

Development

Developing mental health education for health volunteers in a township in South Africa

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South Africa like many countries is moving towards a system of community care for people with mental health problems. This is set against a backdrop of under-resourced and overburdened services. These problems are particularly apparent in the township communities. The aim of this study was to devise an education programme for South African volunteer health workers using principles adapted from the UK evidence base for psychosocial intervention (PSI) and to evaluate the impact of the education programme on community volunteer health workers' knowledge about mental health issues. A stakeholder consultation exercise was held to explore: the context of South African services; the transferability of the UK evidence base and educational strategies to South Africa; and to inform the design of an educational programme. Evaluation of the community volunteer educational programme was undertaken using pre- and post-education focus groups. Twenty-one volunteers working with mentally ill people in the community from one township attended a three-day, six module course. After the course, volunteers: were able to articulate a greater range of aetiological and contributing factors to the development of mental health problems, including stress vulnerability and traditional belief frameworks; could describe a more humanistic model of mental health identification; identified a wider range of both formal and informal helping strategies; were more aware of the negative impact of interpersonal behaviours for people with mental health problems. Volunteer involvement has been confined to communicable diseases in South Africa. Volunteers educated about mental health care could assist in the South African policy of 'horizontal' integration of services into primary care from their current 'vertical', specialist-orientated structures.

Key words: education; lay educators; psychosocial interventions; serious mental illness; South Africa; voluntary mental health workers

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Background

Since moving to majority democratic rule, South Africa faces many challenges, not least in trying

to provide equitable health care services for all its peoples. Mental health services, particularly those that attempt to serve the poorest parts of the population, work against a backdrop of severe deprivation and want (Richards and Nkombisa, 2002). This paper describes in depth the first stages of a collaborative programme of development between the UK and South Africa which aims to develop community volunteer capacity for mental health

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care as part of a programme to improve the health of the people of a large township community in the Nelson Mandela Metropolitan Municipality (NMMM) situated in the Eastern Cape. A descriptive overview of the project has recently been published elsewhere (Mairs *et al.*, 2005).

The Nelson Mandela Metropolitan Municipality

The NMMM consists of Port Elizabeth and its surrounding area. It is predominantly urban however, it includes peri-urban areas as well as underdeveloped communities. The population, estimated at 1.2 million people, constitutes 19% of the total of the Eastern Cape Province, which is one of the poorest in South Africa. Life expectancy in 2000 was 47.8 years. The major causes of death and disability are HIV/AIDS and tuberculosis. Mental health morbidity statistics are poorly researched but mental health has been recognized by the South African Government as an important area requiring further attention.

Mental health services in South Africa

Historically mental health services in South Africa have focussed on patients suffering from serious and enduring mental illness with care normally being delivered within institutional settings (Petersen, 1999). With the end of apartheid in 1994 mental health services have been undergoing a transition towards the delivery of comprehensive community orientated care. Experience in the developed world has shown that implementing community care can be a difficult process (Rogers and Pilgrim, 2001). South Africa has a number of problems which will make the goal of community care all the more difficult to achieve. Mental health services are under-resourced with the ratio of staff to patients being 1:1135 compared to 1:80 in the USA and 1:190 in the UK (Sokhela and Uys, 1999). There are stark differences in the facilities available to patients in private psychiatric hospitals compared to state run institutions. Large areas of urban South Africa, particularly the township communities, do not have access to community mental health care and patients that fail to attend appointments may not be followed up in the community.

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Mental health services in the UK

In a similar way to South Africa, the UK has also moved away from the delivery of institutional-based care for people with serious mental illness to a community-based model. Although this process began several decades earlier the transition has not always been a smooth one. Many of the patients discharged from the large psychiatric institutions soon lost contact with mental health services (Melzer *et al.*, 2001). Community infra-structures were insufficiently developed to meet the needs of seriously mentally ill individuals. Mental health nurses and other workers were criticized for moving away from working with this client group to concentrate on those individuals experiencing mild to moderate mental health problems (Department of Health, 1994a). There has also been a recognition that services were often unable to provide adequate care for the 'new long stay', often a difficult to engage client group who were more likely to lose contact with services, sometimes with drastic consequences (Department of Health, 1994b).

In recognition of the problems outlined above, the current UK government announced in 1999 that community care had failed those with serious mental illness and a new strategy, underpinned by the best available research evidence, would set out standards for the development of mental health services (Department of Health, 1999). The development of new educational initiatives for mental health workers in evidence-based approaches such as psychosocial intervention PSI was central to these standards (National Institute for Clinical Excellence, 2002). PSI is a term for a range of interventions underpinned by the stress vulnerability model of schizophrenia (Zubin and Spring, 1977) which proposes that exposure to stress triggers symptoms of psychosis in individuals who are vulnerable to such experiences.

Although the term PSI is generally accepted to incorporate a range of highly skilled and fairly complex interventions such as cognitive behavioural therapy and family interventions (see Pilling *et al.*, 2002 for a recently published systematic review of the efficacy of these approaches), course participants are taught that the first and arguably most important skill they need to develop is the effective engagement of service users in partnerships based on hope and optimism (National Institute for Clinical Excellence, 2002). In order to be able to establish such partnerships, course participants develop an

understanding of the importance of engagement, are helped to develop positive attitudes towards service users based upon frameworks of recovery (see Repper and Perkins, 2003) and learn effective communication skills. Course participants also explore the importance of helping service users to sort out problems that they are experiencing in their daily lives, often by using practically focussed interventions and the importance of promoting social inclusion (Bradshaw *et al.*, 2000; 2003).

Petersen (1999) developed an educational programme for primary care nurses' in South Africa that had many similarities to UK-based PSI courses. Petersen was critical of the nurses' practice, arguing that it was strongly influenced by a biomedical model of mental illness which together with the shortage of time for consultations often led them to offer medication as the only treatment option. Petersen argued that they failed to collaborate effectively with patients and did not take into account the effects of psychosocial stress on mental health. Petersen developed a programme which aimed to enhance the nurses understanding of mental illness within a biological, cultural, psychological and social framework and to encourage patients to be 'active participants in the healing process as opposed to passive recipients of care' (p. 910). Evaluation of the programme showed that the nurses demonstrated improvements in their relationship skills, micro-counselling, problem identification and problem management and participants reported a feeling of being 'empowered' by the programme to help patients with psychosocial problems whom previously would have made them feel helpless and frustrated. Thus it would seem that the principles which underpin PSI education and some aspects of the interventions may be of value to South African mental health workers.

However, given both the shortage of nurses and other professionally qualified health workers and the levels of physical illness in the most disadvantaged communities in South Africa, even educating primary care nurses is unlikely to lead to a greater level of engagement of those patients with serious mental health problems who are most difficult to reach (Madlala-Routledge, 2004). Lay workers and other volunteers from communities themselves may be one solution to this problem. Volunteers are a central and culturally appropriate South African solution to high levels of need and low levels of professional service provision

(Tshabalala-Msimang, 2004). However, there are no examples of such initiatives for mental health care in South African disadvantaged populations. It may be that combining modern PSI approaches with lay-led mental health care could lead to increased engagement of patients with serious mental health problems, particularly if these initiatives were embedded within the statutory health services.

This paper, therefore, reports on a collaborative project undertaken between members of the Health and Social Care Forum (HSCF) from a large township in Port Elizabeth in the Eastern Cape area of South Africa and academics from the University of Manchester (UoM), UK and the University of Port Elizabeth (UPE), South Africa in order to improve the mental health services available to people in the township. The project stages were:

- 1) adaptation of PSI educational materials for South African community volunteer health workers;
- 2) delivery of an education programme to community volunteers;
- 3) organizational development linking community health workers and statutory services.

In this paper we report in detail on the first two stages to explore the extent to which UK developments in PSI education can be adapted and delivered to South African volunteer health workers and to evaluate the effect of the programme on the knowledge of the workers about mental health issues.

Methods

Stage 1: design of education programme

A consultation exercise was conducted by two members of the UK team by visiting key stakeholders in mental health services in the NMMM to understand the context of South African services. Stakeholders included community mental health nurses serving both rural and urban township communities, psychiatric day hospital and inpatient nurses, service managers, members of the KwaZakhele township HSCF (a group of community members and health care providers in the township) and educators from the UPE. Discussions were held about the potential transferability of the UK evidence base and educational strategies to South Africa. At the end of the period of consultation a presentation from the UK team was made to

a meeting of all the stakeholders, consisting of observations on the difficulties faced by South African mental health services and a distillation of the suggestions synthesized during the consultation period.

Table 1 outlines the results of the stakeholder consultation exercise. Stakeholders reported grossly overstretched nurses unable to engage patients with the most serious mental health difficulties. Treatment services were restricted to dispensing and checking psychotropic medication. Case-load sizes left no time for discussion of other psychosocial elements to patients' lives. Nurses were highly skilled in the administration and monitoring of psychotropic medication but were unable to spend time developing collaborative relationships with patients. Apart from a short period of time during mental health placements from UPE student nurses, patients who did not attend their appointments at the Psychiatric clinic were lost to services. These patients were those most likely to be at risk from the physical, psychological and social consequences of their mental health problems. Some of these consequences included the loss of status in the community of mentally ill people as many residents of the township

regard them as children rather than adults. Occasionally, volunteer health workers helping people with HIV/AIDS and tuberculosis would encounter people with mental health problems during their work in the community but the volunteers rarely felt empowered to assist them due to fear and lack of knowledge about mental illness.

In contrast to the work of Petersen (1999) described earlier who developed a training programme for qualified nurses, the stakeholders decided that a more positive impact could be achieved in relation to the treatment of mentally ill people in the township if a brief training programme was developed for volunteers rather than qualified health workers. Ideas were then discussed, principles established and a joint action plan proposed on the nature of the education programme to be developed.

In order to adapt educational programmes for a South African context, four key principles were extracted from the exercise and potential solutions to underpin the educational initiative were identified: sustainability, success, ownership and accessibility.

Table 1 Themes and their characteristics arising from the stakeholder consultation exercise

Theme	Characteristics
Work-loads	Extremely high: community psychiatric nurses with case-loads of 1000 patients, clinic nurses overwhelmed by appointments
Contact times	Short: huge case-loads restricted time for any therapeutic activity
Model of mental illness	Essentially biomedical: highly educated nurses focus activity on psychotropic medication interventions. No formal or informal PSI services available
Collaboration between health care providers and patients	Limited evidence: interactions between patients and nurses highly directive. No organized user movement or self-management groups
Patient engagement with services	Very problematic: more than 50% of patients 'default' from pre-arranged appointments. High rates of 'non-compliance' with treatment and subsequent disengagement from services
Community outreach	None: nurses unable to engage in assertive outreach activities to deliver care to hard to reach patients including those defaulting from pre-arranged appointments
Community attitudes to people with mental health problems	Unhelpful: many people with mental illness are stigmatized and regarded as 'children' by their families and community
Volunteer community health worker system	Newly developed: volunteers engaged in TB and HIV/AIDS work in people's houses. Volunteers came across people with mental health problems during this work. Volunteers also accompanied nursing students on annual eight-week mental health placement. At other times volunteers acting as the <i>de facto</i> community outreach arm of statutory services, often bringing people into clinics who had serious mental health needs

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- The programme should be designed in such a way that it could continue beyond the participation of the UK team.

Potential solution:

- Devise a 'train-the-trainers' course and leave behind materials which could be used by volunteer health workers who had received the training to use with other volunteers.

Maximize chances of success

- The programme should be realistic, start small and not be so ambitious that it would fail.

Potential solution:

- The project should deliver a short course for a small number of volunteer health workers.

Programme should be owned by the community

- Sustainability will be increased if the community has a sense of ownership and investment in the course.

Potential solutions:

- Delegates attending the course should be selected democratically by the HSCF itself following usual practice.
- Course should be delivered in the community.
- Domestic arrangements should be organized by the community.

Accessibility

- Course should be accessible to key community members whose first language is Xhosa, but the UK educators do not speak Xhosa.
- Course material should be manageable for a lay audience.

Potential solutions:

- Community leaders felt that the first course should be restricted to participants with a good knowledge of English.
- Some translation would be provided by a UPE staff member and members of HSCF themselves.
- The 'train-the-trainers' material should be used by volunteers who had attended the first course

to enable access to the materials by a wider range of community members and health workers in their first language of Xhosa.

- A range of learning methods should be employed and participants should be encouraged to be actively involved in all stages of the course.

These principles were utilized in the design and delivery of the course.

Stage 2: evaluation of educational programme*Participants*

Twenty one people were selected by the HSCF to attend the training programme, 14 women and 7 men, all were residents of the township. All participants selected spoke English as a second language, their first language being Xhosa. All participants were working in a voluntary capacity as health workers in the KwaZakhele township and included members of the HSCF, the pastor of the local church and volunteers who had developed services including a soup kitchen for mentally ill people.

The educational programme

The course materials were planned as six three-hour, half-day blocks to enable maximum subsequent delivery flexibility. Table 2 provides details of the framework of the individual sessions. Each session was laid out as a series of 'activities' and detailed information was supplied regarding the materials required for each activity, the aims and objectives of each activity, as well as teaching methods and summary slides to support either presentations or group discussions/exercises.

Attempts were made to ensure that course materials were culturally appropriate to a South African community and all materials were sent for proof reading by staff from UPE in order to validate these attempts to adapt the materials to a South African culture. The planning and organization of the course, including provision of refreshments, were undertaken by members of the HSCF.

Design

Two focus groups were conducted with the course participants immediately before and after the

Table 2 Content of community volunteers education programme

Theme	Block	Objectives
Understanding mental illness	A. What is mental illness?	Understanding the main features of severe and common mental illness Understanding the impact of symptoms of mental illness on people Recognizing how different mental illnesses can be confused with laziness or childishness
	B. The stress vulnerability model	Understanding what causes mental illness Considering things that have a negative effect on the health of people with mental illness Reviewing how to help mentally ill people
Helping people	C. Drug treatments and mental illness	Awareness of different types of medication used to treat mental illness Examining the benefits of these drug treatments for patients Awareness of the negative aspects of drug treatments including common side effects Considering how to help people get benefit from drug treatments and manage side effects
	D. Responding to people with mental health problems	Reviewing signs/symptoms of mental illness and the stress vulnerability model Examining interactions which may increase or reduce stress for the patient and those looking after them Identifying a range of responses which are helpful to individuals with mental illness
Helping families and communities	E. Helping families cope with mental health problems	Considering the role of families in caring for mentally ill people in the community Discussing the importance of families having an understanding of mental illness Identifying behaviours of family members that may increase stress for the patient Identifying helpful behaviours of family members that reduce stress for the patient
	F. Community and social interventions for mental health	Identifying additional lifestyle factors (eg, diet, exercise and occupation) which influence mental and physical health Highlighting social/community projects already in place which assist people with mental health problems in these areas Considering future projects which may enhance the well being of local people with mental health problems

programme. A topic guide was developed around a series of major questions and prompts (Table 3). These questions were adapted from an interview schedule developed in the UK to assess relatives' knowledge about mental illness (Barrowclough *et al.*, 1987). The focus groups were facilitated by members of the UK team with translation assistance from a lecturer from UPE. Groups were audiotaped and transcribed verbatim by the teachers

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(T.B. and H.M.) who also provided necessary contextual insights.

Data analysis

Using the thematic content analysis technique of Burnard (1991), three members of the project team (T.B., H.M. and D.R.) extracted all elements of potential data from the text and transferred it to a separate data sheet, excluding only words and

Table 3 Prompt questions for focus groups

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1. What do you think causes mental illness?
 2. How do we know when someone is mentally ill?
 3. What sort of things can we do to help people with MI?
 4. What sorts of things aren't helpful to mentally ill people, what might make them worse?
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phrases which added no additional meaning to the data. For each section of the topic guide the data sheet was scanned carefully and common words or phrases were transferred to a second data sheet. Statements expressing similar concepts were grouped together. The second data sheet was then examined and groups of statements which seemed to refer to very similar ideas put together under general thematic headings. Themes were generated separately from both pre- and post-course data and finally combined in an overall model. The development of both data sheets was achieved through a combination of manifest theme identification (where common words or phrases occurred very frequently) and inference (requiring understanding and interpretation from the project team and contextual insights from the two teachers to aid understanding). Differences in coding and grouping were resolved iteratively through discussion between the three team members and reference to the source transcriptions. This resulted in much swapping and re-categorization as overarching explanatory headings developed, based directly on the gradual reduction of the original data.

Ethics

The project followed best ethical principles in place in South Africa. All participants were adults who volunteered to participate in the focus groups and gave consent for the information that they provided to be subsequently used for publication. To ensure that 'informed consent' was obtained the nature of the study and how resulting data would be used was explained to participants in both English and Xhosa. All participants were assured of complete anonymity and retained the right to withdraw their consent at any time.

Results

Four focus groups of between ten and eleven people each were conducted in total, two before

the course and two afterwards. The results are described below.

What causes mental illness?

The themes which emerged in the pre-focus groups were generally consistent with the stress vulnerability conceptualization upon which the course had been written. Participants identified biological – '*something which affects the brain*' – and psychological vulnerabilities to mental illness – '*feeling insecure all the time, stresses you and you can get mental illness*'. In the post-education group, responses acknowledged the role of a wider range of stressors experienced in their community which participants believed contributed to the onset of mental illness:

the stresses around us are the ... cause of mental illness ... stress because of unemployment and because of crime.

of course in some cases mental illness is caused in our people by being tortured by the Police.

fragmented family structures are another cause of mental stress.

The use of substances, notably alcohol and dagga (cannabis), in causing and maintaining mental health problems was also discussed:

In our communities ... we have qualified people that are unemployed, that are holding two or three degrees, they have certificates but they are not getting employed and most of them spend their time in taverns, trying to quench the frustration and they become addicted to alcohol and end up with mental illness.

Most people who are mentally disturbed like to smoke Dagga.

The high prevalence of HIV within the community and associated mental health problems were also highlighted:

mental illness comes in the later stages of the HIV virus.

In addition to the above themes, participants referred to a number of traditional beliefs, ascribing a role to witchcraft and other spiritual influences in the onset of mental illness:

we believe in ancestors and we say those voices are our ancestral voices, they are talking to this person because they want to help the family or they want to help the clan.

people who are born to be witch doctors ... if they do not accept this then they get their mental illness they hear things, they see things that other people don't see, because of their illness and that person needs to go to a qualified witch doctor for her to get well again....

How do you know when someone is mentally ill?

A range of signs of mental illness were elicited in pre- and post-focus group discussions. These included physical signs, for example, '*something wrong with the eyes*', behavioural excesses, for example, '*continue doing one thing or something time and again*' and deficits, for example, '*they don't take care of themselves, they don't wash*'.

Reference to traditional beliefs was also made in that one participant explained that one sign is when '*this person ... is communicating with the spirits*'.

The main difference between pre- and post-groups was that in the pre-groups a number of participants had identified aggressive behaviour as a sign of mental illness, for example, '*can get aggressive, they are very violent, break houses, assault people*' while in the post-group no references to such behaviour were made. In addition in the post-groups a number of participants talked of the affective states of people with mental health problems – '*they feel worthless, sad and frightened*' – something that had not been highlighted in the pre-groups.

What sort of things can we do to help people with mental illness?

In the pre-focus groups a number of helpful strategies were identified. In the main these were modes of engaging the mentally ill although a small number of 'formal' interventions were elicited.

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These included medication, education about the illness and the provision of support for the family:

some of them (mentally ill people) need counselling ... they don't need medicines, they need people who know and understand mental illness.

finding them something to do.

Responses in the post-group revealed considerably more interventions which could be used to help those with mental health problems in the local community. As well as considering how best to engage such individuals, themes relating to a range of formal and informal interventions emerged. These ranged from strategies which could be undertaken by individuals – '*talking to them, orientating them about the illness*' – to a number of community-based strategies such as educating local teachers about mental illness, working with local agencies, providing transport to hospital:

If institutions work together ... if they have the same information ... allow more opportunities for people with mental illness to make use of services.

useful for teachers to know about mental illness so that they can recognize mental illness and may be able to help children with parents with mental illness ... observe children they are teaching – pick them up at an earlier stage and help them....

The individual helping strategies identified in the post-focus group were generally collaborative in nature. Whereas in the pre-focus group participants had suggested that it was difficult to talk to those with mental health problems – for example, '*Difficulty in telling someone he is mentally ill*' – responses in the post-group included: '*Try to find out what is wrong*' and '*Encourage them to take treatment*'.

In summary, the discussions in the post-focus groups suggested that participants could identify a wider range of collaborative interventions and community-based initiatives which would assist those with mental health problems in the local community, compared to responses they gave before they had attended the education programme which were much more limited.

What sorts of things are not helpful to mentally ill people and what might make them worse?

In both pre- and post-groups participants identified a number of examples of unhelpful responses which included modes of engagement – ‘*shouting at him, too much noise*’ abuse and negative attitudes, for example, ‘*labelling can also make it worse, calling him Ekasa, stigma ...*’.

Participants also discussed how current local service configuration did not meet the needs of those with mental health problems. A number of difficulties were highlighted including the distance between the community and the hospital facilities, the failure of services to respond to those with mental health problems in crisis and the fragmentation of local services ‘*having to travel so far to hospital*’.

The primary difference between the pre- and post-group responses was that participants showed a greater awareness of the negative impact of critical comments made by family members towards individuals with psychosis:

Another thing that makes them worse (mentally ill people) is when they don’t get support from the family, when they (family members) say this lazy boy, why is he so lazy ... so that worsens the situation.

Discussion

This study has shown that at the end of attending a collaboratively developed mental health educational programme, community volunteers: were able to articulate a greater range of aetiological and contributing factors to the development of mental health problems, including stress vulnerability and traditional belief frameworks; could describe a more humanistic model of mental health identification; identified a wider range of both formal and informal helping strategies; were more aware of the negative impact of interpersonal behaviours for people with mental health problems. The analysis of the focus group data highlighted volunteers’ multiple understandings of the causes of mental ill health which incorporated both stress vulnerability models and traditional conceptualizations. Physiological, psychological and social causes were all cited as well as examples of the dissonance experienced

by someone trying to deny traditional beliefs. Volunteers had no problems incorporating different belief systems, a phenomenon echoed in the recent South African government approach of incorporating traditional healers into the formal health system (National Health Act, 2004). The analysis also highlighted volunteers originally citing largely negative views of mental health problem indicators and then moving to one where a greater number of signs were acknowledged. After the course, when volunteers talked about helping people with mental health problems, they referred to a wider repertoire of activities, including engaging the wider community in mental health awareness. A similar pattern was observed in terms of unhelpful responses, where volunteers were clearer about how stressful interactions could worsen the outlook for people with mental health problems.

During the stakeholder consultation process the principles of sustainability, success, ownership and accessibility were identified as being of significance. The detailed format of the teaching materials, with the explicit aim that they be delivered by lay people, was developed to increase the probability that the programme would be sustainable. The volunteers who attended the course were each given their own manual which contained all the materials that they needed to educate other people about mental health care from a psychosocial perspective. Indeed, during the course, members of the group began to discuss how they were going to disseminate the programme and which individuals would take a lead in delivering the course.

The principles of success and ownership were operationalized through implementing specific requests from the HSCF during the stakeholder consultation phase. The HSCF requested that the project team develop a short course for volunteer health workers to enable them to help people with mental illness in the community and had promised to identify twenty volunteer health workers to attend. Subsequently, members of the HSCF identified participants to attend the course, arranged a venue in the township where the course could be taught and booked refreshments for the delegates. Catering for meals and refreshments was commissioned from a local business in the township thus ensuring that the small amount of money needed to support the course went back into the local community. Twenty-one people successfully completed this short course; all volunteers were awarded

a certificate of attendance on completion of the programme. We learned how to adapt knowledge to the South African context and how to apply this understanding in a way that enhances the capacity of communities to take action to improve their own health care.

Limitations

This study is limited by its small pilot nature and by the fact that those delivering the course also conducted the focus groups and their analysis. In addition it was not possible to authenticate the themes which emerged during the data analysis with the participants in the study. Although delivering the course in the community itself enhanced the geographical accessibility of the programme, the programme was restricted to volunteers who spoke English. This restriction was imposed by the HSCF itself with the rationale that the lecturers would be able to establish reasonable communication with the group. When difficulties in understanding were encountered the lecturer from UPE (S.J.) whose first language is Xhosa was able to translate. This does not mean that in the future, people who speak only Xhosa will be excluded from receiving mental health education since the nature of the materials allows some of the initial participants to educate other groups of volunteers in their native language later. However, it is unknown to what extent the educational programme would benefit from translation and back translation in order to produce language congruent materials. Finally, the impact on the community generally and people with mental health problems specifically is unknown.

Implications

The focus upon volunteers may be perceived as potentially exploitative. However, volunteers are a cornerstone of health care in South Africa (National Health Act, 2004). The government now awards a small stipend to those volunteers identified as community health workers in recognition of the critical role they play in health care delivery (Madlala-Routledge, 2004).

Their involvement previously has been confined to communicable diseases. Volunteers who have

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received training in mental health issues could assist in the South African policy of 'horizontal' integration of services into primary care from their current 'vertical', specialist-orientated structures. Generalist volunteers with mental health as well as physical health knowledge and skills could work in chronic disease management models by conducting outreach visits for mental health patients in the way they currently work with patients with diseases such as tuberculosis. Outreach by volunteers enhances treatment concordance, a critical variable which affects long-term health in mental health care as well as physical health problems. Further work is required to support educated mental health volunteers as they cascade their learning, implement what they have learnt and begin to work with statutory organizations in order to enhance the services available to people with mental health problems.

Experience in the UK suggests that training in PSI is necessary but not sufficient for the implementation of new skills in mental health practice (Fadden, 1997). In light of this, we are continuing the project to work with the volunteers who have completed the first training course to train a further group of volunteers. We are also developing a system for volunteers to work with statutory service providers to trace patients with mental health problems who had lost contact with services. It is our intention to publish a more detailed account of this final stage of the project together with data from a six-month evaluation of the volunteers works in due course.

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