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Exploring social workers' experiences of providing mental healthcare services in hospital-based setting; The case of Medical Social Workers in Mpumalanga Province.

By

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DECLARATION

This work has not been previously submitted in whole, or in part, for the award of any degree. It is my own work. Each significant contribution to, and quotation in, this dissertation from the work, or works, of other people has been attributed, and has been cited and referenced.

Signature: ………………………………. Date: ………………………………

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DEDICATION

My God is my rock, in whom I take refuge, my shield and the horn of my salvation. He is my stronghold, my refuge and my saviour~2 Samuel 22:3. He has gotten me through what I would describe as the toughest year. I am where I am today because of his grace. An amazing God HE is. I also dedicate this study to my Shining Star and Blazing Sky, I want you to know that mommy loves you so much, and you were my greatest motivators for this thesis. I want you to know that time lost can never be regained, no matter what you go through in life, always push yourselves and never give up. Only you have the keys to your future, seek opportunities, knock on every door and never rest till you find what you're looking for. I love you so much and I want you to keep shining and blazing till the end of time.

Love mom

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ABSTRACT

The discourse of mental illness is construed as an inaudible epidemic throughout with prevalence in most countries of the world; it affects millions of people directly and indirectly. Due to the rising burden of these issues, social workers were added as mental health practitioners, amongst other professionals as enshrined in section 17 of the South African Mental Health Act of 2002. It visibly stipulates that the mental health practitioner should have adequate training. However, evidence suggests that social work training in mental health is inadequate in South Africa. The perceived self-efficacy and ecological theory were used to underpin the study, exploring social workers' experience in providing mental healthcare services in hospital-based settings.

The study utilised a qualitative research approach and exploratory design. In-depth interviews were elicited from respondents using a purposive sample of 20 social workers with experience providing community mental health care services for over five years in hospital settings in Mpumalanga province, South Africa. The findings indicate that a vast number of participants were of the feeling that training at the undergraduate level is inconsequential, inadequate and not in-depth for the mental health settings. This is said to make the social workers feel incompetent in the field. Secondly, participants experience is worsened by the dearth of social and professional support from the department, reporting to the medical manager instead of a social work supervisor is indicated to be a challenge for the majority. Lastly, social workers reported that in multi-disciplinary teams they are either overworked or marginalised and this result in a negative overall experience. The recommendations of this study are for tertiary institutions re-evaluate the social work training curriculum because mental health is sacrosanct and fundamental to be incorporated into the mainstream of undergraduate training for students specialising in social work. It is also important that the Department of Health recognises social workers, provide social and professional support through in-service training that can be managed by social work supervisors. Also, it is crucial that professionals in the social work profession should be recognised as essential members of the multi-disciplinary teams. It is concluded that social workers have negative experiences in providing effective mental healthcare services in hospital-based care settings.

CHAPTER ONE: INTRODUCTION

This chapter entails an introduction to the study; it presents the context of the problem, statement of the problem, the rationale and significance of the study. This includes aims and objectives, along with the research questions, assumptions and clarification of concepts relevant to the study.

1.1 Background and context

Mental health nowadays seems to be the greatest challenge facing our modern-day society. Understanding the root of this problem requires one to have a full understanding of the linked factors initiating this problem such as; social and psychological influences (Lund, Kleintjies, Kakuma & Flisher, 2010). Mental illness is construed as an inaudible epidemic throughout countries of the world, with increasing stigmatization of victims. The term mental illness is a universal term used in the description of a range of illnesses that seems to an individual thought process, behaviour, feelings and disposition towards others. Thus, it is a medical condition that unsettles a person's capability in relating to others, and their functional well-being on a daily basis (National Alliance on Mental Illness, 2013). In other words, any individual irrespective of age, gender, race, religion or sexual orientation can fall victim to the puzzle of mental illness. However, it has been found that it can be exacerbated by poverty, low levels of education, poor housing and low income (Lund et al., 2010).

On a global scale, studies have reported that, an estimate of 14% of the universal encumbrance of diseases are ascribed to mental illness, with approximately 75% of the people affected located in the low-income countries of the world, which includes an expansive range of diagnoses, with the most prominent mental illness comprising of anxiety and drug abuse, to severe illnesses like psychosis (Amuyunzu-Nyamongo, 2013). To put in context, the menace of mental illness affects up to 450 million people universally, and it is estimated that between 25%-50% of the adults' population would be affected with at least one mental disorder in their life epoch (Patel, Woodward, Feigin, Heggenhougen & Quah, 2010).

In the past, during which the apartheid government was in place, issues of mental healthcare were predominantly chiefly on institutionalised care. However, since the policy shift to universal primary health was established, there has been a paradigm shift to a process of deinstitutionalisation (Amuyunzu-Nyamongo, 2013). The adaptation of the policy has thus ensued with a breakup of specialised services and deprived worth of care accessible to the mentally ill patient as it were. This sensation has placed large amounts of compression on out-patient and community care-based facilities, with minimum specialised or appropriate services available (Petersen et al, 2011). This basically means that mental healthcare users are shifted from mental health hospitals to the community, local clinics, general hospitals, Non-profit Organisations (NGOs).

There is a mounting acknowledgement for the expansion and increase of employees in the confines of mental related work setting (Barlow & Durand, 2012). About 80 per cent of the population receives health care from the public health sector (National Department of Health, 2015). Social workers are now hired by mental health hospitals, general health hospitals, and other communities to deliver support to patients, their families and communities (National Association of Social Worker, 2015). On the other hand, social work practice in increasingly specialised environments and frequently assigned to specific medical units that are based on diagnosis, age or gender (Gibelman, 2005).

Social workers located within the hospitals are termed Medical social workers even though the term medical social work is not recognised by the SACSSP. The Department of Health has no precise document detailing the role and responsibilities of social workers (Silence, 2017). The hospital social work departments would have to advance a richer job description stating the specific task and functions of workers (Reish, 2012). With the department being short-staffed, social workers report to a clinical professional.

As already indicated, research is poor regarding the social workers' experiences and roles within the mental health care sector, predominantly mirroring from the South African lens (Lietchy, 2011 & Lund et al., 2010). The existing studies have investigated social worker's remit metal related illness out-patient and communal-based services, social workers' experiences in multidisciplinary teams, the importance of social work administration in the department of health, but none has looked at all these elements holistically to determine the full experiences of Social Work. Willems (2014) study also indicated the following on social workers in the mental health setting; social workers lack lucidity in job depiction and role vagueness is a causal factor to pressure, social work recruitment process is described to be more challenging than the other professionals in primary health care facilities and this result in high demand for workload and mental health social workers are reported to experience burn out due to limited social support.

According to Bland, Renouf and Tullgren (2009) "Social workers have particular expertise in helping people whose mental health problems coexist with other problems such as family distress, drug and alcohol abuse, unemployment, disability, poverty and trauma" (p.171). This means that social workers are best niched to recognise and respond to mental health problems because most of the time mental illness is strongly correlated with social determents. This makes it clear that social work is an important affiliate of the inter-professional primary team. The social work profession is identified as important; however, there is the minimum scope of social work practice in a mental health setting with regards to the range of roles, functions, responsibilities, activities that professionals are educated and authorised to perform (Aschroft, Kourgiantakis, & Brown, 2017). Research with specifics to the role and responsibilities of workers in the domain of mental health provision has been largely described as poor (Ragesh et al., 2015; Lund et al, 2011). Therefore, there seems a research chasm with emphasis on the experiences of social workers for the provision of mental

healthcare services within the South African context which necessitates such a study as it is aimed towards such an effort.

1.2 Statement of the problem

Section 17 of the South African Mental Health Care Act of (2002) construe the mental health care practitioner as “a psychiatrist or registered medical practitioner or a nurse, occupational therapist, psychologist or social worker who has been trained to provide prescribed mental health care, treatment and rehabilitation services” (p.6). The social work professional is thus denoted as a mental healthcare practitioner as stipulated by the Mental Health Care Act and; it visibly stipulates that the mental health practitioner should have adequate training. However, evidence suggests that social work training in mental health is inadequate in South Africa (Ragesh et al., 2015). For instance, as part of their practice requirements, social workers are often expected to use the provisions and guidelines contained in the Diagnostic Statistical Manual of Mental Disorders (DSM) and this weakens the quality of social work training.

Research, on the other hand, shows that social work training does not expose students to the mental health system (Smit, 2012 as cited in Olckers 2013). Limited research and few guidelines exist in the South African context which indicates what are the criteria and who should be given the responsibilities of diagnosing mental and related illness (Olckers, 2013). There is furthermore, no legislature that clearly stipulates or speaks of the DSM system or any other mental health assessment system utilized by social workers within the context of South Africa (Sewpaul, 2007 as cited in Olckers 2013). This has resulted in debates by various authors who are on the notion that social workers are not allowed to diagnose, they can screen but can't diagnose. Social workers are thus often left conflicted given these uncertainties.

Social work is one of the few non-medical service providers in primary healthcare, however, as already indicated greater clarity is needed to help social workers in the provision

of mental healthcare services (Ashcroft et al., 2017). This is more so because social workers often lack specialised training in mental health and are rather generalists (Beytell, 2014). Duncan (2008) as cited in Olckers (2013) contend that "generally trained social workers are out of their depth" in mental health multi-disciplinary teams and that only clinical social workers are trained to operate in mental health institutions and with mental health issues" (p.35). In fact, most social workers are battling with this issue of being recognised as mental health team members, other professionals question their tertiary level training in mental health (Nathan and Webber, 2010). On the other hand, the South African Council for Social Service Professions and the South African Association of Social Workers in Private Practice (SAASWIPP) does not give recognition to clinical social work as a separate specialised area distinct form of social work. Also, the modalities of practice for social workers in mental health practice in the Strategy Guidelines for Course of Conduct, Code of Ethics and Rules of Social Workers (South African Council for Social Service Professions [SACSSP], 2007) seems unclear.

A study by Ting, Jacobson and Sanders (2008) on social workers experiences with support systems within the mental health system, majority of the social workers reported that the available and known support system were clearly ineffective. The social work professionals are recognised as integral members of interdisciplinary hospital teams (National Association of Social Work, 2011). However, Webber (2012) argues that social workers in multi-disciplinary teams are marginalised and under-utilised.

Several other challenges have been reported related to social workers' role in inter-disciplinary teams. Firstly, other professionals, such as psychologist and psychiatrist not understanding the social worker's role, and this result in a barrier to inter-professional collaboration (Easen, Atkins & Dyson, 2000). Second, is the lack of scope of social work role which contributes to confusion among social workers and other professionals of the precise

remit of social work in mental health (Bikson, Blue-Howells & Seldin-Sommer, 2009). According to Sartor (2008), as cited in Olckers (2009), the role of social workers, particularly those in mental healthcare is yet to be fully addressed. A study conducted by Gray and Van Rooyen (2000) revealed that social workers are unsettled with the lack of recognition they receive and status relative to other professions.

Liechty (2011) posits that the information systems within mental health settings are largely feeble and there seems no recognized routine service delivery structure for the valuation of mental health care with emphasis to the South African context. Liechty (2011) also narrated that instruments for the nursing of service delivery within the mental health setting were frail, thus this indicated a necessity for the evaluation of mental health services. This is significant for social work precise services and their responsibilities in mental health, as research concerning their experiences with recourse to the South African context is underprivileged (Liechty, 2011). According to Skweyiya (2008), social workers work long hours, dealing with enormous caseloads, sometimes in testing physical conditions, in remote areas, often lacking resources.

As already indicated, research regarding the experiences and roles of social workers for persons with mental and related illness is pitiable, with emphasis to South Africa (Lietchy, 2011 & Lund et al., 2010). This study seeks to reconnoitre the proficiencies of social work practitioners in a hospital-based setting with regards to providing community mental healthcare services.

1.3 Rationale and significance of the study

The prevalence of mental illness is rising, and it accounts for a large burden of diseases and disability in healthcare. There is an ascending appreciation of the necessity for services related to social work within the confines of a mental health setting (Barlow & Durand,

2012). Social workers are now hired by mental health hospitals, general health hospitals, as well as communities to provide support to patients, their families and communities. However, there are no changes in the practice of social workers within the mental health service system, no change in the tertiary and in-service training (Aviram, 2002). As already indicated, research is poor with respect to the roles of social work in the mental health care, predominantly with reference to the South African case (Lietchy, 2011 & Lund et al., 2010). The existing studies have looked into social worker's remit in mental health outpatient and community-based services, social workers' experiences in mental health multidisciplinary teams and others social work DSM-training, etc., but none had looked at all these elements holistically to determine the full experiences of Social Workers.

It is hoped that the study will make significant contributions to research and knowledge on social workers' experiences within the mental healthcare practice. This research study hopes to offer professional development to social workers in the mental healthcare setting. This study will do so by questioning social worker's perceptions regarding their tertiary training in mental healthcare, and whether it has adequately prepared them to deal with situations they face on a daily basis in their work environment; in-service training as well as the availability of support and feasible policies within the work environment in order to engender effective mental health care services.

1.4 Aims and objectives of the study

The study seeks to uncover social workers' experiences of providing community mental healthcare services in a hospital-based setting in South Africa: Mpumalanga Province.

The specific objectives include to;

- Examine social workers preparedness of providing mental healthcare services.

- Identify professional support, accessibility and availability of resources to social workers in a mental healthcare setting.
- Examine social workers' experiences with working in multi-disciplinary primary healthcare teams.

Research questions

The research questions include the following;

- What are the social workers perceptions on their preparedness to providing mental healthcare services?
- What professional support is available to social workers to effectively provide mental healthcare services?
- What are the social workers' experiences in the multi-disciplinary primary healthcare teams?

Main assumptions

- Social workers are anticipated to offer effective services in the field of mental health regardless of necessary support guidance and receiving general undergraduate training (Silence, 2017).
- Understanding the extensive and diverse roles played by social workers is essential in comprehending the dwelling of social work in the mental health field (Conway, 2016)
- According to Skweyiya (2008), Social workers are reported to be dealing enamours caseloads thus putting on more hours, sometimes they have to work in conditions that are hostile in remote areas, often with resources that are minimal.
- Social workers in mental health multi-disciplinary teams are reported to be side-lined and underused because of their insufficient training with respects to on how pronouncements overtreatment is completed (Webber, 2012)

1.5 Clarification of concepts

Social worker. According to the South African Council for Social Service Profession, (2008a), the social work professional in South Africa is construed as possessing a four-year degree qualification in social work.

Mental Health. In the position of Lester and Glasby (2010), mental health is indicative of the capability to comprehend and make logic of our environments, to be able to manage with the change and to interconnect with others appositely.

Mental illness. This describes "a positive diagnosis of mental health-related illness in terms of accepted diagnostic criteria made by a mental health care practitioner authorized to make such a diagnosis" (Barlow & Durand, 2012 p.7). The term is additionally defined as being “a severe or emotional thought disturbances that negatively affect an individual’s health and safety” (Barlow & Durand, 2012).

Community mental health care services. This is explained as services delivered through public arrangements and establishments. In other words, which are closely merged into patients' physical and social environment (Lund et al., 2010).

Mental health care practitioner. A psychiatrist or registered medical practitioner or a nurse, occupational therapist, psychologist or social worker, trained to provide prescribed mental health care (Barlow & Durand, 2012).

Mental health services. This is construed as the evaluation of a person, analysis, management and prescription observance nursing, enlightening the patient and family members with respect to the diagnosis, adequate information provision in terms of the individual’s diagnosis, symptom management and medication adherence, support in the reintegration of the patient into society, employment support and overall psychosocial support are mental health services (Barlow & Durand, 2012; Petersen et al., 2009).

Multidisciplinary health care teams. In the context of this study, multidisciplinary health care teams consist of a psychiatrist, medical practitioner or a nurse, occupational therapist, psychologist or social worker who fairly share their professional expertise and develop an inclusive healing plan for clients (Valfre & Valfre, 2001).

Hospital-based settings. In the context of this study, hospital-based settings will be defined as services rendered to mental health care users who are hospital bound.

1.6 Structure of the thesis

Chapter One: This chapter comprises of general background, context and rationale and problem statement of the topic under investigation in the report.

Chapter Two: This chapter reviews the literature of the study being conducted. It focuses initially on the Social Workers' experiences in providing mental health care services, internationally and locally and their experiences in multi-disciplinary teams.

Chapter Three: This chapter explores the chosen theoretical frameworks that underpin this study.

Chapter Four: A comprehensive explanation of the study's methodology is presented in this chapter.

Chapter Five: Data analysis and empirical findings as aligned to the goals of the study presented.

Chapter Six: This chapter describes the conclusive section of the study and recommendations based on the research findings.

CHAPTER TWO: LITERATURE REVIEW

A literature review is an analysis of work written by other scholars in a particular field of study (Barzun & Graff, 1985). It is crucial for every study to explore and review the literature that is already in existence and come up with refined work. A literature review forms a crucial constituent of every study.

The starting point of any research is to acknowledge the work done by other scholars on the subject being studied. This helps the researcher to learn and understand how previous writers on the subject approached the problem as well as the recommendations and solutions suggested by them. A review of the existing literature also indicates the identification of research gap in preceding study and revealed how the research has fulfilled filling the vacuum of this identified gap (Delport, Fouche & Schurink, 2011).

Research specifically relating to primary care social work is limited (Walker et al., 2007). For a fuller understanding of the concept of social worker's experiences in mental health, the researcher read on various international contexts literature. Ní Raghallaigh, Allen, Cunniffe, & Quin (2013) steered a study on the experiences of social workers in primary care (Ireland). The finding indicated that the respondents like the general nature of their role and the fact they worked with non-mandated clients. Challenges reported by respondents were related to resources, management structures and inter-disciplinary work. This chapter reviews the social work history with emphasis on the mental health settings, the global mental health burden, the mental health burden in South Africa, mental health policies and legislation, barriers to effective provision of mental healthcare services by social workers, the responsibilities and functions of social workers in hospital-based care settings, social work teachings and qualifications in mental health and multi-disciplinary teams in mental health service provision.

2.1 History of social work in mental health settings

According to Aviram (2002), the social work profession has been enthusiastically enmeshed in the mental health field since the early stages of the profession's development.

Supported by Lubove (1965) as cited in Aviram (2002) that the social work history in its involvement in the mental health filed dates back to the latter years of the 19th century and the two decades of the 20th century. The specialisation in mental health care from the context of the United States began in 1906, wherein the United States Social Service Department of the Massachusetts General Hospital was established to cater for persons with the mental and related illness (Lubove, 1965 cited in Aviram 2002). The social workers were called the psychiatric social workers, and they were mainly involved in after-care of discharged mentally ill patients (Aviram, 2002). The title of Psychiatric social worker was selected by the occupation to designate the field of practice of social work within the mental health confinement (Grob, 1994).

In the 1920s psychiatric social work blossomed and reigned in the profession for several decades after. According to Wenocur and Reisch (1989) cited in Aviram (2002), the flourishing of psychiatric social work was related in part to the role of social workers during World War I. There was an establishment of training programs in psychiatric casework; the Smith College in 1918, the New York School of Social Work and the Pennsylvania School of School and Health Work in 1919 which provided the field with graduates that took further change in the orientation of the profession. In 1920, the profession accepted the psychiatric approach as the basis of all social casework (Lubove, 1965, cited in Aviram, 2002). The social workers were appointed to provide the nexus between patients, their relatives and societies, and to facilitate better discharge arrangement and community care of previous mental hospitals as well as other health-related agencies (Stuart, 1997, cited in Aviram, 2002).

The social work bearings led to the establishment of Mental Hygiene Clinics and Child Guidance Clinics, which resulted in moving from psychiatric social work and much closer to practice in the community (Aviram, 2002). Restrictions between psychiatric social work and other fields of practice within the social work setting were blurred by these trends. Means considered of resolving the problem of the wide-ranging population were the social psychiatry and casework and social workers were relocated into welfare agencies and family clinics (Brieland, 1995, as cited Aviram, 2002). After World War II, the social work practice expanded, particularly in the mental health field. In the beginning, the responsibilities of the social worker in the mental health field were limited to obtaining information regarding patients and their families. Their role later progressed to containing an obligation for stand-in as liaisons between the patient, his/her family and the institution (Aviram, 2002). However, the preparation of the patient for home discharge by psychiatric is utterly composed of the role of other social workers.

In the 1980s and 1990s in South Africa, the practice of social work was commonly specialised by different sorts of charity organisations, societies, settlements, youth services, child welfare services, hospitals and schools (Munson, 2002). During the apartheid regime, mental healthcare was mainly institutionalised; the shift towards deinstitutionalisation has become the emphasis of policies in the post-apartheid. For Lund et al, (2008) due to the closing down of institutions, some clinical social workers specialised in mental health has diminished, and this has led to workers working within the setting of health care notwithstanding inadequate understanding or teaching.

Deinstitutionalisation is thus perceived as a complicated process where the focus is on decreasing institutionalised maintenance, and in turn enhancing community-based treatment, repair and reintegration, toward effectively incorporating the mentally ill patient into society in an attempt to prevent stigmatization and discrimination against such individuals (Lund et

al., 2010). The social work profession thus cannot disregard the vicissitudes that have transpired in the system, because now it meant they had to be more actively involved in the health care system of mental health.

Social workers are now able to render various mental health services in different settings such as hospitals, rehabilitation programs, schools, military services, disaster relief and community mental health organisations (National Association of Social Workers, 2015). In order to have a clear understanding of the place of social workers in the mental health field, it is therefore important to explore the various policies and legislation. The researcher will, therefore, explore the global and local overview of social workers in mental health, alongside the available policies and legislation of the profession put in place (National Association of Social Workers, 2015).

2.2 The global mental health burden

According to Bezuidenhoudt (2016), the mental healthcare sectors in developing countries have unique challenges either leading or worsening mental health disorders. Globally, the number of people suffering from mental disorder keeps increasing. The figures from the World Health Organization (2016) show that about 10% of people suffer from mental health disorder across the world. In South Africa, this percentage is higher with nearly 30.3% of the general population suffering a medical disorder in their life (World Health Organization, 2016). Therefore, it is no strange to observe that despite the progress achieved in the diagnosis, management, and treatment of health mental health disorders, very few people are treated (Prince et al., 2007).

Mental health care remains neglected and not prioritised especially with regards to the allocation of resources; regardless of resources being equally distributed (Bezuidenhoudt, 2016). Prince et al., (2007) discovered a major gap between the amount of mental healthcare needs to be required, and the adequate services available. At about 14% of the world's burden

is triggered by a neurological disorder, yet over 30% of disability-adjusted life-years are caused by the same disorders (Consultancy African Intelligence, 2013). Consultancies Africa Intelligence (2013) further added that of the 75% of the affected group are those from under-developed countries, thus an increase is expected within the next decade.

Mental illnesses tend to dovetail with other physical illnesses including heart diseases, cancer and metabolic diseases and according to Jonsson and Joska (2009), the co-morbid is particularly relevant in the low and middle-income countries (LMICs) within Sub-Saharan Africa where the HIV/AIDS pandemic is rife and adds significantly to the encumbrance of neuropsychiatric diseases and disability. The Lancet (2007) states that mental disorders are answerable to amplified mortality due to perversity and reduced life expectancy. Approximately 86% of the 800 000 annual suicides globally occur in (LMICs) and this may be an underestimate as surveillance and reporting systems are often inadequate within these contexts (Prince et al., 2007).

2.3 Global mental health resources

According to Burns (2011) even with these alarming facts, services for mental illness remain universally inadequate. Advances have been made for promotion and prevention in general health; unfortunately, however, a similar account cannot be said for mental illness. Ignorance, prejudice and stigma are widespread, even worse in the Low and Middle-Income Countries (LAMIC) context. Widespread, systematic and long-term neglect of resources for mental health care in LAMICs was reported by the World Health Organisation's Atlas Project (Saxena et al., 2007). Approximately 60% of countries worldwide have facilities to train primary health care workers in mental health care, while society-based mental health care services exist only in half of LAMICs (Burns, 2011).

According to Burns (2011) within Africa and Asia, there are not enough beds, required for a patient that requires hospitalisation for mental illness. The researcher of the study agrees as with the above author because she has observed the situation at the hospital where she works in South Africa, whereby mental health care users are often based in hospital wards not designed nor suitable for mental health patients due to a shortage of beds.

The number of beds in African countries is 0.34 to 10 000 population and 73% of these are psychiatric hospitals. The situation is worse in Asia, with only 0.33 beds per 10 000 population and 83% of these located in psychiatric hospitals (Mental Health Atlas, 2005). In contrast, Europe is reported to have a median of 8 beds per 10 000 population and, except for some LAMIC countries in central and Eastern Europe, most of these beds are in community-based hospitals (Saraceno & Saxena, 2005).

There is also no equality in terms of trained mental health professionals between high-income countries (HICs) and LAMICS. The average number of psychiatrists in HICs, for example, is 10.5 per 100 000 population as opposed to low-income countries, where the average number is 0.05 per 100 000 (Shah & Beinecke, 2009).

Globally, mental health is funded from the general health budget, where they receive low priority; this is done especially in countries dealing with other major health issues such as HIV/AIDS, tuberculosis and malnutrition (Burns, 2011). Globally, most of the countries (a third) have no mental health legislation and policies, especially the LAMIC, while in Africa, only a half does. A large portion of those countries with the relevant legislation, it has either not revised for decades or it is poorly implemented. This leaves persons with mental illness without legal protection (Shah & Beinecke, 2009).

2.4 The mental health burden in South Africa

South Africa is a middle-income country with a population of 47 million characterised by multiple societal-level socioeconomic risk factors for mental illness (Burns, 2011). South Africa ranks 13th highest in the world, in terms of the proportion of the population living under the poverty line (50%); is second highest in terms of income inequality, 19th in terms of highest number of unemployment rate (24%), coupled with a high rate of urbanisation, lying 41st with a rate of 1.4% (Poverty in South Africa, 2004). South Africa has extraordinarily high rates of crime and violence, one of the highest road accident death rates in the world. According to the United Nations Office on Drugs and Crime (2005), South Africa now ranks within the top 30% of countries in terms of rates of opiate addiction.

South Africa is positioned at the epicentre of the HIV/AIDS epidemic in the Sub-Saharan Africa region has the 4th highest prevalence cumulative rate of 18%, and the highest number of people living with HIV/AIDS worldwide (Mundi, 2009). Despite these risk factors South Africa has been described as a country with racially discriminatory disjointed and inefficiently resourced mental health care services (Seedat et al., 2009). According to Lund and Petersen (2011), approximately16% South Africans are diagnosed with mental illnesses in the range of 12 months and that; an estimate of only 1 in 4 individuals of the affected individuals received treatment.

2.5 Mental health policies and legislation

Mental health is increasingly acknowledged as a crucial public health issue by global institutions such as the World Health Organisation (WHO), who have been engaging with governments worldwide to improve mental health systems. However, in South African, as in many developing countries, mental health doesn't feature as a public health priority; even though with the numerous policies and legislation, there is limited evidence on the delivery of mental health interventions. It is very crucial that the government and other stakeholders

understand the importance of implementing the process of interventions with regards to mental illness. In relation to the study, exploring social workers experiences in providing mental healthcare services, the researcher is going to review the following policies and legislation; The legislation contained in the White Paper on health care system (1997), Constitution of the Republic of South Africa (1996), the National Mental Health Policy Framework and Strategic Plan (2013-2020), the South African Mental Healthcare Act no 17 of 2002 and Sustainable developmental goals.

During the apartheid regime in South Africa, the focus and attention towards mental health services were centralised and institutionalised (Petersen et al., 2009). However, during the post-apartheid, there has been change, a policy shift, a process of deinstitutionalisation whereby mental health services was being decentralised (Lund & Petersen, 2011). Policies and legislative developments including policies contained in the transformation of the health system (1997), the National Health Policy Guidelines for improved mental health in South Africa (1997) and the most recently revised Mental Health Care Act (17 of 2002), which was promulgated in 2004 supported the process of decentralisation (WHO, 2005).

The policy reformation post-apartheid is well documented, very good on paper but not well implemented. Discussions on this leitmotif have evolved that the process of decentralisation and deinstitutionalisation have had an undesirable influence on service rendering and availability with regard to the mentally ill individual (Petersen et al., 2009). In South Africa, the Department of Health, especially in Gauteng has largely failed to deliver on the targets they have signed up for, following the Life Esidimeni tragedy. According to Lund et al., (2008) the process of deinstitutionalisation in South Africa was enacted at a fast degree, with poor comprehension to managing such implications. This process was meant to alleviate the stigma attached to mental illness and to reintegrate mental healthcare users with their families and community members, but the Life Esidimeni tragedy did more harm than good to

the mental healthcare users, their families and the country. The mental healthcare Act was not implemented accordingly, thus it had dire consequences.

Section 17 of the Mental Health Care Act of (2002) stipulates that there are functional primary healthcare clinics with appropriately trained personnel who offer psychiatric assessment and refer special cases to district hospitals if need be. The researcher of this study noticed that South Africa has not reached this level yet mainly due to mental healthcare remaining under budget. The Act section of de-institutionalisation in the researcher's views is that the process should begin after there are fully functioning community services that operate as they should according to the Act.

The South Africa constitution is no doubt one of the regulatory frameworks that well spelt out the modalities upon which South Africans are to be cared for. For instance, chapter 2 of the South African Constitution, which contains the Bill of Rights, lists a number of basic rights including the human rights to human dignity. In relation to this study, provisions of section 27 were explicitly applied to the rationale of this study. Section 27 of the constitution rightly spelt out the right to healthcare services. However, there is an important fissure amid mental illness essentials and the accessibility of excellence services towards addressing those necessities, with unspecialised care rendered through local hospitals (Faydi, Flisher, Funk, Kim, Kleintjies & Mawanza, 2011). The researcher will make use of the Life Esidimeni tragedy again, where the users were moved to unlicensed institutions where they were not receiving the care they required. Section 11 of the constitution, right to life is also relevant but we have mental healthcare users around South Africa who die from dehydration and hunger like the deaths reported from the Life Esidimeni tragedy.

The National Mental Health Policy Framework and Strategic Plan (2013-2020). Unfortunately, South Africa is generally in short of mental healthcare facilities and services.

One of the chief activities of the National Mental Health Action Plan contained in the Mental Health Policy Framework for South Africa and Strategic plan is to establish a specialised psychiatric hospital in Mpumalanga. This will be a great initiative, as Mpumalanga is the only province without a psychiatric hospital.

The South African Mental Healthcare Act no 17 of 2002.

Section 17 of the Mental Health Care Act of (2002) was generally recognised as one of the most progressive pieces of mental health legislation in the world. The purpose of the Mental Health Care Act (No 17 of 2002) is:

> "to provide for the care, treatment, and rehabilitation of person who are mentally ill; to set out different procedures to be followed in the admission of such persons; to establish Review Boards in respect of every health establishment; to determine their powers and functions; to provide for the care and administration of the property of mentally ill persons; to repeal certain laws; and to provide for matters connected therewith" (p.1).

Regardless of the increased focus, mistreatment of persons with mental illnesses continuous in most parts of the world. There are numerous, various incidents that illustrate policies poorly instigated in South Africa. The Life Esidimeni tragedy of a total of 1300 mental healthcare users who were discharged from the institution to organisations that weren't licensed or equipped to care for them is a good example. The transferring process of the patients was chaotic and degrading to the mental healthcare users.

The fortification accrued to mental health care users against abandonment, assured by the Mental Health Care Act was breached by the Department, regardless of several organisations matched against the move. Regardless of the new developed Act, there are many media reports of abuse of patients by the state, institutions or individuals throughout the world. Evaluation of the Mental Well-being Policy and Legislation

According to Lund et al. (2015), few provinces such as the North West have been working with researchers and NGO's in the programme for educating mental well-being care and therefore was said to be making progress. This introduces a question, how about the other provinces in the country? On the new policy and legislative framework, the data on the budget allocation of funds for mental health is non-existent (WHO, 2007). Mental health services are therefore funded through general health budgets (Burns et al., 2011). The fissure amid the encumbrance of mental illness and the absence of mental health resources and services in South Africa is reflected in a human rights issue (WHO, 2007).

In this study, the researcher agrees with Burns et al. (2011) that psychiatric hospitals are still out-dated and communal mental health psychosocial reintegration services persist to bet undersized. The researcher has observed that in most public hospitals, for example, Mpumalanga, there are no separate wards for mental health care users and other patients with no mental disorders. Even though the state is obligated to deliver amenities for the health desires of its people, amenities for the mentally sick patient are frequently insufficient and unreachable (Barlow & Durand, 2012).

2.6 Barriers to effective provision of mental health services by social workers

Mental health has been recognized as a significant challenge to global development and has been framed as a developmental rather than a purely public health challenge (Van Rensburg, Rau, Fourie, & Bracke, 2016). However, according to Okasha (2002) mental health

is still at the periphery of the global health agenda despite all global efforts of maintaining or strengthening the mental health system. Thus, among all global challenges and attempts to address the mental health is still lagging. Accordingly, absence of first-hand data has reduced the discernibility of mental illnesses in contrast with other illnesses and made it problematic to agitate for addition as precedence in health enterprises (Erskine et al., 2015). Hereunder, the researcher will discuss the factors that affect the provision of effective services to mental healthcare users, by social workers.

Mental health literacy (or Knowledge)

Mental health literacy remains a perilous factor in the delivery of mental well-being care by social workers. It helps individual to seek professional help or others to help those with mental sickness to access mental health care. Most individuals with mental sickness are unlikely to look for professional mental health care and wait and it worsens. In rural areas setting where mental health care professionals are few, mental health literacy among social workers is critical in promoting mental health care.

The phrase "*health literacy*" was first used in 1974 and since then it gained interest particularly from1990s (Pleasant, 2011). Accordingly, health literacy has several definitions. For example, the American Cancer Society defines health literacy as skills used to understand and interpret health information. Mental health literacy is closely related to the concept of health literacy. CDC (2011) describes mental health as being in a state in which a person understands his individual abilities to manage normal stresses of life and positively contribute to his/her community. Jorm, et al., (2000) defines mental health literacy as beliefs and knowledge concerning mental disorders that help in its recognition, control or prevention. Jorm (2002) observes that public knowledge and awareness of mental disorders has not been given similar attention as for other diseases like cancer. Being able to understand identify and

understand mental disorders is essential since it influences a social worker's attitude and conduct towards patients and their families.

Findings by Guiliver et al (2010) showed that improving mental health literacy among social workers increases their effectiveness in handling mental disorders and in educating the public, hence reducing stigma. Similar findings have been reported by Svensson & Hansson (2016) who established that increasing mental health literacy significantly improves professional mental well-being care provided. According to Burns (2011) despite commendable efforts taken by South Africa in upholding human rights for the people with disability, it appears that there is a high level of ignorance in the public health sector. Indeed, developing countries such as South Africa have unique challenges that either result or worsen mental health disorder. According to Swartz (2014), the history of apartheid and violence coupled with harsh economic situations, poor living conditions, and infectious disease increases cases of mental illness.

Jacob & Coetzee (2018) shares sentiments of Burns (2011) by stating that South African has not treated the vulnerable population. They note that though policies and the situation regarding mentally ill population have improved slightly in the last ten years, recent cases have shown that mental literacy and mental health care still needs considerable improvement (Jacob & Coetzee, 2018). For example, in 2016, against all professional advice to the government to transfer 1300 mental health patients from a mental health facility to organizations and agencies that were not adequately equipped to offer care for persons with mental and related illnesses. Within a period of four months, 37 of these patients had died (Jacob & Coetzee, 2018). In addition, more than 100 people suffering from mental illness died in Gauteng Province, and this was a big national tragedy. These cases underlined the importance of mental literacy among social workers who are at the frontline in providing mental health care.

Jacob & Coetzee (2018) agrees that mental health considerably impacts the health of an individual and the general society. There is no recent data on mental illness prevalence, but Herman et al (2009) posit in a survey done that nearly 30.3% of South African suffered from some kind of mental disorders in their life. The highest prevalence was reported in Western Cape at 39%. Medical social workers are usually the first responders to people with mental illness in Mpumalanga Province and other areas in South Africa. Therefore, it is critical that they are knowledgeable about mental health issues for them to offer the best professional aid in improving the eminence of life of the patients.

Socio-cultural factors. Cultural groups vary in their values and way of life. With regards to the relationship between culture and mental illness, Swartz (1998) contends that culture has a strong hold on an individual persons' manifest mental illness symptoms, relate symptoms, and survive with psychosomatic dares and their preparedness to pursue treatment. The values and beliefs of cultural groups influence the path of treatment and how the illness is expressed. In mental health care comprehending the role that belief and norms show on illness are important in analyzing and handling mental disorder. A lot of ink has been split by various scholars in an attempt to explain and emphasise the importance of comprehending the place of culture in the services of care and management of mental illnesses in South Africa (Sam & Moreira, 2012).

Culture plays an important role in mental illness through the inclusion of culture-bound disorders. This is a movement from the universalistic perspective that holds that all societies experience and express illness in the same manner. Culture-bound disorders are specific to a particular cultural group and through their expression might be parallel to other disorders. They are recognised as circumstantial and thus help to discover the experience of the illness from the patient's perspective.

Furthermore, the discernment of mental illness across cultures shows a part of the handling measures sought. The perception of mental illness as a mystical factor has led to most Africans pursuing the services of spiritual and traditional healers as they are perceived to have the ability to transgress into the spiritual realm where the illness originates (Sorsdahl et al., 2009). Swartz (2004) emboldens specialists to explore the cultures of their patients and increase their awareness of their discernment of illness and how this plays out and affect treatment and diagnosis. The understanding of clients and their cultural beliefs facilitate a move towards cultural competence.

Customary opinions and practices concerning disease and well-being are still broadly trailed in South Africa (Moletsane, 2004). These opinions and practices form a comprehensible arrangement that has upheld individual and communal symmetry for generations (Louw & Edwards, 1993). Among the alterations across beliefs and culture in Africa, there still remains a common confidence that illnesses are obtained from outward reasons including a breach of a forbidden or tradition, turbulences in communal relatives, unreceptive familial spirits, spirit possession, demonic possession, evil eye, sorcery, natural causes, and affliction by God or gods (Nwokocha, 2010).

Recognition by other health professionals. It is doubted by most mental health experts that social workers possess the necessary know-how to effectively deal with mental health (Beinecke & Huxley, 2009). There is a belief that employees in the social work domain lack the necessary understanding and abilities to work in mental health settings. This is due to the fact that the competencies and skills required for one to be a competent mental health social worker are not being trained and a lot of work needs to be done to describe desirable abilities and train the teachers and workforce of the future in them (Beinecke & Huxley, 2009). It is believed that only medical practitioners, clinical psychologist occupational therapist, and psychiatrist nurses are better qualified to care for persons suffering from mental illness. This

affects the social worker’s self-esteem, confidence and sense of recognition by other professional and makes them feel useless.

Scope of practice in Mental Well-being and role clarification. Social Workers working in the health locale are christened medical social workers, and medical social work is not recognised as a specialised field in South Africa, thus there is no specified scope of practice. Social worker's role in mental health is not clear, character vagueness is related to apprehension, downheartedness and it said to be subjective to workload (Caplan & Jones, 1975 cited in Willems 2014:8). Deficiency of lucidity in job explanation is noted as a causal issue of pressure amid mental well-being workers (Willems, 2014).

Lack of psycho-social support in a mental health setting. According to Ingram (2013) management is conventionally known as a procedure in which more knowledgeable mental well-being workers cares and offers a space for a supervisee to replicate on their practice. Morrison and Wannacot (2010) supports the above mentioned and adds that "Supervision is an integral element of social work practice" (p.1). Mental well-being workers are reported to often understand burn-out due to limited social support (Willems, 2014). Jackson (2014) states that the danger of social workers being uncared for by their employers or recognised is that it reduces their ability to care for their clients and this causes a struggle for both social workers and clients. In addition, Jackson (2014) study recounted that a total of 285 social workers reported that the maintenance structures that were usually accessible to them were not as active in having an encouraging impact. The researcher has observed that regardless of the challenges that frequently accompany the social work career, numerous social workers have initiate means of supporting themselves and each other through social network support groups. The social workers have groups where they share their challenges and experience. In these groups, the members' help each other find solutions and motivate each other.

Mental health caregiving by family members. Regardless of the increased focus on the wellness of the human person, mistreatment of individuals with mental illness continues in most parts of the world. Peterson, Pere, Sheehan, & Surgenor (2004) noted that most people suffering from mental illness are discriminated more by their family members and friends than from any other source. Social workers work with families of individuals who suffer from mental disorders. Undesirable opinions, including those suggesting that persons with mental illness are reckless and thus unqualified of creating their individual choices, are prevalent and adverse opinions often lead to discernment (Gureje, Lasebikan, Ephraim-Oluwanuga, Olley & Kola, 2005).

Traditionally families have been seen as contributing to mental illness - either as causing it or aggravating it (Riebschleger 2001; Marshall, Solomon Steber & Mannion, 2003). Most families prefer to keep the relative with mental illness away from them. They have at various times in the history of mental illness supported institutionalisation (by sending their relatives to psychiatric institutions) (Jones 2002). Many families have failed to assume a caring role for their relatives with experience of mental illness (Mason 1996).

Many mental well-being specialists view families as an annoyance (Angermeyer, Schulze et al. 2003). Families are considered by mental health professionals to be interfering and sometimes over-protective. Family members also reported a strained relationship with mental health professionals, who are perceived as being discriminatory towards family members (Angermeyer, Schulze et al., 2003). This may be because family are perceived by health professionals to be contributing to their relative's mental illness. This, Riebschleger (2001) argues, has been worsened by the fact that the families are uninformed about mental illness and the treatment thereof. Social workers thus face difficulties in dealing with people who are not willing to co-operate for different reasons.

The discernment against, and the humiliation of, persons with mental illness is common in societies (Sayce, 1998). It has an impact on the self-esteem (Link, Struening, Neese-Todd, Asmussen & Phelan, 2001) and recovery (Perlick et al., 2001) of people with experience of mental illness, as well as affecting all aspects of people's lives (Penn & Wykes 2003). Social workers' efforts to assist people with mental illness are therefore thwarted by society's negative attitude towards people suffering from mental illness. Magliano et al. (2004) revealed that family members of people suffering from mental illness do not recognize those people's civil rights to the same degree as the general public and mental health professionals do. This could mean that families are less likely to uphold and assist in the enforcement of those rights thus placing people suffering from mental illness at the risk of ill-treatment and harassment by other members of the society. The implications of this are that family members in this situation may be more likely to withdraw social contact and are less likely to support their relative with their experience of mental illness (Phelan, Bromet et al. 1998). The social worker thus fails to effectively assist the person living with mental illness since the people around him or her will not be treating the person with mental illness as a human being worthy of respect, dignity and equal protection of the law.

2.7 The responsibility of employees in the social work setting

The responsibilities and functions of a social worker in primary health care are minimally known, internationally (Muireann et al., 2013). Walker et al., (2007) agrees and adds that even research related to primary care social work is limited. Communal employees are employed in various settings such as hospitals, reintegration plans, colleges, armed services, adversity and communal mental well-being organisations to provide mental health services (Walker et al., 2007). Services delivered by community workers in Mental Well-being Units include comprehensive psychosocial evaluations, family and patients tutelage on diagnosis and management preferences, assisting in expressive modification to hospital admittance, disaster

interference among other services. Accordingly, “a mental health social worker is a professional individual with at least in possession of social work degree who is employed and works within the mental health setting care setting and gives health services in three (3) broad levels of health care namely, prevention, treatment and rehabilitation” (Muireann et al., 2013, p.121).

The social worker shows a decisive remit in advancing mental health services and mental health outcomes for citizens. Social workers are trained individuals who work in partnership with members of the society and other professionals (nurses and doctors) to improve the lives and living conditions of people. Although social workers are not medical practitioners in the strict sense, however, their expertise to deal with people in the anguish of mental illness has shown very usefully to both the individual suffering from mental illness and the society in general. Kennedy (2017) argues that the scope of social work in a mental health setting is a trifling one and the range of roles, functions, responsibilities, and activities that professionals are educated and authorised to perform. Even so, the researcher observed that generally trained social workers in South Africa play a crucial role in promoting and dealing with mental disease. Although social workers play a vital role in mental health, no or a little research is done on their experiences in providing mental healthcare services.

2.8 Social work training and qualifications in mental health

In this study, tertiary training refers to the opportunities provided to social workers in order to acquire and improve skills in mental health during their undergraduate level. According to the Canadian Social workers Association (2013), a mental well-being employee is an individual with a minimum degree of a Master of Social Work, who is employed in a mental well-being care domain and offers services in different levels of health care; promotion, management and reintegration. Employees in these settings are referred to as medical social workers, and clinical social work can be described as “a practice speciality in social work but build upon

generic values, ethics, principles, practice methods, and the person in environment perspective" (Brandell, 2010, p.7).

The general duration of an Australian Bachelor of Social Work courses is 4years. According to Sheehan & Ryan (2001), the four years study can be taken in any of three ways, as a full 4year integrated course, as a 2 years course or as a 3-year course after 1 year of another relevant first university degree. In order to be an eligible member of the Australian Association of Social Workers (AASW), for Australian-trained social workers, the decision is on the basis of an applicant's completion of a Bachelor's in Social Work (BSW) program. The social work programs are regularly reviewed by the AASW. In the United States of America, there has been some attention paid in the literature to the place of mental health in social work education. Wasow (1991) reported that the deficits of social workers for work in mental health care because of poor training in mental illness and suggested that there is a significant lag between what researchers have found, particularly in biological fields, and what educators teach in social work schools.

At the University of Cape Town (in South Africa), a clinical social worker must have a Clinical Master's Degree in Social Work (Petersen, 2008). Even before 1975, UCT had a clinical master's programme and trained social workers. According to representatives from social work department at the University of Johannesburg (Van Breda, 2008), Cape Town (Addinall, 2008), Kwazulu Natal (Motloung, 2011), Pretoria (Carbonatto, 2007) and Free State (Reyneke, 2008) cited in Olckers (2013), the institutions provide minimum training in mental health at the undergraduate level. Majority of the representatives according to Olckers (2013) seem to think that mental well-being is a specialized area, which that ought to have been upgraded and recognised at the level of postgraduate studies.

Numerous social employees report deficiency, management, public policy, and other non-mental well-being apprehensions and are not clinically skilled to practice the Diagnostic and Statistical Manual (DSM) system (Starnino, 2009). The researcher of the study is of the view with respect to the fact that tertiary training in South Africa for generic social work should be revised since according to Ragesh et al. (2015), a social worker in mental health is expected to have adequate skill in clinical evaluation, knowledge of (DSM) or International Classification of Diseases. Stromwall & Hurdle (2003) believed social work literature pays little attention to psychiatric rehabilitation.

According to Wilson et al. (2008), general practitioners and psychiatrist state that a need for better trained social workers is great so that they are more skilled in practised evaluation and intermediation, and for their role to expand as social aspects of mental health problems in order to receive wider recognition. The present scheme of social work training does not offer learners with adequate repetition learning (Clifton & Thorley, 2014). Zellman, Madden and Aguiniga (2014) state that, it is the charge of the social work occupation and social work training to train well-informed, capable and self-aware social workers who are proficient of offering effective services to people facing an extensive array of mental well-being problems or needs. Social work training must provide learners with professional psychological well-being understanding in other to work proficiently in the field, for instance, have awareness of mental well-being evaluation and mediation (including medication). They need to not lose the prospect of wider ranges of psycho-social essential such as accommodation, emotional reply to the complaint, family teaching and maintenance.

Addinall (2011) cited in Olckers (2013) states that mental well-being training is an internationally recognized field of speciality that requires specialised training. In South Africa, a social work expert is an individual with a four-year graduate qualification in social work (Addinall (2011). Stromwall & hurdle (2003) indicate that they are concerned because

numerous social employees persist to be unacquainted of the perspective and language used in mental health. Addinall (2011) cited in Olckers (2013) believes there is a great need for social work programmes on the undergraduate level and should include the following;

- The systemic perspective of the field of mental health,
- Impact of mental health on society from the following levels;
  - Individual
  - Family
  - Community
  - Societal level
- Legislation and policy governing mental health
- Recognising mental illnesses
- Knowledge of resources to refer to when needed

Qualification as a licensed clinical social work in the United States of America refers to a social worker legally accredited by a state government to practice clinical social work in the State. According to Gibelman (1995), the qualifications differ from state to state, but they all include an accredited school of social work, several years of supervised professional experience and successful completion of a social work licensing exam. About 41% of all outpatient mental health services in the United States are delivered by clinical social workers (Simpson, 2007). In South Africa, there is no accreditation for clinical social work category. For the current study, the researcher found that there is little literature within the South African context pertaining to who is a clinical social worker. Social workers, working in health settings (hospitals) are generally trained social workers, not specialised in-service training or undergraduate training. The current system of social work education does not always provide students with sufficient practice learning (Clifton & Thorley, 2014). Practice education is said to be a problem in mental health social work. In recent years there has been a decline in the

proportion of social work students completing a placement in mental health disability services instead. Recent estimates suggest that fewer than 8% of social work students complete a placement in a mental health setting. This, in turn, may affect the number of newly qualified social workers taking up posts in mental health teams (Clifton & Thorley, 2014).

Generally, completion of undergraduate degree grants the social worker the option to further their studies to obtain a master's degree in social work. Various institutions offer the qualification as a Research Master's degree (Full dissertation) or a Coursework Master's Degree with various specialization. According to the South African Council for Social Service Professions (2008b), the Masters' qualification compares to similar international qualifications for Social Work, verified through the South African structures affiliated with the International Association of Schools of Social Work (IASSW).

Simpson, Williams & Segall (2007) suggested that variance in the nature and depth of mental health content across U.S. Master of Social Work Courses is a cause for concern and reflects the differing views of academic and practitioners around what essential content comprises. In England, the regulatory body for professional social work, the General Social Care Council has not to our knowledge set out detailed mental health curricula content but has a more generalised mandate that social work students must undertake specific learning and assessment in human growth, development and mental health. According to Bland et al., (2010) social work in the UK does not address mental health content in social work course curricula, thus it could be said that Australia is leading the way in the development of specific mental health content of social work students.

In South Africa, there are very limited academic institutions specialising in Masters' degree in mental health work, including clinical social work (the University of Cape Town,

University of Johannesburg, University of Kwazulu-Natal, University of Free State and University of Pretoria). Social workers in healthcare settings have to use their skills acquired in their undergraduate training, with a minimum curriculum on mental health when providing mental healthcare services (Olckers, 2013). In this regard, institutions should offer an in-depth module on mental health for all qualifications with the possibility of working in primary healthcare.

2.9 Multi-disciplinary teams in mental health service provision

The multi-disciplinary team is regarded as the cluster of specialists from the diverse profession, that embrace interrelatedness with a number of professional perceptions that also share the same purpose that will give guidance towards decisions that must be taken therefore requires a great commitment to the collaboration and role identification (Abramson & Bronstein, 2004). The purpose is to undertake a holistic assessment, make professional recommendations, plan and provide the care for people who live with complex needs (Abramson & Bronstein, 2004). According to Kneils and Trigoboff (2008), the description of the roles of psychiatric professionals have developed and multiplied to the extent that other professional elements overlap others.

According to Olckers (2013), "in the South African context, daily interactions take place between health-related problems (heart diseases, depression and stress-related conditions), social problems (child abuse, substance abuse and violence) and socio-economic problems (high unemployment, limited education and poverty" (p.38). Craven and Bland (2013) add that teamwork is one of the most vital tools that can be used to form collaborative care that will help provide special care for families and individuals in the most sufficient and appropriate manner. Wilson et al., (2008) emphasise that teamwork is an important element of good practice in mental health is always meets the needs of the ill person (Wilson et al., 2008).

According to *Mental Health Care Act,* a mental healthcare specialist is regarded as a psychiatric or listed medical consultant or a nurse, professional psychotherapist or psychologist skilful enough to provide approved treatment, healthcare and rehabilitation services. Therefore, social workers should be recognized and appreciated just as much as other health professionals, because they are just as important and resourceful, therefore forming a joined cooperation with other professionals from different disciplines can help improve service delivery (Bronstein, 2003). The Mental Health Care Act contains a list of mental well-being employees and other mental health specialists from other disciplines that have to be aware of a patient's illness, in terms of their emotional and social aspects (National Association of Social Work, 2011).

Mental health teams provide various services in numerous settings such as management of patients, assessment including treatment (Kerr et al., 2007). Rajesh et al, (2015), states that social workers must have knowledge of DSM or ICD in order to be conversant with other health professionals. Lymbery (2006) however, argues that "the uncertain professional status of social work as being an impediment to collaborative work with other disciplines of perceived higher status such as medicine or those having the same status but, at the same time, greater 'public acceptability of their work such as nursing" (p.1124). According to Muireann et al., (2013) it is essential for roles to be clarified because it predicts job satisfaction in a multi-disciplinary setting.

E*xperiences of Social Workers in Multi-disciplinary teams.* According to Godden et al., (2010) in the mental health disciplinary teams, social workers gain different experiences, other members reported having gained higher level experience from high cooperation than the other members, as it enabled them to provide improved services of high quality to mental healthcare. However, there are certain social workers that reported to have had a bad experience in bringing about their social element acquired from their training in the assessment and treatment of

patients, due to their perception that they are being overworked yet undervalued by medical colleagues. However, Fickel et al., (2007) discovered that the lack of resources and understaffing has created a barrier between inter-professional and inter-agency collaboration.

According to the All-Party Parliamentary Group on Social Work (2013) report, the challenges experienced by social workers in multidisciplinary teams are listed as follows;

- Marginalised often
- Social workers often having to 'beat the door down to be heard' by medical colleagues.
- Social work managers are usually not included in making important decisions.
- Social workers are prevented from maximizing their full potential because of their low status.
- Lack of professional respect for social workers from their medical colleagues.
- Sector leaders and specialists fail to bring out the positivity on the social work function.

Webber (2012) believes the underutilization and marginalization of social workers in multi-disciplinary teams are due to their different perception and conception of how patients should be treated from other health professionals. He adds that medical professionals are trained to justify decisions, while social workers knowledge and education limits them to reliance on tacit knowledge gained through continued exposure to service users.

Conclusion

Mental illness is a global epidemic that affects everyone, directly and indirectly. Due to mental illness overlapping with other disorders (physical and mentally), it requires various professional practitioners to collaborate to treat it. Social workers are declared as mental health practitioners by the Mental Health Care Act thus their experiences are impacted by their training at tertiary level, support by employers and other professionals, and their role clarification within multi-disciplinary teams. Even so, various works of literature nationally

have indicated the importance of social workers in mental health. This is of great contrast to the mental healthcare state in South Africa, as there is minimum literature in support of social workers in the mental healthcare field. Literature on Social Workers' experiences in providing mental healthcare services in the South African contexts is minimum, thus this thesis aims to contribute to the body of knowledge in this particular field.

CHAPTER THREE: THEORETICAL FRAMEWORK

A theoretical framework refers to the agenda, outline and theoretical paradigm of a research approach and usually comes before the literature review. Furthermore, a theoretical framework can be described as the structure that holds and supports the theory of the research study. Moreover, a theory explains the justification for making forecasts about the associations among variables of the intended research study. According to Sinclair (2007), a theoretical frame of analysis can be taught of as a plot or travel blueprint; however, Sinclair (2007) cautions the necessity of investigator to appraise the framework and synthesise data consequences at each stage of the research progression to further improve, examine or confirm relationships between the variables. This chapter critically reviews the self-efficacy and the ecological systems theory.

3.1 Self-efficacy theory

With respect to this study, the investigator reconnoitred the experiences of social employees with regards to providing mental health services. It was important for the researcher to note that the state of "experiences" in this regard may be influenced by the social workers' tertiary training in mental healthcare services, in-service teaching of social workers in mental healthcare as well as the availability and accessibility of resources, support and feasible policies within the work environment to provide skilled mental healthcare services. Consequently, in order to specifically analyse the "experience" aspect of the research focus, the researcher utilised the self-efficacy theory. This Theory was propounded by Albert Bandura, it is a portion of the larger philosophy, the Social Learning Theory (Ashford & LeCroy, 2010), which has developed into the Social Cognitive Theory.

> "perceived self-efficacy is defined as people's beliefs about their capabilities to produce designated levels of performance that

> exercise influence over events that affect their lives. Self-efficacy beliefs determine how people feel, think, motivate themselves and behave” (Bandura, 1994.n.p)

For this study, the goal is to uncover social worker involvements and this theoretical framework underpins the study as it requires social workers to evaluate their competency in the hospital setting. The participants were requested to assess their ability to provide mental healthcare services effectively. This theory was used due to it depending on one’s judgement of their performance, it does not manifest uniformly across activity domains and situational conditions but differs across tasks and contexts (Bandura, 1994).

In addition, self-efficacy denotes to an individual self-belief with respect to the capability to achieve precise responsibilities, has been revealed to be a dependable judge of both incentive and task presentation, and to impact individual goal setting (Iroegbu, 2015). Furthermore, although, Bandura's Social Cognitive Theory explains how cognitive, behavioural, personal and environmental factors interact to determine motivation and behaviour (Crothers, Hughes, & Morine, 2008). In the perspective of this study, self-efficacy is described as social workers' beliefs in providing effective mental healthcare services (influenced by tertiary training, in-service training and available resources, support, and feasible policies in the workplace) that they have the capability and competence to provide mental healthcare services

The social work profession is uniquely challenging as well as rewarding, hence, social workers expected not to master varied theories and practical skills but they are also anticipated to use their educational capabilities to endorse social justice, authorize the burdened, heal the injured, and celebrate assortment and do so with honesty, self-awareness, and admiration for the worth and dignity of all persons (International Federation of Social Workers, 2001).

Similarly, Lawlor (2008) construed social work as an occupation saddled with the promotion of communal modification, difficult deciphering in human dealings, and the authorization and emancipation of persons to improve comfort; utilising philosophies of human behaviour and communal schemes, social effort interferes at points where persons relate with their environment; ideologies of human rights and societal impartiality are important to social work. Thusly, the researcher can conclude that if the self-efficacy of a social worker is elevated, this is more likely to have a positive influence on work performance. Also, if the self-efficacy of a social worker is low, work performance is more likely to suffer. This is confirmed by Iroegbu (2015) in stating that an individual with respect to robust sagacity of individual capability in that area, approach difficult task in that purview as encounters to be grasped rather than as hazards to be evaded; Conversely, people with low self-efficacy might consider that things are harder than they actually are, a conviction that nurtures pressure, unhappiness and a thin vision in what was best to resolve a problem.

3.2 Ecological systems theory

In order to understand mental health care and provision of service, a vast overview that includes and reflects all likely important issues to the wants of the psychologically ill is required. This will be best done within the ecological systems theory of human development propounded by Bronfenbrenner. The assumption of this theory is a mutual method of environmental ideologies and structures first offered by Bronfenbrenner in the 1970s as a theory of human improvement (Brofenbrenner, 1994). The approach is of the view that in order to comprehend human expansion, the whole structure in which development occurs must be measured. It is very crucial to recognise the verity that theories possess sure expectations about human nature, human behaviour (or actions), and the extent to which organizations and traditional customs constrain and enable human feat (Brindis, Sattley&Mamo, 2005).

Brofenbrenner (1994) developed this theory centred with the idea that the environment a person subsists comprises of up of three essential systems such that take a straight influence on each other and the overall working of the person. These structures tend to define the inspirations prevailing in an ecosystem as being intercultural, community-based, organisation, relational and individual (Bronfenbrenner, 1994). "The chief emphasis of social work practice is on the association linkages between a person, their natural support resources, the prescribed structures in their communities, and the communal norms and beliefs that shape these interactions" (CASW National Scope of Practice, 2000:2).

Systems' theory is when behaviour is prejudiced by a diversity of issues that function jointly as a scheme. For example, a mental healthcare user's parents, friends, school, economic class, home environment and all other factors influence how a person thinks and acts. This approach emphases on a person as a portion of an assimilating with other arrangements and this model works to analyse the communal background and highlights a communal concentration to address problem circumstances (Payne, 2005). In providing mental healthcare services, communal employees must discern and analyse all the schemes that donate to an individual's behaviour and wellbeing, and work to reinforce those structures. This is because the focus should be placed on how a person interacts with their environment.

"The social work occupation indorses social change, problem deciphering in human dealings and permission and emancipation of people to improve well-being. Applying theories of human behaviour and social systems, social work interferes at the points where people interrelate with their environs. Philosophies of human rights and social justice are essential to social work. Systems theory advocates that a person does not occur in a void instead they fit the household, communal and ethos which inspires them and in turn likewise impact the structure. Therefore the reciprocity of the communication amid the community, social workers, people with mental illness and the instant setting best clarifies their growth, the socio-economic

encounters they face with the way they deal with these encounters. Social workers are involved at micro, meso, exo and macro levels in all sectors.

Micro-system level

According to Bronfrenbrenner (1994), the micro-system denotes the relations of the emerging individual and their close background including school, family, neighbourhood and peer. Furthermore, the author says persons in their own micro-systems are continually formed by not only their situation but by the happenstances and other persons they come in interaction with. Thus the means people with mental dares deal with their life contests typically depends on how helpful their instant environment is concerning the mitigation of those dares. Hence the systems theory will help in providing more light on paying more attention to how their immediate environment impacts on their mental health. At this level, the social worker is chiefly concerned with "the societal well-being of individual clients and their families equally valued with the importance of their physical, mental and spiritual well-being" (CASW National Scope of Practice Statement, 2000:1).

Meso-system level

This system explains the nexus and procedures that unravel amid two or more situations comprising the developing person that is how different parts of a person's micro-system constitute a mesosystem (Bronfrenbrenner, 1994). For example, the family and communal atmosphere can affect a person's future ambitions. Lack of proper care and security can undermine the development and well-being of a person from childhood to adulthood. Therefore, from the systems theory's point of view, the social worker should give support in a bid to produce a harmless environment that promotes the mental healthcare user's development and well-being.

Exo-system level

Thus, the exo-system explains the nexus between a social situation in which a person does not have an energetic part but can incidentally have a robust influence on the person's improvement (Bronfenbrenner, 1994). These links might comprise structures such as communal well-being services, social sustenance collections that offer material resources, standards and ethos that are essential for the expansion and elimination of the encounters a person might be having. Therefore the accessibility and accessibility of source within the exo-system is significant towards the social well-being and full growth of a person. For instance, individuals rising in wrecked exo-system where their opinions are repressed typically face a lot of dares and greatest of them end up in deficiency. Thus the accessibility and availability of resources in the exo-system mean a lot in the physical well-being and development of mentally challenged individuals as it helps in the elimination of the problems they encounter on a daily basis.

Macro-system level

This system construes the ethos through which persons live, that is the socio-economic status, poverty and ethnicity of the country in which the individual lives (Awino, 2010). However, the economic situation of low-income countries in Africa is incredulous thus these countries are described by corpus poverty, malnourishment and high death rate due to poor health services, children from poor households are experiencing a lot of encounters since they are not getting any assistance from their instant environment. At this level, "social employees normally validate a greater volume to look afar the disease and management issues, to reflect the wider human, social and political issues in mental health" (The Development of Competency Standards for Mental Health Social Workers, 1999:23). Thus this study will be based on the interactions between microsystem, mesosystem, exo-system and macro-system in promoting the provision of effective services to mental health care users. History of social work in mental health

According to Aviram (2002), the social work profession has been actively involved in the mental health field since the early stages of the profession's development.

Supported by Lubove (1965) as cited in Aviram (2002) that the social work history in its involvement in the mental health field date back to the last years of the 19th century. The specialisation in mental well-being in the United States commenced in 1906, the Social Service Department of the Massachusetts General Hospital was established in order to work with mental patients (Lubove, 1965). The social workers were called the psychiatric social workers, and they were mainly involved in after-care of discharged mentally ill patients (Aviram, 2002). The title of Psychiatric social worker was chosen by the profession to describe the field of practice of social work in the mental health area (Grob, 1994).

In the 1920s psychiatric social work blossomed and reigned in the profession for several decades after. According to Wenocur and Reisch (1989) cited in Aviram (2002), the flourishing of psychiatric social work was related in part to the role of social workers during World War I. There was an establishment of teaching curriculums in psychiatric casework; the Smith College in 1918, the New York School of Social Work and the Pennsylvania School of School and Health Work in 1919 which provided the field with graduates that took further change in the orientation of the profession. In 1920, the profession accepted the psychiatric method as the foundation of all social casework (Lubove, 1965). The social workers were hired to offer the link amid patients, their families and communities, and to enable better discharge arrangement and community care of ex-patients by mental hospitals as well as agencies (Stuart, 1997, cited in Aviram, 2002).

The social work alignments led to the establishment of Mental Hygiene Clinics and Child Guidance Clinics, which resulted in moving from psychiatric social work and much closer to practice in the community (Aviram, 2002). Restrictions between psychiatric social

work a field of practice and other fields of practice within social work were distorted by these leanings. Means considered of resolving the problem of the overall population were the social psychiatry and casework and social employees were moved into welfare agencies and family clinics (Brieland, 1995). After World War II, the social work practice expanded particularly within the field of mental health. In the beginning, the part of the communal worker in the mental health field was restricted to gaining evidence regarding patients and their families. Their role later progressed to containing an obligation for stand-in as liaisons between the patient, his/her family and the institution (Aviram, 2002).

Deinstitutionalisation is a complex procedure whereby the effort shifts on decreasing institutionalised upkeep, and in effect evolving communal-based treatment, precaution and reintegration, concerning efficiently rehabilitating the mentally ill persistent into society in an effort to avert stigmatization and discernment against such persons (Lund et al., 2010). The social work profession does not disregard the vicissitudes that have happened in the system, because now it meant they had to be more actively involved in the mental health service system.

CHAPTER FOUR: METHODOLOGY

This chapter of the study addresses the methodology used in carrying out this research. This chapter explores the research strategy, the population and sampling, and data collection processes. It further discusses the data investigation, data confirmation, ethical deliberations and restrictions of this research.

4.1 Research paradigm

The researcher used the phenomenological paradigm because it is focused on lived experience, describes the experiences of a phenomenon or concept for several individuals. The focus is positioned for unravelling how people experience and "how" they experience it. A phenomenological study was an appropriate qualitative method because it was used to explore the social worker's experiences in providing mental healthcare services (Creswell as cited in De Vos, 2011).

4.2 Study Strategy

A qualitative research approach was used in this research study. For Fortune and Reid (1999, p.94) qualitative approach is a method in which "the researcher attempts to gain a first-hand, holistic understanding of phenomena of interest by means of a flexible strategy of problem formulation and data collection, shaped as the investigation proceeds". This approach was ideal because the study was dealing with people's experiences, thoughts and feelings. This approach in data gathering has provided an in-depth description, insight and richer content and understanding of the lives and worlds of medical social workers' experiences of providing mental healthcare services in hospital-based care settings.

The study took the form of an exploratory study because it aimed to explore participants' experiences in providing mental healthcare services, particularly in a hospital-based care

setting in Mpumalanga. Face-To-Face and semi-structured interviews were employed as a guide in other to obtain painstaking evidence from the respondents. The researcher made sure that she interacts with the participants and listened to them because, in this investigation, the main goal is to learn from respondents on their experiences with regards to providing mental healthcare services.

4.3 Study site/location

The researcher recruited respondents from 20 different hospitals around Mpumalanga, 6 from Nkangala District, 6 from Gert Sibande and 8 from Ehlanzeni district. The different hospitals are; Kwamhlanga Hospital, Middelburg hospital, Witbank hospital, Ermelo Hospital, Evender hospital, Bethal hospital, Barberton Hospital, Rob ferrera hospital, Shongwe hospital, Tinswalo Hospital, Themba Hospital, Carolina Hospital, Amajuba Hospital, Bongani Hospital, Embhuleni Hospital, Sabie Hospital, Standerton Hospital and Mapulaneng hospital. These hospitals were chosen because they were more convenient for the researcher due to, they have a large number of potential respondents, they are nearest in terms of distance, and they all represent diversity in terms of socio-economic status and they were willing to take part in the study. Some hospitals have more than 3 medical social workers in one department

4.4 Population

The totality of persons or human units from which a sample is drawn in order to study a particular research problem refers to the population (Babbie & Mouton, 2009). Medical Social Workers in hospital-based care setting are the population of investigation in this study. The population size of medical social workers in Mpumalanga is 45. In order for the researcher to obtain diverse experiences, she recruited respondents from all 3 districts; Inkangala district, Gert Sibande district and Ehlanzeni district. The researcher realised that by recruiting in this manner she would have different experiences impacted by the socio-economic status of the district.

4.5 Sampling procedure

Sampling refers to the process of selecting participants who will provide the data that is required for the purposes of the research (Babbie & Mouton, 2009). The purposive sampling technique was used to select social workers to participate in the study. The purposive sampling is also recognized as judgmental, selective, or subjective sampling (Babbie & Mouton, 2009). The study sampled the sample according to composed components that contain the most distinguishing, characteristic or distinctive qualities of the population (De Vos et al., 2011). The purpose sampling was preferred owing to the verity that the issue being investigated is specific to medical social workers' providing mental healthcare services in hospital-based care settings. The total participants interviewed were 20 medical social workers. The recruited possess the following features:

- Qualified medical social workers (Department of Health)
- Employees stationed in the Health Department
- Social workers working in Mpumalanga government hospitals.
- They are already working in the area of mental health and were willing to participate.
- Social workers with working experience of 5 to 30 years.

Recruitment procedure

After the ethical permission was obtained from the University, the investigator met with the relevant research committee from the Department of Health. Permission to conduct research with medical social workers from the different hospitals was granted. The researcher made appointments with the social worker's supervisors to explain the research and requested that she receives contact details of the socials workers who were willing to be interviewed. After receiving the list and contact details of the respondents, the researcher checked with the respondents regarding their willingness to participate and provided all the necessary

information in order for the participants to make an informed decision. This was made so that the members are aware that this is a choice, in case they agreed because they were told by management. Time and dates were agreed upon between the researcher and respondents. Respondents with experience above 5 years were preferred for this study, as it is believed they would give more valuable information, as they would have had more experience in the field.

The researcher recruited respondents from 18 different hospitals around Mpumalanga, 6 from Nkangala District, 6 from Gert Sibande and 8 from Ehlanzeni district. The eighteen different hospitals are Rob Ferreira Hospital, Sabie Hospital, Shongwe Hospital, Amajuba Hospital, Tintswalo Hospital, Embhuleni Hospital, Evander Hospital, Bongani Hospital, Standerton Hospital, Witbank Hospital, Middelburg Hospital. Kwamhlanga Hospital, Carolina Hospital, Bethal Hospital, Themba Hospital, Barberton Hospital and Piet Ritief Hospital.

4.6 Data collection approach

According to DePoy and Gilson (2008), information can be obtained by researchers through exchange with a person or a collection that is recognized or predictable to own the understanding they seek. This study utilised in-depth individual interviews, which was conducted with social workers already working in the mental healthcare field. Interviews are the prime approach of data or evidence gathering in the qualitative investigation (Greef, 2005). The respondents were informed about the goals of the study, the ethical considerations and the whole process of how data will be collected and recorded. The respondents were all comfortable with using English as a medium of communication for the purpose of the study, mostly said they express themselves better in English. The researcher recorded the interview sessions using her electronic device, with permission obtained from the respondents. Taping the conversations certified for a much wealthier explanation of the interview than relying on field notes and it allowed the researcher to concentrate on the flow of the interview rather than on recording the content thereof (De Vos et al., 2011). Interviews were transcribed by carefully

listening to each interview in their office space which was a very conducive environment and typing out word for word, what the participant had responded. A total of 20 interviews were conducted at the different hospitals, unfortunately, four participants had to pull out. Interviews were conducted on for the duration from October till November 2018. Interviews were conducted at the medical social workers' office, at the presence of only the researcher and participant, to ensure privacy. Interviews were conducted for about 30 to 45 minutes each.

Data collection tool.

For the purpose of this study, the researcher utilised the semi-structured in-depth interview schedule for data collection. This method was used to give more flexibility to the researcher and participant, participants were able to openly express themselves and give meaning to their experiences. The semi-structured interview had a set of predetermined questions, but the interview will be guided rather than dictated by the guide. This means that questions were not required to follow exactly as it is the guide, but was made spontaneously. Participants direct the interview and they can introduce an issue that the researcher had not thought of. The questions are nearly always open-ended (Greef, 2005).

The interview schedule explored information about the experiences of medical social workers of proving mental healthcare services in hospital-based settings; their preparedness in providing mental health care services, to evaluate the professional support within the work environment to provide mental healthcare services and to examine challenges of practising social workers in multi-disciplinary primary healthcare teams. (See Appendix C)

The data collection tool was pre-tested with two medical social workers as a pilot study. A pilot study is a small study conducted prior to a large piece of research (Strydom, 2005). This was helpful in determining whether the data-gathering method was suitable or not. The two medical social workers do not form part of the main study. However, they were selected in the

same manner as participants who were part of the main study. The schedule for consistency, regularity, timing and continuity was assessed during this process. Minor changes such as the demographic information, order of questions and the length of interviews were made, resulting from the pilot test.

4.7 Data management and analysis

In this study, thematic method of data analysis was utilised because it organises and describes patterns across the data set with rich detail and progresses a step further by interpreting the many aspects of the research topic (De Vos, 2005). Data analysis was defined by De Vos (2005) as the process of bringing order, structure and meaning to the mass of collected data. A five-stage cyclical process through which data is analysed is outlined as follows.

- Phase 1: Familiarisation and immersion

The researcher collected data through in-depth interviews which were held with the medical social workers at their respective offices. Interviews were recorded using an electronic device and then later transcribed, the participants gave consent to be recorded. The researcher familiarised herself with the data by reading the whole data set and noting down initial ideas by; reading the transcribed interviews several times in order to ensure that she is not missing anything from the initial ideas to the relevant data (Terre Blanche et al., 2006).

- Phase 2: Inducing themes

At this stage, the transcripts and recordings were well organised and specific themes underlying data were identified for analysis. The researcher reviewed the themes and refined them further and producing a thematic map showing relationships between themes and sub-themes (Braun and Clarke, 2006). The recordings were kept with the transcriptions so that the

researcher could listen to them to ascertain the meaning, when necessary and to see if the themes worked in relation to the coded data.

 Phase 3: Coding

This process refers to "break down a body of data (text domain) into labelled, meaningful pieces, with the view to later clustering the 'bits' of coded material together under the code heading and further analysing them both as a cluster and in relation to other clusters" (Terre Blanche *et al*., 2006: 143). After the data collection, the researcher read the transcripts a number of times in order to understand the results before breaking the data down into simpler entities. At this stage, the emerging key concepts were then written down. The researcher coded and identified significant data and organised data into meaningful groups. This process was performed with the intent of gaining a deeper understanding and not forgetting data that did not form part of identified themes.

 Phase 4: Elaboration

At this stage, the researcher identified and named themes and gave them greater meaning with the assistance of a thematic map that the researcher created (Braun and Clarke, 2006). It was a requirement for the researcher to revise the initial coding process in order to develop a more comprehensive analysis of the data. The researcher had to holistically evaluate the transcripts, to avoid making hasty assumptions about the content that emerged; transcripts were read through a number of times, over days in order to attempt to find the meaning in the responses. During this stage, the researcher looked for similarities, categories, themes and comparisons and revised the initial coding process in order to develop a more comprehensive analysis of the data.

 Phase 5: Interpretation and Checking

In this phase, the researcher evaluated the value of the data and its relevance to the research question, this step required the researcher to view the data from all possible angles, not ignoring alternative explanations. The findings were linked to relevant literature and the researchers own critical commentary was added. All findings were compiled into a research report to convince the reader of the merit and validity of the analysis (within and across themes), using data extracts embedded within an analytic narrative to make an argument in relation to the research question (Braun & Clarke, 2006).

4.8 Data verification/trustworthiness

Trustworthiness in research was crucial in establishing the reliability and validity of the qualitative study. Trustworthiness is established by a variety of constructs or criteria of evaluation to ensure that the information gathered is both credible and valid for professional practice (Polit & Beck, 2008). These constructs are credibility, transferability, conformability and dependability. According to Babbie and Mouton (2008), a qualitative study may be regarded as trustworthy when the experience of the study participants is "accurately represented". In efforts to ensure trustworthiness, the researcher used various strategies with the aim of placing the voice of participants as the first priority to the research outcome (Lietz, Langer & Rich, 2006). The strategies are as follows:

Credibility

Credibility refers to confidence in the truth of the data and interpretation of the data. It requires the researcher to strive for confidence in the truth of the findings (Polit & Beck, 2017). To achieve credibility, the researcher used prolonged engagement with the participant as well as member checking, which is the act of going back to the participants to verify if findings reflect their true experience. The interviews were recorded using an electric device and carefully transcribed to ensure credibility.

Transferability

This refers to the extent to which data can be transferred to another setting. This also refers to the probability the research findings have meaning to others in a similar situation (Streubert & Carpenter, 2011). A dense description of the demographics of the participants was made. A rich description of the results with supporting direct quotation of participants are included in order for the reader to be able to make judgements about transferability.

Dependability

Dependability is the stability of data over time and over conditions. It seeks to find out if the findings of the research will still be similar if it were to be repeated (Babbie and Mouton, 2007). This is achieved by using triangulation of methods. This is measured by the standard of which the research is conducted, analysed and presented. Each process in this study will be reported in detail to enable an external researcher to repeat the inquiry and achieve similar results.

Conformability

This refers to the objectivity of data and potential for congruence between two or more independent about the data accuracy, relevance or meaning. It is the gradation that results can be established or substantiated (Kumar, 2014). The researcher has safely kept the audio recordings, verbatim transcribes, interview schedule and field notes to ensure neutrality in the analysis and interpretation of the lived experiences. Should the need arise, this stored data may be reviewed.

4.8 Ethical considerations

According to Strydom (2005), ethics is a set of moral principles that are suggested by an individual or group, is subsequently widely accepted and offers rules and behavioural expectations about the most correct conduct towards experimental subjects and respondents,

employers, sponsors, other researchers, assistants and students. Any activity that focuses on any aspect of human welfare has to give due consideration to ethical issues linked to basic human rights (Burns & Grove, 2009; LaBiondo-Wood & Haber, 2010). Ethical guidelines prescribed by the University of Kwazulu-Natal were adhered to at every step of the research study.

Human participants' protection.

Permission to conduct the research was sought from the Department of Health. A letter seeking endorsement and also assistance with the recruitment of the participants from the managers was written (Hennink, Hutter & Bailey, 2011). Permission was also obtained from the Managers at the various hospitals. The ethical clearance was also obtained solicited from the University of KwaZulu-Natal Humanities and Social Sciences Ethics in Research Committee. Ethical approval was obtained from the study sites. (See Appendix A and B for approval letters)

Risks and Benefits of participating in the study.

Causing no harm to participants is the fundamental ethical rule of research (Barbie, 2009). The researcher made sure that participants are not harmed by participating in this research study (Dhai & McQuoid-Mason, 2011). There was no anticipated risk to participate in this study. The researcher ensured that she in no way inflicts physical or emotional harm on the participants and assured the participants.

It was important that the research not only does not harm but also potentially contributes to the well-being of others. The researcher conducted the research in an effective and significant manner that promotes the welfare of the participants (Bless & Higson-Smith, 2013). The researcher of the study ensured that the principle of beneficence is carried out by making sure that the respondents benefit from this study, professionally and personally. This research hopes

to meet the significant gap in the literature on the experiences of social workers in providing mental healthcare services, the South African context.

Informed consent.

All the participants were given written informed consent forms. It was guaranteed that respondents are educated concerning the aim of the study, the probable period, events to be charted through the study and the trustworthiness of the investigator (Strydom, 2011). The written consent is done after the participants have been informed of the research (Dhai & McQuoid-Mason, 2011). During the time of consenting to participate, the participants were psychologically competent to give consent and were made aware that they are at liberty to withdraw at any time without any consequences. The informed consent form included information about the goal of the research, procedures that will be followed during the research, possible advantages and disadvantages were shared before the interviews were conducted. The participants were not coerced to participant in the research (De Vos et al., 2011). The participants were given an opportunity to choose what shall not happen to them. Participants were required to sign and submit the consent form prior to participating. (See Appendix D)

Voluntary participation and privacy.

Rubin and Babbie as cited in De Vos, Strydom, Fouche & Delport (2011) suggest that participation in research should at all times be voluntary and no one should be forced to participate in the project. Participation will be voluntary, and no one will be forced to participate (Rubin & Babbie, 2005). The participants were informed that their participation in the research study had to be voluntary and their withdrawal to further participate in the study will not have any consequences. The participants were in no way pressured to participate in the study, their participation was voluntary. Written informed consent forms were obtained from all participants prior to the interviews.

Deception of participants.

According to Corey, Corey and Callanan (1993 as cited in De Vos et al., 2011) deception are withholding information deliberately or offering incorrect information in order to ensure the participation of respondents when they would have possibly refused to participate. The researcher avoided deception by being transparent about the purpose of the study and that they would not get paid money for it.

Autonomy

Autonomy demands that the ability of competent subjects to make their own decisions be recognised and respected, while also protecting the autonomy of the vulnerable by preventing the imposition of unwanted decisions. Full autonomy requires that an individual is able to understand what they are being asked to make a reasoned judgement about the effect of participation will have on them and make a choice to participate free from coercive influence (Terre Blanche, 2006).

The researcher explained to the respondents that their identity details will not be in any way linked with their responses in the findings. Their names will be will be replaced with three numbers of their choice that would be used in each interview transcribed, this was done to ensure that their name and details are in no way linked, nor associated with their responses.

Anonymity and confidentiality.

Confidentiality ensures that the right to privacy of the individual is maintained (Polit & Beck, 2010; LaBiondo-Wood & Haber, 2010). Privacy and confidentiality are extremely important ethical issues that needed to be maintained during the research study. The researcher informed the research participants that the information collected during the study will be kept confidential. Participants were able to trust the researcher enough to share information as deeply and as honestly as possible. This allowed the research study to reach valid and

meaningful conclusions that could possibly be used in future research studies. All collected data were handled carefully and strictly to maintain confidentiality and privacy. All data will be stored for a period of 5 years. This information was also reflected in the assent and consent letters. This means that no person other than the researcher and supervisor will have access to the data and participants' information. Information provided by each participant will not be linked to them. On the report, I have used pseudonyms. The tapes are kept in a locked cabinet and only the researcher and the supervisors have admittance to them. The tapes will be damaged five years after completion of the study. Include information about how the ethical consideration of privacy was addressed

Actions and competence of researchers

Researchers are ethically obliged to make sure that they are competent, honest and adequately skilled to conduct research (Walliman 2006 as cited in De Vos et al., 2011). The researcher used skills acquired from her profession (Social Work), to be able to treat respondents with worth and dignity. Interviews were conducted in a professional manner, encouraged open communication and made the respondents feel comfortable in responding to the questions as they so wished. The researcher adhered to the ethical code of the South African Council of Social Services and the research Ethical considerations at all times.

Justice

It is considerations that the researcher needs to make sure that the participants are fairly treated (Dhai & McQuoid-Mason, 2011). This is a belief that people should be treated equally, in this case, this will be referring to the equal treatment of participants in a fair and just manner. The participants were given an equal chance to participate in the study and receive equal treatment throughout, by being treated with worth and dignity.

Release or publication of findings

The findings of this study were recorded in the form of a research report and submitted to the University of KwaZulu-Natal. A copy of the report will be handed over to the social work supervisor of the various Hospitals in Mpumalanga. Research findings will also be shared with the Department of Health. Release of the findings should occur in such a manner that utilisation by others is encouraged (Strydom, 2005). The completed research report could possibly serve as a guide for future researchers, who wish to venture into the same or similar research topic. The researcher aimed that the final report is reported accurately, that it is clear, explicit unambiguous, free from bias and containing all the relevant information (De Vos et al., 2011).

4.9 Restrictions of the study

Study imitations in research studies are vital rudiments which the investigator desires to be conscious of, classify, recognize and present clearly. Due to the study utilising the qualitative research method, the researcher was aware of its limitations of subjective errors. The researcher being a medical social worker herself had to eliminate subjective opinions that could affect the interview process in any way.

The researcher felt that the literature regarding this field of study in the South African context was limited, even though this is an indication that there is a research gap. The researcher would have preferred to have diversity in respondents, in terms of gender and race, because the majority of this population only represented the black and female race.

The researcher is also a medical social worker, working along with the participants and by conducting these interviews the respondents could have felt the need to give what they considered to be socially desirable answers, which has negatively impacted the reliability of their responses.

4.10 Reflexivity

The researcher of this study works at a local hospital in the Ehlanzeni District called Tonga District Hospital. I am passionate about mental health thus rendering effective mental healthcare service is very important to me. During my tertiary level training from the University of Pretoria, I received minimum training on mental health, which I personally feel was not adequate preparation for the practical field. I have been working at Tonga Hospital for more than 5 years now, and I have observed that social workers working in other hospitals, without psychologist are expected to diagnose patients according to the Diagnostic System Manual (DSM-5), which many complain they either had minimum or no training at tertiary level on it and no in-service training either. I am the only social worker at Tonga Hospital; there is an increase of caseload on mental illness on a daily basis, and I experience a lack of support from management in terms of training and resources. Social workers from other hospitals normally complain about not being sure of their scope of practice when dealing with mental healthcare users, in particular, while they find the mental health field rewarding, they are struggling to be recognised in the multi-disciplinary teams.

I hope that the study will make significant contributions to research knowledge on social workers' experiences within the mental healthcare practice. I have my own personal experiences with regards to providing mental healthcare services, but I made sure that I did not impose any of my experiences on the participants when collecting data. During the interview process, I was aware that some of the social workers may have different experiences, thus it was important that I approached the interview subjects from an objective standpoint, my professional training as a social worker helped me keep personal feelings to myself and adhere to the data collection method.

CHAPTER FIVE: PRESENTATION AND DISCUSSION OF FINDINGS

Central to this chapter is the exhibition and examination of the results engendered of the semi-structured interviews elicited 20 medical social workers, around the three (3) districts around Mpumalanga hospitals. To make sense of issues discussed in this chapter, the chapter begins with the explanation of respondent's demographics including age, gender, job location and number of mental health cases attended to per month. In addition, the chapter expressly ensured appropriate research ethics were followed by protecting the anonymity of all respondents in the interpretation of findings. To be sure, participants were all represented with a code and symbol in the interpretation of their responses. For instance, participant one is presented by P1 and so on.

5.1 Description of study participants

For the purpose of this study, 24 medical social workers were recruited among the cohorts of social workers in Mpumalanga, Government hospitals, Republic of South Africa, however, only 20 were able to complete the whole interview process. Speaking to participant's demographics, it was revealed that all the interviewed respondents have had working experiences ranging from 5 years to 18 years. In addition, findings from the interview, also exude that all the respondents that participated were presently working with mental healthcare cases in a hospital-based setting and voluntarily agreed to take part in the study (see Table 1). From the foregoing verity, it is explicit that all the participants possess the required criteria to be part of this study. Thus, the analysis was developed using the main research questions. Based on the information received from the semi-structured interviews conducted, the researcher developed general themes and categories under each theme to facilitate the analysis process.

Furthermore, results from respondent's biographical information revealed that the predominant gender was a total of 18 females, 16 Blacks, while participants who reported to have mental healthcare cases were between 20-30 and the predominant participants have experience over 10 years in the hospital-based settings. Again, in terms of race, results indicate that the overall sample of the study comprised of 2 black males, 18 females, three white females, one coloured and no Indian. Through the biographical information analysis, the participants who reported to have mental healthcare cases between 10 to 20 per month were from the hospitals in semi-urban areas and those that reported having mental healthcare cases between 20-30 are based in

the hospitals in the rural areas. The 13 black participants are also placed in the deep rural areas; social work is a female-dominated profession; it even shows in the sample that only two males out of 20. Only four of the participants furthered their studies after undergraduate training, two with honours in psychology and two have Masters in Occupational Social Work. (see Table 1). The following table refers to information regarding the 20 participants who participated in the study:

Table 5.1: Socio-demographic profile of participants

Participant	**No. of years of experience in a hospital setting**	**Gender**	**Qualifications**
1.	9 years	Female	B Social Work
2.	5 years	Female	Honours in Psychology
3.	12 years	Female	B Social Work
4.	13 years	Male	B Social Work
5.	12 years	Female	Masters' in Occupational Social Work
6.	17 years	Male	B Social Work
7.	5 years	Female	B Social Work
8.	9 years	Female	B Social Work
9.	15 years	Female	B Social Work
10.	17 years	Female	B Social Work
11.	15 years	Female	B Social Work
12	16 years	Female	B Social Work
13.	11 years	Female	B Social Work

14.	7 years	Female	Honours in Psychology
15.	15 years	Female	Masters' in Occupational Social Work
16.	14 years	Female	B Social Work
17.	9 years	Female	B Social Work
18.	10 years	Female	B Social Work
19.	16 years	Male	B Social Work
20.	15 years	Female	B Social Work

Source: *Field Work, 2018*

Table 5.2: Participants' job location

Witbank Hospital	Standerton Hospital	Barberton Hospital
Middelburg Hospital	Piet Ritief Hospital	Bongani Hospital
Kwamhlanga Hospital	Evander Hospital	Rob Ferreira Hospital
Carolina Hospital	Ermelo Hospital	Sabie Hospital
Bethal Hospital	Embhuleni Hospital	Shongwe Hospital
Themba Hospital	Tintswalo Hospital	Amajuba Hospital

Source: *Field Work, 2018*

Table 5.3: Categorisation of respondents based on racial groupings

	Number
Black	**16**
Coloured	**1**
Indian	**0**
White	**3**

Source: *Field Work, 2018*

In a bid to effectively engender a clear analysis from the interview transcripts, a framework was developed using the research questions, and a merge of responses from the interview. From these different groupings, general themes, sub-themes and categories were developed from the findings of the study. However, to analyse the findings properly, the researcher thus, identified different categories under each theme, wherein similarities in responses were grouped together under sub-categories. Table 5.4 explicates the themes, categories and sub-themes below:

Table 5.4: Themes, categories and sub-categories of the semi-structured interviews emerged as follows:

Themes	**Categories**	**Sub-categories**
1. Social work in mental healthcare	1.1 Interventions services	• Focusing on patient holistically • Empower and Support • Psychosocial assessments • Therapeutic intervention • Statutory intervention

2. Mental health experience	1.2 Negative 1.3 Positive	● Stigma ● Mental health specialised field ● Training and recognition
3. Training in mental healthcare	2.1 Undergraduate training in mental health	● No training ● Not sufficient, too limited ● Sufficient training
	2.1 Need for more training	● Undergraduate training ● In-service training
4. Support provided to social workers in mental healthcare	3.1 Professional support base	● No professional support ● Insufficient support ● Positive support from fellow colleagues (WhatsApp group).
5. Multi-disciplinary teams	4.1 Overall experience in Multi-disciplinary team	● Feeling marginalised ● Not recognised as a mental health practitioner ● Works well with other professionals
6. Suggestions or recommendations to assist social workers provide effective mental healthcare services in hospital-based settings.	Need for social work in mental healthcare	● Specialised training ● Recognise social workers as practitioners ● Clarification of role ● Social work supervisor

Source: *Field Work, 2018*

5.2 Communal work interventions in mental health

In line with the mandate of the National Association of Social Workers (2011), social workers in mental health settings, are expected to provide services that include complete

psychosocial assessments, family and patient education on diagnosis and treatment options, aiding in emotional adjustment to hospital admission. Other mental psychological assessment such as crisis intervention, completing referrals to outpatient services, discharge planning, advocating for patient rights, individual therapy, behavioural interventions, substance abuse and group therapy. However, pertinent to this study, questions were posed to social workers to unravel and describe the nature and strand of mental health intervention services provided within the mental health settings of the selected case studies Mpumalanga Province, South Africa. Importantly, this question was asked to unearth and describe the extent to which social workers understood their various roles within the mental health care circle. Findings from the analysis revealed predominant services intervention services, which were not so distinct from the lists of intervention services promulgated by the National Association of Social Workers, with the most frequently occurred a focus on patient holistically, statutory intervention, empowerment and support. Others are therapeutic intervention, family reunification and using the DSM-5. Thus, each of these themes is explained below with corresponding responses from participants.

Focusing on patient holistically.

Precisely, findings exude that majority of the participants reported that one of their intervention services was a holistic focus on the patient with mental illness, and this was evidenced in a number of the statements made by the respondents. For instance, one of the respondents reported the following;

> Before any intervention can begin, it's important that the patient's circumstance has been viewed holistically, we then diagnose using the DSM-5, empower and support patient and families. *(Participant 5)*

In agreement with a holistic focus on the patient with mental illness as a service intervention strategy, another respondent has the following to say:

> We intervene holistically; physically, socially and mentally, guide and give necessary information to ensure that the well-being of the patient is well looked after. We give necessary support and empower our patients. (Participant 14)

Thus, it can somewhat be concluded that to an extent the importance of being a social worker is neatly realised in the mental health field, with regard to findings reported above. For instance, this study, among other conclusion positioned that one of such importance is caring for mental health patient with holistic concerns. To support this contention, one of the participants expressed that they do engage in the initial screening of the patient before he/she is referred for further intervention. This claim was supported by a respondent as reported below;

> I am responsible for the initial screening, evaluation of the patient and their family; I assess the bio-psychosocial needs of the patient, family and their support system at large. (Participant 15)

The above descriptions, to a large extent, was supported by a large chunk of the study population, although some did not report this in direct verbatim, yet it can be inferred that social workers felt their role is assessing the client holistically. This position neatly cements with extant literature that both mental well-being and mental disease are resolute by numerous interrelating influences such as that of emotional, societal and organic elements (Patel *et al*., 2010). The above authors positioned are is further validated by section 17 of the South African Mental Healthcare Act of (2002) where mental well-being position is distinct as

being a level of cerebral comfort of an individual as affected by bodily, societal and emotional factors and which may result in psychiatric diagnosis. Thus, put together, these descriptions clearly explain that the function or role of a social worker is not limited to a focus on the patient, as it seeks to extend to issues around environmental concerns since the mental health itself is a clear description of bi-national. This is also supported by the theoretical framework discussed in this study, the ecological paradigm, through the Systems Theory by (Bronfenbrenner, 1979).

Statutory intervention

In terms of statutory intervention, findings show that the same number of participants (social workers) that revealed and associated their roles in mental healthcare as focusing on the patient holistically, also indicated that statutory intervention and linking patients with relevant resources was as equally important. This claim was recounted in several of the statement reported by respondents. For instance, one of the respondents reported the following;

> ... We focus on the patient holistically and link the patient with all the necessary resources and services. (Participant 2)

Another respondent reported that:

> I work closely with the psychologist and psychiatric nurse, I write psychosocial reports. I am actively involved in the reunification of patients with family. I advocate and link patients with their necessary required needs. (Participant 9)

In support of the other participants, another participant stated:

> Because mental healthcare users are the most vulnerable in our communities, we are their voice, we link them with services and advocate for their rights. (Participant 7)

To put in perspective, although the participants agree to a large extent with the submission of the participants, however, for participant 7, more emphasis was engrossed, because mental health users and their caregivers are very vulnerable, and this calls for social workers to be their advocate and connect them with necessary services and resources. This position neatly dovetails with Johnson & Yanca (2007) study. For instance, Johnson & Yanca (2007) reported in their study that the chief responsibility of the social worker is that of advocating, helping clients to obtain services in conditions in which they may be prohibited or find challenges in terms of access to relevant resources and services. In addition, Bee, Lovell, Airnes and Pruszynska (2016) study also corroborate with this stance. For these authors, the statutory intervention was used in the holistic model implemented by social workers in their service practices to ensure legal acquiescence in mental healthcare services.

Empowerment and support

For this theme, the majority of the social workers (respondents) totalling 12, reported that empowering and supports of mental healthcare users and their families were registered as one of the social worker's important roles. This, supporting patients was signposted in various ways, including supporting patient and family on the need to cope with the diagnosis; supporting in terms of linking and establishing the nexus between resources and services; and support in the area of aftercare and reintegration of patients with their families. For broad explanation two of the respondents reported these narratives below:

> I empower individuals, families and community members through awareness campaigns; I am actively involved in the reunification of patients with families. I give support and

> empower family members to be a good support system for each other. (Patient 12)

> I assess the biopsychosocial needs of the patient, family and their support system at large, thus I empower and give support to patient and family. (Participant 18)

To put in context, the submissions of participants as reflected above validates with the position of the literature. For instance, Gehlert & Browne (2012) study exude remit of social workers in mental well-being, primarily involves the need to work with patients and families in towards facilitating operative message between patients, families and other healthcare teams. In particular, one of the respondents reported the following:

> As a social worker in a hospital setting when rendering services to mental healthcare service users I am required to undertake the initial screening and evaluation of the patient and their families, provide a comprehensive psychosocial assessment of the patient, help patients and families understand the illness and treatment options, as well as consequences of various treatments and treatment refusal, facilitating decision making on behalf of patients providing and making referrals, coordinating patient discharge and continuity of aftercare and families facilitate family reunification. (Participant 3)

Taking an excerpt from the literature, Glandz & Mullis, (1988) reported that behaviour modification is contextualised as being maximised when environmental issues and policies coalesce together to sustain health care choices, in addition to social rules, and other social support issues for healthful choices. Particularly, this becomes more evident when a person is then through, such support systems could have roused and motivated them towards seeking education in other to make varieties which could result to enhanced health behaviour and functioning.

Therapeutic intervention

On this theme, 8 respondents recounted the utility of therapeutic intervention as one of their strategic interventions in mental healthcare. With keen observation, the researcher has come to the knowledge that, among the 8 respondents identified with this theme, for example, that identified with therapeutic interventions are those who reside in urban areas. Possibly, the assumption could be that the caseload is not constraining this process as it requires sessions, and in particular, most of the time one on one. However, respondents who did not identify with the therapeutic interventions, on the other hand, indicated to have mental healthcare cases from 30 to 40 a month, while a few of others mentioned group work as their intervention in mental healthcare cases. The above narratives and analysis are all supported by the respondents below;

> I conduct cognitive behavioural therapy and Multilevel neuroprocessing. So, I focus on the restructuring of thinking and initial impulse received and then let the client explore how to interpret the stimulus differently, through therapeutic intervention. (Participant 11)

> I conduct a therapeutic intervention, sometimes group work, client advocacy, social support and reintegrate patients into normal societal functioning. Some of us use the DSM5 to diagnose patients. (Participant 10)

> We look at the social aspect of the case, psycho-social assessment, family reunification, educating the family on mental health and therapeutic intervention. (Participant 4)

> Social workers assess and diagnose patients, empower and provide support to the diagnosed and their family. Social workers also conduct the therapeutic intervention and family reunification. (Participant 6)

Reflecting on the above findings, social workers should be conceived as a facilitator, employed to work with patients, at both individual levels. For instance, in the form of therapeutic interferences, working with the sick person at a personal and individual. Similarly, level in the form of therapeutic interventions, working with families, toward improved social support, implementing community development schemes towards the need to develop a more positive physical setting and improved resource access, in addition to the dire need of encouraging an enhanced mental health legislation and policy, that is useful for patient and their ideal functioning, treatment, management and recovery (Glanz, Rimer & Viswamath, 2008).

Diagnostic and Statistical Manual of Mental Disorder (DSM-5)

From the findings, a total of four (4) respondents clearly narrated and share their view on the utility of the DSM-5 to diagnose patients. These respondents indicated and explained how there were trained at the undergraduate level with respect to the utility of the DSM-5 in diagnosing the mental disorder in patients. Specifically, two of the respondents indicated and explained their robust understanding and familiarity with the process, particularly as they have an honours degree in psychology. To make sense of this description, two of the respondents have the following to say:

> I use the DSM5 to diagnose patients, conduct the therapeutic intervention and link them with services they need or available for them. (Participant 1)

> Before any intervention can begin, it's important that the patient's circumstance has been viewed holistically, we then diagnose using the DSM-5, empower and support patient and families. (Participant 5)

Thus, findings revealed that other segment of the respondent only reported that they diagnose patient, without specifics to the actual diagnosing measures employed. To be sure, the researcher conveniently concludes and report that these sets of participants are plausibly using the DSM-5 since there is no other known manual to diagnose mental health. Supporting evidence is reported below:

> Social workers assess and diagnose patients, empower and provide support to the diagnosed and their family. Social workers also conduct the therapeutic intervention and family reunification. (Participant 6)

For clarity, participant 6 added and admitted that her tertiary training on mental health was not that robust, so also that her knowledge on the basic concept in psychology, is not that fervent. To be specific admitted not to have been a beneficiary of any training on mental health, but claim intervention is one of the key functions he provides in mental health. Keet (2009) stated that he had no official training on in this field although they used the DSM due to pressure from the agencies. This is evident that social workers to make use of the DSM-5 to diagnose patients. Regardless of Olckers (2013) stating that social workers receive insufficient training in mental health diagnostic system during undergraduate training.

Ore Put together, findings from this study, has therefore neatly conveyed the need for effective social workers remit in order to ensure the adequate and professional service delivery of mental health services. This interrogation was asked to appreciate and understand how social workers viewed their role in mental health. Fortunately, none of the social workers declined on not having adequate knowledge of their roles in mental healthcare services. Thus, the conclusion can then be reached that social work remains a sacrosanct and fundamental profession in the case of mental health care.

5.3 Overall experience of providing mental healthcare services

In the quest to explore to social worker's experiences towards the provision of mental healthcare services, three themes were uncovered, with most of these responses reflected towards the negative than positive. In addition, the findings revealed that few of the respondents reported the duo of negative and positive responses to the inquiry. The respondents indicated their negative experiences due to a shortage of social workers in the hospital based-settings interested in mental healthcare, lack of security to ensure safety, lack of recognition and professional support. The participants that reflected having positive experiences, was due

to the recognition attached to being recognised as a mental health practitioner. However, narratives on both the negative and positives experiences are explicated below. One of the respondents has the following to say:

Negative experiences

For this theme, few of the respondents reported challenges ensuing from negative experiences. To be sure, two participants indicated that it was negative because of the violent patients that they come across without security. Evidence is shown as contained in the narratives below:

> My experience in providing mental healthcare services has not been so good, I have had bad luck of coming across violent patients, and to be honest, my mental healthcare literacy is limited, I can never tell the difference in their diagnosis. Where I work, there is always an inflow of mental healthcare users who are not stable, they are dropped off by policeman with no information of family circumstance, and this means more tracing of families for us social workers. (Participant 12)

The preceding contention was clearly supported by participant 20 in the extract below:

> Mental health care users are very violent and my experience with them is not always good...

Correspondingly, issues raised from the foregoing narratives including the stigma placed on mental healthcare users as being violent were appositely analysed in this study. Thus, varied

conceptualisations of mental illness are engrossed on by the knowledge, insights and opinions reflected concerning those individuals recognized as mentally ill (Lasalvia, 2015). Clearly, it is obvious that mental illness is understood specifically in varied ways by different culturally diverse groups. However, studies on this leitmotif have found that individuals with mental illness are well-thought-out as unintelligent, and are often branded as unclean, unsafe and violent (Chikaodiri, 2009; Gureje, Labebikan, Ephraim-Oluwanuga, Olley & Kola, 2005). Particularly, studies within African continent propose a high level of stigma and discrimination amongst those who provide services for the mentally ill (Egbe, Brooke-Sumner, Kathree, Thornicroft & Petersen 2014; Mirnezami, Jacobsson & Edin-Liljegren, 2016). For clarity, one of this study, have clearly established found that many health professionals held undesirable insights towards the mentally ill and that this could inhibit appropriate treatment and interventions (Sheals, Tombor, McNeil & Shahab, 2016). Thus, the general trends revealed from this type of study within the global community would neatly suggest negative perceptions towards the mentally ill amongst both the general public and healthcare providers.

On the second thought, participants explained that most of the negative experiences were engendered by lack of mental health knowledge and generalised training. For instance, a lack of awareness about mental illness has been found to add considerably towards the stigmatisation of the mental ill (Corrigan, Morris, Micheal, Rafacz & Rusch, 2012). Responses from participants were clearly stated below:

> For me, I would say negative. To be honest, I don't like dealing with mental healthcare cases at all. I don't feel competent or trained enough in that field; if I had a choice I wouldn't work with mental healthcare users at all. Mental healthcare users and their families don't co-operate, they insist on taking the user to

> traditional healers before the doctor officially discharges them. (Participant 15)

> I would describe my overall experience as negative, I truly feel that mental healthcare is a specialised field and remember we have been generally trained. Even here at work, we are rarely invited for mental healthcare workshops unless you attend the ones where you acquire CPD points at your own cost. (Participant 3)

For Johnson & Yanca (2007, workers should upsurge their knowledge and skills, and should work toward ensuring continuous knowledge are delivered to the base of the profession. To be clear, these authors are fundamentally suggesting that social work professionals should be committed to the ethos of advance education by for knowledge pull-out in the course of professional careers. In contrast, although in this study, only about 30% of the respondents have advanced their studies beyond the undergraduate qualifications.

Other negatives experiences expressed are correlated to the shortage of manpower, no resources, support and recognition by the department. The following responses, however, summarises the experiences of employees in the discharge of their roles as mental health care professionals.

> Negative, we are overworked, no budget and there are only two of us in that big district hospital. We are not recognised as important practitioners like the other professionals in mental health, and this makes me feel uncomfortable working with

> mental healthcare cases, as I feel that the other professionals recognise us for only when we have to collect donations and when they have messed up. We are not trained in the mental healthcare Act, as a result, we make a lot of mistakes and we are blamed by the other professionals constantly. (Participant 2)

According to Lund et al., (2008) services for the mentally ill are poor due to lack of resource provision and development within this field. Huxley et al., (2005) also found that common stressors for social workers were a lack of resources, the pressure to work long hours, covering for open positions, the high volume of work and nor feeling appreciated by the employer or general society. So, the above authors support participant 2.

Both positive and negative experiences

> My experiences are both negative and positive. The negative is that I feel as though I am not doing enough to help the users, I wish I had more training and more information in that way, I feel I would do more. I get a sense of fulfilment whenever I have successfully helped a patient until the end using my general social work skills, such as advocating, linking patient with services and mediating when there is a crisis. (Participant 7)

> I would say there are some positives and some negatives. Some of the positives would be when the patients and their families are willing to work with the social workers and they understand what is happening to the patient and are willing to get help. Having

> the opportunity to make an immediate, have a positive impact on the life of an individual or family is also positive. The negative is when the family of the patients are not willing to work with the social worker. It is also hard for social workers within the health care setting to go out into the field and ensure that the referrals that have made really did help the client or not. This may be seen as negative because the social worker is not completely able to know whether they have been able to assist the service user fully because they mostly do referrals to other organizations. (Participant 18)

Positive Experiences

From the 20 interviewed respondents, only 5 positive experiences as a mental health care professional. In other words, these responses were reported who have keenly demonstrated a passion for the profession, and who had more training on mental healthcare, specifically those concentrated in hospitals located in the rural areas: The following submission support this claim:

> My experience has been fulfilling, am very knowledgeable in the field of mental healthcare even other social workers from other hospitals consult me for advice. I am able to give support the family needs and I have a good relationship with other departments, so it becomes easy when I am linking a patient with other services beyond my scope of practice. (Participant 5)

> I have had very good experiences; I understand this field and am passionate about supporting people live their lives as best as they can. I always do my best and my patients appreciate my services and they are always showing gratitude towards me. (Participant 14)

On another count, participant 1 and 11, position their only challenge on the ground of their experience as related to the shortage of social workers in mental healthcare and increasing caseload of mental health. Supporting direct quotes are stated below:

> Mmmh…even though we are understaffed and overpopulated with such cases, my experience is of a positive one because I really have a special interest in mental health, and I take it upon myself to gain more knowledge, skills and experience. (Participant 1)

For Kim and Stoner (2008), findings from their study support the submission of participant 1. The authors identified various factors leading to breakdown amongst social workers, increase in paperwork, high caseloads, roles stress, complicated clients, being short staffed and not having adequate supervision. The following supported these findings;

> My overall experience in providing mental healthcare services has been positive, even though we are short staffed and have limited resources; my experience is of a positive one because I really have special interest in this field, and the other professionals in the hospital trust and recognise me over my other

social work colleagues with mental healthcare cases. They know I have my Masters in Occupational Social Work. (Participant 11)

In a study conducted by Evans, Huxley, Gately, Webber, Maers, Pajak, Medina, Kendall, Katona (2006) it was found that social work staffing is more problematic than any other professional group, primarily in mental health care facilities. This is also evident in this study, where per hospital there are one to three social workers, and this results in excessive workload and work pressure.

5.4 Undergraduate social work training being adequate

In terms of the adequacy of training received on the job, participants were asked to appraise if their undergraduate training was adequate enough to organize them in providing real mental healthcare services. To do this, the themes that were developed in this question reflect that majority of the respondents had only received inadequate training, and only a few indicated they have received sufficient training in tertiary training on mental healthcare. These responses were stated below by selected respondents:

Insufficient training

In terms of insufficient training, the majority of the participant reported that their tertiary training in mental healthcare was inadequate and is not sufficient for them to offer effective mental healthcare services. This is evident in the narratives provided below;

> My training at tertiary was limited; to be honest I don't remember much, it must have been offered to us in a few classes. I was blank on mental health when I came to work at this Hospital, straight from the University. I didn't even know some of the disorders; I struggled a lot with the terminology. (Participant 2)

> No, my second major at varsity was Criminology, so I really had very brief exposure which I can't even remember but because I have Pyc 101 on my academic record. (Participant 7)

> Not at all, training on mental health at my University was cramped into a 3-month module. That is not enough to cover the realities we have to face in practice. (Participant 18)

> The undergraduate training, I have from varsity is not in-depth, especially because my second major was criminology and not psychology. It was not sufficient because it was covered in a module that was only six months long. (Participant 12)

Reflecting from the above, findings exude that majority of the participants are in support of the study conducted by Olckers in (2013). Olckers in (2013) study uncovered that social workers receive deficient training concerning mental health at the undergraduate level. In addition, Aviram (2002) study cogitates mental health as a critical area within the social work profession and believes that it should be a prerequisite at the undergraduate level. In contrast, as seen in this study, participants have indicated that mental health is not regarded as a priority within the social work training at tertiary. According to Aviram (2002), this results in generic social workers and the other mental health professionals acquiring enormous differences in terms of knowledge base regarding mental disorders and the treatment thereof.

Sufficient training

In negation to the findings explained above, few of the participants feel that their undergraduate training was sufficient enough for the mental healthcare field, but with thorough

analysis and observations, these are also the participants who expressed only positive experiences in this field.

> My training at the University was sufficient to prepare me to work effectively with mental health care cases; we were taught on the DSM5 and mental health literacy. I wasn't shocked by anything when I got to practice. I did my internship at a mental health organisation during my fourth year. (Participant 1)

> Yeah, I was one of the students who did psychology as a second major at the university, so I did it up to 3rd level. I then registered for honours in psychology at Unisa and passed it with cum laude. I feel competent and well trained for this field. (Participant 5)

> My undergraduate training was sufficient, yes, psychology was my second major, and I continued with mental healthcare till my Occupational Masters in social work, mental health is my passion, I have even thought of doing clinical psychology too. (Participant 11)

> Yes, my undergraduate training was intense, and it did prepare me for this field. I am trained and have all the required skills within my scope of practice. (Participant 14)

Social workers are trained generally trained (South African Council for Social Service Professions, 2007). Balinksy, (2012) also validate the common nature of undergraduate training.

5.5 Perceived need for additional mental health training

The social workers asked if they felt there was a need for more training in mental health since they have no choice but to deal with mental healthcare cases in hospital-based settings and they were asked to indicate the content of the training. The theme that emerged from this question was yes, from all participants, and various content of training emerged, and this will be reflected in the narratives stated below:

> Definitely, I really believe that social workers need more training in mental health, and I also think that mental health should be a specialised field so that we can have confidence and feel competent when rendering the services. (Participant 2)

Need for more training at the undergraduate was recounted by one of the participants in the following extract:

> Of course, social workers need more training at the undergraduate level and definitely on-going workshops on mental healthcare as in-service training to update our knowledge and skills in mental healthcare. (Participant 7)

> Yes, we definitely need more training in mental health. All tertiary institutions should have intense training on mental health

> because some institutions only do the basics and only at the second level. We also need regular in-service training to keep up with the changing Acts and laws. (Participant 14)

> More training on mental healthcare is needed, mostly at tertiary training so that we are not incompetent when we get to the field, in this way; other professionals will recognise us as one of them in the hospital-based setting. (Participant 12)

Need for training during in-service training was explicated by other participants in the following lines:

> Yes. We do need more training on mental health; some social workers even lack the general mental health literacy, which reflects badly to the other professions. They end up thinking all social workers are not knowledgeable or trained at all on mental disorder. (Participant 15)

> Yes, more mental healthcare training is needed both at tertiary and at work, to ensure competency and effective service rendering. (Participant 18)

> Yes, I think social workers need to undergo thorough training before working with mental health care patients. Mental health care is a very serious and sensitive problem; I feel that some social workers are not adequately trained to provide services to

> mental health care users. I would recommend that social workers undergo at least a 6-month training course upon getting employed so they can have a general idea on mental illness. The course can focus on the different types of mental illness, assessment of mental health care users, the DSM-5 and the mental health care act, because yoooooo the new social worker that was employed here at my hospital is really clueless, so I have to do all mental healthcare cases and the load is too much for one person. (Participant 11).

However, based on the foregoing, the researcher of the study agrees with participant 18, who stated that:

> Yes, more mental healthcare training is needed both at tertiary and at work, to ensure competency and effective service rendering.

5.6 Professional support mechanisms

On this subject of inquiry, participants were asked to describe their professional support base in mental healthcare. Numerous themes appeared from this question, themes including no professional support, Positive support from colleagues and insufficient support in supervision. This is clarified by the study by Poso & Porsman (2013). Poso & Porsman (2013) study found that social work is a profession often characterised by stressors and recompenses, and these recompenses warrant more attention and should be used as a source of impetus. This narrative was supported by another respondent below:

No professional support

> Interviewer: How would you describe your professional support base?
>
> Participant 7: Non- existent
>
> Interviewer: Please elaborate
>
> Participant 7: Social workers are isolated in the department of health, no representative in management that voices the needs of social workers.

> What support? Social workers are not supported however when things go wrong they are the first to be called. Also, social workers are always asked to do things out of their scope of practice even though they are not even allocated a budget or petty cash within hospital budgets. (Participant 18)

Social workers collect general undergraduate training but are expected to function optimally within the field of health without the necessary support and guidance (Silence, 2017). Mental health social workers are reported to often experience burn-out due to limited social support (Willems, 2014).

Participants revealed that supervision and debriefing are very important to the profession. For instance, it was recounted that lack of debriefing and failure to recognise the social work needs could leave social workers vulnerable to mutualisation and burnout, and such discipline-specific supervision is essential. This position was supported by participant 2 as revealed below:

> There is no support, in the 5 years I have worked here I have never been offered a debriefing session. A doctor was once killed here by a mental healthcare user, the social workers were asked to debrief the other staff members but there was one who thought that social workers should be debriefed too.

Moving further, Kadushin (2014) contextualised that social workers are often uncovered and are grossly involved with situations that are no doubt challenging that in dealing with it, the social worker most times becomes emotionally drained. Therefore, within the occupation of social work, there is such great need for sustenance and the restoration of morale which can only be attained by supervision. To support this further, the study of Tafvelin, Hyvonen and Westerberg (2014) have suggested that leadership and supervisors can have a positive effect on the professional well-being of their social work staff.

Supported by participant 15

> I do not have a good professional support base, no supervision or debriefing, limited resources and no budget for mental healthcare services.

To put in context, supervision is traditionally a process in which a more experienced social worker supports and provides a space for supervisee to reflect on their practice (Ingram, 2013). For Gilbert (2009), it was suggested that supervision contributes to competent professional practice that serves the best interests of the clients.

The participants also again expressed how the profession lacks recognition in the department and it was expressed by various participants;

> Social workers at the Department of Health are not seen as health professionals, therefore our needs take the back seat, availability of resources and emotional support is lacking. (Participant 3)

> No, it’s like am a visitor in this department, I don’t belong. We are not prioritised or recognised at all. (Participant 16)

The participants' response correlates with Huxley et al., (2005) whom found that lack of resources, the pressure to work long hours, covering for open positions, the high volume of work and not feeling appreciated by the employer nor by general society caused high stressed among social workers.

Positive support from colleagues

In context, some participants have given a different scenario in terms of where they get their support. For instance, two of the participants explained that they usually get their support from their fellow colleague, particularly, one of them indicated that the support is through a WhatsApp group that they have created. The highlights of the response are recounted below:

> We are hardly ever supported; we only support each other as social workers through the WhatsApp group. We actually isolated from other health professionals. (Participant 12)

For Rueda, Linton and Williams (2014), the importance of a supportive environment such that could attract the advocacy for support groups among co-workers was signalled as a fundamental factor. This supports the participant's response to having her fellow colleagues being the support system.

Insufficient

The few participants, who indicated that it was there but not enough, are quoted below;

> I would describe it as insufficient, it is there but it's not enough, it's a huge challenge... Social workers are still managed by medical doctors who don't understand that we need to do home visits, so we need transportation, we need petty cash for our patients who are discharged without clothes or taxi fare. (Participant 5)

> I have a medical manager who is supportive emotionally, but I feel it's not enough because he doesn't understand the nature of my work. She is not aware of the resources we need to work effectively, and he can't debrief us, even when you present a traumatic case to him. (Participant 1)

> I work well with my supervisor, she always goes out of the way to give me emotional support and she always tries to provide the resources I need, but the other people like the CEO don't support me because she ends up not winning if it's a case towards social workers. (Participant 10)

Of course, the findings emanating from participant's responses correlate with the of study Ting, Jacobson and Sanders (2008). Ting, Jacobson and Sanders (2008) reported that 285 social workers reported that the support systems that were most commonly available to them were not considered effective on how it could affect and engender a positive on their well-being. Thus, in addition, the above findings neatly agree with Kim and Stoner (2008) study, where it was highlighted that, that in order to put more safeguards into the mental health system as a

whole, it is very crucial to tend to the mental well-being of social workers providing services. In other words, this becomes fundamental in line with Jackson (2014) assertion where it was explained that, if social workers are not cared for, their capability to care for their clients would be greatly abridged; this means that when social workers are struggling with their well-being, so will their patients.

5.7 Overall experience in a multi-disciplinary team

Within the hospital settings, social workers also serve as members of a multi-disciplinary team which they work alongside doctors, nurses and rehabilitation staff in order to provide coordinated care to the patient (National Association of Social Workers, 2011). The social workers were enquired to share their overall understandings in mental healthcare multi-disciplinary teams. Thus, themes that emerged from this question are indicative of both negative and positive experiences. These views are shared below:

Negative experiences

Most participants reported having negative experiences in mental health disciplinary teams, mostly it seems to result from lack of recognition, not valued or respected. The experiences are explained below;

> It depends on whether the team understands your role and recognises your importance of being in the team. Some professionals are actually supportive and appreciate your contribution, overall, I would say negative because the majority of the medical doctors don't recognise social workers as a mental health practitioner. (Participant 15)

> Both negative and positive, it is positive when you are recognised as an expert on your field which is the social services. It's negative when a Doctor or a nurse wants to dictate how you should do your job. (Participant 11)

> My experience is not all good, but other professionals undermine the profession. Some, which are the majority do treat us with respect and understand our scope of practice. (Participant7)

In the contention of Duncan (2008) cited in Olckers (213:34), it was conceived that, generally qualified social workers are out of their depth in mental health disciplinary teams and that only clinical social workers are trained to operate in mental health institutions, specifically on issues bordering on mental health issues. In other words, Duncan (2008) position seems to share the same sentiments with the views of the other professionals who consider that social workers are not trained in the mental health field, thus never use them unless they cannot proceed without social worker's report. Thus, there are also a lot of the participants who indicated they had negative experiences because of the other professionals having issues with their level of training but referring only because they had no other choice. Some of their response is captured below:

> I would describe it as negative, because of the basic training we are said to have on mental health according to the other professionals. They want to tell us how to handle a case, they undermine our social workers' knowledge and skills, and they interfere. (Participant 9)

> mmm… most of the time we are not involved, we are only involved when they are stuck, which makes you wonder why you were involved when they had the first meeting. I feel that other professionals look down on social workers in general because they believe our training in the mental health field is lacking. (Participant 18)

In the view of Easen et al., (2000) the issue of specialists and professionals not having a fuller understanding each other's roles have been identified as a barricade to the inter-professional partnership. As indicative in this study, the participants feel that the other professionals are uncertain of their roles and these results in them having undesirable experiences.
Participant 2 reported this evidence in the below extracts:

Participant 2 reported that…

> Negative, we are marginalised, treated like incompetent professionals even on other health cases which are not necessarily mental health related. They exclude us, it's as if we don't belong in the hospital settings. (Participant 2)

According to Webber (2012b), social workers in multi-disciplinary teams are reported to be marginalised and underutilized because of their minimum training from medical professionals with regards to how decisions over treatment are made.

Then there was one different perspective shared by participant 14

> Even though they know that am well trained in mental healthcare, I feel like they undermine me because I am the youngest. I feel

> marginalised; they will request my assistance because they have hit a brick wall.

Positive Experiences

The few that reported having positive experiences seem to be those who feel recognised, respected and valued in their workplace; they also have reported having the support that was there even though it wasn't sufficient. It seems that those participants have also indicated to have a passion for mental health and thus they have had further training beyond undergraduate.

> At this present moment, I would say it is a positive experience because they recognise me as a practitioner and they take my recommendations to account when socially intervening. (Participant 1)

Participant 1 shares the same sentiment with participant 5

> I have had positive experiences since I am valued as a professional in my field. (Participant 5)

5.8 Recommendations for effective mental healthcare services provided in hospital-based settings.

On the need to uncover what are the likely recommendations for effective health care services provisions in hospital-based settings, they were asked to state any known recommendations or suggestions that they can put forward in order to bring about the provision of effective mental healthcare services in hospital-based settings. To achieve this aim, various themes and sub-themes emerged from this question. The main themes include specialised

training; recognise social workers as mental healthcare practitioner; clarification of social work role in mental healthcare and need for social work supervisors in the hospital settings.

Specialised training in mental healthcare

Revealing from the findings, majority of the respondents admitted that mental health is a specialised field in which they somewhat do not have in-depth or intense training on, as such, they have suggested that mental health becomes a specialised field in which only the trained can specialise in. Supporting these narratives are the following recounted by one of the respondents.

> In other countries mental healthcare is specialised, I think it's only in South Africa, where we are still struggling to recognise specialisations such as clinical social worker, medical social workers and many more. Train social workers so that they are competent in this field. (Participant 9)

In support of participant 9, there are other participants quotes that feel mental healthcare is a specialised field that needs specialised training.

> Train social workers on all health issues, because it's specialised. Respect social workers and invite them to workshop and meetings health related. (Participant 12)
>
> At the beginning of the career, weekly supervision and regular training. (Participant 13)

> Specialised training on mental health, since mental health is a specialised field. (Participant 16)

However, it is clear, that participants in this study conceive of mental health as a specialised field with the acknowledgement that their general training is insufficient in this field. In other words, they recommend that social workers be placed on specialising training for effective discharge of their role functions. This position is supported by Silence (2017) that social workers are probable to offer a service within the specialised field of well-being, even though they have been trained broadly (South African Council for Social Service Professions, 2007). In addition, Silence (2007) study had previously added that social work undergraduate training does adequately prepare social workers to function as autonomous practitioners in the mental field. Lastly, Corrigan, Torres, Lara, Sheehan & Larson (2017) contend that mental healthcare needs to be diagnosed by expert therapists, and this can be preserved as a special area of discipline.

Recognise social workers as mental healthcare practitioners.

The South African Mental Health Care Act (17 of 2002) defines a mental healthcare practitioner as "a psychiatrist or registered medical practitioner or a nurse, occupational therapist, psychologist or social worker who has been trained to provide prescribed mental health care, treatment and rehabilitation services" (p.6). So according to the Act, social workers should be recognised as practitioners, and this means they should be trained in mental healthcare in order to provide effective services to their patients and families. Almost half of the sample indicated that it was important to them that they are recognised as mental healthcare practitioners. Supported by various narratives;

> Respect and recognise social workers in the healthcare setting, train social workers in the different healthcare services, then they will be effective. (Participant 18)

> Social workers in hospital-based settings need to be equally recognised as practitioners, have supervisors who are trained on social service and have a budget for emergencies. (Participant 1)

Clarification of social workers role in mental

The participants indicated that they felt like their roles in mental health are not clear to the other professionals, thus they feel that clarification of roles would help the other professionals give them correct recognition and thus this will impact on service delivery.

> ...clarity should be provided of all roles in a multi-disciplinary team setting to ensure effective contribution to patient care by all involved. (Participant 8)

> Other professionals need to understand the role of the social worker. They need to seek clarity if they are unsure. Professionals also need to recognise social work as an equal profession, and even though social workers do not have the amount of training that they do in mental health issues, they need to be treated with respect. (Participant 4)

> Specialised training in mental health, get the other professionals knowledgeable on the role of social workers because they don't understand our role. (Participant 7)

In a study conducted by Keefa, Geron and Enguidanos (2009), it was recognized that the necessity for the social work role to be evidently expressed as an essential prerequisite for effective teamwork by social workers with other team members. For instance, role clarification seems to be a vast problem. This is supported by Bikson et al., (2009) study. For these authors, there are numerous studies that indicate that the lack of understanding of the scope of the social work role. An example of this case is Easen et al., (2000) who indicate that professionals' not understanding each other's roles is an issue which has also been recognized as an obstacle to inter-professional teamwork. In the South African department of health, it is equally reported that there is also no standardised document outlining the role of social work (Silence, 2017).

Social worker supervisor

It was shown throughout the data analysis that the participants strongly feel that their major problem in working in a hospital-based setting is the lack of having a supervisor who is skilled on social services, they lack management from a person who understands their needs professionally, and someone to assist them with challenges in the field.

> Social workers need recognition from the department of health as a healthcare practitioner, have a social workers supervisor in management, have regular training on all health issues. (Participant 2)

> Hire more social workers in hospital settings, hire a person with a social work background to supervise them and give regular training in mental healthcare. (Participant 11)

To put in context, some participants indicated that their specialized support base was poor owing to being managed by a medical manager who lacks a comprehensive understanding of issues about social services. To add, Lord Laming (2009) had rightly stated that managers of social workers reinforce the service they provide, and it is, therefore, the cornerstone of good social work practice. This is signposted by the majority of the participants, the great need for a social work supervisor. For Kim and Stoner (2008), not having sufficient supervision could lead to exhaustion amongst social work population.

5.9 Conclusion

In this chapter, the examination of the results assembled through the semi-structured interview was clearly presented and analysed. To start with, the biographical information of the participants, in terms of the number of years of experience, average caseload per month, gender and the highest educational qualification were explicitly shown. Secondly, six themes were explored, including social worker's intervention role in mental health, the overall experience in providing mental healthcare services, tertiary training in mental health and the need for more training in mental health. Others include social workers' professional support in mental health, their overall experiences in working in multi-disciplinary team and recommendations to help social workers provide effective mental healthcare services in hospital-based settings. Specifically, these subjects were discovered within relevant to other sub-subject and categorization accordingly, thus reflecting from respondent's narratives and responses, and intermingled with findings from extant kinds of literature.

CHAPTER SIX: CONCLUSION

Literature regarding the social workers' experiences and roles within the mental health care sector is poor, particularly within the South African context (Lietchy, 2011). The crux of this investigation was to unravel social workers' experience in providing mental healthcare services in hospital-based settings. The study utilised a qualitative research approach and exploratory design. The study comprised of 20 social workers already providing community mental health care services for more than 5 years to 18 years. Participants were recruited using purposive sampling. Semi-structured in-depth interview was conducted with each participant, and data emanating from the interviews were analysed using thematic content analysis. The goal of the study was accomplished with three main objectives.

This chapter presents the conclusion and recommendation of the research study. Conclusions will be drawn from each objective of this study and propose recommendations which will ultimately improve social workers experiences of providing mental healthcare services in hospital-based settings. This study hopes to make significant contributions to research and knowledge on social workers' experiences within mental healthcare practice and to fill the research gap, in the South African context. In addition, silent recommendations were proffered to assist the social work profession in providing effective mental healthcare services.

The main conclusions of this study are structured according to the empirical findings ensued from the results. Conclusions are presented with respect to biographical information of respondents and drawn from the research findings; they will be offered in relative to the objectives of the study and questions asked to the participants.

The following main conclusions are inferred from the research findings and are presented in relation to the objectives of the study.

- **Examine social workers preparedness of providing mental healthcare services.**

Social workers preparedness in providing mental healthcare services was examined in various questions, such describing the type of intervention social workers provide in mental healthcare and how their training has prepared them for provision of effective mental healthcare services.

The qualitative data gathered from the semi-structured interviews presented that social workers were able to identify their roles in mental health, even though many studies indicated that other professionals and social workers themselves don't know the social workers' roles in the mental healthcare field. The identified roles by the participants were Focusing on patient holistically, statutory intervention, empower and support, therapeutic intervention and using the DSM-5. Focusing on patient holistically was seen as being extremely crucial by the majority of the participants, it is deemed by the participants as a way of understanding patient's wellness, improvement and repossession, such that are more supportable and effectual in nature. The statutory intervention was also deemed by participants as a very important role that social workers play, especially because mental healthcare users and their families are the most vulnerable in our communities.

The social workers are seen as the voice of the vulnerable groups, they have the responsibility to guarantee adequate accessibility of and admittance to resources and subsidy. Empowering and support are also reported by most of the participants as an important intervention by social workers in mental health, they give support and empower both the individual and their family. Social workers are also known for connecting sick persons with and families for basic resources and services. The therapeutic intervention was also reported by the participants as important, and this is the process whereby one on one session with the patient is thought of as being of great importance within the mental wellness profession. There are many studies that support the above roles reported by the participants. Then a sparse number of the sample signposted

that they use of DSM-5. This is a very debatable role, according to literature; some studies indicate that social workers are not well trained on using this diagnostic manual whilst some indicate that they can use it.

The second question to examine social workers preparedness of providing effective mental healthcare was asked if the participants felt that their undergraduate training was sufficient to prepare them for the mental healthcare setting. Majority of the participants indicated that their undergraduate training was basic, introductory and was not in-depth. Participants have also shared how this makes them feel less confident and incompetent in this field. There were very few participants who indicated to have had some form of in-depth training in undergraduate level but indicated that they wish they received more for improvement on the job.

Majority of the participants were adamant that undergraduate student did not obtain adequate teaching in the mental healthcare, it is said not to be in the social work curriculum, but it was identified by all participants as very important as they have increasing caseloads of this nature. Participants indicated it is necessary to integrate mental healthcare into generic social work practice because they are struggling with even minor terminology, this means there will be increased knowledge and training at both tertiary and in-service training. Studies were also found that supports the participants' notion on their undergraduate training and need for more training.

- **Explore professional support, accessibility and availability of resources to social workers in a mental healthcare setting.**

Under this heading, the findings were that the mainstream of the participants deemed that they have no professional support from the department, nor from their medical manager who is supposed to pay the role of their supervisor. This was supported by various literature, Conway (2016) went as far as explaining that when social workers well-being is not well taken off, it

does not only affect the social worker at a discrete level, but it also unswervingly affects support and client consequences, which in turn influences the mental health system. Findings revealed that social workers do not feel supported mainly because they do not have a social worker supervisor, which results in the participants not receiving traditional supervision which entails debriefing in social work practice. Participants expressed that they are in need of supervision because of the nature of their work.

Findings in this study are that social workers shared that they are understaffed, which results in them being overworked. This was expressed by participants who indicated to be only two in a tertiary hospital. Shortage of social workers in hospital-based care settings has been written about in numerous studies. The lack of resources in hospital settings is reported to affect service delivery. Lack of support and recognition from other health professionals was also reported by most participants and this affects the social workers' confidence in providing effective mental healthcare services. The minority that reported to have some form of support from their hospitals, also reported that it was insufficient. Studies have found that the absence of social work supervisor posts in hospital-based care settings, so, unfortunately, they have to report everything to the medical manager who is said to not understand social worker's needs.

- **Examine social workers' experiences with working in multi-disciplinary primary healthcare teams.**

Findings in this study with regards to social workers experiences in multi-disciplinary were mostly negative experiences. Majority of the participants indicated that they are not recognised as mental healthcare practitioners by the other professionals, their training is being questioned and they are not seen as important unless they have to come in and fix what has been done wrong. Social workers are feeling isolated within the department of health, and it is mostly contributed by their generic training in the field that they feel is specialised. Participants even reported to feeling marginalised and under-used by the other professionals in multi-disciplinary

teams. This, however, was in contrast with other participants who felt overworked, and understaffed within their hospitals. According to literature, talking progressive vicissitudes in mental health status necessitates more than an exclusively medical approach (Braveman & Gruskin, 2003). These authors emphasise the importance of working in a multi-disciplinary team in providing effective services in mental health but from the findings of this study, things go wrong when the professionals don't work together, and participants expressed that, that is the only time they are involved, when they have to fix damage done by other professionals who tried playing the social work role.

In this study, role clarification seems to be the other challenge leading to negative experiences, other professionals questioning social workers role, nurses and doctors attempting the social workers' role was also indicated in this study. Role clarification is very important so that the other professionals do not overstep their boundaries and close up exploiting additional damage than good.

Recommendations

Based on the above conclusions made on the study, with the overall intention of unearthing social workers' experiences of providing mental healthcare services in
hospital-based settings, the following recommendations will be made;

1. Training for social workers

Considering the conclusion made on social workers preparedness to providing mental healthcare service, it is evident that tertiary institutions need to re-evaluate the social work training curriculum because mental well-being requires to be integrated into the undergraduate training of social work students. It is evident that there is a sure need for social work professional in mental healthcare, however, grounded on information offered by respondents there is a huge gap in the undergraduate training and even greater during in-service training.

On the legislation and policies. Social workers need training and skills on how to provide effective mental healthcare services. Training on mental health literacy as this affects the provision of mental health care services by social workers. There is a need to fill this gap. If South Africa must achieve greater achievement in early intervention, deterrence, management and patient support, it is important that social workers are well versed in mental health literacy, where they can apply basic and accurate knowledge.

2. Provision of professional support to social workers in hospital-based settings

The researcher of this study recommends that the Department of Health recognises social workers as equally important as the other professionals within the department. This means that the profession will be supported through the allocation of resources, professional development and be funded accordingly. Social workers just like any professionals in the department need to be supervised by a more skilled or experienced social worker, because nurses are supervised by matrons who were nurses and doctors are supervised by a medical manager who also is a doctor by profession, social workers need to be supervised by a professional who understands the nature of social services. This will ensure that social workers receive appropriate professional support and by this, social workers will receive proper supervision which will increase accountability, and this will equip emerging and inexpert employees with the needed aids and information to convey effectual social well-being services to the client system.

The department of health should have an unvarying document detailing the responsibilities of social worker in the hospital-based setting, with the clarification of the roles this will enhance co-operation from the other professionals who seem to isolate social workers because they claim not to understand their role in this specialised field, isolating social workers hinders effective service delivery. Clarity should be provided of all roles in a multidisciplinary team setting to ensure effective contribution to patient care by all involved. Policies that facilitate

better collaboration among the multi-disciplinary team in healthcare can be beneficial in providing better services for social workers as well as improving their experiences in mental healthcare. A social work assessment guideline within the bio-psychosocial framework for social work assessment in mental health setting should be developed to empower social workers in the mental health care setting to conceptualise cases in a comprehensive manner and this will provide rights-based interventions as well.

3. Sensitization programs

It is evident through this study that mental healthcare cases are increasing and since social workers are declared mental healthcare practitioner, spreading awareness about the importance of social workers in caring for mental healthcare users is intensively important. Organising sensitizing programs can help generate positive views about social workers among service users and members of the multi-disciplinary teams.

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