CHALLENGES IN MULTIDISCIPLINARY TEAM WORK IN THE MENTAL HEALTH UNIT AT WINDHOEK CENTRAL HOSPITAL IN NAMIBIA

by

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DECLARATION

I Rufaro Ottiliah Dipura declare that this mini –dissertation is my own original work. The secondary material used has been carefully acknowledged and referenced in accordance with the university requirements.

I understand what plagiarism is and am aware of university policy and implications in this regard.

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ABSTRACT

Challenges in multidisciplinary team work in the mental health unit at Windhoek Central Hospital in Namibia

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Namibia has only one mental health unit with a full Multidisciplinary team which caters for the whole country. The unit is regarded as a ward or department as it is attached to the main referral hospital of Namibia, Windhoek Central Hospital in the capital city of Namibia. Namibia has a total of fourteen regions with different tribes (more than eleven).It is also a multilingual country with more than sixteen different languages.

The goal of the study was to explore and describe the challenges of the multi-disciplinary team in the mental health unit service delivery at Windhoek Central Hospital.

The study adopted a qualitative research approach. It was exploratory and applied. It utilized a case study design. Purposive sampling was used to obtain the study's sample size. A sample size of twelve (12) multi-disciplinary team members was selected. Each discipline namely, social workers, psychologists, occupational therapists, nurses, doctors and psychologists was represented by two members of the chosen sample.

The findings show the gravity of the work that needs to be done at the mental health unit. The challenges faced have existed for years and the Management of the mental health unit has not addressed them. The multidisciplinary team is facing lots of challenges. The Act that is currently in use, Act No. 18 of 1973, is very old. . The Ministry of Health and Social Services (2005: 3) in Namibia states that government must ensure good and adequate service delivery reforms for the health of the nation. However, the government is not doing much for the mental health unit.

The study concludes that the mental health multidisciplinary team needs to be heard and their challenges addressed for the team to deliver quality service to patients. The challenges included a heavy workload and a critical shortage of mental health trained staff. Even the ones not trained are not enough. There is always a shortage of medicine and the equipment is inadequate. The infrastructure itself is not conducive for the whole country and office space is not enough. The unit does not have its own budget hence many programs cannot be conducted because of lack of funds.

Recommendations include; development of policies and guidelines on the multidisciplinary team, decentralization of mental health services, training the mental health staff, a separate budget from the main hospital one and improving the infrastructure.

KEY WORDS

Mental health

Mental illness

Multidisciplinary team

Rehabilitation

LIST OF ACRONYMS

AASW- Australian Association of Social Workers

CRPD- Convention on the Rights of Persons living with Disabilities

DRC- Democratic Republic of Congo

IAPAC- International Association of Physicians in AIDS Care

MDT- Multidisciplinary team

MSF- Medecins sans Frontieres

NGO- Non- Governmental Organisation

SPD- State President Decision Patients

WCH- Windhoek Central Hospital

WCHMU- Windhoek Central Hospital Mental Health Unit

WHO- World Health Organisation

WHO-AIMS- World Health Organisation-Assessment Instrument for Mental Health Systems.

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CHAPTER ONE
GENERAL INTRODUCTION TO THE STUDY

1.1 Introduction

Mental health is very essential in humanity's functionality (Cloninger, 2006:71-76). Psychiatric attention would be required for treatment if a person is living with mental illness (Worden, 2008: 3). The treatment entails both medication and rehabilitation using the multi-disciplinary team approach (Neumann, Gutenbrunner, Fialka-Moser, Christodoulou, Varela, Giustini, & Delarque, 2010:4-8). Liberman, Hilty, Drake and Tsang (2001:1331-1332) suggest that in essence mental health rehabilitation is multi-disciplinary due to the many competencies needed for its successful implementation**.** To promote optimal recovery levels, a multi-disciplinary team combines the expertise of professionals and paraprofessionals as this would increase professional stimulation and consequently, a more effective use of resources. MDT should be able to individualise evidence-based services in a comprehensive array with competency, continuity, collaboration and coordination (Liberman et al., 2001:1332-1335).

Only a team can sustain an efficient and productive range of services (Liberman et al., 2001:1333-1338). This means that an effective synergy of the multi-disciplinary team (MDT) will ensure that a patient is holistically treated and can further reduce relapses or re-admissions. Onyett (2003:47) notes that working in teams enables organisations to rapidly develop and deliver high quality services which are cost effective. Furthermore, the author states that teamwork promotes innovation through the cross-fertilisation of ideas and helps in achieving better integration of information by saving time and having tasks undertaken concurrently.

However, the MDT is prone to inadequate organisational support and dominance of particular discipline(s) causing tension amongst disciplines (Onyett, 2003:48). Globally, it has been realised that mental health care receives a disproportionately small proportion of health budgets, and psychiatric services lag far behind other services in funding, infrastructure development, and human resources (Burns, 2010:2-8). In Namibia, mental health has been put as a unit in a referral hospital run by the State under the Ministry of Health and Social Services. It is a small wing which is supposed to cater for anyone with mental illness from all the 13 regions of Namibia. In 2011 the

population of Namibia was standing at 2 100 000 (Namibia Statistics Agency, 2012) currently the new population statistics are not yet published. The Ministry of Health and Social Services (2005:3) in Namibia states that the government must ensure good and adequate service delivery reforms for the health of the nation. However, the Mental Health Act No.18 of 1973 is still being used to admit patients either under civil or forensic psychiatry. The study aimed at exploring the challenges the multi-disciplinary team is facing in delivering services at the mental health unit at the Windhoek Central Hospital in Namibia. The study was conducted at the Mental Health Unit. The participants were twelve (12) health professionals who were members of the MDT at the unit. They were interviewed using semi-structured questions. All interviews were audio recorded. The researcher transcribed the audio into readable data and used themes and codes to analyse the data. The researcher followed the Tesch's 8 steps in the coding system (Creswell, 2014:198). More information is captured in chapter three.

The following key concepts are relevant to the study:

Mental health: is a successful performance of mental functioning, resulting in the ability to engage in productive activities, enjoy fulfilling relationships, and adapt to change and cope with adversity (Varcarolis, 2013:13). Therefore, for the purpose of the study, mental health will be defined as the full and optimum functioning of the mind as expected in any normal human being.

Mental illness: this is a medical condition that affects a person's thinking, feelings, mood, ability to relate to others, and daily functioning (Varcarolis, 2013:13). Therefore, for the purpose of the current study, mental illness will be defined as a medical condition affecting full and optimum functionality of a human's mind, feelings, moods and relations.

Multidisciplinary Team (MDT): refers to a group of professionals working as a team towards the same goal and it also ensures a more holistic orientation regarding patient care (Cowles, 2000:17). Therefore, for the purpose of the conducted study, MDT is defined as a group of professionals doing teamwork to achieve the same goal.

Rehabilitation: physical therapy or training specially designed by a health professional to assist an individual recover physical skills compromised as a result of illness or injury (Jonas, 2005). Therefore, for the purpose of the current study, rehabilitation will be defined as a readjustment into the society after mental illness.

1.2 Theoretical framework

The researcher is of the opinion that a number of approaches or models may be interlinked in service delivery in mental health. The models in mental health are best described as varying philosophies that support the practitioner's work (Clarke & Walsh, 2009:103). The MDT may use the biopsychosocial model in order for the service to be holistic. Each model represents an evidence-based, logical set of ideas that enable the practitioner or team members to understand the nature of the problem. The model used will also inform the actions taken, as planned interventions, and allow the practitioner to predict outcomes of the patient (Clarke & Walsh, 2009:103). For the study, the researcher utilised the Biopsychosocial model since it is used at Windhoek Central Hospital Mental Health Unit (WCHMU).

Somjee (2017:1-2) states that the biopsychosocial model stems from the general systems theory and has four components, namely, the biological component, behavioural component, psychological component and environmental component. The researcher linked all these to the MDT model and each team member had a role in the biopsychosocial model, this means that the psychologists examine the psychological components such as depression, anxiety, stress and hostility (Somjee, 2017:1-2). The biological needs like managing symptoms and psychotic episodes go hand in hand with the assessment done by doctors and psychiatrists in the MDT (Clarke & Walsh, 2009:122). Social workers deal with the social aspects of the biopsychosocial model. The role of the social worker in this model is to collect the history of the patient. This history will determine whether the illness is generic or is just starting in the family with this particular patient. Without the patient's history, the causes of the illness may not be well known as some mental illnesses are caused by poverty or accidents. Only the history collected by the social worker can give light to the cause. The social workers also help in discharge planning. They do the home visits to see if the environment is

conducive for the patient to live in. If not, it is the duty of the social worker to look for alternative accommodation. Social workers do the psychosocial support and they manage the case of the patient, counselling the patient and his/her family and also educating them on the diagnosis of the patient. Social workers also can approve the discharge of the patient after verifying the conducive safe place for the patient. Follow ups after discharge are done by the social workers who will then update the other MDT members about the progress of the patient (Gould, 2010:161).

In this regard, the researcher realised that the biopsychosocial model was best suited for the MDT approach. It provided an evidence-based, logical set of ideas that enabled the practitioner or team members to understand the nature of the problem. The biopsychosocial model also informs the actions taken as planned interventions, and allows the practitioner to predict outcomes of the patient (Clarke & Walsh, 2009:103). Thus, the biopsychosocial model is holistic. It looks at the whole person and not just the physical side of his/her health. The model takes into account the cultural aspects of a person's life as well. The key assumption of the biopsychosocial model is that, health is the well-being of the human organism, rather than just the absence of disease or pathology in the body (Quiznet, 2019). Wellness is the optimum health of a person of which mind and body mutually influence health and can have multiple causes of illnesses. What this basically means is that body and mind mutually influence health and human organism is influenced by its environment (social and physical) (Quiznet, 2019). This clearly shows that in psychiatry one cannot achieve the whole treatment alone.

A doctor does not deal with the social issues which influence the patient's health. It is the social worker's responsibility to deal with such social issues. Similarly, issues pertaining to the physical body of the patient are the doctor's responsibility and not the social worker's. The psychologist's focus is the psycho of the patient. However, both the psychologist and social worker can work on the behaviour of the patient. If the person's behaviour and mind are affected the occupational therapist will measure the level of functioning of the patient so as to know the type of empowerment the patient can receive. All the investigations from the above mentioned professionals are compiled and

diagnosis and treatment are made with the nurses administering the medicines. The securities make sure the patient does not escape from the hospital. Pilgrim (2002: 585-594) observes that the information provided by all the team members should be thorough because accurate information is needed from other professionals for a proper diagnosis by the psychiatrist, and with this reason, the biopsychosocial model remains an impact to psychiatry.

The training of mental health workers in order to be involved and to implement the biopsychosocial model includes education on effective teamwork and being available to a wide variety of professionals (WHO European Ministerial Conference, 2005). MDT at the Windhoek Central Hospital Mental Health Unit does not have some of the additional team members stated by Patidar (2013). It has social workers, medical doctors, psychiatrists, occupational therapists, clinical psychologists, nurses both registered and enrolled nurses, security staff and cleaning staff. For this reason, biopsychosocial is the most appropriate model since all professionals work on each and every patient. For the team to be effective the professionals have to be qualified specialists in their fields. Jurgutis et al. (2007) state that, for teamwork to be effective, professionals need special competences.

Biopsychosocial is a collaborative holistic approach which means communication among the team members should be professional (Seago.2008:4-19). Lack of or poor communication creates a situation where medical errors can occur. The errors may result in delayed treatment and have the potential to cause severe injury or the unexpected death of a patient (O'Daniel & Rosenstein, 2008). However, effective communication leads to a more effective intervention, improved safety enhances employee morale, and increases patient and family satisfaction. It also encourages effective teamwork and promotes continuity and clarity within the patient care team (O'Daniel & Rosenstein, 2008).

1.3 Rationale and problem statement

In spite of the support from the multi-disciplinary team working from the health policy and service users, there are surprisingly few multidisciplinary teams in adult mental health services due to many barriers to effective multi-disciplinary team development

and functioning (Mental Health Commission, 2006). The Mental Health Commission (2006) reflects that one of these barriers is the limited availability of the mental health professionals in the areas of psychology, social work and occupational therapy to create effective multidisciplinary teams. Such skilled professionals are not readily available hence the MDT is weakened without the adequate representation of these. As the Mental Health Commission (2006) further highlights, professional rivalry and mistrust is also a barrier leading to compromised teamwork with professionals seeking to outperform one another, competing rather than complementing each other. This leads to confidentiality issues, increased risk, lack of knowledge of what other mental health professionals do and what unique skills they have to offer. Lack of training in effective teamwork and coordination is also a significant barrier to efficient teams as well as the omnipresent 'lack of resources' (Mental Health Commission, 2006).

In Namibia, there is only one mental health unit, which is the one at Windhoek Central Hospital [WCH]. Since it is the only mental health unit in the country and is small, it is not adequate to cater for the whole country. Beukes (2017), the Senior Registered Nurse, confirmed that patients come from all the 13 regions of the country. The practitioners are always exhausted and suffer from burn out.

Beukes (2017) mentions that there is limited time for the MDT to attend to all cases and have a proper case conference. The MDT is affected by the inadequate organisational structure and support. Consequently, there is a dominance of particular disciplines and overriding of others, hence the tension amongst the disciplines. The MDT roles are not well defined with clearly specified job descriptions. There is no smooth transition, flow of processes and procedures for the treatment and rehabilitation of patients. Relapses are therefore high because many of the aspects needing to be addressed are skipped or not fully attended to. Beukes (2017) further states that the MDT performance standards are not distinctly set with positive supervision, which means that competency, consistency, continuity, coordination, collaboration, and fidelity are not guaranteed.

Language barrier is also another problem because Namibia has more than 16 languages and tribes, hence the numerous different cultural beliefs (Beukes, 2017). Furthermore, Beukes (2017) asserts that the MDT generally finds it difficult to relate to the patient and get to the core of the problems and effect solutions. She further highlights that, there are many relapses because there is no Community Mental Health Care support/programme. Everything is just centralised at WCH. The lack of Community Mental Health Care involvement makes it impossible for the MDT to do the monitoring and evaluation of discharged patients, hence the relapses are too many.

It has been observed that trained personnel in mental health are limited in the Ministry of Health and Social Services in Namibia. The trained personnel prefer to work in private practices and not for the public sector, hence the WCH's MDT suffocates (Beukes, 2017). The situation is further exacerbated by the inadequate infrastructure. Moreover, newly graduated professionals and inexperienced staff without mental health care qualifications are interested in the public sector just to gain experience. There is very little on the job training offered (Beukes, 2017). The unit is also not adequately funded and should rather be operating on its own on a separate budget but this is not the case. In addition, Beukes (2017) indicates that the Mental Health Unit's core purpose is not adequately met and attention from the authorities is needed because the staff turnover is alarming, thus hampering the mental health service delivery system.

Given the information compiled at WCH presented above, the gap lies largely in the modus operandi of the MDT. As the evidence provided points out, there is a need for optimizing the MDT approach in mental health service delivery so that a patient is effectively treated and rehabilitated with very low (or none) rates of relapses. The researcher could not find any studies conducted on the challenges in multi-disciplinary team work in the mental health unit at Windhoek Central hospital. The only study found was conducted by Shatona (2015) which explored the perceptions of multi-disciplinary team members regarding psychosocial factors contributing to juvenile delinquency in Oshakati, Namibia.

This study is the first in the context of MDT mental health service delivery at WCH, and might assist the Ministry of Health and Social Services to improve and change perceptions on mental health requirements as well as improve the quality of life of service providers. It might also highlight why the system is providing inadequate services. In addition, the study might bring light to what is lacking in the multidisciplinary team in service delivery. This awareness should encourage the team to make adjustments in service delivery and change for the better. This research also brings an awareness of neglected mental health requirements to the Ministry. Hence, the Ministry might be encouraged to clearly examine mental health service delivery, particularly by the MDT, as to why patients are always relapsing and having multiple problems after discharge.

The study was guided by the research question:

- **What are the challenges in multi-disciplinary team work in the mental unit at Windhoek Central Hospital in Namibia?**

1.4 Goal and the objectives

1.4.1 RESEARCH GOAL

- To examine and describe the challenges of the multi-disciplinary team work in the mental health unit at Windhoek Central Hospital in Namibia.

1.4.2 RESEARCH OBJECTIVES

- To examine mental health service delivery within the international and national context
- To conceptualise and contextualise the multidisciplinary team within a mental health unit.
- To examine and describe the experience of the multi-disciplinary team in the provision of mental health services in the mental health unit in Windhoek Central Hospital
- To explore and describe the challenges of the multi-disciplinary team in the provision of mental health services in the mental Health unit in Windhoek Central Hospital

- To suggest strategies to improve the multidisciplinary team approach in the delivery of mental health services.

1.5 Research methodology

This section will give a brief overview of the research methodology used in the study. Chapter three will give a more detailed outline of the research methodology with themes and sub-themes. The research employed a qualitative approach because the researcher studied people through their participation; examined and understood how they interpreted their own experiences. The qualitative approach thus gave the researcher room to collect data in the field, at the site, where participants experienced the problem under study (Fouché & Delport, 2011: 65). The research was both applied and exploratory as it was conducted to gain insight into the situation because there was lack of basic information pertaining to the challenges faced by the MDT in service delivery at the mental health unit (Fouché & De Vos, 2011: 95). The researcher opted for the collective-case study approach which entails a study of more than one profession (Creswell, 2009) and was also an exploration of a bounded system. The study population was the Mental Health professionals at the Mental Health Unit of Windhoek Central Hospital. A number of the MDT members were selected using non-probability sampling and purposive sampling (Strydom & Delport, 2011:391-392). Semi-structured one-on-one interview was the primary data collection method. The information collected was compared to make recommendations (Zucker & Donna, 2009: 14-18). Data analysis was accomplished by means of a qualitative data analysis process (Creswell, 2014:196-200 Barnes & De Hoyos, 2012:6). The ethical aspects relevant to the study are discussed in chapter three.

1.6 Chapters of the research report

Chapter 1: Introduction to the study. The first chapter gives a general introduction to the study. It spells out the goal and objectives, and rationale of the research. The chapter also outlines the problem statement, discusses the theoretical framework and gives a summary of the research methodology. Key concept are also defined.

Chapter 2: Literature review. The chapter reviews related literature on mental health and the multi-disciplinary team approach. It gives an overview of literature that is

significant to one's understanding of the multi-disciplinary team's experiences and those of other teams internationally, regionally and nationally.

Chapter 3: Empirical study. Chapter three presents the research methodology which includes the research design, population of study, data collection and analysis methods to be used and the findings. The ethical considerations of the study are also presented. The research results are discussed using a thematic approach.

Chapter 4: Conclusions and recommendations. This is the final chapter. It contains the key findings of the study. Conclusions and recommendations that are based on the findings are presented.

The next chapter will focus on the literature review.

CHAPTER 2
LITERATURE REVIEW ON CHALLENGES IN MULTI-DISCIPLINARY TEAM

2.1 Introduction

The study's thrust is to examine the challenges in MDT work in the Mental Health Unit at Windhoek Central Hospital in Namibia. Currently, the Mental Health Unit is not a hospital, but is regarded as a department of the main hospital despite it being the only one in the country. Fihlo and Bertolote (2006) note that in many African countries mental health is not recognised as a distinct entity. As a result, mental health professionals face many challenges when performing their tasks.

The Multi-disciplinary Team (MDT) refers to a group of professionals working as a team towards the same goal and it also ensures a more holistic orientation regarding patient care (Cowles, 2000:17). For the purpose of the study, MDT is defined as a group of professionals doing teamwork to achieve the same goal.

This review will explore how mental health is viewed in other countries and continents including Namibia. Such a review will bring to light the challenges the mental health MDTs face in doing their work. Challenges faced by other MDTs outlined in similar studies will be noted. The effectiveness of the MDT and the factors that hinder its success will also be looked at. Comparison and matching of the challenges faced in other countries and the MDT challenges at the Mental Health Unit of Windhoek Central Hospital will be done so as to find the gap. Every approach has its own advantages and obstacles and the MDTs are not exceptions, hence, these will also be highlighted. Different team members and their roles will also be part of this review. In other countries the mental health MDT comprises of para-professionals, these will be described as well.

The International Association of Physicians in AIDS Care (IAPAC, 2011) notes that Multi-disciplinary team models focus on a specific disease and/or are driven by the composition of the team and the team's leadership. The main goal of the MDT is to provide continuous, comprehensive and efficient health services. Team composition

may vary from country to country (IAPAC, 2011). The same applies to the MDT at Mental Health Unit of Namibia.

2.2 Mental health in other continents and countries which also affect MDT work

Filho and Bertolote (2006:560) mention that in contrast to the lack of professionals that is observed in Africa, in Europe most of the countries have psychiatrists, psychologists and nurses with psychiatry training who are able to provide mental health treatment. There are countries like Wales, England, Netherlands, Greece and Scotland to mention a few that have great numbers of trained health workers in mental health. Other countries in Europe hire trained personnel from the countries mentioned above (Clark & Roopai, 2011:52-53).

In India, mental health is only valid in theory but deficient in practice (Fihlo & Bertolote, 2006:560). In 1987, the Indian Mental Health Act was structured over the course of decades and was a legitimate attempt to update humanitarian policies in psychiatry. Nevertheless, the document is still an ideological plan rather than a reality, due to deficient mental health infrastructure (Fihlo & Bertolote, 2006:560). In Namibia, the old Act of 1973 is used. It is similar to the one South Africa used before they amended their Act. It is significant to note that if the policies are out dated then the operations by the MDT will be affected greatly as they need to follow what is stated in the Act (Mushimba, 2018).

India's situation is more challenging because not only is their Act outdated, but there is deficiency in the mental health infrastructure as well (Fihlo & Bertolote, 2006:560). One can conclude that in India mental health is not taken seriously considering that the plan has not been put into action since 1987; it is still in the pipe line. It seems there is no urgency to work on it. One may argue that given such challenges, the MDT is affected as it faces a challenge of using an Act which is no longer applicable to the livelihoods of mental patients. With no policies, the MDT is likely to have problems in its service delivery, and following individual suggestions might create confusion and conflicts among the members.

In America, the state of Nevada faced several problems such as low funding and high staff turnover due to low remuneration (Watson & Marschall, 2013:53, 64-66). Replacing the staff members was also difficult as no one was interested in low salaries. Even though some of the staff members had the relevant qualifications to work in Mental Health Units, they showed no interest. It was also noted that some areas had no psychiatrists in the state. According to Knudsen, Johnson and Roman (2003:129-35), having new recruits all the time delays work progress as members need time for induction, and time to familiarise themselves with the MDT work. Staff members complained of high workloads and always had a backlog in their paperwork. Work overload and pressure, long working hours, poor social support and poor management style result in a high workload and backlog in one's work (Michie & Williams, 2003: 3-9). Other gaps identified included staff issues such as low morale, compensation, recruitment and retention of staff (Test, Flowers, Hewitt & Solow, 2003:276-285), hence the operations of MDT are affected. Although the developed countries have an advantage of trained mental health personnel, they still face challenges of staff turnover because of the low remuneration and underfunding (Aaron & Sawitzky, 2006: 289-301). Such issues have implications on the service delivery in Mental Health Units, hence the function of the MDT in the provision of services leaves a gap (Watson & Marschall, 2013:53, 64-66). The American example above indicates that there are challenges in the Mental Health Hospitals in most of the countries discussed in this study; these challenges affect the MDT work (Watson & Marschall, 2013:53, 64-66).

The researcher concluded that the challenges highlighted for America include low funding of mental health resulting in high staff turnover due to low remuneration. Also noted, is that despite having trained personnel some areas still lack psychiatrists and the workload is heavy.

2.3 Mental Health in Africa

Egypt, Kenya, South Africa, Zimbabwe, DRC and Namibia will be discussed under this topic. According to the World Health Organisation-Assessment Instrument for Mental Health Systems (WHO-AIMS, 2006) in Egypt the mental health professionals have an opportunity to attend refresher courses but many of them do not attend. Egypt also has training in Mental Health Care for Primary staff for both doctors and nurses. Even so,

the total number of human resources working in Mental Health is not evenly distributed just like in the other African countries discussed below.

Kenya has performed relatively well in the training of Psychiatrists in Africa. Even then, it is also under resourced in terms of mental health personnel. Consideration needs to be given to improving the skills related to mental health care delivery (Ndetei, Ongecha, Mutiso, Kuria, Khasakhala & Kokonya, 2007: 33, 36).

Thus, even though Egypt and Kenya have good training in psychiatry, they have a challenge in human resources. Improvement on health care skills needs to be considered. Even though they train mental health personnel, the delivery is done by the MDT only, hence there is a shortage of professionals (WHO-AIMS, 2006: Ndetei, Ongecha, Mutiso, Kuria, Khasakhala & Kokonya, 2007: 33, 36). The critical question, where do these trained professionals go after training remains a mystery.

In South Africa a WHO Assessment Instrument for Mental Health Services was done and it showed that there was an inadequate to nothing budget set aside for mental health (WHO-AIMS 2007: 9). In some provinces the mental health expenditure could not be provided as the mental health budgets fell under general health budgets at primary care level. It was further revealed that there were no nationally agreed indicators on budgets, staff and facilities as well as training of staff (WHO-AIMS 2007: 9). Another research done in KwaZulu–Natal compared budget allocation over a period of 5 years between mental health hospitals and general hospitals. It was found that the increase in the budget for mental health hospitals was between 8-19% over 5 years while for general hospitals it was between 29 to 64% per annum (WHO-AIMS 2007: 9). Another finding was that, there was no funding allowance for mental health staff development. Not surprising, with such a low budget, mental health personnel are bound to look for greener pastures and some opted to go to general hospitals. There were 0.34 psychiatrists per 100 000 population in Kwazulu-Natal. In addition to the lack of funding and a critical shortage of mental health professionals, the workload will be overwhelming in such circumstances. According to the study there was little evidence of the government making an effort to try and achieve or redress inequalities (WHO-AIMS 2007: 9).

From the South African situation one may conclude that there is underfunding, and given such challenges, human resources becomes limited. Professionals want better working conditions and better remuneration. All these should be part of the budget which mental health units or hospitals should consider. If mental health is included on the budget of the general hospitals, caring for the mental health MDTs becomes difficult and some of the resources needed by the MDT to execute their duties become limited. For example at Mental Health Unit in Namibia, materials used for skills development and empowerment, and transport for home visits by social workers for the assessment of the patients' circumstances and discharge planning (Beukes, 2017), are greatly affected.

Zimbabwe uses the mental Health Act of 1996 No. 15. The major aim of the Mental Health Policy is to harmonise mental health activities and improve quality care of the mentally ill patients (Research and information Services Section, 2009). This policy also outlines the frame work within which mental health programmes are designed, implemented, monitored and evaluated using multi-disciplinary, multisectoral approaches and community involvement in order to provide all Zimbabweans with the highest achievable mental health care services. This is done in the context of primary health care. There are nine civilian Mental Health Institutions in Zimbabwe (Research and information Services Section, 2009). Zimbabwe has six (6) Mental Health Institutions in its major towns, and three (3) forensic units, two (2) in Harare and one (1) in Bulawayo. There are Six (6) mental health units and ten (10) community home based rehabilitation centres and homes including resettlements (Ministry of Health and Child Welfare, 2017).

Half way houses are for patients discharged from the main hospital to continue with rehabilitation before going back to their respective communities. This set up shows that Zimbabwe has decentralised the mental health care facilities (Pembere, 2017). There is an MDT team for these halfway houses as well. According to the Research and Information Services, The World Health Organisation's Mental Health Atlas for 2005

described Zimbabwe's mental health facilities and identified training provided to the mental health care workers. However, they also indicated that the shortage of staff and materials has resulted in limited sustainability of the mental health care programmes such as the community care programmes/facilities for patients. Zimbabwe has training for mental health care professionals including nurses, occupational therapists, rehabilitation workers, social workers, and another programme at the University of Zimbabwe for doctors to specialise in Psychiatry (Mangezi & Chibanda, 2010: 94). However, in spite of the training programmes in Zimbabwe, like other African countries, there is a critical shortage of mental health professionals. The professionals have migrated to other countries like South Africa because of the collapse of the Zimbabwean economy. For the past decade, Zimbabwe has experienced an economic decline that has resulted in inflation (Munangagwa, 2009). Those who were working in the village communities have also left for the cities. Most of the half way houses are not in full operation as the shortage of professional looms, the MDTs have been gravely affected. At the Windhoek Central Hospital Mental health Unit, all the occupational therapists are from Zimbabwe and were trained at the University of Zimbabwe (Podoweltz, 2018).

Thus, Zimbabwe's Mental Health delivery system is handicapped by a chronic shortage of trained psychiatrists and psychiatry staff (MDT) (Kadirire, 2018). A senior official at one of the mental health hospitals said the hospital was operating with a skeletal staff since the professionals were leaving the ravaged country for greener pastures in neighbouring countries. Over fifty patients died of hunger due to the acute shortage of food and the institute had run out of food and depleted drug stocks. The official at one of the mental health hospitals also highlighted poor salaries as the main cause of resignation by experienced staff (The Zimbabwean, 2009).

Kadirire (2018) reports that the head of Mission of Medecins Sans Frontieres (MSF) an NGO in Zimbabwe highlighted that they have witnessed untrained healthcare workers in overcrowded and understaffed facilities, improperly sedating patients with the assumption that knocking them out was the best. This clearly shows lack of training and

knowledge. Significant to note is that an MDT full of untrained personnel is health hazardous and the service delivery is of very poor quality.

In view of the above literature, the researcher can conclude that what seems to be common in most African countries is that the MDT is faced with challenges because if the staff is untrained to work within a team, they will not be aware of their responsibilities and roles. This will make the MDT work complicated and the service provided will be inadequate and ineffective. Conflicts may arise because of the high expectance on team members to perform tasks or roles of other members. In some cases, the staff maybe trained but inadequate because of staff shortages caused by the staff turnover. The government on the other hand, makes no effort to rectify these mental health issues.

Moloo (2016) reports that the Democratic Republic of Congo (DRC) also has problems in service delivery. The main challenge that most mental health units in the DRC encounter is that professional workers are trained in general health and hence lack an in-depth knowledge in mental health to deliver quality services. Moloo (2016) also reported that the state's involvement in mental health is minimal, hence a very tiny budget is allocated to mental health, regardless of the many problems faced. In view of these challenges, the researcher may conclude that there is no proper MDT in the DRC since the personnel is not fully equipped to run the mental health units. They lack adequate training in this field and have skeletal knowledge on the subject. It is because of their willingness to help that they are doing what they are not trained for. In such a scenario trained nurses act as specialists just by the mere fact that they are trained to treat people. An MDT of this nature is normally faced with high levels of incompetence and confusion and the service provided will be very poor.

2.4 Namibian Context

As already mentioned, the Namibian Mental Health Act No. 18 of 1973 is outdated. Just like the other African countries mentioned above, mental health in Namibia receives low priority. The budget is included in the general hospital budget and there is nothing stipulated specifically for mental health. In the National Policy, because of the limited

resources, health policies focus mainly on communicable and life threatening diseases (Mushimba, 2018).

Mental health services in Namibia lag behind other health services. There is need for the government to take mental health seriously as a major public health issue through the promotion of mental well-being, prevention of mental illness, treatment and rehabilitation (Ministry of Health and Social Services, 2005:1). A multi-disciplinary team (MDT) comprising of various professionals and paraprofessionals ensures that the patient is holistically treated and rehabilitated and it best facilitates effective mental health (Liberman, Hilty, Drake and Tsang (2001:1331-1332).

Harrison, Geddes and Sharpe (2005:80-82) suggest that the mental health multi-disciplinary team has to be pliable enough to adjust to different types of patients which are: long term inpatients, short term inpatients and outpatients. They should also work within the parameters of the country's legislature under mental health even though the policies are outdated.

In another folding event at the forensic unit, *Thomas* (2018) NBC One television 2000hrs main news stated that, a violent patient was paired with a calm patient and this ended in a tragedy when the violent patient murdered the calm patient. This incident reflects the staff members' inadequate training and knowledge. The incident could have been prevented if the staff members had adequate knowledge on mental health.

On 18 March 2018, the researcher conducted an interview with the Acting Deputy Director of Disability Prevention and Rehabilitation, in which Mushimba, at Franc Indongo offices, highlighted that they have been working on a new mental health bill since 2006. She said the bill is in its final stage for tabling in the house of assembly. She said they were working hard to have changes in mental health. An approval to build two mental hospitals and extend the Windhoek Central Mental Health had been done by the government of Namibia. Windhoek Central Mental Health Hospital will be the main referral hospital. However, the project has been shelved because of the bad economy which has affected the country. During the same interview, Mushimba pointed out that social workers at the mental health unit have no support at national level hence no

training is offered in the form of workshops. Mushimba also said there is a gap in the Ministry of Health and Social Services for skills development. She gave an example of only one educational trip to Bloemfontein and stated that the National Level social worker who represented Windhoek Central Mental Health Unit social workers was not knowledgeable in mental health and knew nothing about the social workers' operations at the Windhoek Mental Health Unit. Some of the information which the researcher expected to get from Mushimba was unavailable; instead, the researcher was referred to the Head of Department who worked half day as she was running her own practice.

The researcher is of the opinion that MDT is vital for mental health service provision. The efficiency of their coordination and synergy will enable a client to be more effectively treated and rehabilitated. As such, the means and ways of applying the MDT concept should be sought, hence this research. The table below reflects the statistics (number) of mentally ill patients attended to at the Windhoek Central Mental Health Unit from 2013 to 2017. The table shows the number of patients treated as out patients and those who were admitted. Patients at the Forensic Unit are only in patients and are admitted for a long period of time. The figures for the forensic unit reflect how many patients were discharged within these five (5) years 2013 to 2017. In 2016 the number of out patients was alarming.

Table 1. Windhoek Central Hospital Mental Health Unit Statistics as from 2013 to 2017 (Windhoek Central Hospital Statistics Department, 2018)

YEAR	***IN-PATIENT CIVIL PSYCHIATRY***	***OUT-PATIENT DEPARTMENT***	***FORENSIC UNIT***	***TOTAL PER YEAR***
2013	99	1202	74	**1375**
2014	165	1067	73	**1305**
2015	133	1646	69	**1848**
2016	137	4644	65	**4846**
2017	82	1650	66	**1798**
TOTAL IN 4YEARS	**616**	**10 209**	**347**	**11172**

Psychiatric hospitals provide institutional care for a small number of patients while the large number is outpatient (WHO European Ministerial Conference, 2005). This also applies to Namibia as evidenced by the statics above. There is currently no community based mental health care in Namibia. The nurses who are members of the MDT at the mental health unit are the same nurses who go for outreach in clinics only around Windhoek city. The whole MDT does not go for these outreach programmes, otherwise the unit has to be closed or will operate with a skeleton staff. Full service from the MDT is only at the mental health unit. This brings back the issue of work overload for the mental health MDT.

2.5 Challenges faced by MDT in general

Many mental health workers are under-skilled and there is no urgency to improve the workers' competencies to meet the future needs of the mental health system. For example, many nursing education programs have limited mental health content. These nurses with their limited knowledge then become part of the MDT at the mental health unit.

Liberman et al. (2001: 1332-1342) states that Multi-disciplinary teams face major challenges in providing individualised rehabilitation services. The time, tools and knowledge of the client's clinical history that are necessary to identify the phase of the client's disorder are often lacking. Although the staff may be competent in providing evidence based services, this may not be enough to move the clients up to the recovery phase. Liberman et al. (2001:1332-1342) also highlight caseloads as a gargantuan task. Administrative and logistical obstacles often interfere with the MDT's ability to maintain clinical contact and treatment responsibility through the different levels and settings of intervention. A breakthrough was realised through the introduction of community treatment which has its principle on a single MDT maintaining full and indefinite clinical responsibility for providing flexible levels of care.

According to *WHO European Ministerial Conference* (2005) there is uneven distribution of mental health workers in most countries. Concentration is given to urban settings and this has contributed to high volumes of work for MDT. For instance, the Windhoek Central Mental Health Unit is in the capital city of Namibia and Ward 16 of Oshakati is in

town. There is no mental health unit in the rural areas of Namibia. Ward 16 and all the other state hospitals always refer patients to the Windhoek Mental Health Unit

The *WHO European Ministerial conference* (2005) of Copenhagen, highlights the importance of communication, together with leadership skills that include being able to organise and lead a productive team meeting and maintain cohesion and morale among team members. Leaders must also provide team members with mechanisms for discussing their concerns and differences of opinion, solving problems and sharing their expertise (Jurgutis, Kummel, Mort & Grinevicius, 2007). MDT is no longer office or hospital bound, it now includes mobile educators, personal coaches, advocates and community organisers. Mental health service have been decentralised by introducing community health care centers thereby making the service available at community level and also easing the congestion at the mental health units (Liberman et al, 2001:1332). These centers have not been introduced yet in Namibia. Instead, all mental health services are offered at the Windhoek Mental health Unit where the MDT is positioned. Because of limited funding for human services and the limited availability of professionals, most workers in hospitals are paraprofessionals with a bachelor degree. or lower qualification without any work experience.

The *WHO European Ministerial Conference* (2005) mentions human resources and training, inadequate supply of mental health workers and recruitment and retention as some of the MDT challenges. On human resources and training, WHO said most of the training for nurses programmes have limited mental health content. Consequently, many mental health workers are under skilled. The urgent need to improve the workers' competences to meet the future needs of the mental health system is non-existent. The inadequate supply of mental health workers was described by WHO as a shortage of skilled mental health workers. The size and quality of the workforce which is the MDT is influenced by factors such as the low investment in mental health as witnessed in many countries, poor working conditions, limited resources for training and education (Bingley & Westgaard-Nielsen, 2004). There is migration of mental health workers from low and middle income countries to high income countries as witnessed in the Zimbabwean situation (*The Zimbabwean*…, 2009). The recruitment and retention is mainly about staff

turnover in an organisation. Workers prefer where there are resources, better salaries and working conditions (Podoweltz, 2018). Retention has to be done by improving the salaries and working conditions, developing career pathways for the mental health workers, providing opportunities for professional development. These are all strategies for improving the retention of staff. All the above have to be considered at the mental health unit of Namibia as they contribute to the challenges of MDT. Aaron and Sawitzky (2006) state that the service provider turnover rates in mental health and human services organisations are often high and an ongoing concern in managing mental health case management, clinical and therapeutic service programme. Bingley and Westergaard-Nielsen (2004:557-563) underscore the effects of turnover as poor staff morale, ineffectiveness of staff, reduced productivity, weaker work teams and increased costs of training new employees. Aaron and Sawitzky (2006) note that in public sector organisations, staff turnover has been attributed to factors such as the high stress environment, lack of support and low pay.

Jurgutis et al. (2007) mention that in Primary Health Care practice there is a growing need for teamwork and cooperation with professionals from other sectors but the education of health professionals remains quite fragmented, and multi-disciplinary and inter professional education are lacking. Reeves, Lewin, Espin and Zwarenstein (2010) claim that professional graduates from universities lack attributes of traditional teamwork which were not part of their training. An effective mental health workforce (MDT) needs to include professional and non-professional workers from different backgrounds since people with mental disorders have multiple needs. Notably, it is also effective for workers with different skills to work together in teams to respond to these needs. The training of mental health workers should also include education on effective teamwork and be available to a wide variety of professionals and non-professional groups (WHO European Ministerial Conference, 2005).

Fleissing, Jenkins, Catt and Fallowfield (2006:940) contend that in MDT there is a problem of incomplete attendance at meetings. MDT work cannot be effective if key members are frequently absent. The three authors cited administrative support as one of the challenges. Administrative support helps to coordinate documents, and

implement the decisions made by the MDT. There is also a challenge of more new referrals and the need to respond quickly and advances in diagnosis and treatment. Therefore, the MDT need to be well organised and supported to succeed.

Beukes (2017) says that the language barrier is also another problem because Namibia has more than 16 languages and tribes with different cultural beliefs. Furthermore, Beukes (2017) asserts that the MDT generally finds it difficult to relate to the patient and get to the core of the problem and effect solutions. Hence, there are many relapses because there is no community mental health care support or programme in the communities. Everything is centralised at WCH.

Another major obstacle highlighted is that in many developing and underdeveloped countries, mental health is not well structured and availability of certain drugs like antipsychotic cannot be guaranteed. In addition, the language barrier was cited as one of the challenges which affects the MDT in their service delivery (Clark & Roopai, 2011:52-53).

Cultural factors also play a role in hindering MDT work. Patients sometimes seek out services from traditional healers and when they are referred to a mental health unit they do not cooperate. As a result, the MDT faces a challenge of assisting the patients and their families. The cultural belief factors may portray the MDT as incompetent.

The researcher could not find literature to prove that the patients' families who have strong cultural beliefs do not cooperate but at the same time expect their family member to improve after meeting the MDT.

2.6 The effectiveness of Teams

For a team to be effective there are inputs which need to be considered. Mathieu, Maynard, Rapp and Gilson (2008: 412) note some of the inputs as follows:

- ✓ Individual team member characteristics such as competencies and personalities.
- ✓ Team level factors which include organisational design features, and environmental complexity. These factors will lead to team processes which describe the team members' interaction directed toward their goal.
- ✓ Outcomes which are the results of team activities.

- ✓ Performance which focuses on quality of work.
- ✓ Affective reactions which refer to satisfaction commitment and viability. Team climate or atmosphere, team commitment and team or group cohesion are indicators of viability.

Jurgutis et al. (2007) posit that for teamwork to be effective, professionals need special competences. They should be able to define a comprehensive and holistic approach of particular patient and his or her family health needs. They also need to recognise what role of the patient or family can be followed in the health care process and try to get support from the family and community. Giving feedback to other team members on their performance is vital. It helps to map the way forward and highlight where more attention may be needed and helps to monitor the progress toward objectives agreed by the whole team (Jurgutis et al, 2007:8).

Liberman et al. (2001:1332-1342) highlight that group dynamics are important attributes and mediate team members' competencies for providing evidence-based services. The group dynamics include group cohesion, leadership, distribution of responsibilities and authority, participation in problem solving and decision making and empowerment through participation in meetings and professional growth.

Fleissig et al. (2006: 938-940) state that the introduction of MDT work could be associated with a change in treatment decisions. Members of the team lead the discussions by participating and expressing their perceptions towards the effectiveness of the teamwork. This will lead to improved outcomes as everyone will have participated in decision making. Fleissig et al. (2006: 939) highlight coordination and the continuity of care as an essential part of effective teamwork. Fleissig et al. (2006: 938-940) state that MDT work can promote communication between primary-care health professionals and hospital based specialists which leads to improved coordination of referral, diagnosis and assessment. Dennill and Rendal-Mkosi (2012:114) facet that adequate resources both human and material, contribute to successful and effective teams. Human resources refers to the professionals in the MDT and material resources refers to physical resources such as infrastructure which must be maintained and improved to ensure a good working environment.

When team members earn each other's trust, they create strong norms of reciprocity and greater opportunities for shared achievements. As such, team members need to trust each other wholly without any doubt. The moment team members start to doubt each other trust is lost such that assigning tasks to doubted team members will be without hope and will be done with hesitation (Mitchel, Wynia, Golden, McNellis, Okun, Webb, Rohrbach & Kohorn, 2012).

2.7 Some of the factors which influence effective MDT work

Working in MDT can be difficult for a number of reasons. Some studies suggest that there is a poor state of inter-professional working in adult community mental health services (Mental Health Commission, 2006). Very little is known as to what makes some teams work very well while others do not. A number of important factors have been identified by the Mental Health Commission as follows:

- ✓ Management structures: it has been recommended that a shared model of team management be considered which helps in team cohesion. A comprehensive operational policy document for multidisciplinary teamwork needs to be drawn up to serve as basic resource for the team. It is also of importance that the general service managers be present at specific team meetings. In Namibia the general service managers are there but there is no policy document for MDT.
- ✓ Alignment of employment contracts of team members with broader employment policy: in order for the team to be effective there must be clear role and position in the organisational structure of service. The organisational structures should reflect the multidisciplinary team as the unit of care delivery. The optimum arrangement for staff on multidisciplinary teams is to be managed by an arrangement which respects the needs of the team.
- ✓ Balancing generic vs specific professional roles: individual professionals should feel valued for the unique expertise and commitment they bring to the team in addition to the generic mental health expertise they share with other members of the group.
- ✓ Conflict resolution: clear mechanisms to resolve conflicts should be in place with the recognition of some authority structures.
- ✓ Training and preparation for working in MDT should be done. This will help in increased sharing of knowledge, skills, protocols and implementation tools,

successful multidisciplinary training and planning. Referral systems also improve together with confidence and competence in decision making skills (IAPAC, 2011: 4). In the case of the Windhoek Mental Health Unit, the staff do not get further training from the employer. The ones who feel they need more knowledge have to do it on their own using their own resources. After acquiring new knowledge they then leave for better salaries.

2.8 Advantages of MDT and its obstacles

Clewley and Bowen-Clewley (2005: 6) have listed the following as the advantages of MTDs;

- ✓ Increased learning and development of people and institutions.
- ✓ Better utilisation of resources and planning for the future.
- ✓ Minimisation of unnecessary costs.
- ✓ Improvements in job performance and work quality
- ✓ Improved outcomes for patients and their families.
- ✓ Improved diagnosis and co-ordination of response with resulting improvements in health status.
- ✓ Increased user satisfaction by improving access to a range of services, and ensuring fewer gaps in service.
- ✓ Possible reduction in workplace supervision due to less dependence on discipline specific paradigms.
- ✓ Increased cost effectiveness achieved by meeting a variety of needs and avoidance of expensive duplication of services.
- ✓ Improved provider satisfaction resulting from a supportive team environment.
- ✓ Breaking down professional silos that encourage isolationist practice.

Clewley and Bowen-Clewley (2005:8) list some obstacles to the MDT approach as; lack of formal evaluating criteria, lack of trust between participating professions, focus on professional autonomy, legislative framework limiting the scope of professional practice and lack of professional training in multidisciplinary approaches. They further highlight that the forming and reforming of MDTs can create issues of team ownership and new

team member acceptance and that frequent changing of team members disturb the team dynamics and impedes communication.

2.9 Multi-disciplinary team approach, roles and contribution in mental health service delivery

Team work is significant in any mental health setting (Clewley & Bowen-Clewley, 2005:8). Qualifications, experience and the skillful handling of situations by all members of the team help to care for patients. Mental health treatment and rehabilitation in essence is multi-disciplinary because of the numerous competencies required in its effective implementation (Liberman et al., 2001:1332-1333). The team members' roles should be well defined with clearly specified job descriptions. Performance standards should be set with positive supervision and competency-based training provided (Liberman et al., 2001:1332-1333). Methods of assessment and intervention should be user-friendly. The mental health rehabilitation teams function better when appropriate face-to-face interaction is permitted. Therefore, a team size of 4 to 12 members is ideal. Hierarchy differences can come into play and diminish the collaborative interactions necessary to ensure that the proper treatments are delivered appropriately. When hierarchy differences exist, people on the lower end of the hierarchy tend to be uncomfortable, speaking up about problems or concerns and larger teams may mean fewer opportunities for effective interactions with all team members (O'Daniel & Rosenstein, 2008).

The four health care professionals which constitute the core mental health disciplines are: psychiatric nursing, psychiatry, clinical psychology and psychiatric social work (Patidar, 2013). Neumann, Gutenbrunner, Fialka-Moser, Christodoulou, Varela, Giustini and Delarque (2010:4-8) suggest the following professional competences which usually comprise a multi-disciplinary team although with overlaps happen considerably in practice:

- ✓ *Physicians*: Carry out medical assessment and treatment after diagnosis. They set up a treatment and rehabilitation plan as well as prescribing pharmacological and non-pharmacological treatment. They also assess a patient's response to these.

- ✓ *Rehabilitation nurses*: They address and monitor the daily care needs of a patient. They also provide emotional support to patients as well as the families.
- ✓ *Physiotherapists*: They do a detailed assessment of movement and posture problems.
- ✓ *Occupational therapists*: They assess the level of functioning on the daily activities of a patient. They also provide strategies useful to the patient and his/her family on how to adapt to the environment and facilitate independence.
- ✓ *Language and speech therapists*: They assess and treat communication disorders.
- ✓ *Clinical psychologists*: They assess in detail the cognitive, emotional, perceptual and behavioural problems. They develop strategies to manage these with the patient inclusive of his/her family in conjunction with the other health professionals.
- ✓ *Dieticians*: They assess and promote adequate nutrition.
- ✓ *Social workers*: They promote participation, reintegration into the community and social support.

Duties of the social workers, Occupational therapists, psychiatry nurses, clinical psychologists and psychiatrists/Doctors are further discussed below as they are the ones at Mental Health Unit.

Patidar (2013) however, suggests the following professionals which in fact are in MDT in other developed countries. He also highlights the qualifications they hold. They are as follows:

- ✓ *Psychiatrist* who is a doctor with post-graduation in psychiatry with 2-3 years residence training. He or she is responsible for diagnosis, treatment and prevention of mental disorders, prescribes medicines and somatic therapy and functions as a leader of the mental health team.
- ✓ *Psychiatric nurse clinical specialist* should have a master degree in nursing, preferably with post-graduate research work.
- ✓ *Registered nurse* in a psychiatric unit undergoes a general nursing and midwifery program or B.Sc. nursing/post-basic, B.Sc. nursing program with an added

qualification such as a diploma in psychiatry nursing, diploma in nursing administration etc. This nurse is skilled in caring for the mentally ill, gives holistic care by assessing the patient's mental, social, physical, psychological and spiritual needs, making a nursing diagnosis, formulating, evaluating and rendering nursing care. She or he communicates with the clinical nurse specialist in a community mental health setting. The nurse updates knowledge via continuing education, in-service education, workshops and courses conducted by open universities.

- ✓ *Clinical psychologist* holds a doctoral degree in clinical psychology and is registered with the clinical psychologist's association.
- ✓ *Psychiatric Social Worker* is a graduate in social work and post-graduate in psychiatric social work. She or he assesses the individual, the family and community support system. The psychiatric social worker helps in discharge planning counselling for job placement and is aware of the state laws and legal rights of the patient and protects these rights. She or he is skilled in interview techniques and group dynamics. More details on the responsibilities of a social worker are explained in this chapter.
- ✓ *Psychiatric Nursing Aids/Attendants* have high school training and are trained on the job. They maintain the therapeutic environment and provide care under supervision.
- ✓ *ECT technicians* undergo training for 6-9 months. Their responsibility is to keep ready the ECT under the supervision of a psychiatrist or anaesthetist.
- ✓ *Auxiliary personnel* are volunteer housekeepers or clerical staff. They just require in-service education to interact with the patient therapeutically.
- ✓ *Occupational therapists* go through specialised training. Their role is to play by using manual and creative techniques to assess the interpersonal responses of the patient. They help patients to develop skills in the areas of their choice and become economically independent. Patients are helped to work in the sheltered workshop.
- ✓ *Recreational therapist* plans activities to stimulate the patient's muscle co-ordination, interpersonal relationship and socialisation.

- ✓ *Diversional play therapist* makes observation of a child/patient during his play, the behaviour of the child while playing, the type of toys and his or her reaction toward the doll, beating, calling or throwing are the focus of attention. The therapist explores the behaviour of the child and relates it to conditions like phobia, child abuse, separation or any other condition.
- ✓ *Creative Art Therapist* is an art graduate and encourages the patient to express his work freely with colours and analyse the use of various colours, drawing of various scenes etc. The therapist helps in diagnosis and also in bringing the repressed feelings of the patient to the conscious level.
- ✓ *Clergyman* are religious persons who may be asked to come to the hospital unit once a week (depending on the patient's religious faith) and have a spiritual talk with the patient.

2.10 Responsibilities of a Social Worker in a Multi-disciplinary Mental Health Team

Social workers make applications for admission to the mental health unit and investigate the home circumstances of the patient and social factors contributing/triggering the mental illness and find a suitable guardian whom the MDT can contact about the patient (Australia Association of Social Workers, 2015). These factors will help with the diagnosis and indicate whether the illness is generic, psychological or has some social issues attached to it (Golightley, 2008:81). Social workers also offer counselling, adherence encouragement and education to patients and their families (AASW, 2015). They also carry out risk assessment, which also may help in hospitalisation and discharge (Gould, 2010:63-161). Advocacy is done for proper care by fighting for the patients' rights and ensuring that any team member does not violate them (Golightley, 2008:55-57).

Social workers bring in the anti-discriminatory practice that addresses personal, cultural and social levels (Gould, 2010:50-63). They use different therapies in their interventions, which include family therapy, cognitive behavioural therapy, and crisis intervention (Golightley, 2008:23-26).

Gould (2010:161) lists some of the aspects to be addressed in the assessment of the social circumstances report as follows:

- The patient's home and family circumstances;
- Views of any lay man who plays a substantial part in the care of the patient;
- the patient's concerns, hopes and beliefs;
- Whether any community support is or will be made available to the patient after discharge like employment and housing facilities;
- The patient's financial circumstances including his or her entitlement to benefits;
- An assessment of the patient's strengths and any other positive factors that the team should be aware of, to determine whether he or she should be discharged (Gould, 2010:161).
- Crisis intervention where necessary.

The researcher can also confirm that these services are similar to those offered by the social workers at the Windhoek Mental Health Unit. The Australian Association of Social Workers (2015) listed the tertiary mental health services which includes assessment, case management, crisis intervention, rehabilitation and inpatient treatment. The researcher can also confirm that these services are the same as those offered by the social workers at the Windhoek Mental Health Unit.

2.11 Responsibilities and Duties of the Occupational Therapists in a Multi-disciplinary Mental Health Team.

Creek and Lougher (2011: 215) describe the duties of the Occupational therapists as the professionals who

- Promote good mental health and assist in recovery through engagement in activities.
- enhance independency and function of the patient,
- Assist in meaningful engagement in community settings.
- As care coordinators
- Occupational therapists improve quality of life as well as decrease people's distress and vulnerability to symptoms.

2.12 Responsibilities and duties of the psychiatry nurse in a Multi-disciplinary Mental Health Team

Patidar (2013) however, suggests the following duties and responsibilities of the psychiatry nurse

- She is responsible for primary, secondary and tertiary prevention of mental disorders.
- She also provides individual, group and family psychotherapy in a hospital and community setting.
- She has the responsibility of teaching, administration, research and publishing work in a mental health setting.
- The psychiatry nurse takes the role of a leader and can practise independently.

Goulter and Kavanagh (2015) also gave the following duties of the psychiatry nurse

- They help with admissions
- Assess risks of the patients that is if the patients is a danger to self or others. If so they put the patient in a more secure room with tight security to safeguard other patients from and to protect the patient from harming self.
- Keeping of records. As one visits the wards only nurses know and are the ones to give the records of the patient (files).
- Provide clinical supervision.

2.13 Responsibilities and duties of the Clinical Psychologist in a Multi-disciplinary Mental Health Team

Green (2017) however, suggests the following duties and responsibilities of the clinical psychologist in Mental Health

- Observing and Interviewing: Clinical psychologists in a mental hospital interview patients before conducting diagnostic tests. The strategies these professionals use to detect the mental characteristics are by asking questions, interacting with patients and observing them in play. The information they get is crucial in diagnosing particular emotional, psychological or behavioral disorders and can help identify indications of abnormal behavior or mental deficiency. At times, clinical psychologists use answers from patients to evaluate problems that are

confusing or worrying, offering alternative ways of interpreting and understanding them.

- Administering Treatment and Intervention: Psychologists use a variety of strategies to address disorders such as schizophrenia and depression. They use information from interviews to diagnose mental health disorders and implement suitable treatment and intervention programs. For instance, for a patient experiencing emotional distress, a clinical psychologist ensures he is adhering to treatment programs while monitoring his progress. Even though clinical psychologists do not prescribe drugs and are prohibited to so, they often consult with doctors and psychiatrists regarding the best treatment for patients, especially where medical procedures are involved.
- Counseling Patients: A clinical psychologist counsels individuals, informing them about their progress and the importance of adhering to their treatment programs. She gives and advises mental health patients on how to cope with difficult family situations, for example death of a close relative or divorce, or overcome drug and substance addictions. This helps modify their behavior, which in turn improves personal and social adjustment. These psychologists also evaluate the effectiveness of counseling and treatment procedures, determine their accuracy and completeness of diagnoses and make modifications when necessary. They also refer to the social workers for social problems.
- Conducting Research: If they meet a patient with strange emotional characteristics, researching can reveal crucial information that can be used to establish individualized treatment programs. Psychologists conduct investigative surveys and laboratory experiments to find more information about numerous mental illnesses.

2.14 Duties and responsibilities of a psychiatrist/Doctor in a Multi-disciplinary Mental Health Team

Fiorillo, Volpe and Bhugra (2016) mention the role and responsibilities of the psychiatrist as including include planning and delivering high-quality services within the resources available. A psychiatrist will also advocate for the patients, the carers, and the services.

This is directed towards psychiatrists and the medical profession as a whole, towards other members of the multidisciplinary teams, as well as to employers and other stakeholders such as policy makers and patients and their families. Other duties are as following:

- Analyse and evaluate patient data ad test or examination findings to diagnose nature and extent of mental disorder.
- Prescribe, direct, and administer psychotherapeutic treatments or medication to treat, emotional, or behavioral disorders.
- Collaborate with physicians, psychologists, social workers, psychiatric nurses, or other professionals to discuss treatment plans and progress.
- Gather and maintain patient information and records, including social and medical history obtained from patients, relatives and other professionals.
- Design individualised care plans, using a variety of treatments.
- Examine or conduct laboratory or diagnostic tests on patient to provide information on general physical condition and mental disorder.
- Advise and inform guardians, relatives and significant others of patients' condition and treatment.
- Review and evaluate treatment procedures and outcomes of other psychiatrists and medical professionals.
- Teach, conduct research and publish findings to increase understanding of mental emotional and behavioral states and disorders.
- Prepare and submit case reports and summaries to government and mental health agencies.

2.15 Summary

This literature review has outlined the challenges faced by MDTs in other parts of the world. Mental health MDTs face challenges such as lack of training, and professional growth because of insufficient budgets. This results in professional stagnation as new MDT members just join without knowledge of how to work as a team. There is no training of team work during undergraduate studies for nurses, doctors, social workers and other professions as well. There is a high staff turnover in most mental health

units/hospitals due to poor remuneration and work overload. In some countries the people who work in mental health are not even trained in mental health. Little knowledge on mental health also affects MDT. There is limited literature on mental health MDT, but the little which is there highlights the need to have this topic researched further. Staff retention is a challenge because professionals migrate or move to better paying hospitals where there is no overload of work. In some cases the infrastructure itself for the mental health unit/hospitals is not conducive enough. Occupational therapists need to have enough space for their projects with patients, in the same way, the social workers need privacy and conducive space for their programmes.

The next chapter which is Chapter 3 describes the research methodology. It also contains the data analysis deduced from the interviews with the participants

CHAPTER THREE
RESEARCH METHODS AND EMPIRICAL STUDY

3.1 Introduction

Multi-disciplinary teams are an essential aspect in mental health treatment. One professional will not yield favourable results alone as mental illness affects the full and optimum functionality of a human's mind, feelings, moods and relations. Therefore, one professional cannot deal with mental illness alone. MDT gives holistic treatment and

care for the patient (Cowles, 2000:17). The researcher has selected the research topic due to professional interest. The research question for the study was “What are the challenges faced by the MDT at the mental health unit at Windhoek Central Hospital in Namibia when doing their work?”

In answering the research question, findings were drawn from the responses to the following sub-questions:

- Describe your feelings and thoughts in working within a multidisciplinary team here at the mental health unit.
- What is your experience in the provision of services as an MDT member at this mental health unit?
- Describe the challenges you are facing as an MDT member in the provision of mental health service at this unit?
- What do you think an ideal MDT should operate in comparison with how your MDT is operating?

This chapter highlights the research methodology used in the study. It outlines the research approach, research type and the research design used. The ethical aspects that guide the researcher as well as how the trustworthiness of the study was upheld are also discussed in this chapter. Since this is a qualitative research, the findings are presented in the form of themes and sub-themes. The participants’ biographical information is presented in the form of charts.

3.2 Research approach

The research approach used for the study was qualitative in nature. The goal of the research was to reflect the thoughts, feelings and experiences of the research participants (Fouché & Delport, 2011: 65) with regards to the challenges they experience as MDT in their work. Using the qualitative research approach enabled the researcher to gather in-depth information through the participants’ own experiences in working as MDT members at a mental health unit (Fouché & Delport, 2011: 65-66). The

study served an exploratory purpose in view of the depth of information on the challenges experienced by MDT in doing their work. There are no other studies which were conducted in Namibia to explore challenges in multi-disciplinary team work in the mental health unit at Windhoek Central Hospital. The findings in the study will help policy makers in decision making and can be further interrogated at a later stage.

3.3 Type of research

The research was applied and exploratory as it was conducted to gain insight into the situation because there is lack of basic information as to the challenges faced by the MDT in service delivery at the mental health unit (Fouché & De Vos, 2011: 95). The applied research findings shape many decisions because it is designed to offer practical solutions to a concrete problem and it addresses the immediate and specific needs of clinicians or practitioners (Neuman, 2011:27).

3.4 Research Design

Bromley (2007:302) suggests that a case study approach is a "systematic inquiry into an event or a set of related events which aims to describe and explain the phenomenon of interest". Yin (2013: 109) indicates that data is processed from documentation, interviews, direct observations, archival records, observations and physical artefacts. The subject of study may vary from an individual to a corporation and anything in between. This method can be used retrospectively and more often, prospectively.The researcher opted for the collective-case study approach which entails a study of more than one profession (Creswell, 2009). A case study is an exploration of a "bounded system" or a case (or multiple cases) over time through detailed, in-depth data collection involving multiple sources of information rich in context (Creswell, 2014). The study's intention was to get in depth information regarding the experiences of the MDT in service delivery. A number of the MDT members were selected and the information collected was compared to make recommendations (Zucker & Donna, 2009: 14-18).

3.5 Research methodology

This involved sampling, population of the study, data collection and data analysis methods as well as how the trustworthiness of the study was improved. It also highlights the limitation to the study, the ethical aspects and how the pilot study was conducted.

3.5.1 STUDY POPULATION

The study population was the Mental Health professionals at Windhoek Central Hospital in totality. There is only one mental health unit in Namibia and a ward at Oshakati hospital.

3.5.2 SAMPLE AND SAMPLING METHOD

The Researcher selected a total of 12 MDT members (health professionals) namely: *2 Nurses, 2 Psychiatrists, 2 Medical Doctors, 2 Occupational therapists, 2 Clinical psychologists and 2 Social workers.* The researcher used non-probability sampling, so all the individuals in the population did not have an equal chance of being selected. She utilized purposive sampling to select the participants, based on characteristics and the objectives of the study since the members involved in mental health care from treatment to rehabilitation at the Mental Health Unit were clearly defined (Strydom & Delport, 2011:391-392). The criteria for the selection of the participants were:

- The stakeholders should be currently practising at the mental health at Windhoek Hospital.
- The seniors/most experienced in their positions; those with more than 2 years of experience were selected.
- The stakeholders should have been in the same professional positions they are working now for the past 2 years.

The researcher requested for the personnel who met the above stated criteria from the Head of Department with an authorisation letter with details of the study from the Ministry of Health and Social Services Permanent Secretary and the Ethical clearance letter from the University of Pretoria.

3.5.3 DATA COLLECTION

Semi-structured one-on-one interviews were employed to obtain the participants' elicit views and opinions where predetermined questions were asked; though order of questions could be modified (Van Teijlingen, 2014:17). This was generally because the semi-structured interview schedule posed the advantages mentioned by Van Teijlingen (2014:21), that it was well suited for exploring and scrutinising attitudes, values, beliefs, and motives and therefore was very essential in sensitive areas. Thus, the researcher could explore non-verbal indicators, which then aid in evaluating truthfulness and the validity of the data. It also facilitated for every question which was answered and ensured the participant was speaking or working on his/her own. The participation rate was highly increased (Van Teijlingen, 2014:21).

However, Van Teijlingen (2014:22), further points out that the semi-structured interview has weaknesses in that: at times, the meaning encoded may not necessarily be the meaning decoded by the interviewer or the interviewee may have a preferred social/technical response. Privacy may also be invaded. Once more, prejudices and stereotypes of the researcher may manipulate responses (Van Teijlingen, 2014:22).

Therefore, for the conducted study to mitigate the weaknesses of the semi-structured interview type, as pointed out by Van Teijlingen (2014:27), the researcher established and maintained rapport during the interview with interviewees and permitted for long, seemingly roaming answers and allowed for pauses, contemplations without interjecting with another question. The researcher mostly listened and spoke less. Questioning was done in a non-threatening straightforward and clear way, with no cues and enjoying the interview (Van Teijlingen, 2014:27, 53).

As such, the questions were open-ended which gave the researcher a chance to probe and get more data from the participants. An interview schedule was used to keep track of the interview (Creswell, 2014:190). The participants were different team members who were interviewed at different times according to their availability. The researcher also considered the techniques and tips for interviewing, and interviews were voice

recorded. The venue was the mental health unit in each one's office as the board room was booked for other functions. The offices had privacy (Greef, 2011:343).

3.5.4 DATA ANALYSIS

This involved transcribing interviews into written field notes, arranging and sorting the data into different types depending on the sources of information. The researcher followed the following steps, as pointed out by (Creswell, 2014:197-199):

- **Data collection and management during and after the interviews**: Professionals in the MDT were interviewed individually and notes were jotted down. A voice recorder was also used. Interview questions were semi-structured.
- **Organising and preparing data from the findings**: Data from the professionals was tape recorded. The researcher organised it, transcribed it and compiled it to be processed into deductive information (Creswell, 2014:197).
- **Coding and describing data captured from the interviews**: The data was processed into information using codes (writing of words representing a category in the margin). Behaviour and trend of the data provided was established using Tesch's 8 steps in the coding system (Creswell, 2014:198).
- **Conceptualisation, classifying, categorising and identifying major themes**: The established trends and behaviour of the information was examined. It was then be put into categories and classes. Major themes and concepts from the information was determined (Creswell, 2014:199).
- **Connecting and interrelating all data**: Links and relationships between and among the data was established using visuals (tables) and narrative passages. The information was interrelated and ready for conclusions and meaning deduced.
- **Interpretation, creating explanatory accounts and providing meaning relative to Challenges in multi-disciplinary team work in the mental health unit at Windhoek Central Hospital in Namibia**: This was the final step in data analysis. It included the lessons learnt and captured the essence of the research. The meaning was derived in comparison with the information interposed from the

literature. The findings confirmed past information, some diverged from it and some was new information different from the one in the literature review.

3.5.5 DATA QUALITY

To ensure trustworthiness of the data, truth value; applicability; neutrality and consistency should be assured and by so doing the role of triangulation should be emphasised to reduce the effect of researcher bias (Gunawan, 2015:11).

Question Asked	Issue	Qualitative Criteria
How trustworthy is the information collected	Truth Value	Credibility
How applicable are the findings in other contexts?	Applicability	Transferability
Would our findings be repeated given the same context with the same subjects?	Consistency	Dependability
How the findings are affected by personal interests and biases?	Neutrality	Conformability

Adopted from: INTREC, 2009

Truth Value [Credibility] which entails the confidence we have in how well the data and processes of analysis address the MDT mental health service provision will be ensured by the use of strategies as adopted from INTREC (2009:3-10) like:

- ✓ Interviewing participants who have been at the same positions for the past 2 years at the Mental Health Unit ensured truth value of the findings. Moreover the use of the semi-structured type of interview ensured that all encoded truth was decoded and also facilitated by the use of a voice recorder (Cohen and Crabtree, 2006:1/1).
- ✓ Triangulation: different members and different professionals who could give different perspective on a question were interviewed (O'Connor and Gibson, 2003:74).
- ✓ Member checks: Where the background and competency of all interview participants was checked and endorsed as part of debriefing (INTREC, 2009:3-10).

Neutrality [Conformability] talks about the extent to which the findings would be affected by personal interests and biases (INTREC, 2009:3-10). This was ensured by employing an unbiased semi-structured interview type.

3.6 Pilot study

A pilot study was carried out during the investigation. This was useful to determine if the research was feasible (Strydom, 2011: 237). The pilot study had to be part of the investigation because most of the experienced MDT members had left the Unit for greener pastures and mostly, they were expatriates whose contracts were not renewed.

3.7 Ethical considerations

Researchers have a set of ethics that they need to bear in mind when conducting research. These are the principles and guidelines developed by professional organisations to guide research practice (Babbie, 2007: 155). The ethics formed the moral compass guiding the study and clarity on the line between ethical and unethical behaviour. Prior to conducting the study, the researcher sought and was granted permission (see Appendix 4) to conduct interviews at the mental health unit with the health professionals of this unit. The approval was granted by the Ministry of Health and Social Services. Thereafter, the researcher sought and was granted ethical clearance by the Research Ethics Committee in the Faculty of Humanities at the University of Pretoria (see Appendix 5). By obtaining the ethical clearance, the researcher used it as a measure to ensure that the benefits of the envisaged study outweighed any potential risks and that no research participants were harmed throughout the research process (Dodd & Epstein, 2012:141). The following ethical considerations were taken into consideration:

3.7.1 VOLUNTARY PARTICIPATION

Participation was voluntary; no one was forced to be involved in the study (Strydom, 2011:116). To ensure that participation was voluntary, no payment or any other incentives were offered to the research participants (Gracia-Moreno, Jansen, Ellsberg, Heise & Watts, 2005: 22).

3.7.2 INFORMED CONSENT

Participants were informed about the purpose of the research and were also given the informed consent letter explaining the research. In this study, they were informed of the one-on-one interviews and that the interviews were audio recorded after the participants had given consent. All interviews were recorded. They were also notified that the research document was to be kept in the University of Pretoria Library for 15 years (Strydom, 2011: 118).

After reading through the informed consent letter, participants were free to either consent or refuse participation. Those who had agreed to participate signed the written consent. However, even after signing they were still free to withdraw from the study at any point if they wished to do so.

3.7.3 VIOLATION OF PRIVACY/CONFIDENTIALITY

Privacy and confidentiality are essential for ensuring the safety of research participants. With these ethical aspects the researcher ensured that interviews were conducted in complete privacy. No names were written in the study; Strydom, (2011:120) notes that "information given anonymously ensures the privacy of subjects." Confidentiality is mainly related to issues of access to research data and how the data is used and handled (Strydom, 2011: 122).

3.7.4 COMPENSATION

No payment or remuneration in any form was made to the participants of the study. The researcher informed the participants about this so they did not expect anything after the study (Strydom, 2011:122).

3.7.5 DEBRIEFING RESEARCH PARTICIPANTS

After transcribing the audio interviews the researcher talked to participants about their experiences of being part of the research. She also made them read the transcribed version of their interviews so that she could confirm what they said. Since debriefing helped the researcher to determine if there was harm and referral to be done to the staff counselor (Strydom, 2011:122), no harm was identified therefore no participant was referred to the staff counselor. Tolme, Muijs and McAteer (2011:63) mentioned that

debriefing at the conclusion of data collection offers the participants an opportunity to receive more information about the research and their involvement in it. Debriefing was done after the collection of data.

3.7.6 COMPETENCE OF THE RESEARCHER

In order for the researcher to produce a valid report, he or she had an ethical obligation to ensure competency, honesty and be adequately skilled to undertake the proposed research (Strydom, 2011: 124). Since the researcher is a masters' student specialising in Social Work Health Care, she deemed herself competent to undertake this study.

3.7.7 PUBLICATION OF FINDINGS

The research is meant to contribute knowledge to the Ministry of Health and Social Services of Namibia and also to other health professionals including social work students. The research findings are presented in this research report in the form of a mini dissertation submitted to the Department of Social Work and Criminology in the Faculty of Humanities at the University of Pretoria. The researcher was honest and did not manipulate the data as she did not alter or manipulate it (Strydom, 2011: 126). A manuscript will be published in this regard.

All the above ethics guided the researcher, however there were some limitations. These are highlighted below.

3.8 Limitations of the study

The study was carried out on the one mental health unit of Namibia. In the study sample the pharmacist was supposed to be part of the study but the researcher was informed that there has never been a pharmacist since the one who was there left about six (6) years back. All the people working in the pharmacy at the mental health unit were pharmacist assistants and the one who was there had only three (3) months of experience. Furthermore, as this study was based on collecting information in the participants' own words, the possibility of some participants to give biased information with the aim of presenting themselves in a positive light could not be excluded. To safeguard against this limitation, participants were informed that their responses would be quoted anonymously and hence would not be linked back to them.

3.9 Empirical findings

This section presents the participants' biographical information. Themes and sub-themes that emerged from the interviews will also be highlighted. Findings are presented in the form of narrative passages and are compared and contrasted with evidence from literature sources. As a measure to protect confidentiality, the participants' job descriptions are referred to as job description 1, 2,3,4,5 and 6.

3.9.1 BIOGRAPHICAL DETAILS OF RESEARCH PARTICIPANTS

The criteria of the study required that all participants who took part in the study be qualified health professionals. Other biographical details that will be highlighted in this section include the research participants' sex, age group and years of experience working at the mental health unit of Windhoek Central Hospital. The details will be presented below.

Participant	**Gender**	**Age-Range**	**Years of Experience**
1	Female	30-39	3
2	Female	30-39	5
3	Female	30-39	4
4	Female	40-49	9
5	Female	50-59	28
6	Male	30-39	5
7	Female	30-39	6
8	Female	21-29	4
9	Female	40-49	2
10	Male	30-39	10
11	Male	30-39	9
12	Female	30-39	3

3.9.1.1 DISTRIBUTION OF RESEARCH PARTICIPANTS BY SEX

As shown in Chart 3.1 below, three out of twelve participants were male whilst nine were female.

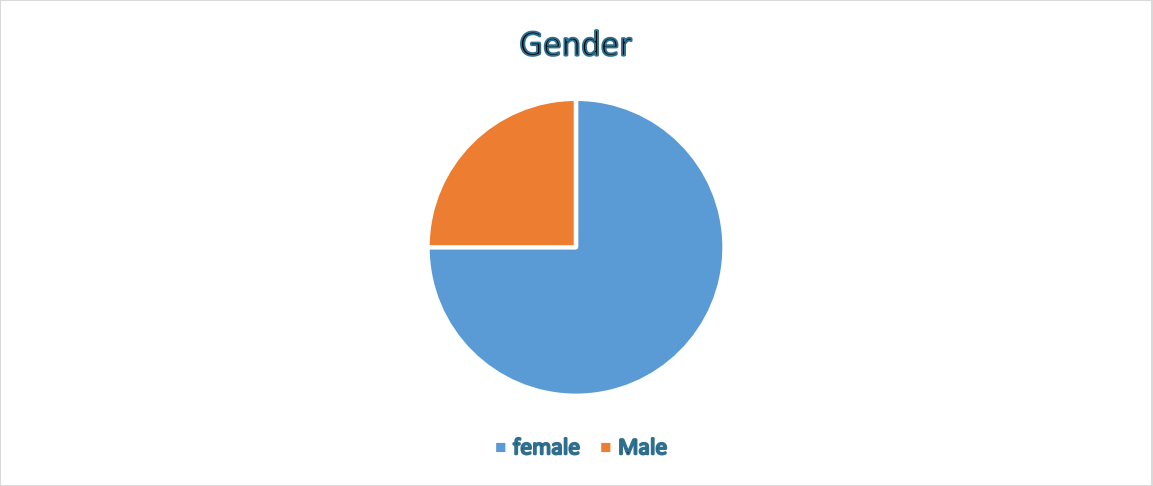

Chart 3.1 distribution of research participants by sex

3.9.1.2 DISTRIBUTION OF PARTICIPANTS BY AGE GROUP

The age group of participants who took part in the study ranged from 21 to 29 years. The oldest was in the 50 to 59 years range. As shown in the chart below, 8 of the participants fell in the age group 30 to 39 years and 2 fell in the age group of 40 to 49. The age range of 30 to 39 had a lot of participants because this was the middle age. At mental health this is the group which still needs experience and from this group that is when they can go and specialise after gaining the required experience. Shatona (2015: 69) in her dissertation, points out that most of the MDT members who participated were in the same age range. It seems most people with work experience of two years and above are within the age range of 30-49 and are interested in participating in research studies.

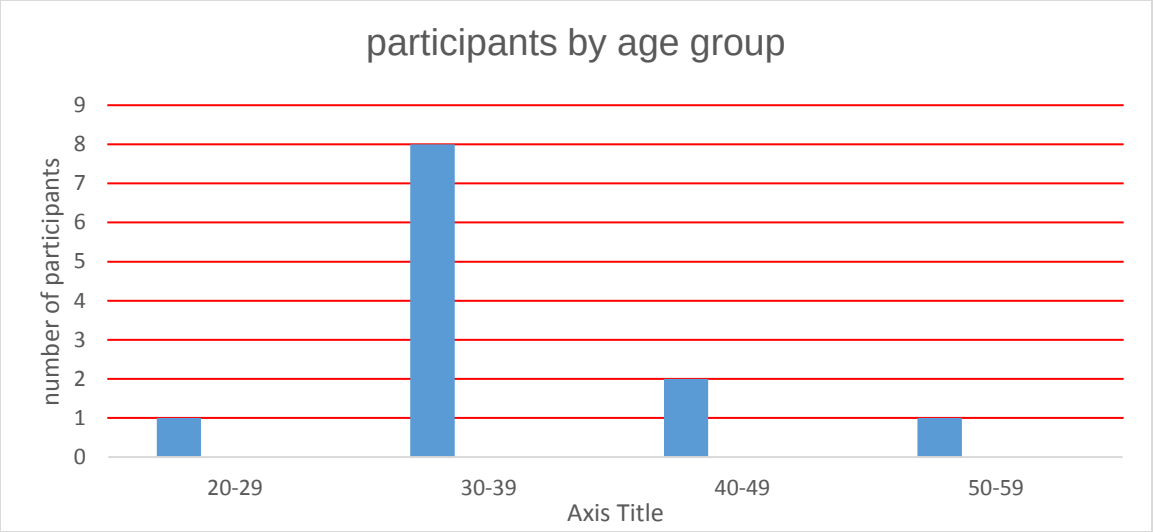

Chart 3.2 distribution of research participants by age group.

3.9.1.3 RESEARCH PARTICIPANTS BY YEARS OF MENTAL HEALTH EXPERIENCE

The years of experience ranged from 3 to 28 years. This is illustrated by the Chart 3.3 below. As illustrated on this chart, the least number of years of experience is 3 which has only 2 participants and the highest number of years of experience is 28 years and has only 1 person with such an experience.

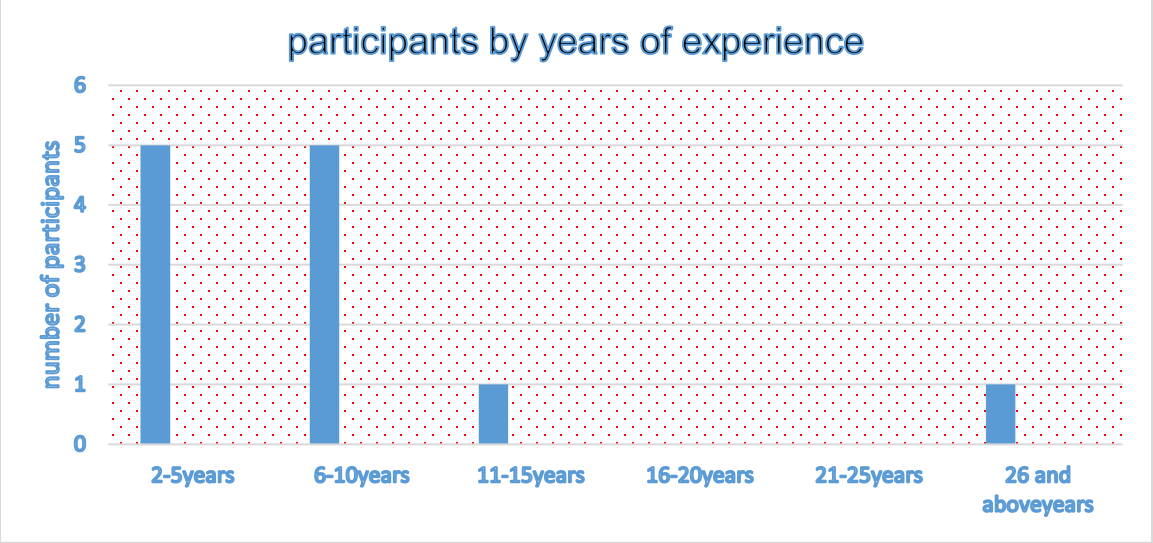

Chart 3.3 Years of experience of research participants.

3.10: DATA ANALYSIS: THEMES AND SUB-THEMES

THEME	SUB-THEME
1. Conceptualization of MDT	1.1 Understanding of MDT 1.2 Team members in MDT 1.3 Duties and roles of MDT 1.4 Utilisation of Knowledge and skills 1.5 Feelings of working within the MDT 1.6 Perceptions of mental health Service delivery 1.7 Comparison of international MDTs with national mental health MDT
2. Experiences of working within the MDT	2.1 Provision of service 2.2 workload
3. Challenges faced by MDT in service delivery	3.1 challenges 3.2 Dealing with challenges 3.3 support
4. Motivation to work within the MDT	4.1 reasons why motivated and Continuing rendering services. 4.3 resources needed for effective Services.
5. General comments	5.1 comments on the MDT 5.2 Suggestions to enhance the service of MDT.

Table 5: summary of the themes and sub-themes

Five main themes, each with a number of sub-themes were identified from the data. The first four themes focused mainly on their experiences as well as the challenges. The last theme is the general comments and in which suggestions were given on the enhancement of the MDT services.

THEME 1: CONCEPTUALIZATION OF MDT

The researcher had to know the team members first and explain their duties as members so that the whole concept of MDT was well understood.

Sub-theme 1.1: Understanding of MDT

All the participants indicated that they understood MDT. Most of them described an MDT as a team of different professionals working together to attain the same goal. The following quotes from three participants (P5, P1 and P7) demonstrate their sentiments regarding their understanding of an MDT:

- *P5: "The multi-disciplinary team is consisting of healthcare workers of different professions or disciplines, they are working together for a common goal that is to provide care to the patients……"*
- *P1: "My understanding of multi-disciplinary team, team who works together, many professionals of different areas… MDT in a mental health unit, could be different professionals coming together, work as team pursuing the same goals basically."*
- *P7: "My Understanding of the multidisciplinary team is involving different professionals….Different professionals but focusing on one goal like here we use bio-psycho social model."*

Although others said that an MDT comprises different professionals they left out the concept of focusing on one or same goal. Their understanding of different professions was clear but with different professions in the department it does not necessarily mean they are working towards the same goal. MDT works towards the same goal. Two participants (3 and 9) viewed MDT as:

- *P3: "Multidisciplinary team basically means when you say multi it means different. Different professions working together as a team to basically resolve a client's presenting problem."*
- *P8: "Multidisciplinary team refers to a team of different professionals in a certain department."*

Having a qualification does not necessarily mean one has knowledge on the MDT approach as it is mostly not offered during training at tertiary level. Reeves, Lewin, Espin and Zwarenstein (2010) claimed that professional graduates from universities lack the attributes of a traditional teamwork which has not been included in their training. Training of mental health workers should include education on effective teamwork and be available to a wide variety of professionals (WHO European Ministerial Conference, 2005).

Sub-themes 1.2: Team members in MDT

Participants mentioned their team members. Some mentioned other team members who are not professionals. Two of them (P5 and P10) said the following:

- P5: "*My core team members are doctors, medical doctors, psychiatrists, social workers, occupational therapists, clinical psychologists and also members like we also depend on non-clinical staff such as our cleaners, kitchen staff, they can be our eyes and ears of the patient's behaviours and report to us, and our security staff."*
- *P10: "We have obviously, occupational therapists, clinical psychologists, nurses, they form the bulk of the team. Then we have the doctors, social workers. I think we also have a pharmacist, he does not feel he is part of the team, we hardly meet but they play a role."*

The four health care professionals who constitute the core mental health discipline are, psychiatric nursing, psychiatrist, clinical psychology and psychiatric social work (Patidar, 2013). Other professionals mentioned are physicians, rehabilitation nurses, physiotherapists, dieticians (Neumann et al., 2010:4-8). Patidar (2013) had additional team members, namely, ECT technicians, Auxiliary personnel, recreational therapists, divisional play therapist, creative Art Therapists and Clergyman. MDT at mental health does not have some of the additional team members stated by Patidar (2013). It has social workers, medical doctors, psychiatrists, occupational therapists, clinical psychologists, nurses both registered and enrolled nurses, security staff and cleaning staff.

Sub-theme 1.3: Duties and roles of MDT members in in MDT

According to the participants, they all knew their roles and duties. Despite knowing their roles some did not perform their duties. Social workers felt they were limited to a certain extent. All participants knew their roles and they said they had identified problems and referred them to the responsible team members. For example, if it is a social problem identified by a doctor or occupational therapist they referred to the social worker. The following were the responses from four of the participants (P8, P6, P11 and P2):

- *P8: "My duties as a social worker within this multidisciplinary team is mainly to offer counselling in certain areas for certain issues. Although this setting is a bit different from most other although we are trained, we are sort of limited to a certain extent."*
- *P6: "My primary role is to rehabilitate the State President Decision (SPD), engage them into activities for them to attain the skills that they will require to go out and live independently as possible."*
- *P11: "As a psychiatrist you manage the patient, not only biological treatment but we also train to do some part of counselling."*
- *P2: "So my duties a medical doctor is to do the initial assessment of the clients who have been referred or admitted to us to make diagnosis as well as to plan around the management of the patient….once I have done my part, my other duty is also to recommend or to make referrals to people that I think might need to see the patient."*

The duties of the social workers are to make applications for admission to the mental health unit and investigate the home circumstances of the patient and social factors contributing or triggering the mental illness and find a suitable guardian whom the MDT can contact about the patient (Australia Association of Social Workers, 2015). These factors will help with the diagnosis and indicate whether the illness is generic, psychological or has some social issues attached to it (Golightley, 2008:81). This is part of the assessment that the social workers do. They also offer counselling, adherence, encouragement and education to patients and their families (AASW, 2015). Risk assessment is done by social workers which helps in hospitalisation and discharge of patients (Gould, 2010:63-161). To ensure that the other team members do not violate

patient rights, social workers advocate for the rights of patients and also for their proper care (Golightley, 2008:55-57). These are some of the duties of a social worker which they need to put into practice. However, as indicated above they were limited to a certain extent. In order for the team to be effective there must be clear roles (Mental Health Commission, 2006). In August 2006 the General Assembly adopted the first UN convention enshrining the rights of persons with disabilities through the Convention on the Rights of Persons with Disabilities (CRPD). The CRPD is the first human rights convention of the 21st century and the first legally binding instrument with comprehensive rights and protection for individuals with disabilities including those with mental and intellectual disabilities. All MDT members should take into consideration this convention, not only social workers (Parwiz, 2015). Other team members will also concentrate on their duties like the psychologist dealing with the psychological effects on the patient. Doctors can also prescribe the medication and nurses administer the medication. In all circumstances the psychiatrists confirm the diagnosis after all the reports have been made and presented. All team members using the biopsychosocial model should give in their inputs per each patient.

Sub-theme 1.4: Utilisation of knowledge and skills by MDT members

Participants had different views with regard to utilisation of knowledge and skills by MGT members. The majority highlighted that they were not fully utilising their knowledge and skills and some said they were utilising them partially and not fully. Here are some of the views from seven participants (P11, P1, P3, P6, P9, P7 and P8):

- *P11: "Not at all, not even… I do not think one third or even half of what I know that being said it is also based on where we are placed….little support we are getting there is not much you can do for your patients.."*
- *P1: "I don't think so that I am fully utilising it because of the setting….there is no much of time and space to do your work. I feel I can do more but the setting is not ideal. We don't have running groups for group therapy, this is a limitation and I could utilise this."*
- *P3: "Hmmm, to a certain extent yes…"*

- *P6: "No, not to the potential that I think I have because of restrictions that we have in terms of the law, in terms of the structure of the environment. It is limiting itself. There is more that I can but I cannot."*
- *P9: "I can say no, I would like to do a lot but there are some limitations of what to do…. In the community I am not fully utilising my skills…. The country is not really utilising me."*
- *P7: "I think I am, though with more training I think we would use more knowledge."*
- *P8: "Not at all. Most of the time I feel like I have underperformed myself. In fact there are times that I regret having done this course but when I look at the whole issue…"*

Due to some of the restrictions and the structure of the mental health that participants have, one cannot fully utilise one's knowledge, hence the biopsychosocial asserts that professionals have to work together and plan together and see the outcome together using their knowledge, qualifications and experience (Clarke & Walsh, 2009:103). Skillful handling of the situation is required of all members of the team to care for patients. Some of the competences needed are good communication, knowledge of treating and rehabilitating patients living with mental illnesses and also good collaboration with other team members (O'Daniel, 2008). Since it is a holistic approach all team members must execute their skills and knowledge to come up with a treatment plan for the patient. According to the participants this is not happening.

Sub-theme 1.5: Feelings of working within the MDT

Participants had different perceptions of their feelings. Most feelings were positive and a few were negative. Seven participants described their feelings as follows:

- *P5*: "*Working within the multi-disciplinary team is challenging but it is quite interesting for me. I like it a lot. It is where I can share my knowledge. I learn from other professions and they are also sharing their experiences and knowledge."*
- *P11: "It is quite frustrating, because sometimes you find that some people we all did not train at the same institutions, therefore the training was different. We are supposed to work according to WHO human rights but then when it comes to*

here you see that most people do not do that and that is quite very frustrating for you who is caring for the patient."

- *P1: "I think it's a variety of feelings depending on the time and the case. However sometimes there are challenges and you might feel frustrated, I might feel that one of my colleagues haven't done certain interventions that I feel should be in place and it can be quite frustrating. I think I am satisfied with working in the team."*
- *P3: "...there is always challenges and blocks along the way."*
- *P6: "It is positive because we have each other in attaining the same goal so it makes life easier for us to work because we are actually seeing patients from different aspects of treatment."*
- *P9: It is fine, there are some challenges here, we differ, and we are all professionals different backgrounds and different personalities or different moods on specific days.*
- *P7: "I think it is a good approach to assist patients using the multidisciplinary team. It is very good and quite effective."*

Participants stated the reasons why they felt positive or negative about working within the MDT. The findings concur with Clewley and Bowen-Clewley (2005:6) who point out that there are some advantages and disadvantages of working within an MDT. These were mentioned by the participants. For example, Clewley and Bowen-Clewley (2005:6) mentions that MDT has increased learning and development of people and institutions which is what one of the participants said (see quote above on sub-theme 1.5). Another advantage mentioned by Clewley and Bowen Clewley (2005: 6) is that there are improvements in job performances and work quality, and also improved outcomes for patients and their families. They further highlighted that MDT breaks down professional silos that encourage isolation practices. However there are some obstacles as well such as lack of a formal evaluating criteria and lack of trust between participating professions. The theoretical framework states that the biopsychosocial model is the best model used in the mental health unit. One has to be prepared to work with other members as the rehabilitation of a patient consists of different professionals. The result of rehabilitation

is not because of one profession but a collaboration of different professionals (Pilgrim, 2002: 585-594).

Sub-theme 1.6: Perceptions of mental health service delivery by MDT members

These are the views of nine of the participants:

- *P2: "I would say it is poor, poor the reason that I have highlighted that they are not yet functioning fully yet as a multi-disciplinary team and because of that we are actually compromising the patient care."*
- *P9: "Here, there are no psychiatrist in other places."*
- *P6: "Treatment should be more at home than in the institution because I have realised you attain better results when you treat a patient in their community. The positive is that medication is free, treatment is free for the citizens"*
- *P1: "We are still lacking and left behind…I would say we are in the middle and still a lot can be improved.*
- *P11: "I think we range at the very bottom."*
- *P10: "…the way mental health cases are managed at the national level, there is still room for improvement…"*
- *P12: "Now at mental health unit, it is actually working out well but I think in other peripheries and the district hospitals it might be a little bit tricky…. It is very difficult these people do not have psychologists in certain areas."*
- *P8: "perhaps in terms of service delivery to patients, it is quite effective but in terms of those delivering the services there is a big question mark"*
- *P4: "Shortage of staff, this is throughout all the disciplines."*

Globally, there seems to be a shortage of mental health care service deliverers (professionals) (Mental Health Commission, 2006). In Africa, mental health lacks professionals (Filho and Bertolote, 2006:560). In Namibia there are limited mental health programmes and this has also impacted on the mental health service delivery. The shortage of staff as viewed above (Beukes, 2017) makes the service delivery weak as the few staff will not cope, hence, resulting in many relapses. The participants noted

that substandard work cannot be ruled out as everyone will be working to clear the queues and putting effort in providing maximum effective service.

Sub-theme 1.7: Comparison of international MDTs with national mental health MDT

Most participants stated that they had never experienced the international MDTs but had only read about them. A participant mentioned that, what is being done in Australia and at Bloemfontein in South Africa by the MDTs is similar to what is being done at the Windhoek Mental Health Unit. However, others mentioned that the international is better because out there mental health professionals are recognised and paid well. It was also noted that there is need for emphasising what it means to work as a team. This also emphasises of the point on training on team work which was mentioned above in sub-theme 1.1. The following six quotes demonstrate the sentiments of the participants with regards to the international and national MDT:

- *P4: "The difference is here at this mental hospital, there is actually poor participation of other disciplines."*
- *P8: "Social workers and psychiatrists are given high regard in other parts of the world. They are doing a lot, they have better salaries, ongoing training and better conditions."*
- *P10: "Where I worked before there was too much power with the medical side….you could not feel your importance in terms of occupational therapists.*
- *P6: "I have realised that some teams are now more of inter-disciplinary team than multi so it is like you work more together if you are inter-disciplinary….. with multidisciplinary team is like you do your part as a profession then you come and present your results."*
- *P2: "Based on other experiences that I have had outside the country elsewhere, I think we need to try and emphasise on really what it means to work as a team."*
- *P5: "Our services have improved over the years compared to the international services. I attended Bloemfontein forensic psychiatry complex and we are on the grounds. What they are doing within the multidisciplinary team in Bloemfontein, what we are doing is just the same, in Australia what I have read from them is that we are doing what they are doing."*

Domination of a discipline, which is also found in the international MDTs was also mentioned. Medical doctors were identified as the dominant discipline by some participants. Apart from the domination of one profession, there is a common challenge both internationally and nationally which is shortage of staff, although internationally they train a lot of mental health professionals (Ndetei et al., 2007:33, 36). This affects the composition of the MDT. Internationally, according to one participant, she had heard from her American intern student that they had better facilities compared to national (Namibia). The researcher concluded that there is no full commitment from all the MDT members hence the biopsychosocial model used at the mental health unit requires input and full participation of professionals. When using the biopsychosocial model there should not be a gap. By implementing it, the mental health unit of Windhoek had the staff composition of all team members essential for this approach.

THEME 2: EXPERIENCES OF WORKING WITHIN THE MDT

From the participants' responses, with regards to their experiences of working within the MDT, the researcher identified two main sub-themes of experiences which are provision of service and workload.

Sub-theme 2.1: Provision of service

Participants responded differently on their experiences in provision of service. Some were optimistic that they were doing well and had good experiences whereas others were of the view that it was not well. On this sub-theme the views of the seven participants were:

- *P5: "So, team members, the service delivery is a collaborative effort in or hospital and team members are working together."*
- *P2: "I have for sometimes trying to speak to relevant members of the other profession just so we can try to have an approach that is working an approach that makes us better as a team. But like I said most of the time my efforts has fallen through because sometimes there is absenteeism from other members of the multi-disciplinary team. Other times people seem not be cooperative, people would agree to do as it has been discussed but in a few weeks' time there is no accountability."*

- *P4: "Time, because of the shortage. No time to attend. We actually informed about things happening."*
- *P8: "I have learnt that working with the multi-disciplinary team is good because it really helps you as a team to cover all the loopholes with the service users lives…We are overworked social workers are overworked. This is the only unit in Namibia and we are only two for the whole country for the civil side. We are overworked and it is discouraging because we work with the whole country."*
- *P12: "There are always differences when you have different people working together but at the end of the day I think we do learn quite a lot and we do tend help a patient when we are working together."*
- *P11: "It has its pros and it has its cons because of the channeling system as much as it is there, you sometimes find that your patient is lost from point A to point B."*
- *P3: "…human beings have their own issues and sometimes bring their own issues to work and you have personal conflicts that sometimes often at times affect the ability of someone to do their work."*

Heavy workload is one of the experiences mentioned by the participants. They said it was because of the shortage of staff and the fact that that there is only one mental health Unit in Namibia. The workload was high, and the experience of the MDT was marred by such negative elements including absenteeism and exhaustion. The shortage of staff was said in so many ways that all of the participants mentioned it one way or the other in different themes.

They pointed out that time to perform all tasks is limited because of the shortage of staff. The biopsychosocial clearly states that different professionals focus on their roles, treating the patients and competence is needed (Quiznet, 2019). In this case the researcher can conclude that if there is shortage of staff and absenteeism, other professionals will end up doing tasks that they were not trained for. For example, when one takes the duty of the psychologist yet one is a doctor. This may hamper the proper service delivery to the patient. Because of doing what one was not trained to do a conflict may arise (Clewley & Bowen-Clewley, 2005:8) The Zimbabwean (2009) senior

official at one of the mental health hospitals said the hospital was operating with a skeleton staff meaning the workload was challenging. There should be a clear mechanism for conflict resolution with the recognition of some structures (Mental Health Commission, 2006).

Sub-theme 2.2: workload

As stated above the workload was high due to shortage of staff. As a result, consultation time with the patient was reduced so as to attend to all the patients. Participants viewed this as a big challenge. All participants mentioned it. All the disciplines at the mental health unit of Windhoek central are highly short staffed. Some of the views from three of the participants were as follows:

- P8: "*Social workers are over worked. We are only two at the civil side and we have five wards. We are only two for the whole country for the civil side. We are overworked and it is discouraging."*
- *P6: "It is overwhelming, we are not fully staffed for us to be able to engage our patients in more activities before we had more staff members but some resigned."*
- *P3: "It gets really overwhelming so we are understaffed, man power is an issue, so we do what we can."*

The following are the views of three participants who felt that because of high volumes of work, consultation with patients was compromised and they are practising crisis management.

- *P11: "The workload is a lot, honestly it is a lot it is something that people are ignoring. You see, per day you see more than twenty patients and remember you are only supposed to have fourty five minutes per person so in that fourty five minutes, it means we are cutting down the time that we are seeing patients, then you neglect some aspects of this patient or if you complete the fourty five minutes it means the others will not be seen."*
- *P10: "From civil side it's kind of crisis management at times."*
- *P3: "So the workload is quite a lot yes, we do try to cope because we know we do not really have a choice and we have to, but it is a little bit difficult when you*

have a lot of patients and sometimes you cannot give them all the care they need. So it is not really easy."

Watson and Marschall (2013: 53, 64-66) facet that in America because of the high staff turnover some areas have no psychiatrists and staff members complain of high workloads. They said they always had backlogs in paper work. Such issues have implications on the service delivery hence the function of MDT in the provision of service leaves gaps. The theoretical framework clearly states that the biopsychosocial model asserts that the approach is holistic hence, all professionals should present their findings so that a proper diagnosis can be made (Pilgrim, 2002: 585-594). The findings show that due to heavy workloads professionals compromised their attention to the patients in order for them to clear the long queues. This means that the information they collected may not be sufficient enough to give a proper diagnosis or a comprehensive rehabilitation hence, the relapses.

THEME 3: CHALLENGES IN SERVICE DELIVERY

Participants highlighted the challenges they were facing which hampered their service delivery. All of them echoed the same challenges and same sentiments. The sub-themes which the researcher came up with are challenges which all participants mentioned, how they deal with these challenges and also the support they get from the national level pertaining to their challenges. The challenges they mentioned are: infrastructure, budget, human resources, lack of communication, leadership and lack of policies. The researcher will explain what was said on each of the challenges.

Globally mental health receives a disproportionately small proportion of health budget. The psychiatry services lag far behind other services in funding, infrastructure development and human resources (Burns, 2010: 2-8).

Sub-theme 3.1: Challenges

As mentioned above the challenges which were common amongst all members will be examined one by one.

SUB-THEME 3.1.1: INFRASTRUCTURE

The participants said there was no space in the wards and the wards were outdated since they were built long back and at times patients escaped because there were no

security features in the wards. If a patient escapes without recovering then it shows the poor service delivery on the side of the MDT. However, this is beyond their control; the infrastructure is poor. Some MDT members do their consultations in the corridors and confidentiality is highly compromised. Some of the views of the three participants were as follows:

- *P4: "Our wards, the male and female wards, built somewhere in the 60s/70s and they were not improved since that time. We need to have security features within the mental hospital, for example the isolation rooms, the construction of the rooms is way outdated, patients are escaping from the hospital, patients are not supposed to escape from a mental hospital"*
- *P11: "…..people are seeing patients in the corridors and I mean it affects to treat the client if you seeing them in the corridor, confidentiality is affected, so it is really quite poor infrastructure."*
- *P8: "In terms of office space, it is a challenge, we have to share with intern social workers, regarding confidentiality, you have to excuse the intern to attend client if the client is not comfortable in front of other people in the office."*

Despite being the only mental health unit, the infrastructure is not conducive and it is very small. Both civil and forensic are very small. The following are some of the views of two of the participants:

- *P11:"…the number of patients has grown that we cannot actually accommodate but you need to admit. Does that mean you are going to discharge patients who are not stable? Which you also cannot do. At the moment there is nothing you can do, you will keep them until they are less symptomatic before you discharge them, if a room for 4 sometimes you will end up putting 6 with mattresses on the floor or you make them share a room or beds."*
- *P1: "I think patients should be placed according to their diagnosis because currently they are kept together and this sometimes interferes with their*

recovery. We have very stable patients with unstable patients and you find a more stable patient mixing with an unstable patient and they relapse. Space wise it should be more beneficial, we can divide patients more relevantly"

All participants echoed the same sentiments on the ward space which they said was not conducive for the whole country and a lot was lacking. For the holistic approach to be effective space is needed since each professional needed time alone with the patient. The biopsychosocial model will also inform the actions taken, such as planned interventions, and allow the practitioners to predict outcomes of the patient (Clarke & Walsh, 2009:103). The findings drawn from this sub-theme is that, consultations are done in corridors which is unprofessional; the confidentiality of patients' information is compromised. Proper and conducive offices are needed.

SUB-THEME 3.1.2: BUDGET

All participants raised a concern on the budget being inclusive in the main hospital. They said there was no specific budget for mental health hence, they could not do some other things like in-house training, attending workshops, buying needed equipment and tools used in some programmes like carpentry tools and also repairing broken items like toilets taps and shower rooms which require funds. Lengthy procedures have to be followed to request for funds. It is not however always the case that they get the requested funds. Some challenges are caused by this inclusive budget as highlighted below by two of the participants.

- *P2: "Mental health unit is operating under Windhoek Central Hospital. It is usually highlighted that as long as the budget is coming from Windhoek Central Hospital, we are limited in how much we can do.*
- *P10: "As far as I know we don't have a specific budget for mental health, it's tricky because I think we just have a blanket budget for the whole hospital as part of the Windhoek Central Hospital. I think there is part of the budget for mental health but we don't know how much is available. The challenge is there is no specific budget for mental health….currently we have some challenges in terms of finances."*

Fihlo and Bertolote (2006) note that in many African countries, mental health is not recognised as a distinct specialty. In Namibia, the participants mentioned that mental health is not a priority; it is treated like a step-son. They said the mental health budget falls under the main hospital Windhoek Central Hospital and when it comes to mental health requests it is always limited, Watson and Marshall (2013:53, 64-66) noted that in America mental health also has low funding.

Moloo (2016) reported that the Democratic Republic of Congo (DRC) government's involvement in mental health is minimal, hence a very minimal budget is allocated to mental health. In Namibia it was highlighted by the Acting Deputy Director of Disability Prevention and Rehabilitation with the Ministry of Health and Social Services that they have been working on a new mental health bill since 2006 (Mushimba, 2018).

The budget has also brought about other challenges such as the shortage of equipment which hampers service delivery and affects the service provider. Some other tests cannot be overridden because they give clues to what medication should be given. No equipment, leads to no proper treatment that is what the researcher found on this sub-theme.

A participant highlighted the following challenge pertaining to the simple and obvious equipment which should be always in the unit but is scarce. This simple equipment can cause loss of life at times. The participant said:

- *P2: "There are times where we have to go to the extent of sending one of our medical intern to the other hospital either Katutura hospital or Central just to get something simple like blood pressure cuff and you if you understand that is already losing time and in emergency situation every second can count (*compromising patient's life) *So at the time someone has gone to Katutura hospital to look for a cuff and brings it back, you have already lost a good ten minutes, and in that good ten minutes a life can be lost."*

The essence of being a health unit is having medication apart from therapies received from other professions. If medication is not readily available, there are challenges for

both the staff members and patients and changing medication can increase side effects. Four participants had this to say:

- *P11: "Our budget would need to be increased…. And we need regular supply of medication so that we are not changing from one medication to another."*
- *P12: "With medication, we have been experiencing some shortage of medication that is a very major challenge.*
- *P4: "The other thing is shortage of medicine, we are not informed by pharmacist. When you discharge a patient the doctor prescribes, the patient goes to collect the medicine, only to be told by the pharmacist there is none."* (Poor communication).
- *P11: "So having to recommend the addition of other medication it is also a process.*

Patients lose trust in the service provider if medication is unavailable. Poor communication leads to frustration on both the patient and doctor. When using the biopsychosocial model, trust is needed among the professionals. Clark and Roopai (2011: 52-53) assert that another major obstacle is that in many countries mental health is not well structured and the availability of certain drugs like antipsychotic cannot be assured. Since the holistically approach is used to treat patients, pharmacists are part of the team in a biopsychosocial model. They work hand in hand with doctors in providing the prescribed medicine. The biological needs like managing symptoms and psychotic episodes go hand in hand with the assessment done by doctors and psychiatrists in the MDT, and the pharmacists provide the medicine (Clarke & Walsh, 2009:122). If they are not present in the meetings then the team will suffer by not knowing what medicine is available to prescribe for managing the symptoms and psychotic episodes.

SUB-THEME 3.1.3: CENTRALISATION OF MENTAL HEALTH SERVICES

Three participants' views were:

- *P9: "It is important for regional hospitals to have a mental health department. That department to have the right MDT not to focus on social*

workers and psychiatrists only. If possible a few selected regions to have a mental health service with MDT there, to improve mental health services in the country."

- *P1: "… there are a lot of people living in the remote rural areas, don't have access to mental health services….. the facilities shouldn't be one unit only….. a lot of countries are moving towards a more community based service delivery and I think it is a huge challenge here. We don't have community based care and it's a challenge, it would be easier to have people trained in mental health in the community and this can prevent a lot of cases."*
- *P7: "… we were hoping that we could even get a half-way house, where we can put our patients and then we could have more programmes with them once they are waiting to be discharged and going home to their family members. We don't have all those things."*

Mental health services have been decentralised in other countries by introducing community health care centers thereby making the service available at community level and mental health units congestion is minimised (Liberman et al, 2001: 1332). However, it is a different story in Namibia as revealed by the participants. The model use at the mental health unit asserts that different qualified professionals from different disciplines work together to provide a holistical treatment for the patient (Jurgutis et al., 2007).

According to Mushimba (2018) the new mental health Bill is in progress although it has taken too long. Many programmes are included in the Bill. Mushimba further said that in Namibia there is nothing called community health center and this contributes to the work overload at the only mental health unit. Beukes (2017) highlighted that because of lack of community health centers there are so many relapses as the MDT at mental health unit cannot do the monitoring and evaluation of discharged patients. There is only one mental health unit which covers the whole country. The low budget hinders the Ministry devising other systems enabling them to decentralise other programmes like community health centers. This helps to ease the congestion at the Windhoek mental health unit. After discharging patients, these can be sent to half way houses for further

rehabilitation. Half houses are really necessary before patients go back to their respective communities fully recovered. Hence, relapses are reduced.

SUB-THEME 3.1.4: HUMAN RESOURCES

All participants expressed concern over the workload. This may cause the MDT to deliver substandard quality of service as they will be working towards attending to all the patients for the day. This has also been discussed above under Sub-theme 2.2., Workload. This is what another participant said:

- *P2: "I have to say the workload is quite overwhelming because as permanent medical doctors who are working here, we are only currently four. Besides the workload of the patient from both civil side and forensic side, we also have students who are in training, we are also having medical interns who need supervision, so you will find that for the number of patients that we receive here, four doctors is actually inadequate…. Because trying to manage both civil and forensic as well as training of students is quite overwhelming."*

Another participant had this to say about shortage of staff:

- *P5: "The workload I would say for us the current staff, it is very huge, they can barely cope with what they are supposed to do. They provide just the basic essentials care and not as we would like them to give, care holistically, to talk with family members and to provide activities that is engaging the patient."* (Poor service which is substandard).
- *P4: "Shortage of staff, this is a shortage throughout all disciplines not only nurses, doctors as well as social workers and occupational therapist. There is a big shortage….in this ward we are working with 23 patients…the maximum number of patients that one nurse can take care of is five. That is the maximum I have heard of, to care alone. Our ratio here is 1:12 or 1:15 patients which is very difficult. The workload is very big, we attend to all patients coming from all over the country.*

In America, the state of Nevada faced several problems like low funding and high staff turnover because of low remuneration. Replacing the staff members is difficult because of the low salaries. It was also noted that some areas had no psychiatrists although the staff members had the relevant qualifications to work in the mental health units. Staff members complained of high workloads and backlog in paperwork. Other gaps identified included staff concerns such as low morale, compensation, recruitment and staff retention. Such issues had implications on the service delivery at the mental health units hence the function of the MDT in provision of services leaves gaps (Watson & Marshall, 2013:53, 64-66).

In Kwazulu-Natal there were 0.34 psychiatrists per 100 000 population. This showed inadequate facilities, funding and critical shortage of mental health professionals. The workload will be overwhelming in such circumstances (WHO-AIMS, 2007:9). According to the study there was little evidence of the government working towards achieving or redressing inequalities.

Findings are that, the Namibian government has since stopped the recruitment of health professionals until further notice. The biopsychosocial approach is compromised as the team may lack other professionals. The government for now is not working towards achieving effective service or addressing inequalities.

SUB-THEME 3.1.5: STAFF RETENTION AND TURNOVER

Two participants said:

- *P10: "From my observation, staff retention is not good. Staff members come and go and a few stay. I think maybe for professional growth, people don't want to stay in the same position for a long time, or their contracts are not renewed, could be for those reasons…"*
- *P4: "A lot of people are resigning from the Ministry."*

At the mental health unit of Windhoek Central Hospital the participants noted that their salaries were not competitive and the environment was not good. Although they all like their job, the challenges stated above forces staff members to look for greener pastures.

The retention of staff at the mental health unit is not easy. There are no incentives to attract employees to stay.

Aaron and Sawitzky (2006) state that the service provider turnover rates in mental health and human services organisations are often high and an ongoing concern in managing mental health case management, clinical and therapeutic service programmes. Bingley and Westergaard-Nielsen (2004:557-563) highlighted the effects of turnover as poor staff morale, ineffectiveness of staff, reduced productivity, weaker work teams and increased costs of training new employees. Aaron and Sawitzky (2006) said in public sector organisations, turnover has been attributed to factors such as the high stress environment, lack of support and low pay.

Podoweltz (2018) states that if a higher post is vacant or created, the public service commission of Namibia's policy requires that the post be advertised, and the commission does not consider promoting those with long service and experience at the mental health unit. The post is advertised nationally and mostly people who have never worked in that area or department get the posts. The old staff members are frustrated as they teach the new manager how the department works. Therefore, those who want professional growth leave mental health for better places to achieve their goals (Podoweltz, 2018).

Clarke and Walsh (2009:103) state that team members using the biopsychosocial model need to understand the nature of the problem (mental illness), and biopsychosocial model users need to be competent in their duties. In the case of posts being advertised and considering there's only one mental health, chances are that the newly appointed professional(s) will not have adequate knowledge of mental health and how to work as a team.

SUB-THEME 3.1.6: LACK OF TRAINED MENTAL HEALTH STAFF

Here is what one participant said:

- *P5: "When it comes to skills we are short. There is only 12 nursing staff that has been trained or has trained in psychiatry. We are seriously shot of staff when it comes to skills and this sometimes hinder our functioning because*

you will find that nurses that trained in psychiatry are scattered all over whereas the ideal situation should have been better for each ward to have a nurse trained in psychiatry."

In the regions where patients come from, there are no trained professionals in mental health hence training needs to be done so as to minimise the number of relapsed patients and referrals for simple procedures. Had it been that there are trained professionals in mental health in the regions, the work load at Windhoek mental health would decrease. Thus, because of insufficient trained personnel, the MDT of mental health becomes responsible for training the regions. One participant said:

- *P10: "Lack of mental health care professionals in the regions, districts and the way mental health cases are managed at national level, there is still room for improvement. We don't have professionals and when we give training in the regions you can easily see people who handle mental health cases, they lack basic skills."*

In every field if trained staff in mental health is inadequate, this will always bring a lot of challenges. The Windhoek Mental Health Unit is not spared from this challenge. Apart from lack of trained personnel, participants raised a concern that their managers go for training and the people who do the ground work are denied such opportunities. In such instances, the managers should consider sending their subordinates to learn and implement new skills in their work. One of the participants highlighted this as follows:

- *P8: "The workshops and trainings the heads go, instead of sending their subordinates, you as the head don't do ground work, allow your subordinates to go for training so that they can learn and implement the new skills that were picked up."*

Jurgutis et al. (2007) state that for teamwork to be effective, professionals need special competences. One of the competences is acquiring relevant skills. Due to lack of skills, more work is loaded back to the mental health unit when a patient relapses in the community, hence, the increase in relapse cases at the mental health unit of Windhoek Central. Lack of trained personnel is a big challenge. With all these challenges, one

would think of training, orientation and induction for the new recruits at the mental health unit which is discussed under the next sub-theme.

The Zimbabwean (2009) reports that the Zimbabwe's mental health delivery system is handicapped by a chronic shortage of trained psychiatrists and psychiatry staff (MDT). Moloo (2016) also reports that the Democratic Republic of Congo (DRC) has problems in service delivery. The challenge faced by most professionals working in mental health units in the DRC is that professionals are trained in general health and do not have an in-depth knowledge of mental health to deliver quality services. It can be concluded that, if there are no specialists such as psychiatrists, mental health nurses, clinical psychologists and mental health social workers then their biopsychosocial approach will not really be implemented correctly because the model requires trained professionals who know what to look for in a patient for a holistic treatment (Clark & Walsh, 2009:122).

SUB-THEME 3.1.7: TRAINING, INDUCTION AND ORIENTATION

Having discussed all the above, the work environment featured also as a challenge from the participants; two of their views were:

- *P10: "If you are looking at a non-professional team, they will also need some mental health training just basics, some of them are just allocated to mental health care center without induction and so on and they might engage with patients in a way which is going against what we are trying to achieve.*
- *P2: "…If people do not know how they are supposed to function then I cannot blame them if the rendering of the service is also sub optional."*

Even if a professional did not receive training in teamwork during tertiary education one can still get it during induction and orientation at a work place. If training and induction is not done, one would wonder how the team is functioning.

According to Thomas (2018) a television programme in Namibia reported on the Namibian 2000hrs main news that, a violent patient was paired with a calm patient and this ended in a tragedy. The violent patient murdered the calm patient in a room they shared. Bimenyimana, Poggenpoel, Myburgh and van Niekerk (2009) assert that

contributing factors to violence and aggression are mental statuses and the conditions in which patients are admitted, the staff shortage, the lack of support among the members of the MDT and lack of structured and comprehensive orientation among newly appointed staff members.

Some of the challenges are intertwined with the lack of a budget. A participant highlighted it when he spoke about finances needed to train. He had this to say:

- *P5: "Financial assistance would be really a good advantage because the team, you need to train staff members, especially on the core function within the team to improve the overall function of the team,…..we can bring in consultants to train people."* (Lack induction).
- *P7: "...no on-going training to help you refresh the skills and knowledge that you have picked from university and to learn new things that are upcoming. There is no specific training. They keep telling you that there is no budget, no money."*

Induction and orientation when someone starts a new job is vital. This is important. Even if it is a graduate from university, induction and orientation are important. Having a qualification does not necessarily mean one has knowledge on the MDT approach as it is mostly not offered during training at tertiary level. Reeves et al. (2010) claimed that professional graduates from universities lack attributes of traditional teamwork which are not included as part of training. Liberman et al., (2001:1332-1333) facet that performance standards should be set with positive supervision and competency-based training provided. The findings on this sub-theme assert that professionals need to be trained especially on the biopsychosocial approach so that they understand what to report to the team after the interventions and also have an understanding on how the model works as the outcome will need to be determined after the treatment plan. Newly appointed professionals will need training on the management of symptoms and psychotic episodes (Clark & Walsh, 2009:122).

SUB-THEME 3.1.8: LACK OF ADEQUATE POLICIES ON MDT

Participants' sentiments were that because there were no policies on conflict resolution amongst MDT members, conflicts are not resolved. If the supervisors do not try to

resolve and report the matter to the superiors it just dies a natural death. Three of the participants' sentiments were:

- *P10: "I am not sure. I know from forensic we do have, we were working on a policy in terms of who is supposed to do what. I am not sure whether it was finalized so I cannot safely say we do. I feel the team works fairly well but on paper nothing".*
- *P2: "There is no written policies and guidelines. When the multidisciplinary team meeting is called for, all the members who are expected to attend will sign a register, to say they have attended. However, for those who have not attended, there is no follow up, not accountability as to who is going to follow up as to why this person was not in the meeting, is there any apology that was send and so forth. So my personal feeling is that people can get away with these things no one is taking responsibility as to what measures should be taken if a member is not playing their part…..if you do something right you are rewarded, if you do something wrong there should be a punishment for that., and I find that because we do not have written policies, there is never accountability, so people know that they can get away with things, simply because they will never get approached and they will never get reprimanded for their action".*
- *P3 "I hope that your research can help with policy making…"*

The MDT at the mental health unit said, they hold MDT meetings every week and discuss admitted patients. They also have ward rounds on Tuesdays and Thursdays where all MDT members are supposed to be present but this is always not the case as some members do not turn up for these ward rounds. During ward rounds, referrals to other team members are made but due to absenteeism some members will not know about the referrals. They do not account for their absenteeism and there is no written record in MDT meetings. Fleissig et al., (2006:940) mentioned that in MDT there is a problem regarding incomplete attendance at meetings, and MDT cannot be effective if key members are frequently absent. Participants echoed the same sentiments on absenteeism in meetings by other MDT members, mainly the Pharmacist and

psychologists. The theoretical framework of this study clearly states that the bio psychosocial model deals with different components of the patient, namely, the biological which is physical, the psychological and the social factors for it to be holistic treatment (Somjee, 2017:1-2). It can be concluded that if the psychological aspect is not attended to then the whole essence of the bio psychosocial model is lost and not complete.

Conflict resolution was cited as a problem. Two participants had these views:

- *P8:* "*You find the colleagues are not talking to each other and there is conflict… we need a policy for the multidisciplinary team on conflict resolution in this department".*
- *P2:* "*When conflict is not resolved, you would be told that it would be taken up further, either with the medical superintendent officer or with HR depending on the nature of the conflict. But to be honest with you, too many times I feel like it just dies a silent death, you never hear the outcome of it, you never get called to be given follow up or feedback on your complaint, it just ends up becoming silent and before you know it, the same thing is happening again."*
- *P8: "The way it is now, usually if one has a conflict or grievance among the team members, we are told that you must report to your direct supervisor… But if she feels like in her power she will not be able to, then her herself is expected to directly report to her supervisor which is then the head of department and then the chain goes on and on".*

The Chief Human Resources Officer also stated that most team members who resign from mental health complain of unresolved conflicts, poor working conditions and professional stagnation (Podoweltz, 2018).

The Mental Health Commission (2006) identified some important factors which enable some teams to function well. Conflict resolution is one of them. They noted that for a team to work very well, a clear mechanism to resolve conflicts should be in place with the recognition of some authority structures.

SUB-THEME 3.1.9: POOR COMMUNICATION AND LANGUAGE BARRIER

Four participants highlighted this sub-theme as a challenge within their MDT:

- *P2: "Our MDT have to focus on improving communication within ourselves, we should do things together."*
- *P4: "People should start having an open communication system."*
- *P1: "We don't really communicate in between ourselves as practitioners, not because we don't want to or have time for it but be busy with something else, but just to keep in mind to communicate and not just do your part. We need to work as a team 100%."*
- *P2: "What I would add, I think its translation, I would say that is a challenge, Namibia is a multilingual country, we have patients/clients from different backgrounds and it is a challenge to find the person who speaks the language you don't understand to find help with translation. The variety of languages work as a problem sometimes. When they communicate their problem to us I think something is missing…"*

Communication is the key to success. If there is no clear communication pattern, team members get frustrated. For good communication to prevail, both the service user and service provider must understand each other.

Clewley and Bowen-Clewley (2005:8) facet that the forming and reforming of MDTs can create challenges, disturb the team dynamics and impede communication. As a result, there will be no notable professional progress as the team will be busy with team formations. The team dynamics such as cohesion will be difficult to achieve as team members will be constantly changing. Communication is also disturbed if members change constantly and need to learn ways of communicating every now and then. Biopsychosocial is a collaborative holistic approach which means communication among the team members should be professional (Seago, 2008:4-19). Lack of or poor communication creates a situation where medical errors may occur. The errors may result in delayed treatment and have the potential to cause severe injury or the unexpected death of a patient (O'Daniel & Rosenstein, 2008). However effective

communication leads to more effective intervention and improved safety, enhances employee morale, and increases patient and family satisfaction. It also encourages effective teamwork and promotes continuity and clarity within the patient care team (O'Daniel & Rosenstein, 2008). Beukes (2017) noted that the MDT generally finds it difficult to relate to the patient and get to the core of the problems and effect solutions due to language barriers.

SUB-THEME 3.1.10: POOR WORK ENVIRONMENT

Participants at the mental health unit also echoed that they have a serious shortage of staff and the workload is overwhelming. This makes the work environment unpleasant. Three participants had this to say:

- *P4: "First thing, safety, due to poor infrastructure, patients can easily attack us. I was injured about 4times so far and never compensated or given anything. Sometimes I experience severe injuries and I spend a lot of money to treat myself. There is no safety and that is why people are leaving ".*
- *P3: "…I mean there are obviously safety concerns if the patient comes and they are aggressive there is not a lot of structure to assist in keeping the staff safe and also the other patients safe as well.*
- *P6: "…some were citing that the work environment is not conducive to work maybe because of human rights abuse…..they were saying that the human rights were not being upheld, some people were frustrated with the work environment in the sense that it does not support you, it means that you are not able to do your work.."*

Regarding salaries, almost all participants expressed dissatisfaction. They said the remuneration was not commensurate with the work they were doing especially considering that this is the only mental health unit for the country. One participant had this view:

- *P8: "The other thing is salary, we are underpaid for the kind of work we do, you cannot even buy a house and care for yourself at the same time. I wish for that to change because people come and go, they see better opportunities and leave*

- *P3: "there are a lot of challenges here……you know the pay, I mean the salaries are not necessarily market related if you compare with other countries in Africa or internationally. We are not paid the same as other professionals in our field….we work hard and the human resource is not there, working extra and you are still not getting the salary that you probably should be getting considering the work load".*

They are overloaded in terms of work and get exhausted and burn out is a lot. Some said there is no wellness program. Every day is overloaded with work and staff have to find their own ways of dealing with this. However, some strategies disadvantage patients as some staff members just take leave and stay at home. A participant had this to say on wellness and burnout:

- *P8:* "*Sometimes you find yourself having a burnout, you just don't feel like going to work for like that specific week….I mentioned burnout earlier, stress, overworked. We don't even have a wellness officer here, so the only coping mechanism here is to go home and go and rest, take a week off or two, but this does not mean it is a solution because you will still come back to the same stressful department or environment….. we do not have a wellness officer and this is a service that we are supposed to have to take care of the workers in this department we do not have."*

Just the fact that there is shortage of staff, the work environment ceases to be relaxed and productive. One participant noted that at times they have to be on call for longer periods because there is no relief staff. They may not go for training even if they are paying for themselves, because there is no time and they are always exhausted. The environment is a health hazard; there is no security for professionals and if injured there is no compensation.

Mangrey (2016:5-41) in his thesis states that injuries to medical staff caused by mental health care users remain a problem in psychiatric hospitals. Certain risk factors that predispose staff to violence are identified, however not all risk factors are modifiable. The psychological impact of such events on staff can progress to the development of post-traumatic stress disorder symptoms which can in turn contribute to low morale at

work, absenteeism, burnout and decreased productivity. He further emphasised that injured staff should get counselling and support. According to Mangrey (2016: 34-40), staff injured by patients at a South African psychiatry institution felt anger towards superiors and the institution for failing to provide adequate security measures. He also states that increasing the security compliment or recruiting ward orderlies in wards might help to assist in the management of aggressive patients which will then result in staff feeling more secure.

SUB-THEME 3.1.11: LACK OF SUPERVISION/MANAGEMENT/LEADERSHIP

One participant highlighted that there is lack of skilled national level managers. The ones who are heading the mental health programmes are not at all trained in mental health, hence the poor leadership. The absence of a proper structure for mental health at the highest management level at times hampers the implementation of programmes which are supposed to be done. Also, the team will lag behind as it fails to access newly released information. Furthermore, the implementation of new information may take long or may never take place. This is what was raised:

- *P9: "There is work to be done from national level where mental health issues can be addressed….we need a coordinator and a clear directorate for mental health services…"*

According to the biopsychosocial model, professionals should be competent and have knowledge in mental health in order to provide effective service as a team (Jurgutis et al, 2007). For a team to be effective it must have good and strong leaders with special competencies (Jurgutis et al, 2007). The researcher therefore can conclude that if the top management lacks mental health knowledge, then it becomes difficult for them to implement essential programmes for mental health. If one is incompetent, one tends to turn a deaf ear to avoid embarrassing oneself. However, the team members do whatever they want and controlling them becomes difficult.

The Mental Health Commission (2006) identified management structures as one of the important aspects in MDT. The commission also mentioned that the general service managers must be present at specific team meetings. Social workers at the mental

health unit have no support from the national level, thus, there is no one leading and supervising them (Mushimba, 2018). Liberman et al. (2001:1332-1342) highlight that group dynamics are important attributes and mediate team members' competences for providing evidence-based services. The group dynamics include group cohesion, leadership, distribution of responsibilities and authority. At Windhoek Mental health Unit, the National level management is incompetent hence, the leadership problems. They do not know what biopsychosocial entails and requires. One cannot supervise what he or she does not know. Competency-based supervision in this case is needed because it will help in explicitly identifying the knowledge, skills and values that are assembled to form a clinical competency. Additionally, it helps to develop learning strategies and evaluation procedures so as to meet the criterion-referenced competence standards in keeping with evidence-based practices and the requirements of the local clinical setting in order to continue improving the service delivery to patients (Falender & Shafranske, 2008:238). Supervision encourages self-efficacy; it builds on the recognition of the strengths and talent of the supervisee. Supervision ensures that clinical (supervision) is conducted in a competent manner in which ethical standards, legal prescriptions, and professional practices are used to promote and protect the welfare of the client, the profession, and society at large (Falender & Shafranske, 2008:238).

Sub-theme 3.2: Dealing with the challenges

Participants stated that they devise their own strategies to deal with challenges. However, the strategies are temporary as the challenges will still persist; one participant's views are highlighted below:

- *P2: "Like I have been here for five years, most of these challenges that I have highlighted have been presented even before I started working here. Up until now despite talking to the relevant supervisors, despite trying to ask for help in terms of resources and staff members, it just dies a silent death. In conclusion nothing has been done…. Like I have highlighted, we have inadequate support from the powers that being able to know that if we are raising concerns to be taken seriously, they are going to be addressed timeously."*

On taking days another participant said:

- *P8: "So the only coping mechanism here is to go home and go and rest, take a week off or two, but this does not mean it is a solution."*

Four participants said:

- *P4: "You approach the matrons, we feel they are sitting on some of our problems without reporting."*
- *P10: "I think we just prioritise the projects and activities."*
- *P1: "We approach our HODs to find a way out of these challenges."*
- *P11: "We put them across, but as an individual every time you write letters, how many times do we have to write letters. We do not have time for that. You write and that is it, you talk and that is it, but there is nothing forth coming. So you just do whatever you can and you do not disadvantage your patients".*

They take days off or fake sick leave as a coping mechanism but that does not help. Although they have highlighted their challenges to the authority, it seems they are taking too long to address them.

Bimenyimana et al. (2009) state that identifying and recognising the problem and taking steps to handle it by negotiation might arguably mitigate the whole process. In dealing with the challenges the focus should be a holistic approach that will take consideration of both the working environment and the member's home environment. Team members may also use the biopsychosocial model to look at their challenges and try to find strategies to effectively tackle their challenges.

Sub theme 3.3: Lack of support

Participants have a view that they do not receive full support, hence, they do not fully utilise their knowledge and skills. Two of the participants said:

- *P2: "The mental health is placed at the overall ministry of health because we are not supported, emotionally, financially, we are on the bottom, little support that we are getting there is not much you can do for your patients. We do a lot and it is quite draining but I think one can do more for patients with a full support".*

- *P12: "We hardly receive any support if I am being honest. So it is really difficult, you really have to go fight tooth and nail…….So the support from up there is not really good compared to how other departments are supported….. I think it goes back to the stigma associated with mental health and also lack of information*

It is a great concern to the participants that they do not have support from their management. They equated their treatment to the one given to a step child. Without support the service delivery may be affected and also compromised as no one appreciates their efforts.

The lack of support is in fact one cause of staff turnover (Aaron & Sawitzky, 2006).

THEME 4: MOTIVATION TO WORK WITHIN THE MDT

Passion is the main motivating factor which the participants mentioned. They like working and serving mentally sick patients. This theme has two sub-themes namely, reasons why they are motivated and continue rendering services, and also the resources they need to make the service effective.

Sub-theme 4.1: Reasons why MDT members are motivated to work within the MDT

According to the participants, their passion to work with mentally challenged people motivates them. They said working at the mental health unit was not a mistake, but a passion and they are eager to help patients with mental health illness. Some of the views from four participants were:

- *P2: "I think what motivates me to be part of the team is that personally I am passionate about psychiatry. I am not doing it just as job that is giving me money, I am doing it because that is what I enjoy, that is what I believe I am gifted in and I believe that as a person I can contribute somehow to the lives of those with mental illness."*
- *P4: "I am a registered nurse in psychiatry."*
- *P3: "My love and passion for my work."*
- *P6: "For the patients. What I do is for the patients."*

Other three participants expressed different views from the above:

- *P7: "We can share information and knowledge, like if there is something that I might not pick another profession can pick it and therefore we can work together so basically the sharing of information is very important for me."*
- *P5: "I am working together as a team because over the years I have realised that if you collaborate the team, work together, you can provide a high quality care to the patient and it motivates me when I see that the patient has improved because there was a collaborative approach from the team."*
- *P12: "I think just knowing that when you work in a team you do more than when you are working alone, and it is quite helpful to work in a team."*

Most participants expressed that they will continue rendering services as they have the passion of working with mentally ill people. In addition, Clewely and Bowen-Clewley (2005: 6) identified increased learning and development of people and institutions, improvements in job performance and quality of work. They also mentioned improved provider satisfaction resulting from a supportive team environment. Thus, the findings show that, because they are using the biopsychosocial model which requires competence in one's duties, members will be pleased to do the job they have been trained for. Collaboration makes it interesting as every team member can be involved in the treatment plan of a patient. Biopsychosocial model is holistic (Clarke & Walsh, 2009:103). Therefore all professionals play a role in the intervention plan.

Sub-theme 4.2: Resources needed for effective services

Participants were very clear as to what resources they need for their team to be an effective one. Some of their seven responses were:

- *P1: "We need more people in psychology, in mental health, in a whole but specifically in psychology department."*
- *P10: "We need finances, we need human resources."*
- *P12: "Our budget would need to be increased, larger spaces, we need more health professionals to be involved in the team and we need regular supply of medication."*

- *P5: "Financial assistance would be really a good advantage because the team, you need to train staff members, especially on the core function within the team, to improve the overall function of the team."*
- *P3: "Having a more positive, supportive environment, work environment would be an edible."*
- *P4:"Enough medicine for patients. We need safety."*
- *P2: "The staffing, adequate equipment, adequate training."*

There are resources which enhance the effectiveness of an MDT. Participants also highlighted that they need to be permitted to attend to patients according to their training so as to be more effective in their duties within the MDT. Restrictions may cause them to do incomplete jobs of rehabilitating and treating patients. This may result in increased relapses.

Dennill and Rendal-Mkosi (2012:114) observe that adequate resources both human and material contribute to successful and effective teams. On human resources all required team members should be available in the mental health unit; these are social workers, occupational therapist, doctors, clinical psychologists, nurses and psychiatrists (Patidar, 2013).

THEME 5: GENERAL COMMENTS ON MDT

General comments were asked to see how participants rated their MDT service delivery.

Sub-theme 5.1: General comments on their performance

Participants were asked to give some comments on their MDT service delivery. Five of the participants' comments in their own words were:

- *P1: "I think I am grateful for each and every one for staying here, for doing their work for trying to do the best in what they can…there are places we could improve in… there is always place to grow and we can look into how to improve and reach out to my colleagues, communicate the frustration and emotions."*
- *P4: "I can say our service delivery as MDT, it is not so poor. It is fair I can say. I cannot say it is good but it needs to improve."*

- *P3: "There are a lot of challenges here."*
- *P6: "I would say we need to work on communication. We need to work on attitude."*
- *P2: "At this unit, I would say that we still have a lot of work to do. We still need to really sit down and define the essence of who we are as a team. I would rate it as poor. I think going forward if we really want to render quality service must really start sitting down and addressing these challenges*.

These were some of the comments put across by participants. O'Daniel and Rosenstein (2008) facet that a study on Professional Communication and Team Collaboration determined that improved teamwork and communication are described by health care workers as among the most important factors in improving clinical effectiveness and job satisfaction. Lack of communication creates a situation in which medical errors can occur and these can cause delays in the treatment of a patient.

Sub-theme 5.2: Their suggestions to enhance the services of MDT

These are some of the comments which were made in concluding the one-on-one interviews by the seven participants:

- *P5: "I would look into the training of staff members to have a better understanding of the roles functioning within the multidisciplinary team."*
- *P2: "... to have a proper working team with accountability, with proper management in place."*
- *P3: "communication possibly also the meetings we could have maybe a meeting once a month to discuss some of the challenges we are facing or discuss exceptional challenging cases and work to find a solution as a team."*
- *P4: "Communication involving every discipline each time we think of talking about anything to do with patients."*
- *P9: "If all the multidisciplinary team be there at morning presentations and ward rounds it will be ideal."*
- *P8: "I would suggest that the infrastructure be improved to make the environment more worker friendly for staff. We should employ more professionals. We need a*

separate budget to be independent to embark on our projects to deliver effective services to our clients."

- *P10: "Improve communication, develop guidelines, have more human resources."*

These suggestions were given by people who are directly involved with helping the policy makers when making MDT policies, and other MDT members. Other countries in Europe hire trained personnel from other countries to curb staff shortages and reduce workload in their mental health units (Clark & Roopai, 2011:52-53). The Windhoek Mental Health Unit can also hire and employ expatriates who are qualified and skilled to ease the workload at the only mental health unit of Namibia. The decentralisation of mental health services is important for easy access by all service users (Pembere, 2017). MDT meetings have to be attended by all team members which constitute the biopsychosocial approach in order for the holistical treatment to be effective (Jurgutis et al, 2007).

3.12: Summary

Chapter three focused on the research methodology and the ethical considerations that were adhered to during the research study. The empirical findings of the study were subsequently presented and discussed. The study was embedded within the biopsychosocial model which focuses on all team members in a multi-disciplinary team of a health care set up like a hospital. In this case a mental health unit.

Five themes emerged and these were; the conceptualization of MDT, experiences of working within the MDT, challenges faced by MDT in service delivery, factors motivating to work within the MDT and general comments on how the mental health is working. Themes and sub-themes that emerged from the transcripts acknowledged and represented the voices and perspectives of participants in the study. These were substantiated through direct quotations with integration of literature where applicable.

In the next chapter key findings of the study will be discussed. The chapter will also contain the conclusions and recommendations that are based on the key findings.

CHAPTER FOUR
CONCLUSIONS AND RECOMMENDATIONS

4.1 Introduction

This chapter seeks to explain how the researcher achieved the goal and objectives of the study. The researcher will explain how the objectives were achieved by highlighting the main findings of the study. Conclusions will be drawn from the study and recommendations will be made on the key findings of the study.

4.2 GOAL AND OBJECTIVES OF THE STUDY

The goal of the study was to explore and describe the challenges of multi-disciplinary team work in mental health service delivery at Windhoek Central hospital's mental health unit. The research question on which the study was based is, what are the challenges faced by the MDT at the mental health unit at Windhoek Central Hospital in Namibia when doing their work?

The goal of the study was achieved through the attainment of the following objectives:

- **Objective1:** to conceptualise and contextualize the multidisciplinary team within a mental health unit.

  The objective was achieved in Chapters 1, 3 and in Chapter 4 especially in sections 4.3 and 4.4 which present the key findings and conclusions. The focus of the biopsychosocial model is based on the notion that the multidisciplinary team comprises all professionals in the health sector. The professionals in the mental health sector cannot work in isolation. All their roles complement each other. Each professional has to be involved in a patient's treatment and this requires them to know each other's roles and also help each other to enhance their knowledge thereby improving the effectiveness of the service delivery system.

  It is important for all professionals involved in the multidisciplinary team to understand the biopsychosocial model in order to influence the type of services rendered. It is also very vital to understand each other's roles and not to isolate any professional who is supposed to be involved. Mental health is mainly about rehabilitation so one cannot say he or she will do the rehabilitation alone. It needs team work. Mental health has many social issues hence a social worker is an important person, and so are the other professions. For other professionals to get to know the history of the patients, it all starts with the collateral information which is done by the social worker. This gives clues as to when the illness started and also what triggered it. It helps to determine if it is generic or not. The history of the patient from the social worker is very important hence no MDT of mental health can do without a social worker. MDTs differ in that at some mental health units they may have additional team members like dieticians and physiotherapists. At the Windhoek Central Hospital Mental Health Unit the team comprises of professionals namely social workers, occupational therapists, psychologists, medical doctors, psychiatrists and nurses. They mentioned that the pharmacist is supposed to be part of the team but at the moment they do not have one. The non-professionals they mentioned were the correctional officers

(prison guards at forensic unit), and the security guards and also the kitchen staff.

- **Objective 2:** To explore mental health service delivery within the international and national context.

  The objective was addressed in Chapters two (literature review) and three, section 3.11 under the sub-theme 1.7. Participants' views on the international context were mainly based on reading articles and what was said by people coming from different countries; they relied on the literature they had read. One participant had a chance to visit another mental health unit in Bloemfontein, South Africa. According to one participant, the South African and Australian mental health MDTs' operations are the same as theirs. The main difference may be that they have better infrastructures (facilities). The American social work student according to one participant said social workers are more respected at the American Mental Health Institutions (international) than at the Windhoek Mental Health Unit (national). She told the participant that salaries are also more competitive than the Windhoek Mental Health Unit ones. Another participant raised a point on better structured mental health units in their country. Regarding security issues, a participant said Windhoek Mental Health Unit does not have any. Some participants hailed the international context as way better than the national one and wished they could improve on some aspects to match the international MDTs.

- **Objective 3:** To examine and describe the experiences of the multidisciplinary team in provision of mental health services in the mental health unit at Windhoek Central Hospital.

  The objective was addressed in Chapter three (sub-themes 2.1 and 2.2) where it became evident that the participants 'experiences are different in some aspects but the overwhelming workload is a common factor. In America due to the staff turnover resulting in shortage of staff and creating a high workload for the remaining staff members, it was noted that the workload was heavy and paperwork lagged behind (Watson & Marschall, 2013: 53, 64-66). Given the fact

that Windhoek Mental Health Unit is the only one serving the whole country, workload challenges cannot be ruled out.

Furthermore, the third objective of the study was accomplished in Chapter three in the presentation of the findings. The participants stated that there are always pros and cons when working with different people. Although knowledge can be shared, working within the MDT may be frustrating as some team members do not do their duties and absenteeism is prevalent. Improvement is still needed in MDT service delivery at the mental health unit. It is important for team members to be accountable for their actions. Sometimes the shortage of equipment and medicine hampers the service delivery. Without the needed equipment and medicine the service becomes ineffective and also affects the service provider and the patient's condition.

- **Objective 4:** To explore and describe the challenges of the multidisciplinary team in the provision of mental health services in the mental health unit at the Windhoek Central Hospital.

  This objective has been met in the empirical study in Chapter three (sections 3.1.1-11) in which the participants highlighted all the challenges which affect their service delivery. The challenges included infrastructure which encompasses office space and wards, and the budget which was said to be non-existent. The budget for mental health is included in the budget of the main hospital hence not easy to trace. They also highlighted that mental health is only centralised at the mental health unit and no community mental health programmes or centres are available, hence the many relapses.

  Human resources covered the aspect of the high shortage of staff which results in high and overwhelming workloads. Participants stated that there are no mechanisms for staff retention hence staff members tend to resign. Most of the staff members at the mental health do not have the relevant training in mental health; they are mostly trained nurses. Training them on the job is not feasible

because of the unavailability of funds. The induction and orientation of new members is not done by all disciplines.

Lack of policies on the MDT is another issue. Participants said there is no accountability or follow up on some issues as there is nothing written down. They also raised conflict resolution which is a problem. Conflicts exist but are not solved due to lack of policies. Poor communication and language barriers also contributed to the challenges. Namibia is a multilingual country and it is difficult to find interpreters for some languages and treating a patient without understanding him or her is not easy. The participants also cited the poor working environment where they mentioned the lack of security measures and poor salaries as contributory factors. They also claimed that their leaders are not knowledgeable on mental health issues. These are people at the highest board which is the national level. The Social work department in particular is not supported by this highest office. It is the worst discipline which lacks supervision and support. One cannot not supervise and support what he or she does not understand.

How they deal with the challenges differed from one participant to the other. The majority said they just take days off so that they rest but that does not resolve anything. Some do not come to work and do not give reasons why they were absent and no one really follows up to ask why they do not attend MDT ward rounds or morning meetings. For some they apply for jobs elsewhere and leave.

- **Objective 5:** To suggest strategies to improve the multi-disciplinary team approach in the delivery of mental health services.

  The objective has been met in Chapter two (literature review) and in Chapter three on empirical findings. Some of the suggestions were discussed in other sub sections of sub-themes. The main strategies suggested are as follows:

  - Training of staff members in both mental health and MDT functioning.
  - Decentralisation of mental health services.

- Improve communication within the MDT and meetings to be attended by all members of MDT.
- Improve infrastructure and work environment.
- Have a separate budget for mental health.
- Develop guidelines/policies on MDT.
- Have people with mental health knowledge at the top mental health body.
- Recruit more professionals to work at mental health …. and an interpreter.

4.3 KEY FINDINGS OF THE STUDY

The researcher will present key findings and conclusions in this section in a sequential manner.

- The findings indicated that all participants understand what is meant by MDT.

- The findings indicated that MDT at mental health has most of the professionals which constitute an MDT although some have no training in mental health.

- The findings revealed that some participants are not fully utilising their knowledge and skills as they are limited by other challenges and restrictions.

- The findings established that although MDT is a good approach. It is marred by challenges of ineffective communication amongst members, frustrations due to some members not playing their roles.

- The findings revealed that improvements are needed at the Windhoek Central Mental Health Unit in order for their MDT to be more effective.

- Findings indicated that international MDTs are better managed than the national one because internationally they have the guidelines and better working conditions.

- Findings have established that the workload at mental health is overwhelming due to centralization of the service, and the critical staff shortage due to staff turnover.

- The findings revealed the challenge of infrastructure, mainly the shortage of offices and wards for patients since this is the only mental health unit in the country. Patients are discharged before they recover fully to cater for other new patients' admissions which results in the relapse of the patients who are prematurely discharged.

- Findings revealed that the mental health does not have its own budget hence participants are obliged to use the little they receive which prohibits and limits them to implement some of their programmes.

- Findings indicated that there is a high staff shortage such that the performance of the professionals no longer matches the proper standards; for example, a doctor has to see more than 20 patients and the ratio of doctor to patient or nurse to patient is abnormal, hence standards are compromised.

- The findings revealed that the staff turnover is caused by poor working conditions and also unresolved conflicts. Also, staff members are not happy with the remuneration which does not match the amount of work they do and cannot be compared with the international salaries as it is very minimal.

- The findings have established that there are only a few mental health trained staff members within the mental health unit. This causes conflicts between those who are trained and those who are not as some programmes are barred because the untrained staff see it as a danger to patients not knowing that it is the rehabilitation the patients need.

- The findings indicated that training, induction and orientation of new staff members is not always done. Some MDT members do what they feel like doing

as no one holds them accountable for their actions. This is all due to lack of guidelines.

- Findings revealed that there is no policy on MDT. Training on the functions of the MDT cannot be done without policies. Most members do not do what is expected of them because they do not know their roles and nothing guides them. Conflicts are not resolved; there is nothing in place on conflict resolution. Members become frustrated and this contributes to staff turnover.
- Findings have established that there is poor communication amongst MDT members. Information at times is ignored or is not disseminated to others. Members abscond meetings and do not go for ward rounds, as a result there are no updates. Language barrier and lack of a professional interpreter were also cited. There's no communication between patients and MDT because of different languages that are used.

- Findings revealed that the work environment is not safe and secure. MDT members who get injured by patients are not compensated. This is supposed to be a policy that anyone who is injured by a patient must be compensated and the treatment catered for. This is not the case at the mental health unit. If one gets hurt by a patient one has to foot his or her medical expenses. There is also no adequate security, hence, patients abscond and relapse in the communities.

- Findings revealed that there is poor management from the national level. Social workers are represented by people who do not have knowledge of mental health. They do not receive supervision and they are not supported. Other disciplines are better but it is worse in the social work department.

- Findings revealed that MDT members have resorted to take days off as a copying mechanism of high workloads.

- Findings established that the MDT members have passion in their work but due to the challenges they face which are not addressed, they feel they are not

offering quality service because they have the potential but are blocked by too many unresolved challenges.

- Findings revealed that all the challenges have been tabled to the responsible authorities but nothing has been addressed for the past five years and some have not been addressed for more than five years.
- Findings indicated the strategies and suggestions that the MDT needs, which included training of staff members, decentralising mental health services, work on communication and employ a professional interpreter, have a separate budget, develop guidelines and policies on MDT, have mental health trained personnel and recruit more professionals in order to have quality mental health service delivery by MDT.

In summary, the overall findings of the study revealed that mental health MDT is marred by challenges which all participants highlighted, and is not receiving attention from the powers that be. The MDT has tried to present some of their challenges to the table but with no success. The study confirms that the services at the mental health unit by MDT is affected by these challenges. Although the MDT members have passion in their work sometimes they fail to cope and some have already left. There is not much research done on the mental health MDT challenges specifically but on other MDTs like the oncology MDT.

The findings of the study show how mental health MDTs are always short staffed and also explain why their service is not of best quality. The members of the team work tirelessly, and help their patients without proper support from their national level managers. The members feel as if they are a step child who is neglected in the family. Fihlo and Bertolote (2006) noted that in many African countries, mental health is not recognised as a distinct specialty. They get little allocation which does not cover their needs but are expected to do their job properly. The literature review shows that in most countries the mental health sectors have inadequate staff and do not have a specific budget. Watson and Marshall (2013:53, 64-66) noted that in America mental health is lowly funded. Moloo (2016) reported that the Democratic Republic of Congo (DRC)

government is barely involved in mental health hence a very tiny budget is allocated to mental health.

It is thus important for governments to consider the mental health professionals' needs and pay attention to their needs so as to promote staff retention and curb staff turnover. Consideration needs to be given to improving the skills related to mental health care delivery (Ndetei et al, 2007: 33, 36).

4.4 CONCLUSIONS

The following conclusions were derived from the literature review and empirical research findings of the study:

- It can be concluded that the multi-disciplinary team approach is understood by the team members who uses it.
- The researcher concluded that some of the MDT members at the mental health unit do not have mental health training and also do not really have knowledge on how to work within the team.
- It can be concluded that some of the MDT members are not fully utilising their knowledge and skills because the environment restricts them.
- The researcher concluded that the communication system of the MDT is poor and it causes other members to be frustrated.
- It can be concluded that there are no polices and guidelines on MDT approach although there is a new Act being drafted and is at its final stage, but at the moment there are no polices and guidelines.
- The researcher has concluded that internationally, MDTs are way better than the national ones in terms of working conditions, for example, remuneration. However, it is also noted that some conditions internationally are as poor as the national ones. The difference is the remuneration and community health programmes which the international MDTs have.
- High workloads are as a result of high staff turnover and that the mental health is centralised only at Windhoek mental health unit for the whole country.

- It can be concluded that the infrastructure of the mental health unit is no longer conducive for the growing population of Namibia, especially regarding the number of wards and office space.

- The researcher concluded that the MDT is failing to implement some programmes due to lack of funds since they do not have a separate budget for mental health unit.
- The ratio of an MDT member to patient is not normal; it is not balanced according to the World Health Organisation's recommended ratios.
- It can be concluded that conflicts amongst MDT members are not resolved since there is no policy on conflict resolution within the MDT members.

- Training, induction and orientation of new MDT members on team work is not always done.
- There's no accountability as to why some members do not execute their roles and do not attend MDT meetings or ward rounds. There are no records on why some MDT members are always absent during meetings.
- The researcher concluded that the work environment is not conducive; there is no compensation for the MDT members injured by patients at work and they are not treated by the authorities. The security system ineffective.
- It can be concluded that due to the defective security system, patients can abscond from wards and disappear from hospital without anyone noticing.
- It can be concluded that relapses are a result of patients being discharged before they are fully rehabilitated or treated, or because of easy access to escape from the hospital without being noticed.
- It can be concluded that the social work department is headed by people without any knowledge on mental health, and the social workers do not receive supervision and are not supported.
- The researcher has concluded that the mental health unit is neglected hence no one addresses their challenges. It can be concluded that the biopsychosocial model used by the MDT is the most appropriate one but not all members come

on board to execute their roles. For some it is not their fault as they are not aware of how an MDT functions. During the professional or tertiary training, the multi-disciplinary approach despite the significant role it plays in mental health is not included

As mentioned in Chapter one, page one, the treatment of mental illness entails both medication and rehabilitation through the use of the multi-disciplinary team approach (Neumann et al, 2012:4-8). An effective synergy of the MDT will ensure a holistic treatment of patients (Liberman et al, 2001: 1333-1338). Working in teams enables organisations to rapidly develop and deliver high quality services (Onyett, 2003: 47) and this leads to professional stimulation and consequently, more effective use of resources. MDT is prone to inadequate organisational support and dominance of particular disciplines (Onyett, 2003: 48). The study has revealed the challenges the MDT at mental health unit is facing. With such challenges the MDT's service delivery is affected. If more than ten participants out of twelve echoed the same sentiments it means they are really affected in their service delivery and their work may appear to be sub-standard yet it is not their making. There are limitations that hinder progress in their service delivery. If the challenges are addressed, then the situation will enable them to be more productive. Most of the challenges can be resolved within a short period of time whereas others for example, building other mental health units in the regions, maybe long term achievements.

4.5 RECOMMENDATIONS

Based on the key findings and conclusions of the study the following recommendations were made:

- **Policies and guidelines on multidisciplinary team functions must be made**.
  It is important that this document be availed to every member who is involved in the MDT. This will give the suggestions as to how communication should be done, how conflicts can be solved and also spell out the consequences for being absent from MDT meetings and ward rounds. The guidelines must clearly state the roles of the MDT member. With the suggestions from this document, MDT members will take responsibility of their actions. Currently, members get away

with their mistakes or willingly make mistakes and some are becoming habitual absentees knowing nothing will be done to them for as long as they are in their offices. Polices and guidelines will make it easy for any selected MDT leader to lead the MDT unlike now where the head of department is always the leader and doctors are dominant in the MDT.

- **Decentralisation of mental health services**

  The government must decentralise this service. The population is growing and having only one mental health unit is not ideal. Some patients may not access it because it is very far from the other regions in the country. The mental health unit must be located in each regional or district hospital with a compliment of a full multidisciplinary team in order for the service providers to provide quality service without hurrying. Patients can be discharged when fully rehabilitated if mental health units are many. Also, community health centres should be introduced in all regions so that the expense of follow-ups is reduced, also, a patient is easily managed in his or her area where people speak the same language with him or her. This will reduce the number of relapse cases.

- **Training of mental health staff**

  Government must provide funds for training mental health staff if employing expatriates is expensive for them. Mental health training should be put in place in all disciplines at tertiary level where the professionals come from. Orientation and induction is important to every new staff member, thus, should be done. Disciplines such as the social work department which does not have trained managers must have a consultant to do the orientation and induction of what is exactly expected of them.

- **Separate mental health budget from main hospital**

  The government must separate the mental health department budget from the main hospital one. The mental health unit must be treated as a separate entity with its own budget which they can account for. The findings indicated that most of the mental health unit programmes cannot be implemented due to lack of funds. It is ideal for the government to give the mental health unit its own budget because they are the ones who know exactly what they want. Their programmes

are as equally important as other programmes of other services. With their own budget they can buy medication and the equipment, and other resources which they need.

- **Expanding Windhoek mental health unit**

  Although it is already one of the government's plans, the expansion should be implemented so that the Windhoek unit becomes the referral for complicated cases. Training on mental health and induction can be done at the Windhoek unit so that when members are deployed to their respective duty stations they would be knowledgeable on how to work within an MDT and be fully equipped. The findings indicated that the Oshakati unit has no ward for mental health and there is no MDT. Patients are also referred to Windhoek for minor ailments which could have been easily dealt with at the regional or district hospital. This could also reduce the work load at the mental health unit of Windhoek. Knowledge of the mental health unit is important to all professionals working in hospitals.

- **Social Work Department needs a manager with mental health knowledge/training**

  The Ministry of Health and Social Services should get a well-trained Social Worker in mental health to lead the department. The findings indicated that this department does not have any support and does not receive supervision. No one knows if they are really doing their work correctly. Their challenges will not be addressed if the National level managers have no knowledge on mental health. The Ministry must employ a qualified National level manager with the right training and knowledge of mental health to head the social work department. People in the directorate of mental health programmes should all hold mental health training.

- **Improving mental health human resources**

  It is the government's responsibility to see to it that the services provided at mental health are adequate. The government should employ more mental health personnel in order to control staff turnover. A professional interpreter needs to be employed for the mental health unit MDT. Namibia has many languages of which not all are found at the mental health unit; but patients who seek treatment

should have interpreters. More security guards are needed for the safety of staff members and patients.

- **Improve the working conditions**

  The findings indicated that the MDT is not happy with their remuneration which is meagre. The government needs to reconsider the salaries of the mental health employees. Above all, it should make a provision of compensating those who get injured at work and also cater for their treatment. The security at the mental health needs to be tight to prevent patients from escaping from the wards.

- **Further research**

  Further research is needed to develop programmes that promote mental health multidisciplinary teams.

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APPENDICES

APPENDIX 1

DEMOGRAPHIC FORM

Research topic: Challenges in multidisciplinary team work in mental health unit at Windhoek Central Hospital in Namibia

The goal of the study is to explore the challenges of multidisciplinary team in mental health service delivery at Windhoek Central Hospital's Mental Health Unit.

1. Gender

Male	Female

2. Age

20 years and below	21-29 years	30-39 years	40-49 years	50-59 years	60 years and above

3. How many years of experience do you have working as a _____ (your Profession) at a mental health institution?

2-5 years	6-10 years	11-15 years	16-20 years	21-25years	26 years and above

4. For how long have you been employed at this mental health unit of Windhoek Central Hospital?

   _____

5. In which department of mental health unit are you working at present

   _____

6. What is your job title

   _____

ONE-ON-ONE INTERVIEW SCHEDULE

MDT MEMBERS

The following issues will be discussed:

Conceptualization and Contextualisation of MDT service delivery at mental health unit

1. What is your understanding of Multidisciplinary team?

2. Who are your co-team members?
3. What are your duties within the MDT?
4. Could you describe how you relate with other team members?
5. Describe your feelings and thoughts in working within a multidisciplinary team here at mental health unit?
6. Do you feel you are fully utilising your knowledge and skills in your work? If not please elaborate further on it?
7. What is your perception of mental health service delivery within the international context?
8. How do you perceive the mental health MDT service delivery at mental health unit nationally?
9. How different is this MDT from other MDT service delivery in mental health?

Experiences of working within the MDT at mental health unit at WCH

10. What is your experience in provision of services as an MDT member at this mental health unit?
11. And how are you coping with the workload?

Challenges in service delivery as a team member

12. Describe the challenges you are facing as an MDT member in provision of mental health service at this unit.
13. Would you describe in detail how you deal with the challenges that you described?
14. What form of support did you receive to address your challenges?
15. If yes, how?
16. If no, what could be the reason why you are not helped?
17. What do you think an ideal MDT should operate in comparison with how your MDT is operating?

Motivation to work within The MDT

18. What motivates you to be part of the team?
19. Would you continue rendering service in your field in the near future?

20. If no, explain and give reasons for your answer.
21. If yes, explain and give reasons why you will continue?
22. What resources would you require to render effective services?

General comments

23. What are your comments on the MDT service delivery at this mental health unit?
24. What suggestions can you give to enhance the service delivery by the MDT at mental health unit?

Thank you for your participation.

APPENDIX 2

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Faculty of Humanities
Department of Social Work & Criminology

01/03/2019

Ministry of Health and Social Services
Windhoek Mental Health Unit
Private Bag 13198
Windhoek

- To suggest strategies to improve the Multidisciplinary team approach in the delivery of mental health service.

What will I be asked to do if I agree to participate?

You will be asked to participate in an individual interview share the challenges you are experiencing as an MDT member in the mental health unit of Windhoek Central Hospital. Semi-structured questions around the subject of challenges in Multidisciplinary team work, will guide the interview discussions.

Would my participation in this study be kept confidential?

I will do my best to keep your personal information confidential. To help protect your confidentiality, the information you provide will be totally private; no names will be used so there is no manner that you can be identified as a participant in this study. The information will be treated with anonymity and confidentiality. Your name will not be reflected on the transcribing or analysis of the data. The information obtained from this interview will be collated with the information from other completed interviews from other participants. Therefore, there will be no way to connect you to the study.

This research project involves making audiotapes of you for better capturing of valuable data during the discussion. For quality assurance, trustworthiness and reliability, the University of Pretoria might need access to the tapes, other than that, under no circumstances will these tapes be out for other use not intended for. These tapes will be destroyed after use intended for.

What are the benefits of this research?

The study will benefit the Ministry's policy makers in decision making and also for policies pertaining mental health to be reviewed. This will also help in highlighting where changes or adjustments have to be made to make the service delivery change for better.

APPENDIX 3

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA
Faculty of Humanities
Department of Social Work & Criminology

01/03/2019

To whom it may concern

Ministry of Health and Social Services
Windhoek Mental Health Unit
Private Bag 13198
Windhoek

CONSENT FOR PARTICIPATION IN A RESEARCH INTERVIEW

I volunteer to participate in a research project conducted by Rufaro Ottiliah Dipura who is Masters in Social Work Health Care Student at University of Pretoria. I understand that the project is designed to gather information about challenges in multidisciplinary team work in the mental health unit of Windhoek Central Hospital. I will be one of the 12 health professionals being interviewed. I have had the purpose and nature of the study explained to me and have fully understood.

1. My participation in this project is voluntary. I understand that I will not be paid for my participation and that I may withdraw from participation at any time without penalty. No one will be told of my withdrawal if I decide to do so.

2. My participation will involve being interviewed by the researcher and the interview will be approximately 45-60minutes. I agree to my interview being audio recorded.

3. I understand that the researcher will not identify me by name in any reports using information obtained from this interview and that my confidentiality as a participant in this study will remain secure.

4. I understand that signed consent forms and original audio recordings will be retained in the University of Pretoria Library until 15 years.

5. I understand that this research study has been reviewed and approved by the Research Board of Ministry of Health and Social Services of Namibia.

6. I have read and understood the explanations given to me. I have had all my questions answered to my satisfaction, and I hereby voluntarily agree to participate in this study.

7. I have been given a copy of this consent form.

My Signature _____ Date _____

Name of the Researcher _____ Signature of Researcher _____

For further information, please contact:

Mrs. Rufaro Ottiliah Dipura
Cell: 0813300407
Email: rufarodipura@gmail.com

APPENDIX 4

REPUBLIC OF NAMIBIA

Ministry of Health and Social Services

Private Bag 13198
Windhoek
Namibia

Ministerial Building
Harvey Street
Windhoek

Tel: 061 – 203 2537
Fax: 061 – 222558
E-mail: btivambi@mhss.gov.na

OFFICE OF THE PERMANENT SECRETARY

Ref: 17/3/3 **ROD**
Enquiries: Mr. B. Tjivambi

Date: 18 July, 2018

Mrs. Rufaro. O. Dipura
PO Box 27125
Windhoek

Dear Mrs. Dipura

RE: CHALLENGES IN MULTIDISCIPLINARY TEAM WORK IN MENTAL HEALTH UNIT AT WINDHOEK CENTRAL HOSPITAL IN NAMIBIA

1. Reference is made to your application to conduct the above-mentioned study.

2. The proposal has been evaluated and found to have merit.

3. **Kindly be informed that permission to conduct the study has been granted under the following conditions:**

3.1 The data to be collected must only be used for **academic** purpose;

3.2 No other data should be collected other than the data stated in the proposal;

3.3 Stipulated ethical considerations in the protocol related to the protection of Human Subjects should be observed and adhered to, any violation thereof will lead to termination of the study at any stage;

3.4 A quarterly report to be submitted to the Ministry's Research Unit;

3.5 Preliminary findings to be submitted upon completion of the study;

3.6 Final report to be submitted upon completion of the study;

3.7 Separate permission should be sought from the Ministry for the publication of the findings.

Yours sincerely,

PERMANENT SECRETARY
MINISTRY OF HEALTH & SOCIAL SERVICES

Ms. Petronella Masabane
Acting Permanent Secretary

APPENDIX 5

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Faculty of Humanities
Research Ethics Committee

10 September 2018

10 September 2018

Dear Mr Dipura

Project:	**Challenges in multidisciplinary team work in the mental health unit at Windhoek Central Hospital in Namibia**
Researcher:	**R Dipura**
Supervisor:	**Dr N Bila**
Department:	**Social Work and Criminology**
Reference Number:	**16034661 (GW0180822HS)**

Thank you for the application that was submitted for ethical consideration.

I am pleased to inform you that the above application was approved by the Research Ethics Committee at the meeting held on 6 September 2018. 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.

We wish you success with the project.

Sincerely

Prof Maxi Schoeman
Deputy Dean: Postgraduate and Research Ethics
Faculty of Humanities
UNIVERSITY OF PRETORIA
e-mail: PGHumanities@up.ac.za

cc: Dr N Bila (Supervisor) Prof A Lombard (HoD)

Fakulteit Geesteswetenskappe
Lefapha la Bomotho

Research Ethics Committee Members: Prof MME Schoeman (Deputy Dean); Prof KL Harris; Mr A Bizos; Dr L Blokland; Dr K Booyens; Dr A-M de Beer; Ms A dos Santos; Dr R Fasselt; Ms KT Govinder Andrew; Dr E Johnson; Dr W Kelleher; Mr A Mohamed; Dr C Puttergill; Dr D Reyburn; Dr M Soer; Prof E Taljard; Prof V Thebe; Ms B Tsebe; Ms D Mokalapa

APPENDIX 6

NAMIBIA UNIVERSITY
OF SCIENCE AND TECHNOLOGY

DEPARTMENT OF COMMUNICATION
Private Bag 13388, 13 Jackson Kaujeua Street Windhoek, NAMIBIA
Tel: (264-61) 207-2409/2443 *Fax: (264-61) 207-2310*

01 April 2019

TO WHOM IT MAY CONCERN

LANGUAGE EDITING – MS RUFARO OTTILIAH DIPURA

This letter serves to confirm that a **Master in Social Work Health Care** Mini-dissertation titled **"Challenges in multidisciplinary team work in the Mental Health Unit at Windhoek Central Hospital in Namibia" by Ms Rufaro Ottiliah Dipura** was submitted to me for language editing.

The dissertation was professionally edited, and suggestions were made in the document, which if followed by **Ms Rufaro Ottiliah Dipura**, will result in a mini-dissertation with a high standard of English.

Please feel free to contact me should you need more information. My contact details are: Tel: +264 61-2072285; Cell: +264 813926498. Email: jpasi@nust.na.

Yours faithfully

Dr Juliet S. Pasi
Senior Lecturer – Communication Department

B. A. English & Linguistics
B. A. Special Honours in English
Graduate Certificate in Education
M.A. in English
DLitt et Phil