Community mental health nurses' experience of decentralised and integrated psychiatric-mental health care services in the Southern mental health region of Botswana (part1)

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Abstract

Since the inception of the decentralisation and integration of psychiatric mental health care services into the general health care delivery system in Botswana, there has never been a study to investigate what community mental health nurses are experiencing due to the policy. Many of these nurses have been leaving the scantily staffed mental health care services in increasing numbers to join other sectors of health or elsewhere since the beginning of the implementation of the policy. During the research study, phenomenological in-depth interviews were conducted with three groups of 12 community mental health nurses altogether. An open central question was posed to each group followed by probing questions to explore and describe these nurses' experience of the decentralisation and integration of psychiatric-mental health care services. After the data was analysed, related literature was incorporated and guidelines for advanced psychiatric nurses were formulated and described to assist these nurses to cope with the decentralisation and integration of psychiatric-mental health care services. The guidelines were set up for the management of the community mental health nurses who are experiencing obstacles in the quest for mental health which also interfere with their capabilities as mental health care providers.

Abstrak

Sedert die ingebruikneming van die gedesentraliseerde psigiatriese geestesgesondheidsdienste en die integrasie daarvan in die stelsel van algemene gesondheidsdienste in Botswana is daar nog nooit 'n studie of indiepte ondersoek gedoen om te bepaal wat die verpleegkundiges in die gemeenskapsgeestesgesondheidsdienste se ondervindings as gevolg van die beleid is nie. Sedert die implementering van hierdie regulasie het baie van hierdie verpleegkundiges die skamele personeelkorps van geestesgesondheidsorgdienste verlaat om in ander sektore van die algemene gesondheidsdienste te werk. Gedurende die navorsingstudie is fenomenologiese, indiepte onderhoude gevoer met drie groepe wat altesame uit 12 verpleegkundiges in die gemeenskapsgeestesgesondheidsdienste bestaan het. 'n Oop sentrale vraag was aan elke groep gestel. Dit was gevolg deur indiepte vrae om te bepaal wat die belewenis van hierdie verpleegkundiges ten opsigte van die desentralisasie en integrasie van die psigiatriese geestesgesondheidsorgdienste is. Nadat die data geanaliseer is, is die nodige literatuur geïnkorporeer en riglyne vir opgeleide psigiatriese verpleegkundiges geformuleer en beskryf om hulle behulpsaam te wees om by te bly met die desentralisasie asook integrasie van psigiatriese geestesgesondheidsorgdienste. Die riglyne is opgestel vir die bestuur van die verpleegkundiges in die gemeenskapsgeestesgesondheidsdienste wat tans hindernisse en probleme ondervind in hulle hoedanigheid as geestesgesondheidsorgvoorsieners.

Introduction

Decentralisation and integration of psychiatric-mental health care services into the general health care delivery system was started in 1980 in Botswana. The introduction of this policy was

- intended to ensure involvement of general health workers at all levels to make mental health services accessable, available and affordable to all people in Botswana; and
- effective utilisation of the community mental health nurses such as supervising and giving guidance on mental health to general health workers.

By 1992, mental health units run by community mental health nurses had been established and attached to general health

facilities all over the country. The World Health Organisation Publication (1990:36) emphasised that for mental health activities to be effective, they should be part of general health workers' everyday tasks and part of everyday work in the general health care facilities. Nevertheless, a report of the Mental Health Workshop for Senior Managers (1993:6) in Botswana indicated that one of the constraints of mental health services is lack of active involvement in the management of mentally ill patients by general health workers. In 1993, a deliberate attempt to effect more integration was taken to facilitate involvement of general health care workers in mental health services. Nurses' roles in community mental health were expanded to include general nursing functions.

Problem statement

Since the policy was implemented, the programme on decentralisation and integration of psychiatric-mental health care services into the general health care delivery system has not been evaluated. Thus, this study looks into the community mental health nurses' experience of decentralised and integrated psychiatric-mental health care services.

Since the beginning of the implementation of the policy in 1993, it seems to have increased the community mental health nurses' workload (Maphorisa 1999: 1-2). In some places, it seems to have withdrawn them from their area of interest. Mental health services were placed first, before general health workers are ready to participate in mental health (Maphorisa 1999:2). It seems that due to this policy, more emphasis is put on the involvement of community mental health nurses in the general health care delivery system while the general health workers remain uninvolved in mental health, whereas the Botswana Seventh National Development Plan (1991-1997:378) emphasises decentralisation and integration of mental health care services. This could probably be responsible for the increasing numbers of departures of these scanty and scarce nurses in the mental health services in Botswana (Maphorisa 1999:3). It could appear that these departures are due to dissatisfaction with the way integration of this programme is been run.

Based on the above problem, the objectives of the study are as follows:

- to explore and describe the community mental health nurses' experience of decentralised and integrated psy -chiatric-mental health care services; and
- to describe guidelines that will assist community mental health nurses to cope with the decentralisation and integration of psychiatric-mental health care services. In this article the first objective of the study will be addressed.

Paradigmatic perspective

This includes meta-theoretical, theoretical and methodological assumptions.

Meta-theoretical assumptions

The researcher will incorporate the Theory for Health Promotion in Nursing (Rand Afrikaans University, Department of Nursing, 1999) as a paradigmatic perspective for this research. It endorses a Christian approach. The following parameters of nursing are also identified: the community mental health nurse, mental health, environment and mental health nursing.

A community mental health nurse as a person is believed to be a whole being who embodies dimensions of body, mind and spirit and who functions in an integrated, interactive manner with the environment (the integrated mental health care services) (Rand Afrikaans University, Nursing Department, 1999:4). Mental health nursing is an interactive process where an advanced psychiatric nurse, as a sensitive therapeutic professional, facilitates the promotion of clients' mental health through mobilisation of resources (Rand Afrikaans University, Nursing Department, 1999:4). These clients can also include community mental health nurses.

The environment includes an internal and external environment. The internal environment of the community mental health nurse consists of body, mind and spirit. His/her external environment consists of physical, social and spiritual dimensions.

Mental health is a dynamic interactive process. This can also include the community mental health nurse's environment. This interaction reflects her/his relative mental health status, which can either contribute to or interfere with her/his promotion of mental health (Rand Afrikaans University, Nursing Department, 1999:4).

Theoretical assumptions

The theoretical model used in this research is the Theory for Health Promotion in Nursing (Rand Afrikaans University, Nursing Department, 1999). A literature control will be conducted after the phenomenological interviews have been analysed; thus the researcher will approach the field with no preconceived framework of reference.

Methodological assumptions

The methodological assumptions, which will guide this study, are in line with Botes' Model of Research (1998:1-13). The assumptions are based on the functional reasoning approach that implies that nursing research must be applicable to improve nursing practice. The usefulness of the research in itself provides its trustworthiness.

In this research, due to its exploratory and descriptive nature, the qualitative method of research is employed.

Research design and method

Research design

The design of this study is qualitative, exploratory, descriptive and contextual in nature (Holloway & Wheeler, 1996:3-9). Its qualitativeness offers the opportunity to uncover the nature of the community mental health nurses' actions, experiences and perspectives of which is little known as yet (Glasser, 1992:12). The purpose of its exploration is to gain a richer understanding of these nurses' experiences, which are not yet known (Talbot, 1995:90; Mouton, 1996:102; De Vos, 1998:124; Polit & Hungler, 1995:90; Strauss & Corbin, 1990:19). According to Burns and Grove (1993:29), a descriptive study is usually conducted when little is known about a phenomenon of interest. Mouton (1996:133) describes a contextual study as one in which the phenomenon under investigation is studied in terms of its intrinsic and immediate contextual significance.

Research method

In-depth phenomenological interviews were conducted with three groups of twelve community mental health nurses altogether. This sample was selected purposively on the basis of the nurses working in mental health units attached to general health facilities.

Small groups were used so that each session became a discourse in practical reasoning because one story organised around particular concerns, raises confirming or disconfirming stories (Benner, 1994:109). Other purposes of small group interviews according to Benner (1994:109) are that it:

- creates a natural communicative context for telling stories from practice, allowing participants to talk to one another as they ordinarily do, rather than translating their clinical world for the researcher;
- provides a rich basis for active listening where more than one listener is trying to understand the story; and
- hearing other nurses' stories creates a forum for thinking and talking about work situations.

Data gathering

Population and sampling

The sample of this study comprised of three small groups of community mental health nurses in the Southern mental health region of Botswana who had been working in mental health units attached to general health facilities for at least one year participated in the study. A total of twelve community mental health nurses altogether took part; eight female and four male nurses. Their ages ranged between 32 and 50 years. The respondents had all worked in the integrated mental health services as community health nurses for at least one year and at the most 15 years in the southern mental health region of Botswana. The sample was purposively selected from the population (Talbot, 1995:254-255; Polit & Hungler, 1995:235). The sample size was determined by saturation of the data on the phenomenon under study (Talbot, 1995:255) as interviews went on. By the end of interviewing the second group the data was saturated, that is repeating themes yielded.

Pilot study

A pilot study was conducted to test the interview question. Thereafter, the question was corrected.

Phenomenological interviews

Phenomenological, in-depth, small group interviews (Benner, 1994:108-109) were conducted and audiotaped with community mental health nurses. The researcher asked one central question: "How is it for you as community mental health nurses working in these health services?" This was followed by probing questions which arose from the respondents' communication, that were aimed at getting a clear picture of these nurses' experiences. Each interview lasted approximately 45 to sixty minutes. According to Marshall and Rossman (1989:82) the interviews were much more like conversations than formal structured interviews. Participants' perspective on the social phenomenon of interest was allowed to unfold as the participants viewed it and not as the researcher observed it.

The groups were instructed to tell their stories directly to each other, to talk as they might do over coffee to ensure active participation and to establish a familiar context for narrative accounts (Benner, 1994:109). The whole group interview session became a discourse in which one respondent's story reminded or revealed to others some aspects of the story and clarified their understanding.

During the research study, that is, during the establishment of rapport, data collection and data analysis, the researcher employed "bracketing" by identifying and suspending her own assumptions, beliefs, values, attitudes, experience and knowledge about the phenomenon under study (Talbot, 1995:467; Polit & Hungler, 1995:198) to avoid biases and to understand the informant's experience better. These interviews were taped and transcribed verbatim.

Follow-up interviews were conducted with some of the participants to validate the information gathered about their experiences.

Field notes

Throughout the research study, that is, during the establishment of rapport and interviews, fieldnotes concerning the researcher's observation (Polit & Hungler, 1995:306); methodological notes (Wilson, 1993:22; De Vos, 1998:286); and personal notes (Talbot, 1995:478) were written.

Data analysis

The method of data analysis by Tesch in Creswell (1994:155) was used to analyse the tape-recorded data after transcription. During the data analysis, all the transcriptions were read to get a sense of the whole. Ideas were jotted in the margin as they came to mind. A list of all topics from all the interviews were made and similar topics were clustered together. These topics were formed into major topics, unique topics and leftovers. They were later taken and returned to the data and abbreviated as codes. The codes were written next to the appropriate segments of the text. The most descriptive wording for the topics were found and turned into categories. The list of categories

was reduced by grouping topics that were related. Data belonging to each category was assembled in one place. Relationships between major and subcategories were identified and reflected as themes. The identified patterns of relationships were interpreted in terms of a social theory as stated by Neuman (1997:426).

The interpreted themes that emerged in the interviews were discussed with the respondents in the follow-up interviews to verify with them that information obtained was representative of what they had meant. The researcher's data analysis was checked by two supervisors who are experts in qualitative research. After the data analysis, conclusions and inferences were made.

Literature control

The results of the research were discussed in the light of related literature. No information could be found from studies since there were no studies that dealt specifically with the topic.

Ethical considerations

Informed written consent was obtained (Democratic Nursing Organisation of South Africa, 1998:3) from all the people involved (the gatekeepers and respondents). Participation was voluntary. Identity of interviewees and health facilities were protected by using numbers instead of names to ensure anonymity (Polit & Hungler, 1995:125; Creswell, 1998:132). Confidentiality was maintained to safeguard the respondents' rights by keeping in confidence the information collected from informants (Wilson, 1993:253). All audiotapes were deleted after completion of the transcription, data processing and member checking with the participants (Denzin & Lincoln, 1994:212). Competence of the researcher was nurtured by two supervisors who are experts in qualitative research, as to being morally just and valid (Minichiello, Aroni, Timewell & Alexander 1990:236-244).

Trustworthiness

Lincoln and Guba's (1985:290-327) strategies for trustworthiness of findings and interpretation were followed. The researcher had a long exposure to the research field to establish rapport. Field notes, which formed part of data collection, were written and kept. Triangulation of the data collection method through interviewing and observation and literature control was done. A dense description of the data and research process by the researcher provides the required information for other researchers, should they want to prove transferability in different contexts with similar characteristics. Member checking was done with one group of community mental health nurses who were in the sample to test data, interpretation and conclusions with the informants for correction of errors and additional information (Polit & Hungler, 1995:362; Talbot, 1995:488; Creswell, 1998: 202). "Bracketing" took place during fieldwork and the researcher entered the field from a "do not know" position.

Results

The results are reflected in Table 1 as themes and categories on community mental health nurses' experiences of decentralised and integrated mental health care services (Maphorisa, 1999: 38-52). These themes and categories are supported or confirmed by literature control and field notes.

Theme 1: Feelings experienced by community mental health nurses

Category:

- Discouragement related to lack of appreciation.
- Frustration related to rejection, resistance, reluctance or negative attitude of general health care workers.
- Disappointment related to general health care workers' disinterest in mental health.
- Unhappiness related to being overwhelmed by work and
- unco-operativeness of general health care workers.
- Confusion related to being ignored by general health care workers.

Theme 2: Surprise related to the feeling that their services are not valued.

Theme 3: Loss of interest in work related to feeling demoralised, desperate and not recognised.

The major themes that emerged were:

Theme 1: Feelings experienced by community mental health nurses.

Categories under this theme were as follows:

- Discouragement related to lack of being appreciated by general health workers, especially their immediate supervisors and nursing management, as described by community mental health nurses during the interview as follows:

"It's very discouraging, especially when you provide services that you know they are not appreciated by somebody who is your supervisor."

- Frustration related to rejection of mental health responsibilities by general health workers; reluctance and resistance to change as well as negative attitude of general health workers (general nurses, nursing management, administrators, and medical practitioners) towards mental health and mental health services. This is supported by Ntebela (1983:11) who states that the Ministry of Health tried to integrate mental health services with other services but they met some resistance and a negative attitude of general health workers towards mental health, mental

health services and personnel. The respondents of this research described this by saying:

"Sometimes when general nurses are posted at the psychiatric unit, we will orientate them on the activities that are supposed to be done... when the non-psychiatric trained supervisor comes around ... to her, it's something that ... waste of time ... It's really frustrating because you are trying to tell this person the right thing. Someone say something from what is supposed to happen."

"We have long been educating our colleagues. They don't want to take it or change."

Uznanski (1993:3) states that there is a lack of interest or a negative attitude towards mental health among general health personnel as well as health planners and administrators in countries of the African region. During the interviews, the community mental health nurses said:

"They are reluctant to support us in another way, such that you end up with problems like maybe transport, ... wrong deployment, being trapped in an area where really you are not supposed to be."

"Sometimes it's, it's really hurting to, to see the negative attitude of people towards mental health ... They don't see what you do. So it makes us to feel ... let's say angry or disappointed and frustrated."

Kgosidintsi (1990:96) states that other general health workers, including some general practitioners, were reported to be negative towards any programme for psychiatric patients. Moreover, Chakalisa (1998:5) indicates that one of the constraints of the mental health situation in Botswana is a negative attitude to mental health at all levels of the health care system. The respondents of this research described this as follows:

"They have no place for psychiatric patients. The fact that she presented with confusion, has a history of crying ... already is a psychiatric patient. So we try to plead that, 'Doctor, please can we try having the patient here for some few days?' 'No, we don't have beds, they are preserved for medical patients, no, we don't have beds."

"In our hospital we have medical officers who have been allocated to our unit ... as we said that people look down upon psychiatric patients. Though they are allocated, they never just go there, just to see the patients ..."

- Disappointment related to general health workers' dis interest in mental health, especially health facility management. The study demonstrated that these nurses are disappointed because mental health services are not included when budgeting and other health activities at management level are carried out yearly. This is indicated by the respondents in the following response:

"I think that it's very disappointing because sometimes at meeting community health nurses will give report, this one will give report, TB will give report. We don't appear on the agenda anywhere."

It was also found that general nurses, general clinic nurses, community mental health nurses' immediate supervisors who are not trained in psychiatry, nursing management and medical practitioners disappoint community mental health nurses by their lack of interest in mental health services. The respondents described this as follows:

"When a client comes, they will call you and say 'Your client is here' or 'As for this one is for the mental health nurse'. Instead of them taking a step, okay, and then if it is out of their scope ... to maybe consult."

This is supported by a report on Mental Health Workshop for Senior Managers (1993:6) which indicates that as one of the constraints, general health workers are not actively involved in the management of mentally ill patients. This is illustrated in the following respondents' responses:

"In the main hospital ... the nurses and the medical team ... they don't see that they should be involved in seeing, prescribing and treating psychiatric patients. Medical officers claim that they don't understand psychiatric patients and they are not trained in the field."

"The nurses in the wards are not willing to take care of patient with a history of confusion."

- Unhappiness related to being overwhelmed by work and lack of co-operation from general health workers, especially medical practitioners who make unnecessary referrals and admissions to mental health units of people with a history of mental illness coming with physical complaints. This finding is supported by McConnell, Interbitzin and Pollard (1992:75) who state that although patients with chronic mental illness may make frequent visits to walk-in clinics or emergency rooms, their physical complaints may not be taken seriously or thoroughly evaluated. The respondents of this research said in their responses:

"The nurses and the medical team ... send to us a lot of referrals which are not supposed to be sent to us ... Anything bordering on psychiatric illness is sent to the psychiatric unit. Psychiatric nurses run up and down trying to treat or look after patients that should have been given treatment by both the medical officers and nurses, particularly in the Accident and Emergency Department or on the ward ... as a result the psychiatric nurses are overwhelmed with a lot of unnecessary work in the unit."

"They refer anything they come across. So this is clearly unfair on us."

A report on Mental Health Workshop for Senior Managers (1993:4) illustrates that there were unnecessary referrals and admissions to psychiatric units for known mental patients suffering from physical illness that end up at the units without being examined properly. It was also found that community mental health nurses in clinics are unhappy because general clinic nurses do not co-operate with them whereas the former are completely involved in all clinic nursing activities. During the interviews, the respondents described this as follows:

"Since we are multipurpose nurses ... everything is on you. You have to take care of pregnant or the antenatal, ... general patients, at the same time this."

"In some clinics the staff is still reluctant to follow-up psychiatric clients at their various homes ... So you will see yourself again going around following these patients."

- Confusion related to being ignored by general health workers, especially their supervisors and management who do not appreciate their work or their contribution in the health of people. This is described by the following respondent's response:

"When it comes eh... to the fact that you don't get the support or whatever, you don't ... you ask yourself ... ah ... what is happening?' 'What am I doing, is it not appreciated or something?'"

Theme 2: Loss of interest in work related to feeling demoralised, desperate and not being recognised by their supervisors and management who do not even support them.

It was found that community mental health nurses regret for having chosen mental health specialisation which frustrates them. The following quotations from the respondents' responses illustrate this:

"It's quite demoralising when one is trying her or his level best and it's like people you are working with do not recognise the good thing you are doing. Because for you to be able to achieve all objectives, you need a lot of support from the management. But if they don't support you, even the dreams you had, they start going down. And it's like you now feel you are no longer interested in your work."

"... So very frustrating. At times you feel that if you haven't gone into this service ... this service, at least if you had done midwifery, you will functioning very well without problems. And this one is really frustrating."

Theme 3: Surprise related to the feeling that their services are not valued.

The findings demonstrated that community mental health nurses felt that their services are regarded as unimportant or are looked down upon by their supervisors, nursing management and authorities in the ministries. The community mental health nurses described this in the following responses:

"When you are walking the patient around, they say 'Those are the mad people. Look at what they are doing'...That's why it becomes hard when it comes to integration of the services. Because nobody value what you are doing. How can that person run the psychiatric services? They think you are playing."

"I think all these problems really crop up from the programme representation, either right from the management, ministry or at the district health team ... Because you find that other programmes are being presented. There is the TB coordinator, rehabilitation officer, the district health education officer and there is no representation from the psychiatric services."

The community mental health nurses perceive their services as being assigned low priority because they are not included in planning committees or budgets. Curran and Harding (1978:75) support this study by stating that since mental health needs may not be readily apparent to general public health professionals and administrators, they tend to assign low priority to the field. The respondents of the study described this in the following responses:

"Even at the Ministry level, they need orientation because it seems that mental health is not known in our health sector right from there ... Because it's like it's given second seating or what."

"This year there is not even a single planned activity on mental health, if you look at our district plan ... It means they don't even regard mental health as something important in our life."

This study demonstrated that community mental health nurses were surprised that their mental health services are not valued because of the way they are neglected by top officials. This is supported by Bhaskara (1999:697) who states that unfortunately the importance of mental health activities is generally not recognised and time and resources are not dedicated to it. Respondents illustrated this finding in the following responses:

"You find that psychiatric nurses end up being deployed completely and absorbed and do most of the part which is general and not mental health."

Limitations

The initial central interview question "Tell me how you experience decentralised and integrated psychiatric-mental health

care services" was found to be ambiguous because it was observed during the pilot study that the use of and perception of the word "experience" was varied and misleading. This necessitated change of the question to "Tell me how it is for you as community mental health nurses working in these health services".

Another shortcoming encountered was that of many interruptions during the interviews, since they were conducted at the respondent's workplace during working hours. In addition, there was a lot of noise outside the interview room from patients and other nurses as well as from sounding bleepers carried by respondents, that made the transcription of audiotapes difficult.

Conclusion

This study demonstrated that community mental health nurses, working in mental health units attached to general health facilities in the Southern Mental Health region of Botswana, experience unhappiness, frustration, discouragement, disappointment, loss of interest in mental health work, disbelieve and confusion due to negative attitudes of their supervisors, management of facilities they work under, top authorities in the ministries, doctors and general nurses towards mental health, mental health services and personnel. There were negligible or insignificant positive experiences of the community mental health nurses yielded from the study, which were badly marred by their massive negative experiences.

Recommendations

Recommendations from the study were made with specific reference to nursing practice, education, research and other health professionals.

- **Nursing Practice**

There is a limited number of mental health trained nurses in Botswana. These nurses work in mental health units and council clinics and need to be utilised properly to make mental health nursing practice more effective. The greater part of their time needs to be devoted to training and supervising general health workers, who should provide basic mental health care. The attitude of negativity of general health workers (nursing management, supervisors, administrators and top authorities) needs to be addressed by involving them in determining and making them aware of the negative effects of the status quo (unequal distribution of health resources, overworking community mental health nurses, low standards of mental health care) to gain their interest in mental health. Their resistance to this change can be decreased by starting the change process with top officials, by emphasising novel and exciting aspects of change and by involving them in planning and implementation.

It is clear from the results that community mental health nurses need support from nursing management or administrators and immediate supervisors. The advanced psychiatric nurses could play an important part by providing support group therapy for the community mental health nurses working in these decentralised and integrated mental health care services.

- **Nursing education**

  General nursing curricula should emphasise a holistic approach to patient care. That is, it should include more psychiatric-mental health topics to equip general nurses with more information on psychiatric-mental health nursing. A much longer period should be given to psychiatric-mental health clinical practice during general nursing training, to equip general nurses with better psychiatric-mental health skills and positive attitudes towards mental health, mental health services and personnel.

Mental health nursing in-service education through seminars or competency building should be instituted regularly for the general practicing nurses and nursing management, to refresh their mental health and develop positive attitudes towards mental health and mental health services.

- **Nursing research**

  Further nursing research based on the identified patterns of interactions between the internal and external environments of the community mental health nurses working in mental health units should be conducted, to understand their experiences in a different context like in the northern mental-health region of the country.

- **Other mental health professionals**

  Community mental health nurses interact with other health professionals such as medical practitioners, who also affect these nurses' experiences. Mental health in-service education in the form of seminars need to be given regularly to medical practitioners by psychiatrists to refresh their mental health knowledge to enable them to better manage mental health problems and develop positive attitudes towards mental health, mental health services and personnel.

Summary

The situation of mental health care services in Botswana, as depicted by the results of this research on the experience of the community mental health nurses of decentralised and integrated psychiatric-mental health care services, shows how dissatisfied these nurse are with the way these services are being run. One can imagine the stress they will be going through until the general health workers are ultimately converted to regard these services with positive attitudes. Hence the necessity of advanced psychiatric nurses to take the responsibility of assisting these nurses cope with the decentralisation and integration of these services, through the use of guidelines formulated during this research.

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