# ATTITUDES TOWARDS MENTAL ILLNESS, MENTALLY ILL PEOPLE AND DEINSTITUTIONALISATION

*by*

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# DECLARATION

**I, FARHEEN BASHEER (Reg. No. 9702843) do hereby declare that this dissertation entitled:**

## ATTITUDES TOWARDS MENTAL ILLNESS, MENTALLY ILL PEOPLE AND DEINSTITUTIONALISATION,

**Is the result of my own investigation and research and that it has not been submitted in part or in full for any other degree or to any other university.**

12/12/98

**Signature** **Date**

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# ABSTRACT

The aim of this study was to assess the attitudes of community psychiatric nurses, mental health professionals and primary health care nurses towards mental illness, mentally ill people and deinstitutionalisation. The sample of this study comprised 38 community psychiatric nurses, 20 mental health professionals and 55 primary health care nurses, all of whom were from Durban, Pietermaritzburg and their surrounding areas. Each participant completed a biographical questionnaire, the Opinions of Mental Illness scale (1962) and the Community Mental Health Ideology scale (1967). Four focus groups on attitudes towards deinstitutionalisation, comprising 25 participants in total, were also conducted. Statistical analyses were computed using the Statistical Programme for Social Scientists. Krueger's (1984) methodology was employed to analyse the focus groups results. The quantitative results revealed that community psychiatric nurses, mental health professionals and primary health care nurses generally tended to express neutral attitudes towards mental illness, mentally ill people and deinstitutionalisation. Significant differences in attitudes towards mental illness and mentally ill people were found amongst respondents in different categories of race, educational levels and treatment of a friend for a mental illness. The focus groups results revealed that while the community psychiatric nurses and mental health professionals were positive about the concept of deinstitutionalisation, they did not favour it's implementation within the current South African economic and social contexts. Based on their fear of mentally ill patients, the primary health care nurses displayed negative attitudes towards the concept of deinstitutionalisation and were also cautious about it's implementation within the current South African context. Implications and recommendations arising from this study are discussed.

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# CHAPTER ONE

# INTRODUCTION

## 1.1. MENTAL HEALTH CARE IN SOUTH AFRICA

It has been well established that the prevalence of mental illness in developing countries is escalating at a rapid pace (Sartorius & Harding, 1983; Desjarlais, Eisenberg, Good & Kleinman, 1995; Freeman & Pillay, 1997). Kramer (in Desjarlais *et al.,* 1995) cites that there were about 23 million people with schizophrenia in 1985, three-quarters of whom were in the less developed countries. According to Kramer, by the year 2000, projected demographic profiles suggest that the absolute number in these countries will have increased from 16.7 million to 24.4 million, a 45% increase.

Epidemiological studies in South Africa add impetus to Kramer's (in Desjarlais *et al.,* 1995) findings. Local research indicates that between 10-40% of the South African population is afflicted with a mental illness (Parry, 1991), which compares well with an estimation made by the WHO (1975), that at least 10% of a population at any one time suffers from some form of a mental disorder. The Mental Health and Substance Abuse Committee (1995) has estimated that currently, over five million people in South Africa would benefit from mental health services and 570 000 people need psychiatric services. Freeman and De Beer (1992) caution however, that these figures could be under-estimates of the actual incidence of mental illness, as the socio-political system of apartheid itself has had a profoundly adverse effect on the South African psyche.

The high prevalence rate of mental illness in South Africa is compounded by the fact that mental health services are characterised by an inequitable deployment of professional resources (Freeman, 1990). In 1997, 427 psychiatrists and 1051 clinical psychologists were registered with the HPCSA (Lee & Zwi, 1997). In other words, there were only three psychologists and one psychiatrist per 100 000 population. This is in stark contrast to the ratio in Western countries, which varies between 15 and 35 psychologists and 5 and 13 psychiatrists per 100,000 population (Freeman & De Beer, 1992). An exacerbating factor is that, for most South Africans, the practitioner to population ratio is even lower than the figures provided above, for several reasons (Freeman & De Beer, 1992). First, a significant proportion of registered practitioners are not presently practicing in their professional capacities. Second, of the remainder, more than 50% are professionally engaged in private practice but only about 20% of South Africans have financial resources which will enable them to seek care in the private sector (Freeman, 1990). Third, an overwhelming percentage of mental health professionals are based in urban zones, whereas approximately 46% of the South African population live in rural areas (Central Statistical Services, 1998).

In their report on practice patterns of clinical and counselling psychologists, Pillay and Petersen (1996) state that the majority of clinical and counselling psychologists consult with mostly White patients. A reason that has been cited for the preponderance of White patients consulting with psychologists, is that the White population, like the majority of psychologists in South Africa, is based in predominantly urban areas. Therefore, consulting with a psychologist is an accessible option for most White South Africans. However, substantial research (Freeman, 1992; Pillay & Petersen, 1996; Foster & Swartz, 1997; Bhana & Pillay, 1998) has found that in relation to Whites, Black and rural South Africans under-utilise mental health services. A primary reason cited for the underutilisation of mental health services by Black and rural South Africans, is the geographical inaccessibility of such services (Bhana & Pillay, 1998). The inordinate pressure on most rural South Africans from stressors such as political violence, racial discrimination, poverty, sub-standard housing, cultural conflicts and identity conflicts strongly suggests that they may actually need more mental health care services than they currently have access to. Further support for this argument is provided by the South African Reconstruction and Development report (1995) which, suggests that the significantly higher rates of mental disorders among the poor (especially in rural areas) are indicators of poor mental health facilities as well as the impact of violence and trauma on many poor people. Hence, it is easy to agree with Freeman and De Beer (1992), who argue that the majority of mental health professionals in South Africa are financially and geographically inaccessible to the majority of the population.

Due to the inaccessibilty of professional psychiatric/psychological services to the majority of South Africans, such services are oftentimes sought from two main sources: primary health care workers and large state psychiatric institutions; both of which are relatively more financially and geographically accessible. Freeman (1992) postulates that up to 1 in every 5 people seeking health care at primary level does so primarily as a result of a mental health problem. A cause for concern however, is that primary health care personnel, such as primary health care nurses are currently not adequately trained to provide mental health care (Swartz, 1997). In her analyses of nurse-patient consultations in a clinic in KwaZulu-Natal, Petersen (1998), reveals that in cases where psychological/ psycho-social problems were overtly raised by patients, some nurses chose to ignore these problems whilst others handled them by offering advice to the patients in a somewhat reprimanding manner, suggesting that patients 'should get themselves right'. Furthermore, in instances of somatisation where no physiological basis for complaints could be identified, the nurses neglected the emotional or contextual bases of the patient's condition.

Petersen's (1998) findings are supported by research findings in other developing countries. Abiodun (1993) found for example, that in a primary health care facility in Nigeria, the health workers involved were only able to detect 13.8% of the psychiatric cases identified in the study population. In an earlier study, Abiodun (1991) found that 82% of the primary health care workers indicated that mental disorders accounted for 5% or less of their patient-load and that the psychopharmacological knowledge of the primary health care workers was found to be poorest for anti-depressant medication. Further, Reeler (1989) noted that some studies which were conducted in Africa, claim that between 80%-96% of mental health problems have been found to remain undetected by the health worker. He argues that such misdiagnosis and mismanagement result in unnecessary and sometimes dangerous use of drugs, expensive investigations as well as unnecessary visits to health centers. Reinforcing this sentiment, Swartz (1997) expresses his concern that the great bulk of professional mental health care, especially in lower income countries, is handled by people with no necessary special interest in the field. It appears then that without a real interest in the plight of mental health care and a lack of training in providing mental health care services, primary health care workers may be consciously or unconsciously compromising the quality of care being offered to psychiatric patients.

As has been previously mentioned, the other 'accessible' source of care for the larger part of the South African population is that of institutional custodial care. However, while such a source of care may be economically accessible to the majority of South Africans, the institutions and the care provided has been severely criticised by many investigative committees (American Psychological Association, 1979; Allwood, 1990; Pretorious & De Beer, 1996). The 1996 report of the task team appointed to investigate human rights violations and alleged malpractice in psychiatric institutions concluded "There is no parity in the standard of care in psychiatric institutions. The standard of care in formerly Black institutions is below that of formerly White institutions" (p.79). The committee recommended reviewing all existing agreements with private organisations that provide psychiatric in-patient care. (This will be discussed at greater length in chapter two). Moreover, although psychiatric institutions are more geographically accessible to the majority population than private psychiatric services, the distance between many communities and the psychiatric hospitals still remains quite large (Foster & Swartz, 1997). Bhana and Pillay (1998) found that *public* mental health facilities tended to be located in predominantly urban and centralised areas, thereby making access more difficult. Furthermore, because of the long periods spent in these institutions, it is very difficult for patients to be integrated back into their community when they are discharged (Allwood, 1990).

The quality of mental health care in South Africa is also marred by the fact that the financing of such services is not accorded the priority that it requires to function optimally. A sophisticated review conducted in the Western Cape by Ensink, Leger and Robertson (1995) found mental health expenditure in State services to be about 8% of total health expenditure. Nationally however, it seems that only around 2.5% of total expenditure and 4.2% of hospital expenditure is spent on mental health services. Less than 5% of the mental health budget, is spent on community care and furthermore, at primary care level, mental health care expenditure is 0.6% of the total primary health care expenditure (Freeman & Pillay, 1997). These meager proportions are tangible illustrations of the lack of precedence of mental health services in financial decisions made by health policy makers. The low status accorded to mental health services by policy makers has partly been attributed to their negative attitudes, prejudices and stereotypes towards mental illness, which amongst other factors, arises from a lack of knowledge about mental illness (Mclaren & Philpott, 1998).

Apart from the above-mentioned shortcomings, South African mental health services are characterised by several other flaws. A major deficit within the national mental health system is the lack of community-based services and facilities, such as day-care centers, suitable educational opportunities and sheltered employment facilities (Mclaren & Philpott, 1998). The South African mental health system is also vertical and fragmented, resulting in duplication of psychiatric services. Poor planning and coordination of services in the mental health system is also viewed as a limitation, and Mclaren and Philpott (1998) attribute this partly to an absence of managerial support, the absence of a national mental health policy and the lack of guidelines on mental health. Outdated referral systems and information management contribute to the defective quality of community mental health services which invariably results in difficulties with follow-up and continuity of care (Petersen, Parekh, Bhagwanjee, Gibson, Giles & Swartz, 1996).

Research also indicates that there appears to be a dire lack of mental health personnel, especially at community and middle management levels (Lee & Zwi, 1997). This problem is further exacerbated by the lack of training of appropriate personnel, excessive workloads, insufficient trainers, no multidisciplinary team approach and a lack of consensus on the role of the mental health team (Lee & Zwi, 1997). The schema of shortcomings of the South African mental health system presented above is not exhaustive. It is important to note however, that the shortcomings of the current mental health system are legacies of the previous apartheid government (Freeman & Pillay, 1997). The ideological framework of mental health services under the apartheid government was a combination of racial discrimination, privatisation, institutionalisation and paternalism, where fragmentation was prevalent on a large scale. Furthermore, government services were separated through the tricameral and homelands systems. The approach was also curative and residual rather than developmental and preventive (Freeman, 1992). These deficits, which had been created in the past, have extended themselves into the current socio-political dispensation. It is apparent then, that the current mental health service, both at a private and community level, is in need of a radical transformation if it is to address the mental health needs of South Africa.

## 1.2. TRANSFORMING MENTAL HEALTH CARE IN SOUTH AFRICA

The mental health problems in South Africa as well as the inefficient mental health system that is being employed to address such problems highlights the need for comprehensive mental health care services. It is encouraging to note that with a change in government and a reprioritising of the health needs of South Africans, greater attention is being accorded to mental health care. While there is no national mental health policy existing at present, efforts are underway by the national directorate and it's counterparts at the provincial level to develop a comprehensive national mental health policy. This is reflected in recent policy documents, where a premium has been placed on the deinstitutionalisation of mentally ill patients within the framework of a primary health care approach to mental health. In the White Paper for the Transformation of the National Health System for South Africa (Department of Health, 1997), the first principle that it is proposed, is that a comprehensive community-based mental health service should be planned and coordinated at the national, provincial, district and community levels, and should be integrated with the other health services provided. This is in accordance with the recommendations of the World Health Organisation (1984). They express the view that "governments should take all necessary steps to improve mental health care at every organisational level, but especially at community level through integration with the primary health care system, supervision being provided by more skilled personnel and referral services being available for the more difficult types of cases" (p.32-33). It is argued (Uys & Sokhela, 1996) that this integration will elicit the following benefits:

a) It will improve coverage of the population.
b) It will reduce the cost of health care as mental health care will be provided by clinic staff.
c) Mental health services will be more geographically and financially accessible to consumers.
d) The prognosis of patients will be improved due to the subsequently greater involvement of families in treatment.

The second principle of The White Paper for the Transformation of the National Health System for South Africa (Department of Health, 1997), under the section entitled "Mental Health", reads that national health research should include mental health and substance abuse to identify the extent of these problems in South Africa. The third principle expresses that human resource development for mental health services should ensure that personnel at various levels are adequately trained to provide comprehensive and integrated mental health care based on primary health care (PHC) principles. Rispel (1995) succinctly summarises the central tenets of the PHC approach as dictated by the WHO. These are:

a) To promote changes in the delivery of health care that ensures equity, universal access, and the provision of essential health care.
b) To improve socioeconomic conditions in order to reduce the number of diseases related to poverty.
c) To promote an intersectoral approach to solving health problems.

d) To encourage the community to participate fully in the planning and implementation of the health service so that the people benefit optimally from the service.

e) To ensure accountability to the people.

One of the most important ways in which national mental health policy has shifted is in its adoption of the notion of community-based care. In this model, treatment programmes for the mentally ill are offered independently of the institutional setting, in order to promote the integration of the individual with his/her community. This approach is in line with the global trend of relocating mentally ill patients away from large institutions and into the community. This shift in care is known as "deinstitutionalisation". Strong arguments from a human rights perspective have been presented in favour of deinstitutionalisation, which emphasises a person's right to be cared for closer to home, outside an institution if no longer requiring hospitalisation (Dartnall, 1998). This outlook is also partly based on the assumption that one's social context plays a significant role in one's mental well-being and that if poor mental conditions arise (even partially) from interpersonal factors, then such conditions should be treated within the context in which they are created (Beckman, 1972). A further argument strongly advocating deinstitutionalisation is that which is presented by Freeman (1992) who concluded that mental health care should be available to all in need, at primary, secondary and tertiary levels. As national director of Mental Health Care services in South Africa, he argues that South African mental health care should be community- based wherever possible, should consist of preventive, promotive and rehabilitative services, and it should consist of medical, social and psychological dimensions. He argues further that in order to attain these objectives, it is necessary to move away from the current emphasis on institutional care and medical intervention to a much greater range and spread of mental health services within a community context.

The deinstitutionalisation movement, in it's redefinition of the role to be played by community psychiatric nurses and primary health care nurses views such personnel as front-line workers in preventive and curative mental health care strategies; and hence as primary deliverers of mental health care services. Other mental health professionals, like psychiatrists and psychologists are envisaged as consultants or supervisors to these front-line workers.

## 1.3. ATTITUDES TOWARDS DEINSTITUTIONALISATION

The available literature has commonly found that mentally ill patients are sensitive to and influenced by the attitudinal atmosphere created by mental health personnel and that the success of reintegrating former psychiatric patients into the community is affected by the attitudes of community mental health care personnel towards mental illness, mentally ill people and deinstitutionalisation (Cohen & Struening, 1965; Rabkin, 1972; Lyons & Hayes, 1993). Concerns have been expressed by Vogelman (1988) that the difficulty that mental health professionals are likely to have in adapting to policy changes like deinstitutionalisation may result in South Africa finding itself in a similar situation to Nicaragua, where many mental health professionals expressed their resistance to social change by emigrating.

The specific emphasis of this study is fuelled by findings in earlier studies (Sartorius & Harding, 1983; Abiodun, 1991), which report that general nurses initially expressed dissent to the concept of community mental health care and their implicated roles in this move. In his review of literature on community mental health care, Freeman (1990) concluded that many general nurses throughout the world are reluctant to take on a mental health function, as they perceive mental health problems as different, bothersome and especially dangerous. Earlier work by Kirk and Therrien (1975) report that the deinstitutionalisation programme in Hawaii ran into several major obstacles, one of which was the treatment preferences and attitudes of community mental health staff towards ex-hospital psychiatric patients and the difficulty of resocialising hospital staff assigned to community mental health programmes. Hence, continunity of care in the community for former hospital patients had partially failed in Hawaii, not because the idea was wrong, but because these patients were not highly valued as clientele by many community agencies.

In his discussion on obstacles facing the success of deinstitutionalisation in the United Kingdom, Lamb (1993) argues that with time, the enthusiasm and excitement displayed by personnel at the inception of community mental health care programmes begins to dissipate. As a result, personnel become less committed and tend to sway towards the bureaucratisation of roles and responsibilities. It is apparent that the role that the attitudes of community mental health care personnel play towards the success of deinstitutionalisation cannot be underestimated. Despite the apparent importance of these issues, there has been a paucity of systematic research examining the relationships between attitudes toward the mentally ill and attitudes towards deinstitutionalisation. Available research has almost exclusively adopted the assessment of attitudes towards mental illness and mentally ill people as its' foci, and in this regard has failed to attend to the impact of such attitudes on the patients' reintegration into society. In her review on studies of attitudes towards mental illness and mentally ill people, Rabkin (1972) claims that studies have consistently found that mentally ill people are generally exposed to rejecting and intolerant treatment from the general public and sometimes from mental health professionals.

## 1.4. RATIONALE FOR THE PRESENT STUDY

The WHO has expressed that the extension of mental health care in developing countries is feasible only if existing health staff in general health services can be actively involved. In order to make this possible, the WHO believes that information on health workers' attitudes, knowledge and skills is a necessary prerequisite to their active engagement in mental health care (World Health Organisation, 1975). The WHO has also recognised and acknowledged the vital role of the community in the move towards deinstitutionalisation and has called for developing countries to investigate the attitudes of the community and mental health personnel towards mentally ill patients (Corin, Uchoa, & Bibeou, 1989).

Despite widespread policy initiatives to deinstitutionalise and integrate mental health care with primary health care in overseas countries, there has been little research conducted on how the deinstitutionalisation of mentally ill patients is perceived by personnel for whom such a policy would bear direct relevance. While some research has been done on the attitudes of primary health care nurses towards deinstitutionalisation and the subsequent integration of mental health care into primary health care, no research has been conducted on the attitudes of community psychiatric nurses towards the deinstitutionalisation and primary mental health care movements. Furthermore, research efforts have failed to examine the attitudes of mental health professionals such as psychiatrists, psychologists, mental health social workers and occupational therapists to deinstitutionalisation and community mental health care. Attaining an understanding of mental health personnels' attitudes to deinstitutionalisation and community mental health care is significant as community psychiatric nurses and mental health professionals are envisioned as key role-players in this process. Unanswered questions on issues such as, the attitudes of mental health professionals towards deinstitutionalisation will be addressed in this study as answers to such questions are crucial in determining the success or failure of deinstitutionalisation of psychiatric care in South Africa.

The attitudes of professional staff tasked with treating the mentally ill are of particular concern as they may be quite significant for the experiences of the patients whom the professional staff has direct contact with in hospitals and communities. Furthermore, the attitudes of professional staff who are involved in mental health education may also be significant for community members whom such educational programmes are targetted at (Eker & Arkar, 1991). Although some South African research ( Mavundla & Uys, 1997; Lee, Thom, Zwi, Clews, Sibeko, Mahlo & Masondo, 1997; Dartnall & Porteus, 1998) has been conducted on attitudes towards mental illness and mentally ill people, and even attitudes towards primary mental health care, very little research has focussed on attitudes towards deinstitutionalisation. Furthermore, an extensive literature search indicated a stark lack of international research on attitudes towards deinstitutionalisation. Hence, this study appears to be unique in this endeavour.

Inquiries into malpractice in many institutions provide further reasons for a critical evaluation of the relevance of psychiatric hospitals. Common complaints center around the inhumane treatment of psychiatric patients by staff, blatant racial discrimination of non-white patients, and poor reporting procedures by staff (American Psychiatric Association, 1979; Pretorius & De Beer, 1996; Foster & Swartz, 1997). It is further believed that results yielded by this study may be useful in informing policy makers on factors that require consideration in order to ensure the successful implementation of deinstitutionalisation, for example, attitudes of chief role players towards deinstitutionalisation. A number of studies (Malla & Shaw, 1987; Bairan & Farnsworth, 1989; Sullivan, 1993; Uys & Sokhela, 1996; Mavundla & Uys, 1997) have revealed that the dissemination of information to general nurses on mental illness and mentally ill people was associated with an improvement in their overall attitudes and behaviour towards the mentally ill. It was argued that such programmes encouraged increased exposure to a psychiatric milieu, which in turn, assisted in dispelling stereotypical perceptions of mentally ill people. This study will also be of benefit to academics interested in such fields of study, especially since, this study marks one of the first few attempts at systematically assessing attitudes towards deinstitutionalisation.

## 1.5. DEFINITIONS OF TERMINOLOGY

### 1.5.1. ATTITUDES

An attitude is a relatively enduring organisation of beliefs around an object or situation, predisposing one to respond in a preferential manner (Ajzen, & Fishbein, 1980).

### 1.5.2. MENTAL ILLNESS

This concept is defined as any disorder or disability of the mind, and includes any mental disease and any arrested or incomplete development of the mind (South African Mental Health Act No.116, 1993).

### 1.5.3. MENTALLY ILL

The term "mentally ill" refers to those individuals, who by reason of mental illness, experience serious limitations in their functioning relative to primary aspects of daily living, such as, personal relations, living arrangements and employment (Test, 1981). This study also uses the term "mentally ill" to refer to persons who have previously been hospitalised as psychiatric patients, individuals currently hospitalised as psychiatric patients as well as those individuals who suffer from a mental illness, but who presently are not and have never been hospitalised.

### 1.5.4. DEINSTITUTIONALISATION

Deinstitutionalisation (in relation to psychiatric patients) is defined by Bachrach (1976) as the reduction of traditional institutional settings in association with an increase in community- based services. Brown (1975) identifies a further vital aspect of deinstitutionalisation: the avoidance of unnecessary hospital admissions.

### 1.5.5 MENTAL HEALTH PROFESSIONAL

This concept refers to those health professionals who are directly or indirectly involved in providing mental health care, for example, psychologists, psychiatrists, medical doctors, occupational therapists, social workers and psychiatric nurses employed in psychiatric settings. Such professionals may be employed either within the private or public sector.

### 1.5.6. COMMUNITY PSYCHIATRIC NURSE

This is a specialist nurse who is registered with an additional nursing degree/diploma in psychiatric nursing science. Such a nurse could be based either in a hospital or in a psychiatric clinic. Irrespective of the base from which she/he operates, a community psychiatric nurse always works within a community. A community psychiatric nurse primarily attends to the mental health care needs of the community, which she/he serves. Amongst many other activities, this may involve counselling psychiatric patients and their families, engaging in follow-up of psychiatric patients, conducting appropriate referrals for psychiatric patients, dispensing but not prescribing psychotropic medication and to an extent, enhancing community awareness of mental health (Democratic Nursing Association of South Africa, 1998).

### 1.5.7. PRIMARY HEALTH CARE NURSE

A primary health care nurse is a registered nurse that holds a degree/ diploma in community nursing science and who is trained to diagnose and treat physical health problems on a general level. Such a nurse is always based in a community clinic and hence renders her/his services therefrom (Democratic Nursing Association of Southern Africa, 1998).

The above definitions will be employed for the purposes of this study.

## 1.6. AIMS

The aims of this study were fourfold:

a) To investigate the attitudes of mental health professionals, community psychiatric nurses and primary health care nurses towards mental illness and mentally ill people.

b) To investigate the attitudes of mental health professionals, community psychiatric nurses and primary health care nurses towards deinstitutionalisation.

c) To investigate the role of demographic variables (age, gender, race[1], socioeconomic status[2], education, level of professional experience) on attitudes towards mental illness, mentally ill people and deinstitutionalisation.

d) To examine the interrelationships amongst the variables of attitudes towards mental illness, mentally ill people and deinstitutionalisation.

## 1.7. HYPOTHESES

The hypotheses guiding this study are as follows:

a) Community psychiatric nurses, mental health professionals and primary health care nurses will differ significantly in their attitudes towards mental illness, mentally ill people and deinstitutionalisation.

b) There will be differences among respondents in different categories of age, gender, race, socioeconomic status, educational level, years of professional experience and treatment of family/friend for a mental illness in their attitudes towards mental illness, mentally ill people and deinstitutionalisation.

c) The demographic variables of age, gender, race, socioeconomic status, level of education, years of professional experience and psychological/ psychiatric

[1] The term 'race' is used in a classificatory sense, rather than as a social construct.
[2] Class is defined in terms of the individual's socioeconomic status which, is assessed through monthly income.

treatment of family/friend will be related to attitudes towards mental illness, mentally ill people and deinstitutionalisation.

d) Attitudes towards mental illness, mentally ill people and deinstitutionalisation will be correlated with each other.

The following chapter reviews the established literature around these issues.

# CHAPTER TWO

# LITERATURE REVIEW

## 2.1. INTRODUCTION

Historically, mental illness and it's treatment have generally evoked negative, stereotypical responses towards people with mental illness. Mentally ill people have often been characterised as dangerous, unpredictable, unable to control their emotions, unhygienic and as having a poor prognosis for recovery (Reda, 1996; Stones, 1996; Wolff, Pathare, Craig & Leff, 1996; Angermeyer & Matschinger, 1997).

The lay public, current and ex- mental patients, general health professionals and sometimes even mental health professionals have reflected rejecting attitudes towards mental illness and mentally ill people (Skinner, Berry, Griffith & Byers, 1995). Various theories have been used to explain the development and maintenance of these negative attitudes. A widely used explanatory theory is Scheff's (1974) labelling theory which states that both mental patients and ex-mental patients will experience stigmatization and rejection by normal people and that they will be punished when they attempt to return to conventional roles, by virtue of bearing the label 'mentally ill'. This theory has been substantiated by current and former patients' reports of experiencing prejudice and discrimination, regardless of how normal they may appear (Link, Cullen, Frank & Wozniak, 1987). Several researchers (Nunnally, 1970; Nieradzick & Cochrane, 1985; Seeman &

Seeman, 1985) have suggested that these negative labels and subsequent stigma may be internalised by mentally ill people who might then act in ways to reinforce the stereotypes held by the general population. The above-mentioned arguments reflect that the stigma of mental illness may have an adverse effect on individual mental well- being as well as increase the duration of the mental illness itself.

A crucial issue in relation to attitudes towards mental illness is the attitudes of treatment providers to deinstitutionalisation. The last three decades have witnessed huge transformations in the delivery of treatment towards mentally ill people in American and Western European countries. Many countries, (Britain, USA, Italy) have shifted their locus of psychiatric treatment from the institutional system to the community (Bollini & Mollica, 1989). Justifications for the transfer of psychiatric patients from mental hospitals into community - based care are linked to the development of effective pharmacological interventions, changing concepts of mental illness, the inability of mental hospitals to provide a healing environment for it's patients as well as economic benefits (Thornicroft & Bebbington, 1989).

The literature indicates however, that studies on the effectiveness of community - based care have yielded mixed results. While some studies commend community-based treatment for it's efforts at facilitating the integration of mentally ill people with their community (Bollini & Mollica, 1987; Durham, 1989; Desjarlais, Eisenberg, Good & Kleinman, 1995; Mechanic, 1996; Jones cited in Hamber, 1997), other studies have expressed concerns regarding the poor quality of life and the sub-standard psychiatric care received by mentally ill patients in the community (see *section 2.4.* for details), (Kirk & Therrien, 1975; Herman & Smith, 1989; Thornicroft and Bebbington 1989; Lamb, 1993). Hence, deinstitutionalisation as a policy issue remains controversial. This controversy has special relevance to the South African context, since national health policy has moved towards the deinstitutionalisation of mentally ill patients as well as the integration of mental health care with primary health care (Towards a National Health System, 1997).

The following review attempts to provide an understanding and an analysis of the attitudes of general health care personnel as well as mental health professionals towards mental illness, mentally ill people and deinstitutionalisation, and the dynamics underlying these variables. Due to the paucity of research on the attitudes of community psychiatric nurses towards mental illness, mentally ill people and deinstitutionalisation, this review is unable to provide empirical information on the attitudes of these personnel towards these variables. This review also contextualises the global trend towards deinstitutionalisation, in terms of it's implications for health policy in South Africa as well as health policy visions for chief role players, such as, community psychiatric nurses, primary health care nurses and mental health professionals. Traditional roles of mental health professionals, community psychiatric nurses and primary health care nurses are examined and this provides the foundation for more contemporary views of the roles of mental health professionals in community mental health care.

## 2.2. ATTITUDES OF MENTAL HEALTH PROFESSIONALS TOWARDS MENTAL ILLNESS AND MENTALLY ILL PEOPLE

Attitudes are possibly one of the most crucial forces determining an individual's response to treatment and rehabilitation. Theorists (Larson, 1987; Reverby, 1987; Warren, 1988; Lyons & Hayes, 1993) have commented that humane attitudes among professionals are the most important dimension of a helping relationship. They argue that the attitudes of mental health professionals are vital in shaping the lifestyle opportunities for mentally ill persons and the roles that they are encouraged to adopt in society. These theorists report that patients' levels of prognosis are greater with caring professionals than those who provide a low level of caring. These sentiments are reinforced by a task team report on World mental health (Desjarlais *et al.,* 1995). The report presents arguments that mental health professionals contribution to society extend beyond their expertise with a certain range of problems or people, to include providing solutions for a very broad range of health and social issues.

The "contact hypothesis" (Amir, 1969) suggests that contact with people from a marginalised, low social status group, for example, mentally ill people, can diminish negative attitudes towards them as it serves to transform the stereotypical relationship into a personal one. It is argued that instead of mentally ill people being seen as an isolated social group, contact with mental patients would enable a mentally ill individual to be viewed as an individual in his/her own right. In other words, the opportunity to develop interpersonal relations through prolonged contact may lead the recipient, (for example, a mental health professional) to realise that the stigmatised group members have characteristics that are incongruent with the recipient's stereotypical views. It might therefore, be thought that mental health professionals who are in regular contact with the mentally ill would be unlikely to share the general public's fearful and rejecting attitudes. Furthermore, mental health professionals are likely to possess sophisticated knowledge about the etiology, treatment and outcome of psychiatric disorders as a result of their training and experience, which is likely to positively influence their attitudes towards their patients. The limited evidence available (Mavundla & Uys, 1997) suggests that while there are indeed mental health professionals who hold positive attitudes towards mental illness and mentally ill people, there are also some mental health professionals who are not immune to the influence of popular stereotypes.

Rabkin (1974) postulates that direct exposure to patients in the form of intense and prolonged contact may improve the impact of education but may do little to change those components of attitudes which are related to more stable personality characteristics of 'normal' individuals. She remarks that only some of the several dimensions of attitudes towards mental illness are accessible to change through variables such as education and improved information. Hence a *generalised* expectation that *all* mental health professionals, by virtue of bearing knowledge on mental illness and by being exposed to mentally ill people, would hold liberal attitudes towards mentally ill people is largely tentative.

Ellsworth (1965) attempted to determine whether the endorsement of attitude dimensions by 65 psychiatric aides and psychiatric nurses working in a psychiatric hospital made any significant difference in their behaviour in relating to psychiatric patients. A total of 188 patients (out of 382 carefully screened patients) rated the behaviour of the ward personnel on a 55-item interpersonal rating scale. The findings revealed that psychiatric staff members who endorsed one of the five "authoritarian-control-restriction" attitude dimensions (indicating a tendency to view the mentally ill as an inferior class requiring coercive handling) were perceived by patients as behaving significantly more often in a controlling, restrictive and domineering manner than staff members who rejected these attitude dimensions. The second major finding was that a staff member who endorsed "protective benevolence" (indicating a tendency to establish a comfortable but aloof relationship, and to rationalize their deceptive behaviour as an act of kindness to patients) was viewed by patients as behaving more frequently in an aloof, distant and cold manner. Third, it was discovered that staff members who endorsed both "authoritarian-control-restriction" attitude dimensions as well as "protective benevolence" attitude dimensions were rated more often by patients as displaying a lack of respect in their behaviour towards patients. For example, patients revealed that they were not honest/dependable and treated patients as children instead of as adults.

The findings in Ellsworth's (1965) study are supportive of the findings of an earlier study by Cohen and Struening (1964) which found that psychiatric institutions whose personnel endorsed attitude combinations of "authoritarianism-restrictiveness" were not especially competent in returning patients to the community. On the basis of findings in these two studies, it appears that a restrictive attitude does impact on a mental health professional's behaviour, and may also largely influence the effectiveness with which she/he works in terms of returning hospitalised patients to the community.

In their review of community mental health care in Hawaii, Kirk and Therrien (1975) reported on interviews with the mental health personnel of the community mental health programmes. The interviews revealed a general perception amongst personnel that they did not believe that recovery or even stabilisation for former hospital patients was likely. They make reference to interviews with the mental health personnel involved in a community mental health care programme in Hawaii. In the interview, it was revealed that ex-hospital patients were routinely referred to as "chronics", a term which is connotative of the patient being hopeless, unable to being helped and being unresponsive to treatment or rehabilitation. There appeared to be a pervasive belief amongst the mental health staff that if patients requested their help, all that was in the staff's capacity to do was to maintain them on high doses of anti-psychotic drugs (Kirk & Therrien, 1975). It is important to note that many of the community mental health professionals in this programme were formerly staff in the state psychiatric hospital and had become as deeply socialised into the values, beliefs and attitudes of the institutional milieu as had the former patients. Nonetheless, even the non-hospital trained mental health professionals within the community mental health programme rarely opted to work with patients whom they perceived as having a poor prognosis. The unanimous choice amongst all the staff was to work with the less disturbed clientele who evidenced better prognosis (Kirk & Therrien, 1975).

It is apparent that the existence of negative attitudes on the part of the mental health caregivers can prove to be detrimental to the psychiatric patient's condition. Mclaren and Phillpot (1998) take this argument further and suggest that low expectations for the recovery of people with a mental illness invariably filters down to health policy makers, who subsequently accord a poor status to mental health services. They tend to focus on the medical rehabilitation of patients with a mental illness, resulting in a neglect of the psycho-social dynamics underlying mental illnesses.

A related study, on social distance and attitudes towards mentally ill patients found results that contradict Kirk and Therrien's (1975) findings. Malla and Shaw (1987) report that their sample of psychiatric nurses, who were based in a hospital setting appeared to have fairly positive attitudes towards interpersonal and social relationships with mentally ill patients as indicated by the nurses' high scores on social distance. These findings are reinforced by the results of Eker and Arkar's study (1991) on Turkish nurses' attitudes towards mental illness. In this study as well, nurses appeared to be comfortable with the mentally ill in terms of social distance. The nurses also displayed quite positive attitudes in terms of therapy and prognosis of the mentally ill patient. Furthermore, organic, psychological and psycho-social causes of mental illness were accepted by the nurses. A more detailed analyses of research findings supporting the idea of mental health professionals holding positive attitudes towards mental illness and mentally ill people is provided in *section 2.4* .

It is clear that research findings on the attitudes of mental health professionals towards mental illness and mentally ill people are inconsistent. The antithetical relationship of research findings could be attributed to the dynamics of the samples that were employed in each study. Kirk and Therrien's (1975) sample constituted mental health professionals who worked in a *community* setting. In contrast, Malla and Shaw (1987) and Eker and Akar (1991) employed sample groups which, were operating within a *hospital* context. The different paradigms and orientations of a community-based treatment setting and a hospital-based treatment setting could have impacted on the attitudes of the groups of mental health professionals towards mentally ill patients. It is also important to note that in comparison to Kirk and Therrien's (1975) study, the studies of Malla and Shaw (1987) and Eker and Arkar (1991) are relatively recent. The 1970's was a decade in which the conceptualisation and treatment of mental illness was largely biased towards a bio-medical paradigm (Rabkin, 1972). This was in contrast to the 1980's, which witnessed a change in the theoretical understanding of mental illness from a bio-medical paradigm to a bio-psycho-social paradigm (Desjarlais, *et al.,* 1995). Changing conceptualisations of mental illness and new treatment methods of mental illness that occurred within the time span of the early 1970's and the late 1980's could have created a change in the attitudes held by mental health professionals towards mentally ill people. This could thus explain why Kirk and Therrien's (1975) sample group responded differently to mentally ill patients than Malla and Shaw's (1987) and Eker and Arkar's (1991) sample groups.

## 2.3. ATTITUDES OF GENERAL NURSES / PRIMARY HEALTH CARE NURSES TOWARDS MENTAL ILLNESS AND MENTALLY ILL PEOPLE

"The importance of nurses attitudes towards mentally ill people lies principally in the fact that their attitudes will affect how they behave towards psychiatric patients when they work with them, even if this may only be when psychiatric patients require nursing when they receive medical or surgical treatment" (Wilkinson, 1982, p.239). There is agreement in the literature that general nurses and primary health care nurses frequently display negative, intolerant and fearful attitudes towards mental illness and mentally ill people (Weller & Grunes, 1988; Ignacio, Arango, Baltazar, Arrigo Busnello, Climent, El Hakim, Giel, Harding, Ten Horn, Ibrahim, Murthy & Wig, 1989; Mavundla & Uys, 1997; Robertson, Zwi, Ensink, Malcolm, Milligan, Moutinho, Uys, Vitus, Watson & Wilson 1997). McDonald (1988) found that medical personnel share the apprehension and irrational expectations of the laity towards mental illness and mentally ill people to a significant extent. These antagonistic attitudes appear to be more pronounced if such personnel have not had any exposure to psychiatric training, education or direct contact with psychiatric patients.

Studies assessing the knowledge and attitudes of primary health care nurses towards mental health problems and their treatment were embarked upon in seven developing countries (Harding, d' Arrigo Busnello, Climent, Diop, El Hakim, Giel, Ibrahim, Ignacio & Wig, 1983) within the context of two WHO coordinated, collaborative studies in Nigeria and Nicaragua. Sample groups of primary health care workers from Colombia, India, Senegal, Sudan, Philippines, Egypt and Brazil were interviewed. These interviews revealed that knowledge of mental health amongst the nurses was quite scant and that nurses had very limited notions of what types of mental health work should be implemented at primary care level. These studies also report that a majority of the health workers believed that mental disorders accounted for less than 5% of all patients that were seen. Many of them in fact reported never seeing any mental disorder being presented at their centers. This was problematic because research has conclusively established that approximately one-third of patients presenting at primary health care facilities suffer from a psychiatric condition (Climent, Diop, & Harding, 1980). Interestingly, interviews conducted by Harding *et al.* (1983) with the primary health care personnel from clinics in the seven countries mentioned earlier in this paragraph, revealed that very few personnel in any center mentioned their involvement in mental health care services; they appeared to perceive mental health as a specialised health concern. Participants of these studies also revealed a poor knowledge of psychotropic drug therapy, where they seemed to be better informed about minor tranquillisers than neuroleptics or anti-depressants. A negative attitude towards mentally ill people was also apparent from the interviews.

Harding *et al.'s* (1983) and Climent *et al.'s* (1980) findings are reinforced in a study (Abiodun, 1991) on knowledge and attitudes concerning mental health of primary health care workers in Nigeria. Employing a structured questionnaire, 207 primary health care workers in Nigeria were assessed on their attitude to, concept of, detection and treatment of mental disorders. It was found that primary health care workers without exposure to mental health training were predisposed to holding cultural views on the etiology of mental disorders (such as, mental illness is caused by spiritual possession). Similar to the results of the previously reviewed study's finding, Abiodun also found that an overwhelming majority of health workers indicated that mental disorders accounted for 5% or less of their patient load. The psychopharmacological knowledge of the primary health care personnel was also found to be poorest for anti-depressent medication. Furthermore, a significant 72% of the sample expressed a generally negative attitude towards mentally ill patients. It is evident that knowledge and attitudes towards mental illness have not changed significantly over the last decade in Nigeria. The nature of such attitudes remains misinformed and stereotypical.

Petersen (1998) attempted to examine the operative discourse in the relationship between a health-care provider and his/her patient. As part of her study, she interviewed primary health care nurses at a clinic in KwaZulu-Natal. Petersen (1998) reveals that although all the nurses had a theoretical understanding of the importance of employing a holistic framework to intervene with general health problems, this understanding was not translated into practice. This was evident in the largely task-centered and biomedical approaches to delivering health care to patients. Petersen argues that the authoritarian attitude of some nurses towards patients does not permit the provision of an empowering discourse of care. Instead, she views such scolding attitudes on the part of the nurses as undermining the subjectivity of the illness experience for the patient as well as disempowering the patient to take control of his/her own health.

Wilkinson (1982) proposes that the principle elements underlying general nurses' negative attitudes towards mental illness and mentally ill people are those of fear and distrust. This proposition is based on his research findings which indicated that general nursing students often regarded psychiatric patients as more frightening, less likely to cooperate with treatment, more likely to be violent and dangerous and more likely to need strict control in hospital. The subsequent finding that these components of fear and distrust prevailed even after a psychiatric training course indicated to Wilkinson (1982) the persistence of the nurses' original, ingrained attitudes of suspicion of psychiatric patients. McDonald (1988) reports that nurses in medical settings are often under stress when attending to patients with a dual diagnosis of physical and mental illness as they feel that such patients should be admitted to the psychiatric unit. General nurses in McDonald's study expressed their feelings in statements like, "We will not be held responsible if this patient jumps out of that window and dies" (McDonald, 1988). Once again, elements of marked apprehension and nervousness in nurses' attitudes towards the 'unpredictability' of psychiatric patients are clear. It is no wonder then that studies have found a great reluctance on the part of general nurses to care for the mentally ill. McDonald's findings are supported by the results of Mavundla's and Uys' study (1997) which attempted to investigate the attitudes of nurses towards mentally ill people in a general hospital setting. This study found that there seemed to be few nurses who had positive attitudes towards mentally ill people in general hospital settings. In other words, most nurses did not find the idea of caring for the mentally ill in these settings appealing. Variables such as level of education and contact with a mentally ill person were found to impact on nurses' attitudes towards the mentally ill (This will be discussed in *section 2.4.*).

A truism that clearly emerges from the review provided above is that the label "mentally ill" conjures images of dangerousness, volatility and unpredictability in the minds of most general nurses. A disconcerting factor is that such professionals are oftentimes the only sources of help for mentally ill patients. However, one must not lose sight of the fact that these negative attitudes arise from a multitude of factors, such as processes of socialisation, which although are varying in their complexity, are not irreversible. Studies in fact have found that these unenlightened attitudes are not resistant to modification and are hence indeed susceptible to change in a positive direction as a result of various experiences, for example, through contact with a mentally ill person and/or training in a psychiatric setting (Keane, 1991). These dynamics will now be discussed.

## 2.4. DEMOGRAPHIC AND OTHER VARIABLES OF RELEVANCE IN RELATION TO ATTITUDES TOWARDS MENTAL ILLNESS AND MENTALLY ILL PEOPLE

Studies on attitudes of the general public, mental health professionals and general health professionals towards mental illness and mentally ill people demonstrate that such attitudes vary as a function of various factors, including age, gender, race, socioeconomic status, education, level of professional experience, and contact with a mental illness or a mentally ill person (Middleton, 1953; Cohen & Struening, 1962; Malla & Shaw, 1987; Eker & Akar, 1991; Mavundla & Uys, 1997).

## 2.4.1. PATIENT ATTRIBUTES

### 2.4.1.1. Patient's Behaviour

Patient attributes that influence attitudes include frequency of actual/ anticipated behavioural events; extent to which violence comes into play; intensity of the behaviour; visibility in the open community; degree of unpredictability and loss of accountability. These perceived attributes of the mental patient may be a major determinant of the positive or negative character of attitudes toward mental illness (Rabkin, 1972).

Baxter and Hafner (1992) studied the attitudes and experiences of psychiatric nurses towards assaults by patients. The results revealed that a majority of 67% nurses believed that legal action should be taken against assaultive patients, especially if the patient was deemed as responsible for his/her behaviour. This conviction in taking legal measures against patients who act out violently towards nurses, suggests largely unsympathetic attitudes of this sample of psychiatric nurses towards assaultive patients. An earlier study, however, (Poster & Ryan, 1989) found that 67% of the participating psychiatric nurses expressed reluctance at taking legal action against assaultive patients. The primary reason cited for this lack of prosecution, even when serious injury was involved, was that mentally ill patients were not considered to be responsible for their violent acts by virtue of being mentally ill. The differing findings in these earlier and later studies could be attributed to the possibility that as a result of the general growing concern about the high spate of violence in society, nurses are experiencing changes in their awareness and attitudes towards physical attacks by patients. Poster and Ryan (1989) state further that anecdotal reports of nurses who have resigned from the field of psychiatric nursing due to feeling at risk for physical harm from patients are not uncommon. Sullivan (1993) observed in his study on occupational stress amongst psychiatric nurses that they experienced the unpredictable and intense nature of aggressive and suicidal behaviours amongst mentally ill patients as being the most stress-inducing element of their profession. Such phenomena no doubt have profound ramifications for the professional appeal of the field of psychiatric nursing and ultimately for the patients themselves.

Given the paucity of literature of literature on general nurses' and mental health professionals' attitudes to mental illness and mentally ill people, an examination of the evidence related to the lay public's opinions of mental illness and mentally ill people may help clarify some of the issues further. Kirk (1974) endeavoured to define the influence of behaviour, labels (such as "mental illness", "moral deficiency", or normal stress), and the labeller (that is, the person who interpreted the cause of the behaviour) on the perception of mental illness. The labellers employed as the informants in this study were "self", "family member", "other people", and "psychiatrist". Three vignettes were employed: case descriptions of a person with paranoid schizophrenia, a person who suffered from anxiety and a normal person. Kirk's study revealed no significant interactions among the behaviour described, what the behaviour was called and who interpreted the cause of the behaviour. Furthermore, the label itself and the persons offering the label had no significant effect on rejection scores; only the behaviour of the individual was important in influencing social rejection. With regard to visibility of behaviour, Rabkin (1972) states that the general public tends to reject disturbed behaviour that is socially visible even if it does not severely incapacitate the patient. Manis, Hunt, Brawerm and Kercher (1965) found that contrary to their hypotheses, psychiatrists as well as the general public were more influenced by the social visibility than the severity of symptoms in deciding whom to label as mentally ill.

#### 2.4.1.2. Gender

Negative attitudes are more likely to emerge if the patient is male. Phillips (1966) concluded that rejection appears to be based on how visibly the behaviour deviates from traditional role expectations; this conclusion arose from findings that revealed that men who evidenced mental illness were rejected more often than mentally ill women by the public. Phillips therefore concluded that males and females exhibiting the same symptoms of mental illness are evaluated differently by the general public, where, mentally ill males are evaluated more negatively than mentally ill females. Hence, it appears that as a result of society's expectations, males are expected to exert greater self-control, self - sufficiency and independence of thought than females. Whether this conclusion can be extended to understanding the impact of the patient's gender on the attitudes of general health professionals and mental health professionals remains undetermined.

### 2.4.1.3. Socioeconomic Status

Another variable that has been found to impact on individuals' attitudes to mental illness and mentally ill people is the patient's socioeconomic status. In a review of studies focussing on social class and mental illness, Hollingshead and Redlich (1958) concluded that relatives of mentally ill people in higher socioeconomic classes experience feelings of shame and guilt, whereas relatives of mental patients with low social status tend to express fear and resentment. With respect to the attitudes of health professionals specifically, Petersen (1998) found that socioeconomic status influences the way in which a health professional relates to his/her patient. Petersen (1998) concluded that primary health care nurses who differ in socioeconomic strata as compared to their patients, are able to easily engage with patients experiencing broader psycho-social problems. It is suggested that the different socioeconomic strata act as a buffer against the stress entailed in helping patients with similar problems to the nurse herself/himself. Van der Walt (cited in Petersen, 1998) proposes that nurses who experienced similar social conditions to their patients, find patient's problems "too close for comfort". They expect patients to transcend the boundaries of their social context in a similar way that they did and hence adopt a reprimanding attitude towards their patients. These findings therefore suggest that attitudes towards mentally ill people may be affected by and hence related to the patient's socioeconomic status.

#### 2.4.1.4. Racial Status

Cook and Wright (1992) quote American studies that continue to report that members of racial and ethnic minority groups receive inadequate mental health services and therefore, such groups ascribe a low status to the mental health profession. According to these theorists, ethnic and racial minorities in America are more likely than Whites to experience discriminatory treatment. They base their conclusion on research which has shown that Blacks are more likely than whites to be restrained, secluded, escorted by police and admitted to psychiatric care involuntarily, even after controlling for illness severity and other patient characteristics. South African psychiatric services in the former apartheid era were also blatantly discriminatory towards Black patients. Mental health care provided for Blacks were inferior and degrading to that provided for White patients (Foster & Swartz, 1997).

### 2.4.2. RESPONDENT ATTRIBUTES

Respondent characteristics also appear to play a primary role in shaping attitudes. Respondents of older age, lower socioeconomic status, lower educational level and lower level of professional experience are generally associated with a greater intolerance and rejection of mentally ill people.

### 2.4.2 1. Age

In 1981, Rabkin reported that literature supports the view that a person's acceptance of the mentally ill diminishes with age. For example, in a series of studies, which used the lay public as a sample, Brockington, Hall, Levings and Murphy (1993) report that younger people (25-44 years old) had relatively tolerant attitudes towards mentally ill people, but those above 44 years of age had the least benevolent attitudes. In agreement with the findings of Brockington *et al.*., Clark and Binks (1966) report that their study, which assessed the relationship of age and education to attitudes toward mental illness, illustrated that people of younger age had more liberal attitudes towards mental illness than older individuals. The positive correlation between age and public attitudes towards mentally ill people extends to the attitudes of general and mental health professionals. Using the Opinions about Mental Illness Scale to assess hospital staff attitudes towards mentally ill people, Lawton (1965) found that the factors of authoritarianism (indicating a tendency to view the mentally ill as inferior and requiring coercive handling) and social restrictiveness (indicating a tendency to perceive the mental patient as a threat to society and in need of restriction in social functioning), as measured by the scale, were positively related to age. In a similar, but more recent study, Scott and Philip (1985) discovered that psychiatric nurses under the age of 30 were significantly less authoritarian and impersonal in their interactions with patients than staff who were over the age of 45. In accordance with these findings, Eker and Akar (1991) report that in their study on Turkish psychiatric nurses' attitudes towards mental illness, the older the nurses, the higher was their rejection of mentally ill people in terms of social distance. They concluded that age was a significant predictor of nurses' attitudes towards mental illness.

A local study however, which assessed the attitudes of South African nurses (Mavundla & Uys, 1997) concluded that the demographic variable of age was not a significant predictor of nurses' attitudes towards mental illness. Mavundla and Uys' (1997) differing finding may be assumed to indicate that differing dynamics (such as, socio-cultural understandings of mental illness) underlie attitudes towards mental illness and mentally ill people in culturally differing societies. Furthermore, it is important to note that Mavundla and Uys (1997) employed only *general* nurses as their research participants. This compares with the other-mentioned studies above, which employed only psychiatric nurses as their research participants. Therefore, it is possible that assessing the attitudes of two differently trained groups of nurses could create a degree of bias in findings. Comparisons of similar/dissimilar findings with other local studies cannot be made due to the paucity of such research. It is important to note that studies, which have measured the impact of age on attitudes towards mental illness, consistently report that older respondents exhibit less favourable attitudes towards mental illness and mentally ill people than younger respondents. However, an existing gap in the literature on age and it's impact on attitudes towards mental illness and mentally ill people, is that the relevant studies have failed to provide theoretical explanations for the consistent finding that increased age is associated with lower degrees of tolerance towards mental illness and mentally ill people.

#### 2.4.2.2. Gender

An additional feature of the respondent, which has been found to impact on his / her attitudes towards mental illness and mentally ill people is the respondent's gender. There appears to be disagreement amongst researchers regarding the exact nature of the impact that one's gender bears on one's attitudes towards mental illness and mentally ill people. In their study which assessed social distance of a lay public sample towards the mentally ill, Angermeyer and Matschinger, (1997), discovered that the gender of their respondents had no influence on whether they would reject a mentally ill person or not. Brockington *et al.*, (1993) and Wolff *et al.*, (1996), in their studies of community attitudes towards mental illness reported similar findings.

Lyons and Hayes (1993) in contrast to Brockington *et al.*. (1993) and Wolff *et al.*. (1996), discuss that females expressed significantly greater acceptance and desired less social distance towards persons with psychiatric disabilities than did males. In accordance with these findings, Bhugra (1989) reports that in her study of people attending a general practice surgery, males were more likely to object to the opening of a hostel for mentally ill people in their street and also were less expressive of liberal attitudes towards mental illness than were females. Similarly, Morrison, De Man and Drumheller (1994) identified significant gender differences on four Opinions of Mental Illness factors in their study on multi-dimensional locus of control and attitudes towards mental illness. Their results revealed that men scored higher on the anti-mental patient factors of Authoritarianism and Social Restrictiveness while women scored higher on the pro-mental patient factors of

Benevolence and Mental Hygiene Ideology. Furthermore, for men and women combined, a correlation was found between Authoritarianism and Chance (fate). Further analyses revealed that for men Authoritarianism was indeed related to chance, but for women no such relation was found. This was taken to suggest that men who believe that the world is unordered and unpredictable and that one is subject to chance or fate tend to view mentally ill persons as inferior and requiring coercive handling.

The ambivalent nature of the findings on the relationship between gender and public attitudes towards mental illness and mentally ill people extends to the relationship between gender and mental health professionals' attitudes towards mental illness and mentally ill people. In one study, sex differences in psychiatric nurses' attitudes towards assaultive patients were found to be non-significant (Baxter & Hafner, 1992). The absence of significant differences between male and female nurses on the Bem Sex Role Inventory was taken to be suggestive of a high degree of androgyny, which in turn was employed as an explanation for the high degree of agreement between the sexes.

In direct contrast to Baxter and Hafner's (1992) findings, Scott and Philips (1985) found that female psychiatric nursing staff were more favourably inclined to physical methods of treatment and were significantly more authoritarian and impersonal towards patients than male staff. Female nurses also exhibited less of an inclination to reveal their individual personalities to patients, opting to maintain a professional persona, which in turn was aimed at avoiding psychological proximity to the patients. The researchers however concluded that these results were not indicative of female nurses not caring about mentally ill patients, but that they preferred to care for them more along the lines of the traditional stereotype of the general hospital nurse. A reason for the differing findings between Scott and Phillips' (1985) study and Baxter and Hafner's (1992) study could be that Baxter and Hafner were assessing nurses' attitudes towards *assaultive* mentally ill patients, while Scott and Phillips were examining nurses' attitudes to mentally ill patients in general.

#### 2.4.2.3. Racial Status

Studies focussing on the effects of ethnic and racial status *per se* on general/mental health professionals' attitudes towards mental illness and mentally ill people are sparse. However, the literature that does pay some attention to such issues, is based on the effects of ethnic and racial status on the attitudes of the general public and the attitudes of university students towards mental illness and mentally ill people. It may be useful to refer to such findings as a means to examine the dynamics of the relationship between an individual's ethnic and racial status and his/her attitudes towards mental illness and mentally ill people.

The literature appears to indicate that ethnic and racial factors do impact on individual attitudes towards mental illness and mentally ill people (Bhugra, 1989; Wolff *et al.*, 1996; Whaley, 1997). In 1979, Waxler (cited in Swartz, 1997) reported a better prognosis for schizophrenia in Sri Lanka, based on her finding that Sinhalese people are likely to attribute mental illness to supernatural causes and are hence less likely to stigmatize the mentally ill. In a similar vein, a South African researcher, Bhana (1986) reports that in her study on Indian indigenous healers, a minority of the mentally ill people (or their families) perceived mental illness as being due to supernatural forces. Another South African study (Uys, Dancel, Oliver, Du Pisani, Du Toit, Levine and Strydom, 1986) assessed the views of an urban Black population on life, illness, behaviour, etiology and treatment, with specific reference to mental illness. The results of the survey indicated that Black families held negative attitudes towards mentally ill people. The research participants reported that they were afraid of mentally ill people and were suspicious of anything that they said. The research participants displayed a strong bias towards a Western, Christian view of these matters.

Uys *et al.'s* (1986) finding is supported by the results of an international study. Whaley (1997) reports that in his study on ethnic and racial differences in perceptions of dangerousness of persons with mental illness, respondents of Asian and Hispanic descent perceived mental patients as significantly more dangerous than did White respondents. He argues that these findings are consistent with the idea that the cultural dimension of stigmatising attitudes towards mental illness is independent of the relational dimension, as may be reflected by the level of contact with a mentally ill person. Similarly, Sue, Wagner and Davis (1976) examined the conceptions of mental illness of Asian and Caucasian students in the USA. The results of their study revealed that Asian-Americans were more likely to believe that mentally ill people look and behave differently, that willpower is the foundation of personal adjustment, that women are more prone to mental disorder than men, that avoiding morbid thoughts enhances mental health and that mental disorder is a product of organic factors. After Sue *et al.*. controlled for age and socioeconomic status, it appeared that the notion of self – control and organic causality were the most significant elements reflecting Asian – Americans' sub-cultural constructs in the etiology of mental illness.

A South African study which assessed the attitudes of 153 first-year psychology university students' to mental illness (Goga, 1998) also found that a cultural difference was evident in students' attitudes. Indian students seemed to display the most liberal attitudes towards mental illness, while Black students' attitudes were to the contrary. The researcher attributed this attitudinal difference to the fact that mental illness has negative connotations amongst the Black population as it is often viewed as occurring as a result of sorcery, bad omens, loss of control and confusion. In their study on community attitudes towards mental illness, Wolff *et al.* (1996) examined the attitudes of 215 community residents towards mental illness and mentally ill people. The sample was an evenly proportioned mix of 4 different ethnic groups; Asians, Carribeans, Africans and Whites. Wolff *et al.* (1996) cite one of their most striking findings as being that of Asians, Carribeans and Africans expressing more intolerant attitudes towards mental illness and mentally ill people than Whites. This finding was based on the higher scores of the Africans, Carribeans and Asians on the scale dimension that measured social control. One might postulate that such attitudinal differences arise from the different conceptual models of mental illness across varying cultures.

### 2.4.2.4. Socioeconomic Status

In contrast to the contradictory reports on the relationship between education and attitudes towards mental illness and mentally ill people, it has been observed that class stratified research on attitudes towards mental illness tends to produce relatively consistent outcomes. It is also important to take into cognisance that class stratified research on attitudes towards mental illness has only been conducted with lay public samples. Although such studies have not employed general/mental health professionals as their samples, the findings of such studies may be useful in shedding light on the dynamics of a respondent's social class and his/her attitude to mentally ill people.

In their classic study, Hollingshead and Redlich (1958) observed distinct differences in attitudes and knowledge about mental illness and mentally ill people as a function of social class. In their studies, where attitudes were inferred from observed behaviour in psychiatric treatment situations, they found that upper- class members are better informed about mental illness and are more accepting of mentally ill people than members of the lower classes. Dohrenwend and Chin-Shong (1967) also found that lower class respondents were more likely to ignore the pathology of withdrawn behaviour and regarded anti- social behaviour as being serious but not mentally ill. Once they decided that an individual was indeed mentally ill, they were more rejecting than were respondents with higher socioeconomic status. As these authors noted: "lower status groups are predisposed to greater intolerance of the kinds of deviance that both they and higher- status groups define as serious mental illness. Their definition of serious mental illness is narrower than that of higher-status groups, giving the appearance of greater tolerance of deviance from the vantage point of higher-status groups, including the mental health professions" (Dohrenwend & Chin-Shong, 1967, p.432.).

#### 2.4.2.5. Education

In her 1989 review on attitudes towards mental illness, Bhugra highlights the consistent finding that, respondents of a lower educational level were more likely to express rejecting and unfavourable attitudes towards the mentally ill. By way of elaboration, Ramsay and Seipp cited in Bhugra report that respondents with higher educational and occupational levels were less apt to view mental illness as the outcome of poor living conditions, were less inclined to believe in the deleterious effects of associating with the mentally ill and were more optimistic about the possibilities of recovery. Other investigators (Appleby, Ellis, Rogers & Zimmerman, 1961; Cohen & Struening, 1962; Lawton, 1965; Wright & Klein, 1966) report that amongst mental hospital personnel, lower status staff groups are more authoritarian and restrictive in their attitudes towards mental patients while those with advanced professional training (psychiatrists, psychologists and social workers) display greater confidence in the patients' strengths, are more liberal and tolerant in their attitudes and are more optimistic about patients' prospects for recovery. A more recent study (Malla & Shaw, 1987) found that university education was able to predict attitudes of nurses on psychotherapy and prognosis of patients with mental illness. The results of this study revealed that nursing undergraduates were less likely than nursing graduates to believe in the usefulness of psychotherapy and also evidenced less faith in a high probability of the recovery of mentally ill patients. Mavundla and Uys (1997) found that while their sample of nurses generally displayed negative attitudes towards mentally ill patients, such attitudes were more intense amongst nurses with lower levels of education.

In contrast to the above-mentioned set of findings, Eker and Akar (1991) found that both their sample groups (Group A- nursing students who had just begun their training course and Group B- nursing students who had already completed two years of their training) appeared to have fairly positive attitudes about interpersonal and social relationships with those identified as mentally ill as indicated by a fairly high score on social distance. These researchers concluded that level of education had no impact on this element of their attitude. Research efforts focussing on the attitudes of the lay public obtained similar results. Nunnally (1961) observed on the basis of his six-year survey in the USA that the stigma associated with mental illness was found to be very general, both across social groups and across attitude indicators, with little relation to education. Like Nunnally, Freeman and Kassebaum (1960) found no evidence to indicate that attitudes towards mental illness are related to educational level, in their study of over 400 adults representing the general public in Washington. More recent studies using lay public samples however, (Cumming & Cumming, 1975; Brockington *et al.*, 1993; Wolff *et al.*, 1996) report a direct correlation between education and increased tolerance towards mentally ill people. Hence, it appears that research findings concerning the influence that education might play in moderating attitudes towards mental illness and mentally ill people remain contradictory. It is likely that the impact of education on attitudes to mental illness and mentally ill people might be a function of the interaction of multiple factors, which implies a need for a multi-dimensional perspective on the relationship between education and attitudes towards mental illness and mentally ill people.

### 2.4.2.6. Years of Professional Experience

Literature on the impact of years of professional experience on attitudes towards mental illness and mentally ill people is very scarce. However, the limited literature that is available appears to be contradictory. Eker and Akar (1991) found it noteworthy that the variable of years of professional experience did not predict the attitudes of their sample of general nurses towards mentally ill people. They argued that this was suggestive of the possibility that nurses attained optimum levels in terms of their attitudes during their formal education and that further change is not possible with more practical experience. As an elaboration of this argument, Malla and Shaw (1987) postulate that direct exposure to patients in the form of prolonged contact may improve the impact of *education* but may do little to change those attitude components which are a function of more enduring personality characteristics.

Poster and Ryan (1989) however, found that in their study of psychiatric nurses' attitudes towards assaultive psychiatric patients, there appeared to be a tendency amongst nurses who had longer experience in psychiatric settings to attribute responsibility for *all* behaviours to mentally ill patients. A mere 2% of the staff with 5 or less years of psychiatric experience agreed that mentally ill patients are responsible for all their behaviour compared with 8% agreement by staff members with more than 5 years of experience". The differing research findings in these studies may be attributed to the fact that the first two studies employed general nurses as their samples, whilst the last study employed psychiatric nurses as it's participants. The specialised nature of the context within which the psychiatric nurse operates may determine whether his/her years of professional experience impacts on his/her attitudes towards mentally ill patients. Furthermore, it is important to note that the latter study focussed on the attitudes of psychiatric nurses towards a specific type of psychiatric patient (assaultive) while the former studies focussed on a broad range of mentally ill patients. This may have obscured the findings of the latter study in terms of its similarity with the other studies.

#### 2.4.2.7. Contact

Contact with mental illness or the mentally ill has also been found to be a significant variable in relation to attitudes towards mental illness and mentally ill people. Procter and Hafner (1991) and Wilkinson (1992) report that fear of the mentally ill amongst nursing students was distinct before their hospital placement. Subsequent to the placement, more than 40% claimed to have found that patients were less violent and dangerous than they had expected. These researchers concluded that these attitude changes were a direct result of the nursing students being brought into contact with the psychiatric patients. In their research synthesis, Kolodziej and Johnson (1996) found that mental health employees' contact with mentally ill patients was associated with a greater acceptance of this marginalised group. In a related study, Brockington *et al.*, (1993) report that acquaintance with mental illness (as shown by having personal experience with mental illness, having a close friend or relative affected, or being a professional care - giver), was associated with increased tolerance towards mental illness and mentally ill people.

Brockington *et al.'s* finding (1993) has been supported by a South African study (Mavundla & Uys, 1997) which concluded that nurses who had a professional relationship with a mentally ill person displayed more knowledge and understanding of mental illness and were hence more positive in their attitudes towards mentally ill patients. Levey and Howells (1995) and Kolodziej and Johnson (1996) caution however that such an association is more complex than what the literature suggests. They argue that the nature of the contact is important, as diverse types of contact appear to have an impact on different attitudinal dimensions. To elaborate, they found that although contact is associated with differential attitudes, it did not serve to diminish stereotypical views of people with schizophrenia as being dangerous, unpredictable and different. Thus, it seems that although contact with a mentally ill person is associated with more liberal attitudes towards mental illness and mentally ill people, it may not strongly challenge the stereotypes underlying stigmatising attitudes. This indicates a need for research to focus exclusively on the effect of contact with a mentally ill person on negative stereotypes held about a mentally ill person.

#### 2.4.2.8. Psychiatric Training

There appears to be a significant relationship between the knowledge people have about mental illness and their attitudes towards mentally ill people. A multitude of studies report a change in attitudes amongst nurses after the inclusion of psychiatric concepts into their training programmes (Harding *et al.*, 1983; Bairan & Farnsworth, Uys & Sokhela, 1996; Lee, Thom, Zwi, Clews, Sibeko, Mahlo & Masondo 1997; Mavundla & Uys, 1997).

A collaborative study undertaken by the WHO on strategies for extending mental health care in developing countries (Harding *et al.*, 1983) found that mental health care training programmes in 7 developing countries led to appreciable transformations in the attitudes and knowledge of health staff that were retained 18-24 months after the initial training programme. Amongst others, these changes included a greater recognition of the link between somatic symptoms and psychological problems, a significant increase in awareness of the extent of mental health problems and an increase in the recognition of the need for preventive mental health work with groups like young children and support for groups such as the mentally retarded. After the training, primary care paramedical health workers displayed a positive change in their attitudes towards different mental health problems. Uys and Sokhela (1996), who developed a mental health care training programme for primary health care nurses in South Africa found similar results. At completion of the in-training programme a radical improvement was noted in the overall quality of care being delivered to psychiatric patients. These researchers also report that the attitudes of the nurses towards the psychiatric component had changed to such an extent that they were getting involved in the psychiatric patients' problems and rehabilitation as well as being supportive to patients' families. Importantly, nurses had become supportive figures to their patients.

Bairan and Farnsworth (1989) found that a psychiatric nursing course was effective in changing nursing students' attitudes in a favourable direction, in other words, nurses tended to become less authoritarian, less benevolent, more inclined toward mental health ideology and less restrictive. These attitudinal changes can be interpreted to mean that after experiencing the psychiatric nursing course, students tended, not to view the mentally ill as an inferior class requiring coercive handling; not to bear a moralistic-paternalistic perspective towards the mentally ill and had a positive attitude towards the mentally ill. Similarly, Wilkinson (1992) reports that psychiatric training enabled nursing students to understand that psychiatric patients were human beings like them and that it could be very satisfying to work with them. Such knowledge supplies the kind of support that mentally ill patients need. Training also appeared to teach the students to use a chronic-acute distinction to differentiate between certain types of patients. This distinction was not evident in their judgements about various case examples before their training.

Employing the same instrument as Bairan and Farnsworth (1989), Olade (1983) discovered differing results. Olade studied a post-basic nursing programme which included psychiatric concepts and which was specifically designed for nursing students who had minimal psychiatric preparation in their diploma course. These students were assessed as they progressed from their first to last year of study. The results showed minimal changes in the students' attitudes, with changes only being exhibited in terms of their authoritarianism and social restrictiveness. The comparative lack of attitudinal change could be attributed to the greater inflexibility of the older students found in post-basic programmes or to the integrated nature of this programme (Mavundla & Uys, 1997). In other words, it is possible that the success of a psychiatric training programme in changing attitudes amongst nurses may be dependent upon the features of the training programme itself.. It is also axiomatic that the success of changing attitudes of a broad range of people towards mental illness and mentally ill people may be dependent upon the *method* utilised to effect such changes.

In summary, it can be concluded that the attitudes of general and mental health professionals towards mental illness and mentally ill people vary markedly. The dynamics of these attitudes appear to be complex in their origin and seem to be related to a multitude of variables. The pessimistic attitudes exhibited by some mental health professionals towards mentally ill people appear to illustrate that fearfulness is a dimension of attitudes to the mentally ill which may be more resistant to modification, despite education or contact with the mentally ill.

## 2.5. THE DEINSTITUTIONALISATION MOVEMENT

The decade proceeding the 1950's witnessed the ushering in of a radical transformation in the structure and delivery of mental health care services, particularly in developed countries abroad. A shift from institutional care towards community mental health care called deinstitutionalisation formed the new vision of psychiatric care for mentally ill patients. This policy shift was associated with the growing consciousness throughout the world that total health is also constituted of mental health and that mental health care should become more integrated into general health care. Justifications for the supplanting of traditional institutional-based care with community-based mental health care have been elucidated at the beginning of this chapter. The author, however, wishes to elaborate on one of the primary forces underlying the international policy shift towards deinstitutionalisation.

Internationally, the benefits of the institutional milieu have especially appeared to be a subject of controversy. Wing and Furlong (1986) argue that the institutional environment can exacerbate a mentally ill person's psychiatric state as it fails to promote the integration of the mentally ill person with his / her community. They state further that mental hospitals in the 1950's were representative of great segregation, wherein inmates were isolated from the everyday life of the community to such an extent that the experience of prison life and life in an asylum appeared to be synonymous. Extending this analogy, Barton (in Thornicroft & Bebbington, 1989) described "institutional neurosis" as a disease in it's own right, characterised by apathy, lack of initiative, inertia and loss of interest. An interesting finding by Bollini and Mollica (1989) illustrates that patients in large psychiatric institutions exhibited greater illiteracy, a longer history of prolonged illness, more organic diagnoses and had lower expectations of their social functioning than did patients in community mental health centers, psychiatric wards in general hospitals or private community facilities. These findings lead to a scrutiny of the actual benefits underlying policies and operations being implemented at large institutions in comparison to those being operationalised into community care.

In spite of the recognition of the disadvantages of psychiatric institutions, the worst aspects of the antiquated mental health systems of Europe and the USA persist in societies that have limited service resources, especially in the poorest societies (Desjarlais *et al.,* 1995). South Africa is a clear example of one such society, where although deinstitutionalisation has entered the policy agenda of the health care system, institutional care still remains a pivotal force in mental health care. Scathing criticisms of South African psychiatric institutions have been issued by local practitioners and policy-makers as well as key international and local psychological organisations. The deleterious care received by patients in these institutions has been cited as a significant justification for deinstitutionalisation in South Africa (American Psychological Association, 1979; Allwood, 1990; Pretorius & De Miranda, 1996; Foster & Swartz, 1997).

In 1979, a task team was sent by the APA to South Africa to investigate the conditions of local state psychiatric institutions. The APA criticised the institutions as being overtly racist in their ethos and practices. The task team also expressed it's shock at the high number of unnecessary deaths amongst Black patients, the grossly inadequate quality of medical care at Black facilities, the lack of access for Black patients to basic necessities such as toilet paper, bed-sheets, shoes, tasteful food and shower facilities. Furthermore, the task team observed that the majority of Black patients were being beaten, assaulted and forced to engage in acts of difficult labour. Interestingly, Foster and Swartz (1997) report that acts of cruelty such as forcing Black patients to labour on asylum estates was condoned by the former local health authorities, who regarded such measures as therapeutic. The irony, however, remains that such forms of 'therapy' was not employed with White patients. The APA task team report (1979) concluded that the degradation that Black patients were forced to endure grew out of the mentality of apartheid, which treated Blacks as inferior and accepted degrading their humanity as a matter of course (APA, 1979). Currently, despite the constitutional demise of apartheid, mental health care in local state psychiatric institutions has improved very little. Although the current Bill of Rights places a premium on adequate and fair treatment for all, historically Black psychiatric facilities still remain as disadvantaged as they were during apartheid rule. This judgement is based on a recent investigative report that was compiled by the Department of National Health in 1996.

In 1995, the Minister of Health instructed a committee to investigate allegations of human rights violations and malpractices in the 32 local psychiatric institutions. The committee's findings in this investigation confirmed the allegations and furthermore were strikingly similar to that of the earlier APA committee's findings. The investigation illustrates that despite the passage of almost two decades since the APA's visit to South African psychiatric institutions, conditions within former Black facilities remain humanly intolerable and symbolise gross violations of basic human rights. In essence, the committee reports that the hygienic conditions in prisons are of far superior standard than that in psychiatric institutions. The committee also reports that the right to dignity is denied to patients and this was evident in the broken toilet doors (which violates privacy), patient sexual abuse, patient physical abuse, distasteful food which has no nutritional value, lack of warm water, lack of heating facilities, worn-out bed-linen, forced labour and a host of accompanying problems. According to the Bill of Rights, every patient has a right to medical treatment. Serious forms of the violation of this right was observed by the committee as taking mainly 3 forms – denial of proper medical treatment, improper medication and over-medication. Worse still, was the report of staff bringing in harmful substances such as cannabis and giving these to patients. The committee also reports that racial discrimination is still implemented in the most blatant manner, where patients at especially formerly Black institutions are subjected to unequal and differentiated treatment.

The committee report (1996) concludes that there is an overuse and indeed abuse of psychiatric institutions in South Africa. They vociferously express that patient care should be decentralised and in-patient care should be transformed from custodial care units to therapeutic units. The task committee appeals in the report that an integrated community care programme be developed in South Africa, that solid efforts be made to transfer as many patients as possible to community care, and that the admission rate of patients entering institutions should be reduced.

Reinforcing the appeals of the task committee, Allwood (1990) states that in examining the problems in institutional care, it is important to note that a significant number of patients are only in those institutions because of a lack of community services and facilities. One is therefore left wondering whether South African psychiatric institutions are fulfilling a therapeutic purpose or are being utilised as a convenient source of welfare. Allwood's (1990) observation introduces a further argument in favour of the importance of introducing community mental health care services and facilities which, if adequately developed, may be more conducive to healing than is currently possible in local psychiatric facilities

It is equally important to note however, that some international literature provides arguments that appear to reject criticisms of institutional care as being less adequate than community care. Lamb (1981) reveals that most controlled studies that compared patients treated in hospitals with those patients treated in community-based programmes found no significant difference between both patient groups' psychosocial functioning, as low levels were observed in both groups. In a later study, Thornicroft and Bebbington (1989) found that patients who, as a result of the move towards community care, were allocated to nursing homes showed significantly worse outcomes in terms of self-care, behavioural deterioration, mental confusion, depression and satisfaction with care, than when they had been institutionalised. An evaluation task team in Canada found that only medical therapeutic needs were being satisfactorily met by the deinstitutionalisation movement – housing, financial, socio-recreational, educational and vocational needs were barely receiving attention (Herman & Smith, 1989). Hence, it appears that in order for deinstitutionalisation to be an effective alternative to institutionalisation, integrated, concentrated and varied community programmes are crucial. The employment of somatic therapy in isolation is unlikely to ensure the success of community- based care as a method of intervention.

Deinstitutionalisation has occurred on a larger scale in developed countries like USA, UK and Italy, than it did in developing countries. The WHO and the international mental health community have, however, created various strategies that have served to foster quality health services in many developing countries. A study cited previously (Desjarlais *et al.,* 1995) also provides evidence that there is increasing hope about the potential for a new community psychiatry for many such countries. As has been mentioned in *section 2.3.* , the WHO has anchored pilot studies that have been conducted in countries as diverse as India, Sri Lanka, Colombia, Philippines and Egypt in order to extend mental health care into both urban and rural communities (Ignacio, de Arango, Baltaza, D'Arrigo Busnello, Climent, Diop, El Hakim, Farb, Gueye, Harding, Ibrahim, Srinivasa Murthy & Wig, 1983). It was found that these programmes have been associated with reduced hospitalisation and have prevented the unnecessary use of district out-patient services to provide quality care (Desjarlais, *et al.,* 1995). The development of psychiatric units in district hospitals rather than continued support for large central psychiatric hospitals has, therefore, been considered most appropriate. Furthermore, understanding such units as extensions of community-based programmes rather than as the essence of the mental health system is viewed as maintaining the emphasis on community-based care (Desjarlais *et al.,* 1995).

Botswana and Nicaragua have been documented as two developing countries, which have participated in the international move towards deinstitutionalisation. The year 1977 witnessed the development of a community psychiatric care programme in Botswana. This programme was fully-fledged and functioning by 1980 (Ben-Tovim, cited in Hamber, 1997). Similar to overseas intentions, the purpose of this community psychiatric service was to place greater emphasis on prevention and to subsequently treat psychiatric patients in their communities. The programme has been successful in reducing the admission rate to the large state psychiatric institutions by 50% and has managed to reduce costs (Ben-Tovim, cited in Hamber, 1997). The goals of the programme have been fulfilled to some extent, but it is expected that a sound service will only be achieved by the year 2000

(Mambwe, cited in Hamber, 1997). The close-knit extended family system in Botswana has been perceived as playing a significant role in the success of it's deinstitutionalisation programme. It nevertheless has been emphasised that despite the strong family system, families are often left frustrated with the burden of care because of the lack of available community support for these families (Mambwe, cited in Hamber, 1997).

Since 1979, a significant effort has been made in Nicaragua to expand the health care system. This has been evidenced by the promotion of primary health care, health campaigns involving the general population as volunteers, the use of paramedical aids and foreign assistance (Kraudy, Liberati, Asioli, Saraceno & Tognoni, 1986). In the early 1980's, the mental health care system in Nicaragua underwent a rigorous transformation from full custodial care to decentralisation of care. Mental health care was decentralised into 15 community mental health care centers. This was paralleled with the employment of general hospitals as referral centers. The avoidance of long-term stay at the psychiatric hospital accompanied by the progressive discharge of patients within the psychiatric hospital was also implemented. Treatment for the mentally ill largely occurred at home or in community facilities (Kraudy *et al.,* 1986). Kraudy and his fellow researchers conducted a survey with psychiatric patients utilising the services in Nicaragua. The survey revealed that the deinstitutionalisation programme was relatively successful and that the programme was able to deliver effective care at community level.

It is important to note that in most developing countries, the shift to community mental health care has been fairly new. Hamber (1997) quotes studies that illustrate examples of other developing countries where deinstitutionalisation has been recently implemented. One such country is Chile. Patients from the four large psychiatric hospitals are gradually being transferred to smaller local clinics while certain psychiatric units are being retained for chronic patients. Likewise, other developing countries, for example, Kenya, China, Cameroon, Malawi and Swaziland have also witnessed changes towards a more community - based model of psychiatric care (Hamber, 1997). Psychiatric care however, is not a priority area of investment of interests and resources in developing countries - other problems that affect the majority of the population are accorded higher priority. Hence the shift towards community - based mental health care in developing countries has been slow in it's progression (Kraudy *et al.*, 1986).

Deinstitutionalisation has progressed at a fairly rapid pace in countries, such as the Netherlands, UK, USA, Italy and Canada. Hafner and An der Heiden (1989) state that "the expansion of custodial mental health care and the accumulation of psychiatric beds peaked in the middle of this century. In 1955 the number of occupied beds in psychiatric hospitals stood at about 350 per 100 000 in England and Wales on a census day in 1981 and 96 per 100 000 in the USA in 1983" (p.12).

Nevertheless, the success of the deinstitutionalisation movement abroad remains controversial. "In many senses, it has been argued that the attempts to 'go community' have floundered and deinstitutionalisation has been labelled a failure as services have not necessarily improved" (Hamber, 1997 p.10). Concerns have been expressed that the needs of former hospital patients and the direction of most community mental health care programmes are disjointed (Kirk & Therrien, 1975) and that oftentimes, the therapeutic panacea claimed by advocates of deinstitutionalisation has not been met. A primary factor underlying some of the failures of deinstitutionalisation has been the lack of funding made available for community-based treatment programmes (Durham, 1989). As a result of poor finances, the closure of psychiatric hospitals was not paralleled with adequately planned and well-resourced community services. As a result, many patients who were discharged from psychiatric hospitals did not have the opportunity to return to a supportive community that was efficiently equipped with mental health care facilities (Durham, 1989). Community mental health care centers were not provided an adequate budget, which would permit a wide range of clinical and educational services. Furthermore, the placement of hospitalised patients back into the community usually meant subjecting the patient to community members' negative attitudes, as well as attempts to exclude former psychiatric patients from the community through the employment of zoning codes, city ordinances and police arrests (Kirk & Therrien, 1975). Hospitals were no longer available to assist in resolving crisis situations and community mental health care centers were not prepared to admit patients whom they perceived as threatening. As a result, prisons became the 'home-base' for those mentally ill people that could not be tolerated in the community (Lamb, 1981). A more serious result of these deficits, was the increasing numbers of severely ill psychiatric patients becoming homeless (Wolff & Fry, 1990).

The inefficient implementation of deinstitutionalisation appears to have made it an important contributory factor to the fact that 20-30% of the homeless population in the USA as well as the UK comprise psychiatrically ill individuals (Scott, 1993). Arguments have further been proposed that the homeless mentally ill are largely constituted of the generation of mentally ill people that appeared after the closure of psychiatric institutions (Durham, 1989; Lamb, 1993). Such people were not afforded the opportunity to utilise treatment facilities and were compelled to make their way in the community. Durham (1989) however cautions that such reports should be interpreted tentatively, as it is important to recognise that deinstitutionalisation has not been the primary catalyst of homelessness in countries like the USA and the UK. Durham (1989) reports that the 1980's witnessed high unemployment rates in the USA; the unavailability of low-cost housing and the migration of workers to large urban areas for jobs. All of these factors created large numbers of homeless people. When the awareness of homelessness grew, attributions were immediately made to the deinstitutionalisation of mentally ill people, despite evidence that two-thirds of homeless people were not mentally ill. Furthermore, most studies assessing the success of deinstitutionalisation employed small, heterogeneous samples with poorly validated, unreliable and imprecise measures, leading to inconclusive results (Avison & Speechly in Freeman *et al.* cited in Hamber, 1997)[3].

In light of the apparent failures of the deinstitutionalisation movement, researchers have argued for a return to the concept of traditional institutional based care (Kirk

[3] Please note that a complete reference to Freeman et al. has not been provided in Hamber 's (1997) study. Attempts to trace this reference were not successful. Therefore, this reference has been omitted from the reference list of the present study.

& Therrien, 1975; Lamb, 1993; Mechanic, 1995). It is argued in a report on issues in international mental health services research, that once the traditional responsibilities of the psychiatric hospital are allocated to the community, the problems of organisation and provision become more complex and formidable (Mechanic, 1996). In an evaluative report on deinstitutionalisation in the USA, Lamb (1993) postulates that it is probable that the problem of homeless, mentally ill people wandering the streets would not have arisen had such individuals been on the case load of a professional trained to deal with their problems, monitor them and facilitate their receiving services. In his evaluative report on deinstitutionalisation in the USA, Mechanic (1995) reinforces Lamb's sentiments. Mechanic expresses the view that in contrast to community care, psychiatric hospitals have the advantage of bringing together a variety of services that mentally ill people require under one institution. These include shelter, supervised living, medical and psychiatric care, monitoring of nutritional intake as well as a programme of activities. While acknowledging that psychiatric hospitals provided substandard care and allowed patients' capacities to deteriorate, Mechanic argues that unlike community care, lack of coordination of care was not the root of the problem.

A further argument favouring the ideology of institutional care as compared to community care, is that put forth by Lamb (1981). He reveals that upon analysis, it was found that for a significant majority of the long-term mentally ill, especially those who have no family, some form of institutional care is necessary. His results are supported by the writings of two local researchers (McLaren & Philpott, 1998). They similarly report that an estimated 11% of institutionalised psychiatric patients have poor family contact while others have nowhere to go to upon discharge. Thus, it is expressed that institutional services are crucial for those patients who have inadequate family and community support.

Despite reports on the inefficiencies of the deinstitutionalisation movement, there remain those researchers who commend deinstitutionalisation for being successful in reducing the use of hospital care and in achieving patient and family satisfaction (Aviram, 1990 cited in Hamber, 1997; Desjarlais *et al.*, 1995; Mechanic, 1996).

It is evident that the success of deinstitutionalisation or the lack thereof remains contentious. What is apparent however, is that hopes regarding the impact of deinstitutionalisation abroad did not materialise as completely as was planned. Kirk and Therrien (1975) and Lamb (1993) elucidate that the concept of deinstitutionalisation was not poor, but the way in which this concept was implemented was problematic. This argument illustrates that despite reports on the failures of deinstitutionalisation abroad, one should not reject the concept itself, but should rather attempt at exercising it in a way that is well thought out. It would be useful for policy – makers to reflect on international mistakes regarding the implementation of deinstitutionalisation as well as to ensure that the development of a community-based programme is sensitive to the needs of mentally ill people residing within a particular context.

The great need for consistent, carefully organised support is a pervasive theme in the literature on deinstitutionalisation. Thornicroft and Bebbington (1989) propose that for the public such support should manifest itself as education aimed at dealing with unrealistic fears towards mentally ill people. They state further that for patients and their families support translates into psycho-educational intervention and counselling about the range of vocational, financial and domestic and mutual help services available. The success of deinstitutionalisation depends partly on the attenuation of negative stereotypes of mental illness (among the general public as well as mental health professionals) which serve as attitudinal barriers to interaction and relationships between the mentally ill and their community. This, many researchers argue may be the true challenge for rehabilitation.

## 2.6. DEINSTITUTIONALISATION IN SOUTH AFRICA

The extent to which South African mental health care has been deinstitutionalised or is being deinstitutionalised remains unclear. What is apparent however, is that innovations towards *decentralisation* and integration of mental health care have begun more than a decade ago. A striking example of this is the development and increase of community psychiatric services in the Free State province (Petersen, 1998). This movement was partly motivated by the ideological preference of community care to hospital care as well as by the need to deploy services to previously under-resourced populations (Freeman & Pillay, 1997). Hence, in 1985 the authorities within the Free State province initiated a programme in which, during a decade, beds in the only psychiatric hospital were reduced by around one-tenth, while community care increased by five-fold. Furthermore, hospital beds decreased from 1250 to 108 and community services expanded from an average of 1000 people consulted per month to more than 5000 people (Freeman & Pillay, 1997). The Free State is thus noted as being the most decentralised mental health service in the country (Lee & Zwi, 1997). However, it has still not managed to completely integrate its services. According to Lee and Zwi (1997), psychiatric patients are still mainly seen by the mental health team as general nurses feel that mental health care is a specialised concern which should be attended to by trained psychiatric workers at the clinics. This situation reflects the concerted effort that is required in order for integration to occur.

The new socio-political dispensation in South Africa is committed to a model of primary health care, where maximum community participation in health care is endorsed. The same community-care model is extended to mental health services as well. The model proposed by the Department of National Health and Population Development in 1993, suggested that between 70-80% of all mental health problems would be treated at the primary health care level and between 10-20% of mental health problems would receive attention at the secondary-care level. It was further suggested that there would be a gradual shift in emphasis from institutional care to community care (Pillay & Freeman, 1996). Therefore, presently, deinstitutionalisation and not simply decentralisation is a movement that is seen as especially pertinent to the South African mental health system (Pillay & Freeman, 1996).

Visions of the nature of a South African deinstitutionalisation programme have been offered by various theorists and academics (Freeman, 1992; Robertson, Zwi, Ensink, Malcolm, Milligan, Moutinho, Uys, Vitus, Watson & Wilson, 1997; Petersen, 1998; Dartnall, 1998). There is agreement that deinstitutionalisation requires psychiatric services to be in place at both a regional and district level and that at both levels such care should be community based. Furthermore, a range of rehabilitation programmes, housing options, and chronic care facilities need to be established at the community level. Robertson *et al.* (1997) believe that psychiatric hospitals should be retained for the purposes of forming small, short - term units for patients who cannot be managed in other settings, medium-term rehabilitation units as well as specialised units such as an addiction unit or an adolescent unit.

A critical issue that remains unresolved is how to implement deinstitutionalisation relatively quickly without the detrimental effects to psychiatric patients experienced in other countries. Robertson *et al.* (1997) offer some suggestions – promoting and providing assistance to service users, family groups, NGO's and private companies to create accomodation facilities in the community through a provincial task group under the auspices of the mental health programme office. The integration of hospital patients into the community should be accompanied by a portion of the hospital budget being transferred to community mental health care programmes. Furthermore, the Department of Housing should make it a policy that a percentage of all sub-economic housing will be retained for disabled people. Researchers believe (Freeman & De Beer, 1992; Lee & Zwi, 1997; Dartnall, 1998; Petersen, 1998) that for primary mental health care to be successful in South Africa, general health workers would need training in mental health care, parallel to which, they would have to accept mental health care as part of general health care. Petersen (1998) argues this could be attained by transforming nurses' discourse of care from one that is bio-medical to one that is bio-psycho-social.

In the South African context, it appears that economic savings also fare amongst the primary reasons for the proposed closure of large state hospitals. The cost of treating patients has escalated with the result that the level of care and affordability of mental health care of mentally ill patients in public health facilities is increasingly compromised (Pillay & Freeman, 1996). Pretorius and de Miranda (1996) report that the no-discharge system which is being exercised in state psychiatric institutions is motivated by the desire to maintain high numbers of patients, which in turn would ensure large amounts of subsidies from the government. In 1995/1996 public mental health expenditure was reported to be of the order of R28 664 000 of the total primary health care expenditure of R3 638 483 000 (or 0,79%) (Pillay & Freeman, 1996). It should be noted that the latter amount excludes the expenditure on hospital care (the bulk of mental health expenditure). As a result, the Center for Health Policy as well as the National Department of Health has forwarded a proposal for South Africa to participate in the global move towards deinstitutionalisation, as such a move is perceived to be a more economical mode of treatment than institutional care.

A review of international research, however, indicates that community mental health care, if implemented in an effective way may actually not be as cheap as it is commonly perceived to be (Thornicroft & Bebbington, 1989). It is stated that community - care programmes result in significant savings in terms of treatment, but that such programmes involve a host of other costs. In other words, the approach has a positive cost-benefit outcome, although in the long-term, it is not necessarily less expensive than institutional care. Freeman (1992) argues that expenditure and personnel must be shifted to community support and rehabilitation programmes and that the move towards community mental health care should not be part of a national savings plan. It is important to take into cognisance that deinstitutionalisation efforts overseas floundered largely due to budgetary constraints and poor finances. Thus, it is likely that South African community mental health care may suffer the same fate if it is part of a national savings plan.

The ideology underlying the move towards deinstitutionalisation in South Africa is positive, in terms of it's aim at integrating mentally ill patients with their communities. Given the need to provide accessible mental health care services to all of South Africa's population, the poor planning and lack of services that characterised the previous government cannot be redressed in the short-term as there are many other competing needs such as housing, general health and education. Hence, deinstitutionalisation efforts in South Africa should not be reactive, but should occur gradually and timeously, based on the availability of necessary and appropriate resources.

## 2.7. ATTITUDES OF MENTAL HEALTH PROFESSIONALS TOWARDS DEINSTITUTIONALISATION

There appears to have been no international research efforts directed towards assessing the attitudes of mental health professionals towards deinstitutionalisation. The few researchers who have written papers on deinstitutionalisation have made peripheral comments about the responses of mental health professionals towards community-based mental health care (Vogelman, 1988; Clark, Drake, Mchugo & Ackerson, 1995). Vogelman (1988) reports that mental health professionals in

Nicaragua had great difficulty in adapting to the move towards deinstitutionalisation and the subsequent shift to community mental health care. Nicaraguan mental health professionals expressed their resistance to the Sandanista government's new emphasis on community mental health care by emigrating. The consequences of these was a drain of key personnel required to supervise the treatment of mentally ill patients (Vogelman, 1988). The experience in Nicaragua illustrates the importance of attaining the cooperation of mental health professionals as chief role players in the shift to deinstitutionalisation.

Clark *et al.* (1995) state that despite the fact that many clinicians, policy makers and researchers believe that working with mentally ill patients in natural, community settings increases the likelihood that psycho-social treatment will be effective, it is very rare that clinicians would offer to provide their services outside their offices or day treatment centers. This suggests a lack of willingness on the part of clinicians to participate in the very treatment programmes, which they advocate. This lack of willingness is attributed to clinicians' beliefs that meeting patients in natural settings is too time consuming, makes them susceptible to danger and is too intrusive. Clark *et al.* (1995) further report that even when fears about the personal safety of mental health professionals are addressed, "the perception that office-based treatment is more prestigious, the relative ease of treating patients who are more compliant or less impaired, the lure of greater revenues from psychotherapy or day treatment, or simple inertia may impede effective implementation of an in vivo treatment programme" (p.730). Clark *et al.'s* findings are supported by the findings of a South African study on practice patterns of clinical and counselling psychologists in South Africa (Pillay & Petersen, 1996).

Pillay and Petersen also found that the majority of clinical and counselling psychologists offer their services at private practice level in mainly urban areas. Furthermore, the majority of the sample of 635 psychologists in Pillay and Petersen's study expressed that they did not favour a change in the finance structure for mental health care. As a result, these researchers concluded that the affordability of psychological services would continue to be a barrier to access to mental health care services in South Africa.

The provision of incentives for mental health professionals may be an effective mode through which their support for community mental health care could be gained. This however also implies the need for additional financial resources being directed towards the mental health budget. Whether or not this would be possible, especially in the light of the current economic situation in South Africa, is debatable.

An extensive literature search illustrated that, until very recently, studies on deinstitutionalisation in South Africa did not receive any attention. This could be attributed to the fact that before 1995, the movement of deinstitutionalisation was not a phenomenon that was seen as relevant to the health care dispensation in South Africa. However, the years post 1995 witnessed a growing interest in the dynamics of deinstitutionalisation and community mental health care amongst South African researchers. Researchers directed their energies towards assessing the implications of the policy shift, the viability of such a shift and also offered their visions on what such a shift should entail. Despite this growing interest in the field of community mental health care, to date, only two research attempts appear to have been directed towards assessing the attitudes of mental health professionals to deinstitutionalisation.

In 1998, Dartnall and Porteus embarked on a study investigating perceptions of context, barriers and opportunities as regards deinstitutionalisation. A portion of their sample comprised the mental health professionals employed by a psychiatric hospital in the Eastern Cape called "Tower Hospital". It is important to note that although this study did not solely assess mental health professionals' attitudes towards deinstitutionalisation, it brought to light important issues and concerns surrounding their perceptions of the viability of deinstitutionalisation. This study found that the potential integration of mental health care into primary health care was considered by management as a positive concept. They expressed the view that the combinination of services would improve access as well as decrease the stigma linked to community psychiatric services (Dartnall & Porteus, 1998). It is also encouraging to note that the majority of mental health professionals were envisaged by management as chief role-players to the deinstitutionalisation process and to its success. A further asset that was identified by management in this regard, was the extended family system, as they perceived this structure as being conducive to effective community mental health care, especially in the South African context. Tying in with this, respondents expressed their conviction that with targeted education, church leaders, community leaders and indigenous healers could play a supportive role to patients in the community. However, amidst these positive assertions, respondents also appear to have expressed many concerns regarding the viability of the deinstitutionalisation process within the current South African context.

An immense barrier to community mental health care was perceived as being that of the socioeconomic context of the communities into which patients would be discharged (Dartnall & Porteus, 1998). The high rates of poverty, unemployment, violence, drug abuse and alcoholism were perceived by the psychiatric staff as being far from appropriate for patients' healing. Respondents expressed the view that the primary and ultimate contribution to successful community discharge would be general community social and economic development. In the face of restricted financial and community resources, the mental health staff was cautious about the appropriateness of community-based care for mentally ill patients. Maximum priority was also accorded by mental health professionals for the need to increase community support services for mentally ill people. Respondents felt that without this basic necessity, successful discharge of patients into the community would not be sustainable (Dartnall & Porteus, 1998). Another barrier that was perceived as impeding the success of community mental health care was the intolerant attitudes of lay community members towards mentally ill people.

Dartnall and Porteus (1998) also requested the mental health professionals to contribute their vision for the development of future community support services. They report that staff viewed a gradual transfer of patients from an institutional setting to a community context as optimal, where residential and occupational facilities would be set up for long-term patients. The hospital setting was perceived as being a specialty center for short-term care of patients whose conditions were episodic. Many respondents however, also expressed the necessity of maintaining some sanctuary for those long-term patients who were unable to survive outside of the institutional setting. The respondents also envisaged a unified hospital and community system, where hospitals would, for example, play a transformative, educational role in the community.

Lee, Thom, Zwi, Clews, Sibeko, Mahlo and Masondo (1997) report similar findings in their study on the training of generalists in mental health care. A cautionary note however, is that their study did not focus on attitudes towards *deinstitutionalisation*, but rather assessed attitudes towards *decentralisation*. Nonetheless, their findings are useful in terms of understanding the attitudes of psychiatric nurses towards the integration of mental health care with primary health care services, especially since this integration process is also going to be a function of the deinstitutionalisation process.

Lee *et al.* (1997) report that the attitudes of psychiatric nurses towards decentralisation and integration of the mental health system was generally favourable, especially with regard to the role of generalists/primary health care nurses in the care of stable mentally ill patients. While, the psychiatric nurses were very positive as to the concept of community mental health care, there were a few concerns expressed with regard to the notion of primary health care nurses delivering mental health care.

Respondents in Lee *et al.'s* study (1997) cautioned that the stigma attached to psychiatric patients could precipitate a drop in the quality of care being offered to patients. They also predicted that there could be a loss of continuity of care and that this may result from generalists taking over patients attended to by a vertical service. The psychiatric nurses also believed that generalist nurses would need additional training in order to adopt a role in primary mental health care. It was expressed that the current 4-year integrated Psychiatry course did not equip nurses with skills as adequately as did the one-year post-graduate diploma in psychiatry (Lee *et al.,* 1997). The psychiatric nurses envisaged their role in community mental health care as being involved in new and referral cases, to prescribe drugs and to be involved in training, supervision and coordination. They however, acknowledged that in order to fulfill these roles, they would need further training in diagnosis, treatment (drugs and therapy) and in specific specialties, for example, child and adolescent disorders, geriatrics and so on.

It is evident from the above reports that while most personnel hold the ideology of deinstitutionalisation in a positive light, elements of concern regarding the pragmatics of the shift towards community-based mental health care are also evident. Such concerns are both understandable and relevant. What appears to be important to the mental health professionals is not the locus of care, but rather the quality of care being offered to mentally ill patients. It is likely that until such personnel are offered the assurances of adequate economic and social development of communities as well as appropriately skilled personnel for their patients, their cautionary attitudes towards the policy shift of deinstitutionalisation may not be easily dispelled.

## 2.8. ATTITUDES OF GENERAL NURSES / PRIMARY HEALTH CARE NURSES TOWARDS DEINSTITUTIONALISATION

Similar to research on attitudes of mental health professionals towards deinstitutionalisation, both international and local research on the attitudes of primary health care nurses towards deinstitutionalisation is also extremely scarce. The few research efforts in this field have been mostly peripheral and insubstantial.

A comprehensive study assessing the role and training of generalists in mental health care was conducted in 1997 by Lee *et al.*. Part of this research effort was directed towards assessing the attitudes of generalists/primary health care nurses towards the integration of mental health care with primary health care. These researchers noted that the nurses' responses to their increased mental health responsibility were mixed. Lee *et al.* (1997) found that the favourable responses of nurses were mostly influenced by the their support of a holistic approach to health and health care delivery. However, all the nurses were concerned about the potential burden that the increased workload would place on them. This issue was expressed in the following way, "A generalist who is expected to do everything usually will end up rushing around and not doing justice to the service she gives to individual clients". The nurses also felt that they had not been consulted about the policy change in mental health care and the implications of such a shift for themselves. Lee and Zwi (1997) report that these findings are similar to a larger study on decentralisation where it was found that a vital concern across provinces was the great uncertainty and insecurity amongst especially nurses, creating an unwillingness to adopt additional responsibilities. This was partly attributed to the lack of clarity about how their professional roles and responsibilities may change as a result of decentralisation. Lee *et al.* (1997) also report that concerns were expressed about the lack of referral resources and the issues of drug dispensing and litigation.

The need for training in mental health care was also raised consistently by the nurses (Lee *et al.,* 1997). The researchers report that the nurses appealed that training needed to be accredited and rationalised in order to prevent the duplication of sessions by different training programmes. Byng (1993) found that primary health care workers in Nicaragua expressed a similar sentiment – the need for further education in order to equip them to deliver mental health care was recognised by these personnel as well. In fact, Sartorius and Harding (1983) report that by virtue of primary health care workers participating in and observing their study process in mental health, the initial resistance to dealing with mental health problems that had been observed amongst these personnel developed into acceptance. Lee *et al.'s* (1997) study also revealed the nurses' desire for self-sufficiency in managing cases and in improving their interpersonal skills. In sum, these groups of nurses were very strong in their view that in order for them to adopt an expanded role in primary care services, they would need adequate psychiatric training, good referral systems and support from the mental health team (Lee *et al.,* 1997).

It is evident from the available limited studies reviewed above that the notion of community-based mental health care has not met with as much enthusiasm by primary health care nurses as it has by mental health professionals. This could be explained by primary health care nurses' lack of training in and exposure to psychiatry. The aura of mystery surrounding mental illness and the treatment of mentally ill people could be a further contributory factor to nurses' lack of willingness. This suggests the need for rigorous training programmes in mental health care to be implemented prior to primary health care nurses delivering mental health services. The need for appropriate resources in order to make community mental health care a viable option has also been expressed by the primary health care nurses. This suggests the need for a concerted effort on the part of the National Health Department to upgrade and improve existing resources in order for community mental health care to function optimally.

The present South African government should be applauded for it's efforts in advancing mental health care to higher levels. In conclusion however, a truism that seems to emerge from the review provided above is that a shift towards deinstitutionalisation requires a vast amount of investment in community development, economic development and personnel development. In the face of limited resources in South Africa, one has to question the appropriateness of such a treatment modality, especially for the psychiatric patient who has a special set of needs. Nevertheless, in view of the fact that deinstitutionalisations *has* become a national health policy and the present government is *committed* to a model of community mental health care, advancement in mental health care may be moderated by the social and economic contexts and hence, needs not to be disregarded altogether.

Chapter three, which follows will provide a description of the methodology that was employed to conduct this study.

# CHAPTER THREE

# METHODOLOGY

## 3.1. INTRODUCTION

It was reported in the first chapter that the purpose of the present study was to examine attitudes towards mental illness, mentally ill people and deinstitutionalisation and the relationships between these variables. It was also pointed out that community psychiatric nurses, primary health care nurses and mental health professionals would be assessed in terms of these variables. This chapter describes the samples used. Also included in this chapter are descriptions of the measures utilised in studying attitudes towards mental illness, mentally ill people and deinstitutionalisation and the relationships between these variables. Details regarding the qualitative dimension of this study are also provided. The procedures used in gathering as well as scoring the data are clarified within this chapter.

## 3.2. THE SAMPLE

The total sample of 130 respondents who participated in this study was made up as follows: 38 (30%) community psychiatric nurses were selected on the basis of their availability, from different clinics which operated in areas that were under the auspices of various metropolitan councils within Kwa-Zulu Natal. These councils were as follows: The Durban North Central Local Council (for example, Inanda, KwaMashu, Tongaat), the Durban South Central Local Council (for example, Lamontville, Chesterville), the Outer-West Local Council (for example, Botha's Hill), the Inner-West Local council (for example, Kwadabeka, Kwangcolosi), the Kwadakuza transitional local council (for example, Stanger, Groutville), the Marburgh transitional local council (for example, Marburgh, Port-Shepstone), the Scottsburgh transitional local council (for example, Scottsburgh, Umzinto) and the Pietermaritzburg transitional local council (for example, Edendale, Central Pietermaritzburg, Howick).

A second sample comprised 20 (15%) psychiatric staff – psychiatrists, psychologists, psychiatric nurses, social workers and an occupational therapist at Fort Napier hospital in Pietermaritzburg.

The third sample constituted 71 (55%) primary health care nurses who, like the community psychiatric nurses were selected on the basis of their availability from various clinics in the Durban-Pietermaritzburg regions. The clinics from which these nurses operated were located in areas that fall under four councils. These councils were: The Durban South Central Local Council (for example, Chatsworth, Cato Manor, Merebank), the Durban North Central Local Council (for example, Phoenix, Sydenham, Clare Estate, Redhill), the Inner-West Council (for example, Westville, Pinetown, Shallcross) and the Pietermaritzburg Transitional Local Council (for example, Eastwood, Esigodini, Oribi).

Descriptive and other details of each sample group are provided in *sections 3.2.1. – 3.2.3.* Table 1 on the following page is reflective of the sample demographic profile.

**TABLE 1**

**Sample Demographic Profile**

| **VARIABLE** | | **N** | **%** |
|---|---|---|---|
| Males | | 16 | 12 |
| Females | | 114 | 88 |
| Age [4]: | 25-35 Years | 25 | 19 |
| | 36-50 Years | 75 | 58 |
| | 51-70 Years | 30 | 23 |
| Advanced Education | | 77 | 59 |
| Basic Education | | 53 | 41 |
| Years of Professional Experience | : 1-3 Years | 38 | 29 |
| | 4-8 Years | 31 | 24 |
| | 9-20 Years | 42 | 32 |
| | 20-40 Years | 19 | 15 |
| Socioeconomic Status: | Working Class | 51 | 39 |
| | Middle Class | 74 | 57 |
| | Upper Middle Class | 5 | 14 |
| Race Groups : | Blacks | 67 | 52 |
| | Indians | 29 | 22 |
| | Whites | 26 | 20 |
| | Coloureds | 8 | 6 |

[4] Respondents' ages were categorised into three age groups in order to facilitate the statistical analyses for differences in attitudes towards mental illness and mentally ill people between older and younger respondents.

A further 24 individuals participated in four focus group discussions. The characteristics of these participants as well as the details of the focus groups are provided in later sections of this chapter.

### 3.2.1. COMMUNITY PSYCHIATRIC NURSES

The first sample comprised 38 community psychiatric nurses. The geographical locations of the areas in which such nurses worked were diverse, ranging from areas along the Durban and Pietermaritzburg regions. Details regarding the nurses' professional locations are provided in *section 3.2.* Only those who were literate in English were accepted as participants, so as to ensure an acceptable degree of comprehension of questionnaire material and procedures.

Thirty-two females and six males comprised this sample group. The preponderance of females in this group can be attributed to the fact that community psychiatric nursing is dominated by women. The respondents' ages ranged between twenty-seven and fifty - eight years. Educational qualifications within this sample group ranged from a diploma in psychiatric nursing to a degree in nursing. The variable of years of professional experience within this sample group varied from one year to sixteen years. The participants of this sample group also ranged in terms of socioeconomic status, where respondents were either working class or middle class. The selection of such a sample was based on the fact that these individuals will be bearing responsibility for the programme of deinstitutionalisation and their perceptions of the movement will be likely to impact on the success of deinstitutionalisation

### 3.2.2. MENTAL HEALTH PROFESSIONALS

A total of twenty (15%) mental health professionals from Fort Napier hospital participated in the present study. Participants were selected from all sectors of the hospital staff who were directly concerned with the care and treatment of psychiatric patients. These included five psychologists, three psychiatrists, three social workers, one medical doctor, one occupational therapist and seven psychiatric nurses. This sample group included 11 females and 9 males. Participants within this group ranged between 23 and 57 years of age. Educational qualifications of this sample group varied from a diploma in Psychiatric Nursing to a doctoral degree in Psychology. The variable of years of professional experience within this sample group ranged from one year to thirty-five years. Participants within this group also ranged in socioeconomic status, wherein a range of respondents from working class to upper-middle class were included in this study.

It was believed that selecting such a sample group would help provide information around the attitudes of mental health professionals towards the policy shift of deinstitutionalisation, as these individuals would be chief role-players in the supervision and monitoring of the deinstitutionalisation movement. Furthermore, the proposed closure of mental hospitals will more likely affect these participants than those mental health professionals who are employed outside of the hospital setting. Understanding their attitudes towards mental illness, mentally ill people and deinstitutionalisation would be valuable in enabling policy makers to assess these key informants' level of reciprocity to the shift towards community mental health care and their roles in such a move.

### 3.2.3. PRIMARY HEALTH CARE NURSES

Sixty-nine primary health care nurses were selected from clinics within the Durban and Pietermaritzburg regions. Details regarding the nurses' professional locations are provided in *section 3.2*. Nurses who were literate in English were eligible for participation; this criterion was employed so as to ensure that they would be able to understand the content within the measures as well as the procedure of participation.

There were 68 females and only one male that participated from this sample group. Once again, the overwhelming majority of females can be explained by the fact that the nursing profession is one, which has a preponderance of females. The ages of participants in this group ranged between 26 and 62 years. Educational qualifications ranged from a diploma in community nursing to an Honours degree in Nursing. Professional experience varied from one year to twenty-eight years. As with the sample of community psychiatric nurses, the nurses in this group were either of working class or middle class status.

The rationale for including primary health care nurses as participants in the present study was that deinstitutionalisation and the concurrent integration of mental health services with primary health care has strong implications for these nurses, particularly with regard to redefining their roles in mental health care. These nurses have been envisioned as primary deliverers of mental health care to mentally ill people once the policy of deinstitutionalisation is translated into practice. Therefore, assessing primary health care nurses attitudes to the proposed shift in their responsibilities would be enlightening to policy makers, especially in understanding the needs and concerns of primary health care nurses regarding the deinstitutionalisation approach.

## 3.3. MEASURES

The present study utilized two attitude scales and a biographical questionnaire. Prior to these measures being administered to the three sample groups, a pilot study was conducted using six Psychology post-graduate students and four Psychologists, 4 of whom were male and 6 of whom were female from the department of Psychology at the University of Durban-Westville. These participants ranged between the ages of 21-50 years. The six participants who were professionally employed were of middle class status. The levels of education amongst these participants ranged from a basic degree to a Masters' degree in Psychology. All the participants were Indian, except for one White participant.

The pilot study was conducted in order to confirm that the items of each instrument were clear, concise and contemporary. At the completion of each measure, the pilot study participants provided a written critique on the scale items, in terms of its' clarity and relevance. The items that were identified by the pilot study participants as being problematic were subsequently modified. Details on the modification of each scale are provided in sections *3.3.2. and 3.3.3.*

### 3.3.1. BIOGRAPHICAL QUESTIONNAIRE (*APPENDIX 1*)

This questionnaire was constructed by the researcher to obtain relevant biographical details as well as information known to be closely related to attitudes towards mental illness, mentally ill people and deinstitutionalisation.

The biographical questionnaire included questions on age, gender, race, occupational status, monthly income levels (in order to deduce socioeconomic status and class), highest educational level, years of professional experience and marital status. The demographic questionnaire also asked whether any friend or member of the respondent's family has experienced or been treated for a mental illness. The presentation of such a question enabled the researcher to determine whether the respondent has had any experience with mental illness or contact with the mentally ill.

### 3.3.2. THE OPINIONS ABOUT MENTAL ILLNESS SCALE[5] (*APPENDIX 2*)

#### 3.3.2.1. Scale Description

The Opinions about Mental Illness Scale (OMI) devised by Cohen and Struening in 1962, was used to assess attitudes towards mental illness and mentally ill people. The OMI scale is one of the most widely employed scales used by researchers to assess attitudes of mental health professionals as well as the lay public towards mental illness and mentally ill people (Rabkin, 1974; Segal, 1978; Taylor, Dear & Hall, 1979; Morrison, de Man & Drumheller, 1994). The OMI scale was originally developed in a study of the attitudes of hospital personnel towards mental illness

(Cohen & Struening, 1962). This scale was considered to be suitable for this study as it was devised specifically to assess mental health professionals' attitudes towards mental illness and mentally ill people. This scale was also seen as ideal for this study as it's development was based on the assumption that opinions about the mentally ill are multi-dimensional and that these multiple factors can best be determined by factor analyses.

The OMI scale comprises 51 Likert - type items scored on a six-point agree-disagree continuum. The 51 items produced a five factor explanatory model of attitudes towards mental illness, which was empirically derived from a total of 100 opinion statements (Struening & Cohen, 1963). The statement pool was compiled on a rational basis to reflect a variety of sentiments about mental illness and mentally ill people, but it also drew upon existing scales such as the Custodial Mental Illness Ideology Scale (Gilbert & Levinson, cited in Cohen & Struening, 1962), the California F Scale (Adorno, Frenkel-Brunswick, Levinson & Sanford, cited in Cohen & Struening, 1962) and Nunnally's (cited in Cohen & Struening, 1962) Multiple Item Scale. Cohen and Struening (1962) have failed to provide information regarding the nature of the above-cited studies and what samples were used in order to establish the reliabilities and validities of the scales that were developed by the above-cited authors. The five dimensions/sub - scales that derive from the OMI are:

a) Authoritarianism, which is defined by Cohen and Struening (1962) as, indicating a tendency to view the mentally ill as an inferior class requiring coercive

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[5] This scale is also referred to as "The Opinions of Mental Illness Scale".

handling. An example of an item reflecting this dimension is "A heart patient has just one thing wrong with him, while a mentally ill person is completely different from other patients".

b) Benevolence is defined as, a kindly paternalistic view of patients based on religious or humanistic ideology, for example, "Patients in mental hospitals are in many ways like children".

c) Mental Hygiene Ideology indicates a positive orientation and acceptance of modern mental hygiene concepts (This scale emphasises the capability of the patient in various life situations to function independently). A type of statement within this scale dimension is, "Most mental patients are willing to work".

d) Social Restrictiveness, which indicates a tendency to perceive the mental patient as a threat to society and in need of restriction in social functioning, for example, "Although patients discharged from mental hospitals may seem allright, they should never be allowed to marry".

e) Interpersonal Etiology is defined as the belief that mental illness is based on interpersonal experience, particularly the deprivation of parental love during childhood, for example, "Mental patients come from homes where parents took little interest in their children".

The OMI is a six-point Likert scale ranging from strongly disagree, disagree, moderately disagree, moderately agree, agree and strongly agree. With respect to items which are negatively worded, strongly agree is allotted a score of one; agree is scored 2; moderately agree is scored 3; moderately disagree is given a score of 4, disagree is allotted a score of 5 and strongly disagree is scored 6.

#### 3.3.2.2. Psychometric Properties of the Opinions of Mental Illness Scale

According to Taylor, Dear and Hall (1979), the scale appears to be a reasonably reliable and valid measure of attitudes towards mental illness and mentally ill people. The OMI scale has performed reliably with alphas ranging from .54 to .56. Cohen & Struening (1962) also report that the validity coefficients ranging from .66 to .69 are also quite satisfactory, especially for the purposes of group comparisons. Taylor *et al.* in fact report that the OMI is the best validated scale that had been developed to measure attitudes towards mental illness and mentally ill people.

#### 3.3.2.3. Modification of the Opinions of Mental Illness Scale

The original version of the OMI scale was modified in terms of it's wording, as the original phrasing was considered to be too sophisticated for nurses who may not have been exposed to psychiatric terminology (*see table two*). The participants of the pilot study indicated that certain OMI items were ambiguous, lengthy and sexist in nature. Those items that were indicated as being ambiguous, as unnecessarily lengthy and sexist were also rephrased.

TABLE 2

**Item Rephrasing in the Opinions of Mental Illness Scale**

| ITEM NO. | OLD WORDING | NEW WORDING |
| --- | --- | --- |
| 3 | If the children of mentally ill parents were raised by normal parents, they would probably not become mentally ill. | If the children of mentally ill parents were raised by normal parents, then these children would probably not become mentally ill. |
| 4 | Many patients in mental hospitals make wholesome friendships. | Mentally ill people can make very good friends. |
| 5 | All patients in mental hospitals should be prevented from having children by a painless operation. | All mentally ill patients should be prevented from having children by a painless operation. |
| 21 | Anyone who is in a hospital for a mental illness should not be allowed to vote. | Mental patients should not be allowed to vote. |
| 22 | Most women who were once patients in a mental hospital could be trusted as baby-sitters. | Most people who were once patients in a mental hospital could be trusted as baby-sitters. |
| 24 | If the children of normal parents were raised by mentally ill parents, they would probably become mentally ill. | If the children of normal parents were raised by mentally ill people, they would become mentally ill. |

Given the length of the two primary questionnaires, certain items were eliminated, primarily because they were repetitive. The items that were not included in the modified version of the scale are presented in table 3 below.

TABLE 3

**Items Eliminated in the Opinions of Mental Illness Scale**

| | |
|---|---|
| 1) | There is hardly anything lower than a person who does not feel a great love, gratitude and respect for his parents. |
| 2) | Obedience and respect for authority are the most important virtues children should learn. |
| 3) | When a person has a problem or worry, it is best not to think about it, but keep busy with more pleasant things. |
| 4) | Mental illness is usually caused by some disease of the nervous system. |
| 5) | If people would talk less and work more, everybody would be better off. |
| 6) | Every person should make a strong attempt to raise his social position. |
| 7) | Nervous breakdowns usually result when people work too hard. |
| 8) | A person who has bad manners and breeding can hardly expect to get along with decent people. |

**TABLE 3 (continued)**

| | |
|---|---|
| 9) | College professors are more likely to become mentally ill than are businessmen. |
| 10) | Anyone who tries hard to better himself deserves the respect of others. |
| 11) | The death penalty is inhuman and should be abolished. |
| 12) | Our mental hospitals seem more like prisons than like places where mentally ill people can be cared for. |
| 13) | If our hospitals had enough well-trained doctors, nurses and aides, many of the patients would get well enough to live outside the hospital. |
| 14) | Many people who have never been patients in a mental hospital are more mentally ill than many hospitalised mental patients. |
| 15) | A woman would be foolish to marry a man who has had a severe mental illness, even though he seems fully recovered. |
| 16) | The law should allow a woman to divorce her husband as soon as he has been confined in a mental hospital with a severe mental illness. |
| 17) | The mental illness of many people is caused by the separation or divorce of their parents during childhood. |
| 18) | Every person should have faith in some super-natural power whose decision he obeys without question. |

A modified version of the scale comprising 33 items was employed in the actual study. A reliability analysis of the modified version of the scale revealed an alpha score of .75. Reliability analyses of each sub – scale revealed the following alphas : Authoritarianism as a sub-scale had an alpha of .76. Benevolence had an alpha of .30. Mental Health Ideology had an alpha score of .40. Social restrictiveness revealed an alpha score of .43. Fifthly, interpersonal etiology indicated an alpha score of .42. Instead of employing the original six response categories of the OMI, the modified version of the scale had five response categories. These categories were worded as follows: strongly disagree, disagree, neutral, strongly agree and agree. This phrasing was chosen as it tends to follow current wording on most Likert-type scales. On negatively worded items, strongly disagree received a score of 5, disagree a score of 4, neutral a score of 3, agree a score of 2 and strongly agree a score of 1. Reverse scoring was employed.

### 3.3.3. THE COMMUNITY MENTAL HEALTH IDEOLOGY SCALE (*APPENDIX 3*)

#### 3.3.3.1. Scale Description

The Community Mental Health Ideology Scale (CMHI) was constructed by Baker and Schulberg in 1967. This scale was designed to measure attitudes towards community mental health care. The CMHI scale was developed as a multiple item scale designed specifically to measure an individual's degree of adherence to community mental health ideology (Baker & Schulberg, 1967). The final version of the CMHI scale was developed through the retention of items which were selected on the basis of joint consideration of item – total score correlations and the results of a principal-components analysis of the initial 64-item questionnaire. Thirty-eight items were found to have corrected item total correlations of .44 or higher (Baker & Schulberg, 1967). In order to ensure that crucial aspects of community mental health ideology were covered, the authors of the scale, (Baker and Schulberg, 1967) constructed the scale through the employment of five conceptual categories. These categories are as follows:

a) A population focus – The view that the mental health professional should be responsible for the entire population of both identified and unidentified mentally ill and potentially mentally ill members in his/her community. An item, which reflects this focus, is "A significant part of a psychiatrist's job consists of finding out who the mentally disordered are and where they are located in the community".

b) Primary prevention – This concept involves decreasing the rate of new cases of mental disorder in a population by counteracting maladaptive forces before they have had a chance to produce illness. An item in this category is "Mental health programmes should give a high priority to lowering the rate of new cases in a community by reducing harmful environmental conditions".

c) Social treatment goals – The notion that the primary treatment goal should not entail the reconstruction of the mental patient's personality, but should rather entail helping him / her to achieve social adjustment in an ordinary life situation as soon as possible. An example of such an item is "We should not legitimately be concerned with modifying aspects of a mental patient's environment but rather in bolstering his/her ability to cope with it".

d) Comprehensive continuity of care – The view that there should be a continuity of professional responsibility as the patient moves from one program to another in an integrated network of care-giving services. This sentiment is reflected in the following item, "The mental health center is only one part of a comprehensive community mental health programme".

e) Total community involvement – The belief that the mental health professional is only one member of a group of community agents caring for the mentally ill and that he / she can extend his / her effectiveness by working with and through other people. (Baker & Schulberg, 1967). An item that falls under this conceptual category is "The mental health specialist should seek to extend his effectiveness by working through other people".

The 38 items in the CMHI scale are arranged in Likert format with provision for respondents to circle one of six response categories for each item: strongly, moderately, or slightly disagree and strongly, moderately or slightly agree. On positively worded items, strong agreement is scored 7, moderate agreement, 6, slight agreement, 5, slight disagreement, 3, moderate disagreement, 2, strong disagreement, 1 (Baker & Schulberg, 1967).

Since there was no scale developed to measure attitudes towards deinstitutionalisation, the CMHI scale was used to measure attitudes towards deinstitutionalisation. An extensive literature search indicated that the CMHI scale was the only scale designed to measure attitudes towards community mental health. The CMHI was viewed as a suitable scale for the purposes of this study, as it allowed for an examination of the relationships between attitudes of individuals and their participation in the development of community programmes. The attitudes of individuals towards community mental health care programmes is associated with attitudes towards deinstitutionalisation as they both tend to occur within a community mental care framework.

#### 3.3.3.2. Psychometric Properties of the Community Mental Health Ideology Scale

Reliability for the CMHI scale is relatively high. According to the authors, the Cronbach Alpha (generalised Kuder-Richardson formula 20) for a total group of 484 respondents on the 38 -item scale score was .94 and the split-half reliability was .95. Evidence for the validity of the CMHI scale is as follows: The scale successfully discriminates groups known to have positive community mental health views from random samples of mental health professionals. Furthermore, CMHI scale scores relate significantly to self-reported responses on degree of identification with a community mental health orientation; interest in keeping up with new developments in community mental health; and preference for a symposium on recent advances in community mental health. Baker and Schulberg (1967) state that "CMHI scale scores also relate significantly to the connotative meanings assigned community mental health on a 19-item semantic differential rating form"( p.223).

### 3.3.3.3. Modification of the Community Mental Health Ideology scale

The CMHI scale was used in a revised form; the purpose of which, was to express the opinion statements in a manner which could be easily understood by respondents who had not received any training in mental health *(see table 4)*. A pilot study using the CMHI scale indicated the need to modify a majority of the scale items (*see table 4*) in terms of their wording. Such questions were therefore rephrased to make their meaning clearer *(see table 4)*.

**TABLE 4**

**Item Rephrasing in the Community Mental Health Ideology Scale**

| ITEM NO. | OLD WORDING | NEW WORDING |
|---|---|---|
| 1 | Every mental health center should have formally associated with it a local citizen's board assigned significant responsibilities. | Every mental hospital should have local people from the community who are given specific responsibilities, formally assigned with it. |
| 2 | Our time-tested pattern of diagnosing and treating individual patients is still the optimal way for us to function professionally. | Our way of diagnosing and treating individual patients is still the best way for us to function professionally. |

TABLE 4 (continued)

| ITEM NO. | OLD WORDING | NEW WORDING |
|---|---|---|
| 4 | Our responsibility for patients extends beyond the contact we have with them in a mental health center. | Responsibility for patients extends beyond the contact one has with them in a mental hospital. |
| 5 | A significant part of the psychiatrist's job consists of finding out who the mentally disordered are and where they are located in the community. | An important part of a mental health professional's job consists of finding out who the mentally disordered are and where they are located in the community. |
| 6 | Such public health programmes as primary preventive services are still of little value to the mental health field. | Public health programmes like primary preventive services will be of little value to the mental health field. |
| 7 | A mental health program should direct particular attention to groups of people who are potentially vulnerable to upsetting pressures. | A mental health programme should give specific attention to groups of people who are easily affected by upsetting pressures. |
| 8 | The planning and operation of mental health programmes are professional functions which should not be influenced by citizen pressures. | The planning and operation of mental health programmes are professional responsibilities which should not involve ordinary citizens. |

**TABLE 4 (continued)**

| ITEM NO. | OLD WORDING | NEW WORDING |
|---|---|---|
| 9 | Mental health programmes should give a high priority to lowering the rate of new cases in a community by reducing harmful environmental conditions. | Mental health programmes should pay special attention to lowering the rate of new mental patients in a community by reducing harmful environmental conditions. |
| 11 | A mental health professional can only be responsible for the mentally ill who come to him; he cannot be responsible for those who do not seek him out. | A mental health professional can only be responsible for the mentally ill who come to him/her; he/she cannot be responsible for those who do not seek him/her out. |
| 12 | Understanding of the community in which we work should be made a central focus in the training of mental health professionals. | Gaining an understanding of the community in which a mental health professional works should be made a central focus in his/her training. |
| 13 | The control of mental illness is a goal that can only be attained through psychiatric treatment. | Mental illness can only be controlled through psychiatric /psychological treatment. |
| 14 | A mental health professional assumes responsibility not only for his current case-load but also for unidentified potentially maladjusted people in the community. | A mental health professional is responsible not only for his/her set of patients, but also for unidentified mentally ill people in the community. |

TABLE 4 (continued)

| ITEM NO. | OLD WORDING | NEW WORDING |
|---|---|---|
| 16 | Our professional mandate is to treat individual patients and not the harmful influences in society. | The mental health professional system should remain being one that treats individual patients instead of focussing on harmful social influences. |
| 17 | Our efforts to involve citizens in mental health programmes have not produced sufficient payoff to make it worth our while. | Efforts to involve citizens in mental health programmes have little value. |
| 18 | The locus of mental illness must be viewed as extending beyond the individual, and into the family, the community and the society. | The cause of mental illness must be viewed as extending beyond the individual, and into the family, the community and the society. |
| 19 | Mental health professionals can be concerned for their patients' welfare only when having them in active treatment. | Mental health professionals should only be concerned for their patient's well-being while they are in treatment. |
| 21 | Care-giving agents who worked with the patient before and during his contact at the mental health center should be included in the formulation of treatment plans. | Care-givers who worked with the patient before and during his /her stay at a mental hospital should be included in the formulation of his/her treatment plans. |

TABLE 4 (continued)

| ITEM NO. | OLD WORDING | NEW WORDING |
|---|---|---|
| 22 | A psychiatrist can only provide useful services to those people with whom he has had direct contact. | A psychiatrist/psychologist can only be of help to those people with whom he/she has had direct contact. |
| 23 | The mental health center is only one part of a comprehensive community mental health programme. | A mental hospital is only one part of a comprehensive community mental health programme. |
| 25 | We should not legitimately be concerned with modifying aspects of our patient's environment, but rather in bolstering his ability to cope with it. | We should not be concerned with changing aspects of a mental patient's environment but rather should focus on his/her ability to cope with it. |
| 26 | It is a poor treatment policy to allow non-psychiatrists to perform traditional psychiatric functions. | It is a poor treatment policy to allow non-psychiatrists / non-psychologists to perform psychiatric tasks. |
| 27 | The hospital and the community should strive for the goal of each participating in the affairs and activities of the other. | The mental hospital and the community should strive towards working together. |
| 28 | Social action is required to insure the success of mental health programmes. | Community participation in mental health programmes is necessary to ensure it's success |

TABLE 4 (continued)

| ITEM NO. | OLD WORDING | NEW WORDING |
|---|---|---|
| 29 | In view of the professional man-power shortage, existing resources should be used for treatment programmes rather than prevention programmes. | Seeing that there is a lack of mental health professionals, current resources should be used for treatment programmes rather than prevention programmes. |
| 30 | Each mental health center should join the health and welfare council of each community it serves. | Each mental hospital should join the health and welfare council of the community it serves. |
| 31 | The responsible mental health professional should become an agent of social change. | The responsible mental health professional should become actively involved in social change. |
| 32 | We can make more effective use of our skills by intensively treating a limited number of patients instead of working indirectly with many patients. | It would be more useful to intensively treat a small number of patients instead of working indirectly with a large number of patients. |
| 33 | By and large, the practice of good psychiatry does not require very much knowledge about sociology and anthropology. | Generally, the practice of good psychiatry / psychology does not require very much knowledge about sociology and anthropology. |

Some items in the CMHI scale were also identified by the researcher and the pilot study participants as being overtly repetitive, outdated and irrelevant to the South African context. Thus, such questions were eliminated (*see table 5*).

**TABLE 5**

**Items Eliminated in the Community Mental Health Ideology Scale**

| | |
|---|---|
| 1) | Our programme emphasis should be shifted from the clinical model, directed at specific patients, to the public health model focusssing upon populations. |
| 2) | Skill in collaborating with non-mental health professionals is relatively unimportant to the success of our work with the mentally ill. |
| 3) | We should deal with people who are not yet sick by helping them to develop ways for coping with expected life difficulties. |
| 4) | Since we don't know enough about prevention, mental health programs should direct their prime efforts toward treating the mentally ill rather than developing prevention programmes. |

Furthermore, four statements measuring the respondents' opinions of and attitudes to deinstitutionalisation, were added to the CMHI scale. These statements were very specific in nature and were as follows: "South African mental health care should move towards a model of deinstitutionalisation", "Mental patients will fail to live successfully in the community, even if they are treated in the community", "

Community-care is a more effective approach to treating mental patients than treating them in a mental institution" and fourthly, "Unlike institutional care, community care is an approach that is of little value in the treatment of mental patients". These statements were added as a direct measure of respondents' attitudes to deinstitutionalisation.

The modified version of the CMHI scale comprises 38 opinion statements expressing the different aspects of community mental health ideology The modified version of the scale differs in that although the 38 items were arranged in Likert format, respondents were only able to select from five response categories for each item: strongly disagree, disagree, neutral, agree and strongly agree. This phrasing was selected as it follows current wording on most Likert type scales. On positively worded items strong agreement was scored 5; agreement was scored four; neutral was scored three; disagree was scored two and strongly disagree was scored one. Reverse scoring was used. When no response was given, a score of 3 was allotted to that item. In the present study, the Cronbach alpha for the modified version of the scale was .81.

## 3.4. PROCEDURE

### 3.4.1. COMMUNITY PSYCHIATRIC NURSES

Access to community psychiatric nurses was attained through relevant authorities at King George V hospital in Durban, the KwaSimama polyclinic in Kwamashu and through Fort Napier hospital in Pietermaritzburg. Separate meetings were arranged with each group of nurses and details on the purposes of the study were provided at these meetings. Information regarding the nature of the study and their participation was also provided to each group of community psychiatric nurses. They were also informed that their participation in the study was valued but voluntary. The respondents were assured of anonymity and the confidentiality of the information they would provide. The participants were advised not to confer on their responses and to complete the questionnaires within the week. Completed questionnaires were collected by the researcher a week after their receipt, from the respective clinics where the nurses were based.

### 3.4.2. MENTAL HEALTH PROFESSIONALS

Access to the mental health professionals at Fort Napier Hospital was attained through their respective management body. Every effort was made to ensure that all of the 77 psychiatric staff in the hospital were included in the sample. However, due to the varying schedules of the hospital staff, this was a difficult goal to achieve. Participants were assured of anonymity and confidentiality. While all staff were encouraged to participate, they were informed that their participation was voluntary and that they may withdraw at any stage of the study. Due to the varying shifts of employment of the psychiatric staff as well as the fact that most of the staff at Fort Napier are also staff members of Townhill Hospital, many of the staff were not available when the questionnaires were administered. Furthermore, it was impractical for the researcher to consult with each participant on an individual basis. Hence, in some instances, heads of departments were requested to submit the questionnaires to the participants and in other instances group meetings at Fort

Napier (which were organised by the researcher and the heads of departments) were held with the other mental health professionals at Fort Napier Hospital, such as psychiatric nurses and social workers. It is important to note that many psychiatric nurses were not willing to participate in this study as there appeared to be a perception amongst these individuals that the researcher was a representative from the Department of Health. Despite verbal assurances from the researcher and written assurances from the researcher's supervisor that the purpose of the present study was academic in nature, many psychiatric nurses declined the invitation to participate in the present study

Participants were provided with information on the purposes of the present study as well as detailed instructions on how to answer the questionnaires. The participants were informed that the questionnaires were to be completed and returned within a week, in a sealed envelope, (which was provided for them by the researcher in order to ensure their anonymity). A week after their receipt of the questionnaires, the researcher personally collected the material from the participants. The return rate was 65%.

### 3.4.3. PRIMARY HEALTH CARE NURSES

Due to geographical convenience for the researcher, primary health care nurses were accessed only through the Durban City Health Department, the Inner West Health Department and the Pietermaritzburg Health Department. The researcher arranged separate meetings with each group of primary health care nurses. These meetings were aimed at clarifying the nature of the present study to the nurses as well as providing information to the nurses regarding the policy shift to deinstitutionalisation and community mental health care as indicated in the White Paper document called "Towards a National Health System" (Department of Health, 1997). It was interesting to note that none of the nurses were aware of the policy shift to deinstitutionalisation and primary mental health care. The research participants were assured of the anonymity and the confidential nature of the information provided. They were also advised that they were not obligated to participate in the study and that they were able to withdraw at any point of the study. Detailed instructions on how to complete the questionnaires were also given to the participants. Those nurses who operated under the auspices of the Durban City Health department completed the questionnaires during the initial meeting. Other respondents (those at Pietermaritzburg and the Inner West areas) chose to complete the questionnaires within the week of it's receipt. Completed questionnaires were collected personally by the researcher from the relevant clinics where the nurses were based.

The focus groups methodology will now be discussed.

## 3.5. FOCUS GROUPS

### 3.5.1. FOCUS GROUPS SAMPLES

#### 3.5.1.1. Focus Group One

The first focus group constituted of five community psychiatric nurses, who were from clinics in varying areas within Pietermaritzburg. Four of the five participants were female, of whom three were Coloured, one was Black and one was White.

#### 3.5.1.2. Focus Group Two

The second focus group was made up of 6 community psychiatric nurses from various areas within Durban. Besides one male, the rest of the group comprised females. All of the participants within this group were Black.

#### 3.5.1.3. Focus Group Three

The fourth sample of focus group participants included 2 psychologists, I psychiatrist, 1 medical doctor, 1 occupational therapist, 1 social worker and 1 psychiatric nurse, all of whom were employed at Fort Napier hospital in Pietermaritzburg. All of the participants were male, of whom 4 were Whites, 2 were Blacks and 1 an Indian.

#### 3.5.1.4. Focus Group Four

The fourth focus group sample comprised six primary health care nurses. Three of these nurses were from clinics within the region of Durban, while the rest were from clinics in the Inner-West area of the KZN province. All the participants within this group were female, of whom 3 were Whites, 1 was Coloured, 1 was Indian and 1 was Black. Fifty percent of the participants had diplomas in Psychiatry.

It is important to note that further sample details of individual focus group participants could not be obtained as the participants did not wish to disclose such information. Nevertheless, the sample group details as was provided in the biographical questionnaire, is listed in section 3.1. These details are inclusive of the focus group participants' demographic details.

### 3.5.2. FOCUS GROUPS PROCEDURE

This section details how the focus groups were set up.

All participants were verbally informed that four 60 minutes focus group discussions surrounding issues mainly regarding deinstitutionalisation would be conducted. By way of introduction, participants were told that a focus group discussion would enhance the researcher's understanding of their attitudes to deinstitutionalisation as well as indicate where their attitudes stem from. Separate focus groups were run for each sample group. Given their various working shifts, participants were selected on the basis of their availability to engage in the focus group discussions.

The focus group participants were assured of their anonymity and confidentiality and were informed of the voluntary nature of their participation. They were also informed that they were free to withdraw from the discussion at any point. Each focus group discussion opened with an introduction by the researcher on the deinstitutionalisation policy in South Africa, as presented in the White Paper document called "Towards a National Health System" (Department of Health, 1997). Proceeding this, a semi-structured focus group interview was conducted. Key questions were standard across all the focus groups interviews.

An hour-long focus group discussion was held with each of the groups of community psychiatric nurses. One was held at a clinic in Pietermaritzburg, while the other was held at King George V Hospital in Durban. The reason for conducting two focus group discussions for this sample group was to allow nurses from different geographical areas to participate in this process. A focus group discussion was also conducted at Fort Napier Hospital with seven mental health professionals employed at Fort Napier Hospital.

Participants from each group of primary health care nurses were also invited to participate in a 60-minute focus group discussion. Due to inflexible schedules and staff shortages, there were no primary health care nurses available from Pietermaritzburg to participate in the focus group discussions. Primary health care nurses from the Durban City Health Department and primary health care nurses from the Inner West city council participated in the focus group discussion, which was conducted in a clinic near the Inner West city council.

Prior to the closure of each discussion, all participants were also assured that they were free to express any issue which they felt had not been covered in the focus questions. At the end of each discussion, each group was served with refreshments as well as 'thank you' notes.

Chapter four presents the results of this study.

# CHAPTER FOUR

# RESULTS

## 4.1. INTRODUCTION

Parametric and non-parametric tests were employed in order to analyse the data and test the hypotheses that were explicated in chapter one (pgs. 13-14). This chapter presents the results of the testing of these hypotheses. The results of the Opinions of Mental Illness scale (1962) and the Community Mental Health Ideology scale (1967) were analysed separately and will therefore be presented in separate sections within this chapter. Such a format will also permit easier reading and comprehension of the results.

The contents of each section will be presented as follows: The first set of analyses will focus on the attitudes of the three sample groups towards mental illness and mentally ill people/ community mental health ideology. A descriptive analysis of the rank order of opinions of mental illness and mentally ill people/ community mental health ideology is provided. This is followed by an analysis of differences between community psychiatric nurses, mental health professionals and primary health care nurses in their attitudes towards mental illness and mentally ill people/ community mental health ideology and in their responses on the five sub – scales of the Opinions of Mental Illness scale. The third set of analyses will focus on differences among respondents in different categories of age, gender, race, socioeconomic status, educational level, years of professional experience and treatment of family/friend for a mental illness in their attitudes towards mental illness and mentally ill people/community mental health ideology. The third set of analyses will be proceeded by a set of analyses that will focus on the relationships between demographic variables such as age, gender, race, socioeconomic status, level of education, years of professional experience, psychological/psychiatric treatment of family/friend and attitudes towards mental illness and mentally ill people/ community mental health ideology. The fifth set of analyses will focus on the relationship between opinions of mental illness and mentally ill people and attitudes towards community mental health ideology.

## 4.2. RESULTS OF ATTITUDES TOWARDS MENTAL ILLNESS AND MENTALLY ILL PEOPLE

### 4.2.1. ITEM RANKING OF OPINIONS OF MENTAL ILLNESS AND MENTALLY ILL PEOPLE

Table 6 below provides descriptions of how the participants in the three sample groups responded to the measure of Opinions of Mental illness. The five items with the highest mean scores are presented in ranking order in table 6.

TABLE 6

**Rank Order of the Opinions of Mental Illness Scale**[6]

| COMMUNITY PSYCHIATRIC NURSES | MENTAL HEALTH PROFESSIONALS | PRIMARY HEALTH CARE NURSES |
|---|---|---|
| 1) People with severe mental illness are no longer really human. | 1) Even though patients in mental hospitals behave in funny ways, it is wrong to laugh at them. | 1) To become mentally ill is to become a failure in life. |
| 2) To become mentally ill is to become a failure in life. | 2) People with severe mental illness are no longer really human. | 2) People with severe mental illness are no longer really human. |
| There is little that can be done for patients in a mental hospital except to see that they are comfortable and well fed. | 3) The best way to handle patients in mental hospitals is to keep them behind locked doors. | 3) The best way to handle patients in mental hospitals is to keep them behind locked doors. |
| 4) Although patients discharged from mental hospitals may seem allright, they should never be allowed to marry. | 4) There is little that can be done for patients in a mental hospital except to see that they are comfortable and well fed. | 4) There is little that can be done for patients in a mental hospital except to see that they are comfortable and well fed. |
| 5) Even though patients in mental hospitals behave in funny ways, it is wrong to laugh at them. | 5) It is wrong to blame a mentally ill person for his/her condition. | 6) Even though patients in mental hospitals behave in funny ways, it is wrong to laugh at them |

[6] This rank ordering reflects items that were most frequently endorsed, either positively or negatively by the three sample groups.

Table 6 reflects that community psychiatric nurses, mental health professionals and primary health care nurses *do not* endorse the views that, "People with severe mental illness are no longer really human" and that, "There is little that can be done for patients in a mental hospital except to see that they are comfortable and well-fed". Both community psychiatric nurses and the primary health care nurses *do not* endorse the view that "To become mentally ill is to become a failure in life". Mental health professionals and the primary health care nurses *do not* endorse the viewpoint that "The best way to handle patients in a mental hospital is to keep them behind locked doors".

Table 6 also illustrates that community psychiatric nurses, mental health professionals and primary health care nurses strongly *endorse* the view that, "Even though patients in mental hospitals behave in funny ways, it is wrong to laugh at them".

Community psychiatric nurses, however, appear to be unique in their strong disapproval of the statement, "Although patients discharged from mental hospitals may seem allright, they should never be allowed to marry". The mental health professionals are also unique in their strong endorsement of the view that "It is wrong to blame a mentally ill person for his/her condition". In sum, it appears that there are very few differences amongst the three sample groups in terms of the items that were most frequently endorsed in the Opinions of Mental Illness scale.

### 4.2.2. ATTITUDES TOWARDS MENTAL ILLNESS AND MENTALLY ILL PEOPLE.[7]

A primary hypothesis of this study was that community psychiatric nurses, mental health professionals and primary health care nurses would differ significantly in their attitudes towards mental illness and mentally ill people. A one-way ANOVA revealed that there were no significant differences between community psychiatric nurses, mental health professionals and primary health care nurses in attitudes towards mental illness and mentally ill people ($F$ (2, 127) = 1.63, $p > .003$). In other words, community psychiatric nurses, mental health professionals and primary health care nurses tended to endorse more neutral attitudes. This deduction was arrived at in the following way: A mean score of 132 and over indicates a positive attitude towards mental illness and mentally ill people. A mean score ranging between 99 –132 indicates a neutral attitude towards mental illness and mentally ill people. A mean score below 99 indicates a negative attitude towards mental illness and mentally ill people. Table 7 below shows the mean and standard deviation scores on the attitudes of community psychiatric nurses, mental health professionals and primary health care nurses towards mental illness and mentally ill people.

[7] A family-wise error rate was used to test for significance in all of the following analyses using the Opinions of Mental Illness scale. That is, .05/19 = p =.003.

TABLE 7

**Mean and Standard Deviation Scores on Attitudes Towards Mental Illness and Mentally Ill People (N=130).**

| SAMPLE GROUP | MEAN | STD. DEVIATION |
|---|---|---|
| Community Psychiatric Nurses | 118.11 | 11.33 |
| Mental Health Professionals | 121.10 | 13.62 |
| Primary Health Care Nurses | 116.06 | 10.73 |

One-way ANOVA's also revealed no significant differences between community psychiatric nurses, mental health professionals and primary health care nurses in terms of their scores on the factors of *authoritarianism* ($F\ (2, 127) = .959,\ p > .003$), *benevolence* ($F\ (2, 127) = 3.936,\ p > .003$), *mental hygiene ideology* ($F\ (2, 127) = 1.175,\ p > .003$), *social restrictiveness* ($F\ (2, 127) = 2.093,\ p > .003$), and *interpersonal etiology* ($F\ (2, 127) = 1.161,\ p > .003$).

Tables 8 - 12 below display the mean and standard deviation scores of community psychiatric nurses, mental health professionals and primary health care nurses on each sub–scale.

TABLE 8

**Mean and Standard Deviation Scores on Authoritarianism (N = 130)**

| SAMPLE GROUP | MEAN | STANDARD DEVIATION |
|---|---|---|
| Community Psychiatric Nurses | 43.24 | 6.58 |
| Mental Health Professionals | 45.46 | 6.72 |
| Primary Health Care Nurses | 43.13 | 7.50 |

TABLE 9

**Mean and Standard Deviation Scores on Benevolence (N = 130)**

| SAMPLE GROUP | MEAN | STANDARD DEVIATION |
|---|---|---|
| Community Psychiatric Nurses | 14.97 | 2.41 |
| Mental Health Professionals | 16.20 | 2.14 |
| Primary Health Care Nurses | 14.70 | 1.95 |

TABLE 10

**Mean and Standard Deviation Scores on Mental Hygiene Ideology (N = 130)**

| SAMPLE GROUP | MEAN | STANDARD DEVIATION |
|---|---|---|
| Community Psychiatric Nurses | 25.05 | 2.60 |
| Mental Health Professionals | 24.30 | 2.95 |
| Primary Health Care Nurses | 24.08 | 3.48 |

TABLE 11

**Mean and Standard Deviation Scores on Social Restrictiveness (N = 130)**

| SAMPLE GROUP | MEAN | STANDARD DEVIATION |
|---|---|---|
| Community Psychiatric Nurses | 16.39 | 2.14 |
| Mental Health Professionals | 15.85 | 2.18 |
| Primary Health Care Nurses | 15.56 | 1.96 |

TABLE 12

**Mean and Standard Deviation Scores on Interpersonal Etiology (N = 130)**

| SAMPLE GROUP | MEAN | STANDARD DEVIATION |
|---|---|---|
| Community Psychiatric Nurses | 15.92 | 2.03 |
| Mental Health Professionals | 16.20 | 1.79 |
| Primary Health Care Nurses | 15.50 | 2.09 |

Despite an absence of *significant* differences amongst the three sample groups in terms of their scores on the five subscales, it was noted that mental health professionals tended to have more authoritarian attitudes towards mentally ill people than community psychiatric nurses and primary health care nurses. The mean scores also reveal that mental health professionals tended to have more benevolent attitudes towards mentally ill people than community psychiatric nurses and primary health care nurses. It appears that community psychiatric nurses tended to bear a more positive orientation and acceptance of modern mental hygiene concepts than mental health professionals and primary health care nurses. It also seems that community psychiatric nurses had a greater tendency to perceive the mental patient as in need of restriction in social functioning than mental health professionals and primary health care nurses. Mental health professionals also revealed a greater tendency to endorse the belief that mental illness is based on interpersonal experience than community psychiatric nurses and primary health care nurses.

### 4.2.3. ATTITUDES TOWARDS MENTAL ILLNESS AND MENTALLY ILL PEOPLE AS A FUNCTION OF AGE

A hypothesis guiding this study was that there would be distinct differences amongst older and younger respondents, in their attitudes towards mental illness and mentally ill people. A one-way ANOVA indicated no significant differences in attitudes to mental illness and mentally ill people amongst respondents of different ages ($F(2, 125) = .369, p > .003$). This finding is not supported by international studies but is similar to the findings of a South African study (Mavundla & Uys, 1997). Table 13 shows the mean and standard deviation scores for each of the three age ranges.

TABLE 13

**Mean and Standard Deviation Scores of Age on Attitudes Towards Mental Illness and Mentally Ill People (N = 128).**

| AGE | MEAN | STD.DEVIATION |
|---|---|---|
| 23-35 Years | 118.64 | 13.01 |
| 36-50 Years | 117.90 | 11.02 |
| 51-70 Years | 116.16 | 10.70 |

### 4.2.4. ATTITUDES TOWARDS MENTAL ILLNESS AND MENTALLY ILL PEOPLE AS A FUNCTION OF GENDER

It was hypothesised that there would be gender differences in attitudes towards mental illness and mentally ill people. The t-test analysis revealed no significant gender differences in attitudes towards mental illness and mentally ill people ($t$ (1, 128) = 1.62, $p > .003$). This finding is similar to the findings of some international studies. Table 14 below reflects the mean and standard deviation scores for gender.

TABLE 14

**Mean and Standard Deviation Scores on Attitudes towards Mental Illness and Mentally Ill People by Gender (N= 130).**

| GENDER | MEAN | STD.DEVIATION |
|---|---|---|
| Female | 145.75 | 11.94 |
| Male | 145.31 | 12.65 |

### 4.2.5. ATTITUDES TOWARDS MENTAL ILLNESS AND MENTALLY ILL PEOPLE AS A FUNCTION OF RACE

It was hypothesised that different race groups would vary in their attitudes towards mental illness and mentally ill people. This hypothesis was strongly supported by the results of this study. A one-way ANOVA revealed that there were significant differences between the four race groups in their attitudes towards mental illness and mentally ill people ($F\ (3, 126) = 12.39$, $p < .003$). A Post-hoc analyses, employing the method of Tukey's Honestly Significant Difference showed that Indian respondents possessed more positive attitudes towards mental illness and mentally ill people (mean = 120.86) than African respondents (112.82). The largest differences however, were found to be amongst White, African and Coloured respondents (Table 15). Further analysis showed that White participants evidenced significantly more liberal attitudes to mental illness and mentally ill people (mean = 126.31) than African (mean = 122.82) and Coloured (mean = 115.75) respondents. Table 15 below displays the mean and standard deviation scores for each race group.

<u>**TABLE 15**</u>

**Mean and Standard Deviation Scores on Attitudes towards Mental Illness and Mentally Ill People by Race (N = 130).**

| RACE | MEAN | STD.DEVIATION |
|---|---|---|
| African | 112.82 | 9.24 |
| Indian | 120.86 | 11.29 |
| Coloured | 115.75 | 14.40 |
| White | 126.31 | 9.84 |

### 4.2.6. ATTITUDES TOWARDS MENTAL ILLNESS AND MENTALLY ILL PEOPLE AS A FUNCTION OF SOCIAL CLASS

A hypothesis in this study was that there would be differences in attitudes towards mental illness and mentally ill people amongst respondents of different social classes. A one-way ANOVA revealed marked differences in attitudes towards mental illness and mentally ill people amongst the three classes in this study, though not at the level of significance of the family – wise comparisons ($F(2, 127) = 4.3340$, $p > .003$). This finding is dissimilar to the results of most international studies. Table 16 below depicts the mean and standard deviation scores of each social class.

**TABLE 16**

**Mean and Standard Deviation Scores on Attitudes Towards Mental Illness and Mentally Ill People by Social Class (N = 130).**

| SOCIO- ECONOMIC GROUP | MEAN | STD.DEVIATION |
|---|---|---|
| Working Class | 114.86 | 11.10 |
| Middle Class | 118.49 | 11.31 |
| Upper-middle Class | 130.25 | 7.50 |

### 4.2.7. ATTITUDES TOWARDS MENTAL ILLNESS AND MENTALLY ILL PEOPLE AS A FUNCTION OF LEVELS OF EDUCATION

It was hypothesised that there will be differences in attitudes towards mental illness and mentally ill people amongst respondents with different levels of education. A one-way ANOVA revealed significant differences in attitudes towards mental illness and mentally ill people amongst individuals who varied in educational levels ($F\ (3,\ 120) = 7{,}2760$, $p < .003$). This finding is in keeping with international findings. A post-hoc analysis employing Tukey's Honestly Significant Difference method showed that respondents with advanced education and training held significantly more positive attitudes to mental illness and mentally ill people (mean = 123.43) than respondents who had only basic levels of professional training (mean = 112.47). These results are shown in table 17.

<u>TABLE 17</u>

**Mean and Standard Deviation Scores on Attitudes Towards Mental Illness and Mentally Ill People by Educational Level (N = 124).**

| EDUCATION | MEAN | STD.DEVIATION |
|---|---|---|
| Basic Diploma Holders | 112.47 | 9.91 |
| Advanced Diploma Holders | 121.40 | 10.57 |
| Graduates | 120.87 | 10.85 |
| Post-Graduate | 123.43 | 10.41 |

### 4.2.8. ATTITUDES TOWARDS MENTAL ILLNESS AND MENTALLY ILL PEOPLE AS A FUNCTION OF YEARS OF PROFESSIONAL EXPERIENCE.

It was hypothesised that a respondent's level of professional experience would be positively related to his/her attitudes towards mental illness and mentally ill people. A one-way ANOVA revealed that there were no significant differences in attitudes towards mental illness and mentally ill people amongst respondents with differing years of professional experience ($F(3, 117) = .267, p > .003$). This finding is supported by some of the established literature in this area. The results of this analysis are displayed in table 18.

**TABLE 18**

**Mean and Standard Deviation Scores on Attitudes Towards Mental Illness and Mentally Ill People by Years of Professional Experience (N = 121).**

| YEARS OF PROFESSIONAL EXPERIENCE | MEAN | STANDARD DEVIATION |
| --- | --- | --- |
| 1-3 Years | 117.37 | 12.76 |
| 4-8 Years | 116.71 | 10.40 |
| 9-20 Years | 119.00 | 11.55 |
| 20-40 Years | 117.27 | 11.68 |

### 4.2.9. ATTITUDES TOWARDS MENTAL ILLNESS AND MENTALLY ILL PEOPLE AS A FUNCTION OF THE TREATMENT OF FAMILY / FRIEND FOR A MENTAL ILLNESS

A hypothesis in this study was that there will be differences in attitudes towards mental illness and mentally ill people between respondents whose family/friend was treated for a mental illness and respondents who had no family/friend that was treated for a mental illness. A t-test revealed no significant differences in attitudes towards mental illness and mentally ill people between those respondents with a family member who was treated for a mental illness and those respondents who had no such history ($t\ (1, 128) = 1.33$, $p > .003$). This result is at odds with the literature. A t-test however, indicated significant differences ($t\ (1, 128) = 3.58$, $p < .003$) in attitudes towards mental illness and mentally ill people between those respondents with a friend who was treated for a mental illness (mean = 121.71) and those respondents who had no such friend in treatment (mean = 114.67). This finding is in accordance with international studies. The results of the t-tests can be found in table 19.

TABLE 19

**Mean and Standard Deviation Scores on Attitudes to Mental Illness and Mentally Ill People by Treatment of Family/friend for a Mental Illness (N = 130).**

| TREATMENT OF FAMILY | MEAN | STANDARD DEVIATION |
|---|---|---|
| Yes | 119.27 | 13.27 |
| No | 116.90 | 10.87 |
| **TREATMENT OF FRIEND** | **MEAN** | **STANDARD DEVIATION** |
| Yes | 121.70 | 13.20 |
| No | 114.67 | 9.22 |

### 4.2.10. RELATIONSHIPS BETWEEN DEMOGRAPHIC FEATURES AND ATTITUDES TOWARDS MENTAL ILLNESS AND MENTALLY ILL PEOPLE

A subset of the first hypothesis was that there will be a relationship between demographic features (age, gender, race, socioeconomic status, level of education, years of professional experience and psychological/ psychiatric treatment of family/friend) and attitudes towards mental illness and mentally ill people. Tables 20 and 21 reflect the results of the testing of this hypothesis.

TABLE 20

**Zero-order Correlations Between Demographic Variables and Opinions of Mental Illness (N=117).**

| | Opinions of Mental Illness |
|---|---|
| Age | .17 |
| Gender | .13 |
| Race | .45 *** |
| Socioeconomic status | .28*** |
| Level of education | .33 *** |
| Years of professional experience | .02 |

* = $p < .003$

Table 20 indicates that there is a significant correlation between the variables of race, socio – economic status, levels of education and opinions of mental illness. Thus, belonging to a particular racial group classified as Black, Coloured, Indian or White is significantly related to attitudes to mental illness and mentally ill people. Furthermore, it appears that the higher a respondent's socio – economic status and educational level, the more positive is his/her attitudes towards mental illness and mentally ill people. Table 20 also reflects that there are no significant correlations between age, gender, years of professional experience and opinions of mental illness.

TABLE 21

**Zero-order Correlations Between the Treatment of Family/Friend for a Mental Illness and Opinions of Mental Illness (N = 117).**

| | **Opinions of mental illness** |
|---|---|
| **Treatment of family for mental illness** | .07 |
| **Treatment of friend for mental illness** | .27 *** |

* $= p < .003$

The results illustrated above indicate that there is no significant correlation between the treatment of a family member for mental illness and attitudes towards mental illness and mentally ill people. However, there is a significant, positive correlation between the treatment of a friend for a mental illness and attitudes towards mental illness and mentally ill people. Thus, the treatment of a friend for a mental illness is related to positive attitudes to mental illness and mentally ill people.

## 4.2.11. RELATIONSHIPS BETWEEN ATTITUDES TOWARDS MENTAL ILLNESS, MENTALLY ILL PEOPLE AND DEINSTITUTIONALISATION

The fourth hypothesis was that attitudes towards mental illness, mentally ill people and deinstitutionalisation/ community mental health ideology will be correlated. Table 22 reflects the results of the testing of this hypothesis.

TABLE 22

**Zero-order Correlation Between Opinions of Mental Illness and Mentally Ill People and Attitudes Towards Community Mental Health Ideology (N=117).**

| | **Opinions of mental illness** |
|---|---|
| **Community mental health ideology** | .79 * |

* = $p < .003$

Table 22 indicates that there is a significant correlation between attitudes towards mental illness and attitudes towards deinstitutionalisation/ community mental health ideology. This positive correlation indicates that a respondent who endorses a positive attitude towards mental illness and mentally ill people will also exhibit a positive attitude towards deinstitutionalisation/ community mental health ideology.

### 4.2.12. SUMMARY OF SIGNIFICANT RESULTS ON ATTITUDES TOWARDS MENTAL ILLNESS AND MENTALLY ILL PEOPLE

The results in section 4.2. illustrate that:

a) Community psychiatric nurses, mental health professionals and primary health care nurses tend to hold more neutral than either positive or negative attitudes towards mental illness and mentally ill people.

b) There are significant differences in attitudes towards mental illness and mentally ill people amongst respondents in different categories of race, educational levels and treatment of a friend for a mental illness.

c) The variables of race, socio – economic status, educational levels and treatment of a friend for a mental illness were significantly correlated with Opinions of Mental Illness.

d) Attitudes towards mental Illness, mentally ill people and deinstitutionalisation are significantly, positively correlated.

Section 4.3. which follows, highlights the results of Attitudes Towards Community Mental Health Ideology/ Deinstitutionalisation.

## 4.3. RESULTS OF ATTITUDES TOWARDS COMMUNITY MENTAL HEALTH IDEOLOGY SCALE

### 4.3.1. ITEM RANKING OF THE COMMUNITY MENTAL HEALTH IDEOLOGY SCALE

Table 23 below provides a description of how the participants in the three sample groups responded to the measure of Community Mental Health Ideology. The five items with the highest mean scores are presented in ranked order in table 23.

TABLE 23

**Rank Order of the Community Mental Health Ideology Scale**[8]

| COMMUNITY PSYCHIATRIC NURSE | MENTAL HEALTH PROFESSIONAL | PRIMARY HEALTH CARE NURSE |
|---|---|---|
| 1) The mental hospital and community should strive towards working together. | 1) The mental hospital and community should strive towards working together. | 1) The mental hospital and community should strive towards working together. |
| 2) Community participation in mental health programmes is necessary to ensure it's success. | 2) The cause/s of mental illness should be seen as extending beyond the individual and into the family, the community and the society. | 2) Community participation in mental health programmes is necessary to ensure it's success. |
| 3) The mental health professional should try to advance his/her effectiveness by working through people in the community. | 3) South African mental health care should move towards a model of community-based care. | 3) The cause/s of mental illness should be seen as extending beyond the individual and into the family, the community and the society. |
| 4) The cause/s of mental illness should be seen as extending beyond the individual and into the family, the community and the society. | 4) Community participation in mental health programmes is necessary to ensure it's success. | 4) Caregivers who worked with the patient before and during his/her stay at a mental should be included in the development of his/her treatment plans. |
| 5) Public health programmes like primary preventive services will be of little value to the mental health field. | 5) Caregivers who worked with the patient before and during his/her stay at a mental should be included in the development of his/her treatment plans. | 5) The mental health professional should try to advance his/her effectiveness by working through people in the community. |

[8] This rank order reflects items that were most frequently endorsed, either positively or negatively, by the three sample groups.

The results presented in table 23 illustrate that the community psychiatric nurses, mental health professionals and primary health care nurses *strongly endorse* the views that "The mental hospital and the community should strive towards working together", "Community participation in mental health programmes is necessary to ensure it's success" and that "The cause/s of mental illness should be seen as extending beyond the individual and into the family, the community and the society".

Table 23 also shows that the community psychiatric nurses and the primary health care nurses *strongly agree* that "The mental health professional should try to advance his/her effectiveness by working through people in the community". The mental health professionals and the primary health care nurses appear to *strongly endorse* the view that "Caregivers who worked with the patient before and during his/her stay at a mental should be included in the development of his/her treatment plans". However, the community psychiatric nurses are unique in their *strong disapproval* of the statement "Public health programmes like primary preventive services will be of little value to the mental health field". Furthermore, it also appears that mental health professionals, unlike community psychiatric nurses and primary health care nurses, most *strongly endorse* the view that "South African mental health care should move towards a model of community-based care". In sum, it appears that except for a few differences, there is general agreement amongst the 3 sample groups in terms of the items that were most frequently endorsed in the Community Mental Health Ideology Scale.

### 4.3.2. ATTITUDES TOWARDS DEINSTITUTIONALISATION / COMMUNITY MENTAL HEALTH IDEOLOGY.[9]

A primary hypothesis of this study was that community psychiatric nurses, mental health professionals and primary health care nurses would differ significantly in their attitudes towards deinstitutionalisation. A one-way ANOVA revealed that there were no significant differences between community psychiatric nurses, mental health professionals and primary health care nurses in attitudes towards deinstitutionalisation ($F(2, 127) = 1.30$, $p > .003$). In other words, community psychiatric nurses, mental health professionals and primary health care nurses tended to endorse more neutral attitudes that were neither positive nor negative. This deduction was arrived at in the following way: A mean score of 152 and over indicates a positive attitude towards deinstitutionalisation. A mean score ranging between 114-152 indicates a neutral attitude towards deinstitutionalisation. A mean score below 114 indicates a negative attitude towards deinstitutionalisation. Table 24 below shows the mean and standard deviation scores of community psychiatric nurses, mental health professionals and primary health care nurses.

[9] A family-wise error rate was used to test for significance in all of the following analyses using the Community Mental Health Ideology scale. That is, $0.05/18 = p = .003$.

TABLE 24

**Mean and Standard Deviation Scores on Attitudes Towards Deinstitutionalisation / Community Mental Health Ideology (N=130).**

| SAMPLE GROUP | MEAN | STD. DEVIATION |
|---|---|---|
| Community Psychiatric Nurses | 146.39 | 12.00 |
| Mental Health Professionals | 149.10 | 13.22 |
| Primary Health Care Nurses | 144.39 | 11.56 |

### 4.3.3. ATTITUDES TOWARDS DEINSTITUTIONALISATION / COMMUNITY MENTAL HEALTH IDEOLOGY AS A FUNCTION OF AGE[10]

A hypothesis guiding this study was that there would be distinct differences amongst older and younger respondents, in their attitudes towards deinstitutionalisation. A one-way ANOVA indicated no significant differences in attitudes to community mental health ideology / deinstitutionalisation amongst respondents of different ages ($F(2, 125) = .319$, $p > .003$). Table 25 shows the mean and standard deviation scores for each of the three age ranges.

[10] Respondents' ages were categorised into 3 groups in order to facilitate the statistical analyses for differences in attitudes towards community mental health ideology between older and younger respondents.

TABLE 25

**Mean and Standard Deviation Scores of Age on Attitudes towards Deinstitutionalisation/Community Mental Health Ideology (N = 128).**

| AGE | MEAN | STD.DEVIATION |
|---|---|---|
| 23-35 Years | 147.28 | 12.64 |
| 36-50 Years | 145.14 | 11.31 |
| 51-70 Years | 146.27 | 13.45 |

### 4.3.4. ATTITUDES TOWARDS DEINSTITUTIONALISATION / COMMUNITY MENTAL HEALTH IDEOLOGY AS A FUNCTION OF GENDER

It was hypothesised that there would be gender differences in attitudes towards deinstitutionalisation. The t-test analysis revealed no significant gender differences in attitudes towards deinstitutionalisation ($t\ (1,\ 128) = .14$, $p > .003$). Table 26 below reflects the mean and standard deviation scores for each gender group.

TABLE 26

**Mean and Standard Deviation Scores on Attitudes Towards Community Mental Health Ideology by Gender (N= 130).**

| GENDER | MEAN | STD.DEVIATION |
|---|---|---|
| Female | 145.75 | 11.94 |
| Male | 145.31 | 12.64 |

### 4.3.5. ATTITUDES TOWARDS DEINSTITUTIONALISATION / COMMUNITY MENTAL HEALTH IDEOLOGY AS A FUNCTION OF RACE

It was hypothesised that different race groups would vary in their attitudes towards deinstitutionalisation. This hypothesis was not supported by the results of this study. A one-way ANOVA revealed that there were no significant differences between the four race groups in their attitudes towards deinstitutionalisation ($F(3, 126) = .2297, p > .003$). Table 27 below displays the mean and standard deviation scores for each race group.

<u>**TABLE 27**</u>

**Mean and Standard Deviation Scores on Attitudes Towards Deinstitutionalisation / Community Mental Health Ideology by Race (N = 130).**

| RACE | MEAN | STD.DEVIATION |
|---|---|---|
| African | 145.07 | 11.63 |
| Indian | 145.18 | 10.94 |
| Coloured | 147.12 | 9.00 |
| White | 147.47 | 14.88 |

### 4.3.6. ATTITUDES TOWARDS DEINSTITUTIONALISATION / COMMUNITY MENTAL HEALTH IDEOLOGY AS A FUNCTION OF SOCIAL CLASS

A hypothesis in this study was that there would be differences in attitudes towards deinstitutionalisation amongst respondents of different social classes. A one-way ANOVA revealed no significant differences in attitudes towards deinstitutionalisation / community mental health ideology amongst the three classes in this study ($F\ (2, 127) = .7237$, $p > .003$). Table 28 below depicts the mean and standard deviation scores of each social class.

<u>**TABLE 28**</u>

**Mean and Standard Deviation Scores on Attitudes Towards Deinstitutionalisation / Community Mental Health Ideology by Social Class (N = 130).**

| SOCIO- ECO. GROUP | MEAN | STD.DEVIATION |
|---|---|---|
| Working Class | 144.18 | 12.33 |
| Middle Class | 146.59 | 11.79 |
| Upper-middle Class | 148.50 | 11.96 |

### 4.3.7. ATTITUDES TOWARDS DEINSTITUTIONALISATION / COMMUNITY MENTAL HEALTH IDEOLOGY AS A FUNCTION OF LEVELS OF EDUCATION

It was hypothesised that there will be differences in attitudes towards deinstitutionalisation amongst respondents with different levels of education. A one-way ANOVA revealed marked differences in attitudes towards deinstitutionalisation amongst individuals who varied in educational levels. However, these differences were not at the level of significance of the family – wise error rate comparisons (F (3, 120) = 2.7525, $p > .003$). These results are shown in table 29.

TABLE 29

**Mean and Standard Deviation Scores on Attitudes Towards Deinstitutionalisation / Community Mental Health Ideology by Educational Level (N = 124).**

| EDUCATION | MEAN | STD.DEVIATION |
|---|---|---|
| Basic Diploma Holders | 142.60 | 10.86 |
| Advanced Diploma Holders | 147.00 | 11.95 |
| Graduates | 148.33 | 12.71 |
| Post-Graduate | 153.42 | 11.58 |

### 4.3.8. ATTITUDES TOWARDS DEINSTITUTIONALISATION / COMMUNITY MENTAL HEALTH IDEOLOGY AS A FUNCTION OF YEARS OF PROFESSIONAL EXPERIENCE

It was hypothesised that there would be differences in attitudes towards deinstitutionalisation amongst respondents with different levels of professional experience. A one-way ANOVA revealed that there were significant differences in attitudes towards deinstitutionalisation / community mental health ideology amongst respondents with differing years of professional experience. However, these differences were not at the level of significance of the family – wise error rate comparisons (F (3, 117) = .212, $p > .003$). The results of this analysis are displayed in table 30.

TABLE 30

**Mean and Standard Deviation Scores on Attitudes Towards Deinstitutionalisation / Community Mental Health by Years of Professional Experience (N = 121).**

| YEARS OF PROFESSIONAL EXPERIENCE | MEAN | STANDARD DEVIATION |
|---|---|---|
| 1-3 Years | 143.00 | 12.39 |
| 4-8 Years | 144.44 | 11.01 |
| 9-20 Years | 149.07 | 12.37 |
| 20-40 Years | 148.45 | 11.27 |

## 4.3.9. ATTITUDES TOWARDS DEINSTITUTIONALISATION / COMMUNITY MENTAL HEALTH IDEOLOGY AS A FUNCTION OF THE TREATMENT OF FAMILY / FRIEND FOR A MENTAL ILLNESS

A hypothesis in this study was that there would be differences in attitudes towards deinstitutionalisation between respondents whose family/friend was treated for a mental illness and respondents who had no family/friend that was treated for a mental illness. A t-test revealed no significant differences in attitudes towards deinstitutionalisation / community mental health ideology between those respondents with a family member who was treated for a mental illness and those respondents who had no such history (t (1, 128) = 1.07, $p > .003$). A t-test also indicated no significant differences (t (1, 128) = 1.33, $p > .003$) in attitudes towards deinstitutionalisation between those respondents with a friend who was treated for a mental illness and those respondents who had no such friend in treatment. The results of the t-tests can be found in table 31.

<u>TABLE 31</u>

**Mean and Standard Deviation Scores on Attitudes Towards Deinstitutionalisation / Community Mental Health Ideology by Treatment of Family/Friend for a Mental Illness (N = 130).**

| **TREATMENT OF FAMILY** | **MEAN** | **STANDARD DEVIATION** |
|---|---|---|
| Yes | 147.79 | 11.73 |
| No | 145.10 | 12.04 |
| **TREATMENT OF FRIEND** | **MEAN** | **STANDARD DEVIATION** |
| Yes | 147.43 | 10.63 |
| No | 144.59 | 13.74 |

### 4.3.10. RELATIONSHIPS BETWEEN DEMOGRAPHIC FEATURES AND ATTITUDES TOWARDS DEINSTITUTIONALISATION / COMMUNITY MENTAL HEALTH IDEOLOGY

A subset of the first hypothesis was that there will be a significant relationship between demographic features (age, gender, race, socioeconomic status, level of education, years of professional experience and psychological/ psychiatric treatment of family/friend) and attitudes towards deinstitutionalisation. Tables 32 and 33 are reflective of the results of the testing of this hypothesis.

TABLE 32

**Zero-order Correlations Between Demographic Variables and Attitudes Towards Community Mental Health Ideology (N=117).**

| | **Opinions of Mental Illness** |
|---|---|
| **Age** | .11 |
| **Gender** | .03 |
| **Race** | .87 |
| **Socioeconomic status** | .06 |
| **Level of education** | .26 |
| **Years of professional experience** | .15 |

Table 32 reflects that there are no significant correlations between age, gender, race, socioeconomic status, level of education, years of professional experience and attitudes towards deinstitutionalisation. It is worth noting however, that a respondent's level of education ($p$ = .005) and years of professional experience ($p$ = .028) were strongly correlated with the Community Mental Health Ideology scale, though not at the level of significance of the family – wise comparisons.

TABLE 33

**Zero-order Correlations Between the Treatment of Family/Friend for a Mental Illness and Attitudes Towards Deinstitutionalisation / Community Mental Health Ideology (N = 117).**

| | **Community mental health ideology** |
|---|---|
| **Treatment of family for mental illness** | .09 |
| **Treatment of friend for mental illness** | .11 |

The results illustrated above indicate that there is no significant correlation between the treatment of a family member / friend for mental illness and attitudes towards deinstitutionalisation / community mental health ideology. Thus, the treatment of a family member/friend for a mental illness does not influence attitudes towards deinstitutionalisation.

## 4.3.11. SUMMARY OF SIGNIFICANT RESULTS ON ATTITUDES TOWARDS DEINSTITUTIONALISATION

The results presented in section 4.3. illustrate that:

a) Community psychiatric nurses, mental health professionals and primary health care nurses tend to hold more neutral, than either positive or negative attitudes towards deinstitutionalisation

b) There are no significant differences amongst respondents in different categories of age, gender, race, socio – economic status, educational level, level of professional experience and respondents whose family / friend received psychological / psychiatric treatment in their attitudes towards deinstitutionalisation.

c) There is no relationship between an individual's demographic variables and his / her attitudes towards deinstitutionalisation.

The next chapter discusses the results of the focus group

# CHAPTER FIVE

# FOCUS GROUP RESULTS

## 5.1. INTRODUCTION

The purpose of this chapter is to explicate the results of the focus groups analyses. The focus group discussions of each sample group was analysed separately, therefore, the results of these analyses will also be presented separately. Krueger's (1994) methodology was used as the theoretical framework to guide the analyses of the focus groups. This methodology required that "the analyst follow a prescribed, sequential process" (Krueger, 1994, p.127). Krueger offered information on the process of a transcript-based analysis (p.157). The information read as follows:

a) Make backup copies of tapes
b) Give the original tapes to transcriptionist for entry onto computer
c) When transcription returns, moderator listens to tapes, adds names of speakers, and completes missing data, if possible
d) File tapes, transcripts, field notes, and the like for future analysis
e) When ready to complete analysis, gather transcripts and field notes by categories of focus groups
f) Read transcripts and field notes one category at a time
g) Look for emerging themes (by question and then overall)
h) Develop coding categories and code the data
i) Sort the data into coded categories
j) Construct topologies or diagram the analysis

k) See what data are left out and consider revision

l) Prepare the draft report-begin with the most important questions.

The above steps had been followed to a large extent in this study – steps b and c, however, were not followed in it's entirety. This was because the researcher herself was the transcriptionist and secondly, in order to maintain participants' anonymity, no names were allocated to specific speakers. The presentation style of the results also follows a model illustrated by Krueger (1994). This descriptive model is composed of the key questions that were asked, which is followed by a summary description of the responses and then includes illustrative quotes. The quotes selected are intended to help the reader understand the way in which respondents answered the specific question. This chapter will close with a comparison of the results of the quantitative and qualitative dimensions of this study.

## 5.2. ATTITUDES OF COMMUNITY PSYCHIATRIC NURSES TOWARDS DEINSTITUTIONALISATION

**a) How do you generally feel about the deinstitutionalisation of mentally ill patients?**

It was noted that the community psychiatric nurses (CPN) in both focus groups displayed ambivalent feelings towards the deinstitutionalisation of psychiatric patients. Whilst the majority of the nurses applauded the *concept* of deinstitutionalisation in terms of it enabling patients to interact with their communities, they expressed great caution and concern with regard to the practicalities of such a move. One practical issue that both groups of CPN were concerned about, and which constituted a major theme of the discussions, was the feasibility of providing such a locus of care for unstable, long-term psychiatric patients. They strongly argued that some form of institutional care would be necessary in order to carry out some mental health care services that could not take place within a community context. Such services constituted treatment facilities for long-term patients, psychiatric observation centers and treatment facilities for psychotic and/or aggressive patients. Ways in which these sentiments were expressed were as follows: "I like the idea of having patients in the community…but my concern is with those patients who just cannot benefit from treatment inspite (sic) of treatment...I think that they should be maintained in the institutions until they are stable…"(sp.a. - gp.2). "If the institutions are not there, patients who are very violent are not going to be managed properly in the community" (sp.b. – gp.2) and, "How are you going to deduce if a person is insane when he is sitting at home? Therefore, he has to be institutionalised for a couple of days, where specialists can observe him and reach a conclusion" (sp.e. – gp.1). It appeared that the participants held more favourable attitudes towards a *reduction* rather than a total closure of institutions. This was displayed in the following statement made by a senior CPN – "I think that maybe the institutions should be reduced but not totally closed down"(sp.b – gp.2).

A distinct theme in the group 2 discussion was that it would be unfeasible to treat mentally ill patients and physically ill patients within the same clinic. This was attributed to the disruptive and sometimes aggressive behaviour of mentally ill patients, who were perceived as being unable to pleasantly interact with other patients. This perception was displayed in the following statements: "When they (mentally ill patients) are with other patients they stand out like sore thumbs; we were in fact chased out of the polyclinic due to this. The pharmacist there could not stand their disruptions...mentally ill patients can't stay with a crowd" (sp.a.- gp 2) and "If you are going to mix mentally ill patients with physically ill patients, it is not going to be successful at all" (sp.c.-gp2). It was also argued that practical, occupational difficulties could also arise in treating mentally ill patients and physically ill patients within the same clinic. Such difficulties were anticipated as arising from the fact that mentally ill patients require far longer consultations than physically ill patients, and that therefore this could result in physically ill patients being neglected and compromised standards of care being delivered to psychiatric patients.

b) **You have made mention of certain patients whom you feel do not qualify for community-based mental health care. Are there any other types of patients who also fall within this category?**

The nurses felt that apart from unstable patients, there were two other types of patients who would also not be able to be sustained within the community. These were State President Patients and patients who were chronically ill and therefore highly institutionalised. It was expressed that when such patients were discharged, they were simply not able to cope within a community context because they had adapted to an institutionalised environment; one which was highly structured and free of responsibility. These sentiments were expressed as follows: "...give them not even a week and they start getting bored cos' in the hospital they are just used to lying and sleeping and smoking, and they come home and think they gonna do the same and their families are gonna wait on them…they can't cope with that" (sp.c. – gp 1) and, "They (State President Patients) have to stay in and once you put them out, you have to put them right back in because they can't cope"(sp.a – gp.1).

c) **Do you think that our national health system is ready for a move towards deinstitutionalisation?**

All the nurses in both groups unanimously agreed that the South African Health system is not currently equipped for a shift to deinstitutionalisation. A primary theme that emerged in response to this question was that there were simply no health resources available to cater for the treatment of psychiatric patients at community level. The lack of clinics, trained staff, patient residential facilities, sheltered employment, support groups and rehabilitation facilities were identified by the groups as being a significant barrier to a move towards deinstitutionalisation – this was expressed in the following manner: "There is a difficulty in this (deinstitutionalisation) being a policy because there is so much working against it…no money from the government, no clinics, poor referral systems and less staff...I shudder to think how we can even think of the deinstitutionalisation policy when we don't have anything" (sp.c – gp.2). "I think they need to restructure community services so that we have enough facilities for patients, like half-way houses, more nurses, sheltered employment…they are gonna actually have to look at a lot of the resources because presently in South Africa, we haven't got much"(sp.a – gp.1).

A further theme flowing from this discussion was that of consultation; the nurses felt that they had not been consulted about this move and that such consultation was necessary to ensure the efficient implementation of deinstitutionalisation. For example, one nurse stated: "They can implement it if they have got something from us as we are working in the community"(sp.b. – gp. 2). Hence, the groups felt that unlike themselves, the policy-makers were not aware of the realities and dynamics of community care and that such knowledge would be an essential guide to the implementation of deinstitutionalisation. There was also a sense of nurses feeling alienated from the entire policy decision making process, and this is reflected in the following statement made by a CPN: "The problem is that politicians are sitting and making decisions. They don't know much about psychiatry; they've got no interest in psychiatry. That is why we have these problems; they don't consult with us, they just take decisions into their own hands" (sp.e. – gp. 1).

The nurses also criticised the health system as being fragmented, vertical and duplicated and hence not conducive to deinstitutionalisation. Themes arising from this issue included the current lack of interaction and collaboration amongst the different clinics and between the clinics and hospitals. This was viewed as a significant limitation of the health system and one, which the nurses felt could jeopardise the success of the envisioned primary mental health care system. These views were stated in the following ways: "We are still functioning very, very badly…there is a lot of duplication – I'm running a clinic here, you are running a clinic there and we don't know about each other…so I don't think that any of this (deinstitutionalisation) will be worked out" (sp.a.- gp.1) and, "You know, we are in the community, but you will never get a hospital staff phoning you to ask for collatoral on a patient that is living in your area....if we don't go to the hospital, they will never call us to check up on a patient" (sp.a.- gp.1).

**d) Does the community have a role to play in the deinstitutionalisation movement?**

All the nurses pointed with conviction that the community played a significant role in the deinstitutionalisation movement. They also expressed the view that this role should be extended to patients' families as well. The roles that were envisioned for the family were those of being emotionally supportive to the patient and of playing an active part in the patient's rehabilitation process. This was expressed in the following way: "They (the family) have to take part in the rehab of the patient and get him out of this sick mind so that he will integrate himself into the community" (sp.e.- gp.1). The community members in turn, were viewed as vital sources of referral in terms of channeling patients towards appropriate mental health services when such needs arise. This was expressed as "If there is a major problem, then it can be referred to us. We can't be all over and this is where the lay person will be helpful" (sp. b- gp.1). "The community needs to be aware of the signs and symptoms of mental illness so that they can refer patients to the clinics" (sp.b- gp2).

A distinct theme in this discussion was the community's lack of acceptance of mentally ill people, for example, a comment that was made was "When people hear that somebody is mentally ill, that person is cast aside" (sp.c.- gp1). The nurses expressed that the stigmatising attitudes of community members towards mentally ill people have been observed as being largely detrimental to patients' prognosis. This was reflected in statements such as "In my career as a community psychiatric nurse, what has stood out is that patients who are accepted tend to be more stabilised than patients who are not. So, acceptance has a lot to do with the patient's improvement or non-improvement" (sp.a.- gp.2). It was articulated that a way in which the community's discriminatory attitudes manifested itself was with regard to the denial of employment opportunities for mentally ill people although such individuals may be capable of fulfilling the specific employment requirement/s. The nurses in turn expressed concern that unless consolidated efforts were made to educate the community about mental health, integration of the patient with his/her community may be far more damaging to the patient's health than institutional care has proven to be. Therefore, the need for community education was a dominant theme of this discussion. It was perceived that such enlightenment would serve to enhance attitudes to psychiatric patients and would thus alleviate stereotypical and damaging responses towards such individuals. This was expressed in the following way: "I think we need to educate the community and make them aware about mental illness so that they can pick up any person in the community who is mentally ill (refer them) instead of abusing them" (sp.b.- gp.2).

**e) What are some of the ways in which we can educate community members about mental illness and mentally ill people?**

Media sources were consistently cited as effective channels of education amongst both participating groups, and thus, media education was a dominant theme in this discussion. The radio was seen as the most popular and accessible source of media and was hence selected as the primary mode through which mental health educational programmes should be conducted. As an example, it was agreed in unison that "The radio is most effective because most people, even the poorest of the poor have got some form of radio". It emerged in the discussions that the government should play a large role in vigorous educational campaigns, such as fun runs, gatherings on mental health awareness, mental health awareness slogans and the like. It appeared that government involvement was required in order to fund such educational campaigns, and this was reflected in the following statement: "At the moment there are no education campaigns; the government feels psychiatric services are a waste of money" (sp.e.- gp1). This statement was also indicative of the nurses' perceptions of the lack of priority being accorded by government authorities to mental health care. The type of education that the nurses envisioned for community members was general in nature. This included "telling them what you mean by mental illness, what to look for and where to go when family or friends become mentally ill...so you have to stay at the grassroots level and then you can develop specific topics, but they ought to be educated from the bottom" (sp.b- gp1). Another nurse added that "Even in school, children should be educated about mental health, self esteem and things like that" (sp.e.- gp 1). In sum, it appeared that nurses felt that mental health education should be accorded higher priority and should operate in a way that ensures maximum community participation and learning.

f) **Do you think that you are adequately equipped to treat mentally ill patients in the community?**

A theme that emerged in response to this question was that of nurses feeling ill-equipped to treat psychotic patients at clinic level. Ingrained within this concern was a distinct sense of hopelessness in treating such patients within the community. This was reflected in statements such as, "Psychotic patients…they don't listen to you, no matter what you say. They will refuse to take medication if they don't want to take it. They will not be able to live in the community…never" (sp.a.- gp1) and "….with dangerous patients, what do we do when he comes in?...we are at a loss; what to do?" (sp.b.- gp2). Another dominant theme in this discussion was the nurses' concerns about the increased work-load that would be allocated to them with the implementation of community mental health care. They expressed that as a result, the quality of care that they would deliver to psychiatric patients may be compromised. This sentiment was expressed by the following comment "We just about manage to do the basic care; if they want to get patients back into the community, then the load becomes too much on the nurses. What happens is that you won't give off your best because you are overloaded" (sp.b.- gp1). There was also a general sense of agreement amongst the nurses that they would need additional training in psychiatry and other spheres of health care, such as pharmacology, community care, family therapy, group therapy and primary health care if and when deinstitutionalisation would be implemented. This was reflected in statements such as "We will need more training because a lot of responsibilities is going to be on us…we need updating on other spheres, apart from psychiatry"(sp.e- gp1).

**g) Do you think that mentally ill patients will be able to live successfully in the community if they are treated within the community?**

There appeared to be a sense of disagreement amongst focus groups one and two with regard to this issue. The participants of focus group one agreed that the outcome of patients living and being treated in a community setting was dependent on characteristics of the community itself. This was expressed in the following manner "If patients were adequately prepared and accomodated for in terms of medication, counselling, community rehabilitation facilities, community residential facilities and follow-up appointments prior to their discharge, they would be able to successfully adapt to a community context "(sp.a.- gp.1). Focus group two in contrast, viewed patient factors as crucial determinants of the success of patients residing and being cared for in a community setting. This was reflected in the following way, "It would depend on the condition of the patients...the severely mentally ill will not be able to be maintained in the community, so it will depend on the level of the mental illness of that client" (sp.e – gp2). "As long as they (stable patients) continue with their medication, they are allright" (sp.d- gp2).

A common theme between the two groups that emerged in response to this question was that historically White psychiatric facilities are significantly superior (in standard of care, facilities, staff, multi-disciplinary teams) than historically Black facilities. It was further expressed that this disparity in services directly affected the way in which patients responded to community-based care, where many White patients were observed as being able to reside at an optimal level within the community as compared to Black patients. This was expressed in the following way: "In my clinic, I deliver medication to a whole lot of White patients that are working...one is an assistant manager...you don't see that with our Black patients and that is because of the way in which psychological facilities have been run for Blacks in the past years...as they speak of rationalisation and equitable distribution of resources, we need to see that and we definitely haven't seen that"(sp.e- gp1).

This statement is also indicative of a sense of disillusionment amongst the nurses towards the stance that the government has adopted in terms of failing to accord priority to previously disadvantaged psychiatric services.

On an evaluation of the above analysis, it seems that although the community psychiatric nurses bear favourable attitudes towards the notion of the deinstitutionalisation of mentally ill patients, they are also uncertain as to the viability of such an option within the current South African social and economic context. It is apparent that they advocate a restructuring and advancement of community facilities and social services in order to make the aim of sustaining mentally ill patients in the community a viable option. Furthermore, the community psychiatric nurses' reasoning with regard to being consulted by governmental authorities on the efficient implementation of the deinstitutionalisation of psychiatric patients and the concurrent integration of such patients into the community is valid. Such consultation could substantially inform health authorities on the dynamics of treating patients at community-based level and could thus assist in the efficient administration of community-based mental health care. The nurses' willingness to play a substantial role in the deinstitutionalisation process and to also advance their training if required can be viewed as an asset to the movement of deinstitutionalisation.

## 5.3. ATTITUDES OF MENTAL HEALTH PROFESSIONALS TOWARDS DEINSTITUTIONALISATION

**a) What are your feelings towards the deinstitutionalisation of mentally ill patients?**

It was emphasised by all the participants that the theory of deinstitutionalisation was very impressive and that a community-based system of treatment was a functionally sound approach to delivering mental health care services. However, it was also expressed that in implementing this policy, the practical issues of such a move should not be ignored. Therefore, a theme in this discussion was that the success of this shift in health care was largely incumbent upon the style in which it was implemented. This theme was reflected in the following statement "I would like to say that it is a good concept; the objective is good…you know we must emphasise that. But what we are saying is that you cannot have grand ideas and not think of the implications" (sp.e). It was also evident that these concerns were based on reports of the outcomes of international efforts at deinstitutionalisation; as is apparent in the following quote "We need to avoid what has happened in some places overseas, which is just kind of chucking people out of hospital and ending up with a lot of dislocated people" (sp.a).

A compelling theme in this discussion was that deinstitutionalisation should be defined in terms of a reduction of psychiatric institutional care instead of a closure of institutional services .The need to retain inpatient care for those patients who would not be able to be sustained in the community was perceived as vital. This sentiment was displayed in the following manner "The reality of the situation is that you have individuals who are acutely ill and you still need places for them – whether they be in a hospital, a smaller unit or some form of in-patient facility…perhaps deinstitutionalisation doesn't mean the shutting down of hospitals; I see it as the down-scaling of hospitals" (sp.b).

A further theme that emerged in response to the above question was that of the motives underlying the policy shift of deinstitutionalisation. It was expressed that the motives of the Health Department for the implementation of the deinstitutionalisation policy appeared to be financial rather than humanitarian. In other words, the participants suspected that this policy shift was part of a national health cost-savings plan. The following quote is illustrative of this "They (health officials) say 'these hospitals cost a lot of money; let us move the patients out of there and put them into the community' on the theory that it may be more cost-effective" (sp.f). The participants argued however that deinstitutionalisation and the subsequent integration of mental health care with primary health care may not be a cheaper alternative to institutional care and that the costs involved in this restructuring process may hinder any hopes of community-based mental health care being a cost-effective system. This sentiment is displayed in the following statement, "In reality, I don't know how much more cost-effective it would be because you have to have such a build-up of services, whether they mean community, clinics or whatever...in reality it's gonna be such a big job" (sp.f). The last theme that arose in this discussion was that the *implementation* of the deinstitutionalisation policy was not anticipated as occuring in the near future. This conviction stemmed from the perception that "If you want to decentralise, if you want to go down to clinic level, then you really have to start investing in that level before you start looking at tertiary care...so I think it's (deinstitutionalisation) going to be a long time coming" (sp.b).

b) **Do you think that our health system is adequately prepared to take on this move towards deinstitutionalisation?**

It was generally agreed that there were substantial deficits in the current health system that may serve to hinder the progress of the move towards community-based mental health care. The poor social and economic development of communities was perceived as a significant obstacle to the implementation of community-based mental health care. This is evident in the following quote "The services out there (in the community) are not developed...and if we have not addressed the socioeconomic conditions of this country, we are still with problems" (sp.c). The lack of mental health care facilities in the community was also cited as an inadequacy and therefore professionals expressed "the need for resources such as half-way houses, day-care centers and rehabilitative facilities" (sp.d).

In this discussion, the participants expressed concern regarding the envisioned role of the primary health care nurse in the delivery of mental health care services. It was felt that professional commitment on the part of the nurses towards the treatment of mentally ill patients was necessary – this was stated in the following way "We have got to get them (PHCN) interested in doing that (treating mentally ill patients); get a group of nurses who are going to say 'fine, I'm gonna do the mental health as well' " (sp.e). A theme that arose from this concern was the need for PHCN to be competently trained in mental health care and psychiatry prior to their inclusion within the community mental health care system. This idea was displayed in the following quote "If you are helping something that you are not trained to help…look, they are not trained well in Psychiatry; so you need to train them in terms of drug-care, side-effects and what have you" (sp.e).

The theme of the financial implications of deinstitutionalisation pervaded this discussion. The health care system was criticised for allocating an insubstantial budget to mental health care, as is evident in the following quote, "The health system budget gives the smallest slice of the pie to mental health" (sp.b). It was held that the implementation of the deinstitutionalisation policy would need to be paralleled by an increase in finance allotted to mental health care in order to facilitate psychiatric training programmes for PHCN and for the deployment of additional community mental health care staff. Therefore, it was further argued that policy officials needed "to come down and and ask what are the financial implications, the legal implications and the medico-legal hazards that might be involved in this" (sp.e).

A further limitation of the health system was identified as the poor work conditions provided for mental health professionals in rural communities and provincial hospitals. This factor was cited as a major deterrent to enabling mental health professionals to choose to practice within such contexts. The following quote is illustrative of this "A lot of professionals do not want to work in rural settings and they are very loath to go and work in the provincial hospitals- financially because the pay is very bad and also because the conditions under which you work are extremely harsh…you've got very poor support services and the equipment and materials just aren't there" (sp.d). In response to this limitation, it was recommended that occupational incentives be provided in order to entice professionals to practice within such settings – this was expressed as follows "You need to give people incentives and make their stay worth-while, whether in terms of salary, subsidising cars, houses or whatever" (sp.e).

One of the roots of the inadequacies of the health system was identified as being that of poor communication systems between health policy authorities and health professionals. It was expressed that "there is a big difference between the decision makers and the people that are implementing the decision…these people (decision makers) have got different objectives; they look at things far differently and until you've got people to come together and look at things with the same eye, you are not going to win" (sp.e).

Tying in with the above sentiment, was the theme that the lack of psychiatric expertise amongst health policy makers may negatively influence the nature of decisions made. This is reflected in the following quote "These people (policy officials) may not even possess knowledge about mental illness…they don't care to come for a day at Fort-Napier hospital and see what happens; it doesn't interest them in the least. What worries me is that their lack of knowledge and expertise on mental illness may impact in a prejudicial manner on policies that have serious implications for the people concerned" (sp.f).

c) **Do you think that the community should play a role in the delivery of mental health services?**

All the participants unanimously answered in the affirmative to the above question. Therefore a dominant theme in this discussion was that of the pro-active role of the community in the deinstitutionalisation process. The following quotes illustrate the roles envisioned for the community in the shift towards community-based mental health care – "We are discharging patients into the community, so the community is their support-base...the community needs to understand what mental illness is so that they can pick it up and refer the patient to wherever" (sp.d) and "We also have to think about the large proportion of mentally ill patients who don't actually have family or representatives in the community to care for them.....you know, they are the responsibility of the community, even if the community doesn't want to take responsibility for them" (sp.b).

A marked theme that emerged in this discussion was that of the community's intolerant attitudes towards mental illness and mentally ill people. Such attitudes were understood as stemming from the community's lack of knowledge about mental health and were also observed as being detrimental to a patient's prognosis. The following quote is illustrative of this: "We see that if we go out with patients, they are not treated properly, they are ridiculed and this in turn causes them to have more problems because you get back and you are back to square one, no matter how much therapy you have done with them" (sp.d).

The participants in this study illustrated that a significant way in which the community's unenlightened attitudes manifests itself is in terms of the employment of mentally ill people. It was expressed that the stigma attached to mental illness leads to discriminatory attitudes in terms of job opportunities for mentally ill people, although such patients may be capable of fulfilling the job requirements. The lack of mental health awareness that was perceived by the participants as being inherent amongst the community members was also attributed to the fact that institutions themselves have created a separate identity for its' residents, especially because such hospitals are geographically "so separate from society" (sp.a).

The theme of community education arose in response to the recognition of the community's stigmatising attitudes. It was felt that educating the community about mental health would serve to quell the community's stereotypical attitudes. This was expressed in the following way "In terms of ways to counter stigmatising attitudes, I think that community awareness programmes would be helpful" (sp.g).

**d) Do you think that mentally ill patients will be able to live successfully in the community if they are treated within the community?**

The essential theme that arose in response to this question was that the success of mentally ill patients residing and being treated within a community context was incumbent upon a wider programme of social and economic development of the communities in which such patients would live. Speaker G related to the group, his experience in the UK, where community members were petitioning against the establishment of half-way houses for mentally ill people in their respective neighbourhoods. It was hence felt that such conflicts would only serve to hinder the success of attempts at integrating mentally ill patients with their communities. Therefore, the need for enlightening the community about mental health was raised again as an important mediator in the establishment of people's attitudes towards mentally ill people.

The other concern that was expressed was that not all types of mentally ill patients would be able to adapt to a community context. The following statement is reflective of this, "I think that there are some patients who cannot be cared for in the community, that is, acute patients and long-term patients. We have had the experience of such patients being discharged into the community and being readmitted to the hospital shortly afterwards...therefore such patients should either be treated in district hospitals or general hospitals that have a psychiatric unit" (sp.b).

On viewing the above results, it is apparent that, like the community psychiatric nurses, the group of mental health professionals perceived the concept of deinstitutionalisation as one which was positive. They however did have a deep awareness of the practical difficulties of implementing deinstitutionalisation within the current South African social and economic context. As a result, the mental health professionals were not positive towards the notion of implementing the deinstitutionalisation policy in the South African context, which they perceived as being economically and socially unprepared for such a move. As the results illustrate, the mental health professionals had definite ideas as to the most effective manner in which deinstitutionalisation should occur. There was also however, an agreement that due to the extended time that would be needed to address the pit-falls of the health system and the community setting, they did not anticipate the implementation of deinstitutionalisation to be occuring in the near future.

## 5.4. ATTITUDES OF PRIMARY HEALTH CARE NURSES TOWARDS DEINSTITUTIONALISATION

**a) How do you feel towards the deinstitutionalisation of mentally ill patients?**

Although a minority of the nurses expressed that the *concept* of deinstitutionalisation was good, the prevalent attitude amongst the participants, towards the deinstitutionalisation of mentally ill people was unsupportive. Such attitudes appeared to be influenced by nurses' perceptions of not being adequately prepared to treat mentally ill patients at community level, for example, one nurse stated "We are definitely not ready for it; the community nurses can't cope with that right now" (sp.a). The perceived lack of preparation centered on staff shortages, work-overload, poor infrastructure and lack of funds.

An overriding theme in this discussion was that of fear; especially fear of the mentally ill patient. Amongst most of these participants, mentally ill patients were perceived as violent, dangerous, unpredictable and therefore unable to be treated or coped with by the nurses and the community. This was reflected in the following statement: "I feel that the nurses, the health staff plus the community are not ready to cope with mentally ill patients" (sp.c.) and "They are institutionalised because they are violent and the community cannot cope with such clients" (sp.b). Furthermore, the nurses identified specific types of patients whom they felt could not be managed at community level – these included patients with mood disorders, schizophrenics and acute patients. Such patients were seen as only suitable for institutional care. Therefore, the nurses unanimously insisted that some level of institutional care was necessary for the treatment of patients whom they perceived as not being able to be managed at community level under any circumstances. A statement that reflects this perception is "You definitely need (institutions)...I mean they proved that in the UK 10-12 years ago when they deinstitutionalised a whole lot of patients, placed them in half-way houses, and then had to reopen the institutions a year or two later" (sp.d.).

A significant theme in this discussion was that of the motives underlying the policy shift towards deinstitutionalisation. The nurses expressed that "the government seems to be doing it (deinstitutionalisation) for economic reasons" (sp.d). The group was concerned that an *efficient* implementation of deinstitutionalisation may not be cost-effective because "you have to think of those families, the heavier work-load, more staff absenteeism, higher staff burn-out and stress" (sp.c). A further theme that emerged from this discussion was that of the implications of deinstitutionalisation for patients' families. It was expressed that deinstitutionalisation may be "better for the patient but worse for the family" (sp.d). The nurses were concerned that most families would not have the necessary resources to care for a mentally ill patient at home and would therefore not be able to sustain the patient. This was reflected in the following way "What kind of support is there going to be for the families who are going to be accepting these patients back....if the family is battling; I mean some families are so stretched; they've got the parents and the children all working and now they have got to care for this person, provide some care-giver and feed and clothe them. That's gonna be a big burden on the family" (sp.c.).

Tying in with the above, were also concerns that the deinstitutionalisation of mentally ill patients may be paralleled with an increase in the birth of children who would be genetically predisposed to mental illness. The quote that follows is reflective of this concern "You are possibly looking at an increase in the percentage of mental illness in a population due to institutionalised people being placed to carry on (procreate) as they wish to in the community" (sp.d). This statement is also indicative of the dominant, biomedical paradigm from which primary health care nurses function.

A strong theme that also appeared to be evident was that of the fear of not being able to cope with the additional work-load of treating psychiatric patients. This was reflected in the following way "I think that a feeling that I am feeling now is fear...our work-load at the moment is so heavy that if deinstitutionalisation takes place, it's going to place an incredible work-load on an already over-extended health service" (sp.e).

In this discussion, concerns were also expressed that the community itself would not be able to cope with the integration of mentally ill patients, especially because they were not educated on how to interact with psychiatric patients. The last theme that emerged in response to the question presented above was that of concerns about the psychiatric patients. The nurses anticipated that most patients would be unwilling to be deinstitutionalised because they would not be able to cope within the community. This sentiment was reflected in the following statement "I'd say about 70% of the patients wouldn't walk out of an institution because they are too frightened to manage on their own" (sp.d). It was also expressed that psychiatric patients may not be prepared for the socio-political changes that have recently occurred in South Africa "because they don't know what's been going on for all the time that they were institutionalised" (sp.a). Lastly, with respect to this theme, the nurses were also concerned that there would be no place of isolation in the community, which may be necessary for dangerous patients. Therefore, it was feared that "we are putting people into danger" (sp.b).

**b) Do you think that our national health system is adequately prepared for this shift towards deinstituionalisation?**

There was a unanimous agreement amongst the nurses that the health system was not efficient enough to endure a move towards the total closure of psychiatric institutions. A dominant theme in this discussion was that of the lack of resources (primarily financial resources) that would be necessary for the competent implementation of deinstituionalisation. It was felt that additional finance was needed to tackle the logistical issues that would arise when enforcing deinstitutionalisation. These included community education campaigns, community-based psychiatric facilities, employment of additional staff, psychiatry training courses for the nurses and patient residential facilities. This concern was expressed in the following manner: "There is a need to educate the community about mental illness...for all this education, they would need to have enough finance"(sp.g) and "We also need more resources like half-way houses, so definitely that will involve money...we need staff to care for them and all that needs finance" (sp.b), and lastly, "They are going to have to plan a refresher course for the psych trained people who haven't worked in the field and then for non-psych trained people there has to be a whole new programme for them, which again needs manpower and therefore money" (sp.c). Another theme that arose in this discussion, was that of the need for multidisciplinary teams in managing the care of psychiatric patients – this was expressed in the following way "We need more social workers, psychologists and psychiatrists…all members of the therapeutic team are needed on a larger scale" (sp.e).

The *modus operandi* of the current health system was also viewed by the nurses as a significant barrier to the success of deinstitutionalisation. Major themes arising from this discussion was the lack of interaction and collaboration amongst the different health authorities and clinics – this was reflected in the following way "I mean Durban (clinics and health staff) hardly talks to Pinetown (clinics and staff)" (sp.c). The lack of interaction and collaboration amongst different authorities was understood by the nurses as being a function of poor interrelations amongst officials at provincial and local authority levels, and it was argued that until "problems at that level get sorted out…because it's the attitudes of the people right there at the top that filters down to the people at the bottom doing the work" (sp.d), poor communication systems amongst different health officials and clinics would prevail. The current referral system was also criticised as being dysfunctional and therefore the need for a strong referral system was also recommended "so that community staff are very sure about where to go when something happens" (sp.d).

**c) Do you feel that you are adequately prepared to deliver mental health care services?**

It was noted that those nurses who had been trained in psychiatry (50%) felt adequately equipped to care for mentally ill patients at community level. In contrast, those nurses who had not been trained in Psychiatry expressed that they did not feel competent enough to deliver mental health care services. This was expressed in the following way "We definitely need proper training in order to deal with them (psychiatric patients) and I mean this is a specialised field we are talking about…..we are talking about a patient who has got definite needs" (sp.f). Hence, the need for additional training was a striking theme in this discussion.

Tying in with the theme of the need for psychiatric training for primary health care nurses, was the nurses' recommendations that either every clinic should employ a nurse with specialised, advanced training in psychiatry or that each clinic should have a separate wing that would be attended to by psychiatric nurses specifically. It was also expressed that apart from psychiatric training, established experience in treating mentally ill patients was an equally important requirement in delivering mental health care. A compelling theme in this discussion was that mentally ill patients and physically ill patients should not be treated in the same clinic. It was perceived that this would lead to volatile interactions amongst patients; this was reflected in the following way: "I've seen patients (psychiatric) coming in to our clinics on a Tuesday…with everybody else there, waiting there for 3-4 hours…they've also got their irritations and there are the other people (physically ill patients) with their own irritations…I don't see it working, I really don't" (sp.f). This perception was reinforced by speaker b, who related an experience of a psychiatric patient disrupting the activities of a clinic by lifting up her dress in front of the staff and patients. She indicated how they felt, "We were so embarrassed, because she was just picking up her dress…the other patients were so worried and embarrassed" (sp.b). Hence, it appeared that the nurses were primarily concerned about their management of mentally ill patients and how this in turn would affect patients' interactions.

**d) Do you feel that the community has a role to play in community mental health services?**

It was expressed that it was largely the choice of the community as to whether it envisioned a role for itself in the shift towards community-based mental health care services. This sentiment was displayed in the following statement "If they (community) want to; nobody should be forced to…you can't force anybody to get involved if they don't want to; you can't force the relatives of an adult mentally ill person to take that person back home" (sp.d). It was also found that the nurses were not very optimistic as to the impact of mental health education on attitudes towards mentally ill patients. This was evident in the following statements "Even if people are educated, they still can't cope…various people have various coping mechanisms; some people can cope with a lot and others cannot cope with anything" (sp.e) and "To try and modify a long established opinion is terribly hard – if the community has a set opinion about mentally ill people, it's going to be very hard to change that" (sp.d). Despite these perceptions, the nurses cautioned that efforts at community education on mental health should not be discarded.

A theme emerging from the above discussion was the lack of consolidated efforts aimed at creating an awareness of mental health amongst members of the community. The nurses attributed this to the inequitable deployment of financial resources to mental health care. This was reflected in the following way "I think that the problem goes back to the people at the top…it is the business about fighting about budgets and mental health has long been known as lagging in the budget…they don't see it as something that is really important and therefore it is not a priority as primary health care is at the moment…so they get the bigger budget" (sp.e). Additional perspectives that were offered in response to the above question were strategies of educating community members about mental health/illness. The media was cited as the most effective source of mental health awareness campaigns with the radio specifically being noted by the nurses as the most accessible media source. It was perceived as an efficient means through which the larger majority could be educated about mental health. Advertisements on busses, fliers and magazines were also viewed as reliable channels of mental health education.

In sum, the results of this analysis have revealed that generally, primary health care nurses are not conducive to the idea of the deinstitutionalisation of mentally ill patients. Essentially, the element underlying their lack of enthusiasm seemed to be that of fear . Specifically, they were fearful of mentally ill patients and the physical threat that they may pose. Their fear was also related to an additional work-load on an already extended service and a rationalisation of current financial resources available to primary medical health care. Professionally, they had fear of being ill-equipped to deliver mental health care services and the impact that their proposed role in community mental health care may have on their own mental health.

## 5.5. COMPARISON OF QUANTITATIVE ASPECTS OF COMMUNITY MENTAL HEALTH IDEOLOGY/ DEINSTITUTIONALISATION RESPONSES AND FOCUS GROUPS.

### 5.5.1. ATTITUDES OF COMMUNITY PSYCHIATRIC NURSES TOWARDS DEINSTITUTIONALISATION

The results of the Community Mental Health Ideology scale, where 84% of the nurses agreed that South African mental health care should move towards a model of community-based care and 87% disagreed that community care is an approach that is of little value in the treatment of mental patients, were reinforced by the results of the focus groups discussions, which indicated that all the participants agreed that the concept of deinstitutionalisation was positive. It was apparent that the questionnaire responses were better articulated through the focus groups on such issues. An emerging stance in the discussions was that, while all the participants agreed that the principle of deinstitutionalisation was positive, they did not agree that this principle was implementable in current South African conditions. The focus groups discussions also indicated that the nurses were of the opinion that if mentally ill patients complied with their treatment and if community mental health care facilities were adequate, such patients will be able to live successfully in the community. This is in unison with the results of the Community Mental Health Ideology scale, which indicated that 92% of the nurses agreed that mentally ill patients will be able to live within a community context.

### 5.5.2. ATTITUDES OF MENTAL HEALTH PROFESSIONALS TOWARDS DEINSTITUTIONALISATION

The focus group analysis displayed that the mental health professionals held the most favourable attitudes towards the idea of the South African Mental Health system moving towards a model of community-based mental health care. This is in unison with the results of the Community Mental Health Ideology scale, which revealed that 100% of the mental health professionals agreed that South African mental health care should move towards a model of community-care and 75% of the professionals disagreed that community mental health care was an approach that had little value in the treatment of mentally ill patients. The focus groups discussions in which most mental health professionals agreed that most mentally ill patients would be able to reside well in a community setting reinforced the results of the Community Mental Health Ideology scale, which revealed that 80% of the mental health professionals disagreed that mentally ill people will fail to live successfully in the community.

### 5.5.3. ATTITUDES OF PRIMARY HEALTH CARE NURSES TOWARDS DEINSTITUTIONALISATION

The focus group discussion with primary health care nurses indicated that primary health care nurses tended not to hold favourable attitudes to the notion of South African mental health care moving towards deinstitutionalisation and community-based mental health care. This was in contrast to the results of the Community Mental Health Ideology scale, which indicated that 75% of the nurses felt that South African mental health care should move towards a model of community-based care and an overwhelming 82% of the nurses disagreed that community-based mental health care is an approach that is of little value in the treatment of mentally ill patients. There was a general agreement amongst the primary health care nurses in the focus group discussion that most mentally ill patients (schizophrenics, psychotic patients, mood-disordered patients) would not be able to live successfully within a community setting. Once again, these results were not supported by the results on the Community Mental Health Ideology scale, which revealed that a majority of 86% of nurses disagreed that mentally ill patients will fail to live successfully in the community.

The contrasting results between the primary health care nurses' responses on the Community Mental Health Ideology scale and their responses in the focus group discussion with respect to their attitudes towards deinstitutionalisation could be taken to indicate that due to the sensitive nature of the statements posed in the Community Mental Health Ideology scale (which measured attitudes to deinstitutionalisation), the primary health care nurses responded in a socially desirable manner, preferring to record positive rather than negative responses. The focus groups however, which were more context-based provided a less formal and more interactive forum through which the primary health care nurses could freely express and elaborate their views and attitudes towards the deinstitutionalisation of mentally ill patients.

Descriptions of the results of this study have been explicated in chapters 4 and 5. Chapter 5 has also briefly discussed the focus groups findings. Chapter 6 presents an integrated discussion of the quantitative and qualitative results of this study.

# CHAPTER SIX

# DISCUSSION

## 6.1. INTRODUCTION

The purpose of this chapter is to integrate, summarise and discuss the results of this study. This chapter will begin by reviewing in turn, the status of each of the hypotheses and research questions that were explicated in chapter one. A careful examination of findings that strongly support, partially support or fail to support the research hypotheses will be presented. The discussion of each finding will be embedded within the theoretical context that was presented in the literature review in chapter two. As the writer marshalls her interpretation of this study's findings, areas of agreement/ disagreement between the findings and conclusions of this study with those of other similar studies will be considered. It is important to note however, that due to the paucity of literature on the attitudes of community psychiatric nurses towards mental illness, mentally ill people and deinstitutionalisation, and the attitudes of mental health professionals and primary health care nurses to deinstitutionalisation specifically, comparisons of this study's findings with the findings of other studies in respect to the above-mentioned areas will be limited.

An examination of the limitations of this study, followed by recommendations for future studies are presented finally.

## 6.2. ATTITUDES TOWARDS MENTAL ILLNESS, MENTALLY ILL PEOPLE AND DEINSTITUTIONALISATION.

The present South African socio – political climate of reconstruction and development is committed to addressing past inequities and imbalances, which were directed by the previous apartheid regime. By virtue of being mentally ill, psychiatric patients were not excluded from the discriminatory and oppressive treatment of the previous government. Currently however, the new socio-political dispensation has accorded greater priority to previously marginalised groups, such as the mentally ill. In particular, the treatment of mentally ill patients has received special attention. A deinstitutionalisation movement, paralleled by the introduction of community mental health care, has been supported through national health policy initiatives.

Implications of the shift in treatment modality for mentally ill patients bear strongly on the professional roles of community psychiatric nurses, mental health professionals and primary health care nurses. The model of community mental health care conceives community psychiatric nurses and primary health care nurses as front – line personnel in preventive and curative mental health care strategies. Mental health professionals, such as, psychiatrists and psychologists are envisaged as consultants or supervisors to the community psychiatric nurses and primary health care nurses.

The literature review of this study has helped to elucidate the importance of mental health care personnels' attitudes towards mentally ill patients, particularly in ensuring the successful implementation of deinstitutionalisation and community mental health care programmes. The present study therefore, set out to assess the attitudes of community psychiatric nurses, mental health professionals and primary health care nurses towards mental illness, mentally ill people and deinstitutionalisation.

In examining the attitudes of community psychiatric nurses, mental health professionals and primary health care nurses towards mental illness, mentally ill people and deinstitutionalisation, the present study found that there were no marked attitudinal differences amongst the three sample groups in their attitudes towards mental illness, mentally ill people and deinstitutionalisation. Community psychiatric nurses, mental health professionals and primary health care nurses tended to express relatively neutral, rather than strongly positive or strongly negative attitudes towards mental illness, mentally ill people and deinstitutionalisation. Thus, the hypothesis that community psychiatric nurses (CPN), mental health professionals (MHP) and primary health care nurses (PHCN) will differ significantly in their attitudes towards mental illness, mentally ill people and deinstitutionalisation was not supported by the results on the Opinions of Mental Illness (OMI) and the Community Mental Health Ideology (CMHI) scales.

Given their advanced knowledge on psychiatry and their prolonged contact with psychiatric patients, it is surprising that mental health professionals and community psychiatric nurses did not display positive attitudes towards mentally ill patients, as international research has suggested (Appleby *et al.,* 1961; Cohen & Struening, 1962; Lawton, 1965; Wright & Klein, 1966; Brockington *et al.,* 1993). It is possible that community psychiatric nurses and mental health professionals may be adopting a neutral stance to affirm their professional attitudes rather than their personal attitudes. To elaborate, it may be that as professionals in mental health care, they are trained to maintain a sense of objectivity when working with psychiatric patients, and thus, this is what is being reflected in their overall scores on the Opinions of Mental Illness scale (1962).

The focus groups discussions offer another perspective in explaining the findings that community psychiatric nurses and mental health professionals endorsed more neutral, than either positive or negative attitudes towards mentally ill people. The participants stated that their roles as mental health personnel were presently saturated. In other words, due to staff shortages, mental health personnel were allocated more professional responsibilities than they should have. Greater professional responsibilities amongst mental health personnel may be paralleled with prolonged contact with mentally ill patients. Hence, another explanation for these results suggests that the close proximity and the increased contact time in which these personnel work with mentally ill patients, may have created a less positive view of mentally ill patients. Support for this position is provided by Levey and Howells (1995) and Kolodziej and Johnson (1996), who argued that the nature of contact between a mentally ill patient and various individuals is important, as diverse types of contact appear to have a differential impact on attitudinal dimensions. To elaborate, they found that although contact is associated with differential attitudes, it did not serve to diminish stereotypical views of mentally ill people as being dangerous and unpredictable.

Given that research has found that mentally ill patients are sensitive to and influenced by the attitudinal atmosphere created by mental health personnel (Cohen & Struening, 1962), the neutral attitudes of community psychiatric nurses and mental health professionals towards mentally ill patients may impede the success of such patients' integration into community mental health care. This highlights the need for attitudinal changes amongst community psychiatric nurses and mental health professionals towards mentally ill patients. Bearing in mind that the prolonged contact between mental health personnel and mentally ill patients may be contributing to the mental health personnel's neutral attitudes towards mentally ill people, it may be useful to reduce either the length or the nature of such contact.

It appears that community mental health care, with it's emphasis on an integrated and adequately staffed health team approach, may assist in allaying the presently saturated roles of mental health personnel which fail to permit an 'objective distance' between a mentally ill patient and his / her professional care – giver. Thus, the phenomenon of psychiatric care being delivered by discrete multi – disciplinary case managers may be mitigated with the implementation of community mental health care. This, in turn, may assist in restoring positive attitudes amongst mental health care personnel towards mentally ill patients. However, as will be seen, such reasoning is complicated by the beliefs of mental health personnel that deinstitutionalisation may exacerbate existing problems.

With regard to the primary health care nurses, their generally neutral attitudes towards mental illness and mentally ill patients could be attributed to their lack of training and knowledge on psychiatry. Greater elaboration through the focus groups indicated that primary health care nurses perceived mentally ill patients as dangerous and unpredictable. It thus seems that an absence of adequate knowledge and exposure of primary health care nurses to mentally ill patients may have created misinformed and hence neutral attitudes amongst such personnel towards mentally ill patients. The neutral attitudes of primary health care nurses towards mentally ill patients which, appears to be based primarily on their fear of the mentally ill patient, illustrates the need for such personnel to receive training in psychiatry and mental health care prior to their placement in community mental health care programmes. Failure to do so may result in the primary health care nurses projecting their fears of mental illness on to the mentally ill patient, thus retarding the patient's assimilation with his / her community. Training programmes in psychiatry may challenge and subsequently temper the existing stereotypical attitudes of primary health care nurses towards mentally ill patients. This view is supported by Harding *et al.* (1983), who found that mental health care training programmes in seven developing countries led to appreciable transformations in the previously stereotypical attitudes and scant knowledge base of primary health care nurses with respect to mental illness and mentally ill people.

An absence of significant correlations between demographic variables and attitudes towards deinstitutionalisation, as well as the absence of significant differences in attitudes towards deinstitutionalisation is not easily explained, especially since there is no literature on these characteristics. Instead a more fruitful discussion might follow by examining these variables in relation to the rich information obtained from the focus groups.

The focus groups discussions permitted a closer examination of the finding that community psychiatric nurses and mental health professionals held generally neutral attitudes towards deinstitutionalisation. As was noted in Lee *et al.'s* (1997) and Dartnall and Porteus's (1998), studies, as well as in the present study, the generally neutral stance as indicated by community psychiatric nurses and mental health professionals on the Community Mental Health Ideology scale appeared to reflect that while these personnel were strongly in favour of the ideology of deinstitutionalisation, especially in it's emphasis on the integration of the mentally ill patient with his / her community, they were not in favour of it's implementation within the current South African socio – economic context. They perceived the present socio – economic context as well as the currently structured health system to be impoverished and inadequate to sustain a shift towards community mental health care. Community psychiatric nurses and mental health professionals cited a lack of community resources and professionally competent personnel, and most especially an inadequately informed shift towards community mental health care as significant barriers to the success of deinstitutionalisation.

The implications of the community psychiatric nurses' and mental health professionals' concerns are far – reaching. The full support of these personnel for the shift towards deinstitutionalisation is crucial, as such professionals are deemed to play a pivotal role in the delivery of community mental health care. However, it appears that policy – makers will fail to enjoy the support of these personnel until the short–comings of the community, economic and social contexts into which psychiatric patients will be deinstitutionalised are addressed. It is also worth noting that, in the face of current demands placed on the government to address broad economic development in South Africa, one cannot readily assume that improvements of the communities into which mentally ill patients will be deinstitutionalised, will become a priority amongst government officials. Mentally ill patients' generally poor prognosis and stigmatisation (even by government officials) may actually result in the mentally ill being further marginalised in development and health care planning. This possible marginalisation of mentally ill patients illustrates the need for a consistent informed lobby from mental health care workers, which should continually express the needs of psychiatric patients and aim to incorporate such needs into development programmes and policies. It is implicit however, that in order for such lobbying to occur, the support of mental health care personnel for community mental health programmes would need to be earned.

The support of mental health care workers could be attained through involving them in discussions around deinstitutionalisation, as their current lack of involvement in the structuring of the deinstitutionalisation policy was expressed by such personnel as a major concern. Implicit within this concern is the possibly greater feeling amongst mental health care personnel of being isolated from decision-making processes regarding deinstitutionalisation. This suggests that it may be useful for policy – makers to make consultation with key personnel (such as community psychiatric nurses and mental health professionals) a necessary prerequisite for the implementation of deinstitutionalisation. Thus, soliciting community psychiatric nurses' and mental health professionals' involvement in the structuring of the policy shift towards community mental health care may not only impart essential knowledge of the dynamics of community – based treatment for mentally ill patients, but would also tend to ensure greater support of such personnel for the shift towards deinstitutionalisation.

With regard to the primary health care nurses, the focus group helped to contextualise their generally neutral attitudes towards the deinstitutionalisation of mentally ill patients. The focus group discussion, which permitted more interactive and less formal responses than the OMI and the CMHI scales revealed that perhaps the relatively neutral attitudes measured on the CMHI scale tended to mask their fear of working with mentally ill patients. Moreover, the nurses tended to reject the idea of the deinstitutionalisation of mentally ill patients per se, as they perceived mentally ill patients as dangerous, volatile and unable to be integrated and treated at community level. The nurses' apparent rejection of the ideology of deinstitutionalising mentally ill patients appears to be a function of their fear of the mentally ill patient rather than a rejection of the concept of deinstitutionalisation per se. It would appear that addressing primary health care nurses' fearful attitudes towards mentally ill people is a necessary prerequisite to addressing their cautious attitudes towards deinstitutionalisation.

It is possible that the root of the nurses' fearful attitudes towards the deinstitutionalisation of mentally ill patients is their lack of knowledge of mental illness and mentally ill patients. Once more, the need for integrated and well structured psychiatric training programmes for primary health care nurses is emphasised as being an effective mode through which the nurses' attitudes towards mental illness, mentally ill people and deinstitutionalisation could be positively transformed. Such training programmes may dispel nurses' misconceptions of mentally ill patients and will also equip primary health care nurses to treat mentally ill patients at community level. The failure to enlighten primary health care nurses on mental illness, mentally ill people and community mental health care could result in many demotivated nurses delivering inadequate mental health services to psychiatric patients who have a special set of needs.

It was also interesting to note in the focus group discussion that most of the primary health care nurses were not clear on what a programme of deinstitutionalisation would entail. Their lack of clarity however, did not appear to be a function of their disinterest in the deinstitutionalisation policy. Rather, it appeared that these personnel had not been informed by policy makers and their respective authorities about the policy shift to deinstitutionalisation and the dynamics of such a shift. The primary health care nurses' uncertainty regarding the implications of deinstitutionalisation on their professional roles, as well as their scant knowledge on the dynamics of deinstitutionalisation could have also persuaded them to adopt a non – committal, neutral stance in their responses on the Community Mental Health Ideology scale. It is therefore recommended that policy officials make a concerted effort to inform the primary health care nurses on the shifts towards deinstitutionalisation and community mental health care, the professional roles envisioned for such nurses in these shifts and the dynamics of such treatment modalities. Isolating key personnel, such as, primary health care nurses from the structural processes of the implementation of deinstitutionalisation and community mental health care could result in a group of alienated care – givers who may feel coerced into working in a system which failed to receive their consultation.

In sum, the focus groups indicated that there *were* subtle differences in attitudes towards the deinstitutionalisation of mentally ill patients amongst community psychiatric nurses, mental health professionals and primary health care nurses. Despite concerns about the viability of implementing the deinstitutionalisation policy within the current South African socio – economic context, community psychiatric nurses and mental health professionals felt positively towards the ideology of deinstitutionalisation. The majority of the primary health care nurses in contrast, did not advocate the deinstitutionalisation of mentally ill patients, irrespective of the social and economic preparedness of the communities into which such patients would be deinstitutionalised. Nevertheless, the findings suggest that such attitudes may not be invariable, but could be susceptible to change through specific strategies.

It was expected that an individual's attitudes towards mental illness, mentally ill people and deinstitutionalisation would be related to his/ her demographic characteristics (such as age, gender) and would vary as a result of such characteristics, as has been suggested by previous research (Rabkin, 1981; Scott & Phillips, 1985; Brockington *et al.,* 1993).

The present study noted that there were no significant correlations or differences in attitudes towards mental illness and mentally ill people amongst respondents in various age groups, respondents of different genders, respondents with differing levels of professional experience, respondents whose family member was treated for a mental illness and respondents whose family member had no such history. A significant correlation was found between the variable of socio – economic status and attitudes towards mental illness and mentally ill people. This correlation was not however paralleled by significant differences in attitudes towards mental illness and mentally ill people amongst respondents in different social classes. Significant correlations and differences in attitudes towards mental illness and mentally ill people were also found amongst respondents of differing race groups, respondents with differing educational levels and between respondents whose friend/s was treated for a mental illness and respondents whose friend had no such history.

While the variable of age has generally been found to be related to attitudes towards mental illness and mentally ill people (Clark & Binks, 1966; Eker & Akar, 1991), no explanation has been provided for these relationships. Similarly, the absence of a significant relationship between age and attitudes towards mental illness in the present study is not easily explained.

The absence of a correlation between gender and attitudes towards mentally ill people, and significant gender differences in such attitudes may be attributed to the unequal distribution of the sexes in this study. Due to the preponderance of females in the nursing and mental health professions in South Africa, this study's sample was mainly constituted of females (88%). Therefore, a variable (gender) that was intended to be dichotomous, tended towards becoming univariate. There were thus no sufficient grounds for a distinction between the responses of the both sexes in this study. Other studies, which employed equal numbers of males and females found results that contrasted with those of the present study (Lyons & Hayes, 1993; Morrison *et al.,* 1994).

An explanation for the absence of a correlation and significant differences in attitudes towards mental illness and mentally ill people amongst respondents with differing levels of professional experience may be that respondents attained optimum levels in terms of their attitudes to mentally ill people during their formal education and training and hence, further change in their attitudes is not possible with more practical experience. This argument is supported by Eker and Akar (1991). However, it is worth acknowledging that most respondents (91%) in the current study had between one and three years of professional experience. This overwhelming majority may have obscured any distinctions in attitudes towards mental illness between respondents with varying levels of professional experience. One study (Poster & Ryan, 1989) which cites differences in attitudes towards mental illness amongst respondents with differing levels of professional experience employed greater numbers of respondents with vast professional experience than the present study did. Therefore, in addressing the present study's limitation, it would be useful for future studies to employ a sample, which is equally distributed in terms of levels of professional experience.

Given that a mere 22% of respondents stated that a family member had received psychological / psychiatric treatment, it is hardly surprising that results revealed firstly, an absence of a significant correlation between the psychological / psychiatric treatment of a family member and attitudes towards mental illness, and secondly an absence of significant differences in attitudes to mental illness between those respondents whose family received psychological / psychiatric treatment and those respondents whose family had no such history. It is possible that due to the stigma attached to mental illness, respondents did not wish to perceive their families as having been, or currently being mentally ill. This explanation may account for the small percentage of respondents who acknowledged that their family had received psychological / psychiatric treatment. It is recommended therefore, that in trying to gauge whether a respondent's family member/s had received psychological treatment, future studies should pose such a question more subtly and in a less obvious manner. This may elicit more accurate responses. More significantly however, concerted efforts need to be directed towards a wider programme aimed at addressing the general stigma attached to mental illness. Educational campaigns and mental health awareness programmes could perhaps facilitate the elimination of stigmatising attitudes to mental illness.

In explaining the significant findings on race and attitudes towards mental illness / mentally ill people, (particularly that White respondents displayed more positive attitudes on the Opinions of Mental Illness scale than African and Indian respondents), it is important to bear in mind that in contrast to the White culture in South Africa, which predominantly follows a Eurocentric, scientific conception of mental illness, the African and Indian cultures in South Africa generally conceives of mental illness as a result of sorcery and bad omens (Bhana, 1986; Uys *et al.*, 1986). Thus, although all the race groups in this sample were trained according to a Western, scientific model of mental illness, it may be possible that cultural conceptions of mental illness may play a more significant role in determining these professionals' attitudes towards mental illness than their educational training.

The perception amongst mental health care personnel that mental illness is the result of supernatural powers, rather than bio – psycho – social forces may negatively affect the manner of interaction amongst professional care – givers and mentally ill patients. In other words, viewing mental illness as being a supernatural phenomenon, which is beyond human control may lead the viewer to conceive of mental illness as being beyond scientific treatment and as having a poor prognosis. Such a belief on the part of health care deliverers may serve to compromise the quality of care being offered to mentally ill patients. An effective way in which to challenge supernatural conceptions of mental illness amongst mental health care professionals may be through targetting continued and advanced education campaigns on the etiology of mental illness, towards such personnel. In fact, Abiodun (1991) reports that with prolonged education campaigns, 'traditional' views of mental illness transformed into more scientific conceptions of mental illness amongst his sample of Nigerian mental health care personnel.

Socioeconomic status as measured in the present study was a function of economic levels. The significant, positive correlation between socioeconomic status and attitudes towards mental illness and mentally ill people may be a function of the generally greater access to knowledge and education that individuals in higher socioeconomic levels tend to have. Therefore, it is not surprising that middle – class respondents in this study reflected more liberal attitudes on the Opinions of Mental Illness scale than working – class respondents. Support for this position is provided by Hollingshead and Redlich (1958) and Dohrenwend and Chin – Shong (1967), who argued that upper – class members are better informed about mental illness and are thus more accepting of mentally ill patients than lower – class members. The explanation attributed to the present study's finding highlights the need for ensuring equal access to education. Thus, rigorous educational campaigns on mental illness may ensure that mental health personnel, irrespective of their social class, enjoy equal access to mental health education. This may redress the presently seeming imbalances in the knowledge - base of mental illness amongst general health and mental health personnel of different social classes.

The present study's findings that there was a significant, positive correlation between educational levels and attitudes towards mental illness / mentally ill people, with those with higher levels of education tending to hold more positive attitudes than those with basic levels of education, is in keeping with international and local studies (Wright & Klein, 1966; Malla & Shaw, 1987; Mavundla & Uys, 1997). The implication of this finding suggests that qualitatively advanced psychiatric training and education predisposes an individual to bearing more positive attitudes towards mental illness and mentally ill people than basic education in psychiatry. In aiming to transform attitudes towards mental illness and mentally ill people to become more positive amongst mental health personnel with basic levels of education, it may appear useful to create some degree of overlap between basic psychiatric training programmes and advanced psychiatric training programmes. The overlap could perhaps centre on key psychiatric concepts such as, mental illness etiology, which are likely to influence an individual's attitude towards mental illness. Training programme officials would however, need to be cautious in maintaining some distinction between basic levels of psychiatric training and advanced levels of training.

The current study's findings, firstly, of a significant, positive correlation between having a friend who received psychiatric / psychological treatment and attitudes towards mental illness and secondly, of respondents whose friend/s was treated for a mental illness holding more positive attitudes towards mental illness than respondents whose friend/s had no such history appears to indicate that contact with a mentally ill person is associated with a greater acceptance and tolerance of mentally ill patients. These findings may be understood to suggest that individuals who are friends with and perhaps even emotionally close with a mentally ill person possess more liberal attitudes towards mental illness and mentally ill people than individuals who have no such friendships. The non-stereotypical attitudes of respondents who have/had mentally ill friends towards mental illness and mentally ill people could be the result of personal experience with a mentally ill person, which may serve to challenge the respondent to view the mentally ill patient as an individual in his/her own right. These results are in concordance with findings elsewhere (Proctor & Hafner, 1991; Wilkinson, 1992; Kolodziej & Johnson, 1996).

It appears that the quality of contact between a mentally ill individual and his / her professional care – givers may play a significant role in influencing the care – giver's perception of the mentally ill individual. Institutionalisation tends to foster and perpetuate the labelling of mentally ill individuals as 'psychiatric patients'. Such labelling is not conducive to viewing a mentally ill person as a human being and tends to 'objectify' the relationship between a mental health professional and his / her 'patient'. It would be beneficial to avoid the labelling of mentally ill individuals, particularly by mental health professionals. In overcoming the tendency to label mentally ill people, mental health personnel may view the mentally ill person as an *individual* in his / her own right and not simply a *patient*. This in turn may lead to more positive attitudes towards mentally ill patients.

The fourth hypothesis in this study that attitudes towards mental illness, mentally ill people and deinstitutionalisation will be correlated was supported by the results of this study. These findings suggest that attitudes towards mental illness and mentally ill people may help us to gain a better understanding of attitudes towards deinstitutionalisation, and that if attitudes to deinstitutionalisation are to change, then such change should be preceded by a change in attitudes towards mentally ill patients.

The implications of this finding are far – reaching for education programmes that may be targeted towards transforming the attitudes of specific groups of personnel towards community mental health care. That is, from the perspective of psychiatric patients, the attitudes of community mental health care personnel who are going to be delivering mental health services to such patients is of primary importance in determining patients' integration into community mental health care. Hence, if existing negative attitudes of key role players towards mentally ill patients can be changed through training programmes to become positive, it is likely that such a positive change would extend to the key role players' attitudes to deinstitutionalisation as well. Therefore, in aiming to transform attitudes towards deinstitutionalisation to become more positive, it may be more useful to first transform attitudes towards mentally ill patients to become more positive. The only other related study, which assessed the relationship between attitudes towards mental illness, mentally ill people and community mental health facilities (Taylor, Dear & Hall, 1979) found similar results.

## 6.3. LIMITATIONS OF THE PRESENT STUDY

A limitation of this study is that of a sample bias. To elaborate, participants were selected on a voluntary basis. Therefore, it is likely that those participants who had volunteered to participate had more positive attitudes towards mental illness, mentally ill people and deinstitutionalisation than those participants who did not choose to participate.

Due to the sensitive nature of the questionnaires, it is possible that the research participants may have felt that they were being evaluated as professionals, and hence recorded socially desirable responses. Some indication of this bias is obtained by the qualitatively different responses that were elicited in the focus groups.

Despite assurances, some respondents were concerned on how their participation in this study would affect their job security. It is possible that this concern may have impacted on their responses as well, where they may have preferred to respond in a socially desirable manner. This may have created a bias in the results of this study.

## 6.4. RECOMMENDATIONS

The recommendations made below arise from the findings of this study as well as from recommendations made by key informants in the focus groups discussions.

Relative to developed countries, research on community psychiatric services in developing countries is scarce. Despite a few pilot projects on community psychiatric services in South Africa, little systematic research has been done in the field of community mental health care. If deinstitutionalisation is to proceed, the need for additional community mental health services and evaluative research into the area of community psychiatric services is crucial. Therefore, in trying to evaluate the success of the policy shift towards deinstitutionalisation, a premium should be placed on the development of pilot deinstitutionalisation programmes, where psychiatric patients are discharged into a structured environment that meets their mental health care needs within a community setting.

Such deinstitutionalisation programmes should be evaluated from their point of establishment in an ongoing manner. Evaluations could centre on a deinstitutionalised patient's quality of life, care – giver burden, cost features of sustaining such a programme and so on. Such evaluations may ensure that potential obstacles to deinstitutionalisation can be identified and consequently removed or controlled at the very least. Furthermore, the task of assessing the viability of deinstitutionalisation will be made easier with the development of such programmes as mental health programmes appear to differ in terms of their development at various sites. Such research may also serve to inform policy – makers on the viability of deinstitutionalising mentally ill patients within current South African contexts. Furthermore such research programmes would also help to provide a theoretical base to foster the development of deinstitutionalisation elsewhere. This, in the long term can contribute to the formation of appropriate and optimal forms of mental health service delivery.

Socioeconomic development is a necessary prerequisite for sustaining mentally ill patients at community level. The current study strongly recommends that mental health resources are adequately developed at social and community levels prior to deinstitutionalising mental health care. Unstructured deinstitutionalisation can result in ineffective patient care, homelessness and a generally poor quality of life for psychiatric patients. As has been previously cited, well – structured deinstitutionalisation programmes may not be necessarily cheaper than institutional care. A shift to deinstitutionalisation that is based on perceptions of such a move being a cheaper alternative to institutional care needs to be guarded against by policy – makers. Unstructured deinstitutionalisation, without the development of appropriate community resources and services could be extremely detrimental to the deinstitutionalised psychiatric patient.

The need for an increase in mental health personnel resources cannot be under-estimated. The introduction of a new dimension in the health system (that is, primary mental health care) demands that current staff shortages are addressed. Failure to do so may result in available mental health care personnel being burdened with additional responsibilities and compromised standards of care being delivered to psychiatric patients. Furthermore, factors like staff absenteeism and burn – out may be a possible consequence of staff being overwhelmed with professional responsibilities. Policy officials need to give careful thought on how to build in financial or career incentives in order to lure professionals to the field of primary mental health care.

Most of the present study's findings have unequivocally elucidated the need for concerted and rigorous educational campaigns that should be targeted towards various groups of individuals (such as mental health personnel, primary health care nurses, lay public). The substance of such programmes should vary according to the needs of each different group of individuals and should be moderated as such. Educational campaigns should however be informed by a sound theoretical understanding. Hence, research projects focussing on training programmes (with a bio–psycho–social orientation) with community psychiatric nurses, mental health professionals and primary health care nurses would be useful. Such training programmes should be aimed at challenging popular, negative stereotypes held by primary health care nurses about mentally ill people (such as, "all mentally ill patients are dangerous"), by equipping nurses with knowledge on mental illness and mentally ill patients. Apart from training primary health care nurses to diagnose psychiatric conditions, the aims of training programmes should be expanded to include the improvement of nurses' interviewing skills, primarily so that psychological and medical hypotheses are both considered during the clinical decision-making process in the assessment phase. Community psychiatric nurses should perhaps be trained further to impart psycho–education to patients and their families. Training programmes also need to be implemented for mental health professionals who have not been professionally employed in a community setting. In other words, it is important that the mind-set often fostered by working in an institutional setting be adapted to suit community mental health care.

Policy officials need to consult more with front-line workers regarding the proposed changes in mental health services if they wish to enjoy the support of these personnel in regard to deinstitutionalisation and community mental health care. Apart from gaining the support of key personnel, consultation would also provide policy officials with first-hand knowledge of the current status of mental health care at primary, secondary and tertiary levels. Such knowledge would efficiently inform the shift to deinstitutionalisation.

An intersectoral approach to the development of community mental health care needs to be fostered. Presently, development tends to occur in an isolated fashion, where sectors (such as the health sector, education sector) are developed independently of each other, without a broad, inclusive focus. It is thus suggested that mental health development occur through the various developmental forums operating in South Africa. Greater networking amongst the various sectors would serve to enrich the shift towards community mental health care, particularly through the development of community resources. This could thus facilitate the successful integration of psychiatric patients into their communities.

A multi–disciplinary approach is necessary within community mental health care programmes. Health care workers operating in isolation will not adequately meet the special needs of psychiatric patients. Integrated teams of psychiatrists, psychologists, community psychiatric nurses and other mental health professionals will be more beneficial to patients. These teams can provide patients and their families with a range of psychiatric as well as medical services. These teams can also be a convenient source of referral to personnel who may not bear sophisticated knowledge on psychiatry.

Given that community mental health care may introduce a range of additional responsibilities for community psychiatric nurses, mental health professionals, primary health care nurses and other health personnel, it is recommended that a support system for such personnel be developed. This support system should perhaps play the role of a buffer against the possible stresses and strains that such personnel may experience as community mental health care workers. Included within such support structures, should be the development of workshops on stress, coping strategies and related areas. Such supportive psychological interventions may maintain optimal levels of motivation amongst such personnel and could relieve the emotional strain experienced by working in a community setting.

Future research efforts need to be directed towards assessing the attitudes of community members towards mental illness, mentally ill people and deinstitutionalisation as they are also significant role-players in the successful social integration of mentally ill patients. An assessment of community members' attitudes would yield information on their preparedness to interact with mentally ill patients at community level or whether such members could be absorbed without support structures for families of mentally ill patients.

There is a need for more local research to assess the attitudes of key role players in community mental health care, towards mental illness, mentally ill people and deinstitutionalisation. The present study has assessed the attitudes of community psychiatric nurses, mental health professionals and primary health care nurses towards mental illness, mentally ill people and deinstitutionalisation. It would be useful to attain an understanding of the attitudes of other health personnel who are envisioned as chief role players in community mental health care (such as medical doctors, speech therapists). This knowledge would enhance policy–makers' understanding of the needs of service providers on a broad scale.

## 6.5. CONCLUSION

The present study may be viewed as an exploratory study within the areas of deinstitutionalisation and community mental health care in South Africa. This study has attempted to make some contribution to the development of the deinstitutionalisation policy, by expanding the base of information available to mental health care policy – makers in the area of community mental health care services. Furthermore, the study has aimed to provide an understanding of community psychiatric nurses' mental health professionals' and primary health care nurses' attitudes towards mental illness, mentally ill people and deinstitutionalisation, and how their attitudes are affected by a range of demographic factors.

A truism that seems to emerge from this study is that in our move towards deinstitutionalisation, we need to be guided by our clinical realities, our economic realities and our social realities. If these observations create a doubt regarding the appropriateness of deinstitutionalisation and primary mental health care within our current context, then it may be necessary that we take these doubts seriously. The limited economic and community resources does not preclude that an ideological shift should occur towards deinstitutionalisation within a model of primary mental health care. Rather, it suggests that in our haste to participate in transformational processes, we should not dismiss the realities with which we are confronted and which are bound to impact on the very systems we seek to transform.

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# APPENDIX 1

# ***ATTITUDES TOWARDS MENTAL ILLNESS, MENTALLY ILL PEOPLE AND DEINSTITUTIONALISATION.***

This study is about understanding the attitudes of mental health professionals, community psychiatric nurses and primary health care nurses towards mental illness, mentally ill people and deinstitutionalisation. Mentally ill people are those individuals, who, due to a mental illness are unable to function normally in certain aspects of daily life, such as in personal relationships, employment and living arrangements. Presently, in South Africa, many mentally ill people are hospitalised in mental institutions. The Department of National Health in South Africa has proposed treating mentally ill people in the community. This method is referred to as deinstitutionalisation.

Please respond to the questions which follow, as honestly as possible. There are NO RIGHT OR WRONG ANSWERS. Your responses are COMPLETELY CONFIDENTIAL.

I thank you for your co-operation.
F. Basheer

Please Turn Over...........

BIOGRAPHICAL DETAILS

AGE:______

GENDER: Male ☐ Female ☐

RACE: African Indian ☐ Coloured ☐ White ☐ ☐

OCCUPATION: (Please be as specific as possible)________________________________

NUMBER OF YEARS OF PROFESSIONAL EXPERIENCE AS A PRIMARY HEALTH CARE NURSE : (Answer only if you are a primary health care nurse).________

NUMBER OF YEARS OF PROFESSIONAL EXPERIENCE AS A COMMUNITY PSYCHIATRIC NURSE : (Answer only if you are a community psychiatric nurse).________

NUMBER OF YEARS OF PROFESSIONAL EXPERIENCE AS A MENTAL HEALTH PROFESSIONAL: (Answer only if you are a mental health professional at Fort Napier Mental Hospital).________

HIGHEST QUALIFICATION:______________________________

NET MONTHLY INCOME:

| R 1000-<br>R 1999 | R 2000-<br>R 3999 | R 4000-<br>R7999 | R 8000-<br>R 15 999 | R 16 000<br>+ | Other<br>(please specify) |
|---|---|---|---|---|---|
| | | | | | |

PLEASE TICK IN THE APPROPRIATE BOX.

A) In the last five years, has any family member experienced or been treated for depression, anxiety (nerves) or any other mental condition?

**Yes** ☐ **NO** ☐

B) In the last five years, has any friend of yours experienced or been treated for depression, anxiety (nerves) or any other mental condition?

**Yes** ☐ **NO** ☐

# APPENDIX 2

PLEASE TICK IN THE RESPONSE BOX WHICH BEST DESCRIBES HOW YOU FEEL.

| QUESTIONNAIRE ONE | STRONGLY DISAGREE | DISAGREE | NEUTRAL | AGREE | STRONGLY AGREE |
|---|---|---|---|---|---|
| 1. If parents loved their children more, there would be less mental illness. | | | | | |
| 2. People would not become mentally ill if they avoided bad thoughts. | | | | | |
| 3. If the children of mentally ill parents were raised by normal parents, then these children would probably not become mentally ill. | | | | | |
| 4.Mentally ill people can make very good friends. | | | | | |
| 5.All mentally ill people should be prevented from having children by a painless operation. | | | | | |
| 6.A heart patient has just one thing wrong with him, while a mentally ill person is completely different from other patients. | | | | | |
| 7.The patients of a mental hospital should have something to say about the way the hospital is run. | | | | | |
| 8.There is something about mentally ill peopl that makes it easy to tell them from normal people. | | | | | |
| 9.Although some mentally ill people seem all right, it is dangerous to forget for a moment that they are mentally ill. | | | | | |
| 10.People with a mental illness should never be treated in the same hospital as people with a physical illness. | | | | | |
| 11.Mentally ill people come from homes where parents took little interest in their children. | | | | | |

| CONT. OF QUESTIONNAIRE ONE | STRONGLY DISAGREE | DISAGREE | NEUTRAL | AGREE | STRONGLY AGREE |
|---|---|---|---|---|---|
| 12.Although patients discharged from mental hospitals may seem all right, they should never be allowed to marry. | | | | | |
| 13.Even though patients in mental hospitals behave in funny ways, it is wrong to laugh at them. | | | | | |
| 14.Many mental patients are capable of skilled labour, even though in some ways they are very disturbed. | | | | | |
| 15. The best way to handle patients in mental hospitals is to keep them behind locked doors. | | | | | |
| 16.More tax money should be spent in the care and treatment of mentally ill people. | | | | | |
| 17. Mental illness is an illness like any other. | | | | | |
| 18.The small children of mentally ill people should be raised by normal people. | | | | | |
| 19.Mental patients should not be allowed to vote. | | | | | |
| 20.If the children of normal parents were raised by mentally ill people, they would become mentally ill. | | | | | |
| 21.People with severe mental illness are no longer really human. | | | | | |
| 22.Most people who were once patients in a mental hospital could be trusted as baby-sitters. | | | | | |

| CONT. OF QUESTIONNAIRE ONE | STRONGLY DISAGREE | DISAGREE | NEUTRAL | AGREE | STRONGLY AGREE |
|---|---|---|---|---|---|
| 23.Many mental patients would remain in the hospital until they were well even if the doors were unlocked. | | | | | |
| 24.To become mentally ill, is to become a failure in life. | | | | | |
| 25.Most mental patients are willing to work. | | | | | |
| 26.It is easy to recognise someone who has had a mental illness. | | | | | |
| 27.People who are mentally ill let their emotions control them; normal people think things out. | | | | | |
| 28.One of the main causes of mental illness is a lack of moral strength or will-power. | | | | | |
| 29.Patients in mental hospitals are in many ways like children | | | | | |
| 30. Every mental hospital should be surrounded by a high fence or guards. | | | | | |
| 31.It is wrong to blame a mentally ill person for his/her mental condition. | | | | | |
| 32.Although they usually aren't aware of it, many people become mentally ill to avoid difficult everyday problems. | | | | | |
| 33.There is little that can be done for patients in a mental hospital except to see that they are comfortable and well fed. | | | | | |

# APPENDIX 3

PLEASE TICK IN THE RESPONSE BOX WHICH BEST DESCRIBES HOW YOU FEEL.

| QUESTIONNAIRE TWO | STRONGLY DISAGREE | DISAGREE | NEUTRAL | AGREE | STRONGLY AGREE |
|---|---|---|---|---|---|
| 1. Every mental hospital should have local people from the community who are given specific responsibilities, formally assigned with it. | | | | | |
| 2. Our way of diagnosing and treating individual patients is still the best way for us to function professionally. | | | | | |
| 3. With our limited professional resources it makes more sense to use established knowledge to treat the mentally ill than trying to deal with the social conditions which may cause mental illness. | | | | | |
| 4. Responsibility for patients extends beyond the contact one has with them in a mental hospital. | | | | | |
| 5. An important part of a mental health professional's job consists of finding out who the mentally disordered are and where they are located in the community. | | | | | |
| 6. Public health programmes like primary preventive services will be of little value to the mental health field. | | | | | |
| 7. A mental health programme should give specific attention to groups of people who are easily affected by upsetting pressures. | | | | | |
| 8. The planning and operation of mental health programmes are professional responsibilities which should not involve ordinary citizens. | | | | | |

| CONT. OF QUESTIONNAIRE TWO | STRONGLY DISAGREE | DISAGREE | NEUTRAL | AGREE | STRONGLY AGREE |
|---|---|---|---|---|---|
| 9. Mental health programmes should pay special attention to lowering the rate of new mental patients in a community by reducing harmful environmental conditions. | | | | | |
| 10. The mental health professional should try to advance his/her effectiveness by working through people in the community. | | | | | |
| 11. A mental health professional can only be responsible for the mentally ill who come to him/her; he/she cannot be responsible for those who do not come to him/her. | | | | | |
| 12.Gaining an understanding of the community in which a mental health professional works, should be made a central focus in his/her training. | | | | | |
| 13. Mental illness can only be controlled through psychiatric/psychological treatment. | | | | | |
| 14. A mental health professional is responsible not only for his/her set of patients, but also for unidentified mentally ill people in the community. | | | | | |
| 15. The current emphasis upon the problems of individual patients is not useful in treating a community's total psychiatric / psychological problem. | | | | | |
| 16. The mental health professional system should remain being one that treats individual patients instead of focussing on harmful social influences. | | | | | |
| 17. Efforts to involve citizens in mental health programmes have little value. | | | | | |

| CONT. OF QUESTIONNAIRE TWO | STRONGLY DISAGREE | DISAGREE | NEUTRAL | AGREE | STRONGLY AGREE |
|---|---|---|---|---|---|
| 18. The cause/s of mental illness should be seen as extending beyond the individual, and into the family, the community and the society. | | | | | |
| 19. Mental health professionals should only be concerned for their patients' well-being while they are in treatment. | | | | | |
| 20. Mental health consultation is a necessary service which must be provided to community caregivers who can help to care for the mentally ill. | | | | | |
| 21. Caregivers who worked with the patient before and during his/her stay at a mental hospital should be included in the development of his / her treatment plans. | | | | | |
| 22. A psychiatrist/psychologist can only be of help to those people with whom he/she has direct contact. | | | | | |
| 23. A mental hospital is only one part of a comprehensive community mental health programme. | | | | | |
| 24. Mental health professionals should only provide their services to individuals whom society defines as mentally ill or who voluntarily seek help. | | | | | |
| 25. We should not be concerned with changing aspects of a mental patient's environment but rather should focus on increasing his/her ability to cope with it. | | | | | |
| 26. It is a poor treatment policy to allow non-psychiatrists / psychologists to perform psychiatric tasks. | | | | | |

| CONT. OF QUESTIONNAIRE TWO | STRONGLY DISAGREE | DISAGREE | NEUTRAL | AGREE | STRONGLY AGREE |
|---|---|---|---|---|---|
| 27. The mental hospital and community should strive towards working together. | | | | | |
| 28. Community participation in mental health programmes is necessary to ensure it's success. | | | | | |
| 29. Seeing that there is a lack of mental health professionals, current resources should be used for treatment programmes rather than prevention programmes. | | | | | |
| 30. Each mental hospital should join the health and welfare council of the community that it serves. | | | | | |
| 31. The responsible mental health professional should become actively involved in social change. | | | | | |
| 32. It would be more useful to intensively treat a small number of patients instead of working indirectly with a large number of patients. | | | | | |
| 33. Generally, the practice of good psychiatry/psychology does not require very much knowledge about sociology and anthropology. | | | | | |
| 34. Community agencies working with a patient should not be involved with the different phases of his/her hospitalisation. | | | | | |
| 35. South African mental health care should move towards a model of community-based care. | | | | | |
| 36. Mental patients will fail to successfully live in the community, even if they are treated within the community. | | | | | |

| CONT. OF QUESTIONNAIRE TWO | STRONGLY DISAGREE | DISAGREE | NEUTRAL | AGREE | STRONGLY AGREE |
|---|---|---|---|---|---|
| 37. Community-care is a more effective approach to treating mental patients than treating them in a mental institution. | | | | | |
| 38. Unlike institutional care, community –care is an approach that is of little value in the treatment of mental patients. | | | | | |

**PLEASE CHECK THAT YOU HAVE ANSWERED EVERY QUESTION.**

**THANK YOU FOR YOUR PARTICIPATION.**