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AN EXAMINATION OF THE ROLE OF REGIONAL PSYCHOLOGISTS IN THE WESTERN CAPE PROVINCE.

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ABSTRACT

In the South African public health services, psychologists have traditionally been placed within the tertiary psychiatric health services. Recognition of the role of psychologists in terms of broader mental health care can be attributed to theoretical development in the field of community psychology and the concomitant search for appropriate roles. The restructuring of the health services following democratic elections in 1994 and resultant policy development have resulted in the development of regional and district health services working towards providing comprehensive mental health care within a primary health care model. In line with this, posts for clinical psychologists were created in the regional mental health teams.

This study examines the roles of the regional psychologists in the Western Cape Province within the regional mental health teams. Semi structured interviews with the relevant psychologists, together with diarised accounts of their daily activities were used. The data was analysed qualitatively, with additional quantitative analysis enriching and informing the results. The nature of the role of the psychologists is described, together with pertinent contextual factors, which influence that role, both at a macro and micro level, as these create and shape the role adopted by the psychologists. Recommendations are made regarding the effective deployment of psychologists. Areas of difficulty, which need to be addressed, are identified, together with ideas for the further development of psychological services within the primary and secondary health services.

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CHAPTER ONE: INTRODUCTION

1.1. Background to the study

South Africa has a limited number of psychologists. Freeman and Pillay (1997) give the figures of 161 psychologists within the public sector of which 24 are categorised as placed within the community. The proposed norm suggested by the Department of Health is 1:100 000 population thus at the Primary Health Care (PHC) level 363 psychologists would be needed. They further suggest that although the training of community health workers in mental health has been mooted, this cannot be effective without skilled support staff. It is crucial that the placement and utilisation of psychologists within the mental health team is both critically evaluated in terms of where they are placed within the health structures and in relation to the goals of policy and service development.

There is momentum within the public sector to reform and transform the health services, using a Primary Health Care (PHC) approach, following the fragmented and inequitable health system pre-1994. The White Paper for the Transformation of Health systems in South Africa (1997) states that:

The new South African health system adopts the PHC approach because this approach is the most effective and cost affective means of improving the population's health. The approach involves a health system led by PHC services, which are at the base of an integrated district health system. (p. 19).

The development of the District Health system is an effort to provide equitable and accessible health care.

Psychologists have traditionally been placed in the public sector in a tertiary psychiatric setting. Recognition of the role of psychologists in terms of broader mental health care has been in part due to the theoretical development in the field of community psychology, together with a search for appropriate services and intervention models for the rich texture and diversity of South African society.

Theory, policy and actual practice are often very divergent. This study is an attempt to examine the description of the role and practice of psychologists placed at a different

interface to that traditionally assigned to them within the public sector and how a variety of macro and micro contextual factors influence the construction of that role. The sample used is psychologists practising at a regional level within the Western Province Department of Health, who interface with the district system and the provincial system. The Western Cape Province has particular contextual differences namely that it is relatively well resourced, there are shifting political alliances influenced by the different proportion of racially based groups of voters in this province and the implementation of national health policy has been slower, and more gradual than in other provinces. The placement of psychologists at a regional level perhaps reflects some of the momentum for change. The examination of their role is necessary in order to both place psychologists effectively and to be able to advocate with regard to further policy decisions i.e. the creation of posts and the structuring of mental health services. However as Reynolds (1997) says: “ There is risk in reform. It requires dialogue on re-definition, re-interpretation, and efficacy. It requires an acknowledgement of impotence and failure.” (p.30).

The methodology used is primarily qualitative and seeks to meet the criteria outlined by Thorne (1997) of moral defensibility, disciplinary relevance, pragmatic obligation and contextual awareness.

1.2. Context of the researcher:

In adopting a qualitative reflexive approach, my own context is relevant to understanding the intersubjective construction, which has occurred during the research process. My own career before coming into psychology was in nursing, with a particular focus on primary health care. During my undergraduate and honours psychology studies there was a strong focus on community psychology and the search for relevant practice within the South African context. My clinical training at Masters level incorporated some of these ideas but also integrated the psychiatric models of mental illness. This study is in part an attempt to refine and define my own ideas and models of practice.

1.3. Structure of the thesis

The thesis is structured to “explore the dialectical process whereby micro and macro forces inform, produce and reproduce each other.” (Bhagwanjee, 1998, p.96).

Chapter Two provides the macro contextual elements within which the research activity is embedded. The literature review will examine some of the broader political and professional forces, which have impacted on the role of a regional psychologist. This includes an overview of the South African Health system with particular focus on the Western Cape Province. Policy, with regard to transformation and the adoption of a PHC approach to health care provision together with how this is translated into mental health policy, is considered. Parallel to this process there has been an ongoing debate within the profession regarding relevant practice and an overview of some of the ideas of community psychology is given.

Chapter Three includes the methodology employed to gain both qualitative and quantitative data. Chapter Four includes the analysis of the interviews and quantitative data collected in order to give a more micro contextual view. The first section includes the demographics of the psychologists, the reasons for their job choice, their own and others expectations of the job, their own professional identity and their vision regarding psychological and mental health services. These serve as a backdrop to the second section, which includes description of their roles and the time allocated to various activities. The chapter concludes with a further section, which looks at the resources and constraints and the issues of race, language and gender that influenced the roles played, together with preparation during and after training. Chapter Five maps out the macro and micro contextual elements identified, and discusses pertinent issues that arise from the results. Chapter Six draws together a composite picture of the role of the regional psychologist, includes the conclusions of the research and makes recommendations for practice.

CHAPTER TWO: CONTEXT AND LITERATURE

REVIEW.

2.1.Introduction:

The thinking and conceptualisation of the research question, the research process and the researcher's own understanding have been informed by several theoretical perspectives. The following review will begin by highlighting some of the main tenants of these theoretical approaches and elaborate on their relevance to the research, although space precludes an in depth examination of these stances. Broadly speaking, these include a post-modern approach inclusive of ideas of social constructionism, activity theory and intersubjectivity. These theories provide a theoretical framework for understanding the importance and interplay of contextual forces, both personal and societal, on the nature of roles adopted by people working within systems.

To elaborate this understanding, the focus will then turn to a description of the health system in South Africa and particularly the Western Cape Province within which the psychologists are working. This will include the recent changes in the system and a brief overview of the historical, ideological, economic and social forces, which have given the impetus and rationale for change.

The review will include an examination of two further parallel processes. One of these has been the development of mental health policy. A further parallel process, alongside these developments has been the search by the psychological profession within South Africa for contextually relevant practice and the introduction and adoption of ideas of community psychology. Finally, these ideas will be drawn together in how they pertain to the research investigation of the role of regional psychologists in the Western Cape Province.

2.2. Role is constructed by context:

That role is constructed by context draws on the Foucaultian understanding that a person is constituted in social practice and reflexive in their action. The socialisation of the psychologists into a particular role by their training and in interaction with other psychologists, together with their own histories, gives rise to their own identity and resultant practice as psychologists. They also practice within a particular system within which an understanding of mental health and mental illness have been constructed by social forces and the meanings have been influenced by dominant ideologies.

The theoretical assumptions on which the preceding statements are based are inclusive of ideas of social constructionism, activity theory and concepts of intersubjectivity. These ideas inform the focus and the process of the research.

Social constructionism:

The social constructionist approach in psychological research arose out of a critique of the hegemony which empirical and positivist methodology had, upon the nature and type of research undertaken. The verification or falsification of hypotheses by means of observation, thus validating a particular theory, is the basis of the empirical approach. The positivist seeks to find general principles or truths, which both explain and describe human actions and interaction.

However, Gergen (1985) relates constructionism to two main epistemological orientations. The exogenic perspective would hold that knowledge mirrors the world out there. The endogenic perspective would hold that knowledge depends on the internal processes of the person. Constructionism seeks to escape this subject versus object dualism and develop a new theory of epistemology and enquiry. It seeks to be a metatheoretical approach, which would develop a relevant knowledge, which will identify and challenge the social origins of the assumptions we take for granted. An important assumption of this approach is the central role of language. Language is used as a commonly constructed and understood communication

system. Language itself is in a dynamic state, as meanings change with time and context. In its verbal and non-verbal forms, it is essential as a medium for the transmission of knowledge. It is influenced and constructed by culture, context and history thus definition is as fluid as the language on which it depends. Understanding is created and recreated. Gergen (1994) states that:

The terms and forms by which we achieve understanding of the world and ourselves are social artefacts, products of historically and culturally situated interchanges among people. (p.49).

And that:

The degree to which a given account of world or self is sustained across time is not dependent on the objective validity of the account but on the vicissitudes of social process. (p.51).

The research process thus seeks to unpack and examine the social construction of the identity and role assumed by psychologists placed within a particular context at a particular time in history. In assuming a social constructionist stance, there is the need to be reflexive at a metatheoretical and theoretical level throughout the research process.

Activity theory:

Another theoretical perspective, which is embedded in the research, is that of activity theory. Vygotsky (1976, quoted by Gilbert, 1998) claims that through activity and doing things we develop a sense of self and that of others and thus become the human beings that we are. An activity is made up of tasks, goals, actions and tools, both material and psychological (Leont'ev, 1981 & von Cranach, 1982 as cited by Gilbert, 1998).

The task is constituted by the creation of a need or problem towards which actions can be directed. The goal is the motivation for the activity that is performed. Actions are sequenced in order to fulfil the task. The tools are the means for achieving the task. Lave (1993, as cited by Gilbert, 1998) embeds activities in social practices. "Knowledge, identity and meaning are not independent of action. They are constructed and reconstructed within the social bounds of activity" (Gilbert, 1998 p. 11).

Many activities become part of our tacit local knowledge. There is a need to engage in metacognition, thinking about thinking, in order to stand back and examine social practices and evaluate them. Likewise this research activity provides an opportunity to reappraise and evaluate the activities with which the psychologists were engaged.

Intersubjectivity:

Intersubjectivity is an interdisciplinary and multilayered concept. It is understood in different ways. Crossley describes Husserl's view of intersubjectivity as:

a view of the world arrived at through mutual confirmation and negotiation between different and independent perspectives. Rationality... is not an individual but an intersubjective attribute. It manifests in a form of interpersonal persuasion and decision-making which relies neither upon force nor upon deception but upon an appeal to common evidence and argument, and thus to a reciprocity of individual perspectives and an interchangeability of individual standpoints. (Crossley, 1996, p.3).

Drawing on Buber's writings, Crossley identifies that human subjectivity can be directed at the I- It, whereby the other is constituted as an object, or as I-Thou, whereby the other is a mutual relationship. Buber also describes the 'interval' or the 'between' and that common linkage is made possible through language. "Ideas are no more enthroned above our heads than resident in them; they wander amongst us and accost us" (Buber, 1958 as quoted by Crossley, 1996, p.12). He also makes the point that intersubjectivity is always political and involves both personal and public relationships.

Hegel's ideas revolve around the human desire and struggle for recognition:

Self-consciousness is an intersubjective phenomenon in this sense, achievable only through mutual recognition between consciousnesses...our sense of self-esteem, pride and dignity is integral to this. These are feelings that we can only have relative to the other and they are thus bound to our relations and interactions with others. (Crossley, 1996, p. 17).

Hegel also shifts his analysis to looking at how the historical dynamic of social relationships affect self-consciousness and that intersubjective relations of recognition are conceived as social and political.

Although it is not within the scope of this research to discuss in detail the development of policy and the role of the state as an expression of power and control from an intersubjective understanding or to debate the use or abuse of that power, it is important to acknowledge that this research is based on ideas that our lives are constituted in an intersubjective way: at the micro level of the individual's view of self, to the intermediary level of their professional identity and role and to the macro level of national and international politics and the structure of systems.

The remainder of the review will examine some of the major variables, which have an intersubjective relationship with regard to the role of the regional psychologists at a macro level. This is inclusive of broader political influence, to the desire for change within the health system and particularly within the arena of mental health, to developments within the profession and practice of psychology.

2.3. The social, economic and historical context of a changing South African health system:

The effects of modernisation, three centuries of imperialism and colonialism and more recently apartheid have had a profound impact on South African society. This, together with pervasive and powerful patriarchal and racist social structures, has contributed to human suffering in ways, which are perhaps inestimable. The legacy in terms of economics, racialised differences and inequalities, power relations, unrecognised and undeveloped potential, and societal and personal pain continues. However, the generation of a strong human rights culture and the principles of a non-racial, non-sexist, democratic and unitary state has also evolved and is given form in the Constitution and the Bill of Rights, which came into effect from February 1997 (Foster & Swartz, 1996).

With the changes in the political system in South Africa during the early to mid 1990's, there were also many debates regarding the whole health system and the need for restructuring and transformation in order to meet the needs of all the peoples of South Africa. [Refer to Peterson (2000) for a full review of this process.] The development of health policy, which reflects and guides this change, has received an enormous investment of time, thought and energy.

The White Paper of 1997, published by the Ministry of Health, proposed a strategy of a Comprehensive Primary Health Care system, which would decentralize management of the health services with the development of a district health system. This would aim to promote equity through a single, unified health system. The role of the national department would be to formulate health policy and legislation, establish norms for quality assurance, and build capacity in provincial and local health structures. It would include equitable allocation and management of the distribution of health resources, co-ordination of health information systems, regulation of the public and private health sector and liaison with other national health departments and international agencies (White Paper, 1997).

The next level within the new unified system would be the provincial health department who would work:

within the framework of national policies, strategies and guidelines... to promote and monitor the health of the people of the province, and develop and support a caring and effective provincial health system, through the establishment of a province-wide district health system (DHS) based on the principles of primary health care (PHC).
(White Paper, 1997, p.13).

There was recognition that, with the gross disparities, in terms of development, in many areas of the country, many districts would not have the capacity to implement a district health system and this would need to be further developed. It was with this in mind that the role of regions within the province was devised. However, this would be a temporary measure as the

regional structures were seen as an intermediary step towards the devolution of control to the district health systems.

Difficulties in implementation in the Western Cape include the need to merge local government staff with provincial services. The development of district services has been slower than in some of the other provinces. However, Mc Coy and Engelbreght (1999) in their evaluation of the development and transformation of the health system make the point that issues of delivery need to take precedence over structure, with the implementation of comprehensive and integrated programmes with decentralised structure, helping to mould the existing service in a more effective way. The Policy for the Development of a District Health System for South Africa (1995) states that the function of the health region was to be as follows: (relevant functions have been singled out and the list is not comprehensive)

- To co-ordinate and support the health district level, district hospitals and primary care services and to provide specialised services and units.
- To manage and control the health budget on a needs based, health outcomes approach.
- To ensure equity between health districts.
- To ensure human resource development including capacity development and training.
- The co-operation of all health service providers in the region.
- The maintenance of a health information system.
- Monitoring, evaluation and research.

Several other points made by the White Paper are of significance. Recognition of the lack of development and skills in many areas led to further policy being devised. The maldistribution of human resources was to be addressed through incentives based system depending on the level of inhospitality of the area. The use of compulsory service following graduation, for health professionals to provide additional services was also mooted. Also of significance to this research is that the training of psychologists, as a category of health worker, was recognised as a priority (White Paper, 1997).

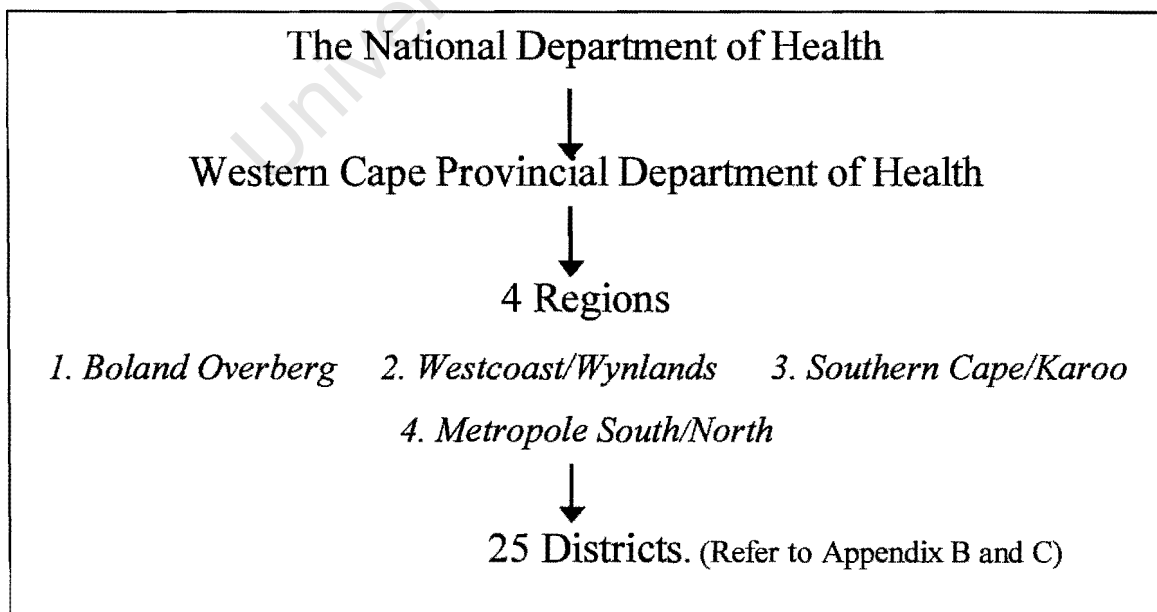
The Western Cape Province: (refer to Appendix A.)

The Mission Statement of the Department of Health in the Western Cape (quoted from the Strategic Goals: 2001-2005) is as follows:

To promote and maintain the optimal health of all people in the Western Cape Province through the integration of health within the broad context of social reconstruction and development, and by ensuring the provision of a balanced health system and all related health services. (n.p.n)

Further goals included the improvement of access to services, progress towards the establishment of a district based health system and a strengthening of the PHC approach to health care delivery, and to progressively re-structure health services. Of particular relevance to this research is the greater focus on human resource management, inclusive of interventions to improve morale and care for staff, appropriate training and retraining, employee assistance programmes, improving productivity, appropriate recruitment, retention and deployment of staff and particularly the retention of skilled staff. Also of relevance is the goal of equitable distribution of resources and services between regions and districts (Strategic Goals of the Department of Health in the Western Cape: 2001-2005, June 2001).

Figure 1: Diagrammatic structure of the South African Health System.



2.4. Mental health policy in South Africa:

There has been a parallel process of health policy development in the mental health arena. [For a summary of the historical path of the concepts of mental health and illness in the South African context, refer to Foster and Swartz (1997).] The predominant theoretical approach in the understanding of mental health has been a biomedical one and this is evident in the language used and meaning given to various forms of “ill health”. There are many competing views and approaches to understanding the causes and cures of mental suffering; biological, social, or constructed and it is beyond the scope of this review to engage with that particular debate. The White Paper of 1997 adopts the following view:

Mental illness is a major cause of morbidity as well as some mortality, particularly amongst citizens at risk in South Africa. The latter refers specifically to communities, which have been ravaged by State neglect and abuse for decades. Generally, mental health promotion and the provision of services have been neglected in the past. Common manifestations are interpersonal violence, gender and age-specific forms of violence, trauma, neurosis of living under continual stress, post-traumatic stress reactions and disorders, substance abuse, suicide and adjustment related reactions and disturbances in children and the elderly.

Mental Health services like other services have been fragmented and are ill equipped to intervene effectively. Available services are neither appropriate nor accessible to the majority of the population, especially those in rural areas... In the past mental health care was largely custodial and based on medical therapy... occupational therapy and in- and outpatient therapy and counselling...[which tended] to be skewed in favour of the urban, wealthier population in terms of access, quality and personnel. (p.78).

There is a stated political commitment to mental health, which is endorsed by the ANC (African National Congress) National Health Plan of 1994:

The aim of the mental health policy will be to ensure the psychological well-being of all South Africans and to enhance their ability to conduct themselves effectively in social, interpersonal and work relationships, As psychological well-being is determined by social and material conditions as well as by physical, spiritual and emotional health, the policy will aim to eliminate the fragmentation of services and ensure comprehensive and integrated care. (p.46).

The South African Health Review (1999) further identifies the key strategic aim in the transformation of the public mental health service to aim to be comprehensive, community-based and integrated with other health services.

The Western Cape Province:

Mental Health has been identified as one of the priority programmes of the Western Cape Health Department (Strategic Goals of the Department of Health in the Western Cape: 2001-2005). The Mental Health Programme is a sub-directorate of the Programme Development Directorate and is responsible for the co-ordination of mental health services in the Western Cape Province, together with the Associated Psychiatric Hospitals and regional mental health structures through which services are delivered (Mental Health Strategic Notions 2001-2010). The Western Cape Mental Health Programme has developed objectives, which in summary are to:

- Educate health and related sectors re service provision.
- Adapt services to ensure implementation of new Mental Health Act.
- Identify research priorities and support research endeavours.
- Run awareness campaigns to improve mental well-being, reduce stigmatisation and improve knowledge re: treatment of mental illnesses.
- Empower and ensure greater participation of the mental health consumer in service development.

- Provide accessible, equitable and integrated services for mental health disorders at all levels of care in the health sector, with a focus shifting from institutional to community based care in mental health.
- Identify and implement best practices in prevention, treatment and rehabilitation to reduce incidence and prevalence of mental and substance abuse disorders.
- Address violence prevention and treatment.
- Develop community based psychosocial interventions for those with chronic mental conditions.
- Focus on vulnerable and disadvantaged groups: children, women, elderly, those living in rural areas, those living with HIV/AIDS and the intellectually, mentally and physically disabled.

Based on these, priority interventions for the period 2001-2010 for the Western Cape include:

- Decentralisation of mental health care and integration of mental health.
- Training of health workers in mental health: policy and curriculum development.
- Mental Health promotion.
- Psychosocial rehabilitation.
- Substance abuse prevention and treatment, including licensing of treatment facilities.
- Child and Adolescent Mental health Care.
- Victim Empowerment Programmes.

(Mental Health Strategic Notions for the Western Cape Province: 2001-2010, n.p.n.).

The Regional Community Mental Health Teams of the Western Cape.

These are interdisciplinary teams, based at regional level of which the regional psychologist is a part. The team consists of the following staff in the metropole and covers both northern and southern areas: psychologists (2), psychiatrists (3), occupational therapists (2), occupational therapy assistants (5), and a social worker.

In the three rural regions the following posts exist for the mental health team at regional level: psychiatrist, psychologist, occupational therapist, and a social worker. This team provides support for the clinical team of 8 mental health nurses who are managed by a chief professional nurse. Only one of the rural regions has a psychiatrist and at the time of the data collection, two of the psychologists posts had been recently vacated, the third was unfilled. Some of the nursing posts, in all of the three rural regions, were filled. The Boland/ Overberg Region has only two mental health nurses for the whole region. Each of the rural regions is linked to a referral centre (psychiatric hospital) in the metropole (S. Kleintjies – Mental Health Programme, personal communication May, 2001).

The overall function is understood to provide clinical support and monitor equity in mental health service provision. This includes:

- Identification of priority mental health problems in the region
- Involvement in development of strategies and protocols for the planning implementation, monitoring and evaluation of district based mental health service delivery in the region, including psychosocial rehabilitation.
- Specialist clinical support service for the mental health services at district level.
- Support the development of district based mental health programmes.
- Promote equitable mental health service delivery in the region.
- Facilitate liaison between district, regional and psychiatric hospitals via efficient referral pathways.
- Capacity development for provision of mental health services in the district.
- Ensuring mental health service development in the community health centre, community and district.

(Community Mental Health Services, n.d., n.p.n.).

[For further identification of key activities at district and community level, refer to the White Paper (1997).] According to the White Paper (1997) the composition of referral teams at the district level are to include, amongst others, psychiatric nurses, clinical psychologists and

specialist personnel who would be positioned at secondary and tertiary levels for referral care. Educational psychologists are also positioned here.

Identified needs in terms of human resource development in the area of mental health in summary were:

- Building capacity of district health teams in terms of mental health programmes at district and community health level
- All mental health staff to undergo training to deal with post traumatic stress and the impact of violence. Upgrading of communication and counselling skills.
- Staff at primary level to be trained to do screening, basic counselling and to identify necessary referrals for further assessment and treatment. (White Paper, 1997).

It is critical to bear in mind that this policy development preceded and accompanied the restructuring of the mental health services in the Western Cape. It both enabled the regional psychologist posts to be created at this level and constructed the expectations of the changes that were needed. Before this, posts for clinical psychologists had only been within psychiatric hospitals. It is also not clear whether in the eventual structure at district level, if there will be posts for psychologists or counsellors.

2.5. Community psychology and the search for a relevant role for psychologists:

During the 1980's in South Africa with heightening political tensions, alternative professional bodies began to emerge such as the Organization for Appropriate Social Services in South Africa (OASSA). [For a full review of this process refer to Maw (1996).] Links with political and community organizations led to a broadening in role from one-on-one consultation traditionally assigned to psychologists to a variety of interventions and working in workshop or consultant mode, learning to network and working more closely with other community organizations and programmes (Swartz, 1996). Questions about psychology and its

application and relevance to the South African context were being asked. Within this context many of the ideas of community psychology seemed relevant.

Historically, community psychology emerged from the civil rights movement in the USA. There was an increasing awareness of the benefits of collective action, the limits of traditional methods of psychological treatment and dissatisfaction with the biomedical model. The medical model identified psychological problems as individually based illnesses and was critiqued for neglecting the broader canvas of contextual factors, which contribute to distress. Community psychology was seen as an alternative to mainstream psychology (Pretorius-Heuchert, Ahmed & Seedat, 2001).

Lazarus and Seedat (2001) present community psychology as defined by its philosophy, ideological assumptions and approach. It is particularly concerned with extending mental health services to all and especially to the historically underserved, unserved and oppressed. Theoretically it is involved in the transformation of the understanding of the genesis and development of psychosocial problems by means of contextual analysis and at an implementation level by radicalising practice to include prevention initiatives. At a professional level it redefines the role of the psychologist to include broader public health issues and include such activities such as advocacy, lobbying, community mobilisation, community networking and policy formation.

They further identify some difficulties in the field of community psychology:

Community psychology theory, which includes macro-level variables, system analyses, and ecological thinking, tends to be presented in vague and global terms without interventions or practical applications, or both, at the level of praxis being clearly defined... fails to take cognisance of how people are limited by institutional structures ... and even though community psychology endorses particularly admirable principles in the formative stages of the discipline, these are rarely applied to specific real-world conditions. (Lazarus & Seedat, 2001, p.5).

Practitioners adopting a community psychology approach come from many disciplines and particular perspectives. Some examples of differing perspectives might include those of mental health, social action, ecological, or organisational approaches. Likewise practitioners draw from a range of theories in their everyday practice (Pretorius-Heuchert, Ahmed & Seedat, 2001).

Julian Rappaport (1977) talks of the community psychologist as being a “boundary spanner”; trying out new roles, being an advocate, consciousness raiser, consultant, and activist. It is about moving beyond the safe confines of the consulting room and engaging with the social forces which impact on people’s lives. Simultaneously Swartz (1996) argues that psychology also introduces the paradox that the setting of boundaries is also important, that psychological skills operate best within a specific context. In the search for a different identity it is important not to discard ways of working and skills as inappropriate, but to use those skills in a different setting.

Simplistic notions of “community” ignore the power relations within those communities. In reference to the mentally ill or the mentally handicapped Swartz argues that: “our responsibility in the field of community clinical psychology is often precisely to those people who will not, in the usual course of events, be identified as needy or deserving by members of their own communities” (Swartz, 1996, p.10).

He further makes the point that:

As we quite appropriately attempt to stretch resources by working more and more in group and workshop settings and in the contexts of prevention and promotion, we must not forget those who will always be on the margins of society. We continue to have a responsibility there. (Swartz, 1996, p.10).

2.6. Conclusion:

This review has been an attempt to embed the examination of the role of the regional psychologists within a theoretical and contextual framework. It has been argued that role is

created by context based upon the theories of social constructionism, activity theory and intersubjectivity. This theoretical framework has informed the research process and influenced the interpretation throughout. Having argued for the relevance of context to understanding the roles played, the review continued with a description of the South African health system, health policy and in particular mental health policy, as pertaining to the Western Cape specifically. Professional debates around community psychology and what this perspective means for practice were also included as pertinent ideas, which would inform and influence role definition and practice.

Having examined the macro level forces, the next chapter will describe the methodology whereby the psychologist's own description and record of their role and daily activities, together with other influencing factors was constructed and analysed.

CHAPTER THREE: METHODOLOGY

3.1.Introduction:

This chapter provides an overview of the research methodology, together with a rationale for particular methods used, in order to examine the perceptions of the psychologists with regard to their role. Semi-structured interviews were held with the four psychologists based in the Cape Town Metropole, Westcoast/Winelands and Boland/Overberg regions of the Western Cape Province. These were analysed using qualitative methods. The psychologists were also asked to complete daily activity sheets, which were analysed quantitatively, with additional comments included in the qualitative data. These were used to complement the verbal material collected. The previous chapter highlighted some of the pertinent macro issues which have impacted on role definition. The methodology of interviews and diaries was chosen in order to give a view into the micro issues, which have been pertinent for the various psychologists.

3.2.Research paradigm:

Both quantitative and qualitative methods were chosen. Both methods have strengths and limitations but are not mutually exclusive methods of enquiry, and can be used to complement and corroborate rather than to test or verify in a positivist sense. It also provides triangulation with both methods being used simultaneously (Bottorff, 1997; Thorne, 1994). The results of the qualitative investigation are linked to the quantitative data. They give a greater depth and support and extend the results of the qualitative work. However, they are both utilised with a constructivist understanding of examining social activity rather than a positivist framework seeking generalizable truths. “ Social constructionist inquiry is principally concerned with explicating the processes by which people come to describe, explain or otherwise account for the world (including themselves) in which they live” (Gergen 1985, p.266).

The researcher’s understanding and interpretation is co-created and is an active process through social interchange. Kvale’s distinction of taking a traveller approach to the

analysis is helpful: “...the analyst co-creates with the subjects the meanings reported and through interpretation constructs elaborate stories” (Kvale, 1996, p.207).

It is acknowledged that the questions asked, the position of the researcher as an intern psychologist, the events preceding the interview and many other contextual variables provide a particular colouring and texture to the picture, which emerges. The research takes an ethnographic approach with a focus on a group of people who have a professional role in common and adopts the central tenant that behaviour cannot be separated from relevant contexts of meaning and purpose (Boyle, 1994; Neuman, 2000).

As the research seeks to be exploratory and descriptive in nature, the participants are understood to be in dialogue with the researcher and the relationship one of interdependent intersubjectivity. The analysis seeks to open debate and widen perspective with the recognition that as some aspects are highlighted so other aspects are obfuscated. Questions do not strictly pertain only to role, but seek to make explicit the contextual embeddedness of role. Interpretation is understood to be a perspective and socially constructed understanding with the aim of providing generative alternatives (Gergen, 1994).

3.3. Research participants:

The focus of the study limited the number of participants to the psychologists employed by the Western Cape Department of Health in the regions of the Metropole, Westcoast/Winelands, and the Boland/ Overberg. There was no psychologist in the post at the time of the data collection in the Southern Cape/Karoo region. The psychologist from the Boland/Overberg was no longer in the post as of a month previously, but agreed to be a part of the study. The psychologist from the Westcoast/Winelands region had resigned and was due to leave the post at the end of June 2001.

Telephonic contact was made in April 2001 and after an explanation of the purpose of the research, verbal consent was obtained to participate in the study. This was followed by a letter explaining the nature of the research, (refer to Appendix D) giving contact details

and included a copy of the research proposal (refer to Appendix E) and a copy of the record form on which diarized notes were to be kept. (Refer to Appendix F).

3.4. Research design:

Kvale's (1996) stages of research design were used as a framework in planning the research design. Using the research question, the purpose of the interview was clarified and ideas were generated, in discussion with colleagues, regarding what should be asked. These were thematized into the following groups:

- Description of past and present working experience and training
- Expectations: self and others
- Vision
- Resources and constraints (including use of time)
- Description of present role
- Training and skills needed
- Issues of language, gender and race
- Networking

Several research tools were designed. Questions were formulated and constructed around these themes and organised into a question guide. (Refer to Appendix G for the interview schedule) In addition, a daily diary was constructed to provide quantitative data recording time spent on different activities. It was also hoped that this would serve as a reflexive tool for the psychologists concerned and give further qualitative data. The psychologists were requested to fill this in for a weeklong period over three months, giving three weeks activities in total. Appointments were made for the interview at a mutually convenient time.

3.5. Data collection:

The semi-structured interviews took place during May 2001. Interviews took place at the regional office of the psychologist concerned although one interview took place in the psychologist's home as the post had already been vacated at the time of the interview. A short briefing was given to contextualize the interview. The sequencing of questions was not strictly adhered to. These interviews were taped and labelled. Diary forms were faxed to the psychologists who were presently employed and were returned after completion. The diarized notes were collected between April and June 2001.

3.6. Method of analysis of the data:

3.6.1. Interviews:

Secretarial staff transcribed the interviews initially. Verbal assent was given regarding issues of confidentiality. The tapes were replayed and corrections written into the copy by the researcher. These corrections were then typed into the transcriptions. This process served the purpose of immersing the researcher in the data (Potter & Wetherall, 1987). Using the interview questions as a guide, the transcriptions were divided into thematic groups using direct quotes and some summarising to provide structuring (Kvale, 1996; Babbie & Mouton, 2001). Boyle (1994) describes the process with reference to Tesch's description of decontextualizing and recontextualizing text data as fragments are regrouped under thematic headings.

Qualitative data from the diaries was also integrated into the analysis at this point. The data was then re-analysed for emergent themes and counter themes, retaining as far as possible the wording of the participants. The process was iterative. This format was used as the foundation for the synthesis of results reported in the next chapter. Morse describes the process:

Synthesis is facilitated by the processes of coding and content analysis. By pooling data from all transcriptions and notes, categories are constructed and data are linked both from transcripts from one participant and between participants (Morse 1994, p.30).

Diagrammatic representation was used to construct the roles that emerged from the data (refer to Figures 2 and 3) and to identify the contextual elements that defined, constrained or challenged that role (refer to Figures 4 and 5) (Pidgeon, Turner & Blockley, 1991).

3.6.2. Diaries:

Each day's activities were translated into minutes and divided into qualitatively derived categories for quantification. These were added on a spreadsheet giving a weekly total with percentage of time spent on each activity. These were calculated again over the three-week period. (For individual breakdown of results, refer to Appendix H). This analysis was initially done before the analysis of the interviews. Greater clarity emerged after the interview analysis and the process was repeated with a reallocation of times to particular categories.

It needs to be borne in mind that there is considerable overlap between some of the activity areas and although the areas were kept as discreet as possible, they are presented as the researcher's interpretation of how that time was spent.

The types of activities allocated to the various categories were:

Administration: mail, e-mail, telephone calls and paperwork. (If specified on the diary administration directly related to one of the categories below was thus categorised).

Teaching/ Training Interns: This category was only applicable to the urban-based psychologists and included intern psychologists.

Teaching /Training Staff: This included all staff other than intern psychologists.

Supervision of Interns: This included supervision of the Intern Psychologists in their work at the community clinics and also only applied to the urban psychologists.

Supervision of Staff: This included supervision of both individual and groups of staff members and involved mainly the Mental Health Nurses, but also included the supervision of other team members.

Travelling: Actual travel time and administrative time related to travel such as logbooks and ordering cars.

Professional Development: Own therapy, group or individual supervision, seminars, extra reading (not directly related to the job).

District /Regional Team Development: Meetings with the teams, feedback sessions, social events, training, developing policy and team building.

Preparation and Planning: Reading, planning, preparation for work related activities (unspecified).

Clinical Work: Long term clients, assessment, emergency/crisis counselling, referrals, notes and reports.

Sick/Annual Leave: Taken during this period.

Research: Any research related activity.

Co-Ordination of Services: Placements of Interns, referral of clients, networking, and informal/ formal meeting with other team members. Making and checking appointments.

Development of Mental Health Services (District/Region): Activities directly related to the development of existing or new services.

The information gathered from the diaries was then used to enrich the interpretation from the interviews based on the premises of activity theory with regard to the relationship between activity and role.

3.7. Conclusion:

In this chapter it has been argued that a qualitative and quantitative method of data collection was useful in the examination of the role of psychologist at regional level and that a constructionist framework of analysis can be applied to both. The intersubjective nature of the research process is acknowledged, as is the value of including an examination of activity, in the form of diarized activity schedule with opportunity for reflection. The following chapter will include the results and interpretation of the data obtained.

CHAPTER FOUR: RESULTS

4.1. Introduction:

This chapter is a description of the positions and views of the psychologists interviewed. The process of transcription and analysis will foreground certain aspects and background other aspects. This is presented as an interpretation of the interviews and reports of the four psychologists employed as regional psychologists in the Western Cape. It includes the analysis of the transcribed interviews and also of the time sheets, which reflect three weeks of working activities during a three-month period. An examination of the roles that evolved, together with the relevant contextual factors, which were reported, is presented. The following letters indicate the respondent.

UP1: Urban based psychologist working within a full team structure.

UP2: Urban based psychologist working within a full team structure.

RP1: Rural based psychologist working in full team structure.

RP2: Rural based psychologist working in partial team structure.

Presentation of these results necessitates a condensation. A balance has to be maintained between the participant's voices, the interpretation the researcher has imposed and the meaning that has been co-constructed. Morse (1997) describes this tension: "The presentation of qualitative research is always an art because of the difficulty of compressing descriptive information without losing the rich description and essence of the message" (p.4). As it is assumed that interpretation occurs from the inception of the research process, this is a continuing tension. This process does not, therefore, claim to be an objective account, but hopes to generate debate and highlight and pose questions around the social processes, which are occurring and being described.

The first section will begin with a brief discussion of the demographics of the psychologists concerned, the reasons they choose this job, their own and others expectations of the job, their vision regarding psychological or mental health services and their own professional identity. This is followed by the main focus of the analysis, which is the description of their role as regional psychologists, inclusive of both the qualitative

and quantitative material. The final section is an analysis of the resources and constraints experienced within the system; the psychologist's preparation during and after training for this role and the impact issues such as race, gender and language has had on their work.

4.2. Section A:

4.2.1. Demographic data:

Demographic data is included in the results chapter in order to provide a micro context for the psychologists interviewed. It also raises some relevant questions with regard to role and contextual positioning.

Length of time in present job:

Two of the psychologists had been in community psychiatric services prior to the restructuring and been through the restructuring process. Both of these psychologists had been in this position for the past 5-6 years. They were both working in the metropole. The one psychologist had worked in the rural regional post for 18 months and the other for 3 years. The former had already vacated the post at the time of the interview and the latter was in the process of working in resignation time and ending. It is noteworthy that the metropole-based psychologists had been in their jobs for longer and were continuing in the present posts. Both the psychologists in the rural areas were vacating their posts although it is also noteworthy that they were still continuing their involvement with mental health activities in the region but in different capacities; that of research and involvement with the NGO (Non-Governmental Organization) which had been formed as a result of the project in the region.

Previous working experience and background:

All four psychologists had a number of years work experience prior to coming into these posts. All four were registered clinical psychologists and had undergone a clinical training. Two had trained at Stellenbosch University, one at the University of Cape Town and one at University of the Western Cape. Three had worked at psychiatric hospitals and one had worked within university psychological services. Two had been involved in

teaching community psychology part-time. One of the psychologists reported significant involvement in community issues and activism prior to becoming a psychologist and had had a teaching career prior to coming into psychology. The only category of psychologist employed in these posts thus far, have been clinical psychologists. All have had some years of clinical experience.

Age, language, gender and race:

All four were between 25-40 years old. Two had Afrikaans as their home language and two had English as their home language. Three were bilingual in these two languages. None were fluent in Xhosa, the other main language group of the Western Cape. Three were female and one was male. Three were 'white' and one was 'black'.¹ These are mentioned, as they are some of the personal features, which punctuate our experiences. They also have a strong influence upon our experience of the world and of others and are part of individual and constructed context. This is particularly so in the South African context and in the Western Cape. I will return to these issues in a later section.

4.2.2. Reasons for job choice.

This section examines the motivation for applying and choosing to work in a regional psychologist post.

A sense of autonomy and freedom:

There was a sense of challenge coupled with an autonomy that appealed to all of the psychologists. Most had moved from more hierarchical and rigid structures to a situation where they were given more responsibility with regard to their work: "I feel quite happy about the fact that I can make decisions about what I do...what I become involved in and what I take on" (UP2).

¹ My own dis-ease with how to language racial categories needs to be owned at this point and reflects a deep reluctance to continue these distinctions and yet needing to recognise the degree to which they continue to "colour" our perceptions.

Needing to move on:

For all of the psychologists, choosing this job signified a different way of working and a step forward professionally: “[I wanted] the potential to reach a lot more people in protective and therapeutic ways...sitting in an office seeing 8 people a day was my definition of burn out” (RP2).

Development of a new structure outside of the hospital:

With the restructuring in the health service, came new opportunities of working in a more community orientated setting, outside of a hospital and within a mental health team. The interest in the development of a new structure was a factor in job choice.

For both the rural based psychologists, an interest in community psychology had been developed during their training, and this job seemed to approximate those parameters: “I was interested from during my training in a community based position”(RP1), and “when they interviewed me and told me more about the job, about the whole context of the job, I just knew it’s exactly what I wanted” (RP2).

The travel and variety (rural psychologists):

For both the rural psychologists the travel was a draw card, as was the variety the job offered: “the things that attracted me [were] the fact that I would be driving to different towns, that my job will never be the same...that you’re always working with different people, in different areas, that interested me” (RP2).

There were a variety of other reasons given, which had to do with preferred ways of working, which the job provided, such as working for the State, networking with a wide variety of people and of being a resource for a poorly resourced area.

4.2.3.Expectations of the job.

This section examines the psychologist’s own expectations of the job and how this differed or coincided with those with whom they were working.

Decreased involvement in direct clinical work:

For one of the psychologists, the job was initially direct clinical work, with patients being referred from satellite psychiatric clinics. As the system changed there was a period of about two years, of confused role and job expectations, followed by more clarity but with a recognition that this is a: “work in progress all the time, dynamic...not static...exciting to be continually having to rethink” (UP1). There was an expectation expressed by the psychologists that the work would be different to the traditional clinical work with which they had previously been involved and certainly that there would be less direct clinical work.

Ideas of doing “community psychology”:

For three of the psychologists this related to ideas of doing “community psychology” although there was not a clear idea of what this would entail: “coming into a kind of community psychology...there was a bit of a fantasy that it was going to be ...something like what community psychology is supposed to be” (UP2). There were also ideas of project management, consulting, and designing programmes to tackle specific problems. These ideas are expanded in later sections of the chapter.

The job would be challenging:

There was a sense of challenge, to be able to create something new, an opportunity for creativity and creating the balance of looking after oneself, in the context of huge need and undeveloped services: “So it was a new post, it wasn’t an existing post. There was nobody before me, so it was...opening a fairly new opportunity to actually create something new” (RP1).

The lack and variety of expectations:

In general there was a lack of expectation from those with whom they worked at a management level, although for one of the psychologists management had clearer expectations: “the manager’s idea [was that] on a regional level you do more policy... planning...co-ordinate the region and develop services” (RP1).

There was space and recognition given, for the need to assess the situation and work out a strategy from there. This also stemmed from others not really knowing what a psychologist in this post ought to be doing. This gave freedom but also created feelings of insecurity: “Both what I like and what I don’t like about the job is there is never really anyone saying to me: “This is what you must do.” ” (UP1), and “we were the...the kind of benchmark for ourselves basically” (UP2).

Expectations varied as the psychologists and other members within the team came from different backgrounds and brought with them, different ideas. They also came from different psychiatric services, historically geared to “different” race groups or from working with in-patients or within the community. Different ideologies and meanings had to be negotiated amongst staff members.

The expectations of mental health nurses:

Those already working within the field and who had been involved in past structures, particularly the mental health nurses, had very clear ideas about what psychologists should be doing. This related chiefly to their need for the clinical burden of work to be shared and also imposed a strong biomedical framework for understanding mental health or illness: “The strongest influences have been the mental health nurses as they have been very clear about what they expect from a psychologist...and ourselves [as psychologists] in the struggle to define what it is that we do... [The mental health nurses felt] that we should be doing clinical work ...and taking referrals that they send us...it created a whole lot of conflict and friction between us initially, when we came back very strongly and said we’re not doing clinical work, we’re only doing training, supervision etc” (UP2).

This conflict, resulting from differing expectations, was felt by several of the psychologists: “I think that I just take a strong position about certain things...I think some people saw me like that and some people thought I was inexperienced” (RP2), and also began to define their activities: “So I felt that if I give something to the nurses, then I can also get something back, and so I did start direct service in the next year” (RP1).

4.2.4. Vision regarding psychological/ mental health services.

This section considers ideas about what the psychologists were working towards. Vision regarding psychological and mental health services includes both long and short- term goals and these in turn relate very closely to the roles adopted by the psychologists. The psychologists working in the rural areas did not verbally articulate their vision as clearly as those working in the urban areas. However, this was articulated in the activities with which they were involved. It thus emerges in the analysis of their role, later in the chapter.

The development of mental health services:

The primary focus of the psychologists in the urban areas seemed to be to work within existing structures, in order to build capacity within those structures. An additional focus was to help to develop mental health services at district level. There was a desire to get involved in developing mental health structures at regional level i.e. regional hospitals. The parameters of the services were defined as providing basic counselling of adults and assessment and containment of children and adolescents, and to increase access, in order to ensure that services were not only for those with known psychiatric diagnoses.

Presently the focus in the urban areas is on attending to chronic patients, supporting devolvement of previous stable mental health clients to the general system, seeing new acute patients and patients in crisis, establishing social rehabilitation groups and involvement in mental health promotion and preventive strategies. The vision seemed to be constrained and limited by the structures already in place and focused on developing them further.

In contrast, for the psychologists working in the rural areas there was little in the way of existing structure and the focus was on developing a structure.

Nurses being seen as primary service provider, but overburdened:

The solution to the dilemma of providing psychological services for under-resourced areas has been to give the task to nurses. One of the psychologists felt that this direction is

correct, and that increasing the capacity of present staff at district level to think more psychologically is the way to go. The psychologist's role was described as: "Working with the [mental health nurses] in order to offer a service to anyone in the community who needs to access the public service for any kind of mental health needs... at present largely to those who would be classified as having a psychiatric diagnosis, approximately 12-13 000 people in the metropole" (UP1).

Whilst there was recognition that the nursing staff are overburdened, it was also perceived that this limited service provision. Nurses are seen as the solution and as the rate-limiting step: " [It would be] really great if more stable patients were devolved to the chronic system, if the nurses were able to free up their time to do more of the other kind of development work that they also do. So do less of the kind of clinical work and more...made space for them to do more...service development, to do mental health promotion and counselling work" (UP2).

The following areas were identified as needing further development (UP2):

- To provide for the psychosocial rehabilitation of the chronic psychiatric patient.
- To offer a more comprehensive health service.
- To provide consultation to parents re parenting skills.
- To give attention to mental health and not only mental illness.

One of the urban psychologists also felt that the ideal would be to have a psychologist in every district to work clinically and, with the amount of trauma experienced and support needed to cope with it, they felt that this could be justified. However it was felt that this is never going to happen with present resources.

The role of the team:

Three of the psychologists saw the team's role as being a supportive one: "mental health is the only programme that has a support team at regional level...The nurses feel a little bit more contained...they're not as burnt out as I think people thought they would be. They are not as negative. They've had a hard road to face and ...they've really come into their own in this process... The sense is that the team provided them with something that they feel has been able to sustain them" (UP2).

For the one psychologist who chose to develop a system of regional counsellors, the vision was very different. There was a conscious initial choice not to get drawn into a support and direct referral role, although this function developed later.

Vision regarding project work:

For the urban psychologists, there was some ambivalence about whether project work should be a part of the vision or if projects are rightly left to Non Governmental Organisations (NGO's). There was also doubt about having the skills and capacity to undertake projects. The rural psychologists had a very different view. For one, project management was the focus of the work and vision underlying it. The other rural psychologist felt it was a definite gap and that project work and developing NGO's was part of the vision of service development as NGO's were largely non-existent.

Expansion of involvement of intern psychologists:

The urban psychologists had a clear vision of expanding psychology intern involvement at district level, as this has both a training and service function. The goal was that all universities would commit to placing M1 students or intern psychologists into a district clinic for one afternoon a week. In one of the rural regions this idea had been mooted with the possibility of creating an internship post at one of the regional hospitals, but this was not practicable.

4.2.5. Personal vision/identity.

This section examines how the psychologists saw themselves in terms of their professional identity. There was a clear identification of themselves as **clinical** (emphasis mine) psychologists based within the community and a value attached to their clinical training. There was a distinction drawn between themselves as psychologists and community development workers. All of the psychologists still worked within a traditional one-on one frame to some extent, although they used different theoretical models. There was also the repudiation of the idea that working within the community was the role of the counselling psychologist and some questioning of the distinctions which the word "clinical" gave: "My focus is still on clinical work, clinical skills...and around increasing accessibility... to those skills... I still work within that same model" (UP2).

One of the psychologists verbalised her confusion as to what it is a community psychologist does and said that the conceptualisation of community work was problematic. This was one of the sub texts, which ran through of all of the interviews: "I can say quite safely that I don't know what it, community psychology is...I don't think that I'm doing community psychology... I'm a clinical psychologist who works outside of the ...hospital" (UP2). The point is made that: "I've just realised more and more that I'm not a community psychologist. I'm not trained to be a community psychologist...I'm a clinical psychologist who works outside a hospital and in that way works in a community, the community outside of the hospital. In a hospital is also a community" (UP2).

Two other areas of professional identity emerged. For one of the psychologists a more active role in research was needed, as a basis for interventions. There was a strong feeling that all research needed to be ethical in terms of putting something back into the community. Several of the psychologists saw themselves as consultants to the State. One of the psychologists felt that for relevant practice to take place within this setting, there needed to be a shift toward health psychology.

Being in the job had also been formative in terms of professional identity:

[It's been] incredibly empowering and I think it's because it's contrasted to the hospital...If I think about how my experience as a psychologist in a hospital, how different it is from my experience as a psychologist here. It's been an incredible experience ...that's why...I like this job so much...In terms of my identity as a psychologist, it's grown amazingly here...I'm much clearer about what I can offer, about what I bring, about the differences I can make...I never felt I had a strong identity as a psychologist at the hospital but I certainly developed one here. It's quite a strong specialist identity... There are certain things that, yes, we can all do, ...but... I bring special skills and unique skills...I've had much more of an opportunity to be a psychologist, in a way that I didn't have in a hospital. And that's been, ...very profound for me. (UP2).

For all of them there was a sense that the work they were doing was important:
“For me it was doing what was relevant...something hopeful and needed and significant and not only for yourself, but I think for other people and for communities” (RP2).

4.3. Section B

4.3.1. Results of the diaries

This section examines the quantitative analysis of the activities of three psychologists over three weeks during a three-month period from April to June 2001. For a detailed breakdown of the types of activities and their classification, please refer to the methodology chapter. (Refer to Appendix H for detailed individual breakdown of activities).

Table 1. gives an analysis of the proportions of time spent on different categories of activity. The largest proportion of time is spent on clinical work overall (16.6%) with a range of 14.2% for the rural psychologist and 18.1% and 17.6 % for the two urban psychologists respectively. Collectively the next main activity was that of the development of mental health services, averaging 12.5%. Again there was a significant difference between the time the rural psychologist gave to this (7.2%) and that of the urban psychologists (17.6% and 12,9%).

Co-ordination of services was a major area of activity for the rural psychologist using 14% of the time whereas it only took 9.9-9.3% of the urban psychologists' time.

Travel also took much of the available time for the rural psychologist with 15.1% of time being spent on this. This is to be expected given the larger distances in the rural areas.

Another area of difference was the time taken for training and supervising intern psychologists. The urban psychologists spent 6.1% in total, whereas staff training and supervision took a large proportion of the rural psychologists' time (17.2%)

One of the psychologists estimated that: “60% of time [is spent] on developing mental health services at the district level, particularly counselling services and the other 40% of time is spent on clinical work. Roughly” (UP2).

Table 1: Analysis of activities of the Regional Psychologists

ANALYSIS OF ACTIVITIES	Psychologist 1 (Urban)	Psychologist 2 (Urban)	Psychologist 3 (Rural)	Average
Administration	5.4%	11.2%	7.7%	8.1%
Training: Interns	2.0%	3.4%	0.0%	2.7% excluding rural psychologist
Supervision: Interns	3.5%	3.3%	0.0%	3.4% excluding rural psychologist
Training: Staff	0.0%	0.0%	4.1%	4.1% excluding the urban psychologists.
Supervision: Staff	4.5%	3.2%	13.1%	6.9%
Travel	6.2%	7.9%	15.1%	9.7%
Prof. Development	18.8%	4.2%	4.5%	9.2%
District/ Regional Team Development	10.9%	6.4%	9.9%	9%
Preparation or planning	6.4%	8.9%	2.5%	5.9%
Clinical work	18.1%	17.6%	14.2%	16.6%
Research	1.5%	2.2%	3.2%	2.3%
Co-ordination of services	9.9%	9.3%	14%	11%
Development of Mental Health Services	12.9%	17.6%	7.2%	12.5%
Sick leave/Annual leave	0%	4.7%	4.8%	3.2%
Total	100%	100%	100%	

Note: Only three of the psychologists were able to provide the researcher with weekly schedules as one had already left the service.

%- the percentage of working time spent on particular activity over a three-week period

Table 2. illustrates a simple ranking system in terms of the activities, which took the most time, and how that varied. This is a very limited sample of time and is used to illustrate the types of activities and the representative time each area took in the three weeks examined. It does not claim to be definitive.

Table 2: Ranking of activities according to time.

ACTIVITY RANK	Psychologist 1 (Urban)	Psychologist 2 (Urban)	Psychologist 3 (Rural)
1	Professional development (18.8%)	Development of MHS (17.6%) Clinical work (17.6%)	Training and supervision of staff (17.2%)
2	Clinical work (18.1%)	Administration (11%)	Travel (15.1%)
3	Development of MHS (12.9%)	Co-ordination of services. (9.3%)	Clinical work (14.2%)
4	District/regional team development (10.9%)	Preparation and planning (8.9%)	Co-ordination of services (11%)
5	Co-ordination of services (9.9%)	Travel (7.9%)	District/regional team development (9.9%)
6	Preparation and planning (6.4%)	Training and supervision of interns (6.7%)	Administration (7.7%)
7	Travel (6.2%)	District and regional team development (6.4%)	Development of MHS (7.2%)
8	Training and supervision of Interns (5.5%)	Sick leave/Annual leave (4.7%)	Sick leave/Annual leave (4.8%)
9	Administration (5.4%)	Professional development (4.2%)	Professional development (4.5%)
10	Supervision of staff (4.5%)	Supervision of staff (3.2%)	Research (3.2%)
11	Research (1.5%)	Research (2.2%)	Preparation and planning (2.5%)
12	Sick leave/Annual leave and staff training (0%)	Staff training (0%)	Training/ supervision of interns (0%)

4.3.2. Description of present role

This section considers the qualitative descriptions which the four psychologists gave of their role. As distinctions between the roles of the urban based and rural based psychologists were evident, they are presented comparatively. The section begins with a contextual picture at their point of entry into the system. The next area is the evolution of their role as regional psychologists and their description of what it is that they do as psychologists in their present role. This is presented diagrammatically. The section ends with identifying who their partners are, which activities are neglected and to whom they primarily provide a service.

Context:

For the urban psychologists the community post was initially based at a tertiary psychiatric hospital, which had responsibility for a number of districts, according to the old magisterial areas. With the advent of the change in health policy initiated after 1994, there was devolution of staff from tertiary centres, to regional (secondary) and district structures (primary), thus integrating with primary and secondary levels of the system. Initially the conceptualisation was that the regional mental health team would only be psychiatrists and psychologists, working at secondary level and providing clinical support. The social workers, occupational therapists, and medical officers would be devolved to primary level and then they would have constituted part of the mental health team at primary level. When that idea was conveyed, there was a lot of resistance from these members and eventually they remained a part of the regional team.

The rural psychologist's experience was different as they were entering a much more emergent system. This contrasted with the urban situation of negotiating change within an already highly structured system. Although the mental health system was less developed, the rural psychologists faced particular challenges and opportunities: "It's a different place and to enter the system is not so easy: " You have to get the trust of people first. You have to spend a lot of time with them...that whole year; I spent on just travelling and meeting people and talking to people, doing kind of a needs assessment. I didn't do any service delivery whatever" (RP1).

It was important for both rural psychologists to do an initial, thorough needs assessment, which was not an easy process: "It's often difficult to determine what real needs are, and

if you don't have direct contact with the community...the staff... when you ask them about needs they don't say what their needs are...it's difficult for me to get a good sense of how psychologists can address those needs" (RP1). One of the rural psychologists was a part of an established mental health team, the other found that the changing structure necessitated a change in function and approach: "I was part of a sub department when I arrived...which consisted of three psychiatric nurses and me...the health structure changed and so I was just one person as part of a comprehensive health programme" (RP2).

The evolution of the role:

For all of the psychologists the role was evolutionary in nature and continues to be. It was also an exploratory process for all the members of the mental health team: "So it developed over a period of time and still continues to develop, I mean it continues to change" (UP2). However, the expectations of the mental health nurses, as mentioned previously, seemed to have been a powerful influence in that process: "We kind of debated all of those things ourselves, and came up with ideas around it [our role] and the mental health nurses then became the people that we negotiated that with" (UP2).

For one of the rural psychologists the job was about policy planning, co-ordination and development of services and management of the mental health services rather than "a hands-on project" (RP1). It was felt that research was not really an accepted part of the job description although it was a needed but neglected aspect of the work. An important aspect of the evolving nature of the job was the need for the job and the person in it, to have a long- term focus. There was also the recognition that being the very first person to hold the position, was something unique and that any person coming into the job now, would have a very different experience of it.

Psychologist's role:

Diagram 2. depicts the roles as described by the urban psychologists during their interviews and presents them comparatively. Diagram 3. depicts this for the rural psychologists.

Diagram 2a: Comparative diagrammatic depiction of role description by urban psychologist.

Developing Mental Health Services at District Level

**CLINICAL COMMUNITY PSYCHOLOGIST
(URBAN)**

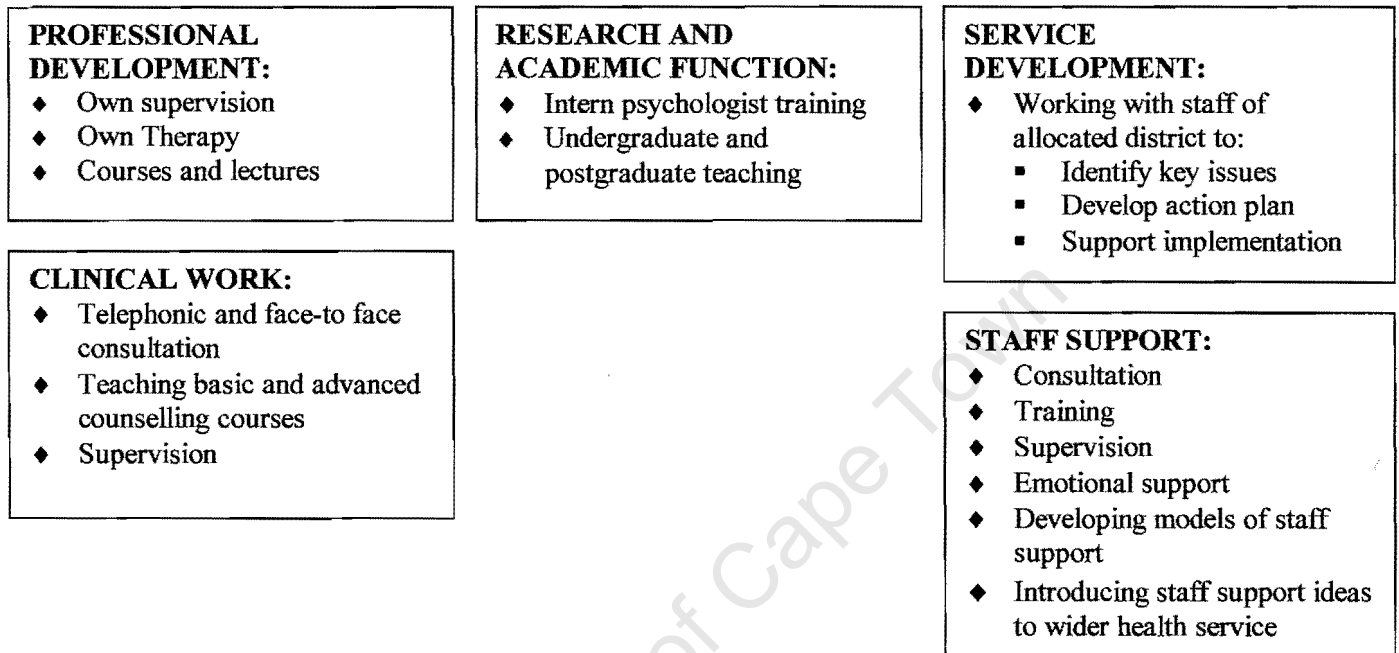


Diagram 2b: Comparative diagrammatic depiction of role description by urban psychologist.

*Develop Mental Health Service of region and districts
Team member of multidisciplinary team and part of bigger structure*

**REGIONAL COMMUNITY PSYCHOLOGIST
(URBAN)**

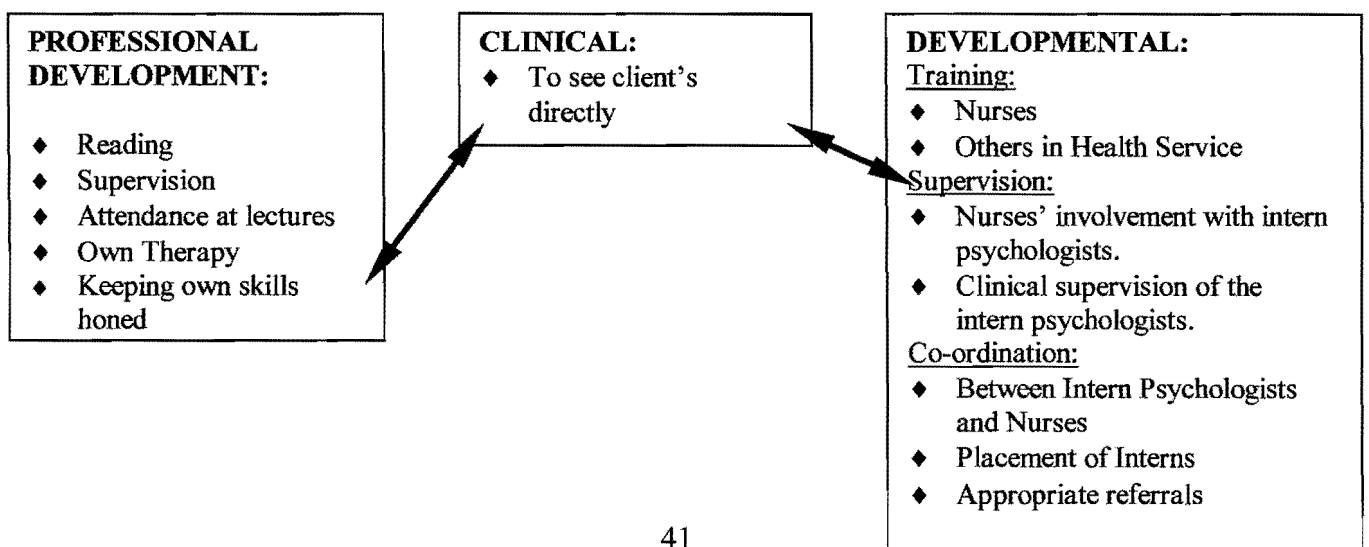


Diagram 3a: Comparative diagrammatic depiction of role description by rural psychologist.

Development of Mental Health services for the region.

**REGIONAL PSYCHOLOGIST
(RURAL)**

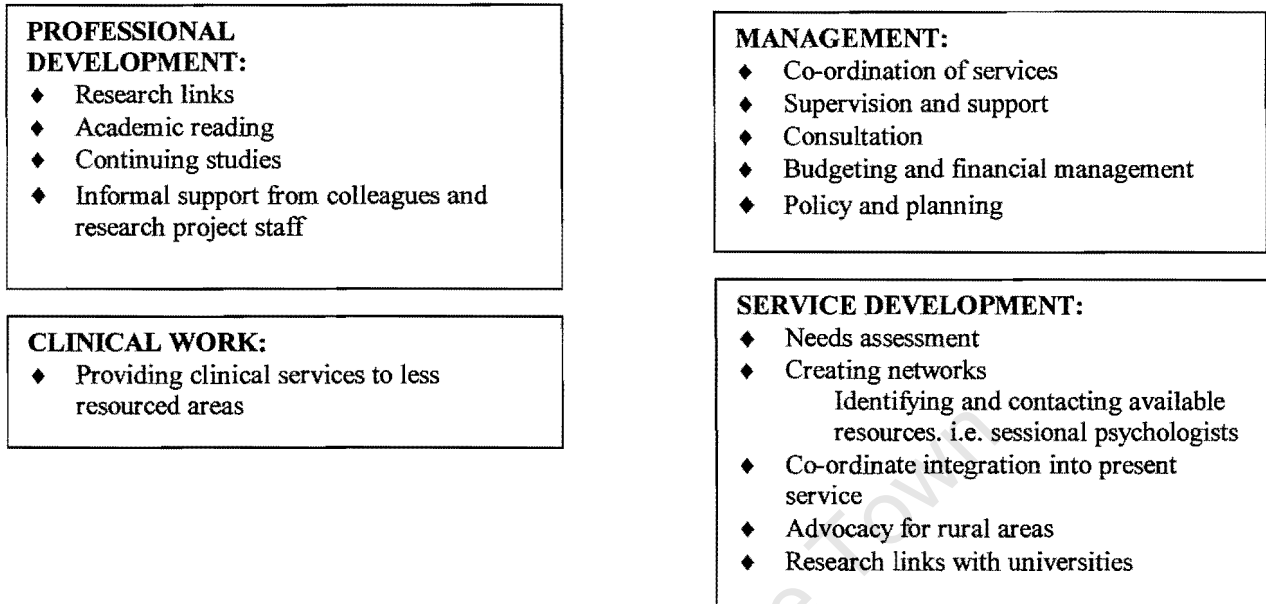
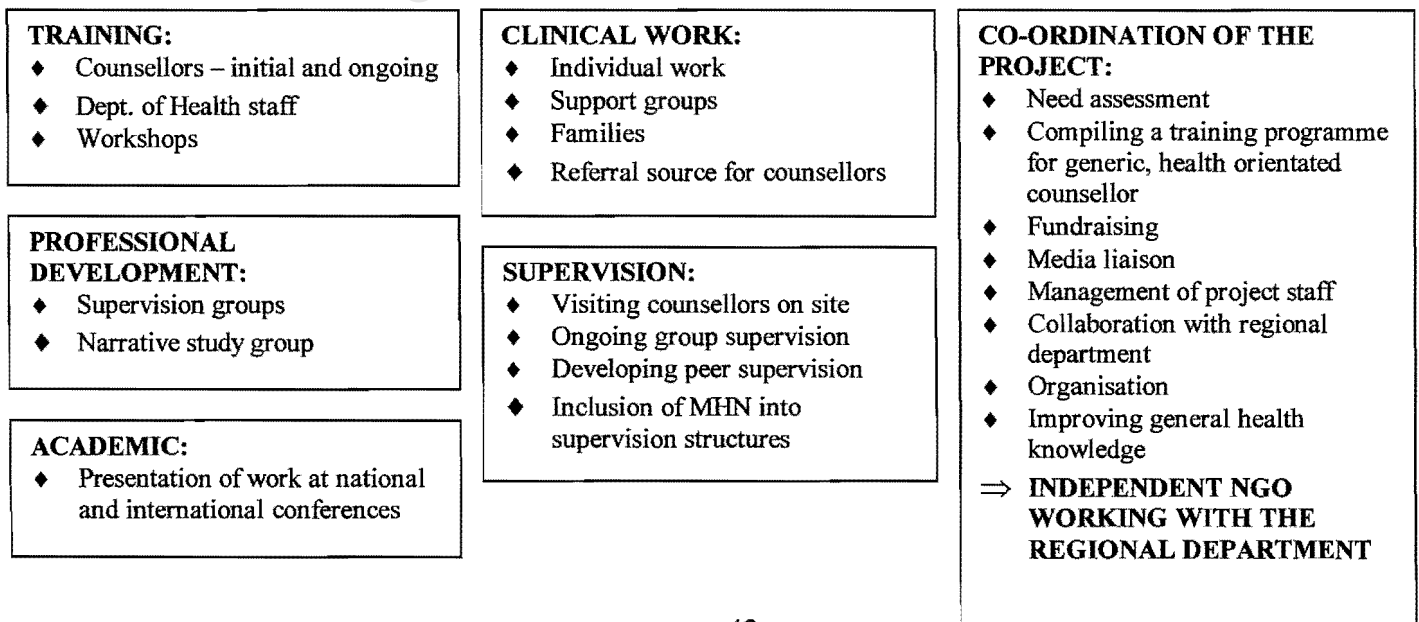
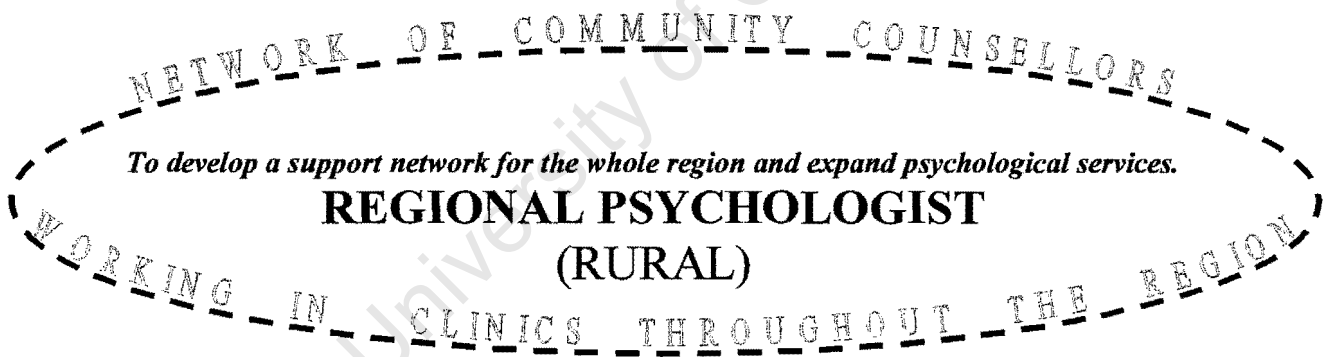


Diagram 3b: Comparative diagrammatic depiction of role description by rural psychologist.



Understanding of roles also included the more psychological aspect of 'holding the vision', together with an acknowledgement of the power of the psychologist within the team. One of the psychologists felt: "quite respected by the team in terms of being able to guide and hold the vision of the team...of what it does, and how it does it, and when it's difficult, what we can and what we can't do" (UP2).

It also included being a container for the frustrations and difficulties, which accompany change:

There's something else that we do that's difficult to describe – which is around... containing a process...not put down on a job description... but it's something that's quite important... It's holding the vision...holding the people in that...it's bearing the frustrations that go with that, voicing it sometimes and ...acknowledging that... It's about being able to bear out change and all the difficulties that [go with change]... To manage or to contain very difficult feelings, very difficult ways of expressing feelings in others... that's part of this work...this is part of what I do... I think that is something that's probably in our training, that enables us to do that" (UP2).

Another point that was made was the need to be flexible regarding the amount of clinical work taken on. The rural psychologist cautioned that: "I did start direct service in the next year but very limited...in ...the area that has the least resources...but once you start a thing you can't just stop it. So although it's part of, for me, part of the needs assessment...for them [the mental health nurses and clients] it's a service that needs to stay" (RP1).

Partners:

The urban psychologists identified their partners as being primarily with the academic institutions. Links with other NGO's were primarily through other members of the team or the mental health nurses who developed links with NGO's at a district level. There was also recognition of being part of a bigger structure and that their partnership as a team, with the primary health care structures was important. This was seen as important in terms of service development: "One of the reasons why the mental health integration has happened is the fact that the team exists" (UP2).

The rural psychologists had to build partnerships with a broad range of community resources as well as with fellow professionals, particularly the nurses and social workers and establish a network:

a lot of people I knew because I worked at the university so that's the one way that I built up networks. The other... I would literally go through the directory – telephone directory- and get all the organisations in each town and then I'd phone and go and visit them and introduce myself and get to know what they were doing...I think it's extremely important... It's just if you refer someone and they know your face they are more willing to go the extra mile... I mean that's reality (RP1).

Neglected activities:

Neglected activities included programme evaluation and the monitoring of service development as well as putting things into writing e.g. operational plans. Several of the psychologists from both urban and rural areas felt that project work was important but didn't happen. One of the psychologists identified that their own administration was given lowest priority and thus space for reflection and review was lost.

The primary service recipient:

Table 3. reflects the psychologists' perception of the people whom they were primarily servicing. This is not given in order of focus.

Table 3: Identification of the primary service recipient.

	Urban Psychologist	Urban Psychologist	Rural Psychologist	Rural Psychologist
Mental Health Nurses	Yes	Yes	Yes	No
Other Nursing staff	Yes	Yes	No	No
Counsellors	No	No	Yes	Yes
Referred clients	Yes	Yes	Yes	Yes
Health Service Management	Yes	Yes	Yes	Yes
Intern Psychologists	Yes	Yes	No	No

4.4. Section C.

4.4.1 Resources and constraints

It is evident throughout this chapter that the role adopted by a psychologist within a particular area is going to vary according to context. Important contextual variables are the resources and constraints of the different situations. The psychologists' perceptions also impacted on the utilization of the resources and dealing with the constraints.

Professional development:

A very important resource was the psychologists' access and utilization of professional activities, which contributed to their own self-care. The need was identified by several of the psychologists to take time within the job for professional development. This took the form of time allotted for reading or academic work or meetings as well as being in therapy or supervision. Supervision took several forms: study groups, one-on-one, or meeting informally with colleagues to discuss common issues. One of the psychologists highlighted the need and opportunity for research. A high risk of 'burnout' was also identified and linked to the need for self-care:

Probably the most neglected part of my course was self care, ways that you look after yourself...study groups, supervision groups... ways of working that could be energising or exhausting...that's the stuff I learnt through experience...my training did not equip me for that. I was just ready to burn myself out. I virtually thought success was about doing as much as possible (RP2).

Personnel:

The urban context provides access to the resources of the metropole. However, there was also recognition of the difficulty of maintaining morale when down sizing and dealing with the loss of posts. One of the urban psychologists stated that: "[we are] told over and over again that the Metropole in the Western Cape is the most well resourced area in the country – we always want more" (UP1).

In urban areas use had been made of student and intern psychologists to service the clinics and both rural and urban areas were looking at greater involvement of these

trainees. The possibility of using the Bachelor of Psychology students as counsellors in rural areas was also recognized as a possibility.

In the rural areas there was the discovery of unknown resources such as a depression and anxiety support group run by the hairdresser's wife in a small town. Interdisciplinary resources were also more accessible within the regional office: "There were all these departments in a regional office, which I didn't find in a hospital setting" (RP2).

However the other gap which was identified, is the lack of personnel in general, in the rural areas, as evidenced by the number of vacant posts, together with in particular: "The need for more social workers within the community, [and] the development of their skills, as there [are] great disparities in what they are able to do" (RP1).

Difficulty with obtaining sessional psychologists in the rural areas was accounted for by their very limited numbers, lack of interest, together with the very low tariffs which psychologists are paid. Compromises were that:

we reach an agreement that they don't necessarily have to work all 8 hours and also take some time for admin work and try and make it more worth their while...people don't last long... It's often beginning psychologists in practice who need some form of income...they often don't have the experience and to work in the community is very challenging, it's not easy work. It can be very demoralising. (RP1).

However commitment to the work was also a problem: "It's just so difficult to find someone... There are many psychologists that are willing... [and are] interested because their practice is going slowly and they need something to carry them over, so they are interested in the money but they are not really interested in that project" (RP2).

Concern was expressed regarding sustainability of the rural regional psychologist posts. Psychologists earn considerably less than in private practice and it is expensive to travel long distances to work. Often inexperienced new psychologists, who have a lot of enthusiasm, would apply for the job. They lack experience and need supervision and also don't last long as the job is seen as a stepping-stone to something else, rather than a long-term commitment: "It's a nice position for psychologists to start off in" (RP2).

On a personal level:

There was a strong sense of personal fulfilment, which the job brought, but also a high degree of frustration: “The level of responsibility is very different, but it’s incredibly exciting and empowering and it’s a wonderful experience, but then you’re also given access to the frustrations of the...system” (UP2). A great deal was learnt: “I think I’ve learnt a hell of a lot, I think I’ve gained more skills than what I would have gained in any other position...it was a great learning curve for me” (RP2).

In particular the rural psychologists reported personal costs, which were experienced as constraining. Some of these included being far away from Cape Town and home and having to live or be at such distance. Family commitments were also a constraint in terms of distance, travelling time and nights spent away from home. Having to use home equipment such as computers presented boundary difficulties for one of the psychologists, as work tended to intrude on home and vice versa.

Nature of the work:

Several psychologists referred to the work being limitless, infinite and potentially overwhelming. This posed difficulties in terms of role definition: It was stated that: “[we] chased our tails trying to work out what are we supposed to be doing” (UP1), and that “the thought of what’s out there puts me off” (UP1).

This was experienced as paralysing rather than enabling but also resulted for some in having to work in different ways. Recognition of their own limitations was crucial as was communicating that to others: “I think it’s very important that people know the limitations as to what you can offer them” (RP1).

Physical resources:

The rural psychologists reported good access to physical resources with the development of the regional offices. Books, office equipment, health promotion literature were available and there were generally good resources in terms of the basics. All the psychologists reported difficulty with computers and technological equipment and often had to use their own or use project funding to buy the equipment. One of the urban

psychologists reported difficulties with services such as cleaning services and infra-structural support for their offices and the demoralizing effect this had on team. There were organisational difficulties attached to being under the administrative structure of a regional hospital and yet operating independently of it. Financial resources varied in their availability. For one of the counsellors there were financial resources within the region for the training of counsellors and another found that there were no funds available for projects.

Supportive relationships:

Several psychologists mentioned the importance of support and mentoring when the job began, as well as ongoing support from other psychologists working in similar settings. This was a crucial resource. For one of the rural psychologists the constraints of isolation and lack of supervision, particularly related to being in a new role, were strongly felt and posed real difficulties:

That's an enormous gap and limitation... and even now, to be able to discuss some of the things that we find, with people in the academic world. It's difficult. They don't really know where you're coming from always...to get supervision for your work – it's difficult...there [are] no formal structures for supervision. Again you have to put everything in place. (RP1).

It was expressed that: “ I had strong links to some people but ... they deal with tertiary hospitals...you often feel nobody will understand your setting...people don't even come out here...they've never been in our region, never. The psychiatrists, they will come out...the psychologists never reach out on their side” (RP1).

4.4.2. Preparation during and after training:

This section examines the reported experience of the psychologists in terms of their initial training as preparation for this role and identifying further learning needs in relationship to their present role.

Table 4. provides a summary of those aspects, which were lacking during initial clinical training, those aspects that the psychologists felt should be included in a Master's programme and those skills which were needed for this particular job and which they had to learn. There was recognition that many of the skills are learnt on an on-going basis and

that an initial training can only provide the groundwork: “[I] don’t think an M1 clinical year can equip you for this job, there is too much to cover” (RP2).

Table 4: Summary of training and ongoing learning needs.

Valuable aspects:	Aspects lacking:	Skills needed:
<p>UP2: Psychodynamic psychotherapy.</p> <p>UP2: Seeing the process through on the long term.</p> <p>UP2: Being able to contain a difficult process.</p> <p>UP2: It’s about the approach rather than the content.</p> <p>RP1: Theoretical knowledge.</p> <p>RP1: How to make contact with resources around you.</p> <p>RP2: Community psychology.</p> <p>RP2: Family therapy training.</p> <p>RP2: Psychopathology.</p> <p>RP2: Research methodology.</p> <p>RP2: Basic cognitive ideas.</p> <p>RP2: Person-centred therapy as the basis for any kind of therapeutic conversation.</p> <p>RP2: Narrative therapy.</p>	<p>UP1: Project management.</p> <p>RP1: Limited training in community and systems aspects.</p> <p>RP1: Relationship between socio-economics and mental health.</p> <p>RP1: Trainers did not have much experience in this form of practice.</p> <p>RP2: More relevant therapeutic modalities.</p> <p>RP2: Narrowed vision in terms of practice options.</p> <p>RP2: Comprehensive health issues. i.e. HIV and TB.</p> <p>RP2: Learning to work within the bigger structures.</p>	<p>UP1: Consultation and supervision skills.</p> <p>UP1: Programme development and evaluation skills.</p> <p>UP1: Research skills.</p> <p>RP1: Project planning ...more developmental skills.</p> <p>RP1: Management skills.</p> <p>RP2: Self care and ways of working that are energising rather than exhausting.</p> <p>UP1: Broader public health issues</p> <p>Specified by others as:</p> <p>RP1: Health policy.</p> <p>RP1: Mental health policy.</p> <p>UP2: Service planning.</p> <p>UP2: Health promotion.</p>

4.4.3. Issues of language, race and gender.

Particularly in the context of post apartheid South Africa, issues of race, language and gender impact on the role of the psychologist, both in how the psychologists are themselves positioned and in the provision of services. There are often areas of overlap.

Impact of language:

For two of the psychologists the lack of language skills was very limiting, particularly in therapeutic settings. However one of the psychologists expressed the concern of a lack of accessibility for Xhosa speakers to the service: "It's not really impacted and that worries me, because very few black people are actually referred to me. So that in itself is...one has to look at why that is... I mean I've seen one or two [Xhosa speaking clients] in three years. That is a major thing" (RP1).

The ability to speak the language in a particular dialect was also recognised as being very helpful: "I think the fact that I speak Afrikaans is very helpful. I will also speak Afrikaans like the Swartlanders – I bray my 'a' so ...they thought that I was local... and that I think helps...If one cannot speak Afrikaans one would be very limited" (RP1).

Impact of race:

There was a consensus amongst the psychologists that issues of race were not addressed as openly and directly as they could and should be: "We talk about race but not... in terms of ourselves" (UP1); "I feel like the issue of race isn't dealt with enough...it's not always overt and sometimes it needs to be overt" (UP2); "On a team level...hidden maybe, there were some tensions... we actually don't talk about it. It's not something that's ever talked about" (RP1).

However in contrast, the experience of being able to talk more easily about racial issues within the different regional structures was also expressed: "I've been very surprised at how it comes up and how some people feel about, about their own...race, how others feel about their own racism, how they feel about their own experiences" (UP2); "The [regional] office was much more realistic in terms of race, I thought it was much more equal and in terms of gender. I didn't experience that at [the psychiatric hospital] ...all the lecturers were white...it was a male dominated context...I just felt so comfortable in that context at regional office...I just felt very much at home" (RP2); "I certainly don't feel like I have to hold back and that's been quite a nice experience. It's been a change because it's new" (UP2).

It is significant that the one psychologist who identified herself as a 'black' psychologist was the one who was able to identify more clearly with issues of race impacting on role: "Issues of race impact on my work all the time... for me issues of race is ever present...it impacts in different ways" and "... in this country where everything about our lives were determined – up until '94- were determined by race, and in some ways still continues to be, but that...we just don't talk about it. We just do not consider it" (UP2).

There was certainly evidence that issues of race impacted on their work and how it was defined. This included choices regarding employing people and discussions of equity, inter-staff conflict between "coloured managers" and other "black" staff. Others felt that race issues had led to misunderstanding between staff, which was loaded, as the staff in more powerful positions were "white": "I think more powerful positions are filled by white people at the moment...knowledge power...So the power relationships are complex, I think, and difficult. I do think it is a bit related to race...or more than I think" (RP1).

Difficulties had also been experienced in relationship to academic departments with regard to racial issues. There was reported experience of racist and prejudiced attitudes of some academic staff. Likewise, the powerful positions remain held by white people. Of concern to the psychologists was the lack of recognition or engagement with racial tensions. This had led to estrangement between the psychologist and the academic department.

Difficulties were also experienced regarding perceptions of clients: " From the client's point of view, I think that they are very much aware that I'm not...- that I'm a white and they will comment about it...it's terrible, it's almost like... I would offer a better service than...- because I'm white...so there's almost that kind of thing that I've battled with...People talked about the 'wit vrou' [white woman] that's coming" (RP1).

For some the issues of race were interwoven into economic or religious issues and others saw them as distinct: " So in my kind of work with my clients...the content often is around the basis of being black in this country, about being black in the world, about being poor...the boundaries seem to be blurred [between being black and being poor]"

(UP2) and “ I think socio-economic differences for me are a more difficult thing to deal with than race...that was more a difficult thing to understand and to relate to...that was more challenging than racial differences” (RP1).

One of the psychologists reported incidents where issues of religious groupings and beliefs had caused conflict.

Impact of gender:

It was reported that gender and professional issues are sometimes imposed by other members of the system, outside of the immediate team, in assumptions made around leadership and authority. The rural psychologists experienced more bias than reported by the urban psychologists. This included sexual harassment within the regional office, gender discrimination and generally a decreased level of gender awareness: “that I was young and inexperienced, that I’m a man and that sort of thing” (RP2); or that “I’m very conscious of gender issues and that is often difficult because the community is not so gender conscious...so I would often work from a gender focus point of view and then client’s wouldn’t know where I’m coming from” (RP1). The story was told of a particular incident:

We were planning a big sports day for mental health day and the team wanted drum majorettes to walk down the road. Everybody was highly excited about this and then the psychiatrist said: “But is this really the kind of image that we want to portray of women?” and the nurses said “ Ag, nee man! Almal like van die majorettes!” [Oh no man! Everybody likes majorettes]... So it is difficult if you are more sensitive about it. I think we try in subtle ways to introduce it. (RP2).

An interesting comment was also around gender bias in terms of clients and reflected gender power dynamics: “I saw mainly women – I mean women are the ones that access the clinics most of the time... I saw few men...very few... and usually I saw them because the women insisted on them coming to see me... because I must now tell them to stop this... so that was quite a problem” (RP1).

4.5. Conclusion:

This chapter has given a comprehensive analysis of the results of both the qualitative and quantitative data gathered, in order to provide as rich a description of the role of the psychologists as possible.

The initial section examined the perceptions and ideas with which the psychologists entered the job including their own personal demographics, their reasons for choosing this job and their own and others expectations. The section concluded with identifying their broader vision with regard to mental health services and their own professional vision and identity.

The next section focused on analysis of the time spent on different activities and ranking those activities. It also included the psychologist's description of their role, it's micro context and evolution, the groups or persons they identified as partners in that role and for whom they primarily provided a service. The section ended with activities, which they felt, had been neglected.

The final section reported the contextual and personal resources and constraints which enabled or disabled them, the preparation during and after training which was needed for this job and the impact issues of language, race and gender had had upon their work.

Many issues emerge from the results and the following chapter will include discussion of the most pertinent of these issues.

CHAPTER FIVE: DISCUSSION.

5.1. Introduction:

This chapter seeks to address what meaning can be made of the research findings.

Thorne's statement regarding the importance of making meaning of the research is useful.

She states that:

[The] critique of qualitative research within the health sciences properly extends beyond mere adherence to the methodological rules and toward examination of the much more complex question of what meaning can be made of the research findings. (Thorne, 1997, p.120).

The first section examines the macro and micro contextual factors, which emerged from the interviews and the interplay between them on the role of the regional psychologists.

These are presented diagrammatically.

The following section discusses a number of issues, which arose from the results. I have chosen to discuss those which appear to be most pertinent in influencing the development of a job identity. These include the effect that being a **clinical** psychologist has had upon the role of regional psychologists. The influence of the concept of community psychology on their role will also be discussed. An issue, which emerged from the results, was the negotiation of role definition and responsibilities between the mental health nurses and the psychologists. Definition of the psychologist's role was influenced by the expectations of the mental health nurses. This was developed within the context of their relationships with the mental health nurses. A critical question emerged from the analysis as to whose responsibility it is to provide psychological services. This section will also consider the extent to which working in the health system, within this particular historical context shaped role definition. It will conclude with an examination of the extent to which issues of race, gender and language affected their roles.

The last section will examine the differences and similarities in role description between the rural and urban-based psychologists. Comparison of the time allocated to various

activities is understood in terms of the unique micro and macro contextual factors with which each psychologist was engaged.

5.2. Macro and micro linkages:

This section prefaces further discussion by mapping the embedded relationship between contextual forces within the macro systems and their impact and interplay upon the micro systems, which construct and co-determine the role the psychologist plays. Morse (1994) endorses this by observing that: "Theorising begins by establishing macro-micro linkages, by identifying beliefs and values in the data and by linking these with established theory" (p.34.).

5.2.1. Macro contextual factors:

This section identifies the macro structures, which impact on the role of the psychologist, and seeks to represent the interplay between these factors. Detailed description is given in Chapter Two. A brief summary is given here, and taken further in the later discussion.

Within the South African context, broad and powerful changes in the political, social, and economic arenas have taken place over the past 10 years. Ideological debate has been solidified in the development of a new constitution and the development of government policy. There is ongoing momentum to change historical systems, which perpetuated racial segregation and the resultant injustices through transformation geared at restructuring and policy implementation and the shifting of resources. This has included the National Health System.

The Western Cape Province has a particular and distinctive contextual flavour. Some of the distinguishing factors are that it is relatively well resourced and more developed than many other provinces of South Africa. Political power has been strongly influenced by the 'coloured' vote, which has been more politically conservative than many other areas. This has resulted in a political majority, which is different to the national majority vote. The political history since the 1994 elections has been that of alliances, counter alliances and many political shifts. This, in part, has resulted in a slower implementation of policy

in the Western Cape than in other provinces. This has been the case in the implementation of health policy.

A part of this restructuring has been the creation of the post of regional psychologist who is part of the regional mental health team. These posts were created to serve a supportive and development function for the district health services which are responsible for primary health services within a particular geographical area. The aim is to provide a comprehensive, community based, integrated service. Diagram 4. depicts the interplay between these factors. Further discussion follows in later sections of this chapter.

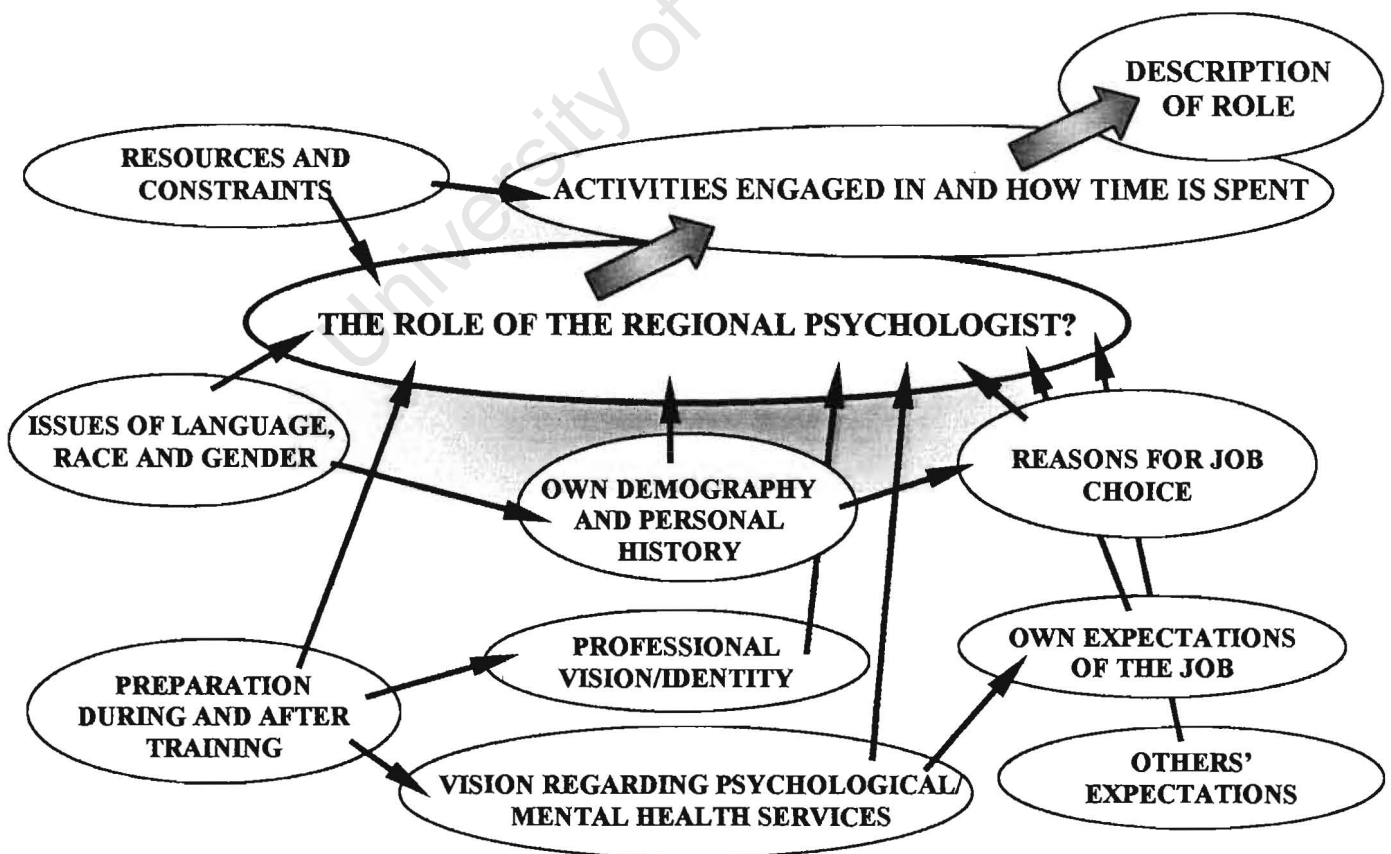
Figure 4: Role of the regional psychologist: Macro Contextual Map.



5.2.2. Micro contextual factors:

Understanding micro contextual influences on the role of the regional psychologist is based on the assumption that the type of activities in which the psychologist is engaged are influenced by a number of factors, as is the time spent on these activities. These activities make up the description of role. The dynamic interrelatedness of the various factors is very complex and is beyond the scope of this research. To track one factor will exemplify this. Race would be formative in terms of the psychologists own demography and personal history both individually and collectively. It would have played a determining role in terms of previous education, placement within tertiary education system, socio economic status and political creed. It would affect motivation for choosing this particular job. Being of a particular race can be both a resource and a constraint in differing situations. This, along with previously mentioned factors will affect the type of activity the psychologist chooses to engage in and thus how they understand and describe their role. Figure 5. identifies the micro contextual elements within the interview material and maps out some of the nature of their interrelatedness.

Figure 5: Role of the regional psychologist: Micro contextual map



5.3. Section A:

In this section selected issues, which arose from the macro and micro contextual analysis, will be discussed further.

5.3.1. Relationship to named identity as ‘clinical psychologists’:

In all of the interviews the psychologists, identified themselves specifically as **clinical** psychologists. This was an identity which was clearly highly valued. This is noteworthy as there is a perceived hierarchy within the profession in terms of the kind of training received and the different categories of registration. In this hierarchy **clinical** psychologists maintain greater authority and power. In part this is due to the training of clinical psychologists being seen as a difficult course in which to be accepted at a post graduate level. This is further amplified by the scarcity of places and the large number of applicants wanting to do this training. There is an elitism, which goes with the grouping of **clinical** psychologist. This affects the dynamic between themselves and the rest of the team. As one of the psychologists noted: “ The psychologists have an incredibly powerful position in this team” (UP2). It is arguable that such power extends beyond the team to colleagues and the wider community. There is a power to recruit others into their way of viewing the world and preferred practices. Recognition of this power is needed and to some extent is acknowledged by the psychologists.

In addition, within a context of change, such as the health system is undergoing, the need for reflexive practice is crucial. This is a skill which is particularly emphasised and developed during clinical training. This is an important aspect of the work and needs to be inclusive in the role. The psychologists argued a strong case for their role in the support and supervision of other health workers. Together with providing support to health workers, the psychologists need to be able to view their own practice, those of their clients and colleagues and wider health systems practices reflexively and critically, as this is crucial to effecting change and movement.

All of the psychologists identified the need for ongoing support. One of the rural psychologists identified the lack of role models and difficulty in terms of finding

appropriate supervision as a critical need. Supervision provides an opportunity for reflexivity and for support of the psychologist.

Undergoing training as clinical psychologists is formative in terms of professional identity and is reflected in the ideas the interviewees held about community psychology, their vision regarding mental health services and the degree to which their experience during and after training would have equipped them to do the job. I would argue that **clinical** psychologists do bring particular and valuable skills to the job. It was clear from the interviews, however, that the psychologists at times felt limited in what they could offer. It would seem that the employment of other categories of psychologists would bring different and useful skills such as research, project management, programme development, and knowledge of public and primary health, to name a few. I would suggest that the job description requirements be broadened to include other categories of psychologists, which would allow the health service to tap into broader psychological skills which are available but not utilized within the health system at present.

5.3.2. Relationship with ideas of community psychology:

It was clear throughout the interviews that all the psychologists came into the posts with ideas, which would fall under the community psychology umbrella, and there was evidence that these had been important in the construction of a professional identity. However, for some of the psychologists there was a marked dissonance between the lived experience of working within the constraints of a stretched public health system and the ideals of change and transformation to which community psychology aspires. It is interesting that both urban psychologists identified themselves either as “not being an activist anymore” or “not being a community psychologist” and this perhaps expresses some dissonance between their identity and their ideals. Both rural psychologists who had left or were leaving the formal public health sector were moving into areas of research and NGO work in which they were better able to implement ideas of community psychology. Rappaport (1977) asks a significant question: Where do these psychologists find their own psychological sense of community? This seemed to be echoed by the interviewees, in their search to find a base from which they could work. Working relationships with people in academic institutions may offer part of the answer. A greater sense of belonging to the mental health services needs to be built. Recognition by mental

health service management of the work that they do by way of visits, telephone calls, addressing and prioritising their needs would create a sense that their context is also heard, understood and valued.

As found by Lazarus and Seedat (2001) praxis of the ideas of community psychology is not clearly defined and practical application tends to be vague. The idealism of community psychology is reflected in many of the policy documents, produced in the last few years, and discussed in a previous chapter. The expectations of other members of the team and of co-workers and the degree to which they are able to accommodate change also places constraints on utilizing these ideas.

Petersen argues that the role of the community psychologist is particularly concerned with: “addressing the social and structural roots of mental ill health, it demands that in addition to providing traditional mental health care services, community psychologists are required, inter alia, to play the role of advocate, activist and facilitator” (Petersen, 2000, p.221).

I would argue for the important role psychologists have at the cutting edge of policy implementation. This is so despite the difficulties: the lack of role models and the tension between ideals and what is achievable with limited resources. Their preparation in training, which is inclusive of community psychology, gives a particular perspective and a critical stance, which needs to be maintained if the ideals enshrined in policy are to become a part of the mental health system. There is also a responsibility for psychologists in academic settings to be proactive and supportive of these psychologists and to build supportive and dialogical relationships where ideas, practicalities, criticisms and experience can be explored and partnerships developed.

5.3.3. Relationship with the primary health care nurses and/or the mental health nurses:

With the integration of mental health into primary health care, as the policy documents suggest, the role of the psychologist who is entering this domain for the first time has had to be negotiated, particularly with the nursing staff.

In a study of a public mental health programme in Guinea-Bassau, de Jong (1996) found that in training health workers to take on mental health problems, supervision was crucial. Acquired knowledge was put into practice after supervision. The successful implementation also pointed to the combined use of epidemiology, anthropology, public mental health interventions and local healing methods. The programme was used to qualify primary health care workers in identifying and managing major psychiatric disorders and epilepsy. However, they were not able to sustain interventions of a purely psychological nature.

This would support the experience described by the psychologists interviewed, of the importance of being able to provide ongoing supervision for other staff members involved in mental health activities. However there are two apparent difficulties. The one is that there is a danger that care and support are seen as specialised activities, and not part of the everyday nature of human interaction. Compassion and respect need to be integral attitudes in the provision of mental health services and a culture of care needs to be nurtured and developed.

The other difficulty is the rather indistinct boundary between counselling and support and more intensive therapeutic work. This boundary poses difficulties as to when the nurses should refer clients and the pragmatic difficulty of services and personnel being available, to which they can refer. Gibson (as referred to by Swartz, 1996) suggests that the role of the psychologists in primary care is to support the nurses and other health care professionals to be better at their jobs rather than to train them to be relatively unskilled counsellors.

Counter to Gibson's argument, it could be argued that nurses should provide counselling services at a primary care level with the consultative support of mental health nurses. Mental health nurses have a largely psychiatric orientation and are skilled in providing care for the mentally ill and certainly have an important and distinct role to play. However, primary health care nurses do not have the time or perhaps the necessary orientation to provide psychological services. To a certain extent they do provide a level of psychological services inadvertently, in providing nursing services with care and respect. However, the responsibility of providing and developing psychological services belongs to psychologists. In our "giving away" (Orford, 1992) of psychological skills, I

would argue that we are being oppressive in expecting nurses to take on more and more with no recognition in terms of status, financial remuneration or professional power. We also fail to give due recognition to the specialised skill of therapeutic work.

Within the primary health care arena, nurses have taken on many medical functions. They are at the interface of the wider community and the health services, however this does not legitimise continuing to load them with tasks and responsibilities, which only serve to dilute what they can effectively do. I would argue that this is oppressive and disrespectful of their role as nurses. Rather than to continue to add on to the ever-expanding role of the primary health care nurse, responsibility for psychological services needs to be taken by psychologists. Research with other groups of nurses and teachers have had similar findings (Evans and Swartz, 2000; Maw, 1996 and Holdsworth, 1994).

Further, within the psychology profession, the degree of support and supervision needed to operate effectively in providing psychological services is acknowledged and yet nurses are expected to take on much of this role and are provided with very little in the way of support. We are placing an intolerable burden upon them in expecting them to also provide psychological services (Holdsworth, 1994).

Although the integration of services is desirable it is questionable if it is feasible without more human and physical resources. There is a need to lobby for more posts directed at providing psychological services. There is a whole new cadre of counsellors being trained by the universities presently, who will graduate with Bachelor of Psychology degrees. There are no posts for them currently in the primary health care services and they represent an untapped resource for psychological services. As mentioned previously the reservation of posts for clinical psychologists within the health structures also needs to be challenged and changed. Different categories of psychologists with different skills have a valuable contribution to make.

I would also argue that psychologists have a different orientation and are able to hold together a broader model of mental health, which is less embedded in the biomedical model and able to work toward incorporating more comprehensive ways of working.

5.3.4. Relationship with the health system:

Some of the systemic issues, which arose, were the perceived advantages of the regional psychologist post. This related to the relative lack of hierarchical structure and the freedom to develop something new. This was one of the predominant reasons given for the choice of job. However, once in the post there was some ambivalence about the already existing structure or the lack thereof and the need for containment and structure in the position. This illustrates the dynamic tension, which has to be held, between the need for structure and definition and the containment it gives and the need for fluidity and responsiveness within the system.

One of the constraints of working within the system was that a sense of vision had to be contextually based, both in terms of the community served but also in terms of the system within which they were operating. An example of this was the context of working in the Western Cape, with a political climate of ongoing strife and uncertainty. The majority political party at provincial level is different from that at national level. This affects the political will to implement national policy. The province also has a highly developed tertiary health care system and is relatively better resourced than many other areas of South Africa. However, in order to develop services at a primary level, resources have to be moved from tertiary areas to primary services and from urban to rural areas. The psychologists, particularly in the urban areas, experienced this change as a loss whereas the sense from the rural regions is that although resources are limited there is a sense of growth and development, which directly reflects this process. There is very strong resistance to this from the powerful and influential tertiary sector who find themselves in the position of reduced and reducing resources.

There are also significant comments made by the psychologists regarding the lack of exposure to the wider health system and perhaps particularly the primary health care system before entering the job. With the use of intern psychologists at a primary level, this gap may be addressed. However the interns' modus operandi is still within an individual or familial consultation model and mental health prevention and promotion or the critical evaluation of services is not really a part of the process. The theoretical orientation is still predominantly within the biomedical model. Again this reflects a gap between knowledge of community psychology and its practice, which needs to be closed.

The psychologists also expressed the frustration of being more peripherally positioned in terms of the health hierarchy. Being within the regional structures, they were much more a part of the primary care services. So whether it was access to cleaning services, isolation from professional support, lack of recognition from tertiary services or academic colleagues, the differential positioning of PHC services in relation to other health services was experienced as problematic.

Recognition in terms of monetary reward and status needs to be given to excellence in primary health care services. The breadth of knowledge that maintaining generalist skills requires, needs to be acknowledged and those of specialist skills need to be toned down. The opportunity to earn the most money, enjoy the most status and access the most resources remains within the tertiary sector. If this were equalized at the primary level, the difficulties with regard to retaining staff, getting staff to work in inhospitable areas, the development and concentration of skills, research, and the development of services would be eased. The power issues with regard to the health structures are very entrenched and staff structures, career opportunities and incentives need urgent attention if the power differential between primary, secondary and tertiary services is to be dissipated.

5.3.5. The broad agenda of 'developing mental health services':

There is an uneasy alliance between social science and medical science with regard to developing mental health services and what that means. Petersen (2000) in her study on rethinking the integration of mental health into a comprehensive model of primary health care indicates that there is a disjuncture between policy and practice. Whilst there is a need to decentralise mental health care and provide for both serious and common mental illnesses and psychosocial problems, implementation has focused on care for the seriously mentally ill and an "add-on" approach has been used to integrate mental health into primary health care. Thus a psychiatric component has been added to the workload of primary health care personnel as has been mentioned previously. A biomedical orientation has characterised implementation. Petersen (2000) argues for an approach, which incorporates the socio-cultural correlates of illness such as social problems, apartheid, poverty, diverse cultural explanations of illness. She states that:

While acknowledging the centrality of biomedicine to health care, this conceptual framework demands, however, that the subjectivity of the illness experience for

the patient **also** be considered and that it be located within the social and economic relations of society...Furthermore it demands a critical reflexivity on the part of health practitioners as to their role in upholding power relations of society. (Petersen, 2000, p.78-9)

Within the world of limited resources, pressurised staff, many pulls in many directions and overwhelming curative mental illness needs, it is difficult to keep this perspective and not be overwhelmed. The predominance of the biomedical model and the need to be doing “something” is very strong. Whilst the policy rhetoric is around transformation, the systemic issues may only allow for the slower process of reformation in developing mental health services. In the interviews, the urban psychologists identified their vision as operating within the given structures. The challenge for the urban psychologists is more difficult in this regard as there is a much more established mental health service already in existence with all kinds of vested interests at play. The rural psychologists, it could be argued, have greater freedom to establish a new system with a different orientation as there are fewer structures already in place and fewer resources and so as one of the psychologists noted, innovation is welcomed although resistance is not absent.

However they chose to define themselves, it could be argued that psychologists, by nature of their training, together with their skill of being able to take a ‘meta’ position and think about process, have a significant role to play. They can introduce creative and critical approaches during supervision, during meetings, in training and support of other health care workers and in their engagement with other members of the health team. They bring a crucial alternative voice, if efforts to develop mental health services are to be proactive rather than merely reactive. As Swartz (1996) points out there is: “ the need for psychologists in community work to play to their strengths as psychologists, to respect what their discipline has to offer while at the same time exploring new ways of thinking and working” (p.15).

5.3.6. Racial, language and gender issues:

Other crucial areas, which need ongoing engagement, are that of race, language and gender, and the interplay between them. These cannot be dealt with fully within this thesis. However the pervasive nature and importance of these areas is acknowledged.

All the psychologists interviewed commented on the consensus around the silence that exists about race. It has become even more difficult to talk about, with the ending of legalized apartheid, so it is ignored. Swartz (1996) notes that:

Social scientists were strongly engaged in the important work of demonstrating that “race” and “culture”, for example, were social constructions and not immutable realities “out there”; they were not determined either by biology or essence. The reality of living through these labels, not simply as they affected material circumstances but also as they affected identity and every aspect of psychological development, was obscured. Talk of the experiences of differences between groups of people on the basis of social categories like race, culture, and social class became dangerous talk, even apartheid talk. (p.4).

We have to be prepared to work with this difficult and painful topic as it continues to play a powerful role in constructing who we are both at a personal level and a professional one and in terms of service provision. Mosse and Roberts (1994) suggest that in organizations under threat, imposed by the restructuring and changes, there is an unconscious pressure to blur difference and that the capacity to notice difficulties is suppressed. This is often experienced as oppressive. There seemed to be an element of this in the description of the dynamic around racial, gender and language issues. The situation within the Western Cape in this regard is particularly complex as political alliance for the ‘coloured’ vote, provision of services by a non-ANC (African National Congress) provincial government and resistance to national policy all interact.

The power differentials connected to racial issues continue to play an important role in relationships, as noted by both the rural and urban psychologists. The racial identity of the psychologists at times opened up therapeutic opportunities in a shared identity and at times imposed prejudice of differing quality of service being provided by different psychologists.

The continued inaccessibility of services, for Xhosa speakers as identified by one of the psychologists, must influence decisions about the activities into which time is channelled. It is noticeable that Xhosa is the one common language group, which is not represented amongst the four psychologists. This reflects a continued scarcity of psychological services for this racial and language group. This continues historical and present

disempowerment. The racial identity of the psychologist is important in how roles and the practice of relevant psychology will be developed. An important part of transformation is confronting and addressing these issues. As the one black psychologist pointed out: “I still feel that more black people need to be trained to do psychology...because it’s one of the ways that we’re going to start to engage with making psychology more appropriate and relevant”.

Promoting gender awareness must be understood as a proactive and necessary component to the development of mental health services. The context of the psychologist seems to reflect gender attitudes with the rural psychologists experiencing greater discrimination and harassment:

on a variety of levels...just in terms of the office here, initially, I often kind of felt people were harassing me – that kind of sexual harassment thing...that was in the beginning difficult for me.... some of the males... men in more powerful positions would come walk past my office and will stand at the door and will just look at me and then giggle... so that was very difficult in the beginning, but I think after a while I also learned how to deal with it (RP2).

Gender issues also played out in the team context as the psychologist reported in the example of using drum majorettes for mental health day celebrations. Different team members viewed the gender issue differently and this had to be negotiated.

What was evident was that the psychologists own position and the interplay in terms of language, race and gender profoundly affected their role. At times the interviewees described their race or gender or language as a constraint and in other instances as a resource in their work with clients and with the mental health team. The context of the society in which they were working reflected current gender, language and racial issues and practices, bringing into conflict their own values and those with which they were working, both clients and colleagues.

5.4. Section B:

This section discusses the differences and similarities in role description and the activities in which the psychologists were engaged as given by the quantitative results.

5.4.1. Allowing for difference:

It is important to acknowledge that different aspects will be more or less important for different psychologists according to context and personal strengths and abilities and that at different stages of development or change within the system, there will be different foci. The following activities were noteworthy:

- All three psychologists verbalised the need for research and evaluation of programmes. The percentage time allocated to this activity was low. (1.5%, activity ranking: 11; 2.2%, activity ranking: 11 and 3.2%, activity ranking 10). Although the psychologists may not be able to put the time into the needed research themselves, this points again to the need for collaboration with academic institutions and the function they can fill in building active research partnerships with psychologists working within the primary health care system.
- All three psychologists gave a high proportion of their time to clinical work (18.1%, activity ranking: 2; 17.6%, activity ranking: 1 and 14.2%, activity ranking: 3). Qualitatively the reasons given were different, but effectively clinical work was ranked amongst the top three activities for all of the psychologists. This was also qualitatively the most debated element of their role. My own opinion is that in order to effectively supervise or teach others, a certain amount of clinical work must be maintained. Without this there is a real danger that the teaching or supervision becomes disengaged from practice. The other argument is that, as clinical psychologists they have been trained to provide a clinical service and those clinical services are needed.
- Differences which reflected personal priorities were in the areas of professional development where this was ranked as one of the psychologists top priorities (18.8%, activity ranking: 1) and that of administration for another (11%, activity ranking: 2).
- One of the psychologists worked very differently from the others in establishing a network of counsellors for the region as a primary focus and the other activities taking a much lower priority. The scope of activities included a range of activities, which were not described by the other psychologists (see Diagram 2b).

5.4.2. Rural vs. urban:

A significant contextual difference, which emerged, was between working within a well resourced urban area and working in an area where there have been virtually no psychological services available previously within the public health system to the vast majority of people. The starting point is very different and necessitates a different way of working. It is very important that this is acknowledged and that structures, which work within an urban context, are not imposed upon a rural context and vice versa.

The following analysis of activities illustrate this:

- For the rural psychologist the highest percentage of time was spent on the training and supervision of staff (17.2%, activity ranking: 1). Both urban psychologists did no staff training and spent a much smaller percentage of time on staff supervision (4.5%, activity ranking: 10 and 3.2%, activity ranking: 10). The rural psychologist spent no time in training or supervising intern psychologists, whereas the urban psychologists spent a moderate amount of their time on this activity (5.5%, activity ranking: 8 and 6.7%, activity ranking: 6). The variation reflects differences in resource availability and capacity within the health structures and illustrates the resultant differentiation of role according to a particular context, in this instance a rural or urban context.
- A further interesting differentiation between urban and rural based psychologists was that the urban psychologists were able to give a higher proportion of time to the further development of the mental health services (17.6%, activity ranking: 1 and 12.9%, activity ranking 3) whereas the rural psychologist ranked this activity in the medium range (7.2%, activity ranking 7). The rural psychologist in turn spent a higher proportion of time co-ordinating services (11%, activity ranking: 4) than the urban psychologists (9.9%, activity ranking: 5 and 9.3%, activity ranking 3).
- As would be expected the amount of time spent on travel was appreciably different for the rural psychologist (15.1%, activity ranking: 2) whereas it was less time consuming for the urban based psychologists (7.5%, activity ranking: 5 and 6.2%, activity ranking: 7)

5.4.3. The recipient of services:

All the psychologists felt that referred clients (clinical work) and the managers of the health service were recipients of their services. Three identified mental health nurses as recipients of their services. The one psychologist actively chose not to focus on the nurses. The two rural psychologists both identified counsellors as recipients but did not identify intern psychologists or other nursing staff as recipients of their services. The urban psychologists saw intern psychologists and other nursing staff as recipients but did not work with counsellors. Again this reflects the contextual differences between the two groups and also highlights that for at least one psychologist there was an active choice not to primarily focus on mental health nurses, whereas for the others they were key players in their work towards developing mental health services.

5.5. Conclusion:

This chapter began with a mapping of the micro and macro contextual factors, which influence, impinge, create and change the role that psychologists adopt. Further discussion included the relationship of the psychologist to the named identity as **clinical** psychologist, with ideas of community psychology, with nursing staff and with the health system and the effect these relationships had on their role. The common agenda of 'developing mental health services' was examined for what that meant and issues of language, race and gender were examined for their effect on the psychologists role. A further section dealt with discussion of the quantitative results with evidence of individual differences in approach reflected in different ranking of activities as well as differences based on an urban or rural context. The final chapter will conclude the research and make recommendations for future practice and investigation.

CHAPTER SIX: CONCLUSIONS AND RECOMMENDATIONS.

6.1. Introduction:

Arising from the results and discussion, this chapter addresses the conclusions and recommendations drawn from the study. A composite role description will be given, which brings together the ideas of the researcher and those of the psychologists interviewed. It is recognized that this will be implemented differently according to personal, political and geographic context, and that the role continues to evolve. Recommendations, which arise from the preceding chapters, are given. The chapter ends with some concluding comments.

6.2. Role description:

Drawing on the data and analysis of the roles of the four different psychologists, the following section presents a composite picture of the kinds of activities in which a psychologist at regional level could be involved. There were marked differences between the activities of the four psychologists. The extent and degree of the activities varied according to the psychologist's own interests, vision and context. However, the overarching principle, which emerged from the interviews, was that the psychologist plays an important role in the development of mental health services at regional and district level. The three main arguments put forward in the discussion were:

- Psychologists bring a wider theoretical perspective by virtue of their training, which is crucial in the implementation of mental health policy.
- They play a particular role in relation to the mental health team and those providing mental health services at a primary level inclusive of training, supervision, consultation and management.
- Given their specialized skills, they provide a referral source at secondary level, of therapeutic services.

Given the development of mental health services as a broad goal, the following activities are described.

6.2.1. Service development:

This would involve such activities as:

- Needs assessment, both initial and ongoing of systemic and contextual mental health service needs.
- Creating networks with available and potential resources. This could take various forms such as establishing new networks between staff members, identifying and incorporating community resources and developing these further.
- Project work according to identified need. It is necessary not to have too closed a definition of project work. It doesn't necessarily need to have outside funding but is perhaps just a particular focus of work for a period of time. Examples drawn from the psychologists experience include: working with existing staff to develop an aspect of the district services; working within the wider health system to develop models of staff support; working with research groups to implement and evaluate new ideas or to evaluate present services or training lay counsellors. Partnership with other people and organizations seems important in this area. Project work is important also for a sense of mastery. It involves a system, a goal, provides a service and provides containment for the psychologist.
- Integrating new aspects of the service into existing structures. This is a key aspect if change and innovation are to be tolerated by and adopted into the existing system.

6.2.2. Clinical work:

This emerged as an important function and activity for all the psychologists interviewed. Primarily, involvement in clinical work enables the specialized skills of the psychologist to be used to provide a secondary level referral source. It is important to have some idea of what others are dealing with at the 'coal face' so as to not get out of touch, particularly in terms of ongoing supervision and training. Again this takes different forms according to the interest and theoretical approach of the psychologists and the context within which they are working. A difficulty is limiting the clinical work to give time to other activities. One of the rural psychologists chose to provide clinical services to less resourced areas, where there were no psychological services whatsoever. Areas of clinical work may include: one-on-one psychotherapy, family work, crisis work and support groups.

6.2.3. Professional development:

The interviews highlighted the need to prevent “burn out”, provide support to the psychologist and to address the need to maintain reflexivity. It included activities such as: reading, supervision in groups and/or individual supervision, their own therapy, continuing studies, informal and formal discussion with colleagues and attendance at courses, lectures and conferences.

6.2.4. Training, supervision and consultation:

An important function, which emerged during the interviews, was the psychologists’ use of their skills in training and staff development, the supervision and support of others engaged in mental health care and to provide a consultative service. The content would vary according to the context and the skills and experience of the psychologist. The following groups of people were identified as target groups: intern psychologists, health department staff, nursing staff, registered or lay counsellors and regional NGO’s

6.2.5. Management:

This was a particularly important activity for the rural psychologists where the management of mental health services is needed as the service itself develops. It included activities such as: the co-ordination of services, policy development and implementation, and budgeting and financial management. Within the urban context this activity was devolved to a greater extent to the broader mental health team.

6.2.6. Research and academic activities:

This would involve:

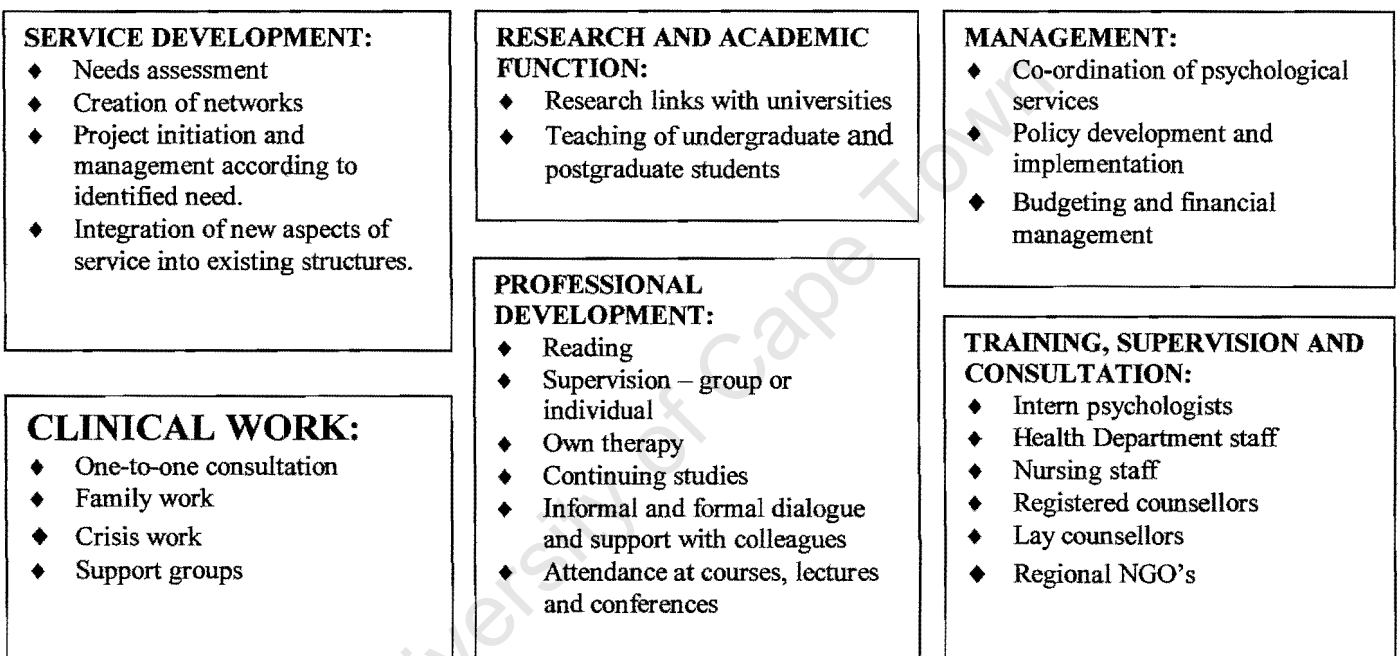
- Establishing research links with universities. This is an important avenue of support for the psychologists as well as keeping academic staff in the universities in touch with work on the ground and allows for the cross fertilisation of ideas. In part, this is one of the aims of this research project. The psychologists in practice have much that is valuable to say to the psychologists who work in the world of ideas and vice versa.
- Teaching of undergraduate and postgraduate students. This provides incoming professionals with role models of different ways of working and provides a source

of service provision in the form of student work, although it also creates work in the form of supervision.

Figure 6. provides a composite summary of the role described above.

Figure 6: Composite diagram of the role of the regional psychologist.

Development of Mental Health Services.
ROLE OF THE REGIONAL PSYCHOLOGIST



6.3. Recommendations:

Supervision:

The analysis of the data highlighted the need for structured supervisory support to be made available for the psychologist. It is important for support, reflexive practice and ongoing professional development. The difficulties faced within a rural region in terms of dynamics, resources, distance and isolation need to be acknowledged and active steps to provide that support must be facilitated.

Creation of posts:

The creation of posts for clinical psychologists to be employed within the structure of a regional mental health team is welcomed. However, there is a need to widen the criteria to include psychologists from a broader grouping. With the phasing out of different registration groups in the near future, the public health sector needs to adapt to changes within the professional structures.

With the training of registered counsellors, currently in process, posts need to be created at a secondary and primary level in order to utilize this resource. In the debate regarding the development and transformation of mental health services in the early 1990's, the limited number of professionals available was identified. Freeman's statement (1992) continues to apply to the present situation:

The first change needed is that more, and more attractive posts must be created in the public sector. If posts were made available, were paid reasonably and allowed for the creative utilization of skills, it is likely that a significant number of practitioners will be attracted from the private to the public sector. Moreover there are very few posts outside of hospital services in the public sector and thus the opportunities for certain professionals in particular to utilise their skills is very limited. More community orientated posts need to be created...a balance between private and state services may allow for job satisfaction not possible in either practice on it's own. The second form of redistribution that is required is from urban to rural areas...A strong recommendation is that a compulsory rural service should be introduced...there should be incentives created to work in the rural areas...increased pay, tax rebates and provision of housing could be offered. (p.31).

As from 2003, intern psychologists will be required to undertake a year's community service (communication: Professional Board for Psychology). Utilization of their skills and appropriate supervision and management are going to provide both challenges and opportunities in the development of mental health services. The need to train more psychologists skilled to do this type of work must become a priority and runs as a parallel process to that of post creation.

Research and academic support:

Working relationships with colleagues from academic institutions need to be established and reciprocity recognized. This will facilitate the development of community psychology ideas into praxis. Likewise participative and action based research which evaluates programmes or projects is needed for the further development of services. In particular, the degree of isolation of those working in rural situations needs to be recognized. Particular effort from urban-based colleagues and institutions is needed, to provide such support.

Creation of psychological services:

It has been argued that regional psychologists are at the cutting edge of policy implementation and that psychologists bring a crucial alternative voice into the biomedical world of mental health. This is needed if the mental health service is going to move towards being comprehensive and begins to address some of the social and structural issues which impact on mental health. I have argued that the responsibility for psychological services should remain with psychologists rather than being delegated to already overburdened primary health care nurses or mental health nurses. The need for nurses to provide care and support, which would make their practice of nursing more effective, should not be confused with the therapeutic and particular psychological skills which the provision of psychological services requires. I have argued for distinct but inclusive psychological services. These should aim to be proactive rather than reactive.

Flattening the health hierarchy:

In order to attract and retain staff at the primary and secondary levels, the power differentials between tertiary, secondary and primary health services need to be evened. This needs to take practical and tangible form in terms of salaries, incentives, career structures and senior appointments. It is recognized that this will be a slow and difficult change process as shifts in power and resources will have to be made.

Ongoing engagement with gender, racial and language issues:

Although painful, the avoidance, silence and denial of how colour, language and gender continue to shape our lives and our South African society prevents healing. Inequalities, injustice, lack of access to services, discrimination, harassment, personal and institutional

dynamics continue to impact on the work and need confrontation and ongoing engagement. The need to train a greater proportion of black psychologists remains. One of the rural psychologists' noted that those seen to have professional authority in the team were white. This was also noted by one of the urban psychologists in relation to the academic structures. Active change in the status quo, in positions of management and authority, has to take place.

6.4. Concluding comments:

I have argued, in the examination of the role of psychologists within the regional health structures of the Western Cape, that these psychologists play an important and particular role in the development of mental health services and in the implementation of policy. This role varies according to individual approaches, rural and urban contexts, the political climate and the direction and pace the implementation of policy takes at the coalface. The role continues to change and evolve. I have sought to describe that role and the micro and macro contextual influences that create and shape it. I have also argued that in the development of comprehensive mental health services, further posts and training are needed within the primary and secondary health services for the development of psychological services in order to utilize the available psychological resources. The study has highlighted the complexity of these issues. It is hoped that these ideas will promote and contribute to the debate with regard to the development of mental health services, both in the Western Cape and within the broader South African context.

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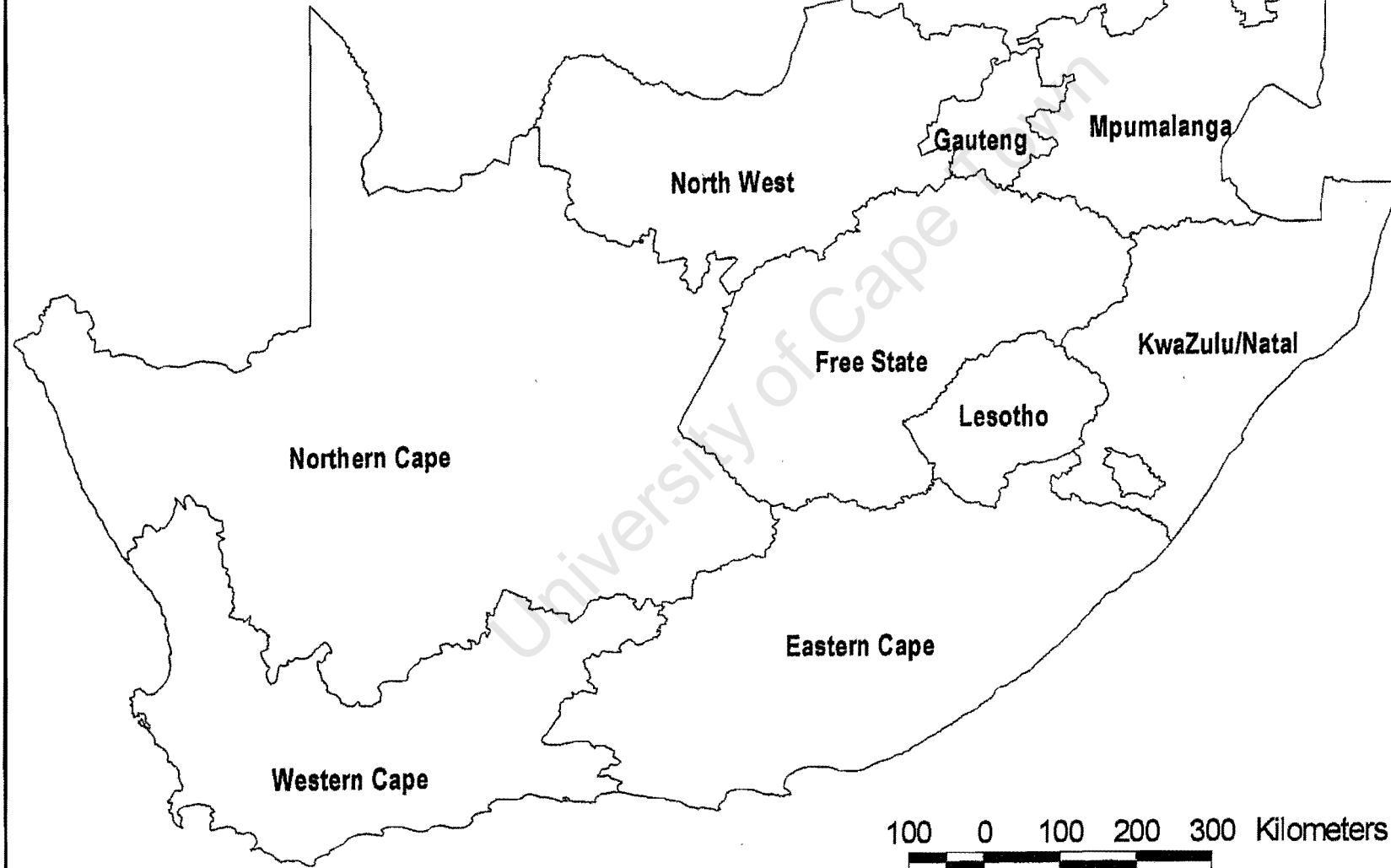
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University of Cape Town

WESTERN CAPE PROVINCE

Locality Map



PROVINCIAL
ADMINISTRATION
WESTERN CAPE

Sub-Directorate
Information Management



COMPILED
BY: C.S. van der Berg
Project: AV0028_2001
Date: 11 April 2001

WESTERN CAPE PROVINCE

Current Health Districts

LEGEND

-  Health Districts
- District Municipalities**
-  Cape Town
-  West Coast / Winelands
-  Boland / Overberg
-  Southern Cape / Karoo

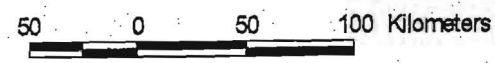
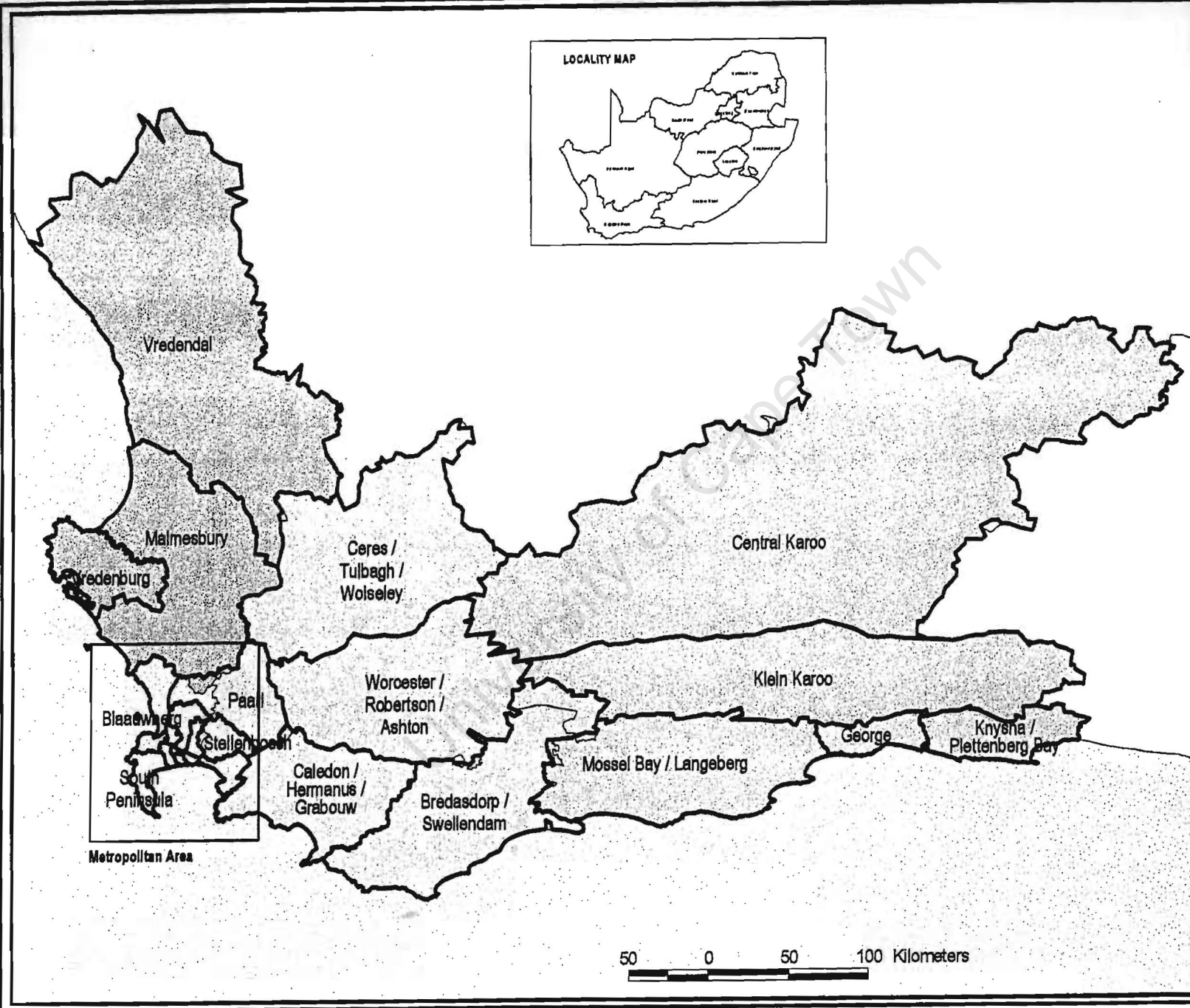
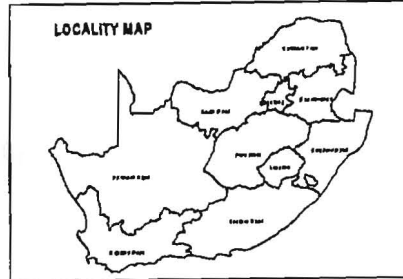


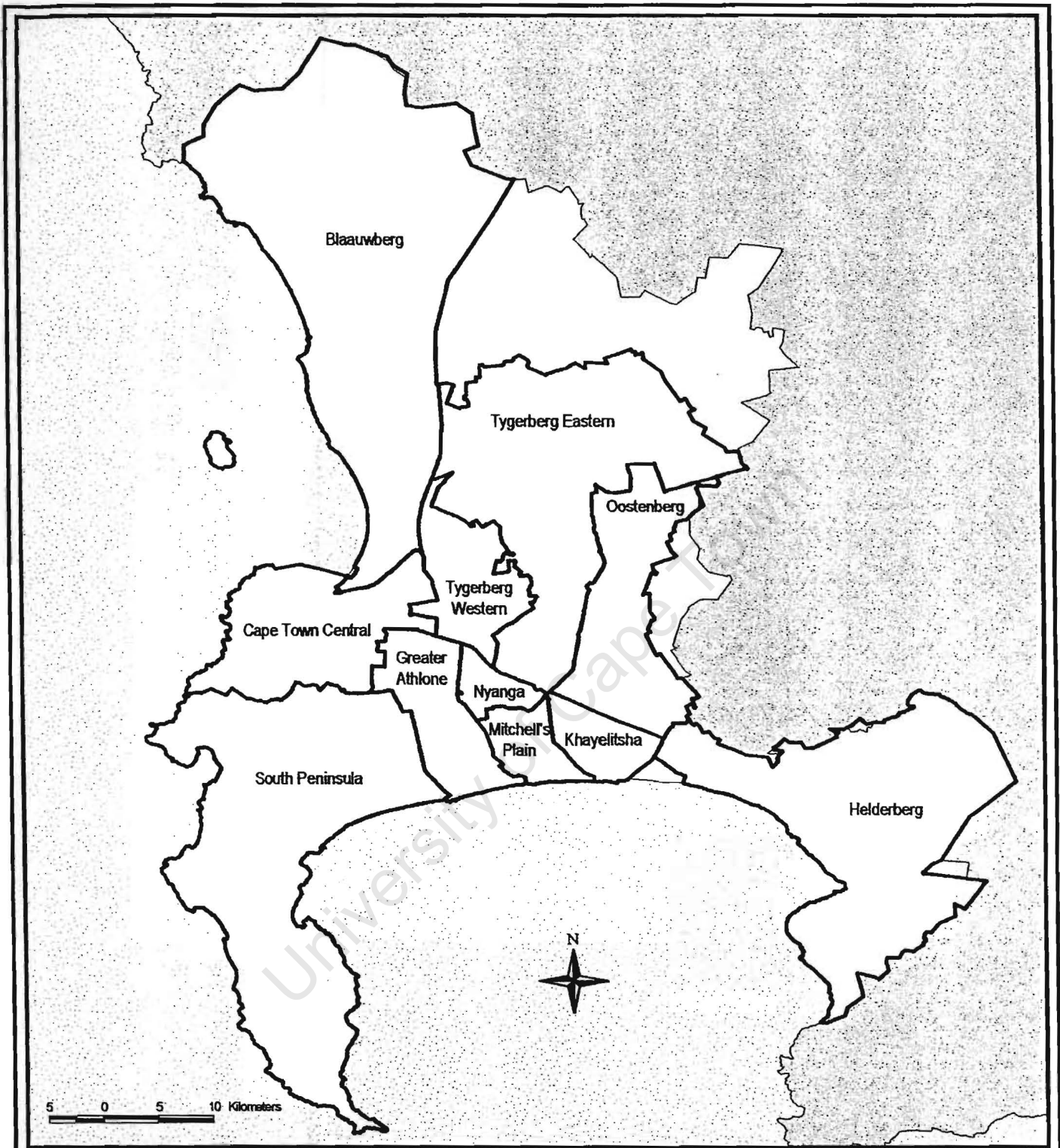
**PROVINCIAL ADMINISTRATION
WESTERN CAPE**




**Sub-Directorate
Information Management**



COMPILED
 BY: C.S. van der Berg
 Project: AV0028_2001
 Date: 11 April 2001





<p style="text-align: center;">LEGEND</p> <p>  Health Districts  Cape Metropolitan Area </p>	<p>WESTERN CAPE PROVINCE</p> <p>Cape Metropolitan Area</p> <p>Current Health Districts</p>	<p> PROVINCIAL ADMINISTRATION WESTERN CAPE Sub-Directorate Information Management </p>  <p> <small>PROJECTION: Latitudes/Longitudes</small> </p> <hr/> <p> <small>COMPILED</small> <small>BY: C.S. van der Berg</small> <small>Project: AV0028_2001</small> <small>Date: 11 April 2001</small> </p>
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Child Guidance Clinic

University of Cape Town · Chapel Road
 Rosebank 7700, Cape, South Africa
 Telephone: (021) 650-3901
 Fax: (021) 689-1006
 E-mail: cgcdir@protem.uct.ac.za

Dear

Thank you for consenting telephonically to participate in the small research project that I am undertaking.

I will fax a copy of my proposal, as soon as it has been accepted by my supervisor, for your interest. I would also be prepared to forward you a copy of my research findings should you be interested.

With regard to confidentiality you will not be identified by name, region in which you work or gender. If there are issues in this regard, please let me know.

With this letter I am faxing you a copy of the diary for the period 2nd-6th of April 2001. I would appreciate it if you would complete it for each day and return it, in the week following the diary entries, by fax or post to

Post: Gill Douglas
 C/o The Child Guidance Clinic
 Private bag
 University of Cape Town
 Rondebosch
 7700

Fax: For Attention: Gill Douglas
 Fax No: (021) 6891006

My e-mail address is pete@ill@mweb.co.za should that means of communication be more convenient.

I shall fax you similar pages for the periods 7th-11th May and 4th-8th of June 2001, during the week prior. I hope to conduct interviews with each of the concerned psychologists during May 2001 and will contact you to set this up a little closer to the time. (i.e. early May)

Could you also fax or post a copy of your job description together with a recent annual report.

Thank you again for being willing to work with me. I really appreciate your contributions and co-operation

Regards

Gill Douglas

Gill Douglas
 Intern Clinical Psychologist

Anastasia Maw

Anastasia Maw
 Supervisor

RESEARCH PROPOSAL: GILLIAN DOUGLAS

Minor Dissertation: MA Clinical Psychology (UCT)

Title:

The evolving role of the psychologist at Regional Mental Health Team level.

Context:

South Africa has a limited number of psychologists. Freeman and Pillay (1997) give the figures of 161 psychologists within the public sector of which 24 are categorised as placed within the community. The proposed norm suggested by the Department of Health is 1:100 000 population thus at the PHC level 363 psychologists would be needed. They further suggest that although the training of community health workers in mental health has been mooted, this cannot be effective without skilled support staff. It is crucial that the placement and utilisation of psychologists within the mental health team is both critically evaluated in terms where they are placed within the health structures and in relation to the goals of policy and service development.

There is momentum within the public sector to reform and transform the health services, using a Primary Health Care approach, following the fragmented and inequitable health system pre-1994. The White Paper for the Transformation of Health systems in South Africa states that "The new South African health system adopts the PHC approach because this approach is the most effective and cost affective means of improving the populations health. The approach involves a health system led by PHC services, which are at the base of an integrated district health system." The development of the District Health system is an effort to provide equitable and accessible health care. As Reynolds says (1997) "There is risk in reform. It requires dialogue on re-definition, re-interpretation, efficacy. It requires an acknowledgement of impotence and failure."

Psychologists have traditionally been placed in the public sector in a tertiary psychiatric setting. Recognition of the role of psychologists in terms of broader mental health care has been in part due to the theoretical development in the field of community psychology, together with a search for appropriate services and intervention models for the rich texture and diversity of South African society.

Theory, policy and actual practice are often very divergent. This study is an attempt to examine the theoretical orientation and practice of psychologists placed at a different interface to that traditionally assigned to them. The sample used is psychologists practising at a regional level within the South African health structure, who interface with the district system and the provincial system. Their placement reflects perhaps some of the momentum for change. The evaluation of their evolving role is necessary in order to both place psychologists effectively and to be able to advocate with regard to further policy decisions i.e. the creation of posts and the structuring of mental health services

Goals:

The goals of this research is:

- To describe the nature of the role of the psychologists employed within the public sector at the level of regional health team.
- To compare the policy with the practice
- To evaluate the usefulness of their particular skills in this role and to identify further skills which are needed
- To explore the effective deployment of psychologists at an appropriate level within the evolving health structures.

Methodology:

The research will use both quantitative and qualitative methods and is exploratory and descriptive in nature and will use the applicable theoretical perspectives and literature, together with present policy to explore the restraints and challenges, which this level of practice provides.

Sample:

The sample will include the four psychologists working within the Western Cape Province at a regional Health team Level and the manager of the Provincial Mental Health Services. The size of the study precludes a larger sample and the researcher recognises the contextual issues at both a national, provincial, regional and district level which makes direct comparisons difficult. Thus the study is exploratory in nature and would serve as an impetus for further discussion, thought and action in the development of appropriate mental health services.

Data Collection:

Data collection will occur over a three month period from April to June 2001. Data will include diarized notes of activities from the four psychologists during 3 week long periods in April, May and June. Individual semi-structured interviews will be held with the psychologists during this period. Further data will include the job descriptions of the psychologists, official mental health service policy documents, recent annual reports of the regional health teams, together with an interview with the mental health team manager for the province.

Data analysis:

The use of time will be categorised and quantified. Qualitative analysis will be used on the remainder of the data. Kvale's (1996) method of analysis of interview material will be used to identify themes from the interviews.

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APPENDIX F:

Name: _____

Region: _____

Date: _____

TIME	ACTIVITY	COMMENTS /REFLECTION
8H00-8H30		
8H30-9H00		
9H00-9H30		
9H30-10H00		
10H00-10H30		
10H30-11H00		
11H00-11H30		
11H30-12H00		
12H00-12H30		
12H30-13H00		
13H00-13H30		
13H30-14H00		
14H00-14H30		
14H30-15H00		
15H00-15H30		
15H30-16H00		
16H00-16H30		
16H30-17H00		

- Please include any after hours professional activities/ work related activities
- Please give as accurate an estimation of time as possible – adjust time slots if necessary
- Please use or ignore the comments/ reflections column to give any necessary explanatory detail

Interview questions for semi-structured interview:

Introduce self and purpose of research and thank for time and participation.

How long have you been in your present job?

What was your working experience/background before now?

Why did you apply to do this job?

What were your expectations?

Have these been met or challenged?

How would you estimate your sense of job satisfaction? And why?

What is your vision regarding psychological services in your area?

What is your role in that?

What are the resources needed to make your vision a reality?

From whom do you need support in order to facilitate your role?

Has / Did your training equip you for the job ?

Have you needed additional skills?

Do issues of language impact on your work? How?

Do issues of race impact on your work? How?

Do issues of gender impact on your work? How?

How did you establish contacts / end up doing what you are doing?

Who are you primarily servicing?

Are there things you would like to spend more time doing?

Are there things you would like to spend less time doing?

What do other staff members or team members think you should be doing?

Is there anything further that you would like to add?

Thanks.

Metro Region**ANALYSIS OF ACTIVITIES-2/4-6/4,7/5-11/5,4/6-8/6/2001**

	WEEK 1 %		WEEK 2 %		WEEK3 %		OVERALL TOTAL	OVERALL %
ADMINISTRATION	120	5.7	90	4.5	120	6.1	330	5.4
TEACHING/TRAINING INTERNS	30		90	4.5			120	2.0
TEACHING/TRAINING STAFF		0.0					0	0.0
SUPERVISION INTERNS		0.0	90	4.5	120	6.1	210	3.5
SUPERVISION STAFF	90	4.3	75	3.8	105	5.3	270	4.5
TRAVELLING	165	7.8	30	1.5	180	9.2	375	6.2
PROFESSIONAL DEVELOPMENT	390	18.4	315	15.9	435	22.1	1140	18.8
DISTRICT/REGIONAL TEAM DEVELOPMENT	180	8.5	120	6.1	360	18.3	660	10.9
PREPARATION/PLANNING	180	8.5	210	10.6		0.0	390	6.4
CLINICAL WORK	420	19.9	360	18.2	315	16.0	1095	18.1
SICK LEAVE/ANNUAL LEAVE							0	0.0
RESEARCH			90	4.5			90	1.5
CO-ORDINATION OF SERVICES	300		300	15.2			600	9.9
DEVELOPMENT OF MENTAL HEALTH SERVICES(district or region)	240	11.3	210	10.6	330		780	12.9
TOTAL TIME SPENT ON ACTIVITIES	2115	100.0	1980	100.0	1965	100.0	6060	100.0

Metro Region

ANALYSIS OF ACTIVITIES-2/4-6/4, 7/5-11/5,4/6-8/6/2001

	WEEK 1 %		WEEK 2 %		WEEK3 %		OVERALL TOTAL	OVERALL %
ADMINISTRATION	145	6.9	240	12.8	300	14.1	685	11.2
TEACHING/TRAINING INTERNS	90	4.3		0.0	120	5.6	210	3.4
TEACHING/TRAINING STAFF		0.0		0.0		0.0	0	0.0
SUPERVISION INTERNS	100	4.7	60	3.2	45	2.1	205	3.3
SUPERVISION STAFF	105	5.0		0.0	90	4.2	195	3.2
TRAVELLING	215	10.2	180	9.6	90	4.2	485	7.9
PROFESSIONAL DEVELOPMENT	120	5.7	75	4.0	60	2.8	255	4.2
DISTRICT/REGIONAL TEAM DEVELOPMENT	240	11.3		0.0	150	7.0	390	6.4
PREPARATION/PLANNING	425	20.1		0.0	120	5.6	545	8.9
CLINICAL WORK	120	5.7	480	25.5	480	22.5	1080	17.6
SICK LEAVE/ANNUAL LEAVE		0.0	290	15.4		0.0	290	4.7
RESEARCH		0.0		0.0	135	6.3	135	2.2
COORDINATION OF SERVICES	90	4.3	360	19.1	120	5.6	570	9.3
DEVELOPMENT OF MENTAL HEALTH SERVICES (district/region)	465	22.0	195	10.4	420	19.7	1080	17.6
TOTAL TIME SPENT ON ACTIVITIES	<u>2115</u>	<u>100.0</u>	<u>1880</u>	<u>100.0</u>	<u>2130</u>	<u>100.0</u>	6125	100.0

Rural region**ANALYSIS OF ACTIVITIES - 21/5/2001-8/6/2001**

	WEEK1 %	WEEK 2 %	WEEK 3 %	OVERALL TOTAL	OVERALL %			
ADMINISTRATION	30	1.3	330	15.0	150	7.0	510	7.7
TEACHING/TRAINING INTERNS		0.0		0.0		0.0	0	0.0
TEACHING/TRAINING STAFF	180	7.8	90	4.1		0.0	270	4.1
SUPERVISION INTERNS		0.0		0.0		0.0	0	0.0
SUPERVISION STAFF	90	3.9	450	20.4	330	15.3	870	13.1
TRAVELLING	180	7.8	345	15.6	480	22.3	1005	15.1
PROFESSIONAL DEVELOPMENT	180	7.8	120	5.4		0.0	300	4.5
DISTRICT/REGIONAL TEAM DEVELOPMENT	330	14.3	210	9.5	120	5.6	660	9.9
PREPARATION/PLANNING	45	1.9	90	4.1	30	1.4	165	2.5
CLINICAL WORK	585	25.3	120	5.4	240	11.2	945	14.2
SICK LEAVE/ANNUAL LEAVE		0.0		0.0	320	14.9	320	4.8
RESEARCH	90	3.9	30	1.4	90	4.2	210	3.2
CO-ORDINATION OF SERVICES	330	14.3	270	12.2	330	15.3	930	14.0
DEVELOPMENT OF MENTAL HEALTH SERVICES (district or region)	270	11.7	150	6.8	60	2.8	480	7.2
TOTAL TIME SPENT ON ACTIVITIES	<u>2310</u>	100.0	<u>2205</u>	100.0	<u>2150</u>	100.0	6665	100.0