental goals.

Funk et al. (2006:70) highlight that in the majority of countries, people with mental disabilities and their families are not able to participate in decision-making processes on issues affecting them. Furthermore, these authors posit the assumption that "people with mental disabilities lack the capacity to make meaningful contributions to the society." The researcher is of the opinion that recovery-oriented mental health practice has brought hope to MHCUs as they have been oppressed for so long. The recovery principles are at centre stage in mental health transformation. Collaborative care is encouraged. In recovery-oriented mental health provision, it has been suggested that consent should be sought from MHCUs in order to involve family, caregivers, friends, and other significant others.

4.2.2 The needs of people living with schizophrenia

Maslow's hierarchy of needs is often represented in a hierarchical pyramid with five levels (Maslow, 1943). The four levels (lower-order needs) are considered physiological needs, while the top level of the pyramid is considered growth needs. As lower-level needs must be satisfied before higher-order needs, this can influence behaviour. The levels are as follows (figure 4.1):

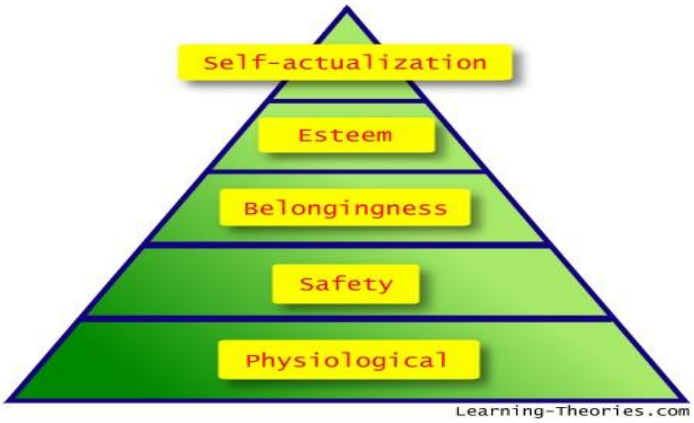


Figure 4.1: Maslow's hierarchy of needs pyramid (Maslow, 2013)

- Self-actualisation – includes morality, creativity, problem solving.
- Esteem – includes confidence, self-esteem, achievement, respect.
- Belongingness – includes love, friendship, intimacy, family.
- Safety – includes security of environment, employment, resources, health, and home ownership.
- Physiological – includes air, food, water, sex, sleep, other factors affecting homeostasis (Maslow, 2013).

For over 50 years, Abraham Maslow's hierarchy of needs has been one of the most cited theories of human behaviour (Kenrick, Griskevicius, Neuberg & Schaller, 2010:292). Maslow's theory is often depicted as a pyramid that places physiological needs (such as food, water, and air) at the base, followed by safety, belonging, and esteem needs moving up the pyramid (Kenrick et al., 2010:293). At the top of Maslow's pyramid is the need for self-actualisation, described as the desire "to become everything that one is capable of becoming" (Maslow, 1943, 2013). This has striking similarities to the overarching goal of the mental health recovery paradigm, which is for people to "strive to reach their full potential" (Substance Abuse and Mental Health Administration [SAMHSA]), 2011). Additionally, SAMHSA (2011) recognises the important overall aspects of the recovery process such as health, home, purpose, and community.

Manamela, Ehlers, van der Merwe and Hattingh (2003) conducted a study in Limpopo, and the findings revealed that the participants had physiological, physical, psychological, social, emotional, and spiritual needs. Furthermore, the participants desired services such as vocational training, individual or family assistance, accommodation, legal assistance, and medical and psychiatric care. The researcher holds the view that recovery-oriented mental health practice can be of benefit, if implemented. Hence, the present study is pertinent to addressing this issue. The researcher has noted that there are striking similarities between Maslow's hierarchy of needs and mental health recovery. It is therefore important that MHCUs be engaged in meaningful activities, and in the process have their needs met.

4.3 Caregiving provided for mental health care users with schizophrenia

Globally, the deinstitutionalisation of MHCUs with mental illnesses has resulted in the responsibility for care devolving to family members (Lippi, 2016:1). Similarly, Chan (2011:339) indicates that families who are caring for persons with schizophrenia within the community or are living with a relative with severe mental illness, live under considerable stressful conditions. Drentea (2007:1) defines caregiving "as an act of providing unpaid assistance and support to family members or acquaintances who have physical, psychological, or developmental needs." Furthermore, the author describes three forms of caring, namely instrumental, emotional, and informational. Instrumental help includes activities such as shopping for someone who is disabled, or cleaning for an elderly parent; emotional support involves listening, counselling, and companionship; and informational care includes learning how to alter the living environment of someone in the first stages of schizophrenia (Drentea, 2007:1).

Studies have shown that in Western countries, 25% to 50% of persons with schizophrenia who live with their family members after being discharged from hospital are depended on the assistance and continued involvement of their families (Yip, 2000:443-449; Chan, 2011:339-349). A primary informal caregiver is the person who provides the most unpaid support to an individual and helps with physical care and emotional and psychological support (Foster, Brown, Phillip & Carlson, 2005:475). In South Africa, deinstitutionalisation resulted in families becoming the main providers of care, with health care professionals playing a secondary role. The informal family caregiver has therefore become the primary person involved in the wellbeing of the individual with mental illness (Mavundla, Toth & Mphelane, 2009:358). The earliest research on the consequences of caregiving focused mainly on its negative conceptualisations. However, more recently, the more positive conceptualisations have been explored (Cohen, Colantino & Vernich, 2002:184; Hunt, 2003:27). While there is abundant literature on the caregiving experiences of families with relatives with mental illness from Western cultures, the experiences of caretakers in less-developed societies are not well understood and inadequately described (Mavundla et al., 2009:359).

In Asian countries, the move toward deinstitutionalisation is limited by cultural and social factors, which relate to accepting people with mental illness as members of society (Yip, 2000:443). However, Asian studies show that 70% of MHCUs with schizophrenia live with their families on whom they depend for care and sustenance (Chan & Yu, 2004:72-83; Sethabouppha & Kane, 2005:44-47). Marsh (2001:1) asserts that families often serve as an extension of the mental health system. Globally, it has been recognised that caregivers continue to play an important and ever-expanding role, as health and social services systems are continually confronted with a lack of resources (World Federation of Mental Health, 2010). If caregivers do not have adequate knowledge and support, they might not be able to take up the responsibilities of taking care of people with schizophrenia, thus leading to relapse or readmission (Chien & Chan, 2005:1276). Some individuals with schizophrenia have impaired cognitive and social functioning as well as residual symptoms, and these could have a significant impact on families (Chien & Chan, 2005:1284).

A study conducted in the United States of America (USA) by Saunders (2003:175), demonstrated that family caregivers of persons with severe mental illness carry a significant burden, often without outside assistance, and suffer significant stress in the process (2003:176). Chan (2011:339) holds the view that the family burden in caring for persons with schizophrenia is a common challenge in both developed and developing countries, encountered in many parts of the world. Chan (2011:340) further asserts that the different health care and social systems in the various countries may influence a family's commitment to care. The author claims that families may have to take full responsibility in caring for individuals with schizophrenia patients, depending on the availability of services, resources, and support to these MHCUs and their family caregivers.

4.3.1 Family caregivers' burden

The World Federation of Mental Health (2010) stipulates that the burden carried by caregivers is a global issue; often, family caregivers receive little recognition for this valuable work, and policies in most countries do not provide financial support for the services they provide (World Federation of Mental Health, 2010). Caregiver burden has

been defined as “a multidimensional response to the negative appraisal and perceived stress resulting from taking care of an ill individual” (Kim, Chang, Rose & Kim, 2012:846). As caregivers struggle to balance work, family, and caregiving their own physical and emotional health is often ignored (Chan, 2011:340). In combination with the lack of personal, financial, and emotional resources many caregivers often experience a significant degree of stress, depression, and/or anxiety in the first 12 months of caregiving (World Federation of Mental Health, 2010). The adverse consequences of taking care of relatives with severe mental illnesses have been studied since the early 1950s when psychiatric institutions began discharging MHCUs into the community (Chan, Mackenzie, Ng & Leung, 2000; Reine, Lancon, Simeoni, Duplan & Auquier, 2003:144).

Studies conducted by Schuilze and Rossler (2005) across England, Denmark, the Netherlands, Italy, and Spain, revealed that caregiver burden in schizophrenia was inordinately high. Caregiver burden was even higher when the caregiver lived with the MHCU (Schulze & Rossler, 2005). Similar findings have been evident in Southern Africa. In a qualitative study, conducted by Seloilwe (2006) in Botswana among 36 family members of MHCUs with mental illness, the findings revealed that family members had become the primary source of psychological support and that they perceived the situation as burdensome because of inadequate resources. Therefore, caregivers’ burden is classified into two categories, namely objective and subjective.

4.3.1.1 Objective and subjective burdens, and the needs of caregivers of persons with schizophrenia

Objective burden is seen as the tangible cost to a caregiver as a result of looking after someone, while subjective burden refers to the extent of a caregiver’s perception of his or her responsibilities as being overly demanding or emotionally taxing (Montgomery, 2002 in Mavundla et al., 2009:359). Objective and subjective burdens have a direct influence on each other. For example, decreased participation in social activities as a result of having to spend many hours caring for an ill relative can lead to increased depressive symptoms which, in turn, can lead to a decreased need to participate in social activities (Lippi, 2016:1). A study conducted in India by Hsiao and Tsai (2013) has revealed that family members caring for relatives with schizophrenia experienced

significantly higher levels of objective and subjective burden than those caring for relatives with chronic physical illnesses or other chronic psychiatric disorders such as depressive disorders, bipolar disorder, and obsessive-compulsive disorder. Similarly, Kate, Grover, Kulhara, and Nehra (2013:380) are of the opinion that severe objective and subjective burdens increase the global burden experienced.

Furthermore, Cuijpers and Stam (2000) conducted a study in the Netherlands, and the findings consistently indicated that family caregivers report high levels of burden related to caring for their family members with mental illness. These authors assert that family caregivers' mental health may become seriously impaired. In addition, Chan, Yip, Tso, Cheng, and Tam (2009:67) contend that many family caregivers reported not having the knowledge and skills necessary to take on the responsibilities of caring for these relatives. They therefore find themselves unable to cope with their caring roles and responsibilities (Chan et al., 2009:67).

Table 4.5: Objective and subjective burdens

Objective burden	Subjective burden
○ Neglect of other family members and disruption of family life; deterioration in social and family relationships and matrimonial problems/breakdown. ○ Disruption and constraints in daily social, work, and leisure activities. ○ Social isolation and lack of social support. ○ Withdrawal of support by/loss of contact with friends, family, and neighbours. ○ Loss of employment/income or reduced productivity/increased absenteeism. ○ Increased medical expenses and financial problems. ○ Increased workload and taking over of tasks such as shopping, repairs, laundry, and minor chores. ○ Changes to household routines. ○ Neglect of hobbies. ○ Difficulties in going on holidays/Sunday outings.	○ Guilt and self-blame for not recognising symptoms earlier and/or for being the cause of the illness. ○ Apathy and denial of illness. ○ Feelings of loss (of the potential of the family member). ○ Worry - mostly about the MHCU's future. ○ Fear (of violence, especially). ○ Tension, anxiety, stress, and shock. ○ Dejection, grief, sadness, crying and distress, leading to depression. ○ Emotional costs/wellbeing, mental health problems, and psychological morbidity. ○ Physical problems. ○ Feelings of resignation, resentment, confusion, loss of control, desperation, and frustration. ○ Helplessness and hopelessness. ○ Aloneness and emptiness.

Objective burden	Subjective burden
○ Difficulties in inviting people to the home. ○ Supervisory obligations and having to accompany the MHCU outside the home. ○ Having a chaotic lifestyle and poor quality of life. ○ Need for care services. ○ Experiencing stigma related to the illness.	○ Embarrassment in social situations, humiliation, and shame. ○ Feelings of having no influence on the illness despite self-sacrificing care. ○ Feelings of being incapable of caring adequately for the MHCU. ○ Exhaustion from increased energy expended in dealing with problematic MHCU behaviour, psychotic symptoms, poor self-care, reclusiveness, poor medication adherence, and confusion. ○ Lack of sleep by excessive noise from the MHCU. ○ Emotional effort expended in encouraging MHCU activity, and medication adherence. ○ Low self-esteem and feelings of inferiority; at wit's end, feeling marginalised and lacking support.

Source Lippi (2016)

The researcher has realised that recovery-oriented mental health practice should be viewed holistically, namely that the family, especially caregivers, can best contribute to the recovery of their family members when their involvement is welcomed and their experience acknowledged. Families are also on their own journey, and when their needs are recognised and supported, they are better able to support the recovery of a loved one. The researcher has observed that objective and subjective burdens are relevant to the needs of caregivers.

4.3.1.2 The needs of caregivers caring for MHCUs with schizophrenia

The needs related to caregiving were summarised by the World Federation of Mental Health Review as follows: "Caregivers are also less healthy than non-caregivers and have more chronic illnesses such as high blood pressure, heart disease, diabetes, and arthritis than non-caregiving peers. They may also suffer from poorer immune function and exhaustion. They may neglect their own care and have higher mortality rates than non-caregivers of the same age. Given these odds, caregivers need to take good care of

themselves and to reduce their level of stress, depression, and anxiety" (World Federation of Mental Health [WFMH], 2013).

Mental illness may cause a variety of psychosocial problems such as a decreased quality of life for MHCUs' family members as well as an increase in social detachment of MHCUs and the families who care for them (Iseselo, Kajula & Yahya-Malima, 2016:2). Family members need to be in an optimal social and psychological state. It is reported that reduced function of one family member contributes to the burden of other members, and this in turn leads to some family members assuming a judgemental attitude towards the MHCU (Larson & Corrigan, 2008: 87).

A study conducted in Tanzania by Iseselo et al. (2016), offers insight into the social and psychological difficulties experienced by family caregivers. Their findings illustrate that the main challenges faced by caregivers of relatives with mental illness are a lack of social support, stigma, and conflict; also, that family members may have to set aside a significant amount of their personal time to care for an ill family member. This can diminish caregivers' chances of obtaining or keeping a job or earning an income, which further increase the risk of poverty and poor mental health of the MHCU. Similar findings were reported in rural Ghana, where caregivers reported financial difficulties, social exclusion, depression, and inadequate time for other social responsibilities as their main challenges (Ae-ngibise, Doku, Asante & Owusu-agyei, 2015).

The researcher holds the view that family caregivers have a unique and critical role in fostering recovery and wellbeing in those living with mental illness. She concurs with the MHCC (2012) that families often have important information that could be useful to clinicians who have to assess and treat their relatives, such as knowledge of the onset, symptoms, and impact of the mental illness. A transformed mental health system requires recovery-oriented programmes and services that acknowledge the importance of family caregivers, who should be supported in their caregiving role, and respond to their needs (MacCourt, Family Caregivers Advisory Committee, Mental Health Commission of Canada [MHCC], 2013:18). Hence, the present study advocatges that mental health care practitioners should respond to the needs of caregivers, and collaborate with them in enhancing the recovery of MHCUs.

4.4 The tasks and roles of caregivers caring for persons with schizophrenia

Chadda (2014:227) asserts that “the family caregiver plays multiple roles in care of persons with mental illness, including taking day-to-day care, supervising medications, taking the MHCU to the hospital and looking after the financial needs.” Furthermore, this author states that the family caregiver also has to contend with the behavioural disturbances caused by the MHCU. Caregiving takes time and energy; financial, emotional, and other resources (MacCourt et al., 2013:18). A study in Canada conducted by MacCourt et al. (2013) that included family caregivers of adults living with mental illness, found that family caregivers can assist with organising, supervising or carrying out shopping, banking, bill payment, meal preparation, and housekeeping; they can monitor symptoms, manage problematic behaviours, situations and crises; and provide companionship and emotional and financial support.

Similarly, Mavundla et al. (2009) conducted a study in Limpopo, the findings of which revealed that the participants provide basic support, such as food preparation and the provision of shelter, taking of medication, and personal hygiene. Furthermore, because of MHCUs’ mental illness, they experience problems in maintaining personal and environmental hygiene and often require assistance. Additionally, some MHCUs have impaired motor control and are unable to care for themselves properly. Therefore, most caregivers reported that MHCUs need food, which they bought, cooked, and served to them every day. Some participants reported this task to be more challenging than thought as their relatives sometimes refused the meals that they had prepared. It is often necessary that adequate shelters be built to provide protection and safety for these MHCUs.

The findings of a study by Mavundla et al. (2009) reveal that caregivers invest a considerable amount of time and effort in accessing the medication needed by MHCUs with schizophrenia. They accompany these MHCUs to and from the clinics to collect their medication, or often collect the medication on their behalf when they refuse to collect it themselves. In rural South Africa, this may take many hours (Mavundla et al., 2009).

Furthermore, participants in this study also needed to supervise the MHCUs to ensure that their medication was taken correctly, and often tried to educate them on how to take their medication (Mavundla et al., 2009). Similarly, recovery-oriented mental health practice acknowledges that families often provide the bulk of day-to-day support, and can be an important part of a person's chosen recovery team as they can be purveyors of hope by helping people recognise and build upon their successes and positive experiences (Topor, Borg, Mezzina, Sells, Marin & Davidson, 2006:17). In addition, the MHCC (2012) asserts that families can foster recovery by expressing hope, building on people's ties to others, reminding them of their strengths and capabilities, assisting them in accessing and navigating the mental health system, and sustaining their involvement in community life (MHCC, 2012). Therefore, in the present study, the researcher takes into account that families have an integral role to play in fast-tracking the recovery of MHCUs.

4.5 Coping strategies of caregivers caring for persons with schizophrenia

Coping is understood as the process of managing external or internal demands that are considered taxing or exceeding the resources of the person (Grover & Pradyumna, Chakrabarti, 2015:5). Furthermore, these authors state that there is no formal classification of coping strategies, and these are understood as adaptive versus maladaptive and problem-focused versus emotion-focused. Weiten, Lloyd, Dunn, and Hammer (2009:105) describe three broad types of coping strategies: appraisal-focused, problem-focused, and emotion-focused coping. Appraisal-focused coping is directed toward challenging one's own assumptions, whereas problem-focused coping strategies are directed toward reducing or eliminating a stressor. Emotion-focused coping strategies are directed toward changing one's own emotional reaction. Appraisal-focused coping is considered adaptive cognitive coping and involves the way one thinks about a situation. In certain instances, appraisal-focused coping includes denial, distancing oneself, and humour (Weiten et al., 2009:105). According to Grover et al. (2015:6), problem-focused coping is considered adaptive behavioural coping and involves dealing with the problem, taking control, information seeking, evaluating the pros and cons, and anticipation

(proactive coping and seeking social support (social coping). Likewise, Folkman and Lazarus in Grover et al. (2015:5) identified disclaiming, escape-avoidance, accepting responsibility or blame, exercising self-control, and positive reappraisal as emotion-focused coping mechanisms. Olff, Langeland, and Gersons (2005:974) state that emotion-focused coping includes distancing oneself, self-medication, and dissociation; and they divided these into positive and negative emotion-focused coping mechanisms.

Furthermore, these authors claim that negative emotion-focused coping, such as distancing or avoidance, can reduce distress in the short term, but in the long term these are considered detrimental and therefore maladaptive or negative. On the other hand, Ben-Zur (2009:87) highlights that positive emotion-focused strategies such as seeking social support and positive reappraisal are understood to be associated with a better outcome. Many studies from India have evaluated the coping strategies of caregivers of schizophrenia MHCUs (Grover et al., 2015:5). These studies suggest that caregivers employ a mixture of both adaptive and maladaptive coping strategies to cope with the MHCU's illness (Aggarwal, Avasthi, Kumar & Grover, 2011; Kate, Grover, Kulhara & Nehra, 2013; Kate et al., 2014; Hedge, 2013; Rammohan, Rao & Subbakrishna, 2002). In terms of most commonly used coping strategies, a study by Nehra, Chakrbarti, Kulhara & Sharma (2005) suggest seeking practical help. A study by Chadda, Singh and Gangully (2007) demonstrates the more frequent use of problem-focused coping strategies rather than social support and avoidance strategies. Another study, based on a family coping questionnaire, indicated that acceptance was the most commonly used coping strategy used by 71% of caregivers. Only about one-fifth to two-thirds of caregivers used coping strategies such as seeking information (40%), positive communication (37%), social interest (21%), coercion (32%), avoidance (35%), and the MHCU's social involvement (34%) (Chandrasekaran, Sivaprakash & Jayestri, 2002).

The researcher has developed a better understanding of the practicalities relating to the coping strategies of caregivers who work with individuals with schizophrenia. Studies have confirmed that caregivers have various ways of coping: positive, negative, adaptive, or maladaptive. The researcher has realised that worldwide, caregivers employ similar techniques when coping with and managing the daily activities of MHCUs. For example,

in Zimbabwe and in South Africa, caregivers exhibit characteristics similar to those of other caregivers, globally.

Her assertion is in line with a study conducted in Zimbabwe by Marimbe-Dube (2013) who found that caregivers used both emotion-focused and problem-focused coping strategies.“Examples of emotion-focused coping strategies used by the family members were avoidance, resorting to alcohol use and resignation. The other coping strategy that emerged from most participants was spiritual assistance from the church as well as prophets and traditional healers. Some of the problem-focused coping strategies used by family members were seeking more information about the condition, talking positively with the MHCU, maintaining the MHCU’s social interests as well as involving them in social activities like going to church with them.”

The researcher has noted that some caregivers rely on spiritual support. Ae-ngibise et al. (2015:6) state that caregivers adopt various coping strategies to deal with the burden of taking care of relatives with mental illness, such as prayer, hope for a miracle, and anticipation of a new treatment regime. A study of 83 caregivers of MHCUs with severe mental illness was conducted in Baltimore by Murray-Swank, Lucksted, Medoff, Wohlheiter & Dixon (2006). Forty of these caregivers showed that they experience less depression, better self-esteem, and better self-care, which they attributed to practising their religious beliefs. The study also revealed that personal religiosity (believing in God as a source of strength and comfort) and receiving spiritual support in coping with the mental illness of a family member were stronger predictors of family member adjustment (depression, self-care, self-esteem) than religious service attendance. Another cross-sectional study conducted by Shibre, Kebede, Negash, Deyassa, Fekadu, Fekadu, Jacobson and Kullegren, (2001) in Ethiopia on the impact of schizophrenia among 178 family members of individuals with schizophrenia, revealed that prayer was a frequently used way of coping by family members, with 65% reporting that prayer was the preferred way of coping. Most of the relatives (27%) attributed the illness to supernatural causes and used prayer for guidance (Shibre et al., 2003:28).

The researcher is of the view that recovery-oriented practitioners should assist caregivers in responding to and dealing with their caregiving responsibilities adequately. Therefore,

the recovery-oriented practitioner has to exhibit an understanding of and show concern for the impact of mental health problems on the family, and support and assist these families in finding hope and healing; and to reconnect them in helpful ways.

4.6 Intervention and support of caregivers of persons with schizophrenia

Lippi (2016:4) indicates that caregivers also require therapy and intervention, aimed directly at improving their own wellbeing. Furthermore, the author asserts that caregivers may require situation-specific therapeutic input intervention, which will address their concerns, fears, and symptoms of depression and anxiety. Health (2016) defines intervention as “a combination of program elements or strategies designed to produce behavior changes or improve health status among individuals or an entire population. Interventions may include educational programs, new or stronger policies, improvements in the environment, or a health promotion campaign. Interventions that include multiple strategies are typically the most effective in producing desired and lasting change.”

Moreover, Lippi (2016:4) states that interventions may be implemented in different settings including communities, worksites, schools, health care organisations, faith-based organisations, or in the home. Interventions implemented in multiple settings and using multiple strategies may be the most effective because of the potential to reach a larger number of people in a variety of ways. Evidence has shown that interventions create change by:

- influencing individuals’ knowledge, attitudes, beliefs and skills;
- increasing social support; and
- creating supportive environments, policies and resources. Hence the next section will be focusing on family interventions (Lippi, 2016:4).

4.6.1 Family interventions

Cheng and Chan (2005:585) indicate that family is the primary long-term caregiver, and that mental health practitioners should assist by assessing families' needs in caring for MHCUs with schizophrenia more effectively, and providing education, in particular enhancing family members' understanding and expectations of the illness and the provision of care. Furthermore, studies in the United Kingdom conducted by Nolen (2001) and the World Federation Mental Health (2010) established that a number of common needs and concerns emerged from caregivers' reports despite their individual and cultural differences. These needs are emotional support, relief from isolation, access to reliable and satisfactory services, information, and recognition of their role and contribution, which can all work well in supporting caregivers (Department of Health, 1999). Chan (2011:344) holds the view that family interventions should be implemented to improve care, and that there are growing numbers of realistic indications supporting the argument that some family intervention strategies such as psychoeducation and support groups demonstrate a beneficial impact on the course of schizophrenia.

4.6.1.1 Psycho-education

Psycho-education is defined as "a strategy of teaching MHCUs and families about mental disorders, their treatments, personal coping techniques, and resources" (Chan, 2011:344). The author highlights that this form of intervention developed based on the observation that people can be better participants in their own care if knowledge deficits are removed. Similarly, Pekkala and Merinder (2008:1) indicate that by teaching skills such as problem solving and communication, it would increase caregivers' coping ability. Muser, Sengupta, Bellack, Xie, Glick, and Keith (2001:3) emphasise that there are various psychoeducation models in different parts of the world such as individual consultation, family psycho-education and therapy, as well as professionally led short-term family educational programmes and family-led support groups.

The programme developed by the Psycho-educational Working Party of the Early Psychosis Prevention and Intervention Center (EPPIC, 2001) in Australia, focuses on early intervention for MHCUs with schizophrenia. A review of the literature has found that

psychoeducation intervention is conducted in a variety of ways. In previous studies, the duration of psycho-education programmes ranged from one to 18 months (Chan, Yip, Tso, Cheng & Tam, 2009:69; Cheng & Chan, 2005:586). Furthermore, these authors assert that psychoeducation programmes consist of 10 or more sessions, and most have group interventions that include MHCUs and their family members.

Chan (2011:345) points out that psycho-education programmes have a common content such as the nature and treatment of schizophrenia, management of problem behaviour, related resources and ways of accessing these resources, and problem-solving and coping skills. Previous studies have demonstrated that psycho-education interventions generally have positive outcomes on family caregivers and MHCUs such as a reduction in caregiver burden (Chan et al., 2009; Cheng & Chan, 2005).

Chien (2008:29) points out that all family intervention programs offer psycho-education and psychosocial support to family members, and some include the patient, although the theoretical orientation of these interventions varies considerably. Common elements in psycho-educational group interventions include the involvement of the family in:

- patient care provision,
- presentation of information about the mental illness and its management,
- discussion of the techniques for patient care such as communication, problem solving, medication compliance, and crisis intervention, and
- development of social network and coping skills.

Peer-led family support and psycho-education

The National Alliance on Mental Illness's Family-to-Family Program (Lippi, 2016:5) is an example of an efficacy- and evidence-based programme which focuses on randomised controlled trials, a model similar to that of substance abuse recovery. The aims of this and similar programmes are to help families obtain information, access support and services, improve coping skills, engage in self-care, improve communication, increase empathy, solve problems, and understand the research that promotes recovery (Lippi, 2016:5). The concept encompasses the utilisation of individuals who have experience

living with illnesses such as schizophrenia for coaching, mentoring, teaching, coping, and advocating guidance (Duckworth & Halpen, 2014:216).

The programme consists of the following: A 12-week skills-building course taught by family members (who have received specific training to lead and facilitate sessions) for family members, with sessions of two and a half hours each (up to 14 sessions) (Duckworth & Halpen, 2014:216). Results of the training course encompass an improvement in knowledge, emotional- and problem-focused coping, problem solving, family coping, overall functioning of the MHCU (including self-maintenance, social functioning and community living skills), reducing stress, addressing the subjective view of the caregiver's burden, and decreasing the number and duration of hospitalisation (Chien & Thompson, 2013:997).

In the recovery-oriented paradigm, there is an emphasis on MHCU involvement and a focus on facilitating a collaborative relationship by providing psychoeducation (APA, 2004). Psycho-education cultivates a shared decision-making approach that brings together the clinician's expertise and the MHCU's treatment preferences (Xia, Merinder & Belgamwar, 2011:1). Shared decision making fosters autonomy, which results in decisions that better serve the individual's choices, values, and interests. "Shared decision making provides an approach through which providers and consumers of health care come together as collaborators in determining the course of care. Research has shown that shared decision making increases consumers' knowledge about and comfort with the health care decisions they make. Psycho-education can be offered to patients, family members, or both" (SAMHSA, 2011).

McFarlane, Dixon, Lukens, and Lucksted (2003:223) claim that effective family psycho-education includes empathic engagement, problem-solving and communication skills, social networking, education on clinical resources, and ongoing support. Moreover, Xia et al. (2011:110) assert that implementing recovery and wellness-oriented psycho-educational programmes and materials as part of standard treatment, may improve mental and physical health outcomes in MHCUs with schizophrenia and their caregivers. Therefore, the researcher is of the opinion that psycho-education programmes are

aligned with recovery-oriented mental health practice. The present study aims to incorporate psychoeducation in the social work recovery-oriented programme.

4.6.1.2 Mutual support groups for family caregivers

The development of mutual support groups in the 1990s formed part of the larger social movement of self-help organisations for people affected by a variety of chronic diseases and needs, inadequately addressed by traditional health care interventions (Chien, 2008:28). Reay-Young (2001:147) defines support groups as “collectives of voluntary associating persons who share a common problem; they are self-governing, rely on the experiential knowledge of their members as the group’s source of authority, provide mutual assistance which is at least emotional support and do not charge fees."

A report published in 1999 by the Surgeon General further defines support groups as being “geared for mutual support, information and growth (and) is based on the premise that people with a shared condition who come together can help themselves and each other to cope, with the two-way interaction of giving and receiving help.” Reay-Young (2001:147) points out that support groups offer many carers an avenue through which to “unburden” themselves among people who face or have faced similar situations, and at the same time provide carers with some sense of control over an otherwise chaotic life experience.

Mutual support is a participatory process of sharing common situations, problems, and experiential knowledge of common concerns within a group session (Chien, Norman & Thompson, 2006:962). Mutual support groups are characterised as MHCU-led and professional-controlled mental health interventions. They are participatory and involve giving and receiving help and learning to help themselves, as well as sharing experiences and knowledge around common concerns (Chien & Chan, 2005:1277). Chien (2009:345) points out that mutual support groups for family caregivers of persons with schizophrenia are based on an empowerment-oriented model, and provide opportunities for family caregivers to develop knowledge and skills in caring for a relative with schizophrenia.

Furthermore, Chien et al. (2006:963) assert that the support group that provides a peer-based support system allows individuals to take on meaningful roles within the group and

their own families, and inculcates a belief system that inspires members to strive for better mental health. These authors further state that support groups require less intensive training than health professionals to serve as facilitators, compared with other treatment approaches. They also provide a flexible, interactive, MHCU-directed approach to help families cope with their caregiving role. Saunders (2003:176) is of the view that mutual support group programmes provide social support, which enhances the implementation of the social networks of family caregivers. There is strong evidence supporting the value of a support group for family caregivers of persons with schizophrenia.

Saunders (2003:176) asserts that research-based evidence appears to confirm the argument that support group intervention is helpful to people from different cultural backgrounds. For example, studies in Western and Asian populations found that family caregivers who participate in family support groups are associated with a significant improvement in the psychological adjustment of families (Chan, 2011:346). Support group interventions are associated with a significant improvement in the family caregiver's ability to cope, and consequently in the physical and mental condition and functioning of the MHCU (Chien et al., 2006:964).

Social support theory holds that social support and social networking are two major mechanisms that may promote mental health (Chien, 2008:29). Chien et al. (2006:964) indicate that social support may result in the following:

- Buffer the effects of stressful life events.
- Directly influence the occurrence of various mental disorders.

Support group initiatives can be regarded as a means to adhere to these prescribed norms within the limits of available resources. Such services can help address the unmet supportive and rehabilitative needs of service users and their caregivers at their local PHC facilities. The nature of support group services is appropriate for providing continuous follow-up care for MHCUs and caregivers, and holds the potential of bringing about improvement in their mental health as well as their social wellbeing and quality of life. This is in line with the recovery model advocated in the Mental Health Policy Framework (Department of Health, 2013). Community-based social support systems

such as support groups can assist MHCUs in adjusting and reintegrating into community life once they have been discharged from hospital and help them manage their symptoms (Meiring, 2015:21). Therefore, the researcher is of the view that support groups can assist caregivers and enable them to assist MHCUs in the recovery process.

4.6.1.3 Behavioural family therapy and multiple family group therapy

Behavioural family therapy (BFT) is a family psycho-educative intervention, which addresses stress management and goal achievement (Berglund, Vahine & Edman, 2003:116). Research has shown that BFT is effective in reducing the stress experienced by service users and their families, and that it can significantly reduce relapse rates and promote recovery, especially for those living with severe and persistent mental health problems (Asmal, Mall, Emsley, Chiliza & Swartz, 2014). Because of this, the focus of delivery has been on working with families where a member experiences psychosis. However, family interventions may be helpful to families experiencing a range of other mental health problems (Asmal et al., 2014:315).

Berglund et al. (20013:117) point out that positive results include decreased family burden, relapses, and the dosages of neuroleptics taken by MHCUs; it also decreases feelings of resignation, and increases optimism in caring for the MHCU. Families gain coping strategies and independence. Furthermore, Burbach and Stanbridge (2006:311) argue that the overall aims of BFT are increased understanding, stress reduction, and improved communication and problem-solving skills within the family; this approach can be used effectively to help meet the needs of other families in contact with mental health services. In addition, there is growing support for using the approach with families experiencing stress in relation to long-term physical conditions (Burbach & Stanbridge, 2006:311).

Family work using the behavioural family therapy model will typically include the following (Christenson, Russel, Bell & Beer, & Hillin, 2014:272-286):

- Meeting with the family to discuss the benefits of the approach.
- An agreement with the family that they are willing to try the approach.

- Assessment of individual family members.
- Assessment of the family's communication and problem-solving skills.
- Review of the assessment information on the family's resources, problems, and goals.
- Meeting with the family to discuss/plan how to proceed, and the establishment of family meetings.
- Information sharing about the mental health issue, and reaching a shared understanding.
- Early warning signs and relapse prevention work – development of "staying well" plans.
- Helping the family to develop effective communication skills.
- Supporting the development of the family's problem-solving skills.
- Booster sessions.
- Review and on-going support or closure.

Multiple group family therapy is a combination of behavioural family therapy and formal psychoeducation, which also concentrates on problem solving (Hazel, McDonell, Short, Betty, Voss & Dyck , 2004:35).

Hazel et al. (2004:35) argue that multiple group family therapy aims to have a positive effect on MHCU outcomes by decreasing symptoms and relapse rates, and increasing social and vocational skills. A family-based group can provide a natural connection for group members to facilitate cohesion and create a context where similarities and differences can be acknowledged (Edwards, 2001:44). Furthermore, the author asserts that combining family therapy with group therapy has the following group therapy advantages: diminished isolation, equal power status which the group confers upon each family, abundant scope for indirect learning, and the provision of role models through subgroupings.

Lippi (2016:5) points out that group intervention consists of the following:

- Provision of new information.
- Presentations are given and families are provided with newsletters, pamphlets, lists of resources and websites, and may borrow books and videos (relatives tend to find videos the most informative and presentations more informative than literature).
- Group discussions and sharing of experiences.
- Question and answer sessions.

The growth of the recovery movement pertaining to serious and persistent mental illness provides an opportunity to revisit the field of family-based recovery-orientated intervention programmes in order to identify techniques that might benefit from further refinement to be more recovery-compatible (Glynn, Cohen, Dixon & Noosha, 2006:463). Recovery from a serious and persisting mental illness has been defined by the President's New Freedom Commission on Mental Health (2003:7) as "the process by which people are able to live, work, learn, and participate fully in their communities.

For some individuals, recovery is the ability to live a fulfilling and productive life despite a disability. For others, recovery implies the reduction or complete remission of symptoms. Science has shown that having hope plays an integral role in an individual's recovery." In serious and persisting mental illnesses, a broader notion of recovery has been postulated to involve the following (Liberman & Kopelowicz, 2005:735):

- The first concept describes recovery as a process in which one is engaged, often implying the word "recovering" (a term used comparably in substance abuse literature), and includes attitudinal and dispositional dimensions in a factor analysis of consumers' responses to a series of items reflecting recovery orientations.
- The second concept explains recovery more as a state or outcome related to objective symptom management and improved functioning. Importantly, for serious psychiatric illnesses, recovery has not been defined as an absence of symptoms with treatment no longer required. It is not denoted as a "cure". Therefore, the researcher holds the view that recovery plays a critical and

indispensable role in enhancing the wellbeing of caregivers as it links with behavioural and multiple group family therapy.

4.7 Importance of families in recovery

Families can provide emotional, social, and material support critical to quality of life. For many people living with mental health problems and illnesses, family – whether made up of relatives or chosen from a person's broader circle of support – constitutes their primary source of support (Reay-Young, 2001:148). Families can help recovery by expressing hope, building on people's ties to others and reminding them of their strengths and capabilities, assisting them in accessing and navigating the mental health system, and sustaining their involvement in community life (McFarlane, Dixon, Lukens & Lucksted, 2003:223). With the MHCU's permission, the recovery-oriented practitioners consistently engage a person's family of choice as early as possible in the care process. Families also have the right not to participate in a caregiving role, and this choice is respected (MHCC, 2012).

Recovery-oriented practitioners understand and show concern about the impact of mental health problems on the family (MHCC, 2015); it is vitally important that they support families in finding hope, healing and when desired, reconnecting with society. Therefore, the researcher concurs with the MHCC (2015) that recovery-oriented services seek to collaborate as partners with caregivers and draw on their intimate knowledge of their loved ones, routinely encouraging them to play a part in assessing their respective roles when planning care. Furthermore, recovery-oriented practice begins with the assumption that family can play a positive role in the journey to recovery and wellbeing, finding a balance between facilitating the family's ability to contribute to decision making, and respecting the privacy of the person living with a mental illness (MHCC, 2015).

4.8 Summary

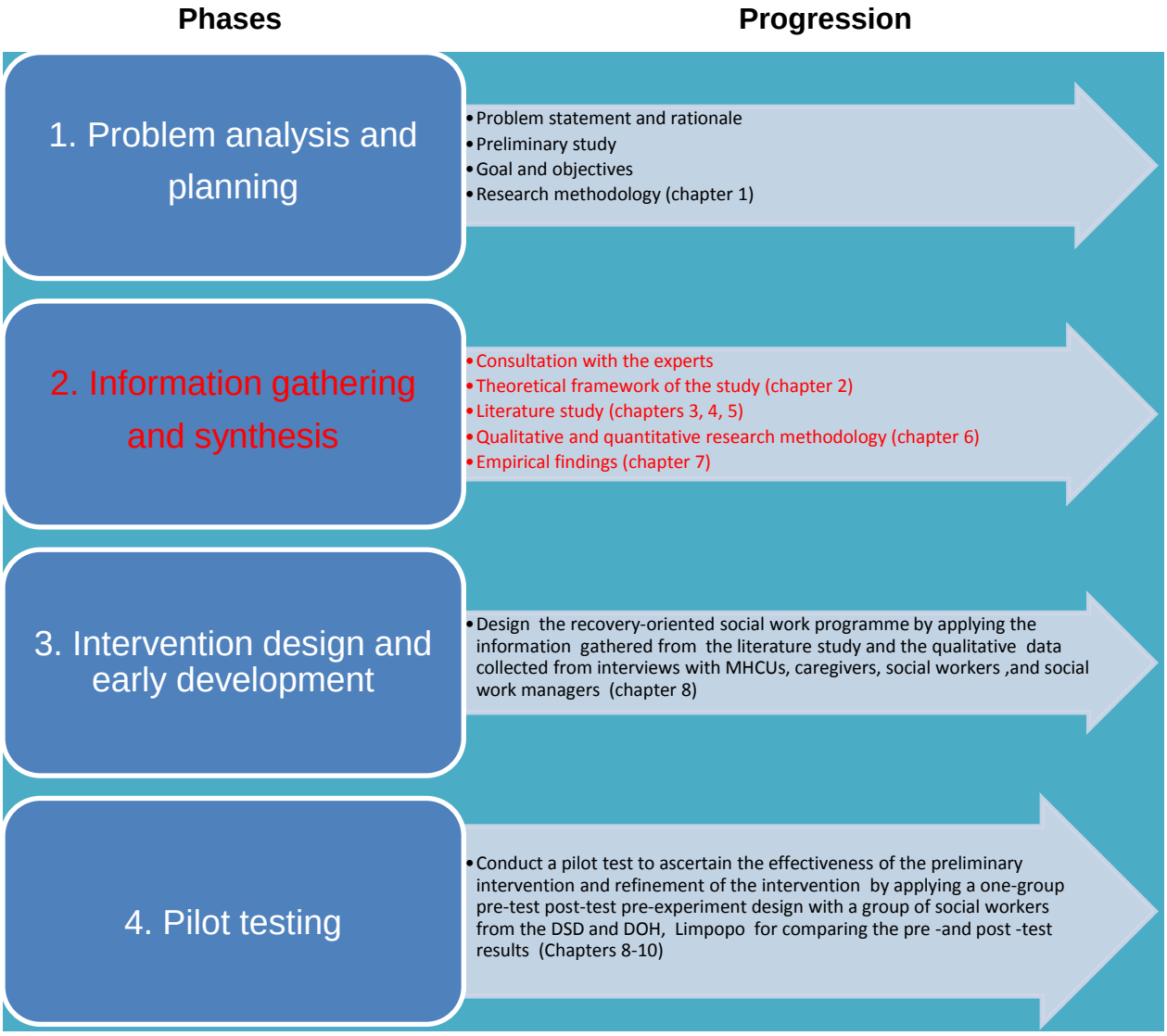
From the available literature reviewed, the researcher has gained significant insight into the challenges experienced by the MHCUs regarding mental health care in the rural areas

of South Africa. The needs and challenges of caregivers caring for people living with schizophrenia . Various aspects were noted and are presented as follows:

The profile of mental illness, in particular the prevalence of schizophrenia, has been highlighted, as are the challenges experienced by MHCUs. It is clear that the issue of caregivers' burden is a global one, but that families nevertheless have a responsibility to take care of MHCUs living with schizophrenia in the community. It is evident that caregivers in general receive little recognition for their valuable work, and that there is no financial support for their services. Furthermore, caregivers' emotional health is neglected and ignored. There are, however, family interventions that can be provided, namely psychoeducation and mutual support groups, behavioural family therapy, and multiple group family therapy. Finally, it is recognised that recovery-oriented mental health practice provides collaborative services that are geared toward facilitating recovery. The next chapter focuses on social work in mental health care and recovery-oriented mental health.

CHAPTER 5

SOCIAL WORK IN MENTAL HEALTH CARE, RECOVERY AND RECOVERY-ORIENTED MENTAL HEALTH CARE



Graphic representation of phases of the intervention research: Adapted from Fraser and Galinsky (2010:463); De Vos, (2011)

5.1 Introduction

The social work profession is constantly under pressure. Increasing demand for social services, regulatory changes, funding cuts, and a lack of support for the workforce is all making it increasingly difficult to deliver the care, support, and protection needed by the most vulnerable members of society (Clifton & Thorey, 2014:6).

> "Social work is a practice-based profession and an academic discipline that promotes social change and development, social cohesion, and the empowerment and liberation of people. Principles of social justice, human rights, collective responsibility and respect for diversities are central to social work. Underpinned by theories of social work, social sciences, humanities and indigenous knowledge, social work engages people and structures to address life challenges and enhance wellbeing" (IFSW & IAASW, 2014).

The movement toward recovery and recovery-oriented services has already had an impact on the direction of recent mental health policy and research (Department of Health, 2001; 2004). Recovery is an ongoing evolutionary process through which individuals enhance their health and wellness, and live sustaining, self-directed lives (SAMHSA, 2009). Recovery often begins as individuals collaborate with their natural support bases and their providers to overcome stigma and identify their own unique strengths, preferences, and support needs (Allegheny County Coalition, 2012). The focus of this chapter is on social work in mental health and recovery as well as recovery-oriented mental health care.

5.2 Social work in mental health care

Social work is crucial in delivering and maintaining excellent mental health services. Good quality social work can transform the lives of people with mental health conditions, and is an essential part of multidisciplinary and multiagency collaboration (Lamb, 2014:2). Furthermore, the author states that alongside professionals in health, social care, housing, employment, and other disciplines social workers play a key role in identifying and accessing local services which meet people's needs at an early stage, helping to improve overall mental health outcomes, and reducing the risk of crisis and more costly demands on acute health services.

Allen (2014:5) asserts that social workers have a crucial part to play in improving mental health services and mental health outcomes for all citizens. The author is of the opinion that social workers bring a distinctive social and rights-based perspective to their work. Furthermore, social workers' advanced relationship-based skills and their focus on personalisation and recovery can support people to make positive, self-directed change. Moreover, social workers are trained to work in partnership with people using these services, their families, and carers to optimise involvement and collaborative solutions. Social workers also manage some of the most challenging and complex risks faced by individuals and society, and make decisions with and on behalf of people within complicated legal frameworks as well as balancing and protecting the rights of different parties. This includes, but is not limited to, their vital role as the core of the Approved Mental Health Professional (AMHP) workforce (Allen, 2014:5). Karban (2011) argues that social work has a vital contribution to make to mental health, based on the professions' values, knowledge, and skills. This author further asserts that "development in anti-discriminatory and anti-oppressive practice of the 1980s and 1990s accompanied by changes in the statutory and legislative role of social workers in mental health. These and other factors have all been influential in shaping the current situation and the potential future role that social work has to play in mental health."

Allen (2014:8) further indicates that social work is crucial to modern mental health services, and excellent social work can transform the lives of people with mental health conditions; it is an essential, highly valued part of multidisciplinary and multiagency systems of support. The researcher is of the opinion that across the adult mental health sector – from social workers, employers, and educationalists as well as from other professions – there is a call for greater clarity about professional social work priorities and roles.

Social work brings a distinctive social perspective to mental health, recognising the social experiences, causes of mental illness throughout its life course, and enhances fundamental human potential and the opportunities they could access to bring about change. Furthermore, social perspectives are rooted in acknowledging the importance of service users' own expertise in their experiences and needs, and involve working closely

alongside people, and using empathy and relationship-building skills to hear and see through the eyes of the service user, family, and friends (Beresford, 2007:7). The National Association of Social workers (NASW) (2008) emphasises that the ethos of social work is to protect human rights and intervene to prevent or end discrimination and inequality, and to protect people who are vulnerable. The NASW makes it clear that social work has a dual mission, namely to enhance human wellbeing and help meet their basic needs, with particular attention to the empowerment of vulnerable groups. The researcher fully agrees with the NASW that social workers play a critical role in enhancing human rights and social justice.

In South Africa, the social work professional is classified as a mental health practitioner (Mental Health Act [No 17 of 2002]) (Department of Health, 2002). However, the researcher has noted that in practice, the role of social work in mental health is misunderstood. This assertion is in line with the findings which emanated from a study conducted by Olckers (2013) and Ornellas (2014). Olckers (2013:30) asserts that there are controversies and questions relating to social work in mental health. The questions relate to whether social workers are adequately trained to work in a mental health setting and are worthy of the designation “mental health team member”. These controversies in effect undermine the role of the social worker in mental health.

Furthermore, Ornellas (2014:37) points out that due to the closing down of some mental health institutions in South Africa as part of the deinstitutionalisation process, poor development of community-based initiatives, and NGO’s single-minded focus on service delivery for the mentally ill, the availability of adequate services and care have dropped significantly. Furthermore, the author asserts that the effects of deinstitutionalisation on the social work profession and the role of the social worker within mental health care have been damaging. In addition, Lund et al. (2008:45) highlight that “there is an existing gap with regard to the availability of social work services within mental health context. The process of deinstitutionalization has made very little room for the practice of clinical social workers within mental health; recent research found that within a population of 100 000 mentally ill patients, data recorded a capacity of only 0.40 social workers.”

The researcher has noted that the situation is worse in the rural areas of South Africa. Social workers are expected to render services to everyone, including individuals living with mental illness, despite inadequate mental health resources. Furthermore, social workers are not trained to deal with mental health-related cases. This assertion is in line with that of a study conducted in Cape Town, South Africa by Olckers (2013:51). The author states that the four-year degree does not prepare social workers as mental health workers or practitioners. There are various challenges experienced by social workers in rural areas, highlighted in a study conducted by Alpaslan and Schenck (2012) in four provinces of South Africa: Mpumalanga, North West, Eastern Cape, and Western Cape. The study findings established that social workers had to contend with the following challenges:

- No resources and infrastructure.
- Community members' lack of understanding of the role of social workers, and social workers being used as "dustbins" for unresolved problems in the community.
- Having to travel long distances to render social work services to clients.
- Lack of support from supervisors and the organisation.
- Clients' cultural/traditional customs and practices hampering social work service delivery.
- Lack of confidentiality.

Against this background, the researcher developed a recovery-oriented mental health programme that is geared towards capacitating social workers in the rural areas of South Africa. The researcher is of the opinion that the programme sheds light on the difficulties social workers have to contend with in mental health care and recovery-oriented mental health practice. The researcher is of the opinion that the developmental social work approach embraces tenets that are similar to recovery principles.

5.3 Developmental social work and mental health care

A “developmental approach to an integrated socio-economic development”’ can be seen as being focused on the strengths of the individual, group, or the community to embark upon activities that contribute meaningfully to planned socio-economic development initiatives. Communities should promote their capacity for growth as well as the development of institutions, processes, and programmes (Department of Social Development [DSD], 2009:13). Moreover, the DSD (2013) asserts that a developmental approach is an integral factor in the delivery of integrated social welfare services. New social welfare thinking has been infused with notions of social transformation, human emancipation, reconciliation and healing, and the reconstruction and development of society. These ideas are enshrined in the Constitution of the Republic of South Africa, 1996 (Act No 108 of 1996) and the subsequent adoption of relevant policies and legislation to reflect the vision and values of a new society. This approach is based largely on the White Paper for Reconstruction and Development (1994) (Republic of South Africa, 1994), which has as one of its goals socioeconomic development through poverty alleviation.

The purpose of developmental social welfare is to enhance social functioning and human capacity, promote social solidarity through participation and community involvement in social welfare, promote social inclusion through empowerment of those who are socially and economically excluded from the mainstream of society, protect and promote the rights of populations at risk, address oppression and discrimination arising not only from structural forces but also from social and cultural beliefs and practices that hamper social inclusion, and contribute significantly to community building and local institutional development (DSD, 2013). On the other hand, developmental social work as an approach,

> “affirms the commitment of the social work profession to uphold social justice and human rights; respects the worth and dignity of service users and acknowledges their right to self-determination and inclusion; challenges structural sources of injustices that contribute to marginalization, social exclusion and oppression; promotes social integration by using empowerment, strength-based, advocacy and non-discriminatory approaches in eradicating poverty and inequality; facilitates social change through micro- and macro-practice by linking the personal and structural contexts/political dimension of intervention; includes maintenance, protection, rehabilitation and development functions; uses social work methods ranging from working with individuals, families, and communities

> to policy formulation and analysis, and advocacy and political interventions; promotes active participation and partnerships, including service users, in all social work processes; positions social work as a role player in achieving social development goals through social investment strategies that promote economic and social inclusion; and promotes sustainable development by integrating social, economic and environmental development activities" (Lombard, 2007:307; Lombard & Wairire, 2010:100; Patel, 2005:206).

The Integrated Service Delivery Model (ISDM) (Department of Social Development, 2005:5) emphasises that developmental social welfare services are classified in terms of levels of intervention, namely prevention; early intervention; statutory, residential, and alternative care; and the reconstruction of aftercare services. All services are aimed at promoting the optimal functioning and the reintegration of beneficiaries into mainstream society. Core services are further classified into five broad categories: promotion and prevention; rehabilitation; protection; continuing care; and mental health and addiction services ISDM (2005:5). Linking all the literature presented above, the researcher has noted that there is synergy between developmental social work and recovery-oriented mental health practice. She has noted, for instance, the issues of social justice and human rights in promoting social integration and empowerment.

The researcher is of the opinion that the developmental social work approach is relevant to mental health care. In most instances, MHCUs are marginalised and discriminated against, and it is the role of a social worker to empower the person to be able to stand for his or her rights. If this approach is applied in practice, it is supposed to promote the optimal functioning of users and assist in their reintegration back into their communities. This is also in line with recovery-oriented mental health practice. Therefore, the researcher has adopted the stance that social work services in mental health care should be inclusive and promote human emancipation, especially for MHCUs living with mental illnesses such as schizophrenia. Social work practice has the tools that can be implemented in mental health care.

5.4 Social work roles in mental health care

Social work has been carried out in many different places and with many different groups (Blewet, Lewis & Tunstill, 2007:4). However, Payne (2006:13) identifies the following three historic models for the role of social work:

- Therapeutic: the process of interaction and reflexivity between the social worker and clients, which leads to clients gaining power over their own feelings or way of life.
- Social order: meeting individual needs during a period of difficulty in order to regain stability.
- Transformational: empowering disadvantaged and oppressed people to take part in a process of mutual cooperation and learning.

Similarly, Dominelli (2009:12) suggests the following three models which are, however, different from Payne's models:

- Maintenance: Aims to improve individual functioning or adaptation to situations. Assistance is provided based on clearly defined criteria.
- Therapeutic: An off-shoot of the maintenance approach but focuses on what an individual can do to improve his or her situation through targeted professional interventions.
- Emancipatory: This is associated with radical social work, and questions the current balance of power in society and distribution of resources. Actions are aimed at helping individuals and achieving structural change.

The researcher has noted that Payne's and Dominelli's models are paving the way for recovery-oriented mental health practice. In addition, the Canadian Association of Social Workers (2000:1) highlights that social workers are involved at micro, mezzo, and macro levels in all sectors. At micro and mezzo levels, social workers are primarily concerned with "the social well-being of individual clients and their families equally valued with the importance of their physical, mental and spiritual well-being" (CASW, 2000:1). The document further states that at macro level "social workers generally demonstrate a greater capacity to look beyond the illness and treatment issues, to consider the broader

human, social and political issues in mental health." This is critical in the present study, and the researcher is of the view that the developmental approach adopted in South Africa gains synergy from the CASW argument as to how social workers are involved in assisting individuals, families, and communities.

AASW (2008) has consistently argued that social workers recognise the complexity of the social context which goes beyond the medical model's focus on individual diagnosis to identify and address social inequities and structural issues. Many of the roles that social workers perform are common to all mental health disciplines (ASSW, 2015). Furthermore, the ASSW (2015) points out that specific to the domain of social work are roles of,

> "building partnerships among professionals, caregivers and families; collaborating with the community, usually with the goal of creating supportive environments for clients; advocating for adequate service, treatment models and resources; challenging and changing social policy to address issues of poverty, employment, housing and social justice; and supporting the development of preventive programmes. Prevention occurs on many levels and includes a focus on early intervention, individual and public education, advocacy and improving access to services, resources and information."

Specific mental health roles and professional services

Mental health settings usually include services on three broad levels of health care application: prevention, treatment, and rehabilitation. It is recognised that individual social workers may either practise exclusively within one setting, or cross the boundaries of all three in response to the diverse needs of the MHCU, family, and community (CASW, 2001:1).

Table 5.1: Roles of social work in mental health care

Level	Roles
Prevention	Aims to reduce the incidences of disease or dysfunction in a population through modifying stressful environments and strengthening the ability of the individual to cope. Prevention involves the promotion and maintenance of good health through education, attention to adequate standards for basic needs, and specific protection against known risks. In mental health settings, preventive activities include public and MHCU education regarding emotional self-care and healthy relationships, building community knowledge and skills (community development), social action, and advocacy for social justice.
Treatment	Aims to reduce the prevalence (number of existing cases) of a disorder or dysfunction and includes early diagnosis, intervention, and treatment. In mental health settings, treatment activities are focused on individuals experiencing acute psychiatric symptoms, emotional trauma, relationship problems, stress, distress or crisis, assessment, risk management, individual, couple, family and group counselling, intervention, or therapy and advocacy. Social work uses relationship as the basis of all interventions.
Rehabilitation	Aims to reduce the after effects of the disorder or dysfunction, and involves the provision of services for retraining and rehabilitation to ensure maximum use of the remaining capacities by the individual. In mental health settings, rehabilitation activities focus on MHCUs who are disabled by mental illness, and may include the individual, couple, family, and group interventions to build knowledge and skills; provision of specialised residential, vocational; and leisure resources; advocating for the development of needed services; and changing community attitudes.

(Source: National Scope of Practice Statement, Canadian Association of Social Workers, 2000)

Similarly, in South Africa, social workers' core services are stipulated in the ISDM (2005) as promotion and prevention, rehabilitation, protection, continuing care, mental health, and addiction. The researcher has noted an alignment with international trends. Furthermore, specific to the employment setting, social workers in mental health deliver the following professional services as stipulated by the IFSW (2000):

- **Case management** – coordinating interdisciplinary services to a specified MHCU, group, or population.

- **Community development** – working with communities to facilitate the identification of mental health issues and development of mental health resources from a community needs perspective.
- **Supervision and consultation** – clinical supervision/consultation and maintaining quality and management audits and reviews of other social workers involved in mental health services.
- **Programme management/administration** – overseeing a mental health programme and/or service delivery system; organisational development.
- **Teaching** – university and college level; workshops, conferences, and professional in-services.
- **Programme, policy, and resource development** – analysis, planning, establishing standards.
- **Research and evaluation**.
- **Social action**.

Starnino (2009:853-854) summarises these views by stating that social workers not only play a significant role in providing care for mentally ill MHCUs, but fulfil a variety of roles such as:

- Case manager.
- Therapist.
- Crisis counsellor.
- Programme evaluator.
- Administrator.
- Policy analyst.

Allen (2014:4) reports that the roles and priorities of social workers in mental health in recent years are often not well defined, the status and authority within multidisciplinary settings are sometimes undermined, and opportunities to realise professional potential are underdeveloped. Allen (2014:5) proposes five key areas of practice that should frame the deployment and development of social work in mental health:

- Enabling citizens to access statutory social care and social work services and advice to which they are entitled, discharging their legal duties, and promoting the personalised social care ethos of the local authority.
- Promoting recovery and social inclusion with individuals and families.
- Intervening and showing professional leadership and skill in situations characterised by high levels of social, family and interpersonal complexity, risk, and ambiguity.
- Working co-productively and innovatively with local communities to support community capacity, personal and family resilience, earlier intervention, and active citizenship.
- Leading the Approved Mental Health Professional workforce (Allen, 2014:7).

Allen (2014:8) is of the view that these areas of practice should shape role descriptions, continuing professional development (CPD) opportunities and curricula, and social work leadership in all adult mental health work contexts. Furthermore, the author states that social work roles are not expected to reflect all five key areas, but should rather be used as a guideline against which roles and professional development plans match for coherence with the latest professional guidance and with a view to nurture, focus, and maximise the impact of skills resources (Allen, 2014:8). Moreover, Gehlert and Browne (2012); Barlow and Durand (2012); and Johnson and Yanca (2007) in Ornella (2014:4) indicate that the traditional role of social workers in health care include "working with patients and families to facilitate effective communication between patients, families, and health care teams in ways that will mitigate barriers caused by low health literacy. This is still a significant activity which needs to be undertaken by the social worker, however, their role has expanded to include many activities such as case management, within both inpatient and outpatient care, supported employment, residential care, psychosocial support, family therapy and support, and assistance in basic reintegration into society and the needs associated with this."

The researcher has noted that social workers have a critical role to play in assisting MHCUs. She holds the view that social workers are in a better position to boost their

recovery, and are responsible for assisting people in need. Social workers have been using the person-in-environment (PIE) phenomenon that focuses on MHCU systems at micro, mezzo, and macro levels. Therefore, the researcher is of the opinion that the development of a social work programme in recovery-oriented mental health might enhance the roles and the knowledge of social workers in mental health. The researcher holds the view that social workers need to be knowledgeable about the different types of mental illness.

5.5 DSM: Social work and diagnostic and statistical manual of mental disorders

The DSM comprises the standard classification of mental disorders used by mental health professionals (APA, 2013). It applies to a wide range of contexts. Clinicians and researchers of different orientations such as biological, psychodynamic, cognitive, behavioural, interpersonal, and family/systems use the DSM. The DSM-5 was designed for utilisation in inpatient, outpatient, and partial hospitalisation; consultation-liaison, clinic, private practice, and primary care settings (APA, 2013). Collin (2008) in Olckers (2013:73) is of the opinion that the DSM is the classification system most often used and referred to in South Africa regarding the diagnosis of mental disorders. The DSM is commonly referenced by social workers, particularly by clinical social workers practising in the field of mental health. DSM diagnoses help social workers and other mental health professionals understand MHCUs, and guide their interventions from an evidence-based perspective. Diagnosis helps professionals with goal setting, treatment planning, and determining a MHCU's prognosis; and because of its use of common jargon, diagnosis facilitates research. Despite the widespread use of the DSM, social workers should be cognisant of the ethical issues that may arise in the context of using this diagnostic tool (Barsky, 2017).

The social work value of "respect for the dignity and worth of all people" (National Association of Social Workers Code of Ethics, 2013) can be translated into ethical guidelines such as being non-judgemental and building on MHCUs' strengths. Diagnosing mental illnesses, however, is essentially an exercise in assessing MHCUs and focusing

on their pathologies or weaknesses, moreover, social workers do not diagnose MHCUs. It should be noted that social workers might argue that DSM diagnoses violate the principles of non-judgementalism and strengths-based practice; others might claim that such diagnoses are ethically justifiable under the principle of beneficence. As noted earlier, diagnoses serve MHCUs by providing a framework for selecting appropriate and effective interventions (Barsky, 2017:1).

Thus, in terms of respect, social workers who use DSM should avoid language that reduces the person to a diagnosis, for example, “he is a borderline personality,” or “she is a schizophrenic”. They should rather use language that separates the person from the problem, for example, “he is a person with borderline personality disorder,” or “she is coping with schizophrenia” (Barsky, 2017:1, Code of Ethics, 2013). Social workers should also ensure that they provide holistic assessments, and not just focus on problems or psychopathologies. Furthermore, Barsky (2017:2) asserts that holistic assessment highlights MHCUs’ strengths, and considers these individuals in the context of their social environments, including their family, friends, co-workers, neighbours, and other social support systems. A holistic assessment includes psychological functioning and problems, but also includes social functioning, spirituality, physical health, and coping abilities (NASW, Code of Ethics, 2013).

Advantages of using the DSM

- The use of the DSM system (Olckers, 2013:96-98) will lead to improved treatment of individuals. Social workers in the mental health field are responsible for making diagnostic decisions and formulate their treatment plans according to the diagnosis.
- Social workers must be able to communicate with their colleagues in order to maintain a position as a respected member of multidisciplinary treatment teams; the DSM manual is the *lingua franca* of mental health professionals.
- The DSM system can serve as a comprehensive educational tool in the teaching of psychopathology and mental disorders.
- Social workers will be enabled to conceptualise MHCUs’ problems.

- Social workers will establish their professional status when utilising the DSM system.

Torrey (2009) in Olckers (2013:69) refers to the International Statistical Classification of Diseases and Related Health Problems as the ICD-10. ICD codes are alphanumeric designations given to every diagnosis, description of symptoms, and cause of death. The World Health Organisation (WHO) has developed and monitors adherence to the copyright relating to these classifications. The ICD-10 coding assigns a code to each mental health disorder (Kaplan, Sadock & Grebb, 1994:280).

In terms of professional competence (National Association of Social Work [NASW] Code of Ethics, 2013), social workers should not diagnose MHCUs unless they have the appropriate training, supervision, knowledge, and skills as well as mandatory licensing. Furthermore, stating that a MHCU has schizophrenia, for instance, indicates that the social worker has made a diagnosis. If social workers lack the competence to provide diagnoses, they should document the indicators of schizophrenia but not draw the conclusion that the MHCU in effect suffers from, for example, depression. If the MHCU needs a formal diagnosis, then the social worker should refer him of her to a properly qualified mental health professional (Barsky, 2007:2). The researcher has observed that this is indeed the case in the South African context; social workers are members of multidisciplinary teams, and the psychiatrist is responsible for making a diagnosis.

5.6 Social work training in mental health care

Cesare and King (2014:1750) express concern about social workers' poor training in mental health, and question their ability to work in the mental health field. Furthermore, these authors indicate that there are concerns in the United States and the United Kingdom regarding social workers' abilities to practise effectively in mental health. Morley and McFarlane (2010:46) affirm the importance of the social work curriculum to address mental health issues and concerns. These authors further assert that critical perspectives, which emphasise an analysis of power relations, structural inequality, and progressive social change ideals, must inform curriculum development for social work in the context of mental health. In addition, Kneisl and Trigoboff (2009:22) believe that professionals

require formal academic instruction at graduate level, coupled with extensive clinical experience.

Beinecke and Huxley (2009:222) contend that many practitioners do not have the knowledge or skills necessary to work in mental health settings; “that the required competences are not being taught…and that much work needs to be done to define needed skills and train the teachers and workforce of the future in them”. Furthermore, Simpson, Williams, and Segall (2007:3) recognise the disparities in the nature and depth of mental health content. In addition, the Department of Health (2002:3) claims that in England, mental health training has a more generalised mandate in that social work students must undertake specific learning and assessment in “human growth, development, mental health and disability”. Bland, Renouf, and Tullgren (2009:9) postulate that social work in the UK continues to be “unsure of how to address mental health content in social work course curricula”. It seems that Australia is leading the way in the development of specific mental health content for social work students.

Morley and MacFarlane (2010:48) indicate that in a psychiatric setting, the combined skills of a multidisciplinary team such as psychiatrists, social workers, psychologists, and occupational therapists are a necessity in order to meet the needs of each mental health care user (MHCUs). These authors assert that professionals should work together on a problem with the common goal of rehabilitating the person within a comprehensive approach**.** Bland et al. (2009:10) indicate that social work is centred on principles of social justice, self-determination and empowerment, and central to the profession are values such as human dignity and service to humanity. However, Cesare and King (2010:1751) point out that despite these strengths, there is a concern that social workers are not adequately trained to effectively meet the needs of people with mental health problems. Renouf and Bland (2005:419) claim that not all social work schools provide a mandatory mental health subject, and education in mental health is often integrated into other subjects, such as law and psychology.

Furthermore, Bland et al. (2009:14) highlight that even the schools that do provide a mental health subject may emphasise sociological (critical) perspectives (the structural understanding of causes of mental health problems and responses, a critique of

psychiatry, institutional practices and power imbalances at the expense of biological and clinical perspectives on risk management and evidence-based practice). The Australian Association of Social Workers (AASW, 2008) has recently recognised the variable education provision of mental health, and implemented the inclusion of mental health in the social work undergraduate curriculum with greater focus on the biological and clinical perspectives than had been the case previously (AASW, 2008). Similarly, mental health social work has struggled to clearly articulate its contribution to the field of practice (Renouf & Bland, 2005:420). In Australia, "there has been no well-articulated identification of the distinctive social work contribution within mental health service" (Renouf & Bland, 2005:420). Cesare and King (2010:1751) highlight that the lack of clarity contributes to the uncertainty felt by health professionals and the public as to how social workers can contribute to the care of people with mental health problems. Furthermore, the authors assert that mental health social work has been described as being concerned with the social context, the social consequences of mental illness, and social justice.

Bland et al. (2009:15) indicate that the implementation of "a mental health component in social work training is likely to be variable in both quantity and quality and there remain tensions between some social work values and attitudes and contemporary approaches to mental health practice." These authors state that it is also important that social workers develop the tools and opportunities to examine the difficult practice of supervision, so that their practice can become more congruent with social work values and the ability to integrate critical and clinical perspectives in their practice, providing a meaningful and distinct social work perspective in mental health. In a study conducted by Olckers (2013) in Cape Town, South Africa, the author explored the social work programmes of the University of South Africa with regard to mental health as part of the curricula. Representatives from social work departments at the University of Johannesburg (Van Breda, 2008), Cape Town (Addinall, 2011), Kwazulu-Natal (Motloung, 2011), Pretoria (Carbonatto, 2007), and Free State (Reyneke, 2008) stated that they provide limited training in mental health on an undergraduate level. The majority of representatives consulted were of the opinion that mental health is a specialised area, which should receive attention on postgraduate level (Olckers, 2013:50).

The South African Council of Social Services Professions (SACSSP) (2008) maintains that the social work qualification in South Africa is an internationally recognised professional degree with an internationally accepted definition by the International Federation for Social Workers (IFSW) and the International Association of Schools of Social Work (IASSW). In South Africa, social work is a four-year degree, and registration with the SACSSP is a prerequisite in order to practise as a social worker. However, Olckers (2013:51) is of the view that the four-year degree does not prepare social workers to be mental health workers, and that academic institutions merely introduce the concept of mental health to the students.

Stromwall and Hurdle (2003:211) raise their concern by stating that many social workers remain unfamiliar with the perspectives and language used in mental health, and they suggest that social work education programmes include content that is more specific. Therefore, the researcher has identified that there is a gap in social work in mental health. She holds the view that social workers are not adequately trained in mental health; the present study is therefore appropriate and is aimed at contributing to the field of social work by capacitating social workers in mental health care. Furthermore, the researcher recommends that social work curricula should incorporate mental health care.

5.7 Recovery

Recovery can be viewed as one manifestation of empowerment, functional ability, improve and maintain personal capacity in one or more of the major domains of life – work, housing, relationships, recreation – and by so doing to "[live] a satisfying, hopeful, and contributing life even with limitations caused by illness...[and to develop] new meaning and purpose in one's life" (Anthony, 1993:15). Recovery research, which has shown that many people with severe mental disorders do recover, has been met with scepticism among some within the field of psychiatry, where severe mental disorders such as schizophrenia is considered by many professionals as a chronic condition (Topor, 2004:34).

Slade and Longden (2015:2) point out that the pessimistic view of severe mental disorders as hopelessly chronic conditions is being contested by the results of several

studies in recovery research. Furthermore, these authors indicate that results have shown that a significant number of MHCUs with severe mental disorders do recover, and that the probability of doing so is relatively high. Similarly, Anthony (1993:1) argues that recovery occurs whether or not mental illness is seen as "biological and/or psychosocial." Furthermore, Topor and Sundstroom (2007:8) highlight that recovery in a social context means that people may still have symptoms and some contact with psychiatric services, but are living normal social lives.

Therefore, Topor (2004:45) states that the results clearly contradict the view that severe mental disorders are chronic, incurable conditions. The researcher is of the opinion that recovery brings hope to MHCUs; they can function even if their symptoms persist. Indeed, this is an example of human transformation and human emancipation. Therefore, recovery is of the utmost importance in the present study. The researcher intends creating awareness of recovery principles in social workers in South Africa.

5.7.1 History of recovery

Roberts and Wolfson (2006:1) traced the origins of recovery practice to the Tuke family who established The Retreat in York at the turn of the 18th century. William Tuke, a Quaker and a lay reformer, set out to create a family-like healing and spiritual environment for members of the Society of Friends. The Tukes showed that moral or psychological forms of treatment in a work-oriented, peaceful, and pleasant environment could replace physical restraint. John Perceval, in *A patient's account of his psychosis 1830-1832*, gave an early autobiographical account concerning that which helped or hindered the treatment of and recovery from psychosis. From the start, personal accounts, alongside more systematic analysis, have been important contributions to the literature on recovery. Recovery experiences highlight that a person is strongly influenced by what is personally meaningful, and being oriented around outcomes. (Woodbridge & Fulford, 2004:1).

However, McCranie (2011:427) is of the opinion that there is nothing new about the term "recovery" in people with mental illness. The term has been used for many years to refer to remission or a reduction of symptoms. In 1937, Abraham Low, a psychiatrist working in state mental hospitals in Illinois, founded a group called "Recovery, Inc." which was

devoted to structured self-help groups to provide “after-care” to recently discharged hospital MHCUs. Recovery, Inc. focused on reducing “relapses” through social coping skills, goal-setting, and increasing self-confidence. While Low's original organisation failed to gain acceptance in the larger research and treatment community and was dissolved, it was reborn as a peer-led group model.

The researcher has observed that there are diverse views of the history of recovery. She noted this trend from the writings of McCranie, which she compares with those of Robertson, Wolfson, and Wooldridge. The accounts of the history as stipulated by McCranie (2011) are described as the roots of a concept of recovery – if not the term - have been traced back to over 200 years ago to Philippe Pinel and his *traitement moral* in Paris asylums. Certainly the concept of recovery is familiar from the field of addictions treatment. Yet, at some points in recent history, recovery was, for some seen as impossible. In the case of schizophrenia, even the clinical definition asserted a declining course and a permanent state of illness - such as in Emil Kraepelin criteria for ’dementia praecox.’ Remission or recovery was seen as *prima facie* evidence that the illness had not been dementia praecox. Eugen Bleuler, who challenged this diagnosis and renamed this condition ’schizophrenia’ in part to remove the connotation with dementia, also challenged the chronicity of the problems, recognizing that people diagnosed with it could get better.

More recently, the recovery approach has emerged from the writings of people who used social work services in the 1980s in the US and in the 1990s in the UK (Deegan, 1988:1). Many wrote about coping with symptoms, getting better, and regaining a sense of personal identity that was not defined by illness. Deegan compared her recovery from schizophrenia with the recovery of her friend who had been paralysed by an accident (Deegan, 1988:1). According to the author, both had experienced anguish, despair, and hopelessness that eventually led to the management of their difficulties and the achievement of meaningful goals. Deegan (1998) became a research psychologist, teacher, and trainer. A wide range of influential writers have greatly encouraged others with their personal accounts of mental illness and recovery, for example, mental health professionals such as Mike Shooter, the president of the Royal College of Psychiatrists

(RCPsych) and Alistair Campbell, the Prime Minister's former director of communications and strategy (Roberts & Wolfson, 2004:2; Cantacuzino, 2002:1).

5.7.2 Conceptualisation of recovery

Slade (2009:4) asserts that recovery is a word with two meanings: clinical and personal recovery. Similarly, Townsend and Glasser (2003:85) explain that "Recovery is what the individual does; facilitating recovery is what the clinician does; and supporting recovery is what the system and community does." From these distinctions, philosophical tensions emerge between the person-focus of recovery and the MHCU- or illness-focus of psychiatric medicine (Buchanan-Barker & Barker, 2008). These tensions are explored by examining recovery through the following lenses of clinical recovery and personal recovery (Slade, Amering & Oades, 2008:12):

- **Clinical recovery** reflects a definition of recovery that has emerged from scientific literature (Slade et al., 2008:12; Slade, 2009:4). The medical model drives the clinical model. It posits that mental illness is a physical disease and recovery refers to the return to a former state of health. According to this model, mental illness is due to permanent chemical brain imbalances, which are present at birth (Ahern & Fisher, 2001:1).
- **Personal recovery** reflects a definition that is individually defined and experienced. This model of recovery is in contrast to the clinical model of recovery, based on a system of health promotion in which individuals actively define their needs, and collaborate with others in the healing process (Schiff, 2004:23; Slade, 2009:4). It is a view shaped through the accounts of people with lived experience of mental illness (Deegan, 1996:1; Mead & Copeland, 2000:3). Anthony (1993) points out that recovery is a familiar idea in physical illness and disability. For example, it is not unusual to regard a person with paraplegia as having recovered, even though the spinal cord has not.

Drawing on rehabilitation research and consumer literature, Anthony has spelled out the elements of a concept of recovery from mental health problems. This, he says, includes "the development of new meaning and purpose in one's life, as one grows beyond the

catastrophic effects of mental illness" (Anthony, 1993:1). Thus, as a useful definition of recovery, he asserts that "recovery is a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by the illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness" (Anthony, 1993:1).

The APA (2005) asserts that "The concept of recovery emphasises a person's capacity to have hope and lead a meaningful life, and suggests that treatment can be guided by attention to life goals and ambitions. The recovery approach recognizes that patients often feel powerless or disenfranchised, that these feelings can interfere with initiation and maintenance of mental health and medical care, and that the best results come when patients feel that treatment decisions are made in ways that suit their cultural, spiritual, and personal ideals. The recovery approach focuses on wellness and resilience and encourages patients to participate actively in their care, particularly by enabling them to help define the goals of psychopharmacologic and psychosocial treatments…the application of the concept of recovery requires a commitment to a broad range of necessary services and should not be used to justify a retraction of resources."

McCranie (2011:427) contends that recovery is actually a complex set of ideas, and asserts that this phenomenon can be understood mostly as hope that individuals who suffer from serious mental health problems can reclaim their lives or create a newly meaningful way of coping. The premise of the present study is based on personal recovery, and the researcher therefore focuses on this aspect.

5.7.3 The personal recovery tasks

Personal recovery is a concept that has emerged from the expertise of people with lived experiences of mental illness (Slade, 2009:1). Personal recovery involves working toward better mental health, regardless of the presence of mental illness. People with mental illness who are in recovery are those who are actively engaged in moving away from floundering (through hope-supporting relationships) and languishing (by developing a positive identity), working toward struggling (through framing and self-managing the mental illness) and flourishing (by developing valued social roles) (Slade, 2010:3). One understanding of recovery is that it emphasises the centrality of hope, identity, meaning, and personal responsibility (Andersen, Oedes & Caputi, 2003:586). Personal recovery is a multidimensional concept; it is a process that happens in various stages, at various times. “There is no single way to measure it, but many different measures that estimate various aspects of it” (Anthony, 1993:8). The author points out that it is about regaining a sense of self; it is about getting control over symptoms; it is not about the absence of symptoms, it is about the development of new meaning; it is not about a return to who the person once was; it is about dealing with the many difficulties that the illness brings. Through a number of steps and at various stages, it may involve overcoming negative factors such as stigma and discrimination, and not only the illness itself.

Slade (2009:4) indicates the tasks needed to be undertaken by people who are in recovery.

Table 5.2: Four tasks of personal recovery

Task	Activity	Explanation
Recovery task 1	Developing a positive identity	Identify elements which are vitally important to one person may be far less significant to another, which underlines that only the person can decide what constitutes a personally valued identity.
Recovery task 2	Framing the ‘mental illness’	Involves developing a personally satisfactory meaning to frame the experience, which professionals would understand as mental illness.

Task	Activity	Explanation
		Involves making sense of the experience so that it can be put in a box: framed as a part of the person but not as the whole person.
Recovery task 3	Self-managing the mental illness	Framing the mental illness experience provides a context in which it becomes one of life's challenges, and self-management is critical. The transition is from being clinically managed to taking personal responsibility through self-management.
Recovery task 4	Developing valued social roles	Involves the acquisition of previous, modified, or new valued social roles. This often involves social roles, which have nothing to do with mental illness. Valued social roles provide scaffolding for the emerging identity of the recovering person. Working with the person in their social context is vital, especially during times of crisis when support, usually received from friends, family, and colleagues can become most strained.

Source: Slade (2009:4)10

The researcher views these tasks as particularly essential, as they show that the person in recovery has to take ownership of his or her positive identity, define the meaning of the illness, how to manage the illness, and how to acquire new valued social roles. The present study will introduces these tasks to social workers who will be trained in the recovery-oriented mental health programme.

5.7.4 Ten fundamental components of recovery

Mental health recovery is defined as "a journey of healing and transformation enabling a person with mental health problems to live a meaningful life in a community of his or her choice while striving to achieve his or her potential" (NAMI, 2016). The 10 fundamental components of mental recovery include the following principles (SAMHSA, 2006; NAMI, 2016):

- **Self-direction**: Consumers lead, control, exercise choice over, and determine their own path of recovery by optimising autonomy, independence, and control of

resources to achieve a self-determined life. By definition, the recovery process must be self-directed by the individual, who defines his or her own life goals, and designs a unique path toward those goals (SAMHSA, 2006; NAMI, 2016).

- **Individualised and person-centred**: There are multiple pathways to recovery based on an individual's unique strengths and resiliencies as well as his or her needs, preferences, experiences (including past trauma), and cultural background in all of their diverse representations. Individuals also identify recovery as being an ongoing journey and an end result as well as an overall paradigm for achieving wellness and optimal mental health (SAMHSA, 2006; NAMI, 2016).
- **Empowerment**: Consumers have the power to choose from a range of options and to participate in all decisions, including the allocation of resources that will affect their lives. They have the right to education and support in accomplishing their goals. They have the ability to join other consumers to collectively and effectively speak for themselves about their needs, wants, desires, and aspirations. Through empowerment, an individual gains control of his or her own destiny and influences the organisational and societal structures in his or her life (SAMHSA, 2006; NAMI, 2016).
- **Holistic**: Recovery encompasses an individual's whole life: mind, body, spirit, and the community. Recovery embraces all aspects of life: housing, employment, education, mental health and health care treatment and services, complementary and naturalistic services, addiction treatment, spirituality, creativity, social networks, community participation, and family supports – as determined by the person. Families, providers, organisations, systems, communities, and society play crucial roles in creating and maintaining meaningful opportunities for consumer access to these supports (SAMHSA, 2006; NAMI, 2016).
- **Non-linear**: Recovery is not a step-by- step process but one based on continual growth, occasional setbacks, and learning from experience. Recovery begins with an initial stage of awareness in which a person recognises that positive change is possible. This awareness enables the MHCU to engage fully in the process of recovery (SAMHSA, 2006; NAMI, 2016).

- **Strengths-based**: Recovery focuses on evaluating and building on the multiple capacities, resiliencies, talents, coping abilities, and inherent worth of individuals. By building on these strengths, MHCUs leave behind their troubled lives and engage in new life roles (for example a partner, caregiver, friend, student, and employee). The process of recovery moves forward through interaction with others in supportive, trust-based relationships.
  - Peer support: Mutual support, including the sharing of experiential knowledge, skills, and social learning, plays an invaluable role in recovery. MHCUs encourage and engage with others in recovery, and provide each other with a sense of belonging, supportive relationships, and valued roles within the community.
  - Respect: Community, systems, societal acceptance, and appreciation of consumers, including protecting their rights and eliminating discrimination and stigma, are crucial in achieving recovery. Self-acceptance and regaining belief in one's self are particularly vital. Respect ensures the inclusion and full participation of MHCUs in all aspects of their lives.
  - Responsibility: MHCUs are personally responsibility for their own self-care and the journey to recovery. Taking steps toward their goals may require great courage, but MHCUs must strive to understand and give meaning to their experiences, and identify coping strategies and healing processes to promote their own wellness (SAMHSA, 2006; NAMI, 2016).
- **Hope**: Recovery provides an essential and motivating message of a better future, that people can and do overcome the barriers and obstacles that confront them. Hope is internalised but can be fostered by peers, families, friends, providers, and others. Hope is the catalyst to the recovery process. Mental health recovery not only benefits individuals with mental health disabilities by focusing on their abilities to live, work, learn, and fully participate in our society, but also enriches the texture of community life (SAMHSA, 2006; NAMI, 2016).

Indeed, the researcher would have to integrate these notions in her newly developed programme. The principles predominantly used in the present study are empowerment, strengths based, person centred, hope, and self-direction.

5.7.5 Stages of recovery

Andresen, Oades, and Caputi (2003:586) have advanced a model of recovery based on accounts of MHCUs' experiences. These authors thematically analysed a large number of personal accounts of recovery, and identified four key component processes of recovery: (a) finding and maintaining hope; (b) the reestablishment of a positive identity; (c) finding meaning in life; and (d) taking responsibility for one's life. In addition to these individual accounts, a number of qualitative studies were examined by these authors which resulted in the conceptualisation of the various stages of the recovery process (Young & Ensing, 1999:219-231; Pettie & Triolo, 1999: 255-262; Spaniol, Wewiorski, Gagne & Anthony, 2002:327-336, Baxter & Diehl, 1998:349-355; Davidson & Strauss, 1992:131-145). The researcher acknowledges that these sources are outdated; however, they constitute seminal work and she is of the opinion that that they contain valuable information to substantiate the stages of recovery. In consolidating the findings from the five studies, five stages of recovery were proposed, explained briefly below.

- **Moratorium**: A time of withdrawal characterised by a profound sense of loss and hopelessness.
- **Awareness**: Realisation that all is not lost, and that a fulfilling life is possible.
- **Preparation:** Taking stock of one's strengths and weaknesses regarding recovery, and starting to work on developing recovery skills.
- **Rebuilding**: Actively working toward a positive identity, setting meaningful goals, and taking control of one's life.
- **Growth:** Living a full and meaningful life, characterised by self-management of the illness, resilience, and a positive sense of self (Andresen et al., 2003:586).

The stage model of recovery, consisting of the four component processes and five stages, combines these findings in a model depicting the personal experience of psychological

recovery. The stages are sequential, with the “growth” stage representing the outcome of the recovery process. The component processes represent the psychological state of the person as he or she progresses through the stages of recovery. Due to the highly personal nature of recovery, the model is purposely flexible in terms of the timeframe and the means by which the person moves through each process. That is, each individual finds his or her own sources of hope and ways of finding meaning and building a positive identity (Andresen et al., 2003:586).

The stage model of recovery is a holistic model, which emphasises the subjective psychological process of recovery from the devastating effects of being diagnosed with a serious mental illness. The stage model of recovery was developed from service users’ personal accounts of their experience (Andresen et al., 2003:587). They stress the complex and non-linear nature of recovery, and hold that individuals in the highest level of recovery may still suffer a relapse of symptoms. This does not mean that they have returned to an earlier stage (Andresen et al., 2003:587). Although setbacks or a recurrence of symptoms undoubtedly has an impact on a person’s happiness, an important outcome of recovery is resilience (Richardson, 2002:307).

Resilience is the process of coping with disruptions in a way that enhances protective factors (Richardson, 2002:307). The ability to manage a relapse of symptoms – even if this requires the use of hospital services – and a return to the previous state of wellbeing is central to recovery. As part of the normal growth process, the person may choose to reassess his or her lifestyle or goals and make adjustments as deemed necessary (Deegan, 1997:11). The researcher is of the opinion that the stages of recovery are essential for this study as they provide an understanding of how recovery services should be. Furthermore, these stages provide the understanding that recovery is a process, and people undertake the recovery journey differently.

5.7.6 Approaches of recovery

There are numerous theories of recovery; the researcher will be focusing on the following theories: recovery model, tidal model and wellness recovery action plan (WRAP); the details are provided below:

5.7.6.1 Recovery model

The mental health recovery model is a treatment concept in which a service environment is designed in such a way that mental health care users have primary control over decisions about their own care. This is in contrast to most traditional models of service delivery, when consumers are instructed what to do; or simply have things done for them with minimal, if any, consultation and taking into consideration their opinions. The recovery model is based on the concepts of strengths and empowerment, indicating that if individuals with mental illnesses have greater control and choice in their treatment, they will be able to take increased control and initiative in their lives (NASW, 2005).

A key point of the model is that it is not the role of service providers to make decisions for consumers, but that they have a responsibility toward providing education, focusing on the possible outcomes that may result from various decisions (NASW, 2005). Many staff members first react with concern when they hear that mental health MHCUs should make decisions about their own care. “What if someone decides they do not want to take prescribed medication?” is perhaps the most common and worrisome concern. Legally, though, no adult can be forced to take medication or undergo certain treatments unless there is a court order or legal guardian directing them to do so (Mental Health Act [No 17 of 2002] (Department of Health, 2002).

The recovery model does not advocate anything different. The reality of practice, though, is that mental health service users (particularly those with more chronic and debilitating disorders) are usually instructed as to what treatments and medications to take, with minimal effort on the part of practitioners to involve MHCUs in making their own decisions. The recovery model states that a programme’s philosophy should acknowledge and encourage mental health care users’ involvement and decision-making. Most MHCUs do ultimately ask for, and take, clinicians’ treatment recommendations, but they need to know that they have both the right and the responsibility to make their own decisions (NASW, 2005).

Social workers have an obligation to continue serving, supporting, and encouraging MHCUs (NASW, 2005). However, social workers must understand and accept that

helping MHCUs make their own choices – good or bad – will ultimately be in the best interests of their recovery and independence, even if social workers believe that a particular action is a bad idea. As professionals, social workers need to learn to take a supportive role, rather than one as a decision maker (NASW, 2005). This may take a change in mind-set for many clinicians, but it is imperative that they make that change (Rammler, 2005:1). On the other hand, there are constraints around the extent to which social workers can help someone who prefers to follow his or her own path to recovery. The recovery model does not call for social workers to do anything unrealistic that would hinder the recovery of the MHCU, or that would involve treating one MHCU more favourably than another. The model calls for social workers to support MHCUs' decisions, within reason, to the best of their abilities (NASW, 2005).

5.7.6.2 Tidal model

All human experience is defined by the fluid nature of human experience (Tidal Model Website, 2016). The tidal model borrows from chaos theory in recognising that all change, growth, or development occurs through small, often barely visible, changes which follow patterns that are, paradoxically, consistent in their unpredictability (Barker & Buchan-Barker, 2005:9). The fluid nature of life itself provides the basis for the core metaphor of the tidal model – *water* (Tidal Model Website, 2016). People are in a constant state of flux as they negotiate their relationships with an infinite number of influences, some of which appear to come from the world outside and others that appear to spring from "within" (Barker & Buchan-Baker, 2005:9). Most of this activity is imperceptible in the way, for example, that we mature or simply grow older. Only when we compare "snapshots" taken at wide intervals, do we detect the changes that have been on-going. These snapshots confirm that change is the only constant; one that is largely silent and unnoticeable, but definitely present, as change flows invisibly through our human experience (Barker & Buchanan-Barker, 2005:9).

Key principles of the tidal model

The tidal model is based on four principles:

- The primary therapeutic focus of mental health care is the natural community. People live on an “ocean of experience” (their natural lives) and psychiatric crisis is only one thing, among many, that might threaten, or metaphorically “drown” them. The aim of mental health care is to return people to that “ocean of experience,” so that they might continue with their “life journey” (Barker & Buchanan-Barker, 2005:9).
- Change is a constant, ongoing process. However, although people are constantly changing, this may be beyond their awareness. The tidal model aims to help people develop their awareness of the small changes that will ultimately have a significant effect on their lives (Barker & Buchanan-Barker, 2005:9).
- Empowerment lies at the heart of the caring process. Professional helpers, however, are defined by discipline, and helping people to identify how they might take greater charge of their lives and all its related experiences (Barker & Buchanan-Barker, 2005:9)
- The therapeutic relationship between the professional helper and the person involves a temporary act of unison. Effective nursing involves caring with people rather than simply caring for them or caring about them. This has implications for not only what goes on within the relationship but also for the kind of support the professional helper might need to maintain the integrity of the caring process (Barker & Buchanan-Barker, 2005:9).

It is clear that, however many efforts we might make to control our lives, ultimately we are powerless to control everything that might happen to us. From the moment we flow out into the world, leaving the safety of the waters of our mother's womb, we face challenges, day in and day out. Many of us will make plans for the future; however, we cannot plan for every eventuality. Life will always surprise us. We need to learn to live with uncertainty. We need to (metaphorically) learn to “swim with the tide or build a boat”. At the centre of

all this flux, lies the person. It is therefore appropriate that the theoretical framework of the tidal model is built around that person (Barker & Buchanan-Barker, 2005:10).

5.7.6.3 Wellness recovery action plan

The wellness recovery action plan (WRAP) is a self-management and recovery system designed to maintain wellness, decrease symptoms, increase personal responsibility, and improve quality of life. It teaches people how to keep themselves well; to be able to identify and monitor symptoms; and to use safe, personal skills, support, and strategies to relieve their symptoms. It involves people listing their maintenance activities, personal triggers, early warning signs, and an intensive crisis plan (Copeland, 2002). The researcher is of the view that these theories are critical as they provide an understanding of the phenomenon. They provide a lens through which the researcher can understand the concept more clearly.

5.7.7 Recovery measurement

These measurements will help evaluate not only change and the impact of interventions, but also contribute to a dynamic model of recovery itself, and help to investigate mediating factors (Care Services Improvement Partnership [CSIP], Royal College of Psychiatrist [RCPsych] & Social Care Institute for Excellence [SCIE], 2007:16). The recovery measurements are discussed below.

5.7.7.1 Empowerment scale

Rogers, Chamberlin, Ellison, and Crean (1997:1042) developed the empowerment scale (making decisions). This scale was developed to measure the personal construct of empowerment as defined by consumers of mental health services. The scale has five factors/subscales and consists of 28 statements, including the following:

- Self-esteem and self-efficacy: “I generally accomplish what I set out to do.”
- Powerlessness: “I feel powerless most of the time.”
- Community activism and autonomy: “People have a right to make their own decisions, even if they are bad ones.”

- Optimism and control over the future: “People are limited only by what they think is possible.”
- Righteous anger: “Getting angry about something is often the first step toward changing it.”

The participants in the present study were asked to respond to what best describes how they feel: strongly agree, agree, disagree, or strongly disagree.

5.7.7.2 Recovery assessment scale (RAS)

The recovery assessment scale was originally developed by Giffort, Schmook, Woody, Vollendorf, and Gervain (1995:1) to provide a scale that measures the concept of recovery for mental health care users. The scale has 24 scales and five subscales: personal confidence and hope, willingness to ask for help, goal and success orientation, reliance on others, and no domination by symptoms. Sample statements include: *Fear doesn’t stop me from living the way I want to be; I know when to ask for help; I have a desire to succeed, even when I don’t care about myself but other people do; Coping with mental illness is no longer the main focus of my life*.

The researcher is of the opinion that the RAS can be applicable in social work practice. This assertion is confirmed by Roestenburg et al. (2016:187) that “in order to facilitate the use of an appropriate clinical perspective in mental illness intervention, social workers opt to use an evidence-based perspective that is supported by the active utilisation of measurement tools and structured clinical approaches that are broadly classified as an ecometric perspective on practice.”

5.7.7.3 Illness management and recovery scales (IMR)

Mueser, Gingerich, Salyers, McGuire, Reyes, and Cunningham (2004:234) developed an illness management and recovery (IMR) scale to measure outcomes targeted by the IMR programme. The IMR programme is an evidence-based practice designed to assist individuals with psychiatric disabilities in developing personal strategies to manage their mental illness and advance toward their goals. The IMR includes 15 Likert scale items, with a 5-point response scale in which response anchors vary, depending upon the item.

The scales are not divided into domains. Rather, each item addresses a different aspect of illness, management, and recovery (Mueser et al., 2004:234). The researcher deemed IMR appropriate in the field of social work practice. Confirming this assertion, Roestenburg et al. (2016:188) states that in using an ecometric approach, a practitioner will typically conduct a thorough social assessment that includes the use of specific measures, scales, and procedures to accurately describe and assess mental health associated with social circumstances, and determine the most suitable interventions. Therefore, the researcher equates the IMR to the ecometric approach within the South African context.

5.7.8 Origin of recovery movement in different countries

The researcher has ascertained the origin of recovery in different countries, and presents the information in this regard from the United States of America, Canada, New Zealand, United Kingdom and Australia.

5.7.8.1 Recovery in the United States of America (USA)

The documented history of recovery for people living with mental illness is strongly influenced by the American perspective and literature on recovery (O'Hagan, 2004:1). It is suggested that the recovery movement had its genesis in the United States (Meehan, King, Beavis & Robinson, 2008:177), and began to take form in the 1970s and 1980s when people with the experience of mental illness began speaking and writing about their experiences of recovery (Ahern & Fisher, 2001:24; Carpenter, 2002:86). This can be traced to the psychiatric survivor movement (Deegan, 2003:373; Ellis & King, 2003:9). People who did not have the lived experience of mental illness were excluded from consumer organisations, as consumers found their radical views on mental illness were not shared by practitioners or the general public (Schiff, 2004:213).

Primarily, professionals and academics, rather than people living with mental illness (Casey, 2008:1) developed the frameworks of recovery in America in a clinical setting. This vision of recovery was exported from America to other countries, notably Australia and New Zealand, and consequently reinforced the dominance of psychiatric rehabilitation and the biomedical model (O'Hagan, 2004:4). It is noted that America and

New Zealand were the first countries to embed recovery principles in their health policies (Ramon et al., 2007:108). Therefore, the researcher has gained an understanding of how recovery emanated from countries such as USA.

5.7.8.2 Recovery in Canada

Canadian mental health policy and practice have developed under the influence of American practice. During the 1970s and 1980s, the Canadian Mental Health Association, supported by the Canadian government and the United States National Mental Health Association, met to discuss recovery practices in mental health care (Rochefort & Goering, 1998:114). Discussions highlighted the need for greater support services for consumers and a community resource base for developing networks of care (Goodrick, 1998:65). In the 1980s, programmes such as the Mental Patient's Association in Vancouver began operating drop-in centres, and provided residences for mental health consumers to meet the need for increased support.

Housing was provided for psychiatric patients throughout Canada as an opportunity to "escape hospitalisation and become responsible for their own care," demonstrating a trend toward self-help programmes in line with American practices (Goodrick, 1998:87). Stronger focus has currently been placed on putting the consumer in the role of the case manager, with initiatives in Canada offering more options for recovery, with larger support networks, and consumer-created recovery programmes (Chamberlin, 1990:47). Further, there has been sustained funding allocated to the Mental Health and Addictions Programme to provide consumers with recovery-oriented mental health services (Berger, 2006:466-467). The researcher has noted that the Canadian recovery system was developed from the American practice. Therefore, the researcher has noted that for the recovery-oriented systems to be developed, benchmarking is critical.

5.7.8.3 Recovery in New Zealand

Gawith and Abrams (2006:143) provide an account of the recovery movement in New Zealand. They documented that in the 1980s, some New Zealand psychiatric survivors were in contact with American, British, and European organisations that were starting to question the values and philosophy behind psychiatry. The first user networks for people

living with mental illness appeared in the early 1990s in New Zealand. In New Zealand, policymakers were critical of the American conceptualisation of recovery, as it was seen to be driven by professionals rather than service users (O'Hagan, 2003:1; O'Hagan, 2004:1).

Furthermore, American recovery literature was criticised for its lack of acknowledgment of important issues such as discrimination, human rights, cultural diversity, or the potential for communities to support recovery (O'Hagan, 2003:1; O'Hagan, 2004:2; Roberts & Wolfson, 2004:37). New Zealand is currently regarded as having one of the most coherent and progressive national recovery policies internationally, with advanced concepts of recovery and recovery-orientated services and practices (Allott, Loganathan & Fulford, 2003:231; Gawith & Abrams, 2006:140; Schinkel & Dorrer, 2007:16). The researcher has noted that the USA is a pioneer in recovery-oriented mental health practice; most countries have benchmarked the American practice.

5.7.8.4 Recovery in the United Kingdom

The recovery movement in the United Kingdom developed in the 1970s and 1980s. This movement was driven by the shift toward community-based care and the stories of ex-service users and mental health professionals and activists, all of whom had roots in the civil rights movements of the 1960s (Allott et al., 2002:232). Groups of professionals and consumers were formed in response to conditions in psychiatric wards, the closure of long-stay psychiatric services, and the need for consumers to have a greater role in choices affecting their quality of life (Wallcraft & Bryant, 2003:3). Recovery was first acknowledged in a UK policy document in 2001. Current policy directions include the vision for the transformation of mental health services to allow mental health care users to be active partners in their treatment, achieve their potential, and be more socially competent and less socially isolated (Ramon et al., 2007:110; Schinkel & Dorrer, 2007:18). The researcher has observed that in the UK, recovery is a collaborative effort between mental health care users and mental health practitioners; this sheds light on the fact that different countries have adopted recovery in divergent ways.

5.7.8.5 Recovery in Australia

The understanding of recovery in Australia is most heavily influenced by recovery literature from the USA, but also from Canada and New Zealand (Rickwood, 2004:1; Slade, Amering & Oades, 2008:131). It is suggested that the term “recovery” has slowly been adopted in Australia from the late 1980s (Lakeman, 2004:212; McGrath, Bouwman & Kalyanasundaram, 2007:10). It has become popular in mental health discourse, and influences policy directives and service delivery initiatives (Meehan et al., 2007:178: Rickwood, 2004:1; Slade et al., 2008:128).

All Australian states and territories have initiatives underway related to recovery, although there is considerable variation evident in the level of knowledge, commitment, and implementation (Rickwood, 2004:2). In Australia, consumer groups have been the main drivers of the recovery movement (Ramon et al., 2007:109). In addition, the non-government sector in Australia has been promoting and applying the use of recovery from mental illness in its literature and many programme guidelines since the early 1990s (Ramon et al., 2007:115). The researcher has observed that Australia has adopted recovery from the USA, Canada, and New Zealand.

The researcher searched for recovery literature pertaining to Africa, especially South Africa, but could not find any information relating to the origin of recovery in Africa. The researcher managed to obtain information on research conducted by De Wet (2013) titled *Hearing their voices: The lived experience of recovery from first-episode psychosis in schizophrenia*. This study was conducted in Stikland Hospital in Cape Town, South Africa. It is evident that there has been limited research conducted in South Africa regarding this concept. Therefore, the researcher is of the opinion that the present study might contribute significantly to this field.

5.8 Recovery-oriented mental health practice

Recovery-oriented practice describes an approach to mental health care that encompasses principles of self-determination and individualised care (Davidson, 2008:1). This author asserts that the mental health care users’ movement has been instrumental in drawing the attention of mental health providers, researchers, and policy makers

toward the concept of recovery from schizophrenia. Service users advocate that mental health services should be recovery-oriented (Curtis, 2001:1; Acuff, 2000:1459). This notion has been incorporated internationally into mental health policy (Allott et al., 2000:13; Jacobson, 2003:378).

To achieve this, programmes based on a service user-oriented model of recovery need to be developed, and a recovery measure based on such a consumer model is required to enable further research into the processes of recovery (Andresen et al., 2006:6). Recovery orientation forges a clear direction as to how mental health services, community mental health sector organisations, and related sectors should provide care and treatment for people living with mental illness. This is evident in policies at international and national levels, with many countries seeking to develop services that work within a recovery-orientation paradigm (Commonwealth of Australia, 2003, 2009; Health Scotland, 2008; Mental Health Commission of Canada, 2009; Mental Health Commission of New Zealand, 2008; New South Wales Health, 2009).

5.8.1 Characteristics of recovery-oriented practice

It is acknowledged that the lived experiences of mental illness must be synthesised with professional experience to determine how recovery-oriented services can be best provided (Glover, 2005:2). Themes identified in the literature as principles that should underpin recovery orientation in services include, are the following:

- Are person-centred (Farkas et al., 2005:145; Walker, 2006:77). This entails services considering a person's preferences, choices, life goals, and roles in balance with their rights and responsibilities (Jacobson & Greenley, 2001:485; Kelly & Gamble, 2005:250; Western Australia Department of Health, 2004:13). It includes treatment and planning conducted in an actual collaborative process, with personal choice and trust underpinning the relationship (Mead & Copeland, 2000:327; Young et al., 2008:1434).
- Promote a person's self-determination and individual responsibility (Farkas et al., 2005:145; Kelly & Gamble, 2005:250; O'Connell et al., 2005:379).

- Treat the person with mental illness as an equal (Mead & Copeland, 2000:327). Understand the person's whole-life context (Mead & Copeland, 2000:327; Young et al., 2008:1434), and consider a person's physical health as well as alcohol and other drug use as these relate to mental illness (Western Australia Department of Health, 2004:13).
- Consider and respect a person's culture (Jacobson & Greenley, 2001:485; Western Australia Department of Health, 2004:13).
- Retain staff whose attitudes and values align with recovery orientation (Mental Health Foundation of New Zealand, 2008:14). This includes services that should focus on how the person feels, what the person is experiencing, and what the person wants, rather than diagnose, label, and predict the course of the person's life. It also entails that service providers should never scold, threaten, punish, patronise, judge, or patronise but should take cognisance of how the MHCU feels when a service provider acts in a threatening or condescending manner. Of central importance is to ensure that a person's recovery goals are their own and not those of the service provider (Mead & Copeland, 2000:327).
- Emphasise a person's strengths and capacity for growth (Farkas et al., 2005:145), foster hope and empowerment, and use empowering and encouraging language (Jacobson & Greenley, 2001:485; O'Connell et al., 2005:379; Western Australia Department of Health, 2004:13).
- Support community integration and provide links to meaningful activities (O'Connell, 2005:379; Western Australia Department of Health, 2004:13; Walker, 2006:77).
- Provide options for treatment, rehabilitation, and support (O'Connell et al., 2005:379). This should include sharing simple, safe, practical, non-invasive, and inexpensive or free self-help skills and strategies that people can use on their own or with the support of carers, families, and/or friends (Mead & Copeland, 2000:327). Psychoeducation should be provided to facilitate an understanding of the illness and its treatment, and information should be provided on relapse prevention and coping skills to reduce the persistence or recurrence of symptoms

(Whitley et al., 2009:202; Mead & Copeland, 2000:327; O'Connell et al., 2005:379; Western Australia Department of Health, 2004:13).

- Practise in a manner that is consistent with national standards and regulations (Western Australia Department of Health, 2004:13)
- Recognise that the lived experiences of mentally ill individuals are essential in informing service delivery (Glover, 2005:2).
- Are informed by best evidence-based practice (Deegan, 2003:374; Mancini et al., 2005:48).
- Facilitate participation in the planning and delivery of services, and advocacy (Farkas et al., 2005:145; O'Connell et al., 20005:379).
- Challenge stigma and discrimination through accurate portrayals of mental illness (Jacobson & Greenley, 2001:485; O'Connell et al., 2005:379).
- Protect a person's human rights (Jacobson & Greenley, 2001:484).
- Encourage and support connections with others who experience psychiatric symptoms (Mead & Copeland, 2000:327).
- Strike a healthy balance between personal growth and risk (Young et al., 2008:1434)

The researcher has observed that the development of recovery-oriented programmes should focus on enhancing the strengths of MHCUs and instil hope, empowerment, and hopeful language.

Davidson (2008:10) provides advice on how the recovery principles might be conceptualised in their application. The information is provided in the table below:

Table 5.3: Application of recovery principles in practice

Recovery principles	What it can mean in practice
Recovery is about building meaningful and satisfying lives as defined by the persons themselves, whether or not there are recurring symptoms and problems.	A move away from the focus on the removal of symptoms as the prime purpose of mental health services, toward a focus on the positive aspects of each person's life.

Recovery principles	What it can mean in practice
Recovery represents a move away from pathology, illness, and symptoms to health, strengths, and weaknesses.	Staying well and building support structures is important. This may include creating crisis prevention plans and advance directives.
Hope is fostered through seeing how to have more active control over one's life, and seeing how others have found a way through.	Having people with the lived experience of mental illness as workers and trainers makes training more real and can lead to cultural change. Training consumers in self-management, and setting their own agendas when working with professionals, becomes important in achieving a partnership way of working.
Self-determination is encouraged and facilitated, with the acknowledgement that what works for one person may be different to that of another.	Individuals define their own goals and agendas. The role of health care professionals is to help a person achieve the goals in ways and settings that are meaningful and acceptable. Examples include the Wellness Recovery Action Plan (WRAP).
The relationship between professionals and service users moves away from being expert/user, closer to peer support.	The qualities and attitudes of staff become at least, if not more, important than skills and knowledge.
Recovery is closely associated with social inclusion and people being able to participate in the community.	Service provision is guided by the intention to support the individual to use the same resources as the general population.
Recovery is about discovering (or rediscovering) a positive sense of personal identity, separate from illness or disability.	People with the lived experience of mental illness retell their stories in the language of empowerment rather than in a language imposed by others. Discrimination and stigmatisation are confronted directly and assertively.
Language used in relation to mental illness should support empowerment and hope for the future. The language used and the stories and meanings that are constructed around personal experience conveyed in letters, reports and conversations, have great significance as mediators of recovery. These shared meanings either support a sense of hope and possibility, or carry an additional	The messages of hope or despair that mental health workers give to people are often pivotal in their recovery. Diagnoses can be helpful or very unhelpful. Therapies can empower or disempower. All aspects of services need to be looked at, including supervision, induction, workload management, appraisal, ward rounds, and partnership working.

Recovery principles	What it can mean in practice
weight of morbidity, inviting pessimism and chronicity.	
The development of recovery-based services emphasises the personal qualities of staff as much as their formal qualifications, and seeks to cultivate their capacity for hope, creativity, care and compassion, imagination, acceptance, and resilience.	Training should include ways that health service professionals can apply to assist recovery, including active listening, rapid response to need, respect for individual choice, and cultural awareness.
Family and other support are often crucial to recovery and where a person with the experience of mental illness consents, should be included as partners to recovery. Peer support is in many cases an important aspect of a person's recovery.	Peer support should be encouraged. Families and other support should be acknowledged in the development and delivery of services.

Source: Davison (2008:10)

This table provides a better understanding in how recovery-oriented mental health can be applied in practice. Shepherd (2007:6) claims that the principles of recovery-oriented practice need to be spelled out to service providers. He suggests that there are recovery-orientation questions that staff can ask people who come for mental health services, which can also be used for evaluation (Shepherd, 2007:6), including:

- Did I promote the person's involvement in their care planning?
- Did I promote their sense of personal control (negotiate over treatment and medication options)?
- Did I promote "hope" (maintain high expectations, a sense that key life goals can be achieved, despite the reality of severe mental health difficulties)?
- Did I help the person develop methods of self-management (for example, give links to useful information sites about mental health problems, treatment, medication and its side effects, self-help materials, local self-help and support groups, and explore and support personal coping strategies)?
- Did I help the person toward employment options? Did I demonstrate a belief that they can work if they want to? Did I show a willingness to listen to the problems

they perceive in getting back to work and advise them as to how these can be solved?

- Did I ensure that they have stable and safe accommodation of a reasonable standard that they are happy with?
- Did I help them access mainstream community activities (education, leisure, sports, church)?
- Am I aware of their existing social networks and want to build on them?
- Did I talk to them about how to best deal with problems of stigma and social inclusion (Sheperd, 2007:6) ?

The researcher is of the view that recovery-oriented mental health services should focus on involving a person in his or her care planning, promotion of personal control – especially for treatment and medication options – belief that MHCUs can keep a job, have a stable income and accommodation, form part of social capital, and be included in community activities. The programme that the researcher has developed integrates these concepts, aligned with recovery principles.

5.9 Traditional mental health versus recovery-oriented approach

The table below compares traditional mental health with the recovery-oriented approach.

Table 5.4: Overview of traditional mental health versus recovery-oriented practice

		Traditional Services	**Recovery-oriented services**
Beliefs	← **Continuum** →		
	View of madness	Pathology No meaning	Crisis of being Fully human experience
	Philosophy	Treatment Paternalism	Recovery Self-determination
	Language	Medical Objective “They”	Personal Subjective “We”
Consumers	**Service**	Passive recipients	Active agents and leaders

		Traditional Services	Recovery-oriented services
	users		
	Families	Unsupported and grieving	Supported and supportive
	Workforce	Mainly medical/clinical Expert authorities	Diverse backgrounds Collaborators
	Communities	Fearful and discriminatory	Accepting and inclusive
Service	**Service Types**	Drugs and hospitals	Broad range of therapies; supports; recovery education; and advocacy
	Service cultures	Authoritarian Segregation from society	Participatory Inclusion in society
	Service settings	Hospitals and clinics	Community and home-based crisis and other services. Online services
Outcomes	**Social networks**	Service community	Natural community
	Housing	Hospitals Residential services	Own home
	Employment	Pre-vocational services Sheltered workshops Unemployment	Real work for real pay A valued contribution to society

Source: Destination Recovery, Mental Health Foundation of New Zealand (2008:49)

Traditional services and recovery-based services are best seen as two ends of a continuum. Most services in 2008 were somewhere between the two. People recognise the importance of social, economic, political, psychological and spiritual, and biological contributors to mental distress and loss of wellbeing. Mental distress is seen primarily as a way of being, with associated personal and social barriers to living well, as well as a fully human experience from which value and meaning can be derived (Roberts, 2000:342). Self-determination is the foundation of service delivery. People working toward benefitting those with mental distress believe in their self-determination. They enhance self-determination by fostering hope, offering a choice of responses, and

ensuring a quick return to active citizenship. They foster the leadership of service users in their own recovery, and at a collective level through their advocacy and workforce roles (Bentall, 2004:1).

Families retain hope for their family members. They are supported and educated to enhance the recovery of a family member as well as the recovery of the family unit from the stresses associated with mental distress. All families have access to family peer support and recovery education (Ministry of Health in New Zealand, 2000). People in the wider community understand that people suffering from mental distress are not especially prone to violence and usually retain their competence, and that services cannot prevent all tragedies. They see major mental distress as a fully human experience, and think discrimination against people with mental distress is wrong. Community members, without the blinkers of fear and discrimination, are valuable stakeholders in the planning, delivery, and evaluation of responses (New Zealand Mental Health Commission. 2003)

The language people use reflects the purpose, values, and assumptions that services are built on, especially the roles of service users as active agents in their recovery, the broad understandings of mental distress, and the anticipation of recovery. The new language values are both subjectivity and objectivity. It emphasises internal autonomy over external authority. In the context of respectful relationships with service users, workers feel uncomfortable describing them with terms such as “non-compliant”, ‘“lacking insight”, ‘“inappropriate”, or ‘“manipulative” (Onken, Craig, Ridgway, Ralph & Cook, 2007:9).

5.10 Implementing recovery-oriented mental health practice

The development and implementation of recovery-oriented mental health policy and services are current themes in the on-going process of mental health reform in many countries (Shera & Ramon, 2013:17). The researcher provides examples of how recovery-oriented practice has been implemented, with a focus on two countries: The United Kingdom (UK) and Canada.

5.10.1 Implementation of recovery-oriented mental health practice in the United Kingdom (UK)

The new meaning of recovery appeared in the national policy arena of the UK in 2001, as yet another import from the US – initially championed by service users, a number of whom feel that it has since been taken over by professionals in terms of claiming the credit for leading and developing this approach without following its key principle – namely the need to ensure that service users are in control of their own lives (Wallcraft, 2005:1). The author further explains that it is clear that without the involvement of professionals in the process of implementation, recovery cannot become embedded in the UK's mental health services. Furthermore, formal decisions were being taken collaboratively through the system of the care programme approach (CPA), which requires a written plan, periodically reviewed. While consultant psychiatrists chaired the meetings, care coordination was carried out by a variety of other professionals (nurses, occupational therapists, social workers) (Wallcraft, 2005:2). The researcher discusses the projects that are recovery-oriented in the UK in more detail:

ReFocus is a five-year project, which began in 2009 and aimed at enhancing the evidence base of recovery-oriented practices (Leamy, Bird, Le Boutillier, Williams & Slade, 2011:445-452). It has created recovery-evaluation tools to accompany the introduction of recovery practice to an urban and a more rural-based mental health trust. The project was funded by the National Institute of Health Research (NIHR) in the UK, and led by Professor Mike Slade at the Institute of Psychiatry. This project has developed its own set of measures and an intervention manual which uses a randomly controlled trial sample (Slade, Bird & Le Boutillier, 2010:185), the largest sample of a UK recovery study.

Castillo (2010) has undertaken a major research project in Colchester, England, and explored the meaning of recovery and of evaluating the contribution of The Haven model to recovery. Qualitative data was collected from 60 service users and six carers, through a number of repeated focus groups and individual interviews (Castillo, 2010). Quantitative data was collected for the Department of Health, which cofunded the project. The findings demonstrate a hierarchy of conditions that have to be met prior to reaching the pinnacle of the pyramid termed "transitional recovery". These include being safe and developing trust in others; feeling cared for, accepting boundaries, community belonging, developing

abilities, hope, ambitions, and achievements. The positive stories of people who have implemented recovery engender hope that the bottleneck can be changed through a cultural change in the organisations in which staff are working (Ramon, 2011:37) and through a fundamental change in the basic training each professional receives (Anderson & Holmshaw, 2012:146). Parallel to working with service users, mainly by other service users who have already applied the recovery approach to their lives and with likeminded service providers, it is necessary to change the internalised negative self-identity (Bovink, 2012:36; Deegan, 1993:7; Glover, 2012:15). A considerable effort to enhance mental health service users' involvement in auditing, planning, and research has been made by the National Health Service in the UK. This development has been in part due to ongoing pressure from the UK service users' movement, which has argued for a long time that no decisions about them should be taken without them. While this is an achievement, too few of them are actively engaged in these activities, and consultation fatigue is often expressed (Bovink, 2012:36).

The concept of shared decision making (SDM) has become the most recent UK policy key word in mental health (National Institute for Health and Care Excellence [NICE], 2009; Department of Health, 2011). SDM is indeed rooted in the recovery and strengths approaches, which argue that people with mental illness are capable of participating in decision making, and in making relevant decisions about their own lives. However, SDM, in the sense of treating the experiential knowledge of service users as worthy of systematically being taken into account in clinical decisions, is hardly in existence in everyday mental health practice, especially concerning psychiatric medication. The latter is an aspect worthy of consideration, and not only because of the centrality of medication as a mental health intervention. It has been known that 50% of service users do not take their medication on a regular basis (Nose, Barbui & Tansella, 2003:1149) and do not share this decision with their prescriber.

Nose et al. (2003:1149) are of the view that people voluntarily decide to stop taking medication, but are afraid to share this information with the professionals they are working with. Furthermore, there is evidence that these are considered decisions not taken simply spontaneously (Roe, Goldblatt, Balush-Klienman, Swarbrick & Davidson, 2009:38-46;

Malpass, Shaw, Sharp, Walter, Feder, Ridd & Kessler, 2009:154). There is limited knowledge about existing alternatives to medication. Likewise, approaching medication as one option within a range of what Deegan has called “personal medicine,” namely the strategies people have to sustain their wellbeing (Deegan, Rapp & Holter, 2008:603), is not practised.

The researcher is of the opinion that the examples that she has provided suggest a guideline on how recovery-oriented mental health practice can be applied in practice, especially in developing countries such as South Africa. This provides an understanding of recovery-orientation in practice. The researcher understands that there are successes as well as challenges in the implementation of recovery-orientation in practice. The lessons learned from these examples can serve as a benchmark for the development of recovery-oriented mental health practice in South Africa, especially in rural areas.

5.10.2 Implementation of recovery-oriented mental health practice in Canada

Many efforts to reform mental health services in Canada have been undertaken over the past several decades (Shera & Ramon, 2013:18). Additionally, Shera and Ramon (2013:18) have identified a number of central themes in these initiatives:

- Correcting the imbalance between institutional and community-based care.
- Moving toward a more comprehensive array of services which include treatment, rehabilitation, prevention, and the promotion of mental health.
- Devolving governance of mental health services at regional and local levels to increase responsiveness.
- The recognition that mental health care should not be limited to formal mental health supports.
- The involvement of MHCUs and their families as partners in the planning, delivery, and evaluation of mental health services.

Shera and Ramon (2013:19) assert that these themes continue to be central to both provincial and national efforts at reform. In Canada, the Canadian Mental Health Association has been very influential in implementing their policy document. Trainor,

Pomeroy, and Pape (2004:5-6) have identified the three pillars of recovery as community, knowledge base, and personal resources of the person experiencing mental illness. Furthermore, in 2004 the federal government requested that the Standing Senate Committee on Social Affairs, Science, and Technology examine the state of mental health in Canada and make recommendations for improving the system (Senate Committee on Social Affairs, 2006). This commission, led by Senator Kirby, conducted its work over a two-year period, looking at background research, the development of working papers, written and verbal testimony by experts, the development of draft reports, and conducting numerous consultations with a wide variety of interest groups. The committee also concluded that working toward a recovery-focused system is a complex undertaking that rests upon three pillars:

- Choice: Access to a wide range of public-funded services and supports that offer people living with mental illness the opportunity to choose those that will be of benefit to them.
- Community: Making these services and support available in the communities where people live, and orienting them toward supporting people living in the community.
- Integration: Integrating all types of services and supports across the many levels of government and across both the public/private divide and the professional/non-professional dichotomy (Senate Committee on Social Affairs, 2006).

In terms of the implementation of this transformed delivery system, the committee strongly endorsed the shifting of resources from the institutional sector to the community. But in recognition of the time that this will take, they recommended a Mental Health Transition Fund to cover the transition costs and make a major investment in community-based services (Shera & Ramon, 2013:19). The commission's knowledge exchange centre (KEC) was designed to improve the lives of people living with mental illness by creating ways for Canadians to access information, share knowledge, and exchange ideas about mental health. This is divided into three major activities:

- ***Sharing*** – facilitates access to information through interactive publications, and the provision of searchable databases and protocols that can be used to identify best practices in mental health.
- ***Collaboration*** – a commitment to collaborate with leading individuals, organisations, and users to bring expertise together and foster knowledge, exchange networks, communities of practice, and inter-agency alliances.
- ***Support*** – which will develop individual and organisational capacity to engage in knowledge exchange by using toolkits, offering workshops, and implementing knowledge activation initiatives (Shera & Ramon, 2013:19)

The researcher has identified the examples of how recovery-oriented mental health practice has been implemented in Canada, the details of which are provided below:

The **At Home project** is based on the Housing First model, which assumes that a place to live is critical to focusing on other personal issues. This initiative received $180 million in federal funding, is being implemented in five cities across Canada, and is intended to provide evidence regarding how to best help people who are mentally ill and homeless. More than 2 000 homeless persons have been involved in this project. A final evaluation of the project was made available in 2013 (Shera & Ramon, 2013:20).

The **Peer project** intends to enhance the utilisation of peer support (O'Hagan, Cyr, McKee & Priest, 2010:1) through the creation and application of national standards of practice. It involves using peer-based education strategies to encourage a change in societal attitudes toward mental illnesses, specifically targeting youth in schools and adults in workplaces. The expectation is to develop evidence-informed standards that will enhance the credibility of peer-based services.

The commission's most ambitious project is the **Partners for Mental Health** initiative, which is a grass roots advocacy movement, committed to repositioning mental health on the national agenda. It uses a web-based social media approach to create an online community that will advocate for major changes in the policies, programmes, and supports in the area of mental health. The target is to mobilise a million people to advocate

for transformation of the mental health system (Canadian Mental Health Association, 2003).

Shera and Ramon (2013:21) assert that there are more than 250 certified WRAP facilitators in Ontario.

A leading example of a consumer/survivor initiative (CSI) organisation is **The Krasman Center,** which promotes itself as a place to be label free, and offers hassle-free recovery-oriented programmes. It offers peer-based programming, wellness and recovery support, family support, a telephone support line (WARM line), arts-based therapeutic programmes, self-help groups, a drop-in centre (with computers, meeting room, laundry and shower facilities for the homeless) and WRAP programmes. Moreover, the authors point out that there has been an increasing demand for peer-support workers, and to help meet this need the centre has developed the peer recovery for employment and resilience programme. The programme is designed to support individuals' personal recovery and to prepare them to enter the peer, recovery, mental health, or social service workforce (Shera & Ramon, 2013:21).

The **Dream Team**, a group of consumer/survivors, has been involved in telling their stories of coping and recovery over a number of years. They obtained a grant from the Wellesley Institute to test their perceived assumption of the value of supportive housing by conducting a community-based research process that brought residents, housing providers, and neighbours together. This study found that supportive housing does not hurt property values or increase crime but that supportive housing residents make important contributions to the strengths of their neighbourhoods and they add to the economy and vibrancy of the area. There is no doubt that the consumer/survivor movement has been a major force in promoting recovery-oriented mental health reform in Canada (De Wolff, 2008:19-22).

Another initiative, **Mental Health First Aid**, has trained more than 50 000 individual Canadians to respond to mental health emergencies. They are taught to recognise the signs and symptoms of mental health problems, provide initial help, and guide people

toward appropriate professional help. Many of these trainees have become instructors (train the trainer model) (Shera & Ramon, 2013:22).

The researcher has noted the differences in the implementation of recovery-oriented mental practice in these two countries. In the UK, recovery-oriented mental health practice was initiated by the users, a number of whom felt that it has since been taken over by professionals in terms of claiming the credit for leading and developing this approach without following its key principles, namely the need to ensure that service users are in control of their own lives. Most of the projects have not incorporated a strengths-based approach, and still focus on deficit-based treatment. On the other hand, in Canada recovery-oriented mental health practice is service-user led, and there is collaboration between the stakeholders. Hence, the present study follows the collaborative route. The researcher's study has similar tenets to those of the Canadian recovery-oriented practice.

5.11 Challenges in implementing recovery-oriented mental health practice

The researcher has identified different challenges that can impede the implementation of recovery-oriented mental health in practice. More details on this issue are provided below:

Stigma, both societal and professional, is one of the most persistent barriers to a more humane, recovery-oriented system of care for persons with mental illness (Shera & Ramon, 2013:28). Rusch, Angermeyer, and Corrigan (2005:529) argue that understanding both public stigma and self-stigma is critical in identifying strategies to reduce stigmatisation. Moreover, these authors point out that mental health professionals also need to question their own potentially stigmatising attitudes toward people with mental illness. The authors also identified three core strategies: protest, education, and contact. Adams, Daniels, and Compagni (2009:30-45), in their comparative analysis of seven countries (Australia, Canada, England, Italy, New Zealand, Scotland and United States of America), identified anti-stigma campaigns as a top priority with a primary focus on the media, young people, and the workforce. They also emphasise the importance of

partnerships with user groups in these efforts, and the need to view these initiatives as long-term commitments.

Political challenges are complex and ever-changing. Mental health (unfortunately not well understood as a key dimension of health) has historically not been high on the priority lists of politicians or of citizens they represent (Shera & Ramon, 2013:30). The researcher concurs with Ramon and Shera. It is also the case in SA, that mental health is not prioritised. Energy is occasionally focused on this area after tragic events such as suicides or maltreatment, but interest soon subsides (Shera & Ramon, 2013:30).

In SA, that has happened in the case of Life Esidemeni Hospital for mental health, where MHCUs were transferred to unlicensed non-profit organisations in the community when the hospital closed down in 2016. The government responded when tragically 94 MHCUs passed away while in the care of these non-profit organisations. Shera and Ramon (2013:13) further state that the political landscape is dominated by political parties that are often in office for a much shorter period than that needed to implement long-term reform in their mental health systems. This also contributes to the problem of many excellent reviews of mental health policies and services being shelved rather than informing public policy. It is very rare that a new government will support the recommendations that emanate from a report commissioned by a previous administration.

Policy challenges involve two key components: the development of policy, and the implementation of policy. Policy emerges from processes of research, stakeholder dialogue, and interest group pressures. It is also significantly influenced by the availability of funds. In these times of fiscal austerity in many countries, decision makers are increasingly looking to other jurisdictions to find out what works. In the context of Australian government policymaking, Banks (2009:33) argues “that it is as important that we have a rigorous, evidence-based approach to public policy today as at any time in our history.” The author also identifies recent public sentiment which is demanding a more transparent, cost-effective approach to policy-making that promotes better use of taxpayer dollars. There are, however, many areas in which clear evidence is lacking, and interventions from elsewhere often need significant modification to be appropriate for

different contexts. A good deal of government policy making is driven by ideology, and not evidence. This characteristic and the process of negotiating changes to obtain approval often undercut the potential of the policy's impact (Mulvale, Abelson & Goering, 2007:363).

Policy implementation is often an even more problematic area (Thornicroft, Alem, Attunes Dos Santos, Barley, Drake & Gregorio, 2010:67). Translation of policies into well-designed programmes with adequate resources, support and monitoring, is the exception rather than common practice. There are, however, some best practice models, for example, in the area of implementing evidence-informed practice that are transferable to promoting recovery-oriented mental health at both organisational and service system levels (Dill & Shera, 2012:11).

Resource allocations for mental health programmes are critical, as is the selection of areas for investment within this broad programme area. Payment systems influence MHCU selection, quality, the availability of medication, and outcomes in more or less favourable ways (Thornicroft & Tansella, 2004:283). In the last few decades, many countries have diverted money away from institutions toward the community, but many would argue that the investment in community-based services has been insufficient to meet the need. Knapp, Funk, Curran, Prince, Grigg, and MCDaid (2006:157) identified the economic barriers to improving availability, accessibility, efficiency, and equity of mental health care in low- and middle-income countries. Many programmes are under-resourced and have little chance of achieving the intended outcomes. Professionals working in human services also need a more advanced level of economic literacy to be able to advocate for more cost-effective programmes for users.

Organisational change, particularly in larger organisations, can be a daunting task. In the current climate, these changes are initiated with few, if any, new resources and often as part of a cut-back or merger strategy (Benton & Austin, 2010:458). Key questions to be addressed in implementing a vision of recovery within organisations are:

- Does the organisation have the financial and human resources needed to implement a recovery approach?

- Does the culture of the organisation support recovery through clear vision and goals, staff cohesiveness, autonomy and openness to change?
- What is the capacity of staff to acquire, assess, and implement a recovery approach to practice?
- Is there an inclusive process of involvement and cohesive leadership both in the development and implementation phases of the organisational change effort?

A number of mental health organisations in Canada have attempted to implement recovery-oriented services, and have identified both their successes and the challenges encountered in these efforts (Casey, 2008:1; Malachowski, 2009:49; Shepherd, Boardman & Burns, 2010:1). The Implementing Recovery – Organizational Change Project in England (Shepherd, Perkins, Repper & Boardman, 2011:1-5) has identified a number of key organisational challenges that are observable in many countries. They include:

- Changing the nature of day-to-day interactions and the quality of experience.
- Delivering comprehensive, user-led education and training programmes.
- Establishing a recovery education centre to drive these programmes.
- Ensuring organisational commitment, creating a culture and leadership.
- Increasing personalisation and choice.
- Transforming the workforce (training and deployment of peer professionals).
- Changing the way we approach risk assessment and management.
- Redefining user involvement to achieve a true working partnership.
- Supporting staff in their recovery journey.
- Increasing opportunities for building a life beyond illness.

One of the most difficult issues in achieving a recovery-oriented approach will be confronted in the process of convincing professionals to practise in a significantly different way (Davidson, Tondora, O'Connell & Rowe, 2009:33-61). These authors pose the following questions: *Will professionals and mental health organisations willingly integrate*

services in the best interest of MHCUs? Can professionals work in a more MHCU-centred, empowering fashion? Will MHCUs have a legitimate role in the planning and delivery of services? On the other hand, MHCUs have been clear about what they really need to deal with their illness and survive in the community (Davidson et al., 2009:33-61; Nelson, Lord & Ochocka, 2001:125-142). Regrettably, many MHCUs are sceptical that mental health professionals and systems of care will significantly shift their attitudes and practices to achieve the goals of recovery. Perhaps continuing pressure to combine recovery principles and evidence-based practices (Torrey, Rapp, Van Tosh, McNabb, & Ralph, 2005:91-100), and a significant restructuring of the educational programmes of mental health professionals (CSWE, 2011), will contribute toward gradual progress.

The **community-capacity building challenge** appears to demonstrate most clearly the differences between a mental health service system view of recovery and a person-centred community-based approach to recovery. Those that are caught up in the service system paradigm often fail to see the broad range of normative resources that are available in communities for those who are experiencing mental illness. This also requires humility in understanding the limited role that formal mental health services play in the process of recovery. There are many excellent resources that have articulated the importance of communities such as Carling's (1995) work on community integration; Nelson, Lord and Ochocka's (2001:12) development of an empowerment-community integration paradigm, and the Canadian Mental Health Association's Framework for Support (Trainor et al., 2004:1-5).

The researcher has observed that these challenges are similar to those experienced by developing countries. Without the political will, policies, resources, and buy-in by the professionals, the community and mental health care users cannot take a leading role, and without resources the implementation of recovery-oriented services will be impossible.

5.12 Evidence-based practice (EBP) and recovery-oriented mental health services

During the past decade, confidence in scientific research, with its objective observations and measures, has increased considerably in the mental health arena (Frese, Stanley, Kress & Vogel-Scibilia, 2001:1462). In recent years, this increased confidence in scientific treatment methods for mental illnesses has given rise to a movement that calls for the more widespread adoption of treatment approaches that are scientifically grounded (Frese et al., 2001:1462). This movement has been developing under the rubric of "evidence-based practices" (Drake, Howard, Goldman, Leff, Anthony, Lehman, Dixon, Mueser & Torrey, 2001:179-182). Under this concept, the call for greater reliance on scientific evidence is being extended to treatment approaches that are supported by psychological and sociological evidence as well as by the findings of biological research (Frese et al., 2001:1462).

Evidence-based practices (EBPs) are defined by the Institute of Medicine as '"the integration of best-researched evidence and clinical expertise with patient values" (Institute of Medicine Committee on Quality of Health Care in America, 2001). The Journal of Psychiatric Services in a series of articles on EBPs has identified a core set of interventions that improve outcomes for persons with serious mental illness (SMI). They include assertive community treatment (ACT), family psychoeducation, medication for specific conditions, supportive employment, and integrated treatment for co-occurring substance use disorders (Drake, Mueser & Torrey, 2000:393). Drake et al. (2001:180) assert that "mental health services should not focus exclusively on traditional outcomes such as compliance with treatment and relapse or rehospitalisation prevention, but should be broadened to include helping people to attain such consumer-oriented outcomes as independence, employment, satisfying relationships, and good quality of life." They claim that evidence-based practices "do not provide the answers for all persons with mental illness, all outcomes, or all settings."

Evidence-based practices (EBPs) are interventions for which there is consistent scientific evidence, showing that they improve MHCU outcomes (Drake et al., 2001:181). For example, research shows that using antipsychotic medications within a specific dosage range and providing education and skills training for family caregivers over several months, prevents or delays relapse in schizophrenic patients (Drake et al., 2001:182).

Moreover, these authors point out that the requirements for scientific evidence used by different groups sometimes vary but, in general, the highest standard is several randomised clinical trials comparing the practice to alternative practices or to no intervention.

Drake et al. (2009:182) indicate that various practice guidelines developed in the 1990s by the agency – then known as the Agency for Health Care Policy and Research – exemplify this approach by using three levels of evidence:

- Level A: refers to good research-based evidence, with some expert opinion.
- Level B: indicates fair research-based evidence, with substantial expert opinion to support a recommendation.
- Level C: denotes a recommendation, based primarily on expert opinion, with minimal research-based evidence.

Bond, William, and Evans (2000:315) assert that although the term evidence-based practice is sometimes used to refer to guidelines that are not based on research, true evidence-based practices are by definition grounded in consistent research evidence that is sufficiently specific to permit the assessment of the quality of the practices rendered as well as the outcomes. The crux of the matter is that precisely because evidence-based practices are grounded in the qualifications imposed by current science, they are standardised, replicable, effective, and a switch to research-based interventions with known effectiveness that can dramatically improve outcomes in large practice systems, for example, the overall rate of employment of persons with severe mental illness (Drake et al., 2001:182). Additionally, the authors assert that the central strategy in defining evidence-based practices is to be straightforward about the limits of the evidence.

The provision of evidence-based practices, even under constrained conditions, would be an improvement and would move stakeholders toward awareness of the potential of other evidence-based practices (Torrey, Drake, Dixon, Burns, Flynn & Rush, 2001:45). For example, research indicates that assertive community treatment does not consistently improved vocational outcomes, and that supported employment must be a well-integrated component of the intervention to achieve high rates of competitive employment (Bond,

Becker & Drake, 2001:313). Thus, providing assertive community treatment should increase pressure to implement supported employment (Torrey, Rapp, Van Tosh, McNabb & Ralph, 2005:92). The researcher has noted that intervention in recovery-oriented practice should go hand in hand with research. Hence, the present study will be published and this might contribute to the social work field and also add constructively to evidence-based practice.

5.13 Social work and recovery-oriented mental health practice

Social work has made significant contributions to the recovery movement and, in turn, the movement has revived the professional position of social work in mental health in the USA (Council on Social Work Education [CSWE], 2012). Historically and currently, social work has been a major provider of mental health services in the USA, by some estimates delivering half the professional services provided to individuals with psychiatric conditions (CSWE, 2012). The profession has strong past links to mental health recovery-oriented frameworks, and shares many of the same vital values, ethics, and practice perspectives. Social workers' training in direct practice, systems change, and policy practice can influence and enhance the recovery of individuals living with mental illness on both micro and macro levels. Social workers are well versed in how to effectively and collaboratively advocate for the rights and protection afforded their MHCUs (CSWE, 2012).

Advocates for Human Potential (AHP) (2011:25) state that "recovery-oriented social workers advocate for organisational change and transformation to a recovery-based system. They promote individual recovery by advocating on behalf of their MHCUs to access resources and services that support their recovery pathways. They understand that education and support for the family and significant others can be key elements to supporting the individual's own recovery process. They recognize that peers 'encourage and engage each other in recovery, often providing a vital sense of belonging, supportive relationships, valued roles, and community.'"

Recovery-oriented mental health practice is aligned to the ethical standards of the social work profession and the core values of self-determination, empowerment, and social justice (CSWE, 2012). Recovery-oriented social workers use the world of the person living

with mental illness as the lens through which they operate and believe that individuals can and do recover from psychiatric conditions; this is the foundation on which recovery-oriented practice is built (AHP, 2011). Research has shown that having at least one person who believes in the individual diagnosed with mental illness encourages his or her recovery, combats the effects of stigma, discrimination, and shame, and is critical to the individual's recovery (CSWE, 2012). Therefore, it is critical to investigate the synergy of recovery principles and social work values.

5.13.1 Synergy of recovery principles and social work values

Social work is a profession inherently aligned to recovery principles, and is therefore in an ideal position to provide participatory and person-centred leadership in the recovery-oriented approach (Hyde et al., 2014:10). These authors further state that the recovery movement has given rise to the acceptance – within mental health service delivery – of many concepts and values that are embedded within social work principles and practice. As social work grows to recognise a new paradigm taking hold in the treatment of persons with serious mental illness, this process of connection between practice and values becomes apparent (National Association Social Work [NASW], 2008). This new paradigm in the recovery from serious mental illness has a strengths perspective at its base (Bensdorf, 2008:1). This author states that this is significantly different from the prevailing paradigm mostly referred to as the "deficit model" in which DSM-5 defines illness. Bensdorf (2008:1) further states that in utilising a recovery paradigm, a clear connection between recovery principles and social work values comes to the fore. These include hope, meaningful relationships, individualising treatment for each MHCU, empowering MHCUs, advocating for MHCUs, working against social injustice, and encouraging the building and maintenance of support networks (NASW, 2008).

There are strong benefits for workers who use this model. They include being a part of the process of healing and wellness for persons previously viewed as having an illness where the best prognosis would be to accept minimal improvements (NASW, 2008). There is satisfaction in participating in growth-producing relationships with MHCUs (Bensdorf, 2008:1). This author asserts that because of the congruence between work and values, social workers can practise more effectively within a framework of

contentment compared with with less fitting models. Social workers' expectations of change are more in line with the reality of their work, and are therefore less stressful (Bensdorf, 2008:1).

Finally, utilising this model reinforces basic social work practice, because it emphasises the person-in-situation, holistic view. The benefits for MHCUs include making choices in life, particularly in the specifics of living situations, daily activities, and treatment (NASW, 2008). These changes bring a sense of empowerment and self-determination to the mental health care user. MHCUs will work actively for change not only for themselves but also for individuals with disabilities in the population as a whole. Services based on the recovery paradigm can potentially lead to the formation of meaningful relationships and ideally the development of an active support network. Finally, and most strikingly, this model is the foundation for providing hope, one of the most necessary conditions for human growth (Bensdorf, 2008:1).

The researcher recognises that there is indeed synergy between recovery principles and social work values. However, in South Africa, social workers have not yet implemented the recovery-oriented practice. This assertion is based on the fact that although the researcher examined different research platforms or databases such as Ebsco Host, Sabinet, and Google Scholar, she was unable to obtain any research authored by South African social workers.

5.13.2 Comparison of social work and recovery principles

The closeness of the fit between social work principles and values and those of recovery, stands out in the reading of many of the policy and guideline documents now published to inform mental health practice (Hyde et al., 2014:11). The table below provides the comparison of social work principles and recovery principles.

Table 5.5: Comparison between social work and recovery principles

Social Work	Recovery principles
Self-determination	Self-determination
Empowerment	Empowerment

Social Work	Recovery principles
Acceptance and uniqueness of individuals	Personal meaning expert by experience
Collaboration and participation	Collaborative relationships
Identifying and developing strengths	Strengths
Respect of inherent dignity, worth, and autonomy of every person	Self-identity, sense of agency, inherent capacity to live a full and meaningful life of their choosing
Respects the human rights of individuals and group	Upholding human rights
Foster personal/social responsibility	Focusing on strengths and personal responsibility
Hope	Hope and optimism
Reflective awareness as part of professional integrity	Staff to engage in reflective practice

Sources: AASW (2010); Rethink (2009); Deegan (1995)

The researcher has observed the link between social work principles and recovery principles, and that social workers have a role to play in facilitating recovery-oriented mental health practice. It has now become a priority that recovery-oriented mental health practice be implemented in SA. The researcher has noted that globally there is a concern that social workers' voices are limited as far as recovery is concerned.

5.13.3 Invisibility of social work in recovery-oriented mental health practice

Hyde et al. (2014:13) conducted a literature review and ascertained that there were few articles authored by social workers in recovery-oriented mental health practice. The authors were astonished by the close fit between social work principles and values and recovery principles. Slade et al. (2008:23) noted the absence of the social work profession from debates on recovery-oriented mental health practice. Ramon (2009:1620) also acknowledges the absence of social workers in dialogues regarding recovery-oriented mental health practice, and concedes that social workers have ironically been responsible for some of the changes in mental health practice such as the inclusion of service users in policymaking. The author is of the opinion that recovery should be a natural domain for social workers given the emphasis on psychosocial and self-determination factors. It is

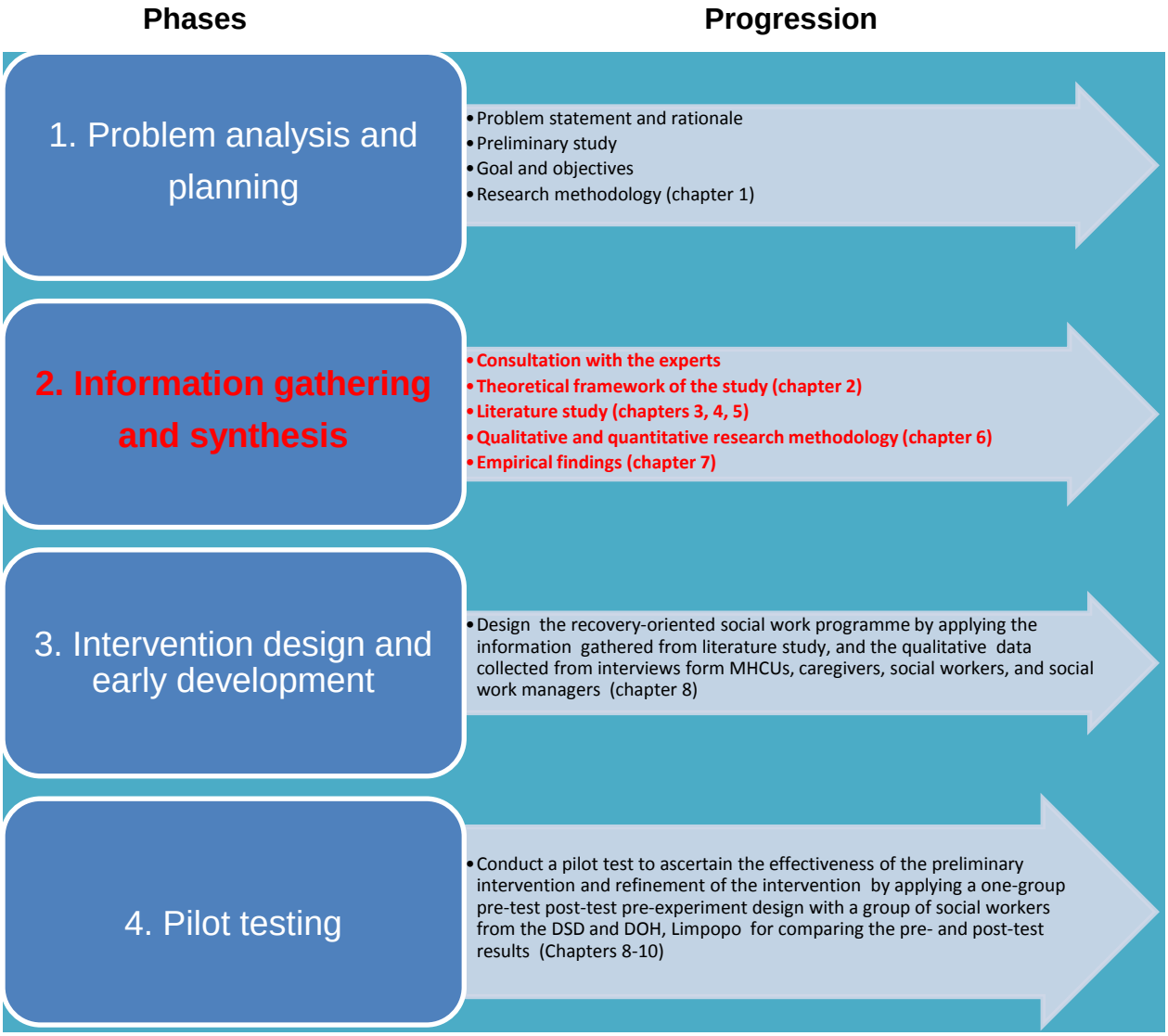
evident that the social work profession is hesitant about engaging in research; as a result, this resulted in a lack of influence in the mental health field. Ramon, Lachman, Healy, Shera, and Renouf (2007:108) express their concern that social work perceives itself as less powerful than other professions in the field of mental health. The researcher supports this view, but could not find literature to corroborate this assertion. Relevant literature is limited, and most of the information is psychology based. Therefore, the voices of social workers need to be heard in current debates of recovery-oriented mental health practice.

5.14 Summary

Globally, recovery has become a catch phrase in the mental health arena. Recovery-oriented practice should be a mandated model of care in mental health service delivery, on a global level. Despite the strong alignment between recovery principles and those of the social work profession, social work has been noticeably absent from international recovery literature. The time has come for social work in all countries and cultures to take up the challenge raised in the mental health sector, to step into leading roles in collaboration with people and their supporters who have experienced mental health issues. However, social workers need to become aware of and acknowledge their professional alignment with principles of recovery and their ability to practise within a recovery orientation in mental health services. They need to explicitly build links between their everyday practice and recovery principles, and take a democratic and person-centred leadership role in the implementation of recovery-oriented mental health practice, in accordance with national policy. The next chapter focuses on the research methodology.

CHAPTER 6

RESEARCH METHODOLOGY (QUALITATIVE AND QUANTITATIVE)



Graphic representation of phases of the intervention research: Adapted from Fraser and Galinsky (2010:463); De Vos (2011)

6.1 Introduction

The previous chapters explored mental health service, living with schizophrenia, caring for a person living with schizophrenia, social work in mental health care, and recovery and implementation of recovery-oriented mental health care. It is evident that globally, the transformation in mental health is significant. However, Africa, especially South Africa, is lagging behind in the implementation of recovery-oriented mental health practice. It should be noted that the Department of Health (2013) has developed a National Mental Health Policy and Strategic Plan (2013-2020) that spelled out that mental health services should adopt the recovery-oriented principles. This chapter focuses on the research methodology undertaken in the present study.

6.1.1 Aim and objectives of the study

Aim

The aim of the present study was to develop, implement, and evaluate a social work intervention programme aimed at recovery-oriented mental health practice in rural areas.

Objectives

Phase 1:

- To explore and discuss mental health services and policies from international, regional, and national perspectives.
- To explore the challenges of MHCUs regarding mental health care services in rural SA.
- To gather information from MHCUs and caregivers regarding their needs in mental health care in rural areas.
- To gather information from social workers and social work managers in the districts, hospitals and the provincial offices of the Departments of Health and Social Development about the current practice of mental health care in rural areas.

Phase 2:

- To design a recovery-oriented social work programme based on the identified needs in the first phase.
- To conduct a pre-test measurement with the social workers regarding their knowledge of the mental health and the recovery-oriented model.
- To implement the recovery-oriented social work programme through the training of social workers during a one-day training session.
- To conduct a post-test measurement with the social workers regarding their knowledge of mental health and the recovery-oriented model after completion of the training.
- To analyse the effectiveness of the programme by comparing the pre-test and post-test results aimed at improving the knowledge of social workers on mental health and the recovery-oriented model.
- To make practice recommendations for the broader utilisation of the recovery-oriented social work programme for MHCUs in rural areas.

6.1.2 Research question

The present study opted for a qualitative approach in response to the research question (first phase). Hofstee (2011:85) holds the view that a research question is used to name as precisely as possible what the study will attempt to ascertain. Moreover, Agee (2009:431) perceives a research question as a starting point for the research, and underscores the strengths of a qualitative approach. A strong mixed-methods study should contain the qualitative question, the quantitative question or hypothesis, and a mixed-methods question. This configuration is necessary because a mixed-methods approach does not rely exclusively on either qualitative or quantitative research but on *both* forms of inquiry (Creswell, 2014:10). Therefore, the following research questions were developed:

The main research questions were formulated as follows:

- Will social workers trained in the recovery model of intervention be more empowered to render recovery-oriented intervention to MHCUs in rural areas?
- Can social workers make a paradigm shift in their intervention approach once undergoing training in recovery-oriented practice?

The following sub-questions informed the main research question:

- What is the state of mental health care services in rural SA?
- What are the current treatment practices utilised for MHCUs in rural SA?
- What are the current mental health care intervention practices used by social workers in rural areas?
- What is the nature of the care that MHCUs receive in rural areas?
- What are the needs of MHCUs and their caregivers in rural areas regarding mental health care?

6.1.3 Hypothesis of the study

For the quantitative approach (second phase), a hypothesis was developed. Babbie and Mouton (2001:643) define hypothesis as “an expectation about the nature of things derived from a theory and is a statement of something that should be observed in the real world if the theory is correct.” The authors further postulate a certain relationship between two or more variables.

Hypothesis

- If social workers participate in the recovery-oriented intervention programme developed in this study, their level of knowledge will improve in rendering mental health services to MHCUs and their caregivers in the rural areas of South Africa.

Sub-hypothesis

- A social work intervention programme based on recovery-oriented mental health will increase the knowledge of social workers in rendering mental health services to MHCUs and their caregivers in the rural areas of South Africa.

6.2 Research approach

The researcher employed a mixed-methods approach in the present study, which is a combination of qualitative and quantitative approaches. This approach provided the researcher with the opportunity to access a blend of different views and perspectives, which alerted her to the possibility that issues are more difficult than they initially appeared to be (Teddlie & Tashakkori, 2009:15). The researcher's selection of a mixed-methods approach for the present study was informed by the fact that the approach can concurrently address a range of confirmatory and exploratory questions with both qualitative and quantitative approaches and provide more clear-cut explanations (Rubin & Babbie, 2013:47). The present study intended to understand the nature of mental health services in rural areas, what the current treatment practices are, and the needs and challenges of MHCUs and their caregivers. This approach therefore seemed appropriate to answer the main research question. It enabled the researcher to integrate, connect, or mix some stages of the research process.

This method was deemed appropriate in the present study as it has the advantage of combining both qualitative and quantitative techniques, methods, approaches, and concepts in a single study (Johnson & Onwuegbuzie, 2004:14). Furthermore, a mixed-methods approach offers a balance between the limitations of a single approach and provides an alternative strategy for the researcher (Durheim, 2006:47; Krysik & Finn, 2013:18). Despite this, conducting mixed methods is not easy. It takes time and resources; it requires specific skills to collect, analyse, and mix both quantitative and qualitative data in a single study. Grinnell and Unrau (2008:558) define a two-phase model as "combining interpretive and positivist approaches in a single study where each approach is conducted as a separate phase of the study." However, Creswell and Plano Clark (2007:10) and Delport and Fouché (2011:441) state that a mixed-methods approach is time consuming.

A mixed-method approach is embedded in a pragmatic paradigm (Creswell, 2014:11). The author further asserts that "pragmatism is the foundation for mixed-method studies whereby the multiple data collection and analysis method are utilised." The researcher has noted that pragmatism is in line with ecological systems theory, which is the premise of the present study (chapter 2). This assertion is based on the fact that pragmatism views knowledge as both function and outcome of transactions between individuals and their environments (Ivankova, 2015:53).

6.2.1 Qualitative approach

Qualitative research purports to comprehend the significance of circumstances or occasions from the viewpoint and understanding of the people involved (Spratt, Walker & Robison, 2004:11). The circumstances in the present study are within the nature of mental health care in rural SA, the current treatment, and the needs of MHCUs regarding mental health care. Punch (2005:238) asserts that qualitative approaches deal more with case studies, and are more focused on settings, methods, and lived experiences to convey a detailed comprehension of social life. The cases in the present study involve MHCUs admitted to three psychiatric hospitals, namely Shiluvana, Evuxakeni, and Hayani Hospitals, as well as caregivers, social workers in the hospitals, social workers in the districts, social work managers in the districts, and the provincial office of the Department of Health and the Department of Social Development in Limpopo Province. Hesse-Biber and Leavy (2011:71) point out that the qualitative phase provides the primary data to develop a theory. The approach has a strong alignment with intervention research. The researcher conducted the first phase (qualitative approach), and based on the findings, the preliminary or prototype programme was developed, supported by the literature review, an essential element in this regard.

Qualitative research is rooted in an interpretivist paradigm that views reality as an attempt to understand the multiple realities of how people interpret and ascribe meaning to their experiences in the world (Merriam, 2009:4). Moreover, Creswell and Plano Clark (2011:79) hold the view that this approach makes use of inductive reasoning where textual data is collected for the purpose of generating concepts. Additionally, Rubin and Babbie (2011:36) assert that this approach aims to attain an in-depth understanding of the phenomena.

6.2.2 Quantitative approach

Quantitative research investigates the relationship between variables that a researcher seeks to find (Creswell, 2009:133). “It places emphasis on measurement to establish objectives that exist independently of the views and values of the people involved” (Spratt et al., 2004:9). Quantitative data allows for objective comparisons as well as measurements of the situations and phenomena under study (Punch, 2005:238).

The approach was used in the second phase. Based on the findings of the first phase, the researcher developed pre-test and post-test questionnaires (more details about the development are given in section 6.4). The researcher prepared for the training in the preliminary or prototype programme. The respondents were social workers from Vhembe and Mopani Districts. The training was conducted for one day. The pre-test questionnaire was given to the respondents before and the post-test questionnaire after the training session. A statistician and a research assistant from the Department of Statistics, University of Pretoria assisted with the data analysis. The approach was deemed appropriate as its objective was to determine the extent of the problem, issue, or phenomenon (Kumar, 2005:12). The present study lends itself to predetermination of the objectives, design, and sample, which correlates with Kumar’s description. The researcher objectively measured the effectiveness of the recovery-oriented social work programme in mental health care in the rural areas of South Africa. The measurement was done by utilising pre-test and post- test questionnaires (Appendices L & M).

The quantitative approach is embedded in the positivist paradigm and it aims at producing precise and generalisable statistical findings in numerical format (Grinnell & Unrau, 2011:33). Moreover, Merriam (2009:5) holds the view that in a quantitative approach the researcher begins with deductively testing hypotheses.

6.2.3 Type of research

The type of research utilised in the present study was deemed applicable as it focuses on scientific, planning-induced change in a situation, and deals with problems in practice (Delport &Fouchè, 2011:108). Additionally, Kumar (2005:4) asserts that “it is through the application of the applied research methodology that a profession is strengthened and advanced.” Csiemik, Bimbaum, and Pierce (2010:10) point out that the data gathered should aim to refine practice, understand the experiences of service users, and empower

communities. The present study focuses on a problem in practice, namely the development of a recovery-oriented social work programme that might potentially benefit rural MHCUs, caregivers, mental health professionals, as well as the community at large.

In the context of applied research, intervention research was applied in the present study. The paradigm was deemed appropriate as the researcher aimed to understand the problem phenomena, and planned to develop an intervention in the form of a recovery-oriented social work mental health care programme (De Vos & Strydom, 2011:473). De Vos and Strydom assert that intervention research is a "concept which grew from the collaboration between two pioneers, Edwin Thomas and Jack Rothman, in the field of developmental research." Rothman and Thomas (1994:50) concede that one of the challenges of intervention design and its development is the extended time required to conduct the study. Due to this fact, the researcher terminated the present study after the pilot testing phase. The pilot testing phase involved the pre-experimental design to test the effectiveness of the developed intervention on the recovery-oriented social work programme in mental health for rural areas of South Africa. An adapted model of intervention research (table 6.1) was drawn from the six-phase models of Rothman & Thomas (1994); Fraser and Galinsky (2010); De Vos, (2011); Strydom, Steyn, and Strydom (2007). Table 6.1 provides the details of the intervention research that guided the process for the development of the intervention programme.

Objectivity/Activity

Table 6.1: Objectives and activities (intervention research)

Objective	Phases	Activity
1.	Problem identification/ problem analysis (Qual)	This results from the origin of the study
	Project planning	○ Policies will be scrutinised ○ Proposal writing will be done
2.	Information gathering/ synthesis (Qual)	Interviews with social workers, social work managers in the districts and provincial offices, MHCUs, and caregivers will be conducted
3.	Intervention design/plan	○ Planning of the CROCMEHC programme will be done ○ The measuring instrument will be developed

Objective	Phases	Activity
4.	Pilot test/refine	The refinement of the tool will be done
5.	○ Pre-testing measurement (Quan) Implement intervention ○ Post-test measurement (Quan)	○ Data gathering will be conducted ○ Social workers will be trained ○ Data gathering will be conducted
6.	Analysis and report writing	Dissemination of the findings

Adapted from Rothman and Thomas (1994); Strydom, Steyn, and Strydom (2007); Fraser and Galinsky (2010); De Vos (2011)

The following process of intervention research was applied:

Phase 1: Problem analysis and project planning

This entailed identifying and involving MHCUs. Social workers in hospitals and in the districts, social work managers in the districts, one manager from the provincial office, MHCUs, and several caregivers were included in the research process. Strydom et al. (2007:334) indicate that a specific social problem within a population be identified on which an intended research is to be based. Moreover, these authors state that it is important to gain access by way of the correct channels of communication, the details explained to the person in charge, and collaborative relationships formed with all involved so that a sense of ownership can develop. The researcher gained entry to the premises by liaising with social work managers in the districts and provincial office, who assisted by introducing her to the chief executive officers (CEOs), superintendents of the hospitals, and social work supervisors in the sub-districts (De Vos & Strydom, 2011:47; Rothman & Thomas, 1994:28).

The Departments of Health and Social Development in Limpopo gave their approval that the present study could be conducted in the Capricorn, Mopani, and Vhembe Districts for the first phase. The second phase was conducted in the Vhembe and Mopani Districts. For the first phase, the researcher interviewed MHCUs from Evuxakeni, Shiluvana, and Hayani Hospitals; caregivers from a village in Malamulele; and social workers from Capricorn, Vhembe, and Mopani Districts as well as hospital social workers from

Malamulele, Hayani, Nkhensani, Evuxakeni, Polokwane, Shiluvana and Seshego Hospitals. The managers were from Polokwane, Malamulele, Thohoyandou and Giyani; and one manager was from the DSD provincial office. For the second phase, the researcher obtained a list of all social workers in Vhembe and Mopani Districts. Potential respondents were selected from the lists, and the researcher sent out the registration form; those selected were required to sign informed consent. The pre-test and post-test questionnaires were developed with the assistance of a statistician and an expert from practice. Sixty-seven participants registered for the training. However, on the day of the training, only thirty-seven participants attended.

Phase 2: Information gathering and synthesis

Strydom et al. (2007:335) point out that during information gathering and synthesis it is essential to discover what has been done and written on the problem being investigated, so that "the wheel would not be reinvented and further insight should rather be gained that can follow on from what has already been done." The researcher used existing sources for the information gathering process by conducting a literature review, checking reported practice, and identifying innovations relevant to recovery-oriented care. She consulted experts in practice to understand what was taking place in practice, and also interviewed MHCUs, caregivers, social workers, and managers in the community in order to obtain more information. The researcher further identified the practical fundamentals of effective models by scrutinising the critical features of the programmes and practices that have been used previously to address the problem in question (De Vos & Strydom, 2011:480; Fraser & Galinsky, 2010:463).

Phase 3: Design

The researcher designed the preliminary or prototype intervention programme, based on the empirical findings of the qualitative approach and literature review. Strydom et al. (2007:335) assert that observing events related to a situation and identifying the effects following intervention are of the utmost importance. Fraser and Galinsky (2010:464) and De Vos and Strydom (2011:483) state that elements should be specified in sufficient detail to enable them to become part of an eventual model which can form part of the final

product. The researcher designed a programme as a training manual that comprises seven sections, namely mental health services, mental health care users and caregivers, social workers in mental health care, approaches used by social workers in mental health care, recovery, recovery-oriented mental health practice, and implementation of a recovery-oriented social work programme. The researcher adapted domains from the Commonwealth of Australia (2013) for the developed programme in the present study.

Phase 4: Early development and pilot testing

An innovative intervention is implemented and used on a trial basis through this process (Rothman & Thomas, 1994:28). Fawcett, Suarez-Balcazar, Balcazar, White, Paine, Blanchard, and Embree (1994:36) point out that during the early development and pilot testing phase a design is developed in a way that can be evaluated under field conditions. De Vos and Strydom (2011:483) hold the view that this phase "includes the important operations of developing a prototype or preliminary intervention and applying design criteria to the preliminary intervention concept." These authors further point out that a pilot test is developed to determine the feasibility of the intervention. Fawcett et al. (1994:36) assert that pilot testing determines the effectiveness of the intervention, and identifies elements of the prototype that may need to be revised. Training in the preliminary or prototype stage was conducted with a group of social workers from Vhembe and Mopani Districts. The researcher intended to present the training over a period of two days. Due to the social workers' protest in Limpopo, she was compelled to scale the programme down to one day per district. From the training it was evident that the recovery-oriented social work programme was effective, and the researcher viewed the recommendations of the participants as design criteria for further development of the programme. The researcher did not employ all the phases of the intervention research, and the implementation ended in the fourth phase.

6.3 Research design

The design utilised in the present study was an exploratory sequential mixed-methods design, which was deemed appropriate as it was used when the researcher first needed to explore a phenomenon using qualitative data, before attempting to measure or test it (Delport & Fouchè, 2011:441). This design followed a particular sequence: firstly collecting and analysing qualitative data. The researcher then conducted a second phase, quantitative phase to test the preliminary intervention programme (Creswell & Plano Clark, 2011:411). The figure below depicts the exploratory, sequential mixed-methods design.

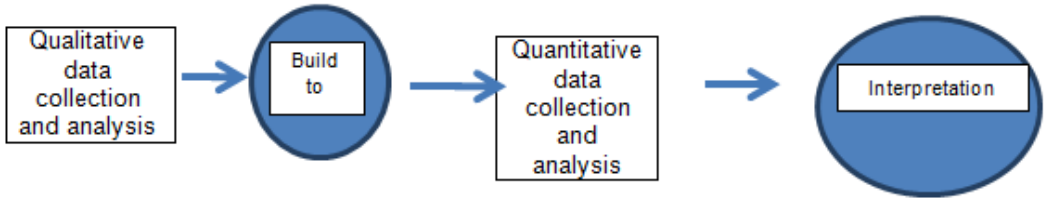


Figure 6.1:The exploratory, sequential mixed-methods design: Adapted from Creswell and Plano Clark (2011:411)

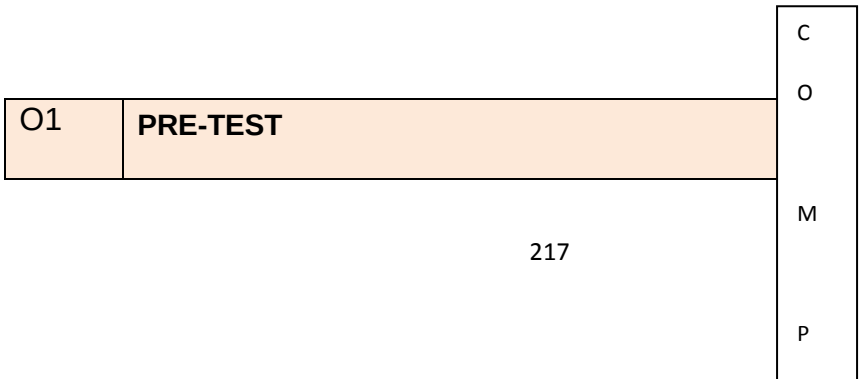
In the present study, the researcher intended to establish the nature of mental health care, the current treatment, and the needs and challenges of MHCUs and caregivers in rural areas. The first phase comprised the qualitative part that attempted to answer the research question; this was crucial before designing a preliminary or prototype intervention programme (Thomas, Nelson & Silverman, 2011:373). This approach aligned well with the intervention research that included creative qualitative as well as evaluative quantitative processes that usually result in two products (Fraser & Galinsky, 2010:464). Furthermore, these authors point out that the two products depict a detailed adaptation of a new programme and an evaluation of the efficiency of that programme. The researcher developed a recovery-oriented social intervention programme, and the researchers terminated the present study at the early development and pilot testing phase due to time constraints. The researcher discusses the qualitative and quantitative designs separately in the next section.

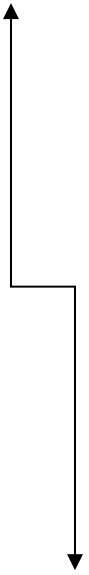
6.3.1 Qualitative research design

The case study design was employed in phase one of the research. Krysik and Finn (2013:165) define a case study as "the rich, detailed and in-depth description and analysis of a single unit or small number of units." The design was appropriate as it involved an exploration of a bounded system or a single or multiple cases over a period of time (Fouché & Schurink, 2011:320). The subtype of the case study design used was the collective case study design (Hesse-Biber & Leavy, 2011:274). This was the most appropriate subtype as it was an instrumental case study extended to a number of cases. Cases can be chosen so that comparisons can be made between cases and concepts; in this way, theories can also be extended and validated (Fouché & Schurink, 2011:320). This was relevant as the researcher was interested in establishing the nature and state of mental health care, the needs and challenges of MHCUs and their caregivers, and the current treatment practices in SA rural areas. Yin (2009:14) cautions that case studies can be time-consuming due to long hours of field work. The researcher had to travel to Limpopo Province. The extensive amount of data obtained from the collective case study, required that the researcher carefully reduce the data. In order to obtain accurate data, the researcher had to solicit the assistance of an independent coder.

6.3.2 Quantitative research design

The experimental design was employed as a quantitative research design in phase two of the study. In this case, the pre-experimental design was proposed, and a one-group pre-test post-test design was considered appropriate; it was administered to social workers in Vhembe and Mopani Districts (Fouché & De Vos, 2011:145). Moreover, these authors state that in the one-group pre-test post-test design is within one group measurement of dependent variable O1 when no independent variable X is present. Measurements of dependent variable O2 are compared for two states of an independent variable within the same group (before and after). If changes have taken place, the researcher could conclude that the intervention was effective (Fouché & De Vos, 2011:148). This design can be written as O1 X O2.





	First measurement (observation) dependent variable
X	**INDEPENDENT VARIABLE-INTERVENTION** A Recovery-oriented social work programme in mental health in rural areas of SA
O2	**POST-TEST** Second measurement (observation) dependent variable (knowledge acquired after the training in recovery-oriented social work intervention programme)

Figure 6.2: One-group pre-test post-test: Adapted from Neuman (2006:255)

It should be noted that there was no control group (Rubin & Babbie, 2013:185). Marlow (2011:96) indicates that the one-group pre-test post-test design is sufficiently significant to facilitate a quantitative measurement of change and improvement in the functioning levels of the participants that occur in the course of administration of the intervention programme. In the present study, the one-group pre-test post-test design was administered to one group of social workers in Mopani District and to another group of social workers in Vhembe District. The researcher administered the pre-test questionnaires to be completed by the respondents. Subsequently, she presented the intervention and afterwards administered the post-test questionnaires. Leedy and Omrod (2005:236) assert that the one-group pre-test post-test design is useful when implemented as a pilot study to measure changes that occur after an intervention. Therefore, the design was appropriate. The details of the empirical quantitative findings are discussed in chapter 9 of the present study.

6.4 Research methods

An overview of the specific methods the researcher employed in selecting the research respondents and gathering the research data, is outlined below under the appropriate headings.

6.4.1 Research population and sampling

The population incorporates all the components of an inquiry required for detailed deduction (Welman, Kruger & Mitchell, 2007:52). Teddlie and Tashakkori (2009:180) identified mixed-methods sampling thus: (a) they combine quantitative and qualitative traits of sampling; (b) they use both formal and informal sampling frames; (c) they generate representative samples that yield rich information; (d) they include multiple samples of varying sizes; (f) they generate both numeric and narrative data; and (g) they start before the study starts. The researcher will discuss the populations and sampling of the qualitative and quantitative approaches separately.

6.4.1.1 Qualitative phase

The focus of this section will be on the study population and sampling method.

- **Study population**

The research population of the study consisted of all the MHCUs in the Evuxakeni, Shiluvana and Hayani Hospital, and all the caregivers in Mapapila Village, Malamulele. The remainder of the study population involved all the social workers employed by the Departments of Health and Social Development in Capricorn, Mopani, and Vhembe Districts; all hospital social workers from Malamulele, Hayani, Nkhensani, Evuxakeni, Shiluvana, Polokwane and Seshego hospitals. Lastly, all social work managers from Capricorn, Mopani, Vhembe, and the DSD provincial office. Inclusion of the entire study population was deemed impractical; hence, a representative sample consisting of a subset of the population was drawn from the population (Maree & Pietersen, 2010:25).

- **Sampling method**

In qualitative research, data is derived from one or two cases; cases are selected randomly and they may be selected because they allow access. Furthermore, the use of appropriate sampling techniques in qualitative research enables collection of the richest data (Strydom & Delport, 2011:391). The purpose of this study was to develop, design, and implement a recovery-oriented mental health programme. Moreover, the present study employed a mixed-methods approach. The qualitative part focused on ascertaining the state of mental health, and the needs and challenges of MHCUs and caregivers

regarding mental health care. The researcher was interested in ascertaining that, if social workers were trained in a recovery-oriented social work programme, there would be an improvement in the service delivery of mental health care. Therefore, the sample comprised the following:

- MHCUs.
- Caregivers.
- Social workers in hospitals.
- Social workers in the districts.
- Social work managers.

Qualitative research methods, namely non-probability, purposive, and snowball sampling were employed to draw a sample of MHCUs from the three hospitals (mentioned in section 6.2.1), caregivers, social workers in the hospitals, social workers in the districts, social work managers in the districts, and provincial offices. Rubin and Babbie (2010:48) describe purposive sampling as units that are most representative of the interest of the study and useful for providing typical divergent and rich detailed data about the phenomenon. The purposive sampling method was utilised for MHCUs, social workers, and social work managers. The researcher had initially planned to interview caregivers of MHCUs who had been admitted to hospital. However, she encountered a problem: the caregivers of the MHCUs admitted to mental health hospitals did not visit their relatives. Hence, she was forced to resort to snowball sampling. She visited Mapapila Village in Malamulele and located one caregiver who referred her to four other caregivers who had relatives living with schizophrenia. Alston and Bowles (2003:90) point out that snowballing is normally utilised when there is no knowledge of the sampling frame and limited access to appropriate participants of the study. The sample size was divided as follows:

Table 6.2: Sample size of the qualitative approach (first phase)

Name	Number
MHCUs	13 = 3 Shiluvana, 5 Evuxakeni, 5 Hayani hospitals
Caregivers	5 = Mapapila Village

Social workers in the hospitals	16 = 3 Polokwane, 1 Seshego, 2 Evuxakeni, 3 Nkhensani, 1 Shiluvana, 4 Malamulele, 2 Hayani
Social workers in district offices	14 = 5 Capricorn, 4 Mopani, 6 Vhembe
Social work managers	8 = 3 Capricorn, 2 Mopani, 2 Vhembe, 1 provincial office

- **MHCUs and caregivers**

The selection and recruitment of MHCUs were carried out with the assistance of the psychiatric nurses and social workers from three hospitals: Evuxakeni, Shiluvana, and Hayani Hospitals. The social workers selected participants who were stable and able to articulate well in English or Xitsonga. The selection of the caregivers was carried out using snowball sampling; the researcher was referred to one caregiver in a village in Malamulele, who in turn referred her to four other caregivers.

- **Social workers and social work managers**

In order to recruit social workers, the researcher communicated with the provincial social work managers who arranged appointments with the district supervisors. She contacted the districts supervisor to make appointments on her behalf. Emails were sent in this regard and follow-up telephone calls were made. The supervisor allowed the researcher to visit the various offices to conduct interviews. There was no list and the researcher only interviewed social workers who consented to be part of the study. Furthermore, the researcher interviewed the managers who consented to be part of the study. She obtained permission from the Departments of Health and Social Development; most of the social workers and managers were willing to participate. The participants met the following inclusion criteria:

Social workers and managers were:

- Employed by the Departments of Health and Social Development, working in any one of the Capricorn, Mopani, and Vhembe Districts, or the provincial office.
- Working in the hospital, district office, or provincial office.

- Had been working as a social worker for at least two years, and at least five years as social work manager.
- Males and females registered with the South African Council for Social Service Professions (SACSSP).

MHCUs were:

- Diagnosed at least two years previously with a psychiatric disorder, specifically schizophrenia.
- Receiving treatment from Evuxakeni, Shiluvana, or Hayani Hospitals.
- Either male or female.
- Aged 20 to 60 years, and proficient in English and Xitsonga.

Caregivers were:

- A family member or guardian caring for an MHCU for at least two years.
- Be either male or female.
- Aged 25 to 60 years, and proficient in English and Xitsonga.

6.4.1.2 Quantitative phase

Study population

The population in this phase consisted of DSD and DOH social workers, working in Vhembe and Mopani Districts. Social workers could be working in the hospital or the district offices. Strydom (2011:223) holds the view that population "is the totality of persons, events, organisation units, case records or other sampling units with which the research is concerned." Therefore, in the present study, the population was the totality of persons working in the same organisation, albeit in different districts.

- **Sampling method**

Sarantakos (2000:139) highlights that the coverage of a total population is impossible; hence, sampling is vital for its feasibility. Furthermore, the author indicates that sampling provides more accurate information than the totality of the population. Hence, the

researcher employed probability stratified random sampling, and systematic sampling to select social workers from Vhembe and Mopani Districts, respectively. The sample was divided into a number of homogenous strata (Strydom, 2011:230). A list of all social workers was obtained from the regional offices of Vhembe and Mopani Districts. The researcher used stratified random sampling, and due to venue constraints a sample of 30 to 35 participants was decided upon. Systematic sampling was used to determine the various respondents from two strata: Vhembe and Mopani. The first name on the list of each district represented respondent number 1, and then every tenth name on the list was included in a sample, until the required sample size was obtained. The researcher was able to liaise with the contact persons in the districts with regards to the planning of the training. The researcher further sent the registration forms and invitation for the training (Appendinces J &K); and those that were selected from the list were requested to register for the preliminary or prototype intervention programme. The contact person sent the registration forms back to the researcher. The total number of registered participants was sixty seven. Regrettably, on the day of the training, only thirty seven participants attended, due to the strike of social workers.

Due to the social workers' strike, a accidental sampling method was utilised as a substitute for the social workers who signed up but did not attend the training session at Vhembe District. The contact person assisting the researcher in organising the training had to call social workers who were available at the time to volunteer as attendees. Rubin and Babbie (2005:245) refer to convenience/accidental sampling as a "convenient, availability sample and respondents are nearer and most easily available."

The discussion now will be based on the methods of data collection; qualitative and quantitative data collection methods are discussed separately.

6.5 Methods of data collection

The intervention research process guided the researcher. The focus is now on how the data collection methods were conducted in the first and second phases. The qualitative data collection will be discussed first, and subsequently the quantitative data collection.

6.5.1 Qualitative data collection

Qualitative data collection comprises the use of semi-structured interviews with social workers in hospitals and districts, social work managers in the district and provincial offices, MHCUs, and caregivers. Greeff (2011:351) points out that a semi-structured interview provides a detailed picture of a participant's beliefs about a particular topic. Harrell and Bradley (2009:2) indicate that the primary data collection is an important piece of many research projects. Furthermore, using proper techniques ensures that qualitative data is collected in a scientific and consistent manner. Moreover, Van Teijlingen (2014:17) claims that the "semi-structured interview can be modified based upon the interviewer's perception of what seems most appropriate, question wording can be changed and explanations given and inappropriate questions for a particular interviewee can be omitted, or additional ones included."

Bless and Higson-Smith (2000:104-109) cite the following as advantages of qualitative interviews:

- Qualitative interviews actively involve the respondents in the research process, thereby empowering them.
- They allow free interaction between the interviewer and the interviewee.
- They allow opportunities for clarification so that relevant data can be captured.
- They maximise description and discovery.
- They offer researchers access to people's ideas, thoughts, and memories in their own words, rather than in the words of the researcher.

As a disadvantage, Denscombe (2007:184) demonstrates "how people respond differently depending on how they perceive the interviewer, the interviewer effect. In particular, sex, the age and ethnic origins of the interviewer have a bearing on the amount of information people are willing to divulge and their honesty about what they have revealed." Goom (2004:120) describes the demand characteristic, which is when interviewees' responses are influenced by what they think the situation requires. The author advises that to avoid this disadvantage, the researcher should make it clear at the beginning what the purpose and topics are, and seek to set the interviewee at ease. The

researcher conducted the interviews in the social workers' offices. There was, however, a challenge as most social workers were sharing offices. There were many disturbances created by people coming in and leaving, and telephones constantly ringing. Social workers who were not part of the study could not leave these shared offices as they were busy with their daily duties. The researcher identified this limitation when she commenced with the interviews.

An interview schedule was developed to provide the researcher with a set of predetermined questions and themes to be used as an instrument to engage the participants and navigate the narrative terrain (Monette, Sullivan & DeJong, 2005:178). Greeff (2011:352) recommends that the researcher think of appropriate questions related to each area in order to address the issues of interest. The author further suggests open-ended questions. The researcher developed five interview schedules, one for MHCUs, one for caregivers, one for social workers in the hospitals, one for social workers in the districts, and one for the social work managers. The researcher designed the interview schedules to incorporate specific open-ended questions. She first went through the informed consent forms with the participants and once signed, handed the interview schedules to the social workers and social work managers. The interviews were audio recorded with the participants' permission. This tool was efficient as the researcher managed to gather all the appropriate data.

The researcher used the following skills and techniques to gather information from the participants:

Reflexivity: Personal introspection to identify any biases, preconceived or culturally defined beliefs on the part of the researcher (Lietz, Langer & Furman, 2006:446).

Logical order: The researcher conducted the pilot-tested interview schedule to determine that questions had been designed as intended. The researcher had to ensure that the questions were presented logically (Maxwell, 2013:101).

Active listening: The researcher utilised the digitally recorded interviews, and took notes of information that the participants shared with her (Hesser-Biber & Leavy, 2011:105).

Clarification: The researcher sought clarification during the interviews as to the meanings respondents attached to the issues at hand; she used open-ended neutral probes during the data-gathering process (Niewenhuis & Smit, 2012:133).

Prior to the interviews, the researcher emphasised confidentiality, and obtained participants' permission to use a digital recorder to record all the interviews. The researcher had a research assistant who signed a confidentiality agreement (Appendix R). The research assistant assisted with the note taking and recording during the interviews.

6.5.2 Quantitative data collection

Babbie (2007:246) defines a questionnaire as "a document containing questions and other types of items designed to solicit information appropriate for analysis." The questionnaires that were utilised in the present study were self-constructed questionnaires. However, these questionnaires were administered in a group on the day of the preliminary intervention. The group-administered questionnaires were utilised as data-collection instruments. Delport and Roestenburg (2011:189) point out that each respondent completes the questionnaire while the researcher is present to provide guidance and clarity where necessary. Bomman (2009:451) points out that there are several advantages to this form of survey:

- A large number of questionnaires can be completed within a relatively short period with a limited amount of effort.
- The researcher can furthermore control the circumstances under which the questionnaires are completed.
- The researcher or a fieldworker is also available to clarify instructions or questions and to render assistance where needed.

The disadvantages of the group-administered questionnaires are the following (as stipulated by Delport and Roestenburg, 2011:189):

- Obtaining a suitable venue and time slot that will suit all the respondents could create some problems.

- Even if the respondents complete the questionnaires independently, there might be some mutual influence among them.
- Some may experience difficulties in understanding the questions and instructions; instead, they may answer questions incorrectly as they might be embarrassed to ask clarification in the presence of the group.

The researcher developed the self-constructed pre-test and post-test questionnaires based on the findings of the first phase (chapter 7) and an intensive literature study (chapters 2, 3, 4, 5). The researcher had several discussions with her supervisor, and on several occasions discussions were held with the assigned statistician and research consultant from the Department of Statistics, University of Pretoria. She requested the assistance of an expert social worker specialising in mental health, who had recently graduated as with a DPhil in Social Work to check the accuracy of the questionnaires. The expert, supervisor, statistician and the research consultant provided valuable information for the refinement of the questionnaires. Different forms of question types were utilised, and the discussion is provided below.

- **Response systems or types of questions**

Delport and Roestenburg (2011:196) indicate that “a variety of response system[s] or question types exist from which the researcher must select in a goal-directed manner in order to obtain the desired information.” These authors further assert that there are different types of questions, namely open questions, closed questions, dichotomous questions, multiple-choice questions, ordinal questions, completion questions, scaled questions, statements, matrix-type of questions, and follow-up questions.

In the present study, the types of questions were the following: closed questions; single questions; dichotomous questions that required a yes or no, true or false; completion questions; aggregated questions; statements; and self-rated questions. Both the pre-test and post-test questionnaires consisted of eight sections (Appendices L & M). The types of questions utilised in the present study were appropriate as they yielded the desired outcomes.

6.6 Data analysis

Patton (2002:432) highlights that qualitative analysis transforms data into findings by reducing the volume of raw information, sifting important information from the trivial, and constructing frameworks of what the data reveals. Additionally, Babbie (2007:378) asserts that qualitative data analysis is the "non-numerical examination and interpretation of observations, for the purpose of discovering underlying meanings and patterns of relationships." Fouché and Bartley (2011:251) state that quantitative data analysis has four main categories, namely descriptive, association, causation, and inference. Creswell and Plano Clark (2011:204) contend that mixed-methods data analysis entails preparing for data analysis, exploring the data, analysing the data, representing the analysis, interpreting the analysis, and validating the data and interpretations. Qualitative and quantitative data analysis will be discussed separately.

6.6.1 Qualitative data analysis

The following analytical steps were implemented and they should be seen as interrelated and spiral analytical steps, adapted from Creswell (2013:177-179):

- **Preparing and organising data**

The volume of data was collected from the interviews conducted with MHCUs, caregivers, social workers, and social work managers. The researcher compiled field notes, and the crucial step was to organise the data by means of transcription of the recorded interviews. The researcher utilised a digital recorder with the permission of the participants. She listened to all the recordings, which she transcribed verbatim. The data was subsequently stored in an electronic folder to enable the researcher to access the files when required for data reduction, presentation, and interpretation (Creswell, 2013:182). The researcher translated the interviews that were conducted in Xitsonga into English, and compared the field notes with the digital recordings to ensure trustworthiness of the data.

- **Making sense of data**

The researcher studied the data several times and listened to the digital recordings in order to gain a better understanding and to determine the quality of the gathered data (Schurink, Fouché & De Vos, 2011:402). The coding process commenced when the researcher re-read the transcripts and field notes; she then identified themes, allocated codes, and added annotations in the margins of the transcripts and field notes. The researcher continued to look for themes that confirm or discount the initially formulated themes; this is a critical step in ensuring credibility of data.

- **Reducing data**

Grinnell and Unrau (2005:410) are of the view that reducing data is the first step in the coding process; it is a combination of identifying the meaning [of] units, fitting them into categories and assigning codes.The research question and the conceptual framework of the study guided the researcher. The conceptual framework shows the core themes, their related primary categories and sub-themes. This was done by selecting conceptualising key data without losing content meaning (Simons, 2009:120). Subsequently, the researcher coded the data into concepts and identified the patterns that described the phenomenon (Royse, 2008:278).

- **Coding data**

The codes may take the form of abbreviations or key words. Coding was done manually where the researcher looked at patterns and their meaning. The researcher compared similar phenomena and assigned the same name to these. She compiled a list of similar themes, which she divided into columns: main themes, subthemes, and categories. The themes were then abbreviated in code form and the codes were assigned to the appropriate segments of the text while observing the organisation of data to establish whether new categories or codes emerge. The researcher used open coding, specifically to the naming, categorising, and close examination of the data. During the open coding, the researcher began to organise the themes that were more focused as she considered their relevance to the research goal and the research problem (Schurink et al., 2011:412).

- **Testing emergent understanding, and searching for alternative explanations**

Kreuger and Neuman (2006:452) suggest that a researcher evaluates items that are not found in the data to determine their importance. The researcher in the present study evaluated data that emerged but did not form part of the study. The importance of the emerged data was evaluated through the use of the research question to assess its relevancy. The data was then explored and studied, creating links to the study, (Creswell, 2009:188). The researcher realised that most of the participants did not have knowledge of mental health care, the types of mental illness, the Act, and the DSM-5. The researcher had to incorporate these issues in the development of the preliminary or prototype intervention programme.

- **Interpreting and developing typologies**

The researcher was able to make sense of the data by comparing and linking the different phenomena. She interpreted the data by determining how the individuals under study see the world, and how they define their situation (Kreuger & Neuman, 2006:161). Interpretation involves making sense of the collected data. The researcher needed to identify the form of interpretation, whether it is based on a hunch, intuition, or insight (Schurink et al., 2011:416). Developing typologies is a process according to which a researcher can link the different phenomena (Welman et al., 2007:116). The researcher interpreted the data based on the insight and personal views gathered from participants. She linked the different phenomena according to common/mutual characteristics.

- **Presentation of data**

The researcher made use of themes, subthemes, and categorises to catalogue the findings of the collected information. She presented the collected and analysed data in the form of a written thesis (Gibbs, 2012:25). The thematic analysis of data is captured in chapter 7.

6.6.2 Data verification and validation

Thomas and Magivly (2011:151) point out that data verification helps researchers in ensuring the trustworthiness of the findings, and the establishment of trust or confidence in the finding of the study. The researcher used the following strategies to ensure the trustworthiness of the qualitative data:

- **Triangulated data**: Different kinds of data-collection methods for different groups of participants were applied for analysis and interpretation in order to enhance the credibility and transferability of findings (Schurink et al., 2011:420).
- **Direct verbatim quotes**: The researcher transcribed the participants' verbatim accounts. The quotes were verified with the literature and theoretical framework; the strengths-based perspective was evident in this process.
- **Participants' feedback**: The researcher ensured that the findings were verified with the participants through debriefing and member checking.
- **Accuracy of reported data**: The researcher reported the findings accurately. The negative findings that emerged during the analysis process were examined and reported (Marlow, 2011:227).

The researcher employed Lincoln and Guba's model of trustworthiness for data validation (Elo, Kaariainen, Kanste, Polkki, Utriainen & Kyngas, 2014:1). The constructs used were credibility/authenticity, transferability, dependability, and confirmability (Schurink et al., 2011:419-422):

- **Credibility/Authenticity**: credibility is defined as "the confidence that can be placed in the truth of the research findings. Credibility establishes whether or not the research findings represent plausible information drawn from the participants' original data and is a correct interpretation of the participants' original views" (Anney, 2014:276). The researcher followed extensive engagement and observation in the field, peer debriefing, and member checks. She ensured that the findings were verified with the participants. Anney (2014:276) asserts that a qualitative researcher establishes rigour of the inquiry by adopting the following

credibility strategies: prolonged and varied field experience, time sampling, reflexivity (field journal), triangulation, member checking, peer examination, interview technique, and establishing authority of researcher and structural coherence.

- **Transferability**: The degree to which the results of qualitative research can be transferred to other contexts. Data from different sources were used to elaborate on the research. The present study employed a mixed-methods approach, which incorporate components of qualitative and quantitative approaches (Shenton, 2004:69). The study could be replicated in other rural provinces as it had been conducted in one rural area of South Africa.
- **Dependability**: The research process is logical, well documented, and has been audited. Gerrish and Lacey (2010:139) assert that dependability relates to the transparency of the research process. In the present study, the informed consent form was drafted, which briefly described the research process. The data were analysed by the researcher as well as the independent coder. The researcher also utilised the services of an independent coder; this facilitated sound analysis and interpretation of the data. Creswell (2014:203) asserts that crosschecked coding determines the level of consistency in the coding process. There were no inconsistencies. Therefore, the use of an independent coder validated the credibility of the research findings.
- **Confirmability**: Kumar (2011:185) refers “to the degree to which the findings could be confirmed by others.” In the present study, the interviews were digitally recorded and data transcribed verbatim to avoid possible bias. An audit trail was established by documenting and saving all the data.

6.6.3 Quantitative data analysis

Rubin and Babbie (2005:552) assert that quantitative data can be referred to as “the techniques by which researchers convert data to a numerical form and subject it to statistical analysis.” In the present study, the data analysis was done in conjunction with the statistician and research consultant from the Department of Statistics at the University

of Pretoria. Sarantakos (2005:364) indicates that data preparation includes checking and editing the collected data before the coding process can commence. The research consultant guided the researcher on how to code the questionnaires. The researcher coded the questionnaires, which were given to the research consultant; a data capturer transferred the data in computer grid format (spread sheet). After the data had been captured, the researcher had to verify that all the data had been captured accurately. Corrections had to be made to rectify a few errors.

6.6.3.1 The scoring of the responses or questions

The researcher prepared a codebook and memorandum on how to score the responses. Schurink et al. (2011:252) assert that the codebook and memorandum describe the coding procedure, and the memorandum would assist the research consultant how to score responses. Individual or single, aggregated, self-rated, and dichotomous questions were scored. The researcher provided a memorandum that stipulated how to score the questions. For example, if the question required a yes or no answer, the researcher provided for a wrong answer as well as a correct answer. This process was followed throughout. Even if the answer required a true and false response, the correct and wrong answers were indicated. In some instances, the respondents were required to mark only one answer, or two out of three questions; if they marked all questions, negative marking was applied. The scoring made it possible to assess whether the level of knowledge decreased or increased in the pre-test and post-test sections of the implementation of the preliminary intervention programme. This process made it possible to gauge whether the respondents had knowledge prior to the intervention as well the knowledge gained after the intervention. Therefore, this process was appropriate as it ensured the accurate and consistent marking of the responses.

6.6.3.2 The process of data analysis using descriptive statistics

Subsequently, the merged pre- and post-scores of the social workers were analysed. The descriptive statistics were utilised in the present study. Fouché and Bartley (2011:251) indicate that descriptive statistics describe numerical data and help in organising and summarising the data in the tables, graphs or scores that are interpreted.

Leedy and Omrod (2013:277) hold the view that inferential statistics are used to test hypotheses, and for testing whether the descriptive results were likely to be due to random factors or real relationships. In this study, a dependent t-test was applied, which Field (2005:286) states is a dependent mean t-test utilised when there are two experimental conditions, (pre- and post-test in this instance) and the same participants took part in both conditions of the experiment. The author states that a dependent t-test is sometimes matched in pairs or paired samples t-tests. The present study meets the criteria of the dependent t-test as the pre-test preliminary intervention post-test, was administered in the same group of social workers in Mopani District and the same group in Vhembe District. The dependent t-test is a parametric test (Kim, 2015:540), which shows the difference between pre- and post-test scores. The data were presented in statistical form by means of tables, showing the mean, the standard deviation, the number of respondents and the p value (Neuman, 2006:343).

The Box and Whisker plot were used to map the distribution of the data knowledge scores. Field (2009:73) asserts that the Box and Whisker plot checks the shape of the distribution. Furthermore, the author explains that the box plot indicates that the distribution is either symmetrical or skewed.

Rubin and Babbie (2008:493) assert that the explanatory power of quantitative research comes from exploring relationship between variables. Therefore, the bivariate analysis tests the relationship between variables. In the present study, bivariate analysis was utilised to test for an increase in knowledge between the dependent groups in the pre-test and post-test.

6.6.4 Data validation and reliability

When utilising a one-group pre-test post-test design, Marlow (2011:93) cautions that the researcher should recognise internal threats such as history, maturation, testing, instrumentation, regression to mean, and interactions of other threats. In the present study, the respondents completed the same pre- and post-test questionnaires. Research results are highly dependent on the validity and reliability of the research instrument (Krueger & Neuman, 2006:434). Reliability is the quality of a test which signifies a test to

be stable, dependable, reliable, and predictable (Salkind, 2006:106). Pilot testing was conducted where the respondents completed the same questionnaire and yielded the same results. To ensure reliability, the researcher made use of paired t-test statistical methods, and a Box and Whisker plot, calculated by a statistician (Hagan, 2010:242). The memorandum was used to score the responses, and all questions were marked consistently and accurately.

Delport and Roestenburg (2011:174) refer to validity as “a degree to which a test measures what it is supposed to measure within a consistent manner” (Delport & Roestenburg, 2011:174). These authors further argue that face validity relates to the apparent face value of the measurement procedure. Criterion validity is the means by which multiple measurements can be recognised by comparing them with external scores on an instrument, for example, the behaviour or concepts being studied (Tredoux & Durheim, 2002:218). The statistical test method used confirmed the reliability of the study. Construct validity focuses upon the logical relationships among variables (Babbie, 2007:14). There was a significant relationship between the pre-test and post-test scores. Content validity refers to the representativeness of the content of the questionnaire. This was applied to ensure that each item was measured in line with the question (Rubin & Babbie, 2001:194). In the present study, this was ensured by using the same questionnaires with the respondents; the pre- and post-test questionnaires were identical in content, and this ensured reliability and validity.

6.7 Pilot study

Van Teijlingen and Hundley (2001:1) refer to a pilot study as “a mini version of a full-scale study also known as a feasibility study, as well as the specific pre-testing of a particular research instrument such as a questionnaire.” These authors indicate that a pilot study is a crucial element of a good study design.

6.7.1 Qualitative phase

The researcher conducted a pilot study, pre-test of the data collection instrument, which entailed that a small amount of data be collected to test-drive the research procedure (Teddlie & Tashakkori, 2009:20). This assisted the researcher in identifying possible problems in the data protocols, and set the stage for the actual study (Delport & Fouchè, 2011:73). The interview schedule, which formed part of the qualitative data-collection procedure, was pre-tested with participants who had the same characteristics as the participants in the actual study. Two social workers and one manager were interviewed at Waterberg District. The researcher could not interview MHCUs in Mokopane Hospital as planned, she was denied access by the CEO of the hospital, even though prior arrangements had been made.

6.7.2 Quantitative phase

The group-administered questionnaire for the quantitative data-collection procedure was pre-tested with social workers from the DoH and DSD district offices and hospitals as mentioned in section 6.4.1.2 and who attended the training on the recovery-oriented social work programme in mental health practice. Furthermore, the researcher approached experts in the field of mental health care to evaluate the appearance and content validity of the questionnaire, and to make recommendations regarding possible improvements. The expert was used to give a professional opinion on the contents of the questionnaires and recommendations were effected .

6.8 Ethical considerations

The present study was granted ethical clearance by the Faculty of Humanities ResEthics Committee, University of Pretoria (Appendix A). The researcher deems the following ethical considerations relevant to the present study:

6.8.1 Avoidance of harm

Research participants can be harmed in a physical and emotional manner. Emotional harm is more prevalent in the social sciences because the feelings and emotions of people are involved (Strydom, 2011:115). The researcher accepted her obligation to protect the participants from any form of physical and emotional discomfort during the

research process. Furthermore, the participants were informed beforehand of the potential impact of the research by disclosing the risks and benefits of participation. The researcher was aware that the present study might be sensitive, especially to the MHCUs in rural areas. The researcher had liaised with the social workers in the hospitals and the district officers to assist with counselling if the participants required this service as the result of the interview (Neuman, 2006:135). It was, however, not necessary with all the groups of participants, except for two caregivers who were referred to the DSD office in Malamulele.

6.8.2 Voluntary participation

Participation should always be voluntary, and no one should be coerced into participate in a research study (Strydom, 2011:116). The researcher informed the participants that their involvement in the study was voluntary, and should they wish to withdraw they can do so without any negative consequences.

6.8.3 Informed consent

The purpose and procedures of the study were explained to the participants. The informed consent was in a written format, in English and Xitsonga which the participants in the study had to sign to indicate their voluntary participation. The participants were briefed about the use of a digital recorder, and they gave their consent for its utilisation (Babbie, 2007:64; Strydom, 2011:117). The researcher informed the participants that the data would be stored in the Department of Social Work and Criminology, University of Pretoria, for a period of 15 years. Permission was obtained from the Departments of Health and Social Development (Appendix B & Appendix C). The informed consent forms for caregivers and MHCUs were translated into Xitsonga (Appendix P). The researcher used the services of a research assistant who took notes and assisted with logistical issues, who signed a confidentiality agreement (Appendix R).

6.8.4 Deception of subjects and/or respondents

Struwing and Stead (2001:69) state that deception refers to the deliberate misleading and withholding of information from participants. The researcher identified all the questions that could be unclear to the participants. The researcher indicated the possible benefits to the MHCUs, caregivers, and social workers; no financial or compensation for participating in the study was offered. The possible benefits included the improvement of mental health services in rural areas. The researcher did not conceal any information or mislead the participants. She indicated the value of the present study to all the participants as well as to the field of mental health care. She explained the goal of the study as specified in the letter of informed consent in a very clear manner that the participants could understand.

6.8.5 Violation of privacy/anonymity/confidentiality

Strydom (2011:119) contends that confidentiality pertains to the handling of information in a confidential manner. Since the researcher worked with mental health care users themselves, it was not necessary for her to disclose their disorder to a third party. The researcher assigned a code to all the participants in order to hide their identities (Babbie, 2007:65). However, anonymity could not be ensured in the training of the prototype or preliminary intervention programme. The training attendees were given name tags with the number/code that they used in the pre-test and post-test questionnaires. The data was stored in the safe place. The research assistant had to sign a confidentiality agreement form and that the contents of the interviews would not be divulged. All the collected data, the digital recordings, and informed consent letters will be stored safely for a period of 15 years in the Department of Social Work and Criminology.

6.8.6 Debriefing of participants

Strydom (2011:122) indicates that debriefing sessions focus on affording an opportunity to participants to work through their experiences and their aftermath. During these sessions, which are conducted after the study, participants can ask questions and discuss possible misconceptions with the researcher. In the present study, the researcher conducted a debriefing session with each participant during the qualitative phase after the data had been collected. During the quantitative phase debriefing was done in a group

format. It was the opinion of the researcher that, due to the sensitivity of the phenomenon under investigation, a debriefing session was necessary, and if further counselling was needed, referrals were made to social workers in Capricorn, Mopani, and Vhembe Districts. These social workers provided counselling to the participants who needed this service subsequent to the interviews. The researcher referred two caregivers for assistance at the Department Social Development, Malamulele office.

6.8.7 Action and competence of the researcher

Researchers are ethically obliged to ensure that they are competent, honest and adequately skilled to undertake a proposed investigation (Strydom, 2011:123). The researcher is competent in that she supervises fourth-year and Master's students during their research projects. She deems herself adequately informed about research processes, is a registered social worker, and holds a Master's degree in social work.

6.8.8 Publication of the findings

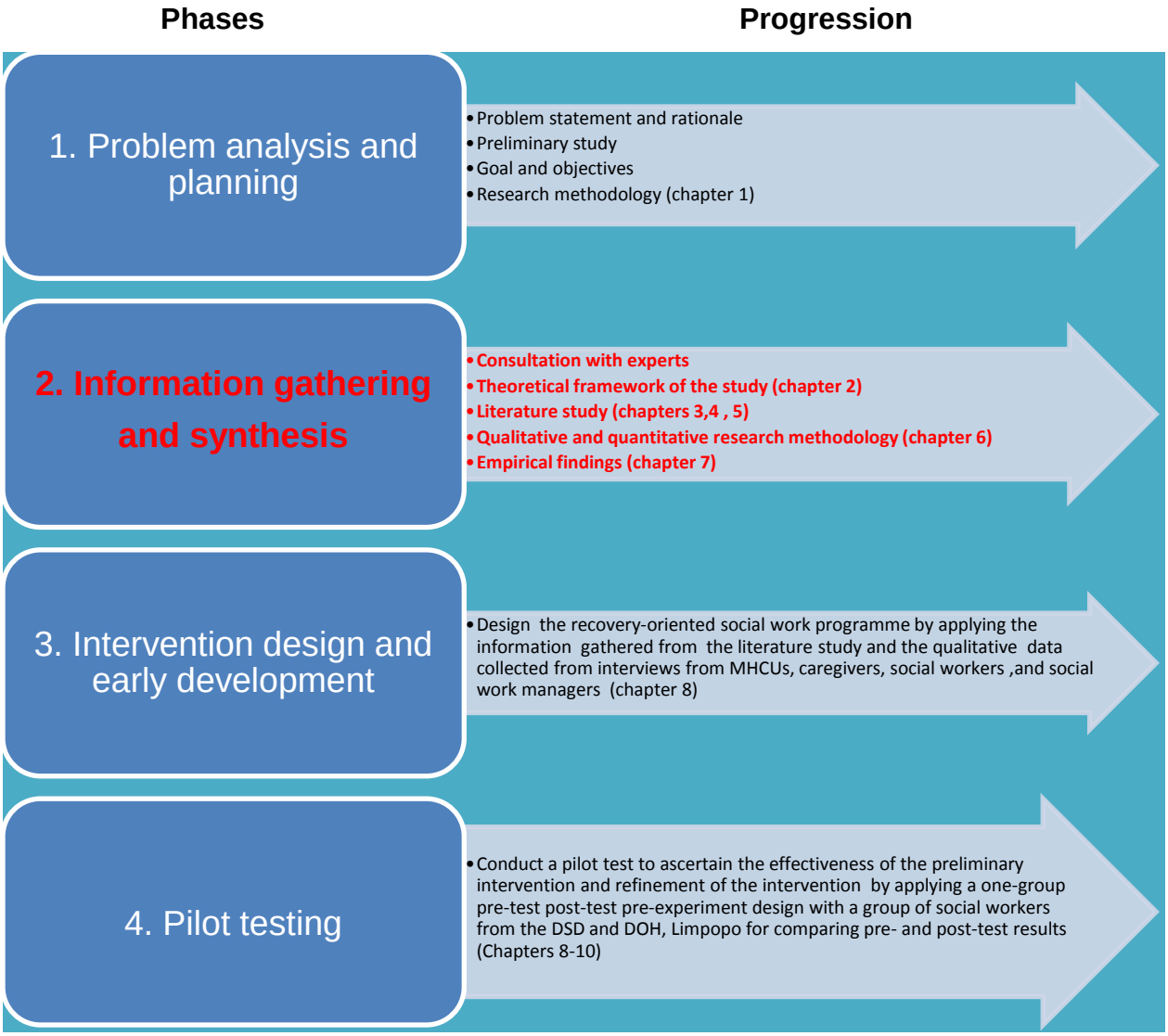
The findings of the study must be introduced to the public in written format to be acknowledged as research (Strydom, 2011:126). This means that peers should access the results from the study. The researcher will conduct seminars, workshops, and training, publish articles emanating from the research findings, and write a doctoral thesis.

6.9 Summary

This chapter focused on the research methodology of the study. The approach utilised for the present study was a mixed-methods approach (qualitative and quantitative approaches). The study consisted of a two-phased model; the first phase qualitative, and the second phase quantitative. The practical implementations of the different facets that formed part of the process in its entirety were discussed according to the methods which were implemented and how it progressed and was achieved. The next chapter focuses on the empirical findings of the qualitative approach (first phase).

CHAPTER 7

EMPIRICAL FINDINGS OF THE QUALITATIVE RESEARCH – FIRST PHASE



Graphic representation of phases of the intervention research: Adapted from Fraser and Galinsky (2010:463); De Vos (2011)

7.1 Introduction

The researcher conducted the first phase, the qualitative phase, of this mixed-methods approach in Limpopo Province with participants sampled from the Department of Social Development and the Department of Health, namely social workers, social work managers, caregivers, and MHCUs. In this chapter, the researcher presents the findings of this qualitative phase**.** The theoretical frameworks of the present study comprise ecological systems theory and the strengths-based perspective, which enabled the researcher to understand the impact of the environment on disability issues. The person operates within a system, which is in constant interaction with other systems and are inter-interrelated. The strengths-based perspective assisted the researcher in viewing not only MHCUs' but also other participants' strengths and capabilities in dealing with their day-to-day functioning. This chapter presents the aim and objectives of the qualitative first phase, research question, and empirical findings of the qualitative approach, linked to the verbatim quotations of the participants, and confirmed with literature.

7.2 Aim and objectives of the study

7.2.1 Aim

The aim of the present study was to develop, implement, and evaluate a social work intervention programme aimed at recovery-oriented mental health practice in rural areas.

7.2.2 Objectives

The objectives of the first phase (qualitative) were:

- To explore and discuss mental health services and policies from international, regional, and national perspectives.
- To explore the challenges of MHCUs regarding mental health care services in rural SA.
- To gather information from MHCUs and caregivers regarding their needs in mental health care in rural areas.

- To gather information from social workers and social work managers in the districts, hospitals and the provincial offices of the Departments of Health and Social Development about the current practice of mental health care in rural areas.

7.2.3 Research question

The main research questions in this phase of the study are the following:

- Will social workers trained in the recovery model of intervention be more empowered to render recovery-oriented intervention to MHCUs in rural areas?
- Can social workers make a paradigm shift in their intervention approach once they have undergone training in recovery-oriented practice?

The following sub-questions informed the main research question:

- What is the state of mental health care services in rural SA?
- What are the current treatment practices utilised for MHCUs in rural SA?
- What are the current mental health care intervention practices used by social workers in rural areas?
- What is the nature of the care that MHCUs receive in rural areas?
- What are the needs of MHCUs and their caregivers in rural areas regarding mental health care?

7.3 Empirical findings –first phase of study (qualitative)

The research findings regarding the qualitative phase of the study are discussed and presented according to each group of participants interviewed, namely (A) caregivers, (B) mental health care users, (C) social workers in the districts, (D) social workers in the hospitals, and (E) social work managers. This is presented for each participant group as follows:

- The biographic profile of participants are firstly provided, and presented in a descriptive format; and where applicable, a graphic illustration of biographic profile is provided.

- The themes and subthemes, as they emerged from the data, are presented in table format. The findings are discussed by means of themes and subthemes. The thematic analysis of the themes is presented using direct quotes from the interviews with the different participants. These research findings have been substantiated with literature.

7.3.1 Section A: Findings from the caregiver participants

The section provides the discussion of the qualitative findings. The interviews were conducted in Mapapila Village in Malamulele. Five participants were interviewed. It should be noted that they were all females; in most instances caregivers are usually women (Nolan, 2001:609). This section focuses on the biographical profile of caregivers, followed by the thematic analysis.

7.3.1.1 Biographical profiles of caregivers

This section gives an overview of the caregiver participants and their biographical profiles (table 7.1), followed by the thematic analysis.

Table 7.1: Biographical details of participants (caregivers)

P	Age	Gender	Marital status	Language	Area	Income	Educational level	Number and age of dependents	Hospital	Years on treatment
1	55	Female	Married	Tsonga	Malamulele	Social grant	Std. 1	3 children (1992 - schizophrenia; 1997, 1998 + 2 adult children	Malamulele home-based care	6 years
2	63	Female	Widowed	Tsonga	Malamulele	Social grant	Illiterate	6 Adult children Child living with schizophrenia - 1977	Malamulele	Cannot recall
3	64	Female	Divorced	Tsonga	Malamulele	Social grant	Illiterate	2 Adult children Child living with schizophrenia - 1986	Malamulele	23 years
4	62	Female	Married	Tsonga	Malamulele	Social grant	Sub B	6 Adult children - ages unknown	Mapapila home-based care	Cannot recall
5	39	Female	Married	Tsonga	Malamulele	Social grant	Grade 10	3 children (ages not recalled) and looking after mother-in-law	Mapapila home-based care	23 years

The figure below presents the caregivers' biographic profiles.

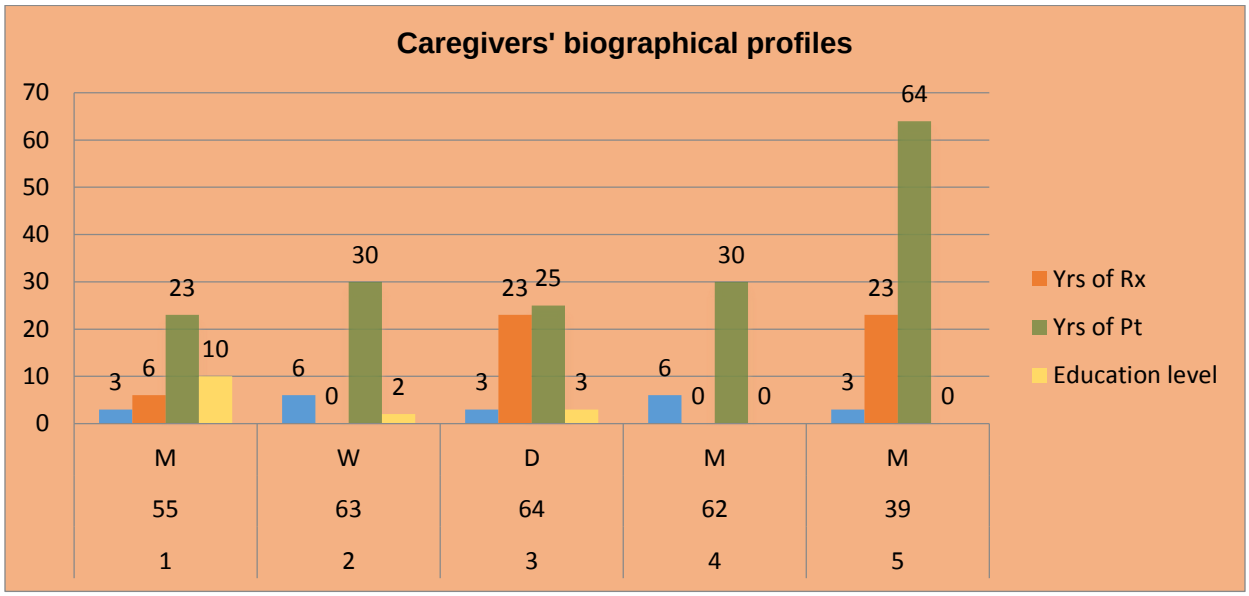


Figure 7.1: Caregivers' biographical profiles (n=5)

The age category of the participants in the present study ranged from 39 to 64 years. All participants were female, and they were all residents of Mapapila Village in Malamulele, Vhembe District, Limpopo Province. Several studies conducted in many parts of the world found that caregivers are more likely to be women. For example, in the United Kingdom about 58% of the caregivers were women (Nolan, 2001:609). Asian studies found that about 70% of family caregivers were females (Chan et al., 2009:70; Cheng & Chan, 2005:585). The World Federation of Mental Health (2010) estimated that globally, about 80% of the caregivers were women. The interviews in the present study were conducted at the participants' homes. All the participants were dependent on social grants. Two participants had a primary-level education, the other two participants were illiterate, and one participant had a secondary-level education. It should be noted that most of the participants were old, except one who was younger than 40. Three participants had reached old age, one had reached middle age, and one was a young adult.

It is affirmed in literature that parents, companions, or relatives typically provide the major part of family caregiving. Asian studies found that most family caregivers of adult children with schizophrenia were their guardians (parents), and they were of a more established

age (elderly). In Asian studies, it was also found that the caregivers' burden score was clearly associated with their age (Chan et al., 2009: Chien, Chan & Morrisey, 2007:1156). However, the findings of the study of Chan (2009) contrasted with the Mexican American study. This study established that caregivers of a more youthful age had to carry family burden to a greater degree (Magana, Ramirez, Hernandez & Cortez, 2007:380). Some parents are understandably anxious that no one would be able to care for their adult children who suffer from schizophrenia when they as parents become too old and infirm or have passed away (Chien et al., 2007:1151). This was the situation in the present study; one participant expressed her anxiety over the fate of her adult child after her demise.

A brief profile of each participant is provided below:

Participant 1: She is a 55-year-old woman and the mother of a mental health care user. She is married; her husband has a hearing disability. She has five children, three of whom are adults. She is unemployed and survives on her husband's disability grant; her son who is living with schizophrenia also receives a disability grant; two of her adult children are employed. She has a primary-level education. The researcher observed that the participant is concerned about the wellbeing of her son; her wish is that he be referred to a special school. She is concerned that he is mingling with bad company in the village, and that these people can have a negative influence on her child, exposing him to smoking and drinking. Apart from her concerns, the participant was not certain of her son's diagnosis. She was of the opinion that he was suffering from epilepsy; she has received no information about his condition. He loves wandering around the community; people abuse and exploit him; sending him, for instance, to fetch water and gather firewood.

Participant 2: She is a 63-year-old widowed woman. She has six adult children. She is illiterate and receives an old-age pension. Her son, who is living with schizophrenia, also receives a disability grant. She felt uncomfortable about speaking about him. His condition is kept secret in the family, and he is constantly kept indoors. Instead, she relies on her daughter's child support grant. She is an elderly parent who is dealing with her adult child alone.

Participant 3: She is a 64-year-old woman, an elderly parent who has to care for her adult child; she is divorced and illiterate. She receives an old-age grant; her son who is living with schizophrenia also receives a disability grant. She has two children, and her daughter is a tertiary-level student who has failed and is repeating her first year at a Further Education Training (FET) College. The family is struggling to make ends meet, as the participant is paying for her daughter's college fees. They therefore have to rely on her old-age pension and the social grant of the mental health care user. She desperately needs home-based-care services to assist her with her son. On the day of the interview, the researcher noticed the mental health care user sitting outside in the sun; he was not well-groomed as his mother has difficulty bathing him.

Participant 4: She is a 62-year-old woman, an elderly parent dealing with a mentally disabled child; she is married; her husband has retired from his employment. He used to work at Malamulele Hospital. Both the participant and her husband receive old-age grants, while her son receives a disability grant. She has six adult children but does not know their ages. She is illiterate and her wish is that her son can be kept occupied by taking part in a project or something similar. He enjoys wandering around, and now and again he would be lost for a considerable length of time. The parents would be called from the neighbouring towns (villages) and they would be informed of his whereabouts.

Participant 5: She is a 39-year old woman, married and her husband is unemployed. He has temporary employment in Johannesburg. The participant herself is also unemployed and she relies on the mental health care user's grant. She has three children and is unable to look for employment as she needs to take care of her mother-in-law. She has a secondary-level education. She needs to be assisted with a grant-in-aid. The figure below presents the relationship between the mental health user and the participant. She is the youngest participant in the study. Her mother-in-law, who at times refuses to eat or bathe, only adds to her distress.

7.3.1.2. Thematic analysis of caregiver participants

This section focuses on the themes subthemes and categories identified in the present study. The table below provides a summary of the themes, subthemes, and categories followed by a discussion of the themes, subthemes, and categories. The verbatim quotatons derived from the face-to-face interviews support the themes, and the findings are substantiated by literature.

Table 7.2: Summary of themes, subthemes, and categories: Caregivers

Themes	Sub-themes	Categories
Theme 1: Perceptions of mental health	**Subtheme 1.1**: Description of how mental health is perceived within participants' cultures	**Category 1**: Mental health care
	Subtheme 1.2: Description of how culture influences own perception of mental health and help-seeking behaviour	
Theme 2: Experiences regarding mental health care services	**Subtheme 2.1**: Experiences regarding services rendered by the hospital/clinic	**Category 2**: Mental health services
	Subtheme 2.2: Experiences regarding services by a multidisciplinary team	
	Subtheme 2.3: Experiences regarding formal support services	
	Subtheme 2.4: Experiences regarding traditional healers	
Theme 3: Experiences related to the specific illness of the loved one and treatment	**Subtheme 3.1**: Description of diagnosis	**Category 3**: Mental health condition and treatment
	Subtheme 3.2: Description on how the diagnosis was explained	
	Subtheme 3.3: Own understanding of diagnosis and illness	
	Subtheme 3.5: Importance of taking medication	
	Subtheme 3.6: Side effects of medication	

Themes	Sub-themes	Categories
	Subtheme 3.7: Accessibility of medication	
	Subtheme 3.8 Effects when medication is not taken	
Theme 4: Experiences of caring for a person living with schizophrenia	**Subtheme 4.1**: Tasks as a caregiver	**Category 4**: Role and needs of caregivers
	Subtheme 4.2: Challenges as a caregiver	
	Subtheme 4.3: Needs of the caregiver	
	Subtheme 4.4: Support systems of the care giver	
	Subtheme 4.5: Community Support	
	Subtheme 4.6 :Professional Support	
Theme 5: Strategies/ recommendations regarding support needed by caregivers of mental health care users	**Subtheme 5.1** Institutional care	
	Subtheme 5.2 Home-based care/ community projects	
	Subtheme 5.3: Material support	

Category 1: Mental health care

In this category, the theme that emerged entailed the perceptions of mental health; and the subthemes described how mental health is perceived within the participants' culture, and how culture influences one's own perception of mental health and help-seeking behaviour. More details on the themes and subthemes are provided below.

Theme 1: Perceptions of mental health

The participants indicated their perceptions and understanding of mental health and how they view the illness of their loved ones. Most of the participants were of the view that their loved ones were bewitched. Two subthemes emanated from this theme, and they are discussed below.

Subtheme 1.1: **Description of how mental health is perceived within participants' cultures**

Most participants ascribed the mental illnesses of their loved ones to witchcraft. One participant indicated that at her church they informed her that the sickness was caused by witchcraft. Another participant indicated she consulted a traditional healer who confirmed that her son was bewitched.

> *P1: "As my husband is not a Christian, he believes that the child might be bewitched."*
> *P3: "I went to a Zion Christian church (Moria). There prophesy indicating the condition of my son has been caused by a person (bewitched)."*
> *P3: "I went to Venda and they said that there is something inside him that drink all the medication and that is why he is not getting well."*
> *P4: "When this sickness started, we thought that the child has been bewitched. Even now we are thinking that because he is not getting better."*
> *P5: "The family believes that this condition has been caused by witchcraft."*

Most of the participants had their own individual perceptions pertaining to mental illness. Some consulted spiritual and traditional healers and were informed that their loved-ones had been bewitched.

Quintanilla (2010:1) asserts that mental illness has been known throughout the history of humankind, and its manifestation has been perceived as an anomaly. In ancient times, madness was viewed as punishment by the gods, or as the unmistakable qualities of an anointed one; the manifestation of mental illness was also seen as a direct message from the gods.

Furthermore, a study conducted by Mavundla et al. (2009:362) confirms this finding; their research uncovered that mostly, mental illness is classified under the umbrella of "franticness"/madness. A general example among traditional clarifications is that the aetiology of mental illness essentially incorporates external causes such as the environment, disease, and substance misuse/abuse. Witchcraft, alongside the egregious violation of human dignity, is perceived as a catalyst for mental disorders and adversity. A study in Switzerland proposed that around 33% of patients with schizophrenia were included in religious groups. Another 10% of patients in the same study were included in minority religious events. A further 33% considered that spirituality played a significant

part in their lives, and they carried out sacred practices each day without necessarily being included in a religious group (Grover, Davuluri & Chakrabarti, 2014:1).

Ecological systems theory posits that development is the result of a range of environmental influences that are divided into five distinct but interrelated layers (Bronfenbrenner, 1994:1). Ecological systems theory focuses on the quality and context of a person's environment by analysing five layers of influence: the microsystem, mesosystem, exosystem, macrosystem, and chronosystem. The microsystem is the level closest to the mental health care user and comprises structures such as family, school, neighbourhood, and childcare environments with which the mental health care user has direct contact. In other words, the microsystem represents the relationships and interactions that individuals have with their immediate surroundings (Pusey-Murray & Miller, 2013:116). Brofenbrenner (1974:2) suggests that these bidirectional influences have a substantial impact on an individual. The mesosystem is the layer that provides the connection between the structures of the child or young person's microsystem, such as the connection between an individual's caregiver, religious institutions, and the neighbourhood (Pusey-Murray & Miller, 2013:116).

Subtheme 1.2: **Description of how culture influences one's perception of mental health and help-seeking behaviour**

The participants explained how culture influences their help-seeking behaviour. One participant indicated that her first point of consultation was the hospital, and that she did not at any stage believe that her son's illness was caused by witchcraft. Conversely, another participant was convinced that witchcraft contributed to her son's illness and was the reason why his mental health did not improve. Because of cultural influence, one participant consulted both traditional and spiritual healers; another participant consulted only a traditional healer. The following statements are evidence of the participants' assertions:

> *P1: "I never thought of bewitchment. I decided to take my child to the hospital and we did not fight about that."*
> *P2: "I have a thought that this might be caused by people [witchcraft]. Even now I am thinking like that because my child is not getting well."*

P3: "I decided to consult spiritual healers and traditional healers before taking him to the hospital."
P4: "I decided to consult a traditional healer before taking him to the hospital."

It should be noted that culture plays a major role in informing help-seeking behaviour. It was evident that most of the participants in this study consulted a traditional healer or spiritual healer before going to a hospital. This is supported by several studies conducted on this issue, showing that alternative practitioners might assume an essential part in tending to the mental health care needs in South Africa by offering culturally fitting treatment (Nattrass, 2005:163; Mbanga, Niehaus & Mzamo, 2002:70). In numerous traditional African structures, mental health problems are observed as being caused by ancestors or bewitchment. Traditional healers and religious guides are perceived as having the ability to tap into the realm of the supernatural. Moreover, these providers of mental health services are in general more accessible than the Western forms of the mental health care (Sorsdahl, Stein, Grimsrud, Seedat, Flisher, Williams & Myer, 2009:2). In the study by Mavundla et al. (2009:364), it was established that some caregivers pursued alternative recovery frameworks, for example, the traditional healer. Caregivers on the whole are of the view that dysfunctional behaviour is connected to witchcraft.

Ecological systems theory implies that the macrosystem is the peripheral level in an individual's environment, comprising cultural values, traditions, and laws (Pusey-Murray & Miller, 2013:116). Whatever the characteristics of the macrosystem, it can without a doubt significantly affect the interactions of all the various layers. Bronfenbrenner (1974:3) states that these issues can adversely affect interactions within the microsystem, and also the capacity of the microsystem itself to operate in a sustainable way to the benefit of the individual. Therefore, in the South African context, the way mental illness is perceived is mainly attributed to cultural connotations. It is evident that culture plays a major role in the lives of MHCUs and their families in relation to their perception of mental illness.

Category 2: **Mental health services**

In this category, the theme that emerged applied to the experiences relating to mental health services; and the four subthemes established a relation to the services rendered

by the hospital/clinic, services rendered by a multidisciplinary team, formal support services, and experiences associated with traditional healers. More details on the theme and each subtheme are provided below.

Theme 2: Experiences regarding mental health care services

Most participants described their experiences pertaining to the services offered by the hospital or clinic. They had mixed feelings in this regard – some participants were satisfied, and others not. Furthermore, they shared their experiences working within a multidisciplinary team. The participants further alluded to other services, which included formal as well as traditional healing services. A description of each subtheme is provided below.

Subtheme 2.1: Experiences regarding services rendered by the hospital/clinic

Three participants indicated that they were satisfied with the services provided in the hospital.

> *P1: "Getting treatment, I am happy about the treatment."*
> *P3: "Receiving treatment at Malamulele hospital and I am happy with the services."*
> *P4: "Receiving treatment at Mapapila home-based centre and I am happy with the services."*

On the other hand, one participant indicated that she was dissatisfied with the mental health services.

> *P2: "I am not happy."*

There were varying views, with some participants being satisfied, while one participant was dissatisfied. Literature has indicated that caregivers have generally been dissatisfied with mental health services. This is affirmed in a study conducted in India by Shankar and Muthuswamy (2006:306), where every one of the participants in their study had encountered levels of weakness and nullification in their communications with mental health professionals. They indicated that mental health professionals often did not listen to what they needed to say, and participants were seldom asked for their views. These professionals took the "expert" stand and did not include them in the choices of ongoing

treatment and care of their relatives. With the exception of three elderly caregivers who communicated acknowledgement and did not anticipate that the professionals' arrogance would change for the better, the others communicated disappointment and were sometimes outraged at this conduct. New caregivers indicated that they felt exceptionally restless and stressed when professionals did not let them know "what was going on" with their relative.

In a study conducted by Mavundla et al. (2009:362), the findings revealed that the participants were not content with the mental health services offered to them. The study found that participants were convinced that mental health care users were rejected not only by the community but also by some medical services professionals. They expressed their disillusionment as to the absence of information from mental health professionals with respect to the MHCU's mental illness. The caregivers further reported that as far as they were concerned, the nurses appeared to be indifferent and unwilling to provide any information regarding their mentally ill relatives when they were admitted to the mental health facility. In a study conducted by Modiba, Schneider, Porteous, and Gunnarson (2001:190), they found that more than 75% of caregivers claimed that the facility was effective in dealing with MHCUs. These caregivers recognised the positive change in the mental health care user's wellbeing and social functioning.

From a strengths-based perspective, people are specialists in their lives, qualities, assets, and also their limits. Saleebey (2006:261) reports that the social worker makes the connection between the individual and his or her strengths. Interventions are based on the strengths approach that provides the perspective that individuals are improving their circumstances; it is the social worker's responsibility to assist the individual in identifying his or her strengths, and continue working toward realising the persons' objectives and dreams (Rangan, 2006:128). The exosystem is the layer in ecological systems theory that characterises the bigger social framework, inside which mental health care users do not work specifically, although they might be influenced and/or impacted by it. The structures in this layer influence the patient's advancement by linking with the different structures in the microsystem; in the present setting, they speak to institutions, government, and the law to translate and apply the appropriate laws, regulations, and approaches to the benefit

of the MHCU. It is important to take note that although mental health care users may not be directly included at this level, they do feel the effect of the positive or negative results of these interactions (Pusey-Murray & Miller, 2013:116).

Subtheme 2.2: Experiences regarding services by a multidisciplinary team

Two participants indicated that they have not worked with a multidisciplinary team:

> *P1: "Yes we work with the nurses only. Not with the doctors and the social workers."*
> *P5: "The time she used to go to the hospital, she used to be treated by doctors."*

On the other hand, two participants indicated the link between nurses and doctors:

> *P3: "The nurses take us to the doctor when we are in the hospital."*
> *P4: "Working with the nurses and doctors."*

Two participants' responses as to the services they received from the social worker and nurses are reflected below.

> *P2: "I was talking to my daughter that we should go back to the hospital next week. She should go and see the social worker. When she went to the social worker I did not go with her, when she went to the social worker, she did not get help and she was told to come on Thursday."*
> *P2: "We worked with the nurses, doctors, social workers but we did not get enough help from the social workers. She was told when she is sick she must not come alone because she did not say what is wrong."*
> *P4: "I have not worked with the social worker."*

It is evident that participants predominantly interact with nurses as mental health care users receive treatment at a home-based centre or mobile clinic operated by these nurses. They receive other services only at the hospital. The researcher was concerned when one participant went to the social worker, no assistance was forthcoming from this particular professional.

Mavundla et al. (2009:362) affirmed this tendency in their study, where the participants demonstrated that when they went to the social workers, they did not receive any assistance. The researcher has interviewed the social workers and they were under the impression that mental health care does not fall within their scope of practice. Mavundla et al. (2009:361) assert that it has been implied that the nurses were filling in as "mini-

doctors" in the rural areas. The nurses are the ones who are rendering essential primary health care.

The strengths-based perspective has been appropriate in this finding. Arbuckle and Herrick (2006:105) state that a vital segment of mental health care is to provide strengths-based care, where the strengths and needs of the MHCU are recognised and utilised by the multidisciplinary team amid the assessment and treatment planning process. These authors contend that services and support must be individualised, based on the strengths of individuals to address their needs in all areas of their lives to advance achievement, wellbeing, and permanency. It is critical that multidisciplinary teams provide mental health care by supporting and affording MHCUs the opportunity to have a voice in the treatment process. Mental health care practitioners must help expand MHCUs' capacity to adapt effectively to life's difficulties, encourage recovery, and build adaptability. The combination of regular support and professional services is a key component in assisting mental health care users to achieve self-sufficiency.

Subtheme 2.3: **Experiences regarding formal support services**

Four participants indicated that they had not used or received any other services. One participant indicated that in the past, home-based care services were provided but currently no services are provided.

> *P1, 2, 4, 5: "None."*
> *P3: "None, in the past the home-based carers used to come, but they have stopped."*

Participant 2 indicated that she went to SASSA for assistance regarding her daughter's child support grant.

> *P2: "I have taken here to SASSA so that she can get the child support grant. She did not get the money. When they phoned, she was told that there is someone who bought electricity and airtime. She has never done that."*

It should be noted that there were no community-based services in rural areas. Apparently, in the village where the study took place, there were home-based care services at one time, but these had been discontinued. Most of the mental health users receive disability grants and support from SASSA.

Mavundla et al. (2009:362) affirm this in their study: four participants indicated that they received government support grants, which were adequate for the needs of MHCUs. In a number of cases, relatives with mental illness declined to hand over their grants to their caregivers, to their detriment as the funds were squandered indiscriminately. McNamee (2014:1) affirms the lack of services in low- and middle-income countries, and that there are no clinical and specialist community-based multidisciplinary teams to provide social services to people living with schizophrenia.

The ecological systems theory plays a major role in highlighting the effects of the environment on mental health care users. The exosystem comprises settings "that do not involve the developing person as an active participant, but in which events occur that affect, or are affected by, what happens in the setting containing the developing person" (Rogers, 2009:18). The exosystem encompasses the links and processes that occur between two or more settings, at least one of which does not ordinarily include the developing person (Greene, 2009:218). Furthermore, Nash et al. (2005:37) state that forces external to the developing person account for the concept of exosystem, which involves one or more settings that do not involve, but nonetheless have an influence on, the developing person. In this case, mental health care users in rural areas are affected by the lack of mental health services, and they do not have the power or ability to remedy the situation. With regard to recovery-oriented mental health care, Davidson (2008:1) indicates that people do not recover in isolation; recovery is closely associated with meaningful and satisfying social roles, and participating in local communities on a basis of equality.

Subtheme 2.4: Experiences regarding traditional healers

One participant indicated that she had never consulted a traditional healer, but that her husband consults these service providers.

> *P1: "I have never consulted a traditional healer, but my husband is the one consulting them."*

Four participants alluded to the fact that they had consulted a traditional healer before taking the MHCU to hospital.

P2: "I decided to consult a traditional healer before taking him to Nkhensani hospital."
P3: "In the beginning of the sickness we went to the traditional healers, but we did not get help. We went to the different places looking for help."
P4: "We went to different traditional healers looking for help, but I did not get it."
P5: "The family has consulted traditional healer. She gone all over the places looking for help, but she did not get it."

One participant reported that she has never consulted a traditional healer; however, her spouse has done so on a number of occasions. The other participants stated that they have consulted traditional healers in the past.

Pathway has been defined as "the sequence of contacts an ailing person makes with services provided by individuals or organisations, prompted by the effort of the distressed persons and those of his or her significant others, in the process of seeking treatment for the sickness" (Adeosun, Adegbohun, Adewumi & Oyetatoo, 2013:1; Turner, Smith-Harmel & Mulder, 2006:421). In a study conducted in Nigeria, Adeosun et al. (2013:1) found that traditional and religious healers were the primary point of help-seeking by most of the patients. Mokgobi (2012:1) demonstrates that for a considerable length of time traditional African healing has been assumed an essential part in the health services framework in South Africa and elsewhere on the African continent.

According to ecological systems theory, human conduct and activities form a unit which is inseparable from their comprehension of culture, which influences the way individuals think, feel, and trust (Mpono, 2007:15). Mpono further expresses the view that individuals' cultures provide the material and symbolic apparatus according to which people adjust to their ecological and social environment, their image of the world, and of themselves. By adjusting to their environment, individuals create different methods for managing different circumstances and occasions within that environment, including an improvement in mental health care services delivery. Mariach (2003:67) asserts that the improvement in frameworks which monitor these illnesses and restore wellbeing to people who are ill cannot be isolated from the social, cultural, and historical realm in which they occur. They claim that traditional healthcare delivery is an essential part of culture and therefore represents the entirety of the beliefs, dispositions, traditions, techniques, and built-up practices which reflect the perspective of the general population (Mpono, 2007:16).

Category 3: Mental health condition and treatment

In this category, the theme that emanated from the participants' experiences relates specifically to the loved one and his or her treatment. Several subthemes emerged from this section.

Theme 3: Experiences related to the specific illness and treatment of loved ones

The participants provided a variety of views pertaining to the diagnosis of schizophrenia, and how they were informed about mental illness. They further explained how they understood this illness, and continued to expound the treatment that their loved ones receive, the importance of taking the treatment, side-effects, accessibility of medication, and the implications of relapsing when the medication is not taken.

Subtheme 3.1: **Description of diagnosis**

Four participants did not have an understanding of the MHCU's diagnosis, and only one participant was familiar with the implications of the diagnosis.

> *P1: "I am not sure, but my child is roaming around and he also has epilepsy."*
> *P2: "No one has told me what is wrong with my child; they just give us treatment."*
> *P3: "My child has epilepsy and I have never been told that he has mental illness. But I suspect that he has mental illness."*
> *P4: "I do not know, but I see him talking alone and he is not like other children."*
> *P5: "My mother-in-law is suffering from mental illness."*

Most of the participants were illiterate; only one had a secondary-level education and understood the diagnosis of the mental health care user's mental illness. In most instances, health professionals do not explain the diagnosis.

This is confirmed in the study conducted by Mavundla et al. (2009:362); most of their participants communicated their dissatisfaction with the absence of information pertaining to their relatives' mental illness, including their medication. However, they communicated their appreciation for finding out about the condition, although they did not know how to deal with it. It was apparent that the participants were generally not aware of the causes of mental illness, particularly in their relatives. Many people are convinced that mental illness is brought about by ecological reasons or witchcraft. Studies have shown that misinformation, or the lack of information, around mental illness contributes fundamentally

to its uncontrolled prevalence in the community, as are avoidance of seeking help or noncompliance with a medication regimen. Instances of help-seeking for and reaction to treatment have been connected to people's beliefs about the causality of mental illness (Link, Phelan, Bresbahan, Stueve & Pescosol, 1999:1328; Wolff, Pathare, Craig & Leff, 1996:192).

The strengths-based perspective has shown that healing implies both the wholeness and the inborn facility of body and mind to regenerate and resist when faced with a disorder, disease, or disruption (Saleebey, 2002:260). Healing requires a beneficent relationship between the individual and the social and physical environment (Saleebey, 2002:261). All human beings have a capacity for healing. Trauma, environmental toxins, physical disorganisation, and even some of our professional intervention philosophies and systems, can compromise this evolutionary legacy (Saleebey, 2002:261). Nevertheless, the bottom line is this: "If spontaneous healing occurs miraculously in one human being, you can expect it occurs in another and another. Healing occurs when the healer of the individual makes an alliance with or instigates the power of the organism to restore itself (Saleebey, 2002:262). Healing and self-regeneration are intrinsic life support systems, always working, and for most of us, most of the time, on call" (Saleebey, 2002:263). Based on recovery-oriented mental health care, Rangan (2006:127) also indicates that people are more motivated to change when their strengths are supported.

Subtheme 3.2: **Description on how the diagnosis was explained**

Most participants reported that no one explained the diagnosis, and one participant indicated that she was asked by a health professional in the hospital whether there was any one in the family with a mental illness, to which she could not respond.

> *P2: "What I have seen about my child who is disabled, we did not go to the traditional healers. We went to the hospital and they ask if there was somebody in the family with mental illness. When I came back, I told my husband about this issue. He said that he had an uncle who had this sickness but he has died. He has this child is like his uncle."*

Four participants indicated that no one explained the condition.

> *P1: "No one told me about the condition of my child."*
> *P2: "No one has told me what is wrong with my child. They just give us treatment."*
> *P3: "I have never been told that he has mental illness."*
> *P3, 4: "No one has told me about his condition."*

One participant indicated that the family formed their own opinion; they were not given a formal diagnosis:

> *P5: "She is suffering from mental illness. I believe that the family has seen that she is sick as she burnt the house."*

Most of the participants were not informed of their diagnosis. They just made an assumption based on the symptoms and the behaviour of the mental health care user. In a search for confirmation of these findings, the researcher consulted various sources regarding the diagnosis of people with schizophrenia.

Schneider, Scissons, Arney, Benson, Derry, Lucas, Misurelli, and Sunderland (2004:568) attest that a diagnosis of mental illness can be problematic, and it is frequently challenging for medical professionals to come to a definitive finding. This in turn places individuals with schizophrenia in a difficult position. Doctors are often hesitant to commit to a particular diagnosis, which can change over a period of years. Individuals are basically not told anything in particular, and this causes a great degree of uncertainly. This absence of clear communication about their illness is especially disturbing, and makes it much more difficult for individuals to manage their lives.

Mavundla's study (2009:360) affirms this finding; it was apparent in this study that the participants were unaware of the causes of mental illness in general, their relative's illness in particular. In most instances, participants believed that mental illness is caused by ecological causes or witchcraft. Outram, Harris, Kelly, Cohen, Sandhu, Vamos, Levin, Landa, Bylund-Lincoln, and Loughang (2014:551) are of the opinion that doctors have an ethical commitment to provide patients with clear, comprehensible data about their disease. Significantly, Jutel and Nettleton (2011:1) attest that a medical diagnosis can be seen as a social process, accepting the ailment and clarifying symptoms, legitimising

illness, and encouraging access to medical resources. These authors are of the view that a diagnosis can provide a point of convergence to treatment and recovery.

The ecological systems theory assumes that the numerous ecological elements act directly on the individual, and that every individual's life is linked to different complex social systems. These systems consist of indirect components that may contribute to vulnerability and resilience, and affect the formative course of mental illness. The ecological systems model structures the danger and the strengths of components within the connection of proximal and distal social frameworks (Bronfenbrenner, 1979).

Subtheme 3.3: **Own understanding of diagnosis and illness**

Most of the participants were unsure of the diagnosis and illness.

> *P1: "I am not sure, but my child is roaming around and he also has epilepsy."*
> *P2: "None."*
> *P3: "My child has epilepsy. But I suspect that he has mental illness."*
> *P4: "I do not know, but I see him talking alone and he is not like other children."*

The majority of participants were not aware of what the illness entailed; however, they had clearly formed their own interpretations.

This is in accordance with a study conducted by Mavundla et al. (2009:362). The majority of participants in this study communicated their dissatisfaction because of the lack of information relating to their relative's illness, including their medication. However, they conveyed their appreciation for being informed the condition, yet they did not know whom to turn to for assistance. In a study conducted in North West by Modiba et al. (2001:192), the widespread lack of, or the limited comprehension of information around mental illness, was clearly documented. Those participants were of the view that it is essential that mental illness in general and the diagnosis of schizophrenia in particular be explained to caregivers and MHCUs.

The ecological systems theory assumes that many environmental factors act directly on the individual; each individual's life is further embedded in multiple complex social systems. These systems may present with additional direct and indirect factors that contribute to the risk, resilience, and influence on the developmental course of mental

illness. The ecological systems model structures the risk and resilience factors within the context of the proximal and distal social systems in which they are embedded (Bronfenbrenner, 1979).

Subtheme 3.4: **Description of treatment received**

Three participants indicated that mental health care users received treatment, while two indicated that mental health care users often discontinue their treatment.

> *P1: "He is receiving treatment, but I do not know the names of the tablets."*
> *P3: "He is receiving tablets, but they are not controlling his epilepsy. They have been changing his treatment, but still is not controlling his condition."*
> *P4: "He is receiving tablets."*

Three participants indicated that mental health care users were receiving treatment, but they did not know the details of their medication and treatment. Treatment regimens are changed from time to time, but they are not given a reason for the change or any details about the new treatment regimen. Patients with schizophrenia require, and ought to receive, an assortment of medications regularly, often from different clinicians. It is therefore incumbent upon clinicians to keep track of these MHCUs, their interaction with other clinicians, and their treatment.

An exact history of past and current medication should be well documented; any reactions to medication, adverse or otherwise, constitute a key element of a treatment plan (APA, 2010:10). A study by APA (2015) shows that 51% of adults who present with schizophrenia are concerned that their medication seems to be ineffective. Two in three caregivers concur that there is a lack of medicine that adequately alleviates their loved ones' symptoms (63%), and they are troubled that medication prescribed for schizophrenia seems ineffective (65%).

The ecological systems theory has been a source of useful links in this study. It is evident that ecological components are crucial as they provide the connection to interpret the more broadly studied individual and biological danger markers of psychosis. Understanding more variables that are distal will turn out to be progressively critical as

the mental health care users advance from an experiential exploration of the diagnosis to a fully developed clinical disorder (DeVyler, 2010:482).

The family microsystem appears to play a central role as a shield against the risk of developing psychosis, reflecting a dynamic family system in which the behaviour of the mental health care user may elicit an unfavourable reaction from family members, which in turn further exacerbates the symptoms of the illness. There are established evidence-based psychosocial interventions, particularly in multifamily psychoeducation groups, that are known to reduce negative emotions and enhance positive family interactions (Lukens & Thorning, 2010:91). For the family microsystem to facilitate the development of viable interventions, care must be taken to ensure that these interventions enhance a family's coping mechanisms while avoiding apportioning blame for the condition (DeVyler, 2010:482).

Subtheme 3.5: **Importance of taking medication**

The participants valued the importance of taking medication, although others decided to discontinue their medication due to its side effects. Other participants confirmed that they do take their medication despite it being ineffective.

> *P1: "I understand it help to control his epilepsy, but the problem he is roaming around."*
> *P2: "It is important, but I have stopped it as it was affecting my child."*
> *P3: "I realised that at least it's helping to such an extent. But it not that effective, but it is keeping him going."*
> *P4: "He was better when we got treatment."*
> *P4: "I see it as very important, he was very sick; at least the treatment is helping him."*
> *P5: "The treatment is important but it has been stopped because it used to affect her."*

It was evident that participants were aware of the importance of taking medication, but some reported that they had stopped mental health care users from taking treatment due to the side effects.

A German study observed that knowledge about medication correlated with adherence (Angermeyer, Daumer & Matshchinger, 1993:114). Besides, a study conducted by Mavundla et al. (2009:364) demonstrated that community attitudes and insight into the

efficacy of medication are the most vital issues around prescribing medication. Thomas (2007:60) looked at the viability of and adherence to antipsychotic medication. The author found that long-term side-effect control, and tolerability and adherence to treatment could all be enhanced by utilising the atypical or second-generation antipsychotic agents instead of the typical antipsychotic drugs. He asserts that antipsychotic treatment for schizophrenia ought to concentrate on enhancing real world outcomes, including the individual's functional capacity and health-related personal satisfaction, because these components are imperative from the MHCU's point of view. The strengths-based perspective attempts to understand these MHCUs in terms of their strengths. This involves systematically examining the survival skills, abilities, knowledge, resources, and desires that can be utilised to help meet the MHCU's goals (Rangan, 2006:127).

Subtheme 3.6: Side effects of medication

Two participants indicated that the medication had side effects, while one claimed that mental health care users respond well to treatment.

> *P1: "There is nothing wrong."*
> *P2: "He is feeling the pains when he drinks it."*
> *P5: "My mother in law used to take treatment at the hospital, but she has stopped taking it. She used to shake, food will be falling down."*

The majority of participants expressed mixed feelings regarding the side effects of medication. One participant indicated that the mental health care user did not exhibit any side effects, while two participants maintained that some mental health care users did in fact show side effects and had to discontinue their medication.

APA (2015:1) concur that a significantly important reason behind non-adherence among individuals with schizophrenia is the side effects of the medicines. Antipsychotic medications frequently have serious side effects that need to be addressed. These side effects include weight gain, loss of sexual libido and, in some cases, diabetes. A study conducted by APA (2015:1) shows that only 10% of the psychiatrists surveyed concurred that a large proportion of their patients with schizophrenia dependably take their medication precisely as prescribed, and 90% claimed that their patients would not take

their medication as recommended. These psychiatrists referred to these side effects as the main factor which confuses patients about their medication.

The APA (2010:85) asserts that the neurological side effects of antipsychotic medication incorporate intense extrapyramidal symptoms; for example, medication prompted the onset of Parkinsonism, dystonia, akathisia, and persistent extrapyramidal side effects such as tardive dyskinesia and tardive dystonia as well as neuroleptic disorders. The APA (2010:85) describes dystonia as continuous spasms and muscle contractions; akathisia as motor restlessness; Parkinsonism as rigidity; bradykinesia as slowness of movement and tremor; and tardive dyskinesia as irregular, jerky movements.

With regard to ecological systems theory, Hadad, Brain, and Scott (2014:48) state that a helpful approach to conceptualise non-adherence is to consider deliberate and unexpected non-adherence. Purposeful nonadherence occurs when a patient settles on a deliberate choice to discontinue medication as prescribed. This is generally because the disadvantages of medication are seen to exceed the advantages; in this situation, the side effects prevent MHCUs from adhering to the prescribed treatment. Inadvertent nonadherence occurs when practical problems interfere with adherence. From an ecological perspective, the issue is not the characteristic neurotic state but is instead reconceptualised as confounding the necessity and ability to adapt to ecological resources and support (Greene, 2009:213).

Subtheme 3.7: Accessibility of medication

The participants were satisfied with the accessibility of medication. They reported that they go to home-based centres to collect the medication for the MHCUs. If they could not get the medication, they would simply go to the clinic or the hospital where medication is usually freely available. One participant indicated that she no longer collects treatment for the mental health care user from the home-based centre.

> *P1: "Yes, in the home-base they sometimes do not have tablets and then I go to the clinic and if they do not have I go straight to the hospital."*
> *P3: "I get the treatment at the hospital every time."*

P4: "If we do not get the treatment at the home based, we go to the clinic."
P2: "I have stopped him from taking treatment [not going to the hospital anymore."

Participants reported that they had never experienced a scarcity of medication. They receive the medication at the home-based centre or they go directly to the clinic or hospital.

This is contrary to the report of Chambers (2015) in the Mail and Guardian that patients with mental illness in Johannesburg's East Rand region have been hard hit by the unavailability of medication. For three months, tablets have not been available at the Daveyton Clinic. Chambers (2015) states that the shortage of mental health medication causes ripple effects affecting patients who spend money to get to the clinic, only to be told that the medication is not available and they should come another time. Chambers (2015) further states that South Africa does not have the resources to meet the demands of mental health care.

In a study conducted in Ethopia, Teferra, Hanlon, Beyero, Jacobsson, and Shibre (2013:3) ascertained that outside the primary urban areas, only psychotropic medication was available, namely the original antipsychotics – generally Chlorpromazine, and sometimes Haloperidol, Trifluoperazine and Fluphenazine Decanoate (depot) – and the more established antidepressants such as Amitriptyline. Medication which eases the onset of adverse reactions to original antipsychotic medicine (anticholinergic medicine) was rarely available.

Ecological systems theory incorporates social structures that do not include, but nonetheless have, an impact on the individual (Bronfenbrenner, 1979). Mental health care users have no control over the dispensing of medication; they depend on the exosystem to provide fundamental commodities such as prescription drugs.

Subtheme 3.8: **Effects when medication is not taken**

The participants indicated that mental illness cannot be controlled without appropriate treatment. One participant mentioned that a mental health care user experienced a relapses because she was prevented from taking her medication.

P1: "Nothing."

P2: "Nothing."
P3: "His epilepsy is uncontrolled if he not taking the treatment. The fits are uncontrollable."
P5: "Treatment has been stopped. My mother in law does not eat her food, she is refusing to bath and as a result she is dirty. She is roaming around. Sometimes people will bring her back home."

Participants were evidently fully aware of the consequences of non-adherence to medication. Most participants agreed that the illness would not be controlled once mental health care users relapse. One participant described the effects of not taking medication; as a family, they were compelled to discontinue providing medication to their loved one because of the side effects. They did not consult the mental health practitioners, but made a unilateral decision.

Mavundla et al. (2009:362) highlight that a number of participants in their study reported that mental health care users' do not appreciate the importance of adhering to their treatment regimens, and caregivers recognise this as feasible because of non-compliance. It is clear that the daily administration of medication should be supervised. A number of participants stated that mental health care users discontinue their medicine when they develop side effects, or become demoralised when they do not feel better. A few MHCUs sought alternative healing methods, notably traditional medicine; they were convinced that mental illness was connected to witchcraft.

The strengths-based perspective demonstrates that healing targets the whole "office of the body and brain" in the recovery process when the individual is confronted with turmoil, infection, and disturbance (Saleebey, 2006:261). Healing facilitates a beneficial relationship between the individual and his or her social and physical environment (Saleebey, 2006:261). Everyone has his or her own viewpoint on recovery. This transformative legacy can be influenced not only by trauma, environmental toxins, or genuine confusion but also by expert mediation methods of intervention and other systems (Saleebey, 2006:262). Healing and self-recovery are inherently emotional and supportive life networks which are continually at work and are, for the vast majority of us, more often than not, accessible as needed (Saleebey, 2006:263).

Category 4: Role and needs of caregivers

In this category, the theme that emerged was around the experiences of caring for a person living with schizophrenia; seven subthemes were identified, namely tasks as a caregiver, challenges as a caregiver, stigmatisation, needs of caregivers, support systems, community, and professional support. More details on the theme and each sub-theme are provided below.

Theme 4: Experiences of caring for a person living with schizophrenia

Participants described their tasks as caregivers and the challenges they face. They explained the support they receive from family, community, and mental health practitioners.

Subtheme 4.1: Tasks as a caregiver

Participants explained the role and tasks that they perform to assist the mental health care user.

> *P1: "Giving treatment, giving food, help the child to bath."*
> *P1: "Other people talk about my child, but what I do I bath him so that when he roaming around he is clean so that people cannot reject him."*
> *P2: "Buying clothes and buying food."*
> *P3: "Bathing, preparing meals and making sure that he takes his treatment."*
> *P4: "Making sure that he is eating and taking his treatment and also he is clean."*
> *P5: "Preparing her meals and she has to see to it that she is clean but unfortunately she is difficult as she refuses to eat her food or to bath."*

They indicated that they provide for the material and physical needs of mental health care users, and ensure that they are well groomed and take their medication; they also purchase and prepare their meals. The present study concurs with that conducted by Mavundla et al. (2009:360). Participants in their study reported that their relatives with mental illness constantly need essential support with, for example, food preparation, provision of safe houses, monitoring the taking of medication, and personal hygiene.

A few participants portrayed this undertaking as more challenging than expected; for example, MHCUs at times refuse the meals that have been prepared for them (Mavundla et al., 2009:360). Ecological systems theory puts in place not only examples of expected practices, but also examples of equal claims and commitments (Greene, 2009:211). A role perspective simplifies comprehension of the social dimensions of development. Role

execution incorporates not only assumptions as to how an individual in a given social position is to act toward others, but additionally how others are supposed to act (Greene, 2009:211). This author claims that role execution or social participation is unequivocally identified with a person's self-regard (Greene, 2009:211).

Subtheme 4.2: Challenges as a caregiver

The participants had different challenges regarding mental health care users.

> *P1: "The problem is that he is roaming, when it's at night and he is not around I become stressed."*
> *P3: "My son is an adult child, he cannot bath himself, and he cannot control his bowels. It is so difficult for me to buy pampers as I have a daughter who is in the university and I am paying for her fees. My son also receives disability grant but the money cannot cater for all his needs."*
> *P4: "He is roaming around as the result I am forced to go and look for him. Even the people when they see him in the streets they bring him back home."*
> *P5: "My mother in law sometimes insults me and my husband is in Johannesburg. I stay alone with her and with my children."*

The participants shared their challenges in respect of caring for the mental health care user with schizophrenia such as wandering around, not being able to bathe themselves, and at times being aggressive. This is affirmed in literature and is commonly alluded to as caregivers' burden. However, this burden is shared by the family who is in close contact with the person with mental health problems. A few authors further recognise objective and subjective burden. Objective burden relates to the patient's symptoms, conduct, and sociodemographic attributes and factors such as changes in household routine, family or social relations, work, recreation time, and physical wellbeing. Subjective burden relates to the mental health and subjective pain suffered by family members (Reine, Lancon, Simeoni, Duplan & Auquier, 2003:137).

Chan (2011:340) affirms that the burden carried by the family in caring for persons with schizophrenia is a typical challenge in both developed and developing countries. The World Federation of Mental Health (2010) shows that as caregivers battle to adjust to work, family, and caregiving their own physical and emotional wellbeing needs are frequently overlooked. In combination with the absence of the individual's financial and emotional resources, numerous caregivers regularly endure considerable anxiety,

depression, and/or nervousness in the first year of caregiving. A Swedish study by Ostman, Hansson, and Andersson (2000) found that the family burden and support in respect of relatives with mental illness need to be assessed, and that intervention aimed at maintaining an effective family system proved to be indispensable. Another Swedish study, by Hjarthag, Helldin, Karilampi, and Norlander (2010), recognised that a worsening of the family's burden could be connected to the deterioration of the MHCU's symptoms and overall functioning, which has a major detrimental impact on the family.

The strengths-based perspective, which is key to empowerment practice, can be linked to an idea as a relationship expression, and not to a method or instrument (Saleebey, 2006:11). Empowerment and trust are unequivocally incorporated in the motivation behind this practice; their association with social structures in the interest of MHCUs are explored, and therefore empowerment is clearly an essential component of the caregiver's function in carrying the burden of caring for a mentally ill person.

Chan (2012:345) asserts that an empowerment-oriented model can be extended to include shared support groups, and provide opportunities for family caregivers to acquire the information and skills necessary to care for relatives with schizophrenia – often with peer support, setting up an agreeable family life, and connecting with professionals as collaborators rather than experts who are detached and impassive. Empowerment within the support group can be reinforced by the provision of a peer-based emotionally supportive network, and permitting people to assume the important roles within the group and their own particular family; and teaching a belief system that motivates individuals to make an attempt to better their mental health.

Subtheme 4.3: Stigmatisation

Participants voiced their frustrations concerning the stigma that they experience in the community:

> *P1: "I am blamed by the community that I am neglecting my child. He is roaming around and then people will make him work and give him food. So they think that I am not taking good care of him. He is now an adult child; I cannot control him."*
> *P2: "I am blamed by the community that I am what caused my children to mental illness. I do not care what they say about me."*

P3: "We are rejected as a family, but that does not bother me that much. They are talking about me."
P5: "Some people blaming me saying that I am neglecting the old lady, some other people who are nearby; they understand and support me."

The participants were frustrated by the way community members treat them as caregivers; they alluded to the fact that they were being accused of neglecting mental health care users**.**

Jack-Ide and Uys (2013:159) assert that mental health services should be made available throughout the healthcare system to empower individuals to acquire services locally, keeping the need to travel to a minimum and enhancing service uptake and the continuation of treatment. Mavundla et al. (2009:362) established that the social exclusion of people with mental illness, isolation, and degradation are harmful to MHCUs and their caregivers. The study revealed that the participants believed that mental health care users were not rejected only by the community but also by some health professionals. They were perplexed by the lack of information and guidance from health professionals with respect to this mental illness. The caregivers further reported that nurses appeared uninterested and emotionless in their interaction with mentally ill individuals. Stigma emanating from the community exacerbates the suffering, disability, and financial misfortune connected with mental illness (Lund et al., 2008). Persons with mental illness are often exploited because of their condition, and face uncalled-for discrimination such as challenges obtaining accommodation and a livelihood, and other societal roles. They are not only regularly abused by members of the community but also by their families and companions (Sartorius, 2007:810-1; Stuart & Sartorius, 2005:79).

A study in South Africa investigated the scope and impact of structural stigma and discrimination. It was established that structural stigma was profoundly predominant, and that stigma-reduction methodologies were expected to address these issues to provide optimum mental health care, and secure the rights of the people with mental health conditions (Kakuma, Kleintjes, Lund, Flisher, Goering & the MHaPP, 2008). The stigma attached to mental illness can exercise pressure on an individual's state of mind, and the sentiment of disgrace can drive the individual toward seeking mental health services (Kakuma et al., 2008).

Bronfenbrenner (1979) is of the opinion that human development is portrayed as an intuitive relationship between an individual and the immediate environment, which in itself is affected by an association with different settings within the bigger connection; if the individual associates stigma with mental illness and mental health treatment, identified from different ecological sources (family, associates, and companions) that have been impacted by fundamental social standards and interactions. It is reasonable to assume that these social convictions could be communicated to the individual, and influence his or her decision to seek relief from mental health care services.

Subtheme 4.4: Needs of the caregiver

One participant indicated that she required formal care for her son.

> *P1: "Since from long time ago, I want my child to be placed in a school for people with special needs. He is always with people who drink alcohol and they also smoke; they will teach him how to smoke and drink."*

Two participants expressed their need for home-based care/community projects.

> *P3: "I need somebody who can come and assist for bathing my son."*
> *P4: "If there can be a project that can accommodate my son during the day."*

One participant voiced her need to be provided with food.

> *P2: "I need food for my adult daughter who is not staying at home; she is relying on my grant."*

A participant indicated that she needed practical/emotional assistance to enable her to attend to her own needs, and another indicated that she needed a support group.

> *P4: "I have a problem of attending community activities, as I need to take care of my son."*
> *P5: "Support group."*

One participant revealed that she required a formal arrangement (special school) for her child; he loved wandering around the town, and was in danger of being abused. In the event that he could be put in a school, she felt that he would be protected and restricted to the school grounds. Another participant voiced her need for assistance in bathing her child. Other participants indicated that a day-care centre would go a long way toward assisting and protecting her child during the day. Another participant needed sustenance for her adult daughter who is no longer at home. A participant referred to her predicament in not having the capacity to take part in community activities as she constantly had to deal with her child.

In a study conducted in China, Yen, Hwu, Che, and Wu (2008:644) recognised the perceived needs of MHCUs, for example assisted patient care, access to pertinent data, and societal support. Caregivers needed to share the burden associated with caring for individuals suffering from mental illness. The development of common support groups in the 1990s proved to be a valuable part of the bigger social development of self-help associations for individuals affected by a variety of chronic mental illnesses, and whose needs were being attended to by traditional health care interventions, however inadequately (Chan, 2006:349).

The ecological structure encourages sorting out the data about individuals and their environment with the specific end goal of comprehending their interconnectedness. People move through a progression of life transitions, all of which require ecological support and coping skills. Social issues include health care, family relations, inadequate income, mental health dilemmas, unemployment, and educational challenges all of which

can be incorporated in the ecological model (Hepworth, Rooney, Rooney, Strom-Gottfried & Larsen, 2010:16).

Subtheme 4.5: Support systems of the caregiver

Three participants indicated they had family support, while two others indicated that they did not have any support:

> *P1: "Here at home as his parents and my relatives we support one another regarding this child."*
> *P2: "None."*
> *P3: "I have another son who sometime assists with the care of my son."*
> *P4: "My husband helps."*
> *P5: "My husband is unemployed and he is in Johannesburg."*
> *P5: "My sister-in-law stays in Mavambe but she is not coming regularly to help her. If she is around, her mother-in-law eats as well she baths."*

The participants expressed diverse views pertaining to support systems. Some participants derived satisfaction from being assisted by their families in taking care of the mental health care user. On the other hand, some participants did not have any support, while others had family members who assisted only intermittently.

Social support is thought to be of an extraordinary quality in many families who have to carry the burden of caring for persons with schizophrenia (Saunders, 2003:56); and family support was undeniably associated with a higher degree of family functioning (Saunders, 2003:56). Lower levels of social support from other relatives and companions of persons with schizophrenia have been observed to be associated with higher scores in need evaluations and unmet needs (Chan, 2006:349).

A study by Chien (2007:345) conducted in Asia established that social support was observed to be the best indicator of caregivers' burden. Magliano's (2003:234) study showed that a strong informal community was found among relatives who reported lower levels of burden and pessimism about schizophrenia. Revitalising families' interpersonal and interdependent relationships could be a valuable technique to lighten the considerable burden families have to bear. The family ecosystem consists of an assortment of related free parts which work together to accomplish a set goal. Every component is interrelated and each one influences the other. The ongoing exchanges

among components (individuals, situations, and family associations) result in change and adjustment in parts of the family biological system. One must look at the persons involved as well as the conditions that influence their existence.

Families extract data from their surroundings, and direct the tasks allocated to their relatives in order to accomplish a predetermined objective; also by partitioning responsibilities among fellow family members, and collectively fulfilling their obligations to ensure that these assignments are completed to the benefit of the entire family, in particular the MHCU.

The environment is the fountain of the family's assets, and is fundamental to family survival (Children & Family Coalition, 1990).

Family association transforms assets into valuable structures that enable families to associate with other individuals within their environment, minimise constraints, and promote human advancement (Children & Family Coalition, 1990). From this portrayal of families and ecological systems, one can understand the behaviour and the advancement of families as an unpredictable assignment. The researcher has noted that different environments influence families, and families affect their environments. Family needs, and the quality thereof, must be considered in the setting of the public, and the ecological community. Therefore, mental health practitioners should have the capacity to recognise these associations in order to provide families with the assistance they require (Bronfenbrenner, 1993).

Subtheme 4.6: Community support

Three participants reported the lack of support in their community.

> *P1: "I do not have any support in the community."*
> *P2: "None."*
> *P3: "I am blamed by the community, saying that I am neglecting my son."*

Two participants reported that the community supports them.

> *P4: "The community helps when they saw him roaming around, they bring him back home."*
> *P4: "I have never got bad reaction. The community support us."*

P5: "The community is supportive; if they see her walking around they take her back home."
P5: "My mother-in-law is loved in the community; there is no problem, but sometimes she likes insulting people without any cause, or you will see her happy."

The participants conveyed their diverse views in relation to the support they received from the community. Three participants indicated that they do not receive any support from the community, they were not happy as they were accused of neglecting their mentally ill children; while two participants were satisfied with the support offered by the community who assisted these mentally ill individuals when found roaming around. These participants felt that community members clearly cared about these MHCUs.

In a study conducted by Mavundla et al. (2009:361), caregivers demonstrated that their families endured the social isolation from community activities with sadness. They had to adapt their social lives to accommodate their mentally ill relatives, and could not attend church services, funerals, and other essential traditional gatherings. Their psychosocial support base was severely compromised. This is a source of extreme of anxiety as they do not have any time for themselves. Families are in the position that they have to support their mentally ill relatives without having been trained in the provision of appropriate support methods in dealing with stress, and they were constantly uncertain as to the value of the support they provide.

In the same study (Mavundla et al., 2009:361), the findings showed that to a large extent, the anxiety experienced by caregivers can be attributed to the absence of crucial support, limited information, continuity of care, psychosocial rehabilitation programmes for skills improvement , training, caregiver counselling, and respite services. It is evident that a holistic approach to deal with their requirements is lacking.

Ae-Ngibise, Doku, Asante, and Owusu-Agyei (2015:5) conducted a study in Ghana, which focused on the support obtained by caregivers. They found that there was no reported support for the caregivers of individuals living with mental illness. The main specified support pertained to the patients with mental illness but not their caregivers. Community support in caring for individuals with mental illness and their caregivers was either inadequate or non-existent. All the study participants were consistent in their views that

there was no external or community involvement in caring for people with mental illness. It was generally incumbent upon immediate relatives such as father/mother/kin to support these individuals.

As stipulated by the strengths-based perspective, people who provide assistance generally need to be dependable and esteemed individuals from the community (Saleebey, 2006:12). Support is premised on the basis that those whom we serve have much in common with everyone else, and deserve our respect and our obligation to participate in tending to their needs (Saleebey, 2006:12). Yet, social specialists are time and again seen to exhibit disagreeable and unsympathetic behaviour toward those with mental illness, as if they have no place in society (Saleebey, 2006:12). Another significance of participation is that "individuals should frequently bunch together to make their voices heard; get their requirements met, to review their disparities and to achieve their fantasies" (Saleebey, 2006:12).

Subtheme 4.7: Professional support

Three participants indicated that they receive support from the nurses when they go to the clinic:

> *P1: "They support me at the clinic because I get whatever I want."*
> *P2, 3, 4: "Nurses."*

Three participants indicated how often they go to the clinic:

> *P1: "I go to the clinic once a month."*
> *P3, 4: "I get treatment at the hospital on the monthly basis."*

These participants were satisfied with the support they received from mental health practitioners; they were frequently assisted by nurses when they visited clinics or hospitals, usually on a monthly basis.

In their study, Shankar and Muthuswamy (2006:306) found that all their participants had experienced varying levels of powerlessness and invalidation in their interactions with mental health professionals, who did not listen to what they had to say, rarely asked for their opinions, or took the "expert" stand and did not involve them in decisions about the ongoing treatment and care of their mentally ill relatives. Except for three elderly

caregivers who seemed to be resigned to their fate and did not expect professional attitudes to change, the others expressed frustration and sometimes anger at these attitudes.

Johnson (2000:214) concurs that a significant source of frustration among caregivers is the attitudes exhibited by professionals who engender feelings of guilt and self-blame in those who seek their help. Indifference on the part of professionals toward the caregivers' experiential knowledge of the illness, exclusion from decisions related to the treatment and care of their relatives, and poor handling by professionals of issues related to privacy and confidentiality, sometimes lead to violence and a rupturing of family relationships.

Friedman and Allan (2010:17) affirm that paying little heed to the system' size (individual, family, gathering, or community) an ecosystems perspective provides an interactional perspective of any system within the setting of its environment. The environmental context incorporates the transaction among, for example, the biological, mental, social, and spiritual impact. An ecological systems perspective focuses the attention on the association between the individual and his or her environment. Therefore, mental health professionals have an obligation to provide support to MHCUs and their caregivers.

Theme 5: Recommendations regarding support needed by caregivers of mental health care users

The participants suggested recommendations regarding the support needed by caregivers, namely institutional care, home-based care, community projects, and material support.

Summary of section A

The researcher's initial plan was to gain access to caregivers within a hospital setting, but experienced some difficulty in this regard as caregivers were not involved, or even present, when MHCUs were admitted to a mental health facility. Families summarily abandoned their relatives with mental health issues at mental health hospitals, or they refused that these patients be discharged into their care. Caregivers are overwhelmed by their caregiving responsibilities. They lack support structures that would ease their

burden, and have very little or no insight into mental health issues and treatment, particularly those that concern MHCUs. Side effects of the medication were severe and most of the MHCUs had stopped taking it. The caregivers had roles and tasks to perform in order to assist the MHCUs. Caregivers have a variety of needs such as practical support (placements), and material support (food and money). The caregivers had challenges in performing their caregiving tasks. Participants voiced their desire for the formation of support groups as well as respite care such as day-care centres and placement in residential mental health facilities. Most of the participants consulted traditional healers before taking their relatives to the hospital. Culture has an influence on how mental illness is interpreted. Most participants were stigmatised by their communities. Community and family support were lacking. Professional support was obtained from clinic nurses as well as mobile clinics; however, the support from social workers was limited.

7.3.2 Section B: Findings of mental health care user (MHCU) participants

This section discusses the findings relating to the MHCU participants. Thirteen participants diagnosed with schizophrenia were interviewed at three different hospitals: Shiluvana, Evuxakeni, and Hayani. These hospitals were located in Vhembe and Mopani Districts, Limpopo Province. The focus will therefore will be on the biographical profiles, the thematic analysis with the themes, subthemes, and categories which emanated from these interviews.

This section provides the biographical profiles of the MHCUs, followed by the thematic analysis.

7.3.2.1 Biographical profiles of MHCUs

This section gives an overview of the MHCU participants and their biographical profiles (table 7.3).

Table 7.3: Biographical profiles of participants (mental health care users) (MHCUs)

P	Age	Gender	Marital status	Language	Area	Income	Educational level	Number and age of dependents	Hospital	Years on treatment
1	56	Male	Married	Tsonga	Ndengeza	Supported by caregiver	Form 2	5 children (born 1981, 1983, 1987, 1998 and 2000)	Evuxakeni	Since 1983 – 32 years
2	42	Male	Single	Tsonga	Chavani	Supported by caregiver	Grade 12	None	Hayani	18 years
3	50	Male	Married	Tsonga	Phalaborwa	Supported by hospital	Diploma in teaching	3 adult children (24, 23 and 18)	Shiluvana	10 years
4	40	Male	Single	Tsonga	Hlaniki	Supported by caregiver	Grade 12	None	Evuxakeni	17 years
5	41	Male	Single	Tsonga	Malamulele	Supported by hospital	Grade 12	None	Hayani	12 years
6	81	Male	Widowed	Tsonga	Tzaneen	Supported by caregiver	Form 3	Children deceased	Shiluvana	10 years
7	36	Male	Single	Tsonga	Mabalana	Supported by caregiver	Grade 9	None	Evuxakeni	16 years
8	46	Male	Divorced	Tsonga	Malamulele	Supported by hospital	Grade 12	1 adult child(23 years)	Hayani	8 years
9	24	Female	Single	Sepedi	Seshego	Supported by caregiver	Illiterate	None	Evuxakeni	3 years
10	28	Male	Single	Tsonga	Nkowankowa	Supported by caregiver	Grade 10	None	Evuxakeni	Cannot remember
11	41	Male	Single	Tsonga	Tzaneen	Supported by caregiver	Grade 12	1 child(17 years)	Hayani	17 years
12	48	Male	Divorced	Tsonga	Dzingidzingi	Supported by caregiver	Diploma in teaching	2 adult children (24, 20)	Evuxakeni	24 years
13	37	Male	Single	Tsonga	Tzaneen	Social grant	Grade 10	None	Hayani	3 years

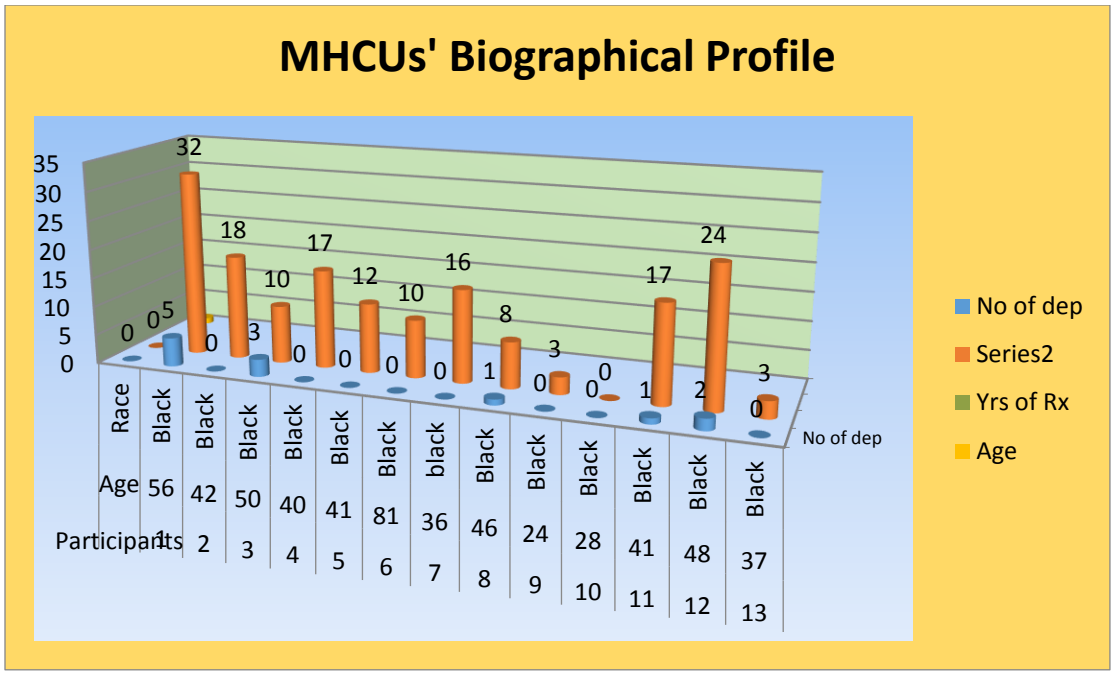


Figure 7.2: MHCU biographical profiles (n=13)

The age category of the MHCU participants in this study ranged from 24 to 81 years; there were twelve African males and one African female. The female participant was a Sepedi-speaking person, while the male participants were Tsonga speaking. They were all in-patients at the above-mentioned hospitals, and were due for discharge after a long stay in these mental health facilities.

Of the thirteen participants interviewed in the present study, two were married, one widowed, two divorced, and eight single. The participants originated from villages in Vhembe and Mopani Districts, Limpopo Province. Seven participants had no dependents, one had five, one had three, one participant's children were all deceased, one had one dependant, and two participants had one dependant each.

In Janse van Rensburg and Olorunju (2010) study, the age of participants ranged from 16 to 80 years, with a mean of 38 years. Gender differentiation of age showed a difference in the mean age of females (43.5 years) and males (34 years). It was also established that the majority of mental health care users living with schizophrenia were admitted to a local medical facility. They were in their late thirties, predominantly male, and had abused liquor and cannabis before admission. The distinction in the present study is that most of

the participants were male, with only one female participant. Their educational status ranged from being illiterate, to secondary, and tertiary school education. However, in Janse van Rensburg & Olorunju (2010) study, the educational level of the participants was not mentioned.

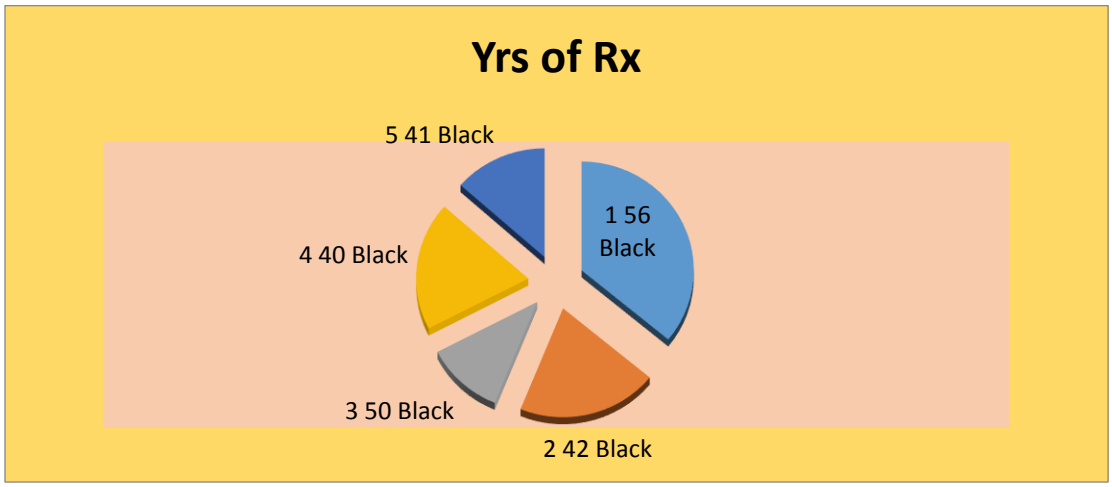


Figure 7.3: Years of treatment (n=13)

The years they had undergone treatment ranged from 3 to 32 years, and only one participant could not recall when his treatment commenced. Janse van Rensburg (2010) affirmed this finding; MHCUs were likewise found to be non-adherent or have discontinued their treatment. In the present study, all participants were adherent and continued with their treatment.

7.3.2.2 Thematic analysis

The analysis of the data is provided below, and a summary of the themes, subthemes, and categories is presented in table 7.4. The following discussion provides the details of what transpired in the interviews. Furthermore, the direct quotes of the participants are presented to support the themes, substantiated by the literature.

Table 7.4: Themes, subthemes, and categories: MHCUs

Themes	Subthemes	Categories
Theme 1: Perceptions of mental health	**Subtheme 1.1**: Description of how mental health is perceived within the participants' cultures	Category 1: Mental health care
	Subtheme 1.2: Description of how culture influences own perception of mental health	
Theme 2: Experiences regarding mental health care services	**Subtheme 2.1**: Experiences regarding services rendered by the hospital	Category 2: Mental health services
	Subtheme 2.2: Experiences regarding services by a multi-disciplinary team	
	Subtheme 2.3: Experiences regarding formal support services	
	Subtheme 2.4: Experiences regarding traditional healers	
Theme 3: Experiences related to the specific illness	**Subtheme 3.1**: Description of diagnosis **Subtheme 3.2**: How diagnosis was explained **Subtheme 3.3**: Own understanding of diagnosis	**Category 3**: Diagnosis and understanding of mental illness
Theme 4: Treatment of illness	**Subtheme 4.1**: Description of treatment received	**Category 4:** Perception of the course and treatment of illness
	Subtheme 4.2: Importance of taking treatment	
	Subtheme 4.3: Side-effects of medication	
Theme 5: Living with mental illness	**Subtheme 5.1**: Sense of self	**Category 5**: Challenges of living with mental illness
	Subtheme 5.2: Ability to continue	

Themes	Subthemes	Categories
	Subtheme 5.3: Challenges as a MHCU	
	Subtheme 5.4: Needs of the MHCU	
	Subtheme 5.5: Support systems of the MHCU	
	Subtheme 5.6: Family support	
	Subtheme 5.7: Community support	
Theme 6: Recommendations regarding support needed by mental health care users		

Category 1: Mental health care

One theme and two subthemes are included in this category. The theme depicts the perceptions of mental health, and the two subthemes describe how mental health is perceived within participants' cultures, and how culture influences his or her perception of mental health.

Theme 1: Perceptions of mental health

The participants illustrated how they perceive their mental health, and all these perceptions are based on the following subthemes:

Subtheme 1.1: Description of how mental health is perceived within participants' cultures

The participants exhibited diverse views pertaining to how they perceive mental health care. Their views are based on their cultural connotations.

> *P2: "When my mother was still alive she went with me to the traditional healers, she believed that I was bewitched."*
> *P3: "My father was the one who believed in traditional healing."*

P7: "They were not sure what was wrong with me and they decided to consult [traditional healer], but later they have realised that I had mental illness, due to the way I was behaving."
P9: "They do not believe in witchcraft."
P13: "My family said that I have been born like this, they do not believe in witchcraft, but I think I am bewitched."

Three participants reflected their opinions on mental health. They stated that their parents believed that mental illness was caused by witchcraft; some parents were confused by not knowing what was wrong with their children; hence they consulted traditional healers to gain a better understanding of the illness. Two participants reported that their families have an understanding of their illness; hence, they went directly to the hospital as they were not convinced that mental illness emanated from witchcraft. One participant indicated even if his family did not believe in witchcraft, he perceived his condition as a result of witchcraft.

Adeosun, Adegbohun, Adewumi, and Jeje (2013:1) declare that the "traditional health care system drives the standard medical practice in Africa and keeps on pulling in high support." According to Adeosu et al. (2013:1), the practice of traditional healers is predictable with traditional sociocultural conviction systems about sickness and its inception, and ideas about man's association with divinities. Mental illness is traditionally perceived as emerging from supernatural factors, such as, the result for transgressions against God, divinities, and ancestors, or as a result of burden from witchcraft and other supernatural strengths. This assertion affirms the findings of this study, that the majority of participants have the same sentiment, namely that mental illness is a result of witchcraft.

A study in Akure, Southwest Nigeria, conducted by Agara and Makanjuola (2006:33), found that around 70% of patients had visited spiritual healers and 43% traditional healers before being admitted to a mental health facility. This finding is consistent with the findings of the present study; participants showed that their relatives consulted traditional healers before they went to a medical facility. Moreover, a number of studies have been conducted in different parts of the world on the management of mental illnesses such as schizophrenia or psychotic disorders (Tanskanen, Morant & Hinton 2011:2; Chong, Mythily, Lum, Chan & McGorry, 2005:27).

There are, however, dissimilarities across countries due to the contrasts in sociocultural, religious, and wellbeing service contexts. Doctors and other medical professionals or services in Western nations are typically the primary point of contact for patients with schizophrenia, while the traditional healer is the first point of contact for services users in Asia and Africa (Chiang, Chow, Chan, Law & Chen, 2005:25; Chong, Mythily, Lum, Chan & McGorry, 2005:27; Yamazawa, Mizuno, Nemoto, Miura, Murakami & Kashima, 2004:77).

Fuchs and Steinert (2004:377) have established that patients whose first contact is the non-physician suffer untreated psychosis for longer periods of time. This is consistent with the findings of the present study; participants reported that they have experienced untreated psychosis for quite a while but they felt better after being admitted to hospital.

Greene (2009:200) asserts that the core focus of ecological systems theory is on "how individuals adapt to environmental demands, it focuses on how an individual's needs, capacities and opportunities for both growth and the individual's ability to adapt to changing external demands are met by, provided for and challenged by environment." It is assumed that "an individual human agency has a capacity to overcome external environmental obstacles, when in reality the individuals may have little ability to exercise their will especially in response to institutional oppression" (Greene, 2009:206). In this case, mental health care users are bound to seek help from traditional and spiritual healers. These convictions are based on how culture interprets the causes of mental illness.

Subtheme 1.2: Description of how culture influences own perception of mental health

Most participants have diverse views on how culture influences their understanding mental health.

P1: "I believe that this illness is caused by witchcraft."
P2: "I do not believe that but my family believes that I am bewitched."
P3: "For me I do not believe [in cultural perception of mental illness/health]."
P4: "I believe that this sickness has been caused by witchcraft."
P5: "I do not think like that."
P6: "I believe in witchcraft. That is why I am like this."

P7: "I believe that my sickness has been caused by witchcraft."
P8: "I went to the sangomas seeking help, but I realised now it was the waste of money. I only managed to be better when I got the hospital treatment"
P9: "I went to the traditional healers before I went to the hospital."
P10: "I believe that my sickness has been caused by witchcraft. I do not believe in the traditional medicine, but for the issue that there are people who are behind my sickness."
P12: "I believe that my sickness has been caused by witchcraft; I became sick in my first year of teaching. I only work for one year and after that I was boarded I got a job last in North West I was sick and I was admitted in the hospital. This year again I got a job but I was admitted in the hospital. All these make me to think that this might be witchcraft."

Eight participants are convinced that their illness stems from supernatural forces, notably witchcraft; hence, they consulted traditional healers to solicit assistance. One participant does not believe that culture has an influence on mental health; however, his family is convinced that there is a connection. Some participants opted to consult traditional healers but subsequently realised that they had wasted their money as traditional services did not yield the intended results. One participant was devastated by his condition as he had lost his teaching job. He was convinced that culture had an influence in his condition, and that witchcraft had the upper hand in his situation.

Traditional healers use divinations, counsel prophets, and make sacrifices to satisfy malignant spirits or offended gods that, in their view, cause mental illness (Kale, 1995:1183). Adeosun et al. (2013:2) hypothesise that in Southwest Nigeria, the god of divination (Ifa) is conceptualised as the god through whom healers can elicit the reason and a suitable remedy for the disease. The practice of traditional healers includes the utilisation of scarification, mixtures acquired from the plant or creature extracts, and holy elements such as ceremonies, supernatural motions, and symbolic items. In a study conducted by Mokgobi (2012), it was found that in numerous South African societies there is still a solid relationship between mental illness and traditional religions, with the culture bound syndrome having been portrayed in different ethnic groups. In a study conducted by Phakathi (2005:37), it was found that as a rule, when families were confronted with an issue, they sought cultural reasons in an attempt to comprehend and resolve the issue. One of the participants in Phakathi's study portrayed how she firmly believed that her son had been bewitched, and that she had taken him to many traditional healers in the quest for the cause and cure of her son's mental illness.

The macrosystem within ecological systems theory consists of micro-, meso-, and exosystems which are characteristic of a given culture or subculture, with a particular reference to belief systems, bodies of knowledge, material resources, customs, lifestyles, opportunity structures, hazards, and life course options that are embedded in each broader system (Bronfenbrenner, 1994:40). On the other hand, Nash et al. (2005:37) state that the macrosystem encapsulates a wider social policy and sociocultural setting, and includes ideological, customary, and legal norms. Therefore, cultural beliefs have a strong bearing on the interpretation of mental illness. The first point of contact for people in Africa and Asia living with schizophrenia is the traditional healer.

Category 2: Mental health services

One theme and four subthemes are included in this category.

Theme 2: Experiences regarding mental health care services

The participants described their experiences regarding mental health care services provided at hospitals. From this theme, several subthemes arose such as experiences regarding services rendered by the hospital, experiences regarding services rendered by a multidisciplinary team; and experiences pertaining to formal support services and those of traditional healers. Each subtheme is discussed below.

Subtheme 2.1: Experiences regarding services rendered by the hospital

Nine participants described the daily services they received at hospitals (inpatient treatment), and the daily activities offered at hospitals for mental health care users.

> *P1: "We have a sewing project. We have a gardening project."*
> *P2: "In the morning, we go for the occupational therapy services until 12h00, again at 14h00 they come to fetch us from the wards to go and play games. Other services we do is gardening and car wash."*
> *P3: "We have gardening, sports, recreational activities, cards, and athletics. I am happy with the services."*
> *P4: "The sponge project, the gardening project. I am happy with the services."*
> *P5: "I am happy with the staff treatment here at the hospital. The projects that I am involved in in the OT are car wash, gardening, feeding of pigs."*
> *P6: "Gardening and sewing. I am happy with the services."*
> *P7: "We plant tomatoes and vegetables (gardening), we attend church service, we are also singing, there is also a car wash and I like the car wash project."*

> *P8: "Here in the hospital what we are doing we get treatment, and after lunch we go to the OT. The patients are elected to be there. Others they are doing garden work, car wash, sewing pillow cases, and other feeding pigs."*
> *P10: "We do gardening, we do sewing and cooking. I am happy with the services. I am involved in the sewing project."*
> *P11: "Here at the hospital we go to the occupational therapy office where we are busy with gardening, pig feeding, car wash, sewing pillow case. I am happy with the services. What I am doing most is to take care of the pigs."*
> *P12: "We have gardening, sports, recreational activities, cards, athletics. I am happy with the services. There are those who run tuck-shop. What I love most is snooker."*

One participant indicated that they engage in occupational therapy services. These services serve as a leisure activity as well as treatment.

> *P13: "They help us by taking us to the OT for exercise, as well as leisure. They are giving us treatment and so that we can feel better."*

One participant was satisfied with the material support, such as food, that she received from the hospital.

> *P9: "I am happy about food provided in the hospital."*

The participants described recreational activities provided in the hospital as a form of treatment such as sewing, gardening, and sponge projects; recreational activities such as playing cards, snooker, athletics, and carwashing; as well as occupational therapy. All these services serve as rehabilitative therapy to mental health care users.

There are similarities in the present study to a study conducted in India by Kumar and Smith (2015:668) where the participants, who were inpatients living with schizophrenia, demonstrated various skills such as making objects out of string, planting, weaving, book-tying, and computer literacy. This study substantiated that social skills planning has been exceptionally valuable in upgrading the social skills of patients with schizophrenia. These skills were taught over a wide timeframe, without significant deterioration in their acquired skills. This study also revealed that patients living with chronic schizophrenia could indeed learn and execute essential social skills, work in any given group, and live autonomously. This demonstrates the success of exhaustive social skills planning programmes.

A study conducted by Lazzaro (2004:3) found that playing recreational games provides a sense of relief, which has a positive impact on the individual's psyche during and after participation. Entertainment of this kind stimulates the imagination and improves comprehension and use of methodologies. Players are encouraged by a demonstration of approval or constructive criticism on their advancement and achievement (Ekman, 2003:1). Social skills training provided to chronic schizophrenia patients has proved to have a productive effect on the patient's ability to work and take part in ward exercises. The social skills approach supports the chronic schizophrenia patient in learning new skills (Tsang & Pearson, 2001:89). Upgraded free-living abilities have been connected to an expansion of subjective capacities (Penades, Boget, Catalan, Bernardo, Gasto & Salamero, 2003:220).

Rangan (2006:2) states that “The strengths-based perspective endeavours to comprehend clients in terms of their strength.” This approach related to efficiency by examining the survival skills, capacities, information, assets, and desires that can be utilised to meet the MHCU’s objectives. From the ecological perspective, Greene (2009:211) states that the competence or the capacity to be compelling in one's environment is accomplished through a background marked by fruitful exchanges with the environment. Activities associated with caretaking lead to a deep-rooted pattern of powerful connections. The capacity to trust one's judgement, to accomplish self-assurance, and to deliver on one’s visualised impact on the environment is incorporated in an existence course of the conceptualisation of ability (Greene, 2009:211). Likewise, the accessibility and purposive utilisation of environmental resources and social support are vital (Greene, 2009:211). This is particularly essential in helping mental health care users to acquire vocational skills.

Subtheme 2.2: Experiences regarding services by a multi-disciplinary team

Six participants could not identify the team members that offer services to them. They merely indicated in general that they were working well with these staff members.

> *P1: “We are working well with the staff here in the hospital.”*
> *P3: “The staff which is working here in the hospital, when you go to them and ask questions they gave you correct answers.”*

P6: "The staff members are good."
P7: "I am happy with how the staff works. There are no problems."
P9: "The staff members are good."
P12: "We working well with the staff members."

Three participants indicated that social workers were helpful in linking them with their families, and were mediating for participants to be accepted by their families and communities.

P2: "Social workers assist to link us with our families. Social workers phone our families to discuss about our conditions and tell them to accept us."
P11: "The social worker talks to them [family] to forgive for what we have done and what we have done was a mistake. By doing that our families are willing to takes us back home. They also talk to the community."
P12: "I have no contact with the social worker."

Four participants disclosed that the nurses were supporting them emotionally and physically. When they had problems, they could discuss their issues with these nurses.

P1, 2, 3: "Nurses are supporting me."
P4: "Nurses take care of us."
P4: "The nurses play a major role to support me."
P8: "Nurses. When I am having a problem, I sit down and discuss it with them."

Five participants identified the team as comprising nurses, doctors, occupational therapists, and social workers who provide social and health services. One participant mentioned the nurses and occupational therapists but stated that he did not have contact with the social workers.

P2, 13: "We work with nurses, doctors, OT and social workers."
P5, 8: "We work with the nurses, doctors, OT, social workers who assist with linking them with their families."
P10: "Nurses, OT; for the social workers we do not have much contact with them."
P11: "We are working with nurses, doctors, OT, and social workers who assist with linking us with our families."

The participants expressed similar views pertaining to the multidisciplinary team. A number of participants indicated that the hospital staff cared for them, without specifying their professional status. On the other hand, some participants mentioned the professionals who provided care in the hospital such as nurses, doctors, occupational therapists, and social workers. However, one participant indicated that he did not have any contact with the social workers.

The Mental Health Commission (2006) alludes to the way that most of the literature in the mental health territory perceives a community mental health multidisciplinary team as requiring the basic skills of nursing, medicine, social work, psychology, and occupational therapy. Once central disciplines have been set up, there can be adaptability in tapping into the skills of additional members of the team, as required by local needs. For instance, family therapists or speech and language therapists might have skills required by the populace that the team is serving. Ownership of the abilities required to convey powerful care in a multidisciplinary team environment ought to be the key determinant of team participation. There should be adaptability, as far as sub-teams are concerned, that might be part of the bigger team; for instance, a home care team. The range of skills of the team must be receptive to the ethnic profile of the locality population.

Lieberman, Hitty, Drake, and Tsang (2001:1331) attest that a crucial part of mental health recovery is that MHCUs set their life objectives; in this endeavour the involvement of their relatives and different supporters is critical. Accomplishing these aims requires reconciliation by a multidisciplinary team of what has generally been alluded to as “treatment” and “rehabilitation,” or the “medical” and “psychosocial” models of intervention. To coordinate these areas of clinical activity, professionals must combine their competencies. Lieberman et al. (2001:1332-1337) have tabulated the roles played by different team members: medical personnel (diagnostic, medical, and pharmacological) and therapeutically trained professionals (psychiatrists, nurses, clinical pharmacists, or physician’s assistants). In the South African context, mental health practitioners comprise psychiatrists, medical officers, and nurses (Department of Health, 2002).

Since nurses by and large have more opportunities to collaborate with and observe MHCUs on the adherence of medication, it is vital that they screen for and identify the remedial impact of medicines and their reactions (Lieberman et al., 2001:1332). Since serious mental illness constitutes a biomedical condition that requires an exact diagnosis, a medico-legal option, pharmacological medication, and the role of the psychiatrist is of particular significance within the mental health team (Lieberman et al., 2001:1336). Social workers possess abilities that are crucial in the community, advocating for programme

advancement, interagency, coordinated efforts, and community contact and consultation. Social workers are usually more receptive to the needs of families, and are geared toward assisting MHCUs in obtaining placements and disability grants (Lieberman et al., 2001:1337). Occupational therapy has matured over time within a reasonably effective structure, including hospital-based practice, aimed at providing physical training and exercises that are beneficial to mentally ill patients who are very often sedentary. However, unlike social workers, occupational therapists do not focus on placements or disability grants (Lieberman et al., 2001:1337).

The concept of relatedness is a concept central to an ecological view of development. Relatedness is the ability to form human relationships or to connect with other people (Greene, 2009:210; Payne, 2005:151). This is particularly applicable to the role of the multidisciplinary team in mental health care. From an ecological perspective, Greene (2009:211) states that the capacity to be competent and compelling in one's environment is accomplished through a background marked by fruitful exchanges with that environment, and that common caretaking can result in a deep-rooted pattern of powerful connections. The capacity to trust one's judgement to accomplish self-assurance and deliver on one's envisaged impact on the environment is incorporated in the conceptualisation of ability (Greene, 2009:211). Likewise, the accessibility and the purposive utilisation of environmental resources and social support are vital concepts (Greene, 2009:211). This is particularly essential in helping mental health care users acquire vocational skills.

Subtheme 2.3: Experiences regarding formal support services

Six participants indicated that they derived satisfaction from the support they obtained from church organisations.

> *P1: "I get support from the church."*
> *P3, 6, 7, 9: "I am going to church."*
> *P10: "I used to go to church."*

Two participants indicated that the ANC and ANC Youth League have been a source of support. One participant indicated that an RDP house had been built for him. Another participant obtained support from the Rastafarian group.

P4: "The ANC and Rastafarian group."
*P8: "ANC youth league, they come and advise me with something, and they built me a four roomed RDP house in my hom*e."

On the other hand, three participants indicated that they did not get any support from any organisation in their community, and that there were no organisations provided to assist mental health care users.

P5, 11: "None."
P12: "There are no organisations that provides services."

The participants presented various perspectives in relation to the support they obtained from the formal sector. A number of participants mentioned a few organisations willing to provide support such as places of worship, and associations such as the ANC and the ANC Youth League. Some participants received no support from any organisation.

Grover et al. (2014:119) assert that religion and spirituality play a significant part in the lives of people, including individuals with schizophrenia. These authors argue that for some patients religion signifies hope and purpose in their lives; while for others, religion results in profound depression. Mental health care users with schizophrenia exhibit religious delusions and hallucination. Furthermore, there is evidence that religion influences the level of psychopathology. Religion and religious practice similarly influence social mix, the danger of suicide, and substance use. Religion and the deep sense of being are compelling factors in adapting to mental illness. Religion also influences adherence to treatment in patients with schizophrenia (Grover et al., 2014:119).

A study conducted in Switzerland claims that around 33% of mental health care users with schizophrenia are included in the religious community, and a further 10% are included in minority religious movements (Huguelet, Mohr, Borras, Gillieron & Brandt, 2006:368). Another Swiss study reports that 33% of patients are included in a religious community, and another third claimed that spirituality plays a critical part in their lives even though they are not part of the religious community *per se* (Mohr & Huguelet, 2004:370).

A study conducted in the south eastern part of the United States of America revealed that as high as 91% of mental health care users reported enjoying private religious or spiritual

activities, and 68% reported their involvement in open religious services or exercises (Nolan, McEvoy, Koening, Hooten, Whetten & Pieper, 2012:1051). A few studies conducted in Switzerland, Canada, and the United States focused on the religious practices of mental health care users with schizophrenia within an all-inclusive community, and found that religious association is higher among patients with schizophrenia (Mohr, Borras, Nolan, Gillieron, Brandt & Eytan, 2012:30).

Conversely, Cohen, Jimenez, and Mittal (2010:917) contend that religious participation is less common in mental health care users with schizophrenia. A study in India demonstrates that numerous mental health care users seek assistance from faith healers to alleviate their symptoms (Kulhara, Avasthi & Sharma, 2000:62); indigenous healing techniques are viewed as integral to the management of mental illness. A survey, conducted by Saravanan, Jacob, Deepak, Prince, David, and Bhugra (2008:231) with mental health care users who visit a clinic in Tamil Nadu, South India, demonstrates that 58% of mental health care users who present with psychosis consulted a religious healer prior to seeking assistance from a mental health facility.

Within the context of ecological system theory, the macrosystem constitutes the peripheral level of an individual's environment, comprising cultural values, traditions, and laws (Pusey-Murray & Miller, 2013:116). The characteristics of the macrosystem have a dominant effect on the interactions of all the various levels. Bronfenbrenner (1974:3) states that these issues can adversely affect the interactions within the microsystem and its capacity to benefit the individual. In the South African context, the way mental illness is perceived is attributed to cultural connotations. Culture plays a major role in the understanding of mental health care users and their families. The researcher is of the opinion that the way mental illness is perceived can have a negative effect on the recovery of the person living with schizophrenia. Religion and spirituality have an influence on how mental health care users with schizophrenia perceive mental illness.

Subtheme 2.4: Experiences regarding traditional healers

Five participants indicated that they have not at any time consulted traditional healers. One participant stated that he did not believe in traditional medicine.

P1: "No, I never went to the traditional healers."
P5: "I have never consulted the traditional healer."
P10: "I do not believe in traditional medicine."
P11, 13: "I have never consulted a traditional healer."

Five participants claimed that they had consulted traditional healers. Other participants consulted spiritual healers.

P6: "I have consulted a traditional healer."
P3: "I consulted a traditional healer. My father took me there. We went to Venda my father believed much in traditional healing."
P8: "I have consulted the traditional healers as well as the spiritual healers."
P9: "Yes, I consulted a spiritual healer."
P12: "I first went to the hospital, but after that I consulted the traditional healers after I was discharged."

Three participants indicated that their families (parents) consulted traditional healers.

P2: "My mother consulted the traditional healers."
P4: "My parents have taken me to the traditional healers."
P7: "My family consulted the traditional healers when they saw that I was sick."

The majority of participants had consulted traditional healers; they were convinced that mental illness is caused by witchcraft. However, they went to a health facility when they realised that they were not recovering. A few participants stated that they had never consulted traditional healers even though they were aware that they were suffering from a mental illness (schizophrenia). Mokgobi (2012:1) asserts that mental health care in South Africa appears to be grounded in either a modern approach or traditional methodology.

Dagher and Ross (2004:462) demonstrate that the modern approach emanates from the Western medical model, and the traditional model from indigenous belief frameworks. In a study conducted in South Africa by Ramgoon, Dalasile and Patel (2011:91), it was assessed that between 70% and 80% of African people in rural and urban South Africa consult traditional healers prior to consulting a doctor, private specialist, or hospital. Mokgobi (2012:1) concludes that traditional medication is usually the first port of call and formal health care a last resort for people with a low socioeconomic status, throughout the developing world. Nelms and Gorski (2006:186) concur that it is difficult to separate

the ministrations of the traditional healer and the concept of traditional African religion and spirituality.

In a study conducted by Phakathi (2005:37), it was established that much of the time when families are confronted with an issue, they seek social reasons in an attempt to comprehend and resolve the issue. One of the participants in Phakathi's study explained how she "firmly trusted that her child was bewitched, and that she took him to a lot of traditional healers in quest for the cause and cure of her child's mental illness."

A study conducted in South Africa by Brooke-Sumner et al. (2014:5) revealed that the majority of their participants (clients and caregivers) had consulted or would consult a traditional healer both voluntarily or at the behest of their families. Several participants were confident that the traditional healer had indeed assisted them in understanding and alleviating their symptoms. Other participants were of the opinion that traditional healing alone was not effective, and that a combination of Western and traditional methodologies could help in their recovery.

The macrosystem is the peripheral level of an individual's environment, comprising cultural values, traditions and laws (Pusey-Murray & Miller, 2013:116). The characteristics of the macrosystem can have a dominant effect on the interactions of all the various levels. Bronfenbrenner (1994:3) states that these issues can adversely affect the interactions within the microsystem and on the capacity of the microsystem itself to benefit an individual. Consequently, in the South African context, the way schizophrenia is perceived is attributed to cultural connotations. Culture assumes a noteworthy part in the comprehension of mental illness, specifically schizophrenia, by mental health care users and their families. The researcher is of the opinion that the way mental illness is perceived can negatively affect recovery.

Category 3: Diagnosis and understanding of mental illness

The theme in this category relates to the experiences associated the schizophrenia. Three subthemes are part of this category, namely description of diagnosis, how the diagnosis is explained, and the individuals' understanding of the diagnosis of his or her illness.

Theme 3: Experiences related to the specific illness

The participants shared their experiences related to their illness. Detailed information for each subtheme is presented below.

Subtheme 3.1: Description of diagnosis

Most participants exhibited a degree of insight into their diagnosis; they realised that they were living with mental illness; some were also aware that they had been diagnosed with schizophrenia, except one participant who indicated that he had been involved in "a car accident and he had many things on his mind". One participant indicated that he was not aware that he was ill until he burned down his home and was arrested. The magistrate ordered that he be evaluated by a psychiatrist – it was at this point that he was diagnosed with schizophrenia.

> *P1, 6, 7, 9, 10, 12: "Mental illness."*
> *P4: "I have been diagnosed with mental illness."*
> *P2, 5, 8, 13: "Mental illness schizophrenia."*
> *P11: "I had a problem with my mother I was not taken to the hospital straight, my mother was no longer trusting me as I have burnt down the house, I was taken to the court and the magistrate said I should be taken to the hospital. It was then that I went to the hospital. I was diagnosed with mental illness called schizophrenia. I have accepted that I have mental illness."*
> *P3: "I was involved in a car accident in 2005; so there are lots of things in my* mind.*"*

The participants in this study were clearly knowledgeable in terms of their illness, and have accepted their diagnosis of schizophrenia. This is in contrast to the study conducted by Brooke-Sumner et al. (2014:4). Their findings revealed that knowledge/understanding of the diagnosis was low among MHCUs; none could give an account of their diagnosis as reflected in their hospital records. Three clients were confident that their illness could be cured, but indicated distrust in the diagnosis. Two participants were adamant in their contention that mental health services provided medication, but the details of the disease were not disclosed to them.

The World Federation of Mental Health (2014) characterises schizophrenia as "a serious mental illness [which] influences how a man considers, feels, and acts. Numerous individuals think that it is hard to differentiate in the middle of genuine and envisioned

encounters, to think intelligently, to express sentiments, or to act properly." There is consensus that internalising or labelling the issue of mental health diagnosis can affect the self-concept of the individual (Haghighat, 2008:550). Research confirms that the way mental health diagnosis is conveyed can influence MHCUs' understanding of their diagnosis, which has been observed to be either conducive to personal satisfaction, or inducing concern and fear of the symptoms (Stainsby, Sapochnik, Bledin & Mason, 2010:41).

Utilising a principle of ecological system theory, Payne (2005:151) states that efficacy translates into trust in the capacity to adapt. Greene (2009:211) asserts that when MHCUs begin to interact effectively with the environment, they develop a sense of power over their own destiny. Once they understand and accept their diagnosis, they may begin to adapt to their circumstances. Another principle that is material to this finding is the concept of adaptiveness, which is seen as "a procedure including a dynamic trade between a man and environment unit" (Greene, 2009:213). It is stated that the person and the environment influence and react to one another to accomplish the ideal match or goodness-of-fit. This occurs when a pervasiveness of person-environment interactions are fruitful or versatile (Greene, 2009:213). Regarding adaptiveness, an ecological social work approach in practice focuses on the degree to which the environment is either helpful or stressful (Greene, 2009:213).

Subtheme 3.2: How the diagnosis was explained

A diagnosis is typically made by mental health professionals such as a psychiatrist, a psychologist, a clinical social worker, or a psychiatric nurse.

The participants indicated that some mental health practitioners such as nurses and doctors do in fact explain the diagnosis to them. One participant indicated that the hospital staff and student doctors also explained his condition.

> *P1: "The doctor and a nurse explain to me."*
> *P2, 6, 9, 12, 13: "The doctor told me that I had mental illness."*
> *P4, 7: "Dr C, and I have accepted."*
> *P5: "Dr W."*

P8: "The hospital staff members told me that I have schizophrenia. Even the students who came here have been given our files so they tell us that you have schizophrenia."
P11: "I was diagnosed by the doctor here at Hayani and he told me that I have mental illness and I accepted what he was telling me."
P10: "The people who told me was a social worker and a doctor."
P3: "The sister explain my condition."

Participants confirmed that mental professionals – nurses and psychiatrists – were responsible for informing them of their diagnosis.

The Commonwealth of Australia (2008:1) stipulates that individuals in rural areas who seek treatment and support could consult a general practitioner (GP). However, accessing these services can be troublesome in areas where GPs may not have the capacity to intervene in the treatment of psychological stress or mental illness (Caldwell, Jorm, Knox, Braddock, Dear & Britt, 2004:774).

A study in Australia, conducted by Caldwell et al. (2004), revealed the lack of experience in mental health issues among GPs in rural areas, who then refer MHCUs to their counterparts who practise in urban areas, which impacts negatively on early diagnosis, mediation, patient-clinician connections, and adherence to and the efficacy of treatment. Hicks (2005:7) points out that the psychologist carries out an appraisal for signs and symptoms of mental illness in order to make a diagnosis. Moreover, Bauman (2015:33) asserts that it is the psychiatrist who has to translate thoughts, sentiments, and practices into appropriate and sustainable treatment. Psychiatrists, through their own interpretations, then arrive at a particular diagnosis. In a psychiatric setting, the accent is on providing MHCUs with a reasonable clarification of the symptoms, and giving functional counsel.

In a study conducted in Ireland, Newman (2015) found that the majority of participants (57%) were satisfied that their psychiatrists paid sufficient attention to them, while 48% felt that nurses were more inclined to listen to them; as indicated by the Care Quality Commission (CQC) inpatient quantitative study (CQC, 2009). Lane (2015) states that since schizophrenia is considered a serious psychiatric illness, much research is being done to discover approaches to identify or screen for mental turmoil before it develops

into mental illness. In any event, diagnosis depends on the vicinity (or history) of clinical indications.

A principle of ecological systems theory is that a role perspective does not exclusively represent a set pattern of expected practices, but rather a pattern of proportional cases and commitments (Greene, 2009:211). A role perspective affords an understanding of the social measurements of development. Role performance encompasses not only assumptions as to how an individual in a given social position is to act toward others, but how others are to act toward the individual (Greene, 2009:211). It is clear that role performance or social interest is unequivocally associated with feelings of self-regard (Greene, 2009:211).

Subtheme 3.4: Own understanding of diagnosis and illness

The participants explained how they understood the diagnosis and illness. They reacted in different ways, however, when informed of their diagnosis. Some participants initially denied that they suffered from mental illness; others understood and/or accepted their condition.

> *P1: "Initially I denied that I had mental illness, but now I have an understanding of this condition and I have accepted."*
> *P4: "I have accepted this condition."*
> *P5: "I have accepted that I have a mental illness and it just happened."*
> *P7, 10, 12: "I have accepted now."*
> *P3: "I deny mental illness. I know that I was involved in a motor vehicle accident and I had a head injury."*
> *P8: "Myself, I understand that because I was abusing drugs, my brain have been damaged with drugs. Even the nerves have been burnt, my concentration is not quick."*
> *P12: "I am addicted to substance that is the thing that cause me to relapse now again."*

Participants articulated their understanding of the diagnosis of schizophrenia. They confirmed that they were aware of their illness, and a few admitted that they were addicted to drugs; these MHCUs were more likely to accept their diagnosis (Delmas, Proudfoot, Parker & Manicavasgan, 2011:137; Derksen, Vernooi-Dassey, Oldo, Rikker, & Scheltens, 2005:525). When a diagnosis of schizophrenia is unexpected, MHCUs often react with disbelief and astonishment (Derksen et al., 2005:525).

Boyle (2002:291) claims that a biological diagnosis of schizophrenia offers a modicum of solace to professionals, MHCUs and their families, and to people in general. By assigning a name to a condition which manifests in perplexing and peculiar behaviour professionals can lead to appropriate treatment to address aberrant behaviour. Nonetheless, a diagnosis of schizophrenia can be terrifying. Clinicians contend that when an individual acknowledges the diagnosis of schizophrenia, this is the beginning of the road to recovery.

Yanos, Roe, Marcus, and Lysaker (2008:1437) deliberated on how acknowledgment of a diagnosis can help MHVUs adjust to a situation in order to enhance recovery. MHCUs may feel that they have lost their identity (self as student, self as worker, self as parent) and adopt a stigmatising view (self as dangerous, self as incompetent, and so on). This sense of non-accomplishment and feeling of a useless and obsessive self is alluded to as internalised stigma; it mirrors the negative view of society, and further adds to the handicap of mental illness that MHCUs have to bear. Self-stigmatisation can ruin the MHCU's journey of recovery. They seem to lose the will or ability to overcome this sense of uselessness. Internalised stigma can inhibit the building of character in the recovery process (Yanos et al., 2008:1437).

The efficacy of ecological systems theory is significant in this finding. Payne (2005:151) states that efficacy denotes the trust in the capacity to adapt. Greene (2009:211) contends that when a client starts to interact with his or her environment effectively, he or she encounters sentiment efficacy or the ability to be powerful. The Council on Social Work Education (CSWE) (2011) demonstrates that recovery encompasses the procedure through which individuals can live, work, learn, and take part in their communities. For some people, recovery means the capacity to carry on with a satisfying and beneficial life, notwithstanding a disability. For others, recovery suggests a reduction in symptoms. Science has demonstrated that an emotion such as hope assumes an indispensable part in an individual's recovery. This seems to be the case with the mental health care users in the present study; they have accepted their diagnosis, and are able to adapt to their circumstances.

Category 4: Perception of the course and treatment of illness

The theme that emanated from this category is the treatment of the illness, with three subthemes.

Theme 4: Treatment of illness

The participants described the treatment that they received from the hospital. The subthemes that emanated from this theme are a description of treatment received, importance of taking treatment, and side effects of treatment. Each subtheme is elaborated upon as follows:

Subtheme 4.1: Description of treatment received

Most participants were knowledgeable as regards their treatment, and could name the various medications. Only two participants were not specific about their treatment; they merely stated that they received tablets and injections.

> *P1: "I receive tablets at Evuxakeni hospital."*
> *P12: "I receive tablets and injection."*
> *P2: "I know the treatment, I get Leponex 75 ml, and also Diazepam 50 ml and also the injection."*
> *P3: "I receive Epilim."*
> *P4: "I receive tablets and injection at Evuxakeni hospital."*
> *P5: "Injection, Epilim 50, Diazepam 500."*
> *P6: "My treatment is Epilim."*
> *P7: "I receive Leponex, Diazepam and injection."*
> *P8: "100 Diazepam, Epilim 600, Leponex 25 and Metrumin 650 for I have sugar diabetes."*
> *P9: "Epilim, Diazepam."*
> *P10: "I receive Leponex, Diazem and an injection."*
> *P11: "I am using Leponex, Epilium 500, Diazapem 100 and at night I take Risperidone 3 and the injection."*

The participants were knowledgeable about their treatment regimen. They also knew the names of the drugs they were taking. A study conducted in South Africa by Brooke-Sumner et al. (2014:3) revealed that general knowledge about drugs and their side effects was low, and none of the clients mentioned their medications by name. The term antipsychotic alludes to different medicines, including first-generation antipsychotic prescription drugs and second-generation agents such as Clozapine, Risperidone, Olanzapine, Quetiapine, Ziprasidone, and Aripiprazole. With regard to their healing

properties, both first- and second-generation antipsychotic agents can bring about an extensive range of side effects (APA, 2010:67).

First-generation antipsychotic medicines are successful in decreasing most symptoms of schizophrenia. In an audit of five extensive studies contrasting antipsychotic with placebo treatments, Klein and Davis (1969), referred to in APA (2010:68), found that patients who received an antipsychotic showed diminishing negative indicators, for example, mind flights, uncooperativeness, threatening sensations, and distrustful ideation. Patients likewise indicated a change in thought patterns, blunted emotions, withdrawal-hindrance, and mentally unbalanced conduct. These discoveries, after many years of clinical involvement with these operators, show that original antipsychotic treatment can lessen positive manifestations (mental trips, fancies, peculiar practices) and diminish negative side effects (detachment, full of feeling, blunting, alogia, and avolition) connected with schizophrenic psychosis.

Second-generation/atypical antipsychotics refer to a heterogeneous group of medications with differing receptor co-operations. They are characterised in line with prior groups regarding methods of activity in blocking both dopamine and serotonin 5HT2 receptors. They are successful as typical agents in lessening the positive elements of psychosis. In other cases, it was evident that second-generation agents are more effective in treating negative components, cognitive deficit, and mood disorders in schizophrenia patients (Baumann, 2015:774).

Antidepressants for schizophrenia patients is subdivided into agents prescribed for the treatment of melancholy and as replacement drug therapy for those who experience side effects from other drugs (negative indicators). Effective clinical practice dictates that clinicians at all times remain alert to the manifestation of mood changes, for example, gloom, in a wide range of psychiatric and medicinal events, and analyse and treat these timeously (APA, 2010:99). The ecological systems theory principle of efficacy is appropriate in this finding; it is stated that long-term efficacy is usually measured by a reduction in either relapse or rehospitalisation of treated patients, and levels of persistent or residual symptoms and general outcome over the course of several years.

Subtheme 4.2: Importance of taking medication

Participants acknowledged the importance of taking their medication. One participant indicated that he becomes stressed and emotional when he does not take his medication. Another participant indicated that since 2001, he has been taking his medication and has never relapsed, which is testament to the importance of taking medication. Some participants indicated that medication controls their illness, and if they do not take it, they relapse. One participant added that he was admitted to hospital again because he stopped taking his medication. Another participant revealed that he has defaulted in his treatment in the past but has learned that it is vital that he should take his medication as prescribed:

> *P1: "Yes, if I do not take treatment I become stressed and emotional."*
> *P2: "Yes I can see the importance. It is helping me. Since I have been using treatment I have never relapse since 2001."*
> *P6, 9, 10: "It controls my sickness."*
> *P7: "I if I do not drink the treatment I have seen a change in me the sickness becomes worse and I will not be happy."*
> *P8: "Yes, I once defaulted, I know now why it is important to take treatment. If I take treatment I can live with every situation. I have been going home, but I have misuse that because I will not drink my treatment and I used to smoke dagga so now I am no longer going home."*
> *P10: "I will relapse if I do not take it."*
> *P11: "The reason why I am back to the hospital is that I have stopped using treatment. When I do not take the treatment I relapse."*
> *P13: "Yes, if I do not take the treatment I am going to relapse."*

One participant revealed that he did not know what would happen if he did not take his medication. Another said that he has never stopped taking his medication and he did not know what would happen; however, he was of the opinion that he would relapse.

> *P3: "I do not know."*
> *P5: "I have never stopped taking treatment. I do not know what will happen, but I think I will relapse."*

All the participants confirmed that they always obtain medication from the hospital.

> *P1,2,3,4,5,6,7,8,9,10,11,12,13: "I get the medication in the hospital; there is no shortage of stock."*

Some of the participants reported that they are aware of the importance of taking their medicine regularly. They confirmed that in the event that they would not take the

treatment, they would relapse. One participant revealed that since he has been taking his medication, he has never defaulted. Others claimed that they did not know what would happen if they did not adhere to their treatment regimen. Most of the participants never encountered a lack drugs in the hospital.

In a study by Brooke-Sumner et al. (2014:3), the majority (eight) participants reported good drug adherence and realised its advantages. Nonetheless, five noted difficulties in adherence, including an inability to get to the facility to collect their medication, forgetting an appointment, or neglecting to take medicine because of its side effects. Five clients said that a relative helped them to be adherent.

Noguchi (2008:191) states that the mental health care users' adherence to an antipsychotic medicine regimen is a basic tenet in the treatment of schizophrenia, especially as nonadherence is a primary driver of relapse. Approximately half of mental health care users do not adhere to their drug regimen (Lacro, Dunn & Dolden, 2002:894). Nonadherence is often identified with absence of understanding, adverse effects of antipsychotic medication, and a restricted doctor-patient relationship. A study conducted by Noguchi (2008:194) in Japan revealed principles that are comparable with the current study. The participants in Noguchi's study had likewise expressed positive views on antipsychotic drugs. They reported on the balancing-out impact of the medicine. Numerous patients realised the impact that their medicine had by contrasting their present condition with past psychotic episodes.

The ecological systems theory indicates that the individual and the environment influence and react to one another to accomplish the ideal or goodness-of-fit match. This happens when an individual's environmental exchanges are indeed effective, albeit perceived as uncertain (Greene, 2009:213). From an ecological perspective this self-assessment is not characterised as a neurotic state, but instead reconceptualised as confusion and a sense of insecurity in adapting to ecological resources and support (Greene, 2009:213). Consequently, mental health care users showed that they perceive their medicine as useful and it helped them to work in their day-by-day lives. It is clear that their mental illness symptoms were controlled by the treatment.

Subtheme 4.3: Side effects of medication

The participants expressed diverse views regarding the side effects of medication. Some participants indicated adverse reactions to the medication such as tremors after an injection or feeling weak; some suffered from insomnia, and others reported a loss of concentration. Two participants seemed confident that they did not experience any side effects from the medication.

> *P1, 6, 11, 13: "I am shaking because of the injection."*
> *P2: "The injection makes me weak."*
> *P8: "It happens that when I do not take Leponex at night, I do not sleep and when I do not take Epilim I lose concentration."*
> *P9: "Memory loss."*
> *P10: "I become sleepy and shaking."*
> *No side-effects:*
> *P5, 7: "Nothing."*
> *P12: "There are no challenges I experienced from the medication."*

The participants reflected on the side effects they experienced. They reported reactions such as tremors and a sensation of weakness.

The National Alliance on Mental Illness (NAMI) (2016) state that side effects that occur regularly include exhaustion, drowsiness, and increased appetite. Weight gain, which could be connected to higher glucose levels, raised blood lipid levels and occasionally, increased levels of a hormone called prolactin, might also occur. Antipsychotic medication such as Haloperidol (Haldol), Thioridazine (Mellaril), Perphenazine (Trilafon), and Molindone (Moban) seldom bring about muscle stiffness, impaired motor coordination, weakness, and awkward muscle jerks (tardive dyskinesia) that could be irreversible (Leucht, Corves & Arbter, 2009:31).

Unusual muscle movements, similar to tremors (for instance, akathisia) or solidness (dystonia) can be minimised by taking medication such as Benztropine (Cogentin) or Amantadine (Symmetrel) (Leucht et al., 2009:31). Meltzer (2012:134) states that Clozapine (Clozaril), while thought to be particularly effective in treating schizophrenia, has serious, even deadly, side effects. These side effects include hazardously low white blood cells, irritation of the heart muscle (myocarditis), metabolic side effects similar to elevated blood pressure and cholesterol levels, weight gain, and raised prolactin levels.

Reserpine, a medicine that also diminishes circulatory strain, has been found to reduce symptoms of psychosis. Prochlorperazine (Compazine) has solid antipsychotic effects and is also prescribed to treat nausea, vomiting, and vertigo. Mild side effects such as a dry mouth, blurred vision, constipation, drowsiness, dizziness usually disappear a few weeks after the person commences treatment (Grohol, 2016). More serious side effects are problems with muscle control, muscle spasms or cramps in the head and neck, fidgeting or pacing, tremors, and shuffling of the feet (much like those affecting people with Parkinson's disease). Side effects due to prolonged use of traditional antipsychotic medications are facial spasms, shoving and rolling of the tongue, lip licking, wheezing, and frowning (Grohol, 2016).

A study conducted in Japan by Noguchi (2008:194) reported that patients communicated stress related to the different antagonistic effects of the antipsychotics they were taking. There were medicine-induced unfavourable side effects, including extra-pyramidal side effects, tiredness, and increased thirst. Angermeyer, Loffler, Muller, Schulze, and Priebe, (2001:501) reported similar side effects among patients in Germany who took Clozapine.

The strengths-based perspective refers to healing and wholeness. Healing suggests both wholeness and an innate ability of the body and psyche to recover, and to resist when challenged with disorder, disease, and disruption (Saleebey, 2006:261). Healing requires a useful relationship between the individual and a more social and physical environment (Saleebey, 2006:261). Every single human being has a predisposition to healing. Healing and self-recovery are inborn life and emotionally supportive networks, continually working, and are, for most people, more often than not, accessible as needed (Saleebey, 2006:263).

Mental health care users do not have any choices. They are compelled to take their medications even if they experience side effects. According to Saleebey (2006:263), "if spontaneous healing occurs miraculously in one human being, you can expect it occurs in another and another." Healing occurs when the healer (for example, the doctor) makes an alliance with the patient, and activates the power of the organism to restore itself; healing and self-regeneration are intrinsic life support systems (Saleebey, 2006:263).

Category 5: Challenges of living with mental illness

In this category, one theme and six subthemes came to the fore.

Theme 5: Living with a mental illness

The participants shared their challenges of living with mental illness. The six subthemes comprised the following: a sense of self and self-image, ability to continue working, challenges as a mental health care user, stigmatisation, needs of the mental health care users, and support.

Subtheme 5.1: Sense of self and self-image

The participants presented different views on their sense of self and self-image. Some participants indicated that they were content and had accepted their illness; others deemed their treatment and therefore their coping mechanisms effective; they were able to watch television and read newspapers. Other participants, however, had different views; they were not able to enjoy their lives since being diagnosed with schizophrenia. One participant indicated that he felt worthless and he could not make choices in life. Another reported that he experienced sadness because of his condition, and sometimes felt suicidal.

> *P1: "I am feeling good."*
> *P3: "I feel okay."*
> *P6, 9: "I am happy."*
> *P7: "I am happy about myself. The treatment that I am drinking it makes me better."*
> *P8: "I am okay. When I experience some problems I just get inside the ward and listen to the radio or watch TV or ask someone who have newspaper and I read."*
> *P11: "I have accepted my situation and I am alright."*
> *P2: "I think I will relapse."*
> *P2: "I am not enjoying my life as before I became sick. I am unable to do things that I want because I am sick."*
> *P4: "I feel worthless, as I cannot make any choice in life."*
> *P5: "Before, it was difficult for me, but now I am feeling much better."*
> *P10: "I am hurt and I wanted to commit suicide, as I feel useless, I think too much, I think that I am useless."*
> *P12: "I am anxious about my future. I do not know where I am going to end up."*
> *P13: "It is so difficult for me; I rest only when I am asleep, when I am asleep I forget everything. When I woke I am feeling sad because my family does not come and visit me here at the hospital."*

Participants expressed different views about the self and self-image. Some were comfortable with their lives and could manage their illness, while others felt worthless and concerned about the future. Some had suicidal ideations.

Self-regard is characterised as an individual's evaluation of his or her self-worth, influenced by thoughts of concern about the future and measuring up to one's own set of goals (Rizwan and Ahmad, 2015:1), as well as the capacity to control the sense of self when interacting with others. These factors can have serious repercussions and negatively affect our sentiments about ourselves (Bordens & Horowitz, 2008:40). Individuals with a high self-regard have self-respect and are, for the most part, satisfied with who they are (Bordens & Horowitz, 2008:40). They present with a positive, embedded, and secure self-esteem and are content in their lives (Kernis, 2000:298). Berk, Macneil, Castle, and Berk (2008:167) are of the opinion that the reality of suffering from a serious mental illness may result in low self-regard and despair.

Sanyal (2008:136) asserts that mental health care users with schizophrenia could believe that they are less astute than others, and this can have a destructive effect on their self-regard, and intensify their isolation. They see themselves as individuals who are deficient in all parts of life compared to others. They are socially incompetent, and lack self-confidence and the capacity to control their lives. Therefore, their mental health issues determine the way they deal with stress and weaken critical thinking and the choice to make decisions. Numerous researchers have reported that the stigma attached to serious mental illness has a devastating effect on the self-regard of mentally ill individuals (Berge & Ranney, 2005:139; Blankertz, 2001:457; Stuart & Sartorius, 2005:79).

The ecological systems theory could be a helpful methodology in restoring the sense of self in people who are mentally ill. However, this could require a measure of community awareness, understanding, and acceptance (Lakhan & Ekúndayò, 2013:103).

The chronosystem of ecological systems theory focuses on the combined interactive encounters which occur throughout a person's life. These encounters incorporate environmental occurrences and other key transitions in life. For example, policies, rules and regulations, and political gatherings in real life have an influence on the individual

and his or her microsystem, and traverses time and all the other systems (Lakhan & Ekúndayò, 2013:105).

Subtheme 5.2: Ability to continue working

The participants were enthusiastic about being part of the country's labour force; they could work as cleaners, gardeners, or car washers. One participant used to be a taxi driver before he became ill, and wished to return to his occupation. One wanted to work as a shop assistant, and another was prepared to do any kind of job so that he could provide for his son. One participant wanted to be trained in plumbing and he was prepared to study his trade at a Technikon. Another wanted to sew garments and sell them in order to make a profit. One participant wanted to apply for a disability grant, and he would sell ice cream as a part-time occupation. Another wanted to apply for a bursary so that he could further his studies. One wanted to return to his teaching profession.

> *P1: "Yes. I can work as a cleaner or a gardener."*
> *P2: "I can work, I can do hand work, I can do anything like gardening."*
> *P4: "Yes, I can work in a car wash."*
> *P5: "When I am discharged from the hospital I will apply for the disability grant and then I will stock ice cream and sell."*
> *P5: "I want to work as a taxi driver. I used to drive taxis before I got sick. "*
> *P7: "I can work as a shop assistant checking the stock as well as cleaning."*
> *P8: "I want to get a job and earn something; I want to buy food so that I can take treatment and then take responsibility of my son."*
> *P8: "If I can get training in plumbing, I can go to the technikon for this."*
> *P10: "When I am discharged, I want to start a sewing project. I can work as a shop assistant, cleaner, or I can sew."*
> *P11: "I can study and I was told that NFSAS give bursaries as long as you are admitted at the tertiary institution."*
> *P12: "I can continue working as a teacher. When I smoke dagga and drink alcohol I relapse. At home I have a short temper and then they take me to the hospital. I have requested my parents to allow me to go back home and I will stop using drugs."*

One participant indicated that he was no longer able to work.

> *P6: "I cannot work anymore."*

The participants were willing to be integrated into the labour market as, for example, manual labourers, cleaners, shop assistants or plumbers. One participant used to be a teacher and wanted to return to his profession as an educator. One participant was of the

opinion that he could no longer work, and another wanted to apply for a bursary so that he could further his studies. In a study by Brooke-Sumner et al. (2014:4), the majority of participants highlighted the significance of profitable activities in their lives such as running errands for the family, and gardening. Seven participants highlighted the significance of work in their view of a positive future. Two participants mentioned the absence of skills the training and the difficulties in find work. Three participants said their mental illness and the impact of symptoms prevented them from performing business-related undertakings (Brooke-Sumner et al., 2014).

Supported employment is a way of enhancing vocational training among mental health care users, including those with schizophrenia (Bond, Drake, Becker & Mueser, 1999:18). The impact and conceptualisation of supported employment for MHCUs with schizophrenia and other serious forms of mental illness were identified by Becker and Drake in their research into the improvement of the individual placement and support (IPS) model/programme (Becker & Drake, 2003:35).

Four studies have examined the adequacy of changing over to day-treatment services to support those in employment (Becker, Bond, McCarthy, Thompson, Xie, McHugo & Drake, 2001:351; Drake, Becker, Biesanz, Torrey, McHugo & Wyzik, 1994:519; Drake, Becker, Biesanz, Gold & Marrone, 1998). It is suggested that any mental health care user with schizophrenia who communicates a willingness for work ought to be offered supported employment (APA, 2010:106).

Payne (2005:151) states that efficacy constitutes confidence in the ability to cope. Greene (2009:211) indicates that when MHCUs begin to actively transact with their environment, they experience a feeling of efficacy or the power to be effective. Mental health care users need to be empowered to enable them to live independent lives. By applying ecological systems theory, the mezzo system is applicable; for instance, hospitals can focus on their projects for training and fostering an awareness of mental illness. Educational and informational training can sharpen an individual's skills, and engender some level of psychological and social ability which can lead to a stable environment, enabling them to obtain care when required, and act as a preventative measure against relapse. Individuals

with mental illness can be included in various projects, and families can be assisted in obtaining medical and financial help (Lakhan & Ekúndayò, 2013:105).

Subtheme 5.3: Challenges as a MHCU

Three participants reported that they did not experience any challenges as mental health care users.

> *P3: "No challenges."*
> *P6, 9: "No problems."*

Most of the participants reported that they have been rejected by their families and friends. Since their admission to hospital, they have never been home. Some participants were of the opinion that their families did not trust them at all, and they quarrelled constantly.

> *P2: "My family comes to visit, but they do not want to take me home. I have been here since 2001. It has been 14 years that I have been in the hospital. My family says they have not forgiven me for what I have done, they do not trust me. They are thinking I will do what I have done before. I was sick and then I fought with my mother, I beat her up and she died because of that, that is why they do not want me at home."*
> *P2: "Since admission I have never been home. My family does not trust me."*
> *P4: "I have been rejected by my family."*
> *P5: "I have last been home in 2007. I was arrested for murder. I stabbed my father to death in 1998. My family comes to visit but they do not want me to go home."*
> *P5: "When I am home, my family quarrels with me."*
> *P6, 9: "My friends have rejected me."*
> *P10: "My brother is in Cape Town, my parents have passed away. I am also staying with my uncle and we are not in good terms as I smoke dagga."*
> *P13: "I have a problem that I am admitted in the hospital and that my family does not want to take me home."*

Three participants reported that they felt ignored and lonely as a result of rejection. They felt that people did not take them seriously.

> *P4: "Sometimes I ask people something. They will not answer me. I feel rejected."*
> *P7: "I feel rejected and lonely."*
> *P7: "People do not take me serious, I just keep quiet and avoid the situation."*
> *P10: "People undermine me; they do not listen to me. As a result I become aggressive."*

Two participants reported memory loss and that it took them some time to recall incidences that had occurred.

P10: "I have a problem of the memory."
P11: "Sometimes I have a problem of loss of memory. It takes time for me to remember what has happened."

The participants reflected on the challenges they experience as mental health care users. Some participants indicated they did not experience any challenges, while others experienced rejection from families and friends. Some felt ignored and lonely and that people did not take them seriously.

Raj (2013:115) asserts that occasionally, the relationships of mental health care users with schizophrenia with their spouses, families, companions, and relatives become strained. The author further contends that individuals find managing relationships difficult once the details concerning the illness become known. Raj further claims that at times mental health care users with schizophrenia show symptoms of paranoia; that family and friends are against them. Starting a conversation with others is often complicated as they have difficulty in gathering their thoughts. Canavan (2000:31) concurs that disputes with relatives are usually basic; schizophrenia influences the sufferer as well as his/her family.

A study conducted in the United Kingdom by Pharoah, Rathbone, Mari, and Streiner, (2003:7) demonstrated that the negative views on the part of relatives can be a primary reason for relapse in mental health care users with schizophrenia. The study further revealed that stigma precluded members of the community from becoming involved in the daily lives of MHCUs. In similar vein, Mulvany (2000:585) is of the opinion that the social lives, particularly social relationships, of individuals with schizophrenia are seriously affected by the illness. Mental health care users with schizophrenia distance themselves from the public, and vice versa. The author argues that MHCUs with schizophrenia isolate themselves from society because they sense the indifference, at times outright hostility, of the community once the diagnosis becomes known. Mental health care users with schizophrenia tend to withdraw from all the social events they used to participate in.

Literature demonstrates that social disability is an inherent component of schizophrenia. It proposes that social dysfunction influences the course and the result of schizophrenia (Switaj, Anczewska, Chrostek, Sabarrego, Cieza, Bickenbach & Chatterji, 2012:193). Similarly, Raj (2013:117) states that family members, too, are affected by the rejection of

society, particularly relatives and neighbours. Consequently, more often than not, relatives hide the truth of mental illness in the family from outsiders. This can unfavourably influence treatment and recovery.

Lakhan and Ekúndayò (2013:104) affirm that the mezzosystem of ecological systems theory incorporates distinctive microsystems, and the different systems that serve these microsystems, formal and informal. They incorporate families and groups (peers, associations, local facilities, and services). People pose the greatest threat by creating psychological distress if communication is poor between different microsystems and if there is detachment or interruption of the smaller scale and mezzo frameworks, causing social panic. Comparably, in the microsystem, individuals are not necessarily detached; they assume a dynamic part in creating a stable environment, building on past encounters and learning. If support is lacking, the relationships between MHCUs and their families can impact negatively on their quality of life, and this could hamper the recovery process.

Subtheme 5.4: Stigmatisation

Participants shared their views as to how they were stigmatised in the community.

> *P1: "Some people they call me names."*
> *P2: "Some people will call me names saying that I am crazy."*
> *P4: "It so difficult when people know that you are sick. You cannot be happy. They will say I have relapsed and also when I am angry they will say I have relapsed. In the matter of fact they will call me crazy."*
> *P5: "They take me as a murderer."*
> *P5: "Not all people are afraid of me, those who are the enemies of my family, they do not like me."*
> *P7: "Some people, they call me names and insult me, and I become stressed."*
> *P8: "People do not understand us, they call us with names, they stigmatise us."*
> *P13: "Some people think that I am powerful [strong] and they are afraid of me. People are good to me, they love me and others are bad saying that I am not sick, why do I get the grant."*

Participants were bewildered by the behaviour of some members of the community. Stigma and discrimination were apparent in the manner community members perceived and treated them. Participants were verbally abused and offended by members of the community. Some were accused of not actually being ill, and that they were taking advantage of the disability grant system.

Stigma contributes significantly to the burden of schizophrenia, and is a noteworthy deterrent to recovery (Koschorke, Padmavati, Kumar, Cohen, Weiss, Chatterjee, Pereira, Naik, John, Dabholkar, Balaji, Chavan, Varghese, Thara, Thornicroft & Patel, 2014:151). The subjective accounts of persons living with mental illness affirm that the effects of stigmatisation are frequently experienced as more oppressive and upsetting than the primary condition itself (Thornicroft, 2006:182). Stigma is alluded to as a social devaluation of a "person" (Thara & Srinivasan, 2000:135) because of an "attribute that is deeply discrediting" (Goffmann, 1963:3). It can be conceptualised as comprising "problems of ignorance, prejudice, and discrimination" (Thornicroft, 2006:182). Discrimination is directly linked to disadvantages in numerous parts of life, including individual relationships, training, and places of employment.

As a consequence of internalised stigma, a few individuals with mental illness might recognise the defaming biases held against them and lose self-regard, prompting sentiments of disgrace, a feeling of isolation, and social withdrawal (Livingston & Boyd, 2010:2150; Ritsher, Otilingam & Grajales, 2003:31). Individuals with mental illness are particular sensitive to "anticipated discrimination," and attempt to conceal their disease or avoid taking up opportunities (Ritsher et al., 2003:32; Thornicroft, 2006:183).

Research in India revealed an increasing number of stigmatising attitudes toward MHCUs with schizophrenia by community members as well as mental health professionals (Loganathan & Murthy, 2008:39). The effects of stigmatisation contribute significantly to help-seeking behaviour (Shidhaye & Kermode, 2013:6). In one Indian study, MHCUs with schizophrenia reported being ridiculed, avoided, or denigrated. Some were fed stale food, prevented from going out, beaten, or hit with stones. Some spoke about the absence of respect from relatives (Loganathan & Murthy, 2008:40). Men experience disgrace more acutely as they are supposed to be head of the family and responsible for the family's livelihood; the female MHCU is scorned because of her inability to function normally in marriage and in the workplace (Loganathan and Murthy, 2011:569). In another study, relatives and neighbours passed stigmatising remarks (Murthy, 2005:28).

Lakhan and Ekúndayò (2013:104) assert that the mezzosystem incorporates distinctive microsystems as well as the different systems that serve these microsystems, formal and

informal. They incorporate families and groups (peers, associations, local facilities and services). People are at a higher risk of psychological distress if communication is poor between different microsystems, and if there is detachment or interruption of the smaller-scale and mezzo frameworks. Compared to the microsystem, individuals are not merely watching or detached; they play a dynamic part in creating a stable environment, building on past encounters and learning. The relationship between mental health care users and their families can affect these systems, and if there is a lack of support, this might hamper the recovery process.

Subtheme 5.5: Needs of the mental health care users

The participants indicated that they have needs just like any other human being. They have a need to work and be independent.

P1: "I need a job as a gardener or cleaner."
P2: "When we want jobs we cannot get them, as we are sick."
P2: "I need money and my own house."
P4: "I need a house."
P5: "I want to be rich and have lot of money."
P12: "I need a house, sufficient food, car, have a woman."
P13: "I wish to get a job. I can work as a gardener or a cleaner or work with a mechanic."

Five participants expressed their desire to be discharged from hospital.

P6: "I need to go home."
P7: "I want to be discharged from the hospital, it because I feel not happy when I am kept in the hospital when I am better and my sickness is controlled."
P10: "I wish this sickness can be controlled as it is not nice to be in the hospital, when I look at other patients they are worse than myself; that makes me sad because there is no need ;for me to stay in the hospital when I am better."
P11: "I want to be discharged, I want to go to school and I want to show people that when you have mental illness it does not mean that you cannot do anything."
P13: "I want to go back home and start my life again, I want to live a good life and I do not want to fight with people."

One participant expressed the need to be assisted in dealing with his emotions/stress.

P1: "I am stressed and emotional."

Another participant voiced the need to be assisted with substance abuse.

> *P1: "For two years I have been smoking dagga* [to deal with emotions and stress] *– self-medication."*

The participants have needs, much like any other person. They need to enter into the labour market; they need their own houses as well as furthering their studies. They need to be discharged from hospital, with the goal in mind that they can carry on with their independent lives.

In a study in North West Province in South Africa, conducted by Brooke-Sumner et al. (2014:4), the majority of participants highlighted the significance of productive activity in their lives, such as family tasks and gardening. The present study established similar findings as those of Brooke-Sumner et al. Participants in the present study also articulated their need to be engaged in productive activities.

Manamela et al. (2003:88) assert that recognisable proof and assessment of the needs of people with schizophrenia in rural areas, is an overlooked, often misinterpreted, aspect of human service programme planning. In addition, Royle and Walsh (1992:5) affirm that all individuals have key essential human needs such as "a sense of security, the maintenance of the identity as an individual, acknowledgment; a sense of being wanted and belonging, the opportunity of socialising, independence; the flexibility to settle on choices and the chance to create and utilize one's innate potential."

The Schizophrenia Society of Canada (2005:5) conducted a study in Canada, which determined that half their participants showed that the most pertinent inadequacies were support for education and training. Approximately one in four recognised as a requirement more money for leisure exercises, practical help around the house, and support to perform an occupation. One in five reported that they did not receive sufficient information from mental health providers about treatment choices or adapting techniques, and around one in ten reported that they occasionally, or never, receive sufficient support from their families, companions, or mental health providers.

In the same review, the Schizophrenia Society of Canada (2005:5) indicated that participants identified an extensive variety of services and support that they believed

would assist them in managing the disease such as a change of mind-set relating to individuals with mental illness, and diminishing social stigma. One in ten respondents desired better access to mental health services.

Lakhan and Ekúndayò (2013:104) state that the mezzosystem incorporates distinctive microsystems as well as the different systems that serve these microsystems, formal and informal. They incorporate families and groups (peers, associations, local facilities, and services). People are at risk of psychological distress if communication between different microsystems is poor, and if there is detachment or interruption of the smaller-scale and mezzo frameworks, causing social panic. Compared to the microsystem, individuals are not merely watching or detached; they assume a dynamic part in creating a stable environment, utilising past encounters and learning. The relationships between MHCUs and their families can affect them. If support is lacking, this might hamper the MHCU's recovery.

Subtheme 5.6: Support systems of the MHCU

The participants shared their views in relation to the support they obtain as mental health care users. They indicated that they receive support from their families, the MHCU community, and other community members. Several participants indicated that they were not getting any support.

> *P1: "I get support from the mother."*
> *P1: "My wife, she is a nurse, and my mother and sister."*
> *P2: "My brothers, my siblings and my aunt."*
> *P3: "My father has just passed away. He used to support me. Now I have my mother and my wife."*
> *P4: "My brother supports me."*
> *P5: "My whole family loves me."*
> *P8: "Most of my family members are worried about my illness. The daughter of my brother supports me and she has two children and we are living on her grant."*
> *P9: "My mother."*
> *P11: "My sister is supporting me."*
> *P13: "My brother used to support me but he has been shot in Pretoria and he died."*

One participant indicated that he did not get any community support.

P3: "I think they are rejecting me since I have been in the hospital they never visited me."

Three participants reported that they receive support from the community.

P11: "I get support from the community where I come from."
P12: "I am treated well by the community. I buy them dagga and booze when I am working that is why they love me."
P6: "The community treats me well."

Three participants indicated that the patient community provided them with support.

P5: "The patients that I socialise with; we help one another."
P7: "Patient M supports me."
P8: "Even some of the patients, they advise me."

Participants confirmed that they obtain support from their families and relatives, and that community members are strong supporters. As many participants were inpatients in psychiatric hospitals, they reported that they enjoyed the support of their fellow patients.

A study conducted in Limpopo by Manamela et al. (2003), found that participants received internal support (father, mother, sister, sibling, or) and external support (companions and mental health experts); these findings are similar to those of the present study. Manamela et al. (2003:93) further state that these support systems are recognised as being functional or structural. These authors claim that functional support includes the provision of material aid, emotional support, agreed affirmation and friendship, while structural support focuses on the scope and type of support.

Bronowski and Załuska (2008:14) contend that the absence of the emotional components of support is particularly damaging to individuals with mental illness, and to those who are segregated or isolated and denied a family network. Individuals with mental illness are of the view that support given to them in the social rehabilitation systems is, for the most part, formal in character. Moreover, Nystrom and Axelsson (2002:171) and Bengttsson, Tops, and Hansson (2001:67) state that emotional support, comprehended as a major aspect of "functioning out-of-institution" is more difficult to identify in social rehabilitation frameworks. Bronowski and Załuska (2008:14) assert that individuals with schizophrenia find it particularly difficult to obtain emotional support; it is therefore of great value to resort to both formal and emotionally supportive networks which present with fewer

institutionalised components. These authors assert that a fundamental shortcoming in the social support system for mental health care users with schizophrenia is the absence of association with individuals outside the formal treatment or rehabilitation structures.

Mares, Young, McGuire, and Rosenhacka (2002:457) contend that social contact constitutes a fundamental element of quality human existence, the lack of which is identified with the unfulfilled lives of individuals, marked by fragile and deficient informal organisations and interpersonal absences. Furthermore, Mares et al. (2002:457) state that the most successful strategies which engender life fulfilment in individuals with serious mental illness would need to encourage the provision of both psychiatric treatment and access to non-medical services such as social support.

Torres, Mendez, Merino, and Moran (2002:799) are of the view that, to individuals with serious mental illness who have spent numerous years the mental health hospitals, social support is key to their recovery. The microsystem of ecological systems theory specifies that the individual is not detached or merely watching; individuals occupy a dynamic part in creating a stable environment, utilising past encounters and learning. Relationships between mental health care users and their families can affect them; if support is lacking, this might impede the recovery process (Lakhan & Ekúndayò, 2013:104).

Theme 6: Recommendations regarding support needed by mental health care users

Participants indicated that they required guidance on acquiring life skills, employment, independence to further their education, structured activities, family involvement, integration into society, and mental health care services. Brooke-Sumner et al. (2014:4) state that although disability grants offer a safety net for MHCUs and their families, information emanating from their study demonstrated that this issue could be a source of contention; among others, finance management and communication skills need to be enhanced. However, participants in their study emphasised that social integration through working and acquiring remuneration underpin recovery. Poverty and unemployment need to be addressed by encouraging additional income-generating projects to augment the disability grants received from government. The study of Modiba et al. (2001:10) revealed

that key informants had comparable perspectives about the requirement for a focal point according to which mental health care users could participate in different exercises such as cultivating vegetables, knitting, sports, brick making, sewing, and craftwork.

The accounts of mental health care users on community living revealed an alarming prevalence of stigmatisation and manhandling on the part of families and the community, frequently bringing about wretchedness and melancholy. By applying the ecological systems theory the mezzo system, which includes hospitals for example, can focus on training and generating awareness of mental illness. Educational and informational training can sharpen individuals' abilities on many fronts, and afford them a greater level of psychological and social ability, which can lead to a more stable environment, the provision of care when required; and counteract or pre-empt disruptive behaviour. Individuals with mental illness could be included in various projects, and medical and financial help can be arranged for their families (Lakhan & Ekúndayò, 2013:105).

Summary of section B

Mental health care users are admitted as inpatients to three mental health facilities in Limpopo Province. The MHCUs in this study were mostly men, all of whom had been diagnosed with schizophrenia. Surprisingly, they exhibited insight into their conditions, and were very eloquent in describing their aspirations; however, they were confined to these medical facilities and could not be discharged despite improvement in their mental health. They faced the challenge of being rejected by their families. They all had the desire to be reintegrated back into the community, join the labour market and, in some instances, further their studies. Most participants were bewildered by the behaviour of some community members. Stigma and discrimination were apparent in the way that the community members treat them. Most participants derived joy from the support they received from their fellow patients.

7.3.3 Section C: Findings of district social worker participants

This section provides the findings of district social work participants. Fourteen particpants were interviewed and they were from the DoH and the DSD Offices in Vhembe, Mopani, and Capricorn Districts.

This section provides the biographical profiles of district social workers, followed by the thematic analysis.

7.3.3.1 Biographical profiles of district social workers

This section gives an overview of district social work participants and their biographical profiles. The following table provides the biographical profiles of district social work participants:

Table 7.5: Biographical profiles of district social workers

P	Age	Marital status	Language	Gender	Qualif	Institution	Attained	Area	Years employed
1	26	Single	Venda	Female	BSW	University of Venda	2009	Vhembe	5
2	25	Married	Tsonga	Female	BSW	University of Limpopo	2014	Capricorn	6 months
3	39	Married	Tswana	Female	BSW	UNISA	2014	Capricorn	6 months
4	26	Single	Venda	Female	BSW	University of Venda	2009	Capricorn	5
5	31	Single	Tsonga	Male	BSW	University of Limpopo	2008	Capricorn	6
6	51	Single	Afrikaans	Female	BSW	UNISA	1987	Modimolle	27
7	30	Married	Venda	Female	BSW	University of Venda	2010	Thohoyandou- Vhembe	4
8	30	Married	Venda	Female	BSW	University of Venda	2011	Thohoyandou- Vhembe	2
9	26	Single	Venda	Female	BSW	University of Venda	2012	Thohoyandou- Vhembe	3
10	30	Single	Venda	Female	BSW	University of Venda	2009	Thohoyandou- Vhembe	6
11	33	Single	Tsonga	Female	BSW	University of Limpopo	2010	Mopani	5
12	30	Married	Tsonga	Female	BSW	University of Limpopo	2009	Mopani	6
13	37	Single	Tsonga	Female	BSW	University of Witwatersrand	2006	Mopani	8
14	27	Single	Tsonga	Female	BSW	University of Venda	2011	Mopani	4

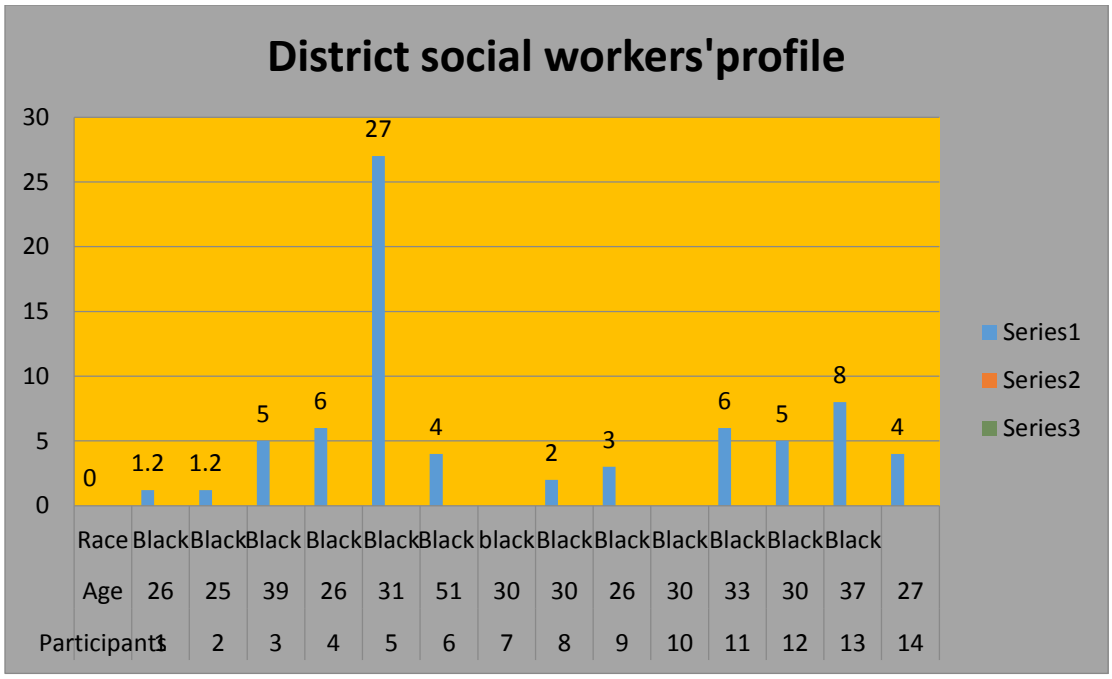


Figure 7.4: District social workers' biographical profiles (n=14)

The ages of these participants ranged from 25 to 51 years. The participants were predominantly female; there was only one male participant. Furthermore, the participants' languages were Tshivenda, Tsonga, Tswana, and Afrikaans. Five participants were married and nine participants were single. Seven participants obtained their social work Bachelor's degrees at the University of Venda, four participants obtained their qualifications at the University of Limpopo, two participants were UNISA graduates, and one participant was a University of the Witwatersrand graduate. The years of employment ranged from 6 months to 27 years. The research was conducted in the rural areas.

In an exploratory study undertaken by Schenck in 2002 focusing on the problems experienced by social workers in rural communities in five provinces in South Africa, the 45 rural social workers interviewed articulated the difficulties they experienced in relation to their working conditions while engaging in social work in rural areas (Schenck, 2004:165):

7.3.3.2 Thematic analysis

This section presents the themes, subthemes, and categories of the data collected from district social workers at Limpopo's Department of Social Development. Subsequently, the table below provides a summary of the themes, subthemes, and categories, followed by a discussion of what transpired from the interviews. Extracts of the participants' interviews are presented verbatim to support the themes as well as linking the findings to the literature.

Table 7.6: Themes, subthemes, and categories: District social workers

Themes	Sub-themes	Categories
Theme 1: A description of mental health services in the communities where the participants worked	**Subtheme 1.1**: The nature of mental health services provided	**Category 1**: Mental health services
	Subtheme 1.2: Effectiveness of current mental health services	
	Subtheme 1.3: The needs for the improvement of services	
	Subtheme 1.4: Knowledge and skills to deal with mental health related cases	
Theme 2: A description of social services in mental health in the communities where the participants worked	**Subtheme 2.1**: Description of the nature of services by social workers	**Category 2**: Social work services
	Subtheme 2.2: Service as part of generic work, not specialised	
Theme 3: Challenges experienced by social workers regarding mental health services	**Subtheme 3.1**: Description of challenges experienced by social workers	**Category 3**: Challenges
	Subtheme 3.2: Support received to address the challenges experienced	
Theme 4: Recommendations regarding social work services in mental health care service delivery		

Category 1: Mental health services

This category comprises the theme and subthemes of mental health services. The theme in this category is a description of mental health services in the communities where the

participants worked. From this theme, three subthemes emanated: the nature of mental health services, effectiveness of current mental health services, and the need to improve mental health services.

Theme 1: A description of mental health services in the communities where the participants worked

The participants described the mental health services in the community where they worked. Subtheme are discussed below.

Subtheme 1.1: The nature of mental health services provided

Two participants indicated that they were not aware of mental health services rendered in the community.

> *P5: "There is none where I work."*
> *P10: "There are no services, no programmes that I know of in the community."*

Another participant indicated that the mental health services provided were limited to financial support (grants).

> *P1: "I can say there are those mental health people who get grants."*

Four participants remarked upon the mental health services provided in the community, notably protective labour/schools for people with special needs.

> *P3 + 4: "There is Reakgona protective workshop; this is a residential facility that caters for people with mental and physical disabilities. The clients stay there."*
> *P12: "There is a school for special needs catering for children around my community."*
> *P14: "We also have protective workshops, stimulation centres."*

Five participants reported that mental health services were rendered at clinics and hospitals.

> *P6: "Services provided by the Department of Health at the different clinics."*
> *P7: "I saw it in the clinic, only they provide information on mental health because they have patients who are mentally ill, but in the community, I did not see any programmes."*
> *P7: "What I know is that they [Hayani Hospital] provide information to the nurses, not to the community."*

> *P7: "In the clinic when the nurses are providing health education in the morning. As social workers we are also part of these health education meetings, we teach patients about their rights; for example, we tell them that they can get married and have families."*
> *P11: "I am not sure, but some clients when they are having problems with mental illness they just consult their nearest clinics. And when the situation is worse they are referred to the hospital, and after the assessment, they just send them to the mental hospital."*
> *P12: "There is a hospital, Evuxakeni; patients suffering from mentally illnesses are normally refer there."*
> *P13: "There are hospitals and centres like Evuxakeni and Limpopo Mental Health in Tzaneen that I know of."*
> *P14: "Department of Health provides services through clinics; they are the ones who offer treatment."*

According to one participant, mental health services are provided by the Department of Health, and they are also responsible for providing medical treatment.

> *P8: "The Department of Health is the one providing services to patients who are mentally ill. They provide medication."*

It should be noted that social workers in the Department of Social Development (DSD) provide generic services and mental health services, even though they fall within a focus area which is neglected. Some participants indicated that there are no mental health services where they work. Other participants were of the view that mental health services are the responsibility of the Department of Health (DoH). Furthermore, the services provided by the Department of Social Development focus on general disabilities. The Department of Social Development (DSD) (2013) confirms that mental health services are incorporated in their programmes which focus on individuals with disabilities. The DSD (2015) states that the overall focus of working with individuals with disabilities is to extend services to rural regions as all individuals with disabilities and their families require access to these services.

Moreover, the protective workshops should be changed and held responsible for developing socioeconomic opportunities by providing a basket of services such as social services, advancing skills development, business enterprises, and exposure to the world of work. The DSD is mandated to empower individuals with disabilities; and the individuals who move on from protective workshops should be encouraged to take advantage of open empowerment opportunities and economic participation. The DSD (2015) stipulates

that social development services should focus on services such as social support services; therapeutic, restorative, and rehabilitative services; continuing care services, reintegration and aftercare services; and economic development services. Ecological systems theory implies that individuals are embedded in differing levels of expanding environmental settings, which, in turn, are embedded in even larger settings (Bronfenbrenner, 1989).

In general, ecological systems theory presents varying levels of environmental influences that impact and interact with an individual's feelings, behaviour, and overall functioning (Okun, 2005:41), although it appears logical that environmental exposure to mental illness (e.g., having different levels of contact with family members, peers, extended family, and/or individuals in society with mental illness) and mental health treatment could potentially impact an individual's response to stigmatising behaviour toward seeking mental health services (Rogers, 2009:14).

Subtheme 1.2: Effectiveness of current mental health services

One participant indicated that she could not respond to the question as she was not aware of any services provided for MHCUs. Another participant claimed that mental health services were not within the scope of social work practice.

> *P2: "I do not know any services that are provided for MHCUs."*
> *P6: "This is not with the scope of my practice. I am not in the position to say they are effective."*

Five participants reported that social work services provided for mental health care users were effective.

> *P3: "Services are effective as the clients are trained in different skills like beadwork, home economics, and woodwork."*
> *P4: "Services are effective; they have woodwork, beadwork and they are selling them; also home economics."*
> *P12: "Yes" they are effective because children are being educated and patients who have mental illness are cared for as well given treatment."*
> *P13: "Yes people with mental illness are referred to these centres like Evuxakeni if the person is uncontrollable in the home setting."*
> *P14: "Yes, they are effective, just not enough; we only have four protective workshops for all the greater Giyani."*

Two participants reported that the social work services provided to mental health care users were not effective.

> *P8: "No, because by checking in the community we have many people who are mentally ill. I do not think the services are meeting the needs of the patients. If these services were effective, we were supposed not to have increased numbers of these patients."*
> *P11: "I am not sure, but I think they are not enough, because at the clinics, they just receive medication and they are doing their general work, receiving every client, the clinic staff has high caseloads."*

Participants exhibited diverse views as to the effectiveness of mental health services. It should be noted that the participants were not conversant with the provision of mental health services; their focus was on the effectiveness of social work services instead of mental health service. Some participants were of the view that mental health services did not fall within the scope of social work practice.

Due to the deficiencies in mental health services, a substantial part of the burden of care of mental health issues in rural areas has shifted to primary health care as a subdivision (Gale & Lambert, 2006). The Department of Health (2013:14) affirms that it is currently expanding the scope for cost-effective interventions for mental health services. Araya, Flyn, Rojas, Fritsch, and Simon (2006:1379) state that collaborative models and stepped care provide an effective structure to coordinate psychological intervention and medication.

Patel, Aravaya, Chattersjee, Chisholm, Cohen, and De Silva (2007:991) state that for the treatment of schizophrenia, antipsychotic medication is effective and cost-effective, and these can be upgraded through community-based models of care. Botha et al. (2008:272) contend that in the Western Cape, the recently established assertive community treatment (ACT) teams have reported a decrease in inpatient admissions and length of stay in mental health care facilities among individuals with serious mental health problems, to the benefit of MHCUs and their families; this also leads to staff fulfilment. Dube and Uys (2015:1) assert that despite the high prevalence of mental health issues, primary health care (PHC) remains ineffective in overseeing patients with mental illness. Before 1994, little thought was given to mental health care, and services mainly consisted of medication and admission to psychiatric hospitals (Petersen et al., 2009:140). Petersen

et al. (2012:42) are of the view that cracks still exist in the administration of patients with mental illness within the South African public health care service. These authors maintain that psychosocial rehabilitation projects are not rendered in rural areas. Furthermore, there is inadequate support for PHC staff in the administration of patients with mental illness (Petersen et al., 2012:42). Similarly, Grandes, Montoya, Arietaleanizbeaskoa, Arce, and Sanchez (2011:428) assert that Primary Health Care (PHC) services prioritise the palliative managing of terminal illnesses that, by their very nature, relate to a steady decline in life expectancy; and neglect illnesses that cause disability.

Lakhan and Ekúndayò (2013:104) affirm that the mezzosystem of ecological systems theory incorporates distinctive microsystems and the different systems that serve these microsystems, formal and informal. They incorporate families and groups (peers, associations, local facilities, and services). People are at a higher risk of creating psychological distress if communication is poor between different microsystems and if there is detachment or an interruption of the smaller-scale and mezzo frameworks, creating social panic. Compared to the microsystem, individuals are not merely watching or detached, they assume a dynamic part in creating a stable environment, utilising past encounters and learning. The relationship between MHCUs and their families can affect them if support is lacking; and this might hamper their recovery.

Subtheme 1.3: The needs for improvement of mental health services

One participant was of the opinion that there is a need to address the abuse of mental health care users.

> *P1: "I can say their relatives are taking advantage of them, because they think that they are mentally disturbed. They misused the grants of the patients."*

Another participant expressed the need to develop client-centred services.

> *P4: "Developing programmes for MHCUs according to their needs, because now they are told what to do."*

Two participants were of the opinion that mental health care in social work should be classified as a specialised field.

> *P6: "Mental health should be regarded as a specialty in social work."*
> *P12: "I think if the department can make a specialisation for social workers to render services for mental health care users."*

The other two participants were of the opinion that there should be community awareness regarding mental health.

> *P8: "Maybe the government or the people in the community they need to be taught on how to deal with mental illness. Knowledge is the most important thing. I think it is important it should be shared with the people in the community."*
> *P10: "I think maybe awareness campaigns can assist, because most of the people who are staying with the people who are mentally ill do not understand how to live with them and how to accept and live with them."*

One participant indicated the need to establish schools for people with special needs. Currently, there are limited facilities that provide services for people with disabilities.

> *P12: "I think there is need for more special schools, as now we refer at Pfunanani Special School, so there is always a waiting list. For them to be admitted is not easy. There is only one school around Giyani so I think there is need for more schools."*

The participants alluded to what needed to be done to improve mental health services. They were of the opinion that there was a need to address the abuse of mental health care users, and to conduct awareness programmes in this regard. They stated that there was a need to develop client-centred mental health services, and to categorise these mental health services as a speciality service in social work.

The WHO (2009) affirms that the issue of inadequate resources relating to mental issues is often inaccurately communicated. Most resources are spent on costly – sometimes inhumane – and ineffectual care in mental health facilities, instead of on effective primary health care and community-based care. The WHO (2009) proposes satellite systems to enhance mental health care. These strategies are the following:

- Promote self-care.
- Build informal community care services.
- Integrate mental health services into primary health care.
- Build community mental health care services.
- Develop mental health care services in general hospitals.

- Limit the number of psychiatric hospitals.

In addition, the WHO (2003) suggests that community mental health services should include “day centers, rehabilitation services, hospital diversion programmes, mobile crisis teams, therapeutic and residential supervised services, group homes, home help, assistance to families, and other support services.” Van Heerden, Hering, Dean, and Stein (2008:2) have made recommendations how to improve mental health care. Firstly, additional information is required on mental illness profiles, the degree of current mental health service provision, and the impact of changes in the framework. Secondly, support for the inclusion of mental health care service in established health care settings such as primary, secondary, and tertiary services. Thirdly, community psychiatry should be revisited and strengthened, focusing on suitable training and research (Van Heerden et al., 2008:2).

Based on the ecological systems theory, the Department of Health (2011) indicates that mental health services promote principles of hope, self-determination, personal agency, social inclusion, and choice. A service environment that supports and advocates for recovery, sustains and communicates a culture of hope and optimism, and actively encourages people’s recovery efforts. The physical, social, and cultural service environment inspires hope, optimism, and humanistic practices for all who participate in service provision.

Category 2: The main tasks of the social worker regarding mental health

This category presents a theme that focuses on social services in mental health care provided to individuals, within the rural communities of Limpopo Province, who are employed. More details and discussions are presented below.

Theme 2: A description of social services in mental health care rendered in communities where the participants worked

The participants described the social work services in mental health care rendered in the communities where they work. From this theme, six subthemes emerged, the details of which are captured below.

Subtheme 2.1: Description of the nature of services rendered by social workers

Four participants were uncertain of the social work services in mental health care. They were of the opinion that most cases were handled in the hospital and that their offices did not render any such services; most of the time they either refer cases to other facilities or professionals.

> *P1: "I do not know. I do not know much about social work services in mental health."*
> *P1: "Most of the cases are done in the hospital; we do not have cases here at the welfare office."*
> *P1: "We do not have mental health services here at the office."*
> *P2: "We are doing generic social work. No idea; I have never had a client."*
> *P5: "I do not think social workers provide a service; only psychologists."*
> *P12: "Here in our offices, we just refer to Evuxakeni; there is nothing much that we are doing regarding mental health."*

Five participants indicated that they rendered generic social work services and that they referred mental health cases to the hospital.

> *P3: "I did not have one-on-one clients. I was doing family preservation."*
> *P8: "Mental health is with our focus area but we are not doing it fully."*
> *P9: "If they are coming with the issue of the family, we just concentrate on the issue of the family, not on their wellbeing."*
> *P11: "When we receive cases of people who are mentally challenged, we just assist them, and if we see that it is not our area we just refer them; but we do home visits and we consult the family members and then we check the problem and when the problem started and then later we refer them to the hospital."*
> *P13: "The social worker's role is to provide counselling to the families affected or people who are living with mental illness."*

Seven participants indicated that they provide services such as counselling, support groups, monitoring, psychosocial support, home visits, assessments, and referrals.

> *P6: "We provide counselling of family members and MHCUs."*

P7: "As social workers here, we are having support groups that we do on a monthly basis. In these support groups, we assist patients and their families, especially the patients who are mentally."
P8: "We conduct home visits, and we do psychosocial support."
P9: "We got support group; the chronic and disability we have got some people like who suffer from schizophrenia who take medication that may find in that group, but when you are there maybe to support them, to encourage them to continue with their medications, but to have a programme we cannot say we have it."
P10: "We provide counselling and monitoring. For instance, community members come here to the offices to report that there are certain people who are mentally ill lingering around the streets, beating people, doing whatever. So after they reported cases, we can intervene. Maybe get assistance from the police to take the person to the hospital, or especially if a person is violent we get assistance from the police to take the person to the hospital. So after that if a person is taking medication we can visit him/her maybe once a month to check if he/she is adhering to the treatment."
P11: "We do assessments and intervene, and then later we refer the client to the mental health care centres"
P13: "What I can say, our goal is to provide support."

One participant indicated that they provided practical support such as applications for disability grant, and assistance cases relating to the misuse of grants.

P7: "When they come to the office, we tell them about the services that we render such as disability grants. If the patient has a problem with the application of disability grant, we assist and if the family misuses the grant, we assist them."

Two participants indicated that they link clients with available resources such as arranging placements in residential facilities, and provide support to mental health care users.

P6: "To ensure that MHCUs receive appropriate care."
P13: "Finding placement for MHCUs."
P13: "What I can say, our goal is to provide support."
P14: "Liaise with NPO centres."
P14: "Referral, linking them to relevant services like care centres, permanent residential or day-care centres."

One participant indicated that social workers conduct follow-ups services such as home-visits. In some instances, they provide information to assist caregivers.

P7: "We go and do home visits. We do follow-ups concerning the problem they report. If the patient has relapsed, we provide them with information on how to contact the police, or how to call an ambulance or emergency services."

Another participant indicated that social workers conduct awareness campaigns.

P14: "The only thing that the DSD does in terms of this is the awareness campaigns that we do."

Four participants reported that they assist MHCUs to function in the family environment and in the community.

P1: "As a social worker I have to intervene in helping the patient, doing awareness campaigns in the communities so that make them aware of the abuse that is happening and also helping them with family problems."
P1: "If the person who is mentally ill has relatives, to ask them to take good care of the patient."
P2: "Assist them to recovery. I mean, they will be better."
P4: "We support MHCUs; we do family preservation; we provide counselling."
P8: "In the process of reunification, we sit down with the whole family and show them the importance of continuing staying with the patient. We also check how they are coping with the patient being at home."
P9: "When they refer those clients, they refer them with different issues. You will find maybe someone is misusing his/her grant or maybe someone is not having a good relationship in the family. At times if they come, it will be the issue of their grants. Most families are complaining about their grants because most of them, they receive grants on their behalf, so they misused it."
P9: "To help them that they get support from their families. We do not encourage them to stay alone. So we do talk to the family that the way this person is, he/she needs to be monitored 24/7 and he/she needs someone that can remind him/her that it is time to take medication, now you have to bath, change the clothes, etc. We make sure that they always have a family or someone to take care of them."

Six participants indicated that they provide protection and empowerment services such as educating MHCUs about their rights.

P3: "Educate MHCUs about their rights."
P4: "We want to show them that they are loved, they are special and they are unique, and they human beings with talents."
P5: "This one is very difficult; to be treated with dignity and respect, to ensure that the patients get treatment."
P9: "The main goal is to make sure that these people are treated as each and every person."
P11: "The main focus is to assist the client to solve his problems and to make sure that the client gets help."
P14: "Our main goal is to care and protect mental health users."

Three participants indicated that they supervised mental health programmes/ projects, and provided funding for non-profit organisations.

P4: "Services are effective in Reakgona; and I am responsible to monitor the centre."
P5: "I do NGO funding; we are responsible to fund mental health services."

P14: "Also monitoring of these centres that deal with people with disabilities. It is not specifically for mental health that we provide services, but all disabilities."

Participants disclosed that the services provided by social workers include counselling, support groups, monitoring, psychosocial support, home visits, assessment, and referrals. Practical support services were geared toward applying for and monitoring the use of disability grants, and placements in residential and day-care centres. They further provided protection and empowerment services such as awareness campaigns, promoting independent living of mental health care users; they also provided support to families. The DSD (2015) asserts that social work services adopt a developmental approach. In rendering services, the department partners with a range of service providers across the province:

- Awareness and educational programmes on disability issues.
- Provision of social work services: counselling services, trauma debriefings.
- Peer-support programmes.
- Family/parental-support programmes.
- Empowerment programmes for persons with disabilities: life skills programmes, programmes to promote a positive self-image and self-perception (DSD, 2015).

A study conducted in the UK by Ray, Pugh, Roberts and Beech (2008) focused on a random sample of 262 individuals with serious and persistent mental health issues. They found that 66% of participants felt that their care programmes helped them in becoming more autonomous. They reported that they were occasionally asked whether they needed their relatives or informal caregivers included in their care. Social work professionals skilled in family work were recognised as being especially suited to this role. Research by Ray et al. (2008) has found that individuals who use these services react more positively, particularly where there has been joint training of social workers and psychiatric nurses who work toward a strengths-based objective of individual-focused practice and a care management model. Individuals who use these services are able to deal with the stigmatisation within their communities and are appreciative of the access to the benefits provided by social workers.

Based on ecological systems theory, at micro and mezzo levels, social workers are primarily concerned with “the social well-being of the individual clients and their families similarly esteemed with the significance of their physical, mental and spirituality well-being” (NASW, 2013). At macro level, social workers generally exhibit a more noteworthy ability to look past the disease and treatment issues, and consider the more extensive human, social, and political issues of mental health care (NASW, 2013).

This expansiveness of its analysis and focus constitute the particular strengths of social work in mental health (ASSW, 2008). Social workers are aware of the intricacies of the social work setting. Social work surpasses the therapeutic model's emphasis on the individual’s determination to recognise and address social imbalances and structural issues. A distinguishing characteristic of social work practice is the “dual focus of the profession”. Social workers have the moral obligation to address both private inconveniences and public issues (ASSW, 2008).

Subtheme 2.2: Working with social workers in psychiatric hospitals

The participants exhibited diverse views in relation to working with social workers in psychiatric hospitals. Some participants reported that they referred cases to social workers in psychiatric hospitals. Others, on the other hand, indicated that they did not have any contact with the social workers in psychiatric hospitals.

P1: “You can call them to refer a case.”
P2: “If we have MHCUs were referred them.”
P2: “No contact.”
P4: “No contact.”
P5, 13: “No.”
P6: “We have allied with health.”
P7: “We have working relationship with social workers in Hayani Hospital. They give us information on admissions in Hayani.”
P8: “Social workers at Hayani do family reunification and they refer cases to us to do monitoring when patients are discharged from the hospital.”
P11: “We just meet once a month, when we are reporting the cases, but we do not meet to share information.”
P12: “Yes, when we have clients who are mentally ill, we just refer to them we them and refer.”
P14: “Yes, for placement.”

Two participants reported that they had been working with the nurses at the psychiatric hospitals/clinics; in some instances, they referred cases to Hayani Hospital. On the other

hand, one participant indicated that in her area they did not have contact with other professionals working in psychiatric hospitals or clinics. She knew about their services, but did not have contact with them.

> *P2: "We had one case from the nurse. So we told her that client with schizophrenia was not falling to our focus area."*
> *P7: "If the referred patients have relapsed we firstly refer them to the clinic and the nurses will do what they have to do. If the situation gets worse, we refer the patient to Hayani Hospital."*
> *P8: "In our area, we do not have contact with them. I just know about their services."*

Ten participants indicated the kind of referrals they make to other service providers, namely non-profit organisations, psychologists, social workers in psychiatric hospitals, and police officers.

> *P4: "I refer to Reakgona when there is a person who needs services."*
> *P5: "I refer clients to Rethabile for psychological services."*
> *P6: "We have contacts in Mokopane. We call them when we have cases. We refer for placements."*
> *P7: "If the patient has relapsed at home, they call us for help and in return we call the police to assist them. We also assist them to refer the patient to Hayani Hospital."*
> *P8: "If the patient relapses, we call the police."*
> *P9: "If a person has defaulted, because we are having a problem of transport, we take those referrals to the home-based care because home-based carers work door by door in the villages. We take those cases to the home-based care that can you please visit this family inform them that the person he/she is not coming to take their medication."*
> *P10: "I refer patients for placements. I to take them to Thabamoopo."*
> *P10: "We usually contact social workers in Hayani Hospital."*
> *P12: "We just write a referral note to ask for assistance from the police officers to take the people to the hospital."*
> *P13: "I refer to the clinic, police station."*
> *P14: "I refer to the hospital for treatment, NPO centres."*

Nine participants mentioned the referrals they received from other service providers/professionals and the caregivers of mental health care users.

> *P4: "I get referrals from Reakgona requesting that I should do family reunifications."*
> *P5: "I get referrals from police station if there are clients who raped."*
> *P6: "I get referrals from police station."*
> *P7: "If the patient is discharged from the hospital, they call us in order to do the home visit and monitor the patient."*
> *P8: "The doctors and nurses refer patients to us who are mentally ill."*

P8: "At the clinic, they have their forms, the nurses refer patients that are violent, the ones that have relapse those who have been discharged from the hospital."
P11: "Let's take a case of mental health and then when a client is admitted at the hospital the social worker just gives us a referral to do after-care to the discharged patients."
P12: "We normally receive cases for people who are suffering from hallucination, schizophrenia."
P13: "Family requiring placements."
P14: "Family requiring placement, food parcels."

The participants expressed different views regarding this issue; some participants did not work with social workers in mental health hospitals, and others reported that when they received mental health cases they referred them to other professionals such as social workers and nurses in mental health care. When MHCUs relapsed, participants liaised with, among others, police officers. They also collaborated with residential and protective workshops.

Das and Bouman (2008:164) highlight that social services assume a vital role in recognising and referring individuals with mental illness to the appropriate professionals, and pledge a quick referral course of action. The Centre for Substance Abuse (2000:90) demonstrates that an all-inclusive perspective of MHCUs is particularly vital for any mental health professional. At the point of referral, there is either an opportunity to address the unmet needs of the MHCU, or a potential risk of losing the mentally ill person in the somewhat bureaucratic process. Cooperation is essential in keeping MHCUs from "falling through the cracks" among independent and self-sufficient organisations. A viable coordinated effort is likely the best way of serving patients in the broadest possible sense. Social work has considered creative approaches to conceptualise the relationship between the individual and the environment, how people function, and how expert practice connects with these capacities (Gray & Webber, 2013:179). The authors further contend that ecological systems theory is significant to social work as it contributes a far-reaching, multidisciplinary, and comprehensive systems inside of which the complex and interrelation components of persons' lives can be associated and understood.

The ecological systems theory is geared toward incorporating the mental health and sociological dimensions of social work practice, supported by a calculated movement in social work practice from a static to a dynamic perspective of the environment (Gray and

Webber, 2013:179). It is further attested that social workers have dependably been concerned with the situational determinants of human functioning, yet until the advancement of ecological systems theory, the profession experienced it as less demanding and more practical in addressing individual functioning (Gray and Webber, 2013:179).

Subtheme 2.3: Knowledge and skills to deal with mental health related cases

The participants reported on the training they received in mental health care.

> *P1: "I have never been trained in mental health."*
> *P2: "I have not gone to any training regarding mental health."*
> *P3: "I do not have training."*
> *P3 + 5, 6, 7, 8, 9, 11, 12, 13, 14: "No."*
> *P4: "Since I have started working I've never been trained. I was just told to go and work at Reakgona. I did not know what to do there."*
> *P10: "No, I have not attended any workshop or training in mental health."*

Participants' knowledge of the DSM classification system and the Mental Health Act was subsequently tested:

Eleven participants recounted their understanding of the DSM. Most participants had limited or no knowledge of this manual.

> *DSM:*
> *P1 + 4, 5: "What is that?"*
> *P2: "Nope."*
> *P3 + 6, 7, 8, 9, 13: "No."*
> *P10: "I have not heard about it."*
> *P11: "I just have a little bit of information that I know the time I was in the university."*
> *P12: "Understand a little bit."*
> *P14: "Yes."*
> *Knowledge of the Mental Health Care Act:*
> *P1 + 2, 3, 8, 9: "No."*
> *P4: "I just saw it but I do not have knowledge about it."*
> *P5: "Yes I know it."*
> *P6, 11, 14: "Yes."*
> *P7: "A little bit."*
> *P10: "No, I do not know."*
> *P12: "I know that there is an act but I can't state the relevant sections."*
> *P13: "Yes but cannot recall it."*

The participants had diverse views in relation to reading up on mental health care. Some participants admitted that they do no reading at all about mental health, while others focus more on disabilities. Others do intermittent reading.

> *P1 + 4, 5, 11: "No, I do not read."*
> *P2: "I read but not every day [referring to reading in general, not specifically about mental health]."*
> *P3: "I sometimes read on disability."*
> *P6: "Read a lot about disability."*
> *P7: "Yes, when I have cases."*
> *P7: "For helping MHCUS we read books without any training."*
> *P8: "No, if I say yes I will be lying."*
> *P9: "No. And if we can take it into consideration to develop myself by reading."*
> *P10: "Not really."*
> *P12, 13: "Once in a while."*
> *P14: "Yes."*

The participants regarded the social work training that they received from tertiary institution as inadequate, as they received no training in mental health care. They were also not conversant with the Mental Health Care Act (No 17 of 2002). They indicated that they did not usually read mental health literature, but rather focused on disabilities in general. Furthermore, the participants exhibited limited knowledge of the diagnostic and statistical manual of mental disorders (DSM).

Cesare and King (2014:1751) demonstrate that social workers work transversely in numerous settings, and frequently encounter people who are disadvantaged and hindered in some way or another. Moreover, the AASW (2008) states that in any setting in which social workers are employed they are liable to have contact with individuals with mental illness. Consequently, social work is centred on the principles of social justice, self-determination, empowerment, and the values of human dignity and worth. Social work supports humankind, social equity, and morality (AASW, 2008). Sheehan and Ryan (2001:351) argue that despite these strengths, there is some apprehension that social workers are not sufficiently trained to adequately address the issues of individuals with mental illness.

Cesare and King (2014:1753) communicate their unease about social workers' poor training in mental health care and their capacity to work in the mental health field. These authors are of the opinion that not all social work schools offer an obligatory mental health

subject and education in mental health, and that this is frequently incorporated in other disciplines such as law and psychology. In a study conducted in Australia, Jorm, Korton, Jacomb, Christensen, Rodgers, and Pollitt (1997:182) found that social workers are unable to diagnose mental illness because they lack the appropriate training/education. This lack of mental health literacy therefore comes as no surprise. Moreover, the practice structure utilised by some social workers may lend itself more to a "medical model" or clinical approach when dealing with individuals with mental health problems; they consequently base their practice on ordinarily utilised and evidence-based treatment. It should be noted that in South Africa, social workers do not provide a diagnosis, they assess, write a thorough psychosocial background report and contribute to the team decision on diagnosis.

From an ecological perspective, Greene (2009:211) states that the competence or the ability to be effective in one's environment is achieved through a history of successful transactions with the environment. Continued activity, combined with consistent mutual caretaking, results in a lifelong pattern of effective relationships. The ability and confidence to make decisions and to trust one's own judgement to produce the desired effects on the environment constitute the conceptualisation of competence (Greene, 2009:211). In addition, the availability and purposive use of environmental resources and social supports are integral concepts (Greene, 2009:211).

Subtheme 2.4: Effectiveness of current social work services in mental health care

Two participants indicated that the existing social work services in mental health were effective. They were confident that the services they rendered promoted empowerment and independent living in the community.

> *P1: "Looking at the case that I have done. The person I have helped is able to look after herself. She is now responsible when she gets the grant; she buys grocery."*
> *P7: "They are effective. The patients are empowered; they know if they are abused at home what to do. As we have taught them how to get help. They come to our offices."*

One participant reported that there was cooperation with clinics, and that social workers were given access to MHCUs.

P7: "They are because we are able to share information with patient at the clinic."

On the other hand, a number of participants expressed their misgivings about the effectiveness of social work in mental health; that there were in fact no mental health services. Other participants reported that they lacked the necessary knowledge to practise mental health care. Others were of the opinion that mental health services were neglected in social work, and that these services were therefore ineffective.

P2: "No services. I cannot comment on this."
P3: "Lack knowledge about mental health, the services are not effective, as we do not know what to do."
P6: "Currently mental health is neglected in social work. Hence, we cannot say the services are effective."
P9: "At some point, yes, they do work, but at the some point they do not do. The problem is we do not know how to treat them and we are not equipped how to deal with these patients."
P10: "The services are not effective as there is not much that we do in mental health."
P12: "It's not easy for me to respond to that because I am not doing anything regarding mental health."
P13: "I can say in between as social workers render generic social work, we do not have social workers who are specialising dealing with mental health."

Three participants indicated that mental health services in social work were ineffective. They argued that social workers did not have access to programmes which focus on mental health, and they were limited to rendering generic social work.

P8: "No, we do not have a programme of our own as social workers."
P9: "Not really, because here in social work we got so many challenges. When we talk about assessment, assessment is so broad. You have to look even in the family, the environment these people come from. But when we are just looking at this person in the office and you write a letter to call the family members and then they come, there is a family conference and it just ends there. You have not made justice to the clients"
P11: "Is not effective because now we are doing generic work."

Participants had mixed feeling about the effectiveness of social work in mental health. Some were of the opinion that social work services were effective, while others were adamant that these services were ineffective.

According to the AASW (2008), "Social work is centered on principles of social justice, self-determination and empowerment. Central to the profession are the values such as human dignity and worth, service to humanity, social justice and integrity." Social workers

have a crucial part to play in improving mental health services and mental health outcomes for citizens. They bring a distinctive social and rights-based perspective to their work. Their advanced relationship-based skills, and their focus on personalisation and recovery, can support people to make positive, self-directed change.

Social workers are trained to work in partnership with individuals who utilise their services, including their families and caregivers, in order to facilitate their contributions toward collaborative solutions. Social workers deal with probably the most difficult and complex risks faced by people (Allen, 2014:1). The author further contends that, in recent years, the roles and priorities of social workers in mental health have not been clearly characterised. The status and power of social workers within multidisciplinary settings have at times been undermined, and their potential as specialists in their field is consistently being overlooked.

From an ecological perspective, Greene (2009:211) states that the ability to be effective in one's environment is achieved through a history of successful transactions with the environment. Continued activity, combined with consistent mutual caretaking, results in a lifelong pattern of effective relationships. The ability to make confident decisions, to trust one's judgement to achieve self-confidence and to produce the desired effects on the environment, is included in the life course of conceptualisation of competence (Greene, 2009:211). In addition, the availability and purposive use of environmental resources and social supports are integral concepts (Greene, 2009:211).

Subtheme 2.4: The needs for improvement of social work services in mental health care

Two participants suggested that home-based support services were needed.

> *P1: "If there were centres employing people to go around visiting the mental health patients, that was going to help so much."*
> *P3: "The clients need caregivers to look after them."*

Some participants were of the opinion that mental health institutional services and programmes should be established in villages for accessibility purposes.

> *P2: "More institutions built in the villages."*
> *P3: "There should be programmes for people with disabilities."*
> *P5: "Eish… that one is very difficult. I do not know where I can start. There is a need to develop mental health services in the community."*
> *P6: "Services are not accessible for rural communities."*
> *P9: "When I talk to my supervisor about him, she always tells me that people at that institution, they do not take a person who is not dangerous from the community. They need him maybe to first broke the law, then they will take him. What about the people he is living with is like sort of abused, he beats them, do all the stuff but because it is a family member, they cannot go and open a case for him. Every time when I talk about it they say if he has not break the law or he is not harmful to the community, Hayani Hospital cannot accommodate him."*
> *P13: "A place to refer MHCUs; I could not get placement at Evuxakeni because it was full."*
> *P13: "I think they need some kind of shelter because the shelter that I am talking about its only Limpopo mental health, and it's very far only situated in Tzaneen, maybe they do not have money to transport those people to that side and if you an concur with me."*

Most participants expressed the need to be provided with an infrastructure. They indicated that they needed stationery, transport, telephones, and office space.

> *P1: "We need stationery; transport is another thing."*
> *P9: "We do not even have telephones, we do not have transport."*
> *P9: "Speaking to clients who use Vodacom, at least they are safe because we can buy airtime and Powerhour, but clients using other networks they do not get any services. There are targets as per our performance agreements that we had to reach on a monthly basis; as the results of this we had to catch a taxi as we do not have transport and we go wherever and render services for the sake of that you must meet the targets."*
> *P11: "We need office spaces here in rural areas because we are working being four or five in the same office, while we are assisting the clients who are having serious problems and then the client maybe thinks that these people are they going to help me because they are many. I can't even myself. I will be afraid of the many people as well. I will not sure whether I am going to get help."*

P13: "I think we need resources, starting from the offices."
P13: "A challenge of transport."

Two participants were of the opinion that social work programmes in mental health were required. Social workers in the clinics were assisting the nurses when they manage/run their mental health programmes.

P7: "What needs to be done is to have our own programme. We do not have any valid programme as social workers. We just assist the nurses at the clinic."
P9: "We do not have maybe like a programme of mental health."

The participants reflected on what needed to be done to improve social work in mental health care. They suggested that infrastructure be developed such as centres or residential facilities, and office space; the shortage of transport also needed to be addressed. They recommended that equipment such as telephones and computers be provided.

In an exploratory study undertaken by Schenck (2004) in five provinces in South Africa, focusing on the problems experienced by social workers in the rural communities, similar issues were identified. The 45 rural social workers interviewed articulated the following as difficulties experienced in relation to their working conditions while engaging in social work in rural areas:

- No resources and infrastructure.
- Community members' lack of understanding of the role of social workers, and social workers being used as "dustbins" for unresolved problems in the community.
- Having to travel long distances to render social work services to MHCUs.
- Lack of support from supervisors and the organisation.
- Clients' cultural/traditional customs and practices hampering social work service delivery.
- Lack of confidentiality.

In concurrence with the findings of Schenck's study (2004), Chibba (2011) states that "the profession is demanding," its "workers remain inadequately remunerated … Many are compelled to leave the country due to the poor working conditions and low pay rates. There are no adequate offices for social workers." Kruger (2008:44) claims that one of

the primary reasons why social work professionals decline to work in rural and remote parts of the country was the poor working conditions. The Minister of Social Development, Bathabile Dlamini (2010:4), concurs with these pronouncements when she says that social workers transfer to areas which provide better working conditions and lucrative pay packages.

The difficulties enunciated above relate to Schenck's study findings (2003, 2004). The participants in her study (Schenck, 2003:55; 2004:165), particularly the rural social workers working in the provincial Departments of Social Development, reported that they have to contend with workplaces and offices which are in a highly unsatisfactory condition. For instance, offices were difficult to reach, office space was limited, and social workers were compelled to share offices; specialists often had no offices, waiting areas, or commodes; even a lack of electricity. A considerable number of participants in her study had no telephones, computers, or even fax machines. Schenck's participants reported a shortage of official vehicles, and the vehicles that were available were unsuitable for travelling on gravel roads or in mountainous areas. Social workers were forced to travel on foot to reach individuals with mental illness.

In a study conducted by Sidell, Boughton, Hull, Ertz, Seeley, and Weider (2006:35) with social workers in one of the rural Pennsylvania provinces in the US, participants alluded to “restricted assets”. Force-Emery Mackie (2007:115) referred to the “absence of services/resources/financing” and a “lack of transportation” as the most crucial difficulties confronted by social workers working in rural areas. Force-Emery Mackie (2007:117) states that the difficulties experienced by rural social workers result in imbalances in service provision, and this complicates access to and the delivery of services. Apaslan and Schenck (2012:3) attest to the fact that the difficulties relating to working conditions experienced by social workers practising in rural areas are mostly linked to service organisations and client-linked issues.

The approach followed in the present study focused on empowerment, based on the principles of the strength-based perspective, as empowerment has become an increasingly important factor in determining employees’ health and wellbeing (Laschinger & Finegan, 2005:439). Durand (2008:36) asserts that empowerment in the workplace has

two meanings. Firstly, it refers to the practice or set of practices involving the delegation of responsibility down the hierarchical structure of the organisation, resulting in increased decision-making authority for employees in respect of the execution of their primary tasks. The second meaning of empowerment refers to psychological empowerment and to the feelings of empowerment as reflected in the competence/confidence in employees' abilities to perform their tasks well, to experience impact or influence in their jobs, and to experience self-determination and a sense of meaning.

Subtheme 2.5: Challenges experienced by social workers regarding mental health care services

Four participants described their challenges as to the lack of information regarding mental health care. They felt that they lacked capacity to deal with this service.

> *P2: "Lack of information regarding mental health care."*
> *P4: "Lack of information regarding mental health care."*
> *P5: "The issue of capacity and lack of knowledge regarding mental health."*
> *P11: "We are clueless; no information about mental health."*
> *P14: "We are hampered by the degree of our training; we are just doing trial and error."*

Five participants voiced their frustration at being unable to deal with mental health care users who had relapsed.

> *P7: "Sometimes when we conduct home visit, if the patient has relapsed it is not easy to gain entry."*
> *P8: "If you are alone in the office and the person with mental illness comes, you are scared."*
> *P9: "We know that some of them, they are very harmful."*
> *P10: "You find that maybe the family members of that particular person wants that person to be transfer to the mental health institution, but the MHCU does not want to go there, so we have to lie to him that we are just going there for a day, you will come back, so that a challenge."*
> *P12: "At some point when you are sitting in the office as a social worker and then MHCU just come in and you thought is a normal person, and while you are talking you discover this person is not okay, so I once had a case like that when we were talking he just got emotional, he wanted to attack me."*

Seven participants explained how they were dealing with the challenges they experienced regarding mental health care users.

> *P3: "Nothing."*

P5: "I read the Act."
P6: "Nothing has been done so far."
P7: "The nurses also help us to give us information as we are working together with them."
P8: "There are securities and then we call them for assistance."
P12: "I just called a security."
P13: "Communicate with the family members as well talk to the supervisor."
P14: "Consult supervisor, consult social workers and nurses in Evuxakeni."

Eleven participants indicated that their supervisors supported them in dealing with the challenges they experienced with MHCUs.

P1: "For the one case that I have done, I got support."
P4, 14: "Yes."
P5: "I get guidance and support from the supervisor, and read the Act."
P7: "Our manager at the district level who provides us with materials or information."
P7: "Yes, she provides us with information."
P7: "Yes, she assists with the channel of communication, she knows who to contact in the district when we have challenges."
P8: "Yes, the supervisor has helped me; I had a case of the patient with mental illness. This patient has debts and his ID and bankcard are with the loan sharks. He came to my office demanding that I should give him his ID and bankcard. I was so scared and the supervisor supported me in this regard."
P9: "Sometimes the supervisor, if there is a car, she assists us."
P10: "I get support from my supervisor for the cases that I am handling not mental health."
P13: "Communicate with the family members as well as talk to the supervisor. I receive support, but there is nothing she could do."

Four participants revealed that their supervisors were not providing any support in dealing with the challenges they experienced with MHCUs.

P3, 12: "No."
P6: "No supervision."
P9: "I do not know how to put it, because you will tell the supervisor and maybe she will say: see what you can do; we will inform the person, but nothing will be done."

One participant found the question difficult to answer, as supervision was focused on the participant's workload and not on mental health care.

P5: "No I do not get support I am not doing mental health."

The participants indicated that they lacked knowledge in mental health. Some participants experienced the challenge of being unable to deal with mental health care users due to their aggression and violent behaviour. They also had to deal with the challenges experienced by other professionals such as supervisors, nurses, and security officers. A number of participants reported that they did not receive any support from their supervisors.

The Reconstruction and Development Programme (Republic of South Africa. 1994:54-55) refers to the change, reorientation, and retention of social workers. In this document, it has been stated that the existing pool of social workers and their conditions of service must be reviewed. The number of social workers at present is inadequate and their training is, in some instances, inappropriate. Many social workers must be reoriented and retrained within a developmental approach to social welfare.

The Department of Health (2016) asserts that in the UK, social workers constitute the core of the Approved Mental Health Professionals (AMHP) workforce. In this role, social workers take crucial, urgent decisions in a least restrictive and most suitable context in which people should receive care and treatment; and they play a vital, statutory role in protecting people's human rights and promoting the principles of the Mental Health Act Code of Practice (UK) (Department of Health, 2015). In applying the principles of personalisation and the opportunities of the Act, social workers are vital in ensuring that people with mental health needs are seen primarily as citizens with equal rights, rather than exclusively through a diagnostic or clinical lens (Department of Health, 2015). Concerns regarding the social workers' abilities to practise effectively in mental health have also been raised in the United States and the United Kingdom (Beinecke & Huxley, 2009:222).

Beinecke and Huxley (2009:222) claim that many practitioners do not have the knowledge or the skills necessary to work in mental health settings and "that the required

competences are not being taught…much work needs to be done to define needed skills and train the teachers and workforce of the future in them." Simpson, Williams, and Segall (2007) suggest that the variance in the nature and depth of mental health content in the Masters of Social Work courses across the US, is a cause for concern, and reflects the differing views of academics and practitioners around what "essential content" involves.

In view of the need for supervision, Green (2003:215) recommends that "rural social workers in Australia must have agency support, adequate supervision and proper training to ensure they can practice competently, professionally and securely in rural and remote locations" (Green, Gregory & Mason, 2003:101). This can be applicable in a South African rural context. Based on the theoretical framework, the approach followed in this study was of an empowerment nature, based on the principles of the strengths-based persperctive, as empowerment has become an increasingly important factor in determining employee health and wellbeing (Laschinger & Finegan, 2005:439). Durand (2008:36) asserts that empowerment in the workplace has two meanings. Firstly, it refers to a set of practices involving the delegation of responsibility down the hierarchical structure of the organisation, resulting in increased decision-making authority for employees in respect of the execution of their primary tasks. The second meaning of empowerment refers to psychological empowerment and to feelings of empowerment as reflected in the competence/confidence in employees' abilities to perform a task well, to experience impact or influence in their jobs, and to attain self-determination and a sense of meaning.

Subtheme 2.6: The needs of social workers to be able to improve service delivery to mental health care users

Most of the participants were of the view that training in mental health was needed in order to improve service delivery to mental health care users.

> *P1: "No knowledge on mental health. I need to be trained in mental health."*
> *P1: "I can say we need training, as I do not know much about mental health."*
> *P2: "DSD should prioritise mental health services. Currently we do not render any mental health services."*
> *P5: "I am not capacitated in mental health; my degree has not prepared me to handle mental health cases. I need training in this regard."*

P7: "Also, only the social workers in the clinic are running the programme. It is therefore important that social workers in the welfare offices and those working in the villages to be trained in mental health; now they do not know anything."
P7: "What I see is that the Department of Social Development; they must have a plan to workshop the social workers. Because we do not have more information on mental health, we depend on the books that we get from the district level and there is no proper person who is chosen to workshop us."
P8: "I need training in mental health care."
P11: "I think there should be more training for social workers because I see that we sometimes struggle when coming to assist these people."
P14: "If I do not have training, what must I give them? They should look at me first what skills I possess."

The participants articulated their need to be capacitated in mental health care, and recommended that the department organise workshops. The training they require should cover a wide range of approaches, including primary mental health care. In particular, useful outcomes of training generally involve trainees' activities which are directly related to their daily practice, such as interviewing patients (Cooper, 2003:2). The importance of supervision to assure appropriate decision making in either case management or stepped care has been mentioned above.

It is crucially important to promote implementation of training programmes and change in health care practice (Da Rocha-Kustner, 2009:231), by enabling health workers to consolidate learning, clarify principles, discuss problem cases, explore treatment options, and share their feelings that inevitably arise when working with patients with mental disorders.

It may be true that social work is "less well prepared to meet specific standards" within the Australian national mental health strategy of such as "mental problems and mental disorders" (Renouf & Bland, 2005:423); however, these authors argue that a critical analysis does provide specific and much needed theoretical and practical insights in terms of a knowledge, skills, and values base for mental health.

Pursuing an empowerment agenda requires a deep conviction of the necessity of democracy (Saleebey, 2006:12). It requires social workers to address the tension and conflict experienced by people within mental health institutions that limit the help these social workers can provide, and which prevent them from helping the mentally ill to free themselves from restrictions that impede their recovery (Saleebey, 2002). The strengths

perspective imposes a different attitude and commitment. The strengths of individuals and communities are renewable and expanded resources, as the assets of individuals are embedded in community interest and involvement (Saleebey, 2006:12).

Theme 3: Recommendations regarding social work services in mental health care service delivery

The participants recommended the following, as summarised by the researcher, that community awareness programmes be conducted; mental health services should be prioritised in the Department of Social Development; training in mental health care for social workers should be facilitated; and mentoring service should be established regarding mental health care. Most of the participants recommended the inclusion of mental health in the programmes aimed at people with disabilities; there should be clarification regarding the role of the social worker within the multidisciplinary team; there should be acknowledgement of safety issues; and there should be additional remuneration in the form of a danger allowance.

Summary of section C

It should be noted that social workers in the districts have limited or no knowledge of mental health services in their communities. It should be noted that the district social workers provide generic services, and that mental health services are not rendered optimally. The difference is essentially that hospital social workers at least have a basic knowledge of mental health services, even though they refer to this as generic social work. The tasks of district social workers included counselling, support groups, monitoring, home visits, assessment, and referrals. Practical support services entail applying for disability grants and monitoring thereof, and placements in residential facilities. Participants were concerned about their lack of knowledge in mental health care, and expressed their need for appropriate training.

7.3.4 Section D: Findings - hospital social worker participants

This section discusses the findings of hospital social work participants. The interviews were conducted with sixteen participants working for the DoH and DSD in Capricorn, Vhembe and Mopani Districts in Limpopo Province. The hospitals were Malamulele, Hayani, Evuxakeni, Nkhensani, Shiluvana, Polokwane, and Seshego. This section focuses on biographical profiles, followed by a thematic analysis.

7.3.4.1 Biographical profiles of hospital social work participants

This section gives an overview of the hospital social work participants and their biographical profiles. The following table provides the biographical profiles of hospital social work participants, followed by a thematic analysis.

Table 7.7: Biographical profiles of hospital social workers

P	Age	Marital status	Language	Gender	Qualif.	Institution	Attained	Area	Years employed
1	23	Single	Tsonga	Female	BSW	University of Limpopo	2014	Mopani Nkhensani	1
2	30	Married	Tsonga	Female	BSW	UNIVEN	2009	Mopani Nkhensani	6
3	38	Single	Venda	Male	BSW	University of North West	2001	Polokwane Hospital, Capricorn	6
4	43	Single	Tsonga	Female	BSW	University of Limpopo	2000	Malamulele Hospital, Vhembe	9
5	38	Married	Tsonga	Female	BSW	UNIVEN	2009	Mopani Shiluvana	5
6	37	Married	Sepedi	Female	BSW	University of Limpopo	2009	Polokwane Hospital, Capricorn	5
7	38	Single	Tsonga	Male	BSW	University of Venda	2012	Malamulele Hospital, Vhembe	2
8	32	Married	Tsonga	Female	BSW	UNIVEN	2009	Mopani Nkhensani	5
9	38	Divorced	Sepedi	Female	BSW	University of Limpopo	1998	Polokwane Hospital, Capricorn	17
10	41	Single	Tsonga	Female	BSW	University of Venda	2010	Malamulele Hospital, Vhembe	5

P	Age	Marital status	Language	Gender	Qualif.	Institution	Attained	Area	Years employed
11	42	Married	Sepedi	Female	BSW	University of Limpopo	1998	Polokwane Hospital, Capricorn	16
12	22	Single	Tsonga	Male	BSW	University of Venda	2015	Malamulele Hospital, Vhembe	6 Months
13	36	Married	Sepedi	Female	BSW	University of Venda	2008	Seshego Hospital, Capricorn Polokwane	7
14	45	Married	Venda	Male	BSW	University of North West	2001	Hayani Hospital Vhembe,	11
15	28	Married	Tsonga	Female	BSW	University of Limpopo	2011	Evuxakeni Hospital, Mopani	3
16	26	Divorced	Tsonga	Female	BSW	University of Venda	2006	Evuxakeni Hospital Mopani	3

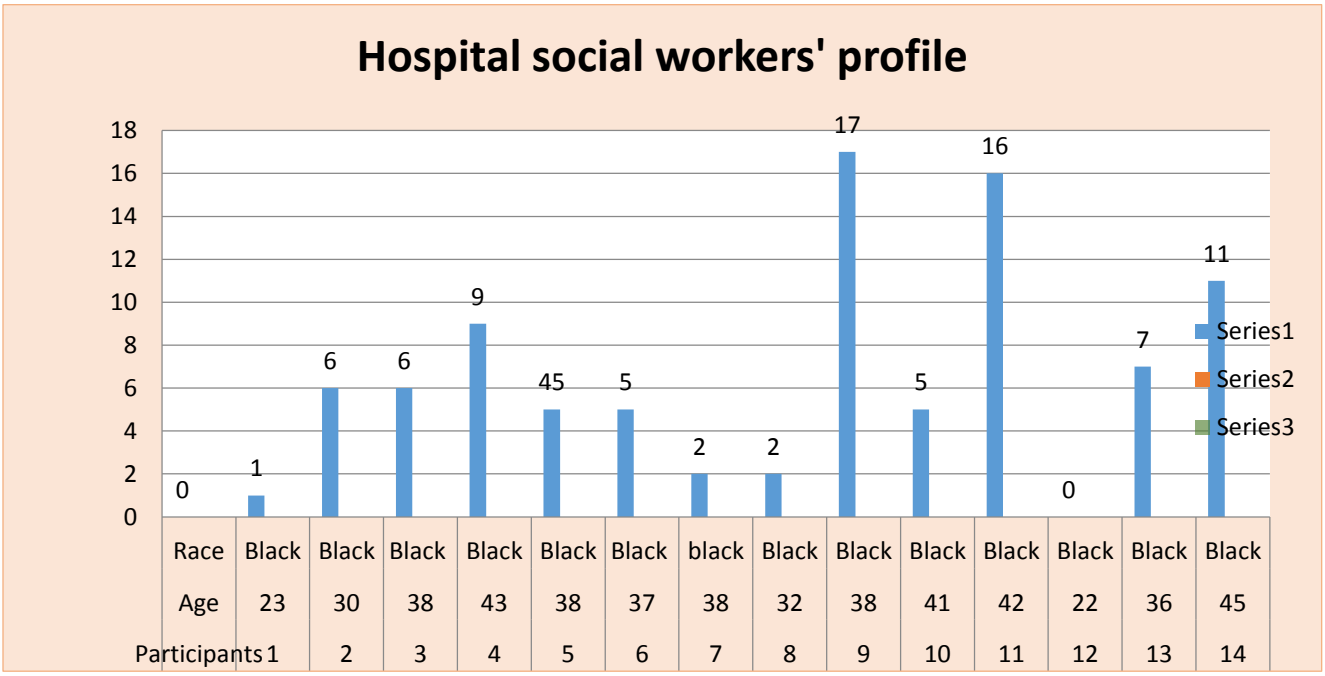


Figure 7.5: Hospital social workers' biographical profiles (n=16)

The ages of these participants ranged from 22 to 45 years; the participants were predominantly female; there were four male participants. Furthermore, the participants'

languages included Tshivenda, Tsonga, and Sepedi. Eight participants were married, two participants were divorced and six participants were single. Nine participants obtained their social work Bachelor's degree at the University of Venda, six participants obtained their qualifications at the University of Limpopo, and two were University of the North West graduates. The years of employment ranged from six months to 17 years.

7.3.4.2 Thematic analysis

This section present the themes, subthemes, and categories of the data collected from hospital social workers at the Limpopo Department of Social Development (DSD) and the Department of Health (DoH). The following discussion provides the details of what transpired in the interviews. Furthermore, the direct quotes of the participants are presented to support the themes, substantiated by the literature.

Table 7.8: Themes, subthemes, and categories: Hospital social workers

Themes	Subthemes	Categories
Theme 1: A description of mental health services in the hospitals where the participants worked	**Subtheme 1.1**: The nature of mental health services provided	**Category 1**: Mental health services
	Subtheme 1.2: Effectiveness of current mental health services	
	Subtheme 1.3: The need for the improvement of services	
	Subtheme 1.4: Knowledge and skills to deal with mental health related cases	
Theme 2: A description of social services in the hospitals where the participants worked	**Subtheme 2.1**: Description of the nature of services by social workers	**Category 2**: The main tasks of the social worker
	Subtheme 2.2: Effectiveness of current social work services	
Theme 3: Descriptions of teamwork when working	**Subtheme 3.1**: Working with professionals in the community	**Category 3**: Social workers

Themes	Subthemes	Categories
with mental health care users		**Category 3**: Other professions and organisations
	Subtheme 3.2: Working within a multi-disciplinary team in the hospital	
Theme 4: Recommendations regarding social work services in mental health care service delivery		

Category 1: Mental health services

The participants reflected on the mental health care services provided at the hospital where they worked. Themes and subthemes are included in this category.

Theme 1: A description of mental health services in the hospitals where the participants worked

The participants provided a description of mental care health services provided at the hospital where they were employed. Subthemes emanated from this theme and are discussed below.

Subtheme 1.1: The nature of mental health care services provided

Three participants referred to the nature of mental health care services provided as treatment and rehabilitation.

> *P2: "Rehabilitation, where we try to teach them [service users] about independence, because most of them when they came from home they depend. We could see that they have not been at the experience where they have been taught about how to do things. Usually most of them you found that they were locked at the houses, they were not used to interact with people and you found they usually want to isolate, because they are not used to the environment where they mingle with others and socialise."*
> *P6: "We assist patients who default treatment. In general, I think the main thing is to give them treatment."*
> *P7: "Our main goal is to ensure that MHCUs do not relapse; some of the patients use substance, and our goal is to help them to stop using the substance."*

Three participants indicated that the services provided were short-term intervention in nature.

> *P6: "The patients are not admitted for the long time here; they are transferred to Makweng Hospital."*
> *P8: "Mostly when they come here they come for observation 72 hours. Then they refer them to Evuxakeni for rehabilitation."*
> *P11: "Screening patients, then admit them in the respective wards. From there they are referred to Makweng Hospital."*

The participants alluded to the nature of the mental health services that were offered at the hospitals. They mentioned services such as rehabilitation, assisting patients who defaulted on their treatment, and providing treatment. Other participants stated that patients with mental illness were not admitted for a lengthy period of time; they were observed for 72 hours and subsequently transferred to other psychiatric hospitals such as Evuxakeni and Makweng Hospitals.

The mental healthcare services offered at these dedicated facilities include general psychiatry, treatment for substance dependence or other addictions associated with psychiatric disorders and, in certain cases, some psychiatric sub-specialities for high- and medium-acute users; post-discharge support is usually also offered (Life Care Mental Health, 2016). The treatment offered includes evidence-based drug therapy, individual psychiatric consultations, psychotherapy, group therapy and where needed, physical therapy.

A multidisciplinary team which, depending on individual patient needs could comprise medical practitioners such as psychiatrists who provide these holistic services as well as other healthcare professionals such as psychologists, occupational therapists, social workers, and nursing practitioners trained in mental health (Life Care Mental Health, 2016).

A growing body of inquiry and practice makes it clear that the rule, and not the exception, in human affairs is that people do rebound from adversity, and that individuals and communities do surmount and overcome serious hardship (Saleebey, 2002). Resilience is neither the cheerful disregard of one's difficult and traumatic life experiences nor the naïve discounting of life's pain (Saleebey, 2002); it is rather the ability to endure in spite

of these ordeals. Emotional and physical scars bear witness to that (Saleebey, 2002). In spite of the trauma, however, for many their trials and tribulations have been instructive lessons learned.

Subtheme 1.2: Effectiveness of current mental health services

Some participants were of the view that the current mental health services were effective.

> *P1: "When we monitor we see progress in this client."*
> *P3: "I think is very good but the families are not supportive."*
> *P4: "Most of them they do not have families and in most cases they stay alone. If you send the patients to the institutions,that is where they are well cared for."*

Contrary to the statements above, five participants were of the opinion that mental health services were ineffective.

> *P3: "They are effective, but to such an extent I indicated we do not work cooperatively as a team."*
> *P5: "I cannot say they are effective. Because you know, you come across a client who has these challenges and you can't even know how to help."*
> *P8: "They are effective, but the challenge is that sometimes the space is a problem, they stay here for long time."*
> *P11: "Not at all."*
> *P13: "It depends on the family of the patient receiving these services, in most cases they are not effective, because families with a MHCU they do not come for follow-ups, they do not come to the family meetings when we call them, they do not implement the programmes we give them at home, and they do not bring the patients back for treatment; as a result the patient relapses. So out of ten I'll say 2 out of 10. We are trying, but because we do not have support, the family is not cooperative."*

Two participants were of the opinion that inpatient treatment was effective, but not the outpatient services.

> *P2: "Even now we are having patients here; maybe we can say we are discharging you today. They go home for two months; down the line you find that their condition has deteriorated because they do not go for follow-up on the treatment, whereas when they are here we give them treatment and they are fine. They don't even resist but when you go home they will tell you that this one does not want to take treatment and you find that a condition back to zero and a person is becoming a threat to the community. They are also exposing them to danger because anything can happen to them."*
> *P10: "I can say services are not effective based on the aftercare services. We do not do thorough service we just go once to conduct home visits."*

The participants had different views about the effectiveness or ineffectiveness of mental health service. Some viewed mental health services as effective; the challenge was with families who were uncooperative. Some participants were of the opinion that inpatient services were effective, but not the outpatient services; the social workers did not render after-care services.

Beytell (2003:1) states that social work within the health care system must not only change their service delivery to communities in order to be more appropriate; they must also change their approach to service delivery as a whole. The White Paper for Social Welfare (Department of Social Development, 1997:88) suggests that consideration should be given to the re-orientation of social work service in health settings towards a developmental social welfare approach. The White Paper for Social Welfare further states that appropriate welfare programmes, which are responsive to the range of social, cultural, and economic conditions in communities, should be implemented. The service should complement and strengthen people's efforts, and enhance their self-respect and independence.

Beytell (2003:2) is further of the opinion that social work is indeed ineffective, inappropriate, and disparate. This is evident when the nature of the present health care service is considered, its mission statement, philosophies, and practice models of the welfare system of SA and that of the international community. The effectiveness, relevance, and equitably of social work within health care, compared to present health care policies and philosophies, should be investigated. Health care social work is not only part of the welfare system but also of the health system. The mission statement of the White Paper for Transformation of Health Systems of SA (1997) (Department of Health, 2007) is that the health of all people in SA should be promoted, and a caring and effective service provided through a primary health care approach. Health teams and workers should not only be responsible for patients who attend health facilities but also have a sense of responsibility toward the health of the population and communities in their areas.

The ecological systems theory is geared toward meaningfully integrating the psychological and sociological dimensions of social work practice, and supporting a conceptual shift in social work practice from a static to a dynamic view of environment

(Gray & Webber, 2013:179). It is further asserted that social workers have always been concerned with the situational determinants of human functioning, but until the evolution of ecological systems theory, the profession found it easier and often more expedient, to only address personal functioning (Gray & Webber, 2013:179).

Subtheme 1.3: The needs for improvement of the mental health services

The participants were of the opinion that social workers need to be trained in order to work with patients with mental health problems.

> *P1: "We need training so that we can be able to provide service to people with mental illnesses."*
> *P5: "I think as social workers we have to go for training in mental health care services so that we can help clients when they come to our offices, because we cannot always refer them."*

One participant indicated that there was a need to focus on promoting the independent living to people living with mental illness.

> *P2: "I think there is need that we should promote independent living. Now, whatever the patient do they being supervised."*

Two participants indicated that there was a need for long-term care and the establishment of mental health facilities.

> *P8: "I think the department needs to make more space for the patients or establish other institutions."*
> *P11: "I will be happy if mental health facility can be established."*

One participant was of the view that there was a need for policy guidelines on how to assist mental health care users.

> *P10: "We need a policy or guideline on how to deal with mental health care users."*

The participants reflected on what needed to be done to improve social work services. They were of the opinion that they needed training in mental health. Others stated the need to focus on the promotion of independent living of the mentally ill. The participants were of the view that there should be policy guidelines.

The study of Cesare and King (2014:1766) has the particular distinction in that it was conducted prior to the curriculum changes; the findings established a baseline that enables evaluation of the effects of these developments. The authors are of the opinion that the implementation of a mental health component in social work training is likely to be variable in both quantity and quality, and that there would remain tensions among some social work values and attitudes as well as contemporary approaches to mental health practice. It is also important that social workers develop the tools to examine difficult practices under the supervision of experts. This could assist in their practice becoming more congruent with social work values (Walsh, Farmer, Taylor & Bentley, 2003:91) and enhance their ability to integrate critical and clinical perspectives, providing a meaningful and distinct social work perspective in mental health (Bland et al., 2009:14).

The findings of Cesare and King (2014:1767) raised questions about the need for a compulsory stand-alone mental health subject in undergraduate social work training. The authors are of the view that a review of study disciplines in a few years' time would help answer this question. If mental health literacy among recent graduates were substantially greater, it would suggest that the curriculum changes recommended by the AASW (2008) would be sufficient. On the other hand, if mental health literacy remains low, it will suggest the need for more focused and substantial training in mental health. It would also be useful to examine how the mental health literacy of mental health social workers compares to that of health care social workers outside the mental health sphere. While this study demonstrated low levels of mental health literacy, it does not suggest that social work interventions as they stand at present are without value. However, social workers should develop a better understanding of psychopathology and the standard approaches to treatment.

Pursuing an empowerment agenda requires a deep conviction of the necessity of democracy (Saleebey, 2006:12). It requires social workers to address the tension and conflict of people within mental health institutions that limit the assistance that those social workers can provide to help people free themselves from the restrictions that impede there recovery (Saleebey, 2002). The strengths perspective imposes a different attitude and commitment to the strengths of individuals and communities, which are renewable

and expanded resources. The assets of individuals are embedded in community interest and involvement (Saleebey, 2006:12).

Category 2: The main tasks of the social worker

One theme and a number of subthemes emanated from the data.

Theme 2: A description of social services in the hospitals where the participants worked

This theme focuses on the description of social workers in the hospitals where they worked. The subthemes are the following:

Subtheme 2.1: Description of the nature of services by social workers

The participants reflected upon the nature of social work services in mental health such as screening, counselling, assessment, awareness campaigns, reunification, after-care services, family preservation, prevention services, crisis intervention, support services, health promotion, assisting MHCUs' in the recovery process, family services, and the supervision of treatment.

> *P1: "Counselling, monitoring, and referring."*
> *P2: "Sometimes we check what the needs are, when we admit them [*service users*] I will have to go and assess. After the assessment we see the gap; maybe the needs which I need to rehabilitate patients with."*
> *P5: "Our main goal is to provide counselling and to assess their home circumstances."*
> *P7: "Our main task as social workers we conduct screening, ward rounds, educating the patients about illness."*
> *P8: "Assessment and sometimes counselling."*
> *P9: "We are stakeholders; so basically we are a support system."*
> *P10: "We do assessments."*
> *P11: "I think it dependents on the type of services that the person needs. We do screening, we do counselling, assessment, awareness campaigns, reunification and after care services."*
> *P13: "We do counselling, we do family preservation, we do prevention services, we do crisis intervention, we do support services, and we do health promotion."*
> *P15: "I think we are responsible to care and help MHCUs to recover, we reunify them with their families, we provide supervision of intake of treatment, we provide counselling and assessment and family services."*
> *P15: "Firstly, when the patient comes, you do an assessment; the role of the social worker is to look at the person's social setting and their background."*

Some participants described the services that social workers rendered such as psycho-educational groups and group work.

> *P2: "We only do psycho-educational groups where we have to teach them [service users] with different topics."*
> *P4: "We have group work. We encourage the MHCUs to be involved in a project for fence-making in order to keep them busy."*
> *P12: "The services are group work."*
> *P14: "Group work."*

A number of participants reflected on the services they offered to assist patients in accessing disability grants, conduct support groups and attend ward rounds; and involvement in the multidisciplinary teams, home visits, empowerment of families, and the provision of psychosocial support to MHCUs.

> *P7: "We do psychoeducation, we access disability grants, conduct support groups, ward rounds, multidisciplinary, case discussion,"*
> *P3: "Mental health services are for counselling, reunification, family preservation (pause), placement, support of family and the clients."*
> *P4: "The services that I know of is aftercare."*
> *P10: "We are providing counselling, doing placements, the aftercare part is lacking but we are trying to conduct home visits to check how the patient is coping after the discharge. Provide support to family members."*
> *P11: "The main focus is to provide quality social work to the mental health care users, to enhance their psychosocial functioning and also empower families that have mental health users, so that they can know how to handle them."*
> *P12: "The services are psychosocial support."*
> *P16: "Here in the hospital we provide psychosocial services to MHCUs, we provide psychoeducation."*

A number of participants indicated that they assisted by tracing the families of MHCUs. They also assisted when MHCUs had family problems, and they facilitated family reunifications.

> *P6: "Mostly we work with psychiatric patients that do not have families. We do tracing of psychiatric patients' families."*
> *P6: "They are some patients who will need a social worker to intervene by tracing their families."*
> *P8: "Just to assist them when they have got family problems or lack of family support. The majority of them they lack family support. We just call the family and we can conduct joint sessions with them to hear their side of the story."*
> *P9: "We try to reunite the family with clients after they have been admitted in the hospital, we do family preservation programmes to the families, we assist family members to understand the illness, we encourage family members to help a patient with their medication, to encourage support system in the family."*

P9: "We try to reunite the family with clients after they have been admitted in the hospital, we do family preservation programmes to the families, we assist the family members to understand the illness, we encourage family members to help a patient with their medication, and we encourage support systems in the family."
P9: "On our side is basically family preservation; to reunite the family with the patient."
P13: "We educate the families about the support they must give their patients and also the families we give them support. Because sometimes the impact of that patient on their family can be very stressful, especially if the patient was a breadwinner or especially if the breadwinner is the one who has to take care of the patient. They cannot compromise their work to come to take care of the patient. Sometimes it becomes a challenge if the patient is an adult who refuses to be cared for, in most cases by their siblings because the parents have died."
P16: "In terms of the family preservation services we tend to be the unifiers, the integrators, we mediate and advocate for the MHCUs."

Some participants indicated that they conducted community awareness campaigns.

P2: "Sometimes we also do community involvement projects where we want at least our patients to interact with people from outside, not only themselves."
P3: "I can say advocate for patients. Awareness in the community; we need to go to the community and indicate that the person has changed. We advocate in order to help the patients not to be stigmatised. Even if the person is rehabilitated, the community still regards him or her as a crazy person. The person can relapse if not accepted either at home or in the community."
P4: "Help them to be accepted in the community. Help them to be accepted in the community."
P13: "We are emphasising on awareness campaigns."
P16: "We do community work and do campaigns and create awareness about mental illness."
P16: "We conduct awareness to the youth about substance abuse as the contributory factor to the mental illness."

Two participants reported that they served as facilitators to case managers in the hospitals.

P2: "To maintain the number of patients which we are having here. Like how many they are, how to assess, the incoming forms or the applications; though I'm not doing alone but I am the facilitator. Facilitate, monitor, evaluate services provided to MHCUs."
P16: "We facilitate the application of identity documents as well as disability grants."

Some participants indicated that general services did not specifically focus on mental health.

P1: "To provide counselling."
P1: "We provide counselling to rape clients and then we refer them to psychologist."
P3: "To give counselling and support to the inpatients and outpatients."
P4: "We do not deal much with mental health cases."
P4: "I am placed at ARV clinic focusing on adherence counselling, trace defaulters, do home visits. Sometimes MHCUs are coming due to HIV-induced psychosis. Most of the patients are not accepting their status. You need to empower patients. You need to conduct home visits."
P5: "I can say I do not provide mental health service in the hospital, only the psychologist provides the services."
P5: "My main task is to provide counselling, to victims of domestic violence and to assess their home circumstances in order to do placements."
P6: "We have to do counselling, but we do not do that because we were supposed to be interviewing the families."
P7: "We provide psychoeducation for MHCUs, and sometimes we write psychosocial reports for those who want to be placed in a mental institution."
P12: "We need to make sure that they take treatment so that they can be able to live in the community."
P16: "Regarding substance abuse, we provide counselling and group work with the MHCUs."

Some participants claimed that they focused on family relationships and contact.

P2: "When it comes to the family issues, that's where I intervene mostly, you find that most of them maybe they have got a family, but there is a problem. The family is neglecting them, they don't even come here, it's like they are in a dumping area. So that where I come from, I encourage the family to maintain regular contact, family to provide support at some time during the holidays. I enforce actually that the family should come and take them home; at least they can have that sense of belonging."
P2: "My goal is based on the social acceptance. That is about the welfare of the patients and the welfare of their families."
P4: "Family reunification…eh…the families do not understand the patient, they reject the patients when they display inappropriate behaviours as they think that they are normal, therefore we empower the families to accept the patients."
P6: "Looking for placement and reunification services."
P10: "To help the patients and the families to understand mental health. It is to understand the illness first before you can get treatment."
P13: "So we try to have lot of the family meetings. Our main focus is to preserve the patient family because if the family has a gap, there is no way that the patient can be assisted. So our main focus is to ensure that there is stability in the family, there is support, and there is common understanding in terms of how to manage the patient."
P15: "I will say is to keep families and the patients together."

Other participants indicated that they were responsible for preparing documentation relating to the discharge of patients.

P3: "To advise the doctor on the discharge preparation and also check psychosocial circumstances of the family."
P3: "Specific to MHCUs, the first one, we provide psychosocial support to the family, we are also involved in multidisciplinary team, prepare patients for discharge."
P10: "I think adherence counselling in terms of treatment."
P 13: "We try to engage the community-based health care providers, the home-based carers to assist once the patient is discharged."
P14: "Our main focus is to see a patient getting back to the community; we rehabilitate the patients until the patient reach the stage that he gets back to the community."
P16: "When the MHCUs go out there they need to be effective. Therefore our main goal is to see them being integrated in the community and also contributing to the society as well as living independently and not to be undermined."
P16: "Usually mental illness is chronic, we do not talk about curing it; instead we focus on maintenance."

Participants indicated that they were responsible for preventing relapse, and the promotion of services.

P13: "Prevention and promotion, we are doing a lot, we are trying to prevent occurrence of relapse, the occurrence of lack of support, so we are emphasising on prevention and promotion."

Other participants indicated that they were responsible for advocating tolerance and acceptance of those who are mentally ill.

P8: "Mostly we want them to be treated like other people; not to be discriminated, because as MHCUs, sometimes people do not take them serious."
P10: "I think I can say I am acting as an advocate between the hospital, patients and other stakeholders."
P14: "So as social workers we advocate on behalf of the patients. We try to talk to the family, we also conduct awareness campaigns, helping the communities to understand what is mental illness, how to live with mentally ill patients. We also have stigma; mentally ill patients are not regarded as humans; whatever they do, community do not feel comfortable with them."
P14: "We have patients, in fact most of the patients that are admitted here they come here without IDs. So we liaise with home affairs helping them to apply or reapply for their IDs. We also help with RDP houses, because it's like mental illness and poverty go hand in hand. Most of patients are from poor background, so we are helping them; we liaise with local municipality to get preference when they allocate these houses."
P14: "The social workers work as the bridge; we link the hospital and the community, we connect them."
P15: "Giving attention to the client and listening that they are being heard and being understood."

The participants reported that social services were provided in the hospitals in which they worked. The services ranged from counselling, assessment, and community awareness. The participants were of the view that advocacy was particularly crucial.

Social work within a medical setting denotes working with the individual and collaborating with medical and paramedical teams as well as families, community partners, and volunteers. They facilitate physical, psychological, social, and spiritual rehabilitation, and assist in the recovery of individuals who suffer, or have suffered, from mental illness. This includes improving or maintaining their quality of life, despite their illnesses; and enhancing acceptance and coping strategies, including bereavement counselling for patients and their families.

According to The Medical setting Social Work Services (2015), the nature of social services relate to casework that focuses on pre-admission planning, psychosocial assessment, discharge planning and follow-up service, referral for practical assistance, counselling for individuals and/or their families, psychoeducation on illness and its progression, and consultation and collaboration with other health care professionals. Group work comprises therapeutic, developmental, educational, and mutual support for patients, their caregivers, and volunteer training groups. A patient/health resource centre which focuses on developmental, educational, and recreational programmes or projects for patients and/or their families could be established and implemented in partnership with hospitals or communities.

The SACSSP (2016) asserts that "social work in health care means a specialisation in social work in the field of health care, which focuses on health promotion, prevention, intervention and research regarding the psychosocial implications of illness and disability, chemical dependence, medical treatment, care and support, hospitalisation, rehabilitation, reintegration of patients with their significant others, and the community from a holistic perspective."

Long (2011:20) contends that if a multidisciplinary approach is adopted, there may be opportunities for the team to collaborate with other professionals and, for example, carry out ward rounds and attend case conferences. Most of the assigned workload would be

illness related or concentrate occasionally on a specific illness or condition, while at other times students would be exposed to a wider spectrum of psychiatric conditions such as schizophrenia, depression, and anxiety disorders.

Long (2011:21) states that psychiatric social workers (PSW) in mental hospitals work toward alleviating the social problems which arise in the lives of patients who have undergone treatment. Those who had worked for local authorities in the past found that many of their cases had been discharged into their care because hospitals had deemed them beyond the help of psychiatric medicine.

Social workers are involved in inpatient care, day hospitals, and outpatient settings across the spectrum of specialty programmes within the department. They assess patients' social, emotional, interpersonal, and socioeconomic issues. They work to enhance patient and family communications with medical team members to enable patients to become active partners in their own care. Depending upon the specialty unit, social workers are often involved in illness education and counselling. In all areas, they are pivotal to the aftercare planning process to facilitate a careful transition back into the family and community (Talwar & Singh, 2012).

A mental health social worker helps the mental health professional-psychiatrist and families of patients in a similar way as that of counsellors and psychologists (Talwar & Sing, 2012). Their main function is to assess patients and develop a specific plan of care for these individuals. They also provide therapy or counselling services to patients, and help family members deal with patients with mental illness in the family (Talwar & Singh, 2012). Mental health social workers generally interview patients who have been admitted to a mental facility or hospital, members of their families, agency staff, and others. The range of services needed by resident patients and their families constitute planning and developing a social plan of care for each resident and his or her family, which may include direct counselling, treatment provided by other agency support services, and/or referral to other agencies (Louie in OnlineMSW, sa).

Payne (2005:154) addresses what social work practice should focus on in relation to ecological systems theory, namely developing caring communities, identifying and

developing activities for the common good, promoting active partnerships, building capacity in individuals and communities, promoting decentralised and localised decision making and helping it to work, promoting community health and social resilience, promoting environmental as well as social justice, reducing human ecological stress, and focusing on natural methods of healing.

Subtheme 2.2: Knowledge and skills to deal with mental health related cases

The participants reflected on the hands-on training they received through mental health related cases. Some participants indicated that they had never undergone any training in mental health care. One participant reported that he attended training organised by the Department of Social Development. The responses on the knowledge and skills in dealing with mental health related cases are captured below:

P1,P2. P4, P5, P8: "No."
P3: "I attended in 2005. It was organised by the department of Social Development."
P6: "I did not go for mental health."
P7: "In service training."
P9: "No training."
P10: "Not yet trained."
P11: "Yes, I have it once in 2004. Since I am working here I have never been trained."
P12: "No training as yet."
P13: "No training in mental health."
P14: "No! I have never."
P15: "No, I am not trained as yet."
P16: "No, I am not trained in mental health."

The participants expressed diverse views regarding their knowledge of the Mental Health Care Act (No 17 of 2002) (Department of Health, 2002). Some had no knowledge at all while others had limited knowledge. Their responses, when asked if they are conversant with the Mental Health Care Act (No 17 of 2002) are captured below:

P1, P5, P15: "No."
P2, P7, P9, P13: "Yes."
P3: "Not much knowledge."
P4: "No I do not know."
P6: "I know that it does exist."
P8: "Yes, but not that much."
P10: "Not in detail."
P11: "Yes, sometimes."
P12: "I know it."

P14: "A little bit."
P16: "Yes, I am aware."

Most participants responded as follows to a question relating to their understanding of the DSM-5:

P1, P2, P5, P9, P11,P13, P15: "No."
P3: "Yes but not conversant with it."
P4: "Yes I just know about it, but not conversant with it."
P6: "No knowledge."
P7: "Not aware."
P10: "Not aware."
P12: "Not aware of this."
P14: "I cannot say I know it."
P16: "Out of my own experience, knowledge from the university as well as I always discuss with the psychiatrist."

Most participants responded as follows to a question relating to the Mental Health Care Act and their knowledge of the different admission procedures in dealing with MHCUs:

P1, P5, P15: "No."
P2: "No, I do not check much."
P3: "Insufficient knowledge."
P4: "I cannot explain the procedure."
P6: "I did not go through this act."
P7, P10: "Not sure."
P8: "I do not know."
P11: "I think a person to be admitted they need to do medical records from different doctors, they also need social work report, and there must be applications for detection order from magistrate."
P12: "I know there are state patients, assisted patients, but I have not much knowledge."
P13: "I do not have much knowledge of the admission procedures."
P14: "There are forms. I am conversant with the forms as I am completing them."
P16: "I know that there are voluntary patients, assisted patients, and involuntary patients."

Most participants responded as follows to a question relating to their knowledge and understanding of mood disorders:

P1: "Little knowledge."
P2: "It is a person who maybe sometime the behaviour can change, today maybe is green tomorrow is red or about mood swings high or low."
P3, P6: "No knowledge."
P4: "No knowledge."
P5: "Person with mood swings."

P7: "I will respond with an example, I have a client who has stopped taking treatment, he has been staying with his mother. The mother was afraid because he will get to her room without knocking; she was scared that he might sexually assault her."
P8: "I forgot."
P9: "Yes I know."
P10: "I am well equipped in the mood disorder."
P11: "I think is somebody who swings the moods. Maybe this time the person is happy the other time the person is not happy."
P12: "Talking of a person who is not happy or angry, the person always changing."
P13: "The patient is going through something that could affect their mood, hence they are behaving in a particular way."
P14: "When we say person we cannot predict him or her. The person is happy or angry."
P15: "Changing of moods."
P16: "Fluctuation of mood."

Most participants responded as follows to a question relating to their knowledge and understanding of bipolar disorder:

P1, P3, P4, P6, P10, P15: "No knowledge."
P2: "I think it is similar to the mood; maybe when someone is depressed may be differently."
P5: "Person is happy now and all of the sudden the person is sad."
P7: "I will respond with an example, I have a client who has stopped taking treatment; he has been staying with his mother. The mother was afraid because he will get to her room without knocking she was scared that he might sexually assault her."
P8: "Knowledge."
P9: "I cannot differentiate between schizophrenia."
P11: "Mostly likely to talk about religious issues."
P12: "Not sure."
P13: "It can be instigated by a traumatic event or depressing events in their life, hence it is episodic today is okay, tomorrow it's not okay."
P14: "We cannot predict happy and angry."
P16: "Little knowledge."

Most participants responded as follows to a question relating to their knowledge and understanding of schizophrenia:

P1, P4, P6, P10, P15: "No knowledge."
P2: "It is someone who are characterised with aggression."
P3: "Little knowledge."
P5: "Person seeing or hearing voices."
P7: "This one is related to the substance abuse."
P8: "I know but can't explain."
P9: "Little knowledge."
P11: "It is a mental illness is a chronic mental illness."

P12: "Fear of heights."
P13: "They are a lot of factors that contribute to be schizophrenic. It could be environmental factors contributing to a patient to be schizophrenic, family issues could contribute, substance abuse."
P14: "Those people who hallucinate and have delusions and see things that we do not see, they hear things
P16: "Hallucination and delusion."

Most participants responded as follows to a question relating to their knowledge and understanding of anxiety disorder:

P1, P3, P4, P6,P7, P15 : "No knowledge."
P2: "Someone who has a lot of fear of something and this fear is not normal."
P5: "Always anxious."
P8: "Knowledge."
P9: "Yes."
P10: "Scarce."
P11: "It's when a person, usually they have hallucinations, they present like those with schizophrenia, they have hallucination, they have fear of unknown."
P12: "People who are afraid to socialise."
P13: "The event that were never doubt in one's life, can it be in a later stage reoccur as a result cause one to experience that."
P14: "They just get afraid of anything."
P16: "Anxious too much."

Participants responded as follows to a question relating to their knowledge and understanding of personality disorder:

P1, P3,P4, P6, P7, P8,P9, P10, P15 : "No knowledge."
P2: "Someone who are very clean it goes with obsession."
P4: "No knowledge."
P5: "I cannot remember."
P11: "It's when a person does something to the extreme."
P12: "Talking person."
P13: "It could be the patients who are not sure of who are they, they do not have the true identity, they have never oriented about themselves."
P14: "They get angry at anything."
P16: "Many characters."

Most participants responded as follows to a question relating to their understanding of psychosis or mania:

P1, P3, P4, P6, P7, P8, P9, P10, P11, P15: "No knowledge."
P2: "Maybe someone with something like schizophrenia."
P5: "I cannot remember."
P12: "I do not know."
P13: "I do not know how to explain it."

P14: "No answer."
P16: "Mental illness."

Most participants responded as follows to a question relating to their knowledge of what the treatment for mental health disorders entails:

P1, P4, P7, P9, P13: "No knowledge."
P2: "I am not familiar. I just saw it on the file."
P3: "I think it is through medication, behaviour modification, and psychotherapy."
P5, P8: "No."
P6: "I do not know the treatment."
P10: "Maybe I can say they are using Dispal."
P11: "Some they give them Leponex, especially patient's with schizophrenia."
P12: "I am not sure of the exact treatment but the people with schizophrenia are given tablets or pills."
P14: "I just know that they have to take the - I forgot the names."
P15: "Not aware of the treatment."
P16: "I am aware but I have forgotten the names of the treatment."

Most participants responded as follows whether they read up on mental health care:

P1, P2, P4, P5, P8: "No."
P3: "It is rare that I read mental health."
P6: "I am not reading that's why I am stuck!"
P7: "Sometimes."
P9: "At times."
P10: "I am trying to read."
P11: "Yes."
P12: "I read but not much."
P13: "Occasionally."
P14: "I read but not that much."
P15: "Yes, I read about mental health."
P16: "I am reading more on mental health so that I can update myself, read the SA Mental health federation bulletins."

The participants reported that they lacked knowledge about mental health care. They had limited knowledge of the types of mental illness. They had no knowledge at all of the Mental Health Care Act (No 17 of 2002) and the Diagnostic Statistical Manual of Mental Disorders (DSM-5).

In her research, Olckers (2013) found that agencies expected her to utilise the Diagnostic Statistical Manual of Mental Disorders (DSM). Because of her interest in mental health, she studied the DSM system in order to understand its utilisation. Olckers (2013) found

that many social workers claimed that it is unethical for a social worker to diagnose, while other social workers utilise a diagnostic system daily as a tool for their assessment.

The South African Mental Health Care Act (Act 17 of 2002, Section 1:xvii) clearly states that a mental health care practitioner is “a psychiatrist or registered medical practitioner or a nurse, occupational therapist, psychologist or social worker who has been trained to provide prescribed mental health care, treatment and rehabilitation services.”

The Mental Health Act (No 17 of 2002) makes no reference to prohibiting social workers from making a diagnosis, and clearly stipulates that social workers must be trained in mental health care. The Policy Guidelines for Course of Conduct, Code of Ethics and the Rules for Social Workers (South African Council for Social Service Professions [SACSSP], 2008) also do not forbid social workers from making a diagnosis. Sewpaul (2007) in Olckers (2013:28) states that she is not aware of any legislation that specifically refers the use of the manual by social workers in South Africa.

Stromwall and Hurdle (2003:209) state that even though social work is the major provider of mental health services, social work literature pays little attention to psychosocial rehabilitation. Newman, Dannenfelser, and Clemmons (2007:1044) state that only two studies on the use of the DSM in social work practice, namely those of Dziegielewski, Johnson and Webb (2002) and Kutchins and Kirk (1988:217), exist in published literature. These two studies provide limited information on the changing trends and reasons for the use of the DSM in social work practice. Olckers (2013:36) asserts that the basic knowledge and application of the DSM can be a tool in making a diagnostic social work impression that will enable the social worker to participate more effectively in a multi-professional team, make appropriate referrals, and provide more insight into clients, holistically. However, it is of concern that social workers utilise the DSM system in making diagnostic social work impressions without any constructive training in the DSM.

Stromwall and Hurdle (2003:211) suggest that social workers receive a more specific educational programme with regard to the field of mental health, its perspectives, and mental health terminology. Olckers (2013:78) explored the social work programmes at the Universities of South Africa with regard to mental health as part of the curricula.

Representatives from social work departments at the University of Johannesburg (Van Breda, 2008), Cape Town (Addinall, 2011), Kwazulu Natal (Motloung, 2011), Pretoria (Carbonatto, 2007), and Free State (Reyneke, 2008) stated that they provide limited training in mental health on an undergraduate level. The majority of representatives consulted were of the opinion that mental health is a specialised area, which should receive attention on a postgraduate level.

A study was conducted in Komani (Queenstown), South Africa by Dlatu, Longo-Mbenza, and Malema (2014) who outlined major findings which were discussed in relation to the level and determinants of awareness of the Mental Health Act (No 17 of 2002) in the King Sabata Dalindyebo (KSD) Hospital. This study showed a low level of knowledge and the implementation of the Mental Health Act (No 17 of 2002) and the care services to be integrated into the primary health care systems in the King Sabata Dalindyebo Sub-district Municipality; OR Tambo District; and Mthatha, Eastern Cape Province. Indeed, the study showed that the integration of mental health care services into the primary health care system was not optimal, despite the dismantling of apartheid practices and the achievements of the Mental Health Care Act.

Roles do not solely depict set pattern of expected behaviours, but a pattern of reciprocal claims and obligations (Greene, 2009:211). A role perspective offers an understanding of the social dimensions of development. Role performance encompasses not only expectations about how a person in a given social position is to act toward others, but also how others are to act (Greene, 2009:211). It is asserted that role performance or social participation is strongly related to one's sense of self-esteem (Greene, 2009:211). Gardner (2000:5) indicates that the process of personal recovery involves challenging assumptions, undoing, and moving beyond traditional patient/client roles. Assumptions underlying traditional professional roles also undergo scrutiny and re-tooling in recovery-focused organisations.

Subtheme 2.3: Effectiveness of current social work services

The participants were of the opinion that the services were effective, especially the multidisciplinary team.

> *P4: "They are effective, especially multidisciplinary team; they meet to discuss the patients and the social workers write a report and the other team members also write their reports."*
> *P9: "They are well as I am also supervising social workers in Makweng and there is a unit there, so all the patients are referred there."*
> *P12: "Effective, social workers help families to monitor patients to take treatment."*
> *P15: "Yes, they are effective; we help families to adjust, understand and accept the mental illness."*

One participant reflected on the client satisfaction regarding counselling services.

> *P1: "Yes, we do counselling and most of the clients are happy about our services."*

Some participants reflected on the improved functioning of patients due to the effectiveness of services.

> *P2: "The services are effective, because maybe we can check the patient the first time when they come here, and after few months you will see a difference."*
> *P7: "If we provide psychoeducation some patients do not relapse any time soon, but there are those who will relapse depending on the family support."*
> *P7: "Social work services are effective because majority of cases we handle are successful; when the patients are discharged from the hospital they spend more time at home than relapsing again."*
> *P9: "They are effective, though if we are not getting the support of the families it turns to relapsing of the patient, because if they do not participate in the treatment of the patient, then they relapse."*
> *P14: "They are effective, because when I came here this hospital was full, so I tried to talk to the communities and the families; now we have many patients that are at home after we have intervene as social workers."*
> *P16: "The programmes that we offer play a major role to our clients; they are not treated well in the community. The social work services are useful - seeing patients being integrated in the community."*

Three participants were unsure as to whether services were effective; they were of the opinion that there was still much that needed to be done. They also attributed the lack of training to the ineffectiveness of services.

> *P5: "They are effectively, depend on how the client is affected, but if I come across a schizophrenic patient it is difficult for us."*
> *P6: "There is not much done in this service."*
> *P8: "Yes, because when we call them and conduct those sessions with the families they respond. Sometimes it is not effective. We can call them and they*

just want the grant. Sometimes the challenge with regard to their money, but after few days when they saw that is payday they come to the hospital and visit the patients that is where we get them."
P10: "Not effective. We are not trained in mental health."
P11: "I cannot say they are effective."

The participants reflected on whether services were effective or not. Some participants attributed the effectiveness of services to the multidisciplinary teams in the hospital, the clients' satisfaction of counselling services, and the improved functioning of clients. On the other hand, some participants were uncertain about the effectiveness of services; they were of the opinion that there was still a great deal be done, and they indicated that the lack of training in mental health was contributing to the ineffectiveness of services.

Ponnuchamy (2012:36) states that the social interventions by mental health social workers were found to be meaningful and beneficial to individuals with schizophrenia. In the context of rural settings, research on the effectiveness of mental health social work intervention, particularly individuals with schizophrenia, is inadequate. In the study conducted in India by Ponnuchamy (2012), it was established that after social work intervention there was a significant reduction in the mean scores of all the domains of disability such as understanding and communicating, self-care, getting along with people, life activities, participation in society, and getting about. This proves that social work intervention could reduce the symptoms of disability, and improve the social functioning of persons with schizophrenia in rural areas.

It is evident from these findings that mental health social work intervention is effective in helping persons with schizophrenia by reducing their symptoms and improving their social functioning. The study established the usefulness of the group work approach in dealing with patients in rural areas who suffer from schizophrenia (Ponnuchamy, 2012:38). Herod and Lymbery (2002:17) assert that social work contributes significantly to multidisciplinary teams. For instance, as a discipline, it is underpinned by a broad range of social science theory which does not only think in terms of individual and family pathology, but takes an ecological perspective to patients' needs. In addition, it is the wider political perspective that it brings to the multidisciplinary teams' knowledge and understanding of oppression that may inform and influence a different and more appropriate type of intervention. In addition, by health and social services working together after the discharge of adults from

hospital, the complex needs of these individuals could be met and assist them in living independent lives in the community.

Based on ecological systems theory, Ponnuchamy (2012:36) states that mental health social work as a professionalised activity focuses on reducing the psychosocial problems of MHCUs and practitioners. They postulate that psychosocial functioning was mostly determined by the interaction between the individual's needs, aspirations, and functional capacities on the one hand, and environmental (situations) expectations, opportunities, and resources on the other. The author emphasises the modification of the client system and the environment for better psychological functioning.

Subtheme 2.4: The needs for improvement of social work services

The participants indicated that there was a need to monitor referred cases and treatment adherence.

> *P1: "Day-to-day monitoring, it needs to be done because sometimes we refer those people and then the psychologists assess them and afterwards we do not have clients [meaning that the social worker is not sure what his/her further role is]."*
> *P2: "If patients go home; they do not take treatment."*
> *P4: "As long as they take their treatment, if they relapse they cannot do anything right."*
> *P 13: "The challenge is in the rural areas where we have to have follow-up sessions; the families are not able to come for follow-up sessions as result of transport, sometimes as a result of funds; in some cases there is a group of patients who use common transport, so we booked them together to come for follow-up, but in some cases it's not and when we do follow up, they will just say they do not have money to come for follow-ups."*
> *P 13: "The other challenge is that the patients themselves refusing to take treatment; she just put the tablets under her towel. Sometimes the patient pretends to take treatment while they are not. It becomes difficult to monitor their progress, it becomes difficult use their IDPS because they are not true to themselves."*

Two participants reported that there was a need to focus on MHCUs living independent lives.

> *P2: "If they [mental health care managers] can promote independent living for patients."*
> *P4: "We want the MHCUs to be self-reliant. They should know that they are like any other person."*

One participant indicated that there was a need to pay more attention to substance abuse.

> *P16: "Yes we need to improve, I think more on substance abuse; we do not have a rehabilitation centre around here. There is a need for the establishment of such a centre."*

Another participant referred to the need for strengthening group work in mental health facilities.

> *P4: "I think group work should be strengthened, that's where MHCUs can meet and discuss their challenges and also be able to socialise."*

Four participants reported on the need for providing resources such as transport, office space, furniture, human resources, and computers.

> *P6: "We are crying about resources, cars, office space, furniture and computers."*
> *P9:"We do not have offices and sometimes it becomes problem when we want to improve our services, because as much as I have said that we are the support system it becomes a problem because we are relying on the hospital files and we are relying basically on the resources of the hospital mostly. So if our department is not supporting us so it becomes a problem."*
> *P14: "We have a shortage of staff, because we are only two. We are dealing with more than 300 patients."*
> *P16: "We need office space."*

One participant remarked upon the need for family involvement.

> *P8: "I think the family must be taught; they need to be educated about patients' conditions and how to treat them at home, even if they are admitted."*

The participants put forward the requirements necessary to improve mental health services; they indicated that there was a need to focus on strategies to promote independent living and programmes for substance abuse, as most of patients with schizophrenia also have substance addiction problems; there was also a need to intensify group therapy. The participants shared the same concerns as those of the social workers in the districts, for example, the shortage of office space.

Louie in OnlineMSW (2015) asserts that psychiatric social work is a specialised type of medical social work that involves supporting, providing therapy, and coordinating the care of individuals who are severely mentally ill and who require hospitalisation or other types of intensive psychiatric care. Psychiatric social workers complete a variety of tasks when

working with MHCUs including, but not limited to, psychosocial and risk assessments, individualised and group psychotherapy, crisis intervention and support, care coordination, and discharge planning services. Mental health social workers are employed in a wide range of settings, ranging from intensive care in inpatient wards to outpatient psychiatric clinics.

Kopelowicz, Liberman, and Zarate (2006:s12) state that social skills training consists of learning activities utilising behavioural techniques that enable persons with schizophrenia and other disabling mental health disorders to acquire interpersonal disease management and independent living skills for improved functioning in their communities. Koperlowicz et al. (2006:s13) assert that group therapy is the principal modality for undertaking social skills training. Furthermore, the training of patients in a group is more cost-effective and enhanced by the cohesion established among the MHCUs.

Roles are not solely a set pattern of expected behaviours, but a pattern of reciprocal claims and obligations (Greene, 2009:211). A role perspective offers an understanding of the social dimensions of development. Role performance encompasses not only expectations about how a person in a given social position is to act toward others, but also how others are to act toward them (Greene, 2009:211). It is asserted that role performance or social participation is strongly related to one's sense of self and self-esteem (Greene, 2009:211). Gardner (2000:5) indicates that the process of personal recovery involves challenging assumptions, undoing, and moving beyond the traditional patient/client role. Assumptions underlying traditional professional roles also undergo scrutiny and re-tooling in recovery-focused organisations.

Subtheme 2.5: Challenges experienced by social workers regarding mental health care services

The participants claimed that the challenges they experienced related to knowledge and skills. They indicated that they lacked knowledge of how to deal with MHCUs. They attributed these challenges to a lack of knowledge in mental health care.

P3: "The challenge is that we do not have much knowledge on how to handle MHCUs."
P4: "We need to have understanding of mental health care; we do not have training, therefore my need I will say is to be trained in mental health."
P5: "I don't know how to deal with these patients. Like a patient will come, let's say schizophrenic patient, I do not know what to say to them. I do not know how what to ask them."
P9: "Workshops regarding mental health; it's rare."
P9: "About training if I say let us be trained, I do not know who is going to train us. As I have said we are relying on the hospital."
P10: "It is difficult to deal with mental health care users, especially if you do not have knowledge like myself."
P11: "I think social workers still need to be empowered in mental health and also be empowered working with other multidisciplinary teams regarding mental health care users."
P12: "I will say these people need support but I do not know how."
P14: "Since I came here I am working using my own general knowledge. I have never been trained in mental health, because I need to understand psychiatry. So I need training."
P16: "I am saying out of experience there is no training. I am here for five years I never been trained, we are seconded from the Department of Social Development, and in the hospital they do not cater for us when it comes to training, and our department is not providing training for us."

Some participants revealed that they had experienced challenges with regard to the support and cooperation from supervisors and members of the multidisciplinary team; and also the shortage of manpower.

P1: "No."
P2: "I am working alone here and if they can increase the staff."
P3: "We can say other stakeholders like doctors, we do not see the patients in the same eye. We sometimes suggest that the patient should be kept in the hospital but they will refuse saying the patient should go home. There is no cooperation."
P3: "Support from management, support from team members, temporal placement while we are tracing relatives of MHCUs."
P3: "Also the supervisor does not have much knowledge about mental health."
P4: "The supervisor is told, but there is no solution."
P5: "The supervisor will say I should refer."
P6: "We are having challenges of where the patients would sleep. In the meantime we are tracing the families of these patients. You find out that the medical team has finished working with the patients and now it is up to us to help them. The problem is we do not have space; if they can give us space that they can lodge."
P7: "With regard to the ward rounds, we had challenges; we are not a collective; sometimes is only a social worker attending or a social worker and a doctor."
P9: "From the supervisor: Not even once."
P9: "We just complain and there is nothing happening."

P11: "The main challenge is that the medical teams usually refer cases without administering treatment first. You see that the patient is still violent, usually when coming to residential. We request them, but some of the medical team they are not cooperative to see them first."
P 13: "Sometimes they [hospital managers] *will tell you that patients are just being taken back home, whereas the patient is a danger to the family. And on the other hand, the family does not want the patient because they believe that the hospital can assist to manage the patient. So it becomes a battlefield between the family and the hospital, they are just passing each other with the patient."*
P 13: "The hospital accommodation. The ward that accommodate the patients, there is no special unit for mental health. As a result the patients are placed with general patients and as the result, the doctors end up discharging them even if we try to advocate for them. I still feel that the patients still need to be managed."
P14: "The problem is that we are employed by Department of Social Development and we are stationed at the Department of Health, so our supervisors at Social Development do not understand anything about mental illness; whatever we do they do not understand mental illness at all."
P14: "SD and supervisor do not understand our services, there is no support."
P16: "We are frustrated that we do not get support from Health or Social Development."

Four participants articulated their challenges regarding substance abuse by and relapse of MHCUs.

P7: "The majority of them are substance abusers and they relapse because of the substances."
P9: "You find that in mostly mental health has to do with substance abuse."
P 13: "Most of them they are using substance."
P16: "Males benefit from the substance abuse programme; their diagnosis is mostly substance induced."

One participant claimed that it was a challenge to provide individual therapy to MHCUs. It was not easy to converse with them.

P12: "It is hard to provide individual therapy to MHCUs when they are not on treatment; it's hard to get each other as they talk without making sense in what they are saying."

Three participants were concerned about safety issues.

P4: "When patients are not on treatment, they become aggressive, and we lack knowledge on how to handle MHCUs."
P8: "Sometimes as you can see here at the office, when they come sometimes they come being more disturbed, sometimes they can threatened us."
P9: "I think the challenge in most case you find that they are violent. So the family thinks they cannot stay with them."

Most participants were concerned about family cooperation, and the lack of contact between MHCUs and their families.

> *P2: "For those who they do not have family at all, that's where we go to do the tracing. Some of them you find that they have been placed here many years ago and there is no family at all; there is no direction. Some you find that they can't tell you specifically what's happening about their lives. Sometimes maybe you publish the story to Daily Sun; somewhere somehow maybe they couldn't recognise the face of the person so that are some of the challenges."*
> *P2: "Families they don't want to cooperate."*
> *P3: "Sometimes we call the family to come to make a decision together, and they are reluctant to come. Even if they come, they are reluctant to give us information."*
> *P6: "These people do not listen and if you work with family it is better."*
> *P12: "Families should be educated."*
> *P 13: "The lack of cooperation patient's family. Once they bring the patient to the hospital, that is the last time of see them. They do not come for meetings, they do not come for follow-ups, and they do not answer the calls anymore."*
> *P14: "So the challenge that we have is rejection or family rejection, because we found that a person is admitted after he has killed or raped and it is difficult for the family or community to accept the person."*
> *P16: "The challenge is where the family wants the patients to be kept in the centre for life."*

Some participants indicated that they had concerns regarding community perceptions and the treatment of MHCUs.

> *P14: "The mentally ill patients are rejected by their family or community, the issue acceptance and stigma towards mentally ill patients."*
> *P14: "The abuse of mentally ill patient in the community."*
> *P15: "MHCUs not fully accepted in the community and by their families."*
> *P16: "The stigma and discrimination is one of the problems they experienced."*
> *P16: "The community, they do not understand that they want the patients to be admitted for life."*

One participant was concerned about the slow pace in completing and processing documentation relating to the admission/discharge of MHCUs.

> *P2: "There are lot of forms that they need to be completed."*

Most participants reflected on how they were dealing with challenges.

> *P2: "We have a programme run by pharmacist."*
> *P3: "We work with the psychiatrist, but they do not tell us what to do, they just say they will attend to the patient."*
> *P4: "We call security."*
> *P5: "I normally refer to the psychology."*

P6: "Engage family to help."
P7: "We report to this to the Allied manager and he calls a meeting to address this."
P7: "Yes, my supervisor provides support to deal with challenges."
P8: "Mostly call the security."
P8: "Yes, my supervisor provides support to deal with challenges."
P10: "I consult my supervisor, get the information, and get support to address the problem."
P11: "Usually you just have to know the people that you are working with, and we try to familiarise ourselves with psychiatric doctors, so that if you come across a psychiatric case I know whom to call. You must at least have relations with doctors and other staff members."
P11: "Yes when we have challenging cases we go to them [supervisors], if it needs management she intervenes on our behalf."
P12: "We postpone the counselling and wait until the person is better, if the patient is in the hospital."
P 13: "We have a communication liaison officer, and we try to involve into mediating for us to say that the families should come to play their role."
P 13: "The issues of facilities in some cases we succeed to advocate for the patient, they keep the patient and they transfer them to the tertiary hospital if there is a need."
P 13: "In some cases we rely on the home-based carers to assist with treatment."
P14: "We conduct family conference where we sit down with the family, we found out what is the problem, how can solve the problem and if there is a need for us to conduct awareness campaigns that we go out to the community to help them to understand mental illness."
P15: "We conduct campaigns."
P16: "We impart information to the community; we explained to them about our admission procedures, we render psychoeducation to the community."

Most of the participants indicated that they were dealing with the challenges as they were obtaining support from their supervisors.

P7: "Yes, my supervisor provides support to deal with challenges."
P8: "Yes, my supervisor provides support to deal with challenges."
P9: "Yes, we are working with area social workers, which it's a challenge. The social workers that are in the community, it's like they see hospital social workers as focusing basically on health issues. Where you have to say let's work together in terms of assisting these clients, they think is not their responsibility as social workers in the hospital whereas our status of course says you have to render services until to a certain or point then you need to refer. So in terms of referrals is where we lose clients, because if you cannot follow up and rely on the area social workers they think it's not their priority."
P10: "I consult my supervisor, get the information, and get support to address the problem."
P11: "Yes, when we have challenging cases we go to them [supervisors], if it needs management she intervenes on our behalf."
P12: "Yes, we are getting support from the supervisor."

P 13: "Yes, my supervisor is always available to assist; in most cases she will say let's try and do this and she's always there in a family meetings if there is a need, so she is very supportive."
P 13: "Yes, we have contact with area social workers, but they have more challenges than we do because their transport is limited. When we request them to go and assess the home circumstances, they will say they do not have transport. It's been months you request them to address the challenges that the families are having; and our jurisdiction is limited to the hospital, we only go home when the is a dire situation. After that we refer to the area social workers, but we end up attending to those cases and sometimes we just pass them because the area social workers have limited resources. They lack resources to go and offer and render proper services."
P14: "We contact them even though in most cases they say that they have their own caseloads. Whenever we need assistance from them, because most of them they are afraid of these patients. When we refer patients who are not psychotic, there is no problem there, they assist. But when you talk about patients maybe sick in the community is troublesome is where there they have a problem."
P15: "The supervisor assists in the planning of campaign and also providing resources."

The participants asserted that the challenges they experienced related to their lack of knowledge and the skills. They indicated that they lack knowledge of how to handle the MHCUs. They also attributed their challenges to the lack of knowledge regarding mental health care. They reported that families left their relatives with mental illness at the hospitals.

The Reconstruction and Development Programme (Republic of South Africa, 1994:54-55) details the change, reorientation, and retraining of social workers. In this document, it is stated that the existing pool of social workers and their conditions of service must be reviewed. The current number of social work is inadequate and their training is to a degree inappropriate. Many social workers should be re-oriented and retrained within a developmental approach to social welfare. The ecological systems theory focuses on modifying the environment, therefore social workers can undergo training in order to improve their mental health literacy (Bronfenbrenner, 1994).

Subtheme 2.7: The needs of social workers to be able to improve service delivery

The participants articulated their need for training in mental health to improve service delivery.

P1: "We need training."

P2: ". It's been two years working here, but I never been trained."
P2: "There is a lack of knowledge about mental health."
P5: "I think we need an in-service training; we need training in mental health as we help all clients across the board."
P8: "Training regarding mental health."
P10: "I think we need training in mental health and guidelines in mental health."
P10: "I need training in mental health."

The participants shared the same sentiments with those of social workers working in the DSD district offices. The participants claimed that they have limited to no knowledge of mental health care.

In this context, training refers to a wide range of approaches, which are intended to affect health worker practices at primary care level in order to facilitate primary mental health care. In particular, useful outcomes of training generally involve trainees in activities directly related to daily practice, for example, interviewing patients (Cooper, 2003:2). The importance of supervision to ensure appropriate decision making in either case management or stepped care has been mentioned above. It is vitally important in promoting the implementation of training and a change in health worker practice (Da Rocha-Kustner, 2009:231). It does so, firstly, by providing health workers with the opportunity to consolidate learning, clarify principles, discuss problem cases, explore treatment options, and share the emotions that inevitably arise when working with patients with mental disorders. It may be true that social work is "less well prepared to meet specific standards" within the national mental health strategy such as "mental problems and mental disorders" (Renouf & Bland, 2005:423). However, these authors argue that a critical analysis does provide specific and much-needed theoretical and practical insights in terms of knowledge, skills, and a values base for mental health.

Pursuing an empowerment agenda requires a deep conviction in the necessity of democracy (Saleebey, 2006:12). It requires social workers to address the tension and conflict of people within mental health institutions that hinder social workers in helping individuals free themselves from the restrictions that inhibit their recovery (Saleebey, 2002). The strengths perspective imposes a different attitude and commitment; the strengths of individuals and communities are renewable and expanded resources. The

assets of individuals are embedded in community interest and involvement (Saleebey, 2006:12).

Theme 3: Descriptions of teamwork when working with mental health service users

This theme focuses on team work in mental health care. The subthemes which emanate from this theme are discussed below.

Subtheme 3.1: Working with professionals in the community

The participants discussed the types of referrals they received from field social workers and other stakeholders.

> *P2: "We receive placement referrals."*
> *P3: "Tracing families, family reunification."*
> *P4: "Referrals for disability grant."*
> *P10: "Placement of patients."*
> *P11: "Regarding mental health, we normally do not get."*
> *P 13: "Most of them will ask to be assisted with admission of the patient because they are violent; please assist, the patient has disappeared; please assist, the abuse of patient's grant; and please assist, the patient need to be referred to Thabamoopo or Makweng Hospital, to the tertiary institution."*
> *P14: "We have different types of patients here. We have got assisted patients, those that do not understand what is going on, they do not refuse anything. We have voluntary patients, those that are admitted with minor crimes; they are sent here from the magistrate. We also have state patients, those that have committed major or serious crimes like murder."*
> *P15: "Community members and field social workers calling to inquire about admission procedure."*
> *P16: "We do get referrals from the community and social workers for placement."*

Some participants reflected on the types of referrals made to other stakeholders.

> *P1: "We refer to social workers."*
> *P2: "We are working together, they are the ones bring patients."*
> *P2: "I usual refer to DSD."*
> *P3: "I refer to area social workers to do after care services."*
> *P5: "If I have a client staying far, and I had a challenge of transport I can refer to the field social worker to take over the case."*
> *P4: "You can refer them to Evuxakeni or Hayani Hospital [for inpatient care]."*
> *P4: "We do referral for placement in institutions like Hayani, Evuxakeni and Lwandlenene."*
> *P7: "We normally refer clients/patients to welfare like for the disability grant – is because SASSA is in welfare."*
> *P9: "Basically, it is where we are looking for placement and if we have to refer for aftercare or when we have a patient."*

P10: "If there are challenges and gaps, I contact them to get more information."
P10: "We do referrals for placement at Evuxakeni, and home-based care for monitoring of treatment."
P11: "We usually refer to the home-based care services to the non-governmental organisations within the community, and even to the clinics within the area where the patient comes from."
P 13: "Home circumstances referrals, family group conferencing referrals, misuse of grants, we ask the social workers to go and assist the family to manage their patient's grant. Most of the times the patients misuse their own grants, but when patients come here they turn things around saying my mother, my sister misuse my grant. I am not taking medication because there is no food."
P14: "SASSA, because most of the patients that are admitted here when they get out to the community we help them with disability grant, so we refer patients for disability grant."
P8: "We refer patients when they are discharged. Let's say the MHCU from another village when they refer a patient, we liaise with them."
P14: "We also refer to the area social workers for food parcels if there is none at home."
P16: "When we have cases we refer, we provide after-care services and we expect social workers in the field to help us in this regard. We do not admit a MHCU without a field social worker."

With regard to mental health issues, some participants reflected on how they work with other professions and organisations.

P1: "We refer to the police station and magistrate court."
P5: "We refer domestic violence cases and sexual assault cases to magistrate offices, police, and psychology."
P 13: "We refer to SAPS, were refer to SASSA, and home-based care."
P14: "We also refer the cases to the SAPS; more especially for those who have relapsed in the community we refer the case to the police so that they can assist."
P16: "We refer patients to SASSA, home affairs, protective workshops."

Das and Bouman (2008:164) highlight that social services assume a vital role in distinguishing and referring individuals with mental illness, and pledge a quick referral course of action. The practice of accepting direct referrals from social services ought to be energised and be made an indispensable part of the referral system. The Centre for Substance Abuse (2000:90) demonstrates that an all-inclusive perspective of the MHCU is particularly vital for any mental health professional in circumventing obstacles that may impede recovery or pose a potential risk of losing the client.

Cooperation is essential in keeping clients from "falling through the cracks" from an independent and self-sufficient organisational perspective. A viable coordinated effort is likely the best way of serving MHCUs, in the broadest sense. Social work has considered

creative approaches to conceptualise the relationship between the individual and the environment, how people function, and how expert practice connects with capacity (Gray & Webber, 2013:179). These authors further claim that ecological systems theory is significant to social work as it contributes to a far-reaching, multidisciplinary, and comprehensive system within which the complex and interrelation components of persons' lives can be understood. This theory relates to the important endeavours in incorporating the mental and sociological dimensions of social work practice, and supports a calculated move in social work practice from a static to a dynamic perspective of the environment (Gray & Webber, 2013:179). It is further shown that social workers have dependably been concerned with the situational determinants of human functioning, yet until the advancement of ecological systems theory, the profession experienced it as less demanding and more practical to address individual functioning (Gray & Webber, 2013:179).

Subtheme 3.2: Working within a multidisciplinary team in the hospital

The participants reflected on referrals to other multidisciplinary team members.

> *P1: "The cases of mental health users, we refer to the psychologist, for example I had a case of a patient with schizophrenia and referred to the psychologist."*
> *P7: "We receive referrals from the wards and also mental health unit."*
> *P8: "We get referrals from the wards."*
> *P12: "We get referral from the wards for placements, and we are required to write a psychosocial report."*

Some participants reflected on the team's perceptions and expectations of the role and tasks of the social worker.

> *P1: "They know that I provide services to victims of domestic violence or sexual offences."*
> *P3: "They view my role as an effective one; it is important one, because if we are not there the team cannot function. We need to give them information of the patient."*
> *P5: "Yes they do [understand participant's role]. They refer cases to us."*
> *P7: "They do understand. I can say that even if we not there as social workers, we are not there they refer clients/patients for social problems."*
> *P10: "I can say they understand, because when it comes to referrals they can see that is a social problem, and then they can refer to us."*
> *P 13: "Yes, we do have MDT and we discuss challenging cases; we collectively come with the way forward and ways to manage patients we are working together."*

Some participants reflected on how team members fail to understand the role and tasks of the social worker.

> *P2: "The team members does not understand task of social workers. When they see me, they see somebody who have to do anything in the hospital. They forget about the tasks of the counsellor - that one they are a not really aware."*
> *P2: "For instance, nurses are under-staffed and they expect me to go and help with feeding of patients. I am facilitating a reading programme, Kaharigude, and they expect me to go and get patient from the units to attend this programme. My role is to facilitate the meetings. "*
> *P2: "They call me MDT and thinking that I own this programme."*
> *P11: "I cannot say they do, they still need education regarding social work services."*
> *P12: "They do not understand the main task as they refer any cases to us."*
> *P 13: "The team thinks our task is to transport patients when they are stranded or when their families are not coming to collect them after discharge. Because they will be saying take the patient home; they are even instructing us and you can imagine if I'll be transporting the patients, the whole day without doing my assigned duties. And we are not drivers. We trace the family; we try to understand why they are not coming and get their patients."*
> *P16: "Other team members, starting from the hospital management, they do not understand the role of the social worker."*
> *P16: "Sometimes we are expected by nurses to go and feed patients or sometimes to go and change diapers. We are assertive enough and we tell them that that is not our role."*
> *P16: "Sometimes they want us to transport patients without a nurse. As I have indicated, I am not even trained in mental health."*

Two participants considered the role of social workers in the team.

> *P9: "Yes, we do multidisciplinary; I do not think they can do most of the things done by the social workers - like placements; I think that is basically the role of the social worker, and in terms of assessment and home circumstances they rely on the social worker."*
> *P16: "Here in the hospital we use biopsychosocial approach; in the MDT we discuss cases, and we tend to take the forefront in the discussions."*

Other participants reflected on how frequently they meet with, and how social workers function within the team.

> *P1: "We exchange cases."*
> *P2: "Yes – but time is a problem."*
> *P4: "You work in multidisciplinary team at least once in three months.*
> *P6: "Participate on a monthly basis."*
> *P7: "We are involved twice a week in a team. On Monday, we do screening and on Thursday we do ward rounds."*
> *P8: "Yes – three times a week."*

P10: "We tend to meet three times a month."
P12: "Yes, twice a week."
P14: "We meet every month as a multidisciplinary team; we also conduct weekly ward rounds where we select patients that we see as good candidates for our social integration. Then we discuss the patient."
P16: "We function daily."

Another participant revealed who the members of the team were.

P2: "So, here we've got different departments, everything we do. We do it as a multi-disciplinary team (MDT) where we have me as a social worker, we have nursing care, we have physiotherapist, we have occupational therapist, we have pharmacist - just for medication only, but mostly where we interact we do groups maybe in collaboration with OT, social worker and physiotherapist, that where we call ourselves rehab."

A number of participants shared their thoughts on the functioning of the team.

P2: "The team, we are doing the rehab together and from there we render phycho educational groups with different topics. For instance, let's say, maybe a patient is aggressive, mostly the ones with schizophrenic, we just put them on hold and then, let's say, maybe in the initial few weeks they will receive nursing care only. By that time they can't cooperate, but when time goes on they are taking treatment and you will found that they come to a level where we can talk; I can talk something and he can be able to understand, though he cannot understand it just like me and you."
P11: "We conduct ward rounds together, we have case discussion together."
P14: "As a social worker, I will come with my report; the OT will come with a report."
P15: "We meet as a team and discuss the patients, depending on what the patient wants. If the family wants to be contacted the social worker will be assign that task in the team."

One participant reflected on the value of the team.

P2: "I get support from the team."

Two participants indicated the challenges of being part of a team.

P10: "Here in the hospital is sometimes difficult to work in the team. It is not easy, because other team members are not always available to participate. Some says that they will come at this time."
P15: "It is a lukewarm situation. I never been experienced this but I heard from my colleagues, they want social workers do things that they are not supposed to do."

The participants described how they worked with other professionals in the hospital. They reflected on their referrals to other team members of the multidisciplinary team. They were

concerned about the role of social work in the multidisciplinary team. Junor, Hole, and Gillis (1994:20) state that the multidisciplinary team is there to "maximise clinical effectiveness." These different definitions and descriptions constitute important features of multidisciplinary work. It is not merely a matter of getting different mental health professionals together, and miraculously a multidisciplinary team comes into being. Teams need to have shared goals and values, understand and respect the competencies of other team members, learn from other disciplines, and respect their different views and perspectives. Individual team members may need to reassess their claim to specialist knowledge and authority in order to form effective multidisciplinary teams, which can provide the best possible care to the individual service user. The Department of Health (2001) asserts that effective teamwork enables the provision of effective and comprehensive care. Meeting the patient's needs is the primary task of the multidisciplinary team (MDT).

All relevant professionals should be able to contribute to this task, while maintaining good inter-professional relationships. There should be shared documentation, e.g., MDT case notes, and patients should receive the benefits of multidisciplinary care planning. Pursuing an empowerment agenda requires a deep conviction of the necessity of democracy (Saleebey, 2006:12). It requires social workers to address the tension and conflict of people within mental health institutions that inhibit and limit the assistance social workers are able to provide, and prevent restrictions that inhibit recovery (Saleebey, 2002). The strengths perspective imposes a different attitude and commitment; the strengths of individuals and communities are renewable and expanded resources. The assets of individuals are embedded in community interest and involvement (Saleebey, 2006:12).

Theme 4: Recommendations regarding social work services in mental health care service delivery

The participants recommended that training in mental health care be classified a specialised field, and that specific guidelines, additional manpower, and resources such as office space, equipment, transport be provided. Multidisciplinary collaboration and cooperation should be entrenched. Other participants recommended that the available

mental health care services form part of the awareness programmes aimed at MHCUs, their families, and the community.

Summary of section D

The participants indicated the nature of mental health services such as rehabilitation as well as assisting patients who defaulted on their treatment. Patients were observed for 72 hours as stipulated in the Mental Health Act No 17 of 2002. Social workers were involved in the multidisciplinary teams. Social workers provided counselling, assessment, applying for disability grants, psychoeducational groups, group work, and community mental health awareness. The social workers had challenges where families of MHCUs were not cooperative. Families tend to abandon MHCUs at the hospitals. The social workers articulated their need of being capacitated in mental health care as they lacked knowledge in relation to mental health care. The participants recommended what needs to be done in order to improve mental health services in South Africa**.** Beyond training itself, its implementation very often requires system changes (for example, time allocated for private consultation) to accommodate new practices, without which any emerging changes cannot be sustained. Many of the observations mentioned above on effective training relate particularly to the training of medical practitioners in general practice. However, there is little doubt that they are equally relevant in other settings/categories/areas of mental health, notably social work practice. The importance of supervision to ensure appropriate decision making in either case management or stepped care, has been mentioned above. However, it is also crucial in the implementation of training and changes in social work in mental health practice.

The strengths perspective imposes a different attitude and commitment; the strengths of individuals and communities are renewable and expanded resources. The assets of individuals are embedded in community interest and involvement. Therefore, there should be a paradigm shift in social work practice in university curricula in South Africa and in the field of social work in mental health practice. Therefore, it is evident that social workers need to be capacitated in mental health care.

7.3.5 Section E: Findings of social work manager participants

This section provides the findings of social work manager participants. Eight participants were interviewed in this study; they were working for the DSD, DoH, and DSD provincial office. The districts were Mopani, Vhembe, and Capricorn.

This section also provides the biographical profiles of social work manager particpants, followed by the thematic analysis.

7.3.5.1 Biographical profiles of social work manager participants

The section gives an overview of the social work manger participants and their biographical profiles (table 7.9).

Table 7.9: Biographical profiles

P	Age	Marital status	Language	Gender	Qualif.	Institution	Attained	Area	Years employed	Years as manager
1	42	Married	Tsonga	Male	BSW Master's degree in Public Health	UNISA UNIVEN	1999 2011	Mopani	12	8
2	47	Married	Tsonga	Male	BSW	University of Limpopo	2008	Capricorn	6	4
3	42	Married	Tsonga	Female	BSW	UNIVEN	1998	Mopani	14	4
4	37	Married	Tsonga	Female	BSW	University of Pretoria	2002	Vhembe - Malamulele District	13	2
5	37	Married	Sepedi	Female	BSW	Durban Westville	1998	Modimolle	16	1
6	56	Married	Tsonga	Female	Master's Degree in Manage-ment	University of Pretoria	2000	Capricorn Head Office	31	17
7	48	Married	English	Female	Master's Degree in	University of Limpopo	2010	Capricorn – Polokwane Hospital	20	6

P	Age	Marital status	Language	Gender	Qualif.	Institution	Attained	Area	Years employed	Years as manager
					Develop-ment					
8	38	Single	Venda	Female	BSW	UNIVEN	2002	Mopani	10	2 weeks

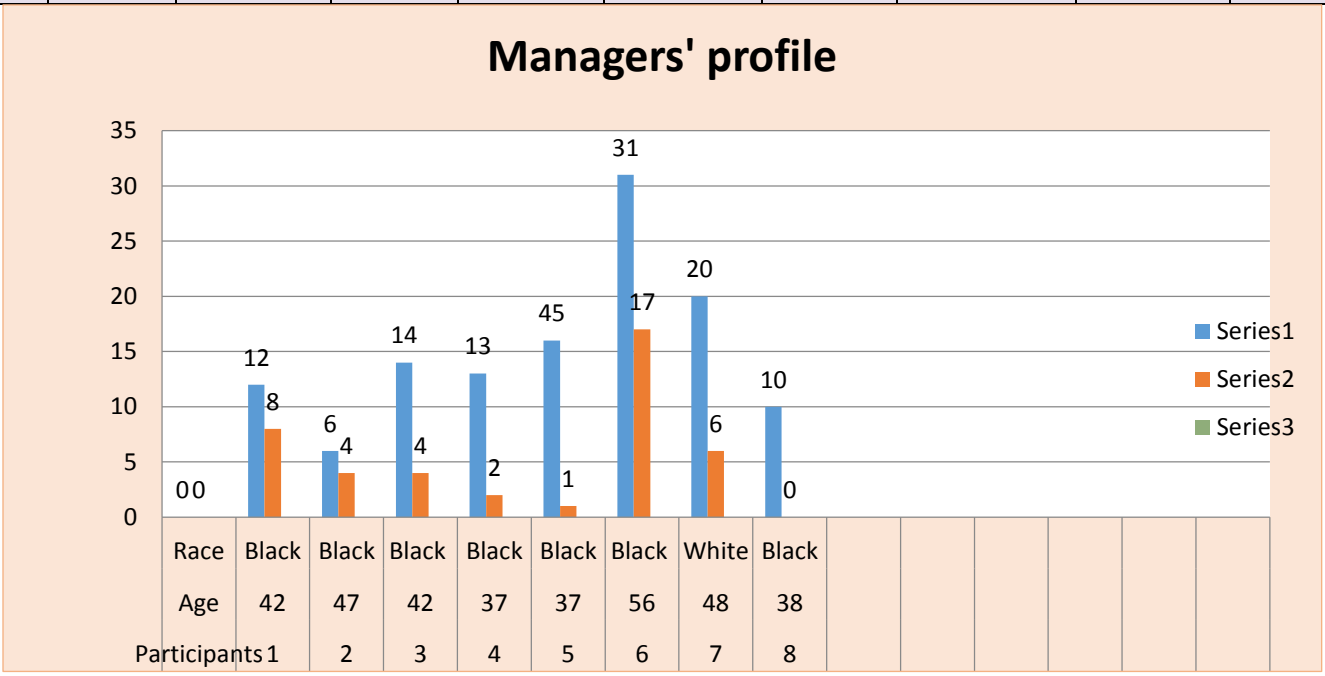


Figure 7.6: Social work managers' biographical profiles (n=8)

These participants were employed by the Departments of Health and Social Development in Limpopo Province, stationed at Vhembe, Mopani, and Capricorn Districts. The ages of these participants ranged from 37 to 56 years. The participants were predominantly female; there were two male participants. Furthermore, the participants' languages were Tshivenda, Tsonga, Sepedi, and English. Seven participants were married and one was single. Three participants obtained their social work Bachelor's degree at the University of Venda, two obtained their qualifications at the University of Limpopo, two participants were University of Pretoria graduates, and one obtained her degree at the University of Durban Westville. Three participants had postgraduate qualifications. One participant had a Master's degree in Public Health from the University of South Africa (UNISA); another participant had a Master's degree in Management from the University of Pretoria, and lastly, one participant had a Master's degree in Development, obtained from the University of Limpopo. The years of employment ranged from six months to 17 years.

7.3.5.2 Thematic analysis of social work manager participants

This section presents the themes, subthemes, and categories of the data collected from managers working at the Limpopo Department of Social Development. The following discussion details that which transpired from the interviews. Furthermore, the accounts of the participants are presented, and the findings are linked to the literature.

Table 7.10: Themes, subthemes, and categories: Social work managers

Themes	Subthemes	Categories
Theme 1: A description of mental health services in the areas where the participants worked	**Subtheme 1.1**: The nature of mental health services provided	**Category 1**: Mental health services
	Subtheme 1.2: Effectiveness of current mental health services	
	Subtheme 1.3: The need for improved services	
Theme 2: A description of social services in the areas where the participants worked	**Subtheme 2.1**: Description of the nature of services by social workers	**Category 2.1.1**: The main focus of interventions with mental health care users
	Subtheme 2.2: Effectiveness of current social work services	
	Subtheme 2.3: The need for improved social work services	**Category 2.3.1**: Challenges experienced by social workers regarding mental health care services
		Category 2.3.2: The need of social workers to improve service delivery
Theme 3: Support provided by managers to social workers in psychiatric hospitals	**Subtheme 3.1**: Support provided to assist social workers with challenges experienced	**Category 3.1.1**: In-service training provided by the participants to social workers regarding mental health care
		Category 3.1.2: Ensuring that social workers have sufficient knowledge and skills in mental health care

Themes	Subthemes	Categories
	Subtheme 3.2: Own confidence in supervising social workers, working in mental health care	
Theme 4: Recommendations regarding social work services in mental health care service delivery		

Category 1: Mental health services

The participants focused on the mental health services provided in the areas where they worked. The details of the theme and subthemes in this category are provided below.

Theme 1: A description of mental health services in the areas where the participants worked

The participants shared their views regarding the mental health services provided in the areas where they worked, and described the nature of these services.

Subtheme 1.1: The nature of mental health services provided

The participants indicated that the mental health services comprised prevention, assessments, and intervention services.

> *P2: "Basically, we provide prevention and promotion services; we provide early intervention services."*
> *P4: "We do case work when social workers work with the clients with mental health problems."*
> *P6: "At the admission phase, we have application and screening forms. The screening is done by the social worker, OT, and physiotherapist; and it is done at the district level."*
> *P1: "Psychosocial services. One should qualify it: debriefing, counselling, trauma counselling and related services that need psychotherapy."*
> *P6: We look at the needs and the competences of the clients. We develop individual development plans (IDPs). The IDPs assist the centres [formal programmes/facilities] to track the development of the client, as well as the optimal functioning of the client. We also do assessment that focusing on checking whether the client reaches the optimal functioning level."*
> *P6: "Support groups for parents at the stimulation centres and protective workshops."*
> *P7: "Mostly assessment, screening."*

One participant referred to the statutory services relating to mental health services.

> *P2: "Some other cases require us to go to court and we do statutory services."*

Another referred to family involvement in mental health services.

> *P7: "Mostly involvement of significant others, family preservation, family reunification."*

One participant indicated that referrals constitute one of the services provided in mental health care.

> *P3: "We are just part of the multidisciplinary team (MDT), attending mainly to outpatients. For outpatients we are mainly referring those that defaulted treatment or those that they have social and family problems."*

Another mentioned the funding and management of formal programmes as components of mental health services.

> *P6: "The services are mainly protective workshops, stimulation centres, and residential care facilities for people with disabilities."*
> *P6: "The stimulation centres cater for children from 0-18; when the child is 18 they are sent to the protective workshops until the age of 59. Even if they are 60, sometimes they continue getting service at the protective workshop. In the protective workshop, the clients make beads, sewing, gardening, carpentry, welding."*
> *P6: "Funding: 77 protective workshops, 3 residential facilities, and 1 facility for children in Bela-Bela."*

Three participants indicated that there were no mental health services provided by social workers in the community.

> *P5: "I would say there no specific mental health services provided in the community. We have programmes for disabilities, and the main focus is on physical disability. One can say mental health services are neglected."*
> *P6: "We normally provide a generic disability services; we do not give much emphasis in mental health; the focus is on physical and intellectual disabilities."*
> *P8: "Here in the office that we are in, we do not focus much in mental health."*

The participants shared their views regarding the mental health services rendered in the area where they worked, notably prevention, assessment, and intervention. They also indicated that the services rendered were statutory services, funding, and monitoring of mental health programmes. Other participants were of the view that there were no mental health services rendered in the areas where they worked.

The DSD (2015) specifies that social development services include prevention and promotion services, and social support services; therapeutic, restorative, and rehabilitative services; continuing care services; reintegration and aftercare services; and economic development services. All these services are elaborated upon below. With regard to mental services in general hospitals, the WHO (2009:38) states that professionals working at this level include hospital physicians, hospital psychiatrists, general nurses, psychiatric nurses working in psychiatric inpatient units, psychiatrists and psychiatric nurses providing consultation-liaison services, social workers and psychiatric social workers, occupational therapists, psychologists, and other health workers in hospitals.

Furthermore, the WHO (2009:37) refers to long-stay facilities and specialist psychiatric services. These are usually facilities based in specialist hospitals, which offer various services in inpatient wards and specialist outpatient clinics. Examples of health workers at this level include psychiatrists, psychiatric nurses, social workers, and occupational therapists who are specialists in their particular fields. The exact functions of these services will depend on the nature of the speciality unit. Personnel at this level of service provision need specific competencies in their particular specialties.

Subtheme 1.2: Effectiveness of current mental health services

Three participants were of the opinion that the current mental health services were effective.

> *P1: "They [referring to services] are effective since we are able to reunite some of our clients to the community, so that they be taken care of in their home environment."*
> *P2: "The services are effective because we have managed to reduce the intake of mental health care users in our caseloads."*
> *P7: "They [services] are very effective because mostly when our mental health care users are admitted firstly they lack family support. By engaging the family we make them aware of the patient's need for support; we make them aware of the needs of the patients, the sense of belonging and the need to be supported in order for the patients to remain positive. When they start understanding they need to support the patient and the patient also feels much better and it improves the mental status. It does become effective because it helps with treatment,*

> *because usually if they [the family] were not supportive, treatment at some cases it does not help because the person starts to think too much of their background, where they come from, and the way they treat me, and the stigma around me. It does not help."*

One participant was of the view that there were limitations to family support. The participant was of the opinion that the success of intervention was reliant on family support.

> *P3: "The problem with mental health patients if there is no support from a family."*
> *P3: "It is very difficult to manage them because mostly the success of our intervention rest much on the support of the family, even if we were assisting them when they are here, they go back home."*
> *P3: "If the family or relatives are not supportive, they are likely to relapse and come back."*

Two participants indicated that the services were not effective.

> *P5: "No specific services rendered for mental health, so we cannot say they are effective.""*
> *P8: "No – the services are not effective."*

It should be noted that the responses obtained from the district social workers and hospital social workers were similar in relation to the effectiveness of the mental health services. The participants had diverse views pertaining to this issue. Some were of the view that the mental health services were effective, and others indicated that they were not.

Due to long-standing deficiencies in mental health services, a major part of the burden of care for mental health issues in rural areas has moved to the primary care subdivision (Gale & Lambert, 2006). The Department of Health (2013:14) states that there is currently substantial scope for cost-effective interventions in mental health services. Araya et al. (2006:1379) state that collaborative models and stepped care provide a demonstrable structure which supports the coordination of psychological, therapeutic, and medical (medication) care.

Patel et al. (2007:991) contend that antipsychotic medication is an effective and cost-effective treatment for schizophrenia, and that its advantages can be upgraded through community-based models of care. Botha et al. (2008:272) asserts that in the Western Cape, the recently established assertive community treatment (ACT) teams have

revealed a decrease in inpatient admissions and the length of stay among individuals with serious mental health problems, which enhances patient, family, and staff fulfilment.

Dube and Uys (2015:1) argue that in spite of the predominance of mental health issues, primary health care (PHC) services remain ineffective in overseeing patients with mental illness. Before 1994, little thought was given to primary mental health care, and the services for mental health care users constituted mainly medication and admission to a psychiatric hospital (Petersen et al., 2009:140). Petersen et al. (2012:42) are of the view that cracks still exist in the administration of patients with mental illness in private health care in South Africa. These authors maintain that psychosocial rehabilitation projects are not rendered in rural areas. Furthermore, there is inadequate support for PHC staff in the administration of patients with mental illness (Petersen et al., 2012:42). Similarly, Grandes et al. (2011:428) found that PHC services prioritise management of the terminally ill who have no hope of recovery, rather than advocating for the recovery from illnesses that cause disability.

Lakhan and Ekúndayò (2013:104) affirm that the mezzosystem of ecological systems theory incorporates distinctive microsystems and the different systems that serve these microsystems, formal and informal. They incorporate families as well as groups (peers, associations, local facilities, and services). People are at greater risk of psychological distress when communication is poor between different microsystems and if there is detachment or interruption of the smaller scale and mezzo frameworks, creating social panic. Compared to the microsystem, individuals are not just detached or watching; they assume a dynamic part in establishing a stable environment, utilising past encounters and learning. The relationship between mental health care users and their families can affect them; if support is lacking, this might hamper the recovery of the mental health care user.

Subtheme 1.4: The needs for improvement of services

The participants discussed resources and budget restraints. They stated that there was a need for resources such as vehicles and computers. They further stated that there was

a need that the government and families talk to one another in order to devise strategies that could assist MHCUs.

> *P1: "To pump in resources that the social workers can use such as vehicles, computers to process information. We depend on manual work in most of the cases."*
> *P1: "Sometimes we get delays because of unavailability of the resources."*
> *P2: "We have problem of departmental budget. For instance, if the mental health users have a disability and he or she requires a wheelchair, we are struggling to provide that service."*
> *P7: "The lack of facilities to place these patients is becoming a problem; they have made it very difficult at the moment with new legislation, you can't place them where you want, now you are stacked with these patient; you do not know where to take these patients. So it is both government and the family should really consult each other to find the way on how to assist our MHCUs."*
> *P8: "Maybe if we can have the governmental institution around where you will be sure that when I have referred the client to the institution the client is rehabilitated and you will be able to make follow up."*

One participant indicated that there was a need to increase human resources which include nurses and psychiatrists.

> *P2: "A lack of human resource when it comes to psychiatrists and psychiatric nurses, and have a challenge when we want to refer."*

Two participants pointed out that there was a need for managers to undergo training in mental health care.

> *P4: "I think we as the managers need training, we do not get much information about mental health. We do not have manuals as well as Internet access, we do not have DSMA (DSM); if we had Internet we will download the document. We only have Mental Health Act; we do not have access to information, therefore training is essential in mental health."*
> *P6: "I think we still need to build capacity, especially to the caregivers in the stimulation centres, create awareness about disability, need to build capacity on social workers regarding monitoring; we need to build capacity to managers of the centres, also capacitate the senior managers in the provincial office, information sharing is important."*

Two participants were of the opinion that social workers should focus on mental health care.

> *P5: "I did come across a case where the social workers said they do not render mental health services. They said this not our focus area. It is of utmost importance to incorporate mental health in disability programmes."*

P7: "I think there is a need for social workers to focus mainly in the mental health services. Mental health should be categorised as a specialty."

The participants were of the opinion that mental health did not fall within their scope of practice.

The South African Depression and Anxiety Group (2016) assert that in aiming to improve mental health in any country, one needs to first evaluate the existing mental health system. In order for an accurate assessment to be made, reliable data on the prevalence and functionality of the mental health system must be analysed. In many developing countries, this is the first problem encountered, as there is a distinct lack of valid data available on the effectiveness of existing interventions. South Africa is no exception in this regard. This group further identified the lack of resources, planning, and implementation of mental health care systems as well as the overcrowded and understaffed primary health care domain (maintained by undertrained staff) as negative variables in need of urgent attention. Poverty poses a significant threat despite the fact that South Africa is one of the more affluent nations in sub-Saharan Africa.

The WHO (2003) stipulates that community mental health services should include "day centers, rehabilitation services, hospital diversion programmes, mobile crisis teams, therapeutic and residential supervised services, group homes, home help, assistance to families, and other support services." Van Heerden et al. (2008:2) have made recommendations how to improve mental health care. Firstly, additional information is required on mental illness profiles, the degree of current mental health service provision, and the impact of changes within the framework. Secondly, there should be support for the inclusion of mental health care in health settings such as primary, secondary, and tertiary services. Thirdly, community psychiatry should be revitalised, with specific emphasis on appropriate training and research (Van Heerden, 2008:2).

Based on ecological systems theory, the Department of Health (2011) stipulates that mental health services should promote the principles of hope, self-determination, personal agency, social inclusion, and choice. A service environment that supports people's recovery sustains and communicates a culture of hope and optimism, and actively encourages people's recovery efforts, should be created. The physical, social,

and cultural service environment inspires hope, optimism, and humanistic practices for all who participate in service provision.

Category 2: The main focus of interventions with mental health care users

The participants articulated their views on intervention strategies with regard to mental health care users. The theme and subthemes in this category are presented.

Theme 2: A description of social services in the areas where the participants worked

The participants provided a description of social services in the areas where they worked. More details are captured below pertaining to the nature of social work services.

Subtheme 2.1: Description of the nature of services by social workers

The participants described the nature of social work services as primary intervention, intake, casework, community work, and group work. A number of participants described the work of social workers as generic, which is focused on working with families, assisting with treatment adherence, tracing families as well as organising placements for MHCUs.

> *P1: "Social workers provide primary intervention, intake-case work, community work, group work."*
> *P2: "Social workers provide generic social work."*
> *P8: "Social workers provide generic services; they help all kinds of problems that they are coming to the office."*
> *P7: "Service are generic; it is the same because social workers are doing all general things in the hospital, all types of illnesses, provide family support, help patients with treatment adherence."*
> *P3: "Most of the times they are involved in mobilising families' support and advocating for the patients to receive other service."*
> *P4: "If they find clients that need placement they actually do the assessments; after that they refer and also advocate for the clients' rights in the community and in the family."*
> *P4: "Most of the services they do are in terms of casework, but from experience case work, the most cases that they do are on institutional placements; they also do assessments, they provide support, they provide counselling."*
> *P5: "The services provided is counselling."*

One participant indicated that social workers provide counselling, home visits, and referrals to various institutions.

P8: "Social workers provide counselling, home visits and referrals to various institutions."

Three participants reported that social workers were involved in research, awareness campaigns, and administration; and that they were responsible for monitoring the centres for people with disabilities; convening screening panels, family preservation programmes, and developing individual development plans (IDPs).

P1: "We do research through community development in the area."
P1: "They [referring to social workers] usually do administration as the core service delivery because there is no way you can do social work without doing administration."
P4: "They also do campaigns in the community."
P4: "We also do – eh – we monitor centres where the MHCUs go for day care, where they go for skill training and development."
P6: "Convening screening panels, facilitation of applications in protective workshops and psychiatric hospitals, members of multidisciplinary teams, screening of applicants, developing IDPs, facilitation of support groups, developing care plans, organising open days, linking families with resources, family reunification programmes, family preservation programmes, organising leave of absence for the patients, running different programmes."
P2: "The main focus is on linking mental health care users with resources like SASSA for disability grant."
P3: "Like they [service users] maybe do not have relatives, do not have close family members and they need placement, and also those that need to be assisted to access services like disability grant and other things."

Two participants were of the opinion that social workers provide no services to mental health patients.

P5: "Social workers feel that mental health services are not within their scope of practice; as the result mental health is neglected."
P2: "Let us be honest, there are no mental health services rendered to MHCUs. It is mainly to empower MHCUs."

The participants reported that social workers were responsible for the reintegration of MHCUs into their communities as well as preparing families for the discharge from hospital of their mentally ill relatives.

P1: "It is to reunite these people [service users] to their communities, since most of the people who our service recipients are mainly in the institutions like Evuxakeni Hospital."
P1: "So that they [service users] will go back to their community."
P4: "They assist the family during the reunification period; assist when there are challenges."

> *P4: "They also monitor treatment adherence and how to deal with the day-to-day living of the patient at home."*
> *P4: "They sometimes do family reunification as well as aftercare."*
> *P6: "Prepare families for discharge. When the person is rehabilitated they need to live independently; need to exit the system. Social workers give information about leave of absence. They link between the area social workers and institution social workers."*

Some participants were of the view that social workers empowered mental health care users with skills and promoted independent living.

> *P4: "To educate and capacitate the MHCUs with skills so that they can rely on themselves."*
> *P4: "Empowering MHCUs so that they can be independent."*
> *P7: "The main goal is to understand the illness, because they [doctors] diagnose them [service users] and they do not explain actually what is happening with this illness. But sitting with the social worker and explaining further how you have to accept it, treat it and the family support and your understanding of yourself with your challenge, it opens up doors for the patient to see himself differently."*
> *P8: "The main goal is to assist the clients to behave, maybe to behave in a normal way."*

The participants described the nature of social work services as primary intervention, intake, casework, community work, and group work. Some participants claimed that social workers merely render generic social work such as working with families, assisting with treatment adherence, tracing families as well as organising placements for MHCUs.

The South African Council for Social Services Professions [SACSSP] (2016) stipulate the following regarding social work in health care:

- Encompasses interface between health conditions and client systems.
- Functioning within a multidisciplinary team.
- Knowledge and understanding of acute and chronic medical conditions and the development of specific intervention strategies.
- Holistic care planning in collaboration within a multidisciplinary team.
- Medico-legal aspects and implications of the conditions.
- Discharge planning and/or end-of-life care.

Social work has adopted a developmental approach to social welfare policy and practice. The White Paper for Social Welfare (Department of Social Development, 1997) sees

social welfare as an integrated and comprehensive system of social services, facilities, programmes, and social security to promote social development, social justice, and social functioning of people. Developmental social welfare integrates social and economic development and is underscored by the principles of a human rights approach, entrenched in the Constitution of South Africa.

Ecological systems theory essentially adopts the "person-in-environment" approach that calls for assessment and intervention at various system levels, namely micro-, mezzo-, exo-, macro- and chronosystem levels; it is an excellent framework for holistic assessment, thus allowing for the possibility of holistic intervention (Brofenbrenner, 2005).

Subtheme 2.2: Effectiveness of current social work services

Participants were of the view that social work services were effective.

> *P1: "They [services] are effective in the sense that social workers are able to take them [service users] back to the community."*
> *P 1: "Most of them [service users], they don't come back since we ensure that as we make reintegration, we prepare them that they should not come back or relapse and go back to the institution."*
> *P3: "Our services are effective because in most cases, if we call the relatives or we conduct a home assessment then we sit down with families trying to make them to understand the conditions of the patients, and also mobilising for their support to the patient, encouraging them to take responsibility to see to it that the patients are adhering to their treatment plans; then many of our patients are improving when the family is actively involved.*
> *P4: "The services are effective; social workers placed patients who are experiencing problems in the community. They also assist patients who are discharged from the hospital to be reintegrated in the family and the community."*
> *P7: "Services are excellent, because in most cases they always want social workers, whatever problem, and it helps them because social workers enable the patient to link them with relevant resources."*

Some participants were not sure about the effectiveness of these services; they alluded to the fact that these services were in fact non-existent.

> *P2: "Social work services are effective, but there is not much we do in relation to mental health services."*
> *P4: "There is still a room for improvement. The information is there but there is a lack of implementation."*
> *P4: "Referral is poor, reunified referral system is not appropriate, there is no takeover, more focus is on placement, and after care has been neglected."*

P5: No services provided in mental health; hence, I cannot respond as say there are effective."
P8: "From the cases that I have conducted, I cannot see any changes to the clients we are assisting."

The participants had diverse views regarding the effectiveness of social work services in mental health. Some were of the view that they were effective while others indicated that they were ineffective.

Ponnuchamy (2012:36) contends that the social interventions provided, particularly by the psychiatric social workers, were found to have meaningful benefits to individuals with schizophrenia. In the context of rural settings, research on the effectiveness of psychiatric social work intervention is inadequate. In the study conducted in India by Ponnuchamy (2012), it was established that after social work intervention, there was a significant reduction in the mean scores of all the domains of disability such as understanding and communicating, self-care, getting along with people, life activities, participation in society, and getting around. This proves that social work intervention could reduce disability and improve the social functioning of persons with schizophrenia in rural areas.

Herod and Lymbery (2002:17) assert that social work contributes to multidisciplinary teams in many ways. For instance, as a discipline, it is underpinned by a broad range of social science theory which does not only think in terms of individual and family pathology, but takes an ecological perspective to patients' needs. In addition, it is the wider political perspectives they bring to multidisciplinary teams' knowledge and understanding of the oppression that may inform and influence a different and more appropriate type of intervention. Additionally, by health and social services working together upon the discharge of MHCUs from hospital, adults with complex needs have access to further means of support, which could assist them in living independent lives in the community.

Herod and Lymbery (2002:18) comment on how the organisational and strategic roles of social work offer a more in-depth understanding of the wider social and family context that service users inhabit. Moreover, social workers' values encompass orientation and the challenges relating to the dehumanising aspects of services, processes, and procedures with the aim of influencing or redefining health services, and focusing on

patient-centred care. Such abilities have a major impact on multidisciplinary functioning. A further contribution to hospital-based social work is the quality of the relationships a social worker is able to establish, which will have a major bearing on the success of social work (Lymbery, 2006:1119). Postle and Beresford (2007:143) claim that another important feature of contemporary social work is the recognition of the importance of building fruitful alliances with people who use social care services. Additionally, the benefits for social work in a multidisciplinary context have been identified, and have given rise to opportunities to boost the understanding of other roles, and improve inter-agency communication.

Based on ecological systems theory, Ponnuchamy (2012:36) states that psychiatric social work as a professionalised activity focuses on reducing the psychosocial problems of patients; and practitioners have postulated that the level of psychosocial functioning was mostly determined by the interaction between the individual's needs, aspirations, and functional capacities on the one hand, and environmental (situations) expectations, opportunities, and resources on the other. The author recommends modification of the patient system and the environment for better psychological functioning.

Subtheme 2.3: Challenges experienced by social workers regarding mental health care services

One participant was concerned about the lack of community resources.

> *P1: "Some of the families of the patients are untraceable; it takes long time for them to be traced."*
> *P1: "Some of them [service users] die in the institutions without relatives to bury them; it becomes our burden."*

Another participant was troubled about the lack of training of volunteers in stimulation centres.

> *P6: "Caregivers are volunteers and they are not trained; most of the people running the stimulation centres are mothers of children with disabilities."*

The participants articulated their concern about the families of MHCUs who abuse their mentally ill relatives, and seemingly do not want to be involved in their care,

P3: "The involvement of the families…many are being ill-treated by their families."
P3: "Sometimes the family comes here frustrated; they will tell you that this person at home, he does this and this, we don't sleep; and when the person comes to the hospital he/she is admitted and just act very normal and they are just being observed for 72 hours; after that the doctor will say I do not see anything wrong with the person, they discharge them, when they go back home they just continue on what they did. So they end up with family sometimes refuse to come and collect when they are being discharged and we get frustrated because we end up not knowing what to do with these patients."
P4: "You find that there are challenges, the clients are being abused."
P7: "The family also neglect the patient, and in the end we do not know where to put the patient, because when you want to reunify the patient with the family, the family do not want the patient at home."

Two participants raised concern about MHCUs being violent and aggressive and posing a danger to social workers.

P3: "Another challenge is the patients who are violent and aggressive."
P7: "I think safety risk. There is a risk involved, because some of the patients can be violent; some of them are abusive emotionally abuse; they even want to beat you up."

Two participants were concerned about the coordination and monitoring of services. They were of the opinion that there was no proper hand-over procedure when area social workers were transferred.

P6: "Hand-over of services, communication and collaboration within the departments."
P6: "No proper hand-over when the area social workers are transferred."
P8: "Poor referral system."

The participants explained the challenges experienced by social workers in practice such as a lack of resources. This has been confirmed by Oliphant (2015), spokesperson for the Department of Social Development. Reconstruction and Development (Republic of South Africa, 1994:54-55) refers to the change, reorientation, and retraining of social workers. In this document, it is stated that the existing pool of social workers and their conditions of service must be reviewed. The present number of social workers is inadequate, and their training in some instances inappropriate. Many social workers must be reoriented and retrained within a developmental approach appropriate to social welfare.

Subtheme 2.5: The needs of social workers to be able to improve service delivery

The participants were of the view that the Department of Social Development should boost the morale of social workers and acknowledge their services. Furthermore, the participants advocated for competitive salaries and improved working conditions for all social workers.

> *P1: "I think is to boost the social workers' morale, when it comes to the employer and they pump in at least a competitive salary and I think will make the social workers to work differently; and at the same time to improve working environment."*
> *P7: "We still lack the understanding of our management to recognise the worth and the needs of social workers in rendering service."*
> *P7: "We lack management support, and we need to be supported."*

The participants recognised the need to provide resources for social workers such as a user-friendly office environment (space), transport, computers, and telephones.

> *P1: "They [social workers] need a user-friendly office environment, where they have all office equipment."*
> *P1: "They [social workers] need vehicles as they do reintegration; and they need to go to the community to prepare the families so that they take back their patients."*
> *P2: "We need to provide resource like computers, telephone, and office space. MHCUs need privacy."*
> *P7: "We still have many challenges, because firstly we get stacked with shortage resources, social workers still sharing offices, we still lack office equipment."*

Two participants were of the view that mental health care should be categorised as a speciality field. They were of the opinion that social workers merely render generic services and that they lack information on and training in mental health care.

> P6: "A lack of specialisation. Always training new social workers are rendering generic services; social workers are not interested in disability, and have no knowledge about mental health."
> P7: "I think the specialisation will assist in more focus because when you are focus based on whatever you are doing on a daily basis, it really assist people to understand themselves fully and to take a different perspectives in addressing their challenges."
> P7: "I think social workers are still doing generic work rendering services for all types of cases, and then they tend to neglect to do intense counselling and involvement of family, because I think they really they need intense counselling, so you can offer that when you are focusing in one area. I am advocating for specialisation."

The participants felt that social workers needed training in mental health care in order to render quality services to MHCUs.

> *P1: "They [social workers] are competent, but they need training so that they have knowledge regarding new trends as well being able to intervene appropriate when working with MHCUs."*
> *P2: "Social workers lack knowledge in how to assist MHCUs. Hence, it is important that there should be a specific training provided in order to gain more knowledge in dealing with MHCUs."*
> *P2: "It's very difficult to us; social workers do not have skills related to mental health services."*
> *P2: "Social workers lack knowledge regarding mental health and there they need training regarding mental health."*
> *P3: "Maybe most of the times we are just using the common knowledge. So maybe there can be trainings focusing on management of mental ill patients, the families, the communities, and maybe that will help to make our services more responsive to needs of the patients."*
> *P4: "In term of aftercare I think there is a need for capacity building, as social workers they do not know what to assist the MHCUs and their families to live independent lives."*
> *P5: "Social workers need to be trained in their role in mental health; they need train in mental health."*

The participants indicated the needs of social workers in terms of improving social work services.

A social work indaba was held in Durban in 2015, which proposed that the following issues be attended to in order to improve social work services:

- Increase salaries.
- Provide more resources (cars, fax machines, computers, etc.).
- Safety.

An exploratory study was undertaken by Schenck in 2004 in five provinces in South Africa, which focused on the problems experienced by social workers in rural communities.

In validating the findings of Schenck's (2004) study, Chibba (2011) concurs that "the profession is demanding," and its "workers remain inadequately remunerated…Many are compelled to leave the country due to the poor working conditions and low pay rates. There are no adequate offices for social workers." Kruger (2008:44) believes that one of

the true reasons why social work professionals do not practise in rural and remote parts of the country was because of the poor working conditions.

Beyond training itself, the implementation of training very often requires system change (for example, time allocated per consultation), without which emerging developments in social work practice cannot be sustained (Chilvers, 2003:341). Many of these observations on effective training relate particularly to training of medical practitioners in general practice. However, there is little doubt that they are equally relevant in other settings and categories of mental health care. The importance of supervision to assure appropriate decision making in case management and stepped care has been mentioned above.

This is also crucially important in the implementation of training and change in health worker practice (Da Rocha-Kustner, 2009:1). It does so, firstly, by providing health workers with the opportunity to consolidate learning, clarify principles, discuss problem cases, explore treatment options, and share their feelings that inevitably arise when working with patients with mental disorders. A second function of supervision is to identify systemic barriers to implementation and to find ways to address them. It is particularly difficult for health workers of a lower or more junior status to take up such issues, and the help of a supervisor, ideally a more senior health worker but alternatively a group of colleagues sharing supervision, may be required (Da Rocha-Kustner, 2009:1). The approach followed in this study was of an empowerment nature, as this has become an increasingly important factor in determining employee health and wellbeing (Laschinger & Finegan, 2005:439).

Category 3: In-service training provided by the participants to social workers regarding mental health care

The focus in this theme was on the in-service training provided by the participants to social workers. The theme and subthemes in this category are discussed below.

Theme 3: Support provided by managers to social workers in psychiatric hospitals

In this theme, the focus was on the support provided by managers to social workers in psychiatric hospitals.

Subtheme 3.1: Support provided to assist social workers who experience challenges

The participants indicated that they provided practical support to social workers so that they could support MHCUs.

> *P1: "For instance, if they [service users] die in the hospital, we bury them through the institutional arrangements."*
> *P1: "For those who are not having people to visit them at all, we treat them as if the institution is their home."*
> *P1: "For those who have recovered, we look for alternative homes; in particular for those who are not having relatives, because institution is not the right place to stay there, even if they are no longer mentally ill."*

One participant reported that there was practical assistance available to deal with the violent behaviour of some service users. Security personnel were always available to assist social workers with MHCUs who were violent.

> *P3: "Security personnel always come to assist us."*

Another participant indicated that the managers support social workers in referring patients.

> *P2: "Social workers, in most instance they refer clients with mental health problems. We support them in the process."*

Two participants indicated that they conduct case discussions in order to assist social workers with difficult cases.

> *P3: "Most of the times here what we do when any one has a case, we sit down and discuss that case and come with ideas on how best can we handle that case so we assist each other."*
> *P7: "We have staff meetings where we discuss cases; we have individual supervision group supervision where colleagues can have inputs on how can they assist, and then we have peer supervision assisting one another and see how others doing things."*

The participants reflected on the support that they provide to social workers. Supportive supervision is concerned with increasing job performance by decreasing job-related stress that interferes with work performance.

The supervisor increases social workers' motivation, and develops a work environment that enhances work performance (NSW, 2003:1). NASW (2012) asserts that supervisees are faced with increasing challenges that contribute to job stress, including the growing complexity of client problems, unfavourable physical work environments, heavy workloads, and emotionally draining environments such as trauma. Supportive supervision is underscored by a climate of safety and trust, where supervisees can develop their sense of professional identity. The combination of educational, administrative, and supportive supervision is necessary for the development of competent, ethical, and professional social workers.

Subtheme 3.2: In-service training provided by managers to social workers regarding mental health care

Three participants described the strategies they employed in providing in-service training to social workers regarding mental health such as supervision and information sharing; sometimes doctors and nurses provide training.

> *P1: "Through supervision and giving in-service training so that they will keep in touch with the current trends in the field."*
> *P1: "We give them information about the process of intervention, how to handle mental health users in the institutions"*
> *P6: "Training social workers in legislations and UN conventions. I provide practical examples and principles in the field of disability."*
> *P7: "Mostly, there is training that we engage with the doctors. They offer training on how to understand and work with people with different mental disorders, and even we engage the nurses that are really taking good care of them. They understand also their treatment. So we enhance their capacity and their learning ability."*

Four participants indicated that no training was provided to social workers in mental health care.

> *P2: "No in-service training provided. I need to be honest; social workers are not providing any services to MHCUs."*

P3: "Ever since I have started working I have never been in-service training any training related to mental health, so mostly we just use general knowledge as at times."
P5: "No in-service training provided."
P8: "There is nothing we do regarding mental health services."

The participants reported that they conducted in-service training in order to help social workers with their work demands. Conversely, some participants did not conduct any in-service training in mental health as these services were perceived to be non-existent in any event.

Practice supervision is described in the NSW Health (2006:2) as a formal and ongoing arrangement between one worker and a (generally) more experienced practitioner, according to which the performance of the social worker is reviewed and discussed in confidence for the purposes of:

- Further developing the worker's professional identity and "clinical" practice skills and knowledge.
- Ensuring that workers are operating within relevant clinical, organisational, ethical, and professional boundaries.

The ASSW (2008) guidelines state that monitoring and supporting social workers' wellbeing and coping capacity in relation to their work are mandatory, and relate to internal (performed by an organisation's employee who is outside the line management structure of a supervisee's team) and external (performed by an external contractor) factors. Practice supervision may also be accessed privately by workers, particularly by counsellors and supervisors, as part of professional development or professional membership requirements. AASW (2008) state that practice supervision can provide benefits, which would otherwise be unavailable, when it is merged with management functions. This is a basis for the strong recommendation in many published "clinical" guidelines that supervision be separate from line management functions. This form of supervision also has its own set of limitations, including the gap between the supervisor and the worker's practice, and the possibility that the supervisor may not be sufficiently experienced.

Subtheme 3.3: Ensuring that social workers have sufficient knowledge and skills in mental health care

The participants reflected on how they ensured that social workers had sufficient knowledge and skills in mental health care.

> P1: "Continuous development as well as keeping in touch with universities for short course, use UNISA, UP through our HRD processes."
> P6: "I invite social workers from the hospitals when we have workshops."
> P7: "The relevant training, the relevant specific training organised."

They described the strategies they employ in ensuring that social workers had sufficient knowledge and skills in mental health care.

The NSW (2012:100) suggests that coaching and the nature of the supervisor-supervisee (coach-coachee) relationship within coaching is more difficult to define compared to traditional counselling. This is particularly difficult if the parties are working from different theoretical models as they may exhibit different cognitive styles, belief systems, and ethical perspectives. They therefore need to be aware of the potential similarities and differences, which are generally derived from systemic developmental models and which start with defining and structuring the supervisor-coach relationship. The coachee's developmental needs include education and work experience:

- Supervisors' competencies in terms of their professional skills and experience (including knowledge of organisational behaviour).
- Limitations, and opportunities provided by work settings so that set goals are practical and realistic.
- Focus on supervisory goals and methods.

Subtheme 3.4: Own confidence in supervising social workers in mental health care

The participants had diverse views of their own confidence in supervising social workers in mental health care. Some participants indicated that they were trained in mental health care and were confident that they could supervise social workers in mental health care. On the other hand, others reiterated their lack of training in mental health. They were not sufficiently confident to supervise social workers in mental health care.

P1: "I have training in mental health in UNISA; intervention processes for people with a mental problem."
P3: "Even myself I feel at time I need the knowledge."
P4: "To a certain extent but I do not have any training."
P5: "I have the knowledge base. I believe also other managers have the knowledge."
P7: "There is limited information. I read on my own."
P8: "if I can be trained I have confidence that I can supervise social workers working in mental health facilities."

A number of participants in the present study indicated that they had considerable knowledge in mental health care while others admitted that their knowledge of mental health care was limited. The latter is confirmed in a South African study conducted by Engelbrecht (2013), which noted that supervisors were not adequately trained. This was a theme reiterated by participants in Engelbrecht's study. The issue of supervision training is encapsulated in the following excerpt from a participant's narrative: "Supervisors are not trained as a specialist and rely on their own experiences of being supervised and their practice (social work) experience." This view is echoed in contemporary research findings in South Africa (Cloete, 2012:35; Engelbrecht, 2010:23). Hair (2012) explicitly refers to repeated recommendations from both practice literature and research that supervision training is necessary for supervisors to provide effective services.

This aspect is emphasised in the South African Supervision Framework (DSD & SACSSP, 2012) which requires *inter alia* that supervisors attend a supervision course presented by an accredited service provider, recognised by the SACSSP. The nature, motives, and integrity of the training service provider are, according to the participants in this study, determining factors in producing quality and highly skilled supervisors. These viewpoints resonate with Hair's (2012:1) argument that supervision training is often focused on the enhancement of organisational performance when training is left up to agencies, and that social work academic programmes (offered by academic institutions) are potentially in the best position to develop sustainable, theoretically founded supervision training programmes. Engelbrecht (2010:25) further asserts that, within the South African context, supervision training can enhance

organisational performance by enabling the supervisee to function independently from the supervisor within a short period of time.

Theme 4: Recommendations regarding social work services in mental health care service delivery

The participants recommended that the Department of Social Development prioritise mental health care in social work practice, and strengthen a multidisciplinary approach by enhancing its protocols, guidelines, and role clarification. The participants further recommended that managers provide moral support to social workers, and that their services be more accessible to mental health care users and their families. Mental health literacy was a prerequisite for educating communities about mental illness. The participants articulated their recommendations regarding mental health care. It was clear that the participants as well as social workers needed training in mental health care.

Summary of section E

The participants alluded to the nature of mental health services. The mental health services rendered in the areas where they worked were prevention, assessment, and intervention. They also rendered statutory services, funding, and monitoring of mental health programmes. Others were of the opinion that there were no mental health services rendered in the areas where they worked. It should be noted that the services mentioned were generic social work services and not mental health services. The participants echoed a need that mental health services should be improved, and therefore training was deemed a necessity in this regard. The managers were knowledgeable but some were of the opinion that social workers do not render any mental health services. Therefore, it is essential that training should be provided for social workers as well as social work managers. Some participants indicated that they were providing in-service training for social workers regarding mental health. There were diverse views regarding supervison; some felt confidendent to provide supervision in mental health while others felt incapacitated. The participants indicated that there was a challenge of limited resources in rural areas. There was a dire need

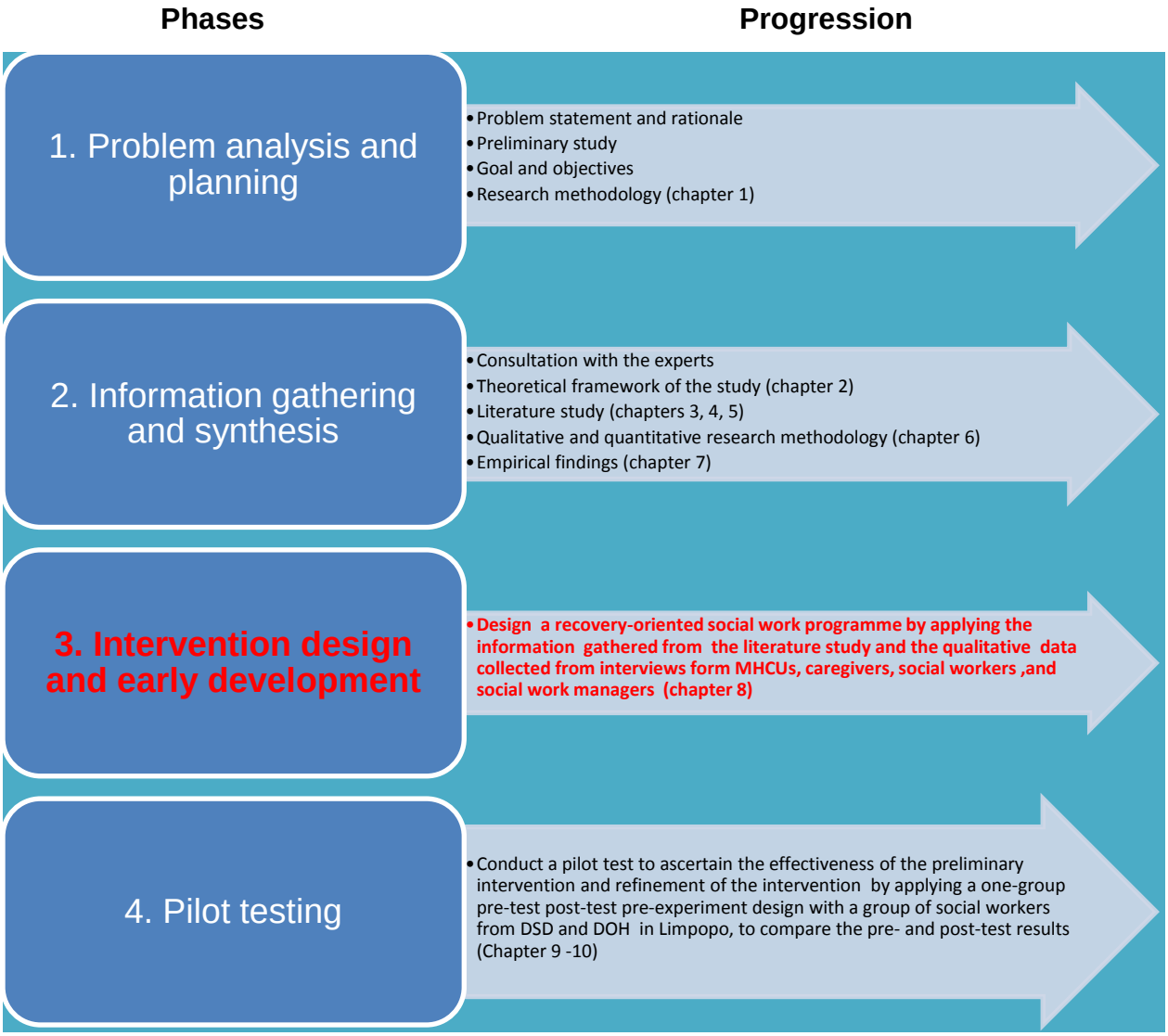
that social work infrastructure needed to be attended to as social workers are unable to perform their duties optimally.

7.4 Summary

The qualitative phase of the present study was conducted between August and September, 2015. Five sets of data were analysed, comprising caregivers, mental health care users, social workers from the district offices of Vhembe, Mopani and Capricorn, and hospital social workers from Malamulele, Hayani, Evuxakeni, Nkhensani, Shiluvana, Polokwane, and Seshego Hospitals, managers from Mopani and Vhembe districts and one from DSD provincial office. It was evident that MHCUs and caregivers have similar needs, and that all social workers and managers require training in mental health care; they felt that the department should provide them with resources so that they could render quality mental health services. Their working conditions were highly unsatisfactory, a contributing factor to the lack of quality in mental health services delivered by the Departments of Health and Social Development. All the participant groups who participated in this study had similar responses; therefore, the researcher had to utilise the same literature. The next chapter focuses on a recovery-oriented social work programme for mental health and the CROCMEHC programme.

CHAPTER 8

A RECOVERY-ORIENTED SOCIAL WORK INTERVENTION PROGRAMME



Graphic representation of phases of the intervention research: Adapted from Fraser and Galinsky (2010:463); De Vos (2011)

8.1 Introduction

Professionals can contribute to the recovery process (Clearly and Dowling, 2009:539; Crowe, Dean, Oades, Caputi and Morland, 2006:1497) and are able to facilitate a recovery-promoting environment for people with serious mental disorders (Corrigan, Steiner, McCraken & Barr, 2001:1599). However, for successful implementation of a recovery approach, mental health care professionals need to change or adapt their attitudes toward this new vision of recovery (Wilrycx, Croon, Van der Broek & Van Niewenhuizen, 2012:1). The authors state that to change the traditional mental health care system to a more recovery-oriented one, many organisations train their professionals in the recovery concept. However, the lack of knowledge and skills, organisational barriers (such as poor leadership), a change-averse culture, insufficient collegial support, and bureaucratic constraints may hinder the dissemination and implementation of innovative approaches (Wilrycx et al., 2012:1).

This chapter focuses on programme development, recovery-oriented mental health programme components, and an overview of the CROCMEHC programme. The researcher developed a CROCMEHC training manual (booklet) comprising seven modules. It was developed with pictures, and the participants commended the creativity of the facilitator (researcher), and this booklet was provided to the respondents. This training manual is in much more detail than the contents of this chapter, which for the purposes of this thesis had to be shortened to provide more of an overview of the programme. CROCMEHC was implemented in a pilot phase in two one-day training sessions and therefore still needs to be refined. More details of the CROCMEHC programme follows late in this chapter. The training manuals will be refined and disseminated once the programme id refined.

8.2 Programme development

Leedy and Omrod (2013:220) assert that developing a programme from both a literature review and empirical findings is in line with the view that research activities must result in an interpretation of the data to solve the problem under investigation. Hence, the researcher developed a programme based on the findings from the first phase, namely

qualitative research (chapter 7)**.** From the findings, it was evident that social workers lacked knowledge of mental health. The researcher was forced to integrate basic knowledge of mental health such as mental health in general, mental illness, DSM, the Mental Health Act (No 17 of 2002), admissions of specifically schizophrenia patients, treatment of schizophrenia, and the needs of mental health care users and caregivers. Subsequently, the recovery and recovery-oriented mental health practices were presented. The literature review proved to be particularly beneficial in the development of the preliminary programme. To be precise, chapters 3, 4, 5 and 6 were utilised for this purpose. Furthermore, the empirical study contributed valuable information from the perspectives of MHCUs, caregivers, social workers, and managers. This provided justification for the development of the social work recovery-oriented mental health intervention programme.

Furthermore, the pillars of the programme were identified as five elements of the developmental approach, namely rights-based, harmonising social and economic policies, participation and democracy, collaborative partnership, and bridging the micro-macro divide (Patel, 2005:25; DSD, 2013). The researcher adopted these social service notions for the preliminary intervention programme, namely social transformation, human emancipation, reconciliation, reconstruction, and development (DSD, 2013).

Moreover, the researcher adopted domains from the Commonwealth of Australia (2013), and five dominant fields of practice were identified:

Domain 1: Promoting a culture and language of hope and optimism.

Domain 2: Person first and holistic.

Domain 3: Supporting personal recovery.

Domain 4: Organisational commitment and workforce.

Domain 5: Action on social inclusion and the determinants of health, mental health, and wellbeing.

Permission was granted by the Commonwealth of Australia to integrate these domains in the designed intervention programme. The domains provided guidelines on how

recovery-oriented mental health practice can be implemented. Therefore, the researcher included these domains in her training manual developed for the intervention programme.

The researcher adopted the name CROCMEHC programme, meaning Collaborative Recovery-Oriented Mental Health Care programme. It should be noted that CROCMEHC is not an acronym; it is a designated title of the designed programme. Recovery does not occur in isolation; therefore, MHCUs should collaborate with caregivers, their families, service providers (mental health care practitioners), and communities. This collaboration enhances the recovery process, which is in line with transformation, human emancipation, social justice, and human rights.

Linked to ecological system theory and the strengths-based perspective, the researcher believes that developmental social work occupies a beneficial stance in the preliminary intervention programme. To qualify this statement, developmental social work is defined as an "integral, holistic approach to social work that recognises and responds to the interconnection between the person and the environment, links to micro and macro practice and utilises strengths-based and non-discrimination model and approaches, intervention and partnerships to promote social and economic inclusion and well-being" (Lombard, 2010:1).

The research findings reveal that there is a lack of knowledge concerning mental health care. Therefore, the researcher has shown how assessment can be performed using ecological systems theory and the strengths-based perspective (chapter 2). The chapter on literature indicates what can be done on the different levels of ecological system theory; for instance, in chapter 3 the focus is on the macro level; in chapter 4 the focus is on the micro-, messo-, and chronosystem levels; and in chapters 5 and 6 the focus is on the macro level. The strengths-based perspective encourages social workers to empower mental health care users. Furthermore, chapter 2 highlights how social workers can use the strengths-based perspective in assessment. The subsequent discussion is based on the components of the recovery-oriented mental health programme.

8.3 Recovery-oriented mental health programme components

The component espoused by Spaniol (2008:57-66) of the recovery-oriented programme framework assisted the researcher in deciding what the recovery-oriented programme should entail. This author argued that the recovery-oriented programme is essential as it provides the knowledge, skills, support, and resources to facilitate the achievement of each individual's recovery. The components that were followed to develop this programme were adapted from Spaniol (2008:57-66):

- **Strongly affirm recovery in the mission statement**: A programme needs to uphold the legislative framework of the country. Hence, the researcher has incorporated the Mental Health Act (No 17 of 2002) and the National Mental Health Policy and Strategic Plan (2013-2020) that provide the guidelines for the provision of mental health services (Department of Health, 2002; Department of Health, 2013)..
- **A climate of hope**: Hope is a combination of empathy with the person's circumstances, and respect for the person's capacity. The role of the service provider is to empathise with the person's situation in life, and help individuals in identifying their aspirations and goals; to provide the knowledge, skills, and resources to achieve these goals. The researcher integrated the concept of hope into the programme as one of the principles of recovery.
- **Affirm key recovery values:** The explicit affirmation of key recovery values is an important component of a recovery-oriented programme. These recovery values include:
  - ***Participation*** – people need to be involved in all aspects of their treatment and recovery.
  - ***Empowerment*** – empowerment means the person is able to say "I can" rather than "I can't" This is built through achieving success in life's many tasks, however small.
  - ***Growth potential*** – it is important to recognise people's growth potential regardless of their current difficulties or disabilities.

- ***Community focus*** – providers need to facilitate integration into community life by providing opportunities for the development of multiple roles to discover and create an identity that is separate from, and greater than, the illness such as being a student, worker, volunteer, neighbour, friend, and one who can enjoy life.

- **Whole person/family centred*:*** People need to be treated as whole human beings with natural responses to profound trauma and with a deeply felt connection to their family, regardless of their current relationships. Service providers in practice will equate recovery with the recovery-oriented programme. Most of these values have been integrated into the programme.

- **Provide acute and ongoing psychiatric care*:*** There are numerous interventions and resources that have been shown to be helpful in a person's recovery. These include crisis intervention, inpatient/outpatient treatment required to help stabilise a person in a crisis, and to assist with re-entry into his or her community. Assertive community treatment involves actively reaching out to people. Respite facilities provide opportunities for people to resolve crises without hospitalisation. Transition-supported housing provides residential options as and when people are released from hospital.
- **Availability of primary health care**: Each individual's life depends on the society he or she lives in as well as the support and services that are available.
- **Respect person and their unique process**: Practitioners will be responsible for the developmental needs, priorities, and choices made by clients.
- **Value the importance of relationships and connectedness**: Provide opportunities for building confidence/self-esteem through meaningful roles.
- **Value involvement**: Listen to what people say they need and want. Encourage people to be involved in all decisions that affect their lives.
- **Include rehabilitation and skill building**: Education and skill building are critical interventions. Focus on strengths. Help people build a relatively normal life. The tendency historically has been to focus on pathology. Practitioners will encourage

clients to set goals and provide the knowledge, skills, and support to achieve those goals.

- **Involvement of family members**: Providers need to value family involvement, and understand its importance in order to reach out to families, develop guidelines, and train staff. The programme can encourage a collaborative alliance among all parties.
- **The active presence of recovered people at all levels of the treatment and rehabilitation process**: People need role models and mentors, that is, other people with psychiatric disabilities who have succeeded in their lives. The active presence of people who have recovered is common practice in recovery programmes for people with other disabilities. People who are fully recovered can and do serve at all levels of mental health programmes – from directors to professionals. Programmes are also being entirely run by peers. Peer support or modelling can be an important factor in helping people to cope, to feel that they are not alone, and to engender hope for their own recovery. Programmes will educate staff about the value of peer support, and actively and assertively involve peers who are in recovery in working for and volunteering for the programme.
- **Provide opportunity to resolve impact of substance abuse**: There is a well-documented need for the integration of mental health and substance abuse services for people with dual disorders. Fifty percent or more of people with mental illnesses will experience a co-occurring substance disorder at some point in their lives. For many, this will be an ongoing struggle, with the need for an integrated treatment programme and a long-term relationship with an assertive community treatment team.
- **Provide long-term commitment to people**: People with mental illness have a right to assistance. This may require a long-term commitment to the programme. The programme should have a “no fail” policy. “No fail” means that people may need “times out” but that the programme allows them to return and continue working with them if they so desire. The use of coercion, obvious or subtle, is never a “first option” intervention. People are treated with respect and there is tolerance

for multiple personal perspectives as to what is helpful or not in their recovery. People are expected to take responsibility for their own recovery.

- **Provide opportunities to contribute to others**: Recovering the capacity to be helpful to others is an important turning point in the recovery process. Many people find that providing assistance to others with mental illnesses is an important aspect of their recovery. Their contributions can become part of a programme where those who are further along in the recovery process can help others who still have a long way to go, or by performing voluntary work in the community. The programme will provide ongoing opportunities for its users to contribute to the programme within a community context.
- **Advocacy**: This is an essential component of a recovery-oriented programme. All parties must share in that advocacy for it to be effective and to achieve its goals. Programmes can establish a collaborative process for assessing and understanding the challenges and needs of all parties. This will lead to a comprehensive grasp and consensus of the policy, programmatic implications of these needs, and a collaborative strategy for change. The programme will encourgage ongoing advocacy to improve the daily lives of people with mental illnesses, their families, and providers.

The researcher has managed to incorporate these crucial components into the development of the preliminary intervention programme. All the components are useful for the development of the recovery-oriented mental health practice. From literature, the researcher has noted that there are different scholars who have developed intervention research on recovery-oriented mental health (Peebles, Mabe, Fenley, Buckely, Bruce, Narasimhan, Frinks & Williams, 2009:239-245; Salgado, Dean, Crowe & Oades, 2010:243-248, Gilburt et al., 2013:167). These scholars provide evidence that structured training on critical components of recovery can increase both knowledge and post-recovery attitudes. The researcher has found various programmes that have been developed on recovery-oriented mental health practice. These studies were conducted in an international context. There are five other examples, from a social work perspective; however, not all these studies were conducted in South Africa.

8.4 International recovery-oriented mental health programmes

In this section, the discussion focuses on intervention programmes that have been designed for recovery-oriented mental health practice, and not only on social work. The focus is on the multidisciplinary team involving psychiatrists, social workers, and psychologists. Other programmes focus on health service researchers, clinicians, mental health care users, and caregivers.

8.4.1 Intervention programme in the UK

The intervention programme of Gilburt et al. (2013) comprised four full-day workshops in a classroom setting, followed by an in-team half-day session. The training was conducted in London, Southwark, and Lewisha. The research team developed the content, and the project steering group comprised health service researchers, clinicians, service users, and carers with the support of the health provider's training department. Training took place between January 2008 and January 2009. Attendance was mandatory.

- **Day 1** comprised an introduction to recovery, and reflection on the different elements that constitute a recovery approach.
- **Days 2 and 3** focused on a recovery training package called Psychosis Revisited – a psychosocial approach to recovery.
- **Day 4** covered a range of topics: assessment and care planning from service users' perspectives; social inclusion/vocational activities from a social work perspective; carer perspectives on recovery; spirituality and reflection on fundamental issues around personal values and beliefs, strengths-based approaches; and the role of hope (Gilburt et al., 2013).

The results of this training support the use of training approaches as a mechanism for knowledge transfer and implementation.

Evaluation of this programme

The researcher based her programme on some of these aspects. The topics that were similar were based on recovery, assessment, and care planning. There were different

stakeholders who showed an interest in the developed programme; the delegates were from a multidisciplinary team which consisted of psychiatrists, social workers, and psychologists – to name but the few. Intervention covered four full-day workshops. The researcher developed a one-day intervention programme; the delegates were only social workers.

8.4.2 The training programme in Breda, Netherlands

In order to implement the new recovery vision of Wilrycx et al. (2012) and to achieve a culture change within the mental health organisation located in Breda, Netherlands, a recovery-oriented care project was developed by three major mental health care organisations: that is, two rehabilitation organisations, “Storm” rehabilitation, and one peer-support organisation. The recovery and recovery-oriented care project was developed especially for the mental healthcare network “impact,” where people with chronic psychiatric disorders, for example psychotic disorders, were treated. Inpatient and outpatient settings were involved. The main goal of the project was to create and promote a new culture of recovery from serious mental illness. The educational programme was offered in two separate intensive training sessions, one in 2008 and a second in 2009.

The training programme was developed for all professionals who were in close contact with mental health care patients such as psychologists, psychiatrists, secretaries, managers, and nurses. The training programme consisted of two modules presented in a two-day session, every six months. The first module focused on the basics of recovery-oriented care in order to familiarise the professional with the concept of recovery.

The second module focused on the attitude of the professional toward recovery-oriented care. An expert from a peer support centre and a professional rehabilitation teacher presented both courses. The results suggest that over the total course of the training programme, predictable changes in attitude toward recovery were found. The study shows that staff knowledge and attitudes regarding recovery from mental illness can improve with training. Mental health care workers exhibited more positive attitudes toward recovery in clinical practice after completing the two training sessions (Wilrycx et al., 2012:1).

Evaluation of this programme

The programme under scrutiny contained themes similar to those in the preliminary intervention programme developed in the present study; however, there were differences in duration, presenters, and attendees; social workers were not mentioned. The training was intensive and consisted of a two-day workshop, every six months. This is different from the preliminary intervention programme developed in the present study.

8.4.3 Social work-based recovery-oriented programmes

The following programmes are discussed, based on strengths-based practice, using mutual aid group work in social work:

8.4.3.1 The "What's Right With Me" programme

Strengths-based practice was utilised in the running of a group in acute units by Hyde et al. (2014), called "What's Right With Me". Even the language chosen for the title was a direct challenge to that of conventional deficit-based language of the medical model, with its emphasis on symptoms and "what's wrong". This group differed from other groups run in the unit in that it used a mutual aid model of group work, and not the didactic approach of other groups that focus on a psychoeducational approach seeking to teach or inform. Over a period of 15 months, 144 evaluations were analysed from 184 participants of the "What's Right With Me" group. Results indicated that participants valued the opportunity to share experiences and provide support to each other. They developed a greater understanding of their own strengths, and appreciated being listened to and having the opportunity to listen to others. A strengths-based approach within a model of a mutual aid group work engenders an empowering perception of care that acknowledges the lived experience and collective resourcefulness of participants (Hyde et al., 2014).

Evaluation of this programme

The programme discussed above has a number of differences compared to the preliminary intervention programme; however, the researcher is confident that group work can assist social workers in integrating into recovery-oriented mental health practice. The group ran for a period of 15 months, and the results indicated that the participants

benefitted from group work. The researcher's programme is also grounded in a strengths-based perspective, which is critical in social work in order to promote recovery-oriented principles.

8.4.3.2 A telephone-mediated mutual aid model of group work for carers

A telephone-mediated mutual aid model of group work was used with carers whose relatives had been admitted to long-term mental health rehabilitation units. Data collection over a seven-year period of evaluations with these groups indicated that the carers valued the supportive and collaborative nature of these groups, consistently reporting a reduction in isolation as well as benefits to their health and well-being in the short term (Hyde et al., 2014).

Evaluation of this programme

The researcher focused on the needs of caregivers. However, due to the lack of resources in rural areas, the researcher deemed this method unrealistic. The researcher explained the role of social workers in helping caregivers, and the guidelines on how to assist caregivers, in her preliminary intervention programme. She noted that social workers used their own mobile phones to communicate with clients, and that the department did not compensate them for this expense. However, a telephone-mediated mutual aid group was deemed too costly.

8.4.3.3 Social work-initiated group: women experiencing chronic and complex mental illness

A social work-initiated group is a unit for women who experience chronic and complex mental illness. This was a most challenging experience but one that demonstrated that recovery-oriented practice is possible in the most oppressive of environments. The majority of women in these units had suffered traumatic histories of personal abuse as well as drug and/or alcohol use. Many of them have been disenfranchised from their families and from community services. All the women had a diagnosis of a long-standing mental illness, and many had suffered the loss of their children, some through forcible

removal. The experience of providing group work in that environment drew on theories of mutual aid, strengths-based practice, an existential group approach, and Gestalt therapy. It expanded the understanding of the application of anti-oppressive practice within an oppressive environment, and ensured patients' self-determination and choice. The group provided a forum for the exploration of suppressed painful emotions (psychotherapeutic focus) and facilitated support between participants (mutual support). Evaluations at the conclusion of the group work session indicated that the participants most appreciated the strengths approach, with one participant articulating her ability to speak about her "buried feelings" for the first time (Hyde et al., 2014).

Evaluation of the programme

The researcher has noted that group work is a powerful tool that impact many people at the same time. Furthermore, the group was created for a vulnerable group – women. The programme was different from the preliminary intervention programme, as it focused on social workers; it was training, and not a group work session. However, the researcher noted that the group work programme provided a forum where women could share their pain and obtain mutual support from fellow group members. The evaluations at the conclusion of the group sessions indicated that most participants appreciated the strengths approach.

8.5 South African national programmes

Assertive community treatment (ACT)

Fifty-six percent (56%) of African countries have community-based mental health services, and only 50% have existing mental health policies. There is a call for the scaling up of cost-effective, community-based mental health services in middle- and low-income countries, citing successes in countries such as India, Chile, and China where interventions had been modified to meet the needs of the community. An example is an intervention in Somalia, which offered a 10-month programme to a group of 35 outpatients

with chronic psychotic disorders. The intervention was a home-based programme, which incorporated psychoeducation, relapse prevention, and family support and was found to be cost-effective and feasible in a low-income country (Botha et al., 2014).

In South Africa, similar attempts have been made to address these challenges in finding a cost-effective community-based initiative. As part of a provincial initiative, the Western Cape Province launched three assertive community treatment (ACT) teams in 2007. The teams followed a modified version of the ACT model, particularly in terms of caseloads and visit frequency. It was reported that at the first year follow-up the patients who completed the intervention demonstrated a significant reduction in days spent in hospital and improvements in social functioning, in comparison to patients who received the standard care service package. Though the follow-up period was only 12 months, these were the first indicators that assertive interventions could be successfully modified to meet the needs of under-resources areas without compromising the efficacy of the intervention. This supports past arguments by international authors that assertive interventions may be more effective in under-resourced areas where standard care services are less comprehensive (Botha et al., 2014:56).

Evaluation of this programme

The researcher is aware that recovery-oriented mental health practice that has been implemented in the Western Cape, South Africa; however, services are limited. The researcher has therefore incorporated the ACT in her programme.

8.6 Overview of the researcher's CROCMEHC programme

The researcher has explained her motivation for developing this programme, which she called CROCMEHC (Collaborative Recovery-Oriented Mental Health Care) programme. The information is provided in the introduction of this chapter. This programme is premised on a developmental approach, which has been adopted in South Africa in other contexts (Patel, 2005:26). The researcher conducted training in the Mopani and Vhembe Districts on 16 and 18 August 2016. Her initial plan was to conduct the training over a two-day period but due to financial constraints she opted for a one-day training session. The researcher was fully aware that one day would be insufficient and therefore

requested that social workers register beforehand. She anticipated 67 delegates, but only thirty-seven attended. This was indeed a drawback in terms of the reduced number of respondents as well as fruitless expenditure.

The researcher developed a CROCMEHC training manual (booklet) comprising seven modules. It was developed with pictures, and the participants commended the creativity of the facilitator (researcher), and this booklet was provided to the respondents. This training manual is in much more detail than the contents of this chapter, which for the purposes of this thesis had to be shortened to provide more of an overview of the programme. CROCMEHC was implemented in a pilot phase in two one-day training sessions and therefore still needs to be refined. More details of the CROCMEHC programme follows late in this chapter. The training manuals will be refined and disseminated once the programme id refined.

8.6.1 Contents of the preliminary intervention programme of the present study

The programme was divided into two parts:

Part A: Four modules: mental health and mental illness, MHCUs and caregivers, social work in mental health, and intervention methods.

Part B: Three models: recovery-oriented mental health practice.

The purpose of the programme was to provide knowledge pertaining to mental health care, recovery-oriented mental health care, and the implementation of the CROCMEHC programme. Each module had its own objectives and practical exercises.

The introduction commences by illustrating the prevalence of mental illness (schizophrenia) and the development of recovery-oriented mental health services. The researcher described this as a journey of collaboration between individuals in recovery, their families, and caregivers, and to give guidance to mental health practitioners. Social workers can gain valuable information from a number of strategies which would quantify recovery abilities, convictions, and strong connections, including mechanisms to gauge an individual's experience of trust and hope, connectedness, individual personality, empowerment, and the presence of meaning and motivation in life.

Table 8.1: Summary of the CROCMEHC programme

Part	Module	Topic	Content
A	**1**	○ **Mental health and mental illness**	○ Mental health services ○ Mental health care in rural areas ○ Definition of mental health ○ Definition of mental illness ○ Types of mental illness (DSM 5) ○ Schizophrenia ○ Causes of schizophrenia ○ Potential causes of schizophrenia ○ Phases of schizophrenia ○ Clinical features ○ Prognosis ○ Epidemiology ○ The outlook of schizophrenia ○ The influence of culture ○ Treatment of schizophrenia ○ Biological intervention ○ Pharmacological intervention ○ Conventional or typical antipsychotics ○ Atypical antipsychotics ○ Side effects of the medication ○ Antidepressants ○ Adverse effects ○ Common treatment settings ○ Hospitals ○ Long-term hospitalisation ○ Crisis residential programmes ○ Day treatment ○ Housing - transitional halfway houses, long-term residences, cooperative apartments, intensive care ○ Cross-cultural treatments ○ Spirituality
	2	**Mental health care users (MHCUs) and caregivers**	○ Definition of mental health care ○ Definition of caregiver ○ The needs of mental health care users ○ Social impact-homelessness, education opportunities, income generation, health impact, human rights, and social justice ○ The caregiver's burden ○ Needs of the caregivers

Part	Module	Topic	Content
			○ Problems are attributed to the stress of caring, social isolation, loneliness, changing relationships, loss, and grief ○ Caregivers experienced stress ○ Impact of caregiving on the caregivers ○ How can the mental health and the caregivers be supported
	3	**Social work in mental health care**	○ Social work and social work services ○ Social workers provide social work values, standards and principles in mental health care ○ Principles ○ Social work in mental health care ○ The role of social work ○ Purpose and function of social work ○ Social work and DSM 5 ○ South Africa's legislative framework ○ Theories and models in mental health care
	4	**Intervention methods used by social workers in mental health care**	○ Work with individuals ○ Individual intervention ○ Work with groups ○ Family-based interventions ○ Psychoeducation ○ Counselling ○ Mutual support groups ○ Social skills training ○ Vocational rehabilitation and supported employment ○ Assertive community treatment ○ Multidisciplinary teams
B	**5**	**Recovery**	○ History of recovery ○ Definition of recovery ○ What recovery does not mean ○ What does recovery mean ○ Theories of recovery ○ Recovery model ○ Tidal model ○ Components of recovery ○ Recovery principles ○ Stages of recovery ○ Measurement of recovery ○ Recovery assessment scale

Part	Module	Topic	Content
			○ Illness management and recovery scale (IMR)
	6	**Recovery-oriented mental health care**	○ Definition of recovery-oriented mental health practice ○ Recovery-oriented service delivery ○ Social work and recovery oriented mental health practice ○ Synergy of social work values and recovery-oriented principles
	7	**Implementing the CROCMEHC programme**	○ CROCMEHC in practice ○ Pillars ○ The role of the individual social worker to facilitate recovery ○ Recovery-oriented practice ○ How to become a recovery-oriented social worker ○ Five elements of developmental approach ▪ Rights-based ▪ Harmonizing social and economic policies ▪ Participation and democracy ▪ Collaborative partnership ▪ Bringing the micro-macro divide ○ Domain 1: Promoting a culture and language of hope and optimism ○ Domain 2: Person first, and holistic ○ Domain 3: Supporting personal recovery ○ Domain 4: Organisational commitment and workforce development ○ Domain 5: Action on social inclusion and determinants of health and mental health wellbeing

The table above provides a summary of the preliminary intervention programme. It consists of seven modules. The researcher compiled a detailed booklet that was presented to each attendee on the day of the training.

8.6.2 Developed CROCMEHC model

The graphic presentation below depicts the model that the researcher has developed (figure 8.1 below).

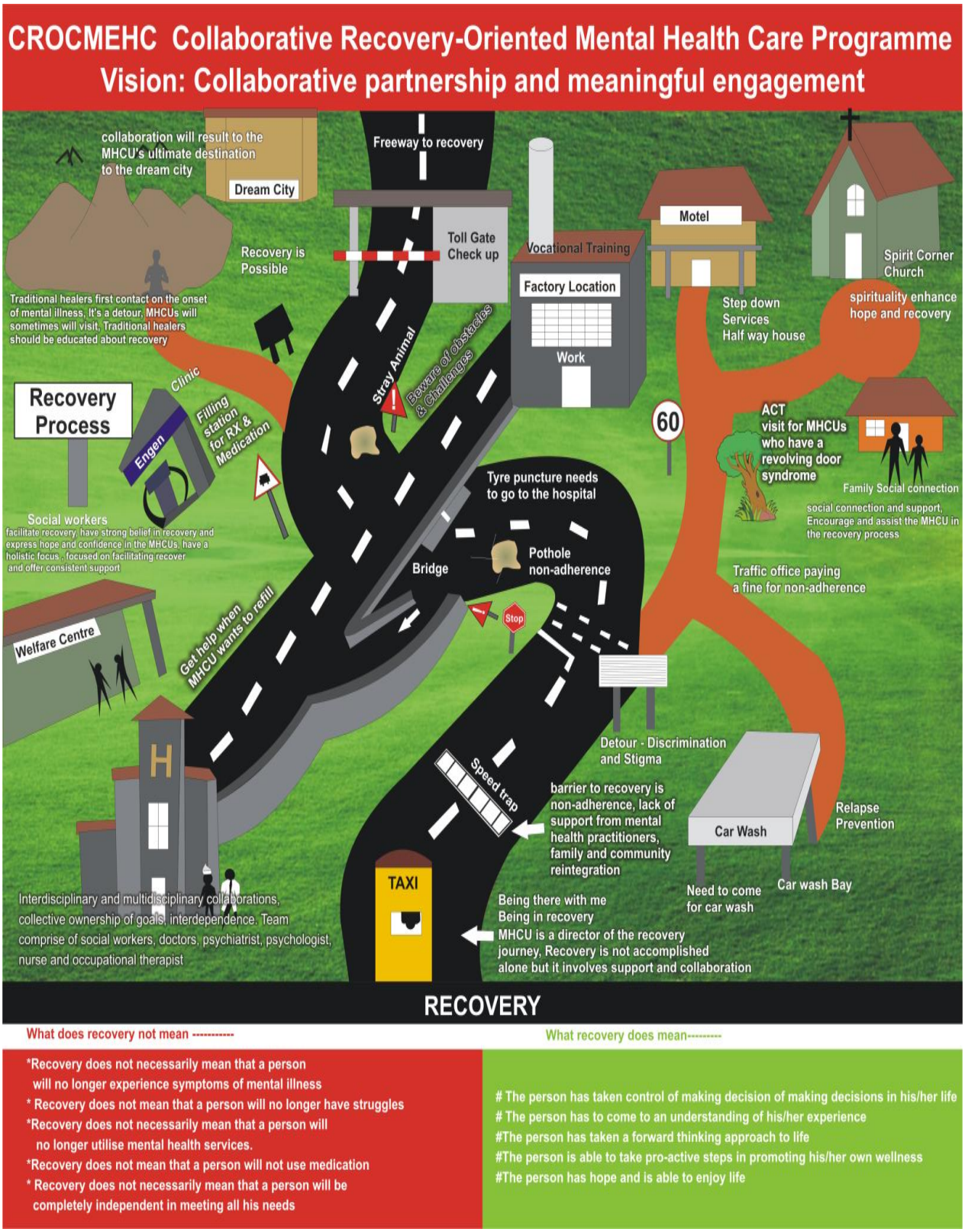


Figure 8.1: Graphic design of the MHCU's journey to recovery, presentation and interpretation provided in section 8.7.

8.7 Interpretation of the CROCMEHC model

The researcher has developed her own model: the CROCMEHC (Collaborative Recovery-Oriented Mental Health Care) model. Figure 8.1 depicts a graphic design of the MHCU's journey to recovery, and illustrates a person who is commuting in a taxi. Along the way there are detours, speed traps, stop signs, a service station, car wash, workplace, step-down facilities, a transitional halfway house (motel), and toll gates. In order for MHCUs to reach their "destination," the support of the multidisciplinary team, family, and caregivers is required. This portrayal has taken the form of ecological system theory as well as the strengths-based perspective. The researcher also explains what recovery entails, and highlights the following:

- The person has taken control of his or her life, and is making personal decisions.
- The person has to live his or her own experiences.
- The person has to take a forward-thinking approach to life.
- The person is able to take proactive steps in promoting his or her own wellbeing.
- The person has hopes and is able to enjoy life.

Furthermore, the researcher elucidates what recovery does not mean, and highlights the following:

- Recovery does not necessarily mean that a person will no longer experience symptoms of mental illness.
- Recovery does not mean that a person will no longer have any struggles.
- Recovery does not necessarily mean that a person will no longer need to utilise mental health services.
- Recovery does not mean that a person will not need medication.
- Recovery does not necessary mean that a person will be completely independent in meeting all his or her needs.

The CROCMEHC programme advocates that MHCUs be afforded the opportunity to take control of their lives, and the right to be supported during the journey of recovery by mental health care practitioners, family, caregivers, and friends. Medication has an important

place in recovery-oriented mental health care. Therefore, the researcher advocates for a collaborative partnership between the MHCU, the significant other, and the mental health care practitioner. In the present study a detailed booklet was compiled and given to participants where the contents (table 8.1) were discussed in detail.

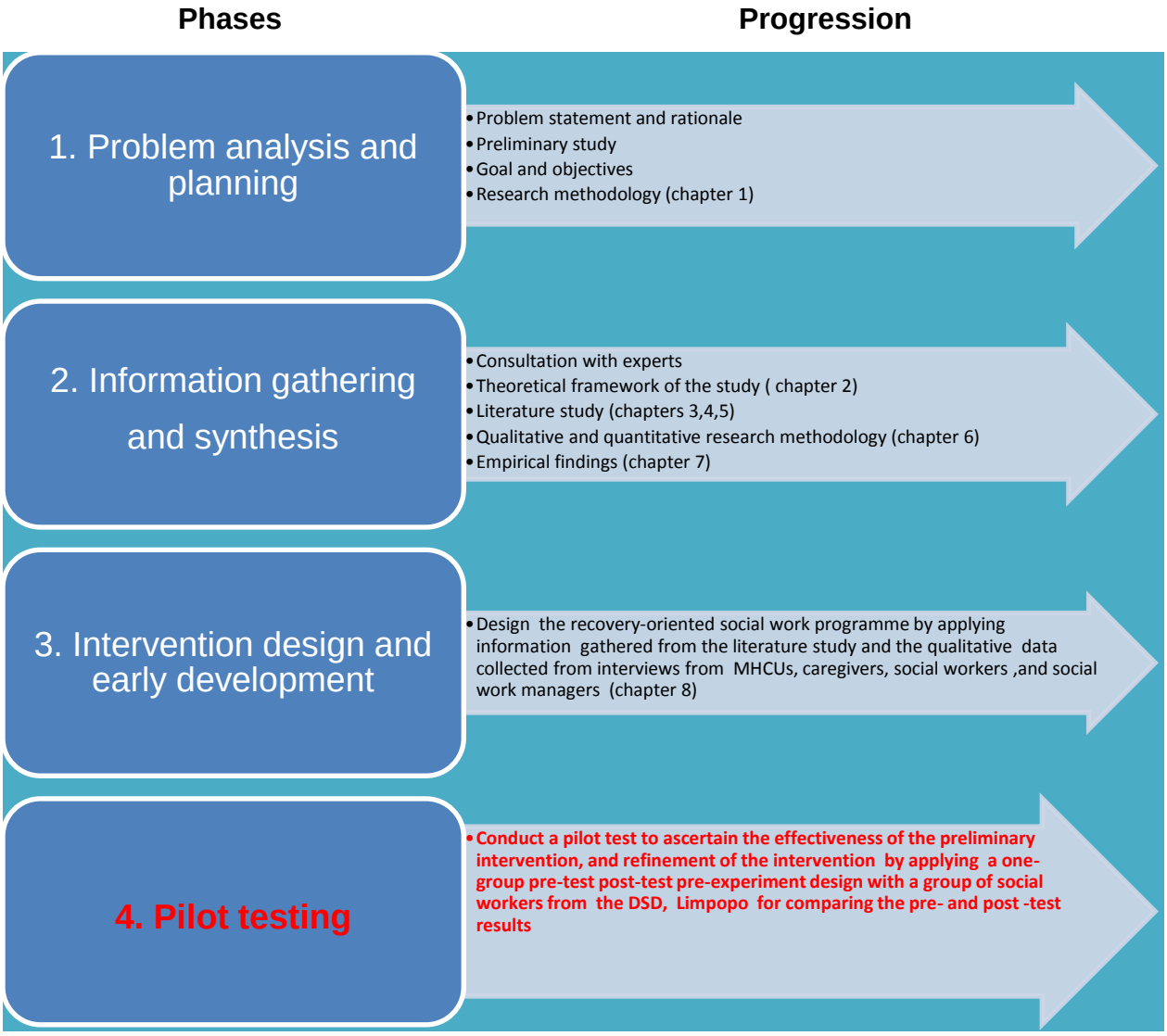
8.8 Summary

This chapter provided information about the training programmes in recovery-oriented mental health practice. These programmes were based on an international context. The researcher could not find any intervention programmes based on the South African context; the only information she could find is the ACT, initiated in the Western Cape. The researcher scrutinised the SADAG website, and the only information available is the definition of schizophrenia, its symptoms, and causes. The researcher also found three examples of recovery-oriented social work programmes that were relevant to the present study, as the CROCMEHC programme was developed specifically for social workers. The researcher provided an outline of what the CROCMEHC programme consists of.

The next chapter will focus on the empirical results of the quantitative research (second phase).

CHAPTER 9

PILOT TEST OF A RECOVERY–ORIENTED SOCIAL WORK INTERVENTION PROGRAMME



Graphic representation of phases of the intervention research: Adapted from Fraser and Galinsky (2010:463): De Vos (2011)

9.1 Introduction

The research at hand is based on the mixed-methods approach, namely both the qualitative and quantitative approaches. The mixed-methods design utilised in the present study is an exploratory sequential mixed-methods design (Creswell & Plano Clark, 2011:71). The present study was categorised into two phases: the first pahse was qualitative (chapter 7). The qualitative approach played a major role in the development of the programme piloted in the second phase The theoretical frameworks that underpinned the present study were ecological systems theory (EST) and the strengths-based perspective (SBP). The theoretical frameworks were appropriate as they provided an understanding of the role of the environment in influencing the lives of people with schizophrenia. Furthermore, the strengths-based perspective provided an understanding that people living with schizophrenia have the potential to recover, that they have talents and the potential to live meaningful lives despite their disability.

This chapter will focus on the second phase namely the quantitative phase. Stratified random sampling and systematic sampling were applied for social workers, more information in this regard is captured in chapter 6. The population was divided into a number of strata, which were homogenous in nature (Strydom, 2011:230). Due to the strike of social workers in Limpopo, convenience/accidental sampling was also employed in the second phase (quantitative approach). The sampling was only used in Vhembe district and the details of the quantitative research methodology were discussed in chapter 6.

From the first phase, the researcher established different themes that were critical to the development of the programme, namely general knowledge of mental health and mental illness, and the needs and challenges of mental health care users (MHCUs) and their caregivers, roles of the social worker in mental health care, training in mental health, and recovery and recovery-oriented mental health practice. The intention of the study was to develop a recovery-oriented mental health programme for social workers in the rural areas of South Africa. However, from the first phase it became clear that social workers lacked knowledge of mental health care; hence, the focus was on mental health,

specifically schizophrenia, and the role of social work in mental health care. The information was fundamental before introducing the recovery-oriented mental health programme. It should be noted that the conducted study was based on intervention research. Of the six phases of the intervention research, only four phases were implemented in the present study (chapter 6). Therefore, the focus of this chapter was on the presentation of the second phase of the study, namely the quantitative empirical findings.

9.2 Aim and objectives of the study

9.2.1 Aim of the study

The aim of the present study was to develop, implement, and evaluate a social work intervention programme aimed at recovery-oriented mental health practice in rural areas.

9.2.2 Objectives of the study

The objectives of the second phase (quantitative) were:

- To design the recovery-oriented social work programme based on the needs identified in the first phase.
- To conduct a pre-test measurement with the social workers regarding their knowledge of mental health and the recovery-oriented model.
- To implement the recovery-oriented social work programme through the training of social workers.
- To conduct a post-test measurement with the social workers regarding their knowledge of mental health and the recovery-oriented model.
- To analyse the effectiveness of the programme by improving the knowledge of social workers on mental health and the recovery-oriented model.
- To make practice recommendations for the broader utilisation of the recovery-oriented social work programme for MHCUs in rural areas.

9.2.3 Hypothesis of the study

For the quantitative approach (second phase), a hypothesis was developed. Babbie and Mouton (2001:643) define hypothesis as “an expectation about the nature of things derived from a theory and is a statement of something that should be observed in the real world if the theory is correct.” The authors postulate a certain relationship between two or more variables.

The hypothesis for this phase of the study was as follows:

If social workers participate in a recovery-oriented intervention programme developed by this study, their level of knowledge should improve in rendering mental health services to mental health care users and their caregivers in rural areas of South Africa.

The sub-hypothesis for this phase of the study was as follows:

A social work intervention programme based on recovery-oriented mental health will increase the knowledge of social workers in rendering mental services to mental health care users and their caregivers in the rural areas of South Africa.

9.3 Quantitative research methods

The quantitative approach was informed by the empirical findings of the qualitative approach, and an in-depth literature review was conducted prior to the commencement of the present study. Therefore, in this section, the researcher briefly discusses the quantitative research methods as most of the information was presented in chapter 6. The pre-experimental one-group pre-test post-test design was chosen because it includes a pre-test following intervention, thereafter followed by a post-test that provided the basis for comparison (Grinnell & Unrau, 2011:278). Furthermore, Marlow (2011:96) asserts that this design is beneficial and is always utilised in programme evaluations, even if there is no control group.

9.3.1 Sampling method and sample

The sample was selected from a population of social workers working in the Departments of Health (DOH) and Social Development (DSD) in Limpopo Province. The social workers

were from Mopani and Vhembe Districts. A list of all social workers was obtained from the regional office. The researcher utilised a stratified random sampling, and a sample of 30 to 35 was decided upon in consultation with the statistician and the supervisor. Systematic sampling was used to determine the various respondents from two stratums: Mopani and Vhembe Districts. The first name on the list of each district was given a number, respondent number 1; thereafter every tenth name on the list was included in the sample, until the required sample size was obtained. For more details on the sample frame and limitations see chapter 6, section 6.4.1.

The researcher sent out the invitation, registration form, and the agenda for the CROCMEHC programme to the two contact persons who were responsible for assisting the researcher in organising training in the districts; the information was sent via email. (Appendices J,K,L). The emails indicated how the respondents were selected, and how the training would unfold, namely the aim, nature, dates, times, and venues. The respondents were informed that an informed consent form needed to be completed prior to the training, giving their voluntary consent, as well as a questionnaire before and after the training. Only those who were interested in voluntarily participating in the research by attending the training were asked to respond, complete the registration form, and return it to the researcher via email. In total, 67 respondents responded, and signed and returned the registration forms. On the day of the training the convenience/accidental sampling was employed to substitute the participants who did not attend the training.

9.3.2 Method of data collection

A self-constructed questionnaire was utilised as a data-collection instrument, based on the findings of the first phase and an intensive literature study. The questionnaires comprised a mixture of multiple-choice and open-ended questions. Both pre-test and post-test questionnaires comprised nine sections each (Appendices M & N).

The following was undertaken before the process of quantitative data collection:

- The pre-test and post-test questionnaires were designed and discussed on several occasions with the assigned statistician and a research consultant from the

Department of Statistics, University of Pretoria as well as the researcher's supervisor.

- The questionnaires were also discussed with an expert social worker, specialised in mental health care practice, who has recently graduated with her DPhil degree.
- Reminders of the training date were again sent to the respondents who had responded, closer to the date of planned CROCMEHC programme implementation.

The following were performed during the quantitative data-gathering process:

All the respondents were provided with a letter of informed consent. The researcher explained the contents of the research to the respondents as a group before the CROCMEHC programme training commenced, as follows:

- The researcher also ensured the respondents that she had been granted permission by the Departments of Health and Social Development, and granted clearance by the Res-Ethics Committee of the Faculty of Humanities, University of Pretoria.
- The ethical considerations were discussed before training commenced, emphasising confidentiality, protection of their identities by using numbers (codes), the right to withdraw, debriefing, and storage of data for 15 years at the University of Pretoria.
- Once the contents of the letter of informed consent were explained the respondents individually signed the letter.
- Each respondent was given a name tag with a number for identification purposes that they were required to write on their pre-test and post-test questionnaires, as this was their respondent number for the researcher to use in data processing and analysis.
- They were firstly given the pre-test questionnaire to complete as a group, and then the CROCMEHC programme training commenced.

- After the CROCMEHC programme training was completed at the end of the day, they were given the post-test questionnaire to complete as a group.
- The respondents were provided with a pencil and an eraser to complete the questionnaires, and the instructions as to how to the questionnaires were to be completed were explained.

The researcher organised and paid for the venues in the respective districts for one day each, including catering, training material, and certificates for 67 respondents, although only thirty-seven persons attended, resulting in a financial loss for the researcher. Further costs were incurred in printing new certificates for the replacement respondents, recruited by means of accidental sampling.

9.3.3 Method of data analysis

The merged pre- and post-scores of the social workers were analysed. The descriptive statistics were utilised in the present study. Fouché and Bartley (2011:251) indicate that descriptive statistics describe numerical data and help in organising and summarising the data in the tables, graphs or scores that are interpreted.

Leedy and Omrod (2013:277) hold the view that inferential statistics are used to test hypotheses, and for testing whether the descriptive results were likely to be due to random factors or real relationships. In this study, a dependent t-test was applied, and a Box and Whisker plot mapped the distribution of the data knowledge scores. Field (2005:286) states that a dependent mean t-test is utilised when there are two experimental conditions, (pre- and post-tests in this instance) and the same participants took part in both conditions of the experiment. The author states that a dependent t-test is sometimes matched in pairs or paired samples t-tests. The present study meets the criteria of the dependent t-test as the pre-test preliminary intervention post-test, was administered in the same group of social workers in Mopani District and the same group in Vhembe District. The dependent t-test is a parametric test (Kim, 2015:540), which shows the difference between pre- and post-test scores. The data were presented in statistical form by means of tables, showing the mean, the standard deviation, the number of respondents, and the p-value (Neuman, 2006:343). Field (2009:73) asserts that the Box

and Whisker plot checks the shape of the distribution. Furthermore, the author explains that the box plot indicates that the distribution is either symmetrical or skewed. The sample was too small and there was no need to reflect on the extent of the effect, as recommended by the statistician.

The researcher analysed the data after the data collection, and the following steps were undertaken:

- The questionnaires were coded and submitted to the Department of Statistics. The research consultant provided assistance in this process. The data was captured in an Excel worksheet by a data capturer.
- The researcher verified the captured data; inaccuracies were corrected and the data re-submitted to the research consultant. A memo was included to assist her in scoring the responses.
- The statistical significance of the present study was tested. The mean average was calculated, the dependent t-test was employed, and the standard deviation and p-values were calculated to show the significance. The t-test evaluates different scores from measurements taken at two different times on the same individual (pre-test and post-test).
- The Box and Whisker plot, also known as boxplot, was employed to show the distribution of the data in the pre-test and post-test.

9.4 Empirical findings-second phase (quantitative)

The quantitative reseach findings are presented according to the self-constructed questionnaires administered in the pre- and post-tests. The pre- and post-tests are compared throughout to indicate the knowledge gained by the respondents after their training in CROCMEHC programme. The researcher starts this section by discussing the learning expectations as expressed by the attendees/respondents.

Theme 1: Expectations of training

In response to the first item, an open question, the respondents listed their expectations pertaining to the training on the pre-test questionnaire. The first phase of the current study, however, revealed the participants' lack of knowledge of mental health care. As a result, the researcher developed a programme that would address this need. She identified five subthemes from the expectations listed, namely mental health and illness, caregivers and mental health care users, social work in mental health, recovery and social work, and recovery-oriented mental health practice. These subthemes, with their responses, are captured below.

Subtheme 1: Mental health and illness

Most of the respondents articulated their need for more knowledge in mental health and mental illness.

- *VH15: "Learn about the type of mental illness, and how I can work with people suffering it."*
- *VH25: "What mental health is all about, and how do we deal with people with mental health problems."*
- *M001: "How does mental health related to social work profession."*

Subtheme 2: Mental health care users and caregivers

A number of respondents expressed their desire to acquire more knowledge on mental health care users and caregivers.

- *M035: "Coping strategies for caregivers of mental health care users."*
- *VH01: "To understand more about mental health users in the community."*
- *VH17: "Challenges that mental health care users in rural areas experience."*

Subtheme 3: Social work in mental health care

Respondents wished to acquire more knowledge about social workers within mental health care.

- *VH4, VH05: "How the social workers intervene in clients with mental health illness."*
- *VH6, VH20: "Role of social workers on mental health."*
- *VH9: "The functions of a social worker in a health care setting."*
- *VH16: "Get more knowledge about mental health and social work."*

Subtheme 4: Recovery

Respondents expressed their interest in acquiring more knowledge about recovery.

- *VH3: "The dynamics of the recovery mental health care plan."*

The researcher has concluded that respondents of the present study demonstrated a quest to know more about mental health and mental illness. They wanted to know more about how social workers can intervene in working with people living with schizophrenia. Furthermore, they wanted to know what the coping strategies of caregivers are in caring for people living with schizophrenia, and the challenges experienced by the MHCUs. The researcher concluded that social workers need training in mental health.

9.4.1 Biographical profiles of respondents

Thirty-seven respondents attended the CROCMEHC programme training from both districts, and completed the pre- and post-test questionnaires. Prior to commencement of the training they were required to complete the pre-test questionnaire, subsequently collected by the researcher and her research assistant. The programme was presented as part of the early development and pilot-testing phase of this research (phase 2). After the training, they were required to complete the post-test questionnaire. The same process was followed as that in the pre-test. The pre-test and post-test questionnaires were identical, with the exception of the biographical details only included in the pre-test and the evaluation of the CROCMEHC programme only included in the post-test. The table below provides the demographic details of the respondents. Each variable will be discussed separately.

Table 9.1: Biographical profiles of respondents who attended CROCMEHC programme

Name	Age	Gender	Marital status	Race	Office	Sector	Qual.	Univ.	Year graduated
MO01	31	Female	Married	African	Mopani	Other	BA SW	Venda	2008
MO02	24	Male	Living together	African	Mopani	Health Center	BA SW	Venda	2015
MO06	30	Female	Married	African	Mopani	Health Center	BA SW	Limpopo	2009
MO08	29	Male	Single	African	Mopani	Sub-district office	BA SW	Limpopo	2011
MO016	39	Male	Married	African	Mopani	Sub-district office	BA SW	Venda	Unknown
MO21	41	Female	Married	African	Mopani	Sub-district office	BA SW	Limpopo	1999
MO23	34	Female	Divorced	African	Mopani	District office	BA SW	Venda	2009
MO27	42	Male	Married	African	Mopani	Sub-district office	BA SW	Venda	2011
MO35	29	Female	Married	African	Mopani	District office	BA SW	Venda	Unknown
MO37	43	Female	Married	African	Mopani	District hospital	BA SW	Venda	1998
VH01	43	Female	Married	African	Vhembe	District hospital	BA SW	Venda	Unknown
VH02	28	Male	Single	African	Vhembe	Clinic	BA SW	Venda	2012
VH03	50	Male	Married	African	Vhembe	District hospital	BA SW	Venda	2011
VH04	35	Male	Married	African	Vhembe	Clinic	BA SW	Venda	2009
VH05	41	Male	Married		Vhembe	Sub-district office	BA SW	Limpopo	2001
VH06	41	Female	Living together	African	Vhembe	Sub-district office	BA SW	Venda	1999
VH07	42	Female	Single	African	Vhembe	District office	BA SW	Venda	2010
VH08	35	Female	Married	African	Vhembe	Sub-district office	BA SW	Venda	2002

Name	Age	Gender	Marital status	Race	Office	Sector	Qual.	Univ.	Year graduated
VH09	37	Male	Married	African	Vhembe	Sub-district office	BA SW	Venda	2003
VH10	37	Female	Married	African	Vhembe	Sub-district office	BA SW	University of Pretoria	2002
VH11	31	Male	Single	African	Vhembe	Clinic	BA SW	UNISA	2012
VH12	33	Male	Divorced	African	Vhembe	District hospital	BA SW	Limpopo	2008
VH13	33	Female	Married	African	Vhembe	Health centre	BA SW	Venda	2013
VH14	33	Female	Single	African	Vhembe	Health centre	BA SW	Venda	2012
VH15	29	Female	Single	African	Vhembe	Health centre	BA SW	Limpopo	2010
VH16	34	Female	Single	African	Vhembe	District hospital	BA SW	Venda	2007
VH17	44	Female	Living together	African	Vhembe	Sub-district office	BA SW	Venda	2001
VH20	28	Male	Single	African	Vhembe	District hospital	BA SW	Venda	2011
VH21	30	Male	Single	African	Vhembe	District hospital	BA SW	Venda	2011
VH22	28	Female	Married	African	Vhembe	District hospital	BA SW	Venda	2012
VH23	34	Female	Divorced	African	Vhembe	Health centre	BA SW	Venda	2012
VH24	41	Female	Married	African	Vhembe	Health centre	BA SW	Venda	2000
VH26	54	Female	Married	African	Vhembe	Sub-district office	BA SW	Limpopo	Unknown
VH27	32	Female	Single	African	Vhembe	District office	BA SW	Limpopo	2011
VH30	36	Female	Married	African	Vhembe	Sub-district office	BA SW	Venda	2011
VH33	38	Female	Married	Black	Vhembe	Health centre	BA SW	Venda	2008

Name	Age	Gender	Marital status	Race	Office	Sector	Qual.	Univ.	Year graduated
VH34	38	Female	Married	Black	Vhembe	District office	BA SW	Venda	Unknown

Biographical questions (Questions 1.1 to 1.9)

- **Age**

The ages of the respondents ranged from 24 to 54 years. There were no age criteria stipulated for the study. The majority of the respondents were in the category 24 to 39 years. The mean average age was 35.5. The present study is similar to the study conducted by Alpaslan and Schenck (2012) pertaining to the challenges experienced by social workers in rural areas. Their sample consisted of 32 social workers and the age category of the Alpaslan and Schenck study ranged from 28 to 53 years.

- **Gender**

There were 24 (64.86%) females and 13 (35.14%) males. It should be noted that, in general, the social work profession in South Africa consists of more females than males. The findings of the present study corroborate those of the Alpaslan and Schenck, (2012:402) study. Christie and Kruk (1998) in Alpaslan and Schenck (2012:405) concur that social work is a female-dominated profession. This was also noted by Khunou, Pillay, and Nethononda (2012:122) who assert that in South Africa, 85% of social workers are female.

- **Race**

All thirty-seven (100%) of the respondents were Africans, which could be attributed to the geographic area; Mopani and Vhembe Districts are on the outskirts of Limpopo Province. Tsongas and Vendas are natives of these districts, and the languages spoken are predominantly Tshivenda and Xitsonga. The present study proved to be different from Alpaslan and Schenck's study. Their study comprised diverse racial groups, namely Africans, Whites, Coloureds, and Indians (Alpaslan & Schenck, 2012:405).

- **Marital status**

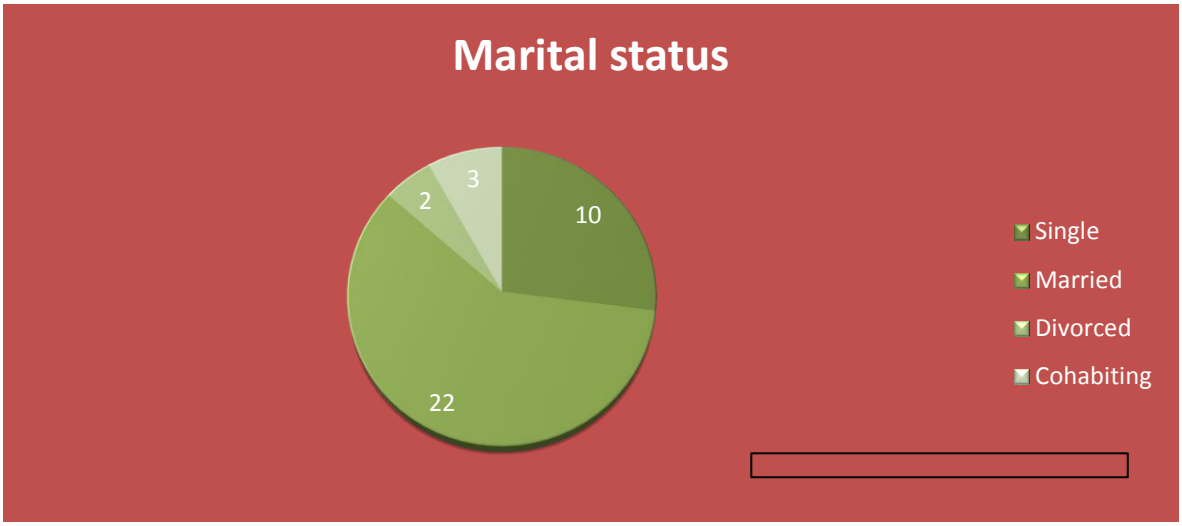


Figure 9.1: Marital status (n=37)

Twenty-two (59.46%) respondents were married; ten (27.03%) were single; three (8.11%) were living together/cohabitating; and two (5.41%) were divorced.

- **Districts**

Twenty-seven (72.97%) respondents were from Vhembe and ten (27.03%) from Mopani Districts. The training was conducted in the two districts in Limpopo Province mentioned above. The choice of the two districts was based on the rural landscape of these two locations. Furthermore, the researcher selected the two districts due to their proximity; they are not far from each other. As the study was in the piloting phase, this made economic sense in terms of travelling time and cost.

- **Sector**

The majority of respondents were working in the sub-district offices of the DOH & DSD: twelve (32.43%) and eleven (29.73%) were working in the district hospitals; eight (21.62%) in the health centre; and six (16.22%) did not specify where they worked. The study conducted by Olckers (2013): 35.4% worked for non-governmental organisations (NGOs), while 31.7% worked in private practice, and 30.4% for the government.

- **Qualifications**

Thirty-seven (100%) respondents in the present study had a Bachelor of Social Work degree - BA (SW) or BSW. However, none of the respondents possessed any postgraduate qualifications, which could have attributed to their lack of knowledge in mental health. Mostly, mental health is presented on postgraduate level. The majority of the respondents in the study of Olckers (2013) had undergraduate degrees.

University

Table 9.2: University attended

Universities		
n=37	**Frequency *(f)***	**Percent (%)**
Venda	27	72.97
Limpopo	8	21.62
Pretoria	1	2.7
UNISA	1	2.7
Total	37	100

Most of the respondents had studied at the University of Venda – twenty-seven (72.97%); University of Limpopo – eight (21.62%); University of Pretoria – one (2.7%); and UNISA – one (2.7%). The fact that most of the respondents graduated from the University of Venda can be attributed to the fact that it is located within the district of Vhembe; the present study was therefore conducted in this district. Furthermore, Mopani is in close proximity to both the Universities of Limpopo and Venda. These findings are in line with those of Olckers (2013) whose participants had graduated from the University of Stellenbosch, University of Western Cape, University of Cape Town, Huguenot College, University of Pretoria, University of Johannesburg, University of the Free State, UNISA, and the University of Limpopo. Similarly, most of the respondents in the present study were graduates of Western Cape universities; the study was conducted in that province. Table 9.3 details the academic institutions from which the respondents had graduated.

- **Year graduated**

Table 9.3: Year graduated

Year graduated	Frequency (*f*)	Percent (%)
No response	5	13.51
1998	1	2.7
1999	2	5.41
2000	1	2.7
2001	2	5.41
2002	2	5.41
2003	1	2.7
2007	1	2.7
2008	3	8.11
2009	3	8.11
2010	3	8.11
2011	7	18.92
2012	5	13.51
2015	1	2.7
Total	**37**	**100**

The graduation dates of the respondents in the present study ranged from 1998 to 2015; five (13.5%) did not answer this question. The researcher concurs with Olckers (2013) that mental health, and the training of social workers in this field, is neglected in SA tertiary institutions, with only a few universities offering modules in this field.

9.4.2 Mental health in general

In this section, respondents were required to reflect on their general knowledge of mental health and mental health training. Certain questions, notably v2.3 to v2.5, were merely referred to and not discussed in detail.

9.4.2.1 Mental health knowledge (Question 2.1)

Table 9.4 provides details of respondents' knowledge of mental health.

Table 9.4: Mental health knowledge

	Pre-test		Post- test	
	Frequency *(f)*	**Percent (%)**	**Frequency *(f)***	**Percent (%)**
Rate your mental health knowledge				
Excellent	1	2.7	13	35.14
Average	27	72.97	24	64.68
Poor	5	13.51	-	-
None at all	4	10.81	-	-
Total	**37**	**100**	**37**	**100**

As mentioned in chapter 6, the present study used a variety of questions. Therefore, a self-rated question was included to assess their knowledge of mental health. It should be noted that there was no right and wrong answer. The scores show that prior to the CROCMEHC training, twenty-seven (72.97%) rated their knowledge as average, and four (10.81%) indicated that they had no knowledge at all.

This corroborates the findings and concerns raised in the United States (USA) and the United Kingdom (UK) that social workers' abilities to practice effectively in mental health (Olckers, 2013:152) are inadequate. Moreover, Beinecke and Huxley (2009:222) contend that many social work practitioners do not have the knowledge or skills necessary to work in mental health settings.

The researcher has noted an increase in knowledge on mental health among respondents after the training. Twenty-four (64.68%) rated their knowledge as average, and thirteen (35.14%) rated their knowledge as excellent. The CROCMEHC programme training appears to have had an impact on the knowledge of the respondents.

That was also the case in a study by Olckers (2013), where an increase in knowledge was evident after training. Moreover, in an intervention study on recovery-oriented mental health practice conducted in London by Gilburt et al. (2012), participants were evaluated after training; all the changes were reported. Studies in USA (Peebles et al., 2009:239-245) and Australia (Salgado et al., 2010:243-245) provide some evidence that the structured training on critical components of recovery can increase both knowledge and pro-recovery attitudes.

Table 9.5 details the t-test dependent samples on general knowledge in mental health. All subsequent t-test tables will reflect on the mean, standard deviation (Std.Dv), number of respondents (N), difference (Diff), t-test (t), degree of freedom (df), and the p-value (p).

Table 9.5: T-test dependent samples general knowledge

Variable	t-test for dependent samples Marked differences are significant at p < .05000							
	Mean	Std.Dv.	N	Diff.	Std.Dv. Diff.	t	df	P
Pre-General	15.83784	4.412819						
Post-General	23.91892	2.277650	37	-8.08108	4.303606	-11.4219	36	0.000000

Aggregated or single questions were utilised to measure the significance of the difference between dependent variables. The researcher investigated the level of the respondents' general mental health knowledge. The t-test was employed to ascertain the association between the dependent variables and mental health knowledge in the pre-test and post-test. In this instance, a dependent t-test evaluated the different scores from measurements taken at different times of the same individual (pre-test and post-test.

Table 9.5 indicates statistically significant differences between pre- and post-test knowledge. The mean was 15.8 in the pre-test and 23.9 in the post-test, this shows that there was an increase in the post-test. The standard deviation 4.4 for the pre-test and 2.3 in the post-test. The p-value was = 0.00000 (below 0.005). This shows that there was an increase of knowledge after the training in CROCMEHC.

The post-knowledge score was significantly higher; the respondents had therefore gained knowledge. Ecological systems theory provides a holistic theoretical base that social workers can retrieve from effective intervention in assisting mental health care users. This reveals that social workers have a fundamental role to play in recovery-oriented mental health practice. An important aspect in this theory is that the mental health care user has a role to play in shaping the environment (Gray & Webber, 2013).

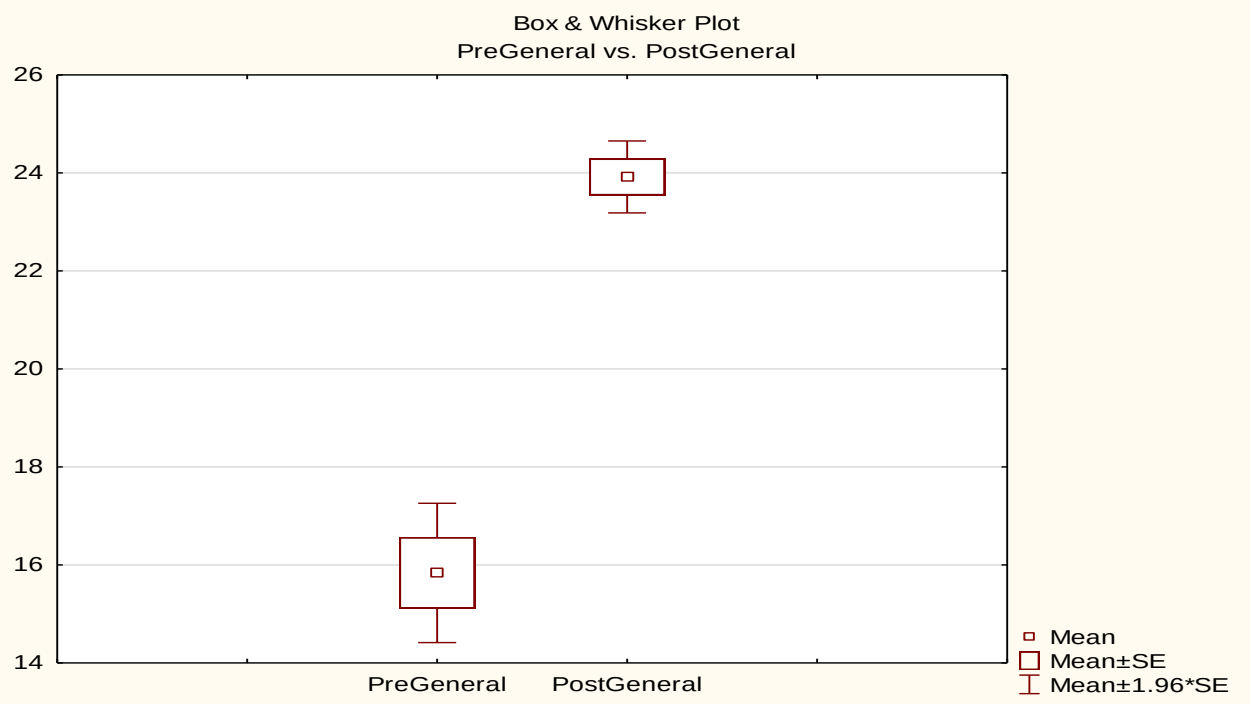


Figure 9.2: Box & Whisker plot: General knowledge

The Box and Whisker plot figure above illustrates the information stipulated in table 9.5. The Box and Whisker plot is a standardised way of displaying the distribution of data. This confirms that there was a significant difference between the pre- and post-test knowledge scores. The application of the Box and Whisker plot (figure 9.2) depicts the distribution of pre- and post-test scores for general knowledge in mental health. The p-value for both elements was 0.000000, which indicates statistical significance. Therefore, it is evident that the CROCMEHC programme training was effective, and that there was an increase in respondents' knowledge. The strenghts-based perspective emphasises the importance of empowerment; therefore, to acquire knowledge is a form of empowerment.

9.4.2.2 Mental health training (Questions 2.2a to 2.2e)

The table below provides the responses of respondents regarding mental health training during the pre-test.

Table 9.6: Mental health training

	Pre-test	
	Frequency (f)	**Percent (%)**
Mental health training - undergraduate		
No response	11	29.73
Yes	8	21.62
No	18	48.65
Mental health training postgraduate		
No response	18	48.65
Yes	3	8.11
No	16	43.24
Mental health training - continuing education		
No response	20	54.05
Yes	2	5.41
No	15	40.54
Mental health training - self-study		
No response	14	37.84
Yes	12	32.43
No	11	29.73
Mental health training - other		
No response	30	81.08
No	7	18.92
Total	**37**	**100**

This was a dichotomous question where the respondents were required to mark yes or no. The respondents were required to indicate whether they were trained in mental health. The majority of respondents were not trained in mental health. In the pre-test, eighteen (48.65%) responded that they did not have any training in mental health in their undergraduate studies, and eight (21.62%) indicated that they did not have any training at all. Pertaining to the mental health training (postgraduate), eighteen (48.65%) did not

respond to this question; and three (8.11%) had postgraduate qualifications. This was surprising because none of the respondents reported in a previous question on qualification that they had the aforementioned qualification. Sixteen (43.24%) responded that they did not have postgraduate mental health training. It was evident that most respondents engaged in self-study to augment their knowledge about mental health; however, fourteen (37.84%) did not respond to this question, while twelve (32.43%) were engaged in self-study. Lastly, eleven (29.73%) reported that they were not engaged in any self-study activities. The study conducted by Olckers (2013:52) confirms that most of the South African universities merely introduce the concepts of mental health in their undergraduate courses. Therefore, the four-year BSW degree does not prepare social workers for mental health care. The results in the present study confirm that there is a need for training in mental health care. The Ecological systems theory asserts that social work should seek innovative ways to conceptualise the relationship between the individual and the environment (Gray & Webber, 2013:179). Therefore, if social workers are trained in mental health they will be able to assist MHCUs to deal with the challenges they experience in their environments.

9.4.2.3 Knowledge regarding mental health and mental illness (Questions 2.3, 2.4)

These questions were to determine the respondents' knowledge of mental health and mental illness.

Table 9.7: Mental health and mental illness

	Pre-test		Post- test	
	Frequency *(f)*	**Percent (%)**	**Frequency *(f)***	**Percent (%)**
Knowledge of mental health and mental illness				
True	20	54.05	29	78.38
False	12	32.54	8	21.62
No response	5	13.51	-	-
Knowledge of types of mental illness				
Excellent	1	2.7	8	21,62
Average	9	24.32	23	62.18
Poor	-	-	-	-
No knowledge at all	-	-	1	2.7
Total	**37**	**100**	**37**	**100**

Question 2.3: The respondents were required to respond with a true or false answer; questions 2.3a, b, c and e were correct, while question 2d was incorrect. It should be noted that in the pre-test, twenty (54.05%) provided a true response, while twelve (32.45%) provided a false response. Moreover, the post-test revealed an increase of knowledge. The researcher noted that twenty-nine (78.38%) respondents provided a true response as compared to the initial twenty (54.05%). Furthermore, there was a decrease to eight (21.62%) from twelve (32.54%). This revealed that the training had managed to impact the knowledge of the attendees positively.

Question 2.4: This question was self-rated, and respondents were required to indicate their knowledge pertaining to the types of mental illnesses. They were to mark whether

excellent, average, poor, or no knowledge at all. This was a subjective assessment as it depended on how the respondents felt about their knowledge. It should be noted that initially one (2.7%) and three (8.11%) rated themselves as having excellent knowledge. Twenty-three (62.18%) reported an average knowledge; nine (24.32%) and one (2.7%) had no knowledge at all. The findings reflected limited knowledge, and therefore the training in mental health proved to be pivotal. The findings correlated with those of Beinecke and Huxley (2009:222), for example, who commented that many practitioners do not have the knowledge or the skills necessary to work in mental health settings.

Thus, these questions demonstrated that their knowledge of mental health and mental illness improved in the post-test. Gray and Webber (2013:179) assert that ecological systems theory is relevant to social work as it provides a comprehensive, multidisciplinary and holistic framework within which the complex and interrelation elements of people's lives can be connected and understood. Therefore, if social workers have necessary skills in working in mental health facilities, then ecological systems theory will be appropriate and practical.

9.4.2.4 Schizophrenia as a classification of mental illness (Questions 3.1, 3.6, 3.7a, 3.7b)

These questions were to determine the knowledge of respondents in defining schizophrenia, whether culture influences the understanding of schizophrenia, and whether antidepressants are utilised to treat schizophrenia.

Table 9.8: Schizophrenia classification

	Pre-test		Post- test	
	Frequency (*f*)	**Percent (%)**	**Frequency (*f*)**	**Percent (%)**
Definition of schizophrenia				
No knowledge	7	54.05	1	2.7
Poor	20	18.95	6	16.22
Average	8	21.62	6	16.22
Excellent	2	5.41	24	64.86

	Pre-test		Post- test	
	Frequency (*f*)	**Percent (%)**	**Frequency (*f*)**	**Percent (%)**
Culture influences understanding of schizophrenia				
Yes	30	81.08	35	94.59
No	7	18.92	2	5.41
Antidepressant used to treat schizophrenia				
Yes	20	54.05	34	91.89
No	17	45.95	3	8.11
Motivation knowledge level				
No response	30	81.08	9	24.02
Limited	1	2.7	-	-
Average	5	13.51	-	-
Excellent	1	2.7	28	75.68

Question 3.1: The respondents had to provide a definition of schizophrenia. The responses were rated as 0 (no knowledge), 1 (poor knowledge), 2 (average knowledge), and 3 (excellent knowledge). The question was self-rated. In the pre-test, seven (54.05%) had no knowledge, and two (5.71%) had excellent knowledge. In the post-test, twenty-four (64.86) had excellent knowledge, and one (2.7%) had no knowledge. It was evident that after the training the respondents had acquired knowledge.

Question 3.6: The respondents were required to indicate whether culture had an influence on their understanding of schizophrenia. The question was dichotomous in nature, and they had to provide a yes or no answer. The correct answer was yes. In the pre-test, thirty (81.08%) marked yes, and seven (18.92%) marked no. In the post-test, thirty-five (94.59%) marked yes, and two (5.41%) marked no. It was evident that after the training, most of the participants acquired knowledge.

Question 3.7a: The respondents had to state whether antidepressants were used to treat schizophrenia. The question was also dichotomous, requiring a yes or no answer. The correct answer was yes. In the pre-test, twenty (54.05%) marked yes, and seventeen (45.95%) marked no. In the post-test, thirty-four (91.89%) marked yes, and three (8.11%) marked no. Therefore, in the post-test it was evident that the respondents acquired knowledge.

Question 3.7b tested the knowledge level relating to antidepressants, and the responses were rated as no response, limited knowledge, average knowledge, and excellent knowledge. The question was self-rated. In the pre-test, thirty (81.08%) did not respond, and one (2.7%) reported excellent knowledge. In the post-test, 28 (75.68%) reported excellent knowledge, while nine (24.02%) reported did not respond. It was evident that the respondents consistently acquired knowledge relating to antidepressants as a treatment for schizophrenia.

The APA (2013) provides a sound guideline as to the symptoms of schizophrenia. This has been captured in chapter 4 of the present study. Furthermore, the APA (2010) indicates how schizophrenia is treated. This is also captured in chapter 4 of the present study. Table 9.9 depicts the significant differences between the pre- and post- tests.

Table 9.9: T-test for dependent samples: Schizophrenia

Variable	t-test for dependent samples Marked differences are significant at p < .05000							
	Mean	Std.Dv.	N	Diff.	Std.Dv. Diff.	t	df	P
Pre-schizo	19.27027	4.369393						
Post-schizo	25.29730	3.089992	37	-6.02703	5.090768	-7.20146	36	0.000000

Table 9.9 indicates statistically significant differences between pre- and post-test knowledge. The mean was 19.3 in the pre-test and 25.3 in the post-test; this shows that there was an increase in the post-test. The standard deviation was 4.3 in the pre-test

and 3.1 in the post-test. The p-value was = 0.00000 (below 0.005). This shows that there was an increase of knowledge after the training in the CROCMEHC programme.

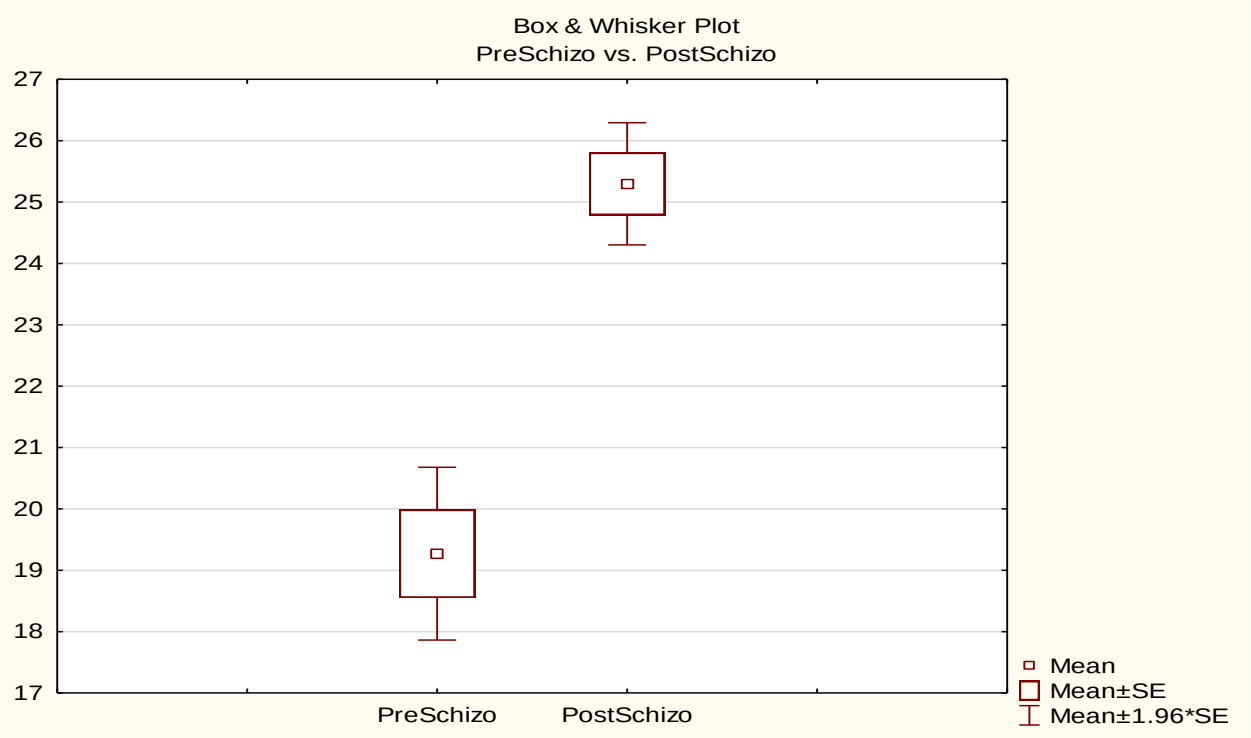


Figure 9.3: Box and Whisker plot: Schizophrenia

The application of the Box and Whisker plot (figure 9.3) depicts the pre- and post-scores for schizophrenia as consistent. It should be noted that the box plot for the post-test was higher, while the pre-test was lower. This indicated a significant increase in knowledge relating to schizophrenia in the post-test. The p-value for both elements was 0.0000000, which indicated statistical significance.

Thus, these questions relating to the definition of schizophrenia, the influence of culture on the understanding of schizophrenia, and the utilisation of anti-depressants in treating schizophrenia, demonstrated that knowledge had increased. From an ecological perspective, Greene (2009:211) states that competence is achieved through a history of successful transactions with the environment. Therefore, when social workers are competent in the knowledge of schizophrenia, they will be able to intervene appropriately.

9.4.2.5 People living with schizophrenia (mental health care users)

This section focuses on people living with schizophrenia. People living with schizophrenia are frequently stigmatised and discriminated against. Service providers also have prejudices and negative attitudes towards MHCUs. The researcher intended to gauge the perceptions of respondents regarding people living with schizophrenia.

Attitudes and stereotypical ideas regarding people living with schizophrenia (Question 4.1)

This question was self-rated, and dealt with the attitudes and stereotypical ideas regarding people living with schizophrenia. A few respondents thought that people living with schizophrenia were “crazy/mad” (16.22% to 13.51%); in the post-test, knowledge increased that schizophrenia might be caused by trauma/genetic factors (51.34% to 75.68%) and the result of drug abuse (48.65% to 70.27%). It should be noted that many people, including mental health practitioners, hold different views about people living with schizophrenia. Most people assume that schizophrenia is attributed to cultural connotations such as witchcraft or punishment from the ancestors. More details have been captured in chapter 4. Moreover, Mandelli, Toscano, Porcell, Fabbri and Serreti, 2016:247) indicate that schizophrenia usually results from a complex interaction between genetic and environmental factors. The mesosystem comprises the “linkages and processes taking place between two or more settings containing the developing person.”

Table 9.10: T-test for dependent samples people living with schizophrenia

Variable	T-test for dependent samples Marked differences are significant at p < .05000							
	Mean	Std.Dv.	N	Diff.	Std.Dv. Diff.	t	df	P
Pre-PLWS	4.297297	1.927360						
Post-PLWS	6.108108	2.065373	37	-1.81081	2.706349	-4.06996	36	0.000246

Table 9.10 depicts the significant difference between pre- and post-tests. The mean for the pre-test was 4.3 and the standard deviation 1.9. Moreover, the mean for the post-test was 6.1 and the standard deviation 2.1. The p-value equalled to 0.000246; the post-knowledge score therefore tested significantly higher. The respondents had gained knowledge.

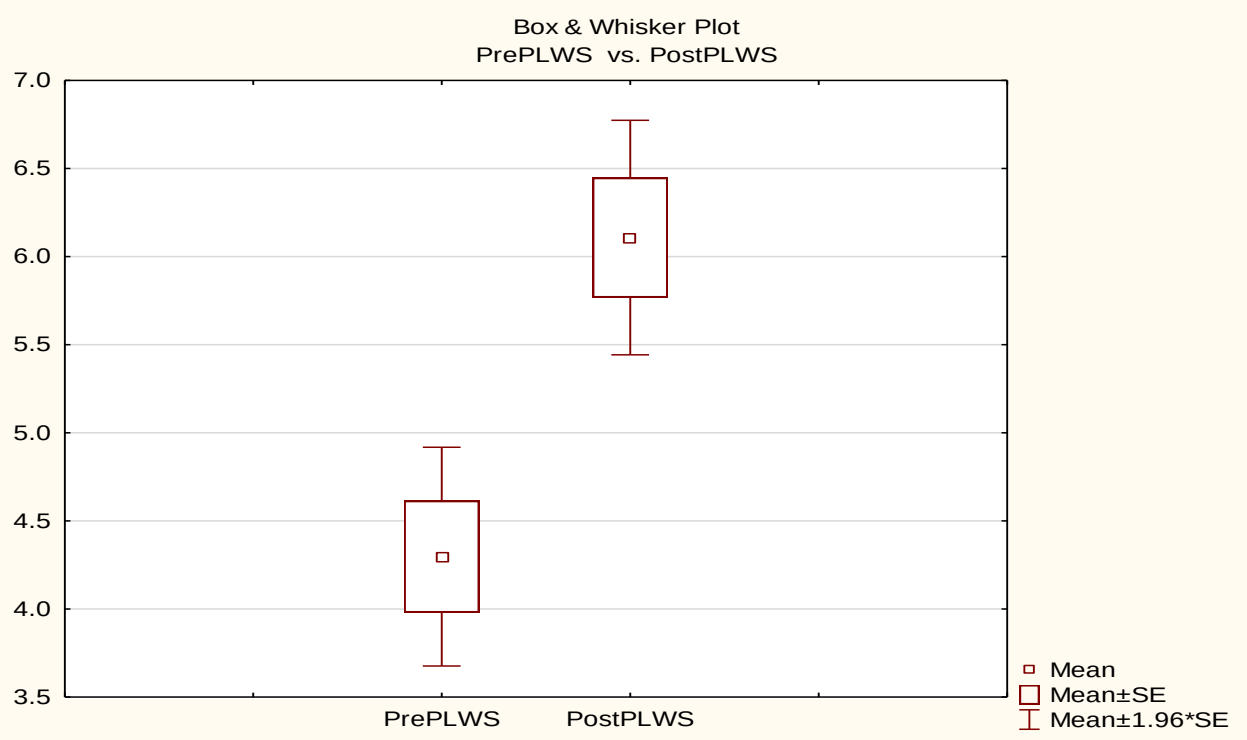


Figure 9.4: Box and Whisker plot: PLWS

The Box and Whisker plot consistently depicts the same information mentioned above in table 9.10. Box plots are used to show the overall patterns of response for a group. They provide a useful way to visualise. The post-test scores were slightly higher, while the pre-test scores were lower. This shows that the respondents gained knowledge in the section relating to people living with schizophrenia. It should be noted that both the pre- and post-p values equalled to 0.000246, which is below 0.05. It is evident that there was a statistical significance.

It was clear that these questions relating to people living with schizophrenia demonstrated an increased knowledge in the post-test. One of the goals of the strengths-based perspective is suspension of disbelief. This goal asserts that within a culture of professionalism, it would be difficult to take at face value MHCUs' bizarre accounts of their experiences, which may clearly lack plausibility (Saleebey, 2006:25). Therefore, it is vital that social workers gain knowledge on people living with schizophrenia as they will be able to assist these MHCUs appropriately.

9.4.3 Caregivers of people living with schizophrenia (PLWS)

As the result of deinstitutionalisation, family caregivers are compelled to care for their relatives living with schizophrenia in their homes or community. In most instances, this task is characterised by burden and stress. The researcher intended to establish the perceptions of the respondents regarding this issue.

Caregivers of people living with schizophrenia (PLWS) (Questions 5.1 to 5.3)

Question 5.1 was self-rated and the respondents had to rate whether they agreed, were not sure, or disagreed with the statement.

Table 9.11: Caring for people living with schizophrenia when they are discharged from the hospital

	Pre-test		Post- test	
	Frequency *(f)*	**Percent (%)**	**Frequency *(f)***	**Percent (%)**
Family				
Agree	37	100	33	89.19
Not sure	-	-	-	-
Disagree	-	-	4	10.81
Who should care for PLWS after discharge? - multidisciplinary				
No response	6	16.22	2	5.41
Agree	22	59.46	28	75.68

	Pre-test		Post- test	
	Frequency *(f)*	Percent (%)	Frequency *(f)*	Percent (%)
Not sure	5	13.51	2	5.41
Disagree	4	10.81	5	13.51
Who should care for PLWS after discharge? - inter-sectoral				
No response	10	27.03	3	8.11
Not sure	9	24.32	9	24.32
Agree	10	27.03	9	24.32
Disagree	8	21.62	16	43.24
Who should care for PLWS after discharge? - interdisciplinary				
No response	10	27.03	4	10.81
Agree	10	27.03	10	27.03
Not sure	8	21.62	7	18.92
Disagree	9	24.32	16	43.24
Who should care for PLWS after discharge? - strangers				
No response	8	21.62	6	16.22
Agree	2	5.41	13	35.14
Not sure	2	5.41	16	43.24
Disagree	25	67.57	2	5.41
Who should care for PLWS after discharge? - hospice				
No response	12	32.43	5	13.51
Agree	8	21.62	9	24.32
Not sure	7	18.92	15	40.54
Disagree	10	27.03	8	21.62

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The questions were self-rated, and the respondents were required to indicate whether they agreed, disagreed, or were not sure about who cares for PLWS when they are discharged. The majority of the respondents clearly had knowledge that the family is responsible to care for PLWS when discharged from hospital. Globally, the deinstitutionalisation of patients with mental illness has resulted in an increase in responsibility for care to be supplied by the family and its members (Lippi, 2016:922). Similarly, Chan (2011:339) indicates that families are caring for persons with schizophrenia in the community, and that living with a relative with severe mental illness is stressful. The mesosystem encompasses the linkages and processes occurring between two or more settings containing the developing person such as school and the family.

Table 9.12: T-test for dependent samples for caregivers

Variable	t-test for dependent samples Marked differences are significant at p < .05000							
	Mean	Std.Dv.	N	Diff.	Std.Dv. Diff.	t	df	P
Pre-carers	6.486486	1.464802						
Post-carers	5.675676	1.055516	37	0.810811	1.761279	2.800221	36	0.008161

This table depicts the statistical difference between the pre- and post-tests. The mean for the pre-test was 6.5 and the standard deviation 1.5. However, the researcher noted that there was a decrease in knowledge in the post-test; the mean was 5.7 and the standard deviation 1.1. The p-value equalled to 0.008161. However, the t-test indicated that the post-knowledge score was significantly lower.

Therefore, the respondents did not gain knowledge in this regard. It should be noted that there was only one question asked in this section, and this might have influenced the results. Furthermore, the researcher drafted a memorandum and the responses were marked strictly. Negative marking was applied if the respondents marked all the answers.

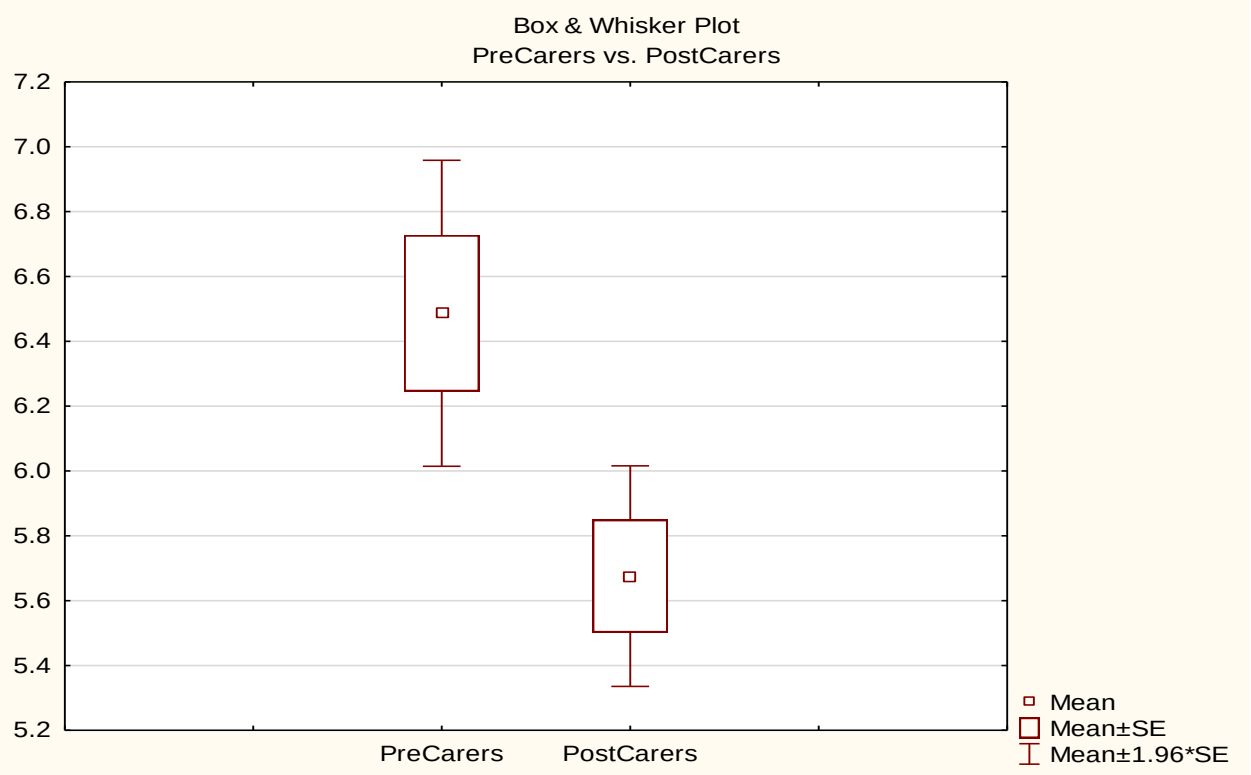


Figure 9.5: Box and Whisker plot: Caregiving to people living with schizophrenia

This Box and Whisker plot confirms the information captured in table 9.12. It should be noted that there is an overlap in the Box and Whiskers plot of the pre- and post-tests. The pre-test scores were higher and the post-test lower. Therefore, the post-knowledge scores were significantly lower, and there was therefore no statistical significance. Thus, the training was not sufficiently effective to impact the knowledge of the respondents.

The questions could therefore not yield the expected positive results. There was no statistical significance. Therefore, there was no knowledge gained in this section. The other goal of the strengths-based perspective is dialogue and collaboration. This goal asserts that an individual's humanity can only come to the fore through a creative and emergent relationship with others (Saleebey, 2006:20). Therefore, social workers have to understand the role of cargivers in caring for people with schizophrenia.

9.4.4 Social work in mental health care

The Mental Health Act (No 17 of 2002) is aimed at social workers as mental health care practitioners. However, in practice, most social workers are not fulfilling this role. This

section includes the tasks of social workers, training needs of social workers, mental health intervention, knowledge of mental health, and the multidisciplinary team tools used when working with and diagnosing PLWS.

Table 9.13: Hospital social workers' tasks

	Pre-test		Post-test	
	Frequency (*f*)	Percent (%)	Frequency (*f*)	Percent (%)
Social work tasks - tracing families				
TRUE	36	97.3		
FALSE	1	2.7	1	2.7
FALSE	2	5.41	-	-
Social work tasks - individual care plans				
TRUE	32	86.49	37	100
FALSE	5	13.51		
Social work tasks - discharge planning				
TRUE	34	91.89	36	97.3
FALSE	3	8.11	1	2.7
Social work tasks - liaise with field social worker				
TRUE	36	97.3	35	94.59
FALSE	1	2.7	2	5.41
Social work tasks - attend ward rounds				
TRUE	31	83.78	33	89.19
FALSE	6	16.22	4	10.81
Social work tasks - bath and dress people				
FALSE	37	100	4	10.81
TRUE	-	-	33	89.19
Social work tasks - part of the quality assurance team				
TRUE	26	70.27	28	75.68
FALSE	11	29.73	9	24.32
Social work tasks - feed people				
No response	-	-	1	2.7
FALSE	37	100	31	13.51
TRUE	-	-	5	83.78

	Pre-test		Post-test	
	Frequency (*f*)	Percent (%)	Frequency (*f*)	Percent (%)
Social work tasks-advanced relationship skills				
No response	1	2.7	1	2.7
TRUE	23	62.16	31	83.78
FALSE	13	35.14	5	13.51
Social work tasks-provide bedpans				
No response	1	2.7	1	2.7
FALSE	36	97.3	36	97.3

Social work tasks (Questions 6.1a to 6.1k)

- **Hospital social work**

Social workers in hospitals perform different tasks in assisting people living with mental illness. Various statements that illustrate these tasks were posed to the respondents. It was evident from both the pre- and post-tests that the respondents were knowledgeable about the tasks performed. The questions required respondents to mark whether the statements were true or false. Statements g, i, k were false, and a, b, c, d, e, f, j were true. The responses showed that the respondents were knowledgeable; thirty-six (97.3%) responded accurately, and only one (2.7%) was not sure. The responses confirmed that this was indeed the respondents' field of expertise. These findings are in line with those of the NASW (2011), namely that hospital social workers help patients and their families understand a particular illness, work through the emotions of a diagnosis, and provide counselling about the decisions that need to be made. Social workers are also essential members of interdisciplinary hospital teams. Social workers operate in collaboration with doctors, nurses, and allied health professionals to sensitise other health care providers to the social and emotional aspects of a patient's illness. Table 9.14 depicts the pre- and post-test results.

Social work task (Questions 6.2a to 6.2i)

These questions determine the knowledge of respondents regarding social work tasks.

Table 9.14: District social workers' tasks

	Pre-test		Post -test	
Variable	**Frequency (*f*)**	**Percent (%)**	**Frequency (*f*)**	**Percent (%)**
District social work - involved in ward round				
No response			1	2.7
TRUE	24	64.86	25	67.57
FALSE	13	35.14	11	29.73
District social work - provide schizophrenia diagnosis				
No response	1	2.7	1	2.7
TRUE	8	21.62	13	35.14
FALSE	28	75.68	23	62.16
District social work - provide family support				
No response	-	-	1	2.7
TRUE	34	91.89	33	89.19
FALSE	3	8.11	3	8.1
District social work - disability grant applications				
No response	-	-	1	2.7
TRUE	31	83.78	31	83.78
FALSE	6	16.22	5	13.51
District social work - home visits				
No response	-	-	1	2.7
TRUE	32	86.49	32	86.49
FALSE	5	13.51	4	10.81
District Social work - linking clients with resources				
No response	-	-	1	2.7
TRUE	36	97.3	34	91.89

	Pre-test		Post -test	
Variable	**Frequency (*f*)**	**Percent (%)**	**Frequency (*f*)**	**Percent (%)**
FALSE	1	2.7	2	5.41
District social work - awareness campaigns				
No response	-	-	1	2.7
TRUE	36	97.3	34	91.89
FALSE	1	2.7	2	5.41
District social work - reunification and after-care				
No response	-	-	1	2.7
TRUE	32	86.49	32	86.49
FALSE	5	13.51	4	10.81
District social work - advanced relationship skills				
No response	-	-	2	5.41
TRUE	28	75.68	27	72.97
FALSE	9	24.32	8	21.62

- **District social workers**

The questions required that the respondents indicate whether the statements were true or false. The majority of respondents were knowledgeable about the role of social work in the districts. Therefore, there was no difference between the pre-test and post-test scores. The DSD (2015) indicates that social development services provide prevention and promotion services, social support services; therapeutic, restorative, and rehabilitative services; continuing care services; reintegration and aftercare services; and economic development services with regard to mental health care. Table 9.15 below summarises the social workers' tasks.

Table 9.15: T-test for dependent samples social work in mental health

Variable	t-test for Dependent Samples Marked differences are significant at p < .05000							
	Mean	Std.Dv.	N	Diff.	Std.Dv. Diff.	t	df	P
Pre-Social W	32.05405	4.326571						
Post- Social W	33.08108	3.130303	37	-1.02703	5.204093	-1.20043	36	0.237811

This table illustrates that there was no statistical significance between the pre- and post-knowledge scores. The dependent t-test was administered and the results showed that there was no statistical significance. The researcher noted that the mean for the pre-test was 32 and the standard deviation 4.3; moreover, the mean for the post-test was 33 and the standard deviation 3.1. The p-value equalled to 0.237811, which is greater than 0.05. Therefore, the respondents did not gain any knowledge in this section. This could be attributed to the fact that the respondents had prior knowledge in this regard. The respondents' day-to-day functioning was based on the roles specified in the question. As a result, most of the respondents recommended that the section should be eliminated from the CROCMEHC programme as this constituted a subject in their undergraduate studies. The macrosystem encompasses the micro-, meso, and exosystems characteristics of a given culture or subculture, with particular reference to the belief system, body of knowledge, material, resources, customs, lifestyle, opportunity structures, hazards, and life course options that are embedded in each broader system (Bronfenbrenner, 2005).

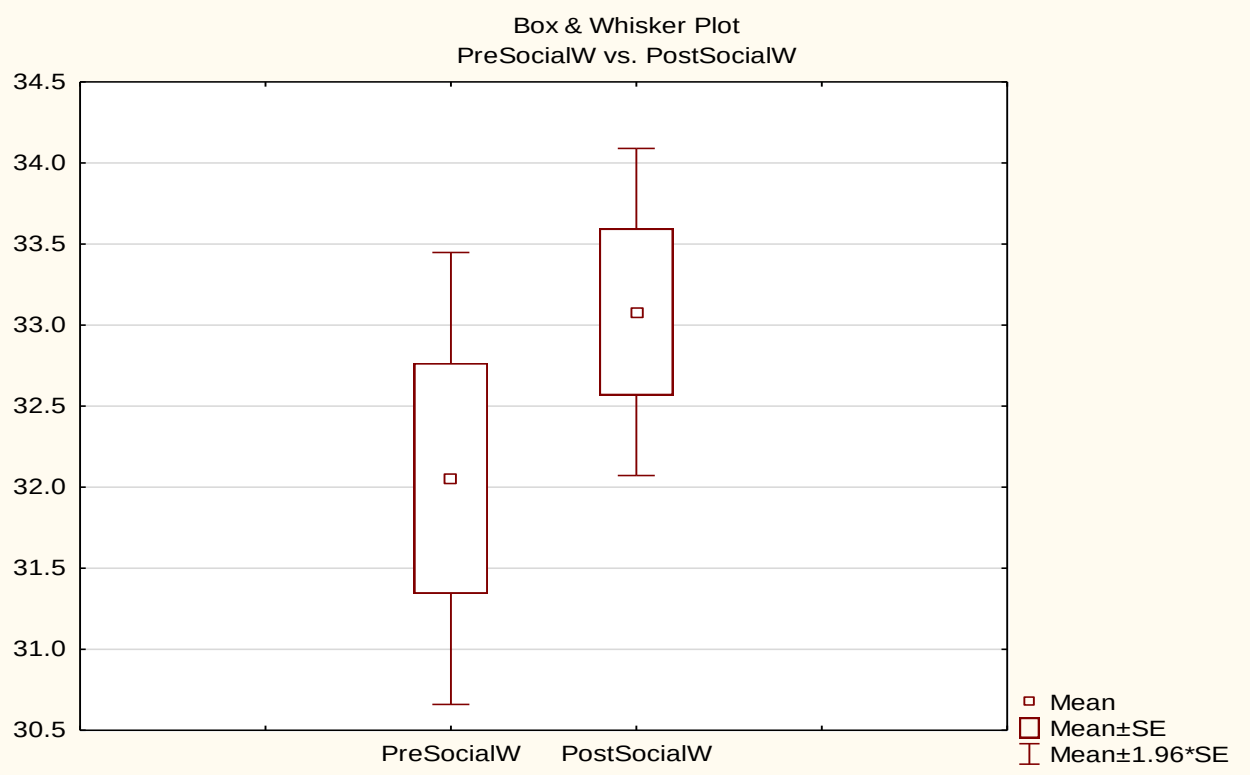


Figure 9.6: Box and Whisker plot: Social work in mental health

The Box and Whisker plot depicts the information detailed in table 9.15 The Whisker of the pre-test overlaps the box plot in the post-test. However, the pre-test box plot looks slightly higher than the post-test box plot. This shows that the respondents had prior knowledge about the tasks of the social workers. The p-value equals to 0.237811, which is greater than 0.05. Therefore, there is no statistical significance.

Training needs

The researcher intended to establish the training needs of the respondents prior to and after the training. It was clear that the one-day training had managed to impact knowledge in some areas of mental health. Respondents recommended that training in mental health be continuous and presented over a longer period of time.

Table 9.16: Training needs

	Pre-test		Post-test	
	Frequency (*f*)	Percent (%)	Frequency (f)	Percent (%)
Need training - mental health in general				
No response	2	5.41		
Yes	33	89.19	19	51.35
No	2	5.41	18	48.65
Need training - mental illness focusing on schizophrenia				
No response	1	2.7		
Yes	32	86.49	23	62.16
No	4	10.81	14	37.84
Need training - social work in mental health care				
No response	1	2.7	1	2.7
Yes	35	94.59	19	51.35
No	1	2.7	17	45.95
Need training - assessment tools for schizophrenia				
No response	1	2.7		
Yes	32	86.49	23	62.16
No	4	10.81	14	37.84
Need training - intervention methods for schizophrenia				
No response	1	2.7	1	2.7
Yes	34	91.89	16	43.24
No	2	5.41	20	54.05
Need training - recovery and social work				
No response	1	2.7	1	2.7
Yes	33	89.19	21	56.76
No	3	8.11	15	40.54

	Pre-test		Post-test	
	Frequency (*f*)	**Percent (%)**	**Frequency (f)**	**Percent (%)**
Need training - recovery-oriented mental health practice				
No response	1	2.7	1	2.7
Yes	30	81.08	24	64.86
No	6	16.22	12	32.43

Training (Questions 6.3a to 6.3h)

The questions were dichotomous in nature, and the respondents were required to indicate whether or not they required training in mental health. **Prior to the training**, Thirty-three (89.19%), indicated the need to be trained in mental health in general, while thirty-two (86.19%), needed training in dealing with schizophrenia; thirty –five (94.59%), needed training in social work in mental health care, while 86.49%, needed training in the assessment tools of mental illness; thirty-three (89.19%), needed training in recovery and social work, while thirty (81.08%), recovery-oriented mental health practice. It was evident that **after the training**, that it had an impact on the knowledge of the respondents. 18 (48.65%) respondents did not want to be trained in mental health; therefore, respondents acquired knowledge.

54.04% respondents indicated that they do not require training for the assessment tools of mental illness, as compared to 86.19% who indicated that they required training. The researcher accepts that one-day training cannot provide comprehensive knowledge. However, the findings confirm that there is a need that social workers should be trained in mental health. Therefore, training in mental health is justified and crucial. Moreover, Karban (2011:4) asserts that social work has a vital contribution to make in mental health care, based on the profession's values, knowledge, and skills.

Table 9.17: Mental health intervention

	Pre-test		Post-test	
Variable	**Frequency (*f*)**	**Percent (%)**	**Frequency (f)**	**Percent (%)**
Mental health interventions - counselling				
No response	2	5.41		
Yes	32	86.49	34	91.89
No	3	8.11	3	8.11
Mental health interventions - diagnose schizophrenia				
No response	3	8.11	1	2.7
Yes	6	16.22	17	45.95
No	28	75.68	19	51.35
Mental health interventions - work alone				
No response	2	5.41		
Yes	3	8.11	1	2.7
No	32	86.49	36	97.3
Mental health interventions - do not intervene				
No response	2	5.41		
Yes	1	2.7	1	2.7
No	34	91.89	36	97.3
Mental health interventions - refer to hospital				
No response	2	5.41	1	2.7
Yes	35	94.59	34	91.89
No			2	5.41
Mental health interventions - refer to psychologist				
No response	1	2.7	1	2.7
Yes	34	91.89	34	91.89
No	2	5.41	2	5.41

	Pre-test		Post-test	
Variable	**Frequency (*f*)**	**Percent (%)**	**Frequency (f)**	**Percent (%)**
Mental health interventions - refer to psychiatrist				
No response	2	5.41	1	2.7
Yes	35	94.59	35	94.59
No			1	2.7
Mental health interventions – other				
No response	26	70.27	22	59.46
Yes	7	18.92	9	24.32
No	4	10.81	6	16.22

Mental health intervention (Questions 6.4a to 6.4h)

The questions were dichotomous in nature, and the respondents were required to mark yes or no to the statements. **Prior to the training**, thirty-two (86.49%) of the respondents indicated that they provide counselling, and **after the training** thirty-four (91.89%) indicated that they provide counselling as a form of mental health intervention. Therefore, there was an increased level of knowledge.

For the statement regarding the diagnosis of schizophrenia, there was no difference; the majority of respondents had the knowledge that they do not provide a diagnosis of schizophrenia.

Sufficient knowledge (Question 6.5)

Pertaining to the sufficient knowledge for appropriate intervention **prior to the training**, seven (18.92%) indicated that they had sufficient knowledge, while thirty (81.08%) indicated that they did not have the knowledge. **After the training** there was contrariwise information: thirty (81.08%) reported that they had sufficient knowledge, while 18.92% indicated that they still have limited knowledge. There was an increase in the knowledge after the training; however, some respondents still indicated that they had limited

knowledge. The researcher fully agrees with this response in that comprehensive knowledge cannot be imparted in a one-day training session.

Multidisciplinary team tools that are used when working with PLWS (Question 6.6)

The respondents were required to mark all the tools that they knew were used by the multi-disciplinary team to assess a patient with schizophrenia. They had to mark any two from the DSM-5, NHI, the Constitution, or the Mental Health Act. The correct answers were DSM-5 and Mental Health Act. In response this question, 70.27% marked DSM-5; 24.32% marked the NHI; 29.73% the Constitution; and 91.89% the MHCA. It should be noted that some respondents were not sure. This was evident in the post-test as 8.11% marked the NHI, which was incorrect. Therefore, there was an increase in the level of knowledge: DSM was 100% and the MHCA 91.89%.

South Africa enacted the Mental Health Care Act in 2002 and it was promulgated in December, 2004. Its focus was access to mental health care and the rights of mental health care users, family members, and other caregivers. Its focus is also the competency and capacity of people with mental illness (Department of Health, 2002). The researcher is of the opinion that recovery-oriented practice is therefore in line with what the Act as it aims to support and maintain a meaningful and satisfying life of people with mental health problems, regardless of whether or not there are ongoing symptoms of mental illness (Shepherd, Boardman & Slade, 2008:3). More details on the DSM and social work were presented in chapter 5.

Who decides on the diagnosis of PLWS? (Question 6.7)

An identification of who decides on the diagnosis of PLWS was required. **Prior to the training,** 29.73% respondents indicated that psychiatrists make the decision, and 62.16% marked the team. **After the training**, an increase in the level of knowledge was evident: 86.49% marked the team, and 10.81% maintained that the psychiatrist makes a decision.

These questions yielded positive results; therefore, the conducted training seemed to have impacted knowledge to the respondents effectively. The Department of Health

(2001) asserts that good teamwork enables the effective provision of comprehensive care. Ecological systems theory is relevant to social work as it provides a comprehensive, multidisciplinary, and holistic framework. It is evident that social work has a vital role in assisting people living with schizophrenia.–A multidisciplinary team is also clearly essential.

9.4.5 Recovery and social work (Questions 7a to 7h)

This section determines the knowledge of respondents regarding recovery and social work.

Table 9.18: Recovery and social work

	Pre-test		Post-test	
	Frequency (f)	**Percent (%)**	**Frequency (f)**	**Percent (%)**
Recovery component positive impact - Empowerment				
Weak	4	10.81		
Moderate	4	10.81	2	5.41
Strong	29	78.38	35	94.59
Recovery component positive impact – Hope				
Weak	6	16.22		
Moderate	8	21.62	3	8.11
Strong	23	62.16	34	91.89
Recovery component positive impact - Self-direction				
No response			1	2.7
Weak	6	16.22		
Moderate	11	29.73	5	13.51
Strong	20	54.05	31	83.78
Recovery component positive impact - Disempowerment				

	Pre-test		Post-test	
	Frequency (f)	Percent (%)	Frequency (f)	Percent (%)
No response	1	2.7		
Weak	31	83.78	35	83.78
Moderate	3	8.11	1	2.7
Strong	2	5.41	1	2.7
Recovery component positive impact - Pathological centred				
Weak	10	27.03	20	54.05
Moderate	20	54.05	8	21.62
Strong	7	18.92	9	24.32
Recovery component positive impact - Strengths-based				
Weak	2	5.41	1	2.7
Moderate	12	32.43	1	2.7
Strong	23	62.16	35	94.59
Recovery component positive impact - Restraining				
No response	1	2.7		
Weak	18	48.65	26	70.27
Moderate	12	32.43	6	16.22
Strong	6	16.22	5	13.51

The respondents were required to indicate if any of the following components of recovery impact positively on the lives of people living with schizophrenia: empowerment, hope, self-direction, disempowerment, pathological centred, strengths based, and restraining. They had to answer all the questions by indicating weak, moderate, or strong.

Prior to the training, the respondents indicated as follows:

Empowerment: weak - 10.81%; moderate - 10.81%; and strong - 78.38%. Hope: weak - 16.22%; moderate - 21.62%; and strong - 62.16%. Self-direction: weak - 16.22%;

moderate - 29.73%; and strong - 54.05%. Disempowerment: no response - 2.7%; weak - 83.73%; moderate - 8.11%; and strong - 5.41%.

After the training, there was an increase of knowledge: weak - 83.78%; moderate - 2.7%; and strong - 2.7%. Strengths-based: weak - 5.41%; moderate - 32.43%; and strong - 62.16%. After the training, there was an increase in the level of knowledge. Empowerment: weak - 2.7%; moderate - 2.7%; and strong - 94.59%. Restraining: 2.7% did not respond; weak - 48.65%; moderate - 32.43%; and strong - 16.22%.

Thus, in this section there was an increased of knowledge gained. SAMHSA (2006) highlights the principles of recovery as self-direction, empowerment, strengths based, and hope. Therefore, the strengths-based perspective is aligned to recovery-oriented mental health practice. The strengths-based perspective encourages healing by focusing on individual's attributes that promote health instead of focusing on symptoms and pathologies that induce sickness (Xie, 2013:6).

9.4.6 Recovery-oriented mental health (questions 8.1a to 8.1h)

This section focuses on ascertaining the knowledge of respondents regarding recovery-oriented mental health.

Table 9.19: Recovery-oriented mental health

	Pre-test		Post-test	
	Frequency (*f*)	**Percent (%)**	**Frequency (f)**	**Percent (%)**
Recovery-oriented mental health - supports people to define their goals				
Agree	32	86.49	37	100
Not sure	5	13.51		
Recovery-oriented mental health - helps support people to understand				
Agree	33	89.19	37	100
Not sure	4	10.81		

Recovery-oriented mental health - acknowledges diversity of people and values				
No response			1	2.7
Agree	25	67.57	33	89.19
Not sure	11	29.73	3	8.11
Disagree	1	2.7		
Recovery-oriented mental health - addresses a range of factors				
No response	1	2.7		
Agree	30	81.08	34	91.89
Not sure	5	13.51	1	2.7
Disagree	1	2.7	2	5.41
Recovery-oriented mental health - considers the possibility of unresolved trauma				
No response	1	2.7		
Agree	23	62.16	34	91.89
Not sure	12	32.43	1	2.7
Disagree	1	2.7	2	5.41

Question 8: There were statements such as (a) supports people to define their goals, exercise their capacities and use their strengths to attain their potential; (b) helps families or support people to understand their family members' experiences and recovery processes; (c) acknowledges the diversity of peoples' values and is responsive to people's gender, age and developmental stage, culture, and families as well as people's unique strengths; and (d) addresses a range of factors, including social determinants. The respondents were required to respond to each: agree, unsure, or disagree. This was a self-rated question.

Prior to the training, 86.49% respondents agreed that recovery-oriented mental health supports people to define their goals; and 13.51% were not sure. 89.19% respondents agreed that recovery-oriented mental health helps people understand mental illness; and 10.81% were not sure. 67.57% respondents agreed that recovery-oriented mental health acknowledges the diversity of people; 29.73% were not sure; and one 2.7% disagreed. 2.7% did not respond to the question that recovery-oriented mental health addresses a range of factors, while 81.08% agreed, and 2.7% disagreed. 2.7% did not respond to the question that recovery-oriented mental health considers the possibility of unresolved trauma, while 62.16% agreed, 32.43% were not sure, and 2.7% disagreed.

After the training, there was an increased level of knowledge from 86.495% to 100%; from 67.57% to 89.19%; and only 8.11% were not sure. The Mental Health Commission of Canada (2015) asserts that recovery-oriented mental health practice supports people in defining their goals, and exercising their capabilities and strengths in order to attain their potential. Gable and Haidt (2005:103) state that a strengths-based perspective provides an understanding of the strengths that can help prevent or lessen the damage of disease, stress, and disorder. Therefore, if social workers are competent in recovery-oriented mental health practice, MHCUs will be assisted appropriately.

Table 9.20: T-test for dependent samples recovery

Variable	t-test for dependent samples Marked differences are significant at p < .05000							
	Mean	Std.Dv.	N	Diff.	Std.Dv. Diff.	t	df	P
Pre-recovery	13.75676	3.744666						
Post-recovery	17.43243	2.192671	37	-3.67568	4.327265	-5.16683	36	0.000009

The table above illustrates the statistical significance. The mean for the pre-test was 13.8 and the standard deviation 3.7. Furthermore, the mean for the post-test was 17.4 and the standard deviation 2.1. The p-value was 0.000009, which is below 0.05. The mean shows that that there was an increase of knowledge in the post-test. The CROCMEHC training

was effective; the post-knowledge score was significantly higher, and the respondents gained knowledge.

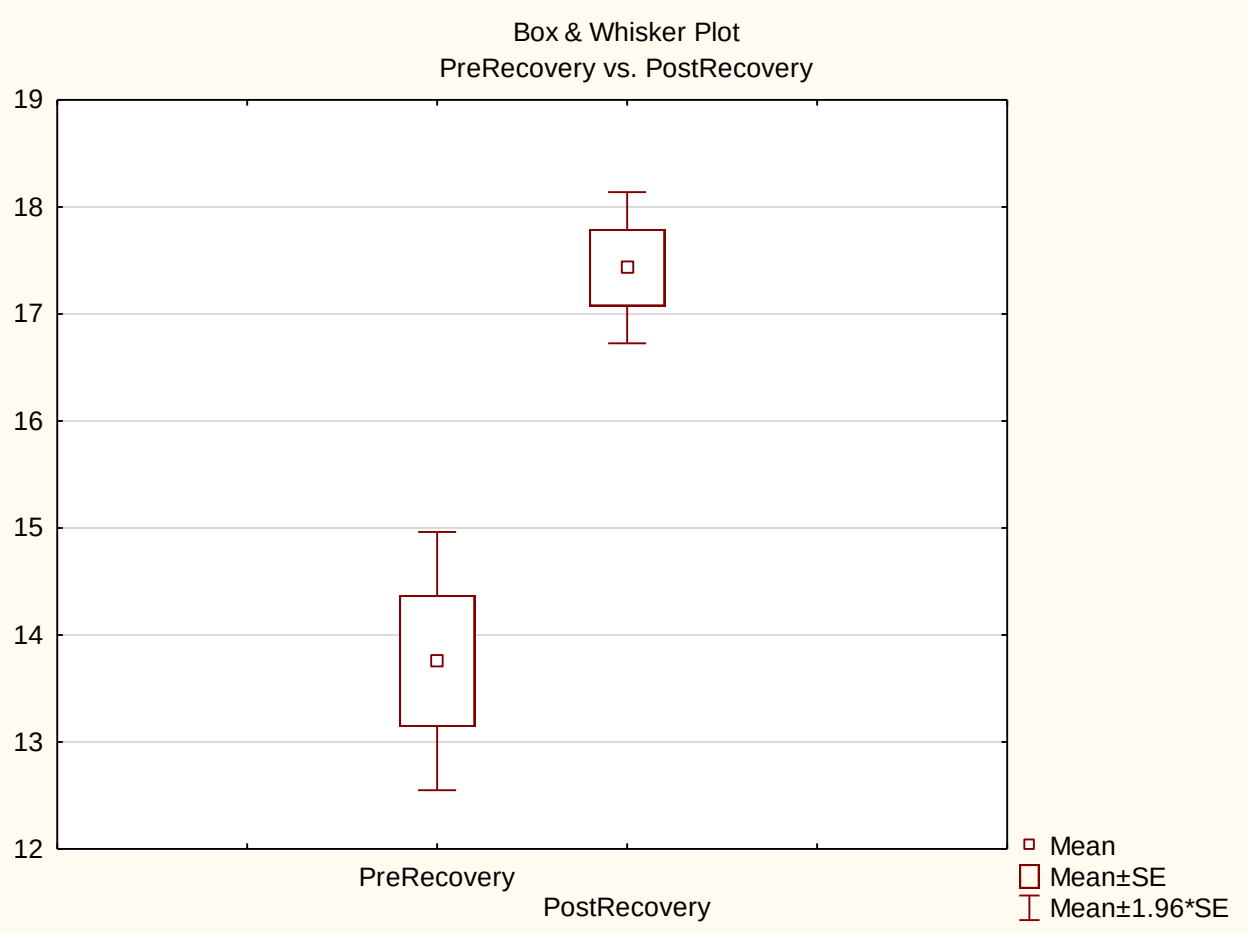


Figure 9.7: Box and Whisker plot: Recovery

The Box and Whisker plot diagramme displays the information in table 9.20. The post-test scores were slightly higher and the pre-test scores were slightly lower. This shows that the level of knowledge was higher in the post-test. The p-value for both was 0.000009, which is below 0.05. Therefore, there was a statistical significance.

Similarities between social work and recovery-oriented mental health practice (ROMHP)

This section focuses on the showing the similarities between social work and recovery-oriented mental health practice.

Table 9.21: Similarities between Social Work and Recovery-Oriented Mental Health Practice (ROMHP)

	Pre-test		Post-test	
Count similar core values SW and ROMHP	**Frequency (f)**	**Percent (%)**	**Frequency (f)**	**Percent (%)**
0	20	54.05	4	10.81
1	11	29.73	11	29.73
2	2	5.41	11	29.73
3	2	5.41	6	16.22
4	2	5.41	5	13.51

Table 9.22: Core values of social work and recovery-oriented mental health practice

Pre-test				Post-test		
Similar core values of social work and recovery oriented mental health practice	**Frequency**	**% Responses**	**% Respondents**	**Frequency**	**% Responses**	**% Respondents**
Self-determination	5	17.24	13.51	18	25	48.65
Empowerment	3	10.34	8.11	6	8.33	16.22
Acceptance	5	17.24	13.51	10	13.89	27.03
Collaboration	5	17.24	13.51	7	9.72	18.92
Strength	6	20.69	16.22	6	8.33	16.22
Respect	4	13.79	10.81	7	9.72	18.92
Responsibility	1	3.45	2.70	7	9.72	18.92
				3	4.17	8.11

Pre-test				Post-test		
Similar core values of social work and recovery oriented mental health practice	**Frequency**	**% Responses**	**% Respondents**	**Frequency**	**% Responses**	**% Respondents**
				4	5.56	10.81
				3	4.17	8.11
				1	1.39	2.70

Prior to the training, 54.05% respondents exhibited limited knowledge about the similarities between social work and recovery-oriented mental health service. 29.73% respondents knew that social work values and ROMP were to respect diversity, while 5.41% indicated social justice, 5.41% marked empowerment, and 5.41% person-centered. After the training, only 10.81% had limited knowledge and there was significant change; an increase from 5.41% to 29.73%; from 5.41% to 16.22%, and from 5.41% to 13.51%.

To correlate the findings, the researcher has noted that there is synergy between the principles of recovery-oriented practice to the principles of practice and values of the social work profession as set in the AASW (2008) and the International Federation of Social Workers (IFSW) codes of ethics. The identical principles are self-direction, individualised and person-centred, empowerment, holistic, nonlinear, strengths based, peer support, respect, responsibility, and hope (Amering & Schmolke, 2009:14).

Table 9.23: T-test for dependent sample recovery social work

Variable	T-test for dependent samples Marked differences are significant at p < .05000							
	Mean	**Std.Dv.**	**N**	**Diff.**	**Std.Dv. Diff.**	**t**	**df**	**p**
Pre-recover SW	4.675676	1.732917						
Post-recover SW	6.432432	3.602010	37	-1.75676	4.166036	-2.56501	36	0.014631

Similarly, this table illustrates the statistical significance. A dependent t-test was administered and there was statistical significance. From the table above, the mean for the pre-test was 4.7 and the standard deviation 1.7. Furthermore, the mean for the post-test was 6.4 and the standard deviation 3.6. The p-value was 0.014631, which was below 0.05. The CROCMEHC training was effective; the post-knowledge score was significantly higher, and the respondents gained knowledge.

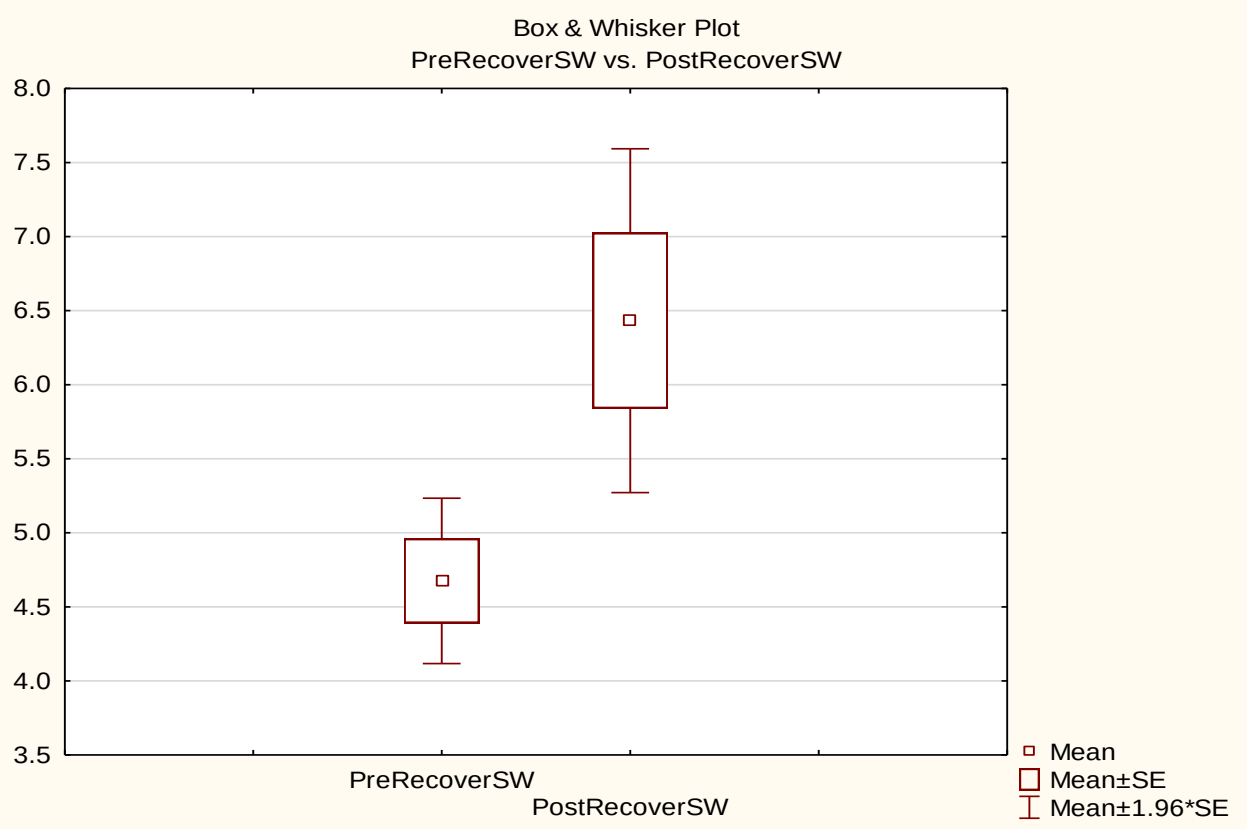


Figure 9.8: Box and Whisker plot: Recovery and social work

The Box and Whisker plot depicts the same information as that in table 9.23. The post-test scores were slightly higher and pre-test scores were slightly lower. There was a difference between the pre- and post-test scores. This shows that the level of knowledge acquired in the post-test was higher. The p-value was 0.014631, which is below 0.05. Therefore, there was statistical significance.

Thus, in this section there was an increased of knowledge regarding the similarity between social work and recovery-oriented mental health practice. Payne (2014:185) posits that social work practice should focus on ecological theory: promoting active partnerships, promoting environmental as well as social justice, and reducing human ecological stress. Therefore, there is synergy between social work and recovery-oriented mental health practice.

Training in recovery-oriented mental health practice (ROMHP), focusing on the post-test

Table 9.24: Acquired knowledge

	Frequency (f)	Percent (%)
Acquired knowledge - mental health		
Yes	37	100
Acquired knowledge - mental illness		
Yes	37	100
Acquired knowledge - social work in mental health care		
Yes	37	100
Acquired knowledge - assessment tools		
Yes	37	100
Acquired knowledge - intervention methods		
Yes	37	100
Acquired knowledge - recovery and social work		
Yes	37	100

The questions were dichotomous in nature. 97.03% of the respondents were of the opinion that the training in recovery-oriented mental health practice can assist social workers, and 2.7% respondent indicated that the training will not assist. This finding correlates with that of Khoury and del Barrio (2015:27) that social workers' training in direct practice, systems change, and policy practice can influence and enhance the recovery of individuals with lived experiences of psychiatric diagnoses on both micro and macro levels.

The CROCMEHC programme seems to have been effective in impacting knowledge. It should be noted that 100% respondents indicated that they had acquired knowledge in mental health, and in general mental illness, mental health care, assessment tools, intervention methods, recovery model, and social work. Therefore, the researcher had clearly managed to impact the basic knowledge of the respondents. More details about CROCMEHC programme have been captured in chapter 8 of the present study.

In this section there was an increased knowledge in the post-test. Ecological theory facilitates the restoration of an adaptive balance between the person and the environment by reducing stress, enhancing coping mechanisms, or establishing stability (Nash et al., 2005:33). Therefore, when social workers are trained in mental health, they will be able to assist MHCUs appropriately.

Summary

The empirical findings of the second phase – quantitative approach has been discussed. It should be noted that the training has yielded positive results. In most sections, there was an increased knowledge gained by the respondents. This shows that the CROCMEHC programme was effective to impart knowledge in the present study. Moreover, the refinement is still required for this programme.

9.4.7 Qualitative data from the respondents' views on the CROCMEHC training

The respondents were required to write down what they had learned from the CROCMEHC training in the blank space provided; the following themes were identified:

Theme 1: Mental health and illness

- *VH13: "The meaning of mental health, mental illness."*
- *VH10: "I learnt about mental health and illness."*

Theme 2: Schizophrenia

- *VH13: "schizophrenia, intervention methods in working with people living with schizophrenia."*
- *VH12: "I have learnt about mental health care."*

- *VH11:"Mental health."*
- *VH10:"I learnt about the types of mental illness especially schizophrenia."*
- *VH04: "I have learnt about the definition of schizophrenia."*

Theme 3: Social work in mental health

- *VH9: "I have learned theories of the social worker in facilitating recovery."*
- *VH05, M002: "Role of social work in mental health."*
- *MO35: "The intervention methods which include individual, intervention, group intervention and family intervention."*

Theme 4: Recovery

- *VH10: "I have learnt about recovery-oriented mental health."*
- *VH05: "Recovery and social work."*
- *VH3: "Recovery-oriented mental health care plan will contribute much in the well-being of mental health care users."*
- *VH30: "The theories of recovery model."*
- *VH26: "Recovery is a journey which the clients have a right to set their own goals."*
- *MO16: "Recovery process."*

Theme 5: CROCMEHC programme

- *MO16: "I have learned about CROCMEHC programme."*

Theme 6: Implement CROCMEHC

- *VH10, VH01: "I have learned about CROCMEHC programme implementation."*

9.4.7.1 Discussion based on the themes

Six themes emanated from that which the respondents had stated they had learn from the training, namely mental health and mental illness, schizophrenia, social work in mental health, as well as the essence of the CROCMEHC programme. The training was

a one-day training session only; however, it had managed to impact the knowledge of the respondents.

9.4.7.2 Programme content of training recommendation and general recommendation

Theme 1: training

- *VH14: "More workshops must be conducted and all social workers provided with information."*
- *VH17: "To be trained again."*
- *VH21: "Social workers must be trained at all levels."*
- *MO37: "Training to be rolled over to all social workers as it is informative."*
- *MO23: "To train and give information to others."*
- *MO21: "Retraining to gain more insight."*
- *VH25: "The training be continuous, all social workers be exposed to. It may have advance course."*
- *VH7: "Presentation and workshop like this should be done annually."*

Theme 2: Time

- *VH22: "The course should be given more days in order to do it detail."*
- *MO35: "More time and days for presentation."*
- *MO06: "It was done in short time and we need to learn more on mental health of schizophrenia."*
- *MO02: "Enough time for training should be allocated."*
- *MO01: "Time should be extended for training a day is not enough."*
- *VH01: "I recommend that we must be trained for a week if not a month."*
- *VH13: "Must take maybe three days."*

Theme 3: Curriculum

- *VH15: "CROCMEHC programme must be used to SW students. It must be practice in the field."*

- *MO16: "CROCMEHC programme to be included as a subject in social work training."*
- *VH6: "All universities to train in mental health."*
- *VH10: "The CROCMEHC programme be implemented as part of the social work degree curriculum"*

Theme 4: Visuals

- *VH02: "They should have videos as scenarios to relate to."*
- *VH13: "Group discussion will also help."*
- *VH11: "To add visuals as well."*

Theme 5: Model adopted

- *MO08: "The model must adopted, further training be adopted."*

Theme 6: Case study

- *VH30: "More of case studies."*

Theme 7: Provincial plans

- *VH26: "To have it incorporated in the provincial plans of the departments."*

The respondents added that CROCMEHC was well presented and the manual creatively designed, and that the facilitator's presentation was excellent. They also suggested that other professionals such as psychologists, nurses, and psychiatrists be included in this programme. Furthermore, they suggested that people living with schizophrenia should be invited to be part of this training.

Discussion

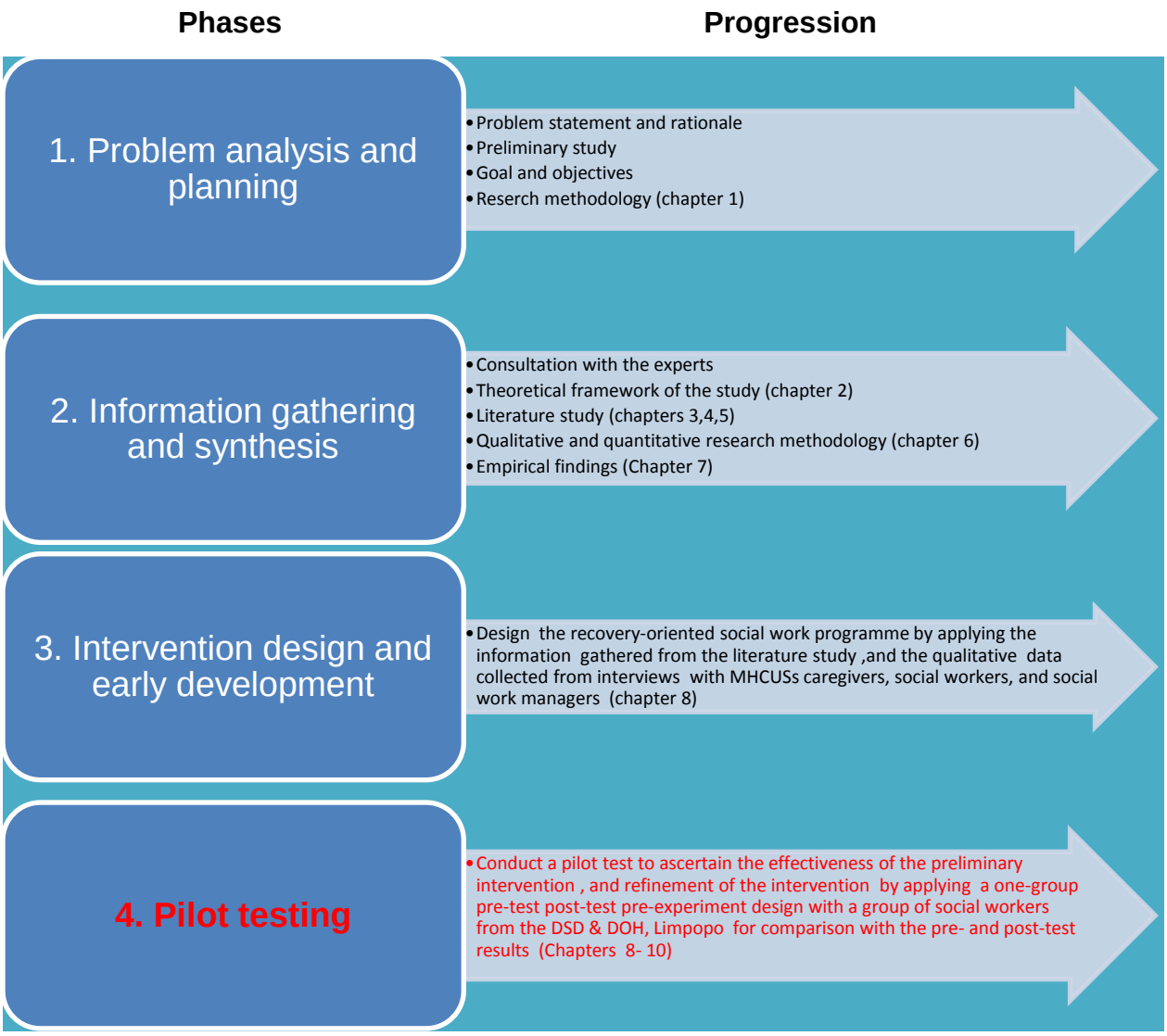
The respondents recommended that training should be continuous and the CROCMEHC programme incorporated in the curricula of social work. The programme should be presented over a longer period and the visuals and case studies should be incorporated. The provincial office should adopt this programme.

9.5 Summary

This chapter focused on illustrating the empirical findings of the present study as well as the inclusive analysis of the quantitative data and the summarised themes of the qualitative data. The CROCMEHC programme was presented as a pilot test to thirty-seven attendees at Mopani and Vhembe Districts. The researcher presented a one-day course at each of the locations. The next chapter focuses on the summary, conclusions, and recommendations.

CHAPTER 10

KEY FINDINGS, CONCLUSIONS, AND RECOMMENDATIONS



Graphic representation of the phases of the intervention research: Adapted from Fraser and Galinsky (2010:463); De Vos (2011)

10.1 Introduction

Globally, recovery-oriented mental health practice has taken centre stage in the mental health arena. The Commonwealth of Australia (2013:17) states that “Recovery-oriented approaches provide a transformative conceptual framework for practice, culture and service delivery.” Despite all these changes, countries such as South Africa have not yet tried this approach. Robertson (2017) confirms this assertion, which is also in line with the findings of the present study. Furthermore, the principles of social work have similar tenets with regard to recovery-oriented practice; however, globally social workers are absent from debates on recovery and recovery-oriented social work (Shera & Ramon, 2013). Literature authored by social workers in this regard is limited (Slade, 2009). The researcher has developed a recovery-oriented social work programme for rural areas of South Africa. She is of the opinion that this programme is applicable to both rural and urban areas. The developed programme aims to improve mental health services in South Africa.

The intention of this chapter is to provide the key findings, conclusions, and recommendations of the present study. The initial discussion is based on how the goal, objectives, and research questions are realised and hypothesis tested. Subsequently, the key findings, conclusions, and recommendations of the first and the second phases of the research are discussed.

10.2 Aim and objectives of the present study

The g of this study was to

(1) develop,
(2) implement, and
(3) evaluate a social work intervention programme aimed at recovery-oriented practice in rural areas.

This aim was achieved as the researcher developed the CROCMEHC programme from the findings of the first phase, and evaluated and implemented the programme in the form of a pilot test. Social workers completed the pre- and post-test questionnaires. It was

evident that there was a need for a recovery-oriented mental health programme in the social work arena in South African rural areas.

The achievement of the aim is evident through the achievement of the objectives. The objectives were categorised into two phases, namely qualitative and quantitative approaches. The discussion focuses on how the objectives of the first phase were realised.

10.2.1 Realisation of the first phase objectives

The objectives of the first phase were as follows:

Objective 1: To explore and discuss mental health services and policies from regional and national perspective

In chapter 3, the literature study concentrated on mental health services and policies. The literature study was based on the mental health services globally, sub-Saharan Africa including South Africa. The researcher explored the legislative framework that underpinned mental health services within the South African context. The following sections were covered:

- Mental health.
- Context of mental health.
- Legislative framework of mental health.
- Mental health, human rights, and social justice.
- Mental health in the context of culture.
- Poverty and mental health.
- Strengths and weaknesses of the mental system in South Africa.
- Mental health care in rural areas.
- Investing in rehabilitation is essential in addressing the gap in mental health care service in rural areas.
- Recovery-oriented mental health services.

Therefore, the exploration and discussion led to the achievement of this objective.

Objective 2: **To explore the challenges of MHCUs regarding mental health care services in rural SA**

In chapter 4, the literature study explored the profile and challenges of living with mental illness, especially schizophrenia. The subsequent discussion was based on the prevalence of mental illness, globally and nationally. Furthermore, in section 4.3 the discussion explored the challenges of mental health care users, namely the social impact of homelessness, education opportunities, and employment opportunities in relation to mental health care. In chapter 7, in the qualitative phase, the challenges such as the rejection by families and friends were identified. They felt discriminated against and not taken seriously by community members or their families.

Objective 3: **To gather information from MHCUs and caregivers regarding their needs in mental health care in rural areas**

The researcher employed a mixed-methods approach that comprised qualitative and quantitative approaches; methodology details were captured in chapter 6. The needs of the MHCUs and caregivers were explored in the qualitative phase through semi-structured interviews (chapter 7). Thirteen MHCUs from three psychiatric hospitals in Limpopo were interviewed and the following needs were identified:

- To enter in the labour market.
- To have their own houses.
- To further their studies.
- To be discharged from hospital with the goal that they could carry on with their independent lives.

In relation to the caregivers, five caregivers were interviewed and their challenges were identified as follows:

- Receive assistance in caring for mental health care users.
- Required special schools and day-care centres.
- Required material assistance.

- To be involved in the community activities.

These needs were discussed in the thematic analysis in chapter 7.

Objective 4: To gather information from social workers and social work managers in the districts, hospital and provincial offices of the Departments of Health and Social Development about the current practice of mental health care in rural areas

In chapters 4 and 5, the researcher discussed the role and current practices in mental health care. In chapter 4, sections:

- 4.1.4.1.1. Conventional or typical antipsychotic medication
- 41.4.1.2. Atypical antipsychotics medication
- 4.1.4.3. Psychosocial intervention
  - Individual therapy (Micro intervention)
  - Group intervention (mezzo intervention)
  - Macro intervention
  - Counselling
  - Psycho-educational counselling
  - Referral

In chapter 5, section 5.4, the topic was social work in mental health care was discussed. Furthermore, in the qualitative data collection, the researcher conducted semi-structured interviews with eighteen social workers in the districts, thirteen social workers in the hospitals, and eight social work managers – one in the provincial office, two in the hospital, and five in the district office. It was evident from the data gathered that there was a lack of knowledge of mental health care and recovery-oriented mental health practice. As a result, limited mental health services were offered by social workers.

Most of the social workers reported that they refer MHCUs to other professionals such as nurses, doctors, and psychologists. From the gathered data, it was evident that there was a need for training for social workers in mental health care. The information obtained from this phase necessitated the development of the CROCMEHC programme. The researcher developed the programme from the findings in the first phase in such a way

that it could provide a synopsis of mental health, schizophrenia, treatment, and caregiving. Subsequently, she focused on recovery-oriented mental health practice. More details in this regard have been captured in chapters 8 and 9.

10.2.2 Realisation of the second phase objectives

The objectives of the second phase are as follows:

Objective 5: To design a recovery-oriented social work programme based on the needs identified in the first phase

The CROCMEHC programme was developed based on the comprehensive literature study and the findings of the first phase (qualitative) of the present study, from which a number of needs were identified. In chapter 8, the researcher explored other recovery-oriented programmes; however, they were programmes within a global context. In South Africa, only one programme on ACT was discussed; however, it was not within the social work field. The researcher developed a CROCMEHC training manual (booklet) comprising seven modules. It was developed with pictures and images, and the participants commended the creativity of the facilitator (researcher); this booklet was provided to the respondents. This training manual is in much more detail than chapter 8, which for the purposes of this thesis had to be shortened to provide more of an overview. It was implemented in a pilot phase in two one-day training sessions, and therefore still needs to be refined. More details of the CROCMEHC programme were captured in chapters 8 and 9.

Objective 6: To conduct a pre-test measurement with social workers regarding their knowledge of mental health and the recovery-oriented model

As indicated, the present study employed a mixed-methods approach. The second phase was based on the quantitative approach using the one group pre-test post-test design. The researcher developed a self-administered pre-test questionnaire that comprised eight sections. The respondents were required to complete the questionnaire prior to the CROCMEHC programme training**.**

Objective 7: To implement the recovery-oriented social work programme through the training of social workers during a one-day session

The CROCMEHC programme was implemented and presented in two districts, namely Mopani and Vhembe in Limpopo Province. The training was presented in one day in each district. Thirty-seven attendees were trained in the aforementioned programme, and respondents received detailed booklets setting out the contents of the programme. Details were captured in chapters 9.

Objective 8: To conduct a post-test measurement with social workers regarding their knowledge of mental health and the recovery-oriented model after completion of the training

The self-administered post-test questionnaire comprised eight sections. After the CROCMEHC programme training, the attendees were required to complete the afore-mentioned questionnaire for the post-test. Details were captured in chapter 8.

Objective 9: To analyse the effectiveness of the programme by comparing pre and post-test results aimed at improving the knowledge of social workers on the recovery-oriented model

The respondents provided valuable feedback about the CROCMEHC programme as discussed in chapter 9, indicating that the programme was valuable and that it should be allocated more time as well as being incorporated in the BSW/BA (SW) university curricula. The respondents were of the view that if the CROCMEHC programme could be implemented, other professionals would place a higher value on social work.

Objective 10: To make practice recommendations based on the broader utilisation of the recovery-oriented social work programme for MHCUs in rural areas

Objective 10 is addressed at the end of this chapter where recommendations are provided. However, as regards the qualitative (first) phase, caregivers, MHCUs, social workers, and social work managers articulated their recommendations pertaining to mental health care (chapter 7). In chapter 9, the respondents indicated the recommendations concerning the implementation of the CROCMEHC programme.

Based on the above-stated information, it is evident that the goal and objectives of the current study were realised.

10.3 Research questions

The **main research questions** were formulated as follows:

- Will social workers trained in the recovery model of intervention be more empowered to render recovery-oriented intervention to MHCUs in rural areas?
- Can social workers make a paradigm shift in their intervention approach once they have received training in recovery-oriented practice?

The research questions were answered based on the quantitative findings. Respondents were of the view that the social work profession would be valued to a higher degree by other professionals if the CROCMEHC programme could be implemented. Furthermore, they wanted the training to be conducted more frequently and over a longer period. Prior to the training, most of the respondents were of the view that mental health care did not fall within their scope of practice. Subsequently, after the training there was a paradigm shift as they came to realise that social workers have a critical role to play in mental health care. They felt more empowered to render recovery-oriented mental health intervention to MHCU in the rural areas.

The following **sub-questions** informed the main research question:

- What is the state of mental health care services in rural SA?

In chapter 3, section 3.4, the focus was on mental health services in rural areas. Chapter 7, theme 2 addressed mental health services, and the table below illustrates the information.

Theme 2: Experiences regarding mental health care services	**Subtheme 2.1**: Experiences regarding services rendered by the hospital/clinic	**Category 2**: Mental health services

- What are the current treatment practices utilised for MHCUs in rural SA?

Chapter 4, section 4.1.4.1 indicates the current treatment practices utilised for MHCUs. Chapter 7, theme 4 indicates the treatment received by MHCUs; the table below illustrates the information.

Theme 4: Treatment of illness	**Subtheme 4.1**: Description of treatment received	**Category 4**: Perception of the course and treatment of illness

- What are the current mental health care intervention practices used by social workers in rural areas?

Chapter 4, section 4.1.4.2 described the psychosocial intervention in the treatment of schizophrenia; social workers are part of the mental health care practitioners offering these services. Chapter 7, theme 2 described the social services in mental health rendered by social workers in the communities and hospitals. The table below provides the information.

Theme 2: A description of social services in mental health in the communities and hospitals where the participants worked	**Subtheme 2.1**: Description of the nature of services by social workers	**Category 2**: Social work services

- What is the nature of the care that MHCUs experience in rural areas?

Chapter 7, theme 2, subthemes 2.2, 2.3, and 2.4 described the nature of care that MHCUs in rural areas receive. The table below depicts the information.

Subtheme 2.2: Experiences regarding services by a multidisciplinary team
Subtheme 2.3: Experiences regarding formal support services
Subtheme 2.4: Experiences regarding traditional healers

- What are the needs of MHCUs and their caregivers in rural areas regarding mental health care?

In chapter 4, section 4.2.2 the discussion was based on the needs of people living with schizophrenia. In the same chapter, section 4.3.1.1 the discussion focused on the needs of the caregivers. Chapter 7, theme 5 described the needs of MHCUs. The table below depicts the information.

Theme 5: Living with mental illness	**Subtheme 5.4**: Needs of the MHCU	**Category 5**: Challenges of living with mental illness

In the same chapter, the needs of the caregivers were stipulated. The table below illustrates the information.

Theme 4: Experiences of caring for a person living with schizophrenia	**Subtheme 4.3**: Needs of the caregiver	**Category 4**: Role and needs of caregivers

Based on the discussion above, it is evident that the research questions were answered.

10.4 Hypothesis of the study

Hypothesis

If social workers participate in a recovery-oriented intervention programme developed during this study, their level of knowledge will improve in rendering mental health services to mental health care users and their caregivers in rural areas of South Africa?

Sub-hypothesis

A social work intervention programme based on recovery-oriented mental health will increase the knowledge of social workers in rendering mental health services to mental health care users and their caregivers in the rural areas of South Africa.

The hypothesis and sub-hypothesis were tested when an intervention programme was developed and presented in the present study. The one-group pre-test post-test design proved to be effective in giving credence that the hypothesis and sub-hypothesis should be tested. The pre-test questionnaire was administered prior to the preliminary CROCMEHC intervention programme. After the preliminary intervention programme had

been presented, a post-test questionnaire was administered to measure if the intervention had increased the level of knowledge. The pre-test and post-test were merged and analysed.

Subsequently, a statistical test, namely the dependent t-test, was administered to test the level of knowledge gained by the respondents; the p-value was calculated to determine the statistical significance, and the Box and Whisker plot to show the distribution of scores. The statistical findings revealed that in six sections of analysed data, there was a statistical significance with improved knowledge in mental health and recovery-oriented mental health intervention; and in two sections of the data, there was no statistical significance. Therefore, the statistical findings show that there was a level of increased knowledge after the intervention training. The merged scores of the pre- and post-tests resulted in an alternative hypothesis. The alternative hypothesis stated that there was a statistical significance. It can be concluded that the pilot test of this intervention research had yielded results that were positive, and affirmed that the preliminary CROCMEHC intervention programme can be effective and should be refined further before implementation. It can be recommended that the CROCMEHC programme be adapted, refined, and implemented for social work practice in the rural areas.

10.5 Theoretical frameworks of the present study

The present study is based on ecological systems theory and the strengths-based perspective. The core focus of ecological systems theory is how individuals adapt to environmental demands; it focuses on how an individual's needs, capacities, and opportunities for both growth and ability adapt to changing external demands, are they are provided for, and challenged by the environment. From an ecological systems theory perspective, the different environmental levels are in continuous interaction with, and have mutual influence on, each other, either negative or positive.

The different environmental levels, based on ecological systems theory, allowed the researcher to categorise the interactions and dependability of each level. Social workers and other mental health care practitioners design intervention programmes to address mental health problems at the micro- and macrosystems levels. It can be concluded that

ecological systems theory was appropriate, as the researcher gained a better understanding of how the environment affects MHCUs and caregivers.

The strengths-based perspective attempts to understand MHCUs in terms of their strengths. This involves systematically examining survival skills, abilities, knowledge, resources, and desires that can be used to help meet client goals. From a strengths perspective, the major focus is on the collaboration between social workers and clients. This perspective has tenets similar to those of recovery-oriented mental health care, namely to develop or strengthen independent thinking, problem solving, and self-advocacy skills; and to assume responsibility for MHCUs' personal decisions. These theories were linked to the qualitative and quantitative findings of the present study. They were deemed relevant as the researcher gained a better understanding of how the environment impacts the wellbeing of MHCUs. Furthermore, the strengths-based perspective was essential in demonstrating that MHCUs have strengths like any other person. More details of the theoretical framework were captured in chapter 2 of the present study.

10.6 Key findings and conclusions

The key findings and conclusions are discussed, based on the literature review, research methodology, and empirical findings of the study.

10.6.1 Key findings and conclusions of the literature review

The literature review comprised chapters 3, 4, and 5; the researcher had to gain comprehensive knowledge prior to data collection. The researcher wanted to obtain more knowledge about mental health and recovery-oriented mental health as this is not a familiar terrain for social work practice. The key findings are discussed below.

10.6.1.1 Mental health

This chapter focused on mental health care and mental health services. The following key findings are outlined:

- In Africa, the political socioeconomic and cultural features of the environment impact considerably on the degree of epidemiology and the natural history of psychotic illness and schizophrenia.
- Mental health care is persistently neglected in the African countries, including South Africa.
- Mental health policies indicate the government's determination to address the mental health needs of its population.
- In Africa, culture has a critical role in understanding the etiology of mental illness.
- Poverty is rife among people living with mental illness.
- Mental health services create a challenge for both developing and developed countries, although the nature of these challenges may differ.
- In Africa, as in other third-world countries around the world, there is a challenge with regard to resources and the political will to provide mental health services to people with mental illness.
- The provision of mental health services in South Africa is in line with the categorisation of the World Health Organisation (WHO, 2009) of mental health services,
- There is a call for mental health services to be integrated actively into primary health care.
- In South Africa, mental health services are delivered via the private and public sectors.
- Mental health care in rural areas has been consistently neglected over time.

Conclusions

Based on the information provided the following conclusion can be made:

- It can be concluded that mental health is a challenge of considerable proportions facing every country in the Southern African region.
- The researcher concludes that mental health is, and has been, consistently neglected in SA. However, significant strides have been made in improving mental health provision; for example, legislation, which is human rights based, has been put in place to benefit general health services.

- The researcher further concluded that culture plays a significant role in the way mental health problems are interpreted in SA communities as a result of the use of the traditional health system.
- It is clear that poverty is rife in families affected by mental illness, especially in rural areas.
- The researcher has no doubt that mental health services in rural areas are severely limited.

10.6.1.2 Schizophrenia

Chapter 4 focused on living with schizophrenia, caring for people living with schizophrenia, and the treatment thereof. The following key findings are outlined:

- It has been noted that living with schizophrenia is characterised by different challenges such as social impact, homelessness, lack of educational opportunities, employment opportunities, and health.
- Although individuals with mental disabilities may not be able to work during periods of untreated illness, thus limiting their earnings, the overwhelming majority of people with mental disorders who experience acute episodes interspaced with good health, can manage their illness with treatment and support.
- Someone with schizophrenia, much like a cancer patient who intermittently enjoys periods of remission, can for the most part lead a healthy life.
- However, for someone recovering from mental illnesses, discrimination severely limits income-generating opportunities.
- Treatments such as antipsychotic and psychosocial intervention are available.
- Psychosocial intervention aids individuals in maintaining and adhering to their medication, learning social skills, and supporting their goals and community activities.
- Living with a relative with severe mental illness is stressful.
- Families are now caring for persons with schizophrenia in the community.
- Caregivers do not have adequate knowledge and support; they might not be able to take up the responsibilities of taking care of mentally ill persons, thus leading to relapse or readmission.

- Some individuals with schizophrenia may have residual symptoms, and impaired cognitive and social functioning; these could be a significant family concern, and would only add to the burden which caregivers have to contend with.

Conclusions

The following can be concluded :

- It can be concluded that living with schizophrenia is encumbered with different challenges.
- However, there is treatment available that is effective in managing the symptoms, and MHCUs must be linked with resources which would ease the way to recovery.
- It can be concluded that people living with schizophrenia can lead healthy lives, provided the illness is under control through medication.
- Furthermore, it can be concluded that caring for people living with schizophrenia can be stressful and result in often overwhelming caregiver burden.
- It can be concluded that caregivers require the necessary support in order to deal with this situation.

10.6.1.3 Social work in mental health care

Chapter 5 focused on social work in mental health care and recovery-oriented mental health care. The following key findings are outlined:

- Social work profession has a critical role to play in mental health care,
- Social workers regard themselves as ill-equipped to deal with this task.
- It is evident that there is a dearth in articles authored by social workers on recovery-oriented mental health practice.
- Literature indicates a link between the values of social work and the principles of recovery-oriented mental health practice.
- The role of social workers in mental health care is often disregarded or misunderstood.
- Globally, there is a paradigm shift as far as mental health services are concerned.

- Recovery and recovery-oriented mental health practice have taken centre stage in the mental health arena.
- Mental health professionals are required to work in collaboration with people living with mental illness.
- People with lived experiences of schizophrenia can contribute substantially to the recovery movement.
- However, a recovery approach has not yet been tried in South Africa.
- Countries such as Australia, Canada, UK, and the USA have implemented recovery-oriented practice with success; and also approaches of recovery such as a recovery model, tidal model, and wellness recovery action plan (WRAP).
- Furthermore, there are scales used to measure recovery such as an empowerment scale, recovery assessment scale, and illness management and recovery scale.

Conclusions

The following conclusions are made:

- It can be concluded that social work has a critical role to play in mental health care.
- It is evident that there is a lack of knowledge in mental health care among social workers, and that training is needed in this regard.
- It can be concluded that mental health services are in the process of being transformed significantly, and that recovery and the recovery-oriented mental health practice are at the centre of mental health service delivery.
- The researcher concludes that people living with mental illness should be leading the process while working in collaboration with professionals.
- It can also be concluded that SA has not yet tried this approach but that globally, some countries have made some strides in implementing such an approach.
- It can be concluded that recovery-oriented practice involves approaches such as a recovery model, tidal model, and wellness recovery action plan that can be utilised in practice.

10.7 Key findings and the conclusions of the empirical study

The present study has employed a mixed-methods approach, namely qualitative and quantitative approaches. These approaches are discussed separately, and the subsequent discussion is based on the empirical findings of the qualitative approach.

10.7.1 Empirical findings of the qualitative phase

The researcher provides the key findings and conclusions based on the targeted group, namely caregivers, mental health care users (MHCUs), social workers in the district, social workers in the hospital, and social work managers (chapters 7 and 9).

10.7.1.1 Key findings of caregivers (section A, chapter 7)

The section focuses on presenting the key findings of the caregivers. The key findings are set out in the table below.

Table 10.1: Key findings: Caregivers

Themes	Key findings: caregivers	Conclusions
Biographical details	Most of the participants were females aged between 39 and 64 years. They were all unemployed and were struggling to make ends meet.	The caregivers of the mental health care users were elderly females and who were unemployed.
Mental health care	The findings depict that most of the participants ascribed mental illness to witchcraft. The findings revealed that cultural beliefs influenced the help-seeking behaviours of the participants; they consulted the traditional or spiritual healer before going to the hospital.	Cultural beliefs played a major role in the understanding of mental illness and the influence of the help-seeking behaviour of the participants.
Mental health services	The findings show that most of the participants were satisfied with the mental health services received from the hospitals and clinics. The findings revealed that most of participants received treatment at a home-based centre, working predominantly with community health nurses.	Mental health services were accessible and satisfactory. The services were rendered in the hospitals and clinics where the MHCUs receive their treatment. However, social work services were limited.

Themes	Key findings: caregivers	Conclusions
	They had never solicited services from social workers unless other mental health care practitioners referred them. However, one participant went to the social worker but she did not receive any assistance.	It can be concluded that social work services in mental health care were ineffective
Diagnosis and treatment	The findings show that most of participants did not know the diagnosis and the treatment of the mental health care users that they cared for. The findings depict that most of the participants acknowledged that it was important for the mental health care users to adhere to their treatment. Some participants stopped the treatment of the mental health care users in their care without consulting the mental health professionals. This was ascribed to the side-effects of the treatment.	There was a lack of knowledge of mental illness and treatment of mental health care users The cessation of treatment can be apportioned to the side-effects
Experiences of caring for a person living with schizophrenia	The findings depicted that the roles of the participants were physical and materialistic in nature. The findings revealed that the participants experienced challenges in caring for mental health care users. Most of the participants were experiencing stigmatisation and discrimination from the community. The findings portrayed that most of the participants had diverse needs, varying from respite care and day care centres to material assistance. The findings highlighted that some participants received assistance from family members, while others did not get any support.	Caregivers were responsible for providing the physical and material needs of the mental health care users, and this came with challenges. Stigma and discrimination were rife in the community. Respite care, day-care centres, and material assistance were required. Family support was limited.

Based on the above-mentioned findings, it is evident that the caregiving tasks rendered by elderly females were overwhelming and that they needed support from the social workers. Brofenbrenner (1974:2) describes the interactions and relationships that individuals have with their immediate surroundings. It is clear that caregivers have a critical role in facilitating the recovery process of MHCUs.

10.7.1.2 Key findings of the mental health care users (section B, chapter 7)

The section focuses on the key findings of the mental health care users. The key findings and conclusions are set out in the table below.

Table 10.2: Key findings: MHCUs

Themes	Key findings: MHCUs	Conclusions
Biographical details	Most of the participants were males and one female, aged between 24 and 81 years. They were all inpatients in mental health facilities. They were all diagnosed with schizophrenia and the majority were on treatment. Most of them had post-secondary education.	Mental health care users were admitted at the mental health facilities, diagnosed with schizophrenia, and they had been residents for a long period. Predominantly, the participants were males, while only one female participated. Most of the participants had a post-secondary level of education.
Mental health care	The findings depicted that most of the participants ascribed their mental illness to witchcraft. Some participants regarded this as merely an illness. The findings revealed that cultural beliefs influenced the help-seeking behaviours of the participants, The findings depicted that the participants consulted a	Cultural beliefs play a major role in the understanding of mental illness and the influence of help-seeking behaviour on the participants. Moreover, some participants regarded this as merely an illness.

Themes	Key findings: MHCUs	Conclusions
	traditional or spiritual healer before going to the hospital. Few of the participants went to the hospital straight away, without consulting alternative healthcare services.	
Mental health services	The findings showed that most of the participants were satisfied with the activities they were involved in at the hospital, such as sewing, car washing, gardening, project piggery, recreational activities, and occupational therapy services. The findings revealed that most of participants received services from the multidisciplinary team, such as social workers, doctors and nurses. Social workers had a major role in linking them with their families. Most participants received support from various organisations from the community and from other individuals.	The hospitals provided activities to stimulate the MHCUs such as sewing, car washing, piggery, occupational therapist services, and gardening projects. The multi-disciplinary team played a major role in providing services; and social workers had a major role in linking participants with their families.
Experiences related to the specific illness	The findings depicted that most of the participants had knowledge and insight into their illness. The doctor or nurse informed most of the participants of their illness.	The participants had knowledge and insight into their diagnosis. The mental health care practitioners such as doctors and nurses were responsible for divulging the diagnosis of mental illness.

Themes	Key findings: MHCUs	Conclusions
Treatment of illness	Most participants were knowledgeable about the treatment regimen they were receiving for their illness, and were able to state the names of their medication. Most participants were aware of the importance of taking medication, and they were aware that if they defaulted they would relapse. Some participants had experienced different side effects such as shaking, feeling weak, sleeplessness, and loss of concentration. However, some had never experienced any side effects.	All participants had knowledge of their treatment and the importance of adhering to their treatment regimen. Participants had insight into their illnesses and accepted their condition. However, the side effects were affecting their well-being.
Challenges of living with mental illness, and needs	Most participants had accepted their illness and developed good agencies to manage the illness. Most of the participants were keen to join the labour market, whatever the challenge, as they had been hospitalised for a long period. Most of the participants experienced rejection from their families. Most of them experienced stigmatisation and discrimination from the community.	The participants accepted their illness and they had developed good strategies in managing their illness Independent living and reintegration in the community were of the outmost importance Their families rejected them, which resulted in their spending a longer period of time in the hospital. Stigma and discrimination were rife in the community.

It is evident that the participants had very specific needs; however, as they were inpatients in mental health facilities, they could not realise their aspirations. Ecological systems theory focuses on how individuals adapt to environmental demands; it focuses on how individuals' needs, capacities, and opportunities for both growth and the ability to adapt to changing external demands are met, provided for, and challenged by the environment. Therefore, MHCUs have to adapt within their mental health status and take charge of their recovery process.

10.7.1.3 Key findings of social workers in the districts and hospitals (section C, chapter 7)

This section focuses on the key findings of social workers in the districts and hospitals.

The key findings and conclusions are presented in the table below.

Table 10.3: Key findings: Social workers in district and hospitals

Themes	Key findings: social workers in districts and hospitals	Conclusions
Biographical details	Most participants were females who worked for the DSD and DOH in Limpopo. The ages of these participants ranged from 25 to 51 years. However, the ages of social workers in the hospitals ranged from 22 to 45 years. Most of the social workers graduated at the University of Venda and University of Limpopo.	Predominantly, the participants were females and most graduated at the Universities of Venda and Limpopo.
Mental health services	Social workers in the DSD rendered generic services, and mental health cases were referred to the hospitals. However, social workers in the hospitals were rendering treatment and rehabilitation services, and also referred patients to the mental health facilities for observation after 72 hours. They also referred to the	Generic social work services were rendered by social workers in the districts who also render mostly general disabilities services. In most offices of the DSD, mental health services were not rendered.

Themes	Key findings: social workers in districts and hospitals	Conclusions
	other team members in the multidisciplinary teams. Most of the DSD social workers were not rendering mental health services; they were of the view that mental health services were the responsibility of the DOH. The services provided by the Department of Social Development focus on disabilities in general. Social workers in the hospitals were rendering mental health services. Both the social workers in the districts and hospitals deemed mental health services ineffective. Lack of knowledge and skills in dealing with mental health-related cases prevail among social workers from both the DSD and DOH. Lack of supervision in mental health care was evident. Social workers in the hospitals demonstrated a lack of knowledge of the DSM and the various types of mental illness. Social workers in the hospitals demonstrated a lack of knowledge of admission procedures as stipulated by the Mental Health Act (No 17 of 2002) and treatment provided to mental health care users Most participants needed training in mental health care. A lack of infrastructure such as office space and community-based centres were identified by social	Social workers in the hospitals rendered treatment and rehabilitation services, preparation for discharge, tracing family and family reunifications a well as psychoeducation, and individual and group work. Mental health services were viewed ineffective. Limited knowledge skills in mental health care were demonstrated. Limited knowledge of DSM, legislation and types of mental illnesses were demonstrated. There is a need to train social workers and supervisors in mental health care. Inadequate and non-existent infrastructure was emphasised.

Themes	Key findings: social workers in districts and hospitals	Conclusions
	workers from both the DSD and DOH.	
The main tasks of the social worker regarding mental health	Social workers in both the districts and hospitals described their tasks as similar, such as assessments, counselling and community awareness. Social workers in the districts rendered other services such as support groups, monitoring, home visits, referrals, psychosocial support, practical support, placement in the residential facilities, and day-care centres, and providing support to the families. However, they experienced that families were not willing to participate when the patients are in the hospital. Social workers in the hospitals rendered other services such as family reunification, tracing families, psychoeducation, preparing MHCUs for discharge, rendering individual and group work for prevention and promotion services, and advocating for the rights of patients.	Participants rendered treatment and rehabilitation services, preparation of discharges, tracing families and family reunifications, psychoeducation. Families were not interested in becoming involved when patients were admitted in the hospitals.

Based on these findings, it was evident that there was a lack of mental health knowledge and training. Gray and Webber (2013:179) assert that social work should seek innovative ways to conceptualise the relationship between the individual and the environment.

10.7.1.4 Key findings of social work managers (section D, chapter 7)

The section focuses on the key findings of the social work managers. The key findings and the conclusions are presented in table below.

Table 10.4: Key findings: Social work managers

Themes	Key findings: social work managers	Conclusions
Biographical details	Most participants were females and two were males, they were working for DSD and DOH in Limpopo. The age of these participants ranged from 37 to 56 years. The participants graduated from different universities, three graduated from the University of Venda, two from the University of Pretoria, while two graduated from the University of Limpopo, and another from the University of Durban Westville. Three participants had postgraduate qualifications.	Predominantly, the participants were females.
Mental health services	Mental health services in their opinion included prevention, assessment, intervention services - such statutory funding, and monitoring of mental health programmes. However, some participants reported no mental health services were rendered where they were working. Diverse views pertaining to effectiveness prevailed; some were of the view that they were effective while others were of the opinion that they were ineffective. Lack of resources and planning of mental health services were evident.	The social workers they supervised regarding mental health services, rendered prevention, assessment and intervention services; however, some offices were not rendering any mental health services. Different perceptions regarding effectiveness were evident; some reported effectiveness while others viewed the services as ineffective. Limited resources and lack of proper coordination of mental health services prevailed. There was a need to train social workers and supervisors in mental health care. However, lower scale social work managers would

Themes	Key findings: social work managers	Conclusions
	Improving working conditions of social workers was emphasised. Lack of capacity of social workers and managers regarding mental health care was emphasised. Supportive services rendered to social workers were inefficient. In-service training was provided to social workers to help them cope with their work demands. Some participants were not confident in supervising social workers in mental health, as they lacked knowledge in this regard. Protocols and guidelines were needed to render mental health supervision appropriately.	conduct in-service training and supportive services to assist social workers to cope with their work demands. Limited knowledge regarding mental health care was emphasised. There was a need for the development of protocols and guidelines. to be developed with regards to mental health care.
The main tasks of the social worker regarding mental health	Tasks of social workers they supervised were identified as primary intervention, intake, casework, group work, community work, generic social work, and assistance with treatment adherence, family support, placements, and tracing of families.	The tasks performed by social workers were generic social work, intake, casework, group work, community work, treatment adherence, family support, placements, tracing of families, and family support.
Support provided by managers to social workers in mental health hospitals	Most participants indicate they were providing support when social workers had challenging cases. In-service training was provided to assist social	Supportive services provided by social work managers to support social workers rendering mental health care. In-service training organised to capacitate social workers

Themes	Key findings: social work managers	Conclusions
	workers working in mental health facilities. Supervision was rendered; however; managers felt incapacitated to be effective in supervision.	working in mental health facilities. Supervision is rendered either in an individual or group method. Social work managers felt incapacitated to render effective supervision.

Based on the findings, it was evident that social work services in mental health were viewed as ineffective. There was a lack of resources and a lack of training with regard to mental health. Supervision was ineffective as social work managers also lacked knowledge of mental health. Gray and Webber (2013:179) assert that social work should seek innovative ways to conceptualise the relationship between the individual and the environment.

10.7.2 Key findings of the quantitative phase

The researcher provides the findings of the quantitative approach, and more details are provided below.

10.7.2.1 Expectations of training

The social work respondents identified five themes, and their expectations were listed as mental health and illness, caregivers and mental health care users, social work in mental health, recovery and social work, and recovery-oriented mental health practice.

10.7.2.2 Key findings and conclusions

The table below focuses on the key findings of social workers' expectations of the training.

Table 10.5: Key findings

Sections	Key findings	Conclusions
Biographical details	The majority of respondents were females with only a few men, and the ages ranged from 24 to 54 years. All the respondents were Africans. Most of the respondents were working for the DSD and DOH in Limpopo. Some were working at the sub-district offices of the DSD**;** some were working at the district hospitals, and others were working in the health centre of the DOH. All the respondents had a BA (SW) or BSW qualification, and the majority had graduated from the University of Venda and the University of Limpopo.	The respondents were mainly female, which is generally the case in the social work profession. They were Africans and this was based on the geographic area of the present study. They were working for the DSD and DOH. The respondents possessed a BA (SW) or BSW qualification, and the majority had graduated from the Universities of Venda and Limpopo.
Mental health in general	Prior to the CROCMEHC training programme, most respondents reported that they had average knowledge, while some respondents indicated that they had no knowledge at all. Moreover, after the training, some respondents indicated that they had excellent knowledge, while	The majority of respondents had limited or no knowledge at all. The respondents acquired increased knowledge on mental health in general after training in the CROCMEHC programme.

Sections	Key findings	Conclusions
	most respondents reported that they had average knowledge. With regard to mental health training, during the pre-test, the majority of the respondents did not have training at all from undergraduate and postgraduate degrees regarding mental health. The majority of respondents were engaging in self-study in order to acquire knowledge in mental health.	
Knowledge regarding mental health and mental illness	Most respondents had limited knowledge of mental health, mental illness, and the types of mental illnesses before the training, while after the training, there was increased knowledge in the afore-mentioned issues.	The CROCMEHC training programme has provided some light on mental health and types of mental illness. There was an increased knowledge regarding mental health and mental illness.
Schizophrenia as a classification of mental illness	Both in the pre-test and post-test, the respondents were able to define schizophrenia. They managed to define schizophrenia accurately; hence, there was no knowledge gained in this regard. Prior to the training most respondents had limited knowledge regarding the tools used to diagnose schizophrenia, symptoms, the specifiers of schizophrenia, treatment of schizophrenia and side-effects thereof while in the post-test, there was an increase of knowledge.	The respondents had knowledge of what schizophrenia was. They had limited knowledge of the tools used to diagnose schizophrenia. After the CROCMEHC training programme, there was an increased level of knowledge.
People living with schizophrenia (mental health care users)	The majority of respondents ascribed mental illness to cultural connotations.	Mental illness in general is usually attributed to cultural beliefs.

Sections	Key findings	Conclusions
Caregivers of people living with schizophrenia	The majority of respondents agreed that the family had a pivotal role in caring for people living with schizophrenia. Most respondents ascribed the age, years of caring, and stages of illness to the challenges experienced by the caregivers.	The family has a pivotal role in caring for people with schizophrenia. Caregivers experienced different challenges, based on their age, years of caregiving, and the stage of illness.
Social work in mental health care	Both in the pre-test and post-test, the respondents working in the hospitals and health centres had knowledge of the tasks performed by hospital social workers. Most of the respondents working in the districts felt that mental health is not within the scope of their practice.	Social workers working in the hospitals had knowledge of the roles they played in mental health care. However, social workers in the districts felt mental health care did not fall within their scope of practice.
Training needs in mental health care	Most of the respondents expressed a need to be trained in mental health care. This need has been raised in both pre-test and post-test questionnaires.	There was a lack of knowledge and capacity in mental health care. There was a need for training in mental health care. Social workers are willing to enhance their knowledge in mental health.
Mental health intervention	Both in the pre-test and post-test, the respondents had basic knowledge of mental health intervention such as counselling, and working in multidisciplinary teams.	Social workers on their day-to-day functioning render services to MHCUs such as counselling and working in multidisciplinary teams. There was no knowledge gained in this aspect, as social workers already had the knowledge prior to the training.
Knowledge acquired in mental health care	The majority of respondents acquired knowledge, as demonstrated in the post-test, after	After the CROCMEHC programme training, the majority of respondents had

Sections	Key findings	Conclusions
	the training, as compared to the limited knowledge reported initially in the pre-test.	an increased level of knowledge.
Recovery and social work	The respondents strongly believed that empowerment, hope, self-direction and a strengths-based perspective had a positive impact on recovery of people living with schizophrenia. Moreover, in the post-test, they believed that disempowerment and restraining had a negative impact on the recovery of people living with schizophrenia.	Recovery has been deemed a powerful tool that can enhance empowerment, hope, self-direction, and strengths of MHCUs. Social workers believe recovery can positively impact the lives of people living with schizophrenia. Restraining and disempowerment were perceived as restricting that can hinder the recovery of the people living with schizophrenia.
Recovery-oriented mental health practice	Most of the respondents agreed that recovery-oriented mental health practice supports people in defining their goals, helps people understand mental illness, and acknowledges the diversity of people.	Recovery-oriented mental health practice is deemed an appropriate practice that can be applicable in the SA rural context. The practice can support people living with schizophrenia to find meaning in their lives.
Similarities of social work values and recovery-oriented mental health care	In the pre-test, most of the respondents exhibited limited knowledge on the similarities of social work values and recovery-oriented mental health care. Moreover, most of the respondents showed increased knowledge in this regard in the post-test.	There was a lack of knowledge of what could be the similarities of social work and recovery-oriented principles. After the CROCMEHC training programme, there was an increased level of knowledge. Social workers were made aware of the synergy between recovery-oriented principles.

Sections	Key findings	Conclusions
Evaluation of CROCMEHC programme	The majority of respondents felt that the CROCMEHC training programme could assist social workers in gaining more knowledge in mental health. The respondents viewed the CROCMEHC training programme as beneficial, and they acquired knowledge of mental health care and recovery-oriented mental health care through the training. The respondents recommended that the programme be provided for a longer period, be continuous, be incorporated in the social work curricula, and be adopted in the provincial government plans. The respondents indicated that the CROCMEHC programme was presented well, and the manual designed creatively. They felt that the facilitator was excellent. The programme should involve other mental health practitioners such as nurses, psychologists, and psychiatrists. Mental health care users should be involved.	There was information acquired in the CROCMEHC training programme regarding the mental health intervention. The CROCMEHC programme has managed to impact knowledge, and social workers deemed it beneficial for the social work profession as a whole. It should be adopted in the social work curricula, be conducted over a longer period, and be adopted in provincial government plans. It was recommended that case studies and visuals be included. Other mental health care practitioners should be involved in the CROCMEHC programme.

Based on these results, it is evident that the CROCMEHC programme has impacted the knowledge of social work respondents regarding mental health care and recovery-oriented mental health practice. The CROCMEHC programme has been deemed beneficial, and it can be incorporated in the social work curriculum. Ecological systems theory and the strengths-based perspective were appropriate as they assisted the researcher in understanding the circumstances of the caregivers, MHCUs, social workers, and social work managers.

10.8 Recommendations

Based on the key findings and the conclusions, the recommendations are discussed from the qualitative and quantitative approaches. Each phase will be discussed separately.

10.8.1 Recommendations from the qualitative approach

10.8.1.1 Recommendations with regards to caregivers and mental health care users (MHCUs), are as follows:

- Psycho-education aimed at social workers relating to the onset of schizophrenia, its diagnosis, treatment, and side effects is essential.
- Understanding the cultural connotations in the treatment of mental illness is necessary.
- Social workers play a critical role in assisting caregivers of people living with schizophrenia.
- The establishment of respite and support group services are needed.
- Recovery-oriented mental health services should be adopted for MHCUs in mental health facilities (hospitals).
- Social workers should facilitate the reintegration of MHCUs into community activities, and encourage family involvement.
- Community awareness is to be encouraged in order to reduce the stigmatisation faced by caregivers and MHCUs.
- The promotion of independent living for MHCUs is encouraged, as they should not be admitted to mental health facilities for long periods of time.
- Establishment of community-based centres such as vocational rehabilitation centres, day-care centres, halfway houses, clubhouses, and step-down facilities in rural areas.
- Social workers should facilitate the re-integration of MHCUs into the labour market.

Recommendations with regards to social workers and social work managers in the districts, hospital and provincial offices

- Mental health care practice should be classified as a specialty in social work.
- The task and roles of social work in mental health should be clarified.
- Social workers should be capacitated in the legislative frameworks of mental health care and the DSM.
- Train social workers in mental health through in-service training, workshops, and short courses for continued professional development.
- Provision of adequate infrastructures for social workers employed by the DSD and DoH as well as adequate resources such as offices, computers, phones, and cars is necessary.
- Recovery-oriented mental health practice should be adopted in the field of social work.
- Train social workers and social work managers in recovery-oriented mental health practice.
- Supervision should be strengthened in the DSD and DoH; and individual and group supervision should be enhanced.
- Social work managers should be capacitated to render effective supervision to social workers in mental health care.
- Social work managers must ensure that they support social workers rendering mental health services.
- Social work managers should facilitate the proper coordination of mental health services by social workers.
- Social work managers must develop protocols and guidelines with regard to social work in mental health care.

10.8.2 Recommendations of the quantitative approach

- The CROCMEHC programme should be refined and adopted as a fully-fledged programme for social workers in practice, and be incorporated in the undergraduate social work curricula of universities.
- A short course should be developed for continuity professional development (CPD). Social workers expressed an interest in follow-up training; this will further necessitate the practical implementation of the CROCMEHC programme.
- The CROCMEHC programme training should be presented over a period of five days.
- Training should include other team members of the multidisciplinary team; and the CROCMEHC programme should be integrated in this process.
- Training in managing chronic mental illness should be made available to caregivers and mental health care users in both rural and urban areas.

10.8.3 Recommendations for future research

For future research, the following should be considered:

- Implementation of additional phases of intervention research.
- Similar studies should be conducted in all provinces as the present study only focused on three districts in Limpopo Province.
- A study should be conducted for mental health care users and caregivers to ascertain their levels of understanding regarding recovery-oriented principles.
- Researchers should target multidisciplinary team members working with people with mental illnesses.
- The CROCMEHC programme should be refined and tested in semi-rural areas.
- The CROCMEHC programme should be implemented in urban areas.
- The evaluation of the effectiveness of CROCMEHC programme in other mental illness other than schizophrenia is encouraged.
- Large-scale studies which focus on other racial groups are encouraged.

- Studies in social work are encouraged using the recovery model, tidal model, and wellness recovery action as a theoretical framework.

10.8.4 Recommendations for policy

- Development and implementation of recovery-oriented mental health practice in hospitals, centres, and districts.
- Development of policies which are recovery-oriented in all disciplines.
- Development of guidelines on recovery-oriented mental health services for social workers in government departments.
- Inclusion of recovery-oriented mental health care in the curricula in social work schools.
- Recognition of mental health care as a specialty by the SACSSP.
- The Mental Health Act (No 17 of 2002) should be revised to incorporate a recovery-oriented stance.
- DoH should ensure that recovery-oriented mental health practice is implemented as stipulated in the National Mental Health Policy and Strategic Plan (2013-2020).

10.9 Limitations and strengths of the study

Limitations

A number of limitations were identified during the course of this study:

- It proved to be difficult to find caregivers who visit hospitals to participate; the researcher planned to interview fifteen participants from the three hospitals; however, it was established that caregivers do not visit the MHCUs in these mental health facilities. Caregivers were not involved in the lives of the MHCUs once they were admitted. Hence, the researcher was obliged to change the sampling method from purposive sampling to snowball sampling. She travelled to a village in Malamulele but only managed to interview five participants.
- The clinical manager of Thabomoopo Hospital refused the researcher entry to the hospital. This was after the researcher had made appointments through the chief

executive officer, who gave her permission to collect data at the hospital. On the appointed day, the researcher went to the hospital but, unfortunately, the CEO was not available. The CEO was called, who instructed that the clinical manager should assist. The researcher was allowed to proceed. The clinical manager, however, still refused to assist. As a result, research at Thabomoopo Hospital was not conducted as planned.

- The shortage of offices, and the resultant lack of privacy, turned out to be a limitation. Employees shared office space, and the interviews were conducted in the presence of others. The constant movement of clients in and out of these offices caused an unceasing disturbance and lack of privacy. The telephones were also ringing constantly. All of these factors could have affected the richness of the data.

- A pilot study could not be done with the caregivers and mental health care users. The researcher planned to conduct this in Waterberg District. She was denied access by the CEO of Modimolle Hospital.

- At the time of the second phase of the study, social workers in Limpopo were on a go-slow strike. As a result, only 10 social workers in Mopani District attended training in the CROCMEHC programme, instead of the 37 social workers who initially registered. The researcher designed and printed materials and certificates at a cost of nearly R30 000 of her own money for the training; but in the end the turnout was very low, resulting in a substantial loss. Ten social workers attended; and the manager agreed to attend the training and recruited four social workers as substitutes for those who were on the go-slow strike. This is the convenience/accidental sampling method mentioned in sampling section in chapter 6. As a result, the researcher had to print new certificates, incurring additional costs. The cost (calculated per head) of food, refreshments, and the use of the venue resulted in a substantial loss .

- In Vhembe District, twenty-seven social workers attended the training and three did not. The researcher had to incur an additional cost to provide certificates for those who replaced the social workers who did not attend.
- This was a very costly exercise as the researcher did not have a sponsor and had to use her personal funds.
- The training on the 2 days was intended to start at 8:00, but due to the strike and many respondents not arriving, accidentalsampling had to be done there and then to recruit more respondents. Thus the training only started at 11:00 and had to be rushed, which could have affected the quality of the data collected and evaluation of the training.

Strengths

The strengths of the present study were identified as follows:

- Despite all these challenges, most of the respondents were grateful for the training, and they requested that this training be allocated more time in future. They also recommended that the programme be incorporated in the curriculum of the Bachelor of Social Work programme.

Utilisation of the mixed-methods approach contributed to a comprehensive study:

- The researcher has learnt that MHCUs are able to clearly and unambigiously articlute their needs and challenges.
- A qualitative approach has provided an enriching experience.
- The possibilities for CROCMEHC are endless.
- Once finalised, CROCMEHC can be implemented on a large scale.
- The literature review proved to be enriching and empowering.
- The quantitative phase was a rewarding experience.
- The preliminary/pilot phase was effective.
- CROCMEHC proved to be beneficial

- The use of an independent coder reinforced the trustworthiness of the study.

10.10 Concluding remarks

MHCUs are competent and they can live fruitful lives. Caregivers need assistance and support to care for MHCUs. Social workers and social work managers need to be capacitated in mental health and recovery-oriented mental health practice.

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Appendix A: Ethical clearance from the University of Pretoria

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Faculty of Humanities
Research Ethics Committee

19 June 2014

Dear Prof Lombard

Project:	**A recovery-oriented social work programme for mental health in a rural area in South Africa**
Researcher:	**NJ Bila**
Supervisor:	**Dr CL Carbonatto**
Department:	**Social Work and Criminology**
Reference numbers:	**23189259**

Thank you for your response to the Committee's correspondence of 5 June 2013.

I have pleasure in informing you that the Research Ethics Committee formally **approved** the above study at an *ad hoc* meeting held on 18 June 2014. Data collection may therefore commence.

Please note that this approval is based on the assumption that the research will be carried out along the lines laid out in the proposal. Should your actual research depart significantly from the proposed research, it will be necessary to apply for a new research approval and ethical clearance.

The Committee requests you to convey this approval to the researcher.

We wish you success with the project.

Sincerely

Prof. Karen Harris
Acting Chair: Research Ethics Committee
Faculty of Humanities
UNIVERSITY OF PRETORIA
e-mail: karen.harris@up.ac.za

Appendix B: Permission from DSD

LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

DEPARTMENT OF

SOCIAL DEVELOPMENT

Confidential

Ref : S5/3/1/2
Enq : Ledwaba MS
Tel : 015 293 6466
Date : 08 April 2015

To : Ms Bila NJ

RESPONSE ON THE REQUEST TO CONDUCT A RESEARCH STUDY TITLED: A RECOVERY-ORIENTED SOCIAL WORK PROGRAMME FOR MENTAL HEALTH IN A RURAL AREA IN SOUTH AFRICA

1. The above matter refers to the letter dated, **04 March 2015**.
2. The Department of Social Development hereby grant permission to conduct the above-mentioned research study, on the provision that the Ethics Committee for the University of Pretoria provided clearance for the study.
3. **NB**. On completion of the study, a copy of the mini dissertation should be submitted to the Department in honour of your commitment.
4. The Department take this opportunity to wish you well during the period of research.

SENIOR MANAGER: HUMAN CAPITAL DEVELOPMENT AND ORGANISATIONAL STRATEGY

DATE 21/04/2015

18 College Street, Polokwane, 0700, Private Bag x9710, POLOKWANE, 0700
Tel: (015) 293 6027, Fax: (015) 293 6211/20 Website: http/www.limpopo.gov.za

Appendix C: Permission from DoH

LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

DEPARTMENT OF HEALTH

Enquiries: Latif Shamila Ref:4/2/2

Bila Nontembeko J
University of Pretoria
P. O. Box 667
Pretoria
0001

Greetings,

Re: A recovery –orientated social work programme for mental health in a rural area in South Africa

1. The above matter refers.
2. Permission to conduct the above mentioned study is hereby granted.
3. Kindly be informed that:-
   - Further arrangement should be made with the targeted institutions.
   - In the course of your study there should be no action that disrupts the services.
   - After completion of the study, a copy should be submitted to the Department to serve as a resource.
   - The researcher should be prepared to assist in the interpretation and implementation of the study recommendation where possible.

Your cooperation will be highly appreciated.

Head of Department

16/07/2014
Date

18 College Street, Polokwane, 0700, Private Bag x9302, POLOLKWANE, 0700
Tel: (015) 293 6000, Fax: (015) 293 6211/20 Website: http/www.limpopo.gov.za

The heartland of Southern Africa - *development is about people*

Appendix D: Interview schedule - social workers

SEMI-STRUCTURED INTERVIEW SCHEDULE FOR SOCIAL WORKERS

Goal of this study

To develop, implement and evaluate a social work intervention programme aimed at recovery-oriented practice in rural areas.

SECTION A: BIOGRAPHICAL DETAILS OF THE PARTICIPANTS

Age distribution

20-25 yrs		26-31 yrs		32-37 yrs		38-42 yrs		43-47 yrs		48-50 yrs	

Marital status

Single		Married		Divorced		Widowed		Living with partner	

Language

Sepedi	Tswana	Sotho	Tsonga	Venda	English	Afrikaans	Other, specify

Gender

F		**M**	

Qualification

SW Diploma		BA SW		BSW Honours		Master's Degree		Doctorate		Other, specify

Name of institution that you have studied at:

UP	Wits	UCT	UFS	UNISA	UNW	U L	Univen	Walter Sisulu	UWC	Other , specify

When attained?

Area of practice

Vhembe	Area:	Mopani	Area:	Capricorn	Area:

Years of employment

>1 yr		1yr		2yrs		3yrs		4yrs		5yrs		6yr+	

SECTION B: MENTAL HEALTH CARE

MENTAL HEALTH SERVICES

What mental health services provided in your community where you work?

How effective are these services? Explain in your own views.

What are the needs in terms of improving the services?

NATURE OF SOCIAL WORK SERVICES

What is the nature of services you render as a social worker?

What would you say is the main focus or goal of intervention with Mental Health Care Users (MHCUs)?

In your own opinion, how effective are social work services?

What do you think must be done differently in order to improve social work services?

What are your needs as social worker for better services?

Do you have contact with social workers in psychiatric hospitals?

What are the main types of referrals you get?

What are the types of referrals you do?

KNOWLEDGE AND SKILL OF MENTAL HEALTH CARE

Have you undergone or have any training or in service training in mental health care?

Do you have an understanding of the DSM classification manual?

Do you know about the Mental Health Care Act?

Do you ever read more about mental health care?

Do you get any support (supervision) regarding mental health care cases from your supervisor?

CHALLENGES EXPERIENCED WHEN PROVIDING MENTAL HEALTH CARE SERVICES

What are the challenges you experienced regarding mental health care services?

How do you deal with these challenges?

Do you get any support from your supervisor in addressing these challenges?

RECOMMENDATIONS

What are your recommendations regarding mental health care services?

Appendix E: Interview schedule – social work managers

SEMI-STRUCTURED INTERVIEW SCHEDULE FOR SOCIAL WORK MANAGERS

Goal of this study

To develop, implement and evaluate a social work intervention programme aimed at recovery-oriented practice in rural areas.

SECTION A: BIOGRAPHIC DETAILS OF THE PARTICIPANTS

Age distribution

20-25 yrs		26-31 yrs		32-37 yrs		38-42 yrs		43-47 yrs		48-50 yrs	

Marital status

Single		Married		Divorced		Widowed		Living with partner	

Language

Sepedi	Tswana	Sotho	Tsonga	Venda	English	Afrikaans	Other, specify

Gender

F		**M**	

Qualification

SW Diploma		BA SW		BSW Honours		Master's Degree		Doctorate		Other, specify	

Name of institution that you have studied at:

UP	Wits	UCT	UFS	UNISA	UNW	U L	Univen	Walter Sisulu	UWC	Other , specify

When attained?

Area of operation

Vhembe	Area:	Mopani	Area:	Capricorn	Area:

Years of employment

>1 yr		1yr		2yrs		3yrs		4yrs		5yrs		6yr+	

Years as a manager

>1yr		1yr	2yrs		3yrs		4yrs		5yrs		6yrs+	

SECTION B: MENTAL HEALTH CARE

MENTAL HEALTH SERVICES

What mental health services are provided by social workers in your area?

How effective are these services? Explain in your own views.

What are the needs in terms of improving them (services)?

NATURE OF SOCIAL WORK SERVICES

What is the nature of services rendered by social workers in your area?

What would you say is the main focus or goal of intervention with Mental Health Care Users (MHCUs) provided by social workers?

In your own opinion, how effective are social work services?

What do you think must be done differently in order to improve social work services?

What are the needs of social workers in order to render better services?

Do you provide any supportive service to social workers in psychiatric hospitals or social workers rendering services to mental health care users?

KNOWLEDGE AND SKILL OF MENTAL HEALTH CARE

Explain what in service training you provide to social workers regarding mental health care?

How do you ensure that social workers you supervise have sufficient knowledge and skill in mental health care?

Do you feel confident in supervising social workers working in mental health care?

CHALLENGES EXPERIENCED WHEN PROVIDING MENTAL HEALTH CARE SERVICES

What are the challenges experienced by social workers regarding mental health care services?

How do you deal with these challenges in order to support social workers?

RECOMMENDATIONS

What are your recommendations regarding mental health care services?

Appendix F: Interview schedule - hospital social workers

SEMI-STRUCTURED INTERVIEW SCHEDULE FOR HOSPITAL SOCIAL WORKERS

Goal of this study

To develop, implement and evaluate a social work intervention programme aimed at recovery-oriented practice in rural areas.

SECTION A: BIOGRAPHIC DETAILS OF THE PARTICIPANTS

Age distribution

20-25 yrs		26-31 yrs		32-37 yrs		38-42 yrs		43-47 yrs		48-50 yrs	

Marital status

Single		Married		Divorced		Widowed		Living with partner	

Language

Sepedi	Tswana	Sotho	Tsonga	Venda	English	Afrikaans	Other, specify

Gender

F		**M**	

Qualification

SW Diploma		BA SW		BSW Honours		Master's Degree		Doctorate		Other, specify	

Name of institution that you have studied at:

UP	Wits	UCT	UFS	UNISA	UNW	U L	Univen	Walter Sisulu	UWC	Other , specify

When attained?

Area of practice

Vhembe	Area:	Mopani	Area:	Capricorn	Area:

Years of employment

>1 yr		1yr		2yrs		3yrs		4yrs		5yrs		6yr+	

SECTION B: MENTAL HEALTH CARE

MENTAL HEALTH SERVICES

What mental health services do you provide in your hospital where you work?

How effective are these services? Explain in your own views.

What are your needs in terms of improving the services?

NATURE OF SOCIAL WORK SERVICES

What is the nature of services you render as a social worker?

What would you say is the main focus or goal of intervention with Mental Health Care Users (MHCUs)?

In your own opinion, how effective are social work services?

What do you think must be done differently in order to improve social work services?

What are your needs as social worker for better services?

Do you have contact with area or field social workers?

What are the main types of referrals you get?

What are the types of referrals you do and to which organizations?

What would you say is your main task in the hospital

What would you say the team thinks your main task is?

Do you function and partake actively in the team on a daily basis - motivate

KNOWLEDGE AND SKILL OF MENTAL HEALTH CARE

Have you undergone or have any training or in service training in mental health care?

Do you have an understanding in the DSM classification manual?

Do you know about the Mental Health Care Act?

Can you explain what are the different admission procedures are according to the act for a MHCU?

Can you briefly explain how you understand the following mental health conditions?

Mood disorders

Bipolar mood disorders

Schizophrenia disorders

Anxiety disorders

Personality disorders

Psychosis or mania

What does the treatment of these patients entail?

Do you have ever read more about mental health care?

CHALLENGES EXPERIENCED WHEN PROVIDING MENTAL HEALTH CARE SERVICES

What are the challenges you experience when rendering mental health care services in your hospital?

How do you deal with these challenges?

Do you get any support from your supervisor in addressing these challenges?

RECOMMENDATIONS

What are your recommendations regarding mental health care services provided in psychiatric hospitals by social workers?

Appendix G: Interview schedule – caregivers

SEMI-STRUCTURED INTERVIEW SCHEDULE FOR CAREGIVERS

Goal of this study

To develop, implement and evaluate a social work intervention programme aimed at recovery-oriented practice in rural areas.

SECTION A: BIOGRAPHICAL DETAILS OF THE PARTICIPANTS

Age distribution

20-25 yrs		26-31 yrs		32-37yrs		38-42 yrs		43-47yrs	48-50 yrs	

Gender

Female		Male	

Marital status

Single		Married		Divorced		Widowed		Living with partner	

Language

Sepedi	Tswana	Sotho	Tsonga	Venda	English	Afrikaans	Other, specify

Area of residency

Vhembe	Area:	Mopani	Area:	Capricorn	Area:

Sources of income (mark all those are applicable)

Social grant		Employed		Partner		Other, specify	

Education level

Primary education		Secondary education		Tertiary education		Other, specify	

Number of dependants

1-2		3-4		5-6		7-8		9+	

Age distribution of dependants

< 1 yr		1-4yrs		5-9yrs		10-14 yrs		15-19 yrs		20 yrs	

In which hospital does your loved one get treatment?

Hayani Hospital	Evuxakeni Hospital	Shiluvani Hospital

How many years are you caring for your loved one?

< 1 yr		1yr		2yrs		3 yrs		5yrs		6 yrs+	

SECTION B: MENTAL HEALTH CARE

MENTAL HEALTH CARE SERVICES

What are your experiences of hospital services?

What are your experiences of multi-disciplinary team (nurses, doctors, social workers)?

What are your experiences of support you receive from other services like NGOs?

Have you consulted the traditional healer regarding the condition of your loved one?

How does culture view the illness of your loved one?

How does culture influence the way you view the illness of your loved one?

How does culture influence the choice of the treatment of your loved one?

MENTAL HEALTH CONDITION

What is the diagnosis of your loved one?

Which member of the team explained the condition of your loved one to you? Do you understand what this condition is, explain?

TREATMENT

Explain the treatment your loved one is receiving and why?

Explain the importance of taking the medication each day as prescribed.

What challenges does your loved one experience from taking the medication?

What happens when your loved one does not take the medication as prescribed?

Do you ever experience that the hospital does not have stock of the medication?

What happens if your loved one does not have any medication?

CHALLENGES AND NEEDS

Explain your challenge as a caregiver in your daily caregiving.

What do your tasks entail in caring for your loved one?

What are your needs as a caregiver?

Who are your support systems, in your family and community?

Who at the hospital provides support?

How often do you consult with the team or with someone at the hospital or clinic?

Tell me about the attitude of the community towards you knowing you are caregiving a MHCU?

Do you experience stigmatisation or rejection from the community regarding your loved one?

RECOMMENDATIONS

What are your recommendations regarding provision of mental health care services in the hospital or clinic?

Appendix H: Interview schedule – MHCUs

SEMI-STRUCTURED INTERVIEW SCHEDULE

Goal of this study

To develop, implement and evaluate a social work intervention programme aimed at recovery-oriented practice in rural areas.

SECTION A: BIOGRAPHICAL DETAILS OF THE PARTICIPANTS

1. **Age distribution**

20-25 yrs		26-31 yrs		32-37 yrs	38-40 yrs		

2. **Gender**

Female		Male	

3. **Marital status**

Single		Married		Divorced		Widowed		Living with partner	

4. **Language**

Sepedi	Tswana	Sotho	Tsonga	Venda	English	Afrikaans	Other, specify

5. **Area of residency**

Vhembe	Area:	Mopani	Area:	Capricorn	Area:

6. **Sources of income (mark all those are applicable)**

Social grant		Employed		Caregiver		Other, specify	

7. **Education level**

Primary education		Secondary education		Tertiary education		Other, specify	

8. **Number of dependants**

1-2		3-4		5-6		7-8		9+	

9. **Age distribution of dependants**

< 1 yr		1-4yrs		5-9yrs		10-14 yrs		15-19 yrs		20 yrs	

10. **Which hospital do you get your treatment?**

Hayani Hospital	Evuxakeni Hospital	Thabomoopo Hospital

11. **Number of years being on treatment**

< 1 yr		1yr		2yrs		3 yrs		5yrs		6 yrs+	

SECTION B: MENTAL HEALTH CARE

MENTAL HEALTH CARE SERVICES

1. What are your experiences of hospital services?
2. What are your experiences of multi-disciplinary team (nurses, doctors, social workers)?
3. What are your experiences of support you receive from other services like NGOs?
4. Have you consulted the traditional healer regarding your illness?
5. How does culture view your illness?
6. How does culture influence the way you view your illness?

MENTAL HEALTH CONDITION

1. What is the diagnosis of your illness?
2. Which member of the team explained your illness? Do you understand what this condition, explain?

TREATMENT

1. What is the treatment you receive from the hospital or clinic?
2. Explain the importance of taking the medication each day as prescribed.
3. What challenges do you experience from taking the medication?

CHALLENGES AND NEEDS

1. What are the challenges you experienced as a MHCU?
2. What are the needs you have as a MHCU?
3. Do you feel that you can continue working while you have your illness?

4. How do you feel about yourself?
5. Who are your support systems, in your family and community?
6. How is community attitude to you knowing you are MHCU?
7. Do you experience stigmatisation or rejection from the community regarding your illness?

RECOMMENDATIONS

What are your recommendations regarding provision of mental health care services in the hospital or clinic?

Appendix I: Invitation for CROCMEHC programme

Date: 15/05/2016

Dear Social Worker

Invitation to a Free Training programme for a social work recovery-oriented mental health programme (CROCMEHC) programme

I am currently doing a DPhil Social Work degree, through the University of Pretoria. The research topic is as follows:

A recovery-oriented social work programme for mental health in a rural area in South Africa

Social work has a vital contribution to make to mental health care, drawing on the values, knowledge and skills of the profession. Social work as a profession is embedded within a complex web of relationships with other professions and agencies as well as with families, caregivers and individuals. Furthermore, social workers focus on the social context of individuals and the influence on both behaviour and recovery. The profession acknowledges the worth of each individual, which means that social workers are committed to the idea of social inclusion. Above all, it stands in direct opposition to the traditional medical model of diagnosis, prescription and treatment that does not fully acknowledge MHCUs as the people who are best informed about their needs. The researcher is of the opinion that social workers have an enormous role to play in assisting people with mental illness to regain their personal dignity and identity. Social workers are often the advocates of vulnerable groups such as people who are affected by mental illness.

The **goal of this study** is to develop, implement and evaluate a social work intervention programme aimed at recovery-oriented practice in rural areas.

The two-day training will focus on the following modules:

- **Module1:** Mental Health and Mental illness
- **Module2:** Mental Health Care Users (MHCUs) and Caregivers
- **Module3:** Social work in mental health care
- **Module4:** Interventions methods of social work in mental health care
- **Module 5:** Recovery
- **Module 6:** Recovery –oriented mental health care
- **Module 7:** Practice guidelines

- **Module 8:** Implementations of CROCMEHC

The training session will take place over two days and there is no cost involved. The respondents are required to attend the full two days, please let me know if there is an emergency so that I can get another respondent. The venue will be confirmed as soon as it has been secured in your district.

Attached you will find the registration and the programme.

I hereby invite you to this training session. This is very valuable in the social work arena.

Kind regards

Nontembeko Bila

PHD student

University of Pretoria

Cell No: 0718815161/0825558196

Appendix J: Registration for CROCMEHC programme

Registration and Bookings

The training is free of charge, but booking is essential due to a limited number of respondents.

Enquiries:

Telephonic enquiries: Nontembeko Bila

Email enquiries: nontembeko.bila@up.ac.za/ vakhusibnb@gmail.com

Venue: To be confirmed

Registration form

Complete all your details

Full name(s) ---------- Preferred name: ----------

Surname: ----------

District ---------- Office---------- Telephone no: ----------

Cell No: ---------- Council No: ----------

Please Complete and send via email or give it to your supervisor

Email: nontembeko.bila@up.ac.za / vakhusibnb@gmail.com

Appendix K: Agenda/ Programme for CROCMEHC programme

Invitation to a Free Training programme for a social work recovery-oriented mental health programme (CROCMEHC) programme

Tuesday, 16 August 2016 & 18 August 2016

08:00	**Tea/Coffee**
08h20	**Ice breaker**
08h25	**Introduction**
08h30	**Pre-test questionnaire completion**
09h00	**Module 1: Mental health and mental illness**
09h30	**Case study and practical exercise**
09h40	**Module 2: Mental health care users (MHCUs) and Caregivers**
10h00	TEA
10h15	**Practical Exercise**
10h15	**Module 3: Social Work in health care**
11h00	**Video viewing and Practical exercise**
11h05	**Module 4: Intervention methods of social work in mental health care**
11h40	**Practical exercise**
11h45	**Module 5: Recovery**
12h35	**Practical Exercise**
12h40	**LUNCH**
13h15	**Module 6: Recovery-oriented mental health care**
13h50	Practical exercise
13h55	**Module 7: Implementation of CROCMEHC**
14h15	**World Café**
15h00	**Post-test questionnaire completion**
15h40	**TEA**
16h00	**Certificates and Closure**

Appendix L: Pre-test questionnaire

Questionnaire: PRE-TEST CROCMEHC PROGRAMME

Dear Respondent

Please note that the content of your completed questionnaire will be kept confidential. Your participation is highly appreciated, as it will establish the appropriateness of the CROCMEHC programme.

Instruction: Read instruction by each question by marking it with an X in the appropriate shaded block.

PRE-TEST QUESTIONNAIRE

Respondent no:	For office use V0	
Date:----------		
What is the most important aspect you hope to learn from this **training**? Write your answer in the space provided below.	V00	
BIOGRAPHIC DETAILS		
1.1. Indicate your age in years	V1.1	
1.2. Indicate your **gender**	V.1.2	

F	1	M	2

1.3. Indicate your **marital status** — V1.3

Never married (Single)	1
Married	2
Divorced	3
Separated	4
Widowed	5
Living together (cohabitating)	6

1.4. Indicate your **race** — V1.4

Black	1
White	2
Indian	3
Coloured	4
Other (specify)	5

1.5. Indicate the district where your **office** is located — V1.5

Vhembe District	1
Mopani District	2

1.6. Indicate in which **sector** you work in

District Hospital	1	V1.6	
Psychiatric hospital	2		
Welfare office	3		
Health centre	4		
Other please specify	5		

1.7. Indicate your **highest educational qualification**

BA (SW)	1	V1.7	
Master's Degree in SW	2		
PhD in SW	3		
Other	4		

1.8. Indicate the **University** at which you obtained your highest degree

University of Venda	1	V1.8	
University of Limpopo	2		
University of Pretoria	3		
University of Witwatersrand	4		
University of Johannesburg	5		
University of Cape Town	6		
University of North West	7		
UNISA	8		
Other	9		

1.9. Indicate the **year** you qualified

	V1.9	

MENTAL HEALTH IN GENERAL

2.1. How would you rate your knowledge of the field of **mental health?**

Excellent	1	V2.1	
Average	2		
Poor	3		
No knowledge at all	4		

2.2. Did you receive any **training in the mental health** field?

	Yes	No		
a. Under-graduate	1	2	V2.2a	
b. Post-graduate	1	2	V2.2b	
c. Additional courses- continuing education	1	2	V2.2c	
d.Self study	1	2	V2.2d	
e.Other specify	1	2	V2.2.e	

2.3. Indicate if you think the following statements about **mental health and mental illness** are true or false. Mark the appropriate answers.

Mental Health	True	False		
a.a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life.	1	2	V2.3a V2.3b	
b.is a level of psychological well-being or an absence of mental illness.	1	2	V2.3c V2.3d	
c.it comprises of emotional, psychological, and social well-being and it affects how we think, feel and act as we cope with life	1	2	V2.3e V2.3f	
Mental illness d.is a group of conditions with onset in adolescence stage.	1	2		
e.it produces impairments of personal, social, academic, or occupational functioning	1	2		
f.is a vague, uncomfortable feeling of fear, dread or danger.	1	2		

2.4How do you rate your knowledge of the types of **mental illness**?

Excellent	1	V2.4	
Average	2		
Poor	3		
No knowledge at all	4		

2.5.Do you think any of the following are types of mental illness? Indicate '**Yes'** or '**No**' for each item.

	Yes	No		
a.Neurodevelopmental disorders	1	2	V2.5a	
b.Schizophrenia spectrum and other psychotic disorders	1	2	V2.5b V2.5c	

c.Bipolar and related disorders	1	2	V2.5d	
d.Depressive moods	1	2	V2.5e	
e.Anxiety Disorders	1	2	V2.5f	
f.Obsessive Compulsive and related disorders	1	2	V2.5g V2.5h	
g.Trauma and stress related disorders	1	2	V2.5i	
h.Dissociative disorder	1	2	V2.5j	
i.Somatic symptom and related disorders	1	2	V2.5k	
j.Feeding and eating disorders	1	2	V2.5l	
k.Elimination disorders	1	2	V2.5m	
l.Sleep Wake Disorder	1	2	V2.5n	
m.Sexual dysfunctions disorders	1	2	V2.5o	
n.Gender dysphoria	1	2	V2.5p	
o.Personality disorder	1	2	V2.5q	
p.Paraphillic disorders	1	2	V2.5r	
q.Disruptive impulse-control and conduct disorders	1	2	V2.5s	
r.Substance-Related and addictive Disorders	1	2		
s.Neurocognitive disorders (NCD)	1	2		

2.6.Generally, **mental illness** is characterised by abnormal or unstable behaviour and impaired cognitive function. When a person is mentally ill she/he has a problem with **---------** Mark the correct word from the list below: V2.6

Feelings (emotions)	1
Thinking	2
Behaviour	3
Personality	4

2.7.What **is mental health**? Write your answer in the space provided below. V2.7

2.8. What is **mental illness**? Write your answer in the space provided below. V2.8

2.9. There are **different types of hospital admission** procedures utilised for people living with mental illness as stipulated in the Mental Health Act. Mark all the types that you know in the list below.

Voluntary	1	V2.9a	
Involuntary	2	V2.9b	
State patient	3	V2.9c	
Criminal	4	V2.9d	

3. SCHIZOPHRENIA AS A CLASSIFICATION OF MENTAL ILLNESS

3.1 What is schizophrenia? Write your answer in the space provided below: V3.1

3.2. A **diagnosis of schizophrenia** can be made when a person shows symptoms of ---- (Mark any **three** from the list below):

a. Delusions	1	V3.2a	
b. Hallucinations	2	V3.2b	
c. Disorganised speech	3	V3.2c	
d Split personality	4	V3.2d	
e. Grossly disorganised or catatonic behavior	5	V3.2e	
f. Negative symptoms	6	V3.2f	

3.3. Choose two **diagnostic tools** used to diagnose schizophrenia. V3.3a

a. Disability rights movement	1	V3.3b	
b. DSM V	2		
c. Patients' Rights Charter	3		
d. Mental Health Act	4		
e.X-rays	5		
f.CAT scan	6		

3.4. Do you think **People living with Schizophrenia** have:

a. Positive symptoms e.g. hallucinations and delusions	1	3.4a	
b. Negative symptoms e.g. social withdrawal	2	V3.4b	
c.Both	3	V3.4c	

3.5. Identify **the specifiers/ characteristics of schizophrenia** as stipulated in the DSM 5 **(**Mark any that you know)

a. Episode e.g. specified duration of time in which the symptoms developed.	1	V3.5a	
b. First episode e.g. occur once in a lifetime.	2	V3.5b	
c. Multiple episode e.g. determine after minimum of two (2) episodes.	3	V3.5c	
d.Remission e.g. when disorder specific have not been present for a period of time.	4	V3.5d	
e.Catatonic e.g. stupor	5	V3.5e	
f.Bulimia e.g. distorted body image	6	V3.5f	
g. Partial remission e.g. improvement of a defined magnitude after a previous episode is maintained.	7	V3.5g	
h.Full remission e.g. no disorder-specific symptoms are present	8	V3.5h	

3.6. In your opinion, does **culture** have an influence on the understanding of schizophrenia?

Yes	1	V3.6	
No	2		
Motivate			

Treatment of **schizophrenia**

What does treatment of schizophrenia entail: Mark the appropriate answers.

a. Medical	1	V3.7a	
b.Pharmocological	2	V3.7b	
cPsychosocial	3	V3.7c	
d. Psychological	4	V3.7d	
		V3.7e	

e.Psycho educational	5		

3.8.1 Identify **typical anti-psychotic medication**, Mark **any three** from the list below:

V3.8.1a
V3.8.1b
V3.8.1c

a.Chlorpromazine	1	
b.Haloperidol	2	
c.Lithium	3	
d.Ativan	4	
e.Fluphenazine	5	

3.8.2. Identify **atypical anti-psychotic medication**, Mark **any two** from the list below:

V3.8.2a
V3.8.2b

a. Aripiprazole	1	
b. Pain killers	2	
c. Clozapine	3	
d.Perphenezine	4	

3.8.3. In your own opinion are **anti-depressants** used to treat schizophrenia. Mark **one** statement.

a. Yes	1	V3.8.3
b.No	2	
Motivate		

3.8.4 Treatment has its **side effects for People living with schizophrenia (PLWS)**. Mark **three** side effects from the list below

V3.8.4a
V3.8.4b
V3.8.4c

a. Dry mouth	1	
b. Blurred vision	2	
c. Drowsiness	3	
d.Limping	4	
e.Muscle spasm	5	
f.Chest pain	6	

3.8.5. Choose any **other treatment** apart from medication (Indicate **two**)

V3.8.5a
V3.8.5b

a. Disability grant; Housing/residential programmes	1	
b.Straight jacket	2	
c.Electroconvulsive therapy (ECT)	3	
d.Behaviour modification	4	
e.Sleep therapy	5	
f.Hypnosis	6	
g. Crisis intervention	7	
h.Partial hospitalization	8	

i.Imprisonment	9		
j.Acupuncture as alternative treatment	10		

PEOPLE LIVING WITH SCHIZOPHRENIA (Mental Health care users)

4.1. Do you think that **people living with schizophrenia** are:

a. Crazy/mad	1	V4.1a	
b. Lazy Incompetent	2	V4.1b	
c.Bewitched/cursed	3	V4.1c	
d.Cannot make decisions	4	V4.1d	
e.Punished	5	V4.1e	
f. Born with it	6	V4.1f	
g.Developed as a result of a trauma	7	V4.1.g	
h.Developed after drug abuse	8	V4.1.h	
i.None of the above	9	V4.1i	

4.2. Evaluate the following factors as contributing to the challenges experienced by **people living with schizophrenia** (PLWS)

	Weak	Moderate	Strong		
a. Homelessness	1	1	1	V4.2a	
b. Education opportunities	2	2	2	V4.2.b	
c. Laziness	3	3	3	V4.2.c	
d.Unemployment	4	4	4	V4.2.d	
e.Stigma	5	5	5	V4.2.e	
f.Sleeping problems	6	6	6	V4.2.f	
g.Relationship problems	7	7	7	V4.2.g	

CAREGIVERS OF PEOPLE LIVING WITH SCHIZOPHRENIA

5.1. In your opinion who is **caring for PLWS** when they are discharged from the hospital

	Agree	Not sure	Disagree		
a.Family	1	2	3	V5.1a	
b. Multidisciplinary team	1	2	3	V5.1b	
c.Intersectoral team	1	2	3	V5.1.c	
				V5.1d	
				V5.1e	

d.Intedisciplinary team	1	2	3	V5.1f	
e.Key workers	1	2	3		
f.Hospice workers	1	2	3		

5.2. Do you think any of the following factors can affect the well-being of the **caregivers.** Mark **three** from the list below.

a.Mental exhaustion/burnout	1	5.2.a
b.Stress	2	5.2.b
c.Boredom	3	5.2.c
d.Frustration	4	
e.Finances	5	

5.3. Caregivers' **experiences and needs** may vary considerably depending on several factors such as……Mark **two** from the list below.

a. Age	1	
b.The years of caregiving	2	
c.The stage of illness of the family member	3	5.3a
d.The level of support the caregiver receives	4	5.3b

SOCIAL WORK IN MENTAL HEALTH CARE

6.1. Indicate if you think the following tasks are applicable to **social work in mental** health care in a **hospital**. Answer by marking true or false for each statements.

	True	False	
a. Tracing families of PLWS	1	2	
b. Conduct a thorough psychosocial assessment of patient and family	1	2	6.1a
c.Developing individual care plans	1	2	6.1.b
d.Involved in the discharge planning	1	2	6.1.c
e.Liaise with field social workers for after care services	1	2	6.1.d
f. Attend ward rounds	1	2	6.1.e
g.Bath and dress people living with schizophrenia	1	2	6.1.f
h. Form part of the quality assurance team	1	2	6.1.g
i.Feed people living with schizophrenia	1	2	6.1.h
j. Offer advanced relationship based skills	1	2	6.1.i
k. Provide bedpans to the people living with schizophrenia	1	2	6.1.j 6.1.k

6.2. Indicate if you think the following tasks are applicable to **social work** in mental health care in the **district**. Answer by marking true or false for each statement.

	True	False		
a.Render reunification services	1	2	V6.2a	
b.Do a thorough psychosocial assessment ofpatient and family	1	2	V6.2.b V6.2.c V6.2d	
c.Provide family support	1	2	V6.2e	
d.Assist with disability grant applications	1	2	V6.2f	
e.Conduct home visits	1	2	V6.2g	
f.Linking clients with resources	1	2	V6.2h	
g.Conduct awareness campaigns	1	2	V6.2i	
h.Provide after-care services	1	2		
i.Offer advanced relationship based skills	1	2		

6.3. Do you have a **need for training** with regards to any of the following?

	Yes	No		
a.mental health as a field in general	1	2	V6.3a	
b.mental illness focusing more on schizophrenia	1	2	V6.3b V6.3c V6.3d	
c.social Work in mental health care	1	2	V6.3e	
d.assessment tools in working with people living with schizophrenia	1	2	V6.3f V6.3g	
e.intervention methods in working with people living with schizophrenia	1	2		
f.recovery and social work	1	2		
g.recovery-oriented mental health practice	1	2		

6.4. How do you intervene with clients presenting with **mental health problems**?

	Yes	No		
a.Provide counseling	1	2	V6.4a	
b.Do therapeutic interventions	1	2	V6.4.b	
c.Focus on the social issues – apply for social relief of distress	1	2	V6.4.c	
d.Apply for a disability grant	1	2	V6.4d	
e.Refer them to the hospital	1	2	V6.4e	
f.Refer them to the psychologist	1	2	V6.4f	
g.Refer them to the psychiatrist	1	2	V6.4g	
h.Other, specify	1	2	V6.4h	

6.5. Do you have enough knowledge regarding **mental health** care to provide appropriate intervention?

a. Yes	1	V6.5	

b. No	2			
Motivate				

6.6.Mark all the tools that you know that are used by t**he multi-disciplinary team** to assess a patient with schizophrenia. Mark any **two** from the list.

DSM V	1	V6.6a	
Nation Health Insurance (NHI)	2	V6.6b	
Constitution	3	V6.6c	
Mental Health Care Act	4	V6.6d	

6.7.What is the **procedure** in the psychiatric hospital to decide on the patient diagnosis?

Psychiatrist decides alone	1	V6.7	
Pyschologist decides alone	2		
Allied team members contribute information	3		
Team has a meeting and decides after a holistic discussion	4		

6.8.Which **legislation** is applicable when you are working with patients with schizophrenia

National Health Insurance (NHI)	1	V6.8	
Mental Health Care Act	2		
The Bill of Rights	3		
Traditional Health Practitioners Act	4		

6.9.Can the following **interventions methods** have a positive impact on the lives of people living schizophrenia?

	Sometimes	Always	Not at al		
Individual intervention	1a	2a	3a	V6.9a	
Group intervention	1b	2b	3b	V6.9b	
Family intervention	1c	2c	3c	V6.9c	
Psycho-education	1d	2d	3d	V6.9d	
Support groups	1e	2e	3e	V6.9e	
Social skills training	1f	2f	3f	V6.9f	
Vocational rehabilitation and supported employment	1g	2g	3g	V6.9g	

6.10.Rate your knowledge regarding **Assertive Community Treatment** (ACT) when working with people living with schizophrenia.

a.Excellent	1	V6.10a	
b. Average	2	V6.10b	
c. Poor	3	V6.10c	
d. No knowledge at all	4	V6.10d	
		V6.10e	

6.11.Social workers have a critical role to play in the multidisciplinary team when working with people living with schizophrenia. Such as:

	Yes	
		V6.11a
a.Psychosocial assessment	1	V6.11b
b.Compile psychosocial report	1	V6.11c
c.Involve in disability grant screening	1	V6.11d
d.Advocating for the rights of the PLWS	1	V6.11e
e. Acting as a liaisson between the patient, the mental health practitioners and the social service professionals in the community.	1	

7. RECOVERY-ORIENTATED CARE WITH PEOPLE LIVING WITH SCHIZOPHRENIA

7.1. **Recovery** is ----------complete the sentence by choosing the correct statement below.

a. …an ongoing evolution through which individuals enhance their health, wellness and living sustaining self-directed lives	1	V7.1
b. …… only possible through medication due to permanent chemical imbalances, which are present at birth.	2	
c. ….not possible as it a physical disease.	3	

7.2. Which **two words** reminds you of the concept recovery. Choose from the list.

a. Scientific	1	
b. Clinical	2	V7.2a
c. Physical	3	V7.2b
d.Personal	4	

7.3. Identify the applicable **models for recovery** of people living with schizophrenia.

a. Psychodynamic model	1	V7.3a
b. Recovery model	2	V7.3b
c. Strengths based perspective	3	
d.Tidal model	4	

7.4. Can any of the following **components of recovery** impact positively on the lives of people living with schizophrenia? (Answer all)

	Weak	Moderate	
a.Empowerment	1a	2a	
b.Hope	1b	2b	
c.Self-direction	1c	2c	
d.Holistic	1d	2d	
e.Person-centered	1e	2e	
f.Strengths-based	1f	2f	
g.Peer support	1g	2g	

V7.4a
V7.4b
V7.4c
V7.4d
V7.4e
V7.4f
V7.4g

7.5. Indicate if you think these are the **principles of recovery**. Indicate with a true or a false.

	True	False
a. unique for each individual and goes beyond an exclusive health focus to include an emphasis on social inclusion and quality of life	1a	2a
b. supports and empowers individuals to make their own choices	1b	2b
c. is the place where the person acts out everyday life with other people—family, friends, neighbours, work colleagues, professionals	1c	2c
d. involves working in positive and realistic ways with individuals and their carers to help them realise their own hopes, goals and aspirations	1d	2d
e. the distress or difficulty of problems in living are first experienced	1e	2e
f. Instills hope in an individual about their future and ability to live a meaningful life	1f	2f
g. challenges discrimination wherever it exists within our own services or the broader community	1g	2g

V7.5a
V7.5b
V7.5c
V7.5d
V7.5e
V7.5f
V7.5g
V7.6

7.6. Do you believe that people living with schizophrenia can recover?

Yes	1
No	2
Unsure	3

V7.7a
V7.7b
V7.7c
V7.7d

Motivate		

7.7. Do you think that the following scales can be used to measure recovery. Mark the correct option.

a.Empowement scale	1
b.Recovery assessment scale (RAS)	2
c.Illness management and recovery scales (IMR)	3
d.Stages of recovery instrument (STORI)	4

V8.1a

V8.1b

8.RECOVERY-ORIENTED SOCIAL WORK IN MENTAL HEALTH CARE

8.1 Indicate your opinions regarding recovery-oriented mental health care. Mark the appropriate statements.

V8.1c

V8.1d

V8.1e

	Agree
a. Supports people to define their goals, exercise their capacities and use their strengths to attain their potential.	1a
b. Acknowledges that each person's journey is both unique and complex, and assists people in maximizing their ability to direct and manage it themselves.	1b
c.The primary mission of the social work profession is to enhance human wellbeing and to help meet the basic human needs of all people,	1c
d. It is how people look at themselves, their lives, and the other people in their lives; evaluate their challenges and problems; and explore their choices.	1d
e.Understands that people who have lived experience of unresolved trauma struggle to feel safe, considers the possibility of unresolved trauma in all service settings, and incorporates the core	1e

V8.2a

V8.2b

principles of trauma-informed care into service provision			

8.2. **Recovery-oriented service** acts within legislative framework to (Mark two from the statements below) V8.3

Develop and draw the clients' expertise and resources.	1	
Successful performance of mental function, resulting in productive activities, fulfilling relationships with other people.	2	
Support people as they take responsibility for and reclaim an active role in their life.	3	
The ability to adapt to change and to cope with adversity.	4	
Support people to embrace their strengths, resilience and inherent capacity.	5	V8.4

8.3. **Recovery-oriented social workers** ---------- (Complete the sentence by choosing the correct words).

a. ..are well-versed in how to effectively and collaboratively advocate for rights and protections that must be afforded to their clients	1	
b. ..use the world of the person with lived experience of psychiatric diagnoses as the lens through which they operate and believe that individuals can and do recover from psychiatric conditions.	2	
c…seek to amplify the voices of individuals with lived experience of psychiatric diagnoses.	3	

8.4. What are re the **similarities between the core values of social work and tenets of the recovery oriented** mental health practice? Write your answer in the space provided below V8.5

8.5. In your own opinion, do you think that training in **recovery-oriented mental health** care can assist social workers rendering services to people living with schizophrenia?

Yes	1	
No	2	
Unsure	3	
Motivate		

Thank for you time and co-operation in answering this questionnaire		

Appendix M: Post-test questionnaire

Questionnaire: POST-TEST CROCMEHC PROGRAMME

Dear Respondent

Please note that the content of your completed questionnaire will be kept confidential. Your participation is highly appreciated, as it will establish the appropriateness of the CROCMEHC programme.

Instruction: Read instruction by each question by marking it with an X in the appropriate shaded block

POST-TEST QUESTIONNAIRE

For office use

Respondent no: V0

Date:----------

MENTAL HEALTH IN GENERAL

1.1. How would you rate your knowledge of the field of mental health? V1.1

Excellent	1
Average	2
Poor	3
No knowledge at all	4

1.2. Indicate if you think the following statements about mental health and mental illness are true or false. Mark the appropriate answers.

Mental Health	True	False	
a.a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life.	1	2	V1.2a
b.is a level of psychological well-being or an absence of mental illness.	1	2	V1.2b
c.it comprises of emotional, psychological, and social well-being and it affects how we think, feel and act as we cope with life	1	2	V1.2c
Mental illness d.is a group of conditions with onset in adolescent stage.	1	2	V1.2d
e.it produces impairments of personal, social, academic, or occupational functioning	1	2	V1.2e
f.is a vague, uncomfortable feeling of fear, dread or danger.	1	2	V1.2f

1.3.How do you rate your knowledge of the types of mental illness? V1.3

Excellent	1
Average	2
Poor	3
No knowledge at all	4

1.4.Do you think any of the following are types of mental illness? Indicate 'Yes' or 'No' for each item.

	Yes	No		
a.Neurodevelopmental disorders	1	2	V1.4a	
b.Schizophrenia spectrum and other psychotic disorders	1	2	V1.4b	
c.Bipolar and related disorders	1	2	V1.4c	
d.Depressive moods	1	2	V1.4d	
e.Anxiety Disorders	1	2	V1.4e	
f.Obsessive Compulsive and related disorders	1	2	V1.4f	
g.Trauma and stress related disorders	1	2	V1.4g	
h.Dissociative disorder	1	2	V1.4h	
i.Somatic symptom and related disorders	1	2	V1.4i	
j.Feeding and eating disorders	1	2	V1.4j	
k.Elimination disorders	1	2	V1.4k	
j.Sleep Wake Disorder	1	2	V1.4l	
m. Sexual dysfunctions disorders	1	2	V1.4m	
n.Gender dysphoria	1	2	V1.4n	
o.Personality disorder	1	2	V1.4o	
p. Paraphillic disorders	1	2	V1.4p	
q. Disruptive impulse-control and conduct disorders	1	2	V1.4q	
r. Substance-Related and addictive Disorders	1	2	V1.4r	
s.Neurocognitive disorders (NCD)	1	2	V1.4s	

1.5.Generally, mental illness is characterised by abnormal or unstable behaviour and impaired cognitive functioning. When a person is mentally ill she/he has a problem with --------- Mark the correct word from the list Below:

V1.5

a.Feelings (emotions)	1
b.Thinking	2
c.Behaviour	3
d.Personality	4

1.6.What is mental health? Write your answer in the provided space below.

V1.6

1.7.What is mental illness? Write your answer in the provided space below.

V1.7

1.8.There are different types of hospital admission procedures utilised for people living with mental illness as stipulated in the Mental Health Act. Mark all the types that you know in the list below.

a.Voluntary	1	V1.8a
b.Involuntary	2	V1.8b
c.State patient	3	V1.8c
d.Criminal/ forensic	4	V1.8d

2. SCHIZOPHRENIA AS A CLASSIFICATION OF MENTAL ILLNESS

2.1 What is schizophrenia? Write your answer in the space provided below:

V2.1

2.2. A diagnosis of schizophrenia can be made when a person shows symptoms of ---- Mark any three from the list below.

a. Delusions	1	V2.2a	
b. Hallucinations	2	V2.2b	
c. Disorganised speech	3	V2.2c	
d Split personality	4		
e. Grossly disorganised or catatonic behavior	5		
f. Negative symptoms	6		

2.3. There are diagnostic tools used to diagnose schizophrenia. Mark two diagnostic two you know.

a. Disability rights movement	1	V2.3a	
b. DSM V	2	V2.3b	
c. Patients' Rights Charter	3		
d. Mental Health Act	4		
e.X-Rays	5		
f.CAT scan	6		

2.4. Do you think People living with Schizophrenia have:

a. Positive symptoms e.g. hallucinations and delusions	1	V2.4	
b. Negative symptoms	2		
c. None of the above	3		

2.5. Identify the specifiers/characteristics of schizophrenia as stipulated in the DSM 5 (Mark any five that you know)

a. Episode e.g. specified duration of time in which the symptoms developed.	1	V2.5a V2.5b	
b. First episode e.g. occur once in a lifetime.	2	V2.5c	
c. Multiple episode e.g. determine after minimum of two (2) episodes.	3	V2.5d V2.5e	
d.Remission e.g. when disorder specific have not been present for a period of time.	4	V2.5f V2.5g	
e.Catatonic e.g. stupor	5	V2.5h	
f.Bulimia e.g. distorted body image	6		
g. Partial remission e.g. improvement of a defined magnitude after a previous episode is maintained.	7		
h.Full remission e.g. no disorder-specific symptoms are present	8		

2.6. In your opinion, does culture have an influence on the understanding of schizophrenia?

Yes	1	V2.6	
No	2		
Motivate			

2.7.Treatment of schizophrenia
What does treatment of schizophrenia entail: Mark the appropriate answers.

a. Medical	1	V2.7a	
b.Pharmocological	2	V2.7b	
cPsychosocial	3	V2.7c	
d. Psychological	4	V2.7d	
e.Punishment	5	V2.7e	

2.7.1 Identify typical anti-psychotic medication, Mark any three from the list below.

a.Chlorpromazine	1	V2.7.1a	
b.Haloperidol	2	V2.7.1b	
c.Lithium	3	V2.7.1c	
d.Ativan	4	V2.7.1d	
e.Fluphenazine	5	V2.7.1e	

2.7.2. Identify atypical anti-psychotic medication, Mark any two from the list below.

a. Aripiprazole	1	V2.7.2a	
b. Pain killers	2	V2.7.2b	
c. Clozapine	3		
d.Perphenezine	4		

2.7.3. In your own opinion are anti-depressants used to treat schizophrenia. Mark 'Yes' or 'No' and motivate why?

a. Yes	1	V2.7.3	
b.No	2		
Motivate			

2.7.4 Treatment has its side-effects for People living with schizophrenia (PLWS). Mark three side-effects from the list below

a. Dry mouth	1	V2.7.4a	
b. Blurred vision	2	V2.7.4b	
c. Drowsiness	3	V2.7.4c	
d.Limping	4	V2.7.4d	
e.Muscle spasm	5	V2.7.4e	
f.Chest pain	6	V2.7.4f	

2.7.5. Choose any other treatment apart from medication. Mark any two that you

a. Disability grant ; Housing/residential programmes	1	V2.7.5a	
b.Straight jacket	2	V2.7.5b	
c.Electro-convulsive therapy (ECT)	3	V2.7.5c	
d.Behaviour modification	4	V2.7.5d	
e.Sleep therapy	5	V2.7.5e	
f.Hypnosis	6	V2.7.5f	
g. Crisis intervention	7	V2.7.5g	
h.Partial hospitalization	8	V2.7.5h	
i.Imprisonment	9	V2.7.5i	
j.Acupuncture as alternative treatment	10	V2.75j	

3.PEOPLE LIVING WITH SCHIZOPHRENIA (Mental Health care users

3.1.Do you think that people living with schizophrenia are:

a. Crazy/mad	1	V3.1a	
b. Lazy Incompetent	2	V3.1b	
c.Bewitched/cursed	3	V3.1c	
d. Cannot make decisions	4	V3.1d	
e. Punished	5	V3.1e	
f. Born with it	6	V3.1f	
g.Develop as a result of a trauma	7	V3.1.g	
h. Developed after drug abuse	8	V3.1.h	
i.None of the above	9	V3.1i	

3.2. Evaluate the following factors as contributing to the challenges experienced by people living with schizophrenia (PLWS)

	Weak	Moderate	Strong		
a. Homelessness	1	2	3	V3.2a	
b. Education opportunities	1	2	3	V3.2.b	
c. Laziness	1	2	3	V3.2.c	
d.Unemployment	1	2	3	V3.2.d	
e.Eating too much	1	2	3	V3.2.e	
f.Sleeping problems	1	2	3	V3.2.f	
g.Relationship problems	1	2	3	V3.2.g	

4.CAREGIVERS OF PEOPLE LIVING WITH SCHIZOPHRENIA

4.1. In your opinion who is caring for PLWS when they are discharged from the hospital

	agree	Not sure	Disagree		
				V4.1a	
a.Family	1	2	3	V4.1b	
b. Multidisciplinary team	1	2	3	V4.1.c	
c.Intersectoral team	1	2	3	V4.1d	
d. Intedisciplinary team	1	2	3	V4.1e	
e.Strangers	1	2	3	V4.1f	
f.Hospice workers	1	2	3		

4.2. Do you think any of the following factors can affect the well-being of the caregivers. Mark any three from the list below.

a.Mental exhaustion/burnout	1	V4.2.a	
b.Stress	2	V4.2.b	
c.Boredom	3	V4.2.c	
d.Frustration	4		
e.Finances	5		

4.3. Caregivers' experiences and needs may vary considerably depending on several factors such as……Mark two from the list below.

a. Age	1	V4.3a	
b.The years of caregiving	2	V4.3b	
c.The stage of illness of the family member	3		
d.The level of support the caregiver receives	4		

5.SOCIAL WORK IN MENTAL HEALTH CARE

5.1. Indicate if you think the following tasks are applicable to social work in mental health care in a hospital. Mark 'True' or 'False' for each statement.

	True	False		
			V5.1a	
a. Tracing families of PLWS	1	2	V5.1.b	
b. Conducting a thorough psychosocial assessment of patient and family	1	2	V5.1.c	
			V5.1.d	
c.Developing individual care plans	1	2	V5.1.e	
d.Involve in the discharge planning	1	2	V5.1.f	
e.Liaise with field social workers for after care services	1	2	V5.1.g	
			V5.1.h	
f. Attend ward rounds	1	2	V5.1.i	

g.Bath and dress people living with schizophrenia	1	2	V5.1.j	
h. Form part of the quality assurance team	1	2	V5.1.k	
i.Feed people living with schizophrenia	1	2		
j. Offer advanced relationship based skills	1	2		
k. Provide bedpans to the people living with schizophrenia	1	2		

5.2. Indicate if you think the following tasks are applicable to social work in mental health care in the district. Mark 'True' or 'False' for each statement.

	True	False		
			V5.2a	
a.Involved in a ward round	1	2	V5.2.b	
b. Provide a diagnosis of schizophrenia	1	2	V5.2.c	
c.Provide family support	1	2	V5.2d	
d.Assist with disability grant applications	1	2	V5.2e	
e.Conduct home visits	1	2	V5.2f	
f.Link clients with resources	1	2	V5.2g	
g.Conduct awareness campaigns	1	2	V5.2h	
h.Provide after-care services	1	2	V5.2i	
i.Offer advanced relationship based skills	1	2		

5.3. Do you have a need for training with regards to any of the following?

	Yes	No		
			V5.3a	
a.mental health as a field in general	1	2	V5.3b	
b.mental illness focusing more on schizophrenia	1	2	V5.3c	
c.social Work in mental health care	1	2	V5.3d	
d.assessment tools in working with people living with schizophrenia	1	2	V5.3e	
e.intervention methods in working with people living with schizophrenia	1	2	V5.3f	
f.recovery and social work	1	2	V5.3g	
g.recovery-oriented mental health practice	1	2		

5.4. How do you intervene with clients presenting with mental health problems?

	Yes	No		
			V5.4a	
a.Provide counseling	1	2	V5.4.b	
b. Provide a diagnosis of schizophrenia	1	2	V5.4.c	
c. Work alone without other allied team members	1	2	V5.4d	
			V5.4e	

d. Do not intervene at all and chase the mental health care users out of the office	1	2	V5.4f	
e.Refer them to the hospital	1	2	V5.4g	
f.Refer them to the psychologist	1	2	V5.4h	
g.Refer them to the psychiatrist	1	2		
h.Other, specify	1	2		

5.5. Do you feel you have enough knowledge regarding mental health care to provide appropriate intervention?

V5.5

a. Yes	1	
b. No	2	
Motivate		

5.6.Mark all the tools that you know that are used by the multi-disciplinary team to assess a patient with schizophrenia. Mark any two from the list below.

V5.6a
V5.6b
V5.6c
V5.6d

a.DSM V	1	
b.National Health Insurance (NHI)	2	
c.Constitution	3	
d.Mental Health Care Act	4	

5.7.What is the procedure in the psychiatric hospital to decide on the patient diagnosis?

V5.7

a.Psychiatrist decides alone	1	
b.Psychologist decides alone	2	
c.Social worker decides alone	3	
d.Team has a meeting and decides after a holistic discussion	4	

5.8.Which legislation is applicable when you are working with patients with schizophrenia

V5.8

a.National Health Insurance (NHI)	1	
b.Mental Health Care Act	2	
c.The Bill of Rights	3	
d.Traditional Health Practitioners Act	4	

5.9.Can the following intervention methods have a positive impact on the lives of people living schizophrenia?

	Sometimes	Always	Not at all	
a.Individual intervention	1	2	3	V5.9a
b.Punishment	1	2	3	V5.9b
c.Family intervention	1	2	3	V5.9c
d.Isolation	1	2	3	V5.9d
e.Group intervention	1	2	3	V5.9e
f.Social skills training	1	2	3	V5.9f
g.Vocational rehabilitation and supported employment	1	2	3	V5.9g

5.10.Rate your knowledge regarding Assertive Community Treatment (ACT) when working with people living with schizophrenia.

a.Excellent	1	V5.10
b. Average	3	
c.Poor	4	
d.No knowledge at all	5	

5.11. Social workers have a critical role to play in the multidisciplinary team when working with people living with schizophrenia. Mark 'Yes' or 'No' for each item.

	Yes	No	
a.Psychosocial assessment	1	2	V5.11a
b.Not involved at all	1	2	V5.11b
c.Allowed to take minutes only and not to participate in the discussions	1	2	V5.11c
d.Advocating for the rights of the PLWS	1	2	V5.11d
e. Acting as a liaison between the patients, the mental health practitioners and the social service professionals in the community.	1	2	V5.11e

6.. RECOVERY-ORIENTATED CARE WITH PEOPLE LIVING WITH SCHIZOPHRENIA

6.1. Recovery is ----------complete the sentence by choosing the correct statement.

a. …an ongoing advancement through which individuals enhance their health, wellness and living sustaining self-directed lives	1	V6.1

b. …… only possible through medication due to permanent chemical imbalances, which are present at birth.	2		
c. ….not possible as it is a physical disease.	3		

6.2. Which words reminds you of the concept recovery. Mark any two words from the list below.

a. Scientific	1	V6.2a	
b. Clinical	2	V6.2b	
c. Physical	3	V6.2c	
d.Personal	4	V6.2d	

6.3. Identify the applicable models for recovery of people living with schizophrenia. Mark any two that you know.

a. Psychodynamic model	1	V6.3a	
b. Recovery model	2	V6.3b	
c. Strengths based perspective	3		
d.Tidal model	4		

6.4. Can any of the following components of recovery impact positively the lives of people living with schizophrenia? (Answer all)

	Weak	Moderate	Strong		
a.Empowerment	1	2	3	V6.4a	
b.Hope	1	2	3	V6.4b	
c.Self-direction	1	2	3	V6.4c	
d. Disempowerment	1	2	3	V6.4d	
e. Pathological centred	1	2	3	V6.4e	
f.Strengths-based	1	2	3	V6.4f	
g.Restraining	1	2	3	V6.4g	

6.5. There are principles of recovery. Mark 'True' or 'False' for each statement if they are/not the principles of recovery.

	True	False		
a. unique for each individual and goes beyond an exclusive health focus to include an emphasis on social inclusion and quality of life	1	2	V6.5a	
b. supports and empowers individuals to make their own choices	1	2	V6.5b	
c. is the place where the person acts out everyday life with other people—family, friends, neighbours, work colleagues, professionals	1	2	V6.5c	
			V6.5d	
			V6.5e	
			V6.5f	
			V6.5g	

d. involves working in positive and realistic ways with individuals and their carers to help them realise their own hopes, goals and aspirations	1	2		
e. the distress or difficulty of problems in living are first experienced	1	2		
f. Instills hope in an individual about their future and ability to live a meaningful life	1	2		
g. challenges discrimination wherever it exists within our own services or the broader community	1	2		

6.6. People living with schizophrenia can recover from their illness. Do you believe this statement? V6.6

Yes	1
No	2
Unsure	3
Motivate	

6.7. There are scales used to measure recovery. Mark any two scales you know.

V6.7a
V6.7b
V6.7c
V6.7d

a.Empowement scale	1
b.Recovery assessment scale (RAS)	2
c.Illness management and recovery scales (IMR)	3
d.Stages of recovery instrument (STORI)	4

7.RECOVERY-ORIENTED SOCIAL WORK IN MENTAL HEALTH CARE

7.1. Recovery-oriented mental health practice refers to the application of sets of capabilities that support people to recognise and take responsibility for their own recovery and wellbeing and to define their goals, wishes and aspiration. Mark the statements with ‘Agree’ or ‘Unsure’ or ‘Disagree’ on what recovery-oriented mental health care entails.

	Agree	Unsure	Disagree	
a. Supports people to define their goals, exercise their capacities and use their strengths to attain their potential.	1	2	3	V7.1a
b. Acknowledges that each person’s journey is both unique and complex, and assists people	1	2	3	V7.1b
				V7.1c
				V7.1d
				V7.1e

in maximizing their ability to direct and manage it themselves.					
c. Acknowledges the diversity of peoples' values and is responsive to people's gender, age and developmental stage, culture and families as well as people's unique strengths, circumstances, needs, preferences and beliefs	1	2	3		
d. Is how people look at themselves, their lives, and the other people in their lives; evaluate their challenges and problems; and explore their choices.	1	2	3		
e.Understands that people who have lived experience of unresolved trauma struggle to feel safe, considers the possibility of unresolved trauma in all service settings, and incorporates the core principles of trauma-informed care into service provision	1	2	3		

7.2. Recovery-oriented service acts within legislative framework to ----Mark two appropriate statements.

V7.2a
V7.2b
V7.2c
V7.2.d
V7.2e

a……..develop and draw on the clients' expertise and resources.	1
b…….successful performance of mental function, resulting in productive activities and fulfilling relationships with other people.	2
c……support people as they take responsibility for and reclaim an active role in their life.	3
d……. adapt to change and to cope with adversity.	4
e……..support people to embrace their strengths, resilience and inherent capacity.	5

7.3. Recovery-oriented social work……(Complete the sentence by choosing the correct words.

V7.3

a. ..are well-versed in how to effectively and collaboratively advocate for rights and protection that must be afforded to their clients	1
b. ..use the world of the person with lived experience of psychiatric diagnoses as the lens through which	2

they operate and believe that individuals can and do recover from psychiatric conditions.			
c…seek to amplify the voices of individuals with lived experience of psychiatric diagnoses.	3		

V7.4

7.4. What are re the similarities between the core values of social work and tenets of the recovery oriented mental health practice? Write your answer in the space provided below

V7.5

7.5. In your own opinion, do you think that training in recovery-oriented mental health care can assist social workers rendering services to people living with schizophrenia?

Yes	1
No	2
Unsure	3
Motivate	

8. EVALUATION OF THE PROGRAMME

8.1. In this training did you acquire knowledge in the following aspects. Mark 'Yes' or 'No' for each item.

	Yes	No	
a.mental health	1	2	V8.1a
b. mental illness	1	2	V8.1b
c.social work in mental health care	1	2	V8.1c
d.assessment tools in working with people living with schizophrenia	1	2	V8.1d
e.intervention methods in working with people living with schizophrenia	1	2	V8.1e
f.recovery and social work	1	2	V8.1f
g.recovery-oriented mental health practice	1	2	V8.1g
h.implementation of CROCMEHC	1	2	V8.1h

V8.2

8.2. Write what you have learnt in this training in the space provided below.

	V8.3	

8.3.Would you recommend the CROCMEHC to your colleagues?

Yes	1
No	2
Motivate	

8.4.What are your recommendations regarding the course content?

	V8.4a	
	V8.4b	
	V8.4c	
a)		
b)		
c)		

8.5.Please indicate what else needs to be included in this programme

	V8.5a	
	V8.5b	
	V8.5c	
a)		
b)		
c)		
	V8.6a	
	V8.6b	

8.6.Indicate what needs to be discarded in this programme

a)		
b)		
	V8.7	

8.7.In your opinion, would other professionals value the services provided by social workers, if social workers can implement the CROCMEHC programme

Yes	1	
No	2	V8.8a
Unsure	3	V8.8b
	V8.8c	
	V8.8d	

8.8.Mention the aspects you value from the CROCMEHC

a)		
b)		
c)		V8.9a
d)		V8.9b
	V8.9c	

8.9.Mention the aspects that were irrelevant

a)			
b)			
c)			

8.10. What are your recommendations?

a)		V8.10a	
b)		V8.10b	
c)		V8.10c	
d)		V8.10d	

End of questionnaire

Thank for you time and co-operation in answering this questionnaire

Appendices N: Informed consent: Caregivers and MHCUs

Faculty of Humanities

25 May 2015

INFORMED CONSENT FORM FOR MHCUs AND CAREGIVERS

Title of the study: A recovery-oriented social work programme for mental health in a rural area in South Africa

Researcher: Nontembeko Joyce Bila

Contact details: 0718815161/012-420 2599

Purpose of the study:

Is to develop, implement and evaluate a social work intervention programme aimed at recovery-oriented practice in rural areas.

Procedures:

I will be asked to partake in an interview which will be conducted at the hospital and the duration will be sixty (60) minutes. The interview will be tape recorded with my permission

Risks and Discomfort:

The interviews will be conducted in a safe secure environment. Any information provided during the interviews will be treated confidentially. I will not be required to furnish my personal details or particulars. I am aware that if I need counselling as the result of this interview I will be referred to a social worker. As a caregiver, I will be eligible to give consent on behalf of the patient if he or she is unable to consent for the interview.

Benefits:

I will benefit from the research in the long term if the mental health services are improved as a result of this study.

Participant's Rights:

My participation in the research is on a voluntary basis. I may, if I wish to withdraw at any time that I want to or prefer. Upon my withdrawal, the information I provided for the research will be destroyed.

Confidentiality:

All information gathered for this research will be treated confidentially. The researcher and her supervisor will have access to the information. The thesis will be compiled reflecting the research results and my name will not be mentioned. I am aware that the researcher will use numbers or a letter of the alphabet in the report and this will enhance the confidentiality.

Data storage:

I am aware that the collected data will be stored for 15 years at the Department of Social work and Criminology according to the policy of the University of Pretoria and when necessary may be used for future research.

I ……., understand my rights as a research participant, and I voluntarily consent to participate in this study. I understand what the study is about and how and why it is being conducted.

Participant: ----------

Date: ----------

Signature: ----------

Researcher: ----------

Date: ----------

Signature: ----------

Appendices O: Informed consent: Social workers and social work managers

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Faculty of Humanities

Title of the study: A recovery-oriented social work programme for mental health in a rural area in South Africa

Researcher: Nontembeko Joyce Bila

Purpose of the study:

I have been asked to participate in training (research) with the aim to test the effectiveness of the preliminary programme that has been designed on a recovery-oriented mental health practice for social workers in rural areas. I am fully aware that this training is meant for doctoral research and I should not copy, reproduce or distribute the materials provided. The training will take place for one day and it will start at 8:00 to 16h00.

Procedures:

I agreed to participate, I have completed a registration form, and I am fully aware that the following will occur:

Before the training commences I will be required to complete a Pre-test questionnaire and subsequently after the training has been presented, I will be required to complete a Post-test questionnaire. A code will be given to me and my identity will never be linked to the data or the thesis. I will also not be compensated for my participation in this training, but I will be given free training and a certificate of attendance. I am aware that the researcher will organise a venue and catering. I am aware that I must attend the training for a full day, until the end of the session.

Confidentiality:

I understand that the data collected via the questionnaires will be kept confidential and will be stored in the Department of Social Work and Criminology, University of Pretoria for 15 years. I also understand that my identity will be protected and I will remain anonymous. I also understand that the data will be analysed and reported in the thesis and scientific journals, but will not include any information that can identify me or any respondents in this study.

Kind regards

Mrs NJ Bila

Researcher

I, _____ (Full name and surname of respondent) hereby acknowledge that I have been informed about the research and training. I am aware of what is required of me as a respondent. I have read and understand the process that will be followed. I have asked questions I may have had and I am aware of the confidential nature of the study. As a respondent, I also understand that my identity will be protected and I will remain anonymous. Finally, if at any point I choose to withdraw from the study I understand I will not suffer any negative consequences.

Respondent:

Name and Surname: ……..

Date: ……..

Signature: ……..

Researcher:

Name and Surname: ----------

Date: ……..

Signature: ……

Appendix P: Informed consent in Xitsonga language

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Faculty of Humanities

25 May 2015

PAPILA RA MPFUMELELO WA VUTIVI-VUENTI

Nhloko-mhaka ya ndzavisiso: Nongonoko wa wa nkongomelo kuhola eku rihanyu ra miehleketo hi mutirheli wa nhlayiso eka matiko xikaya ya Afrika Dzonga.

Mulavisisi: Nontembeko Joyce Bila

Tinambara ta rinqingho: 0718815161

Nkongomelo wa ndzavisiso:

Kutumbuluxa, ku andlala, ku kambisa ekaku nghenelela kongomiseke eka matirhelo yak u kuhola loku ngongomeke ematiko xikaya ya Afrika Dzonga.

Maendlelo:

Ndzi ta komberiwa ku va xiyenge xa ndzavisiso lowu nga ta endliwa xibedlele xa Thabomopo, Evuxakeni na Hayani na swona vulavisis lebyi byi lehile ti minete ta 60. Vulavisis lebyi byi ta kandiyisiwa hi mpfumelelo wa mina.

Vuxangetu vutomi ni kupfumalo ntshamiseko:

Vulavisisi lebyi byi ta endliwa eku ndhawu leyi hlayisekeke. Vuxokoxoko lebyi byi ta paxiwa byi ta vaxihundla. Ndzi takomberiwa kunyika vuxokoxoko bya mina. Ndzi swi tiva leswaku loko ndzi lava mbulavulo wa mpfuno ndzi ta rhumeriwa eka Mutirheli wa nhlayso. Tani hi muhlayis was muvabyi ndzi ta fanele ku nyika mpfumelelo wa vutivi-vuenti ematshanwini ya muvabyi anga swikotiki ku endla tano.

Mbuyelo:

Ndzi ta vuyeriwa hi ndzavisiso lowu ekuheteleni loko mintirho ya rihanyo ra miehleketo ya antswisiwa hikokwalaho ka nongonoko lowu. Timfanelo ta vuteka swiyenge : kuteka

ka mina xiyenge eka nongonoko lowu aku kutihlawulela loko ndzi lava kuhuma eka ndzavisiso lowu ndzi nga huma nkhari wihi na wihi. Ndzi ta tsakela kumbe ndzinavela leswaku ekuhumeni ka mina eka ndzavisiso, vuxokoxoko lebyi dzi byi nyikeke byi herisiwa.

Vaxihundla:

Vuxokoxoko hinkwabyo lebyi hlengeletiweke eka ndzavisiso lowu byi ta hlayisiwa ta ni hi xihundla. Mulavisis na mudzaberi wa yena va ta van i lungelo eka vuxoko lebyi. Nkatssakanyo wa vulavisisi lebyi wa ta endliwa hi ndlela yak u palaxa mbuyealo kambe mavito manga ka mange palaxiwi. Ndza switiva leswaku tinamabra na ma letere yak u ngavi mavito na swona leswi swi ta tlkusa ximo bya xihundla.

Vuhlayisi bya vixokoxoko:

Ndza switiva leswaku xuxokoxoko lebyi hlengetiweke byi ta hlayisiwa malembe yo ringana khumentlanu (15) eka departmente ya vutirheli bya nhlayiso na vungebenga ku ya hi nawu wa university ya Pitori na swona loko swi fumerile byi nga tirhisiwa eka mindza visiso ya mundzuku

Mina---------- ndzi twisisa timfanelo ta mina tani hi muteka xiyeng eka ndzavisiso na swona ndzi nghenelela hi ku rhandza ka mina eka ndzavisiso lowu. Ndzi twisisa leswi ndzavisis wa nga xiswona na leswaku wata endlisa kuyini ni leswaku hikokwalalo ka yini wu endliwa

Muteka yiyenge: ----------

Siku: ----------

Kusayina ----------

Mulavisisi: Nontembeko Joyce Bila

Siku: ----------

Kusayina: ----------

Appendix Q: Confirmation of independent coder

hugenote kollege
Waar Christenwees grondvat in opleiding

3 May 2016

To whom it may concern

Confirmation of independent coding

I hereby confirm that I acted as independent coder for Ms N. Bila during November 2015. The research topic: A mental health intervention programme aimed at recovery-oriented practice in rural areas.

Dr M.A. van der Westhuizen

(DPhil in Social Work)

DR Marichen van der Westhuizen
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Appendix R: Confidentiality agreement form

Faculty of Humanities

25 April 2016

CONFIDENTIALITY AGREEMENT

In contemplation of my active involvement in the study conducted by Ms NJ Bila in my capacity as a research assistant. I fully understand that,

I shall keep all the information strictly confidential

I shall not disclose the details and identity of the participants

I shall not disclose the findings of the study

I fully understand that the disclosure of any information of the study is the breach of this contract

The agreement is binding and I will adhere to it

Signed at ----------this day of ---------- 2016

Signature

Appendix S: Confirmation from editor

CERTIFICATE OF VERACITY

DOCTOR OF PHILOSOPHY IN SOCIAL WORK

A RECOVERY-ORIENTED SOCIAL WORK PROGRAMME FOR MENTAL HEALTH CARE IN A RURAL AREA IN SOUTH AFRICA

NONTEMBEKO JOYCE BILA
(23189259)

I, the undersigned, hereby certify that the editing process comprised the following:

Language editing

- Syntax.
- Sentence construction.
- Grammar, punctuation, and spelling.
- Appropriate word selection.
- Final proofreading.

Format/layout editing

- Uniformity in page layout.
- Comparing in-text citations/sources in reference list.

Freelance editor	:	S M Bell
Completed	:	June 2017
Signature	:	Sue Bell

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