A NEEDS ASSESSMENT OF PERSONS SUFFERING FROM SCHIZOPHRENIA IN THE MOGOTO VILLAGE, ZEBEDIELA DISTRICT

by

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I declare that *A NEEDS ASSESSMENT OF PERSONS SUFFERING FROM SCHIZOPHRENIA IN THE MOGOTO VILLAGE, ZEBEDIELA DISTRICT* is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references.

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A NEEDS ASSESSMENT OF PERSONS SUFFERING FROM SCHIZOPHRENIA IN THE MOGOTO VILLAGE, ZEBEDIELA DISTRICT

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Summary

The system of care for persons suffering from schizophrenia is in a state of upheaval and the community in general is visibly frightened of an illness it knows little about except for the information acquired often from media reporting. Considering persons suffering from schizophrenia as holistic beings, this study explored and assessed the needs of these persons residing in the Mogoto Village, Zebediela District in the Northern Province.

The primary purpose of the study was to explore and describe the holistic needs of persons suffering from schizophrenia thus facilitating the planning of care and care facilities for these individuals to enable them to function optimally in the community. To accomplish this purpose, specific objectives were formulated.

A quantitative, exploratory and descriptive study based on the Nursing Theory for the Whole Person was carried out. Through purposive sampling 60 respondents were selected. A questionnaire was administered to the respondents. Data from questionnaires revealed that despite the diagnosis of schizophrenia, the respondents were still regarded as valuable members of the community by those who cared for them.

There was also an indication that the needs of persons suffering from schizophrenia in the Mogoto Village did not differ from the needs of other persons in the rest of the world. Like any unique person they have specific needs. There was also an indication that mental illness is still rated low in the prioritisation of health problems, hence the lack of resources and support needed for the rehabilitation of persons suffering from schizophrenia, especially in the rural areas.

KEY TERMS

Needs, assessment, schizophrenia, community assessment, social needs, psychological needs, physical needs, spiritual needs, emotional needs, community resources.

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Dedication

This study is dedicated to my family, my mother, my sisters, Fetty and Regina, my brother, Andy, and my two beautiful daughters, Angela and Jaynise.

Table of contents Page

Chapter 1

Orientation to this research 1

Table of contents Page

Table of contents Page

Table of contents Page

Table of contents Page

Chapter 5

Summary, limitations, conclusions and recommendations of the study

List of tables

Page

List of tables

Page

List of figures

Page

Abbreviations

%	=	Percentage
ANC	=	African National Congress
APA	=	American Psychiatric Association
DHS	=	District Health Services
DHWS	=	District Health and Welfare System
DNHPP	=	Department of National Health and Population Development
EPS	=	Extrapyramidal Side Effects
n	=	In this study "n" refers to the total number of respondents included in the study (in this case 60)
IPCC	=	International Pentecostal Christian Church
ORU	=	Oral Roberts University
RAU	=	Rand Afrikaans University
SAFMH	=	South African Federation for Mental Health
SANA	=	South African Nursing Association
SPSS	=	Statistical Package for Social Scientists
UNICEF	=	United Nations Children's Fund
Unisa	=	University of South Africa
WHO	=	World Health Organization
ZCC	=	Zion Christian Church

Definition of terms

DSM IV	=	Diagnostic and Statistical Manual IV This refers to the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders, published in 1994 and is used to provide a clear description of diagnostic categories in order to enable clinicians and investigators to diagnose and communicate about the study and treat the various mental disorders like schizophrenia (Spitzer & Williams 1997:vii).
External environment	=	This includes those situation or conditions outside the individual that exerts an influence on his/her life (Oxford Advanced Learner's Dictionary 1989:403, 426).
Internal environment	=	The internal environment of the individual encompasses the totality of processes occurring in the body and is bodily, mental (psychological) and spiritual in nature (Oral Roberts University, Anna Vaughn School of Nursing 1990).
Mean	=	The sum of all scores divided by the number of scores.
Median	=	The middle value, or the score for which half of the respondents have higher value and half a lower value.
Mode	=	The score or value of the variable that occurs most often.
Patterns of interaction	=	This refers to the unique characteristic patterns of interaction between the *internal* and *external* environment of the individual. This implies movement on the health or illness continuum on which a person's health status is reflected. The individual's position on any of the two continuum is at any time dependent on the interaction between his internal and external environment (Merriam-Webster 1989:389).
Person	=	A person is a spiritual being who functions in an integrated biophychosocial manner to achieve the quest for wholeness. A person interacts with his internal and external environment holistically (Oral Roberts University, Anna Vaughn School of Nursing 1988:1990:195).
Psychosocial rehabilitation	=	Is a process aimed at the improvement of the *psychological* and *social* functioning of persons whose functioning have been impaired by a psychiatric condition (South African Federation of Mental Health 1997:4). The World Health Organization (1996:3) defines psychosocial rehabilitation as a process that facilitates the opportunity for individuals who are *impaired, disabled* or *handicapped* by a mental disorder.

Definition of terms

Psychosocial rehabilitation (cont)	=	*Impairment*: any loss or abnormality of psychological, physiological or anatomical structure or function *Handicap*: a disadvantage for a given individual resulting from an impairment or a disability that limits or presents the fulfilment of a role that a normal person performs depending on age, social and cultural factors for that individual (Cornielje 1993:26). *Disability*: any restriction or lack of ability (resulting from impairment) to perform activity in the manner or with range considered normal for a human being, referring mainly to the deficiencies in coping, social and vocational skills

CHAPTER 1

Orientation to this research

1.1 INTRODUCTION

Mental health services in South Africa are currently highly institutionalised and based on an outdated model of care. This is made more complex by a context of limited community mental health care budgets and competing community development needs.

In addition to the above, the discipline of nursing is faced with a challenge in terms of persons suffering from mental illnesses, specifically the care of persons suffering from schizophrenia in rural areas. In this context there is a need to develop strategies that consider persons suffering from schizophrenia as total human-beings with specific needs whilst assisting them to make use of their remaining capabilities in the community.

This research demonstrated the acceptance of the challenge by exploring and describing the holistic needs of persons suffering from schizophrenia and living in a rural area. This

chapter outlines the background, guiding principles and practices in the development and implementation of mental health needs assessments with special reference to those persons suffering from schizophrenia.

In recent times worldwide, the formal assessment of needs has become an important and integral part of health service planning. Considerable time in this context has also been devoted to the assessment and analysis of needs of people requiring mental health services (Carter, Crosby, Geerthuis & Startup 1995:383). However, experiences with placing mentally ill persons, specifically those suffering from schizophrenia, in the community have not been favourable in all countries. While some efforts demonstrated positive results, others resulted in worsened states for the persons and their families due to inability of the government, the community, the health care delivery system and the family to meet these persons' needs. Where deinstitutionalisation is done too hastily and the needs of the person have not been met in the community, both the person and the community might suffer adverse effects.

According to Clark (1999:669) identification and assessment of needs of individuals suffering from schizophrenia in rural areas is a neglected, and often a misunderstood aspect, of human service programme planning.

This neglect of the mentally ill was also identified by John F Kennedy in an address he presented in the United States of America when he maintained:

> "We as a Nation have long neglected the mentally ill and the mentally retarded. This neglect must end, if our Nation is to live up to its own standards of compassion and dignity and achieve the maximum use of its manpower.
>
> This tradition of neglect must be replaced by forceful and far-reaching programs carried out at all levels of government, by private individuals and by

State and local agencies in every part of the Union.

We must act —

- to bestow the full benefits of our society on those who suffer from mental disabilities
- to prevent the occurrence of mental illness and mental retardation wherever and whenever possible
- to provide for early diagnosis and continuous and comprehensive care, in the community, of those suffering from these disorders
- to stimulate improvements in the level of care given to the mentally disabled in our State and private institutions, and reorient those programmes to a community-centred approach ..." (Breakey 1996:43).

This concern with the neglect of persons suffering from mental illness stimulated the development of nursing as a more academic discipline and promoted a more systematic approach to the identification and assessment of needs of individuals and their carers (Ong 1991:16). To this effect, the current research described the central issues surrounding the identification and assessment of the needs of persons suffering from schizophrenia in the Northern Province, by concentrating on Region 6 (Southern Region), Greater Zebediela District, Mogoto Village.

The Mogoto Village is 19 km from Groothoek Hospital (see table 1.1). Information collected as described above, included objective data such as census data as well as information from various health departments, libraries, registers of certain diseases, various state departments, key persons, schools, local and provincial services. Planning however, still remains essentially a human valued-based process due to the inadequacy of knowledge and skills as well as the discomfort people (some nurses, health care providers and the community members) experience when dealing with persons suffering from schizophrenia (Reutter & Ford 1996:14; Dreyer, Hattingh & Lock 1999:122).

Table 1.1: Mogoto Village population and distance to health services

			Distance (km) from ...	
Segment/ward	**Village**	**Population**	**... hospital**	**... clinic**
SZ 1	Mogoto	63 000	19 km	5 km

(Northern Province, Southern Region 1996:175).

In the view of the above, the researcher views the planning of health care services for persons suffering from schizophrenia, as a collaborative and multidisciplinary effort as well as the inclusion of the community to ensure that the needs of persons suffering from schizophrenia, are identified and can be met through a team approach. Team effort, in turn, contributes towards the understanding of persons suffering from schizophrenia and the acceptance of them into the community. Without adequate assessments of human service needs in this particular village, the planners and programme administrators might find it difficult to establish and maintain a comprehensive health care programme for this area.

In South Africa, a large number of psychiatric hospitals still continue to play a central role in the care of persons suffering from schizophrenia. This approach promoted inpatient care and institutionalisation which led to overcrowding in psychiatric wards (Gagiano, Van Rensburg & Calitz 1995:203).

To overcome the problem of overcrowding, the psychiatric nurse should be prepared to assess and identify specific problems, needs and resources in a community if he or she is to contribute fully to the process of providing meaningful comprehensive care for persons suffering from schizophrenia and to meeting wellness needs of families who care for these persons. These assessed needs will, in turn, lead to the importance of ongoing needs identification essential in ongoing formal programme planning processes (Siegel, Attkisson & Carson 1988:215; Clark 1999:841).

1.2 BACKGROUND TO THIS RESEARCH

According to the 1996 census printed in the Progress and Discussion Document, Northern Province, Southern Region (Department of Health 1996:175). Mogoto is predominantly a rural area with approximately 63 000 persons as indicated in table 1.1. This village is located in the Northern Province under Region 6 (Southern Region), with its clinic falling under Groothoek Hospital health wards (Groothoek Hospital is the only psychiatric hospital in the Northern Province, and the main provider for psychiatric services in the community).

The Mogoto Village is situated 19 kilometres from the hospital and five kilometres from the clinic. In addition to this, due to the fact that 15 clinics, 16 session points and 17 other points, for example under trees or at cafes are visited monthly, staff members do not have enough time to listen to the persons' problems, give health education or create situations where privacy can be ensured. Home visits are done once a month to one of the villages where the clinic is situated without subsequent follow-up visits. The failure to do follow-up visits plays a major role in overcrowding in the hospital. This continues in early discharges to the community before ascertaining whether persons suffering from schizophrenia are ready for the process, hence aggravating the *revolving door syndrome* (Taylor 1994:59).

In a study done by the Integration Committee (unpublished information), Groothoek hospital in 1997 on the relapse of persons suffering from schizophrenia, it was found that early discharge as a result of overcrowded psychiatric units led to frequent relapses of persons.

Faced with this problem on a daily basis, the researcher was motivated to conduct a needs assessment in this area with the aim according to DSM-IV (Diagnostic and Statistical Manual IV) of determining various aspects of holistic needs of persons diagnosed with schizophrenia (Spitzer & Williams 1997:vii).

The community health nurse is seen by the community as a key figure in providing comprehensive health care. A needs assessment of persons suffering from schizophrenia in this area, could assist the community health nurse to plan and implement care according to

needs of the persons suffering from schizophrenia in this community.

1.2.1 The Mogoto community

The community of the Mogoto Village can be considered as a mainly "traditional" rural community. Although this community consists of people from different cultures, namely Ndebeles, Shangaans and North Sothos. The community live in harmony with each other. The unemployment rate of this community is high and the majority of the inhabitants are poor. There are no proper recreation facilities for the members of the community as a whole and nothing specific is available for persons suffering from schizophrenia and other mental illnesses.

Those persons suffering from schizophrenia depend on the health care support services provided by the nurses at the local clinic or the services offered at the local hospital. There is no active multidisciplinary mental health care team support service that the community can depend upon. Although psychiatric patients make use of the formal health care services, they also visit the traditional healers in the community. These traditional healers encourage their clients to continue with their prescribed medication and to go for follow up treatment at the hospital and clinic to avoid relapses.

1.3 RATIONALE FOR THIS RESEARCH

The rationale on which this research was based was as follows:

- Hospitals were overcrowded.
- Hospitals were short staffed.
- Persons suffering from schizophrenia were discharged early as a result of overcrowded hospitals and the lack of trained staff to care for the patients in hospital.
- Persons suffering from schizophrenia were therefore cared for by relatives and friends in the community who often could not care properly for these persons because of a lack of knowledge and skills. This resulted in relapses and readmittances of these

patients to the hospital.

- Properly organised community services to support the carers of persons suffering from schizophrenia in the community did not exist in the Mogoto Village.
- Services of this nature could not be planned before an assessment of the needs of persons suffering from schizophrenia in Mogoto Village was done.

1.4 CENTRAL STATEMENT

Insight into the holistic needs of the persons suffering from schizophrenia in the Mogoto Village in the Zebediela District is necessary for the planning of care and care facilities for these persons to enable them to function optimally in the community.

1.5 PROBLEM STATEMENT

The development of a unified approach to the caring of the persons suffering from schizophrenia in the community has been hampered by a lack of data concerning the needs and the status characteristic of persons suffering from schizophrenia and living in Mogoto Village (Omohundro, Schneider, Marr & Grannemann 1983:19; Clark 1999:678; Dreyer et al 1999:108). This lack of data in the Mogoto Village prevents the implementation of a holistic approach in the management and care of persons suffering form schizophrenia.

This research, as the first stage of a research project, assessed the lack of this data by attempting to explore and describe the holistic needs of persons suffering from schizophrenia in the rural community of Mogoto, Zebediela District.

Based on the problem statement, the following research questions were formulated:

- What are the unique physical, psychological, social, emotional, spiritual, economic and educational needs of persons suffering from schizophrenia in the Mogoto Village in the Zebediela District?
- What resources and support systems are available in the community of Mogoto

Village for persons suffering form schizophrenia?

1.6 AIM OF THE RESEARCH

Keeping the abovementioned research questions in mind, the aim of the research was to explore and describe the holistic needs of the persons suffering from schizophrenia in the Mogoto Village, Zebediela District.

1.6.1 General objectives

The general objectives of the research were to review the literature to identify the needs of persons suffering from schizophrenia, especially those living in rural areas.

1.6.2 Specific objectives

The specific objectives of the research were to

- identify and describe the **physical needs** of persons suffering from schizophrenia in Mogoto Village, Zebediela
- identify and describe the **psychological needs** of persons suffering from schizophrenia in the Mogoto Village, Zebediela
- identify and describe the **social needs** of persons suffering from schizophrenia in Mogoto Village, Zebediela
- identify and describe the **emotional needs** of persons suffering from schizophrenia in Mogoto Village, Zebediela
- identify and describe the **spiritual needs** of persons suffering from schizophrenia in Mogoto Village, Zebediela
- identify and describe the **economic needs** of persons suffering from schizophrenia in Mogoto Village, Zebediela
- identify and describe the **educational needs** of persons suffering from schizophrenia in Mogoto Village, Zebediela

- identify the **support system** for persons suffering from schizophrenia in the Mogoto Village, Zebediela
- identify the **resources available** for meeting the needs of persons suffering from schizophrenia in the Mogoto Village, Zebediela
- make **recommendations** to meet the needs of persons suffering from schizophrenia in the Mogoto Village, Zebediela
- make **recommendations** for further research in this field

1.7 SIGNIFICANCE OF THE RESEARCH

No data could be found on research that has been done on the holistic needs of persons suffering from schizophrenia in the Mogoto Village, Zebediela District. Data on the holistic needs of these persons will be valuable for the future planning of health care services and health care facilities and other support systems for meeting the needs of persons suffering from schizophrenia living in this community.

1.8 PARADIGMATIC PERSPECTIVE

Paradigms in the human sciences can help the health care workers to understand the needs of the persons suffering from schizophrenia in their communities as well as shaping the development of concepts and themes which can be applied to practice (Brink 1996:28; Creswell 1994:1; Mouton 1996:21; Polit & Hungler 1997:12).

The researcher based the assumptions for this research in terms of the paradigmatic perspective. The researcher views nursing as a nurturing response of one person to another in a time of need and aims towards the development of well-being and more being (Chinn & Kramer 1995:192; George 1995:303).

The paradigmatic perspective as presented in The Theory of Nursing for the Whole Person (Oral Roberts University, Anna Vaughn School of Nursing 1990) views man as a unique integrated whole, central to the model (see figure 1.1).

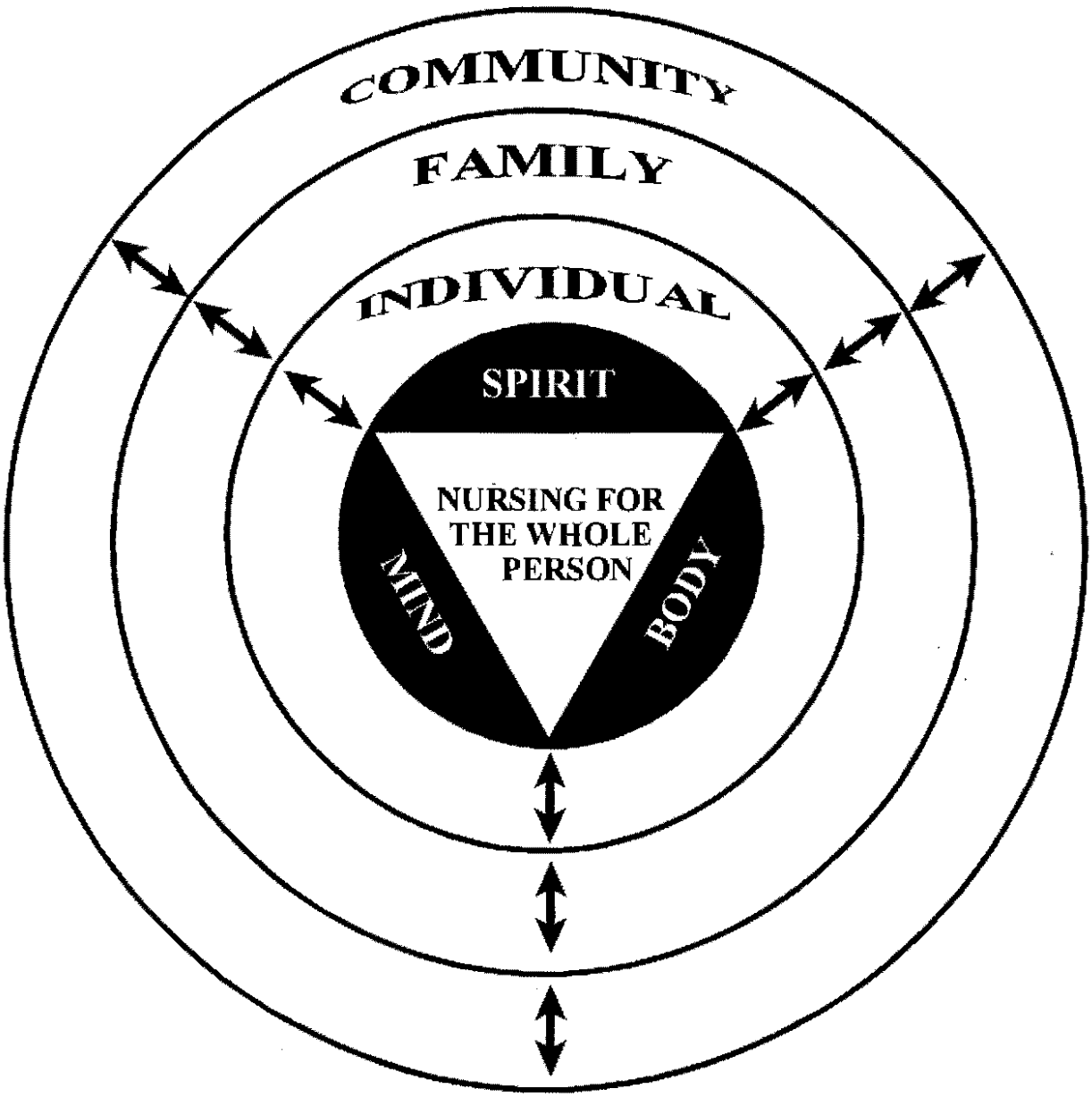

Figure 1.1
The theory of nursing for the whole person
(Oral Roberts University, Anna Vaughn School of Nursing 1990:136, 142)

This theory describes a person as consisting of mind, body and spirit. The mind, body and spirit forms the individual (whole person) who is a member of the family, with the family being a component of the community. To be whole, the person should be viewed as an individual (with a mind, spirit and body – not only one of the three) who belongs to a family and is a member of the community. When illness, for example mental illness, has taken its toll the individual becomes affected, his or her family and the community may also become affected. When healing has occurred, the individual becomes an integrated whole again (mind, body and spirit). This whole person can then take up his or her place in the family thus making the family whole again. The family is then healthy or whole again and can contribute to the wholeness of the community (Oral Roberts University, Anna Vaughn School of Nursing 1990:136, 142).

The use of the Theory of Nursing for the Whole Person (Oral Roberts University, Anna Vaughn School of Nursing 1990) as a philosophy underlying psychiatric nursing practice, means devotion to the interests of human beings wherever they live and whatever their status may be. Persons are approached in a holistic way, reflecting the interrelationship and interaction of biophysical, psychological and socio-economic cultural dimensions of human life (Oral Roberts University, Anna Vaughn School of Nursing 1990:16). This theory will be discussed in more detail in chapter 2. This increases the number of factors which the researcher must consider in exploring and describing the holistic needs of the persons suffering from schizophrenia, in the Mogoto Village, Zebediela.

The paradigmatic perspective selected and used as the conceptual framework for this research, consisted of the following meta-theoretical, theoretical and methodological assumptions.

1.8.1 Meta-theoretical assumptions

Meta-theoretical statements are basic assumptions and value statements of a philosophical nature that are accepted as being true on the basis of logic and reason, without proof or verification (Mouton & Marais 1996:37; Polit & Hungler 1997:12). The meta-theoretical assumption of research therefore cannot be tested and deals with the researcher's view of

man and society and offers a framework within which theoretical statements are made. The researcher recognises a Judeo-Christian world-view and accepted therefore the following statements:

- **Man/a person/an individual**

Man (or woman) as a person and an individual is a spiritual being who functions in an integrated bio-psycho-social manner in his quest for wholeness and therefore interacts as a whole with his or her internal and external environment. Even in traditional African cultures man is seen as a spiritual being and the traditional health process concentrates on the facilitating process towards wholeness (Oral Roberts University, Anna Vaughn School of Nursing 1990:16).

- **Community health**

Community health is the identification of needs and the protection and improvement of collective health within a geographically defined area (Spradley & Allender 1996:12). In community health, the need to reduce disability and restore function applies equally to families, groups and communities as well as to individuals. Many groups form to offer support and guidance for those recuperating from some physical or mental disability, for example half-way houses for discharged psychiatric persons, alcoholics anonymous or drug rehabilitation programmes (Oral Roberts University, Anna Vaughn School of Nursing 1990:16).

- **Nursing and/or community nursing**

Nursing and/or community nursing is a purposeful health care service established to promote the health of the individual, family and community and to maintain health and to prevent illness. Central to this service is the concept of nursing for wholeness (Oral Roberts University, Anna Vaughn School of Nursing 1990:16). The promotion and maintenance of health and the prevention of illness/restoration of health is seen as:

- *Promotion of health* referring to the activities in nursing that will facilitate wholeness.
- *Maintenance of health* referring to the nursing activities that will keep the individual, family and community healthy/whole.
- *Prevention of illness/restoration of health* referring to the nursing activities that facilitate the return to acceptable levels of health of the individual, family and community.
- *Illness* is a condition that reflects the individual's interaction with his internal and external environment. Illness can also be indicated qualitatively on a continuum from seriously ill to minimally ill. Any individual has the potential to become ill (Oral Roberts University, Anna Vaughn School of Nursing 1990)

1.8.2 Theoretical assumptions

Theoretical assumptions are testable statements about social phenomena. It will therefore include all statements which form part of the models and theories (Mouton & Marais 1996:21).

This research was based on the phenomenological approach with the following assumptions:

- The human being (the person suffering from schizophrenia in Mogoto Village) is a unified whole possessing individual integrity and manifesting characteristics that are more and different from some of the parts.
- The individual and the environment are continuously exchanging matter and energy with each other.
- Pattern identifies and individual and reflects his or her innovative wholeness.

This research also endorsed the theoretical assumptions of the Theory of Nursing for the Whole Person (Oral Roberts University, Anna Vaughn School of Nursing 1990).

The theoretical assumptions of the Theory of Nursing for the Whole Person applied to this research were the following:

- **Person: The person suffering from schizophrenia in the Mogoto Village**

The person in this research referred to the person diagnosed according to the DSM-IV guide as specified by the American Psychiatric Association (APA) (APA 1994) as a schizophrenic in the Mogoto Village.

Although the person suffering from schizophrenia is diagnosed on the basis of definite signs and symptoms, a person is at all times considered as a unique human being who is in constant interaction with his or her environment.

This uniqueness of human beings required individualised approaches to any programme implementation. Persons suffering from schizophrenia meet their needs in each dimension in different ways, for example, one person may cope with social isolation through group participation, another through informal individual friendships, and still another through school or work environment.

- **Environmental holistic needs of the person suffering from schizophrenia**

The environment of the person suffering from schizophrenia include the external environment and internal environment. These can be described as follows:

- ***External environment***

According to Pender (1998:115) persons suffering from schizophrenia do not exist in isolation. They can function within various settings such as familial, occupational, communal, social and cultural if given opportunities to do so. The beliefs and behaviours developed in these settings influence their mental health and mental illness. The holistic perspective consider these setting to be of importance in the maintenance of the whole

person. A person's life context largely determines the recovery or near recovery options available at a given time. Taking into consideration the availability of financial, social, familial and community resources which will influence the needs intervention of persons suffering from schizophrenia, a holistic perspective helps to identify and develop individual options and resources. The external environment includes physical, social and spiritual aspects (Oral Roberts University, Anna Vaughn School of Nursing 1990). In this study the external environment relates to the services and support systems for the person suffering from schizophrenia in the Mogoto Village.

- ***Internal environment***

In this study the internal environment includes aspects such as:

- body
- mind – intellect, emotion, volition
- spirit (Oral Roberts University, Anna Vaughn School of Nursing 1990)

- **Health/mental health**

There is no universal definition of health. The meaning of health has changed through the ages and across different cultures. The term *health* was derived from the Anglo-Saxon word *helth*, meaning safe, sound or whole. In medieval times *haelthing* meant sharing a few drinks with one's friends, having previously meant *hello* and *holiness* (Engel 1996:1). Health in proactive terms, includes building on strengths, enhancing resources, and fostering resilience to enhance prospects for effective living (Pender 1998:129).

Health in this study refers to a person's physical, mental and spiritual state; it can be positive (as being in good health) or negative (as being poor health). The World Health Organization (WHO) (WHO 1981:3) defines health positively as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity". The WHO's

definition, however, has the following characteristics that promote more holistic concepts of health:

- A concern for the individual as a total system.
- A view of health that identifies *internal* and *external* environments.
- Acknowledgement of the importance of the individual's role in life (Potter & Perry 1995:26).

Last (1987:5) and Picket and Hanlon (1990:4) define health as "a state of equilibrium between humans and the physical, biologic, and social environment ...". Harper and Lambert (1994:96) describe health as "a condition involving a subjective sense of well-being". In 1986, the Ottawa Charter for Health Promotion, described health as follows: "Health is created and lived by people within the setting of their everyday life; where they learn to work, play and love". Health is created by caring for oneself and others, by being able to make decisions and having control over one's life circumstances, and by ensuring that the society one lives in creates conditions that allow the attainment of health by all its members (Canadian Public Health Association 1986).

The idea of health as the absence of disease or infirmity is shifting towards an image of an optimal state of well-being for body and mind. The emerging biophychosocial model of health as indicated in figure 1.2 regards mind, spirit and body as an intertwined unit and tries to treat people less mechanistically as *whole persons*, paying more attention to emotional, psychological, physical, social and spiritual factors.

The abovementioned factors are influenced by the individual's cultural beliefs and the type of environment in which he finds himself. Environment includes external factors that make illness more or less likely.

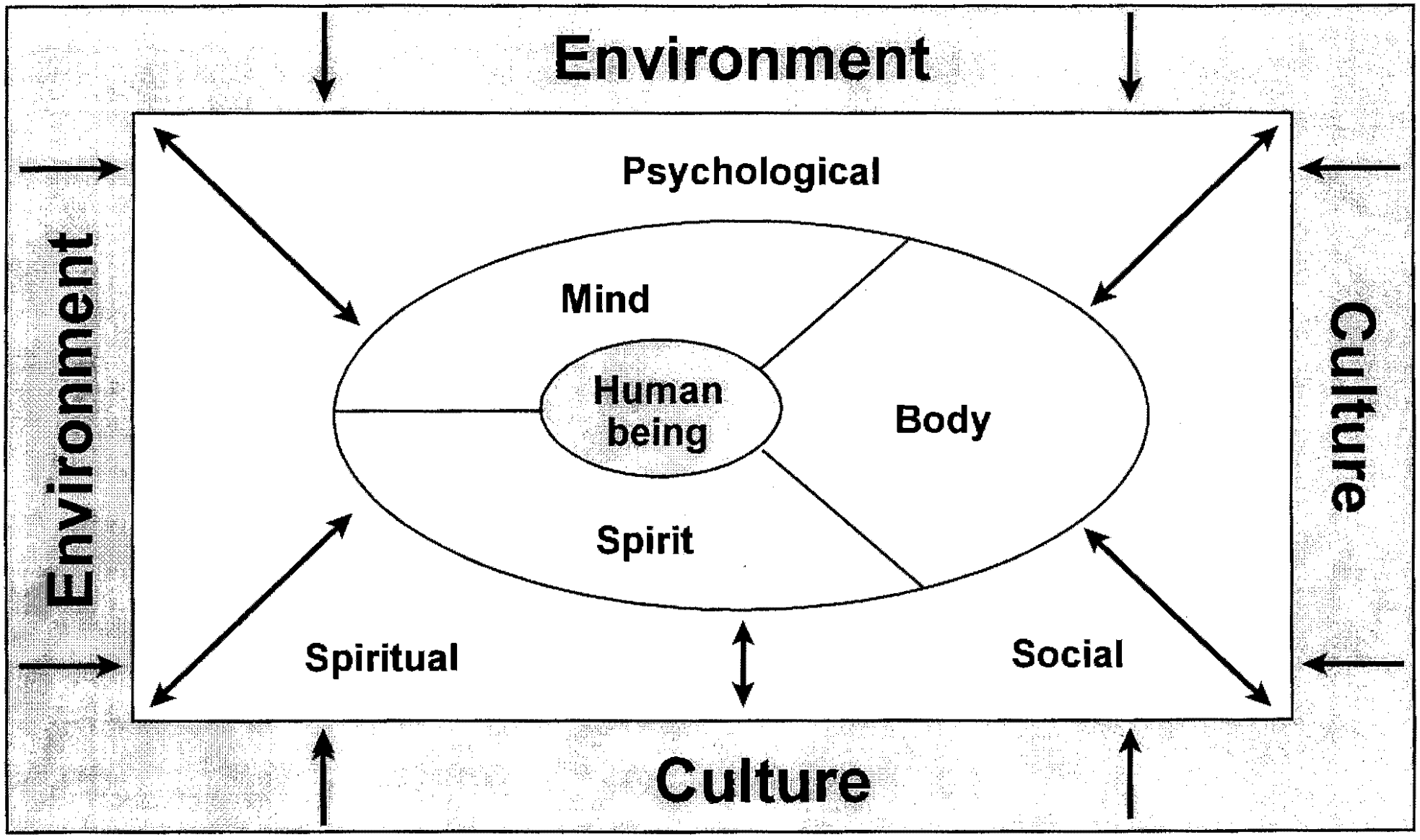

Figure 1.2
Biopsychosocial model of health

Health was referred to in this research as mental health and illness as mental illness, these two concepts were seen as being opposite sides of a continuum. Health/mental health was seen as a condition of the interaction of internal demands and needs brought into harmonious relationship with the reality of the individual's environment. Health/mental health and wholeness was used synonymously in this study. All individuals were seen as having the ability to become whole.

Illness/mental illness are seen as personal as well as social problems. Where equilibrium existing in healthy human beings is disrupted, the particular individual is not regarded as being whole anymore (Oral Roberts University, Anna Vaughn School of Nursing 1990).

- **Process to wholeness: nursing action**

The role of the nurse is to facilitate the quest for wholeness. When making use of the remaining capabilities, the person suffering from schizophrenia needs to be assisted in recognising different needs to attain meaningful life goals, for example, a person who has well-developed problem-solving skills but cannot maintain support systems may need help in developing this social dimension. A person who has a well-developed social support system but experienced a loss of purpose in life may need to consider what is lacking in the spiritual dimension.

Through nursing action the nurse helps those suffering from mental illness to view mental illness as an opportunity for regaining control of their lives as well as an opportunity to discover new ways of living and becoming whole again. Persons suffering from schizophrenia are encouraged to use the information given, to set new goals and move in a new direction in terms of their remaining capabilities. This approach is consistent with holistic health philosophy which asserts that there is personal meaning or message in any illness and discovering what that message as such, provides an opportunity for growth (Honkonen 1995:30).

1.8.3 Methodological assumptions

Methodological assumptions reflect the researcher's view of the nature and structure of science in the discipline (Oral Roberts University, Anna Vaughn School of Nursing 1990).

Methodological assumptions develop or refine procedures for obtaining, organising or analysing data (Polit & Hungler 1997:431). In this research, methodological assumptions were used to redefine or develop procedures for obtaining, organising or analysing data obtained from persons suffering from schizophrenia from Mogoto Village. Using basic principles that were accepted as true gave a basis for logical assessment of the needs of the person suffering form schizophrenia in the Mogoto Village by identifying these needs and for making recommendations that could improve the quality of care for these persons. The research methodology is discussed in chapter 3.

1.9 RESEARCH DESIGN AND METHOD

A research design is the overall plan for obtaining answers to the research questions and it spells out the strategies the researcher will adopt to obtain the stated objectives (Polit & Hungler 1997:129).

The research design used was a quantitative, explorative, descriptive, contextual study of the needs of persons suffering from schizophrenia in the Mogoto Village, Zebediela District.

Quantitative research involves the systematic collection of numeric information, usually under conditions of considerable control and the analysis of that information using statistical procedures (Burns & Grove 1997:37).

The research method considered to be the most appropriate for the study was **explorative research** enabling the needs of persons suffering from schizophrenia in the Mogoto Village, Zebediela District to be identified, enabling the needs of persons suffering from schizophrenia in the Mogoto Village, Zebediela District, to be described.

A **descriptive study** includes observation, description and classification, raises questions based on ongoing events of the present and is of considerable value to the nursing profession (Polit & Hungler 1997:14).

Contextual research was appropriate within the context of the study as persons suffering from schizophrenia where studied in the Mogoto Village, Zebediela District.

Data for this research was collected through a structured questionnaire.

1.10 RELIABILITY, VALIDITY AND TRANSFERABILITY OF THE RESEARCH FINDINGS

- **Reliability**

Reliability is defined as "the degree of consistency or dependability with which an instrument measures the attributes it is designed to measure" (Polit & Hungler 1997:467). This was achieved in the study by pretesting the instrument.

- **Validity**

Validity can be defined as "the degree to which the instrument measures what it is intended to measure" (Polit & Hungler 1997:471). This was achieved by extensive literature reviews, the researcher's own experiences, the opinions of other health team members, the research promoters and a statistician.

- **Transferability**

Transferability is concerned with the extent to which the outcomes of a specific study can be applied to other situations and the extent to which they can be generalised (Brink 1996:125; Merriam 1988:173). The reliability, validity and transferability of the research and the pilot study are discussed in more detail in chapter 3.

1.11 SIGNIFICANCE OF THE STUDY

Of all the professions involved with the care of persons suffering from schizophrenia, nurses have the greatest contact with this special group of individuals. The recovery process of these individuals depends upon the identification and assessment of their needs and the quality of nursing care provider in reaction to the identified needs. Effective health care planning and the provision of facilities in this context requires in-depth knowledge of these needs by the authorities and those responsible for planning these services. All health care workers have an inherent responsibility to assist their respective communities in the quest for optimum health (King 1988:1; Murray & Zentner 1997:i; WHO 1995).

The ultimate goal of community health care is to ensure good health for everyone. Without knowing the health care needs of their respective communities, health care workers will not know whether their efforts to satisfying such needs are successful or not (Hammond & Gear 1986:23). A research such as this, assessing the health care needs of persons suffering from schizophrenia can:

- help care providers gain new knowledge of the needs of the persons suffering from schizophrenia in Mogoto Village
- assist health care providers with the planning of future health care services and facilities in the Mogoto Village
- influence public policy
- influence the quality of services and in turn the mental health of the community
- create awareness in the community of the needs of the persons suffering from schizophrenia
- promote acceptance by the community of persons suffering from schizophrenia
- promote planned deinstitutionalisation of the mentally ill

The information contained in this research could therefore be of help to health care workers who are involved in the assessment of the health care needs of their particular communities. It is highly likely that the structure and socio-economic conditions evident in the Mogoto

Village are similar to those found in most other villages of a similar nature. It is also most likely that the health care needs of the population suffering from schizophrenia in Mogoto Village will correspond to those found in similar villages. Even though situations and local conditions may differ, the principles underlying health care needs remain the same in all areas.

The information gathered through this research will provide important inputs to the planning process leading to the selection and prioritising of problems of persons suffering from schizophrenia in the Mogoto Village, Zebediela District.

1.12 DELIMITATION OF THE RESEARCH

This research involved psychiatric persons diagnosed with schizophrenia according to DSM-IV (APA 1994; Spitzer & Williams 1997:vii) who had been discharged from Groothoek Hospital psychiatric section to the community of Mogoto Village and who came for follow-up services at the clinic or were seen in their homes.

1.13 LIMITATIONS OF THE RESEARCH

Limitations identified during the course of the study are discussed in chapter 5.

1.14 OPERATIONAL DEFINITIONS

- **Patient** (in this research referred to as the person suffering from schizophrenia): According to the Mental Health Amendment Act 19 of 1992 (chapter 1:575) a *patient* refers to a person who is mentally ill to such a degree that it is necessary that he/she be detained, supervised, controlled and treated, and includes a person who is suspected of being or is alleged to be mentally ill to some degree. In this research the person/patient referred to an individual/person diagnosed with schizophrenia according to the Diagnostic and Statistical Manual-IV (DSM-IV) (APA 1994; Spitzer & Williams 1997:vii) living in the Mogoto Village in Zebediela District.

- **DSM-IV**: By definition, the DSM diagnosis of schizophrenia was established by determining the presence of firstly fundamental and secondarily associated disturbances of mental life. Disturbance of *reality relationships* and disturbances of *concept formation* were designated as the two fundamental disturbances. Disturbances in *affect* and *intellect* were designated as associated disturbances. This distinction roughly captures what could be considered to be positive and negative symptoms (Holliday, Ancill & McEwan 1997:70).

  DSM-IV refers to the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders, published in 1994 and is used to provide a clear description of diagnostic categories in order to enable clinicians and investigators to diagnose, communicate about, study, and treat the various mental disorders like schizophrenia (APA 1994; Spitzer & Williams 1997:vii).

- **Schizophrenia**: Schizophrenia is a complex syndrome involving psychotic disturbances of thinking, perception, emotions and behaviour, commonly leading to disintegration of the personality. Schizophrenia is an illness characterised by exacerbations and remissions. During acute psychotic events, persons suffer impairments in their ability to test reality. Persons frequently experience hallucinations such as hearing voices speaking to or about them, believing that they are being persecuted and behaving in bizarre ways (Stein 1993:7). During remissions persons are generally in touch with reality. However, they suffer from other impairments that interfere with their abilities to organise and maintain the resources required to make unassisted, stable adjustments to the community life. According to DSM-IV schizophrenia is "a disorder of brain structure and function which is characterised by extreme disruptions of thought, emotion, behaviour and perception, leading to progressive deterioration of the person's ability to relate to others and to social withdrawal" (APA 1994; Spitzer & Williams 1997:vii).

- **A need**: A need is referred to as specific areas related to the client's health identified for intervention (Spradley & Allender 1996:673). In this research a need was defined as the gap between what is evaluated as a necessary level or condition by those responsible for this assessment and what actually existed. It was seen as a relative concept dependent primarily on those who undertook the identification and assessment (Ironbar & Hooper 1989:3).

- **Needs identification**: Needs identification is "a description of mental health and social services needs in a geographic or social area" (Ironbar & Hooper 1989:3). In this research needs identification for the schizophrenic person was done in the Mogoto Village, Zebediela District.

- **Needs assessment**: Needs assessment is a study in which the researcher collects data from estimating the needs of a group (such as the persons suffering from schizophrenia in the Mogoto Village), community or organisation and provides input in the planning process (Brink 1996:117; Polit & Hungler 1997:175). Needs identified in this research were:

  — ***Physical needs.*** Physical needs involve all the physiological processes of a human being, for example, breathing, elimination, eating and health (Ellis & Nowlis 1981:90; Luckmann & Sorenson 1980:7). In this research the need of the person suffering from schizophrenia included the need to care for his or her own body.

  — ***Psychological needs.*** Psychological needs enable an individual and in this case, the person suffering from schizophrenia in this study, to strike a balance between his own needs and those of society and were concerned with the feelings that a person experiences throughout his life, for example, fear, anxiety, happiness, loneliness (Luckmann & Sorenson 1980:7).

  — ***Social needs.*** Social needs involve the need of the person suffering from schizophrenia referred to in this study, to belong, to communicate and to interact with other human beings and is contribute to society in a meaningful

way (Luckmann & Sorenson 1980:7; Meyer, Moore & Viljoen 1997:329).

— ***Spiritual needs.*** Spiritual needs represent the meaning an individual, in this study the person suffering from schizophrenia, attaches to life experiences at any stage and represent a holistic integration of physical, social, psychological, cultural, sexual and theological experiences. (Phipps, Cassmeyer, Sands & Lehman 1995:51).

— ***Education needs.*** Educational needs refer to the needs considered important for the mentally ill person, in this study the person suffering from schizophrenia, in order for him to get to know himself, to develop his remaining potential, and to identify his goals (Luckmann & Sorenson 1980:7; Meyer et al 1997:360).

- **Wholeness.** In Mogoto Village health and wholeness were used synonymously. This wholeness or health refers to physical, mental, social and spiritual wholeness (Poggenpoel 1994:52).

1.15 ETHICAL CONSIDERATIONS

The researcher did everything in her power to ensure that the **rights** of the participants were respected. The researcher ensured that **no** participant was subjected to any physical, emotional, spiritual, economical, social or legal **harm**. The **privacy** of the participant was ensured by not sharing any of the collected information with others. All data gathered was kept **confidential** unless the researcher was given permission by the participant to make it known. **Informed consent** was obtained from each participant in the research project. **Permission** to conduct the research was obtained from the Training and Development committee after written explanation of what the research was about. **Permission** was also obtained from the Southern Region where the research was conducted and from the participants and their families. The respondent's **participation** was **voluntary** and any participant was free to withdraw at any time. **No treatment** or nursing care was **withheld** from those who elected not to participate. The ethical considerations of this research are

described in detail in chapter 3.

1.16 OUTLINE OF THE RESEARCH

Chapter 2: Literature review

Chapter 3: Research methodology

Chapter 4: Data analysis

Chapter 5: Summary, conclusions, recommendation and implication of research findings

1.17 SUMMARY

Mental health cannot be considered in isolation from physical health. A human being is made up of interrelated components, physical, mental, emotional and spiritual and must be viewed as a whole person (Ellis & Nowlis 1981:237; Murray & Zentner 1997:i). Meyer et al (1997:329) also state that every individual is unique, and to understand the individual and his needs he must be studied as a whole. It is for this reason that this research will be based on the Theory of Nursing for the Whole Person.

This research was concerned with the situation where professionals together with community members will ultimately assist the person suffering from schizophrenia to meet their full potential as far as possible. For this reason it was important that an assessment of the various needs of the persons suffering from schizophrenia in the Mogoto Village, Zebediela District should be done.

In this chapter an overview of the research was given, highlighting inter alia the aim, objectives and paradigmatic perspective of the research.

The next chapter is a literature review of relevant sources consulted for this research topic.

CHAPTER 2

Literature review

2.1 INTRODUCTION

In this age of accountability and the expanding role of the nurse, the psychiatric nurse must be prepared to assess problems, needs and resources in the community if he/she is to contribute to the wholeness of the person suffering from mental illness. To be effective nurses must be aware of the network of formal and informal systems within the community in which they work.

A review of literature suggests that the assessment of needs is frequently a neglected misunderstood aspect of human service programme planning (Ruybal, Bauwens & Fasla 1975:365; Breakey 1996:43). These authors recognise the fact that, optimal social and health programmes can emerge from systematic and scientific needs assessments, especially those designed to identify the extent and degree of needs for specific services in any community.

Ruybal et al (1975) and Breakey (1996) observed that national programmes emerged from a political context of confrontation between special and general interests, social service ideologies, demands for services and the extent of competition for access to resources. As a result, communities may be inundated with uncoordinated and loosely integrated programmes that overlap and compete for limited resources. One such uncoordinated action is the deinstitutionalisation of mentally ill persons. Before the mentally ill can be deinstitutionalised (meaning the movement of the mentally ill inpatient out of the hospital into the community), the scarce and often inadequate community services must be assessed. Many mentally ill persons have been left to wander the streets, joining the ranks of the homeless where they might be abused and robbed of their human dignity, because their needs have not been assessed and services have not been provided to meet their needs after being discharged from institutions (Krupinski 1995:577-579). The community could abuse mentally ill persons due to their unpreparedness and prejudices towards these persons.

The assumption that all mentally ill persons respond favourably to deinstitutionalised care may not be justified (Lawrence, Copas & Cooper 1990:157). Moreover, cost savings, a major motivation for placing the mentally ill in the community have, according to Dartnall, Modiba, Porteus and Lee (2000:2) not materialised.

There is a clear understanding that community services need to be developed to meet the needs of the mentally ill, either prior to or in conjunction with patient discharge, necessitating additional resources.

McClaren and Philpott (1998:20) found that community-based home care services were poorly developed and where they existed, were threatened by the lack of emphasis on mental health in the overall health agenda, inadequate financial assistance and limited communication between the government and non-government sectors. The absence of a guiding framework for mental health care services further perpetuated the apparently ad hoc and fragmented nature of the development of these community-based mental health services.

2.2 WORKABLE PHILOSOPHY

Futuristic philosophers invite people to develop world views which will enable them to be innovative and successful. According to Hardy and Cull (1989:103) and Smith and Maurer (2000:340-350) successful needs assessment involves genuine interest in the patient and flexible programmes that focus on the inherent strengths and hopes of the patient as well as flexible relationships among staff members. This view is supported by Fanslow (1992:141) who maintains that "the most important quality of the nurse researcher is that he/she possesses an "attitude of wholeness", a holistic approach to man and that these abilities should be integrated into effective need assessment processes that will boost hope which is the core of every person's true being".

2.3 NEEDS IDENTIFICATION AND ASSESSMENT

A need assessment process is not necessarily a success with all individuals, but must build upon a guiding philosophy that develops each person's capabilities and strengths to the fullest while minimising the detrimental effects of personal, vocational and social limitations. A honest holistic approach is essential if one is to effectively conduct a needs assessment process for mentally ill persons in the community.

According to Fanslow (1992:141) it is essential to identify and maintain each patient's hope system throughout the entire process of need/health assessment. Health assessment programmes should adapt to the patient's unique characteristics and concerns, at all times reinforcing the belief in potential growth. Some programmes will succeed and some will possibly fail, just as some persons will profit and some will possibly abandon their efforts. This should be regarded as a difficult time for the person's family as they also require a great deal of support and encouragement.

Utilisation of this philosophy and support for the individual's hope system assists those persons suffering from mental illness to live fuller and more meaningful lives. It also enables them to reach a deeper understanding of their own potential, as well as to recognise their

limitations (Moss 1990:112).

In the final analysis, the ultimate success of a needs assessment programme must be defined in personal and human terms by each person, family and professional.

2.4 THE IMPORTANCE OF NEEDS IDENTIFICATION AND ASSESSMENT IN THE NURSING PROFESSION

The development of nursing as an academic discipline has stimulated a more systematic approach to the assessment and identification of the needs of individual clients, and the translation of these needs into care plans (Ong 1991:638).

As pointed out by Smith and Barton (1992:33) community needs assessment plays a key role in community health nursing care. Unfortunately conducting studies for the identification and assessment of needs are time consuming and often inefficient as data could easily be lost or over-looked. However Smith and Barton (1992:33) believe that the process helps the nurses to understand community strengths, resources, limitations and needs.

In this context Saloojee (1998:13) and Clark (1999:669) agree that assessment of needs for services were frequently neglected and often a misunderstood aspect of human services programme planning. Without adequate assessment of human service needs, this poorly monitored and uncoordinated situation will persist and may even worsen.

2.5 NEED CATEGORIES

Dennill et al (1999:154) categorised four types of needs:

- **Normative needs**

A normative need is a need defined by a professional or expert, based on value judgement or standards according to professional experts. A "desirable" standard is laid down by the

expert or professional and is compared with the standard which already exists. If an individual or group falls short of the "desirable" standard then this is identified as being a need. The normative definition of need is by no means absolute. It may not correspond with other definitions of need and, of course, different experts might have conflicting standards. Normative definitions of need might also be different according to the value judgements of the experts concerned. A possible solution to this dilemma is offered when individuals with potential service needs are responsible for their identification, that is, the felt needs of these individuals themselves (Dennill et al 1999:154).

- **Felt needs**

Felt needs are needs in which people identify what they want. Here the identification of need becomes synonymous with want. However, a felt need by itself is an inadequate measure of a "real need". Either individuals may express a desire for help without "really needing it" or at the other extreme individuals with the potential need for service may not be willing to identify it (Dennill et al 1999:154).

- **Expressed needs**

Expressed needs are what people say they need when a felt need has been turned into an expressed request or demand. Expressed needs are felt needs put into action and play an important part in determining the standard of services provided. Demands, particularly as manifested in the length of waiting lists, may be poorly correlated with normative or felt needs (Dennill et al 1999:154).

- **Comparative needs**

Comparative needs refer to the inputs of needs of a group who are not in receipt of services but who have similar characteristics to a group receiving the service. For example, a person is in receipt of a service because he has certain particular characteristics. Another person also has these characteristics but is not receiving the service. Therefore, the second person

is seen to be in need of such a service (Glampson, Scott & Thomas 1982:13). It is therefore up to the health service agencies to allocate their resources. These choices will be influenced by factors such as the availability of skills and resources to determine felt and comparative needs, as well as views of policy-makers about the priorities of normative and expressed needs.

2.5.1 Definition of unmet needs

Nguyen, Attkisson and Bothino (1976:126) brought to the fore the definition of unmet needs:

> "An unmet need is said to exist when a problem in living, a dysfunctional somatic or psychological state, or an undesirable social process is recognised, for which a satisfactory solution requires a major mobilization of additional resources and/or major reallocation of existing resources".

This definition stated differently, defines an unmet need upon:

- "The recognition of a problem, a dysfunctional somatic or psychological state or an undesirable social process.
- The judgement that satisfactory solutions are not accessible, are not currently adequate, or do not exist in the community.
- The necessity to reallocate existing resources or to appropriate new resources"

(Bell, Sundel, Aponte, Murrell & Lin 1983:99; Honkonen 1995:29).

2.5.2 The meaning of the term "need"

There is no immediate all purpose solution to the issues of how to define needs or who is to define them. Definitions of a need will not only change over time but will vary from area to area and with political pressures and considerations. Different members of each department will operate on different definitions of needs, and there will be differences in the way in which individuals and families experience "need" and thus in their expectations of

help (Glampson et al 1982:10; Potter & Perry 1995:26).

The word "need" describes a single aspect or a part of the person, yet the concept of need is far too complicated to be reduced to a simple definition (Perko & Kreigh 1988:115). A need is actually a bodily phenomenon and involves the whole person with a total response. Since the person also interacts with the environment, the interchange with environmental forces and interpersonal relationships will also affect these needs (Murray & Huelskoetter 1987:78).

Need assessments also includes taking into account the needs and interest of the community as a whole, the people being served and the community health service. It includes as well learning about the person's culture, health beliefs, health behaviours, experiences, skills and attitudes (McAllister & Farguhar 1992:1447).

Human needs and the behaviour to meet these needs, are influenced by the brain and cognitive processes, biochemical responses, anatomical and activities, physiological activities, physiological and neurological activities and psychological as well as sociological responses (Potter & Perry 1995:33).

Human needs have been defined and classified by a number of people, of which Maslow is best known of. Potter and Perry (1995:35) differentiated between the types of need as shown in figure 2.1, describing their relationship hierarchically. Maslow's describe human needs in terms of physiological to self-actualisation needs. Basic needs are well recognised such as accommodation, food and warmth but it is much more difficult to measure less tangible psycho-social-spiritual needs which are very important to individuals, families and groups in the community.

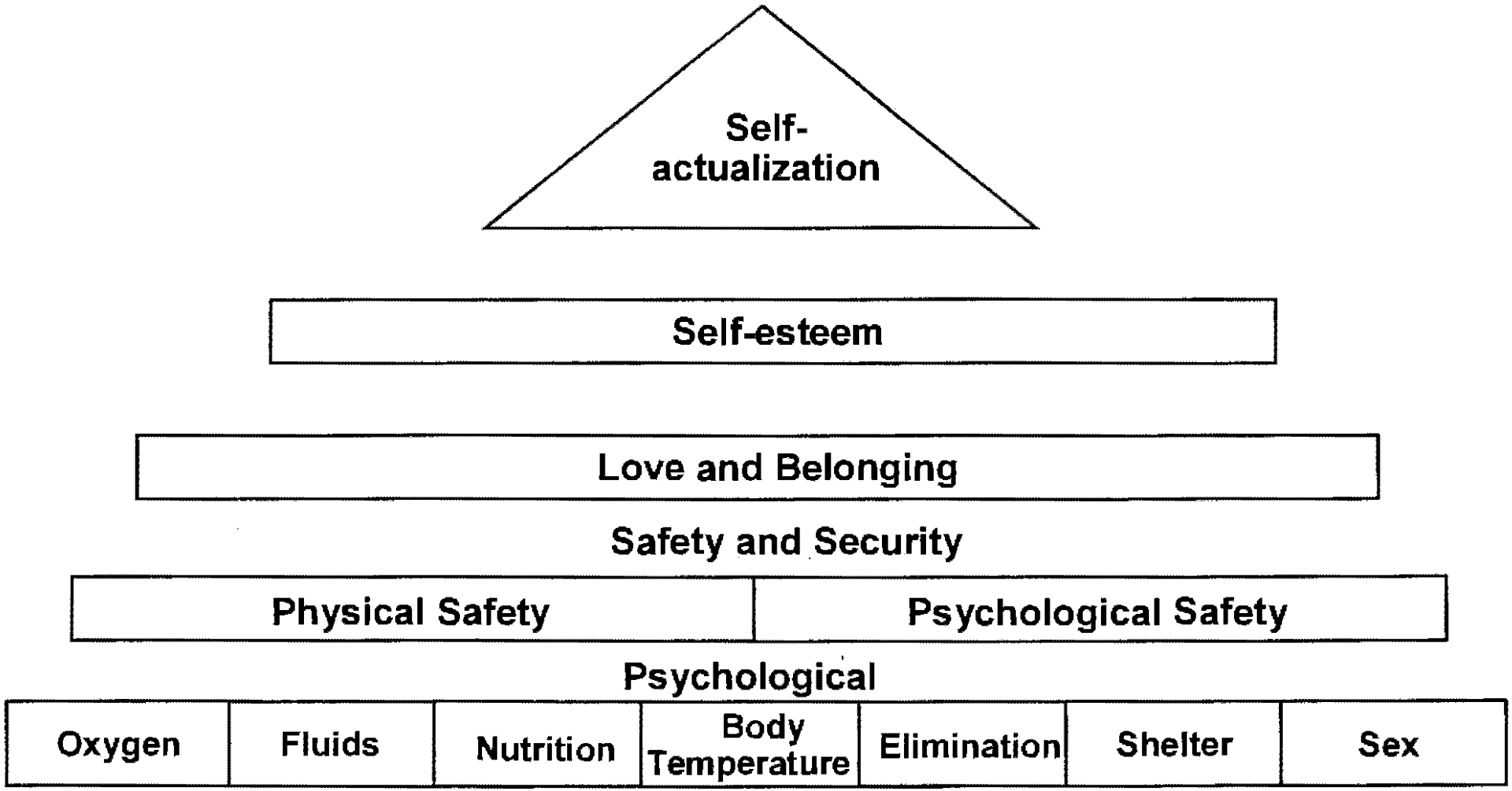

Figure 2.1: Maslow's hierachy of needs
(Potter & Perry 1995:32)

In practice, the difficulty in measuring the less tangible needs, may occur because the different groups or individuals contributing to policy-making in the health services will differ in the degree of importance they attach to each of the different levels in the hierarchy (Glampson et al 1982:11). However, definitions of needs, if they are to be of practical value in the tasks of needs assessment and service delivery, must lend themselves to operationalisation.

Dennill et al (1999:154) produced a similar category or classification of needs, that also allows service agencies to make policies and deliver services based on needs assessments done by both professionals and consumers.

2.6 THE BASIC PURPOSE OF A NEED ASSESSMENT

Beyond describing what needs are, assessment is also useful in identifying those factors within the human service network which aid or impede attempts to meet those needs.

Firstly, an assessment may be used to specify current and/or potential resources that can be channelled or reallocated to respond to unmet needs.

Secondly, an assessment is useful in gaining an understanding of the political and social value system underlying a particular social area. These values often determine the needs identified and also tend to determine which needs receive priority in the programme planning process.

Thirdly, analysis of "assessment data" may suggest new interventions and may ultimately be helpful in uncovering the etiology of certain conditions.

Information from a needs assessment also provides important inputs to the planning processes leading to

- deinstitutionalisation or determining the discharge potential of patients (Dartnall et al 2000:2)
- the selection and prioritising of problems and target populations to be addressed
- the selection and operationalisation of specific community programme activities
- the evaluation of these activities
- additional input to the ongoing planning process
- minimising the impact of vested professional and community group views in terms of the needs expressed (Reinhardt & Quinn 1987:141)

Within the limits of current assessment methodologies, information about needs is also useful in

- describing demands for services
- assessing service resources
- developing detailed community descriptions
- delineating groups likely "to be at risk"
- examining the relevance of existing services
- clarifying those factors that influence the occurrence of social and health problems
- identify factors that aid or impede effective service delivery (Chadwick 1997:29)

Assessment activities also study the population distribution of social problems and the factors influencing their distribution. In this research the assessment of the needs of persons suffering from schizophrenia are compatible with the view of Attkisson et al (1978: 222) namely that when it is possible to identify the population at risk, such findings are very important in planning services, especially those of preventive, consultative and rehabilitative nature.

According to Lear (1993:27) although an assessment is basically a descriptive process, it may be useful in identifying factors within the human service network that either impede or enhance attempts to meet the needs of persons suffering from schizophrenia in specific social areas.

In this research assessments were used to

- identify current and potential resources that could respond to identified needs for schizophrenic persons in the Mogoto Village
- provide an understanding of the political and social value systems underlying Mogoto Village
- analyse data that could be used to suggest new interventions and could also be helpful in uncovering the causes as to why persons suffering from schizophrenia are not sufficiently cared for to enable them to live independently

The researcher is of the opinion that knowledge about such social, environmental and biologic etiology will facilitate a more effective need assessment process in the future in this area.

2.6.1 Health care needs

Community health care should include the assessment of the health needs of a community in which a person suffering from schizophrenia is a member. This should include the establishment of priorities. The importance of rational allocation and distribution of resources in an attempt to satisfy identified needs should be stressed (Smith & Maurer 2000:343). This view is also shared by all the member states of the WHO and supports an equitable distribution of health resources, both among countries and within countries (WHO 1981:34; King 1988:41).

In terms of Maslow's hierarchy of needs, the basic needs which Maslow identified as being of importance to the individual also applies to the community as a whole. Some of the functions necessary to satisfy the basic needs of persons suffering from schizophrenia include the correct utilisation of space, for example, the availability housing and recreation, as well as adequate means of livelihood incorporating aspects such as employment and health.

If health professionals accept the definition of needs and health care needs as those which refer to circumstances or conditions in which a person suffering from schizophrenia are limited in meeting his or her full potential, but which would be satisfactorily attended to by the presence of effective health care services, the importance of the availability of a comprehensive health care system for all people becomes obvious (King 1988:42). This view is supported by Van Rensburg and Mans (1982:296) who maintain that serious attention should be given to the provision of health services to all people according to their specific health care needs. Persons suffering from schizophrenia can have a marked influence on the health needs of a population as their individual needs might differ considerably from those of the rest of the population concerned.

Spencer (1980:11) refers to the term epidemiological "wholism" when discussing the importance of considering all the different needs that would influence a given situation. In order to obtain a total picture of the identified needs of persons suffering from schizophrenia, it is necessary to be aware of all aspects influencing the population and its health situation. In this way priorities with regard to health care provision could become apparent (Stanhope & Lancaster 2000:419).

2.7 NEED ISSUES

Need assessment studies, monitor social area characteristics and population characteristics which influence needs, wants and demands for human services. These issues include the value systems of ethno-cultural backgrounds indigenous to all population groups being served. Especially important in this regard is the analysis of cultural, psychological, physical, environmental and linguistic barriers to appropriate service utilisation (Attkisson, Hargreaves & Horowitz 1979:223; Baldwin & Woods 1994:326).

Need issues in the mentally ill also address the levels of functioning of the patient prior to discharge. Dartnell et al (2000:5-6) describe the following discharge potential in mentally ill patients:

- **Low support**

Some patients experience good functioning and have access to a recovery environment or support system. These patients require minimal community services to fulfil their needs. These patients can be discharged and would function well within the community.

- **Low support, no recovery**

These patients experience good functioning, however do not have access to a recovery environment in which their needs are fulfilled. Although these patients require very few supports in the community to be discharged, the lack of family supports may act as a barrier to discharge given the current lack of alternative residential supports and thus unmet needs.

- **High support**

These patients experience poor functioning, but do have access to a supportive recovery environment. The availability of a recovery environment in the community may overcome the deficiencies associated with the poor functioning of these patients.

- **High support, no recovery**

These patients experience poor functioning and do not have access to a recovery environment. For these patients, community living may not be feasible because their specific needs cannot be met, particularly in the absence of any community facilities to support these patients with high care needs.

Need assessments must therefore focus on issues related to the population characteristics, the individual patient's state of functioning and his or her potential to function in the community, as well as five other critical issues related to the overall effectiveness and appropriateness of the total service delivery system, namely:

- Availability of services relative to population characteristics and distribution of the social area.
- Accessibility of services relative to the population need status, environmental characteristics and distribution of service resources.
- Awareness of service opportunities among the residents of the social area.
- Level of service integration and continuity of services vis-à-vis multi-problem individuals and the availability of service network linkages.
- Level of resources and distribution of available resources vis-à-vis need states in the social area (Baldwin & Woods 1994:326).

These issues should be addressed by the researcher when undertaking a need assessment process and when considering the results obtained during the process. One must be aware that all human service programmes have a heterogeneous group of vested stakeholders with conflicting interests and expectations. The vested stakeholders include elected representatives to the legislature and congress, appointed or elected governmental personnel, programme funders, tax-payers, administrative and service personnel and other community service providers, community residents and persons themselves (Ong 1991:638).

The task of translating assessment information about the needs of persons suffering from schizophrenia into relevant service programmes is thus not a simple, orderly process, because of the conflicting expectations of these various groups.

According to Reinhardt and Quinn (1987:140), "although assessment information may frequently have an aura of objectivity, planning necessarily remains a human process", for example:

- Social, health and mental health care issues are interrelated and not easily identifiable singular entities. It is also often difficult to clearly identify which are primary and secondary needs. This makes it difficult for planners to establish priorities rationally and to determine which needs can be met most effectively and by which agency.
- Human service needs are dynamic and in a state of continual flux. The communities

are in perpetual transition. The needs that may have given rise to original programme objectives may not be of the same magnitude at a later stage. This supports the rationale for an ongoing programme of community needs assessment.

- The translation of identified community needs into programmes will also be influenced by characteristics of human resources, the capabilities and interests of staff, the availability of appropriate service technologies and adequate financing (Reinhardt & Quinn 1987:140; O'Brien 1998:42).

In figure 2.2 the service needs of the mentally ill are indicated. The level of functioning of the patient plus the recovery environment will determine the needs of the patient when discharged and this in turn will determine the service needs.

2.8 SCHIZOPHRENIA: DIFFERENT PERSPECTIVES

Schizophrenia is a complex and confusing illness for mental health professionals, persons and family members alike. For the general public might be a terrifying concept. Table 2.1 reflects some of the myths that make the community terrified of this population as well as the facts indicating the truth about the mentally ill person who is seen as a person with a seriously disturbed, "split personality" (Strauss 1996:283).

Schizophrenia is the name given to a group of mental illnesses that cause a major disturbance in the functioning of a person's thinking and ideas between the ages of 16 and approximately 45 years (Department of National Health and Population Development 1994:22). What happens is that the parts of the brain that control the thoughts and feelings are no longer in harmony with each other. The person begins to experience the world around him differently from the general public and his behaviour changes markedly.

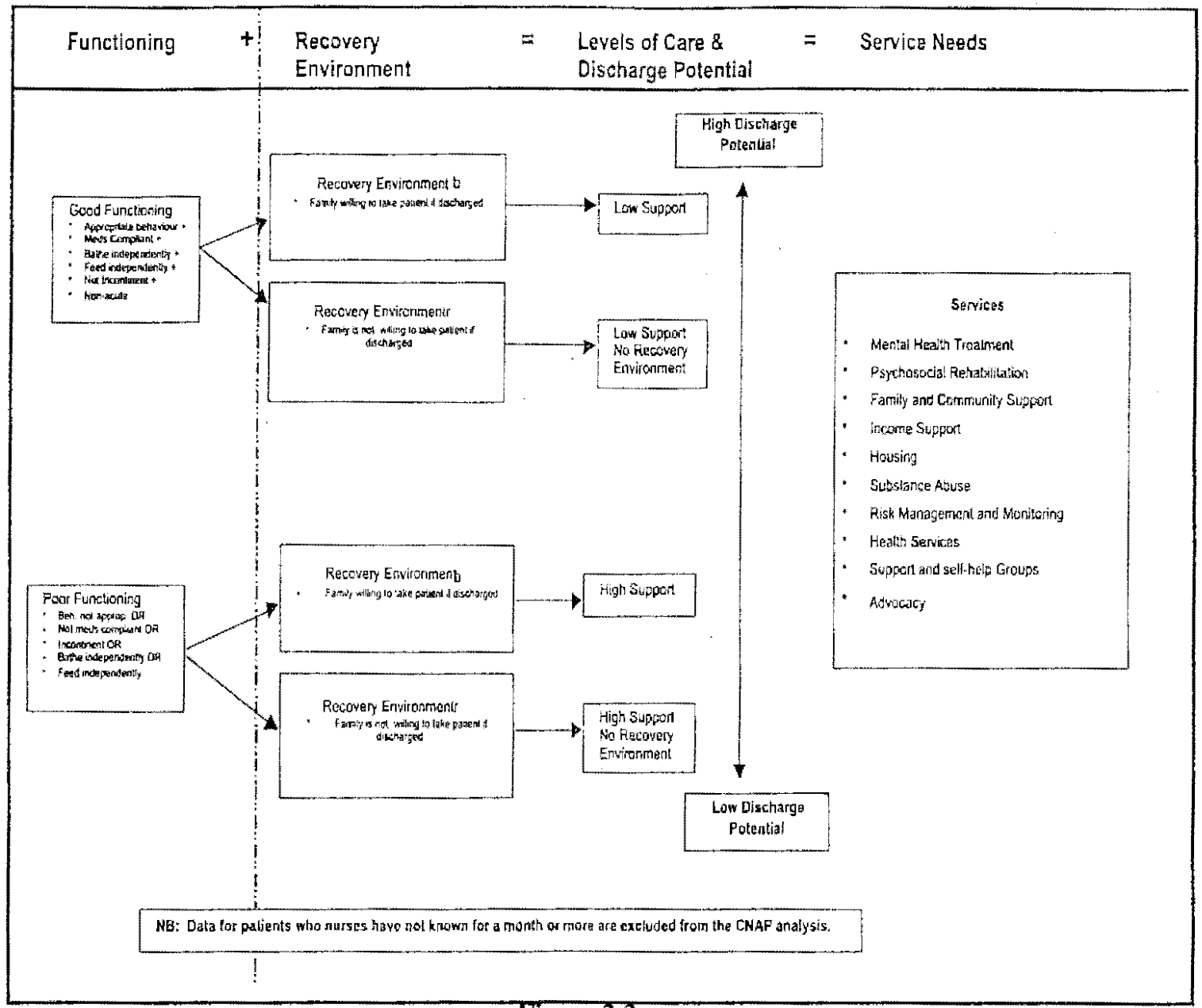

Figure 2.2

Service needs of the psychiatric patient in the community

(Adopted from Dartnell 2000:5)

Table 2.1: Myths and facts about people with mental illnesses

Myths	Facts
A person who has been mentally ill can never be normal.	Mental illness is often temporary or episodic. Former mentally ill persons deserve to be judged on their own merits.
Even if some mentally ill persons return to normal, chronically mentally ill people remain different — in fact, crazy.	Many people who have chronic mental illnesses have been hospitalised for a long time. After discharge, they must continue to take medication. The combination of the illness and medication is side effects may cause them to look or act strangely, but the longer they are in the community the more they look like everyone else.
If people who recover from other illnesses can cope on their own, recovered mental persons should be able to do so, too.	Most people who have been through a disabling illness, mental or physical, need rehabilitation. For mentally ill people this is focused on social support.
Persons with mental illness are unpredictable.	Although some mentally ill people are impulsive and unpredictable when they are actively ill, most are consistent in their behaviour when recovered.
Those with schizophrenia or other severe mental disorders must be really crazy.	With appropriate treatment, people who have severe mental disorders tend to be calm and reliable.
Mentally ill persons are dangerous.	Persons who have come through mental illness and have returned to the community are apt, if anything, to be anxious, timid, and passive. They rarely present a danger to the public.
Recovered mentally ill persons are surely potentially dangerous. They could go berserk at any time.	Most people who are mentally ill never went "berserk" in the first place. Mentally ill persons are more likely to be depressed and withdrawn than wild and aggressive. Most relapses develop gradually.
Anyone who has had shock treatment must *really* be in a bad way.	Shock treatment (electroconvulsive therapy, or ECT) is an effective treatment for serious depression. There is no reason to assume that someone who has received this therapy is sicker than others.
When you learn a person has been mentally ill, you have learned the most important thing about his or her personality.	Every type of disturbance is different in every person. A recovered person needs to be viewed as an individual rather than as an anonymous member of a stereotyped group.
You can't talk to someone who has been mentally ill.	Most recovered people who have had mental illnesses are rational and intelligent. Even people with current illnesses are likely to be rational in many ways.
If a former mentally ill person has a really bad history there isn't much hope.	Some people may be ill for many years before they receive effective treatment or their conditions improve for other reasons. Once recovered, they may remain well for the rest of their lives.
A former mentally ill person is bound to make a second-rate employee.	Many recovered persons make excellent employees. Some people who are subject to relapses may need to work in flexible situations.
Perhaps recovered mentally ill persons can work successfully at low-level jobs, but they aren't suited for really important or responsible positions.	The career potentials of recovered mentally ill persons, as with anyone else, depend on the persons' talents, abilities, experience, motivation, and health status.
Recovered mentally ill persons have a tough row to hoe, but there's not much that can be done about it.	The way we act toward former mentally ill persons can make all the difference.

(Rawlins, Williams & Beck 1993:64)

- **Traditional medical perspective**

The traditional *medical perspective* views schizophrenia in terms of disease. However, this perspective results in a dilemma since the medical profession is uncertain whether Schizophrenia represents a disease, a group of diseases or a complex of symptoms manifesting an incapacity to adapt to stress (McKenna 1985:56; Desjarlais, Eisenberg, Good & Kleinmann 1995:42).

Schizophrenia is generally thought of in terms of its dramatic effects - hallucinations or delusion with difficulties in interpersonal relationships and deficient coping skills and difficulty in transferring learning from one situation to another. The less obvious symptoms, such as poor concentration or lack of motivation appear to be ignored (Lear 1993:26).

- **Rehabilitative perspective**

The *rehabilitative perspective* views schizophrenia as a deficit, rather than a disease. Since this deficit is manifested in impaired functioning, the impairment becomes the target for concern. Need assessment requirements for persons suffering from schizophrenia are shaped by a knowledge base which includes a host of very poorly understood biological, psychological and environmental factors (Uys 1994:329).

Beyond the inadequacy of present knowledge, what seems to have been lacking in need assessment of persons suffering from schizophrenia is some integrated psychosocial biological position regarding an assumed pathogenesis from which a reasonable need assessment formulation would logically follow (Lear 1993:27).

The various phases of need assessment must be clearly linked to a knowledge of the client's overall level of functioning.

2.8.1 Typical needs of persons suffering from schizophrenia

Like all people, persons suffering from schizophrenia have specific human needs requiring that those who care about them see them as unique persons (Bachrach1982:390). Ideally, a small group of close friends validate their personal worth and serve as the first resource for dealing with their mental disabilities.

The typical needs of a person suffering from schizophrenia are discussed below. These include the physical, psychological, social, emotional, economical, educational needs as well as the needs for support systems, resources and job-related rehabilitation programmes. These needs also apply to those patients suffering from schizophrenia in the Mogoto Villiage.

- **Physical needs**

Related research suggests that the schizophrenic level of physical illness may exceed those found in the general population therefore adequate medical and mental health care is needed (Desjarlais et al 1995:42).

It is in this context that the need for case management services becomes important as one person or team should be responsible for remaining in touch with the client. This provides the essence that binds otherwise fragmented services into a format that responds to the unique and changing needs of persons suffering from schizophrenia.

- **Psychological needs**

Persons suffering from schizophrenia are vulnerable to stress and because their psychiatric problems tend to recur, acute treatment may be required periodically, often on an emergency basis. They need a range of resource options including twenty-four-hour emergency telephone services, trained personnel able to visit the clients' homes or workplaces, and places in the community that offer treatment of emerging schizophrenic symptoms or at least an asylum from unendurable stress.

- **Social needs**

The person suffering from schizophrenia also has a need for basic activities of daily living because of their apparent lack of either motivation or their inability to seek help from a sustained rapport with service workers; their extreme vulnerability to stress; their tendency towards episodes of acting out behaviour that interferes with their own well-being or that of others and the fact that their illnesses or disabilities do not usually respond to short-term treatment (Moss 1990:113).

Mastering of social skills in terms of interpersonal relationships is also a problem as they have difficulty in initiating conversation and are incapable of forming and maintaining friendships.

This affects their ability to participate in group and community life and can prevent them from joining church groups and social clubs, or using available community services such as libraries, sports facilities, other recreational facilities and health services by means of a systematic integration programme (Uys 1994:329).

The persons suffering from schizophrenia also needs assistance in planning their activities and time economically for a day or a week as they often require help in this regard. They should develop positive patterns for spending their free time as they tend to lack drive and interest in their surroundings (Uys 1994:330).

- **Emotional needs**

Persons suffering from schizophrenia cannot build and sustain mutual relationships. They need opportunities to become useful to others, thus overcoming the handicapping effect of their mental and/or emotional disorders (Uys 1994:328).

- **Economic needs**

Problems associated with schizophrenia that developed early in life, have prevented persons with schizophrenia from having a vocation. Therefore they need assistance in applying for a source of income, as well as medical and other benefits.

- **Educational needs**

Schizophrenic persons, if they are to gain a sense of personal worth, need resources including goal oriented rehabilitation evaluation; training in community life skills preferably in a natural setting and opportunities for developing social skills, interests and leisure activities.

Psycho-educational strategies also need to be drawn up to teach these persons about their illnesses and their treatment.

- **Support systems**

Schizophrenic persons need supportive services of indefinite duration as some of these persons may need periodic or continuing long-term assistance from the formal health system, often for most of their lives, although those that have greater potential, can in fact, be come more independent.

In this context there is also a need for self-care programmes as due to their diminished drive and disturbances of thought, persons suffering from schizophrenia have difficulty in accepting responsibility for self-care. They need support in their efforts to improve their personal appearances and should be gradually encouraged to accept responsibility for personal grooming.

- **Available resource**

Accommodation is often a problem as persons suffering from schizophrenia cannot always be placed with their families. If accommodation means only somewhere to stay, persons are inclined to wonder socially and geographically.

- **Job rehabilitation programme**

There is a need for job rehabilitation programmes that includes promoting appropriate work behaviour, as persons suffering from schizophrenia usually have poor work records due to their lack of drive, limited interpersonal and social relationships, lack of job experience and almost complete lack of job specialisation.

The major problem presented by persons suffering from schizophrenia who are attempting to build up a stable life in the community is helping them to organise and sustain their needs. Like any other person, persons suffering from schizophrenia need exactly what the rest of us do: places to live, opportunities to socialise, useful vocational or vocational activities, finances, medical services, crisis resolution services and mental health services.

2.9 MENTAL ILLNESS AND CULTURE

Identification of a mental disorder as an illness and what is regarded as appropriate behaviour, largely depends upon culture and the traditional focus in the social sciences. In whichever way culture is defined, it primarily provides guidelines for a way of life, and is the result of the way that people have adapted to a particular environment.

People act in fixed ways which are in line with the ideas, precepts and shared knowledge of their culture (Bouwer, Dreyer, Herselman, Lock & Zeelie 1997:31). Culture is dynamic, and cultural changes also occur in reaction to external influences. Prolonged and intensive contact between diverse societies produces comprehensive changes in a culture.

In South Africa cultural change has taken place because of the contact between different representatives of Western culture and indigenous societies, but also because of contact between different indigenous groups, for example, the custom of circumcision was introduced among the Venda as a result of their contact with the Lemba. Later this practice spread to other indigenous societies (Kavanagh & Kennedy 1992:22). In this context the anthropological principle of "holism" emphasises the importance of the whole of the sociocultural context when people and their behaviour are being assessed.

Health care phenomena are related to culture. A cultural system of beliefs and behaviour about health and illness called a medical system, is universal to all societies, although the manifestation of such beliefs and behaviour is different in each case. For instance, there are many medical practitioners in all societies, who are identified differently as doctors, indigenous practitioners and shamans each of whom claim a special method of expertise for maintaining health and preventing ill health (Bouwer et al 1997:32).

Each culture ascribes a cause to a pathological condition, and prescribes ways of diagnosing, preventing and treating mental and physical disorders. Accordingly, what is regarded as pathological in one society may be regarded as normal in another. The Pedi do not necessarily regard individuals who behave irrationally and dream incessantly as being mentally disturbed. Instead their behaviour may be interpreted as "possessed by the ancestoral spirit "calling" them, as it were, to become indigenous practitioner". These practitioners are highly respected in their communities of origin (Herselman 1994:85).

2.10 CAUSATION AND CULTURE

For many persons suffering from schizophrenia a condition becomes meaningful once a cause has been ascribed to it. Consequently the identification of a cause is a significant factor in a person's decision about subsequent coping strategies, such as who should be consulted and the form of treatment that should be followed (De Villiers 1993:150).

Illness causation is generally rooted in a person's sociocultural environment, and in the system of health beliefs as part of that environment in particular. In indigenous health belief systems, illness is more frequently believed to be caused intentionally and as such ascribed to supernatural (mystical) causes (De Villiers 1993:67). This implies that there is a disfavour or anger of some maligned supernatural being such as a god or spirit, or the activities of witches or sorcerers. This is commonly found in persons suffering from schizophrenia and their families who believe that the condition did not happen because of natural causation but because of angry ancestors or bewitchment. In case of angry ancestors, where the symptoms of schizophrenia are believed to have been "sent" in reaction to neglect of custom, the family usually takes the person to the traditional or faith healers who will advise them to make a sacrifice, by slaughtering a cow or goat for the ancestors.

When a sacrifice is required to thank, remember or rest the spirit (known among Pedi as "go phasa badimo") a goat or cow is slaughtered in the presence of "Malopo" (spiritual representatives) who are believed to be able to talk to the "gods" on that person's behalf. In case of witchcraft, this refers to the activities of a person who maliciously manipulates a supernatural power to harm others whereas the traditional healer uses medicines to get rid of the symptoms of schizophrenia. When the condition gets worse, where the person for example becomes psychotic, the person is taken to hospital for stabilisation. After discharge from hospital the person is required to complete the course of treatment from the traditional healers in fighting the witches.

There is a strong belief in some cultures in South Africa that if someone has an inexplicable condition, this person is often colloquially described as having been "bewitched" (Bouwer et al 1997:35). Failure to sacrifice an animal gives the witches more power over the person and the "gods" will not protect that person against evil powers as the person has neglected them.

In most cases, persons suffering from schizophrenia consult both faith and traditional healers with the hope of regaining their mental health. The person suffering from schizophrenia with grandiose delusions believes that he, as a prophet, is encouraged to preach or pray for those

who are ill until the church members realise that this is more than just a prophet but a sign of mental illness. These persons become even more difficult to deal with when the mental illness is linked to hallucinations that support them especially if these hallucinations are visual and/or auditory.

Ancestrally caused illness may, therefore, be interpreted as punishment, the result of deviation from accepted norms, or as means by which ancestors communicate with their descendants.

2.11 RESOURCES AND SUPPORT SYSTEMS IN SOUTH AFRICA AND OTHER COUNTRIES

In any developing or developed country a range of resources is available for the care and treatment of the mentally ill.

In some countries, particularly developed countries and welfare states, for example the United Kingdom it is the government's responsibility to provide resources at the disposal of the individual. These resources enable the mentally ill to develop their physical, psychological, social, intellectual and spiritual potentials to levels at which he or she feels comfortable (Vitus 1990:58).

In the case of those who cannot choose/decide, the parents, guardians or personal curators make decisions. In many cases the government finances as well as provides these services, which are usually free or are covered by a form of national insurance.

- **Sweden**

Sweden for instance, has a very sophisticated scheme for meeting the needs of their mentally disabled people. Medical, educational, recreational and transport services are organised so that all individuals irrespective of disability or level of development can make use of them.

There is a general policy of bringing the service to the individual rather than vice versa. There is therefore a movement away from institutions and situations where people are separated into groups depending on their disabilities, beliefs or capabilities. Instead an effort is being made to deal with an individual as a person in the context of his or her natural grouping in the community where rehabilitation processes are going to continue.

The system functions well and the bureaucracy is minimal as executive power is decentralised. The people themselves take the necessary decisions within the framework of a very well-organised system of accountability and supervision (Vitus 1990:59).

- **United Kingdom**

In the United Kingdom, the mental health care system is similar to the one in Sweden, but is not operating as well in view of the heterogenous population in recent years.

The exaggerated democracy whereby committees rather than individuals appear to have responsibilities also caused confusion to the system leaving many decisions unattended.

The State is no longer able to develop the welfare state of the United Kingdom any further and relies on private initiatives to establish and maintain new services. Once they have been established, the State usually takes responsibility for running them. Generally, the State takes responsibility for the development of the individual's potential.

Supportive facilities like transport, home aids, meals on wheels, after school centres and sheltered workshops are more readily available than in South Africa. Unlike Sweden services are not free, but the national security benefits paid to individuals are adjusted individually to enable people to afford services they require.

There is therefore a tendency to subsidise the individual rather than the service. This has the advantage of encouraging independence but does stifle initiative towards the development of community services.

The general policy in the United Kingdom appears to be to provide the individual with the means and to leave it to him to decide how and where to develop his remaining potential (Vitus 1990:59).

- **United States and Canada**

In the United States and Canada there is no specific policy for caring for the mentally disabled. Services are rendered on the federal, state, regional and local levels. In addition some services, particularly in Canada, are provided by private service organisations. The service provided depends very much on the authority which takes the initiative and is also heavily dependent on political lobbying.

Funding by an authority is usually project-based. An organisation will motivate for a project and obtain funds from different government levels, sometimes from two or more levels simultaneously (Vitus 1990:59).

In view of the tax system, large amounts of money are also available from foundations and trusts. The free enterprise system provides for healthy competition and high standards of service. On the other hand, there is no definite uniformity of service delivery. However, numerous newspapers and journal articles from the United States document the failure of mental health services in this country to respond adequately to the shift to community-based care for mentally ill persons (White 1991:12).

- **Australia**

In Australia the responsibility for the provision of mental health services lies with various authorities as well as private enterprise. There is a definite psychosocial rehabilitation policy and an Act of Parliament that provides for the coordination of all psychiatric services. The onus, however, rests with the individual to seek help.

Services are liberal but those who can afford them must pay. Incentives are paid to organisations in respect of employees in sheltered workshops who are placed in the open labour market. In addition, to a means test, free incentives are paid to mentally disabled persons suffering from schizophrenia employed in sheltered workshops. The overall policy could be described as one of encouraging the individual to become a useful and productive citizen (Vitus 1990:59).

- **Netherlands**

A report by Reker, as cited in Uys (1993:17) states that there are 55 facilities offering sheltered employment for 1 650 people, for a population of nine million. Three percent of the workforce in any institutional/factory/office can be made up of rehabilitated persons suffering from schizophrenia. It is evident from this statement that in the Netherlands serious attention is given to the rehabilitation of patients in order to place them in the community as fully productive individuals.

- **South Africa**

The provision of mental health services for mentally ill persons in South Africa's larger urban industrial areas resemble those of more developed countries. There is considerable work still to be done in less developed urban, rural and informal settlement areas (White 1991:12). There is a general shift in psychiatric services from custodial care to community care which is attributable to the introduction of major tranquillising drugs, especially the phenothiazines. With medical control of symptoms of the schizophrenic person in particular, custodial care is no longer warranted. It has thus become necessary to consider the diminished abilities of persons suffering from schizophrenia and the stigma of their condition in the context of an urban industrial society which emphasises competitiveness, success, the importance of work and financial and social independence (White 1991:12).

In South Africa, persons suffering from schizophrenia are often rehabilitated to work in sheltered workshops thus excluding them from challenges in the open labour market. Due

to political instability and the high unemployment rate it is now more difficult to place persons suffering from schizophrenia in any type of employment (Gagiano et al 1995:1). A wide spectrum of mental health services is also more easily available within urban areas than in the rural areas. The attitude of the government is very similar to that of Australia, in that it promotes and aids in the holistic approach to care of persons suffering from schizophrenia, but wishes the individual and private enterprise to take the initiative. The fact remains that the mentally ill person will not be able to participate or survive in the community unless special provisions are made to meet his or her needs.

In a sense it is necessary to translate the common human needs into human rights, for example the right to work and to recognise that the special circumstances of mentally ill persons necessitate special arrangements in order to meet their needs and uphold their rights (White 1991:12).

Several problems have been identified that form the rationale for this research as stated in chapter 1, paragraph 1.3. The person suffering from schizophrenia needs support from the community in which he or she lives, which is not usually a specific requirement for other groups in a community (Lear 1993:26). Any researcher working with this population must understand that supporting the community is just as important as providing support to the person. Persons suffering from schizophrenia have difficulty in organising and maintaining basic necessities and this needs to be addressed on an ongoing basis.

It is therefore important to work with the person suffering from schizophrenia and with the community to effectively help him or her to achieve life of a decent quality in the community (Stein 1993:8).

2.11.1 Problems posed by persons suffering from schizophrenia

The fact that the vast majority of persons suffering from schizophrenia live at home rather than in an institution is admirable. However, care of this population in the community places a heavy burden on families. Family members are exposed to continuous call with few

opportunities for relief. This can mean being physically exhausted and being under considerable emotional stress. This can also mean being socially isolated and can bring financial difficulties (Robinson 1988:30; Honkonen 1995:26).

All the above problems can be resolved with minimal assistance from either within or outside the family. An increasing number of persons suffering from schizophrenia are being placed in a position of being almost wholly dependent on a relative with their needs dominating the life of another individual. Their need for care and support is being met largely by relatives regardless of the relative's ability or willingness to provide care. Apart from the impact on relationships, this has grave implications for the quality of care and for the mental and physical health of both parties.

2.12 THE INTEGRATED APPROACH TO THE NEEDS OF PERSONS SUFFERING FROM SCHIZOPHRENIA

The primary goal of nursing care is to help persons develop strategies to achieve harmony within themselves and others, nature and the world. Integrative functioning of the person's physical, emotional, social, intellectual and spiritual dimensions provides the basis for reaching wholism (Rawlins et al 1993:17). Each person is considered as a whole with many factors which integrate with one another in order to contribute to health or illness.

2.12.1 Viewing the whole person

The Theory of Nursing for the Whole Person, as put forward by Oral Roberts University, Anna Vaugh School of Nursing (1990:16), provided the basis for this research. The researcher is of the opinion that a person should always be seen in totality. This theory is central to the philosophy as well as to the conceptual framework for the need assessment of these persons. The *whole person* incorporates the concept of body, mind and spirit. The concept *mind* includes those processes described as emotional, volitional and intellectual.

The concept body includes those processes that are physiological (biological) in nature, and the concept *spirit* refers to that part of man created in communion with God (Poggenpoel 1994:52).

Wholism is, then, seen as part of the biblical understanding of the nature of human life, namely, "we are, in our several "parts", a total unit, and our several parts have an equal importance and value" (Meyer 1989:116).

Physical, spiritual, social/emotional aspects of the self always belong together (Meyer 1989:116). The major concepts in this theory are the individual, the family and the community as parameters of nursing; promotion, maintenance and restoration of health as the goals of nursing services; health/wholeness as the desired personal outcome; internal environment, external environments as the basis for needs assessment and diagnosis, and body, mind and spirit as the internal environment of the individual (Poggenpoel 1994:52).

2.12.2 Human uniqueness

Within a holistic health framework, each individual is unique. Complex factors including human dimensions, determine how people view themselves, the world, health and illness. For every person, the interaction of the different dimensions and the interaction of the person with his or her environment are unique. This uniqueness require individualised approaches to health and care (Rawlins et al 1993:48).

To stay balanced, individuals must meet different needs within themselves and in their particular life situations. Recognition of these needs helps them to attain their goals for health and to make full use of their remaining potentials. For example, a person who is physically fit but is unaware of his feelings needs help in developing the emotional dimension. Another person who has a well-developed social support system but experiences a loss of purpose in life may need to consider what is lacking in the spiritual dimension. The individual who is attuned spiritually but neglectful of exercise or nutrition may need to direct his or her attention towards the physical dimension (Rawlins et al 1993:48).

When a person's uniqueness is ignored, a rehabilitation approach programme that has been effective for some persons, may fail in others. This happens when health care professionals consider only the disease process (schizophrenia), the symptoms (hallucinations) or the label (lunatic), and disregards the goals and values of the individual. Sole reliance on labels makes it difficult to view the wholistic needs of the individual as a priority (Meyer et al 1997:350).

To add to human uniqueness, one must consider the individual's goals and values in terms of their importance in predicting the individual's behaviour towards the programme. A person's attitude towards the group of which he or she is a member should also be considered as this can affect the person's self-esteem, since people typically interpret the value placed on their social group as the value placed on them as unique entities (Ellis & Nowlis 1981:239).

2.12.3 "Parts" of the whole

2.12.3.1 Intellectual

Keeping the mind healthy is part of being whole. Keeping current in one's skills, reading in areas of interest or curiosity, enjoying dramatic and musical events, and exploring new areas of understanding are all ways to exercise the mind to health. As the Christian history can attest, Christians have a great respect for the intellect and see its usage as a matter of stewardship and work to utilise it in the service of God, the church and the world (Schultz & Videbeck 1994:13)

2.12.3.2 Social/emotional

To be whole means to be at one with others, with one's environment and with one's self. How we fit in with all that surrounds us is a measure of our health and well-being. To be socially and emotionally whole is to be aware of one's self, one's needs, one's motivation and one's connectedness in such a way as to cultivate wholesome and beneficial interpersonal and intrapersonal relationships (Meyer 1989:117).

2.12.3.3 Spiritual

Man is a spiritual being who functions in an integrated bio-psycho social manner to achieve his quest for wholeness. Some pursue an interest in the whole person and overlook the importance of their spiritual life, giving further credence to the idea that wholistic health has the air about it of being its own religion.

Our spirituality shows itself in trust and in the choice and commitments that fill our life. If one is whole, he/she will understand not only the nature of trust as it operates within us, but will also understand the identity of that which we trust ultimately. It is from that ultimate trust that one generates values, priorities and fundamental life principles (Meyer 1989:119). Our spirituality takes life in one's actions. Those who are spiritually whole display a life style that represents a harmony between belief and activity (Schultz & Videbeck 1994:14).

2.12.3.4 Physical

Physical well-being and conditioning are a reminder of the unity of one's physical natures with all the other components of self. Paying attention to one's physical wholeness requires an appreciation of one's health habits: knowing how to choose food wisely, how to eat for the benefit of one's heart, and how to avoid food increasing one's potential for disease and obesity (Meyer 1989:120).

It requires an appreciation for one's physical development: pursuing appropriate exercise, ending bad habits and being aware of an optimal level of health for a person of one's age and size. It also requires genuine love for one's self: practising good eating habits, looking well after one's physical appearance and carrying one's self with good posture.

The nurse must always see the individual as a whole (in totality).

2.12.4 Relationship with the environment (external and internal)

A person relates to the environment through all human dimensions (see figure 2.3) often simultaneously, thus satisfying personal needs and helping satisfying the environmental needs.

When considering the person-environment-interrelationship, it is crucial to remember that each individual interacts with the environment based on subjective experiences as well as actual external stimuli (Reynolds & Cormack 1990:364). One's perceptions of and responses to the environment are largely determined by one's attitudes, values, feelings and beliefs. Past experiences, attributed meanings and expectations of the future contribute to an inner reality; from this reality, one interacts with and adapts to the environment (Munich & Lang 1993:664).

- **Physical environment**

The physical environment may contain elements that help meet one's needs in all dimensions, needs such as adequate living quarters, a safe neighbourhood, availability of cultural events and opportunities for spiritual growth.

Conversely, the physical environment can inhibit a person's development through crowded living conditions, excessive crime and lack of essential resources (Rawlins et al 1993:28).

- **Emotional needs**

Emotional needs are frequently met through environmental interaction. One's environment is conducive to health when emotional support is readily available and when one has numerous avenues for expressing feelings. Such an environment encourages development in all dimensions (Rawlins et al 1993:28).

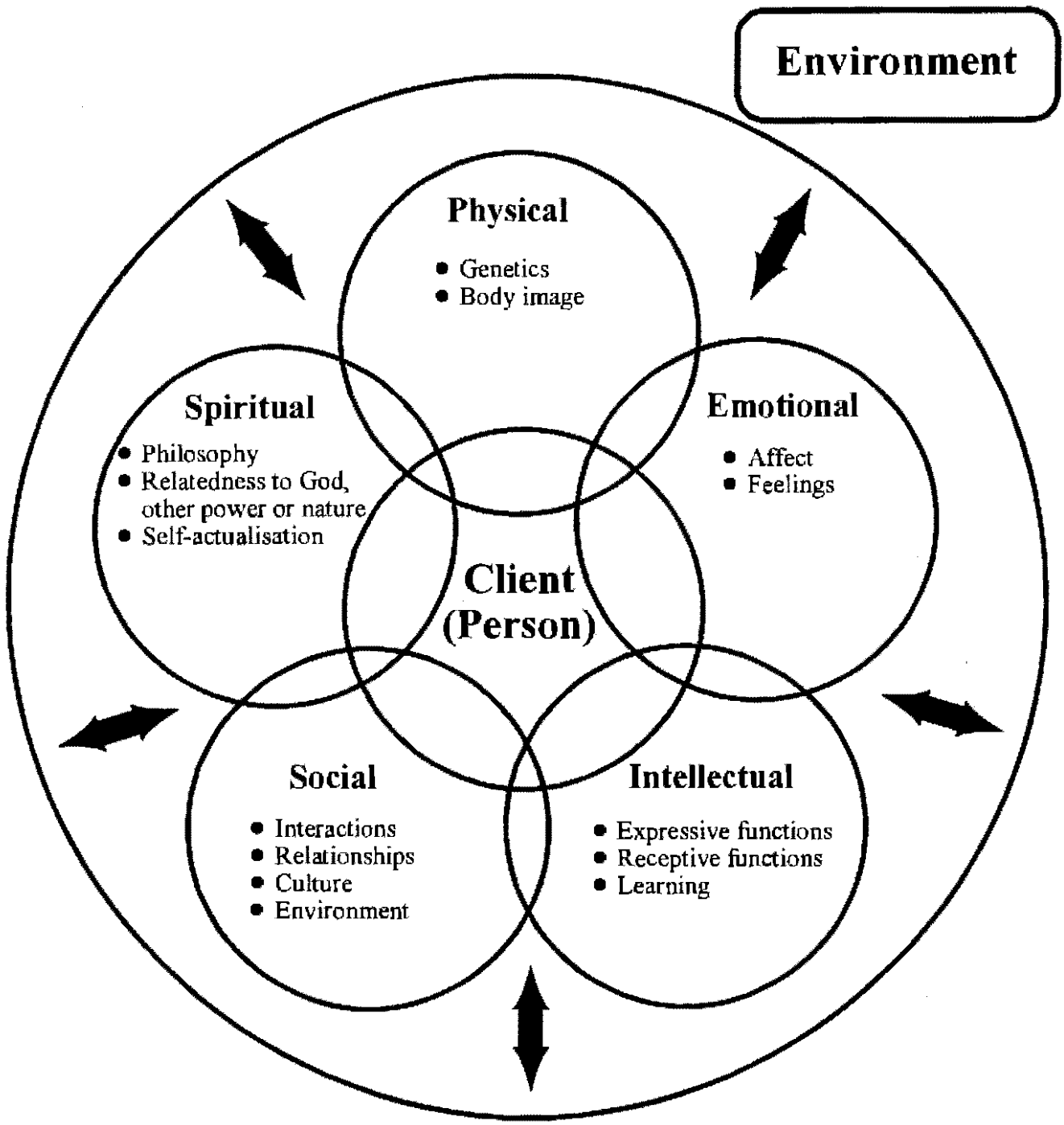

Figure 2.3
Integration of the five dimensions of the person

- **Intellectual development**

An intellectual environment provides opportunities for intellectual growth and development as well as adequate stimulation and encouragement to learn. In turn such an environment facilitates the ability to meet one's needs in other areas (Meyer et al 1997:107).

- **Social dimension**

A person suffering from schizophrenia is simultaneously a dependent part of society and also an independent whole within society. Through environmental resources, people can meet their physical needs such as food, shelter and health care. One can create caring relationships primarily through the social dimension, fulfilling many basic needs (Rawlins et al 1993:28).

- **Spiritual beliefs**

Together with experiences, spiritual experiences are greatly affected by the beliefs of the society in which a person lives. A rich spiritual environment offers many opportunities for personal exploration and expansion. This enhances the individual's ability to cope effectively with stressors in all other dimensions (Rawlins et al 1993:29).

- **Spirituality**

Spirituality is a person's beliefs, values, and/or philosophy of life. The person may consider spirituality to be extremely important or not to be a part of his or her life. The spiritual realm may be a source of strength, support, security and well-being in a person's life. On the other hand, the individual may be experiencing problems that have caused him or her to lose faith, to become disillusioned, or to be in despair (Schultz & Videbeck 1994:13). The individual may also have psychiatric symptoms that have a religious focus that may or may not be related to his or her spiritual beliefs such as religiosity. Spiritual belief systems differ greatly among people. It is therefore important to assess spirituality in the individual's present

problem and life situation. It is also important to be respectful of the client's beliefs and feelings in the spiritual realm and to deliver nonjudgmental nursing care regardless of his or her spiritual beliefs. Knowledge from devine revelation is based upon faith, nursing care can then continue in conjuction with this faith to meet the client's needs in a holistic manner (Uys 1994:3).

- **Community resources**

Community resources play a major large role in the support that can be offered from the environment. There are many health-related resources available, although a given community may have an abundance or a scarcity. Community health centres and community mental health centres often provide information to individuals and families about available support, education or intervention services (Rawlins et al 1993:29).

Some health-related community resources are managed by health professionals, for example professional community services include halfway houses, community homes, alcohol and drug treatment programmes, therapy groups, crisis management, crisis hotlines, various information hotlines and smoking cessation clinics.

Self-help groups, generally led by lay people have in recent years become an increasing source of support. These groups offer support and encouragement to their members who share some common problems of mental disability (Breakey 1996:100).

2.12.5 Context of health and illness

The various settings within which the individuals function influence their health care. The beliefs and behaviours developed in these settings influence health and illness. A holistic perspective considers these factors as being significant. For example, a community may provide areas for physical exercise and activities that encourage social interaction whilst a different community may be physically unsafe and socially hostile (Rawlins et al 1993:48).

Viewing health and illness within the context of person's life, one can understand how the person experiences health and illness. One can also understand that people with similar schizophrenic symptoms react in different ways, and do not necessarily respond to identical interventions hence the importance of assessing individuals' specific needs. The availability of financial, social, family and community resources will also influence health and illness. A holistic perspective helps identify and develop individual options and resources rather than assuming that what worked for one person suffering from schizophrenia will work for another (Engel 1996:55).

2.12.5.1 Health

A holistic health philosophy focuses on health promotion, or health as a positive process, rather than limiting itself to the elimination of illness. Health is more than the absence of disease, it is a dynamic active process of continually striving to reach one's own balance and highest potentials. Health involves working towards optimal functioning in all areas. Health is a life style that leads to optimal functioning and therefore can be pursued only by the person, family or community. Health is a personal responsibility and includes recognising needs, strengths and weaknesses, and internal and external factors that affect all dimensions: physical, emotional, intellectual, social and spiritual (Rawlins et al 1993:50). Health is said to be the product of a person's positive interactions with his or her total environment (Dennill et al 1999:7). The aspects of this holistic approach towards attaining what people refer to as health, are illustrated in the mandala of health (see figure 2.4).

Health of individual and families remains a goal and is possible even in chronic illnesses like schizophrenia. Persons suffering from schizophrenia have optimal functioning levels. The focus is on maintaining optimal energy and striving towards attaining one's health potential.

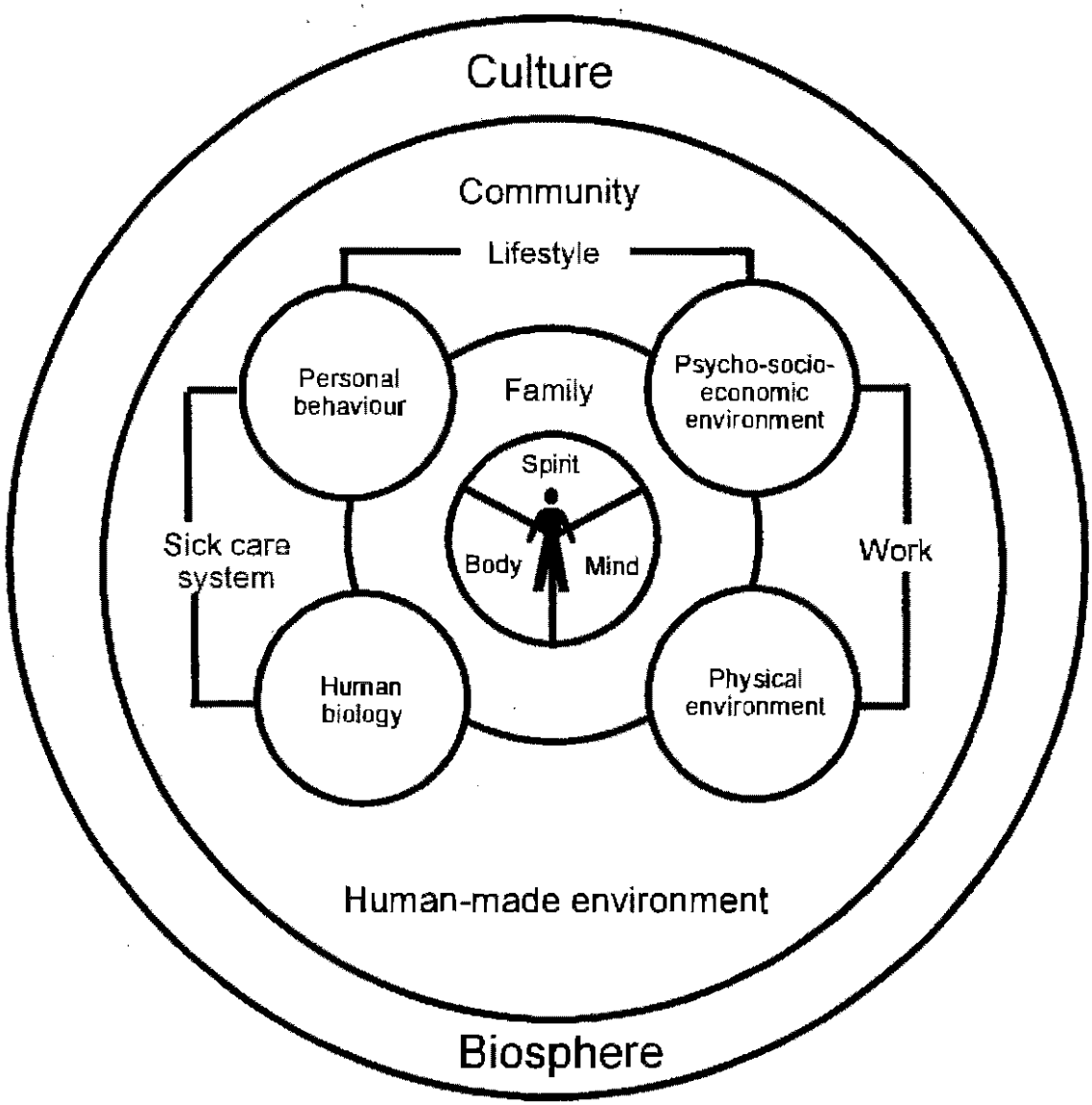

Figure 2.4
The mandala of health — a model of the human ecosystem
(Gilbert et al 1996:8)

2.12.5.2 Illness as an opportunity

The impact of an illness is determined by one's attitudes towards it; what one is able to learn from it, and what growth results from the illness (Rawlins et al 1993:49). Other people see illness as an opportunity to evaluate their current life situation, and view themselves as maintaining control of their lives and seeking to discover the way in which they have contributed to the illness. They acknowledge the availability of pertinent information and turn to use this information to set new goals and move in new directions.

Persons suffering from schizophrenia need guidance and support from professionals and family members to set these goals. This approach is consistent with a holistic health philosophy, which asserts that there is personal meaning or message in any illness. Discovering what that message entails, provides opportunity for growth.

Illness may often be related to a person's unmet needs. A look at how one's situation changes as a result of illness, or what one gains from being ill will offer clues to needs that are not being met (Meyer 1989:120). These needs may be relatively simple such as more time alone, less responsibility, restructuring a relationship, changing jobs or setting new priorities. Illness can therefore be an opportunity to the extent that people are willing to create various healthy meanings to illness and thus broaden the scope of their responses.

2.12.5.3 Nurse-client partnership

The holistic framework supports the nurse-person relationship as an active partnership, where responsibility for rehabilitation and growth is shared. The nurse attempts to create conditions that are conducive to healing and optimal health. The person's belief system is the beginning framework, and from this point the nurse provides support and helps the person find healthy ways to meet individual needs (Lintner 1995:15).

This process will include, but is not limited to expanding self-awareness, evaluating life style factors, identifying stressors and coping mechanisms, exploring meanings of illness and considering alternative beliefs and response patterns and implementing health habits that are acceptable and appropriate to the person. Persons in the holistic setting are co-participants in healing and health promotion. They are working closely with the nurses to determine necessary and appropriate interventions hence the importance of the need assessment process. Persons do not consider themselves passive recipients of health care but learn to consider themselves the experts regarding their own needs and health status. In this way they are able to retain their sense of personal power rather than conceding it to the health care system and assuming the roles of helpless victims (Rawlins et al 1993:491). As whole persons with unique valid needs, they begin to realise that there are many alternatives for meeting their needs.

2.13 MULTIDISCIPLINARY TEAMWORK INTERDISCIPLINARY AND INTERSECTORAL COLLABORATION

Participants attending 1978 World Health Organisation Conference laid the foundation for a Multidisciplinary Intersectoral team approach in health care delivery. The conference strongly reaffirmed that "health, which is a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important worldwide social goal whose realisation requires action of many other social and economic sectors in addition to the health sector" (Dennill et al 1999:59).

It was realised at this Conference that the goal of helping the public to attain an optimal level of health would not be possible without the active participation and cooperation of all members of the multidisciplinary health team whose members individually could contribute in some way to the well-being of the community

This would only be possible if a holistic approach to health care was adopted, an approach which necessitates a multidisciplinary and intersectoral cooperative team effort.

Dennill et al (1999:70) cite Cooney's (1994) definition of the term *multidisciplinary* as the "... juxtaposition of various disciplines, sometimes with no apparent connection between them, and where members from such disciplines would work together as a team, they do not necessarily spend all their time working together but at times would rely on themselves and on other members to achieve the goals or functions of the team".

Intersectoral action was seen as the action in which the health sector and other relevant sectors collaborate on the achievement of a common goal (Dennill et al 1999:70).

Coordination within the health sector was seen as organised collaboration necessary among those who provide the services at the same level, as well as at different levels within the health system in order to make the most efficient use of resources. This included various categories of health workers once agreement on the division of labour was reached (Department of National Health and Population Development 1994:65).

Multidisciplinary and intersectoral approaches in health care are not only a way of satisfying individual health needs, but are also the effective ways in which the many pressing health issues facing the world can be addressed.

The ANC policy guidelines on health, adopted at a national conference on 28 to 31 May 1992, included the following statement regarding intersectoral cooperation (African National Congress 1992:393). "At all levels of government the health services should promote intersectoral cooperation to promote the health of communities. The health service will play a role in coordinating government authorities responsible for sanitation, water supply, food and agriculture, housing, and other social services. To the extent that a threat to public health is identified, the health service will ensure that the necessary steps are taken to remove such a threat".

The effectiveness of a multidisciplinary health team can be described as the success it has in addressing the total health care needs of the community and by so doing improving the health and well-being of the community (Poulton & West 1993:921).

Teamwork must be seen as a process rather than an end to itself. Teamwork is defined by the WHO (1981:6) "as coordinated action, carried out by two or more individuals jointly, concurrently or sequentially".

Goddard (1981:37) states that "there are two vital components of such a team, the professional group who contributes to effective health care of the community by applying their specialised knowledge and skill, and the client together with his family and the community". He also stressed the importance of teamwork to ensure a holistic approach to mental health care which will help to ensure the satisfaction of the health care needs of persons suffering from schizophrenia.

To ensure cooperation between the community and the health team, there must be a relationship of trust between them.

Higgs and Gustafson (1985:18) stressed the importance of health care workers remaining objective in their assessment of the community, also taking into consideration the perspectives which the community members have on their health care needs.

The most important function of any team is to set aims and objectives related to the problem of a particular area and to make decisions which directly affect the individual concerned. Another important function of the team is to provide a supportive framework, from a professional and sometimes personal point of view for team members. In the rural areas particularly, team members need planned and regular contact with the team where sharing, support, evaluation and new ideas can be found (Crouch 1986:2).

Professional people often asked the question as to how one would know that teamwork is the answer to the needs of persons suffering from schizophrenia. The answer to the challenge was as follows:

"Teamwork should not only be seen as an answer to the needs of the persons suffering from schizophrenia, although this is the ultimate goal. It also satisfies the needs of the various

members of the community, professions and allied worker who make up the team" (Crouch 1986:3).

There is no doubt that the number of skills available in the team is proportional to the type of care that the client receives. This is particularly relevant when considering the mental health care when carrying out a needs assessment. This approach has a vital role in the country's management of mental ill health in various communities.

In this context professionals and allied workers involved in teamwork should work together in a cohesive manner. The team needs to understand each other and cooperate with each other. Covering large areas with few team members, spreading skills thinly but effectively and using volunteers and less skilled workers will not occur, unless firm team cohesion is brought about.

In many cases, interdisciplinary interventions are required in meeting the needs of persons suffering from schizophrenia. Interdisciplinary interventions that cut across disciplines and across ministries of health, public housing, labour, finance, security and social welfare as well as the legal system.

The challenge is to prioritise those identified needs, to develop additional strategies and to replicate it in culturally appropriate ways, to enhance the success of each effort in diverse community settings (Poulton & West 1993:923).

2.13.1 Interagency coordination and linkage

In any geographic area, there are a variety of agencies responsible for providing a range of human services. As a programme is developed to address consumer needs, efforts should be made to avoid duplicating services already available. Coordinating and linking relevant service providers to meet an identified consumer need is generally economically advantageous. Planners occasionally make the unfortunate error of assuming that a programme can only be effective if one agency is involved. Unfortunately, due to competition for funds,

territorial disputes, personality conflicts, and other factors, some cooperative efforts do fail (Neuber, Atkins, Jacobson & Reuterman 1980:60). Needs assessment data is a tool which can be used to bridge some gaps between providers. If the needs assessment survey has been a multi-agency endeavour, the framework then exists for cooperative use of the data to address consumer needs.

2.13.2 Health policy

Health policy is any policy that constitutes the governing framework (structure, process, outcome) for providing health services on a local, state, national or even international level (Spradley & Allender 1996:203).

Structure is the number of and types of agencies, programmes and services, as well as providers and targeted clients (Harper & Lambert 1994:21).

Process is how the agencies, programmes and services are going to be provided, managed and funded, and how clients are to receive services (Keltner, Schweke & Bostram 1995:112).

Outcomes are the actual consequences of a health policy being implemented and are described in terms of effectiveness, efficiency, equity, innovativeness and empowerment (Spradley & Allender 1996:637). Figure 2.5 outlines a health policy from this perspective.

A health policy which influences the health and disease profile of the country, is therefore determined to a large extent by the level of importance that the government in power places on health, as well as the percentage of the national budget the government allocates to health (Dennill et al 1999:174).

Theoretically, a health policy should empower the community for which it is intended. A health policy also empowers the health care provider by deeming the provider's services as essential, subsidising the provider's education, and directly reimbursing the provider.

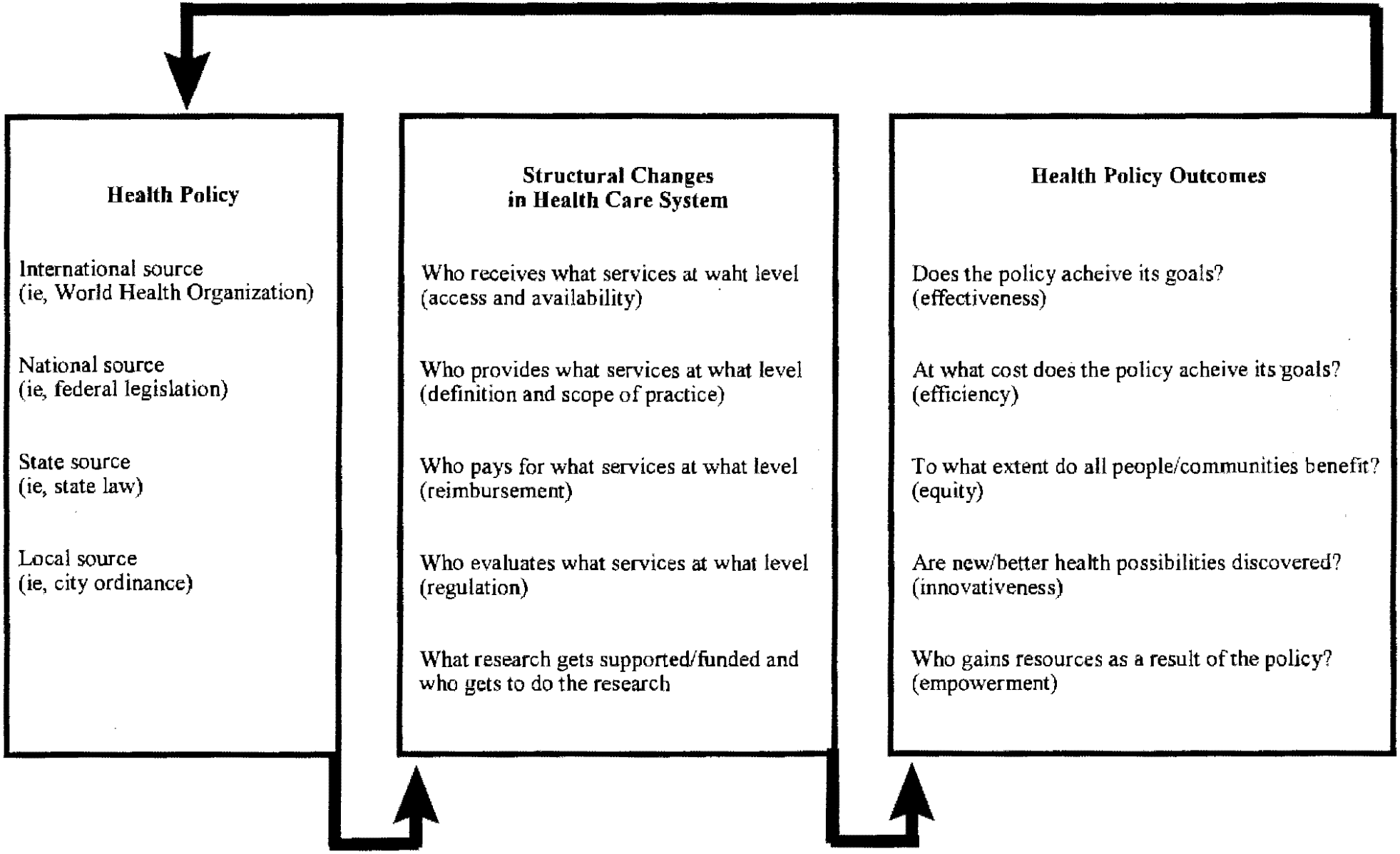

Figure 2.5
Health policy as a governing framework
(Spradley & Allender 1996:637)

Because a health policy affects a community's health status and determines who will be reimbursed for what by whom, politics are involved in every step of its development, implementation and education. When a health policy fails to provide a workable framework at the community level, the health care needs of communities are not met in a cost-effective ways (Spradley & Allender 1996:175).

While the development of mental health policies for needs assessment is essential, it is equally important to develop what Dr Julio Frenk of Mexico calls "healthy policies" at national and international level if progress is to be made in addressing many of the significant problems of persons suffering from schizophrenia (Frenk 1994:11).

For this reason explicit attention should be paid to the consequences of social and economic policies related to mental health by researchers, national government, private organisations and international agencies. Policies to be encouraged are those that promote gainful employment, reduce poverty, protect the environment, improve the quality of leisure time, provide universal basic education, primary health care, after care services and adequate nutrition.

- **Mental health policy services in South Africa**

Mental health policies in South Africa are not merely a concession to an abstract vision of social justice; they have real effects on the mental health of individuals and communities including:

- "A major initiative to upgrade the quality of mental health after care services in African continent because:

  — Mental health services have a crucial role to play in alleviating the sufferings associated with Schizophrenia, and this population can be helped substantially by competent mental health staff.

— With recent advances in psychiatric medications and specialised forms of psychosocial intervention, the potential for benefit for this population suffering from schizophrenia in the community is greater than at any time in history" (Department of National Health and Population Development 1994:31).

Yet, mental health after care services in most rural communities are inadequate. Well-trained practitioners are scarce, drugs and psychosocial interventions are unavailable or of poor quality, and even where expertise and resources exist, they seldomly reach into communities where the needs are the greatest (Department of National Health and Population Development 1994:31).

Lazare (1995:17) stated the following:

- Extensive and flexible use of a multidisciplinary team is required when using community services to manage the needs of persons suffering from schizophrenia.
- Assertive adaptability, ie recognition that there is no "quick fix" for the problems of designing service systems for the persons suffering from schizophrenia and that successful care models must address changes at many levels.
- Contextualisation, or keeping schizophrenic persons in a close contact with their usual geographic and interpersonal surroundings as possible, is necessary if support from the client's family network is to be enhanced.
- Normalisation, or supporting the persons as they apply problem-solving skills to activities of daily living, such as work and housing options is required to foster a sense of personal efficacy through real accomplishments, no matter how small, in a normal world.
- Preservation and enhancement of personal power and control among clients is essential. This can be achieved by providing information, exercising advocacy, helping to identify options and in general keeping persons engaged in self-care processes.
- Grievance procedures and mechanisms to protect the persons' rights in terms of his needs should be established.

- The effective use of formal and informal support systems by the person suffering from schizophrenia that assists them in identifying and meeting their needs.

Of importance to the schizophrenic person is the right to participate in the life of the community and the right to full personal identity as the social role of the person is redefined into not only that of a consumer, but also a policymaker and planner in order to change society's attitudes and the physical environments (Hoffmann 1986:28).

In this context the Declaration of Luxor (World Federation for Mental Health 1989:114) states the following:

Article 1

"Mental health promotion is the responsibility of governmental and nongovernmental authorities as well as the intergovernmental system and in keeping with WHO definition of health, health and mental health programmes shall contribute both to the development individual and family responsibility for personal and group health and to promoting the highest quality of life".

Article 4

"The fundamental right of persons who are labelled or diagnosed, treated or defined as mentally ill, shall be the same as those of all citizens"

These include the right to coercion-free, dignified, humane and qualified treatment with access to medically, psychologically and socially indicated technology, freedom from discrimination, regarding equitable access to therapy or inequitable restraint on grounds of political, socioeconomic, cultural, ethnic, racial, religious, gender or age status or sexual orientation.

The right to treatment shall include hospitalisation and outpatient or psychosocial treatment as appropriate, with the safeguards of accepted medical, ethical and legal opinions.

Article 4 is supported by the statement of President TM Mbeki who in his foreword to the "Integrated National Disability Strategy" stated that "the concept of caring is strengthened and deepened when we recognise that disabled (mental and physical) people enjoy the same rights as we do and that we have responsibility towards the promotion of their quality of life" (South African Federation, Mental Health 1999:15).

Article 5

All mentally ill persons have the right to be treated under the same professional and ethical standards as other ill persons. This standard must include efforts to promote the greatest degree of self-determination and personal responsibility on their part.

Treatment for persons whose capabilities for self-management have been impaired by illness shall include psychosocial rehabilitation aimed at reinstating skills for living and shall take into account their needs for housing, employment, transportation, income, information and continuing care after hospital discharge.

These human rights of persons shall require protection in terms of the Mental Health Legislation (Freeman 1999:4).

2.13.3 Community assessment of Mogoto Village

- **Community density**

Mogoto Village is not an overpopulated areas, as the area is big enough to accommodate its residents. Playgrounds are available though not well-developed. There are no parks nor nursing homes in this area. Cemeteries are allocated according to the subsections of this village. The area has got ± ten subsections under one headman.

- **Cultural blending and stability**

Despite the fact that the population consists of Ndebeles, Shangaans and North Sothos, there are few set values and traditions in Mogoto Village. These groups live in harmony without cultural tensions. The population is made up of a mixture of the aged, young married, couples with children and single parents. Females are in the majority. The majority of this population falls into the lower socio-economic groups and receives government or welfare help for health care. There are also a number within this community who represent a middle-class people and who, therefore, receive little or no financial help for health care (Northern Province, Southern Region 1996:175).

- **Educational level**

There is a mixture of different professionals in Mogoto village, such as, teachers and nurses. Individuals learn from formal schooling or informally from neighbours, friends and nurses during clinic visits. The majority of the persons suffering from schizophrenia have attended school up to the primary level but some did not attend school at all.

- **Traditional schools**

It should be noted that the traditional schools are for every young member of the community, but persons suffering from schizophrenia are not excluded. There are traditional schools for boys and girls who have reached puberty. Boys are sent to the mountains under the care of a traditional healer (man) and older men who have been to the mountains before. The boys are taught rules and the principles of manhood and parenting after the circumcision which is performed without analgesics. The proceedings at the mountains remain a secret amongst men and are never divulged to women or nongraduates of these traditional (male) schools.

Girls, during the initiation ceremonies, are kept indoors in a selected house under the care of a traditional healer (woman) and elderly women who know the rules and principles of the process. Candidates are preferably those who started menstruating for the first time. Girls

are also circumcised and taught the rules and principles of womanhood, childbearing and parenting. The proceedings remain a secret and are not divulged to nongraduates of these traditional (female) schools.

Some boys and girls take this "graduation" seriously and dropout from formal education as they regard themselves as mature enough to attend the initiation schools' objectives.

- **Available transport**

Transport is limited. There are several bus stops around the village with the taxis stopping where the individuals instruct the drivers to do so.

- **Population, size and distribution**

According to the 1997 census, Mogoto has a population of 63 000 (Northern Province, Southern Region 1996:175).

The able-bodied male members of the community have moved to urban areas in search of employment, leaving behind the women, children, the elderly and the mentally and physically disabled.

- **Accommodation**

There is no formal nor informal government or private accommodation for psychiatric persons in and around the village or in nearby villages. Persons stay with families and some with relatives.

- **Employment opportunities**

The unemployment rate is high. Educated and healthy people currently find it difficult to get employment. This situation becomes even more complicated and serious for psychiatric

persons. There are also no long range employment opportunities in this area.

- **Psychosocial clubs for skills and development**

There are no social clubs, recreational or special facilities for socialising in which psychiatric persons can develop skills that will help them fit in the community, such as, women's or men's clubs with common goals, tennis courts, recreational halls and play fields for various sports activities.

- **Multidisciplinary mental health support services**

Persons suffering from schizophrenia in the Mogoto Village depend upon the nurses at the local clinic or when visiting the local hospital. There are no active multidisciplinary mental health support services available for this group of persons.

- **Available community resources**

Community resources that are available include crèches, preschools, primary and high schools. The hospital is situated seven km from the village. Shops, for example, spa's, general dealers, café's and hard ware stores, are distributed all over the village with a large chain group of wholesalers in the village. There is one clinic available in Mogoto Village. It is situated at a walking distance for the community. There are no formal self-help or support groups although community members have different groups with different objectives and goals, which appear to be of little assistance to the person suffering from schizophrenia.

2.13.4 Treatment of ethnic groups

It would appear from the literature that Black persons are often inappropriately diagnosed as being schizophrenic by white practitioners. This could relate to cultural beliefs not fully understood by Western health care workers, but it may also be the result of communication problems and the process of translation or be related to inadequate attention being given to

eliminating other conditions which mimic schizophrenia (Uys 1994:313).

In this context controversy also exists over the effectiveness of psychotherapy for ethnic minority persons, especially when given by white therapists. Some researchers and practitioners believe that ethnic persons are less likely to benefit from such treatment. Others maintain that ethnic persons are just as likely as whites to show favourable outcomes from treatment and that ethnic or racial matching of person studies have failed to show different outcomes on the basis of the race or the ethnicity of patients and clinicians. However, ethnic matches could also result in cultural mismatches, as persons and clinicians from the same ethnic group may show markedly different values (Lefley 1990:277).

Conversely, ethnic mismatches may be cultural matches because persons and clinicians from different ethnic groups may share similar values, lifestyles and expectations. Thus sociocultural sensitivity refers to respect for individual differences regardless of one's age ethnicity, gender, education, income and belief system.

The consideration of all these characteristics and the ability to individualise persons' care appear to be the best predictors of treatment outcome (Stuart & Sundeen 1996:167).

- **Human resources for the health team**

During 2000 the human resources in the Mogoto Village consisted a registered nurse, a registered midwife, an enrolled nurse, an assistant nurse and three general workers (one cleaner and two security men).

There was no social worker stationed at this village. The available social worker allocated to Mogoto Village was permanently stationed at Groothoek Hospital. The visiting social worker visited the village when there was an urgent or an ongoing case requiring assistance. Persons suffering from schizophrenia who experienced social problems related to finance, lack of food or family disputes, visited the social worker at Groothoek Hospital on their own or could be referred from the clinic by the registered nurse.

There was no psychologist based in Mogoto Village. Persons had to travel to Groothoek Hospital to consult with the visiting psychologist who visited the hospital on Wednesdays and Thursdays. The psychologists came from the University of the North and some from the University of Pretoria.

There was one female white psychiatrist, assisted by an Indian medical doctor and rotating interns. The psychiatrist and her colleagues were all stationed at Groothoek Hospital and did not visit the clinic. Persons suffering from mental illness, including schizophrenia visited the therapists when referred to them. The racial difference referred to in 2.13.4 raised questions as to whether ethnic minority persons should be treated by white therapists.

There were eight traditional healers and five faith healers known in Mogoto Village. Throughout the exposure to psychiatric persons, most persons consulted either the traditional or faith healers or both before seeking psychiatric help. This was influenced by the belief in witchcraft and ancestral powers (Northern Province, Southern Region 1996:216).

There was one medical practitioner in the village. His services were utilised by those who could afford to pay him. This excluded most psychiatric persons, especially those suffering from schizophrenia, as most of them were unemployed or came from the lower socio-economic groups within the community.

2.13.5 Interdisciplinary collaboration in Mogoto Village

- **Traditional healers and other health care providers**

Through discussions, awareness campaigns and workshops held with different leaders from both traditional and faith healers, referral systems did not appear to be a major problem. Persons were often referred from both traditional and faith healers to the clinic for further management by the medical and nursing staff. On discharge from the psychiatric institution some of these persons continued to make use of both medical and indigenous health services. Emphasis was given to these healers on the importance of encouraging their "clients" to

continue with their medications and to come for follow-up treatment to avoid relapses. Traditional and faith healers performed rituals, for example, making the person vomit or giving enemas before the person could take his/her medication (Felhaber 1999:98; Swartz 1998:195). The private medical practitioner from Mogoto Village did refer some of the persons to the hospital either for further management by a psychiatrist, psychologist, social worker or even for admission to the psychiatric wards at Groothoek Hospital.

- **Nursing**

Nursing staff attended to all persons referred from other disciplines such as faith healers, traditional healers and sangomas. They also referred persons to other health team workers, for example, psychologists, social workers and occupational therapists, as the needs arose.

The growing recognition that persons suffering from schizophrenia are a heterogeneous population with a multiplicity and diversity of needs has led to the recognition and utilisation of the theory for the whole person. By assessing this population's multiple-diverse needs, those involved with the case will obtain greater insight and plan programmes relevant to these needs.

- **Holism, paradigms and needs assessment**

Central to the discussion of different practice paradigms, is the theoretical framework, selected by the caring professional for practice in the field of needs assessment, is a definition of the term "wholism" as used within this context. A practice paradigm defines the location of unmet needs/problems experienced by persons suffering from schizophrenia as being mainly within the realm of the physical and social environments in terms of the limitations imposed by these environments (Slade 1994:294).

A holistic community-based mental health needs assessment programme should be planned and coordinated at the national, provincial, district and community levels and integrated with the needs of other health services in order to share decision on identified needs and work together toward programme planning.

The basic philosophy of a needs assessment programme is that living skills and social skills lead to increased self-esteem and confidence and better integration into the community emphasising achievements and strengths which encourage persons to be active participants in identifying their own needs. Needs assessment information provides important input into the planning process. Without adequate information gathered during the needs assessment process, no effective planning might be possible.

There is also a need for close supervision of clients in the community by an interdisciplinary team consisting of a physiotherapist, occupational therapist, nurse and social worker depending on the nature of the need as this will ensure a holistic approach to needs assessment and cooperation of all concerned (Chabalala 1997:522).

Mental health care in rural areas might be one of the most neglected areas of health care in South Africa due to policies that limit the fundamental rights of these persons. The primary stumbling block in developing effective plans for rural interventions is the lack of concrete data concerning the needs of rural persons suffering from schizophrenia as well as the lack of affordable services.

According to Ong (1991:638) "Needs issues include elected representatives to legislature and congress appointed or elected governmental personnel, programme funders, tax-payers, administrative and service personnel and other community service providers, community residents and persons themselves". This team can establish the kind of services considered essential for a comprehensive system determined by the functional characteristics of persons suffering from schizophrenia.

Each person in this paradigm is considered as "whole" with many factors contributing to health and illness. In the needs assessment process various settings (clinics and homes) within which the individuals function influence their health/illness.

As a discipline, nursing is faced with the responsibility of establishing networks of committed people for the care of persons suffering from schizophrenia in order to assist them to meet their needs, and develop their potentials without being unnecessarily isolated from their communities. Needs assessment is geared to the participants' environments of choice, and care givers are assisted and supported in adjusting their environment and treatment to meet more effectively the needs of significant others.

The goal would be to assist each person to compensate for deficits related to the mental illness, through advancing coping skills and a supportive environments. Often individuals needs to develop and practise community living skills. These skills may include personal hygiene, housekeeping, street survival, use of public transportation, social skills, problem-solving, prevocational skills, and any area of persons' lives affected by psychiatric disabilities (Breakey 1996:288).

Such strategies will help in counteracting the effects of secondary symptoms by restoring a sense of confidence and building on the strengths of each person, emphasising wellness rather than illness. This can be achieved by considering the following principles according to Breakey (1996:288):

- A belief in the potential for growth and change in the most severely disabled persons. Hope is an essential ingredient in this process.
- The whole person, not the illness, is the focus of care. "Personhood rather than patienthood".
- Behaviour and functioning, not symptoms, are the focus of interventions. "Health induction rather than symptom reduction".
- Minimise the distance between practitioners and clients/members in order to strengthen the working partnership between them.

- Programmes and services are oriented towards the practical, day-to-day needs of each person.
- All interventions are based on the principle of client self-determination. Efforts are made to involve the client/member as an active participant in all areas of the programme.
- Programmes and services provide opportunities for people to participate as fully as possible in normal roles and relationships in the community.
- Unnecessary hospitalisations are avoided.
- Interventions are designed to meet the individual needs of each person.
- The development of coping skills is a major goal.

2.14 CHALLENGES FACING THE NURSING DISCIPLINE

Persons suffering from schizophrenia experience problems in meeting their needs thus presenting a particular challenge to the health care workers (Bachrach 1982:40). As a discipline, nursing is faced with the responsibility for networking the care of persons suffering from schizophrenia by people committed to assist this vulnerable population to meet their needs and develop their potentials without being unnecessarily isolated or excluded from the community.

In the previous era in South Africa the mental health system, through its institutions, took responsibility for meeting the needs of people with schizophrenia. Responsibilities remain fragmented at state and community levels posing a particular challenge at community level to design and maintain service networks that are truly comprehensive. This service network should ensure that the persons' unmet needs are met but should not meet needs that the person is able to meet himself, implying that self-sufficiency should be promoted and dependency diminished as far as possible (Turner & Shifren 1979:11).

This poses a challenge for nurses in terms of seeking mechanism, for identifying persons in need and the ability to offer appropriate services. Nurses should engage and involve concerned community members in such ways as to maximise the contribution of natural

helping networks, self-help groups and voluntary community organisations in meeting the needs of the target population. There should be provision for the binding, integration and coordination of all services needed for particular persons (Bachrach 1982:41).

The kinds of services considered essential for a comprehensive system should be determined by the functional characteristics of persons suffering from schizophrenia, including:

- Difficulty with tasks of daily living.
- Recurrent problems in meeting basic survival needs.
- Extreme vulnerability to stress.
- Lack of either motivation or the ability to seek help from human service workers.
- The tendency towards episodes of "acting out" behaviour that may interfere with the well-being of themselves or others.
- A lack of ability to develop personal social networks and the fact that these illnesses (schizophrenia) or disabilities are not usually remediable by short-term treatment (Turner & Shifren 1979:3).

Because of this, their primary social roles may remain those of persons or clients rather than as useful members of society. Another challenge comes from the problems these persons have in sustaining rewarding interpersonal relationships. Like all of us, persons suffering from schizophrenia need others who care about them as unique persons.

This is regarded as an enduring pattern of continuing or intermittent ties that play a significant part in maintaining the psychological and physical well-being of the individual (Turner & Shifren 1979:3). It is therefore important for nurses to have organised service systems designed to help persons suffering from schizophrenia (and other vulnerable people) to meet their life support needs. Opportunities should be provided for them to become useful members of society and to overcome the limiting effects of their mental or emotional disorders.

2.15 CONCLUSION

This chapter provided basic information concerning a needs assessment process with regard to persons suffering from schizophrenia. For the process to be successful, the theoretical framework of "wholism" formed the basis on which individuals' needs could be assessed. "Wholism" refers to physical, mental and spiritual wholeness of the individual.

Health and illness were viewed as the two opposite concepts on the health-illness continuum. In this context a person's patterns of interactions with his internal and external environments determined his health status. Health potentials do exists even in those who are ill. Such potential could be enhanced if these persons' health care needs could be met, based on effective assessments of such needs.

This chapter also contributed to the understanding that despite problems, difficulties and weaknesses, a person suffering from schizophrenia should always be approached in terms of wholism.

Chapter 3 will provide an overview of the methodology adopted to conduct this research.

The purpose of this research is to assess the health care needs of persons with schizophrenia living in a specific community – as the first step in a process of providing more effective health care services in this community.

CHAPTER 3

Research methodology

3.1 INTRODUCTION

This chapter outlines the procedure used to obtain data. It also describes the study design, the population, the sampling techniques, the research instruments used as well as the ethical aspects involved in this research project.

3.2 SUMMARY OF THE MODUS OPERANDI THAT WAS FOLLOWED

The following steps were followed in order to complete this research project:

- A preparatory in-depth literature study was undertaken in order to provide background information necessary to proceed with the required research.
- Key concepts were defined or explained.
- A questionnaire was designed to be used during data collection.
- The researcher applied for permission to conduct the research project (annexure 1).

- Permission to conduct the research project was obtained from Groothoek Hospital Research Committee (annexure 2); Department of Health and Welfare (training section) (annexure 3).
- A convenience sampling technique was used.
- With the help of a computer program and operator, data was coded and analysed.
- The analysed data was presented in tables and graphs.

3.3 RESEARCH METHODOLOGY

3.3.1 Purpose of this research

The purpose of this research was to identify and assess the needs of persons suffering from schizophrenia in Mogoto Village.

3.3.2 Research design

A quantitative, exploratory, descriptive design, using a close-ended questionnaire, was used in this study. This type of research design was considered to be appropriate as the researcher was interested in determining how the participants perceived their needs as little was known about the perceptions of these persons suffering from schizophrenia (Bush 1985:60; Woods & Cantanzaro 1988:156; Nieswiadomy 1993:157; Brink 1996:116).

The design was chosen because

- there was no manipulation of the dependent variable by the researcher
- the researcher observed the action of one variable as it occurred in the natural setting
- it was flexible and broad in scope
- large samples could be obtained
- it collected information about people's actions, knowledge, intentions, opinions, attitudes and values

3.3.3 Steps adopted while evaluating effectiveness of design

In evaluating the effectiveness of the design, the likelihood of four critical factors were considered:

- That the design would address the research question.
- That the design would produce results that are meaningful.
- That the design would demonstrate any cause implied in the study question.
- That the results were generalisable to other similar situations (Mouton 1996:103).

- **Population and sampling method**

A population is the entire aggregation of cases that meets a designated set of criteria (Polit & Hungler 1997:223). Sampling refers to the process of selecting a portion of the population to represent the entire population.

- **Sample**

A sample refers to the sum of individuals within a specific territory or a small portion of a population or a smaller representation of a larger whole, intended to reflect and represent the character, style or content of a population from which it is drawn (Brink 1996:133). In this research 60 patients suffering from schizophrenia were selected at the clinic from Mogoto Village.

There was a total number of 108 psychiatric patients at Mogoto Village of which 88 were diagnosed with schizophrenia. This number did not include patients who preferred to be treated at the hospital due to the stigma attached to their psychiatric conditions.

3.4 SAMPLING METHOD

A sampling method refers to the process of selecting the sample from a population in order to obtain information regarding a phenomenon in a way that represents the population of interest (Brink 1996:133). Using a convenience sampling technique 60 persons suffering from schizophrenia were selected by the registered nurse at Mogoto clinic. This registered nurse had full knowledge about these persons at the clinic as she was in frequent contact with them.

- **Sampling criteria**

The persons were selected in accordance with the following criteria:

Those selected were:

- persons aged between16 and 65 years, irrespective of being male or female
- individuals diagnosed with schizophrenia that had resulted in impairment in either social relations or daily living functioning or some impairment in both these areas
- those who were oriented to time, place and person and were not paranoidal at the time of the investigation, suicidal and who had no secondary diagnosis of substance abuse or organic mental disorders
- those who attended the clinic

3.5 DATA COLLECTION

Data was collected from two sources.

- **Secondary data**

Secondary data was from community health nurses, health inspectors, social workers, historical documents such as hospital and clinic statistics and research reports. These sources were discussed in greater detail in chapter 2.

- **Primary data**

Primary data was the data collected by the researcher from the respondents as follows:

- The researcher met each respondent at the clinic and at his or her home for completing the questionnaire
- The questionnaire was completed by the researcher in cases where respondents could not read and/or write.
- During the session the researcher explained in more detail the purpose of the research and its significance in order to increase the respondents' understanding of the meaning of the questions and to encourage them to answer all questions carefully and as completely as possible. The researcher was available to answer any questions.

3.6 RESEARCH INSTRUMENT

The specific tool, often a questionnaire or interview guide, used to measure the variables in a study is called a research instrument (Spradley & Allender 1996:604).

In this research the following instrument was used:

3.6.1 Questionnaire

A questionnaire was used as it is a useful self-report instrument where the respondents were required to write their answers in response to questions asked (annexure 5).

Questionnaires were selected as

- they guide the researcher in obtaining data
- they are less expensive in terms of time and money
- they are the easiest research instruments to test for reliability and validity

- subjects/respondents feel a greater sense of anonymity and are more likely to provide honest answers
- the format is standardised for all respondents and is not dependent on the mood of researcher (Polit & Hungler 1997:259)

3.6.2 Design of the instrument

Based on the literature study which was undertaken, the questionnaire was designed to be used during the data collecting process. The aim was to assess the needs of persons suffering from schizophrenia in Mogoto Village and their own perception of their needs. All respondents were assured of anonymity as their names and addresses would not be revealed in the collected data.

3.6.3 Format of the questionnaire

A total of 115 questions were included in the questionnaire. Questions were constructed as closed-ended questions with alternatives from which to choose an answer. In certain instances some questions had to be further discussed with the respondents in order to ensure that they understood the meaning of the specific questions.

Valuable information was obtained in this manner which would not have been achieved if the questionnaires had been distributed to be completed by the respondents on their own.

The questionnaire was subdivided into different sections concerned with the following aspects:

- Section A of the questionnaire was concerned with general information of the respondents.
- Section B dealt with the assessment of the physical, psychological, social, emotional and spiritual needs of persons suffering from schizophrenia.

- Section C was concerned with the support systems that the respondents used to cope with life's problems.
- Section D attempted to identify the community resources that the respondents utilised to use their remaining capabilities and to remain in the community.
- Section E attempted to prioritise those needs as stated by the respondents themselves.

In designing the questionnaire the researcher tried to ensure that it was free from bias by giving the same questionnaire to each respondent. It was also constructed in such a way as to facilitate the easy administration thereof, as well as to satisfy computer coding requirements in preparation for later computerisation of the responses. Each question was given a code for subsequent computerisation.

3.6.4 Validity and reliability

To evaluate the instruments' accuracy, two tests were used, namely validity and reliability (Spradley & Allender 1996:609). Guyatt (1993:461) points out that "questionnaire design can be problematic and that scales need to be adequately tested for their reliability and validity, and these are the two important criteria by which an instrument's quality is evaluated". According to Polit and Hungler (1997:467) "an ideal instrument is one that results in measures that are relevant, accurate, unbiased, sensitive, undimensional and efficient". After the instrument was developed, it was tested for its validity and reliability before the actual data collection was done.

3.6.4.1 Validity

Brink (1996:124) and Nieswiadomy (1993:204) agree that validity refers "to the extent to which the instrument measures what it is supposed to measure". Validity is concerned with soundness and the effectiveness of the measuring instrument. It is the assurance that an instrument measures the variables it is supposed to measure. In this research a written questionnaire was the instrument used. Questions included were evaluated to make certain they were appropriate to the subject (content validity) and whether the variable of interest

(needs) was actually being measured (construct validity).

- **Content validity**

This refers to the extent to which the instrument samples the situation under study. Nieswiadomy (1993:205) defines content validity as the representativeness of the behaviours samples by a measuring device, the extent to which an instrument samples "... all relevant aspects of the domain of behaviours which are to be assessed" and concerned with the scope or range of items used to measure the variable. It is concerned with how accurately the questions asked tend to elicit the information sought (Leedy 1992:25; Treece & Treece 1986:265; Polit & Hungler 1997:375). Content validity involves getting a panel of judges or rather experts in the field under study to review and analyse all items to see if they adequately represent the content universe (Seaman 1987:318). In this study, to test content validity, the instrument was given to the members of the multi-disciplinary team, namely:

- A psychiatrist from Northern Province
- A psychologist from University of the North
- A social worker from Groothoek Hospital
- Nurse educators from the University of the North and from Groothoek Nursing School (psychiatric nursing)
- District Health Services (DHS) staff for Greater Zebediela

The above members were requested to examine the instrument and to add items which they felt were necessary to take out items which they deemed to be irrelevant (annexure 4). The instrument was also sent to the research project supervisor and to the Department of Statistics at the University of South Africa (Unisa). The supervisor together with the statistician approved the instrument containing the questions pertained to the details of psychiatric patients' needs assessment.

- **Face validity**

Face validity refers to whether the instrument appeared to be measuring what it purported to measure, was found to be present because all questions in the instrument appeared to focus on the selected topic of needs assessment of suffering from schizophrenia in Mogoto Village (Treece & Treece 1986:130).

- **External validity**

External validity refers to the degree to which the results of a study can be generalised to settings or samples, other than the ones studied (Brink 1996:125). In this study the researcher provided a detailed database and dense description so that someone other than the researcher could determine whether the findings of the study were applicable in other settings or contexts where the method of data collection was precisely and thoroughly reported (Woods & Cantanzaro 1988:318; Brink 1996:124).

- **Threats to external validity**

- *Selection of respondents*

All the psychiatric patients diagnosed with schizophrenia who were receiving their monthly treatment from Mogoto clinic were used in the study, thus the research population was a convenience group of respondents. Respondents were selected with the study style and purpose in mind to ensure an appropriate population was used (Talbot 1995:214).

- *Setting*

The correct setting in which to collect the data is important to eliminate threats to external validity. The study was done in the natural setting because the purpose of the study was to analyse a phenomenon occurring in the community were persons suffering from schizophrenia live (Talbot 1995:214).

- *History*

The influence of previous research was not applicable, neither was the issue of a research grant and the resultant responsibilities and expectation (Talbot 1995:214), therefore history posed no threat to the external validity of the study.

3.6.4.2 Reliability

Nieswiadomy (1993:201), Brink (1996:124) and Polit and Hungler (1997:367) agree that reliability refers to "the degree with which the instrument measures the attributes it is supposed to be measuring". Reliability entails the stability, consistency, accuracy and dependability of a measuring instrument.

Muller (1996:54) gives the guidelines on how the reliability of validation results can be controlled. The researcher adopted these guidelines in ensuring the reliability of the validation results. These guidelines are:

- Clearly written and/or verbal instructions are given to participants.

- The anonymity of the respondents will be assured, in order to encourage objectivity and honest debate and grading of the standards.

3.7 ETHICAL CONSIDERATIONS

In this research, human beings were the respondents. As such, great care was taken to order to protect their rights. Permission to conduct the research at Groothoek Hospital, Psychiatric Department, was requested through the Medical Superintendent in writing (annexure 1) who referred the application to the Hospital Training Committee which also responded in writing (annexure 2). The application was further referred to the Secretary, Department of Health and Welfare, Training Section, Southern Region, who responded in writing to confirm the permission to continue with the study project (annexure 3).

In addition to the ethical consideration stated above, the researcher also ensured the protection of human rights which are claims and demands that have been justified in the eyes of an individual or by the consensus of a group of individuals (Burns & Grove 1999:340). Having rights is necessary for the self-respect, dignity and health of an individual.

Apart from permission obtained from the various authorities mentioned above, the following ethical principles were followed during the research process.

- **The right to self-determination**

The right to self-determination is based on the **principle of respect** for persons, which states that humans are capable of self-determination or controlling their own destiny (Burns & Grove 1999:340). In this research participants were treated as autonomous agents, who had the freedom to conduct their lives as they chose without external control from the researcher.

These participants were informed about the proposed study and were allowed to voluntarily choose to participate or not to participate. The participants were free to withdraw from the study at any time without any penalty. No treatment nor nursing care was withheld from those who elected not to participate. All participants were aware that they were research subjects of this study and none were coerced to participate. No deception took place during the study, as participants were fully informed, with explanations done in their own language (Northern Sotho) about the purpose of the study.

- **The right to privacy**

A major ethical issue in most researches is the invasion of privacy (Neuman 1997:264). Privacy is the freedom an individual has to determine the time, extent and general circumstances under which private information will be shared with or withheld from others (Burns & Grove 1999:342).

From the South African Nursing Association's (1991:2) perspective, privacy means that "a person can behave and think without interference, or the possibility of private behaviour or thoughts being used to embarrass or demean that person at a later stage". In this study a quiet relaxed private room was used for completion of the questionnaire by respondents without interference from any source whatsoever and for respondents who could not read and write the questionnaire was completed by the researcher.

The participants were informed about the purpose of the study and consented to participate. They voluntarily shared the information with the researcher. The respondents thus had the right to decide when and to whom to reveal personal information.

- **The right to confidentiality and anonymity**

Based on the right to privacy, research subjects have the right to anonymity and the right to assume that data collected will be kept confidential (Burns & Grove 1999:343). Anonymity exists if the subject's identity cannot be linked, even by the researcher, with the individual responses given.

According to the South African Nursing Association (1991:2), confidentiality and anonymity means that "any information that a subject divulges will neither be made public or available to others". When the subject agrees to take part in a research project this right is waived, as information has to be made public in research reports. Anonymity for the subjects was ensured through the design and coding of the questionnaire and the fact that the names of participants did not appear on the questionnaires.

- **The right to fair treatment**

The right to fair treatment is based on the ethical principle of justice. This principle states that "each person should be treated fairly and that the person should receive what he or she is due or owed" (Burns & Grove 1999:344).

In this research, the selection of subjects and their treatment during the course of the study was fair as

- subjects were selected for reasons directly related to their problems and the needs assessed

- **The right to protection from discomfort and harm**

The right to protection from discomfort is based on the ethical principle of beneficence. The research project should benefit the participating individual and society in general (Parahoo 1997:78; Burns & Grove 1999:345).

Due to the fact that the research was a quantitative, exploratory and descriptive study, there were no anticipated negative effects for the subjects.

- **The right to informed consent**

A fundamental ethical principle of social research is "to never coerce anyone into participating. Participation should be voluntary" (Neuman 1997:450). Consent also means participating in the research study out of one's own free will without any undue pressure or intimidation of any kind, after having received all the pertinent information relating to the research project and having understood this.

In this study the following explanation was given to the subjects:

- Purpose of the research
- Objectives of the research
- Method or the procedure to be used
- Duration of the study
- The type of participation expected from the subject
- How the results could be used and published
- The identity and qualifications of the researcher and supervisors
- How confidentiality, anonymity and privacy would be safeguarded

- **Waived consent**

The requirement for written consent was waived in this study as subjects could withdraw at any time (Burns & Grove 1999:353). The subject's completion of the questionnaire served as consent. The following statement was given at the beginning of the questionnaire: "Your completion of this questionnaire indicates your consent to participate in this study" (see questionnaire). In addition, subjects received verbal explanations that provided the essential information for informed consent.

3.8 PRETESTING OF THE INSTRUMENT

On completion of the questionnaire, a small scale trial run was conducted. A pretest is a small scale trial run of the major research study, which is done before the actual major research can be carried out (Nieswiadomy 1993:200; Brink 1996:174). The pretest was conducted to

- establish the instrument's content validity
- ascertain the clarity and reduce any ambiguity in the wording of the items
- determine how long it would take for the researcher and the subjects to complete the questionnaire
- determine the weaknesses in the administration and organisation of the questionnaire
- enable the researcher to make improvements and corrections prior to embarking on the actual data collection phase (Nieswiadomy 1993:200)

A pretest was conducted on five persons, diagnosed with schizophrenia who were purposely selected from Mogoto clinic. They were chosen from this clinic as it was the place were the research took place and it was convenient for both the researcher and the respondents. Selection of the respondents depended upon the availability of subjects. The registered nurse-in-charge of Mogoto clinic was requested to note who met the criteria for the research and to refer them to the researcher. The purpose of the research was explained to the respondents. Questions which were not clear to the respondents were rephrased. No undue pressure to answer any question was exerted to any respondent if he or she did not feel like answering. It took 30 to 35 minutes to complete the questionnaire which was regarded as too long considering the persons' actual concentration span. The second pretest was carried out with other respondents diagnosed with schizophrenia from the same clinic, but not included in the first pre-test. The questionnaires were completed within 25 minutes which was regarded as more feasible. None of the respondents who participated in the pre-test were included in the actual research.

3.9 DATA ANALYSIS

Data was analysed with the assistance of a statistician using the Statistical Package for Social Scientists (SPSS) statistical software package. Analysis of assessed data is used to suggest new interventions and to uncover certain overlooked needs. The collected data will be presented in graphs, tables and diagrams and these findings will be discussed in chapter 4.

3.10 SUMMARY

Involvement in needs assessment research can be an exciting opportunity to contribute to the body of nursing knowledge and influence changes in community health programmes and policies. This chapter highlighted the methodology that was adopted to complete this research. A quantitative, exploratory, descriptive research design was chosen and a questionnaire was used for collecting data. The instrument was tested for validity and reliability. The target group for this study was persons suffering from schizophrenia from Mogoto Village. They were involved because their participation in their needs assessment might help to redress the imbalance between needs defined normatively and those expressed by the persons suffering from schizophrenia. As human beings were participants, great care was taken throughout the process to protect their rights. An analysis of data collected from completed questionnaires will be presented and discussed in chapter 4 of this report.

CHAPTER 4

Discussion of the findings

4.1 INTRODUCTION

In this chapter, the statistical analysis of data obtained from the questionnaires will be analysed using the SPSS and discussed according to the research objectives specified in chapter 1.

4.2 RESEARCH OBJECTIVES

The research objectives aimed to identify and describe the:

- **physical needs** of the persons suffering from schizophrenia in Mogoto Village, Zebediela
- **psychological needs** of the persons suffering from schizophrenia in Mogoto Village, Zebediela

- **social needs** of the persons suffering from schizophrenia in Mogoto Village, Zebediela
- **emotional needs** of the persons suffering from schizophrenia in Mogoto Village, Zebediela
- **spiritual needs** of the persons suffering from schizophrenia in Mogoto Village, Zebediela
- **economic needs** of the persons suffering from schizophrenia in Mogoto Village, Zebediela
- **educational needs** of the persons suffering from schizophrenia in Mogoto Village, Zebediela
- **support systems** for the persons suffering from schizophrenia in Mogoto Village, Zebediela
- **resources available** for meeting the needs of the persons suffering from schizophrenia in Mogoto Village, Zebediela

4.3 SUBSECTIONS OF THE QUESTIONNAIRE

The findings are discussed in terms of the following subsections:

- **Section A: Demographic data**

- **Section B: Needs of persons suffering from schizophrenia**

- Basic physiological/physical needs
- Psychological needs
- Social needs
- Emotional needs
- Spiritual needs

- **Section C: Support systems**
- **Section D: Community resources**
- **Section E: Service needs**

4.4 SECTION A: DEMOGRAPHIC DATA

In this section, demographic data related to the respondents is presented.

Item A1: Home language (n=60)

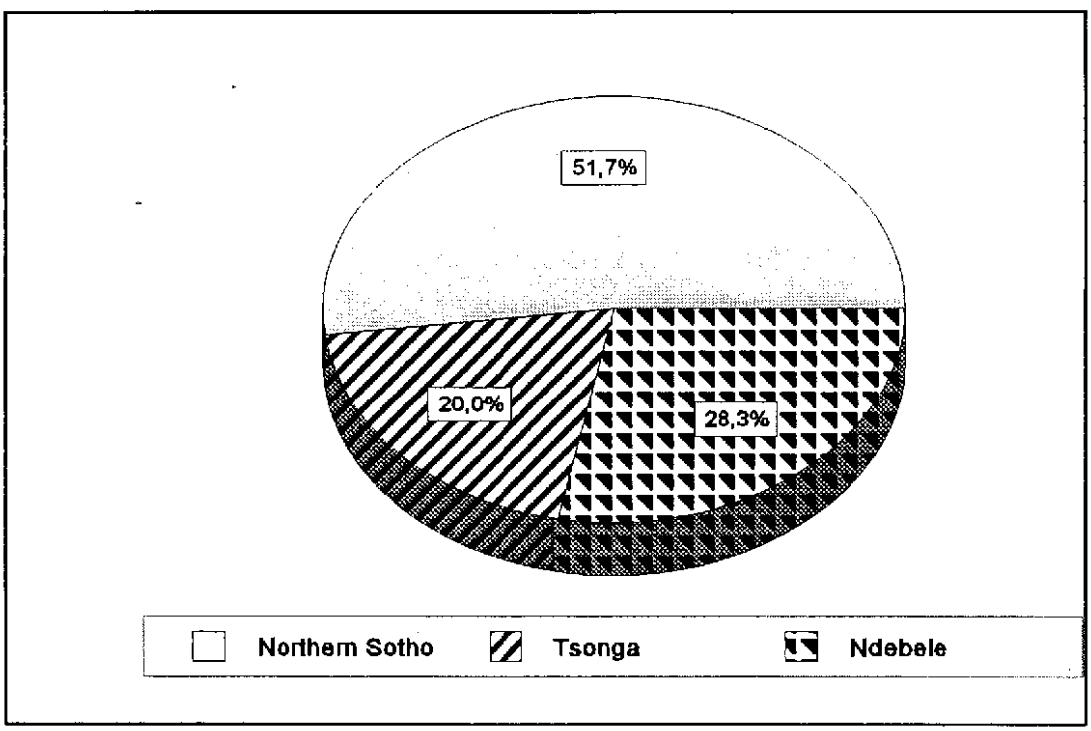

Figure 4.1

Home language (n=60)

More than fifty-one percent (51,7%; n=31) of the respondents indicated that their home language was Northern Sotho; twenty percent (20%; n=12) indicated that they were Tsonga speaking; and more than twenty eight percent, (28,3%; n=17) were Ndebele speaking (see figure 4.1).

The majority of the respondents therefore belonged to the Northern Sotho group. Those from other language groups did speak and understand Northern Sotho. They did, however, speak their own home languages when they were with their families. The explanation of questions was done in Northern Sotho as it was the language that all respondents understood. The use of Northern Sotho did not pose any difficulties for either the researcher nor the respondents.

Item A2: Gender (n=60)

Both males (51,7%; n=31) and females (48,3%; n=29) took part in this research. It would appear that schizophrenia was equally prevalent among men and women in Mogoto Village.

Item A3: Age (n=60)

Table 4.1: Age (Items A2 and A3) (n=60)

AGE	GENDER				TOTAL	
	MALE		FEMALE			
	n	%	n	%	n	%
21-40 years	15	48,4	11	37,9	26	43,3
41-60 years	16	51,6	18	62,1	34	56,7
TOTAL	**31**	**100,0**	**29**	**100,0**	**60**	**100,0**

The majority of the respondents, approximately fifty-seven percent (56,7%; n=26) fell within the age group of 41 to 60 years; almost fifty-two percent (51,6%; n=16) were males and sixty-two percent (62,0%; n=18) females. The total number of respondents aged between 21 and 40 years both males and females was just over forty-three percent (43,3%; n=26), and almost fifty-seven percent (56,7%; n=34) of the respondents were between 41 and 60 years of age (see table 4.1). These findings indicated that there were more females than males at certain peak ages of schizophrenia in this sample. These findings were consistent those of Stuart and Sundeen (1995:476) who stated that "about ninety percent (90,0%) of the

persons being treated for schizophrenia are between 15 and 55 years old".

It would appear that more than half of all male persons suffering from schizophrenia and only a third of all female persons suffering from schizophrenia had their first episodes before the age of 25. This was apparently consistent with what Kaplan, Sadock and Grebb (1998:461) found, reporting that "the peak ages of onset of schizophrenia for men are 15 to 25 and for women the peak ages are 35 and above". Referring to table 4.1, it can be seen that there were more males, approximately forty-eight percent (48,4%; n=15), than females, approximately thirty-eight percent (37,9%; n=11,) who were affected by schizophrenia and that in the age group between 21 and 40 there were more females, approximately sixty-two percent (62,1%; n=18). All of the respondents approximately fifty-two percent (51,6%; n=16) fell between 41 and 60 years.

Item A4: Marital status (n=60)

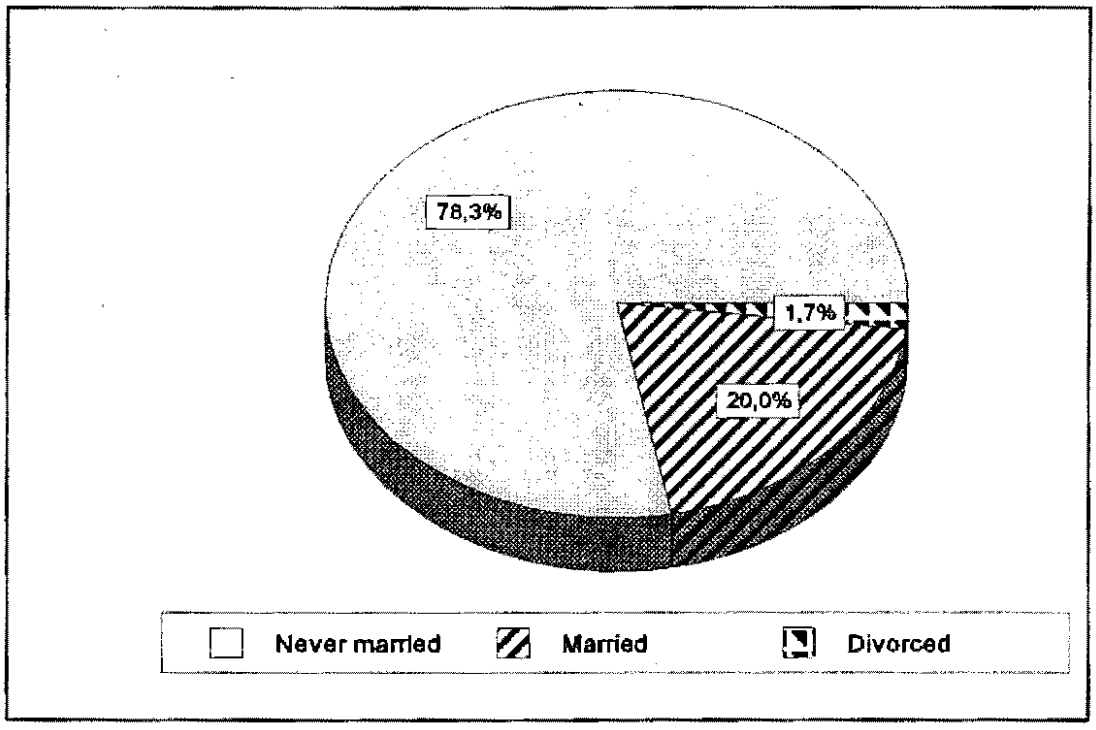

Figure 4.2

Marital status (n=60)

The majority of the respondents, approximately seventy-eight percent (78,3%; n=47) never married, twenty percent (20%; n=12) were married; and approximately two percent (1,7%; n=1) were divorced (see figure 4.2).

None of the respondents was separated, widowed or had his/her or marriage annulled. This high percentage (78,3%) of respondents who never married correlated with the view of Engel (1995:372) who stated that "respondents who were never married signifies the fact that the persons suffering from schizophrenia are shy people and find intimate and sexual relationships difficult".

Other factors according to Stuart and Sundeen (1995:486) which might have contributed to the high percentage (78,3%) of the unmarried status of persons suffering from schizophrenia in Mogoto Village could be:

- The inability of these persons suffering from schizophrenia to form cooperative and interdependent relationships with others, especially those of the apposite sex.
- Symptoms that prevent the individual from socialising within accepted sociocultural norms.
- Deterioration of the brain function to the point where there is no motivation.
- Withdrawal and isolation from life's activities.
- The inability to communicate coherently, loss of drive and interest, deterioration of social skills and personal hygiene and paranoia.
- Low self-esteem related to poor academic and social achievement compared with other community members.
- Social inappropriateness, disinterest in recreational activities as well as gender identity confusion.
- The stigma and rejection encountered in the community that may discourage persons suffering from schizophrenia from entering into any relationship.

Item A5: Religious affiliation (n=60)

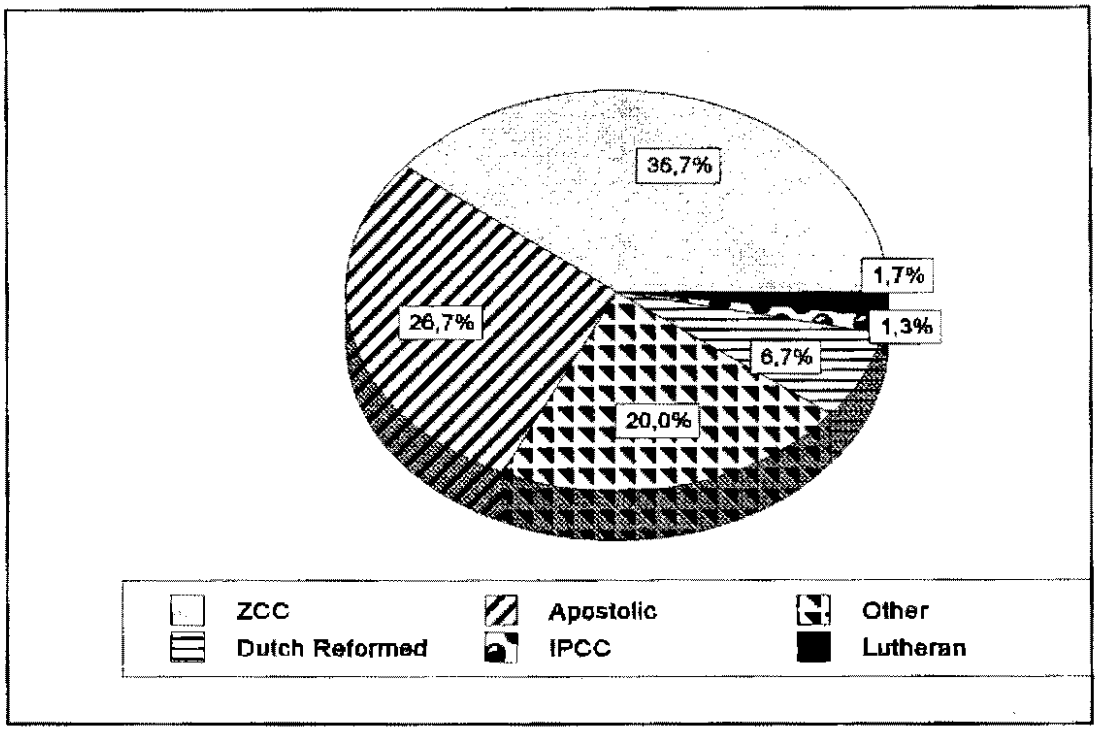

Figure 4.3

Religious affiliation (n=60)

All the respondents (100%; n=60) indicated that they were affiliated to a church. The majority of the respondents, almost thirty-seven percent (36,7%; n=22) belonged to the Zion Christian Church (ZCC). The second largest group, namely almost twenty-seven percent (26,7%; n=16) belonged to the Apostolic church, approximately two percent (1,7%; n=1) of the respondents belonged to the Lutheran Church (see figure 4.3).

The largest percentage of Zionist church members (36,7%; n=22) indicated that they had trust, hope and faith in the church's treatment of their schizophrenia. The ZCC headquarters were situated nearby and it was easy to visit the headquarters when experiencing mental problems. The faith was vested in the church leader who was believed to perform miracles and to be able of curing various illnesses.

Some persons suffering from schizophrenia visited the ZCC headquarters prior to admission and also after discharge from psychiatric hospitals. Their reasoning was that drugs used for

the treatment of schizophrenia stabilised these individuals but did not cure the condition, hence they visited the headquarters to get cured.

A total of approximately twenty-seven percent (26,7%; n=16) of the persons suffering from schizophrenia belonged to the Apostolic church. The Apostolic church was the most common religious affiliation in most villages in this area. These individuals believed that their condition was attributed to being bewitched. The treatments they got from faith healers included drinking a lot of "holy" water which induced vomiting, or enemas inducing diarrhoea.. They believed that whatever was driving them "crazy" would be expelled with the water taken orally or rectally. Both churches, the ZCC and the Apostolic, gave their clients "holy" water to take home as treatments.

The persons suffering from schizophrenia affiliated with the Roman Catholic, Lutheran and International Pentecostal Christian Church (IPCC) churches were those who responded well to their psychiatric treatment and therefore remained at these churches. Other members from other churches left to join either the ZCC or Apostolic churches. Twenty percent (20,0%; n=12) of the persons suffering from schizophrenia did not belong to any religious organisation as they had little or no faith in God in terms of curing their condition.

Items A6 and A7: Citizenship and home area (n=60)

Respondents were requested to indicate their citizenship as in most areas of South Africa there are citizens from other neighbouring countries. All the respondents (100%; n=60) in this research were South African citizens and all of these respondents lived in the Mogoto Village.

Item A8: Educational level (n=60)

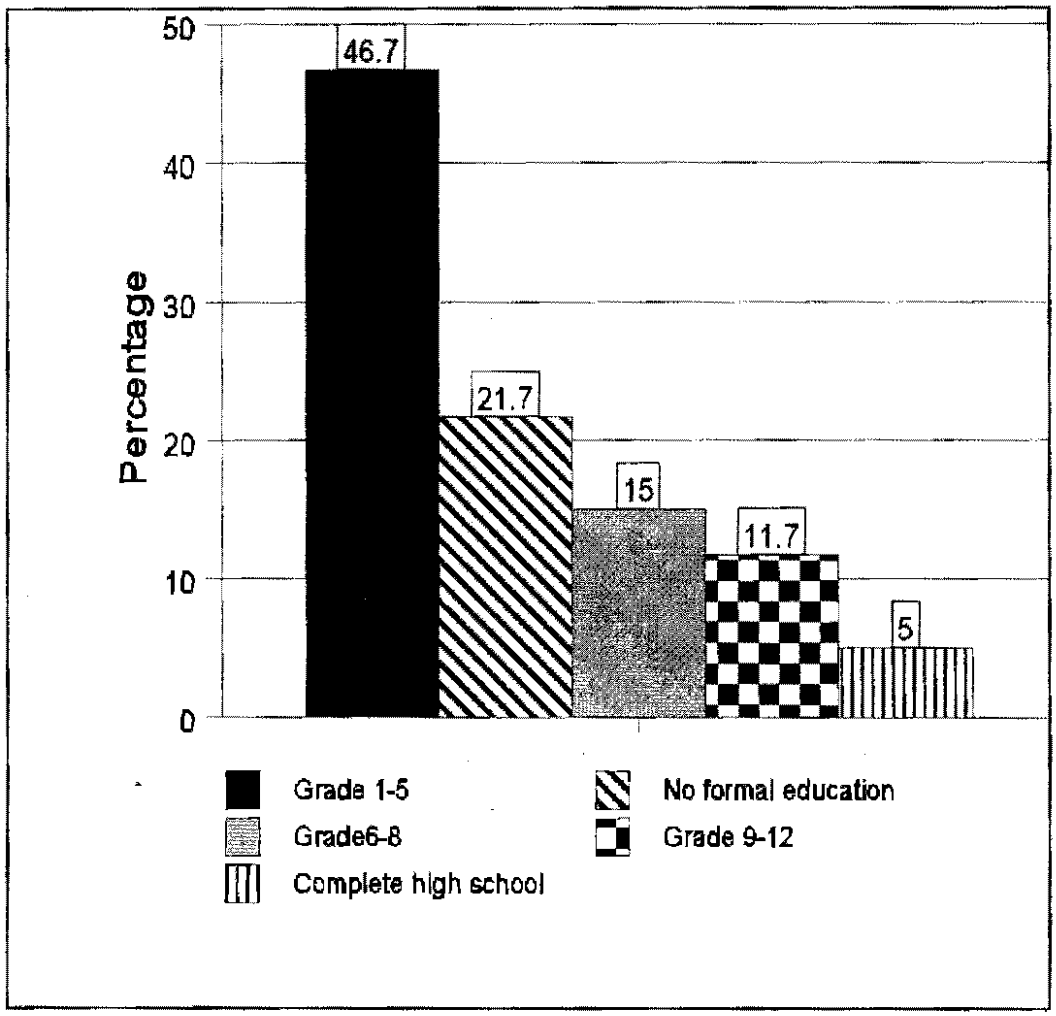

Figure 4.4

Educational level (n=60)

Only five percent (5,0%; n=3) of the respondents completed their high school training. The majority were barely literate with almost twenty-two percent (21,7%; n=3) having had no schooling and almost forty seven percent (46,7%; n=28) having completed grade 1 to grade 5 (see figure 4.4).

The low educational standards of most persons suffering from schizophrenia could be due to the alteration in their thoughts which making it difficult for them to progress at school. Common thought alterations experienced by persons suffering from schizophrenia include

flight of ideas, thought retardation, thought blocking, autism, poverty of speech, poor concentration and confusion (Keltner et al 1995:364).

Item A9: Number of dependents and living arrangements (n=60)

Table 4.2: Number of dependents and living arrangements (Items A9 and A10) (n=60)

LIVING ARRANGEMENTS	n	%
Number of dependents:		
Self only	11	18,3
One	12	20,0
Two	26	43,3
Three	7	11,7
Four	1	1,7
Five	1	1,7
Five or more	2	3,3
Living arrangements:		
Living alone	11	18,3
Living with spouse	12	20,0
Living with one or both parents or step-parents	26	43,3
Living with other relatives	7	11,7
Living with nonrelatives	1	1,7
Other	1	1,7
Unknown	2	3,3
TOTAL	**N=60**	**100,0**

Respondents were asked to indicate the number of dependents in their care in order to indicate their responsibilities in this regard. The results of this study indicated that there was a high number, almost forty-seven percent (46,7%; n=28) of respondents who did not have dependents; approximately twenty-two percent (21,7%; n=13) had two dependents, approximately eighteen percent (18,3%; n=11) had five or more dependents, approximately eight percent (8,3%; n=5) had three dependents; and approximately three percent (3,3%; n=2) had four dependents and only less than two percent (1,7%; n=1) had one dependent (see table 4.2).

The majority of the persons in this study suffering from schizophrenia did not have the responsibility of looking after dependents as they themselves were dependent on family members, friends and professionals for their care. Forty percent (40,0%) did have dependents. In terms of their cultural beliefs even if a person was mentally ill, he or she should have at least one dependent who would take care of him or her in future (Stuart & Sundeen 1995:486).

The contributing factor for approximately forty-seven percent (46,7%; n=28) of the respondents who did not have dependents might be that they also had problems in interacting with persons of the opposite sex because of their mental condition, and they feared rejection and failure in relationships. The other contributory factors could be a lack of motivation, loss of drive and interest, low self-esteem related to poor academic and social achievement and unemployment (Stuart & Sundeen 1995:485).

Item A10: Living arrangements (n=60)

The respondents were requested to indicate their living arrangements to establish the need for accommodation. The results of this study indicated the importance of the family in this culture with regard to the care of mentally ill family members. It also indicated the dependency of persons suffering from schizophrenia on their family members. As indicated in table 4.2 approximately forty-three percent (43,3%; n=26) of the respondents lived with one or both parents or step-parents. Hatfield (1995:203) reported that sixty-five percent (65,0%) of persons suffering from schizophrenia lived with their families. It was therefore important to assess family resources when assessing the needs of persons with schizophrenia. Twenty percent of the respondents (20,0%; n=12) lived with their spouses; approximately eighteen percent (18,3%; n=11) lived alone; almost twelve percent (11,7%; n=7) lived with other relatives; approximately three percent (3,3%; n=2) did not know with whom they were staying as they moved from one relative or friend to another; less than two percent (1,7%; n=1) lived with non-relatives and less than two percent (1,7%; n=1) lived with other friends.

Item A11: Income sources (n=60)

Table 4.3: Income sources (n=60)

INCOME SOURCES	n	%
Earnings	4	6,6
Disability benefits	44	73,3
Family	33	55,0
Friends	1	1,7
Social security	1	1,7

Respondents could give more than one answer to this question. Respondents were requested to indicate their income source. Approximately seven percent (6,8%; n=5) of the respondents were receiving earnings from different sources. No respondent indicated that his or her sources of income were from interest earned or from income derived from rent or dividends. Approximately seventy-five percent (74,6%; n=44) of the respondents indicated that their source of income was from disability benefits; approximately fifty-six percent (55,9%; n=33) respondents were receiving financial assistance from their family members whilst approximately forty-four percent (44,1%;N=26) of the respondents were not. Less than two percent (1,7%; n=1) of the respondents received financial assistance from a friend and social security respectively. All the respondents, hundred percent (100,0%; n=60) indicated that there was no financial assistance nor any income from workman's compensation or from public assistance (see table 4.3).

Item A12: Income category (n=60)

Table 4.4: Income category (n=60)

INCOME CATEGORY	n	%
Less than R100	8	13,3
R100-R500	8	13,3
R501-R1 000	44	73,3
TOTAL	60	100,0

Respondents were asked to indicate their respective income category to establish the total income for the individual and/or supporting family. Results indicated that approximately thirteen percent (13,3%; n=8) of the respondents' income per month was within the category of less than R100 and between R100 and R500 respectively. Approximately seventy-four percent (73,3%; n=44) of the respondents indicated that their monthly income was between R501 and R1 000 which was mainly from disability grants (R540 per month) and from family members (see table 4.4).

Item A13: Work status (n=60)

The respondents were requested to indicate their current work status. The results shown in table 4.5 indicated that almost seven percent (6,8%; n=4) of the respondents were employed outside the home, whilst the majority, approximately ninety-two percent (91,7%; n=55) of the respondents were unemployed and less than two percent (1,7%; n=1) were not sure about their work status. Some unemployed respondents stated that they were too disabled to work, while others indicated that, although they were able to work, due to the lack of job opportunities and the high unemployment rate in the country, they remained unemployed. Some indicated that they were not part of the potential work force.

Item A14: Previous occupation (n=16)

Table 4.5: Work status, previous occupation and number of previous employers (Items A13, A14, A18) (n=60)

WORK STATUS	n	%
Employment outside the home	54	6,7
Unemployed	55	91,7
Unknown	1	1,7
TOTAL	**60**	**100,0**
Previous occupation:		
Technical	1	1,7
Labourer	48	80,0
Other	10	16.7
Unknown	1	1,7
TOTAL	**60**	**100,0**
Number of previous employers:		
Nil	14	23,3
One	4	6,7
Two	7	11,7
Three	18	30,0
*Four or more	17	28,3
TOTAL	**60**	**100,0**

Respondents were requested to indicate the number of previous occupations held to establish whether their work sphere was wide enough to accommodate a planning programme. Consistent with the employment status, less than two percent (1,7%; n=1) indicated that they were employed as technical workers; eighty percent of the sample (80,0%; n=48) were employed as labourers; nearly seventeen percent (16,7%; n=10) were employed in a wide variety of jobs and less than two percent (1,7%; n=1) could not name any type of work they had done.

Respondents were requested to indicate the number of previous employer/s to determine the length of time they stayed with any employer (Item A18). The results indicated that

approximately twenty-three percent (23,3%; n=14) were never employed; almost seven percent (6,7%; n=4) had worked for one employer; approximately twelve percent (11,7%; n=7) had worked for two employers; thirty percent (30,0%; n=18) had worked for three employers whilst approximately twenty-eight percent (28,3%; n=17) had worked for four or more employers (see table 4.5).

The number of employers could be related to issues such as their illness or the stigma attached to persons suffering with schizophrenia. If the individual had been diagnosed with a mental illness, the likelihood of been unemployed was high. If employed one could easily lose the job after relapses.

Item A15: Current employment service (n=60)

Table 4.6: Current employment service (n=60)

EMPLOYMENT	n	%
Current employment service status:		
Under vocational rehabilitation services	1	1,7
Home bound	58	96,7
Unknown	1	1,7
TOTAL	**60**	**100,0**

Respondents were requested to indicate the current services from which they were receiving employment benefits. Looking at these services, the results indicated that less than two percent (1,7%; n=1) were involved in vocational rehabilitation services with approximately ninety-seven percent (96,7%; n=58) of the respondents being homebound. Homebound referred not only to the person's home as was the case in this study, but included nursing homes, halfway houses, prisons, shelters and the homeless (Keltner et al 1995:341). Less than two percent (1,7 percent; n=1) of the respondents did not know their current employment service status (see table 4.6).

Item A16: Sources of transport (n=60)

The respondents were requested to indicate their source of transport.

All the respondents, hundred percent (100,0%; n=60) indicated that they were using public transport to go wherever they wanted to go especially to the hospital or nearest town. None of the respondents made use of private transport, had their own transport or donkey cart as they indicated that they could not afford to buy or maintain such services.

Item A17: Main caregivers (n=60)

Table 4.7: Main caregivers (n=60)

MAIN CAREGIVERS	n	%
Self	29	48,3
Family member	31	51,7
TOTAL	**60**	**100,0**

Respondents were asked to indicate who their main caregivers were to enable the programme planners to include these caregivers in programmes planned to meet their future needs, for example, recreation programmes. The results indicated that approximately forty-eight percent (48,3%; n=29) of the respondents indicated that they were looking after themselves as they were getting support from family members and professionals whilst almost fifty-one percent (51,7%; n=31) of the respondents indicated that they were dependent on their families as caregivers. The implication on dependency is that their personal strengths and potentials were not developed to help them develop independent living skills, interpersonal relationships and coping resources and thus their special needs which would change their self-concepts and increase their self-esteem were not being met (Stuart & Sundeen 1995:311). Their negative self-concepts and low self-esteem, characteristic of people with schizophrenia, interfered with the ability to see themselves as individuals with strengths and

potential of caring for themselves (see table 4.7).

Item A19: Type of dwelling (n=60)

Table 4.8: Type of dwelling and number of rooms (Items A19 and A20) (n=60)

LIVING CONDITIONS	n	%
Type of dwelling:		
House	26	43,3
Flat	32	53,3
Room	2	3,3
Number of rooms in dwelling:		
One	1	1,7
Two	11	18,3
Three	15	25,0
Four	15	25,0
Five or more	18	30,0

Respondents were asked to indicate the type of dwelling in which they lived. Approximately three percent (3,4%; n=2) of the respondents indicated that they were residing in one room; approximately forty-three percent (43,3%; n=26) of the respondents lived in a house; and approximately fifty-three percent (53,3%; n=32) of the respondents lived in a flat (see table 4.8). The results indicated the type of housing the respondents made use of, despite their mental illness they were still regarded as part of their families and resided in the same houses with other family members.

Item A20: Number of rooms (n=60)

Respondents were asked to indicate the number of rooms in their place of residence to establish if there was a problem of overcrowding and lack of privacy so that these needs could be considered during the planning process. The results indicated that less than two percent (1,7%; n=1) of the respondents were staying in a one-roomed flat; approximately eighteen percent (18,3%; n=11) lived in a two-roomed flat; twenty-five percent (25,0%;

n=15) indicated that they were residing in a three- and four-roomed houses respectively; whilst thirty percent (30,0%; n=8) indicated that they were residing in a five-roomed house. In Mogoto Village the type of accommodation available included rondavels, separate one- or two-roomed flats attached to the house in which the family lived (see table 4.8). The type of housing in Mogoto Village is not exclusive for persons suffering from schizophrenia only, but members of the community who are not mentally ill reside in the same type of accommodation. There was no discrimination with regard to the number of rooms occupied by the respondents compared with other members of the community.

4.5 SECTION B: NEEDS OF PERSONS SUFFERING FROM SCHIZOPHRENIA

In order to maintain their physical and mental health, people have certain essential requirements or needs that must be met. When people have mental health problems, however, their ability to meet these needs independently could be adversely affected. This could result in frustration, conflict or deprivation for the person. The fundamental role of the mental health nurse, therefore, is to enable people with mental health problems to meet their needs and to restore the individual's well-being as far as possible. This process is only possible if a needs assessment is carried out in order to establish the unmet needs and the problems that individuals experience in their daily living that hamper them from meeting those needs. In this section the needs were assessed as follows:

- Subsection 4.3.1 (physiological/physical needs)
- Subsection 4.3.2 (psychological needs)
- Subsection 4.3.3 (social needs)
- Subsection 4.3.4 (emotional needs)
- Subsection 4.3.5 (spiritual needs)

4.5.1 Physiological/physical needs

In this section a systematic appraisal of type, depth and scope of physiological/physical needs as perceived by persons suffering from schizophrenia will be discussed.

Item B1: Current health status (n=60)

Table 4.9: Current health status (n=60)

HEALTH STATUS (PHYSICAL)	GENDER				TOTAL	
	MALE		FEMALE			
	n	%	n	%	n	%
Poor	0	0,0	1	3,5	1	1,7
Fair	6	19,4	5	17,2	11	18,3
Satisfactory	8	25,8	14	48,3	22	36,7
Good	17	54,8	9	31,0	26	43,3
Excellent	-	-	-	-	-	-
TOTAL	31	100,0	29	100,0	60	100,0

Respondents were asked to indicate their current state of physical health to enable the researcher to verify the existence of current physical needs. The results indicated that out of sixty (n=60) respondents, less than two percent (1,7%; n=1) indicated a poor state of health; approximately eighteen percent (18,3%; n=11) indicated a fair state of health; nearly thirty-seven percent (36,7%; n=22) indicated a satisfactory state of health and just over forty-three percent (43,3%; n=26) indicated a good state of health (see table 4.9). Cross tabulation was done to determine, according to gender, the state of health of the respondents. The results indicated that none (0,0%) of the male respondents indicated a poor state of health whilst less than two percent (1,7%; n=1) female respondents indicated a poor state of health. More than nineteen percent (19,4%; n=6) male respondents indicated a fair state of health, approximately seventeen percent (17,2%; n=5) of the female respondents, indicated a fair state of health. Approximately twenty-six percent (25,8%; n=8) of the male respondents and just over than forty-eight percent (48,3%; n=14) of the female respondents indicated a satisfactory state of health. Almost fifty-five (54,8%; n=17) of the male respondents and thirty-one percent (31,0%; n=9) of the female respondents indicated a good state of health. None of the respondents (male or female) indicated an excellent state of health. The results indicated that due to the mental ill health no respondents indicated good health. This might be the results of medication, depression and/or psychotic episodes.

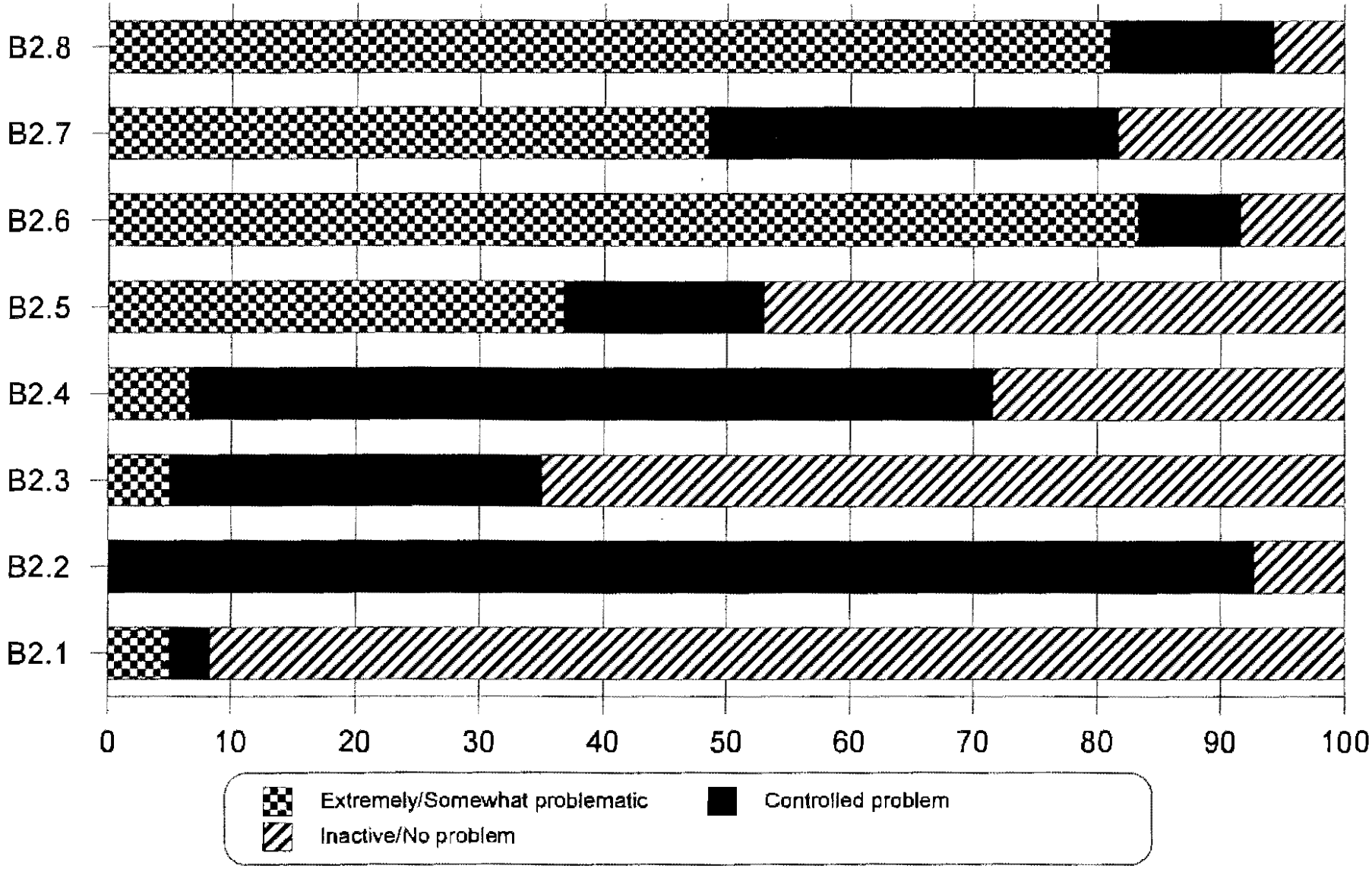

Figure 4.5
Basic physical/physiological needs (n=60)

B2: Physical and physiological needs of the person suffering from schizophrenia determined on a scale from 1-5 (see figure 4.5)

In this section respondents were asked to rate their need on a scale from 1-5 where 1 was extremely problematic and 5 was no problem.

Item B2.1: Vision (n=60)

In accordance with this scale from 1-5 respondents were asked to indicate their degree of need concerning their vision.

Five percent (5%,0; n=3) of the respondents indicated that as far as their vision was concerned this had no major problems; more than three percent (3,3%; n=2) of the respondents indicated that problems with their vision was under control; over twenty-six percent (26,7%; n=16) indicated that vision was not an active problem whilst sixty-five percent (65,0%; n=39) of the respondents indicated that vision was no problem at all.

Vision problems could result from the extra pyramidal side-effects in the treatment of patients with schizophrenia (Keltner et al 1995:363). In this study problems with vision did not appear to be a major problem.

Item B2.2: Mobility (n=60)

Respondents were asked to indicate any problems they had with their mobility. Approximately seven percent (7,3%; n=4) of the respondents indicated that mobility was a controlled problem, more than twenty-six percent (26,2%; n=16) of the respondents indicated that mobility was an inactive problem whilst almost sixty-seven percent (66,5%; n=40) of the respondents indicated that mobility was no problem at all.

The results indicated that even though problems with mobility could be due to treatment

taken by persons suffering from schizophrenia, 66,5 percent reflected the extend of proper management of side effects of medications because their mobility was not adversely affected by the medications.

Item 2.3: Sleep (n=60)

Respondents were asked to indicate whether they experienced sleep problems. Five percent (5,0%; n=3) of the respondents indicated that their sleeping patterns were somewhat problematic; thirty percent (30,0%; n=18) indicated that sleep was a somewhat controlled problem; thirty-five percent (35,0%; n=21) indicated that sleep was an inactive problem whilst thirty percent (30,0%; n=18) of the respondents indicated that they had no problem at all with their sleeping patterns.

Item B2.4: Anxiety/depression (n=60)

Respondents were asked to indicate whether they were anxious of depressed. More than six percent (6,7%; n=4) of the respondents indicated that anxiety/depression was somewhat problematic; sixty-five percent (65,0%; n=39) indicated that anxiety/depression was a controlled problem; just over sixteen percent (16,7%; n=10) indicated that anxiety/depression was an inactive problem and approximately twelve percent (11,7%; n=7) of the respondents indicated that anxiety/depression was no problem at all.

It is indicated in Perko and Kreigh (1988:127) anxiety reduces the individual's perceptual field and cognitive functioning. Because of this deficit in functioning, the individual is unable to pursue problem-solving. The results indicate that anxiety as a deficit is under control.

Item B2.5: Energy level (n=60)

On the question of energy level less than two percent (1,7%; n=1) of the respondents indicated that their energy level was extremely problematic; thirty-five percent (35,0%;

n=21) indicated that energy level was somewhat problematic; just over sixteen percent (16,5%; n=10) indicated that their energy level was a controlled problem; approximately thirty-seven percent(36,8%; n=22) indicated that their energy level was an inactive problem and ten percent (10,0%; n=6) of the respondents indicated that their energy level was no problem.

Item B2.6: Recreation/play (n=60)

On the question of recreation/play twenty percent (20,0%; n=12) of the respondents indicated that recreation/play was extremely problematic, approximately sixty-three percent (63,3%; n=38) indicated that recreation/play was somewhat problematic; approximately eight percent (8,3%; n=5) indicated that recreation/play was a controlled problem; less than two percent (1,7%; n=1) indicated that recreation/play was an inactive problem; whilst more than six percent (6,7%; n=4) of the respondents indicated that recreation/play was no problem.

The results indicated a great deficit in the recreational aspect calling for concern and intervention in this regard.

Item B2.7: Exercise (n=60)

On the question of exercise more than six percent (6,7%; n=4) of the respondents indicated that exercise was extremely problematic, approximately forty-two (41,9%; n=25) indicated that exercise was somewhat problematic; more than thirty-three percent (33,2%; n=20) indicated that exercise was a controlled problem; ten percent (10,0%; n=6) indicated that exercise was an inactive problem whilst approximately eight percent (8,2%; n=5) of the respondents indicated that exercise was no problem.

In this aspect the respondents indicated that exercise was problematic as they did not have a place for exercising, no activities that could make them exercise and some indicated that treatment given to them made it difficult to exercise and rendered them weak and tired.

Item B2.8: Sexual libido (n=60)

On the question of sexual libido, a high number, more than fifty-seven percent (57,3%; n=35) of the respondents indicated that sexual libido was extremely problematic; more than twenty-three percent (23,7%; n=14) indicated that sexual libido was somewhat problematic; approximately thirteen percent (13,3%; n=8) indicated that sexual libido was a controlled problem whilst approximately six percent (5,7%; n=3) of the respondents indicated that sexual libido was no problem whatsoever.

The results in this item correlated with items B2.1-2.3 which involved the extrapyramidal side effects (EPS) experienced by persons suffering from schizophrenia who were on antipsychotic medications. The EPS causes anxiety and depression to low energy level, poor sexual libido and lack of energy for recreation and exercise (Keltner et al 1995:364).

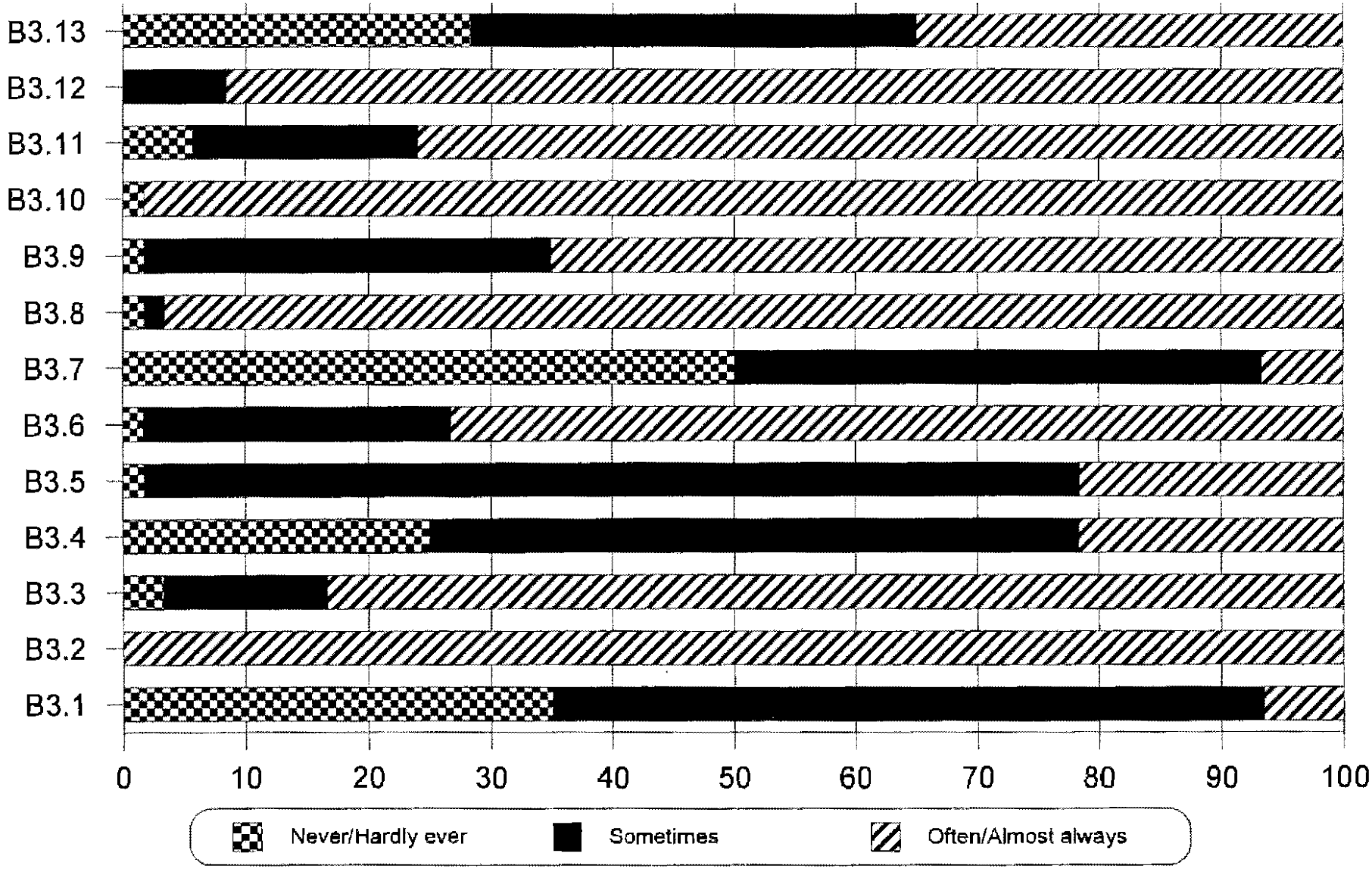

Figure 4.6
Basic physical/physiological needs (n=60)

B3: Physiological and physical needs of the person suffering from schizophrenia on a rating scale 1-5 (see figure 4.6)

In this section respondents were asked to indicate the extent of their needs using a rating scale 1-5 in which 1 = never and 5 = almost all the time to indicate the extent of their need in terms of the items discussed.

Item B3.1: Eating a well-balanced diet (n=60)

Respondents were asked to give information related to their eating habits. Approximately two percent (1,7%; n=1) of the respondents indicated that they never ate a well-balanced diet; more than thirty-three percent (33,4%; n=20) indicated that they hardly ever ate a well-balanced diet; approximately fifty eight percent (58,3%; n=53) indicated that they sometimes ate a well-balanced diet; approximately three percent (3,3%; n=2) indicated that they frequently ate a well- balanced diet; whilst approximately three percent (3,3%; n=2) of the respondents indicated that they always ate a well-balanced diet.

The above information could assist the care providers when giving advice and counselling on dietary habits as understanding the biological, psychological, sociocultural and environmental factors influences food selection and eating behaviours.

For the maintenance of good physical and mental health, individuals need to take a well-balanced diet as throughout the world malnutrition affects both physical and mental health and development. Besides diet a person needs to exercise regularly to promote both physiological and psychological health, together with enough rest and sleep could be associated with high energy levels (Stanhope & Lancaster 1995:556).

Item B3.2: Prescribed medications (n=60)

Questions were asked about the type of medication prescribed. Approximately seventeen percent (16,7%;N=7) of the respondents were utilising prescribed medication frequently whilst the majority of respondents, approximately eighty-eight percent (88,3%; n=53) took their prescribed medications on a permanent basis.

The results indicated how committed the respondents were in taking their prescribed medication. This indicated the understanding of the importance of medications to someone suffering from schizophrenia.

Item B3.3: Patent medicines (n=60)

Questions were asked about the extent to which patent medicines were prescribed. More than three percent (3,3%; n=2) of the respondents indicated that they had never taken any patent medicines; approximately thirteen percent (13,3%; n=8) indicated that they sometimes took patent medicines whilst more than eighty-three percent (83,4%; n=50) of the respondents indicated that they took patent medicines prescribed by the doctor almost all the time.

The results indicated the use of physicians by the schizophrenic patients when they experienced physical ailments.

Item B3.4: Daily exercise (n=60)

Questions were asked on the type of daily exercises taken by persons suffering from schizophrenia. Approximately two percent (1,7%; n=1) indicated that they did not take exercise on a daily basis; more than twenty-three percent (23,3%; n=14) indicated that they hardly ever exercised on a daily basis; approximately fifty-three percent (53,3%; n=32) indicated that they sometimes exercised on a daily basis; nearly seventeen percent (16,7%; n=10) indicated that they often exercised on a daily basis whilst five percent (5,0%; n=3) of

the respondents indicated that they exercised every day.

Item B3.5: Minimum hours sleep per day (n=60)

On the question as to the amount of sleep respondents suffering from schizophrenia had daily, approximately two percent (1,7%; n=1) indicated that they slept six to eight hours per day; approximately seventy-seven percent (76,7%; n=46) sometimes slept for six to eight hours daily whilst approximately twenty-two percent (21,6%; n=13) of the respondents indicated that they, in most instances, slept for six to eight hours daily.

The results indicated that like any other persons, the respondents suffering from schizophrenia still needed their daily rest and sleep for certain hours.

Item B3.6: Rest periods during the day (n=60)

On the question of rest periods during the day, nearly two percent (1,7%; n=1) of the respondents indicated that they hardly even took rest periods during the day; twenty-five percent (25,0%; n=15) indicated that they sometimes took rest periods during the day; more than sixty-eight percent (68,3%; n=41) indicated that they often took rest periods during the day whilst five percent (5,0%; n=3) of the respondents indicated that they took rest periods during the day on a regular basis.

Item B3.7: High energy level experienced by persons suffering from schizophrenia (n=60)

Respondents were asked to give information on their high energy levels. Nearly two percent (1,7%; n=1) of the respondents indicated that they never experienced high energy levels; approximately forty-eight percent (48,3%; n=29) indicated that they hardly ever experience high energy levels; more than forty-three percent (43,3%; n=26) indicated that they sometimes experienced high energy level whilst nearly seven percent (6,7%; n=4) of the respondents indicated that they experienced high energy levels frequently.

The results indicated that due to the side effects and the lack of motivation from the respondents, the energy levels were high and some were roaming around aimlessly in the community.

Item B3.8: Signs of relapse (n=60)

On the question about signs of relapse, nearly two percent (1,7%; n=1) of the respondents never (or hardly ever) respectively watched themselves for signs of relapse; nearly two percent (1,7%; n=1) indicated that they sometimes watched themselves for signs of a relapse; nearly seven percent (6,6%; n=4) indicated that they often watched themselves for signs of relapse whilst ninety percent (90,0%; n=54) of the respondents indicated that they watched themselves for signs of relapse almost all the time.

Relapse takes place when the condition of persons suffering from schizophrenia or other mental illness' worsens (Tsuang & Faraone 1998:137). These findings indicated that the majority of the persons suffering from schizophrenia did look after themselves and as a result they did not relapse into a state of psychosis and disorganisation.

Item 3.9: Relaxation (n=60)

On the question of relaxation nearly, two percent (1,7%; n=1) of the respondents indicated that they hardly ever relaxed, more than thirty three percent (33,3%; n=20) indicated that they sometimes relaxed, approximately forty-one percent (40,5%; n=24) indicated that they often relaxed, whilst twenty-five (25,0%; n=15) of the respondents indicated that they relaxed almost all the time.

Item B3.10: Conservation of the health status (mental and physical health) (n=60)

Approximately two percent (1,7%; n=1) of the respondents indicated that they hardly ever took any measures to conserve their health, approximately twenty-five (25,4%; n=15) indicated that they often took measures to conserve their health whilst approximately seventy-three (72,9%; n=43) of the respondents indicated that they took measures all the time to conserve their health.

This indicated the lack of motivation and withdrawal effects of persons suffering from schizophrenia who gave the responsibility of preserving their life to others.

Item B3.11: Objections expressed (n=60)

On the question as to whether the respondents had any objections to taking preventive health measures, approximately six percent (5,7%; n=3) of the respondents indicated that they hardly ever objected taking special measures to conserve their health, approximately eighteen percent (18,3%; n=11) indicated that they did sometimes object to taking special measures to conserve their health whilst seventy-six percent (76,0%; n=46) of the respondents indicated that they never objected to taking measures to conserve their health.

The results indicated the lack of knowledge and motivation in preserving good health and sometimes they lacked the means to carry out such activities.

Item B3.12: Giving up activities for the sake of health (n=60)

On the question of giving up activities for the sake of health approximately eight percent (8,4%; n=5) of the respondents indicated that they sometimes objected to giving up activities for the sake of their health, approximately twenty-three percent (23,3%; n=14) indicated that they often did not object to giving up activities that they liked for the sake of their health, whilst approximately sixty-eight percent (68,3%; n=41) of the respondents indicated that they almost all the time did not object to giving up activities that they liked for the sake of their health.

Item B3.13: Confidence in meeting future needs (n=60)

Respondents were asked to give information about their confidence in meeting their future needs. Approximately three percent (3,3%; n=2) of the respondents indicated that they were never confident about meeting their future needs, twenty-five percent (25,0%; n=15) indicated that they were hardly ever confident that they would meet their future needs, approximately thirty-seven percent (36,7%; n=22) indicated that they were sometimes confident about meeting their future needs, approximately twenty-seven percent (26,7%; n=16) were usually confident about meeting their future needs whilst nearly eight percent (8,3%; n=5) of the respondent indicated that they were nearly always confident about meeting their future needs.

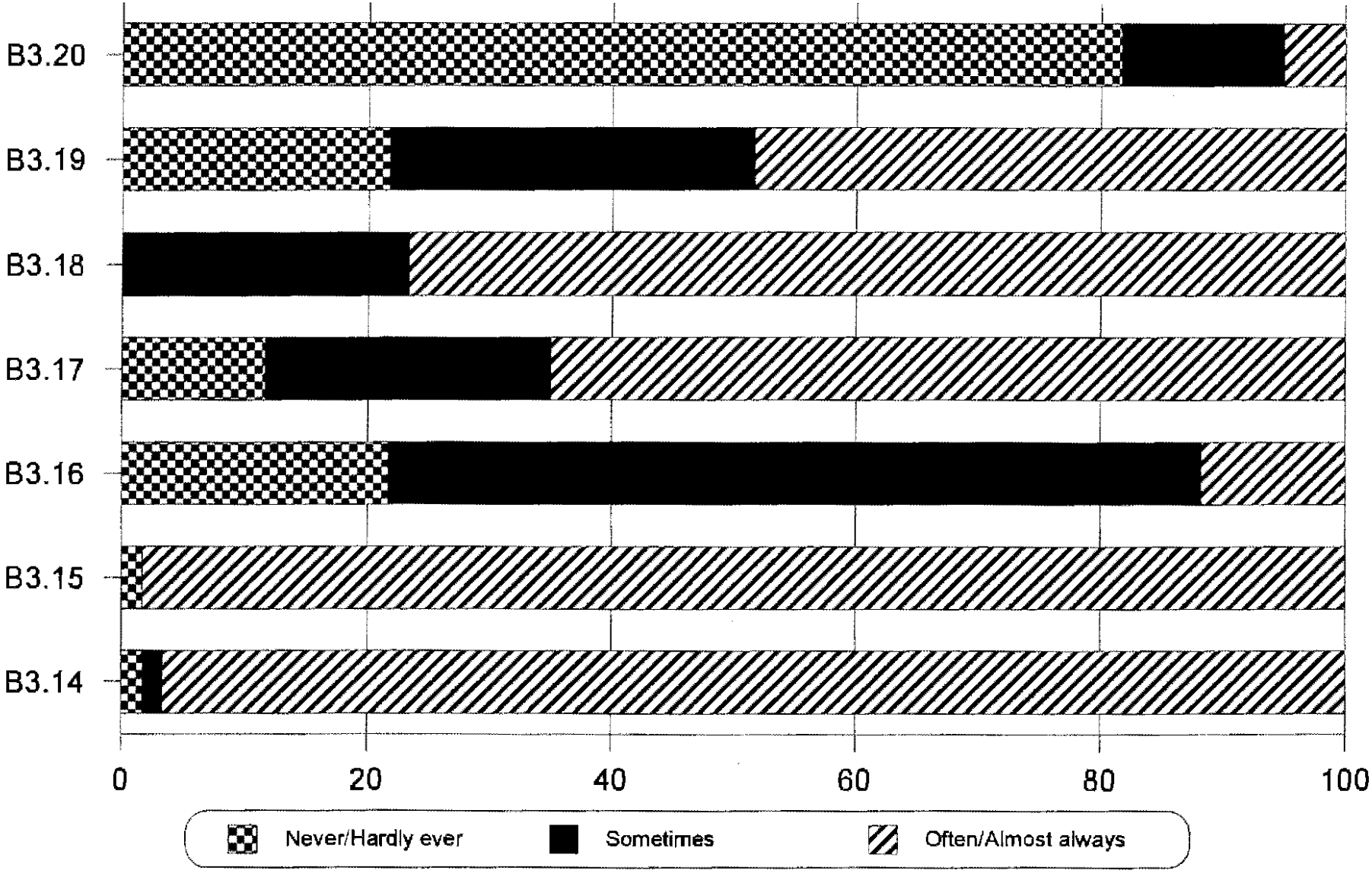

Figure 4.7
Psychological needs (n=60)

4.5.2 Psychological needs

This section on a scale 1 to 5 respondents were asked to indicate the degree to which they felt secure in different situations (1 = never and 5 = almost all the time) (see figure 4.7)

All people have essential basic human needs, programme planning and implementation are indicated when the individual cannot independently satisfy these needs. Significant psychosocial needs of importance for planning include a sense of security; the maintenance of identity as an individual; acceptance; a sense of being wanted and belonging; the opportunity of socialising; independence (and at times dependence and interdependence); freedom to make decisions and the opportunity to develop and use one's innate potential. Individuals should have interests and goals and opportunities for developing self-respect, in addition to feeling useful and having a sense of achievement (Royle & Walsh 1992:5).

Item 3.14: Physical safety in the home environment (n=60)

Respondents were asked to give information on the physical safety in their home environment. Approximately three percent (3,3%; n=2) of the respondents never and sometimes respectively felt secure about their physical safety in the home environment. Approximately thirty-two percent (31,6%; n=19) indicated that they often felt secure about their physical safety in the home environment whilst sixty-five (65,0%; n=39) of the respondents indicated that they almost always felt secure about their physical safety in the home environment.

The results indicated that the persons suffering from schizophrenia had a need for safety and in this regard the need for safety was not a problem to them.

Item B3.15: Special precautions regarding physical safety (n=60)

Approximately two percent (1,7%; n=1) of the respondents indicated that they sometimes felt secure about the special precautions taken regarding their physical safety, approximately

thirty-two percent (31,6%: n=19) indicated that they often felt secure about the special precautions taken regarding their physical safety whilst approximately sixty-seven percent (66,7%; n=40) of the respondents indicated that they almost all the time felt secure about the special precautions taken.

Persons suffering from schizophrenia need safety and protection at all times in their living situations. The greater percentage (66,7 percent) indicated that this need was taken care of.

Item B3.16: Financial position (n=60)

Respondents were asked to indicate how secure they felt about their financial position. Approximately two percent (1,7%; n=1) of the respondents indicated that they never felt secure about their financial position, twenty percent (20,0%; n=12) indicated that they hardly ever felt secure about their financial position, approximately sixty-seven percent (66,6%; n=40) indicated that they sometimes felt secure about their financial status, approximately twelve percent (11,7%; n=7) of the respondents indicated that they often and almost all the time respectively felt secure about their financial positions.

The results indicated the extent to which the respondents were dependent financially (66,6 percent) and this might be due to the disability grants received by the respondents.

Item B3.17: Medical expenditures (n=60)

Respondents were asked to give information about their medical expenditures. Approximately twelve percent (11,7%; n=7) of the respondents indicated that they hardly ever felt secure about meeting the expenses of their routine medicines and supplies, nearly twenty-three percent (23,3%; n=14) indicated that they sometimes felt secure about meeting the expenses of their routine medicines and supplies whilst sixty-five percent (65,0%; n=39) of the respondents indicated that they often felt secure about meeting the expenses of their routine medicines and supplies.

The persons suffering from schizophrenia do not pay for their routine medications and are able to visit physicians for physical ailments making use of the grants they received on monthly basis.

Item B3.18: Transportation plans (n=60)

Respondents were asked to give information about their transportation plans. Approximately twenty-three percent (23,3%; n=14) of the respondents indicated that they sometimes felt satisfied about their transportation plans, approximately seventy-two percent (71,7%; n=43) indicated that they often felt satisfied about their transportation plans whilst five percent (5,0%; n=3) of the respondents indicated that they felt satisfied about their transportation plans almost all the time.

The results indicated that the need for transport had been taken care of as public transport was always available and affordable.

Item B3.19: Long-term plans (n=60)

Respondents were asked to give information about their long-term plans. Approximately twenty-two percent (21,7%; n=13) of the respondents indicated that they hardly ever felt satisfied about their long-term plans for their care, thirty percent (30,0%; n=18) indicated that they sometimes felt satisfied about their long-term plans for their care, forty-five percent (45,0%; n=27) indicated that they often felt satisfied about their long-term plans whilst approximately three percent (3,3%: n=2) of the respondents indicated that they felt satisfied about their long-term plans for their care almost all the time.

Due to lack of motivation, persons suffering from schizophrenic do not have long-term plans for their care. It was therefore imperative for health care providers to include long-term plan in their rehabilitation programmes.

Item B3.20: Present occupational status (n=60)

Work is an important source of self-esteem for anyone, whether mentally ill or not.

Respondents were asked to give information on their present occupational status. Approximately eight percent (8,3%; n=5) of the respondents indicated that they never felt satisfied about their present occupational status, approximately seventy-two percent (72,4%; n=44) indicated that they hardly ever felt satisfied about their present occupational status, approximately thirteen percent (13,3%; n=8) indicated that they sometimes felt satisfied about their present occupational status, approximately three percent (3,3%; n=2) indicated that they often felt satisfied about their present occupational status whilst approximately two percent (1,7%; n=1) of the respondents indicated that they almost all the time felt satisfied about their present occupational status.

The need for employment as indicated in the results was not met probably due to the stigma attached to the diagnosis of schizophrenia.

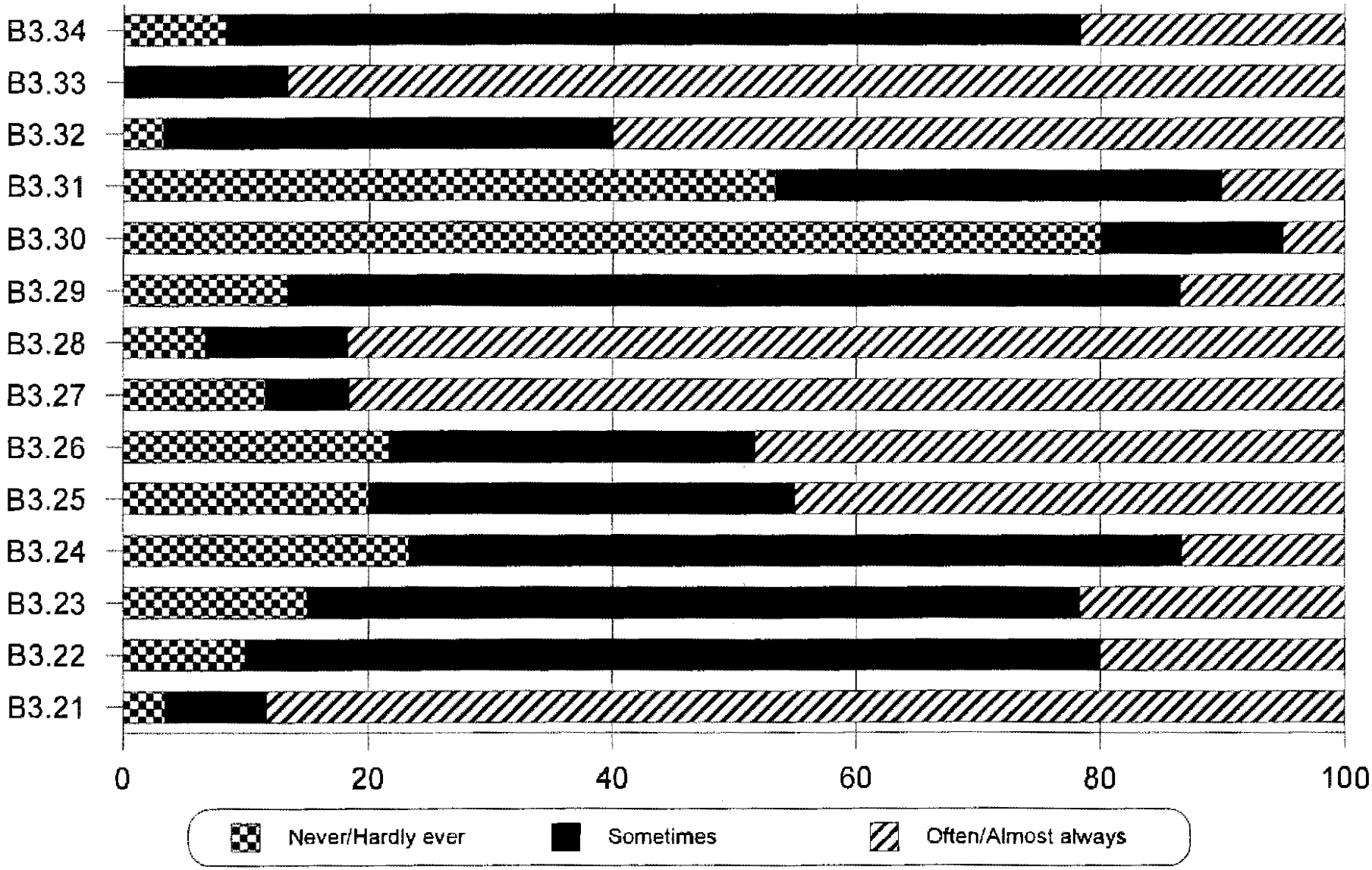

Figure 4.8
Social needs (n=60)

4.5.3 Social needs

The social needs have been illustrated in figure 4.8.

Item B3.21: Love from family (n=60)

Respondents were asked to give information on the love they received from their families. Approximately three percent (3,4%; n=2) of the respondents indicated that they never or hardly ever felt satisfied with the love received from their families, approximately eight percent (8,3%; n=5) indicated that they sometimes felt satisfied with the love from their families whilst approximately forty-eight percent (48,3%; n=29) indicated that they often felt satisfied with the love received from their families whilst forty percent (40,0%; n=24) of the respondents indicated that they felt satisfied with the love received from their families almost all the time.

Families also need support to help them come to terms with their relatives' illness. In this research it was indicated that 48,3 percent of the respondents found their families' love as satisfactory.

Item B3.22: Love from friends (n=60)

Respondents were asked to give information on love received from friends. Approximately two percent (1,7%; n=1) of the respondents indicated that they never felt satisfied with the amount of love received from friends, approximately eight percent (8,3%; n=5) indicated that they hardly ever felt satisfied with the amount of love received from friends, seventy percent (70,0%; n=42) indicated that they were sometimes satisfied with the amount of love received from friends, approximately eight percent (8,3%; n=5) indicated that they sometimes felt satisfied with the amount of love received from friends and approximately twelve percent (11,7%; n=7) of the respondents indicated that they almost all the time felt satisfied with the amount of love received from friends.

It is difficult for people to keep their friends after they become ill with schizophrenia, hence 70,0 percent indicating nonsatisfaction with the love from friends. Friends must learn to deal with and love their schizophrenic friends. This could be achieved through support groups.

Item B3.23: Stress in home life (n=60)

Respondents were asked to give information on stress experienced in home life. Fifteen percent (15,0%; n=9) of the respondents indicated that they hardly ever coped well with stress in home life, approximately sixty three percent (63,3%; n=38) indicated that they sometimes coped satisfactorily with stress in home life, approximately eighteen percent (18,4%; n=11) indicated that they often coped satisfactorily with stress in home life whilst approximately three percent (3,3%; n=2) of the respondents indicated that they almost all the time cope satisfactorily with stress in home life.

Stress can menace the quality of life even within the family (Polit & Hungler 1997:407). The results of this item indicated that stress could be found in families and could be negative to the extent that it could create a demand upon the system exceeding available coping resources.

Item B3.24: Stress in other aspects of life (n=60)

Respondents were asked to give information on stress in other aspect of their lives. Approximately twenty-three percent (23,3%; n=14) of the respondents indicated that they hardly ever coped satisfactorily with stress in other aspects of their lives, approximately sixty-three percent (63,4%; n=38) indicated that they sometimes coped satisfactorily with stress in other aspects of their lives, ten percent (10,0%; n=6) indicated that they often coped satisfactorily with stress in other aspects of their lives whilst approximately three percent (3,3%; n=2) of the respondents indicated that they coped satisfactorily with stress almost all the time in other aspects of their lives. The results indicated that 63,4 percent sometimes coped with stress in other aspects.

Item B3.25: Level of social effectiveness (n=60)

On the question of level of social effectiveness. Twenty percent (20,0%; n=12) of the respondents indicated that they were hardly ever satisfied with their level of social effectiveness, thirty-five (35,0%; n=21) indicated that they were sometimes satisfied with their level of social effectiveness, approximately forty-three (43,3%; n=26) indicated that they were often satisfied with their level of social effectiveness whilst approximately two percent (1,7%; n=1) of the respondents indicated that they almost all the time were satisfied with the level of social effectiveness.

The diagnosis of mental illness could make one to be alienated from and discriminated against when coming to other social activities. This was reflected by the 43,3 percent indicating low level of satisfaction with their social effectiveness.

Item B3.26: Social participation (n=60)

On the question of social, participation approximately two percent (1,7%; n=1) of the respondents indicated that they were never satisfied with their social participation, twenty percent (20,0%; n=12) indicated that they were hardly ever satisfied with their level of social participation, thirty percent (30,0%; n=19) indicated that they sometimes felt satisfied with their level of social participation whilst approximately forty-eight (48,3%; n=28) of the respondents indicated that they often felt satisfied with their level of social participation.

Item 3.27: Role in the family (n=60)

On the question of their role in the family, approximately three percent (3,3%; n=2) indicated that they were never satisfied with their role in the family, approximately eight percent (8,3%; n=5) of the respondents indicated that they were hardly ever satisfied with their role in the family, approximately seven percent (6,8%; n=4) indicated that they sometimes felt satisfied with their role in the family, approximately sixty-three percent (63,3%; n=38) indicated that they were satisfied with their role in the family whilst approximately eighteen percent (18,3%; n=11) of the respondents indicated that they felt

satisfied with their role in the family almost all the time.

Item B3.28: Asking for help (n=60)

On the question of asking for help, approximately two percent (1,7%; n=1) of the respondents indicated that they were never comfortable asking for help even if it was needed, five percent (5,0%; n=3) indicated that they hardly ever felt comfortable asking for help when needed, approximately twelve percent (11,6%; n=7) indicated that they sometimes felt comfortable asking for help when needed, sixty-five percent (65,0%; n=39) indicated that they often felt comfortable asking for help when needed whilst approximately seventeen percent (16,7%; n=10) of the respondents indicated that they felt comfortable almost all the time when asking for help.

Item B3.29: Participation in family and traditional activities (n=60)

Respondents were asked to give information on their participation within the family and in traditional activities. Approximately three percent (3,3%; n=2) of the respondents indicated that they were never satisfied with family activities and the traditions in which they participated, ten percent (10,0%; n=6) indicated that they hardly ever felt satisfied with family activities and the tradition in which they participated, approximately seventy-three percent (73,3%; n=44) indicated that they sometimes felt satisfied with family activities and traditions in which they participated whilst approximately thirteen percent (13,4%; n=8) of the respondents indicated that they felt satisfied almost all the time with family activities and the tradition in which they participated.

Item B3.30: Sexual fulfilment (n=60)

Respondents were asked to give information on their sexual fulfilment. Twenty percent (20,0%; n=12) of the respondents indicated that they never felt satisfied with their level of sexual fulfilment, sixty percent (60,0%; n=36) indicated that they hardly ever felt satisfied with their level of sexual fulfilment, fifteen percent (15,0%; n=9) indicated that they

sometimes felt satisfied with their level of sexual fulfilment, approximately three percent (3,3%; n=2) indicated that they often felt satisfied with their sexual fulfilment whilst approximately two percent (1,7%; n=1) of the respondents indicated that they almost all the time felt satisfied with their level of sexual fulfilment.

Item B3.31: Knowledge about human sexuality (n=60)

Respondents were asked to give the information about their knowledge on human sexuality. Approximately three percent (3,3%; n=2) of the respondents indicated that they were never satisfied with their level of knowledge about human sexuality, fifty percent (50,0%; n=30) indicated that they were hardly ever satisfied with their level of knowledge about human sexuality, approximately thirty-seven percent (36,7%; n=22) indicated that they were sometimes satisfied with their level of knowledge about human sexuality, approximately eight percent (8,3%; n=5) indicated that they were often satisfied with their level of knowledge about human sexuality whilst approximately two percent (1,7%; n=1) of the respondents indicated that they almost all the time were satisfied with their level of knowledge about human sexuality.

Item B3.22: Feelings of love and belongingness (n=60)

Respondents were asked to give the information on their feelings of love and belonging. Approximately three percent (3,3%; n=2) of the respondents indicated that they were hardly ever satisfied with the feeling of love and belongingness they received from others, approximately thirty-seven percent (36,7%; n=22) indicated that they were sometimes satisfied, approximately fifty-eight percent (58,3%; n=35) indicated that they were often satisfied whilst approximately two percent (1,7%; n=1) of the respondents indicated that they were satisfied almost all the time.

Item B3.33: Love and affection given to others

On the question of love and affection given to others. Approximately thirteen percent (13,3%; n=8) of the respondents indicated that they were satisfied sometimes with the amount of love and affection they gave to others whilst approximately eighty-three percent (83,3%; n=50) indicated that they were often satisfied, and approximately three percent (3,3%; n=2) of the respondents indicated that they were satisfied almost all the time.

Item B3.34: Social gatherings with friends (n=60)

On the question of social gatherings with friends of their own age, approximately three percent (3,3%; n=2) of the respondents indicated that they never had social gatherings with friends of their own age, five percent (5,0%; n=3) indicated that they hardly ever had social gatherings with friends of their own age group, seventy percent (70,0%; n=42) indicated that they sometimes did, approximately seventeen percent (16,7%; n=10) indicated that they often did whilst five percent (5,0%; n=3) of the respondents indicated that they did have social gatherings with friends of their own age almost all the time.

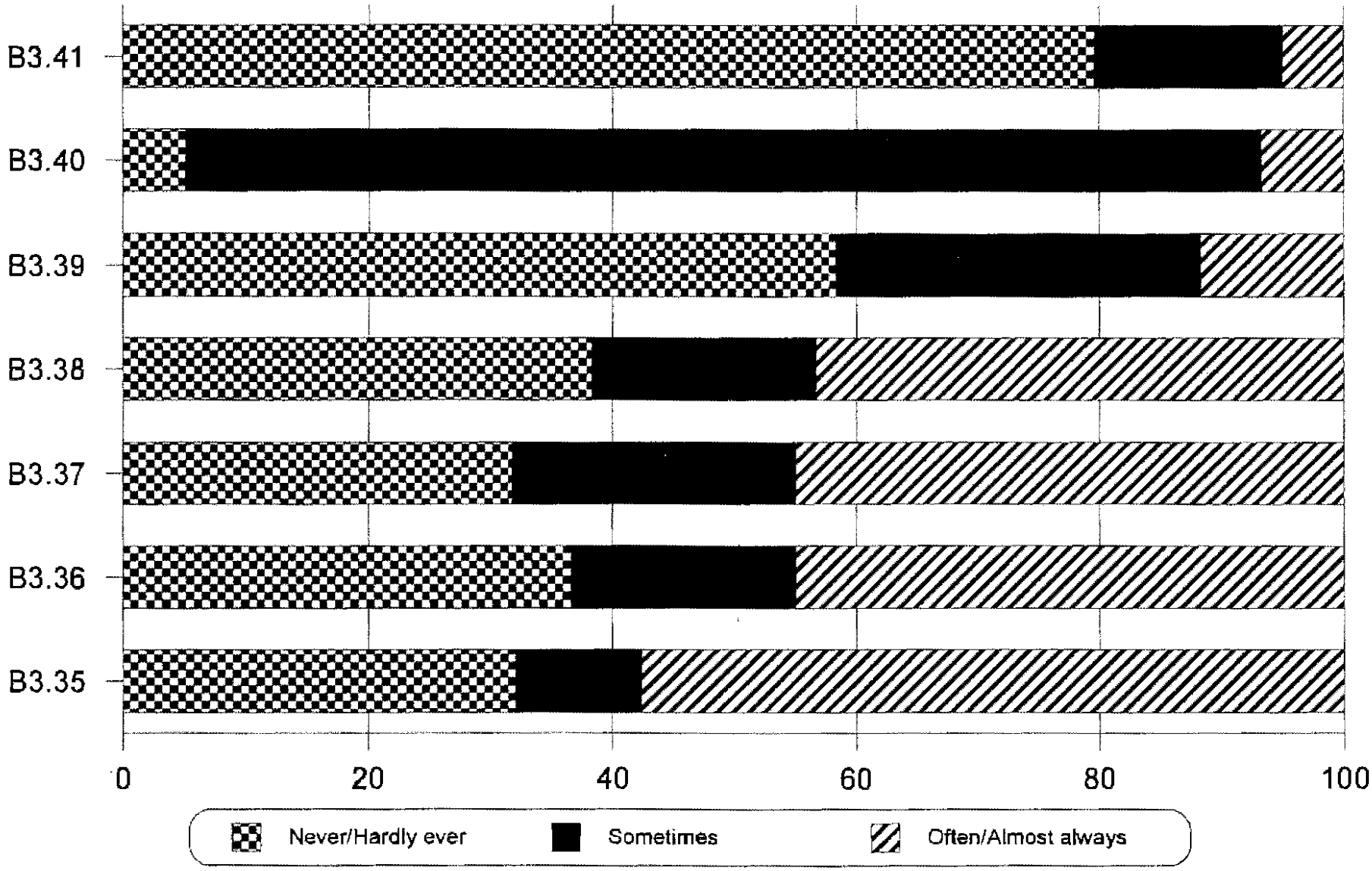

Figure 4.9
Emotional needs (n=60)

4.5.4 Emotional needs

Emotional satisfaction is derived largely from feeling that one is valued by those around one. Emotional satisfaction comes from within. It is related to our assessment of our own adequacy, our performance and capacity in the various arenas of our lives, both personal and professional. Self approval (that is liking oneself no matter what) is essential (Ellis & Nowlis 1981:38). A need arises when there is dissatisfaction. The emotional needs of persons suffering from schizophrenia (respondents) portrayed in figure 4.9.

Item 3.35: Body image (n=60)

When asked about their body appearance, approximately two percent (1,7; n=1) of the respondents indicated that they were never satisfied with their body appearance, approximately thirty percent (30,3%; n=12) indicated that they were hardly ever and sometimes satisfied respectively with their body appearance, approximately fifty-six percent (55,9%; n=33) indicated that they were often satisfied with the appearance of their body whilst approximately two percent (1,7%; n=1) of the respondents indicated that they were satisfied with the appearance of their bodies almost all the time.

Item B3.36: Intellectual functioning (n=60)

When asked about their intellectual functioning, approximately three percent (3,3%; n=2) of the respondents indicated that they were never satisfied with their intellectual functioning, approximately thirty-three percent (33,3%; n=20) indicated that they were hardly ever satisfied with their intellectual functioning, approximately eighteen percent (18,4%; n=11) indicated that they were sometimes satisfied and approximately forty-three percent (43,3%; n=26) indicated that they were often satisfied whilst approximately two percent (1,7%; n=1) of the respondents indicated that they were almost all the time satisfied with their intellectual functioning.

Item B3.37: Personal characteristics (n=60)

When asked to state their personal characteristic, five percent (5,0%; n=3) of the respondents indicated that they were never satisfied with the characteristics that could be said to describe them, approximately twenty-seven (26,7%; n=16) indicated that they were hardly ever satisfied, approximately twenty-three percent (23,3%; n=14) indicated that they were sometimes satisfied, with approximately forty-three percent (43,3%; n=26) stating that they were often satisfied, whilst approximately two percent (1,7%; n=1) of the respondents were satisfied almost all the time.

Item B3.38: Past accomplishments (n=60)

When asked about their past accomplishments, five percent (5,0%; n=3) of the respondents indicated that they were never satisfied with a past accomplishments, approximately thirty-three percent (33,3%; n=20) were hardly ever satisfied, approximately eighteen percent (18,4%; n=11) were sometimes satisfied, forty percent (40,0%; n=24) were often satisfied whilst approximately three percent (3,3%; n=2) of the respondents were satisfied with their past accomplishments almost all the time.

Item B3.39: Present accomplishments (n=60)

When asked about their present accomplishments, approximately twelve percent (11,7%; n=7) of the respondents indicated that they were never satisfied with their present accomplishments, approximately forty-seven percent (46,6%; n=28) indicated that they were hardly ever satisfied, thirty percent (30,0%; n=18) were sometimes satisfied, ten percent (10,0%; n=6) were often satisfied whilst approximately two percent (1,7%; n=2) of the respondents were satisfied with their accomplishments almost all the time.

Item B3-40: Emotional state (n=60)

When asked about their emotional state, approximately two percent (1,7%; n=1) of the respondents indicated that their predominant emotional state had never been happy and content, approximately three percent (3,3%; n=2) indicated that their emotional state had hardly ever been happy and content, approximately eighty-eight percent (88,3%; n=53) indicated that their emotional state had been happy and content sometimes, five percent (5,0%; n=3) indicated that their emotional state had been happy and content often whilst approximately two percent (1,7%; n=1) of the respondents indicated that their emotional state had been happy and content almost all the time.

Item B3.41: Level of education (n=60)

When asked about their satisfaction level in terms of education, five percent (5,0%; (n=3) of the respondents indicated that they had never been satisfied with their level of education, approximately seventy-five percent (74,6%; n=43) indicated that they had hardly ever been satisfied with their level of education, approximately fifteen percent (15,4%; n=11) indicated that they had been satisfied with their level of education sometimes whilst five percent (5,0%; n=3) of the respondents indicated that they had often been satisfied with their educational level.

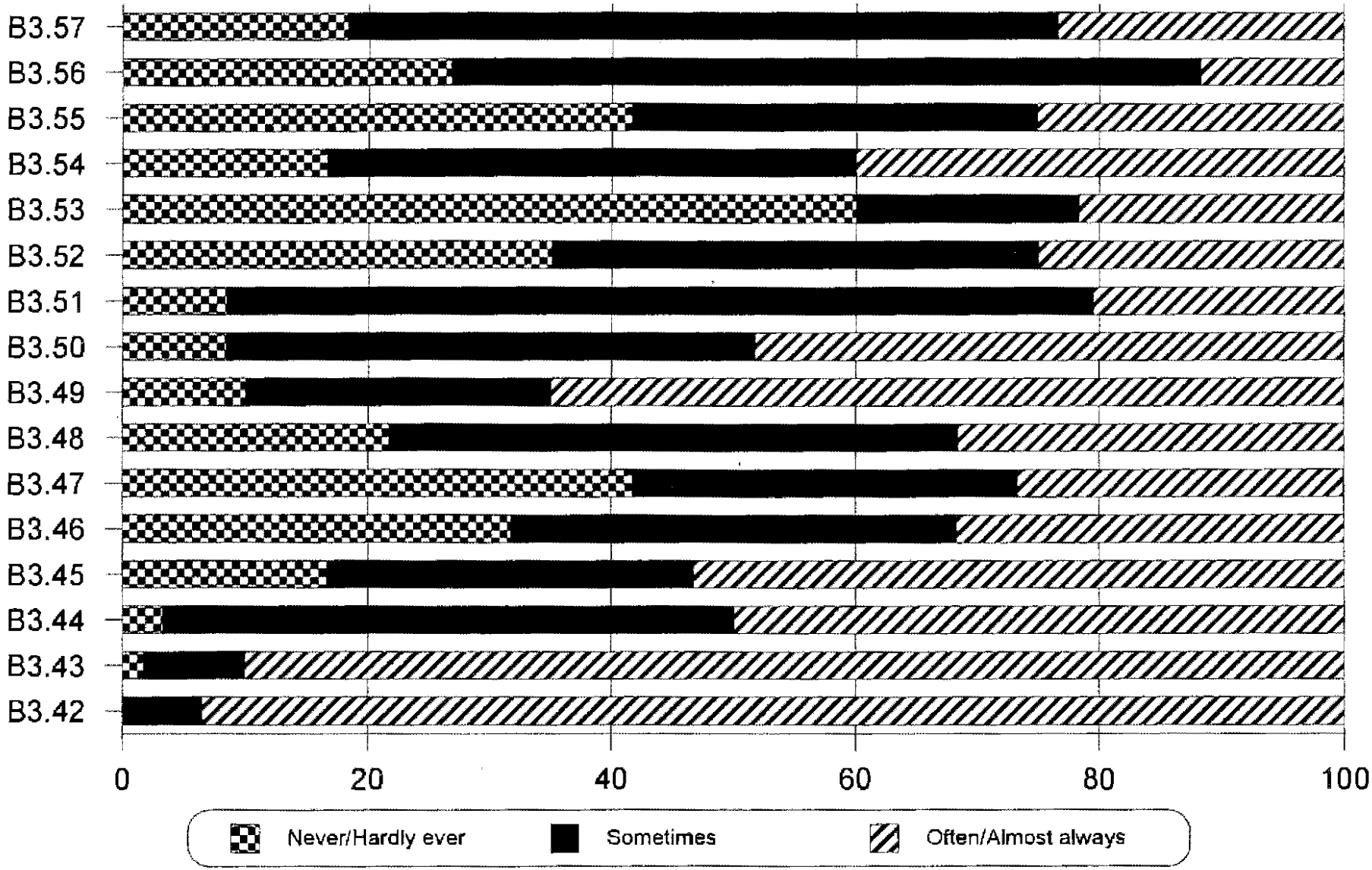

Figure 4.10
Spiritual needs (n=60)

4.5.5 Spiritual needs

Those in scientific disciplines often overlook the spiritual sphere of life, namely the wish to know life's ultimate meaning and purpose. Efforts to care for the whole person should recognise the role of spiritual needs (Ellis & Nowlis 1981:256).

Respondents were asked to rate their spiritual needs on a scale 1-5 where 1 = never and 5 = almost all the time.

The spiritual needs of persons suffering from schizophrenia are outlined in figure 4.10.

Item B3.42: The extent to which religion played a part in the lives of persons suffering from schizophrenia (n=60)

Respondents were asked to give information on the extent religion played a part in their lives. Approximately seven percent (6,5%; n=4) of the respondents were sometimes satisfied with the amount of religion in their lives, approximately seventy-three percent (73,4%; n=44) were often satisfied with the amount of religion in their lives whilst approximately twenty percent (20,1%; n=12) of the respondents were satisfied with the amount of religion in their lives almost all the time.

Item B3.43: State of fulfilment (n=60)

Respondents were asked to give information on their state of fulfilment. Less than two percent (1,7%; n=1) of the respondents indicated that they were hardly ever satisfied with their state of fulfilment, approximately eight percent (8,3%; n=5) indicated that they were sometimes satisfied with their state of fulfilment, seventy-five percent (75,0%; n=45) indicated that they were often satisfied with their state of fulfilment. Fifteen percent (15,0%; n=9) of the respondents indicated that they were satisfied with their state of fulfilment almost all the time.

Item B3.44: Enjoyment in everyday life (n=60)

Respondents were asked about the state of enjoyment in their everyday lives. Approximately three percent (3,3%; n=2) of the respondents indicated that they were never satisfied with the amount of enjoyment in their everyday lives, approximately forty-seven percent (46,7%; n=28) indicated that they were sometimes satisfied with the amount of enjoyment in their everyday lives, whilst approximately three percent (3,3%; n=2) of the respondents indicated that they were satisfied with the amount of enjoyment in their everyday lives almost all the time.

Item B3.45: Plans to increase levels of fulfilment (n=60)

When asked about their plans to increase their levels of fulfilment, approximately three percent (3,3%; n=2) of the respondents indicated that they never made plans to increase their level of fulfilment, approximately thirteen percent (13,4%; n=8) indicated that they hardly ever made plans, thirty percent (30,0%; n=18) sometimes, approximately fifty-two percent (51,6%; n=31) often, and less than two percent (1,7%; n=1) of the respondents made plans to increase their level of fulfilment almost all the time.

The majority of the respondents (90,0%; n= 54) indicated that they were often satisfied and were satisfied with their level of fulfilment. This could explain why the majority of the respondents (53,3% n=32) did not have plans to increase their level of fulfilment.

Item B3.46: Potential for achieving higher goals (n=60)

When asked about their potential for achieving higher goals, approximately seven percent (6,7%; n=3) of the respondents indicated that they were never optimistic about their potential to reach higher goals, twenty-five percent (25,0%; n=5) indicated that they were hardly ever, approximately thirty-seven percent (36,6%; n=22) indicated that they sometimes were optimistic of reaching their life goals, thirty percent (30,0%; n=18) indicated that they often felt optimistic about reaching their life goals, whilst less than two percent (1,7%; n=1) of the

respondents indicated that they were optimistic about the potential to reach higher level life goals almost all the time.

The majority of the respondents did not feel optimistic that they were able to achieve their goals with 1,7 percent feeling optimistic. This was an indication that persons suffering from schizophrenia lack confidence in whatever they are doing due to low self-esteem experienced.

Item B3.47: Satisfaction with tasks accomplished (n=60)

When asked about satisfaction with tasks accomplished, five percent (5,0%; n=3) of the respondents indicated that they were never satisfied with their tasks accomplished, approximately thirty-seven percent (36,7%; n=22) indicated that they were hardly ever satisfied, approximately thirty-two percent (31,6%; n=19) indicated that they were sometimes satisfied whilst twenty-seven percent (26,7%; n=16) of the respondents indicated that they were often satisfied with the tasks accomplished in their lives.

Item B3.48: Satisfaction with motivational levels reached (n=60)

When asked about satisfaction with the motivational levels reached five percent (5,0%; n=3) of the respondents indicated that they were never satisfied with the motivational level reached, approximately seventeen percent (16,7%; n=10) were hardly ever satisfied, approximately forty-seven percent (46,7%; n=28) were sometimes satisfied, approximately twenty-eight percent (28,3%; n=17) were often satisfied, whilst approximately three percent (3,3%; n=2) were satisfied about the motivational level reached almost all the time.

Item B3.49: Satisfaction with the motivational level of family and friends in supporting the goals of persons suffering from schizophrenia (n=60)

When asked about the motivation level of family and friends in supporting their goals ten percent (10,0%; n=6) of the respondents were hardly ever satisfied, twenty-five percent

(25,0%; n=15) were sometimes satisfied, approximately fifty-seven percent (56,7%; n=34) were often satisfied whilst approximately eight percent (8,3%; n=5) were satisfied with the motivational level of family and friends to support their goals almost all the time.

Item B3.50: Satisfaction with the level of responsibility given (n=60)

When asked about their satisfaction with the amount of responsibility they were given, approximately two percent (1,7%; n=1) of the respondents indicated that they were never satisfied with the amount of responsibility given, approximately seven percent (6,7%; n=4) indicated that they were hardly ever satisfied, approximately forty-three percent (43,3%; n=26) were sometimes satisfied, approximately forty-two percent (41,6%; n=25) were often satisfied whilst approximately seven percent (6,7%; n=4) of the respondents were satisfied almost all the time with the amount of responsibility they had been given. The majority (41,6%) of the respondents were thus given enough responsibility.

Item B3.51: Satisfaction of the level of spontaneity in life (n=60)

When asked about their satisfaction with the level of spontaneity they had in their lives, approximately three percent (3,3%; n=2) of the respondents indicated that they were never satisfied with the level of spontaneity they had in their lives, approximately five percent (5,1%; n=3) indicated that they were hardly ever satisfied, approximately seventy-one percent (71,1%; n=37) were satisfied sometimes, approximately nineteen percent (18,8%; n=17) were satisfied often whilst less than two percent (1,7%; n=1) of the respondents were satisfied with the amount of spontaneity in their lives almost all the time.

Item B3.52: Satisfaction with the level of hope in the lives of persons suffering from schizophrenia (n=60)

When asked about their level of hope, five percent (5,0%; n=3) of the respondents indicated that they never had a satisfactory level of hope, thirty percent (30,0%; n=18) hardly ever, forty-percent (40,0%; n=24) sometimes, approximately twenty-three percent (23,3%; n=14)

often whilst less than two percent (1,7%; n=1) of the respondents had a satisfactory level of hope almost all the time.

Item B3.53: New interests (n=60)

When asked whether they had new interests, ten percent (10,0%; n=6) of the respondents indicated that they never had new interests in their lives, fifty percent (50,0%; n=30) indicated that they hardly ever had new interests in their lives, approximately eighteen percent (18,3%; n=11) indicated that they sometimes had new interests in their lives, approximately seventeen percent (16,7%; n=10) indicated that they often had new interests in their lives, whilst five percent (5,0%; n=3) of the respondents indicated that they had new interests in their lives almost all the time. The majority of the respondents (50,5%; n=30) did not have new interests in life, probably due with their lack of energy and/or willpower.

Item B3.54: Satisfaction with the meaning and purpose in their lives (n=60)

When asked about the degree of meaning and purpose in their lives, less than two percent (1,7%; n=1) of the respondents indicated that they were never satisfied with the amount of meaning and purpose in life, fifteen percent (15,0%; n=9) were hardly ever satisfied, approximately forty-three percent (43,3%; n=26) were satisfied sometimes, approximately thirty-eight percent (38,3%; n=23) were satisfied often and less than two percent (1,7%; n=1) were satisfied with the amount of meaning and purpose in life almost all the time.

Item B3.55: Level of satisfaction with a change in life-style (n=60)

When asked how they had accepted their change in life-style, approximately eight percent (8,3%; n=5) of the respondents had never reconciled to a change in their life-style or to their disability, approximately thirty three percent (33,3%; n=20) had hardly ever reconciled, approximately twenty percent (20,1%; n=12) had reconciled often whilst five percent (5,0%; n=3) of the respondents had reconciled to the change in their life-style due to their disability almost all the time.

Item B3.56: Coping reactions of persons suffering from schizophrenia (n=60)

When asked about their coping reaction to suffering, approximately twenty-seven percent (26,7%; n=16) of the respondents indicated that they were hardly ever satisfied with their coping reaction to suffering, approximately sixty-two percent (61,6%; n=37) were satisfied sometimes, ten percent (10,0%; n=6) were satisfied often whilst less than two percent (1,7%; n=1) of the respondents were satisfied with the coping reaction to suffering almost all the time. The majority of the respondents (61,6%) indicated that they were dissatisfied with their coping reactions to their disease.

Item B3.57: Satisfaction with levels of strength to cope with their situation (n=60)

When asked whether they had sufficient strength to cope with their situation, approximately three percent (3,3%; n=2) of the respondents indicated that they were never satisfied with the amount of strength they had, fifteen percent (15,0%; n=9) were hardly ever been satisfied, approximately fifty-eight percent (58,3%; n=35) were satisfied sometimes, approximately twenty-two percent (21,7%; n=13) were satisfied often and less than two percent (1,7%; n=1) of the respondents were satisfied with the amount of strength and courage they had all the time.

4.6 SECTION C: SUPPORT SYSTEMS

A support system is identified or categorised in various ways in the literature. The Oxford Advanced Learner's Dictionary (1989:426), for example, conceptualises *support systems* as being functional, or structural.

- *Functional support* provides one or more of the following: material aid, emotional support, affirmative acknowledgement, information guidance and companionship (Baldwin & Woods 1994:324).
- *Structural support* can be analysed in terms of size, type and others but does not necessarily imply functional support (Masilela & Macleod 1998:11).
- In this study *support* was seen as functional support.

Item C1.1-5: Internal support (n=60)

Table 4.10: Internal and external support (Items C1 and C2) (n=60)

INTERNAL AND EXTERNAL SUPPORT SYSTEMS	n	%
Internal support		
Mother	36	60,0
Father	12	20,0
Grand parents	24	40,0
Other siblings	22	36,7
Extended family member	26	43,3
External support:		
Friends	23	38,3
Professionals	58	96,7
Nonprofessionals	1	1,7

(More than one answer could be given by respondents for this question. Therefore the total number of responses to any possible answer could exceed 60.)

When asked to state the source of assistance within the family, the majority of the respondents, sixty percent (60,0%; n=36) indicated that support was received from the mother, twenty percent (20,0%; n=12) from the father, forty percent (40,0%; n=24) from grandparents, approximately thirty-seven percent (36,7%; n=22) from other siblings and approximately forty-three percent (43,3%; n=26) of the respondents indicated that they received assistance from extended family members (see table 4.10).

It was surprising that despite the problems posed by persons suffering from schizophrenia towards their families, it appeared that families were still committed to giving unconditional assistance to their mentally ill children or next-of-kin.

Item C2.1-3: External support (n=60)

When asked to state the external support systems they were utilising, the majority of respondents, approximately ninety-seven percent (96,7%; n=58) indicated professional

systems, approximately thirty-eight percent (38,3%; n=23) indicated friends whilst less than two percent (1,7%; n=1) of the respondents indicated that assistance was obtained from non-professional systems (see table 4.10).

The above findings indicated the trust and confidence the persons suffering from schizophrenia had in the professional team due to the fact that caregivers accepted and understood persons suffering from schizophrenia better more than friends and non-professionals. On the other hand, the literature states that persons suffering from schizophrenia need friends to turn to in times of crises (Palmer-Erbs & Anthony 1995:38).

Item C3.1-8: Advice or help received from rehabilitative care centres (n=60)

Table 4.11: Advice or help received from rehabilitative care centres (n=60)

ADVICE OR HELP RECEIVED	n	%
Alternative accommodation	0	0,0
Finance	2	3,3
Medical and psychiatric matters	60	100,0
Someone to talk to	46	76,7
Assertive approach	0	0,0
Social and leisure activities	11	18,3
Counselling and support	6	10,0

More than one answer could be given to this question. The main goals in a rehabilitative care approach is to increase the functioning potential in the major role areas with emphasis on the development of skills and the resources necessary for support as well as those needed for successful living, learning, and working in the community (Palmer-Erbs & Anthony 1995:40). When asked about the rehabilitative care and the advice or help received all the respondents (100%; n=60) indicated that they had received advice on medical and psychiatric matters. Almost seventy-seven percent (76,7%; n=46) indicated that they had someone they could consult. Approximately three percent (3,3%; n=2) of the respondents received advice on finance whilst a hundred percent (100,0%; n=60) on the other hand, had received no advice nor help on matters pertaining to an assertive approach or finding alternative

accommodation. Almost nineteen percent (18,6%; n=11) of the respondents received advice or help pertaining to social and leisure activities and approximately ten percent (10,2%; n=6) in counselling and support (see table 4.11).

Item C4.1-4: Sources of advice or help (n=60)

Table 4.12: Sources of advice or help (n=60)

SOURCES OF ADVICE OR HELP	n	%
Professionals	59	98,3
Friends	19	31,7
Relatives	45	75,0

More than one answer could be given to this item. When asked from what source they received advice or help the majority of respondents (98,3%; n=59) indicated that they received advice from professionals followed by approximately seventy-six percent (76,3%; n=45) who had received advice from relatives and approximately thirty-three percent (32,8%; n=19) from friends. It would appear from these findings that professionals cannot succeed alone in advising persons suffering from schizophrenia about mental health matters. Support from relatives and friends is needed as well (see table 4.12).

Item C5.1-7: Type of contribution received in the past year (n=60)

Table 4.13: Type of contribution received in the past year (n=60)

TYPE OF ASSISTANCE	n	%
Help concerning housing	60	100,0
Vocational training	1	1,7
Medical and psychiatric care	59	98,3
Individual or family assistance	10	16,7
Counselling	8	13,3
Legal assistance	60	100,0

More than one response was possible to this question. When asked about the type of assistance they had received in the past year, the majority of respondents (98,3%; n=59) responded positively in the areas of medical and psychiatric care. Approximately two percent (1,7%; n=1) of the respondents in vocational training, approximately seventeen percent (16,9%; n=10) in individual and family assistance and approximately fourteen percent (13,6%; n=8) in counselling. The others responded negatively in areas of help concerning housing (100,0%; n=60), vocational training approximately ninety-eight percent (98,3%; n=59), individual and family assistance approximately eighty-three percent (83,1%; n=49) in counselling approximately eighty-six percent (86,4%; n=51) and in terms of legal assistance a hundred percent (100,0%; n=60) (see table 4.13).

Item C6.1-5: Services required (n=60)

Table 4.14: Services required (n=60)

SERVICES REQUIRED	n	%
Accommodation	47	78,3
Vocational training	54	90,0
Medical and psychiatric care	5	8,3
Individual or family assistance	50	83,3
Legal assistance	24	40,0

More than one response could be given to this question. When asked about which services they would like to have available to them, approximately ninety-two percent (91,5%; n=54) indicated that they needed vocational training, approximately nine percent (8,5%; n=5) indicated that they needed medical and psychiatric services, approximately eighty-five percent (84,7%; n=50) indicated that they needed individual and family counselling, approximately forty-one percent (40,7%; n=24) needed legal assistance whilst approximately eighty percent (79,7%; n=47) of the respondents indicated that they needed alternative accommodation (see table 4.14).

Vocational training is considered important by society as it gives independence, image,

money and prestige. Persons suffering from schizophrenia a who became ill during their youth, most often offer little to society except their existence (O'Brien 1998:40).

The need for alternative resources related to accommodation could be due to the following reasons:

- Depressed income levels
- Shortage of affordable accommodation
- Rejection of mentally ill persons by families
- Difficulties experienced in living independently
- The stigma of psychiatric illness
- Less supportive family networks (White 1991:13)

Item C7.1-6: Special needs available in the community

Table 4.15: Special needs available in the community

SPECIAL NEEDS AVAILABLE	n	%
Social training and opportunities	3	5,0
Work training and employment opportunities	3	5,0
Living arrangements	3	5,0
Study opportunities	2	3,3
Other	1	1,7
None	50	83,3

More than one response was possible to this question. When asked which services were available in their community, the response were as follows: social training and social opportunities five percent (5,0%; n=3) work training and employment opportunities ninety percent (95,0%; n=57); living arrangements five percent (5,0%; n=3); study opportunities approximately three percent (3,3%; n=2) whilst approximately eighty-three percent (83,3%; n=50) of the respondents indicated that there were no services in their community (see table 4.15).

4.7 SECTION D: COMMUNITY RESOURCES

In terms of the environment in which the person functions, it is important to consider the naturally occurring support and services that might be utilised.

Firstly, resources should be identified which enable persons suffering from schizophrenia to gain access to the roles, relationships, facilities and activities desired.

Secondly, facilities should be identified that could be employed to minimise the disruptive impact of any disabilities and problems they might have. These might include family, friends, neighbours, non-psychiatric services, churches, self-help groups as well as the psychiatric services on which mental health professionals tend to focus most frequently (Baldwin 1997:68).

Item D1.1-8: Counselling services

Ideally, counselling should begin as soon as possible after positive symptoms have been controlled to get people back on their feet by helping them come to terms with their emotions.

When asked to indicate the counselling services available in their community, all the respondents (100,0%; n=60) indicated that there were no counselling services, no social department services, no government psychological services or veteran centres available. Approximately twelve percent (11,9%; n=7) of the respondents indicated that there were comprehensive care facilities in their area whilst approximately eighty-eight percent (88,1%; n=52) stated that there were none. Approximately ninety-seven percent (96,7%; n=58) indicated that their were religious services within the community whilst approximately three percent (3,3%; n=2) indicated that there were none. The significance of the large number of respondents, approximately eighty-eight percent (88,1%; n=58) who indicated that they did belong to some form of religion was of importance especially for spiritual healing as well as for their physical and mental health. Item A5 of this study (religious affiliation) supported

this high percentage. The spiritual realm in Mogoto Village was taken as a source of strength, support, security and well-being. Approximately twenty-eight percent (28,3%; n=17) of the respondents indicated that life educator services were available whilst approximately seventy-two (71,7%; n=43) indicated that there were none.

Item D2.1-6: Services for alcohol and drug abuse (n=60)

Item D3.1-4: Education facilities (n=60)

Item D4.1-5: Financial aid (n=60)

Item D5.1-6: Employment (n=60)

All the respondents (100%; n=60) indicated these facilities were not available in Mogoto Village. These results implied that there were still barriers within the health system separating physical and mental illness. These barriers could be due to the lack of available resources, for example, mental health resources such as inadequate community treatment centres, inadequate numbers of services for those dually diagnosed with mental illness; inadequate numbers of crisis intervention centres; inadequate public and other transport services; inadequate employment opportunities and inadequate facilities in general for meeting the needs of these persons suffering from schizophrenia (Holliday et al 1996:4).

Item D6.1-4: Advocates (n=60)

The literature states that advocacy is "an act in which one acts or speaks on behalf of clients to help them gain greater independence or self-determination to make the system more responsive and relevant to their needs" (Dreyer et al 1997:27). On the question of advocacy seventy-five percent (75,0%; n=45) of the respondents stated that there were long-term care facilities whilst twenty-five percent (25,0%; n=15) on the other hand stated that there were no long-term facilities. All the respondents (100%; n=60) indicated that there were no local government, citizen advocacy services, no department of social services and no department

of public services in Mogoto Village.

The results indicated the need for advocacy services in Mogoto Village especially from the local government/someone or some agency to advocate on the respondents' behalf to help them gain their independence.

Item D7.1-4: Potential sources of help in times of trouble (n=60)

- **Religious beliefs (n=60)**

When asked whether their religious beliefs helped them in times of need, approximately eighty-six percent (85,5%; n=51) of the respondents indicated that their religious resources and their different beliefs did support them – see items A5 (religious affiliation) and B1.3 (church social services and spiritual needs).

- **Family (n=60)**

On the question of family as a potential source of help in times of trouble, approximately ninety-three percent (93,3%; n=56) of the respondents indicated that the family was a potential source which helped them in times of trouble whilst approximately seven percent (6,7%; n=4) stated that the potential source that helped them in times of trouble was not the family. It would appear that despite the burden on the family of caring for persons suffering from schizophrenia, families still showed concern, love and understanding of their family members suffering from schizophrenia thus reducing risks of a relapse.

- **Friends (n=60)**

When asked about friends, thirty percent (30,0%; n=18) of the respondents indicated that they were helped by friends in times of trouble whilst seventy percent (70,0%; n=42) indicated that friends were not of assistance to them. Friends are regarded as individuals who are always there for you when you need them. Persons suffering from schizophrenia in this context had friends who accepted them unconditionally and helped them to meet their needs.

- **Professionals (n=60)**

When asked about the help received from professionals, all the respondents, hundred percent (100,0%; n=60) indicated that professionals were the source that helped them most at times of trouble. Professionals were regarded by the community as the health agents who disseminated information not only about schizophrenia but public health information as well and those who influenced health policies and were advocates for the promotion of health (Spradley & Allender 1996:27).

Item D8.1-6: Services used in times of crisis (n=60)

When asked about services they used in times of crises, all the respondents (100,0%; n=60) indicated that services such as crisis line were not used in times of crisis. Approximately ninety-three (93,3%; n=59) of the respondents made use of the clinic staff whilst approximately two percent (1,7%; n=2) did not, ten percent (10,0%; n=6) made use of police against nineteen percent (90,0%; n=54) who did not. Approximately ninety-three percent (93,3%; n=56) made use of family members whilst approximately seven percent (6,7%; n=4) did not, approximately thirty-eight percent (38,3%; n=23) made use of community members whilst approximately sixty-two percent (61,7%; n=37) did not.

Item D9.1-6: Available human resources in the community (n=60)

When asked about the available human resources in the community, thirty percent (30,0%;

n=18) of the respondents indicated that there were community psychiatric nurses whilst seventy percent (70,0%; n=42) indicated that there were none. There was confusion related to this finding as thirty percent (30,0%; n=18) of the respondents assumed that the available registered nurse issuing their psychiatric treatment was a psychiatric nurse whilst in fact there was no community psychiatric nurse at the clinics. All of the respondents (100,0%; n=60) indicated that there was no social worker, or psychologist at Mogoto Village, approximately ninety-eight percent (98,3%; n=59) indicated that traditional healers were available. It would appear that persons suffering from schizophrenia consulted the traditional healer first before visiting the hospital thus satisfying cultural myths that they might have related to their illness. Approximately sixty three percent (63,2%; n=36) of the respondents indicated that there were faith/spiritual healers whilst approximately thirty-seven percent (36,8%; n=21) stated that these were not known to them.

Item D10.1-5: Available psychiatric services (n=60)

Table 4.16: Available psychiatric services (n=60)

PSYCHIATRIC SERVICES	YES	%	NO	%	TOTAL
Awareness campaigns	57	96,6	3	21,7	60
Transport for patients	0	0,0	60	100,0	60
Crisis intervention	15	25,4	45	75,0	60
Mental health promotion	49	83,1	11	37,9	60
Other	-	-	-	-	-

When asked about the availability of psychiatric services, approximately ninety-seven percent (96,6%; n=57) of the respondents indicated that there were awareness campaignes in the village whilst approximately twenty-two percent (21,7%; n=3) of the respondents indicated that there are no such campaigns. All the respondents (100%; n=60) indicated that there were no transport arrangements for persons suffering from mental illnesses. Approximately twenty-five percent (25,4%; n=15) of the respondents indicated that there

was a crisis intervention centre at the clinic whilst seventy-five percent (75,0%; n=45) of the respondents indicated that there are no crisis intervention centre available. Approximately eighty-three percent (83,1%; n=49) of the respondents indicated that there were mental health promotion sessions at the clinic whilst approximately thirty-eight percent (37,9%; n=11) of the respondents were unaware of any mental health promotion sessions at the clinic.

The findings indicated a need for transport and crisis intervention services. If crisis intervention services were available at the clinic it would appear that persons suffering from schizophrenia and their carers should be informed about the existence of these services.

Item D11.1-5 Recreational services (n=60)

When asked about recreational services, all the respondents (100,0%; n=60) indicated that there were different choirs in their community, approximately ninety-three percent (93,3%; n=56) indicated that there were different dances whilst approximately seven percent (6,7%; n=4) stated that none of these services were available. All the respondents (100,0%; n=60) indicated that soccer/netball services were available in Mogoto Village. All the respondents (100,0%; n=60) indicated that there were no other forms of recreational services available to them in the community.

Item 12.1-5: Involvement with recreational services (n=60)

When asked about their involvement in the recreational services provided. Approximately twenty-four percent (23,7%; n=14) of the respondents indicated that they were involved in different choirs whilst approximately seventy-six percent (76,3%; n=45) indicated they were not involved, approximately nine percent (8,6%; n=5) indicated that they were involved in dancing activities whilst approximately ninety-one percent (91,4; n=53) were not involved, approximately nine percent (8,5%; n=5) were involved in soccer/netball activities whilst approximately ninety-two percent (91,5%; n=54) were are not involved, approximately sixty-seven percent (67,2%; n=39) indicated that they were involved in at least one of the recreational activities whilst approximately thirty-three percent (32,8%; n=19) of the

respondents indicated that they were not involved in any of the recreational activities.

Item D13.1-5: Rehabilitation services available (n=60)

All (100,0%; n=60) respondents indicated that there were no workshops, halfway houses, industrial training centres or private dwellings for psychiatric rehabilitation.

These findings were similar to those reported by White (1991:12) who states that "... there is much work still to be done in less developed urban, rural and informal settlement areas with regard to rehabilitation of persons suffering from schizophrenia if disabilities and the stigma attached to the condition are to be diminished".

Item D14.1-5: The cause of not being completely happy (n=60)

Table 4.17: The cause of not being completely happy (n=60)

CAUSE	YES		NO		TOTAL
	n	%	n	%	
Financial troubles	42	70,0	18	30,0	60
One's self	-	-	60	100,0	60
One's family	5	8,3	55	91,7	60
Lack of opportunity	54	90,0	6	10,0	60
One's social life	45	75,0	15	25,0	60

When asked which factors made them less than completely happy, seventy percent (70,0%; n=40) of the respondents indicated that financial troubles were the main causes of them being less than completely happy in their lives whilst thirty percent (30,0%; n=18) said this was not the main cause. All of the respondents (100,0%; n=60) indicated that they themselves were not the cause. Just over eight percent (8,3%; n=5) indicated that their families were the cause whilst approximately ninety-two percent (91,7%; n=55) said that their families were

not the cause. Ninety percent (90,0%; n=54) of the respondents indicated that lack of opportunity was a major cause whilst ten percent (10,0%; n=6) said this was not a cause. Seventy-five (75,0%; n=45) indicated that an unstable social life was the cause of them being less than completely happy in their lives (see table 4.17).

Item 15.1-5: Conditions making it possible to remain in the community (n=60)

Currently it is emphasised worldwide that persons suffering from schizophrenia should be encouraged to live in their respective communities as this facilitates acceptance and understanding of their condition by fellow community members and enables them to fit into in the framework of the community system (Tsuang & Faraone 1998:32)

When asked about the possible conditions that would enable them to remain in the community, approximately seventy-three percent (73,3%; n=44) of the respondents indicated the existence of appropriate employment whilst approximately seventeen percent (16,7%; n=16) did not. Approximately eighty-three percent (83,3%; n=50) indicated that adequate financial support was a possibility whilst approximately seventeen percent (16,7%; n=10) did not, approximately seventy-two percent (71,7%; n=43) indicated suitable accommodation was a possibility whilst approximately twenty-eight percent (28,3%; n=17) did not. Approximately eighty-seven percent (86,7%; n=52) of the respondents indicated that the existence of social support systems was a possibility whilst approximately thirteen percent (13,3%; n=8) did not see this as being an incentive.

Item 16.1-4: Problems of daily living that prevent the use of available resources (n=60)

When asked about problems of daily living, approximately sixty-seven percent (66,7%; n=40) of the respondents indicated that stigma was a problem that they experienced in their daily lives and in their view this was a factor that could contribute to their failure to make use of the available resources whilst approximately thirty-three percent (33,3%; n=20) said this was not the case. Approximately ninety-eight percent (98,3%; n=59) of the respondents indicated that lack of information was a problem whilst less than two percent (1,7%; n=1)

said this was not the case. Approximately sixty-eight percent (68,3%; n=41) of the respondents indicated that gaps and inadequacies in services was a problem whilst approximately thirty-two percent (31,7%; n=19) said they had no problems with the services..

4.8 SECTION E: SERVICE NEEDS

Item E1.1-2: Medical care (n=60)

Table 4.18: Medical care (n=60)

MEDICAL CARE NEEDS	GENDER				TOTAL	
	MALE		FEMALE			
	n	%	n	%	n	%
Specific health care	9	29,0	14	48,3	23	38,3
Psychotropic medicine	22	71,0	15	51,7	37	61,7
TOTAL	31	100,0	29	100,0	60	100,0

"There is no doubt that the discovery of the neuroleptic drugs revolutionised the treatment of schizophrenia enabling the vast majority of these persons to remain in the community" (Lintner 1995:57). The above statement was supported by the responses given to this question when respondents were requested to indicate the most important service in terms of these needs. Approximately sixty-two percent (61,7%; n=37) of the respondents indicated psychotropic medicine whilst the remaining respondents, approximately twenty-eight percent (28,3%; n=23) indicated specific health care services (see table 4.18).

Data was analysed further to determine whether there were different views between males and females (see table 4.18). Nineteen percent (19,0%; n=9) of the male respondents and approximately forty-eight percent (48,3%; n=14) of the females selected specific health care services. Seventy-one percent (71,0%; n=22) of the males and approximately fifty-two

percent (51,7%; n=15) females indicated psychotropic medications.

With a difference of only approximately twelve percent (11,7%; n=7), it would appear that both groups were concerned about their medications.

Item E 2.1-7: Counselling needs (n=60)

Table 4.19: Counselling needs (n=60)

COUNSELLING NEEDS	GENDER				TOTAL	
	MALE		FEMALE			
	n	%	n	%	n	%
Socialisation groups	6	19,4	3	10,3	9	15,0
Self-help groups	15	48,4	18	62,1	33	55,0
Group therapy	0	0,0	0	0,0	0	0,0
Alcohol	0	0,0	0	0,0	0	0,0
Drug	1	3,2	0	0,0	1	1,7
Marital/family	9	29,0	7	24,1	16	26,7
Parenting	0	0,0	1	3,5	1	1,7
TOTAL	31	100,0	29	100,0	60	100,0

According to Lintner (1995:71) "it is quite fundamental for someone who has or is recovering from schizophrenia to find a counsellor that they can trust. This does not necessarily mean a doctor, although it should certainly be someone who has a sound knowledge of the illness".

In terms of where counselling was found to be of the greatest benefit, fifteen percent (15,0%; n=9) of the respondents indicated socialisation groups, fifty-five percent (55,0%; n=33) self-help groups, approximately twenty-seven percent (26,7%; n=16) marital/family, with less than two percent (1,7%; n=1) stating the use of drugs. There was a negative response related

to group therapy and alcohol zero percent (0,0%; n=0), with parenting being less than two percent (1,7%; n=1).

Further cross-tabulations of data according to gender were carried out. Approximately nineteen percent (19,4%; n=6) of the male respondents indicated socialisation groups and approximately ten percent (10,3%; n=3) females, approximately forty-eight percent (48,4%; n=15) of the males indicated self-help groups and approximately sixty-two percent (62,1%; n=18) of the females, approximately three percent (3,2%; n=1) of the males opted for drug and nil percent females. Twenty-nine percent (29,0%; n=9) of the males indicated marital/family counselling and approximately twenty-four percent (24,1%; n=7) females. Approximately four percent (3,5%; n=1) of the females indicated parenting with nil percent of males indicating this option. There was a difference of approximately six percent (6,4%; n=2) between the male and female respondents' views on the importance of counselling (see table 4.19). It would appear that all persons suffering from schizophrenia needed counselling regardless of gender.

E3.1-3: Leisure time activities (n=60)

Table 4.20: Leisure time activities (n=60)

LEISURE TIME ACTIVITIES	GENDER				TOTAL	
	MALE		FEMALE			
	n	%	n	%	n	%
Social groups	9	29,0	10	34,5	19	31,7
Recreational activities	22	71,0	18	62,1	40	66,7
Arts/crafts	0	0,0	1	3,5	1	1,7
TOTAL	31	100,0	29	100,0	60	100,0

Chadwich (1997:57) states that "in mental illness failure to find satisfaction in leisure activities is very common. Many people use their leisure time for the pursuits they most enjoy and which make their life richer and more worthwhile".

In terms of their preference related to leisure time activities, approximately thirty-two percent (31,7%; n=19) of the respondents indicated the importance of social groups, approximately sixty-seven percent (66,7%; n=40) selected recreational activities whilst less than two percent (1,7%; n=1) indicated preference for arts and crafts.

Cross-tabulation of data was done to determine gender preferences. Twenty-nine percent (29,0%; n=9) of the males indicated social groups and approximately thirty-five percent (34,5%; n=10) females, seventy-one percent (71,0%; n=22) of the males indicated recreational activities and approximately sixty-two percent (62,1%; n=18) of the females with approximately four percent (3,5%; n=1) of the females indicating arts/crafts. There was a total of approximately fifty-two percent (51,7%; n=31) males and approximately forty-eight percent (48,3%; n=29) females (see table 4.20). Both the males and the females alike needed leisure time activities to make their lives more meaningful.

E4.1-3: Financial support (n=60)

Table 4.21: Financial support (n=60)

FINANCIAL SUPPORT	GENDER				TOTAL	
	MALE		FEMALE			
	n	%	n	%	N	%
Public assistance	1	3,2	0	0,0	1	1,7
Food stamps	21	67,7	21	72,4	42	70,0
Government grants	9	29,0	8	27,6	17	28,3
TOTAL	**31**	**100,0**	**29**	**100,0**	**60**	**100,0**

When asked to indicate the most important service needs with regard to finance, seventy percent (70,0%; n=42) of the respondents indicated a need for food stamps, less than two percent (1,7%; n=1) indicated public assistance and approximately twenty-eight percent (28,3%; n=17) government grants. Data was further cross-tabulated in terms of gender. The results indicated that both males and females approximately sixty-eight percent (67,7%; n=21) indicated food stamps, twenty-nine percent (29,0%; n=9) of the males indicated government grants and approximately twenty-eight percent (27,6%; n=8) females. Only one female (1,7%; n=1) indicated public assistance (see table 4.21). It would appear from these findings that there was little significant difference in the preference of the two groups and that both males and females needed financial assistance and to a lesser extent food stamps.

E5.1.2: Support to relatives (n=60)

Table 4.22: Support to relatives (n=60)

SUPPORT TO RELATIVES	GENDER				TOTAL	
	MALE		FEMALE			
	n	%	n	%	n	%
Counselling with family members	17	56,7	17	58,6	34	57,6
Support groups for family members	13	43,3	12	41,4	25	42,4
TOTAL	**31**	**100,0**	**29**	**100,0**	**60**	**100,0**

Initial reactions to the demands made on the carers responsible for the care of persons suffering from schizophrenia ranged from bewilderment, anxiety and denial through to unrealistic expectations both about recovery and the clients' role performances (Wykes, Tarrier & Lewis 1998:204). During this phase, the relatives needed some kind of support. Approximately fifty-eight percent (57,6%:N=34) of the respondents indicated that relatives needed counselling together with the persons suffering from schizophrenia whilst approximately forty-two percent (42,4%; n=25) indicated the need for support groups for

family members.

Cross-tabulation of data according to gender was done. Approximately fifty-seven percent (56,7%; n=17) of both males and females indicated the need for counselling with family members, approximately forty-three (43,3%; n=13) of the males and approximately forty-one percent (41,4%; n=12) of the females indicated the need for support groups for family members (see table 4.22). There was a difference of less than two percent (1,7%; n=1) between the two groups of respondents which was not significant. Both males and females were concerned about their relatives and realised that relatives needed support when caring for their relatives diagnosed with schizophrenia.

E6.1.4: Activities of daily living (n=60)

Table 4.23: Activities of daily living (n=60)

ACTIVITIES OF DAILY LIVING	GENDER				TOTAL	
	MALE		FEMALE			
	n	%	n	%	n	%
Financial management	15	48,4	10	34,5	25	41,7
Home management	15	48,4	19	65,5	34	56,7
Personal care	1	3,2	0	0,0	1	1,7
TOTAL	31	100,0	29	100,0	60	100,0

When asked whether the following needs were regarded as being the most important in terms of daily living, approximately fifty-seven percent (56,7%; n=34) of the respondents indicated home management was the most important, followed by financial management approximately forty-two percent (41,7%; n=25) and personal care less than two percent (1,7%; n=1) of the respondents. None of the respondents indicated that transportation use was important in terms of priority needs.

Cross-tabulation of data according to gender was carried out. Approximately forty-eight percent (48,4%; n=15) of the males indicated financial management and home management with approximately thirty-five percent (34,5%; n=10) of the females indicating financial management and approximately sixty-six percent (65,5%; n=19) indicating home management with only three percent (3,2%; n=1) of the males and no females indicating personal care (see table 4.23) as being the most important activity of daily living needs.

A difference of just over six percent (6,4%; n=2) between the two groups of respondents was not considered to be significant. It would appear that both males and females alike regarded activities of daily living most important with the female respondents showing a greater need for home management than males (65,5%; n=19) vs (48,8%; n=15).

E7.1.5: Vocational rehabilitation (n=60)

Table 4.24: Vocational rehabilitation (n=60)

VOCATIONAL REHABILITATION	GENDER				TOTAL	
	MALE		FEMALE			
	n	%	n	%	n	%
Job placement	16	51,6	15	51,7	31	51,7
Work adjustment/vocational training	14	45,2	13	44,8	27	45,0
Prevocational counselling	1	3,2	1	3,5	2	3,3
TOTAL	**31**	**100,0**	**29**	**100,0**	**60**	**100,0**

The need to work exists among all people, including those persons suffering from schizophrenia. Limited access to formal employment opportunities results in social withdrawal. Consequent feelings are those of loneliness, low self-esteem, stigma of mental illness, rejection by society and above all, lack of vocational skills (White 1991:13).

In their response to the question related to vocational rehabilitation, the respondents who indicated that they needed job placements were approximately fifty-two percent (51,7%; n=31), work adjustment/vocational training forty-five percent (45,0%; n=27) and pre-vocational counselling approximately three percent (3,3%; n=2). Work evaluation and job readiness were not considered as needs.

Cross tabulation of data according to gender indicated that approximately fifty-two percent (51,6%; n=16) of the males and approximately fifty-two percent (51,7%; n=15) of the females opted for job placement, approximately forty-five percent (45,2%; n=14) of the males and approximately forty-five percent (44,8%; n=13) of the females opted for vocational training whilst approximately four percent (3,5%; n=1) of both males and females opted for prevocational counselling (see table 4.24).

These findings indicated the importance that in persons suffering from schizophrenia, both males and females attach to vocation. Being employed enables a contribution to society in one way or another.

E8.1.2: Education (n=60)

Table 4.25: Education (n=60)

EDUCATION	GENDER				TOTAL	
	MALE		FEMALE			
	n	%	n	%	n	%
Formal education	4	12,9	4	13,8	8	13,3
Informal education	27	87,1	25	86,2	52	86,7
TOTAL	31	100,0	29	100,0	60	100,0

Schizophrenia can be diagnosed in the later school years or at university. How this will affect education will depend upon the severity of the illness, and in particular, the effect that it has on thinking and intellectual performance (Lintner 1995:107). When asked about

education approximately eighty-seven (86,7%; n=52) would prefer informal education whilst thirteen percent (13,3%; n=8) indicated that they would prefer formal education.

Cross tabulation of data according to gender, indicated that both the male and female respondents, approximately fourteen percent (13,8%; n=4) opted for formal education whilst approximately eighty-seven percent (87,1%; n=27) of the males and approximately eighty-six percent (86,2%;; n=25) of the females opted for informal education (see table 4.25). Education was thus recognised equally as being of value to both males and females suffering from schizophrenia

E9.1-8: Appropriate living arrangements (n=60)

Table 4.26: Appropriate living arrangements (n=60)

APPROPRIATE LIVING ARRANGE-MENTS	GENDER				TOTAL	
	MALE		FEMALE			
	n	%	n	%	n	%
Own apartment	21	67,7	19	65,5	40	66,7
With parents	1	3,2	4	13,8	5	8,3
With spouse	9	29,0	6	20,7	15	25,0
TOTAL	**31**	**100,0**	**29**	**100,0**	**60**	**100,0**

When asked to indicate which of the living arrangements they would regard as being most important, approximately sixty-seven percent (66,7%; n=40) of the respondents indicated their own apartments as the most important, (indicating that persons suffering from schizophrenia like any other human beings, needed their independence and they needed to grow and to be responsible for their own affairs) (Hirsch & Harris 1994:195). Approximately eight percent (8,3%; n=5) indicated staying with parents was most important whilst twenty-five percent (25,0%; n=15) of the respondents indicated that staying with spouses was most important.

Cross tabulation of data according to gender indicated that approximately sixty-eight percent (67,7%; n=21) males and approximately sixty-six percent (65,5%; n=19) females opted for their own apartments. More females, approximately fourteen percent (13,8%; n=4) than males approximately three percent (3,2%; n=1) opted to stay with parents. Nine (29,0%) of the males and approximately twenty-one percent (20,7%; n=6) of the females opted to stay with spouses (see table 4.26).

It would appear that males (51,7%; n=31) were more concerned with retaining their independence than females (48,3%; n=29).

E10.1-9: Needs in order of priority (n=60)

Table 4.27: Needs in order of priority (n=60)

NEEDS	MEAN	MEDIAN	MODE	RANK
Medical care	2,50	2,0	1,0	1
Financial support	2,53	2,0	2,0	2
Support to relatives	4,77	5,0	5,0	3
Counselling	5,00	5,0	4,0	4
Leisure time activities	5,67	6,0	6,0	5
Vocational training	5,87	6,0	8,0	6
Appropriate living arrangement	6,07	7,0	9,0	7
Activities of daily living	6,12	6,5	7,0	8
Education	6,45	8,0	9,0	9

According to Tsuang and Faraone (1998:103), a full picture of the person should include their views about what they need and how these should be provided should be prioritised.

The respondents were asked to list their needs according to a scale 9 to 1, where 1 was the

The respondents were asked to list their needs according to a scale 9 to 1, where 1 was the greatest need and 9 the smaller need. The results were as follows:

- medical care was ranked first with the mean of 2,50 and 2 median mode 1
- financial support was second with the mean of 2,53 and 2 median mode 2
- support to relatives was third with 4,77 mean and 5 median mode 5
- counselling was fourth with 5,00 mean, 5 mean and 4 mode
- leisure time activities was fifth with 5,67 mean, 6 median and 8 mode
- appropriate living arrangement was seventh with 6,07 mean, 7 median and mode of 9
- activities of daily living was eight with a mean of 6,12, median 6,5 and mode of 7
- education was ranked last (ninth) with a mean of 6,45, median of 8 and mode of 9 (see table 4.27)

NB:

1 The median (mc) is that point on a scale of measurement with scores arranged in order of size above which exactly half the cases fall and below which the other half falls.

2 The mode (mo) is the most frequently occurring observation (Uys & Basson 1990:121).

3 Mean refers to the sum of all scores divided by the number of scores.

4.9 CONCLUSION

In this chapter the statistical analysis of data obtained from the completed questionnaires was discussed. The conclusions drawn form the study, the recommendations and the limitations will be identified and discussed in the next chapter.

CHAPTER 5

Summary, conclusions, recommendations and limitations of the study

5.1 INTRODUCTION

This chapter presents the summary, limitations, conclusions and recommendations of the study based on the data analysed in chapter 4.

5.2 SUMMARY

A review of the literature suggests that the assessment of needs in terms of the expressed views of individuals who require mental health services could be one of the most neglected areas in health care services. This could be due to a lack of sensitivity to these needs.

Being insensitive to the expressed needs of persons suffering from schizophrenia was identified as one of the problems within the community in the Mogoto area. The major aim of this research was to assess the needs of persons suffering from schizophrenia in Mogoto Village. The physical, psychological, social, emotional and spiritual needs were assessed together with the support systems and community resources available for meeting these needs.

In chapter 2, information on needs assessment, as portrayed in the literature, was outlined. In terms of needs and information associated with schizophrenia, the Theory for the Whole Person was described. Needs assessment done in other developed and underdeveloped countries was described and compared with the situation in the Republic of South Africa.

In chapter 3 the research methodology was outlined in detail. The study design as well as the sample population used in the study were described. The sampling technique used was the convenience sampling of persons suffering from schizophrenia who were collecting their psychiatric medications at Mogoto clinic on monthly base.

A quantitative exploratory descriptive design was used in this study because it was viewed to be the most appropriate for this research. Data was collected by using a questionnaire that focused on the health needs of persons suffering from schizophrenia as outlined in the research objectives. It was considered to be an appropriate instrument for obtaining the data relevant to this study.

In chapter 4 findings were presented from the statistical analysis done after the completion of the questionnaire by the respondents through the main frame computer system at the Unisa, using the SPSS.

This chapter will present the summary of the research, conclusions, recommendations, limitations and challenges to health care providers. The summary based on the results of the survey will be discussed according to the research objectives presented in chapter 1 of this dissertation.

5.3 CONCLUSIONS

The conclusions are based on the findings of the study and discussed in accordance with the conceptual framework used and the research questions guiding this investigation.

5.3.1 Section A: Demographic data

- All the respondents could speak Northern Sotho.

- There were more males (51,7%) than females (48,3%) who received treatment at Mogoto Village.

- The majority of respondents, (56,7%) fell into the age category of 41 to 60 years of age, indicating that there were more older persons suffering from schizophrenia compared to the younger ones.

- Persons suffering from schizophrenia found it difficult to initiate conversations and almost impossible to develop and maintain friendships thus finding it difficult to express their needs and feelings to other persons. As many as 78,3 percent of the respondents under study were unmarried.

5.3.2 Section B: Needs of persons suffering from schizophrenia

5.3.2.1 Physical needs

- Almost all persons suffering from schizophrenia needed to continue taking antipsychotic medications for many years. This is based on the fact that schizophrenia is a long-term illness which progresses slowly throughout life (Bachrach 1982:388).

- Like everyone else, individuals suffering from schizophrenia presented with other illnesses and required medical care, this need was ranked the highest in the

prioritisation of physical needs from the respondent's point of view.

5.3.2.2 Psychological needs

Persons suffering from schizophrenia needed more than simply the basic mental health services of chemotherapy and counselling; they also needed social rehabilitative services.

5.3.2.3 Social needs

Over half of the respondents (90,0%; n=54) needed social skills development and opportunities for socialising.

- A large percentage of the respondents (78,3%), both males and females were never married, which could indicate that these persons suffering from schizophrenia experienced difficulties in building satisfactory long-lasting interpersonal relationships.

- Most of the persons suffering from schizophrenia, (96,7%) were home bound. This could be due to the fact that the challenges of the outside world were so overwhelming that they could not cope with living outside the home. Job opportunities were limited, but only a minority of these persons had ever been engaged in paid work.

- In addition to the brain dysfunction that might interfere with social relationships, persons suffering from schizophrenia also had to contend with the stigma attached to their illness.

5.3.2.4 Emotional needs

- Friendship is needed by persons suffering from schizophrenia, just as by everyone. The barrier to meet this need could be aggravated by the symptoms and brain

dysfunction from the disorder.

5.3.2.5 Spiritual needs

- The majority of the respondents (36,7%), both males and females, belonged to Zion Christian Church. Apparently religion played an important supportive role in meeting the spiritual needs of persons suffering from schizophrenia .

- Like all human beings, persons suffering from schizophrenia need to relate to a god or philosophical world-view allowing them to place themselves and their lives within a larger context. Apparently these needs could be met in the area investigated.

5.3.2.6 Economic needs

- The main source of income for 74,6 percent of the respondents, both males and females, was from disability benefits. This grant was mainly received from government sources.

- The income for a large percentage of the respondents (73,3%) ranged between R501 to R1 000 per month. This income was received once again mainly from the government's disability grants as well as from family members and friends.

- Formal employment opportunities for persons suffering from schizophrenia were limited, as 93,2% were unemployed.

- The most common occupation status of the respondents (81,4%) appeared to be that of labourers. Persons suffering from schizophrenia generally appeared to lack skills for employment due to their low standard of education, the mental condition and lack of vocational training aggravated by their lack of willpower.

- It would appear that persons suffering from schizophrenia did not stay in employment with one employer for a long period of time. Frequent changes in employment often resulted in individuals not working at all.

- Past employment could be the best predictor of future employment for a person suffering from schizophrenia; a person who became sick after having a job would be more likely to find work than a person who became sick without ever having worked. Only a minority of respondents had ever worked – reducing their chances of becoming economically active in future.

5.3.2.7 Educational needs

Most respondents (90,0%, n=54) indicated a need for vocational training and employment opportunities which would promote the normalisation of the mentally ill especially those persons suffering from schizophrenia.

- With regard to the educational qualifications, 46,7 percent of the respondents had not reached a high level of education as they fell into the category of grades 1 to 5 only limiting their chances of gainful employment and of meaningful recreation activities.

5.3.2.8 Resources and support systems

- Persons suffering from schizophrenia had little social support and found it difficult to support themselves as all the respondents depended on family members (see table 4.11).

- It would appear that only 46,7 percent of persons suffering from schizophrenia had dependents and were faced with reduced responsibilities for looking after dependents as they were only looking after themselves.

- In general 44,8 percent of the persons suffering from schizophrenia lived with one or both parents despite their age, gender or marital status.

- The majority of these persons discharged from hospital suffering from schizophrenia were cared for by family members, thus the families still played a major role in caring for the schizophrenic family members.

- It would appear that the persons suffering from schizophrenia despite their disability, were still regarded as valuable members of the family as they shared accommodation with other family members.

5.3.2.9 Resources available

- It would appear that there were no means of transport for persons suffering from schizophrenia when visiting the hospital or clinic for treatment.

- The hospital and community mental health agencies that served the community did not have special substance abuse programmes for persons suffering from schizophrenia. This problem might justify further investigations.

5.4 RECOMMENDATIONS

The results of this research support the following recommendations based on the conclusions and findings of this study:

— Physical needs
— Psychological needs
— Social needs
— Emotional needs
— Spiritual needs
— Economic needs

- Educational needs
- Support systems
- Resources

- Persons suffering from schizophrenia need a therapeutic programme which shows a balance between stimulation, support and protection.

- Persons suffering from schizophrenia have fewer alternative resources and tend to be sicker. For this reason priority should be given when resources are allocated.

- Supportive psychotherapy is of vital importance for persons suffering from schizophrenia as it provides them with friendship, encouragement and practical advice. Community resources on how to develop a more active social life, vocational counselling, suggestions for minimising friction with family members, and above all, hope should be provided so that the person's life-style can be improved.

- The care of persons suffering from schizophrenia demands and needs group effort and needs the participation of all available team members.

- Good rehabilitation, treatment of acute psychiatric episodes, appropriate medication, monitoring, maintaining of nutrition and general health, provision for shelter and community participation, provision of crisis support, and building on or enhancing a person's capabilities through continuing education efforts need to be considered.

- Support from significant others is absolutely critical and helpful to persons suffering from schizophrenia. These individuals need contact with people who were supportive and affectionate to them even when behaviour is bizzare.

- The government apparently did not meet the mentally handicapped persons' needs as there were no rehabilitation programmes and sheltered workshops in the area under study.

- Above all, a person suffering from schizophrenia is a physical, psychological, social, emotional and spiritual holistic being with needs, similar to those of all human beings.

- Addressing the socialisation, residential, and vocational needs of persons suffering from schizophrenia requires the community mental health system to operate in a manner different for what it has traditionally done. Rehabilitative services require a greater creativity and a greater expenditure of resources, but the benefits in terms of reduced hospitalisation can potentially become a cost saving exercise and provide a better quality of life for the persons.

- The psychosocial rehabilitation programme is of utmost importance to persons suffering from schizophrenia and is aimed at addressing physical, psychological, emotional, social and spiritual needs with the following objectives in mind:

  — Improved mental state, for example, reduction of psychotic episodes, depression, malfunctioning and other typical symptoms of mental illness.

  — Improved life-skills focusing on the self-image, communication, relationships, motivation as well as caring for and teaching in basic human skills such as personal appearance and hygiene, nutrition and ability to prepare meals, use of leisure time and hobbies, time management, home improvement, budgeting, shopping and competence in using public transport.

  — Improved vocational adjustment focusing on motivation and preparation for employment.

  — Improved utilisation of support systems on the family, social clubs, fellowship groups and other support systems.

- The development of participatory education for mentally ill persons about their condition, its course and treatment implications. The aim would be to allow these individuals to form a cognitive link between so called "traditional" explanations and treatment and psychiatric explanations and treatment. From the above evidence, it seems important that persons suffering from schizophrenia develop a more integrated and consistent understanding of their condition to facilitate their own progress to full mental health, as well as understanding and recognising their needs.

5.4.1 Community development

Considering the nature of needs and problems of some of the South African communities the most recommended suitable approach is community development.

Rubin and Rubin's (1992:44) definition is most appropriate in this connection, namely: "Community development involves local empowerment through organised groups of people acting collectively to control decisions, projects, programmes and policies that affect them as a community".

In the implementation of the programme, empowerment comes from having a sense of ownership of the programme, from having clear expectations, control of resources, and responsibility for action. It is further recommended that the following **roles of the health professionals** as community developer be executed in the implementation of programmes and projects relevant in meeting the needs of persons suffering from schizophrenia , namely:

- **catalyst**, to stimulate others to take action on problems they face
- **teacher**, to develop people's capacity to solve their own problem
- **facilitator**, to provide information and enable people to manage their own lives
- **linking person**, to connect community organisations and groups to information, allies, skills and power structures outside the organisation or group
- **policymaker**, to influence and formulate policy in order to enhance the well being of

persons suffering from schizophrenia in the community

5.4.2 Health care professionals

Health care professionals can develop family support groups to provide

- education about the diagnosis of schizophrenia and how to cope with and treat it
- a place where parents can discuss their feelings and concerns and receive acceptance and empathy as they grieve losses in the situation
- information about available services and resources in the community
- assistance with fulfilling role responsibility and demand
- assistance to parents to become advocates for their children in negotiating for services, education, and favourable legislation.
- social functions to reduce the sense of isolation

5.4.3 Rehabilitation programmes

Future rural rehabilitation programmes will have to

- provide services that address the needs of the rural persons suffering from schizophrenia as they perceive them
- be consistent with realities of rural employment opportunities
- be suited to rural concepts of productivity and self-worth
- adequately inform potential clients the appropriateness of their services in meeting client needs

5.4.4 Recommendations for day programme services

- social clubs and social function opportunities
- specialised programmes for groups such as persons suffering from psychotic episodes, higher functioning individuals suffering from schizophrenia and lower functioning

individuals suffering from schizophrenia in the community.

- more vocational training efforts, expanded supported employment efforts
- maintainment of a regular programme of medication
- a secure and therapeutic living environment, for example, supportive, stimulating and tolerant environment
- involvement in a daily living routine especially to improve self-sufficiency, and an acceptable standard of personal care
- a base for life-skills training

NB: **This programme apart from social work services should be subsidised by the Directorate of Mental Health Services.**

5.4.5 Recommendations for employment programme

- regular employment within an accepting environment
- a supplementary source of income
- ongoing work ability assessment
- manageable work tasks and achieveable work goals
- training in new skills, including improvement of concentration on perseverance and appropriate behaviour
- social contact and increased opportunities for relationships
- opportunities for personal advancement and improved self-image
- opportunities for engaging in meaningful leisure activities

5.4.6 Other services

A wide range of services must be provided to all persons suffering from schizophrenia in the community. Table 5.1 (comprehensive array of services and opportunities for chronically mentally ill persons) can help as a guideline on which services to provide in the Mogoto Village.

Table 5.1: Comprehensive array of services and opportunities for chronically mentally ill persons

Basic needs/opportunities	Special needs/opportunities
Shelter *... (with health, rehabilitative, or social services provided on site).* Hospital Nursing Home Intermediate-care facility Crisis facility *Semi-independent (linked to services)* Family home Group home Cooperative apartment Foster care home Emergency housing facility Other board and care home *Independent apartment/home (access to services)* **Food, clothing, and household management** Fully provided meals Food purchase/preparation assistance Access to food stamps Homemaker service **Income/financial support** Access to entitlements Employment **Meaningful activities** Work opportunities Recreation Education Religious/spiritual Human/social interaction **Mobility/transportation**	**General medical services** Physician assessment and care Nursing assessment and care Dentist assessment and care Physical/occupational therapy Speech hearing therapy Nutrition counselling Medication counselling Home health services **Mental health services** Acute treatment services Crisis stabilisation Diagnosis and assessment Medication monitoring (psychoactive) Self-medication training Psychotherapy Hospitalisation: acute and long-term care **Habilitation and rehabilitation** Social/recreational skills development Life-skills development Leisure time activities **Vocational** Prevocational assessment counselling Sheltered work opportunities Transitional employment Job development and placement **Social services** Family support Community support assistance Housing and milieu management Legal services Entitlement assistance
Integrative services Client identification and outreach Individual assessment and service planning Case service and resource management Advocacy and community organisation Community information Education and support	

5.5 RECOMMENDATIONS FOR FURTHER RESEARCH

The researcher has identified several areas in which development is needed to improve the care of persons suffering from schizophrenia in the community.

- The study attempted to assess only the needs of persons suffering from schizophrenia only, further studies will be needed to assess the needs of other categories of mental illness, for example, persons who are depressed, epileptic, alcohol and drug dependent and others.
- To address the shortage of qualified psychiatric nurses, other health care professionals and paraprofessionals especially at Mogoto Village.
- Curricula for training psychiatric care to nursing and medical students should be reviewed to increase the emphasis on community psychiatric care.
- Outperson care must be expanded, and day centres and other community services must be developed.
- More efficient cooperation must be developed within the primary health care system.
- Additional research is needed in the home environment of discharged persons suffering from schizophrenia. Information that could help nurses better assess the needs of this population could be obtained.
- How policy principles can translate into the effective delivery of mental illness services based on an individual assessment of needs where one aim is to arrive at a greater understanding of what the user has to say concerning his or her own needs.
- The role of traditional and faith healers in caring for the mentally ill persons to assist cooperation in the many cases (shown in the study) in which these persons avail themselves of both traditional/faith healers and psychiatric services.

5.6 LIMITATIONS

During the course of the study certain limitations were identified. Apart from the limitations which call for further research the most prominent were the following:

- There was no information on the assessed needs of persons suffering from schizophrenia in Mogoto Village. Mainly overseas and the WHO literature was used. Therefore, the needs assessment of persons suffering from schizophrenia may not have been fully covered in the questionnaire as it related to the needs in Mogoto Village.

- The research focussed only on persons suffering from schizophrenia staying in Mogoto Village and who received treatment at Mogoto clinic. Persons suffering from schizophrenia who received treatment from private practitioners, the pharmacy and Groothoek Hospital were not included in the research. More complete information might have been obtained from those excluded.

- The views of the carers of these persons may have given a wider perspective on the needs of the schizophrenic person.

- Despite the pretesting of the instrument some of the questions were still not understood and had to be explained again and again in simple terms thus consuming even more time for the session.

- The questionnaire was also too long as the respondents displayed impatience with the length of the questionnaire.

- The research proved to be very broad in scope. Community resources and support systems could be studied in more depth separately.

- It is doubtful whether the 5-point (*never, hardly ever, sometimes, often* and *almost all the time*) scale yielded more information than the 3-point (*never, sometimes* and *almost all the time*) scale would have done. Open-ended questions could have elicited more information.

5.7 A CHALLENGE FOR US ALL

Statistically, wherever in the world one happens to live, the chances are roughly one in a hundred that one will at some time in life suffer from schizophrenia.

While one may well recover from an initial bout and never be troubled again by the condition, one may need to take powerful drugs to minimise the chances of relapse. In about one in ten cases, one will require almost constant care for the rest of one's life, a roughly similar proportion will commit suicide.

The psychiatric and scientific community frankly admits that it knows comparatively little about the cause of the illness, its relationship with other conditions, and its responsiveness to treatment. Regarding to the cure there are many theories on the subject but no one seriously proposes that a definite cure is within sight.

The system of care for people suffering from schizophrenia is not satisfactory and the community at large openly appears to be frightened about an illness it knows little about, save what it has acquired from media reporting. Health professionals are obliged to educate communities about psychiatric conditions including schizophrenia.

The key to some, if not all, of the problems enumerated in this dissertation lies within the community. More and better research into the illness is urgently needed, the mental health-care system requires funds commensurate with its aims and responsibilities. Enlightened public understanding of schizophrenia, and other mental illnesses, demands education and promotion resources to counter the negative images of the illness persisting in many societies.

Only a concerted programme of public education and enhanced awareness, coupled with increases of resources for clinical research and practical care will suffice to guarantee the schizophrenic individual his or her care in the community settings.

5.8 CONCLUSION

As the health care professionals move forward with health care reform, a strong commitment must be made to provide for a hopeful outcome and improved quality of life for this vulnerable and neglected group of people required to continue living in communities.

The success or failure of this policy is a test of the civilisation and moral worth of society, judged not by the success of suppressing or concealing from view the less conventional members, but by how well they are assimilated and protected through learning, work and ultimately, love (Tsuang & Faraone 1998:166).

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Annexure 1

Application for permission to conduct research

PO Box 541
GROOTHOEK
0628

16 October 1996

The Medical Superintendent/Nursing Service Manager
Dr Machupe Mphahlele Memorial Hospital
PO Box 1
GROOTHOEK
0628

Sir/Madam

APPLICATION FOR PERMISSION TO CONDUCT RESEARCH

I am hereby requesting for permission to conduct a research in the Psychiatric Department – Poly Clinic with ± 60 clients who are consulting for the first time and their relatives, if possible.

The topic for the research is: *Psychosocial Rehabilitation Needs Identification and Assessment of Psychiatric Patients in the Rural Area: a Programme Planning Perspective*.

I am presently registered with the University of South Africa and being supervised by Mrs M Ferreira and Professor MJ Dreyer.

Any further information needed concerning the research I am at liberty to furnish you with.

Yours sincerely

Elizabeth K Manamela
Nurse Educator – Psychiatric Nursing

Annexure 2

Reply from Groothoek hospital regarding application to conduct a research project

Northern Province

DEPARTMENT OF HEALTH & WELFARE
SOUTHERN REGION

Ref. No.
Enquiries : D.C. Matabane
Tel. No. : 015-6423132
Fax No. : 015-6423138

Dr M.M.M. Hospital
PO Box 1
GROOTHOEK HOSPITAL
0628

19.02.1997

Ms K.E. Manamela
Dr Machupe Mphahlele Memorial Hospital
PO Box 1
GROOTHOEK
0628

APPLICATION FOR PERMISSION TO CARRY OUT RESEARCH

You are hereby granted permission to conduct research as per your request.

The following aspects should therefore be considered throughout:

- The said research should not interfere with your working hours.
- Ethical implications.

A copy of your findings will be appreciated for references.

.....

pp **SENIOR MEDICAL SUPERINTENDENT**

Annexure 3

Reply from Northern Province, Department of Health and Welfare, Southern Region regarding application for permission to carry out research on part-time basis

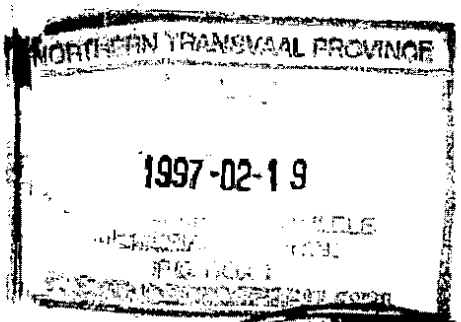
Northern Province
DEPARTMENT OF HEALTH & WELFARE
SOUTHERN REGION

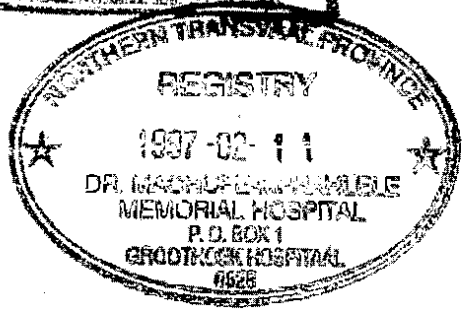
REFERENCE: S5/2/3/19

ENQUIRIES: Mabasa G.R. (Mr)

TEL. NO.: 015 - 6337100

FAX NO.: 015 - 6337113
6337927





PRIVATE BAG X04
CHUENESPOORT
0745

97/02/05

The Snr. Med. Superintendent
Dr Machupe M.M. Hospital
P.O. Box 1
GROOTHOEK
0628

APPLICATION FOR PERMISSION TO CARRY OUT RESEARCH ON PART TIME BASIS: MS K.E. MANAMELA:

1. Receipt of the above-mentioned application in respect of Ms K.E. Manamela is hereby acknowledged.

2. Please be informed that the Regional Office has approved her application on conditions that;

   2.1 the said research should not interfere with her working hours,
   2.2 her research should be monitored and that the results of the research should be submitted to the Department before it is sent to her supervisor and that it should be published only when the Department has allowed her to do so.

3. Kindly inform Ms Manamela about the contents of this minite accordingly.

4. Your co-operation is always appreciated.

REGIONAL DIRECTOR: SOUTHERN REGION

Annexure 4

Research project on psychiatric patients:
a letter to multidisciplinary team members

PO Box 541
GROOTHOEK
0628

16 June 1996

The Psychiatrist, Psychologist, Social Worker,
Occupational Therapist, Psychiatric Nurse

.....

.....

.....

Dear Sir/Madam

RESEARCH PROJECT ON PSYCHIATRIC PATIENTS

I am a student with the University of South Africa (Unisa) conducting a research project on *A needs assessment of persons suffering from schizophrenia in the Mogoto Village, Zebediela District.*

I am presently preparing the questionnaire which will be completed by the researcher during her interview with the selected participants.

As a member of the multidisciplinary team, you have been selected to assist in testing the instrument for face validity. Kindly go through the questionnaire and please add some items which you consider to be included and point out where you think the items/questions are not clearly stated or should have been omitted. Do not fill in the questionnaire.

Thank you for your contributions.

Yours sincerely

Elizabeth K Manamela

Annexure 5

Questionnaire

Questionnaire

I am an Unisa student doing my Master's degree. This is part of my research.

Objective of the study

An assessment of the needs of persons suffering from schizophrenia in Mogoto Village.

Your completion of this questionnaire indicates your consent to participate in this study.

All information will be treated as strictly confidential. Participation in this study is voluntary. In no way will this questionnaire be linked to your name.

Instructions:

Please answer all the questions. Answer each question objectively, as it applies to your situation.

Kindly respond to the following questions by marking (X) over the appropriate numbered circle.

FOR OFFICE USE ONLY	
	☐☐☐ 1-3

Section A: Demographic data

1	**Home language**		
	North Sotho	①	
	Tsonga	②	
	Venda	③	
	Ndebele	④	
	Tswana	⑤	
	Other (specify)	⑥	☐ 4

			FOR OFFICE USE ONLY
2	**Gender**		
	Male	①	
	Female	②	☐ 5
3	**Age**		
	0-20	①	
	21-40	②	
	41-60	③	
	61+	④	☐ 6
4	**Marital status**		
	Married	①	
	Separated	②	
	Widowed	③	
	Never married	④	
	Divorced	⑤	
	Marriage annulled	⑥	☐ 7
5	**Religious affiliation**		
	Lutheran	①	
	Dutch Reformed	②	
	Apostolic	③	
	Roman Catholic	④	
	ZCC	⑤	
	IPCC	⑥	
	Other (specify)	⑦	☐ 8

			FOR OFFICE USE ONLY
6	**Citizenship**		
	South African	①	
	Other (specify)	②	☐ 9
7	**Home area**		
	Town	①	
	Village	②	
	Farm	③	
	Township	④	☐ 10
8	**Educational level**		
	None	①	
	1-5 grade	②	
	6-8 grade	③	
	9-12 grade	④	
	High school graduate	⑤	
	Vocational technical	⑥	
	Attended college 1-2 years	⑦	
	Attended college 3-4 years	⑧	
	Four-year college degree	⑨	
	Graduate degree (master's)	⑩	
	Graduate degree (doctorate)	⑪	☐ 11

			FOR OFFICE USE ONLY
9	**Number of dependents**		
	Self only	①	
	One	②	
	Two	③	
	Three	④	
	Four	⑤	
	Five or more	⑥	☐ 12
10	**Living arrangements**		
	Living alone	①	
	Living with spouse	②	
	Living with one or both parents (including step-parents)	③	
	Living with nonrelatives	④	
	Living with other relatives	⑤	
	Other (specify)	⑥	☐ 13

			FOR OFFICE USE ONLY
11	**Income sources**		
	Earnings	① = Yes ② = No	☐ 14
	Interest	① = Yes ② = No	☐ 15
	Rent	① = Yes ② = No	☐ 16
	Dividends	① = Yes ② = No	☐ 17
	Disability benefits	① = Yes ② = No	☐ 18
	Family	① = Yes ② = No	☐ 19
	Friends	① = Yes ② = No	☐ 20
	Social security	① = Yes ② = No	☐ 21
	Workman's compensation	① = Yes ② = No	☐ 22
	Public assistance	① = Yes ② = No	☐ 23
12	**Income category**		
	Less than R100 per month	①	
	R100-R500 per month	②	
	R501-R1 000 per month	③	
	R1 001-R3 000 per month	④	
	More than R3 000 per month	⑤	☐ 24

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13	**Work status**		
	Employed outside the home	①	
	Competitive labour market	②	
	Sheltered workshop	③	
	Employed, home	④	
	Unemployed	⑤	
	Self-employed, home	⑥	
	Student	⑦	
	Retired	⑧	
	Domestic	⑨	☐ 25
14	**Previous occupation**		
	Professional	①	
	Technical	②	
	Labourer	③	
	Semiprofessional	④	
	Nontechnical	⑤	
	Other (specify)	⑥	☐ 26
15	**Currently employment service**		
	Vocational rehabilitation services	①	
	Home bound	②	
	Other (specify)	③	☐ 27

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16	**Sources of transport**		
	Private automobile	①	
	Public	②	
	Own transport	③	
	Donkey cart	④	
	None	⑤	☐ 28
17	**Main caregivers**		
	Self	①	
	Family member	②	
	Full-time attendant	③	
	Part-time attendant	④	☐ 29
18	**How many employers have you worked for in the past?**		
	Nil	①	
	One	②	
	Two	③	
	Three	④	
	More than five	⑤	
	Don't know	⑥	☐ 30
19	**Type of dwelling**		
	House	①	
	Flat	②	
	Room	③	
	Shack	④	
	Other (specify)	⑤	☐ 31

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20	**Number of rooms**		
	One	①	
	Two	②	
	Three	③	
	Four	④	
	Five or more	⑤	☐ 32

Section B: Needs of the persons suffering from schizophrenia

Directions: Please choose the response that most clearly describes your answer to the question regarding your present need

Basic physiological/physical needs

1	**How is your current health status?**		
	Poor	①	
	Fair	②	
	Satisfactory	③	
	Good	④	
	Excellent	⑤	☐ 33
2	**Rate each of the following needs on a scale from 1-5**		
	1 = extremely problematic		
	2 = somewhat problematic		
	3 = controlled problem		
	4 = inactive problem		
	5 = no problem		
2.1	Vision	① ② ③ ④ ⑤	☐ 34
2.2	Mobility	① ② ③ ④ ⑤	☐ 35
2.3	Sleep	① ② ③ ④ ⑤	☐ 36

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2	**Rate each of the following needs on a scale from 1-5** **1 = extremely problematic** **2 = somewhat problematic** **3 = controlled problem** **4 = inactive problem** **5 = no problem**		
2.4	Anxiety, depression	① ② ③ ④ ⑤	☐ 37
2.5	Energy level	① ② ③ ④ ⑤	☐ 38
2.6	Recreation, play	① ② ③ ④ ⑤	☐ 39
2.7	Exercise	① ② ③ ④ ⑤	☐ 40
2.8	Sexual libido	① ② ③ ④ ⑤	☐ 41
3	**Rate the following items on a scale 1-5** **1 = never** **2 = hardly ever** **3 = sometimes** **4 = often** **5 = almost all the time**		
3.1	I eat a well-balanced diet	① ② ③ ④ ⑤	☐ 42
3.2	I take prescribed medications	① ② ③ ④ ⑤	☐ 43
3.3	I take patent medicines only as directed by my physician	① ② ③ ④ ⑤	☐ 44
3.4	I exercise daily	① ② ③ ④ ⑤	☐ 45
3.5	I get 6-8 hours sleep minimum daily	① ② ③ ④ ⑤	☐ 46
3.6	I take rest periods during the day	① ② ③ ④ ⑤	☐ 47
3.7	I experience a high energy level	① ② ③ ④ ⑤	☐ 48

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3	**Rate the following items on a scale 1-5** **1 = never** **2 = hardly ever** **3 = sometimes** **4 = often** **5 = almost all the time**		
3.8	I watch myself for signs of relapse	① ② ③ ④ ⑤	☐ 49
3.9	I am able to relax	① ② ③ ④ ⑤	☐ 50
3.10	I take special measures to conserve my health	① ② ③ ④ ⑤	☐ 51
3.11	I do not object to having to take special measures to conserve my health	① ② ③ ④ ⑤	☐ 52
3.12	I do not object to giving up things I like for the sake of my health	① ② ③ ④ ⑤	☐ 53
3.13	I am confident I can meet my future health needs	① ② ③ ④ ⑤	☐ 54
Psychological needs			
3.14	I am secure about my physical safety in my home environment	① ② ③ ④ ⑤	☐ 55
3.15	I feel secure about special precautions I take regarding physical safety	① ② ③ ④ ⑤	☐ 56
3.16	I feel secure about my financial position	① ② ③ ④ ⑤	☐ 57
3.17	I feel secure about meeting the expenses of my routine medicine and supplies	① ② ③ ④ ⑤	☐ 58
3.18	I feel satisfied about my transportation plans	① ② ③ ④ ⑤	☐ 59

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3	**Rate the following items on a scale 1-5** **1 = never** **2 = hardly ever** **3 = sometimes** **4 = often** **5 = almost all the time**		
3.19	I am satisfied about long-terms plans for my care	① ② ③ ④ ⑤	☐ 60
3.20	I am satisfied about my present vocational/ occupational status	① ② ③ ④ ⑤	☐ 61
Social needs			
3.21	Are you satisfied with the amount of love from your family?	① ② ③ ④ ⑤	☐ 62
3.22	Are you satisfied with the amount of love from friends?	① ② ③ ④ ⑤	☐ 63
3.23	Are you coping satisfactorily with stress in the home life?	① ② ③ ④ ⑤	☐ 64
3.24	Are you coping satisfactorily with stress in other aspects of life?	① ② ③ ④ ⑤	☐ 65
3.25	Are you satisfied with your level of social effectiveness?	① ② ③ ④ ⑤	☐ 66
3.26	Are you satisfied with your social participation?	① ② ③ ④ ⑤	☐ 67
3.27	Are you satisfied with your role in the family?	① ② ③ ④ ⑤	☐ 68
3.28	Are you comfortable asking for help when needed?	① ② ③ ④ ⑤	☐ 69

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3	**Rate the following items on a scale 1-5** **1 = never** **2 = hardly ever** **3 = sometimes** **4 = often** **5 = almost all the time**	
3.29	Are you satisfied with family activities and traditions in which you participate? ① ② ③ ④ ⑤	☐ 70
3.30	Are you satisfied with your level of sexual fulfilment? ① ② ③ ④ ⑤	☐ 71
3.31	Are you satisfied with your level of know-ledge about human sexuality? ① ② ③ ④ ⑤	☐ 72
3.32	Are you satisfied with the feelings of love and belongingness you receive from others? ① ② ③ ④ ⑤	☐ 73
3.33	Are you satisfied with the amount of love and affection you give to others? ① ② ③ ④ ⑤	☐ 74
3.34	Do you have social gatherings with friends of your own age? ① ② ③ ④ ⑤	☐ 75
Emotional needs		
3.35	Are you satisfied with the appearance of your body? ① ② ③ ④ ⑤	☐ 76
3.36	Are you satisfied with your intellectual functioning? ① ② ③ ④ ⑤	☐ 77
3.37	Are you satisfied with the kind of charac-teristics what could be said to describe you? ① ② ③ ④ ⑤	☐ 78
3.38	Are you satisfied with past accomplishments in your life? ① ② ③ ④ ⑤	☐ 79

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3	**Rate the following items on a scale 1-5** 1 = never 2 = hardly ever 3 = sometimes 4 = often 5 = almost all the time	
3.39	Are you satisfied with present accomplishments in your life? ① ② ③ ④ ⑤	☐ 80
3.40	Is your predominant emotional state happy and content? ① ② ③ ④ ⑤	☐ 81
3.41	Are you satisfied with your level of education/ occupation? ① ② ③ ④ ⑤	☐ 82
Spiritual needs		
3.42	Are you satisfied with the amount of religion in your life? ① ② ③ ④ ⑤	☐ 83
3.43	Are you satisfied with your state of fulfilment? ① ② ③ ④ ⑤	☐ 84
3.44	Are your satisfied with the amount of enjoyment in your everyday life? ① ② ③ ④ ⑤	☐ 85
3.45	Do you make plans to increase your level of fulfilment? ① ② ③ ④ ⑤	☐ 86
3.46	Are you optimistic about your potential to reach higher life? ① ② ③ ④ ⑤	☐ 87
3.47	Are you satisfied about with task accomplishment in your present life? ① ② ③ ④ ⑤	☐ 88
3.48	Are you satisfied with your own motivational level? ① ② ③ ④ ⑤	☐ 89

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3	**Rate the following items on a scale 1-5** **1 = never** **2 = hardly ever** **3 = sometimes** **4 = often** **5 = almost all the time**		
3.49	Are you satisfied with the motivational level of family and friends to support your goals?	① ② ③ ④ ⑤	☐ 90
3.50	Are you satisfied with amount of responsibilities you have in your life?	① ② ③ ④ ⑤	☐ 91
3.51	Are you satisfied with the amount of spontaneity in life?	① ② ③ ④ ⑤	☐ 92
3.52	Do you have a satisfactory level of hope in life?	① ② ③ ④ ⑤	☐ 93
3.53	Do you have new interests in life?	① ② ③ ④ ⑤	☐ 94
3.54	Are you satisfied with the amount of meaning and purpose in life?	① ② ③ ④ ⑤	☐ 95
3.55	Are you reconciled to change your lifestyle from the disability you are having?	① ② ③ ④ ⑤	☐ 96
3.56	Are you satisfied with your coping reaction to suffering?	① ② ③ ④ ⑤	☐ 97
3.57	Are you satisfied with the amount of strength (courage) you have?	① ② ③ ④ ⑤	☐ 98

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Section C: Support system			
1	**Internal support**		
	Mother	① = Yes ② = No	☐ 99
	Father	① = Yes ② = No	☐ 100
	Grand parents	① = Yes ② = No	☐ 101
	Other siblings	① = Yes ② = No	☐ 10
	Extended family member	① = Yes ② = No	☐ 103
2	**External support**		
	Friends	① = Yes ② = No	☐ 104
	Professional system	① = Yes ② = No	☐ 105
	Nonprofessional system	① = Yes ② = No	☐ 105
3	**Advice or help received from rehabilitative care centres**		
	Alternative accommodation	① = Yes ② = No	☐ 107
	Finance	① = Yes ② = No	☐ 108
	Medical and psychiatric matters	① = Yes ② = No	☐ 109
	Someone to talk to	① = Yes ② = No	☐ 110
	Assertive approach	① = Yes ② = No	☐ 111
	Social and leisure activities	① = Yes ② = No	☐ 112
	Counselling and support	① = Yes ② = No	☐ 113
	None	① = Yes ② = No	☐ 114

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4	**Source of advice or help**	
	Professionals ① = Yes ② = No	☐ 115
	Friend ① = Yes ② = No	☐ 116
	Relative ① = Yes ② = No	☐ 117
	Other (specify) ..... ① = Yes ② = No	☐ 118
5	**What type of contribution received in the past year?**	
	Help concerning housing ① = Yes ② = No	☐ 119
	Vocational training ① = Yes ② = No	☐ 120
	Medical and psychiatric care ① = Yes ② = No	☐ 121
	Individual or family assistance ① = Yes ② = No	☐ 122
	Counselling ① = Yes ② = No	☐ 123
	Legal assistance ① = Yes ② = No	☐ 124
	None ① = Yes ② = No	☐ 125
6	**Services required**	
	Vocational training ① = Yes ② = No	☐ 126
	Medical and psychiatric services ① = Yes ② = No	☐ 127
	Individual and family counselling ① = Yes ② = No	☐ 128
	Legal assistance ① = Yes ② = No	☐ 129
	Accommodation ① = Yes ② = No	☐ 130

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7	**Special needs available in the community**	
	Social training and social opportunities ① = Yes ② = No	☐ 131
	Work training and employment opportunities ① = Yes ② = No	☐ 132
	Living arrangements ① = Yes ② = No	☐ 133
	Study opportunities ① = Yes ② = No	☐ 134
	None ① = Yes ② = No	☐ 135
	Other (specify) ..... ① = Yes ② = No	☐ 136

Section D: Community resources

Please indicate the resources available in your community

1	**Counselling services**	
	Alternative for women ① = Yes ② = No	☐ 137
	Comprehensive care ① = Yes ② = No	☐ 138
	Church social services ① = Yes ② = No	☐ 139
	Social department services ① = Yes ② = No	☐ 140
	Life educators ① = Yes ② = No	☐ 141
	Family counselling services ① = Yes ② = No	☐ 142
	Government psychological service centre ① = Yes ② = No	☐ 143
	Veteran centres ① = Yes ② = No	☐ 144

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2	**Services for alcohol and drug abuse**		
	Alcohol anonymous	① = Yes ② = No	☐ 145
	Comprehensive care	① = Yes ② = No	☐ 146
	Detoxification programmes	① = Yes ② = No	☐ 147
	National council on alcoholism	① = Yes ② = No	☐ 148
	Narcotics anonymous	① = Yes ② = No	☐ 149
	Rehabilitation counselling centres	① = Yes ② = No	☐ 150
3	**Education facilities**		
	Parents in training programmes	① = Yes ② = No	☐ 151
	Parents-plus for handicapped	① = Yes ② = No	☐ 152
	Vocational/technical school	① = Yes ② = No	☐ 153
	Other (specify)	① = Yes ② = No	☐ 154
4	**Financial aid**		
	Department social insurance	① = Yes ② = No	☐ 155
	Salvation army	① = Yes ② = No	☐ 156
	Red cross services	① = Yes ② = No	☐ 157
	Unemployment insurance	① = Yes ② = No	☐ 158
	Other (specify)	① = Yes ② = No	☐ 159

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5	**Employment**	
	Community service employment programmes ① = Yes ② = No	☐ 160
	Local government employment and training centre ① = Yes ② = No	☐ 161
	Workshops for the mentally handicapped ① = Yes ② = No	☐ 162
	Private employment agencies ① = Yes ② = No	☐ 163
	Vocational/rehabilitation services ① = Yes ② = No	☐ 164
	Other (specify) ..... ① = Yes ② = No	☐ 165
6	**Advocates**	
	Long-term care ① = Yes ② = No	☐ 166
	Local government citizens advocacy ① = Yes ② = No	☐ 167
	Department of social services ① = Yes ② = No	☐ 168
	State public service ① = Yes ② = No	☐ 169
7	**Potential resources of help in time of trouble**	
	Religious beliefs ① = Yes ② = No	☐ 170
	Family ① = Yes ② = No	☐ 171
	Friends ① = Yes ② = No	☐ 172
	Professionals ① = Yes ② = No	☐ 173
	Other (specify) ..... ① = Yes ② = No	☐ 174

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8	**Services used in times of crisis**	
	Crisis line ① = Yes ② = No	☐ 175
	Clinic staff ① = Yes ② = No	☐ 176
	Police ① = Yes ② = No	☐ 177
	Family members ① = Yes ② = No	☐ 178
	Community members ① = Yes ② = No	☐ 179
	Other (specify) ..... ① = Yes ② = No	☐ 180
9	**Available human resources in the community**	
	Community psychiatric nurses ① = Yes ② = No	☐ 181
	Social workers ① = Yes ② = No	☐ 182
	Psychologists ① = Yes ② = No	☐ 183
	Traditional doctors ① = Yes ② = No	☐ 184
	Priests ① = Yes ② = No	☐ 185
	Other (specify) ..... ① = Yes ② = No	☐ 186
10	**Available psychiatric services**	
	Awareness campaigns ① = Yes ② = No	☐ 187
	Transport for individuals ① = Yes ② = No	☐ 188
	Crisis interventions ① = Yes ② = No	☐ 189
	Mental health promotions ① = Yes ② = No	☐ 190
	Other (specify) ..... ① = Yes ② = No	☐ 191

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11	**Recreational services**	
	Choir ① = Yes ② = No	☐ 192
	Dances ① = Yes ② = No	☐ 193
	Soccer/netball ① = Yes ② = No	☐ 194
	None ① = Yes ② = No	☐ 195
	Other (specify) ..... ① = Yes ② = No	☐ 196
12	**Involvement with recreational services**	
	Choir ① = Yes ② = No	☐ 197
	Dances ① = Yes ② = No	☐ 198
	Soccer/netball ① = Yes ② = No	☐ 199
	None ① = Yes ② = No	☐ 200
	Other (specify) ..... ① = Yes ② = No	☐ 201
13	**Rehabilitation services available**	
	Workshop ① = Yes ② = No	☐ 202
	Halfway house ① = Yes ② = No	☐ 203
	Industrial training centres ① = Yes ② = No	☐ 204
	Private dwelling ① = Yes ② = No	☐ 205
	None ① = Yes ② = No	☐ 206
14	**The cause of not being completely happy**	
	Financial troubles ① = Yes ② = No	☐ 207
	One's self ① = Yes ② = No	☐ 208
	One's family ① = Yes ② = No	☐ 209
	Lack of opportunity ① = Yes ② = No	☐ 210
	One's social life ① = Yes ② = No	☐ 211

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15	**Conditions making it possible to remain in the community**	
	The existence of appropriate em-employment ① = Yes ② = No	☐ 212
	Adequate financial support ① = Yes ② = No	☐ 213
	Appropriate accommodation ① = Yes ② = No	☐ 214
	Existence of social support system ① = Yes ② = No	☐ 215
	Other (specify) ..... ① = Yes ② = No	☐ 216
16	**Problems of daily living**	
	Stigma ① = Yes ② = No	☐ 217
	Lack of information ① = Yes ② = No	☐ 218
	Gaps and inadequacies in services ① = Yes ② = No	☐ 219
	Other (specify) ..... ① = Yes ② = No	☐ 220

Section E: Service needs

Which of the following service needs would you regard as the <u>most</u> important?

1	**Medical care**	
	Specific health care ①	☐ 221
	Psychotropic medicine ②	

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2	**Counselling needs**		
	Socialisation groups	①	
	Self-help group	②	
	Group therapy	③	
	Alcohol	④	
	Drug	⑤	
	Marital/family	⑥	
	Patenting	⑦	☐ 222
3	**Leisure time activities**		
	Social groups	①	
	Recreational activities	②	
	Arts/crafts	③	☐ 223
4	**Financial support**		
	Public assistance	①	
	Food stamps	②	
	Government grants	③	☐ 224
5	**Support to relatives**		
	Counselling with family members	①	
	Support groups for family members	②	☐ 225
6	**Activities of daily living**		
	Financial management	①	
	Home management	②	
	Personal care	③	
	Transportation use	④	☐ 226

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7	**Vocational rehabilitation**		
	Job placement	①	
	Work adjustment/vocational training	②	
	Pre-vocational counselling	③	
	Work evaluation	④	
	Job readiness	⑤	☐ 227
8	**Education**		
	Formal education	①	
	Informal education	②	☐ 228
9	**Appropriate living arrangements**		
	Own apartment	①	
	With parents	②	
	With relatives/friends	③	
	Group home	④	
	Half-way house	⑤	
	With spouse	⑥	
	Supervised cooperative apartment	⑦	
	Independent cooperative apartment	⑧	☐ 229

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10	**Needs in order of priority**		
NB:	*Having responded to the above question, you are hereby requestion to arrange the above needs in order of priority as you view them, for example 6 = 1 etc*		
	Medical care	1	
	Counselling	2	
	Leisure time activities	3	
	Financial support	4	
	Support to relatives	5	
	Activities of daily living	6	
	Vocational training	7	
	Education	8	
	Appropriate living arrangement	9	

Thank you for participating in this study.