Evaluation of the experiences of Clinical Psychologists Providing Community Services within the Community Service Psychology Program in KwaZulu-Natal, South Africa

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Abstract
This study investigated the differences and similarities in the experiences of community service psychologists placed within the KwaZulu-Natal region.

It comprised of eight (8) community service psychologists, seven (7) females and one male, placed at some point within a two year period at different sites within the region. Seven (7) community service psychologists were still in community service while one (1) had already completed their stipulated year of service.

A single, structured interview was used to collect the data. Grounded theory was utilized in the analysis of the qualitative data. Comparisons were drawn between the experiences of the community service psychologists in relation to their individual experiences in order to extract common themes. Significant individual experiences where noted and discussed.

The findings indicate dissatisfaction with the management and implementation of the Community Service Psychology Program amount the participants. In addition, psychological trauma in regard to fear over safety and abusive or alienating management structures within the environments serviced by the Community Service Psychologists was noted.

The implications and applications of this study can be far-reaching as research is direly lacking in the arena of Community Service structures and facilitation within the South African context.
Acknowledgements

I would like to express my gratitude to my supervisor, for his assistance and patience, support and encouragement. In addition, I am grateful to the community service psychologists that took time away from their busy schedules to share their stories.

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But most of all I would like to be noted that this dissertation is a testament to the love, respect, compassion, devotion and sheer determination to succeed shared by my children and myself during the many traumatic and difficult years we have spent toiling for a better life. I declare this dissertation in honour of my parents and my three children, Nazeera, Waseem and Azeeza. May God be with them, bless them, provide for them and protect them now and forever. Ameen.
Declaration

This dissertation was undertaken at the school of Psychology, University of Zululand, Empangeni. Unless specifically indicated to the contrary in the text, this dissertation is a product of the author’s own work.

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Sherona Rawat

Durban, South Africa

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Chapter 1

Introduction

Community service for clinical psychologists in South Africa was made mandatory by the Minister of Health as from January 1st, 2003. It was anticipated that a small number of clinical psychologists from universities across South Africa would supposedly begin community service during each given year. The universities generally accept between five (5) and seven (7) graduate psychology students into their respective masters programs.

The rationale behind this project was and is to provide much needed psychological services to as many South Africans as possible. Given the shortage of clinical psychological skills, mandatory service preceding registration for independent practice would ensure a steady flow of service providers within this particular skills base. In addition, the success of similar skills based programs for medical doctors and other allied health care professionals proved encouraging if not extremely optimistic. The small number of clinical psychologists and the shortage of said service to the community at large seemed daunting. However, while clinical psychology shares many commonalities with other healthcare professions, the path to qualification differs considerably.

It is required that clinical psychologists finish their degree coursework, hand in their dissertation and have had met all requirements pertaining to their degree before entrance into community service. The dissertation is a full coursework dissertation and requires time and energy as such. As a result, delays in the completion and handing in of dissertations resulted in delays in the placement of community service psychologists to their allotted posts. In addition, service provision requires sensitivity to the site, so that the clinical psychologists are providing a service which is valued by the patient basis within that area or zone.
Hence, the plan may have been a little simplistic from the outset and required a far more intensive design and procedure. In addition, a needs analysis may have proved beneficial in the planning of such an intervention.
Chapter 2
Literature Review

2.1 Nature of an evaluative study

According to Weiss (1998, p. 4) evaluation is defined as “the systematic assessment of the operation and or the outcomes of a program or policy, compared to a set of explicit or implicit standards, as a means of contributing to the improvement of the program or policy”. However, an evaluative study examines the techniques and process of program evaluation and policy research in addition to studying the social and political context within which evaluation occurs (University of Minnesota, Evaluation Studies, n.d.). Furthermore, most of the evaluative studies utilize the same methodologies used in traditional social research. However, since evaluation takes place within a political and organizational context, it requires group skills, management ability, political dexterity, sensitivity to multiple stakeholders and other skills that social research in general does not rely on as much (Introduction to Evaluation, n. d.). Hence, there exist challenges in describing what is specific to it (Bernard & Goodyear, 1992). On the other hand, Weiss (1998) reveal that, in evaluation research the main focus is on evaluating an event and to make judgment about its usefulness. This suggests that, due to the elements of value judgement made by an individual it is more qualitative than quantitative.

Evaluation is an aspect of supervision. Evaluation is implicit in supervisors’ mandate to safeguard clients – both those currently being seen by interns and those who will be seen by interns who finish the training program. Evaluation is also a tool because it provides the supervisor with an important source of interpersonal influence. For instance, although most interns have a very high degree of intrinsic motivation to learn and use feedback to self-correct, evaluation can provide an additional, extrinsic
motivation to change or evolve, particularly to those interns who might not be as self-monitoring as they should be (Bernard & Goodyear, 1992).

In terms of methodology, a consensus exists with respect to the fact that both quantitative and qualitative methods have an important place in programme evaluation (Clarke & Dawson, 1999). Impact evaluation uses the canonical research procedures of social sciences (Research Designs in Education, 2010). In addition, Clarke and Dawson (1999) mention that the importance of systematic evaluative research as a phenomenon across the Social Sciences has been evident in recent years.

Weiss (1998) note that, evaluation is inherently political: what happens when a new technology is introduced is both affected by organizational and implementation processes, as well as affecting them. This political nature of evaluation draws from the fact that, it concerns needs, values, and interests of different stakeholders. Hence, evaluation can be employed to influence system design, development, and implementation. While results of post-hoc or summative assessments may influence future development, formative evaluation, which precedes or is concurrent with the processes of systems design, development, and implementation, can be a helpful way to incorporate people, social, organizational, ethical, legal, and economic considerations into all phases of a project (Research Designs in Education, 2010). Weiss (1998, p. 20) identifies several purposes for evaluating programs and policies. They include the following:

- Determining how clients are faring
- Providing legitimacy for decisions
- Fulfilling grant requirements
- Making midcourse corrections in programs
- Experiences of Community Service Psychologists

- Making decisions to continue or culminate programs
- Testing new ideas
- Choosing the best alternatives
- Recording program history
- Providing feedback to staff
- Highlighting goals

2.2 Advantages of program evaluation

Program evaluation is the procedure used to determine the degree to which a comprehensive guidance and counselling program is in place and functioning fully. Judgments are made about the status of a program using program evaluation standards and criteria that are derived directly from the language of the framework of comprehensive guidance and counselling programs (Gysbers & Henderson, 2006). Program evaluation reviews the status of a program against established program standards to ascertain the degree to which the program is being implemented.

Enough program evaluation standards and criteria are required to ensure that a complete comprehensive guidance and counselling program is fully represented. Once the standards and criteria have been chosen that fully represent a comprehensive guidance and counselling program, a scale is created for each criterion that can range from 5 to 6 or 7 points. Sometimes a scoring guide is provided that describes what an evaluator would look for at each point. A scoring guide can also include examples of evidence evaluators would expect to find along with the documentation required to show the degree to which the standards and criteria have been met (Gysbers & Henderson, 2010).
The purpose of most evaluations is to provide "useful feedback" to a variety of stakeholders. Furthermore, in most cases feedback is perceived as "useful" if it facilitates decision-making. However, there is a complex relationship between informed decision making and evaluation. For instance, studies that seem critical sometimes fail to influence short-term decisions, and studies that initially seem to have no influence can have a delayed impact when more congenial conditions arise (Introduction to Evaluation, n. d.). Therefore, the major goal of evaluation should be to influence decision-making or policy formulation through the provision of empirically driven feedback (Trochim, 2002).

Whether program evaluation is done yearly or periodically, this type of evaluation provides the opportunity to determine if the written provincial program matches the actual implemented provincial program. The results of program evaluation reveal where progress has been made or whether progress is lacking in overall comprehensive guidance and counselling program implementation (Gysbers & Henderson, 2010).

Program evaluation does not seek to appraise or assess individuals. It will be successful in achieving its aims only if a multiplicity of stakeholders is included. Therefore program evaluation allows for participatory learning and action to be implemented (IBO, 2005). According to Sampong (2009) program evaluation is the systematic investigation of the worth of an ongoing or continuing activity. There are as many different models of or approaches to evaluation as there are philosophical underpinnings of definitions of evaluation. The needs of each particular program determine the evaluation model suitable for use (Simonson, 1997).
2.3 Types of evaluation
There are two types of evaluation namely; summative and formative evaluation.

2.3.1 Summative evaluation
Summative evaluation seeks to understand the outcomes or effects of something, for example where a test for children in school is used to assess the effectiveness of teaching or the deployment of a curriculum (Changing Minds, n.d.).

Summative evaluations can assess such concepts as:
- **Finance**: Effect in terms of cost, savings, and profit and so on.
- **Impact**: Broad effect, both positive and negative, including depth, spread and time effects.
- **Outcomes**: Whether desired or unwanted effects are achieved.
- **Secondary analysis**: Analysis of existing data to derive additional information.
- **Meta-analysis**: Integrating results of multiple studies.
  (Trochim, 2002; Changing Minds, n.d.)

The questions and methods addressed under summative evaluation include:

2.3.1.1 What type of evaluation is feasible?
Evaluability assessment can be used here, as well as standard approaches for selecting an appropriate evaluation design (Introduction to Evaluation, n. d.).
2.3.1.2 What was the effectiveness of the program or technology?
One would choose from observational and correlational methods for demonstrating whether desired effects occurred, and quasi-experimental and experimental designs for determining whether observed effects can reasonably be attributed to the intervention and not to other sources (Introduction to Evaluation, n. d.).

2.3.1.3 What is the net impact of the program?
Econometric methods for assessing cost effectiveness and cost/benefits would apply here, along with qualitative methods that enable us to summarize the full range of intended and unintended impacts (Introduction to Evaluation, n. d.).

The need to improve, update and adapt these methods to changing circumstances means that methodological research and development needs to have a major place in evaluation work (Trochim, 2002).

2.3.2 Formative evaluation
Formative evaluation is used to help strengthen or improve the person or thing being tested (Evaluative Research, n. d.).

Formative evaluations can assess such as:

- **Implementation**: Monitoring success of a process or project.
- **Needs**: Looking at the type and level of need.
- **Potential**: The ability of using information for formative purpose (Trochim, 2002).
2.4 Management Models
The CIPP Model is a simple systems model applied to program evaluation. A basic open system includes input, process, and output (Payne, 1992). Stufflebeam (1971) added context, included input and process, and relabelled output with the term product. Hence, CIPP stands for context evaluation, input evaluation, process evaluation, and product evaluation (Payne, 1992). These types are typically viewed as separate forms of evaluation, but they can also be viewed as steps or stages in a comprehensive evaluation (Payne, 1992).

2.4.1 Context evaluation
This includes examining and describing the context of the program you are evaluating, conducting a needs and goals assessment, determining the objectives of the program, and determining whether the proposed objectives will be sufficiently responsive to the identified needs (Payne, 1992).

2.4.2 Input evaluation
Involves activities such as a description of the program inputs and resources, a comparison of how the program might perform compared to other programs, a prospective cost/benefit assessment (i.e., decide whether you think the benefits will outweigh the costs of the program, before the program is actually implemented), an evaluation of the proposed design of the program, and an examination of what alternative strategies and procedures for the program should be considered and recommended (Payne, 1992). In short, this type of evaluation examines what the program plans on doing. It helps in making program structuring decisions (Payne, 1992).

2.4.3 Process evaluation
Process evaluation focuses on “what the program actually does” (Research Designs in Education, 2010). There exist some form of similarity between
process indicators and performance measures, but the former focuses more on activities and procedures of the organization than on the products of those activities (Research Designs in Education, 2010). Process evaluation involves examining how a program is being implemented, monitoring how the program is performing, auditing the program to make sure it is following required legal and ethical guidelines, and identifying defects in the procedural design or in the implementation of the program (Payne, 1992). It is here that evaluators provide information about what is actually occurring in the program (Payne, 1992). Evaluators typically provide this kind of feedback to program personnel because it can be helpful in making formative evaluation decisions (Weiss, 1998, p. 9). Therefore, in general, process evaluation helps in making implementing decisions.

2.4.4 Product evaluation
Product evaluation includes determining and examining the general and specific outcomes of the program (i.e., which requires using impact or outcome assessment techniques), measuring anticipated outcomes, attempting to identify unanticipated outcomes, assessing the merit of the program, conducting a retrospective cost/benefit assessment (to establish the actual worth or value of the program), and/or conducting a cost effectiveness assessment (to determine if the program is cost effective compared to other similar programs) (Payne, 1992). Product evaluation is very helpful in making summative evaluation decisions. For example, what is the merit and worth of the program? Should the program be continued? (Payne, 1992).

2.5 History of the community psychology program
The recognition that the psychological well-being of individuals cannot be understood in isolation from broader social contexts is what influenced the beginning of community psychology as a field. During the 1950’s and
1960’s some factors that contributed to the beginning of community psychology in the U.S. included:

- A shift away from socially conservative, individual-focused practices in health care and psychology into a progressive period concerned with issues of public health, prevention, and social change after World War II (Wikipedia, 2008).

- The perceived need of larger-scale mental illness treatment for veterans (Wikipedia, 2008).

- The development of community mental health centres and deinstitutionalization of people with mental illness into their communities (Wikipedia, 2008).

The Swampscott conference of 1965 is considered the birthplace of Community Psychology. The field has since expanded nationally and globally. Community Psychology is a field with a unique new perspective for understanding the individuals within their environment which includes the larger social systems that affect their lives. The focus is on person-environment fit, while working collaboratively with groups and fostering empowerment, are emphasized. Prevention and early intervention through collaborative research and action are seen as valuable tools for improving people’s lives. Community psychology does not focus on “problems” but rather on the strengths and competencies of community members.

The field draws on a variety of interdisciplinary perspectives and approaches to examine social problems and promote well-being of people in their communities. Some fields that contribute to Community Psychology
include, but are not limited to, Sociology, Community Development, Ecology, Public Health, Anthropology, Cultural/Performance Studies, Public Policy, and Social Work. Community Psychologists value human differences and can inform social policies, social service work, helping practices, and community change (McDermott, 2008).

At least since the appearance of psychoanalysis, the helping professions have sought to alleviate problems by one form of therapy or another. Some approaches have emphasized insight; others have sought to change behaviour more directly. Whatever the differences in approaches, their basic common focus has been on the individual who has already developed psychological problems (Introduction and History of Community Psychology, n. d.). Hence, clinical psychology has been a psychology of the individual.

At the theoretical level, psychologists have long accepted the idea that all behaviour, pathological or otherwise, is a joint product of context and personality. The troubled individuals engage the help of an expert, and by this act he or she submitted to the role of patient (Introduction and History of Community Psychology, n. d.). However, given the rate of mental health problems in the world today, some have questioned whether this general approach is a reasonable one (Introduction and History of Community Psychology, n. d.). For them, a relatively newer approach, community psychology, shows great promise for addressing mental health problems (Vogelman, Perkel, & Strebel, 1992).

It is obvious that South Africa’s political history and context has had a significant influence in shaping the development of community psychology in South Africa. During the apartheid era, community psychology provided a theoretical base for psychologists concerned with the provision of more
appropriate and accessible psychological services to traumatized communities who could not access such services. It also provided a legitimate approach for psychologists to engage in social change activities under the apartheid regime to address socio-political factors impinging on the mental health plus well-being of the individual and the community (Swartz et al., 2002). These activities largely took place within activist non-governmental organisation (NGO) settings (Swartz et al., 2002).

The community psychology experience in Cameroon was highly depended on building upon its indigenous spirit (Nsamenang, Fru & Brown, 2007). However, unlike in Cameroon, in South Africa community psychology has tended to ignore such influences, focusing more on issues of class and operation of disadvantaged groups. Hence, it is imperative that such differences be understood in relation to the unique political background of South Africa (Bhana, Petersen & Rochat, 2007).

Post-apartheid, community psychology has grown as an academic field of study, from mainstream to more liberal critical approaches, depending on the political persuasion of its advocates. Just as community psychology in South Africa was historically informed by a political context, it is likely that theoretical boundaries will shift to take into account indigenous knowledge systems, especially as more and more black intellectuals enter academia. However, the growth of community psychology in South Africa as an academic field has not been accompanied by a concomitant growth as a field of practice, even though the introduction of community service psychology posts presents an opportunity for expansion. This is perhaps a reflection of the continued hegemony of biomedical ideology, which still retains centre stage and compliments the political persuasion of the new democratic dispensation that highlights individualistic capitalist
socioeconomic principles as an important vehicle for social change (Bhana, Petersen & Rochat, 2007).

2.6 Reason for Community Service Psychology Program for Clinical Psychologists in KwaZulu-Natal Province

According to the KZN Department of Health (2010) the main objective of community service psychology is to ensure improved provision of health services to all the citizens of South Africa with the emphasis on rural and underserviced populations. Community service provides a workforce to address unmet needs in South Africa. Besides, community service psychology also provides young professionals in South Africa with an opportunity to develop skills, acquire knowledge, behaviour patterns and critical thinking that will help them in their professional development (How Doctors and Dentists experience their Community Service, 2011).

Even as more clinical psychologists and psychiatrists were trained; demands for their services outstripped their increase in numbers (Introduction and History of Community Psychology, n. d.). Many of the newcomers were entering private practice, and others were being diverted into teaching or research (Introduction and History of Community Psychology, n. d.). In any event, the supply of trained professionals for service in hospitals and clinics was hardly keeping pace with the demand (Introduction and History of Community Psychology, n. d.). To grapple with these shortages, it became imperative that new sources of personnel be sought, that more effective use be made of professional time, and that new models of coping with human problems be developed (Introduction and History of Community Psychology, n. d.). Albee (1959, 1968) predicted that it would be literally impossible to train enough mental health professionals to meet existing and future needs, and recommended that prevention be pursued as a strategy.
According to Vogelman (1987) the history of psychology and mental health care in South Africa is not a proud one. This history helps to explain why South Africa's mental health care system is still characterised by racism, sexism and the fragmentation of services, with its corresponding problems of inadequacy, inefficiency and discrimination (Psychology and the Community: Issues to consider in a changing South Africa, n.d.). Clinicians working in psychiatric settings, for example, have argued that existing services are inadequate; few can afford to consult private practitioners; and South Africa's mental health services have not been adapted to the African context so that problems are not targeted and diagnoses are often missed (Schoeman, Robertson, Lasish, Bicha & Westaway, 1989; Psychology and the Community: Issues to consider in a changing South Africa, n.d.). In addition, South African psychology has a commercialised emphasis on private practice and urbanised form, and its emphasis on a curative medical model. The above have helped divorce psychology from the daily life experience of the black majority (Vogelman, Perkel, & Strebel, 1992).

This suggests that, for significant change to take place in the field of psychology, a greater orientation or emphasis towards community work is required. Imposing an unchanged psychological practice onto communities presently deprived of services may fail in its attempt to address real structural problems. Any strategy geared towards changing psychology and community work should note that the root of exclusive psychology lies not only in the profession itself but also in the structure of South African society (Vogelman, Perkel, & Strebel, 1992; Psychology and the Community: Issues to consider in a changing South Africa, n.d.).

2.7 Shortfalls in design of such programs
According to Bhana, Petersen and Rochat (2007, p. 384) there are several challenges encountered in community psychology. These include; lack of
support for community service psychologists, the lack of equipment, language barriers, and absence of a supervisory structure, including a shortage of supervision from universities and training institutions with most citing resource constraints as a contributor to the inability to support trainees in the community service year. The greatest concern however, is the lack of clear practice guidelines for community service for clinical psychologists to include prevention and promotion activities. Furthermore, although compulsory community service for clinical psychologists may have the desired effect of providing better access to ameliorate psychological services, it is at risk of following a similar route to that of the community mental health movement in the United States in the 1960s where mental health services were made more accessible through the establishment of community mental health centres. The service rendered, however, remained strongly clinical and individually centred and was criticized as being more of the same. While the newly established community service requirement runs a similar risk, it clearly acknowledges mental health issues and provides community-based services to rural areas.

Researchers are faced with numerous conceptual and operational challenges in conducting community-based intervention trials in the developing world given the lack of adequate community-level demographic and socioeconomic-level data. The collection and synthesis of community-level data integrated with the spatial analysis tools of GIS technology resulted in well-defined and understood communities that were the units of investigation in this trial. In addition to building community rapport and aiding in understanding the lived experiences of communities, the community ethnography and GIS methods enabled the study team to address critical design questions relating to matching of community pairs and enabled us to effectively plan for the implementation of the intervention (Chirowodza, Van Rooyen, Joseph, Sikotoyi, Richter & Coates, 2009).
2.8 Current description and status of the community psychology program

Bhana, Petersen and Rochat (2007) note that, community psychology is to date not a formal category of registration. However, community psychology has been included in the curricula of some tertiary institutions and even community based training sites and internships have been established.

The urban bias of provision of psychological services in South Africa in both public and private sector left rural communities poorly serviced. As a result, the Minister of Health established a compulsory duration of one year of community service for clinical psychologists and the service be done in outlying areas and mostly close to hospitals servicing rural communities.

Bhana, Petersen and Rochat (2007, p. 387) note that, post-apartheid South Africa brought about theoretical shifts in community psychology. With political freedom came an expectation from the general populace, academics and activities alike that the move towards an egalitarian society would help correct the injustices of the past. Therefore, addressing historical disadvantages was a main concern of community psychology immediately after the country’s first democratic elections. This further implies that, community psychology had to address itself to issues of access, redress and equity.

According to Petersen (2005) in Bhana, Petersen and Rochat (2007, p. 387) significant proportions of South Africans continue to have limited access to resources, largely because of historical imbalances in psychological service provision. Identifying and developing mechanisms for ensuring access to previously denied resources is, thus, an important focus for community psychology in post-apartheid South Africa, particularly given the trauma experienced as a result of apartheid, poverty, and more recently HIV/AIDS.
Experiences of Community Service Psychologists

(Petersen, 2005). It is not surprising therefore that community psychology has recently been criticized for having an agenda other than a transformation in post-apartheid South Africa. The challenge for community psychology is however, to redress historical imbalances in the distribution of power and resources, while at the same time retaining a transformative agenda, as well as not losing sight of the need to help empower communities to act on their own behalf. Liberatory and critical theoretical models of community psychology similar to those promoted by Nelson and Prilleltensky (2005) have therefore been adopted by a number of training institutions.

In addition, given widespread poverty as well as the AIDS pandemic in South Africa, which currently affects 11% (5 million) of its population, the need for prevention and health promotion interventions is increasingly gaining importance in post-apartheid South Africa (Bradshaw et al., 2000). While mainstream prevention and promotion activities largely adopt individualistic models that focus on strengthening individual resilience, increasing attention is being given to approaches such as a community health psychology that help promote social change towards more health-enabling socio-contextual environmental influences (Campbell & Murray, 2004). Akotia and Barimah (2007) indicates that, there is similarity to the Ghanaian approach to community psychology due to the fact that individual problems are to a great extend a function of cultural beliefs, systems and policies in that society. Although South Africa and Ghana arrived at the same point through different historical influences, a holistic ecological understanding of individuals within their social context is therefore crucial to community psychology.

Community health psychology draws heavily on Freire’s (1973) concept of conscientization with critical social analysis of social conditions that undermine a group’s well-being as the first step in facilitating two
processes. The first relates to the renegotiation of collective social identities that may undermine the groups’ health towards health-enhancing alternatives. The second relates to empowering the group to engage in collective action for social change that will provide more health enhancing community contexts (Campbell & Murray, 2004).

On the other hand, the most salient criticism of community psychology in South Africa is that it has not engaged in systematically developing and building a theory of practice that is recognized as being South African. Indeed, even though community psychology in the United States is “described as largely anglo- and andro-centric scholarship” (Angelique & Culley, 2007), it has refocus its efforts in building theoretical models that specifically attempt to address the issues from a critical feminist standpoint and a return to ecological explanations to champion the cause of social justice. In fairness, it is now beginning to emerge that community practice is helping to build theory that has contextual relevance for South Africa.

Despite these theoretical shifts, it is of concern that the integration of indigenous knowledge systems into the training and practice of community psychology is still marginal. This is despite the extensive network of indigenous healers who are recognized as vital to providing community-based health services through their understanding of cultural practices and beliefs that lead to ill health as well as the fact that indigenous healers are soon to be registered with the HPCSA and will have statutory and legal rights in treating individuals. Community psychology in South Africa has generally eschewed indigenous knowledge systems in understanding and intervening with problems, showing a continued bias towards theories and models emanating from Europe, North America, Latin America and even Asia. Indigenous knowledge systems in South Africa, particularly among blacks, have relied primarily on its oral tradition. Rapid urbanization and
increasing literacy has created new opportunities for debating and understanding the various influences on ordinary people’s lives. For example, much has been written about the extent of the orphan problem in Sub-Saharan Africa, particularly in view of the number of parents succumbing to the AIDS virus. However, it is becoming apparent that the family systems modelled in Western standards fail to account for the role of multiple caregivers in any one household and that absent fathers are often not experienced as such. The complex relationship is beginning to change with urbanization. Community psychology has to understand these complex relationships as it attempts to develop interventions in situations that address issues of risk and resilience for developing children and youth. It is these forms of knowledge that will assist in building a knowledge base that speaks to local contexts and cultures (Bhana et al, 2007, p. 389).

2.9 Supervision

2.9.1 Definition of supervision

Supervisors do seem to gain clarity of perspective about the counselling or therapy precisely because they are not one of the parties involved. Hence they work from a unique vantage point that is not afforded by the therapist. According to Levenson a former therapist in Bernard and Goodyear (1992, p. 3), unlike when you are a therapist, when you supervise everything becomes clear. Despite this, however, supervisors do not have supervision, nor does this definition of the term capture supervision’s essential meaning. The definition of supervision is simply “to oversee” (Merriam-Webster Dictionary, 1974). Therefore in simple terms, the task for clinical supervisors is just to oversee. This definition encompasses the activities of a great number of other professionals, including possibly administrative supervisors in business and industry; its range even could extend to such groups as financial auditors and probation officers (Bernard & Goodyear, 1992, p. 4).
Loganbill et al. (1982) define supervision as “an intensive, interpersonally, focused one-to-one relationship in which one person is designated to facilitate the development of therapeutic competence in the other person”. On the other hand Hart (1982) defines supervision as “an ongoing educational process in which one person in the role of the supervisee acquires approximate professional behaviour through an examination of the supervisee’s professional activities”. Hence, the above definitions suggest a one-to-one focus. However, according to Bernard and Goodyear (1992, p. 4), supervision is defined as “an intervention that is provided by a senior member or members of that same profession”. This implies that, there is an evaluative relationship which extends over time and has the simultaneous purpose of enhancing the professional functioning of the junior member, monitoring the quality of the professional services offered to the patients she, he, or they see as well as serving as a gatekeeper for those who are to enter the particular profession (On-site Supervisor Orientation and Training, n. d.).

2.9.2 Supervision is a distinct intervention
Supervision is an intervention as are education, psychotherapy and mental health consultation (Supervison.psy.ku.dk, n.d). Although there are ways in which it overlaps substantially with these other interventions, it is unique.

2.9.3 Education versus supervision
The similarity between education and supervision is that, the purpose of supervision is to teach; the role of the supervisee is that of a learner and there is an evaluative aspect to the intervention. Both of them ultimately serve a gate-keeping function, regulating who is legitimized to enter the world of work in a chosen area. However, in the field of education, usually there is an explicit curriculum with teaching goals that are imposed uniformly on everyone. In this sense, education certainly does occur in
clinical preparation. Although the focus of supervision might seem to point to common goals, the actual intervention is tailored to meet the needs of individual trainees and their patients (Bernard & Goodyear, 1992, p. 5).

2.9.4 Counselling versus supervision
The supervisor may help the supervisee to examine aspects of his or her behaviour, thoughts, or feelings that are stimulated by a patient, particularly when these may act as barriers to the work with the patient (Professional Feelings, n.d.). This suggests there are elements of counselling, or therapy in supervision. However, any therapeutic intervention with the trainee should be only in the service of helping the trainee to become more effective with patients. The issue of choice brings about the difference between counselling and supervision. For instance, patients generally are free to enter therapy or not; when they do, they usually have a voice in choosing their therapists. Whereas trainees are not given a choice about whether to receive supervision and often have no voice in whom their supervisor is to be. Furthermore, most therapists do resist actively imposing their values on patients or making explicit evaluations of them. Whilst on the other hand, supervises are evaluated against criteria that are imposed on them by others (Bernard & Goodyear, 1992, p. 6).

2.9.5 Consultation versus supervision
Mental health consultation is yet another intervention that overlaps with supervision. In the case of senior professionals, supervision often evolves into consultation. This means experienced therapists might meet informally on an occasional basis with a colleague to get ideas about how to handle a particularly difficult patient or to regain needed objectivity. However, although there are similarities between the two, they do differ.
The parties involved in the consultation relationship often are not of the same professional discipline. Besides, consultation is more likely to be a one-time only event than is supervision.

Consultation-supervision distinctions echo distinctions already made between therapy and supervision. One of which is that supervision is more likely imposed whereas consultation is typically freely sought. More significantly, there is no evaluative role for the consultant whereas evaluation is one of the defining attributes of supervision. (Bernard & Goodyear, 1992, p. 6).

2.9.6 Supervisors and supervisees are of the same profession
According to Bernard and Goodyear (1992), the main purpose of supervision is to facilitate supervisees’ development of therapeutic and case management skills. Moreover, it is possible to accomplish this purpose when the supervisory dyad is comprised of members of two different disciplines. Although this results in technical competence, it is an arrangement that overlooks the socialization function that supervision serves. Bernard and Goodyear (1992, p. 7) suggest that, a sense of professional identity is best acquired by trainees through association with senior members of the interns own professional discipline. This implies that, if supervisees are socialized into a profession through supervision, that is, social work student should receive supervision from social workers; clinical psychology students should receive supervision from clinical psychologists.

According to Bernard and Goodyear (1992) supervision is a means of transmitting the skills, knowledge and attitudes of a particular profession to the next generation within that profession. It is also an essential means of ensuring that patients receive a certain minimum quality of care while interns work with them to gain their skills (Bernard & Goodyear, 1992).
Supervision is an essential aspect of professional training, and as a result, is a common activity for mental health professionals. Garfield and Kurtz (1976) in Bernard and Goodyear (1992) revealed that supervision was fifth in a list of activities in which clinical psychologist engaged, and it ranked ahead of activities such as group therapy and research. Furthermore, supervision has elements in common with other intervention such as teaching, therapy and consultation but is unique among them therefore, practitioners should receive specific preparation. Although the importance of supervision has been stressed, Bernard and Goodyear (1992) note that the levels of supervisor training are not adequate. There are many mental health professionals taking the supervisor role without formal preparation, and they believe they are well equipped and skilled at being supervisors. Since these supervisors mostly serve as role models for trainees, the trainees tend to believe they can also supervise with formal preparation as well.

2.9.7 Supervision as a way to evaluate the functioning and management of the community service psychology program in KwaZulu-Natal

Clinical supervision of the Community Service Officers must lie within the line manager’s function to ensure safe, professional practice.

In order to ensure appropriate supervision of community service officers, the following mentoring framework will be applied with identified mentors at each site:

- The role of the mentor should be to develop a professional development plan as soon as possible and to communicate this plan to the manager. This will ensure that there is clarification of roles and responsibilities and ensure that the development needs of the individual are congruent with the needs of both the facility and the
manager. Further education opportunities should also be agree on at this stage to allow for proper planning during the course of the year.

- It is desirable that a facility-based mentor is available to community service officers at each site. This need not be the medical/professional or line manager but should be a member of staff who wants to fill this role. The aim is to facilitate easier interaction with senior staff. Ideally the mentor could jointly identify specific projects with which the community service officers could become involved. It is expected that where such projects are identified the community service officers feel supported, useful and may have enhanced learning opportunities.

- The Provincial coordinator, supported by Health Programme, should meet with site mentors at prearranged times during the year to identify problems that need to be addressed. This would obviate the need to meet with community service officers and provide an opportunity for sharing of best practices when dealing with community service officers.

- Appropriate professional conduct must be reinforced by supervisors and mentors, as there are shortages of adequate role models, partly as a result of the high turnover of staff at some institutions (KZN Health Department, 2010). Placing community service officers where appropriate and adequate role models are not present may not be in their best interest. A confidential arrangement could be formalized whereby they are able to raise such issues with a senior manager (KZN Health Department, 2010, p. 10).
Chapter 3
Research Design and Methodology
The research design and methodology are based on a plan, which is essential for research, which assists to dictate and illustrate materials, methods, techniques and procedures used. The research design and methodology that will be used to execute the study aim and objectives will be discussed in this chapter.

3.1 Research Aim
The research aim for this study is to evaluate the functioning and management of the community service psychology program in KwaZulu-Natal province of South Africa. Open ended interviews with community psychologists currently in service, previously in service and those awaiting service will be conducted and then analyse the data using qualitative research methodology.

3.2 Description of the study area
KwaZulu-Natal is the largest province in South Africa and comprises 21% of the country’s population (Chirowodza, Van Rooyen, Joseph, Sikotoyi, Ritcher & Coates, 2009). KwaZulu-Natal is on the east coast of South Africa, bordering Mozambique and Swaziland in the north, Mpumalanga and Free State in the west, Eastern Cape in the south and Lesotho in the south west as illustrated in Figure 3.1 above (KwaZulu-Natal, South Africa Travel and Tourist Guide, n.d.). According to Statistics South Africa (SSA) (2003) the province encloses 92 100 km$^2$, constituting 7.6% of the total land area of the country and the average population density during 2002 was 100 persons per square kilometre (2000 South African Burden of disease study estimates, n.d.). During the 1996 Census, 57% of the population lived in non-urban areas (SSA, 1998). Prior to 1994, the province territorially consisted of several patches of the self-governing area of KwaZulu and
together with the ‘national state’ of Transkei in the southern part of the province, these areas formed part of the former homelands (2000 South African Burden of Disease Study Estimates, n.d.). Durban, housing an international airport and one of the 10 largest ports in the world, and served by an extensive national road network, is one of the fastest growing urban areas in KwaZulu-Natal province (2000 South African Burden of Disease Study Estimates, n.d.). In addition, the economy of the province is powered by; steel production, coal mining and export, a rich wildlife protected in several game parks, holiday resorts along the coast, forestry, tea plantations, meat processing, and mixed agriculture (2000 South African Burden of Disease Study Estimates, n.d.). The coastal belt agricultural enterprises includes yields of sugar cane, oranges, wood, bananas, mangos and other tropical and sub-tropical fruits, while farmers in the hinterland focus on vegetable, dairy and livestock farming (Bradshaw et al., 2004).

According to GCIS (2004) the rapid wave of industrialisation that swept through the province has resulted in the establishment of industries in towns such as Dundee, Hammarsdale, Ladysmith, Mandeni, Newcastle, Richards Bay, and Richmond. In 2001, KwaZulu-Natal made the second highest gross geographic product (GGP) contribution of all the provinces to the national gross domestic product (GDP), providing 15.5% of the total GDP at R152 703 million (GCIS, 2004). Although it is performing well at the macro-level, high levels of unemployment and poverty are still evident.
Figure 3.1 Map of KwaZulu-Natal Province
3.3 Research design
The research will be qualitative in nature. According to Strauss and Corbin (1994), qualitative research is defined as “any type of research that delivers findings not arrived at by statistical procedures or other means of quantification”. Qualitative methods are becoming increasingly popular. Although they were once viewed as aberrant and probably the refuge of those who had never studied statistics, now they are recognized as valuable additions to evaluation studies (Weiss, 1998, p. 252). Hence, qualitative research techniques are coming of age.

3.4 Research methodology
3.4.1 Sampling
The aim of qualitative research studies is not necessarily to generalise the research findings, but rather to gain a deeper understanding of a certain variable or situation. Therefore, random sampling is not necessary, and much smaller sample sizes are also used. This implies that, the researcher should identify participants with the capacity to provide the most information regarding the topic and ask them to participate in the study (Coetzee & Schreuder, 2010, p. 31).

The sample was targeting KwaZulu-Natal province community service psychologists in order to keep the project manageable and because each province has their own mandates and procedures in conducting placements. Only clinical psychologists provide community service and are mandated to do so by government legislature. No other category of psychologist is required to complete community service; Clinical Psychologists are required to do so in order to register with the Board and the HPCSA as a Clinical Psychologist independent practice. In other words, clinical psychologists cannot practice without community service and community service is dependent on the completion of a master’s dissertation, which is dependent
on the standards and time frame of the university. Hence, the process is complex because no one institution can be held accountable for community service psychologists and neither can they get any mandates changed with all parties in agreement. In addition, there is a lack of sound communication between parties and mandates are held with different parties so that there is no continuity.

There are relatively a small number of psychologists that are available to provide community service across the country due to the fact that psychologists have to complete their masters dissertation before they can begin community service even if they have already finished their coursework and internship. Hence, due to problems with getting interviews secured some of the participants were from other provinces. Therefore, this presented the researcher with an opportunity to opinions of community service psychologists in different provinces as well as their satisfaction level. As a result of time and demographical restraints, eight usable interviews were extracted and utilised.

3.4.2 Qualitative study
Qualitative study or research is mostly used as an umbrella term covering a wide range of methods found within different research disciplines. This implies that defining qualitative research is a complex task. The qualitative models emphasize the importance of observation, the need to retain the phenomenological quality of the evaluation context, and the value of subjective human interpretation in the evaluation process (Introduction to Evaluation- Social Research Methods, n.d.). Included in this category is the grounded theory approach of Glaser and Strauss (1967) among others.

Qualitative research is used to find out about people’s attitudes and feelings. It explores how people feel about themselves and about the products and
services they use (Practical Guide to Market Research, n.d.). Finding out about people’s thoughts and feelings through qualitative research are often pivotal in the exploratory stages of a new research project (Chapter 5, Introduction to Qualitative Research, n.d.). These research findings can provide a starting point when little or no previous research has been done on a subject (Chapter 5, Introduction to Qualitative Research, n.d.). Qualitative research can also provide background, for example, interviewing experts in an industry or business area, to get insight into a problem (Practical Guide to Market Research, n.d.). If some conclusive findings are also needed, it would be necessary to carry out a second phase of research to collect quantitative data (Chapter 5, Introduction to Qualitative Research, n.d.). Qualitative research is only widely used where small segments of the population (or groups of people who have a common characteristic) are of specific interest to a researcher (Chapter 5, Introduction to Qualitative Research, n.d.).

Below is a list of some of the main reasons for carrying out qualitative research (Chapter 5, Introduction to Qualitative Research, n.d.):

- To evaluate a market, product or consumer where no information exists

- To identify and explore concepts

- To take researchers rapidly up the learning curve when they know little about a group of consumers

- To identify behaviour patterns, beliefs, attitudes, opinions and motives
To establish priorities amongst categories of behaviour, beliefs, opinions and attitudes

To identify problems in depth and develop models for further research

To put flesh on the bones of points arising from a pilot or major survey

To provide verbatim comments and anecdotes from participants – so that the research findings can be brought alive for the client

To test how a questionnaire works by going through question by question asking about routing, signposting, understanding and ambiguity

Where direct questioning will not give us personal or hidden details about respondents.


Researchers carry out the data collection and do the analysis and interpretation. They have a feel for the subject that others cannot have because they have acquired the information first hand (Chapter 5, Introduction to Qualitative Research, n.d.).

The main techniques that are used in qualitative research are:

- Focus groups
- Depth discussions
- Observation
3.4.3 Qualitative Methods

There is a wide variety of methods used in qualitative measurement. Here, are some of the more often utilised methods.

3.4.3.1 Participant Observation

Participant Observation is a demanding and common mode of qualitative research as it requires that the researcher become a participant in the culture or context being observed (Qualitative Methods, n.d.). The literature on participant observation discusses how to enter the context, the role of the researcher as a participant, the collection and storage of field notes, and analysis of field data (Qualitative Methods, n.d.). Participant observation often requires months or years of intensive work because the researcher needs to become accepted as a natural part of the culture in order to assure that the observations are of the natural phenomenon (Qualitative Methods, n.d.).

3.4.3.2 Direct Observation

Direct observation is distinguished from participant observation in that first, a direct observer does not typically try to become a participant in the context and second, that direct observation suggests a more detached perspective and thirdly, direct observation tends to be more focused than participant observation and lastly, direct observation tends not to take as long as participant observation (Qualitative Methods, n.d.).

3.4.3.3 Interviewing

Unstructured interviewing involves direct interaction between the researcher and a respondent or group (Qualitative Methods, n.d.). It differs from traditional structured interviewing in several significant ways- firstly,
although the researcher may have some initial guiding questions or core concepts to ask about, there is no formal structured instrument or protocol, and secondly, the interviewer is free to move the conversation in any direction of interest that may come up during the interview (Qualitative Methods, n.d.). Consequently, unstructured interviewing is particularly useful for exploring a topic broadly (Trochim, 2002). However, there is a price for this lack of structure. Because each interview tends to be unique with no predetermined set of questions asked of all respondents, it is usually more difficult to analyze unstructured interview data, especially when synthesizing across respondents (Trochim, 2002).

In-depth interviews will be used as the most salient data collection technique in the evaluation. Interviews are one-on-one sessions between an interviewer and an interviewee, typically for answering a specific research question (Coetzee & Schreuder, 2010, p. 33). The qualitative research interview seeks to describe the meanings of central themes in the life of the subjects. The main task in interviewing is to understand the meaning of what the interviewees say (Kvale, 1996). A qualitative research interview seeks to cover both a factual and a meaning level, though it is usually more difficult to interview on a meaning level (Kvale, 1996). Interviews are particularly useful for getting the story behind a participant’s experiences. The interviewer can pursue in-depth information around the topic. Interviews may be useful as follow-up to certain respondents to questionnaires, e.g., to further investigate their responses (McNamara, 1999). According to Coetzee and Schreuder (2010, p. 33) interviews are a more natural way of interacting with people than filling out a questionnaire or completing some experimental task. Apart from the degree to which they are structured or not, interviews can also vary in terms of several other dimensions, depending on the purpose of the interview.
Interviews are completed by the interviewer based on what the respondent says (Employee Satisfaction Manual, n.d.). Interviews are a far more personal form of research than questionnaires (Interviews- Wikipedia, the free encyclopaedia, n.d.). In the personal interview, the interviewer works directly with the respondent and has the opportunity to probe or ask follow up questions (Interviews- Wikipedia, the free encyclopaedia, n.d.). Interviews tend to take much less effort on the part of the respondents as the interviewer is often after the respondent’s opinion. The setback of interviews is that can be time consuming and may require extensive resources. Furthermore, the interviewer is considered a part of the measurement instrument. This implies that the interviewer has to be well trained in how to respond to any contingency (Babbie & Mouton, 2001, p. 258). To sum up, this study will use qualitative interviews emphasizing on the active participation of interviewees. The interviews will focus mainly on the perceptions of community psychologists about the functioning and management of community service psychology program in KwaZulu-Natal.

There are different types of questions which can be used, for example, open instead of closed, single instead of multiple responses, ranking, and rating. Many advise against using open-ended questions and advocate using closed questions (University of Leeds- Guide to the design of questionnaires, n.d.). However, open questions can be useful.

3.4.3.4 Case studies
A case study is an intensive study of a specific individual or specific context (Qualitative Methods, n.d.). For instance, Freud developed case studies of several individuals as the basis for the theory of psychoanalysis and Piaget did case studies of children to study developmental phases (Qualitative Methods, n.d.). There is no single way to conduct a case study, and a
combination of methods (for instance, unstructured interviewing, direct observation) can be used (Trochim, 2002).

3.5 Summative evaluation

A summative evaluation is a method of judging the worth of a program at the end of the program activities (summation) (Formative and Summative Evaluations…, n.d.). Summative evaluation is used to assess whether the results of the object being evaluated (program, intervention, person, etc.) met the stated goals (Scriven, 1967). Hence, the focus is on the outcome. Trochim (2002) concurs with this suggestion, since he notes that, the aim of summative evaluation is to understand the outcomes or effects of something for instance, where a test of children in school is used to assess the effectiveness of teaching or the deployment of a curriculum. The children in this case are not direct beneficiaries - they are simply objects that contain information that needs to be extracted (Evaluative Research, n.d.).

Summative evaluations can assess such as:

- **Finance**: Effect in terms of cost, savings, and profit and so on.
- **Impact**: Broad effect, both positive and negative, including depth, spread and time effects.
- **Outcomes**: Whether desired or unwanted effects are achieved.
- **Secondary analysis**: Analysis of existing data to derive additional information.
- **Meta-analysis**: Integrating results of multiple studies (Trochim, 2002).
However, Saettler (1990) indicates that, summative evaluation is undertaken to test the validity of a theory or determine the impact of an educational practice so that future efforts may be improved or modified.

3.6 Grounded theory
Anselm Strauss’ need to respond to critics led him in 1987 and 1990, together with Corbin, to modify their description of grounded theory from its original concept of emergence to a densely codified structure operation (Stern, 1994). Hence, instead of a single approach to grounded theory with minor differences in opinion, two decidedly different approaches developed. Glaser (1992) repeatedly mentioned that grounded theory is a general methodology which can employ both qualitative and quantitative methods. However, most of the work done by means of grounded theory place emphasis on qualitative analysis. Qualitative researchers do not regard themselves as collectors of facts about human behaviour that will lead to verification and the extension of theories that enable researchers to determine causes of, and to predict human behaviour. Instead, the emphasis is on improved understanding of human behaviour and experience.

“Grounded theory is a general methodology for developing theory that is grounded in data systematically gathered and analysed. Theory evolves during research, and it does this through continuous interplay between analysis and data collection” (Strauss & Corbin, 1994, p. 4). It is a structured and investigator directed strategy of naturalistic inquiry. Its purpose is primarily to develop and verify theory. Relationships are illuminated, and knowledge can be weaved together from different studies into more abstract theory (Neuman, 1997). Grounded theory consists of a systematic set of procedures, and theorists designed its procedures so that, if they are carefully carried out the method meets the criteria for doing good science (Strauss Corbin, chq 1-3, n.d.). “Good science refers to significance,
theory observation compatibility, generalizability, reproducibility, precision, rigor and verification” (Strauss & Corbin, 1990, p. 27).

Since the theory’s introduction about thirty years ago, researchers who were actively involved in the field added a number of guidelines and procedures with which they aimed to enhance the effectiveness of this methodology in research (Strauss & Corbin, 1994). Glaser (1992) highlighted that the logic of grounded theory is to ask two formal (not preconceived) questions. Firstly, “what is the chief concern or problem of the people in the substantive area and what accounts for most of the variation in processing the problem”? And secondly, “what category or what property of what category does this incident indicate?” (Glaser, 1992, p. 4). Therefore, the researcher should ask these questions while constantly comparing incident to incident, and coding and analysing. Glaser (1992) concluded that the logic of grounded theory as presented by Strauss and Corbin (1994) is not to ask the two questions mentioned above. Rather, Glaser (1992) posits that Strauss and Corbin’s (1994) method is to compare for a while, but then to interrupt true emergence by asking many preconceived, substantive questions, which distracts the analyst from what is actually going on, what is genuinely an issue for the participants, what is relevant, and what should have been allowed to emerge naturally from the outset.

Strauss and Corbin (1990) state that certain variables like sex, age and conditions are essential to refer to when documenting the action observed. The required conceptual skills for doing grounded theory are to absorb the data as data, to be able to step back or distance oneself from it, and then to conceptualise the data (Glaserian Grounded Theory in Nursing Research, n.d.).
According to Glaser (1992), a well-constructed theory will meet its four most central criteria; they are fit, work, relevance and modifiability:

- **Fit** – this means that if a grounded theory is carefully induced from its substantive area its categories and their properties will fit the realities under study in the perceptions of subjects, practitioners and researchers in the area.

- **Work** – this means that if a grounded theory works it will explain the major variations of behaviour in the area, with respect to the processing of the main concerns of the subjects.

- **Relevance** – if the grounded theory fits and works, it has achieved its relevance

- **Modifiability** – the theory should be readily modifiable when new data presents variations in emergent properties and categories.

Grounded theory meets two main criteria of a legitimate scientific inductive theory, namely parsimony and scope. It reports as much as variation in behaviour in the action scene with as few categories and properties as possible. Hence, the researcher should immerse him/herself into the data, while conceptually transcending it by a conceptual model that explains the variation in whatever behaviour is going on.

### 3.6.1 Principles and concepts of grounded theory

Glaser (1992) believed that the researcher doing grounded theory should allow the theory to emerge as she/he observes codes and analyses data. Strauss and Corbin (1990), on the other hand, believed that the researcher should do more than just wait for the theory to emerge. This implies that, grounded theory capacitates the researcher to generate a theory through its procedures and techniques.
As in other qualitative approaches, the data for a grounded theory can come from various sources. The data collection procedures involve interviews and observations as well as such other sources as government documents, videotapes, newspapers, letters, and books – anything that may shed light on questions under study each of these sources can be coded in the same way as interviews or observations Glaser and Strauss in Corbin and Strauss (1990).

Grounded theory may be particularly difficult for beginning student researchers to grasp because the process reverses the order of empirical research – hypothesis generation followed by data collection (An Evening of Grounded Theory…, n.d.). Students of social problems deal with complex issues that can be analyzed in all of their dimensions by methods of inquiry such as grounded theory, which rely on more than analysis of quantifiable data (Huehls, 2005).

3.7 Ethical considerations

The research proposal for this study will be presented to the research panel and fellow researcher students for scrutiny and guidance. This is to ensure objectivity and to enhance quality control. Presentation of the proposal for approval to the ethics committee in an attempt to protect the rights and interests of the participants as Babbie and Mouton (2001, p. 258) instigated.

The participants’ involvement in the study will be voluntary since the study involves participation of humans and can result in intrusion into their lives. This implies that no one will be forced to participate in the research. Participants will be informed thoroughly and timeously about all aspects of the study. This will allow them the necessary information to make informed decisions on whether to participate or not. However, responses of individuals will be made available to the public, but their particulars will be
kept confidential, so as not to respect the participants right to privacy and confidentiality.

Harm will be minimised by a debriefing session which will then be followed the focus group interview. According to Vos, Strydom, Fouche and Delport (2005, p. 66) debriefing corrects problems generated by the research experience through discussing the respondents’ feelings about the research.

According to Trochim (2002) in order to protect better the rights of research participants, contemporary social and medical research establishment created a system of ethical protection. In addition, Coetzee and Schreuder (2010, p. 39) note that, the South African Psychological Association (PsySSA) (1992) set a code of ethics that must be honoured by all PsySSA members who conduct research. The ethical standards for conducting research in organisations have at least four basis requirements. Firstly, no harm should be inflicted on an individual as a result of his or her participation in the research study. According to Trochim (2002), harm can be defined as both physical and psychological. Hence, as per ethical standards it is imperative that participants not be placed in a position of physical and emotional danger as a result of them participating.

Secondly, the participant must be fully informed of any potential risk or consequences to his or her partaking in the study. Thirdly, interviewees must understand that their participation is voluntary. In other words, it requires that people not be coerced overtly or covertly into participating. In short this is known as informed consent. In instances where the researcher need to ask some personally searching questions, it helps to explain as much as possible about the research to the participant, both at the beginning and throughout the interview (University of Leeds- Guidelines to the design of Questionnaires, n.d.). Essentially, this means that potential research
participants must be fully informed about the procedures and risks involved in research and must give their consent to participate (Trochim, 2002).

Fourthly, all reasonable measures should be taken to ensure that anonymity and confidentiality of data collected are maintained. In this study, promises of confidentiality will be made to the participants to reassure and encourage replies. Furthermore, the interviewer will comply with any such promises. However, explaining to the potential participant what is meant in lay terms rather than giving a blanket assurance of confidentiality might help in getting responses. For example, informing the participant that his or her responses will be treated with confidence and that at all times data will be presented in a form and manner that fosters anonymity on the part of the participant in such a way that identity cannot be traced or connected with specific published data. This concurs with Trochim (2002) who note that, almost all research guarantees the participants confidentiality. This implies that participants are assured that identifying information will not be made available to anyone who is not directly involved in the study (Human Biomonitoring, Data Interpretation and Ethics, Obstacles…, n.d.).

There are two standards that are applied in order to help protect the privacy of research participants (Trochim, 2002). Almost all research guarantees the participant’s confidentiality -- they are assured that identifying information will not be made available to anyone who is not directly involved in the study. The stricter standard is the principle of anonymity which essentially means that the participant will remain anonymous throughout the study – even to the researchers themselves (Trochim, 2002). Clearly, the anonymity standard is a stronger guarantee of privacy, but it is sometimes difficult to accomplish. Increasingly, researchers have had to deal with the ethical issue of a person's right to service (Trochim, 2002). Good research practice often requires the use of a no-treatment control group – a group of participants
who do not get the treatment or program that is being studied. However, when that treatment or program may have beneficial effects, persons assigned to the no-treatment control may feel their rights to equal access to services are being curtailed (Trochim, 2002).

Even when clear ethical standards and principles exist, there will be times when the need to do accurate research runs up against the rights of potential participants (Trochim, 2002). No set of standards can possibly anticipate every ethical circumstance. Furthermore, there needs to be a procedure that assures that researchers will consider all relevant ethical issues in formulating research plans (Trochim, 2002).

3.8 Data Analysis
The basic tasks of data analysis for an evaluative study are to answer the questions that must be answered in order to determine the success of the program or service, and the quality of the resources (Research Designs in Education, n.d.). The purpose of analysis is to convert a mass of raw data into a coherent account (Research Designs in Education, n.d.). Whether the data are quantitative or qualitative, the task is to sort, arrange, and process them and make sense of their configuration (Research Designs in Education, n.d.). The intent is to produce a reading that accurately represents the raw data and blends them into a meaningful account of events (Weiss, 1998, p. 271). Those questions should, of course, be closely related to the nature of what is being evaluated and the goals and objectives of the program or service (Research Designs in Education, n.d.). In addition, the nature of the data analysis will be significantly affected by the methods and techniques used to conduct the evaluation (Research Designs in Education, n.d.).

Most data analyses, whether quantitative or qualitative in nature, will employ some of the following strategies: describing, counting, factoring,
clustering, comparing, finding commonalities, examining deviant cases, finding co-variation, and ruling out rival explanations, modelling, and telling the story (Research Designs in Education, n.d.). Evaluators conducting quantitative data analyses will need to be familiar with techniques for summarizing and describing the data, and if they are engaged in testing relationships or hypotheses and or generalizing findings to other situations, they will need to utilize inferential statistics (Weiss, 1998).

As part of planning, the evaluator should have considered how and to whom the findings will be communicated and how the results will be applied. A complete report will be characterized by clarity, effective format and graphics, timeliness, candour about strengths and weaknesses of the study, and generalizability (Weiss, 1998), as well as by adequacy of sources and documentation, appropriateness of data analysis and interpretation, and basis for conclusions (Research Designs in Education, n.d.).

However, the analysis of data started while the interviews were underway. This preliminary analysis helped the researcher to redesign the questions to focus on central themes as they were continuing interviewing. After completing the interviews, the researcher made a more detailed analysis of the participant’s responses. This process was assisted by making use of available computer aided software for the analysis of qualitative and quantitative data.

3.9 Parameters of study
The informants were carefully selected to ensure the trustworthiness of the results of the evaluation process. All the data collection instruments were also pre-tested before actual data collection was administered. The researcher assigned appropriate and qualified, multi-disciplinary team of experts, with experience in research works and evaluations.
Parameters are the exact dimensions or fixed limits that clearly define the area of evaluation. They establish the frame of reference within which the process will take place and are essential to accurate interpretation and meaningful use of the results of the evaluation. Parameters considered include the framework of time within which the data gathering will take place, description of the kinds of data obtained, and specification of the participants selected for evaluation.
Chapter 4
Results
4.1 Introduction

Data analysis in the grounded theory approach is conducted using a method called constant comparative analysis. Described by Glaser and Strauss (1967, p. 103), it is designed to generate “a theory that is integrated, consistent, plausible, close to the data – and at the same time is in a form clear enough to be readily, if only partially, operationalized for testing in quantitative research”. Strauss and Corbin (1998) point out that comparative analysis is regularly used in research in the social sciences. However, the nature of comparative analysis used in grounded theory has some unique features. In summary, it is a process of comparing “incident with incident, incident with category, and, finally, category with category or construct with construct” (Hutchinson, 1993, p. 210).

The responses from the community service psychologists were initially analysed using content analysis (Hsieh & Shannon, 2005; Polit et al., 2001). This involved “analysis of the content of the data to identify easily identifiable themes and patterns among the themes” (Polit et al., 2001, p. 394). Data from the interviews were analysed using constant comparative analysis (Strauss & Corbin, 1998).

Following each interview, the tapes were transcribed to allow the data to be read and organised. Interview tapes were transcribed by me as it assists me in becoming immersed in the data (Schneider et al., 2003). The scripts were edited continuously, a process that provided useful initial exposure to the data. Confidentiality of the material was assured. Since the research sample was not large data were managed and organised by the researcher instead of making use of sophisticated computer programs such as NVivo 2.
The data obtained in the interviews was analysed using constant comparative analysis, using the three procedures of open coding, axial coding and selective coding as outlined by Strauss and Corbin (1998). Line-by-line identification of codes where noted as they became apparent. This is the process of open coding in which: data are broken down into discrete parts, then examined closely and compared for similarities and differences (Roots of Clinical Intuition in Counselling, n.d.). Events, happenings, objects, and actions or interactions that are found to be conceptually similar in nature or related in meaning are grouped under more abstract concepts termed categories (Roots of Clinical Intuition in Counselling, n.d.). Closely examining data for both differences and similarities allows for fine discrimination and differentiation among categories (Strauss & Corbin, 1998, p. 102). Hence, in this context a category is a phenomenon that has significance to the participants in the study, and may be a problem, issue, event, or happening.

While open coding was occurring, I concurrently began the process of axial coding which is used to relate “categories to subcategories along the lines of their properties and dimensions” (Strauss & Corbin, 1998, p. 124). It is a process used to link categories with each other and involves an examination as to how various categories relate to each other, “commonly referred to as hypotheses” (Strauss & Corbin, 1998, p. 103). These hypotheses are based on hunches the researcher has about conceptual relationships.

Although they need to initially be considered as untested suggestions, as the study progresses particular relationships can be verified (Glaser & Strauss, 1967). This involved carefully studying all the data that were linked to a particular category to clearly identify the category’s dimensions and properties.
In this chapter, I discuss the first of four categories, namely working environment that make up the basic management function in the community service psychology program. Included in this discussion will be an outline of the way in which: the positive and negative factors of the working environment influence the community service psychologist. The positive include the availability of information and communication infrastructure (ICTS), transport and having one's own office. The negative include limited access to ICTs, too many patients, the absence of personal security, emergency response, and privacy, the lack of transport and being isolated from colleagues. The work environments in which clinical psychologists in community service find themselves in will be discussed in the following section.

4.2  Working environment

The category working environment is composed of positive and negative attributes. Working environment of a community service psychologist tends to have an influence on the output which he or she brings forth. Many community service psychologists work in environments which bring them into situations that would be considered, by the general public, to be either motivating or de-motivating. The nature of community service work is such that it requires community service psychologists to carry out functions which would be considered most irregular in conventional social settings. Such environments bring with them a plethora of ethical challenges requiring community service psychologists to be strong if they are going to cope with the situations they encounter. In this section, I will start by discussing the positive responses then lastly the negative of the working environment which make them feel supported. The themes that arose are discussed below.
4.2.1 Positive attributes of working environment
The responses indicate it to be easier to serve communities effectively within an environment in which the necessary resources are made available to the community service psychologists. Aside from physical support, participants also indicated that supervision and guidance facilitated better delivery of services to the patients within their respective placements.

4.2.1.1 Availability of Information and Communication Infrastructures (ICTs)
Almost half of the community service psychologists who were interviewed did have access to information and communication technologies (ICTs). According to UNDP (2003), ICTs include technologies and tools or instruments that can be employed for storing, managing, communicating and sharing information. These tools can be either manual or computerized (digital) (Information and Communication technologies (ICTs) for…, n.d.). ICTs not only include hardware, that is, PCs, radios and other wireless devices, telecommunications towers, and connections and other physical components (Information and Communication technologies (ICTs) for…, n.d.). They also comprise software and software systems including management information systems (MIS), as well as management methods and practices. Justification of the use and investment in ICTs is rendered by their multiple value adding applications (MCT, 2002). The community service psychologists displayed fair knowledge of the importance of ICTs in their work environment.

The following quotes reflect the knowledge:

“With relation to internet facilities and all that, do you have access to that kind of thing” [Researcher]

[Agrees]
“We have internet, just internal. This hospital doesn’t have any money, there is no money” [CP3]
“So on the internet do you have any mail of your own” [Researcher]
“Yes I have one but it’s still on the other psychologist name. I have one that comes to me” [CP3]

It is also evident that although access to ICTs is available, significant forms of limitation still exist. According to one community service psychologist, she has access to electronic mail but not with an account that is in her name. This indicates a lack of control over information of a personal or confidential nature that one might have to communicate to others which inevitably points to there being an infringement on the community service psychologist’s right to privacy.

4.2.1.2 Transport and mobility
The availability of transport facilitates the dispersion of scare skills to those areas that are more remote and hence less likely to receive steady and ongoing service provision, particularly of those of a specialist nature such as the Clinical Psychologist. Remote areas within the KwaZulu-Natal Province seem to benefit from community service. Some community service psychologists indicate that they enjoy partaking in community outreach programs as compared to staying within the confines of the larger clinic or hospital. In addition, community outreach programs make it easier for the patient as they then do not have to travel considerable distances and pay large amounts or money in order to access mental health facilities.

CP1 mentions in the following quote:
“Work out well...daily transport from some of the clinics” [CP1]
Participant [CP1] pointed out that she has easy access to transport which enables her to travel to other more remote sites, implying that given the option, many community service psychologists might, of their own accord, enjoy going the extra mile in providing service to the community.

4.2.1.3 Consultation and office space
Participants highlighted the availability of a personal consultation or office space at the hospital as a motivating factor when engaged in community service.

One of the respondents expresses it as follows:
“...that’s one good thing that we get our own offices....” [CP4]

This community service psychologist revealed that being allocated a personal office positively influences the nature of the working environment.

4.2.1.4 Accommodation
Responses also dealt with provision of accommodation and the significance it has to one’s working environment under the community service psychology program. While some community service psychologists indicated that they were not provided with accommodation at their respective sites, some were able to secure accommodation through various avenues.

This is how one fortunate community service psychologist put it:
“I was given accommodation on the second day because she [senior psychologist at the hospital] was there and followed it up...and even reported to the medical management” [CP4]
“...so many people handling accommodation so it is every body’s responsibility and then nobody is responsible in the end because everyone keep lying...” [CP4]

Although she secured a place to stay, the community service psychologist revealed that the hospital management did not know of her arrival, and nothing had been done with regards to her accommodation arrangements at the hospital. However, it was through the help of the senior psychologist that she ended being provided a place to stay.

4.2.1.5 Supervision and Guidance
Many community service psychologists indicated that they felt isolated. There was a lack of orientation on the part of the hospital management in most instances. Orientation programs are beneficial in that they help familiarise the new member to the institution as well as introduce that individual to work colleagues and other staff. Orientations help adjust the new individual, hence providing a smooth transition and more productivity.

The following quotes reveal that the community service psychologists received some form of guidance:

“You were quite lucky to have a senior psychologist there to help you out” [Researcher]

[Agrees]

“Yes” [CP4]

Instead of the hospital management managing such issues as orientation, in many instances, where there may be a senior psychologist placement, he or she might take it upon him or herself to orientate the junior psychologist within his or her relatively new environment. The community service
psychologist agrees that she was fortunate to find guidance in the form of her senior psychologist.

4.2.1.6 Evaluation

Evaluation of the work done or the community service rendered by the community service psychologists should be both a requirement of and a service provided by the Department of Health. The main purpose it should serve are to assess the implementation of the program, community outreach implemented, if any, and to assist the community service psychologists in developing and maintaining dynamic programs that reflect the philosophy and the program standards and practices of the Department of Health.

Responses that were sorted out beneath this code dealt with working in isolation without any evaluation of the job done by the community service psychologists. Although all the four participants who highlighted the issue of evaluation, [CP4] went further to express her feelings on what is exactly missing when it comes to the issue of evaluation.

The following quotes show how community service psychologists expressed their concerns about evaluation:

“In KwaMashu and Mahatma Gandhi and even at Phoenix Assessment Centre, I’m basically working myself most of the time. You do just end up making those decisions. You check afterwards and say this is what I did, is this okay - it’s not so much that the support is not there, it’s hard to say how we could change it.” [CP2]

“You just sort yourself out which is not like we instructed to...here is someone from...and this is what is expected of you.” [CP4]
“There should be some kind of structure kind of thing to show this is the program, this is what is expected, this is the support you get, these are educational...if it means paying for them there should be that kind of structure” [CP4]

“I think the hospital could have arranged something where the community service together with the psychologists or whoever to all to put it that way to meet and discuss issues around the community service. With issues that upset the people, the patients of the community that we render our services to but I don’t know maybe it will happen eventually, I don’t know” [CP6]

4.2.1.7 Familiarity, attachment and identification

These responses deal with the participants’ ability to relate to the communities they have been contracted to service.

The following quotes suggest familiarity with the province and some of the communities in which the community service psychology program officers served:

[CP4 currently in service] “I did my internship in 2008 at Midlands Complex. I’m now doing community service at Madadeni Hospital.” [CP4]

“I did my Bachelors, Honours and Masters there, and then did my internship in Pietermaritzburg as well” [CP5]

[CP6 currently in service]

“...in 2008 I went and did my internship in Port Elizabeth Duncan Psychiatry Hospital up in Kloof. In 2009 I was placed in CJ Crooks
Hospital in Scottsburg in the South Coast of KwaZulu-Natal. That is where I did my community service” [CP6]

“I’m currently doing community service in Port Shepstone Hospital. My internship was first six months in King George Hospital in Durban. My last six months was in R.K. Khan also in Durban, Chatsworth” [CP7]

“I am from KZN; my parents are living in Hillcrest” [CP8]

The quotes above reflect that community service psychologists prefer to practice in locations which are as near as possible to their relevant everyday social contexts and to which they might have completed their internships.

The community service psychologists revealed that they are mainly from Durban and surrounding areas and had completed their studies at the University of KwaZulu-Natal. However, participant [CP6] revealed that she completed her internship in the city of Port Elizabeth in the Eastern Cape Province.

4.2.2 Negative attributes of the working environment
While there were positive attributes to the working environment in which community service psychologists operated. Unfortunately, there were significant negative influences that discourage or impact negatively on service provision within the community services program for the dispersion of clinical psychological services. The themes below discuss these negative factors.
4.2.2.1 Limited access to information and communication technology (ICTs)

The extensive use of ICTs which facilitate near instant global transactions and exchanges of information has led to the emergence of a knowledge-based economy and society that thrives on an easy accessibility and availability of information and knowledge. Clinical Psychology students thrive on such resources and generally are schooled within institutions which allow for such resources to be readily available to them. Coming from a research and academic structuring, it is hardly being spoilt, or fussy but a necessity if one is to honour ones training and quality of service provision to make such readily available to the community service psychologist. To not do so is to clip his or her wings, so to speak.

The quotes below indicate that community service psychologists lack access to ICTs or have minimal access to these vital resources:

“I don’t have a telephone line or anything like that. It’s just a communal line.” [CP2]

“...if you want to discuss your case with a senior psychiatrist at another clinic and if they not available except maybe one day a week. It’s not an easy process. It makes it like it’s not worth doing it, especially in terms of telephone use and computer use because I’m sharing a computer with all these other people. It is a problem, if I had to try and write a report or something I can’t guarantee that the computer is not going to be read” [CP2]

“Do you find that your work is affected in any way by the lack of technology; with the training that we psychologists do there is a lot of computer work” [Researcher]

[Agrees]
“Yes, for example, if you want to discuss your case with a senior psychiatrist at another clinic and if they not available except maybe one day a week. It’s not an easy process. It makes it like it’s not worth doing it, especially in terms of telephone use and computer use because I’m sharing a computer with all these other people...”

[CP2]

According to Munyua (2000), modern ICTs have reduced the world to a “global village,” unbounded by language, distance, or culture. Community service psychologists indicated that they practice in remote areas and have many sites to service. Therefore, while subtle, the implication to community service psychologists is that they may then be compromised in spreading their wings, or accessing information which may be beneficial to them when trying to overcome issues related to language, distance and culture.

4.2.2.2 Service population.

Data in the current study indicate that community service psychologists serve a large number of patients [CP1]. They encounter problems of immense backlogs due to loopholes in the management of the community service psychology program within their sites [CP2] and misunderstandings caused by lack of knowledge of the local customs or languages, such as Zulu [CP3].

The quotes below suggest this:

“...too much” [CP1]

“It’s severely under service. There is a huge waiting list and lots of patients because it is a huge hospital with a huge patient load and we trying to work a way through the waiting list, but its hard doing
that because we try to book patients and there’s more referrals coming in.” [CP2]

“I see a lot of children...it’s given me a wide range of cases and, a lot experience with a lot of different patients with different disorders...” [CP2]

“...in Phoenix Assessment and Therapy Centre I’m there one day a week, there is one other permanent psychologist most of the time so that’s also incredibly busy...” [CP2]

“Majority of my patients are Zulu speaking. I understand a little bit, but I can’t speak it and also I do seven clinics and all the rural areas” [CP3]

It is critical to note that community service psychologists serve in many instances, more than one site, as illustrated by the response given by participant [CP3] above.

In practical terms, this results in more patients than there are professionals. The system does not allow at present for individuals to put in overtime or work after hours. All work has to be completed within the work day. Within a typical work day, community service psychologists then may be subtly pressured by sheer need within the mental health provision services of that institution to squeeze in more patients than he or she can under normal circumstances manage. Over the long haul, one is left with professionals that are exhausted or burnout. Hence, this results in a reduced ability to deliver the range and quality of services that the health institution has committed to delivering.
4.2.2.3 Personal safety concerns
Mention was made during the interviews by community service psychologists of incidences of violence being heard of or reported as well guidelines in the management of potentially violent patients.

“...in a community health centre itself we had a few incidents were other nurses or others counsellors have been attacked by patients” [CP2]

“...they [staff members] always advise me if I’m seeing a patient, especially if it’s a male patient that I shouldn’t shut my door so they can see what’s going on...” [CP2]

There is evidence that fellow members of staff within the institutions are concerned with the safety of the community service psychologists. These responses indicate an underlying fear for one’s personal safety when treating patients. Hence, the level of danger inherent in the delivery of mental health services, especially that of community service psychologists, appears to be minimised to a large extent.

4.2.2.4 Emergency procedures
Communication tools such as the telephone were noted as one of the ways to make hospital security staff aware of any danger that may arise during the course of treatment. As mentioned previously, most community service psychologists do not have access to a telephone within their office or consultation space.

One community service psychologist said:

“I don’t have a phone in my office so I can’t call for help, so you know and, obviously there are implications.” [CP2]
Although the community service psychologist did not clarify what she meant by “implications”, it is evident she is quite fearful when it comes to treating male patients alone and within a closed environment.

4.2.2.5 Privacy and the lack thereof
Psychotherapeutic treatment protocol requires that one consult with patients in a safe, private and relatively comfortable space.

The response below highlights the challenges encountered when operating in an environment which the patient lacks privacy:

“...no patient is going to come and talk to you with the door wide open and then also my office has the toilets....someone will just barge in and come and use the bathroom, and you also get the doctors from other departments coming in and using the bathroom”

[CP2]

The connection to an uncomfortable hostile environment was evident. The community service psychologist indicates that patients do not continue with psychotherapy and hence drop out of treatment as a result of the lack of privacy. In addition, the movement of doctors from other departments making unwelcome visits while therapy is in progress is a sign of a lack of respect for the profession of psychology and the services such a profession provides as a whole.

4.2.2.6 Community outreach programs
As a rule, the development of outreach programmes by the psychology and mental health professional in general should be facilitated and encouraged as it adds to the effectiveness and resourcefulness of the hospital itself. Community service psychologists mention the need for drivers within their respective institutions.
Response to follow-up questions indicated that the availability of transport facilitates would help improve access to treatment of patients who reside in remote areas and also those who lack financial resources to travel to the hospitals in the less rural centres in order to receive treatment [CP2].

“...the usual problems of accessing treatment like transport, paying, all of those things which the patients aren’t able to afford and, if you a patient once a month, it’s very difficult to continue with therapy.” [CP2]

“...because the issue of the outreaches and going to the clinics...there has been a problem here in Mathathene, there are no drivers hired by the hospital. I have not had a license, it was a limitation for me to go and visit the clinic which I felt I’ do be much more help there than I would here. I think I would like to go to the clinics and that kind of thing so that I think on my part probably I not having a license had also an impact on me going to more outreaches and that kind of stuff so I feel I end up sitting in the office and waiting for the assessment all those kind of things” [CP4]

“Do you feel like you getting any benefit at all from the community service placements at the moment” [Researcher]
[Disagrees]

“No and I think to some extent I am also accountable for it because the issue of the outreaches and going to the clinics whatever, there has been a problem here at Mathathene unlike Pietermaritzburg, in PMB the hospitals have drivers to take you wherever you went to the clinic and whatever” [CP4]
In lieu of the above, it is implied that some patients discontinue therapy because they cannot afford to travel to the major centres in order to receive specialised mental health care.

In addition, a theme that arose related to the travelling to clinics in remote areas by community service psychologists. Although the hospitals accommodate the community service psychologist, one community service psychologist [CP4] placed part of the blame on herself for the failure of service provision being as a result of her lack of a driver’s license. In lieu of this, it is significant to note that community service psychologists are encouraged to obtain a driver’s license before completing their academic qualifications.

4.2.2.7 Isolation

Much reference was made to this theme within the interviews, and expressions such as working on your own were common. A connection to the evaluation of community service psychologists is evident in that isolation would be minimised if one where being supervised, mentored or even just observed. It is essential to have a system of evaluation in place so as not only to rate performance and growth as a clinical psychologist in order to help improve the program but also to guard against professional isolation.

Responses to follow-up questions indicated that isolation has a negative influence on the performance of the community service psychologists [CP4].

The quotes below suggest this:

“Isolation...no help...differs from one province to next” [CP1]
“...it’s quiet isolating for one out there.” [CP2]

“I’m pretty much left to do whatever I want to do...” [CP3]

“Yes....it’s quite isolating here [rural communities]” [CP3]

“...when you out there like here in Mathathene, the nearest community service well for now is at Mathathene Provincial, from there, there is no one around me so yeah it’s a bit of a challenge” [CP4]

“...you find it a bit isolating as well” [Researcher]
[Agrees]
“Yes I do” [CP4]

“Do you think this would affect your performance as a clinical psychologist” [Researcher]

“To some degree I think it would if I let it because now I’m at a placement where I would be learning so much in the private practice that I am here in a public hospital. Like I said earlier the issue of supervision I felt if I just go for supervision at this stage I would be wasting time.” [CP4]

“...so in another sense it added to the isolation?” [Researcher]
[Agrees]
“Yes” [CP6]

“We are alone, you do this community service, there is nothing more than that” [CP6]
“I found community service very isolating. I actually tried to see if other community services got a meeting once a month, or something, but there was nothing this year. Yes I felt a bit isolated in your work” [CP7]

“...it is because we working in isolation for a year...” [CP7]

“...the daunting thing about community service is that you basically on your own...” [CP8]

“...the saddest part is we not actually a group where you feel that you can reach out to other psychologists...” [CP8]

The notion that in doing community work, community service psychologists work in isolation is clearly expressed by participant [CP8]. In addition, she expresses feelings of isolation and alienation, implying that contact with community psychologists would help prevent feelings of isolation and alienation and provide much needed emotional support.

It is evident that platforms where community service psychologists could meet such as regular meetings were not available and, this further added to isolation [CP7]. In addition, many hospitals and institutions refuse to allow the community service psychologist to attend such community service support meetings, subtly and sometimes, not so subtly discouraging them. In lieu of the fact that more resources and options for supervision or mentoring are available in private, one community service psychologist felt that she would have learnt more within the private sector and would have felt less isolation in the process [CP4].
4.2.2.8 Accommodation
The availability of accommodation at the respective hospitals where community service psychologists are based is perceived by the psychologists as being a vital and an indispensable element in their general level of comfort and feelings of safety. Some of the problems experienced by community service psychologists include; long distances to work, large amount of time required travelling to and from work, extended separation from family, travelling costs, lack of or inappropriate forms of accommodation and the financial impact.

The following quotes below suggest this:
“No, I am. I live in Howick, but I stay in Greytown. I stay in the week, and I drive on the weekends” [CP3]

"You travel every day?” [Researcher]
“No! I don’t, I used to and now I live in a guest house in Greytown” [CP3]

“In regard to accommodation, you said a guest house now that must be a bit expensive. How are you coping?” [Researcher]
“I’m doing it out of my own pocket, but its fine” [CP3]

“...there wasn’t a provision made because I didn’t ask for provisions. When they offered the job to me I assumed I shouldn’t have but I should have clarified, but when I started driving the first month, it took a toll. I leave at four, get home at six...paying for accommodation is easier than driving that far” [CP3]

“...not knowing where you going to sleep that night was probably quite a frightening experience” [CP4]
[CP4, responding mentions of turning down the offer to do community service]

“...because when you applying just like the university, for example, will you be needing accommodation or not, so it goes in the same form. So when they say you have been accepted, or whatever, clarification need to be given to you if you will have accommodation and whatever...and that was another reason why I considered this placement...according to the placement, they show if the particular hospital has accommodation for you or not. According to that form that we select options from it was said that Mathathene does have accommodation. I wouldn’t cope in the new place having to find a flat to rent or whatever at that time when I had to start...” [CP4]

“I did not experience any problems except for the fact that they tried to provide me with accommodation but when I got there, there was nothing” [CP6]

“I was lucky in that I found a place just after three weeks. I was staying with my sister initially. We commuted from Durban to Stanger every day and then I found a place in Mkwanazi which is a place 15 minutes away from Stanger and it has been very convenient. I love where I stay” [CP8]

The responses indicate that although community service psychologists were not provided with accommodation, they were promised such during the application. Furthermore, some community service psychologists had made prior arrangements with hospital management before going to their sites, only to find out there was no accommodation available or arranged for them on arrival. In some cases, the community service psychologist considered
turning down the placement offer when she found out there was no accommodation being made available for her at the hospital she was going to be based at [CP4]. In any event, it appears that most of the community service psychologists resorted to arranging their own accommodation when they failed to secure accommodation at their places of employment. In addition, no compensation is provided to the psychologist for unplanned and sometimes exorbitant rentals, as well as for unexpected travelling expenses to and from work.

4.2.2.9 Hostility

The presence of a relaxed work environment provides individuals with the opportunity to share and learn from each other, in other words it helps improve the efficiency of its participants. Group members with different organizational roles interact and collaborate with one another in order to gain better understanding of each other’s perspectives in the larger scheme of serving the that particular community.

The responses below reveal how community service psychologist felt about the atmosphere within their work environments:

“There was no bonding” [CP6]

[CP6, responding mentions of her view of the community service meetings]

“We would feel as outsiders or something” [CP6]

“So there wasn’t room for your essential capacity?” [Researcher]

“...the psychiatrist is very bossy and domineering...Mr know it all in a sense and you felt not supported” [CP6]
The responses to follow-up questions reveal that the participant’s felt as if they were not given the opportunity to develop her full potential. The lack of multiple perspectives in the work environment results in a poor learning environment. Hence the community service psychologist talks of feeling like an “outsider”, which again provides evidence of a lack of a sense of belonging.

4.3 Emergence of deficits within the program
Proper program management includes identifying what is required in order for a program to impact as per design, in other words evaluation. Other important elements involved in the management and functioning of a program include organisation of resources, monitoring performance and task completion, planning ahead in order to meet future requirements and the ability to deal with any problems appropriately and successfully as they may arise.

The issues that were found to cause major deficits in the community service psychology program are described in detail below, along with examples of the consequences of those deficits.

4.3.1 Health Professions Council of South Africa (HPCSA) Registration
This code discusses the participants’ experiences in terms of registration with the Health Professions Council of South Africa (HPCSA).

The following quotes suggest the themes that emerged from the participants’ responses:

“Also just in terms of the HPCSA that is a whole other issue with registering and paying. A lot of people, health professionals have the same sort of problem with it. It’s not very clear what registration
process you have to do, what information you need and also it’s a lot of money to pay the fees and to pay the registration.” [CP2]

“So things were up in the air...you weren’t sure what sort of arrangement you were to be making?” [Researcher]
[Agrees]
“yes and then obviously to apply once the thesis is marked, final comment was given etc, from the HPCSA to get my community service certificate because you can’t start without that. I went to Pretoria to do that.” [CP3]

“So there is lack of understanding and communication between the people and the community service psychologists” [Researcher]
[Partially agrees]
“I think so.....and also I think there is a bit of confusion with payment and stuff because if you paid just the amount stipulated in the form you far short of actually what you supposed to pay” [CP5]

“So the HPCSA is giving you trouble” [Researcher]
[Agrees]
“Yes....they did mess up things this year” [CP5]

“Not allowed to start before I couldn’t register with the HPCSA before my thesis was finished and they didn’t allow me to start working before registration. It took some time, so that was the only major hiccup” [CP7]

“Did you have any problems with the procedures, the applications, pro community service, any hiccups, and any problems” [Researcher]
“I did have, I still have difficulties with the Health Profession because it was a bit ambiguous when I registered about whether our thesis had to be completed and stuff or whether just handing it in was sufficient” [CP5]

It is evident from the responses given above that registration process and details related to the payment of the registration fees is not clear to the participants [CP2, CP5]. One response indicated that after paying the amount stipulated in the registration form, it came to the participant’s awareness that the amount she had paid actually was not enough and she was required to top up [CP5]. In addition, the participants highlight that it is expensive to register with HPCSA [CP3, CP5, and CP7].

The other theme that emerged was that it was not quite clear whether only submission of the clinical psychology related masters’ dissertation without the student obtaining his or her graduation certificate was sufficient enough to allow registration with HPCSA [CP3, CP5, and CP7].

This implies that the Health Professions Council of South Africa has not communicated the issue of registration, registration fees payable and general procedure regarding the movement form registration as intern psychologist to community service psychologist.

4.3.2 Motivation
Motivation within the community service psychology program is essential to encourage community service psychologists to perform at their peak. Community service psychologists reveal that motivation can be fostered in many ways, such as with compensation for time, travel, diversity of cases
The following quotes below suggest this:

“No compensation for time and costs in relation to demands....no compensation for travel....far away from home....no accommodation...pressure from peers” [CP1]

“I see a lot of children.....it’s given me a wide range of cases and a lot experience with a lot of different patients with different disorders.” [CP2]

“I have to get some experience in the meantime...” [CP2]

“Do you feel like you getting any benefit at all from the community service placements at the moment?” [Researcher]

“At the moment...No and I think to some extent I am also accountable for it because the issue of the outreaches and going to the clinics....there has been a problem here...In Mathathene there are no drivers hired by the hospital.” [CP4]

“...then you realize, why am I here?...it kind of feels like a waste of time all round really speaking...it almost like it stops you.” [CP6]

“with very little jobs available...you feel you too young in the profession but the other option is going out of the country...that transition from community service now to the next step, it is a bit daunting at this stage for me” [CP7] availability of jobs abroad
“yes it is...however why I say it’s such a rich experience that I’m finding with the military you have a specific epidemic that you deal with like alcoholism, depression to deal with specific pathology, here it’s all different kinds of things, you have to be on your toes every day, you never know what is going to walk into your office also at times you really want to go back to your books to figure out how you can help somebody so that’s why I say its fulfilling in that way, it’s very challenging and you wage your way through in trying to improve the system as you can however by the time you try to figure it out your time is pretty much limited.”  [CP8]

Community service psychologists clearly indicate the challenges they are faced with and feel there should be some form of compensation allocated to them [CP1]. Although community service psychologists face overwhelming challenges within their community service year, they maintain a significant motivating factor is the diverse and varied work experience [CP2].

4.3.3 Continuity

A dominant theme in the responses surrounding recommendations for the community service psychology program was the importance of continuity. The implication is that there should not be long periods of time between the movements of community service psychologists after completion of their prescribed community service year in any given placement. In addition to that, once a community service psychologist completes his or her prescribed year, placements should be made available to them within the system in order to retain the talent so to speak. Responses to follow-up questions suggested there is lack of continuity within the community service psychology program [CP7].
The quotes below suggest the above mentioned findings:

“There is nothing really that is available. It’s a bit daunting to think what will follow.” [CP2]

“...with specifically to regards to community service the only suggestion will be when the department is making the post, when giving people their choices that they take into consideration when the other community service psychologists are leaving. I only just started in April and the community service psychologist that was here in the hospital was leaving in January” [CP5]

“So you find no continuity” [Researcher]
[Agrees]
“Yes” [CP7]

“I feel it would have been nice to kind of have a continuation overflow from internship Department of Medicine, maybe from that would have been nice to just kind of continue kind of in the process...” [CP7]

“So you actually looking for someone who can manage and keep it moving” [Researcher]
[Agrees]
“Yes! I think that is the problem” [CP7]

“...we [trainee clinical psychologists] are such a small little group because we are coming from a system where you have to do your thesis or you actually can do your community service so you find here in Stanger...you leave in August and we don’t know who is taking her place.” [CP8]
Community service psychologists complain of uncertainty in regard to their future as a result of being channelled into the health system and then left in the lurch once that prescribed service is completed. Signs of the stressfulness of the unknown are evident in the community service psychologist’s responses [CP2].

Interestingly, follow-up questions probing the issue of continuity reveal that some community service psychologists fear that there are no mechanisms in place that might assist in relieving the stress of uncertainty as there are not stakeholders at institution level managing the in-flow of new community service psychologist resources into individual sites [CP7]. It was indicated that as much as four months or more can pass without the replacement of the community service psychologists and this one of the greatest contributing factors to backlogs in service delivery.

4.3.4 Treatment backlog
Treatment backlog is an element closely related to continuity. Besides continuity, treatment backlogs are also affected by the scarcity of community service psychologists and psychological skills in general, as well as the large number of sites having to be serviced within the health department. Furthermore, while rules do exist in lieu of forensic cases, since the community service psychologist works at a hospital where such cases may be managed, such referrals may be entertained and hence add to the already overstretched resource pool.

The quote below suggests this:

“It’s severely under service. There is a huge waiting list and lots of patients because it is a huge hospital with a huge patient load and we trying to work a way through the waiting list, but it’s hard doing that because we try to book patients and there’s more referrals
coming in and so also from there you work from a crisis centre where they do all the forensics cases. So whenever there is a sexual assault then they come through there. So the other psychologists do most of the assessments for forensic purposes and I’m doing more of the general counselling and assessments and that sort of thing.” [CP2]

“Working at the sites one day at a week is very hard to keep it continuous. So in other words in these satellite sites it’s really hard to optimize treatment.” [CP2]

It is quite evident that there is a continuous stream and inevitable piling up of work for the community service psychologist. A major contributing factor is the high level of specialisation that the clinical psychologist has acquired, which attracts huge numbers of referrals seeking specialised forensic, clinical, neuropsychological and educational services at the hospitals. In addition, the community service psychologists mention that the hospitals are short staffed. Therefore, although the participant indicated that she is the one who does the general counselling and assessment, the other psychologists who have to attend to forensic cases and the huge demands of court protocol, procedure and attendance results in large backlogs within the clinical arena.

4.3.5 Awareness of therapy within the community
It seems plausible to assume that an increased awareness of the availability of a certain service within a community increases the demand for the service. While this is likely to apply to the field of clinical psychology, the response below indicate a lack of knowledge of what clinical psychologists do within the services target populations.
The following quote below suggests this phenomenon:

“I’m not sure if people know what clinical psychology is, I’m not sure and I think if people are made more aware of it could be marketed more effectively, these posters could come up sort of explaining you know in lament terms what we do then I think that people would access the service more quicker” [CP8]

“if you’re placed in disadvantaged communities, you find that people are coming in with all sorts of problems mainly social-economic based problems...I do struggle with the language and I struggle with the understanding and I wonder whether you know if you White or Coloured or Indian our own community thing with the people [patients] that come in so you know I found that one of my biggest things I’m struggling to communicate with therapy especially with the African community...They don’t know who we are and what we do? Why we placed here? So I found that a big shock for me is half of the session I spent trying to explain therapy....maybe communicating that is aiding you is half the battle won because they [patients] do feel that why should I talk to people that I think the biggest struggle for me is making it relevant for the community in trying to assist” [CP8]

“You feel that in a sense what you doing at the moment are a slight mismatch to what the community is expecting” [Researcher]

[Agrees]

“Yes” [CP8]

Hence, it becomes evident that the current educating, communicating and propagating psychology are proving ineffective. The participant highlights that if only community members were more informed and aware of the
services that a clinical psychologist could provide, they would seek out such services.

4.3.6 Meetings
Community service psychologists have the desire to learn new and better ways of working but sometimes appear to feel discouraged by the environment that surrounds them. Meetings are arranged platforms for individuals to come together to discuss issues that are of interest to them. Hence it is through occasions as these that community service psychologists might get to learn and improve on how to better conduct clinical practice procedure and protocol. Participants revealed that on occasion they attend meetings [CP3], commented on how the meetings are structured [CP3, CP6, CP7] and the frequency with which they meet [CP8].

The following quotes below suggest this:

“...I’m like the head of my own department, it’s just me. I sit in meetings when it comes to finance and costs” [CP3] capacity of attending meetings [head of department]

“...how do you feel about that in relation to community service? Do you feel that it benefits you at all with actually being involved with management issues in the hospitals which actually takes time away from actual community service you know, that is servicing patients. How do you feel about that?[Researcher]

“The meetings are like 7:30 in the morning. If we had one it would be like once a week or like a Wednesday morning. We have to make provisions for that. We do group stuff like we get involved in getting money together for orphanage. We do fund raisers and stuff like that as well so we plan for those because, but it doesn’t really affect my timing.” [CP3]
“Did you actually attend any community service kind of meetings?”
[Agrees]
“Yes...first week, first Friday of each month... I didn’t enjoy it to the fullest because I was not going to benefit like quite a bit but it turned out okay. The bulk of the students were from UKZN so they were old and vibrant or I don’t know how to call it, but we studied here and the 2% started from whatever you call it. It was beneficial in a way. I wouldn’t force myself to go there because I was hoping to find the support that I actually needed” [CP6]

“There was no bonding” [CP6]
[CP6, responding mentions of her view of the community service meetings]

“We would feel as outsiders or something” [CP6]

“Yes....in a way, but when you think of going there it’s like oh my God!” [CP6, responding mentions of how thinking of attending community service meetings is challenging] [CP6]

“So you dreaded going to these meetings” [Researcher]
[Agrees]
“I did” [CP6]

“So that was the only kinds of peer support that might have been available to you at the time” [Researcher]
[Agrees]
“Yes” [CP6]
[CP6, responding mentions of ways to improve the community service program]

“I think the hospital could have arranged something where the community service together with the psychologists or whoever to all to put it that way to meet and discuss issues around the community service. With issues that upset the people, the patients of the community that we render our services to but I don’t know maybe it will happen eventually, I don’t know. We are alone, you do this community service, there is nothing more than that” [CP6]

“You do your job and go home and that’s it” [CP6]

“Group discussions...if so and so have to come up with a talk after the next meeting in either reading material or in notes. Everybody would get there for a consult. Everyone knows what going to take place. Someone can crack a joke and people can just laugh and at the end of the day, it is the purpose of being there in psychologist in training.....you just get there you don’t know what is going to happen. Someone is going to come up with something creative or something of a learning nature, you don’t know, you not even comfortable with the topic that is being discussed....now is the time to go to the reading and make use of what is available to you. There is such group discussions well in advance......it would have made a huge difference” [CP6]

“So you find that it was much unstructured and very casual in the sense” [Researcher]

[Agrees]

“Yes” [CP6] [CP6, mentions of tense meetings]
“I actually tried to see if other community services got a meeting once a month, or something, but there was nothing this year.” [CP7]

“the year that you were there, this last year, there haven’t been any community service meetings, peer groups and that kind of thing” [Researcher]
[Disagrees]
“No” [CP7]

[CP7, responding mentions of things about the community psychology service program which need improvements]
“All the psychologists in the area started to get together once a month so that, and also if I had a meeting going on I do try to do it then. Maritzburg usually happens once a year you know, mental health, things like that I attended and you get to speak to others and hear what others have to say” [CP7] meetings once a month, mental health issues/agenda, sharing ideas

“With the general clerk I went once a month, there was no interfering with that, the other things I attended was mainly not during working hours on Saturdays” [CP7]
[CP7, gives her view about attendance of meetings] frequency

“so you had to take time out of your schedule, your personal schedule in order to go for these things, and they were possibly more related to work than personal life” [Researcher]
[Agrees]
“Yes” [CP7]
“We do have meetings where we meet once a month but it has been a while...” [CP8]

The responses above clearly indicate that community service psychologists feel subtly discouraged by firstly having to attend compulsory meetings that are not relevant to their field of practice or part of their job description and secondly, discouraged by management from attending meetings that are beneficial and form part of psychological practice but require attendance away from the institution.

The reasons for attending are quite diverse. One response indicated that it is only a matter of responsibility that drives her to attend meetings [CP3]. On the other hand some community service psychologists made mention of community service psychology meetings to which there seemed to be poor or unmotivated attendance in some and a much needed break and re-connecting with others [CP6].

4.3.7 Appointment to placements within the program
The Policy for Community Service Psychologists (2010) stipulates that “An Allocation Committee will oversee and approve the allocation process. It must be stressed that the individual interests of Community Service Psychologists and managers should not be considered unless there are compelling reasons for their personal interest to be considered.” This implies that community service psychologists awaiting placement cannot influence the placement process in lieu of timelines regarding their placement. The speed at which allocation or placement is done, and the cut off dates as well as start up dates of ones personal placement are decided upon and implemented solely at the discretion of the committee. As a result, there is a lengthy time lag between application and placement itself [CP2].
The response below suggests this:

“...and also it took them a very long time to place us. We only get our posts officially at the end of October, beginning of November last year. Our details had to be in by the end of June – so you sit for a few good months wondering and then give us a schedule as to expect when things and they didn’t stick to it at all – you end up wondering, do I have a place or not and then you try or make a back-up plan. I know, for me, I was lucky that I was placed in the first round, I know of a few people that weren’t...” [CP2]

“I know of a few people that weren’t or whose applications went missing or somehow. So that was and then there had to be a second round – they get random places from there – it was okay – there was also not a lot of communications of once you have your placement.” [CP2]

4.3.8 Networking

The response below reveals that the participant was interested in networking with other community service psychologists at meetings in order the deal with the issue of isolation within the work environment.

“So that would be community service psychologists?” [Researcher] [CP3, responding mentions of professionals that she wants to network with] [Agrees] “Yes...” [CP3]

4.3.9 Choice of community/sites

In terms of choice, Guidelines in the Policy for Community Service Psychologists (2010) stipulates that “Applicants whose applications are forwarded to the province from the National Department of Health will be
processed provincially to ensure that preferences are accommodated as far as possible, but not guaranteed.” This implies that the Department of Health does not offer applicants posts in the area of preference.

The responses below suggest that not all participants managed to secure posts in areas they wanted:

“In terms of the process of applying, you know it’s just something that happened to me is that I applied for, I had five options you know you have the five districts that you have to apply for and my first choice I put down Mahatma Gandhi Hospital on the list. It was on the list Mahatma Gandhi Memorial Hospital in KwaMashu so in my mind you know I had a vision I would be placed in Mahatma Gandhi and I was placed there, but when they came to me it was at the Mahatma College Community Health Centre. So it wasn’t part of what I was expecting and it was made clear on interns in the application process but obviously I was, you know, I didn’t want to turn it down and not get another place” [CP2]

“Then regarding to choices, was Correctional Services your first choice the first time round?” [Researcher]  
[Agrees]  
“Yes, I applied at Correctional Services and Military and I think R. K. Khan, it was actually”  
[CP3]

“Second time round you had options that were too far out and you chose the one that was nearest?” [Researcher]  
“...they [Department of Health] offered me Stanger, Durban.”  
[CP3]
“...the biggest challenge is that you could only select one per district so it ends up being forced to make a choice to a district where you know not much about it and in any case I think that the individual didn’t know the whereabouts.” [CP4]

“So you feeling as though you didn’t have enough information in relation to choosing the option and not aware of the living standard or the area where the hospital fell in” [Researcher]

[Agrees]

“Yes” [CP4]

“it was just that thing of choosing because they were very straight about one per district so it ended up just naming because they didn’t know where else to put you, not knowing even the structure of the hospital, knowing whether there is a psychiatrist, where I’m going or whatever that is there, that was the difficult part” [CP4]

“You felt a bit blind in making that choice” [Researcher]

[Agrees]

“Yes” [CP4]

“actually yes, because my choice [meaning first choice] was C J Crooks, second was Port Shepstone Hospital, so yes I did” [CP6]

“...however the community service aspect the government places you. I would much rather prefer a place close to home but unfortunately Stanger is what I got. No regrets currently...excellent!” [CP8]

[CP8, responding mentions of challenges encountered in the application procedure]
“I did in that when I received the form for application there is a little section in the bottom that says; write down your reasons why you want to be placed closer to home. My son lives with my parents at the moment. I would have preferred a placement in Pietermaritzburg or Natal Rhodes however I was not made aware that I actually had to write a written motivation so unfortunately I lost out” [CP8]

[CP8, responding mentions of suggestion to community service procedure]

“I think it would be important to stipulate and make it very clear for some reason you know you don’t have much choice with a place where there is a need in your community. I think they should make it clearer in terms of stipulating that I understand you know about people that are married and like to be together and single parents...show preference as well. As far as I’m aware single parents do get first preference?... may be a mistake on my part” [CP8]

The theme of options was dominant in the responses [CP2, CP3, CP4, CP6, and CP8]. This in itself implies that choice does exist when applying for posts. Responses to follow-up questions revealed that some participants managed to secure their first choice [CP6] whereas others failed and but were afraid to pursuing the matter further [CP2].

Applicants did not have adequate information pertaining to the location of available sites within the program [CP4]. Although the Policy for Community Service Psychologists clearly indicates that in some cases preferential treatment is offered in many instances, the lack of awareness of
this avenue left some participants feeling cheated and at a disadvantage [CP8].

A related response dealt with the issue of dissertation submission and placement. In this instance, it was revealed that the Department of Health allowed for an extension of the deadline for completing the dissertation in order to secure the choice which the participant had chosen [CP3]. So while the black and white states that participants do not have a choice in the matter of placement, practice indicates that when pushed the department is able to bend a rule or two in favour of an applicant. Unfortunately, this does not allow for fair practice and does result in confusion and mayhem in regard to the placement process.

4.3.10 Challenges of the application process

The application process should be smooth, clear and unambiguous. This is important so as to foster confidence in and enthusiasm for the program. Trust and faith in the program are important factors in the successful implementation of a program. One dominant theme in the responses surrounding the application process is a lack of clarity caused by a lack of information regarding the application process.

The following responses suggest this:

“Gaps in procedure...” [CP1]

“The process was also quite unclear. We got the forms to fill out but we had to – we were not very sure with what we needed, trying to contact people was another problem. It is very unpleasant and when you do speak to them they make it as if you are putting them out...you should know what’s happening and also it took them a very long time to place us.” [CP2]
“so there was a lot of hiccups, a lot of things were not prepared for, a lot of setbacks and that kind of thing that might have been explained to you before you started with the procedure or process that you would be more prepared for it” [Researcher]
[Agrees]
“Absolutely” [CP3]

4.4 Emergence of strong points within program

The issues that were found to make a major contribution to the community service psychology program are described below by the following quotes:

4.4.1 Specialised resources

“yes it is.....however why I say it’s such a rich experience that I’m finding with the military you have a specific epidemic that you deal with like alcoholism, depression to deal with specific pathology, here it’s all different kinds of things, you have to be on your toes every day, you never know what is going to walk into your office also at times you really want to go back to your books to figure out how you can help somebody so that’s why I say its fulfilling in that way, it’s very challenging and you wage your way through in trying to improve the system as you can however by the time you try to figure it out your time is pretty much limited” [CP8]

“...a lot of children get sent to assessment centre, a lot of ADHD patients, and that’s probably the best site in terms of resources in terms of the actual site itself.” [CP2]

The participant expressed her opinion by indicating that the site where she is based is the best in terms of resources. Hence, it gives the community
service psychologists a greater opportunity to learn more and draw huge benefits in terms of specialised experience and knowledge [CP2].

4.4.2. Stability
Responses to follow up questions indicated that stability is one advantage of working in the public sector. The quote below suggests this:

“There’s pro and cons to each, working in government you have your set salary so it’s bit more stable in that regard...if you working in private you have to work for a certain time before you get that going plus you get to have some sort of capital, something to start up with so it’s quiet a daunting thing for me to for so long, you know in study for so long your internship is planned out for you so you know you got a job for two years and then after that now you suddenly find a job, there is very little available and in terms of posts that are available in government, that’s another story. There is nothing really that is available. It’s a bit daunting to think what will follow.”
[CP2]

4.4.3. Diversity and language
Another strong point which emerged is the issue of diversity and languages. It is essential in a psychotherapeutic as well as an assessment environment to be able to communicate with and understand your patient. A positive response which was given included the fact that the Department of Health does consider the background of community service psychologists in terms of knowledge of languages.
The quote below emphasized this:

“In regard to language do you think there is any accommodation made by the department [Department of Health] to manage that better” [Researcher]

[Agrees]

“Yes, I think people look at us in terms of why you not positioned yet because of the language. We should be professional, I’m Afrikaans speaking, I don’t have anything to do at all. The hospital with placements, you need to sort it out. We should be able to speak it. I think that because in some places you don’t need it....had I known and had I time on my hands, I would have because I would have helped myself a lot more” [CP3]

It was revealed in interview that language is a significant problem within the placement scenario. The participant indicated that while she is Afrikaans speaking, the community service psychology program made her realise the usefulness of learning other languages especially indigenous ones such as Zulu and Xhosa [CP3]. The participant indicates that other methods of interacting so as to facilitate understanding and co-operation within the therapeutic environment. Translators are sometimes made available for interpretation during assessment and therapy sessions.

The quotes below indicate that:

“Don’t you find the Zulu spoken in those [rural areas] areas are much higher spoken in the cities?” [Researcher]

[CP3, responding mentions of her encounters pertaining to the language issue]

“I don’t really know language. I read a lot from people’s faces so I haven’t been able to have an interview. I always have some people to help us” [CP3]
“I’m a one off skills people that do work. I think it would be great if they placed Zulu speaking psychologists in that area or Xhosa’s in that area...that is probably causing to some extent you know what we trying to do or separate different cultures or whatever but there is a struggle because you dealing with people.....they need to communicate clear for you to hear it” [CP8]

4.4.4. Master dissertation submission
The Department of Health engages itself with the applicant who fails to secure posts due to delays in submission of their masters’ dissertation. However, it is always at the discretion of the applicant that they be approached for assistance.

The following quote below suggests this:

“Did you know that you had to re-apply once you were unable to make it to the first placement” [Researcher]

“Yes they [Department of Health] told me. They would give me a month’s extension which extended into August and then obviously my thesis is still not marked.” [CP3] Informed, extension of application deadline

4.4.5. Single parent
The last response dealt with the issue of preferential treatment of community service psychologists who are single parents. The community service psychologists stressed the importance of family prior to making her application for placement within the community service psychology program with the aid of a motivation letter.

The following quote suggests this:

“...I’m aware single parents do get first preference...” [CP8]
4.5 Forms of support for community service psychologists

Support for community service psychologists encourages development and facilitates growth. The following responses present multiple dimensions through which community service psychologists are supported. Positive responses included the importance of team effort in the work environment [CP1], assistance with establishment of private practice [CP2], having the service of a translator for community service psychologists who are not well knowledgeable with indigenous languages [CP3], orientation from the resident or senior psychologist at the site which they serve [CP4, CP5, CP6], a feeling of a sense of belonging and stability [CP4], the main source of support at the hospital [CP3, CP4, CP5, CP6]. A connection was made to establish how community service meetings can be a much needed means of support for community service psychologists [CP6].

On the negative side of support, it was mentioned that it is challenging to get support in writing publications by the senior psychologist [CP7].

[CP1, responding mentions of support system and staffing at hospitals]
“Too much to cope with....the nurses and doctors and management not willing to educate“ [CP1]

Want a team effort in practice...” [CP1]
“I mean I know from colleagues who did counselling psychology; they got quite a bit of guidance in terms of building your own private practice. There were a lot of things that was made available to them and I get the feeling that with clinical they don’t, they want you to come back in government [public sector]...” [CP2]
“They just say you have been placed here...here is the number...you need to report at this stage and of course if you like me and can’t report, you have to delay it, then they won’t be helpful in terms of what do I do?” [CP2]

“The support is there, but it’s difficult to judge...they feel I’m not coping, not that you are not coping but that you are uncertain, that you don’t know what you doing.” [CP2]

“I think if my seniors were not around I didn’t know what I would have done.” [CP4]

“You were quite lucky to have a senior psychologist there to help you out” [Researcher]
[Agrees]
“Yes” [CP4] got support to secure accommodation on her second day of arrival to her site

“...so I take it is my responsibility to try and make sure that when he arrives he already have a room because I do not want the same thing that happened to me to happen to him” [CP4]

“...the good thing is support, she is very supportive” [CP4]
{Memo by CP – the senior psychologist is quite helpful in all areas with regards to the community service}

“Is a bit more stable in that sense that there are people who would refer to assist in the hospital” [CP4]
“...in Pietermaritzburg the community servants there, they would make their own teachings like maybe go to Greys Hospital and on a Friday morning there would be an election or something. But that was only something they organized for themselves...” [CP4]

“You were oriented?” [Researcher]
[Agrees]
“Yes” [CP5]

“So you are not experiencing any problems” [Researcher]
[Agrees]
“Yes” [CP5]

“I only know the immediate staff that I’m working with, I’m not sure if there is any other support group” [CP5]

[CP6, responding mentions of orientation]
“When I initially came there she [senior psychologist at CJ Crooks Hospital] did that [orientation]...” [CP6] {Memo by CP6 – though she did not receive continued support she received support to settle in}

“...other than that there was no support” [Researcher]
[Agrees]
“No” [CP6]

“So that was the only kinds of peer support that might have been available to you at the time” [Researcher]
[Agrees]
“Yes” [CP6] meetings were source of peer support
“...not the supervision the support that you actually managed to get during community service basically on a therapeutic level in relation to journal articles kind of thing...nothing actually on the level of administration you actually having to discuss issues with community service, that kind of thing” [Researcher]

[Agrees]

“Nothing...” [CP7]

“I do have support, my supervisor is here, she is amazing...” [CP8]

There were insights highlighted by the participant personal experience with counselling psychology friends who she claims were coached in the ins and outs of private practice [CP2]. The participant believed that this was not done as a means to keep clinical psychologists trapped within the health department rather than having the skills and means to venture into private.

4.6 Academic background of community service psychologists

4.6.1 Qualifications of community service psychologists

It emerged that community service psychologists are required to complete a Masters degree in clinical psychology. In order to get an understanding of the type of qualification and its influence on placement overtime the following responses were quoted:

4.6.1.1 In regard to academic institution attended

“How last year 2008, through UKZN. Howard College...” [CP2]

“Well worry for me at the moment is getting my Masters Degree. I’m supposed to be graduating in 2 weeks and I’m not sure I’m going to get the correct degree. They keep telling me that my Masters will be
marked as Social Science psychology and not Clinical Psychology and trying to communicate with people from the post graduates office, School of Psychology and try to ask them what is happening, no one seems to know and no one actually seems to care or do anything...” [CP2]

“Are you the only one who’s having this problem” [Researcher] [CP2, responding mentions of uncertainty surrounding graduation]

“I don’t know because half the people haven’t even received their graduations” [CP2] [CP2, fails to give reasons for short-comings in graduation process]

“I have no idea. No one is able to explain to me, I don’t know where it went wrong” [CP2]

“I studied in UKZN in Pietermaritzburg...I did my Bachelors Honours and Masters there...” [CP5]

“...masters program at Nelson Mandela Metropolitan University in Port Elizabeth.” [CP6]

4.6.1.2. In regard to the title of the qualification
“I see your certificate has Clinical Psychology” [Researcher] [Agrees]
“Yes, because as far as they can tell me in university it’s all under one code. There is no specific clinical, counselling, and educational?” [CP2]
“Is it Durban campus?” [Researcher]

[Agrees]

“Yes, but UKZN” [CP2]

“Yes I am...I did my Masters at Medunsa in 2006.

4.6.1.3. Location of internship

The following quotes suggest that most of the participants in the study did their internship in the KwaZulu-Natal Province. One did not mention [CP1] and the other two [CP6, CP8] did their internships in Port Elizabeth and Pretoria respectively. In addition, there was a connection between location of internship and location of the academic institution at which community service psychologists attended probably as a result of internships being attached to placement on the program initially within the greater area of the university where the community service psychologists received his or her training.

“...my internship last year [2009] and I was based in, based at King Edward Hospital also based at King Moshene...” [CP2]

“I did my internship between the district between R.K. Khan and King George in Chatsworth, rather in Durban.” [CP3]

“I did my internship in 2008 at Midlands Complex” [CP4]

“...did my internship in Pietermaritzburg as well...” [CP5]
“...and in 2008 I went and did my internship in Elizabeth Duncan Psychiatry Hospital up in Kloof.” [CP6]

“Alright, where did you actually do your internship?” [Researcher]
“ I did it in Port Elizabeth, Elizabeth Doncan Psychiatric Hospital” [CP6]

“My internship was first six months in King George Hospital in Durban. My last six months was in R. K. Khan also in Durban, Chatsworth” [CP7]

“I went on to do my internship in 2007 at Warnville Hospital in Pretoria...” [CP8]

4.6.2 Dissertation related issues
There was a consistent concern over the issue of the masters’ dissertation. The themes which emerged were similar for most of the respondent. Nurturing of well skilled graduates by supervisors at academic institutions was raised [CP1]. A further theme connecting supervisors at academic institutions was the delay in marking of the final dissertation after it has been submitted by the students [CP2, CP3, CP4, CP8]. Furthermore, there emerged a connection between placement and completion of the masters’ dissertation [CP1, CP2, CP3, CP4, CP5, CP8]. One of the responses also dealt with the impact of delays in marking the dissertation on placement [CP3].

The following quotes below suggest this:
“Why not PhD” [Researcher]
[CP1, responding mentions of academic or institutional issues related to furthering studies and also community service]
“Supervisors [supervisor from academic institutions] need to prepare students well...new [new practice]...dissertation now before internship... [CP1]

“I started in KwaMashu at the beginning of February while I had to wait because my dissertation was still being marked and the mark was only coming in January. There was a delay with internal markers, so I started on 1st of February” [CP2]

“I completed my Thesis. They [supervisors] took seven months to mark it so I lost my first community service job which was at Correctional Services in Westville, which was last year in July and I had to re-apply and I don’t actually have to apply, they offered me four positions because I live in Howick which is the closest for me. So it fell into my hands, luckily. [CP3]

“...we are waiting for another guy who is going to do community service at any stage now because of the problem with dissertation...” [CP4]

“...there are four of us currently because people are having problems marking the thesis, getting their results....” [CP8]

4.7 Patient impressions

The community service psychologist impressions of patients contained codes relating to psychotic patients, violence, personal safety, application of theory to solve practical situations, patients’ level of education, types of problems encountered by patients, familiarity with therapy, client level of functioning, social problems, depression, relationship with patients, frustration, defaulters, treatment interruption, transport [emergence of
deficits within the program], continuity with treatment, satellite sites, effectiveness of treatment, expansion of clientele base. These themes will be discussed below:

4.7.1. Psychotic and very unstable patients
The notion that community service psychologists are exposed to hostile and dangerous circumstances is clearly expressed in the quote below.

The idea of being exposed to risky situations was highlighted in the quote below:

“I have had one patient that was a bit problematic and referred the patient... Psychiatric Clinic which is nearby but there is nothing on site and there’s no doctor in the centre where I am so this patient came in for an appointment and was quiet unstable, not totally psychotic but very unstable and he seemed a bit problematic..” [CP2]

4.7.2. Patients as a threat to Community Service Psychologists safety
The quote below suggests that community service psychologists are fearful of their personal safety when they deal with unstable patients on a one on one basis. Absence of male nurses at the sites served by community service psychologists also emerged as a factor that adds to a feeling of insecurity. It would be useful for there to be male nurses available in psychiatric clinics and wards so as to assist female community service psychologists manage the situation should violence erupt during therapy.

In addition, it emerged in one of the responses that the community service psychologists and nurses had been attacked in the past by a patient [CP2].
I referred him out for treatment but he keeps coming back and it's quiet unsettling for myself and the rest of the staff because if he does you know bring violence or if something happens there is no one there to sedate him, there's no one there to restrain him although there is one, the sister in charge is a female, I mean a male nurse but that's the only man in the centre. So that has been a little bit of a worry but only really on that one occasion although in a community health centre itself we had a few incidents were other nurses or others counsellors have been attacked by patients” [CP2]

4.7.3. Effectiveness of therapy

Community service psychologists perceive their university education as inadequate. This implies that there exist a partial skills mismatch between what community service psychologists are taught and what is actually required in the field in order to deliver effective service to communities.

The following quotes suggest that it is challenging to effectively treat uneducated and lowly educated patients.

“...you get taught all the theory and methods of therapy but a lot of the patients that I see are not very highly educated. They don’t have a high level of insight. They are psychology minded.” [CP2]

“In this hospital the best thing we can do is the patients are so low functioning and you sit with a patient, maybe read a magazine or whatever, there is not much you can do here unlike when you can engage with high functioning patients because that was my other area of interest doing groups...” [CP4]
4.7.4. Patients’ awareness and understanding of psychology

The following quotes suggest that community service psychologists perceive patients as lacking knowledge in terms of what psychology as a profession has to offer and how can it be of use to them within the context of their lives. Emphasis was placed on education and the development of awareness in regard to the utilization, accessibility and effectiveness of therapy.

*A lot of the patients have never heard of a psychologist, they don’t know what we do? To try and do psycho dynamic theory with them and get very symbolic. It goes way over their heads. So I find that I try and do more structured, therapeutic, it depends on the clients level of functioning and also what the problem.”* [CP2]

“I’m not sure if people know what clinical psychology is, I’m not sure and I think if people are made more aware of it could be marketed more effectively, these posters could come up sort of explaining you know in lament terms what we do then I think that people would access the service more quicker.” [CP8]

This suggested that the lack of knowledge and exposure to psychotherapy has resulted in a lack of knowledge and understanding in regard to psychological and the seeking of psychological treatment.

4.7.5. Problems faced by patients

Some responses given by participants suggested that most patients seek psychotherapy in regard to social and economic problems they encounter. Hence, the following quotes suggest that there is a mismatch between what patients expect and what in reality can be provided:
“There are a lot of social problems because if you take a patient who is having a problem with their family, there’s a lot of stress, a lot of tension resulting in depression...The patient is not always willing to engage. Depression and anxiety plays a role in the interaction with their families so they don’t really want to change. I get the impression that they resisting, so it’s also quite frustrating a lot of times....Treatment is very interrupted. It doesn’t flow smoothly plus there’s the usual problems of accessing treatment like transport, paying, all of those things which the patients aren’t able to afford and if you a patient once a month, it’s very difficult to continue with therapy...People are becoming more moved in psychology. You are providing a service which is desperately needed but on the other side of the part, it is not as effective for the other social, it’s different.” [CP2]

“Most of the patients who come here, mostly of the patients that I have seen from last year, they just come for grant...” [CP4]

“yes it is.....however why I say it’s such a rich experience that I’m finding with the military you have a specific epidemic that you deal with like alcoholism, depression to deal with specific pathology, here it’s all different kinds of things, you have to be on your toes everyday, you never know what is going to walk into your office also at times you really want to go back to your books to figure out how you can help somebody so that’s why I say its fulfilling in that way, it’s very challenging and you wage your way through in trying to improve the system as you can however by the time you try to figure it out your time is pretty much limited.” [CP8]
4.7.6. Language barriers
There is considerable support for the idea that the language spoken by a candidate community service psychologist should be part of the criteria used in making allocations [CP8]. Aside from that, it clearly emerged that language is at the centre of good communication between community service psychologists and their patients [CP3, CP8].

The quotes below suggest this:

“...language is a bit of an issue, obviously. Majority of my patients are Zulu speaking. I understand a little bit but I can’t speak it...” [CP3]

“I’m a one off skills people that do work. I think it would be great if they placed Zulu speaking psychologists in that area or Xhosa’s in that area....that is probably causing to some extent you know what we trying to do or separate different cultures or whatever but there is a struggle because you dealing with people....they need to communicate clear for you to hear it” [CP8]

4.7.7. Friction and the workplace
The availability of a senior psychologist to assist with guidance and mentoring is adequate for community service psychologists, but insufficient as a guarantee for effective delivery of treatment.

“you working with this person every single day, you refer patients to him for medical management in terms of the medication and treatment and you come up with your own psycho functional management and the patient problem and you find that this person doesn’t agree with you, then you realize why am I here?...it kind of feels like a waste of time all round really speaking...” [CP6]
“You feel that in a sense what you doing at the moment are a slight mismatch to what the community is expecting” [Researcher]

[Agrees]

“Yes” [CP8]

4.8  Management functions within the program

4.8.1  Supervision

Supervision was a serious issue of contention among the community service psychologists. It emerged that supervision is critical in many cases due to the lack of experience in regard to the community service psychologists.

“...difficult to manage supervisors” [CP1]
[CP1, responding mentions of her view of the community psychology program]

“Two supervisors....control issues incidents” [CP1] competition, hostility
[CP1, responding mentions of her supervision experience]

“You don’t have a supervisor at the beginning, its kind a like an impulse – you take everything to your boss or senior. They feel you need to run things by them a lot so it’s learning and make decisions more independently which is quite different. So I think that I have adjusted to that now in two months.” [CP2] senior psychologist acts as the supervisor

“I don’t really report to anyone, there is not really a structure so we have a medical manager sort of my boss. I’m pretty much left to do whatever I want to do” [CP3]
“I don’t mind the issue of paying for my own supervision but I felt that itself was just not structured...” [CP4] paying for supervision

“...if it means paying for them there should be that kind of structure” [CP4] paying for supervision

“I understand the path of paying for your own supervision but I feel there is no structure at all” [CP4] limited supervision options

“if facilities like that should be made available even if it is in the private sector that would be something that you think people would look into” [Researcher]
[Agreed]
“Yes” [CP4] prepared to pay for supervision from private sector practitioners

“Do you think this would affect your performance as a clinical psychologist” [Researcher]
“I am here in a public hospital. Like I said earlier the issue of supervision I felt if I just go for supervision at this stage I would be wasting time. There is nothing I would like more depending on the cases I have previously we used to have recordings of our patients then for supervision, you will be shocked. I felt that kind of growth for me was terminated which was now my responsibility to show after community service or whatever stage of my career, but I think educational wise I have not benefited...” [CP4] preference of private sector

“Kind of just going and do your work and go home and that kind of thing” [Researcher]
“I would sometimes be confronted with a problem or with a kind of patient that I would like for supervision in order to continue with that patient but would find that the psychologist is not available. Most of the time she is not there” [CP6]

“You do your job and go home and that’s it” [CP6]

“There is no communication and that kind of thing. Nothing except for your communication between you and the psychiatrist.....even in that relationship there was a power struggle in a sense where you kind of second” [CP6]

“you working with this person every single day, you refer patients to him for medical management in terms of the medication and treatment and you come up with your own psycho functional management and the patient problem and you find that this person doesn’t agree with you, then you realize, why am I here?” [CP6]

“I’m not being funny but here in Mathathene they teach me something’s that I don’t know...I treat it as a learning environment.....but for someone to say this is how we do that and do it this way then for me it just something I won’t do” [CP6]

“So there wasn’t room for your essential capacity” [Researcher]

“The psychiatrist is very bossy and domineering.....Mr know it all in a sense and you felt not supported” [CP6]
“The only difference [between internship and community service psychology program] is that...you don’t really have a supervisor and finding someone it’s not always easy to find someone. There are people in private but they don’t really want to help supervision for government employees” [CP7] difficult to find a supervisor in the public sector, private sector has capacity but is not willing to help

[CP7, responding mentions of who qualifies to offer supervision for the community service psychologist]

“Someone with appropriate experience....I would have liked maybe some of the others or maybe someone else also in Department of Health who understand the system. I’m not too fussy about supervision even someone in private would not mind supervision. But private people don’t have the time. They don’t really want to do it” [CP7]

Supervisor should have appropriate experience, department of health supervisor, private supervision [potential supervisors from the private sector are unavailable]

“I do have support, my supervisor is here, she is amazing and you kind of think one of the most daunting things in internship is you have a supervisor everyday breathing down your neck when you at work and the daunting thing about community service is that you basically on your own, fortunately we do have somebody that we get guidance” [CP8]

“So she is employed by the hospital” [Researcher]
[Agrees]
“Yes, she is, she is the senior psychologist, she’s been here quite a while” [CP8]

Availability, senior psychologist [supervisor], experience

4.8.2 Communication

The operational definition of communication used in this study was adopted from the sixth edition of the Oxford advanced learner’s dictionary. Communication can be defined as “the activity or process of expressing ideas and feelings or of giving people information” (Oxford advanced learner’s dictionary, 2006, p. 225). The responses given below dealt with this code and several themes emerged from within its parameters.

4.8.2.1. Communication between the Department of Health and the hospital administration

There is considerable evidence that substantiates a breakdown in communication between all parties concerned, including the universities, the HPCSA, hospital management, professional work colleagues such as doctors and nurses and between and among the community service psychologists themselves.

The following quote below highlight this notion:

“...management [Department of Health] should help update the administration [hospital administration]...who are the community services psychologists?...supervisors [supervisors at hospital] to manage procedure” [CP1]

4.8.2.2. Communication in lieu of employment options

Community service psychologists voice a concern that the department of health shows indifference to their general well-being by not showing concern for the psychologist’s future prospects in lieu of job placements.
The Department of Health lapses in communicating availability of opportunities within the department itself and so hinders the community service psychologists’ options in lieu of future prospects.

The following response suggests this:

“Yet, there's nothing...there is not much communication to you about what is available and they [Department of Health] could improve on that a little bit more in terms of communicating with us. I just think they're trying to discourage people who are going into private” [CP2]

4.8.2.3. Lack of communication during the application process

Participants suggest that during the waiting period intermittent updates from the department of health in an effort to keep them informed about their progress within the system would go a long way in appeasing their anxiety and hence preventing them from moving on to other job opportunities due to the lack of faith within the system.

“Our details had to be in by the end of June...so you sit for a few good months...you end up wondering, do I have a place or not and then you try or make a back-up plan” [CP2]

4.8.2.4. Communication with the Department of Health after placement

The following quote suggest that even after community service psychologists have been allocated posts, there is still minimal communication between themselves and the Department of Health. This lack of communication creates unnecessary difficulties within the system. It appears that although community service psychologists make an effort to
contact the Department of Health, it is very difficult to access assistance and secure relevant information. It is quite clear that the participant below experienced a significant level of anxiety and confusion as a result of this lapse in judgement on the side of the Department of Health.

“....there was also not a lot of communication of once you have your placement.” [CP2]

“There were a lot of rumours that you had to get a letter....everyone got a different story. If you phone the Department of Health and they say it’s not true....so lots of different things.” [CP2]

“...basically with the situation there was a lot of confusion, no information, no guidance really given, difficulty actually contacting them, which actually put a lot of stress on your internship year?” [Researcher]
[Agrees]
“Yes” [CP2]

“Also I’m taking the board exam, I’m writing on the 5th of May and I don’t really know what I’m supposed to be studying or what it entails. It’s very hard again to get in contact with people, you try to phone and you on hold for about 20 minutes, you e-mail, no one answers, so that’s another thing.” [CP2]

“I lost my first placement already and then a Department of Health worker phoned me and said we have four positions, which one you want. It was like an agreement for four months so I was quite nervous; I didn’t get my contract sort of started” [CP3]
“It is so difficult to get hold of the Health Professionals Board” [CP5]

“What about from the Department of Health, the people that allocated you in community service. Was there any support from them?” [Researcher]
“I never contacted them so I wouldn’t say they were not supportive enough. I didn’t take the initiative to contacting them and informing them about my problems” [CP6]

“There is no communication and that kind of thing.” [CP6]

4.8.2.5. Communication within the hospital

The quotes below suggest that there is a breakdown in communication within the hospital, and in particular between hospital management and the staff, between staff and patients and between staff members themselves.

The following responses below suggest this observation:

“Majority of my patients are Zulu speaking. I understand a little bit but I can’t speak it and also I do seven clinics and all the rural areas...” [CP3]

“According to that form that we select options from it was said that Mathathene does have accommodation. I wouldn’t cope in the new place having to find a flat to rent or whatever at that time when I had to start, so it’s like a communication thing as well” [CP4]

“when I called the clinical psychologist at Mathathene she asked me if I had called previously and I said yes, but it appeared to me that he had not made any arrangements or called to say that I’m coming
so it was just the formality of me informing them, and then telling everyone else” [CP4]

“I’m sensing that you feeling there is not enough communication with the hospitals or the powers [management] within the hospital” [Researcher]
[Agrees]
“Yes...” [CP4]

“So there is lack of understanding and communication between the people and the community service psychologists” [Researcher]
[Partially agrees]
“I think so...” [CP5]

“Nothing except for your communication between you and the psychiatrist...even in that relationship there was a power struggle in a sense where you kind of second” [CP6]

“our hospital communication system is not very effective even in the hospital things happen and you do not know, getting communication, maybe someone can phone you or send you an e-mail is more appropriate but sending a letter through the administration office would not be very effective” [CP7]

“Yes....especially because I’m a psychologist, community service, the other doctors they put in more effort to communicate with them in ways even if they not going to be someone doing the job properly. It is not really important giving us all the information.” [CP7] preferential treatment in terms of communication and information flow
The dominant theme which emerged was that of an ineffective communication system. Further probing clearly suggested that staff at hospitals lack information. In addition, participants suggested that it is more reliable to communicate via telephone and electronic mail.

4.8.3 Staffing
The responses that refer to this category and indicate the stance of management with regards to staffing requirements are: having a diverse skills base of health professions, the lack of staff at some hospital which leads to under service, being able and willing to accept a superior role and honour the responsibilities of being a leader. It is important in lieu of being a leader that one understand that in order to be a good leader one is sometimes required to issue orders and to be authoritative.

4.8.3.1. Diversity of staff and fields of specialisation
The responses given reveal the community service psychologists are often required to work as part of multi-disciplinary teams. Staff members from other professions might work alongside but not directly with the community service psychologists at their respective sites. In addition, community service psychologists may be required to work in environments with other professionals who are not directly or even indirectly related to their area of specialisation. While it is clear that community service officers do draw from the experience with and exposure to other specialisations, it is important to note that over-exposure can result in significant stress and anxiety.
This is suggested by the quotes below:

“Phoenix Assessment Centre is very organized, a lot of different health professionals, they have OP, physiotherapist there get a doctor and also the rehabilitation facility” [CP2]

“In KwaMashu.....Its crisis centre and rehabilitation centre, so in the site we have about 3 nurses, we have a physio and OT aid, a dietician, a speech therapist and myself...also another psychologist who is on maternity leave at the moment, but she is coming back sometime in May, I think. So it is quiet limited...” [CP2]

“Here I work with all community services. All are different issues. It would be nice to share cases” [CP3]

“...not knowing even the structure of the hospital, knowing whether there is a psychiatrist...that was the difficult part.” [CP4]

4.8.3.2. Staff and jobs shortage
The responses below reveal the concerns and reservations that community service psychologists have in regard to shortages of staff within the hospital setup as well as a lack of future prospects within the Department of Health in regard to job creation for clinical psychologist posts.

The quotes below suggest this:

“There is just not enough staff and it’s not as though you working with other colleagues. It’s a difficult one too” [CP2]

“....you know in study for so long your internship is planned out for you so you know you got a job for two years and then after that now you suddenly find a job, there is very little available and in terms of
posts that are available in government, that’s another story. There is nothing really that is available. It’s a bit daunting to think what will follow.” [CP2]

[CP3, responding mentions of internal tension at the sites]
“‘I’m like the head of my own department, it’s just me.’” [CP3]

“...with specifically to regards to community service the only suggestion will be when the department is making the post, when giving people their choices that they take into consideration when the other community service psychologists are leaving...” [CP5]

“I am the only community service psychologist” [CP5]
[CP5, responding mentions of being the only community service psychologist at the hospital]

“Well when we were told we got the posts at the hospitals and we were emailed through the hospital” [CP5]

“‘With very little jobs available you feel you too young in the profession but the other option is going out of the country’” [CP7]

4.9 Conclusion
The themes about refer to the implementation, functioning and management of the community service psychology program for clinical psychologists in the KwaZulu-Natal Province. These themes support and serve as a starting point for the reassessment of the program and fine tuning major key areas within the current program. The policy for Community Service Officers appears to require revision in order to encourage a new and improved community service psychology program.
Chapter 5
Discussion

5.1 Introduction
The aim of this study was to evaluate the functioning and management of the community service psychology program in KwaZulu-Natal province of South Africa. Open ended interviews with community psychologists currently in service, previously in service and those awaiting service were conducted and the data analysed using Grounded Theory which is a form of qualitative research.

5.2 Research method
The write-up began with an explanation of Grounded Theory, the primary technique utilized in analysing the data. Grounded theory is a ground breaking technique that adds quality as well as structure to the research process. It encourages constant comparison and the layering of data that allows for the contextualisation of the acquire data, resulting in the conversion of such data into useful and meaningful knowledge.

Grounded theory is especially helpful in areas where little research exists because it casts a wide net that brings key concepts to the forefront as a natural progressive process. Grounded theory can be described as the kind of research that encourages more research, discussion, action and enquiry into a given area given the vast amount of untainted knowledge that results from such research. In so doing, this study attempts to do just that, bring about a solid body of knowledge regarding an area of practice that little to none research has been carried out in and then to encourage discussion and appropriate action in lieu of this new knowledge.

By making new connections between old and new knowledge, this study brings to the regarding the practical functioning, management and
prospective growth opportunities that lay undiscovered within the community service psychology program.

5.3 The Emergent Theory
The new theory in this study provides a description of the functioning and management of the community service psychology programme. It highlights the difficulty of implementing and managing such a program given the number of elements that require synchronisation such as different government departments, universities and individuals. In addition, individual elements incorporate substantial diversity as the community service psychologist’s hail from different cultural, geographic and racial backgrounds hence making the management of the program to all stakeholders’ satisfaction highly unlikely.

An interesting aspect of such a scenario is the unfolding of the interaction between the world-view of the community service psychologists with that of the patient. Hence, the community service psychologist is called upon to respond to issues with the potential for conflicting values, beliefs, and opinions to become highlighted.

This new theory offers insight into the way psychologists are required, at times, to grapple with conflicts between the context of the patient and their professional responsibilities. It identifies ways that are likely to assist community psychologists work effectively and efficiently within their scope of practice while optimising contextualization of treatment to the individual patient.
5.4 Major findings

5.4.1 Program design
The design of a program begins with the establishment of the stakeholders and the part they will play in the development, initiation, implementation and monitoring of the program. The community service psychology program as a result lends itself to six individual and mutually exclusive stakeholders: that is the government legislature, the department of health, the hospital, the university, the clinical psychologist and the prospective patient. Interestingly, while all of the above have a share in the product, that is the positive effects of the practice and application of clinical psychology, only two plays an active role in providing such service that is the hospital and the clinical psychologist. It is also significant to note that the two who are responsible for providing the service have no role in the design of the program or say in the development and implementation of policy regarding the program. The key role players are hence excluded from the decision making process. Hence vital ground roots information that would cause the program to run more smoothly and develop over time is cut off due to there being no process being available in the initial design to allow such communication as well as such flexibility. As a result, the program hits problems and breaks in service provision on a regular and constant basis.

It is important to note that not only does this hurt the program objectives and bring down effectiveness but also produces disillusionment and lack of faith in the program within the very individuals who are required to implement it at ground roots level, a key deficit in the implementation and management of a successful program.

5.4.2 Qualification Criteria
While it might be difficult to phantom that educated individuals might lack understanding in their own professional pathway, the new community
service psychologists appear to hold a vague understanding of the requirements of admission into the program. It appears that the registration requirements for admission into the community service psychology program are not made clear enough to applicants. In addition, serious time lags between the submission of the final draft of the Masters dissertation and the marking of said dissertation by both internal and external examiners at the universities appear to be almost indeterminate time wise and as such leaves the completion of the degree indeterminable at worst and in the hands of a third party at best. As a result, one is left with a bottle neck within the program that results from elements outside to the program.

In trying to understand how the programme functions it is essential to understand who qualifies for the programme and which qualifications are required. According to the Practice framework for psychologists, (HPCSA, 2008, p. 8) a community psychologist must complete a programme in Clinical Psychology at NQF levels 7 to 9 (Bachelors, Honours and Masters Programs) at an accredited education and training institution. In addition, the individual concerned must complete an internship with an accredited institution and/or supervision with an accredited Clinical Psychologist.

In this study, it was clear that all participants were not well informed about the academic pre-requisites that need to be satisfied in order for an individual to begin community service. In addition, the marking of the masters’ dissertation is a major consideration and huge obstacle in the processing, and placement of clinical psychologists into community placements. Time lags marking the masters’ dissertation not only affect potential entrants into the programme but also cause areas of no-service in regard to community placement positions within the health department.
5.4.3 Management

Management is a process that includes basic management functions such as planning, organizing, staffing, directing and monitoring. Monitoring the running of a program is crucial in implementing corrective or preventive measures and in so doing producing an efficient, effective and productive program.

Communication was identified as a weak component of management within the community service psychology program. Information transfer was poor and so the environment was ripe for the development of misunderstanding, miscommunications and general inefficiency in regard to procedure and policy implementation. This scenario impacts negatively on service delivery and the general community service learning experience of the service providers that is the community service psychologist and the hospital staff.

For instance important elements that should have been discussed and resolved amicably by management include:

- Safety and security: Female community service psychologists appear to be risking their lives when dealing with unstable psychiatric patients. Community service psychologists spend considerable time alone and isolation with patients while providing psychotherapy and assessment. Security procedure and protocol needs to be discussed and implemented in order to prevent injury to community service psychologists in the line of duty. Such protective measures need to be sensitive to the integrity of psychotherapeutic environment and so not compromise the therapy process while still providing much needed protection. These avenues need to be made readily available to the community service
psychologists so as to help them provide the best unencumbered service possible.

- Transportation and accessibility: Transport to and from outlying hospital venues and clinics was sadly lacking within the structure of the community service psychology program. Availability of transportation is a significant deterrent in regard to the reach and affect of service provision in KwaZulu-Natal. It has impacted negatively on the program in that it has resulted in significant limitation in service provision in areas where such service is desperately needed.

- Consultation: The tools of psychology can be brought down to just one fundamental element, a private space to carry out the consultation. A private consult room, office, lounge or ward is important in the implementation of the psychotherapeutic process. One needs to have a private space to interact with a patient such that the patient feel safe enough to allow one into his or her private world. The space needs to be comfortable enough to sit, undisturbed and unobstructed for a period of time. It needs to be somewhat predictable, and free from annoyances such as bad smells, people walking through, extreme heat or cold and the like. While luxury is not a requirement, a basic well ventilated room with two chairs and a couple of side tables should be adequate. Given the authority, such is easily accessible within a hospital setting.
- Experiences of Community Service Psychologists

- Accommodation: Rumour has it that management plays a primary role in the allocation of hospital accommodation. However, it is clear from experiences of the community service psychologists that there is a lack of planning in the allocation process in regard to such allocations. Community service psychologists arrive at their posts assuming that they have a place to stay for the duration of their term and are shocked to learn that no arrangements were made for their arrival. It is important to note that community service placements are not often in city and built-up areas but rather mainly in rural and outlying areas where there is a shortage of readily available accommodation in lieu of hotels, motels, and bed and breakfast accommodation. As a result, community service psychologists have been known to have slept in their cars on occasion. Such a turn of events is completely unacceptable and can result in serious and significant damage to the department and the program if any harm should come to any community service psychologist who might have been forced to such an extreme.

- Orientation: The lack of clear cut procedures in lieu of orientation results in disjointed and disorganised service provision by de-motivated and isolated community service psychologists. From a psychological point of view, orientation is a key aspect of acculturation into a new environment. Sadly, within a psychological service provision scenario orientation is often left out or ignored by management as there is no legislature that distinctly stipulates that it be enforced as part of protocol.
Community psychologists within the health department work in environments that are significantly clinical. While the medical model is adequate in helping articulate clinical psychology within the medical sciences, it is important to allow clinical psychology some lee-way in lieu of the fact the clinical psychology straddles medicine and humanities as such requires some adjustment in environment and practice and procedure to function optimally. The work environment is crucial in setting the stage for any profession to flourish. It is the role of management to create a motivating working environment in order to maximise the effects of the intervention or program. Hence, more active efforts need to be made by Government, the Department of Health and the hospitals to factor in the unique and multidimensional facets of the field of clinical psychology.

In addition, management needs to take a more active role in policy development at a micro level as community service psychologists find that they are forced to make decisions independently that should have been covered by hospital policy but is undeniably absent. In lieu of this community service psychologists mention the lack of evaluation on ground roots level. The absence of evaluation at ground roots level might be traced back to the lack of communication between the different stakeholders and the disjointed and chaotic allocation of roles among the stakeholders, in particular the Department of Health, the universities and the hospitals.

5.5 Community Service Psychology program: In practice
Many of the themes that arose during this research process indicate that while community service psychologists are technically considered still in training, and criteria for registration for independent practice stipulates that clinical psychologists need to complete one full year of community service, in practice clinical psychologists placed in community service are practicing in and of their own accord. No supervision is provided, and in most
instances there are no senior psychologists available, let alone other medical staff. As such, it is interesting to note that clinical psychologists, contrary to government and board legislature are practicing in the capacity of an independent practioner while in community service.

The issue of registration was deemed to be central and very important to entry into the community psychology programme. And in lieu of the above no clear discussion or attention appears to have been given to the above mentioned scenario and raises question as to not only how well thought out the program is but also how much consideration went into the registration processes that govern the profession as a whole.

While its importance was highlighted, the issue of fees payable and qualification criteria appeared to be unclear to most of the community service psychologists interviewed. Community service psychologists are not made aware in a clear and unambiguous manner as to the fees payable. The problem is further complicated by the fact that the fees payable to the boards are independent of each other and yet still have authority over the individual applying for a position as a community service psychologist. The fees payable to the HPCSA, a full fee, is required in order to practice as a community service psychologist. It appears that this full fee is an unfair burden placed on a student who now and for the first time is reporting to work as it does not allow for independent practice and if unpaid excludes the individual from fulfilling the post of community psychologist. Fees should be adjusted to the level of progression within the field so that an individual whose scope of practice is restricted should pay less than one who is not.

The issue of motivation mainly in lieu of monetary compensation for time and work load were elicited as common. The ability to secure a job
immediately after the community service psychology programme emerged to be crucial for the officers who are currently serving. In addition, community service psychologists felt that they are not being supported with basic essentials at their different sites. Some went on to mention that after training they hope to work abroad. This suggests that the community psychology profession will be faced with an acute shortage of practitioners if management does not realise the need to provide incentives for psychologists.

It also emerged that staffing or recruitment of new community service psychologists is poorly managed and coordinated. This was suggested by the lack of continuity as highlighted by time lags between appointing a new community service psychologist and the time which the previous community service psychologist left.

Furthermore, there is a general lack of understanding in the rural communities of the role played by community service psychologists. This confirms literature by Schoeman et al. (1989) that highlighted that services offered by South Africa’s mental health services are not yet adaptive to the Africa context hence rendering them inadequate.

In addition, community psychologists are operating in isolation. Workshops or meetings where practitioners gather and exchange their experiences and ideas that facilitate more efficient delivery of service are rarely held. Unfortunately, as a result of there not being a clear document stipulating such meetings be part of the community psychology experience hospital managers and senior staff are not keen to allow the community service psychologist to frequent such meetings.
5.5.1 Deficits within the program

5.5.1.1 Allocation process

The allocation or placement process is plagued by a number of weaknesses that render it inefficient:

- Inadequate process design. The allocation process appears to be poorly put together and of inadequate design. While the theory seems adequate it is far from satisfactory in practice. Applicants are requested to choose three sites in order of preference. Applicants that have extra-ordinary circumstances are invited to attach a letter of motivation and attach proof, if any, of their unusual predicament in order for them to receive first preference in lieu of their choice of placement. Unfortunately, it falls far short in practice due to the fact that the department that receives the applications is in one province and the department that does the placements in another. Applications and all supporting documents are notoriously lost on a regular basis resulting in desperate applicants having to either be placed in rural sites that make it impossible to manage their personal predicament or having to wait a whole year to begin community service. Such a scenario costs the clinical psychologist much not only in lieu of financial losses but also in the delay in ones professional development as Clinical Psychologists are not allowed to work in their chosen field while awaiting community service.

- Poor communication between role players. It appears that the different departments do not communicate much with one another and it is not uncommon for there to be huge discrepancies in what one is told from one department to the next such that it becomes impossible to decide upon a plan of
action. Often one is promised something by one department and then finds that the other was not made aware of it and that it is now too late to do anything about it. In addition, when documents are lost the only time that an applicant becomes aware of it is when their name does not appear on the list. In general, previous enquiry would have not indicated a problem until it became too late. Hence, there is a communication problem between the departments, between the different institutions and between the departments, institutions and the applicant.

- Poor co-ordination between role players. There appears to be poor co-ordination and co-operation between the different role players, especially between the department of Health, the universities and the hospitals. There appears to be no-one individual or department that manages the program but rather a haphazard combination of individuals who in addition tend to pass on the buck from one to another due to the vague conceptualisation and lack of clarity regarding the program.

- Inadequate management of program. Management plays a key part in the success of a program. Good management in regard to the community psychology program is sadly lacking. Not only does the program not speak for the community service psychologist it also inevitably does a disservice to the community. Here we have the scarce skills, willing workers and infrastructure but no driver to maximise the output. A well oiled machine it is not, leaving the community service psychologist feeling used and
abused, the patient intermittently out of proper psychological treatment and potential of a brilliant outreach program wasted. Sadly, the only reason it seems to have survived is because of the strong motivation of the clinical psychologists who require the completion of community service in order to qualify for independent practice. It is unfortunate that such a program is not managed well enough to entice the clinical psychologists who move through it to stay and continue to service the community.

5.5.1.2 Supervision

According to the HPCSA’s (2008, p. 9), practice framework for psychologists it is the responsibility of a senior psychologist to train and supervise other registered psychological practitioners in relation to clinical psychology. Although it is clearly stated in the framework, the community service psychology programme management seem to be negligent in monitoring whether community service psychologists are receiving any supervision during their community service year. While as mentioned earlier the inadequate structure of the program does not make clear the element of supervision, the above criterion which is envisaged to be in regard to universities and the department of Health clearly indicates such. In so much as the Clinical Psychologist be placed for community service within the framework of the hospital it then becomes clear that the policy above would then become active. However, most participants indicated that senior community service psychologists are not willing to help in most cases. Seeking supervision from the private sector can become extremely costly. As a result, clinical psychologists within the community service year remain without any form or means of receiving supervision, debriefing and/or mentoring. In addition, no mechanism or structure has been developed or enforced in lieu of providing such a vital service to the
community service psychologist by any of the role players even though community service psychologists have voiced their concern over the issue repeatedly and avenues are available by law for the implementation of such a service.

5.5.1.3 Working Environment
The working environment is influenced by a number of factors and affects the quality and output of services. The main problem that emerges in regard to the community service psychologist is the lack of room within the hospital system for the needs and practices of clinical psychology. The physiotherapist has the equipment she needs, the occupational therapist the same, the dentist, the pharmacist and the medical practitioner all are surrounded by the needs and requirements that allow them to practice at their optimum. The Clinical Psychologist on the other hand is told to find a quiet enough corner to chat with the patient. No respect is given to the needs and requirement of good psychotherapeutic practice. The requirements of the Clinical Psychologist is simple enough, a private, safe, comfortable, well ventilated space with a couple of chairs, a side table and possibly a desk, a luxury would be the provision of a computer, telephone and psychometric tests. In addition, it is important that one be respectful of the therapeutic process. The right to privacy, so as to provide adequate and valid psychotherapy is important rather than having doctors and nurses popping in to pick up a file or gather their lunch.

In addition, safety is a key issue with the Clinical Psychologist, especially when dealing with significantly unstable patients. Clinical psychologists are especially at risk in that psychotherapy is generally cared out, out of necessity in private settings even within the hospital system. The psychiatric clinic is likely to be set aside form the main hospital buildings and patients
may well out number staff, with the access to security being restricted due to the great distance between the clinic and the security posts.

Due to the inefficiency of the community service psychologists program and the shortage of Clinical psychologists within the country there is a huge backlog of patients across all hospitals and clinics in KwaZulu-Natal. Backlog in the provision of Clinical Psychology services within the Department of Health and within the regional and district hospitals is significant. This is due to the shortage of Clinical Psychologists within the hospitals as well as the inefficient provision of community service psychologists via the community service psychology program. Hence, while the shortage of Clinical Psychologists within the department of health is food for debate and falls outside the scope of this write-up, in lieu of the community service psychology program more efficient and effective planning, organisation and management of the program is required in order to at the very least provide a self-sustaining and reliable source of clinical psychologists into the hospitals and clinical.

5.5.1.4 Patients

The needs and requirements of psychiatric patients are the main concern of Clinical psychologists and as such the program should be designed in a manner that addresses such concerns. There appears to be no such feedback loop that allows for the Clinical Psychologists to provide feedback and pertinent information in regard to the treatment of the target population. In addition, the needs, requirements and request of Clinical Psychologists within the hospital environment in lieu of good professional practice and ethical and valid treatment protocols go largely unheard resulting in frustration on the part of the Clinical Psychologist and ineffective treatment protocols in relation to the patient. In as far as multidisciplinary team work goes, there appears to be no significant problem. Professionals are able to
work well together and are largely able to respect each others disciplines. The problem is not with staff at the hospital level but rather with protocol and procedure and the lack of documentation stipulating regulations, job descriptions and requirements that need to be satisfied in lieu of the Clinical Psychologist as a member of staff as well as in regard to the profession of Clinical Psychology within the medical climate of a hospital. It appears that most individuals, including management within the hospitals are not completely certain as to which domain Clinical Psychology falls and as a result tend to chop and change protocol and requirements at their own discretion or as they see fit.

5.5.2 Emergence of strong points

5.5.2.1 Support for community service psychologists

Theoretically there is much support for Clinical Psychology as a whole as well as the inclusion of Clinical psychological services being inculcated into the mainstream medical management of patients among the key role players of the community service psychology program and within the community. Generally, the impression is positive and the welcome sincere as Clinical Psychologists try their hand at the provision of basic mental health interventions, psychotherapy and psycho-education. While this is the case however, there is still much ground to cover in regard to education about the role Clinical Psychology can play within the broader scope of health in the hospital setup and in the day-to-day life of the patient.

Clinical Psychology, true to the medical model at present delivers intervention in lieu of treatment, while prevention seems to be a largely overlooked avenue. Again, while there is theoretical support for such within the health sector, resources need to allocate in order to allow Clinical
Psychology to provide a more balanced model of care that is one that addresses both prevention and cure.

5.5.2.2 Provision of services

The emergent data provides clear evidence that community service psychologist regularly encounter challenging situations, within the workplace, which encroach on their ability to service the communities, as per placement by the Department of Health (DoH).

The main concern being, the disruption and irregularity of service provision within the hospitals due to the lack of permanent Clinical Psychology staff and the mismanagement of the community service psychology program. And with secondary concerns being the lack of relevant resources, the unavailability of proper facilities and the neglect in providing proper and adequate infrastructure within the program and within the hospitals.

In addition, it goes without saying that the community service psychology programme is meant to serve the community. However, no means or mechanisms exist in the structure of this program that allow for the periodic evaluation of the service provided. There appear to be no means of accessing the opinion of those who receive and benefit from the service that is the mental health patient. While understandably it is difficult to access clear and concise and reliable opinion from all of such a population, effort need to be made in designing instruments that might allow one to measure such reactions. In other words, the development of a method of evaluating the service provided and most importantly making adjustments in order to improve the service. In addition, it is imperative in the management of a program to evaluate its level of function and to ascertain if it is meeting requirements stipulated in design.
5.6 Implications of the study
This study has resulted in the generation of substantive theory that provides the community service psychology program with a new insights and an objective picture of the program as it stands in practice. In addition, it provides much needed knowledge from the perspective of clinical psychologists themselves. This study highlights the great possibilities that lie dormant and in some instances unnoticed within the program. In addition, it provides an evaluation of the program which is much needed and sadly lacking to date. As a result, the insights provided elicit critical though and highlight the implications of neglect and mismanagement in terms of psychology practice within the hospital setting. Current understandings of the programme need to be reconstructed in light of the above information and the new program needs to have evaluation built into its inherent structure not only to make it more self sustaining but also to help develop the program and provide the best service possible.

In order to formulate a coherent and fuller understanding of the needs of the people, to develop a framework that acknowledges issues relating to social identity and mental health and to incorporate the social context of the patients into the structure of the program an instrument needs to be developed to measure such constructs.

In addition, policy makers, the Department of Health and service providers have a responsibility to manage the program at an adequate level and to increase the understanding within the community of mental health as an important aspect of overall personal health, and with the inclusion of the benefits that clinical psychology bring to them as members of that community.
5.7 Limitations of the study

It is expected that research have identifiable limitations irrespective of the design of the study. It might be said that only a limited number of studies have the advantage of time and resources which allow sufficient depth and breadth of investigation so that limitations are minimised significantly enough to produce negligible effect or excluded entirely.

This study is no exception and as a result it is important to acknowledge these shortfalls when considering the findings. The sample size of eight participants could be viewed by some as a limitation of the study. However, it was adequate to satisfy data and category saturation, which in grounded theory studies is the more important determinant of appropriateness of sample size, rather than participant numbers *per se*. Generalization to the broader community service psychology was not the aim of the study, but rather generation of a substantive theory from the data.

The current findings are based on eight participants’ perspectives and the researcher’s interpretations of this. The results are one possible representation of the data and could therefore be said to be bound to the context and conditions of the study.

Lengthy quotations have been presented to provide the reader with the opportunity to make their own interpretations as well as to add to their understanding of the emergent data and the subsequent conclusions drawn by the researcher. It could be argued that respondent validation might be enhanced by this method of representation of the data.

5.8 Conclusion

This research proposes a substantial theory on the KwaZulu-Natal’s community service psychology programme. As such, it is an adequate and
reliable starting point for further inquiry. While there are limitations to this work, there are also great opportunities for extended inquiry and scholarly activity.

This study has from various perspectives suggested that the community service psychology programme although being a good initiative lacks good management. The most important implication of this study is that it has contributed to making the invisible dynamics and undocumented protocols within the management functions of the programme overt.

The issues raised in this study are open to discussion among the key role players and stakeholders of the program and are now explicit enough to be easily addressed within the institutions and subsequently resolved.

Investigating elements within each management function, the verification and refinement of the theoretical categories and the investigation of how re-categorization and ethical expression contribute to effectiveness would be important research initiatives. Given that the theory emerged from the study data and involved interpretations that are conceptual and broad it should be possible to claim applicability in contexts similar to those of the participants under study. Furthermore this study would contribute towards the level of understanding in initiatives with a similar community focus programs and might assist in helping address and expand upon the question of management within other similar settings.
References:


Kwa-Zulu Natal Health Department. (2010). Policy Community Service Officers. Durban, South Africa


## Appendix One:

### Axial Coding.

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>SUB-CATEGORY</th>
</tr>
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<tbody>
<tr>
<td>COMMUNITY</td>
<td>FAMILIARITY WITH COMMUNITY, LANGUAGE, BELIEFS, CHALLENGES, ENGAGEMENT, SUPPORT, MOBILIZATION, NEEDS OF PEOPLE, LANGUAGE IN RURAL COMMUNITIES</td>
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<tr>
<td>EDUCATIONAL</td>
<td>TYPE OF QUALIFICATION, INSTITUTION, CHALLENGES, GRADUATION, CODE OF</td>
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<td>BACKGROUND OF</td>
<td>COMMUNITY</td>
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<tr>
<td>SERVICE OFFICER</td>
<td>QUALIFICATION, ADMINISTRATION/EXAMS OFFICE, TRANSPARENCY, ACADEMIC INSTITUTION, LEARNING OTHER LANGUAGES</td>
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<td>APPLICATION</td>
<td>HPCS DETERMINES ELIGIBILITY, REQUIREMENTS, CHOICE, FIRST CHOICE, FEAR TO APPEAL, UNCLEAR, HELP, ARROGANT DEPARTMENT OF HEALTH OFFICERS, EMPLOYMENT CONTRACTS, MISSING APPLICATIONS, COMMUNICATION WITH APPLICANTS, APPLIED TWICE, EXTENSION OF APPLICATION DEADLINE, PROCESSING IN PRETORIA, CHALLENGES, PREPARATION, SETBACKS, LANGUAGE, LIMITED PARTICIPATION IN SELECTION, SECURED FIRST CHOICE, GOVERNMENT</td>
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DOES, AWARENESS OF OPTIONS

[SUPPORTIVE] SITE/PLACE, CRISIS AND WORKING REHABILITATION CENTRE, STAFF, ENVIRONMENT LIMITATIONS, SKILLS MISMATCH, GOVERNMENT INSTITUTION, AGE GROUP OF STAFF, PATIENTS, GENDER, SECURITY, SAFETY, EMERGENCY RESPONSE, PRIVACY, SERVICE PROVISION, REFERRALS, ISOLATION, TREATMENT INTERRUPTION, LACK OF ICT INFRASTRUCTURE, LOGISTICS CHALLENGES, TEAMS, DIVERSITY, DRIVER, GOOD ENVIRONMENT, NO GROUP OF COMMUNITY SERVICE PSYCHOLOGISTS RESOURCE OFFICE, INFORMATION AND ENDOWMENT COMMUNICATION INFRASTRUCTURE (ICTs), OWNERSHIP, TRANSPORT, DEPARTMENTS/WARDS, FINANCES SUPPORT FOR INTERACTION, WORK EXPERIENCE, ICTs, COMMUNITY TRANSLATOR, SENIOR PSYCHOLOGIST SERVICE OFFICERS ASSISTED IN ALLOCATION OF ACCOMMODATION MANAGEMENT POOL OF STAFF, SPECIALISATION, [ACTIVITIES] LIMITED ACCESSIBILITY OF SUPPORT, MEETINGS, HEAD OF DEPARTMENT, INTERNAL PROBLEMS, TASKS GROWTH FUTURE PLANS, WORK EXPERIENCE, GOVERNMENT/PRIVATE SECTOR,
DOCTORATE STUDIES, SALARY/INCOME, POSTS, LIMITED SCOPE OF DUTIES, CHALLENGING CASES IN PRIVATE PRACTICE, STAGNATION IN PUBLIC SECTOR, LIMITED CAREER DEVELOPMENT

STABILITY

SALARY/INCOME, RISK, JOBS/POSTS, START UP FUNDING

PRIVATE PRACTICE

SET UP SUPPORT, START UP

SET UP

REQUIREMENTS, CHALLENGES, INFORMATION,

MANAGEMENT

SUPPORT AFTER PLACEMENT,

AFTER PLACEMENT

REPORTING [MEASURING AND REPORTING PERFORMANCE], GUIDANCE, DEPARTMENT OF HEALTH LETTER, CONFUSION, NO INFORMATION, NO GUIDANCE, NO COMMUNICATION, NO MANAGEMENT STRUCTURE, LACK OF SOLID COORDINATION BETWEEN DEPARTMENT OF HEALTH AND HOSPITALS, RESPONSIBILITY OF PLACEMENT REST ON INTERN

INTERNSHIP VS COMMUNITY SERVICE

UNDERSTANDING OF WORK ENVIRONMENT,

CONTACTS/NETWORKING, REFERRALS, DIAGNOSIS, WORK LOAD, RELATIONSHIP BUILDING, NO SUPERVISION, DUTIES, DECISION MAKING, SUPPORT, EVALUATION OF SUPPORT, DOUBT,
<p>| COMMUNITY                        | INEXPERIENCE, CHILDREN CASES, GOOD SUPPORT SYSTEM, INTERVIEW, |
| PSYCHOLOGY                      | ENJOYING PROGRAM, DECISION MAKING, ISOLATION, SELF-EVALUATION, STAFF SHORTAGE, |
| PROGRAM                         | CHALLENGING WORK ENVIRONMENT, RURAL SITES, PRACTICAL APPLICATION OF THEORY, PATIENTS FAMILIARITY WITH THERAPY, EDUCATION LEVEL OF PATIENTS, CLIENT LEVEL OF FUNCTIONING, RELATIONSHIP BUILDING WITH PATIENTS, FRUSTRATION, DEFAULTERS, SATELITE SITES, EXPANSION OF CLIENTEL BASE, PERSONAL ATTITUDE, POOR PLANNING, CONTINUITY, NOT LEARNING, OUTREACHES, VALUE ADDITION/BENEFITS, OVER STAFFED, BACKLOGS, |
| PATIENT PROBLEMS                | SOCIAL, SOCIO-ECONOMIC, DEPRESSION, CONTINUITY WITH TREATMENT PROGRAM, LANGUAGE BARRIER WITH PATIENTS, SOCIAL GRANTS, LOW FUNCTIONING PATIENTS, |
| HEALTH                          | REGISTRATION AND PAYMENT, |
| PROFESSIONS                     | UNCLEAR REGISTRATION PROCESS, |
| COUNCIL OF SOUTH AFRICA [HPCSA] | CONFUSION WITH REGISTRATION, |
|                                 | EXPENSIVE REGISTRATION FEE, NO GUIDANCE FOR BOARD EXAMS, |</p>
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<th>Category</th>
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<td>insurance, lack of confidence in Department of Health officials,</td>
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<td>Dissertation marking delay, legal action, completion of dissertation</td>
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<td>and HPCSA registration, second application</td>
</tr>
<tr>
<td>Accommodation</td>
<td>Misinformation, long distance to workplace, time, commuting, guest</td>
</tr>
<tr>
<td></td>
<td>house, cost/expensive, self funding, application, rent vs commuting</td>
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<td></td>
<td>daily, no accommodation, formal arrangements, accommodation as a</td>
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<td></td>
<td>necessity, hosting medical institution, lack of accountability,</td>
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<td></td>
<td>renting, accommodation forms, many people handling accommodation,</td>
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<td></td>
<td>responsibility, HPCSA and hosting hospital carry the blame,</td>
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<td></td>
<td>convenience, distance to work</td>
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<tr>
<td>Choice</td>
<td>Secured first choice, Department of Health made the choice,</td>
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<td></td>
<td>justification of choice/hospital</td>
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<tr>
<td>AGE</td>
<td>VARIATION OF AGE GROUPS, FEW OLD COMMUNITY SERVANTS</td>
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<tr>
<td>SUPERVISION</td>
<td>SUPERVISION AS A PREREQUISITE TO CONTINUE TREATMENT, SENIOR PSYCHOLOGIST, PAYING FOR SUPERVISION, LIMITED SUPERVISION OPTIONS, PREPARED TO PAY FOR SUPERVISION, GROWTH, AVAILABILITY, POWER STRUGGLE WITH SUPERVISOR, UPSETTING, TENSION WITH PSYCHIATRIST</td>
</tr>
<tr>
<td>ISOLATION</td>
<td>HANDLING ISOLATION, SUPPORT SYSTEM, EFFECT OF ISOLATION ON PERFORMANCE, NEGLIGENCE, CONSIDERATION OF PRIVATE PRACTICE, NETWORKING,</td>
</tr>
<tr>
<td>COMMUNICATION</td>
<td>ICTs, INTERNET, PERSONAL ELECTRONIC MAIL, LACK OF INITIATIVE</td>
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<tr>
<td>ORIENTATION</td>
<td>WHERE YOU GOING YOU KNOW, WHAT IS WHERE, WHERE ARE YOU SUPPOSED TO BE STAYING, ORIENTATION/SUPPORT</td>
</tr>
<tr>
<td>STRUCTURING OF THE PROGRAM</td>
<td>EVALUATION SYSTEM, GROWTH, CONTINUATION, PAYING OF SUPERVISION, CONTACT THROUGH THE HOSPITAL, MEETINGS, PEER GROUP SUPERVISION, EVALUATION,</td>
</tr>
<tr>
<td>MEETINGS</td>
<td>BENEFITS DERIVED, DID NOT ENJOY MEETINGS, ATTENDENCE, FREQUENCY, PARTIALLY BENEFICIAL, LACK OF</td>
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INTEREST IN MEETINGS,
COMMUNICATION AT MEETINGS,
BONDING AT COMMUNITY SERVICE
MEETINGS, DOES NOT ENJOY MEETINGS,
SOURCE OF PEER SUPPORT, HOSPITALS
AND COMMUNITY SERVANTS
EVALUATION MEETINGS, AGENDA OF
MEETINGS, PROVISION OF AGENDA,
RELAXED ENVIRONMENT FOR
MEETINGS, UNSTRUCTURED MEETINGS
Appendix Two:
Data Transcription and Interpretation.

N.B: Abbreviation key
- Community Service Psychologist (CP)
- Researcher (I)

<table>
<thead>
<tr>
<th>Data Transcript (CP1)</th>
<th>Interpretation</th>
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<tbody>
<tr>
<td>[CP1, responding mentions of the number of patients she treats] CP1 “too much”</td>
<td>PRESSURE IN THE WORK ENVIRONMENT</td>
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<tr>
<td>[CP1, responding mentions of her view of support in terms of transport to visit sites] CP1 “work out well...daily transport from some of the clinics”</td>
<td>SUPPORTIVE WORKING ENVIRONMENT</td>
</tr>
<tr>
<td>[CP1, responding mentions of her view of the community psychology program] CP1 “gaps in procedure....difficult to manage supervisors”</td>
<td>MANAGEMENT</td>
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<tr>
<td>[CP1, responding mentions of her experience in the district she served] CP1 “isolation....no help...differs from one province to next”</td>
<td>SUPERVISION</td>
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<tr>
<td>[CP1, responding mentions of her supervision experience] CP1 “2 supervisors....control issues...incidents”</td>
<td>ISOLATION</td>
</tr>
<tr>
<td>[CP1, responding mentions of the challenges she faced with community psychology program] CP1 “No compensation for time and costs in relation to demands....no compensation compensates...time”</td>
<td>COMPETITION</td>
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<td></td>
<td>MOTIVATION</td>
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<td></td>
<td>NO ACCOMMODATION</td>
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Experiences of Community Service Psychologists

for travel...far away from home...no accommodation...pressure from peers” [CP1, responding mentions of support system and staffing at hospitals] CP1 “too much to cope with...the nurses and doctors and management not willing to educate...Gaps in service due to the dissertation and provincial placements. Want a team effort in practice....psychiatric block” I “why not PhD” [CP1, responding mentions of academic or institutional issues related to furthering studies and also community service] CP1 “supervisors [supervisor from academic institutions] need to prepare students well....new [new practice] ...dissertation now before internship....not used to having a full time community service (training)...management should help update the administration...Who are the community services psychologists?....supervisors [supervisors at hospital] to manage procedure.
**Data Transcript (CP2)**

CP2 “just starting kind of from the beginning my Masters last year 2008, through UKZN. Howard College and my internship last year and I was based in, based at King Edward Hospital also based at King Moshene and then three of the department of head will meet someday”

**Interpretation**

- **MASTERS UNIVERSITY OF KWAZULU-NATAL, HOWARD COLLEGE**
- **INTERNERSHIP**
- **KING EDWARD HOSPITAL**

CP2 “In terms of the process of applying, you know it’s just something that happened to me is that I applied for, I had five options you know you have the five districts that you have to apply for and my first choice I put down Mahatma Gandhi Hospital on the list. It was on the list Mahatma Gandhi Memorial Hospital in KwaMashu so in my mind you know I had a vision I would be placed in Mahatma Gandhi and I was placed there, but when they came to me it was at the Mahatma College Community Health centre. So it

- **PLACEMENT/APPLICATION**
- **CHOICE**
- **DID NOT SECURE FIRST CHOICE**
- **MAHATMA COLLEGE**
- **COMMUNITY HEALTH CENTRE**
- **FEAR TO APPEAL**
wasn’t part of what I was expecting and it was made clear on interns in the application process but obviously I was, you know, I didn’t want to turn it down and not get another place”

CP2 “I started in KwaMashu at the beginning of February while I had to wait because my dissertation was still being marked and the marks was only coming in January. There was a delay with internal markers, so I started on 1st of February”

CP2 “at the moment I’m actually working in three different sites. I’m mainly at KwaMashu where I’m based but only there three days a week and I’m at Mahatma Gandhi one day a week and the Phoenix Assessment Centre one day a week”

CP2 “In KwaMashu we work out of a one of those container buildings. Its crisis centre and rehabilitation centre, so in the site we have about 3 nurses, we have a physio and OT aid, a dietician, a speech therapist and myself....also
another psychologist who is on maternity leave at the moment, but she is coming back sometime in May, I think. So it is quiet limited although we do have our own office which is basically just for myself”

CP2 “in terms of the resources out there you know there is no air conditioning so it’s extremely hot and uncomfortable.....In terms of other resources I don’t have a telephone line or anything like that. It’s just a communal line. You know we have our own filing cabinet, just one, I don’t have my own computer, it is a communal computer as well....I know that in government it’s like that across the board.

CP2 “the other people we all quiet young so we all at the same age so it is quiet enjoyable working with them......if you want to refer it is very easy”

CP2 “there is no psychiatric service there at all. So I have had one patient that was a bit problematic and referred the
Experiences of Community Service Psychologists

Patient.....Pothy My Know Psychiatric Clinic which is nearby but there is nothing on site and there’s no doctor in the centre where I am so this patient came in for an appointment and was quiet unstable, not totally psychotic but very unstable and he seemed a bit problematic. I referred him out...for treatment but he keeps coming back and it’s quiet unsettling for myself and the rest of the staff because if he does you know bring violence or if something happens there is no one there to sedate him, there’s no one there to restrain him although there is one, the sister in charge is a female, I mean a male nurse but that’s the only man in the centre. So that has been a little bit of a worry but only really on that one occasion although in a community health centre itself we had a few incidents were other nurses or others counsellors have been attacked by patients”

CP2 “...they [staff members] always advise me if I’m seeing a
patient, especially if it’s a male patient that I shouldn’t shut my door so they can see what’s going on but also I don’t have a phone in my office so I can’t call for help, so you know and obviously there are implications. The treatments you going to give the patients because no patient is going to come and talk to you with the door wide open and then also my office has the toilets....someone will just barge in and come and use the bathroom, and you also get the doctors from other departments coming in and using the bathroom”

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<tr>
<th>Patient</th>
<th>SAFETY</th>
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<tr>
<td>Privacy</td>
<td>EMERGENCY RESPONSE</td>
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<td>Disturbances</td>
<td>PRIVACY</td>
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<td></td>
<td>DISTURBANCES</td>
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<td><strong>MAHATMA GANDHI</strong></td>
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So that’s KwaMashu really and then in terms of the other sites that I’m at, at Mahatma Gandhi I’m one of only two psychologists so I’m there only one day a week. The other psychologist does a seasonal one day a week so I’m there only one day a week. It’s severely under service. There is a huge waiting list and lots of patients because it is a huge
hospital with a huge patient load and we trying to work a way through the waiting list, but its hard doing that because we try to book patients and there’s more referrals coming in and so also from there you work from a crisis centre where they do all the forensics cases. So whenever there is a sexual assault then they come through there. So the other psychologists most of the assessments for forensic purposes and I’m doing more of the general counselling and assessments and that sort of thing.

CP2 “It is a bit better there, they have a big crisis centre where most of the staff are and so we are, it is just small, and two doctors and the psychologist and we share an office...but there is no permanent post there or anything at the moment or apparently that might be changing for next year. So that’s a bit better in terms of resources and things like that. So it’s not as frustrating but its quiet isolating for one out there. There
is quite a big psychology unit there but you try to track them down and you can’t track them down. It’s a big – there’s not a lot of interaction between psychology and psychiatrists at all. I find that in some hospitals where they have a dedicated psychiatrist it is a lot easier in Dundee, they don’t really have a psych ward so its, there’s not much interaction”

CP2 “in Phoenix Assessment and Therapy Centre I’m there one day a week, there is one other permanent psychologist most of the time so that’s also incredibly busy. I see a lot of children.....it’s given me a wide range of cases and a lot experience with a lot of different patients with different disorders. Phoenix Assessment Centre is very organized, a lot of different health professionals, they have OP, physiotherapist there get a doctor and also the rehabilitation facility”

CP2 “a lot of children get sent to assessment centre, a lot of ADHD

PHOENIX ASSESSMENT AND THERAPY CENTRE
FREQUENCY
PATIENTS
WORK EXPERIENCE
MANAGEMENT/ORGANISATION
POOL OF STAFF
ASSESSEMENT CENTRE
patients, and that’s probably the best site in terms of resources in terms of the actual site itself.

CP2 “So all in all it’s going well, obviously there are frustrations working in government, I think at the beginning of the year to a certain extent, I didn’t want community service until next year. I would see myself in maybe private practice in the future but I have to get some experience in the meantime and possibly before because I do like to do a PhD or something as well before I do that to work in government and I’m quite optimistic about it. I know there are issues, the pay and the occupation with what we supposed to be getting and we fill out forms and all sort of things but it doesn’t really, there is never any confirmation”

CP2 “There is a lot of instability. Things just change; human resources could come and tell you no one can take leave in May as well as during the world cup. Its minor things but its just
frustrating and just make you wonder whether it’s worth the issues. There’s pro and cons to each, working in government you have your set salary so it’s bit more stable in that regard – if you working in private you have to work for a certain time before you get that going plus you get to have some sort of capital – something to start up with so it’s quiet a daunting thing for me to for so long, you know in study for so long your internship is planned out for you so you know you got a job for two years and then after that now you suddenly find a job, there is very little available and in terms of posts that are available in government, that’s another story. There is nothing really that is available. It’s a bit daunting to think what will follow.
I “What needs to be done? So, there’s no baggage with that maybe that is something that needs to be looked at. [agrees] CP2 “Yes. I mean I know from colleagues who did counselling
Experiences of Community Service Psychologists

psychology; they got quite a bit of guidance in terms of building your own private practice. There was a lot of things that was made available to them and I get the feeling that with clinical they don’t, they want you to come back in government – they don’t give you the choices. Yet, there’s nothing, your options there is not much communication to you about what is available and they could improve on that a little bit more in terms of communicating with us. I just think they’re trying to discourage people while going into private”

[CP2, responding mentions of her view of the community service application process] CP2 “The process was also quite unclear. We got the forms to fill out but we had to – we were not very sure with what we needed, trying to contact people was another problem. It is very unpleasant and when you do speak to them they make it as if you are putting them out – you should know
what’s happening and also it took them a very long time to place us. We only get our posts officially at the end of October, beginning of November last year. Our details had to be in by the end of June – so you sit for a few good months wondering and then give us a schedule as to expect when things and they didn’t stick to it at all – you end up wondering, do I have a place or not and then you try or make a back-up plan. I know, for me, I was lucky that I was placed in the first round, I know of a few people that weren’t or whose applications went missing or somehow. So that was and then there had to be a second round – they get random places from there – it was okay – there was also not a lot of communication of once you have your placement.

I “what exactly are you supposed to do” [CP2, responding mentions of the role of the applicant] CP2 “They just say you have been placed here – here is the number – you need to report at this stage

7 MONTHS BEFORE OFFICIAL ENDORSEMENT
CURIOSITY
LUCK
MISSING APPLICATIONS
SELECTION ROUNDS
COMMUNICATION
SUPPORT AFTER PLACEMENT
REPORTING
and of course if you like me and can’t report, you have to delay it, then they won’t be helpful in terms of what do I do? There were a lot of rumours that you had to get a letter – you know everyone got a different story. If you phone the Department of Health and they say it’s not true – so lots of different things” I “basically with the situation there was a lot of confusion, no information, no guidance really given, difficulty actually contacting them, which actually put a lot of stress on your internship year” [agrees] CP2 “Yes” I “in terms of adjusting from internship to community service it is a big jump” CP2 “You got to learn its quiet different from the beginning to adjust – just everyday things on how things are run on sites and who are your contacts, who are your referrals, you know your chain of referrals – that sort of thing. It can be quiet stressful because when you
working at a place for a certain amount of time you see a patient and you feel this is what is wrong with him, the diagnosis, then you know automatically what the treatment plan should be. So you kind of have to build that off from scratch – also I work at three different places, I find that a bit in the beginning.

You don’t have a supervisor at the beginning, it’s kind a like an impulse – you take everything to your boss or senior. They feel you need to run things by them a lot so it’s learning and make decisions more independently which is quite different. So I think that I have adjusted to that now in two months. The support is there, but it’s difficult to judge – they feel I’m not coping, not that you are not coping but that you are uncertain, that you don’t know what you doing. During your internship everything should click, for me, there was never a major click. For me it was more
of a gradual process. I think everyone has moments of doubts, am I really cut out to do this and we don’t have that experience, especially when the cases are quite complicated because especially with children cases a lot of the time – the symptomology is quite complex. There are numerous different diagnoses that you could treat and then you start feeling pretty sure of what you doing. Part of the learning” I “a lot of the decisions have to be made on the spot” [agrees] CP2 “exactly. In KwaMashu and Mahatma Gandhi and even at Phoenix Assessment Centre, I’m basically working myself most of the time. You do just end up making those decisions. You check afterwards and say this is what I did, is this okay - it’s not so much that the support is not there, it’s hard to say how we could change it. There is just not enough staff and it’s not as though you working with other
Experiences of Community Service Psychologists

It’s a difficult one too.”

I “do you find that there’s a big gap between your training and what you doing” [agrees] CP2

“there is a very big gap especially for me working in rural sites like KwaMashu and Umlazi and with that specific population as well. You know you get taught all the theory and methods of therapy but a lot of the patients that I see are not very highly educated. They don’t have a high level of insight. They are psychology minded. A lot of the patients have never heard of a psychologist, they don’t know what we do? To try and do psycho dynamic theory with them and get very symbolic. It goes way over their heads. So I find that I try and do more structured, therapeutic, it depends on the clients level of functioning and also what the problem. There are a lot of social problems because if you take a patient who is having a problem with their family, there’s a lot of stress, a lot
of tension resulting in depression. You can’t sale the stress; you can only help the patient.

The patient is not always willing to engage. Depression and anxiety plays a role in the interaction with their families so they don’t really want to change. I get the impression that they resisting, so it’s also quite frustrating a lot of times. There are a lot of defaulters, a lot of patients don’t return or they will come and not come and they won’t come back.

Treatment is very interrupted. It doesn’t flow smoothly plus there’s the usual problems of accessing treatment like transport, paying, all of those things which the patients aren’t able to afford and if you a patient once a month, it’s very difficult to continue with therapy. Working at the sites one day at a week is very hard to keep it continuous. So in other words in these satellite sites it’s really
hard to optimize treatment. People are becoming more moved in psychology. You are providing a service which is desperately needed but on the other side of the part, it is not as effective for the other social, it’s different. I “do you find that your work is affected in any way by the lack of technology, with the training that we psychologists do there is a lot of computer work” [agrees] CP2 “Yes, for e.g. if you want to discuss your case with a senior psychiatrist at another clinic and if they not available except maybe one day a week. It’s not an easy process. It makes it like it’s not worth doing it, especially in terms of telephone use and computer use because I’m sharing a computer with all these other people. It is a problem, if I had to try and write a report or something I can’t guarantee that the computer is not going to be read, I motivated for a computer but I’ve been told “No” [administration failed to support].
There are no resources for any of those sorts of things. There are a lot more things I could do even basic assessments, things like the MCSI – I would like to maybe access, if I did do that I would have to borrow a book from somewhere else, use it, take it back, so you do sometimes think is it worth it, is it going to change the treatment plan or not”

CP2 “Also just in terms of the HPCSA that is a whole other issue with registering and paying. A lot of people, health professionals have the same sort of problem with it. It’s not very clear what registration process you have to do, what information you need and also it’s a lot of money to pay the fees and to pay the registration. Also I’m taking the board exam, I’m writing on the 5th of May and I don’t really know what I’m supposed to be studying or what it entails. It’s very hard again to get in contact with people, you try to phone and you on hold for about 20 minutes,

LOGISTICS CHALLENGES

HEALTH PROFESSIONS COUNCIL OF SOUTH AFRICA [HPCSA]
REGISTRATION AND PAYMENT PROBLEMS
UNCLEAR REGISTRATION PROCESS
EXPENSIVE
NO GUIDANCE FOR BOARD EXAM
INEFFECTIVE COMMUNICATION
you e-mail, no one answers, so that’s another thing. It’s all this minor things that kinds of adds up.

And in terms of other institutions like PsySSA, again, I find that PSySSA itself set out to give us information and say you know come on and join, you know it’s all these things that you hear about.

Another is professional insurance. Everyone talks about it but there’s no real direction...u have no clue what is you need to be doing and how. How you should be covered and when you should be covered? So there’s a lot of things that are minor but they do exist there.

You kind of have to worry about when you think you kind of finished with those things, something else pops up and you have to deal with. So those are our frustrations. Any worry for me at the moment is getting my Masters Degree. I’m supposed to
be graduating in 2 weeks and I’m not sure I’m going to get the correct degree. They keep telling me that my Masters will be marked as Social Science psychology and not Clinical Psychology and trying to communicate with people from the post graduates office, School of Psychology and try to ask them what is happening, no one seems to know and no one actually seems to care or do anything” I “are you the only one who’s having this problem” [CP2, responding mentions of uncertainty surrounding graduation] CP2 “I don’t know because half the people haven’t even received their graduations” [CP2, fails to give reasons for short-comings in graduation process] CP2 “I have no idea. No one is able to explain to me, I don’t know where it went wrong” I “I see your certificate has Clinical Psychology” [agrees] CP2 “Yes, because as far as they can tell me in university it’s all
under one code. There is no specific clinical, counselling, and educational?

[CP2, responding mentions of where she obtained her qualification] I “is it Durban campus] [agrees] CP2 “Yes, but UKZN”
Data Transcript (CP3)  
CP3 “I did my internship between the district between R.K. Khan and King George in Chatsworth, rather in Durban. I started my community service this February this year and I’ll finish in February next year”  

[CP3, responding mentions of her account of community service application procedure] CP3 “I completed my Thesis. They [supervisors] took seven months to mark it so I lost my first community service job which was at Correctional Services in Westville, which was last year in July and I had to re-apply and I don’t actually have to apply, they offered me four positions because I live in Howick which is the closest for me. So it fell into my hands, luckily.  

[CP3, responding mentions of where she secured accommodation] CP3 “No, I am. I live in Howick but I stay in Greytown. I stay in the week and I drive on the weekends” I “how many hours of commuting is that” [CP3, estimates the distance] 

Interpretation  
CHATSWORTH  
FEBRUARY 2010  
12 MONTHS COMMUNITY SERVICE  
APPLICATION PROCEDURE  
SEVEN MONTHS MARKING  
INCONVINIEINCE  
APPLIED TWICE  
HOWICK  
EASILY SECURED POST  
ACCOMMODATION  
GREYTOWN  
LONG DISTANCE TO WORK PLACE  
TRAVELLING
CP3 “between an hour and half in the morning and an hour and half in the evening”

I "You travel everyday” CP3: No – I don’t, I used to and now I live in a guest house in Greytown”

I “In regard to accommodation, you said a guest house now that must be a bit expensive. How are you coping” [CP3, responding mentions of her view] CP3 “I’m doing it out of my own pocket, but its fine” [CP3, responding mentions of her account of hospital accommodation arrangements] CP3 “there wasn’t provisions made because I didn’t ask for provisions. When they offered the job to me I assumed I shouldn’t have but I should have clarified but when I started driving the first month, it took a toll. I leave at four, get home at six….paying for accommodation is easier than driving that far”

I “did you know that you had to re-apply once you were unable to make it to the first placement” CP3 “Yes they [Department of Health] told me. They would give me a
month’s extension which extended into August and then obviously my thesis is still not marked. I then took it up with Duncan Attorneys and that was sorted out very quickly then but then I lost my first placement already and then Kershini from Health phoned me and said we have four positions, which one you want. It was like an agreement for four months so I was quiet nervous; I didn’t get my contract sort of started” I “so things were up in the air you weren’t sure what sort of arrangement you were to be making” [agrees] CP3 “yes and then obviously to apply once the thesis is marked, final comment was given etc, from the HPCSA to get my community service certificate because you can’t start without that. I went to Pretoria to do that.

I “so there was a lot of hiccups, a lot of things were not prepared for, a lot of setbacks and that kind of thing that might have been explained to you before you started
with the procedure or process that you would be more prepared for it” 
[agrees] CP3 “absolutely” 
I “then regarding to choices, was Correctional Services your first 
choice the first time round” [agrees] CP3 “Yes, I applied at Correctional 
Services and Military and I think R.K.Khan, it was actually” 
I “second time round you had options that were too far out and you chose the one that was nearest” CP3 “they [Department of Health] offered me Stanger, Durban. 
[CP3, responding mentions of her view of the community service program after 4 months] CP3 “I love it. It’s absolutely amazing” 
I “that’s good, that makes it a lot easier” [CP3, highlights the fact that attitude shapes the perception about community service] CP3 “No, I have forgotten about the hiccups, since then it has been wonderful” 
CP3 “I don’t really report to anyone, there is not really a structure so we have a medical manager sort of my boss. I’m
pretty much left to do whatever I want to do. I haven’t really had, language is a bit of an issue, obviously. Majority of my patients are Zulu speaking. I understand a little bit but I can’t speak it and also I do seven clinics and all the rural areas”

I “In regard to language do you think there is any accommodation made by the department [Department of Health] to manage that better” [agrees] CP3 “Yes, I think people look at us in terms of why you not positioned yet because of the language. We should be professional, I’m Afrikaans speaking. I don’t have anything to do at all. The hospital with placements, you need to sort it out. We should be able to speak it. I think that because in some places you don’t need it.....had I known and had I time on my hands, I would have because I would have helped myself a lot more”

I “don’t you find the Zulu spoken in those [rural areas] areas are much higher spoken in the cities? [CP3,
responding mentions of her encounters pertaining to the language issue] CP3 “I don’t really know language. I read a lot from people’s faces so I haven’t been able to have an interview. I always have some people to help us”

I: Okay – you have any actual problems or anything that you feel might be improved on with regard to the community service program itself? [The Department of Health allocation of community service psychologists to different hospitals]

CP3 “there are very few resources here but I haven’t really needed to have certain things like fill IQ tests or anything. We refer them to Child and Family Assessment Centre in Maritzburg. At this hospital I’m only able to screen”

I “but there haven’t been politics” [CP3, responding mentions of internal tension at the sites] CP3 “I’m part of a rehabilitation team but I’m very much on my own. I’m like the head of my own department, it’s just me. I sit in meetings when it comes to finance
and costs.
I “is there anything you feel might be improved on in the system at present, anything you feel could be added or corrected or taken away, any ideas that pop into mind at the moment” CP3 “I think what would be nice if all community servants could meet at some point in the year because I have no contact with other community servants really” CP3 “Here I work with all community services. All are different issues. It would be nice to share cases” I “so that would be community service psychologists” [CP3, responding mentions of professionals that she wants to network with] [agrees] CP3 “Yes.....it’s quite isolating here [rural communities]” I “are you coping with that [isolation] at the moment” CP3 “Fine. Look I’m a lot older, I’m 39. I’ve worked before I started studying when I was 31 so I really have come a long way. It’s isolating in terms of when we speak
to other psychologists.

I “with relation to internet facilities and all that, do you have access to that kind of thing” [agrees] CP3 “we have internet, just internal. This hospital doesn’t have any money, there is no money”

I “so on the internet do you have any mail of your own” CP3 “Yes I have one but it’s still on the other psychologist name. I have one that comes to me”
Data Transcription

(CP4)

CP4 [CP4 currently in service] “I did my internship in 2008 at Midlands Complex. I’m now doing community service at Madadeni Hospital.”

Interpretation

{before doing community service CP4 went for an internship}

LACK OF FAMILIARITY WITH COMMUNITY

LACK OF CHOICE

LACK OF INFORMATION

LACK OF INFORMATION
straight about one per district so it ended up just naming because they didn’t know where else to put you, not knowing even the structure of the hospital, knowing whether there is a psychiatrist, where I’m going or whatever that is there, that was the difficult part”

I “You felt a bit blind in making that choice” CP4 [agrees] “Yes” CP4 “problems I think I would say there were internally, most of them, because when I got here my community service started last year in June, it was on a Monday, so I arrived here on a Sunday, so I arranged with another friend of mine to a sleepover but on the first it seemed that no one had made arrangements, which is why I’m saying it was an internal problem. I didn’t have a place to stay; it specified on the form that I would get accommodation, the first night I slept in my office” I [surprised] “wow” [CP4, responding mentions of lack of formal arrangements]
CP4 “I think if my seniors were not around I didn’t know what I would have done. Starting in the middle of the year everyone else is already placed, to other interns, medical interns and whatever. So it seems as if no one knew I was coming”

CP4 “not knowing where you going to sleep that night was probably quiet a frightening experience” [CP4, responding mentions of turning down the offer to do community service]

[CP4, responding to arrangements such as accommodation indicates]

CP4 “is the co-coordinator for placing or whatever, I’m not really sure what his role is, that’s the one you would call when having complains with research or whatever, according to my application” [CP4 adds on, making arrangements with department of Health authorities]

“I just don’t see the relevance having called him and stuff like that, how it benefited me, I don’t know, I think it was just the
formality of informing someone that where I’m going to be starting and whatever month. I don’t remember having benefited from all those arrangements where I think I had to report to someone”

CP4 “when I called the clinical psychologist at Mathathene she asked me if I had called previously and I said yes, but it appeared to me that he had not made any arrangements or called to say that I’m coming so it was just the formality of me informing them, and then telling everyone else”

I [CP4 commenting on the responsibility of placement state that] CP4 “I felt that way too, but then the psychologist told me before like in March when I phoned him for the first time that I am starting in April he told me the sensors or co-coordinators or something sent for the placements for community service. He needs to know who is starting where, so I am not sure whether it had

LACK OF SOLID COORDINATION BETWEEN DEPARTMENT OF HEALTH AND HOSPITALS

RESPONSIBILITY OF PLACEMENT RESTS ON INTERN
something in connection to salary or whatever, I really do not know. I just know that I had to phone him before I start, really I do not know”

CP4 “I am just glad for me it’s over, but I wish something to that could be done, I mean, it is like when you supposed to start at a new place, probably, some arrangement have to be made, some arrangement for going to that place, whatever. So I believe that is not something you can do yourself for someone who’s not been working there to say. I want to come on this day to see the hospital and whatever but I think that should be kind of prior arrangement for the people who are co-coordinating the whole thing so that you know where you going you know, what is where, where are you supposed to be staying and all those kind of things. So on the 1st of June when I was supposed to come here, well although I had no patients booked on that day but I had to do my
orientation and I was supposed to start from 8am to 4pm, so already I was, it was as if I started working again. I never had a break to sleep and I ended up sleeping in my office. It was kind of poor planning if I may say that”

CP4 “In felt that way too, but I didn’t know who to blame if I had…….There was a lady who was responsible for us and whatever. She just told me straight she doesn’t know anything about me, the forms about accommodation and whatever, those are the forms that go to the same guy Peter Chain so the people at the hospital except the senior psychologist, no one else knew who I was, what I came there for, what I needed all those kind of things” I “so you had submitted forms for accommodation to the coordinator” [agrees] “yes” CP4 “because when you applying just like the university, for example.: will you be needing accommodation or not, so it goes in the same form. So when they
say you have been accepted or whatever, clarification need to be given to you if you will have accommodation and whatever......and that was another reason why I considered this placement according to the placement, they show if the particular hospital have accommodation for you or not. According to that form that we select options from it was said that Mathathene does have accommodation. I wouldn’t cope in the new place having to find a flat to rent or whatever at that time when I had to start, so it like a communication thing as well”

CP4 “that’s one good thing that we get our own offices” [CP4, responding mentions of having a personal office at the hospital]

CP4 “I was given accommodation on the second day because she was there and followed it up and whatever and even reported to the medical management” [CP4, responding mentions of getting assistance from senior

ACCOMMODATION FORMS
INFLUENCE OF
ACCOMMODATION ON FIRST CHOICE
RENTING
ALLOCATED OWN OFFICE
SENIOR PSYCHOLOGIST
ASSISTED IN ALLOCATION OF ACCOMMODATION
MEDICAL MANAGEMENT
Experiences of Community Service Psychologists

psychologist] I “you were quite lucky to have a senior psychologist there to help you out” CP4 [agrees] “yes”

CP4 “I think she was aware of the difficulties but because I had made these arrangements I told her that I am not coming because of the accommodation whatever, so, she had been talking to them prior, the people who was organizing the accommodation so I’m not sure if they took her seriously or whatever because when I came I was very surprised with the lady who was organizing accommodation but then I am sure that she had communicated with them because when I spoke to her in May, I already had my accommodation and those kind of things or if I needed to come then and there and this place or something prior to the welcome then accommodation would be given to me, they had spoken to someone in the accommodation offices. When I think of the other problem which is an internal thing {having a senior or someone you know at the hospital or institution which you are placed go a long way to ease the pressure of settling down}
as well. So many people handling accommodation so it is every bodies responsibility and then nobody is responsible in the end because everyone keep lying and whatever so as the result I feel now that I’m already doing community service, we are waiting for another guy who is going to do community service at any stage now because of the problem with dissertation, so I take it is my responsibility to try and make sure that when he arrives he already have a room because I do not want the same thing that happened to me to happen to him”

CP4 “the good thing is support, she is very supportive” [CP4, makes a comparison between her internship and the community service program] CP4 “most of the patients who come here, mostly of the patients that I have seen from last year, they just come for grant or its not much of any issue where I feel like I am going, I was when I was doing

RESPONSIBILITY

GOOD SUPPORT SYSTEM

{memo by CP – the senior psychologist is quite helpful in all areas with regards to the community service}
The same like to me now that the problem for internship was structured in as much as it was catering patients, it was catering for my growth too. So now I feel as if I’m not learning and I planned for myself that when I started community service that I would go for supervision, myself, but now I feel if I go for supervision, I’m wasting my money” I [CP4, responding mentions of loopholes in community service program] CP4 “the cases that I see here are the grant cases and all those kind of things. So that on its own to some degree it has to do with us and comprehensive and all those kind of things to say this is what a psychologist is doing, whatever we have done a couple of things like outings and campaigns, whatever but I feel that, the problem itself for community services just listening, you just sort yourself out which is not like we instructed to okay, here is someone from and this is what
is expected of you. These are the things, you know, I don’t mind the issue of paying for my own supervision but I felt that itself was just not structured, I am sorry to say that”

I “there is a lot of things that are lacking, that you not quite happy with in a sense” [agrees] “yes and so that’s one area that’s getting fulfilled but not others.

I “Do you feel like you getting any benefit at all from the community service placements at the moment” CP4 “at the moment.....No and I think to some extent I am also accountable for it because the issue of the outreaches and going to the clinics....there has been a problem here.....In Mathathene there are no drivers hired by the hospital. I have not had a license, it was a limitation for me to go and visit the clinic which I felt I’d be much more help there than I would here. I think I would like to go to the clinics and that kind of thing so that I think on my part probably I
Experiences of Community Service Psychologists

not having a license had also a impact on me going to more outreaches and that kind of stuff so I feel I end up sitting in the office and waiting for the assessment all those kind of things”

I “do you feel like you getting any benefit at all from the community service placements at the moment” [disagrees] CP4 “no and I think to some extent I am also accountable for it because the issue of the outreaches and going to the clinics whatever, there has been a problem here at Mathathene unlike Pietermaritzburg, in PMB the hospitals have drivers to take you wherever you went to the clinic and whatever. In Mathathene there are no drivers hired by the hospital. I have not had a license, it was a limitation for me to go and visit the clinic which I felt I’d be much more help there than I would here. I think I would like to go to the clinics and that kind of thing so that I think on my part

NO DRIVER, TRANSPORT PROBLEMS, LACK PARTICIPATION IN OUTREACHES

{memo by CP – Mathathene lacks drivers as compared to Pietermaritzburg where you afford many trips}
probably I not having a license
had also an impact on me going to
more outreaches”
I “I’m sensing that you feeling
there is not enough
communication with the hospitals
or the powers within the hospital”
[agrees] CP4 “Yes, but even if it
is for a short while I feel as if I
will be guilty to some extent you
know, when you have an idea this
is what I like to do. I love going
out to the clinics, love going to
the places where there is less
resources because here in
Mathathene we have two of us so
the sources is still okay. But I feel
sometime it is wasted to deliver
because of the lack of resources
which is why I think mostly of my
difficulties or off my complaints
because of the internal structures
because I do not think the
problem that is here at
Mathathene, they have it in
Newcastle Provincial. I’m not
sure if they have driers or
whatever so for me that is another
issue which is kind off”

LACK OF COMMUNICATION,

ENJOYS OUTREACHES [memo by
CP – servicing poorly resourced areas
is her main concern]

OVER STAFFED

WEAK INTERNAL STRUCTURES

AT HOSPITAL
CP4 “is a bit more stable in that sense that there are people who would refer to assist in the hospital”

STABILITY

CP4 “the major problem for me is the structuring of the program”

STRUCTURING OF THE PROGRAM

[CP4, concludes that her internship was way better] CP4 “there should be some kind of structure kind of thing to show this is the program, this is what is expected, this is the support you get, these are educational...if it means paying for them there should be that kind of structure.

EVALUATION SYSTEM

At this stage, at every stage we should keep on learning of growing. At this stage you feel as if the end and not much is going on”

PAYING FOR SUPERVISION

CP4 “I understand the path of paying for your own supervision but I feel there is no structure at all”

GROWTH

I “if facilities like that should be made available even if it is in the private sector that would be something that you think people would look into” [agreed] CP4

SUPERVISION

LIMITED SUPERVISION OPTIONS

PREPARED TO PAY FOR SUPERVISION
“yes” [CP4, mention of lack isolation] “in Pietermaritzburg the community servants there, they would make their own teachings like maybe go to Greys Hospital and on a Friday morning there would be an election or something. But that was only something they organized for themselves not because of the problem itself. So, when you out there like here in Mathathene, the nearest community service well for now is at Mathathene Provincial, from there, there is no one around me so yeah it’s a bit of a challenge”

I “you find it a bit isolating as well” [agrees] CP4 “yes I do”

I “do you think this would affect your performance as a clinical psychologist” CP4 “to some degree I think it would if I let it because now I’m at a placement where I would be learning so much in the private practice that I am here in a public hospital. Like I said earlier the issue of supervision I felt if I just go for
supervision at this stage I would be wasting time. There is nothing I would like more depending on the cases I have previously we used to have recordings of our patients then for supervision, you will be shocked. I felt that kind of growth for me was terminated which was now my responsibility to show after community service or whatever stage of my career, but I think educational wise I have not benefited at all. Well I do go for journal class, they presentation that are made for us by the hospital in Pietermaritzburg but it is all inclusive of other things. It is not a program made for me as a junior which caters for my needs” I “in that sense you have been neglected in the system” [CP4, confirms the claims of negligence and isolation] [agrees] “Yes I felt that way; I really do which is why I say if I have to go to a private practice to some extent maybe I feel I need much more. I found interesting cases; I found cases that would challenge me. Even

<table>
<thead>
<tr>
<th>CONTRIBUTION OF SUPERVISION TO GROWTH</th>
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<tr>
<td>VALUE ADDITION/BENEFITS MEETINGS</td>
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<tr>
<td>BENEFITS DERIVED</td>
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<td>ISOLATION/NEGLIGENCE</td>
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<td>CONSIDERATION OF PRIVATE PRACTICE</td>
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<td>CHALLENGING CASES IN PRIVATE PRACTICE</td>
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<td>LOW FUNCTIONING PATIENTS</td>
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here there is not much we can do. In this hospital the best thing we can do is the patients are so low functioning and you sit with a patient, maybe read a magazine or whatever, there is not much you can do here unlike when you can engage with high functioning patients because that was my other area of interest doing groups. A lot of things have been put on hold in terms of my profession at this stage”

I “so in other words it wasn’t a step forward, it was just degenerated a little because you only focusing in one area for the entire year” [agrees] CP4 “yes”

{memo by CP = community psychology program does not help in career development}

STAGNATION IN PUBLIC SECTOR

LIMITED CAREER DEVELOPMENT
### Data Transcript (CP5)

<table>
<thead>
<tr>
<th>CP5 [CP5, currently in service] “I did my Bachelors, Honours and Masters there, and then did my internship in Pietermaritzburg as well”</th>
<th><strong>Interpretation</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>FAMILIARITY WITH COMMUNITY</strong></td>
<td></td>
</tr>
<tr>
<td>{before doing community service CP5 went for an internship}</td>
<td><strong>ENJOYS PROGRAM</strong></td>
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<table>
<thead>
<tr>
<th>CP5 “I am really enjoying it”</th>
<th><strong>DIFFICULTIES PERSIST</strong></th>
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<tbody>
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<td><strong>HPCSA</strong></td>
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<tr>
<th>I “did you have any problems with the procedures, the applications, pro community service, any hiccups, and any problems” [agrees] CP5 “I did have, I still have difficulties with the Health Profession because it was a bit ambiguous when I registered about whether our thesis had to be completed and stuff or whether just handing it in was sufficient”</th>
<th><strong>COMPLETION OF DISSERTATION/LACK OF INFORMATION</strong></th>
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<tr>
<td></td>
<td><strong>INEFFECTIVE COMMUNICATION CHANNELS</strong></td>
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</table>

<table>
<thead>
<tr>
<th>CP5 “It is so difficult to get hold of the Health Professionals Board” I “so there is.....lack of understanding and communication between the people and the community service psychologists” CP5 [partially agrees] “I think so.....and also I think there is a bit of confusion with payment and stuff because if you paid just the amount stipulated in the form you far</th>
<th><strong>CONFUSION WITH REGISTRATION</strong></th>
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<tbody>
<tr>
<td></td>
<td><strong>LACK OF INFORMATION</strong></td>
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</table>
short of actually what you supposed to pay”
CP5 “the Department of Health here in KZN”
[CP5, responding mentions of confusion in HPCSA]
I “so the HPCSA is giving you trouble” [agrees] CP5 “yes....they did mess up things this year”
CP5 “no, they were fine” [CP5, mentions of the hospital stuff connected with placement arrangements]
[CP5, responding to application process in terms of first choice mentions] “there was nothing, I got my first choice”
I “you were oriented” [agrees] CP5 “yes”
I “so you are not experiencing any problems” [agrees] CP5 “yes”
[CP5, responding highlights solutions to shortcoming of program] CP5 “with specifically to regards to community service the only suggestion will be when the department is making the post, when
Experiences of Community Service Psychologists

Giving people their choices that they take into consideration when the other community service psychologists are leaving. I only just started in April and the community service psychologists that was here in the hospital was leaving in January.”

CP5 “it does leave a potential for backlog. I think the management here is quiet good”

I “how is the environment setup for the community service psychology in your post” [expresses satisfaction]

CP5 “best as it could be”

CP5 “I only know the immediate staff that I’m working with, I’m not sure if there is any other support group”

[CP5, responding mentions of a support system at the hospital]

CP5 “I am the only community service psychologist” [CP5, responding mentions of being the only community service psychologist at the hospital]

[CP5, responding mentions of contact with former interns] CP5 “Just my other interns who I worked with last year”

CP5 “I do not know any other

PLANNING/CONTINUITY

BACKLOGS

GOOD HOSPITAL

MANAGEMENT

GOOD ENVIRONMENT

[CP5 acknowledges that there is room for improvement]

SUPPORT SYSTEM

NO GROUP OF COMMUNITY SERVICE PSYCHOLOGISTS

NETWORKING

INFORMATION
community service psychologist at the same time I wanted to find out whatever I could about the hospital and staff"

CP5 “well when we were told we got the posts at the hospitals and we were emailed through the hospital”

I “no other information has been made available to you in regards to what facilities are made available in particular to community service psychologist only whether you have meetings or peer group supervision or anything else, what kind of options you may have available during this year, anything like that that has been made or available” [agrees] CP5 “no formal instruction”

I “kind of just going and do your work and go home and that kind of thing” [agrees] CP5 “yes”
<table>
<thead>
<tr>
<th>Data Transcript (CP6)</th>
<th>Interpretation</th>
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</thead>
<tbody>
<tr>
<td>CP6 [CP6 currently in service] “in 2008 I went and did my internship in Elizabeth</td>
<td>COMMUNITY</td>
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<tr>
<td>Duncan Psychiatry Hospital up in Kloof. In 2009 I was placed in CJ Crooks Hospital</td>
<td>SERVICE/PLACEMENT</td>
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<tr>
<td>in Scottsburg in the South Coast of KwaZulu-Natal. That is where I did my community</td>
<td>KWAZULU-NATAL</td>
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<td>service”</td>
<td>PROVINCE</td>
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<tr>
<td>I “were there any problems that you experienced before you went into community</td>
<td>CJ CROOKS HOSPITAL</td>
</tr>
<tr>
<td>service” [agrees] CP6 “yes” [CP6, responding mentions of promises for</td>
<td>{before doing community service</td>
</tr>
<tr>
<td>accommodation] CP6 “I did not experience any problems except for the fact that they</td>
<td>CP6 went for an internship}</td>
</tr>
<tr>
<td>tried to provide me with accommodation but when I got there, there was nothing”</td>
<td>PLACEMENT CHALLENGES</td>
</tr>
<tr>
<td>[CP6, responding mentions of accommodation] “it was the hospital”</td>
<td>SMOOTH APPLICATION</td>
</tr>
<tr>
<td>I “so there were problems with the hospital and accommodation but no problems</td>
<td>PROCESS</td>
</tr>
<tr>
<td>with community service”</td>
<td>NO ACCOMMODATION</td>
</tr>
<tr>
<td>CP6 [disagrees] “No”</td>
<td>MISINFORMATION</td>
</tr>
<tr>
<td>CP6 “actually yes, because my choice was CJ Crooks, second was Port Shepstone</td>
<td>HPCSA AND HOSTING</td>
</tr>
<tr>
<td>Hospital, so yes I did” [CP6, agrees that she secured her first choice]</td>
<td>HOSPITAL CARRY THE</td>
</tr>
<tr>
<td></td>
<td>BLAME</td>
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<td></td>
<td>SECURED FIRST CHOICE</td>
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</table>
I “With your experiences with community service there was not any problems at all [agrees] CP6 “there were some problems, obviously” [CP6, responding mentions of forms of support] CP6 “I was coming from a very supportive environment from my internship and my belief was that I would also get that kind of support from community service because there was a resident psychologist at CJ Crooks Hospital. But to my surprise, there was nothing. No support, nothing....I would sometimes be confronted with a problem or with a kind of patient that I would like for supervision in order to continue with that patient but would find that the psychologist is not available. Most of the time she is not there” [CP6, responding mentions of orientation] CP6 “when I initially came there she did that” I “other than that there was no support” [disagrees] CP6 “no” I “what about from the Department of Health, the people that allocated you in community service. Was there any
support from them” [CP6, responding mentions of communication with HPCSA] CP6 “I never contacted them so I wouldn’t say they were not supportive enough. I didn’t take the initiative to contacting them and informing them about my problems”

I “did you actually attend any community service kind of meetings” [agrees] CP6 “Yes….first week, first Friday of each month... I didn’t enjoy it to the fullest because I was not going to benefit like quite a bit but it turned out okay. The bulk of the students were from UKZN so they were old and vibrant or I don’t know how to call it, but we studied here and the 2% started from whatever you call it. It was beneficial in a way. I wouldn’t force myself to go there because I was hoping to find the support that I actually needed”

CP6 “there was no bonding” [CP6, responding mentions of her view of the community service meetings] CP6 “we would feel as outsiders or something”

CP6 “Yes….in a way, but when you
thought of going there it’s like oh my
God!” [CP6, responding mentions of
how thinking of attending community
service meetings is challenging]
I “so you dreaded going to these
meetings” [agrees] CP6 “I did”
I “so that was the only kinds of peer
support that might have been available
to you at the time” [agrees] CP6 “yes”
[CP6, responding mentions of ways to
improve the community service
program] CP6 “I think the hospital
could have arranged something where
the community service together with
the psychologists or whoever to all to
put it that way to meet and discuss
issues around the community service.
With issues that upset the people, the
patients of the community that we
render our services to but I don’t know
maybe it will happen eventually, I don’t
know. We are alone, you do this
community service, there is nothing
more than that”
CP6 “you do your job and go home and
that’s it”
CP6 “Group discussions......okay.......if
so and so have to come up with a talk
after the next meeting in either reading

ATTENDING

DOES NOT ENJOY MEETINGS

SOURCE OF PEER SUPPORT [I
memo – community service was
the only form of peer support]

HOSPITALS AND
COMMUNITY SERVANTS
EVALUATION MEETINGS

COMMUNITY
ISOLATION

NO
EVALUATION/SUPERVISION
GROUP DISCUSSIONS
PROVISION OF AGENDA
material or in notes. Everybody would get there for a consult. Everyone knows what going to take place. Someone can crack a joke and people can just laugh and at the end of the day, it is the purpose of being there in psychologist in training.....you just get there you don’t know what is going to happen. Someone is going to come up with something creative or something of a learning nature, you don’t know, you not even comfortable with the topic that is being discussed....now is the time to go to the reading and make use of what is available to you. There is such group discussions well in advance......it would have made a huge difference”

I “so you find that it was much unstructured and very casual in the sense” [agrees] CP6 “yes” [CP6, mentions of tense meetings]

I “so in another sense it added to the isolation” [agrees] CP6 “yes”

CP6 “I did it in Port Elizabeth, Elizabeth Doncan Psychiatric Hospital” [CP6, highlights where she did her internship]

CP6 “there is no communication and
that kind of thing. Nothing except for your communication between you and the psychiatrist.....okay, even in that relationship there was a power struggle in a sense where you kind of second” I “so the whole experience sounds very uncomfortable” [agrees] CP6 “it is kind of upsetting” I “is there anything you feel could be done after community service” [CP6, responding mentions of how she viewed community service] CP6 “you working with this person every single day, you refer patients to him for medical management in terms of the medication and treatment and you come up with your own psycho functional management and the patient problem and you find that this person doesn’t agree with you, then you realize why am I here.....it kind of feels like a waste of time all round really speaking.....it almost like it stops you. I’m not being funny but here in Mathathene they teach me something’s that I don’t know....I treat it as a learning environment.....but for someone to say this is how we do that and do it this way then for me it just something I
won’t do”

I “So there wasn’t room for your essential capacity” CP6 “the psychiatrist is very bossy and domineering.....Mr know it all in a sense and you felt not supported”
Data Transcript (CP7)

CP7 [CP7 currently in service] “I’m currently doing community service in Port Shepstone Hospital. My internship was first six months in King George Hospital in Durban. My last six months was in R.K. Khan also in Durban, Chatsworth”

CP7 “No that really went smooth. With the application what I found really frustrating was the completion of my thesis. Okay. You need to tell them when you going to start and the university process you have to tell them when to start, so that for me was frustrating”

I “did you have any problems with the procedures, the applications, pro community service, any hiccups, and any problems” CP7 [agrees] “I did have, I still have difficulties with the Health Profession because it was a bit ambiguous when I registered about whether our thesis had to be completed and stuff or whether just handing it in was sufficient”

CP7 “not allowed to start before I couldn’t register with the HPCSA

Interpretation

FAMILIARITY WITH COMMUNITY

COMMUNITY SERVICE {before doing community service CP7 went for an internship}

SMOOTH APPLICATION

MARKING OF DISSERTATION

FRUSTRATING

DIFFICULTIES PERSIST

LACK OF INFORMATION

HPCSA REGISTRATION
before my thesis was finished and they didn’t allow me to start working before registration. It took some time, so that was the only major hiccup”

I “community service itself, how was the experience” [CP7, makes comparison] “It was not much different from what I experienced especially during my time in R.K. Khan in my internship. The only difference is that you work – you don’t really have a supervisor and finding someone it’s not always easy to find someone. There are people in private but they don’t really want to help supervision for government employees”

CP5 “the Department of Health here in KZN”

[CP5, responding mentions of confusion in HPCSA]

CP7 “I found community service very isolating. I actually tried to see if other community services got a meeting once a month, or something, but there was nothing this year. Yes I felt a bit isolated in your work”

I “the year that you were there, this last year, there haven’t been any community service meetings, peer
groups and that kind of thing”
[disagrees] CP7 “No”

[CP7, responding mentions access to information at the hospital] “our hospital communication system is not very effective even in the hospital things happen and you do not know, getting communication, maybe someone can phone you or send you an e-mail is more appropriate but sending a letter through the admin office would not be very effective”

[CP7, responding mentions her views of how being a community service psychologist affect access to information at the hospital] CP7 “Yes! In Port Shepstone there are a lot of community service people, doctors and so it is not really we are under......... in the rest of the hospital. You kind of feel like an outsider but it was not really a big problem. I did not really enjoy community service that much”

I “so you find no continuity” [agrees] “Yes”

I “Do you find that it was because of actual administrative things or was there, there wasn’t a fit between your clinical training and internship and
what they expect you to do in community service” [disagrees] CP7

“No – that was not it. What they expected me to do was, it was nothing different from what I did in my internship. Okay. No expectations that were inappropriate or whatever. It was more admin thing”

[CP7, responding mentions of running of the community service psychology program, proceedings and information follow] CP7 “Yes – especially because I’m a psychologist, community service, the other doctors they put in more effort to communicate with them in ways even if they not going to be someone doing the job properly. It is not really important giving us all the information. CP7 “it makes you feel not really part of the whole system”

[CP7, responding mentions of who qualifies to offer supervision for the community service psychologist] CP7 “someone with appropriate experience – okay I would have liked maybe some of the others or maybe someone else also in department of health who understand the system. I’m not too
fussy about supervision even someone in private would not mind supervision. But private people don’t have the time. They don’t really want to do it”

CP7 “I feel it would have been nice to kind of have a continuation overflow from internship department of medicine, maybe from that would have been nice to just kind of continue kind of in the process.....maybe department of behavioural medicine would be the perfect place for something like that and I think also then they can be more organized” [CP7, responding mentions of the best institution with ability to organise community service]

I “so you actually looking for someone who can manage and keep it moving” [agrees]

CP7 “Yes! I think that is the problem” [CP7, responding mentions of things about the community psychology service program which need improvements] “All the psychologists in the area started to get together once a month so that, and also if I had a meeting going on I do try to do it then. Maritzburg usually happens once a year you know, mental health, things like
that I attended and you get to speak to others and hear what others have to say”

CP7 “With the general clerk I went once a month, there was no interfering with that, the other things I attended was mainly not during working hours on Saturdays” [CP7, gives her view about attendance of meetings]

I “so you had to take time out of your schedule, your personal schedule in order to go for these things, and they were possibly more related to work than personal life” [agrees] CP7 “Yes”

I “not the supervision the support that you actually managed to get during community service basically on a therapeutic level in relation to journal articles kind of thing – nothing actually on the level of administration you actually having to discuss issues with community service, that kind of thing” [agrees] CP7 “nothing”

I “so that still led to it being kind a temporary individual. Did you feel having the title of a temporary individual move you into this peer group” [disagrees] CP7 “No! Not really”
CP7 “they kind of understood that I might not be there all the time when other psychologists entered the group and exited again. So it wasn’t a problem”

CP7 “it is a small group, it is not a very big group and yes it allowed for me at the community service to grow from that”

[CP7, responding mentions of her relationship and differences with other members doing their community service] CP7 “main thing is specifically in the setting that I am in Port Shepstone I’m a bit older than the average community service person. I am a lot older than the average. Most of them stay in these communal flats, so they form their own groups. I did not join into that group so I found myself a bit different from the rest of the community service group but I think that it was more of a personal thing for me, my age, and where I am in life”

[agrees] CP7 “Yes”

CP7 “in the age group with the other community service most of them are young and early twenties. So you find that with psychology you going to find
a lot older people actually coming into community service”

I “in your group of community service psychologists in the group or in the class would you have found quite a few individuals that were old” [agrees] CP7 “Yes”

I “so then you would find a lot of people your age than the younger ones would actually be going into community service” [agrees] CP7 “Yes”

I “that would be quite different from the doctors, physiotherapists and OT’s, pharmacist as well” [CP7, responding mentions of her experience in terms of age groups] CP7 “I do not want to generalize but that was my experience”

I “you would find allot of people with age difference in psychology than you would find in doctors or medicine” [agrees] CP7 “Yes! they are normally the younger age group”

CP7 “with very little jobs available – you feel you too young in the profession but the other option is going out of the country – you know – that transition from community service now to the next step, it is a bit daunting at
this stage for me”

CP7 “it is because we working in isolation for a year I feel like I’m out of resources on what is going on out there”
Data Transcript (CP8)
CP8 “yes I am... I did my Masters at Medunsa in 2006. I went on to do my internship in 2007 at Warnville Hospital in Pretoria and now I am currently doing my community service at Stanger Hospital”

CP8 “I chose the internship so that is the placement I wanted, you go for the interview process and you know they choose you, you choose the hospital where you want to go to, however the community service aspect the government places you. I would much rather prefer a place close to home but unfortunately Stanger is what I got. No regrets currently......excellent!

CP8 “I am from KZN, my parents are living in Hillcrest”
CP8 “I was lucky in that I found a place just after three weeks. I was staying with my sister initially. We commuted from Durban to Stanger everyday and then I found a place in Mkwanazi which is a place 15 minutes away from Stanger and it has been very convenient. I love where I stay”

Interpretation
MEDUNSA
INTERNSHIP AT
WARNVILLE HOSPITAL
PRETORIA
COMMUNITY SERVICE
AT STANGER
INTERVIEW
GOVERNMENT
 PLACEMENT/LIMITED
CHOICE
COMMUNITY SERVICE
CLOSE TO HOME
SATISFIED
COMMUNITY
KWAZULU-NATAL
RENTING/OWN
ACCOMODATION
DISTANCE TO WORK
CONVENIENCE
CP8, responding mentions of the duration of community service at the time of the interview] CP8 “it’s now my fifth month.....at Stanger Hospital. I’m based here everyday from 8am until 4pm”

CP8, responding mentions of problems she faced with community service] CP8 “Just the usual, not getting along with the psychiatrist....nothing to do with community service per se. [supports her statement] CP8 “No” [CP8 gives a brief comparison] CP8 “I have no complaints...I will be honest with you.......its proven to be a very, very rich experience.......I thought it would be somewhat the same thing as having to do the internship but you know it had its own thing and its proven that Stanger also a different experience that you can’t compare to anything else”

CP8 “I did in that when I received the form for application there is a little section in the bottom that says; write down your reasons why you want to be placed closer to home. My son lives with my parents at the moment. I would have preferred a placement in Pietermaritzburg or Natal Rhodes however I
was not made aware that I actually had to write a written motivation so unfortunately I lost out”

I “so that been one quiet a big disappointment” CP8 “it was frustrating but I did try, I went to the department of health, I tried speaking to them and by that time unfortunately everybody had been placed and it was too late....but I’m dealing with it, the reason why I went to study in Pretoria is basically one in the same thing and I wanted a position where I could be with them”

CP8 “it’s not even resigned, I think if they are talking about January then you can say I’m resigned to be here but there has been allot of acceptance that has come with it and as I say because its proven to be such a rich experience I’m not complaining”

[CP8, responding mentions of suggestion to community service procedure] CP8 “I think it would be important to stipulate and make it very clear for some reason you know you don’t have much choice with a place where there is a need in your community. I think they should make it clearer in terms of stipulating that I understand you know about people that are married and like to be
together and single parents...show preference as well. As far as I’m aware single parents do get first preference?... may be a mistake on my part”

CP8 “we are such a small little group because we are coming from a system where you have to do your thesis or you actually can do your community service so you find here in Stanger.....you leave in August and we don’t know who is taking her place. We do have meetings where we meet once a month but it has been a while, there is four of us currently because people are having problems marking the thesis, getting their results and actually being placed so for that is the saddest part is we not actually a group where you feel that you can reach out to other psychologists in community service for you and you support each other....I do have support, my supervisor is here, she is amazing and you kind of think one of the most daunting things in internship is you have a supervisor everyday breathing down your neck when you at work and the daunting thing about community service is that you basically on your own, fortunately we do have somebody that we get guidance”

I “so she is employed by the hospital” [agrees] CP8 “Yes, she is, she is the senior

DEPENDENCE

CHOICE

CONTINUITY

MEETINGS/FREQUENCY

SIZE OF GROUP

DISSERTATION

ISOLATION

SUPERVISION

SUPPORT

FREQUENCY OF

SUPERVISION

ISOLATION/FREEDOM

AVAILABILITY

SENIOR PSYCHOLOGIST
psychologist, she’s been here quite a while” EXPERIENCE
CP8 “if you’re placed in disadvantaged COMMUNITY
communities, you find that people are SOCIO-ECONOMIC
coming in with all sorts of problems mainly PROBLEMS
social-economic based problems and you CULTURE
struggle allot even in your own, the Black COMMUNICATION
psychologists who is in touch with your LANGUAGES
cultures and the languages you find you RACE
stuck or you cannot communicate in order to LANGUAGES
what it is that you want to assist them..... I do PURPOSE OF THERAPY
struggle with the language and I struggle communicating with therapy especially with
with the understanding and I wonder whether the African community..... They don’t know
you know if you White or Coloured or Indian who we are and what we do? Why we
our own community thing with the people placed here? So I found that a big shock for
that come in so you know I found that one of me is half of the session I spent trying to
my biggest things I’m struggling to explain therapy..... so basically my thing for
communicate with therapy especially with this year is to try and find out how I can find
the language that will communicate what it is that I do.... they don’t understand what we
this year is to try and find out how I can find, they don’t understand maybe
the language that will communicate what it is communicating with that is aiding you is half
the battle won because they do feel that why should I talk to people that I think the biggest
struggle for me is making it relevant for the community in trying to assist”
I “you feel that in a sense what you doing at the moment is a slight mismatch to what the community is expecting” [agrees] CP8 “Yes”
CP8 “I’m a one off skills people that do work. I think it would be great if they placed Zulu speaking psychologists in that area or Xhosa’s in that area....that is probably causing to some extent you know what we trying to do or separate different cultures or whatever but there is a struggle because you dealing with people.....they need to communicate clear for you to hear it”
CP8 “I’m not sure if people know what clinical psychology is, I’m not sure and I think if people are made more aware of it could be marketed more effectively, these posters could come up sort of explaining you know in lament terms what we do then I think that people would access the service more quicker”

CP8 “yes it is.....however why I say its such a rich experience that I’m finding with the military you have a specific epidemic that you deal with like alcoholism, depression to deal with specific pathology, here its all different kinds of things, you have to be on
your toes everyday, you never know what is
going to walk into your office also at times
you really want to go back to your books to
figure out how you can help somebody so
that’s why I say its fulfilling in that way, its
very challenging and you wage your way
through in trying to improve the system as
you can however by the time you try to
figure it out your time is pretty much
limited”
Appendix Three:

Figure 4.1 Core Category: Community Service Psychology Program