

EXPLORATION OF MENTAL HEALTH
PSYCHOSOCIAL REHABILITATION BELIEFS,
GOALS AND PRACTICES OF REGISTERED
NURSES WORKING IN PRIMARY HEALTH CARE
CLINICS WITHIN THE ETHEKWINI DISTRICT. A
PILOT STUDY

**A research project submitted to the College of Health Sciences
School of Nursing and Public Health
University of KwaZulu-Natal**

In partial fulfilment of requirements for the Course work Master of Nursing
Degree (Mental Health Nursing)

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DECLARATION

I, Ashley Christopher Govender, declare that this dissertation entitled “Exploration of Mental Health Psychosocial Rehabilitation beliefs, goals and practices of Registered Nurses working in Primary Health Care Clinics within the eThekweni District”, is my own work and has not been submitted for any other degree or examination in any other university other than the University of KwaZulu-Natal. I have given complete acknowledgment to the resources referred to in the study.

This research project has been read and approved for submission by the supervisor, Ms A.A.H. Smith.

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Date

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Ms A.A. H. Smith

(Supervisor)

.....

Date

DEDICATION

This work is dedicated to people living with a psychiatric illness and to those committed to collaborating with them to enable successful and satisfied lives.

ACKNOWLEDGMENTS

My appreciation to my supervisor Mandy Smith who succeeded in helping me to finish this dissertation and in the process has become a friend. My appreciation also to previous supervisors and staff of the College of Nursing (UKZN) that have always provided assistance.

The participants of this study, the various hospital and clinic managers including the District and Provincial managers that made it possible to gather the necessary data.

My family and friends for the constant encouragement and support, and above everyone- my Creator. I am living my dream!

ABSTRACT

Aim:

To describe psychosocial rehabilitation beliefs, goals and practices of registered nurses' working in Primary Health Care clinics in the eThekweni District.

Methodology

This study was based on an interpretivist approach using a quantitative cross sectional survey. The population included all registered nurses working for at least three months at any of the PHC clinics where treatment to MHCUs was provided.. The Psychiatric Rehabilitation Beliefs, Goals, and Practices (PRBGP) scale was used to collect data from participants. Descriptive statistics were requested using SPSS version 18. Non-parametric tests were employed for analysis of associations between the scale scores and the demographic variables; and inter-correlations between factor scores.

Results

The sample consisted of 41 participants. The age group 22-29 years and nurses with a Diploma had the majority of contacts with MHCUs.. All nurses who had PSR training had contact with MHCUs. Nurses who had SANC Psychiatric Nurse registrations or PSR training were significantly more likely to have contact with MHCUs. Most participants did not favour consumer directed agendas and lacked flexibility when dealing with the unique needs of MHCUs.. There were disagreements between the claims of nurses' consumer driven approach and allowing MHCUs' needs to actually direct the process including personalizing the services; and between claims that nurses used PSR evidence and the actual process of allowing consumers' needs to direct this process. The Cronbach's alpha coefficient for the PRBGP scale was .81.

Conclusion and Recommendations

Nurses working in PHC have the potential to adopt a PSR approach and they are able to articulate PSR beliefs, goals and practices but were unable to translate this into their actual practice settings. Future research should; differentiate between the ideological stance of nurses and their actual beliefs, determine the support for PSR from both organizational structures and colleagues, determine the actual content of PSR programmes in South Africa ,determine whether the age of nurses independent of PSR training or SANC psychiatric

registration influences the attitude of nurses towards MHCUs and finally whether advanced nurses have a more positive attitude towards MHCUs ..

Keywords

mental health, nurses, primary health, psychosocial rehabilitation, PRBGP, South Africa

ABBREVIATIONS

DoH	Department of Health
KZN	KwaZulu Natal
MHCU	Mental health care user
PHC	Primary Health Care
PRBGP	Psychiatric Rehabilitation Beliefs, Goals and Practice
PSR	Psychosocial Rehabilitation
SA	South Africa
US	United States of America
WHO	World Health Organization

TABLE OF CONTENTS

CONTENTS

Declaration	ii
Dedication and Acknowledgments	iii
Abstract	iv
Abbreviations	vi
Table of Contents	vii
List of Tables	x
List of Figures	x
List of Annexures	x

Chapter One : Introduction to the study

1.1. Introduction and Background	1
1.2. Problem Statement	4
1.3. Rationale / significance of the study	5
1.4. Purpose of the study	5
1.5. Operational definitions	6
1.6. Research objectives and questions	7
1.7. Conceptual framework	8
1.7.1. Donabedian's Structure-Process-Outcomes Model	8
1.7.2. Unfolding of Donabedian's Model in this study	8
1.8. Summary	9

Chapter Two: Literature review

2.1. Literature review	10
2.2. Primary Care and provision of services	10
2.3. Integration of Mental Health Care within PHC	11
2.4. Psychosocial Rehabilitation at the core of mental health services	13
2.5. Summary	17

Chapter Three: Methodology

3.1. Research design	18
3.2. Setting and Target population	18
3.3. Sample and sampling procedure	19
3.4. Data collection Procedure / Plan	19
3.5. The Instrument	20
3.6. The Instrument's Validity and Reliability	23
3.7. Data Analysis	23
3.8. Ethical Considerations	24
3.8.1. Respect for persons	24
3.8.2. Right to privacy and confidentiality	24
3.8.3. Benefits and risks	24
3.8.4. Informed consent	25
3.9. Summary	25

Chapter Four: Data Presentation and Analysis

4.1. Introduction	26
4.2. Description of the sample	27

4.3.PRBG Scale Items, Subscale (Factor) Scores and Total Scores	30
4.3.1. Factor I	31
4.3.2. Factor II	32
4.3.3. Factor III	33
4.3.4. Factor IV	34
4.3.5. Factor V	35
4.4.Associations	36
4.4.1. Associations between Contact with MHCUs and Demographic Variables	37
4.4.2. Associations between Subscale Scores and Demographic Variables	37
4.4.3. Associations between Total Scores and Demographic Variables	38
4.5.Inter-Correlations between Subscale Scores	38
4.6.Summary	39
Chapter Five: Discussion, conclusions and recommendations	
5.1.Introduction	40
5.2.Discussion	40
5.2.1. Nurses’ understanding of PSR beliefs, goals and practices	40
5.2.2. Younger nurses would allow consumers’ needs to direct treatment interactions and would individualize services	42
5.2.3. Nurses with PSR and Psych registration more likely to interact with MHCUs	42
5.3.Limitations of this study	43
5.4.Recommendations	44
5.5.Conclusions	44
References	45
Annexures	62

List of Tables

Table 3.1: Summary of the PRBGP subscales and related beliefs, goals and practices	22
Table 4.1: Summary of participants' response rate	27
Table 4.2: Summary of demographic characteristics of participants	29
Table 4.3: Item statements 1 to 6	32
Table 4.4: Item statements 7 to 14	33
Table 4.5: Item statements 15 to 19	34
Table 4.6: Item statements 20 to 23	35
Table 4.7: Item statements 24 to 26	35
Table 4.8: Spearman Rank Order Correlation between subscale scores	39

List of Figures

Figure 1: Application of Donabedian's Model in this study.	9
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List of Annexures

A1: Letter to Gatekeepers: District Office	62
A2: Letter to Gatekeepers and Research Summary: PHC Clinic Managers	63
B: Information Sheet for participants	67
C: Informed consent Form	68
D: Self Report Questionnaire: Section 1	69
D: Self Report Questionnaire: Section 2	70
E: Clinics per PHC area	72
F: Statistics for Factor I	73
F: Statistics for Factor II	73
F: Statistics for Factor III	74
F: Statistics for Factor IV	74
F: Statistics for Factor V	75
F: Statistics for Total Scale Items	76
G: Summary of Statistical Analyses for All Factors and Total Score	77

CHAPTER ONE

INTRODUCTION TO THE STUDY

1.1. Introduction and background

South African mental health services are an important element of integrated, community-based, comprehensive primary health care services and their delivery is described and legally provided for in the Mental Health Care Act 17 of 2002 (Department of Health, 2002). This act emphasizes the primary, secondary and tertiary (or rehabilitative) nature of an integrated mental health service. The Act and policy produced by the Department of Health (DoH) further tasks all health care institutions with the responsibility of ensuring that clients have access to those services and of integrating rehabilitation services into primary health care (DoH, 2002) further indicating an inclusive, empowerment philosophy where communities, including people with disabilities, were actively involved in planning, providing and improving the rehabilitation services (DoH, 2002). This empowerment philosophy is evident in mental health legislation.

Rehabilitation is defined in the Mental Health Care Act 17 of 2002 (DoH, 2002) and the National Health Act 61 of 2003 (DoH, 2004) as a goal-orientated and time-limited process aimed at enabling impaired persons to reach an optimum mental, physical or social functional level. The Mental Health Care Act specifically says in chapter three, section 8 that “every mental health care user must be provided with care, treatment and rehabilitation services that improve the mental capacity of the user to develop to full potential to facilitate his/her integration into community life” (DoH, 2002, p. 16). This statement has an implicit reference to the concept of recovery, a concept closely linked to psychosocial rehabilitation and empowerment. Briefly, recovery is defined as “a journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential” (National Consensus Statement on Mental Health Recovery, U.S. Department of Health and Human Services quoted in Otto, Goldrick, & Helm, 2009, p 126). The use of specific approaches or technologies (such as diagnosing, planning and intervening through skills training and environmental support development) was called psychosocial rehabilitation or psychiatric rehabilitation that aimed to improve the psychological and social functioning of the MHCU (Anthony, Cohen, & Farkas, 1990). While psychosocial rehabilitation is a mutually agreed

process with a focus on specific approaches that ultimately improved the independent functioning of a MHCU in the environment of choice (i.e. a process of empowering the MHCU), recovery encompasses the level of functioning in the environments of choice which were personally determined by the MHCU and is the goal of psychosocial rehabilitation (i.e. the MHCU is empowered). That was evident in Reeve's (1999) description of recovery as "finding one's balance, through a holistic approach to life, and as a journey of self-discovery and growth" (as cited in Turner-Crowson & Wallcraft, 2002, p. 249). Recovery was suggested to be evidenced by symptom remission (not cure), involvement of the MHCU in work or study, independent and unsupervised living, non-dependence on disability grants and a well developed network of social interactions with friends on a regular basis (Shean, 2009). Thus PSR could be defined as the process of empowerment to achieve recovery.

Although several countries subscribed to a PSR philosophy, the role of the PSR counsellor was carried out by "specialist teams" and not by practitioners in primary care (England & Lester, 2005; Funk, Saraceno, Drew, & Faydi, 2008; Jenkins, Kiima, Okonji, Njenga, Kingora, & Lock, 2010). Instead, primary care practitioners in countries such as the United Kingdom, Scotland, the United States of America, Australia, Russia, Uganda, Zambia and Kenya focused on providing integrated physical and mental health diagnosis and treatment based on the bio-medical model (Jenkins & Strathdee, 2000; Woods & McCollam, 2002; Sousa & Zunkel, 2003; Cook, Howe, & Veal, 2004; Judd, Davis, Hodgins, Scopelliti, Agin, & Hulbert, 2004; Gask, 2005; Westheimer, Steinley-Bumgarner, & Brownson, 2008; Jenkins, et al., 2009; Kigozi & Ssebunnya, 2009; Mwape, et al., 2010; Jenkins, Kiima, Okonji, Njenga, Kingora, & Lock, 2010).

The province of KwaZulu-Natal (KZN) responded to the need for psychosocial rehabilitation through the development of a PSR policy, 'Mental Health for Psychosocial Rehabilitation' (KZN, DoH, 2006). The overall goal of this policy is to "...ensure that MHCUs sustain an optimum quality of life and integration into community life through comprehensive psychosocial rehabilitation" (KZN, DoH, 2006, p. 15). This policy summarized the goals, purposes and outputs that should be achieved (KZN DOH, 2006). The outcome domains were intended to be measured at intervals within a 10 year period and included evidence of a functional comprehensive PSR programme in all mental health care sites; MHCU's improved functional status; mental health care practitioners' proficiency in PSR and their capability at all levels of supporting PSR programmes (KZN, DOH, 2006). Whilst this policy had clearly

identified and outlined what should be done for MHCUs and the timeframes over which those goals should be realized, these targets were suggested to be overly optimistic. There was no evidence that any of the proposed indicators had been assessed according to the outlined time frame (2007, 2008, 2009 and 2011).

There is wide recognition of the benefits of the integration of Mental Health into Primary Health Care (PHC) (England & Lester, 2005; Boardman, 2006; Funk, Saraceno, Drew, & Faydi, 2008; Kigozi & Ssebunnya, 2009; Shean, 2009; Mwape, et al., 2010). The integration of the services improves coverage of the general population and thus early detection of mental health problems (Westheimer, Steinley-Bumgarner, & Brownson, 2008). The additional benefits were reduction in cost, integrated accessibility, and services would be nearer to meet the multiple needs of the MHCU which would result in increased MHCU satisfaction with reduced incidents of treatment defaulting and possible relapse (Nickels & McIntyre, 1996; Aboidum and Freeman cited in Uys & Schene, 1997; Dea, 2000; Dodds, et al., 2004; Marion, Brauns, Anderson, McDevitt, Noyes, & Snyder, 2004; Rees, Huby, McDade, & McKechnie, 2004; England & Lester, 2005; Boardman, 2006; Reynolds, Chesney, & Capobianco, 2006; Mwape, et al., 2010; Smith in Uys and Middleton, 2010). Integration also included reduced stigma, human rights protection, reduced chronicity and improved social integration for the MHCU (Funk, Saraceno, Drew, & Faydi, 2008; Kigozi & Ssebunnya, 2009). Uys and Schene (1997) indicated that the integration of mental health services into PHC could have taken different approaches in the South African context. The first was limited to the identification of at-risk groups (early childhood and adolescence) and interventions that provided primary prevention of all diseases including mental illness. In that route, limited in-service training of nurses working in PHC would have been provided, whilst the main psychiatric services would have been provided at district hospitals or by specialist teams (Uys & Schene, 1997). Rehabilitation would have not formed part of those nurses' functions in that approach. The second approach suggested by these authors was a more comprehensive approach that included primary, secondary and tertiary prevention strategies such as treatment adjustment (medication), assistance with finding work and obtaining entitlements (such as grants, housing, child custody, legal aid, training and counselling) (Uys & Schene, 1997). That approach would clearly include a rehabilitation focus. These trends were similar to international trends (Westheimer, Steinley-Bumgarner, & Brownson, 2008).

Provincial evidence suggested however that nurses working in PHC had little preparation and little facilitation of appropriate beliefs, knowledge and skills development that would have fostered a rehabilitation approach to care (Petersen, 1999; Petersen, 2000). Petersen (1999) suggested that the rehabilitation approach included three orientations to care: problem (symptom management and cure), environmental (support and care) and developmental (rehabilitation). This author argued that nurses working in PHC focused on the ‘problem orientation’ with a focus on medication and failed to appreciate the MHCU’s ability to engage in rehabilitation and recover (Petersen, 1999; Petersen, et al., 2009). The evidence of mental health focus relating to the PHC principles of intersectoral collaboration, promotion of healthy lifestyles, and empowerment of individuals and communities could be seen in primary care (psycho-education and multi-sectoral development projects), secondary care (identification and referral of clients with serious mental disorders, managing minor mental disorders and psychosocial problems, and the provision of emergency treatment of clients with acute psychosis), and tertiary care (monitoring medication compliance, psycho-education and provision of repeat medication) (Petersen, 1999; 2000).

In 2004 Uys suggested that the process of integration had only started and its successful outcome was heavily dependent on nurses working in PHC settings being able to master the new context-driven knowledge and skills they needed in order to implement comprehensive PHC (Uys & Middleton , 2004). Although policies exist that promote mental health services being integrated into primary health care in South Africa (SA) this did not necessarily translate into practice (Petersen, Ssebunnya, Bhana, & Baillie, 2011), and where integration has occurred these services are generally based on a bio-medical approach of care where the emphasis is on identifying and caring for neuropsychiatric effects with medication compliance as the main focus and uneven delivery of psychosocial rehabilitation (Petersen, Lund, Bhana, & Flisher, 2010). Evidence suggests that this mastery of new knowledge and skills has not occurred and although obvious psychosis was recognized and treated by nurses in PHC, other psychiatric disorders were either undiagnosed or wrongly diagnosed and mistreated (Meszaros, 1999; Jenkins, et al., 2009; Petersen, et al., 2009; Petersen, Lund, Bhana, & Flisher, 2010). The present training did not prepare nurses working in PHC to provide comprehensive mental health services and failed to address psychosocial issues of health (Petersen, et al., 2009; Petersen, Ssebunnya, Bhana, & Baillie, 2011; Petersen, Lund, Bhana, & Flisher, 2010). Lack of resources and the nurses’ bio-medical orientation resulted in comprehensive PHC roles being subsumed by the task orientated role, reducing the

possibility for the provision of emotional support to MHCU (Petersen, 1999; Carpenter, 2002; Bradshaw, Mairs & Richards 2006; Lund and Flisher, 2006; Petersen, Lund, Bhana, & Flisher, 2010).

Nurses are the majority work force in PHC clinics and are thus the group tasked with delivering integrated, client-centred and community based care at places where clients live, work and socialise (Petersen, 1999; Petersen 2000; Petersen, et al., 2009). However they were generally not trained in psychiatric nursing and those that were trained had received their training in hospitals which produced negative perceptions of MHCUs and did not prepare the nurses for a rehabilitation and recovery approach (DoH, 1997; Uys & Schene, 1997; Petersen, 2000). The specialised and resource-intensive nature of PSR also meant that there was a perception that not all nurses working in PHC should or must be PSR specialists (Uys & Schene, 1997). However, nurses working in PHC need to have a PSR focus when interacting with MHCUs and this should include an understanding of the importance of PSR philosophy in mental health services. Uys and Schene (1997) and Petersen (2000) agreed that nurses working in PHC should provide integrated mental health services to their users. In essence, nurses in the PHC context should be able to effectively support MHCUs through the manner in which they relate to MHCUs, beliefs they hold about the potential for the MHCUs to recover, their focus on goals that encourage MHCUs' hope for the future, and practices that empower MHCUs to seek fulfilling roles of their choice in the community.

1.2. Problem statement

Registered nurses, the majority work force in PHC clinics, provide services which are generally based on a bio-medical approach. These nurses are generally not trained in psychiatric nursing and those that are trained have received their training in psychiatric hospitals that is a context of chronicity that facilitated negative perceptions of MHCUs' recovery and rehabilitation potential.

These registered nurses working in PHC are charged with a PSR focus to effectively support MHCUs in their bid for recovery. The PSR beliefs, goals and practices of nurses working in PHC clinics have not been examined in the SA context, and how much these nurses know about PSR practices.

1.3. Rationale/ Significance of the study

Knowledge of registered nurses' beliefs, goals and practices inherent in their approach to MHCUs is particularly important at a time when the eThekweni district office is designing and implementing training programs for nursing practitioners in PHC clinics (eThekweni Municipality, 2011; Department of Health, 2012) The results of this study could be used to inform existing and future training programs targeted at changing approaches and treatment approaches. In addition, information from this study could be used to inform new nursing curricula to assist in introducing a PSR philosophy.

The successful PSR implementation at PHC level could significantly affect the quality of life of MHCUs and contribute to the national goals of poverty and unemployment reduction¹ (Department of Labour, 1998). This study would determine whether PSR implementation at PHC level is possible. There are current PSR policies in the DoH. This study could provide direction to new PSR policy development and improvement of existing PSR policies.

This phenomenon has not been investigated in the SA context using the Psychiatric Rehabilitation Beliefs, Goals and Practice (PRBGP) Scale (Casper, Oursler, Schmidt, & Gill, 2002). This is the first step in understanding a new phenomenon and would direct future research and exploration (Burns & Grove, 2005). This study would therefore contribute to the general body of scientific knowledge currently available. More particularly this study could provide valuable information about the PSR beliefs, goals and practices of registered nurses working in PHC in South Africa and would help in guiding nurses' evidence-based practice by allowing registered nurses to reflect on their current practices.

1.4. Purpose of the study

The purpose of this study was to describe psychosocial rehabilitation beliefs, goals and practices of registered nurses' working in Primary Health Care clinics in the eThekweni District.

1. There is an association between unemployment, poverty and mental illness. For further readings on the association between mental health and poverty see: The Mental Health and Poverty Project, 2008; and World Health Organization, 2007.

1.5. Operational Definitions

- 1.5.1. Beliefs:** A conviction of the truth of some statement or the reality of some being or phenomenon especially when based on examination of evidence (Merriam-Webster Dictionary, 2013).
- 1.5.2. Bio-medical:** A generic understanding of Western medicine, or describing and understanding pathology in terms of biological mechanisms (Merriam-Webster Dictionary, 2013).
- 1.5.3. Goal:** The end towards which effort is directed (Merriam-Webster Dictionary, 2013).
- 1.5.4. Integration:** Can be distinguished into horizontal and vertical integration. Horizontal integration refers to collaboration or bringing together of services, professions or organisations that operate at similar levels in the care hierarchy. Vertical integration refers to collaboration between different levels in the care hierarchy (Woods & McCollam, 2002). In this study integration refers to horizontal integration.
- 1.5.5. Mental health care user:** For the purpose of this study MHCU refers to ‘a person receiving care, treatment and rehabilitation services or using a health service at a designated PHC clinic aimed at enhancing the mental health status of the user..’ who is over the age of 18 and not a state patient or a mentally ill prisoner (DoH, 2002, p 6).
- 1.5.6. Practice:** To do or perform often, customarily or habitually (Merriam-Webster Dictionary, 2013). The practical implementation of PSR in nursing care.
- 1.5.7. Primary Health Care Clinic:** A building at which comprehensive health services are provided by the appropriate health care practitioners to anyone needing assistance with health or illness issues and is normally the first point of contact with the district health system. For the purpose of this study a primary health care clinic was defined according to the listing provided by the eThekweni district office (DoH, KZN, 2001a).
- 1.5.8. Psychosocial rehabilitation:** Process, facilitated by collaboration and counselling, that offers the opportunity for individuals who are impaired, disabled or handicapped by mental disorders to reach their optimal level of independent functioning in the community. The interventions inherent in the process assists a person suffering from a serious or long term mental illness to be successful and satisfied within the life roles (housing/living, working/vocation, learning/education and socialising/leisure) that they choose to fulfil in the community (WHO 2008; Uys & Middleton, 2010).
- 1.5.9. Recovery:** A journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential (Otto, Goldrick & Helm, 2009, p. 126).

1.5.10. Registered nurse: For the purpose of this study a registered nurse was a person who had a current registration with the South African Nursing Council (SANC) as a ‘Registered General Nurse’ (Government Gazette, 2006)

1.5.11. Treatment Approach: The techniques or actions customarily applied [to move towards an outcome] in a specific situation (Merriam-Webster Dictionary, 2013). This includes the core beliefs, values, goals and practices that guide the provision of mental health care

1.6. Research Objectives and Questions

The research objectives were threefold and are presented below with the associated research questions for readability.

1.6.1. To describe the treatment approach/es inherent in the beliefs, goals and practices of registered nurses working in PHC clinics.

1.6.1.1. What are the PSR beliefs, goals and practices of registered nurses working in PHC clinics?

1.6.1.2. What is the treatment approach that registered nurses working in PHC clinics more or less subscribe to: consumer driven, staff driven, evidence based practice, standardised disease and or recovery?

1.6.2. To determine if there were relationships between different treatment approaches to care.

1.6.2.1. Are there relationships between the approaches to care (consumer driven, staff directed, evidence based practice, standardised disease orientation, and recovery mission orientation)?

1.6.3. To describe associations between demographic and service variables and specific treatment approaches to care

1.6.3.1. Are there associations between the demographic variables (gender, age, experience, qualification, and training in PSR) and each of the approaches to care (consumer driven, staff directed, EBP, standardised disease orientation, and recovery mission orientation)?

1.6.3.2. Are there associations between the service variables (Rural or urban setting and exposure to MHCU) and each of the approaches to care (consumer driven, staff directed, EBP, standardised disease orientation, and recovery mission orientation)?

1.7. Conceptual Framework

This study drew on Avedis Donabedian's tripartite model (1996) incorporating structure-process-output measures (Zinn & Mor, 1998).

1.7.1. Donabedian's Structure-Process-Outcomes Model

Donabedian (Mitchell, Ferketich, & Jennings, 1998) outlined the structure-process-outcomes model as an interrelationship between outcome standards (the technical and interpersonal results of interventions or output standards), and structure standards (professional and organisational resources associated with the provision of service) and process standards (the actual practice implemented). The author further described the linear relationship between structures (having the right things), processes (doing things right) and outcomes (having the right things happen) (Mitchell, Ferketich, & Jennings, 1998). In health care those standards would be described as professional and organisational resources associated with the provision of care (structure standards), things done to and for the patient by practitioners during the course of treatment (process standards) and results due to the course of treatment (outcome standards) (Zinn & Mor, 1998).

1.7.2. Unfolding of Donabedian's Model in this study

There were several core beliefs that were common within a psychiatric PSR treatment approach: hopefulness that recovery was both desirable and attainable; a belief that long-term drug treatment was often necessary, but it was rarely sufficient on its own in assisting the MHCU in attaining a satisfying life experience through social connectedness (meaningful work, decent housing, financial security, friendships); and empowerment of the MHCU evidenced through increasing self efficacy which was desirable (Anthony, Cohen, & Farkas, 1990; Bond & Campbell, 2008; Provencher, 2007; Shean, 2009). Those core beliefs resulted in treatment goals that manifested in a practice that included the active involvement of the MHCU in treatment decisions and focused on improving their competencies (Anthony, Cohen, & Farkas, 1990). That study thus focused on the structure and process standards of the framework only. Outcome standards were not the focus of the study, it was not within the scope of that masters dissertation to measure outcomes. Structure standards considered

included registered nurses' knowledge and exposure to PSR training; psychiatric training and extent of exposure and experience with MHCUs; knowledge of PSR legislation and policy; and specific beliefs and goals as they related to treatment approaches towards MHCUs. Process standards included participants' treatment approach to MHCUs and the practice behaviours as evidenced by the treatment approach. Five treatment approaches were specifically measured: consumer driven, staff directed, evidence based practice, standardised disease orientation, and recovery mission orientation (Casper, Oursler, Schmidt, & Gill, 2002).

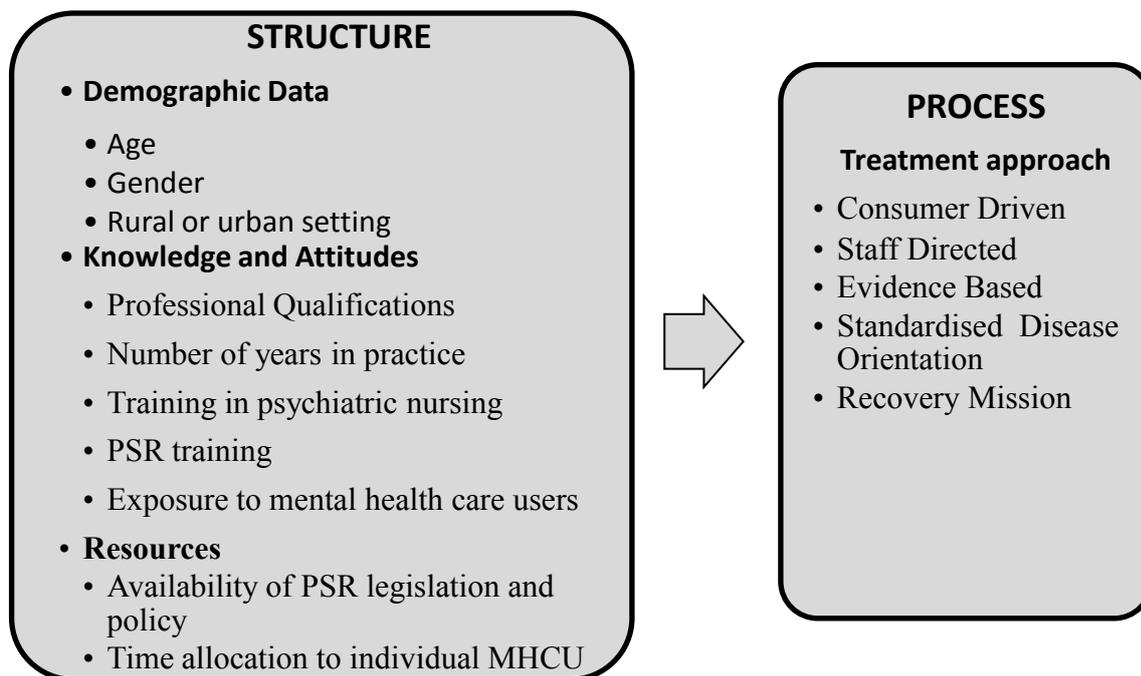


Figure 1: Application of Donabedian's Model to this study.

1.8. Summary of the chapter

South African mental health services are an important element of integrated, community-based, comprehensive primary health care services. The Mental Health Care Act 17 of 2002 and the National Health Act 61 of 2003 addresses recovery and rehabilitation of MHCUs, and a psychosocial approach to recovery is described by the language used. The KwaZulu Natal Department of Health has produced a document that specifically addresses PSR for MHCUs in a PHC setting. The ability of nurses in South Africa working in a PHC setting to facilitate a PSR agenda has not been determined and this study used Donabedian's Model to access the structure and process of this interaction between registered nurses working in PHC and MHCUs.

CHAPTER TWO

LITERATURE REVIEW

2.1. Literature review

Data bases searched to access electronic journals included CINAHL, Academic Search Complete, Health Source- Consumer Edition, Health Source- Nursing/ Academic Edition, MEDLINE, Google Scholar and PsychInfo. Keywords included ‘psychiatric primary health’, ‘psychosocial rehabilitation’ and ‘recovery’. The journal articles cited in the found articles were used to expand the search using those authors and journals cited. The literature review presents the status of primary health offered in communities and the major role of nurses working in primary health care settings in the context of the integration of mental health into PHC within SA and more specifically KZN with a focus on their ability to implement PSR practice.

2.2. Primary Health Care and provision of services

Primary health care (PHC) is defined as “a strategy and a set of activities to reach the goal of “health for all...” (WHO, 1978 quoted in De Maeseneer, Willems, De Sutter, Van de Geuchte, & Billings, 2007, p. 2). It could also be defined as “essential... first level of contact... where people live and work (World Health Organization, 1978, p. 1). This approach to health care provision has become the focus of all countries (Gardner, Dowden, Togni, & Bailie, 2010; Felix-Bortolotti, 2011; Freeman, et al., 2011; Hansson, Rasmussen, & Ahlstrom, 2011; Arvidsson, Andre, Borgquist, Andersson, & Carlsson, 2012) with the implementation uniquely adapted to each country’s situation. The nurses role in effective implementation of a PHC services is well established in most countries (Sapountzi-Krepia, Antonakis, Sgantzios, & Lionis, 2003; Daviaud & Chopra, 2008; Jatrana & Crampton, 2009; Borkan, Eaton, Novillo-Ortiz, Corte, & Jadad, 2010; Gardner, Dowden, Togni, & Bailie, 2010; Mann, Eble, Frost, Premkumarc, & Boone, 2010; Pfeiffer, et al., 2010; Chibanda, Mesu, Kajawu, Cowan, Araya, & Abas, 2011; Felix-Bortolotti, 2011; Freeman, et al., 2011; Grant, et al., 2011; Hansson, Rasmussen, & Ahlstrom, 2011; Arvidsson, Andre, Borgquist, Andersson, & Carlsson, 2012; Bjerrum, Rose, Bygbjerg, Mfinanaga, Tersboel, & Ravn, 2012). In other countries such as Bangladesh (World Health Organization, 2008a), France (World Health Organization, 2008b) and UK (Drennan, Andrews, Sidhu, & Peacock, 2006) where PHC was

the exclusive domain of medical practitioners, the role nurses could play in the PHC team approach is becoming increasingly recognised (Drennan, Andrews, Sidhu, & Peacock, 2006).

A multidisciplinary approach to PHC is adopted by most countries (Sapountzi-Krepia, Antonakis, Sgantzios, & Lionis, 2003; Drennan, Andrews, Sidhu, & Peacock, 2006; World Health Organization, 2008a; Jatrana & Crampton, 2009; Borkan, Eaton, Novillo-Ortiz, Corte, & Jadad, 2010; Gardner, Dowden, Togni, & Bailie, 2010; Felix-Bortolotti, 2011; Freeman, et al., 2011; Grant, et al., 2011; Hansson, Rasmussen, & Ahlstrom, 2011; Arvidsson, Andre, Borgquist, Andersson, & Carlsson, 2012) with some even incorporating indigenous practitioners into the team (World Health Organization, 2008a; Jatrana & Crampton, 2009; Gardner, Dowden, Togni, & Bailie, 2010; Grant, et al., 2011). Nurses are always included in the multidisciplinary team and provide the major part of health care (World Health Organization, 1978, p. 1) Sapountzi-Krepia, Antonakis, Sgantzios, & Lionis, 2003; Drennan, Andrews, Sidhu, & Peacock, 2006; Borkan, Eaton, Novillo-Ortiz, Corte, & Jadad, 2010; Freeman, et al., 2011; Jatrana & Crampton, 2009; Felix-Bortolotti, 2011; Grant, et al., 2011; Hansson, Rasmussen, & Ahlstrom, 2011; Arvidsson, Andre, Borgquist, Andersson, & Carlsson, 2012).

In African countries such as South Africa (Daviaud & Chopra, 2008), Mozambique (Pfeiffer, et al., 2010), Zimbabwe (Chibanda, Mesu, Kajawu, Cowan, Araya, & Abas, 2011) and Tanzania (Bjerrum, Rose, Bygbjerg, Mfinanaga, Tersboel, & Ravn, 2012) nurses and midwives continue to play a central role in the provision of PHC. Even in India and Goa (West India) PHC comprises a team with nurses again featured prominently (Pereira, Andrew, Sulochana Pednekar, Kirkwood, & Patel, 2011). Clearly a multidisciplinary approach is ideal but from the above discussion it can be seen that in many instances nurses are carrying much of the burden of care provision due to limited human resources within other professional groups.

2.3.Integration of Mental Health Care within PHC

The world health organisation (WHO) published recommended guidelines for the inclusion of mental health care in primary healthcare settings (World Health Organization, 2001). WHO also recommended the establishment of national policies, programmes and legislation to ensure significant and sustained actions (World Health Organization, 2001). In some countries such as Australia, US, Austria, Germany, Japan and Netherlands the provision of

separate mental health and medical health is maintained by the funding of these parallel systems and leads to the increased costs associated with these models whilst other countries have successfully implemented integration (Kigozi & Ssebunnya, 2009; Jenkins, Kiima, Okonji, Njenga, Kingora, & Lock, 2010; Morasae, Forouzan, Asadi-Lari, & Majdzadeh, 2012). Therefore the models of integration range from coordinated relationships between providers, co-located services with providers offering distinct services, to fully integrated healthcare where there is a single point of treatment with providers working as equal “team mates” (Woods & McCollam, 2002; Westheimer, Steinley-Bumgarner, & Brownson, 2008, McDonald, Campbell, & Lester, 2009; Jenkins, Kiima, Okonji, Njenga, Kingora, & Lock, 2010; Meehan & Robertson, 2013). South Africa has responded to the WHO recommendations by developing appropriate legislation and policies.

Several legislatures have been published to align the health systems of South Africa to international standards. The National Health Act 61 of 2003 clearly identifies the responsibility of the minister of health to protect, promote, improve and maintain the health of the population (chapter 1, section 3.1a) and must have regard to the “needs of vulnerable groups such as...persons with disabilities (chapter 1, section 4.2d) (DoH, 2004). Furthermore, the human resources provision, distribution, development, management and utilization are clearly laid out and is the responsibility of the National Health Council (chapter 7, section 48.1) (DoH, 2004). The National Health Research Committee is tasked with advising the minister of health on health research priorities and specifically identifies the health needs of vulnerable groups (chapter 9, section 70.2d) (DoH, 2004). It is also clear that these services should be provided in the “general health services environment” (chapter 2, section 3aiii) which includes primary, secondary and tertiary levels (chapter 2, section 4a) (DoH, 2002, p. 14). Similarly, the Department of Health KwaZulu Natal website articulates the focus of implementing mental health policies that promote the well-being of the mental health care user including the integration of mental health into primary health care (check under index: Mental Health and substance abuse) (Department of Health KwaZulu Natal, n.d.).

The integration of mental health into PHC is supported by evidence that clearly shows a link between mental illnesses such as depression and physical illnesses such as diabetes and cardiac diseases (Chapman, Perry, & Strine, 2005) and healthcare professionals therefore have positive opinions about the integration of mental health and primary health care (McDonald, Campbell, & Lester, 2009; Meehan & Robertson, 2013) with increased

likelihood that patients would engage in treatment. Integration of mental health and primary healthcare is also possible with nurses working in PHC competently diagnosing and treating common psychiatric disorders with appropriate training (Sokhela, 1999) but they may not be skilled to deal effectively with mental health disorders due to a lack of clinical expertise (Golomb et al, 2000). The successful integration of mental health and PHC services requires specialist psychiatric nurses (Ronald et al, 2007) but in many low- and middle-income countries it is not always possible to have specialist psychiatric nurses working in PHC, and the general PHC nurse is required to providing mental health services. Admittedly, integrating services has challenges (Horsburgh, Goodyear-Smith, & Yallop, 2007) and benefits (Meehan & Robertson, 2013). Integration of mental health and physical health is however central to the way primary health is and should be practiced with resultant neutral or reduced costs (Klinkman & Okkes, 1998; Reiss-Brennan et al, 2006; Morasae, Forouzan, Asadi-Lari, & Majdzadeh, 2012) and other benefits including better communication and patient care (Dea, 2000; Meehan & Robertson, 2013). This provides opportunities for nurses working in PHC to also facilitate the PSR agenda when engaging MHCUs. However nurses are trained in the biomedical model of care (Petersen, 2000) and this has to change to a psychosocial model of care to facilitate a PSR agenda.

2.4. Psychosocial Rehabilitation at the core of mental health services

The destructive effects of psychiatric illnesses have been acknowledged and many countries have refocused services and legislation to support this vulnerable group through rehabilitation services and a focus on recovery (Black, Morris, Harbert, & Mathias, 2008). In South Africa the National Health Act recognises the right of individuals to participate in the decisions affecting “his or her personal health and treatment (chapter 1, section 8.1) (DoH, 2004, p. 22). This Act (chapter 11) also refers to regulations the minister of health may make to enable rehabilitation (section 90.11). Chapter 2 of the Mental Health Act indicates that the aim of the act is to regulate the mental health care in a manner that makes the “best possible mental health care, treatment and rehabilitation” (DoH, 2002, p. 12). There is therefore clearly identified in these acts the persons responsible for ensuring optimal health care including rehabilitation. Additionally, the respect of the mental health care user as a person whose dignity and privacy must be respected (chapter 2, section 8.1), the aim to improve the mental capacity of the user to develop to their full potential and to facilitate reintegration into the community (chapter 2, section 8.2) (DoH, 2002), the focus on empowerment, respect, dignity, involvement of the consumer in decisions, protection from unfair discrimination,

exploitation and abuse supports the view that policies and regulations in South Africa are aligned to PSR philosophy. However, the strategic plan for 2010/11 to 2012/13 did not mention the mental health of the population and the rehabilitation agenda is also not featured (DoH website) (Department of Health, n.d.). Even a cursory glance at the heading 'Rehabilitation & Disability' on the DoH-KZN website indicates a focus on physical rehabilitation and disability. As argued earlier the legislation and policies are aligned to WHO recommendations but implementation of PSR policies are inadequate even at provincial and local levels (Department of Health KwaZulu Natal website, n.d.). There is therefore superficial support of PSR in official documents to meet international expectations but there is clearly no support for PSR in practice (Fydi, et al., 2011).

Legislation and policy recognize that individuals with severe mental illness have the same aspirations as those in the general population (Bond & Campbell, 2008), that there is the possibility of 'living a full life within the limitations of a mental illness' and has resulted in a move away from pessimistic views regarding the outcomes for patients with severe mental illness such as schizophrenia towards more evidence-based services that promote recovery (Shean, 2009) with a commitment to the recovery process and the explicit belief that people with psychiatric illness can and do recover (Corrigan & McCracken, 1995; Black, Morris, Harbert, & Mathias, 2008). Recovery is defined as "a journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential" (National Consensus Statement on Mental Health Recovery, U.S. Department of Health and Human Services quoted in Ho, Chiu, Lo, & Yiu, 2010, p. 72). Recovery is a "deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills, and/ or roles...living a satisfying, hopeful, and contributing life even with limitations caused by illness" (Anthony, 1993, p. 17). The process of recovery may "involve either teaching persons the specific skills needed to function effectively or developing the community and environmental resources needed to support or strengthen their present levels of functioning" (Lieberman & Evans, 1985 cited in Anthony & Lieberman, 1986, p. 542). This speaks to the mental health care practitioners, specifically nurses, role in implementing psychosocial rehabilitation counselling in order to facilitate the MHCUs recovery process. Psychosocial rehabilitation is "a therapeutic approach that encourages a mentally ill person to develop his or her fullest capacities through learning and environmental supports" (Bachrach, 1996 quoted in American Association of Community Psychiatrists, 2011). The focus of PSR is on consumer and family driven

services with a commitment to psychosocial rehabilitation services guided by evidence-based practices that enable consumers to recover (Cook & Razzano, 2000; Black, Morris, Harbert, & Mathias, 2008). This has meant that providers of care have to be adequately trained or re-trained to be knowledgeable about the new focus of psychiatric rehabilitation and recovery services, are exposed to evidence-based best practice principles (Black, Morris, Harbert, & Mathias, 2008) and move from 'knowing' to 'doing' (Rogers, Cohen, Danley, & Hutchinson, 1986). "There must be a change in practice expectations so that mental health practitioners value each of the components of the process of recovery" (Black, Morris, Harbert, & Mathias, 2008, p. 165). These components include self-direction, individualized and person-centered interventions, empowerment of consumers, focus on consumers' strengths, use of peer support, respect of consumers' rights as human beings, allowing consumers to accept responsibility for the process of recovery and the instilling of hope (Ragins quoted in Black, Morris, Harbert, & Mathias, 2008; Menear, et al., 2011). Clearly, mental healthcare providers, specifically nurses need to embrace a more social model of care in order to effectively implement psychosocial rehabilitation practices.

Several countries have noted the benefits of PSR to the consumers of mental health services (patients and caregivers) (Jacobs, Davidson, Steiner, & Hoge, 2002; Koukia & Madianos, 2005; Murugesan, Amey, Deane, Jeffrey, Kelly, & Stain, 2007; Pereira & Pereira, 2009; Kenaley & Williams, 2011; Choe, et al., 2012; Choe, et al., 2012). In the US the integration of treatment and rehabilitation was a priority together with the development of agreements with other rehabilitation providers to enable a team approach to care (Jacobs, Davidson, Steiner, & Hoge, 2002) and countries like Greece provided PSR to patients based on extensive occupational therapy, social skills training, group psychotherapy and recreational activities with positive outcomes for patients and "on caregivers emotional well-being" (Koukia & Madianos, 2005, p. 420). Thus the value of PSR services was noted by most countries and were extended in the communities for adults and children (called Child Psychosocial Rehabilitation) (Kenaley & Williams, 2011). Similarly, other countries such as Taiwan (Choe, et al., 2012), Brazil (Pereira & Pereira, 2009), Australia (Murugesan, Amey, Deane, Jeffrey, Kelly, & Stain, 2007) and Greece (Koukia & Madianos, 2005) also expanded their programmes to cover discharged patients and inpatients (Koukia & Madianos, 2005; Murugesan, Amey, Deane, Jeffrey, Kelly, & Stain, 2007; Pereira & Pereira, 2009; Choe, et al., 2012). Brazil offered workshops to enhance social and cognitive functioning (Pereira & Pereira, 2009). In the UK however, the term "psychiatric rehabilitation" was not viewed

favourably (Holloway, Carson, & Davis, 2002). Policy did favour key rehabilitation principles even though practice of PSR seems to have had less support due to early interventions such as hostels and assertive community treatment receiving less positive study reviews (Holloway, Carson, & Davis, 2002).

As noted by Gupta, Castillo-Laborder and Landry (2011) “data [regarding information on the availability of rehabilitation personnel] remain fragmented and inadequate, especially in low- and middle-income countries” (Gupta, Castillo-Laborder, & Landry, 2011, p. 2). There is a paucity of literature from Africa regarding the current situation around PSR practice. Uys, Phillips and Zulu (1997) examined vocational rehabilitation in South Africa, whilst Pillay and Lockhat (1997) focused on children’s mental health services in South Africa. Burns (2010) noted the inequitable funding, inadequate facilities and significant shortage of mental health professionals prevalent in KwaZulu Natal, South Africa. Even though mental illness has a high prevalence rate, mental health does not take priority in Africa (Bird, Omar, Doku, Lund, Nsereko, & Mwanza, 2011). This may be due to the competing health challenges specifically HIV/AIDS faced by countries such as Ghana, Uganda, Zambia and South Africa (Bird, Omar, Doku, Lund, Nsereko, & Mwanza, 2011). Even though mental health has gained priority in South Africa since 1994, in general mental health “was largely considered a low priority at national and regional/ provincial levels in all four study countries [Ghana, South Africa, Uganda and Zambia]” (Bird, Omar, Doku, Lund, Nsereko, & Mwanza, 2011, p. 359). Almost half of the countries in Africa had a mental health policy in place by 2005, but not much is known about the quality of these policies (Fydi, et al., 2011). Further, Fydi et al. (2011) identified the lack of internal consistency in the policy structure and content, superficiality of key concepts and ‘politically correct’ discourse rather than real political commitment to change, lack of evidence-based decision making, poor integration of mental health policies into the national policy and framework and lack of financing for mental health policy. Petersen, Lund, Bhana and Flisher (2010) acknowledge that some gains have been made in decentralizing and integrating services in South Africa but the debate seems to be around human resources issues rather than the implementation of PSR practice and there were still substantial gaps in service delivery (Petersen & Lund, 2011).

2.5. Summary of the Chapter

The concept of empowerment has been defined in several ways making it possible to employ the concept in sometimes very vague ways (Cattaneo & Chapman, 2010). The process of empowerment is about gaining power which is in itself embedded in social interactions where influence is exerted (Cattaneo & Chapman, 2010). “Thus, an increase in power is an increase in one’s influence in social relations at any level of human interaction” (Cattaneo & Chapman, 2010, p. 647). Ultimately therefore, PSR should change the way consumers interact in social interactions with mental health service providers in relation to power differentials. Cattaneo and Chapman note that empowerment is mastery, is participation, forwards the social good, and is goal achievement (Cattaneo & Chapman, 2010). As noted by Linhorst, Hamilton, Young, and Eckert (2002) participation in treatment planning can be seen as empowering clients.

However this can only occur if clients can meaningfully participate (psychiatric stability and decision-making skills of clients are present) and staff have the time, respectful attitudes, appreciation for clients ability to participate meaningfully, the availability of a range of treatment options and a strong philosophical commitment to client empowerment in order to engage meaningfully with clients (Linhorst, Hamilton, Young, & Eckert, 2002). Similarly, PSR activities and level of global functioning of clients, the duration of PSR, the types of settings in which PSR was done were all contributing factors to the perceived quality of PSR (Bassi, Ferrario, Ba, Delle Fave, & Vigano, 2012). “A strategy for effectively integrating mental health into PHC includes promoting mental health by addressing the key determinants of social inclusion, freedom from discrimination and violence, and economic participation” (Kermode, Herrman, Arole, White, & Patel, 2007, p. 234). This is clearly an empowerment philosophy that relates to PSR principles.

Therefore with the integration of mental health into PHC, nurses who work in these settings have to understand PSR principles and more importantly should be able to implement these principles through empowerment of MHCUs.

CHAPTER THREE

METHODOLOGY

3.1. Design

This study was based on an interpretivist approach (Roth & Mehta, 2002). There were multiple realities which were constructed by individuals participating in research (Polit & Beck, 2008). A quantitative cross sectional survey that was primarily descriptive in nature was used. The methodology was considered appropriate to facilitate the collection of data that enabled a description of the beliefs, goals and practices of registered nurses working in the PHC clinics, as they related to PSR (Burns & Grove, 2005).

3.2. Setting and target population

The population included all registered nurses working in PHC clinics who were providing treatment to MHCU in eThekweni District KwaZulu-Natal, a geographical area of 2.297 km² and an estimated population of 3.5 million (eThekweni Municipality, 2002; Statistics South Africa, 2006; Statistics South Africa, 2008). The eThekweni District consisted of rural and urban PHC clinics (as determined by the District Office) operated by local authority, provincial authority and state aided non-governmental organisations (DoH, 2001a).

The target population included all registered nurses working for at least three (3) months at any of the PHC clinics in the city of Durban and its surrounding towns. Determining the actual number of PHC clinics was problematic. A situational analysis conducted in 2002 by the Population Council Inc. (in co-operation with Horizon and the KwaZulu Natal Department of Health) identified 56 clinics and 7 community health centres in eThekweni (The Population Council Inc., 2003). Another on-line list produced in 2009 by the G15 Unit of the KwaZulu Natal Department of Health identified 69 local authority and 52 provincial clinics with an additional 4 operated jointly by both local authority and provincial Departments of Health (KZN, DoH, 2009). The same KwaZulu Natal Department of Health website also indicated that there were 46 provincial and 58 local government PHC clinics. It was therefore not possible to produce a definitive operational sampling frame for this study. In addition, the actual number of registered nursing staff working in clinics was not readily available to the researcher (personal communication with the Department of Health-KwaZulu Natal, January & February 2011). Telephonic contact was made with the Deputy

District Manager (Monitoring and Evaluation) and a formal written request was made for the list of PHC clinics in the eThekweni District (Annexure A1, p. 63). It was confirmed by the Deputy District Manager (Monitoring and Evaluation) that there were 113 PHC clinics in the eThekweni District (personal communication).

3.3. Sample and sampling procedure

The eThekweni district was sampled purposively to facilitate transportation and access to PHC clinics. Within this district the lack of a reliable sampling frame and uncertainty regarding numbers of staff within PHC clinics in the eThekweni District resulted in a decision to abandon randomly sampling the PHC clinics within the district including the registered nurses within each of those PHC clinics. Data collection was initially planned to occur over a twelve week period to facilitate the contacting of all the clinics on the list in an attempt to obtain a representative sample that was large enough to have statistical power (at least 100 participants from the list of 113 PHC clinics). The final period of data collection was over a four week period due to gatekeeper issues and time constraints.

It was assumed that there were at least two registered nurses at each PHC clinic (N=226). Each listed PHC clinic was phoned four times between 09h00 and 14h00 Monday to Friday. Ultimately 5 PHC clinics were included and achieved a sample of 41. Participants who had emergencies to attend to, were allowed to manage the emergencies and then return to complete the questionnaires. This resulted in uncompleted questionnaires or inappropriate responses given by participants who had to get back to those duties and also contributed to the small size of the final sample due to nonparticipation by those who could not leave their duties.

3.4. Data collection procedure/ plan

Following ethical clearance of the University Of KwaZulu Natal ethics committee, district Department of Health and provincial Department of Health permission the researcher began contacting the PHC clinics as per the KwaZulu Natal Department of Health (2009) provided service list (N=131). Once confirmation of the clinics existence was confirmed by the researcher (10 clinics) (see point 3.3- Sampling and Sampling Procedure, p. 20), and the clinic manager confirmed that MHCUs were registered users of the PHC clinics services (10 clinics), a letter was faxed to the clinic manager giving a brief outline of the study and requesting the participation of the registered nurses, who had been employed at the PHC clinic (Appendix A2, p. 64). A clinic sample was achieved of n=5 due to non telephonic

response (121 clinics) or refusal to allow access to staff (5 clinics). A date and time was negotiated with PHC clinics (n=4) who agreed to participate. Upon arrival, the researcher gave a verbal and written explanation (information sheet- Annexure B, p. 68) to each participant that included guarantees of anonymity, expected date of written feedback that focused on all clinics and was not specific to individual clinics and identifying who else received feedback. Time was given for questions and reassurances and an explanation of the data collection process including the expected length of time required to complete the self-report questionnaire was given.

The participants were required to sign informed consent forms before the data collection began (Annexure C, p. 69). The researcher remained available to read the self-report questionnaire and to define any terms that the participants requested to ensure that each participant understood what was required. Requests for definitions were noted including any hesitation, ambivalence, or requested explanations as a possible defect of the tool. Questions were not explained to participants but reassurance was given that there was no right or wrong answer and therefore no personal or professional risk associated with choosing a response. No assistance or guidance was given to participants regarding answers selected. On completion of the self-report questionnaire participants were asked to not discuss the contents of the questionnaire with staff from other clinics for twelve weeks, until the data collection process was completed. Completed self-report questionnaires were deposited by the participants at the clinic into a sealed box which was opened at the end of the data collection process to facilitate coding of questionnaires.

3.5. The Instrument

The Psychiatric Rehabilitation Beliefs, Goals, and Practices (PRBGP) scale was used to collect data from participants (Casper, Oursler, Schmidt, & Gill, 2002) (Annexure D, Section 2, p. 71). The scale has twenty six (26) items that measured the registered nurses' knowledge of current beliefs, goals and practices in psychiatric rehabilitation (Casper, 2005). The researcher was unable to contact Dr Edward Casper because he had retired and was unavailable to provide written consent to use the tool. However, the tool was published in a journal article and was therefore in public domain. It was assumed that there would be no objection from the author or publisher to use that tool. In addition the author indicated in the journal article that "researchers...use the scale in their studies to further test its validity and

utility” (Casper, Oursler, Schmidt, & Gill, 2002, p. 233). Within the 26 items the instrument identifies beliefs, goals and practices that are associated with five different factors or approaches adopted by the participant (Casper, Oursler, Schmidt, & Gill, 2002). Thus there are five (5) subscales.

Factor I, the consumer driven approach (1, 2, 3, 4, 5 and 6) is defined by beliefs that emphasized the MHCU’s capacity to make healthy choices, goals that included community integration of the MHCU in normalized settings with skill and preference development, and practices that emphasized consumer preferences, choice and individualized assessments.

Factor II, the Staff-directed approach (7, 8, 9, 10, 11, 12, 13 and 14) included beliefs about the limiting effect of the illness, goals aimed at protection of the MHCU from stress, and practices that were staff-directed and paternalistic.

Factor III, the evidence-based approach (15, 16, 17, 18, 19) included beliefs that MHCUs had strengths that enabled them to have an improved quality of life, goals that included MHCU’s personal choice regarding housing, employment and educational goals, and practices that emphasized rapid placement, supported skill development and focused on the MHCU’s strengths.

Factor IV, standardized-services approach (20, 21, 22, 23) included beliefs that individualized services for MHCUs were not worth the effort, goals that ensured MHCUs accepted group norms and expectations, and practices that emphasized standardized, disease-oriented services that did not consider the individual MHCU’s needs and aspirations.

Factor V, recovery mission approach (24, 25, 26) reflected a belief that recovery was possible for the MHCU, goals that were humanistic and focused on the individual MHCU’s needs and aspirations, and practices that enabled the individual MHCU to recover (Casper, Oursler, Schmidt, & Gill, 2002).

Table 3.1: Summary of the PRBGP subscales and related beliefs, goals and practices

Factor	Statements	Beliefs	Goals	Practices
1 Consumer-Driven	<ol style="list-style-type: none"> 1. I like to have a client's preferences & choices direct every aspect of the rehabilitation process, including where and when I intervene. 2. When exploring potential residences, I rely on the person's housing preferences to direct the search. 3. A mentally ill person's housing, work and education should be in the same settings as persons who do not have the illness. 4. An overall goal of Psychiatric Rehabilitation is to assist mentally ill people in developing their preferences and skills, in reference to where they want to live, work and socialize. 5. If given the opportunity, people with a mental illness would choose the same kinds of things any of us would want. 6. I prefer a situational assessment rather than a global one to plan a client's skill training program. 	MHCU has the capacity to make healthy choices.	To integrate MHCU into the community in normalized settings with skill and preference development.	MHCUs preferences, choice and individualized assessments considered.
2 Staff Directed	<ol style="list-style-type: none"> 7. Psychiatric Rehabilitation is a consultative process in which the client should always discuss his/her decisions with the counsellor before making them. 8. A good rehabilitation plan identifies the person's greatest problems and weaknesses. 9. One consequence of having a mental illness is that people tend to lack personal preferences. 10. People with mental illness need more protection from society than help to participate in it. 11. Making choices for a person suffering from schizophrenia is not the same as making choices for a person who is not sick. 12. Because of the stress associated with it, working competitively should probably not be a goal for many mentally ill people. 13. I'm not comfortable with a client that I serve joining a consumer-run self-help group. 14. Competitive employment is a proper goal so long as the person has had prior competitive experience. 	Psychiatric illnesses have a limiting effect on MHCUs functioning and ability to make choices	To protect the MHCU from challenges.	Staff directed choices and paternalistic decisions.
3 Evidence Based	<ol style="list-style-type: none"> 15. A rehabilitation plan to help a mentally ill person go to work should always include gradual, incremental steps in order to reduce stress and maximize skill acquisition. 16. Living alone in one's home if one wants that, is only a proper Psychiatric Rehabilitation goal for persons whose symptoms are completely stable. 17. Psychiatric Rehabilitation professionals should be as concerned with client's quality of life as with their symptoms. 18. Educating Mentally Ill people about their illness, its symptoms, and their medication's benefits and side effects, is the best way to encourage cooperation with treatment. 19. Having a mental illness means in part that the capacities to learn and grow are greatly diminished. 	MHCUs have strengths that enable them to have an improved quality of life.	To enable MHCUs to choose, get and keep housing, employment and education of their choice.	Rapid placement, support skill-development and focus on strengths.

4 Standardized Services	20. The outcomes achieved from individualized Psychiatric Rehabilitation services are often not worth the high cost and extreme complexity of providing them. 21. Providing supports to the mentally ill in their jobs or residences should be time limited so that they don't become too dependent on the supports. 22. When developing a Mentally Ill person's rehabilitation plan & goals I am guided primarily by a good assessment of their mental status. 23. I can usually judge how well a client will do at work or school settings by how well he/she does in his/her residence.	Individualized services are not worth the effort.	To ensure MHCUs accept group norms and utilize available services.	Standardized, disease-oriented services, individualized needs and aspirations not addressed.
5 Recovery Mission	24. Support development and environmental modifications may be more important than skill training in the long run for helping Mentally Ill persons achieve success in community integration. 25. Helping Mentally Ill persons fashion a new, positive self image is a viable, long-term goal for Psychiatric Rehabilitation. 26. Real recovery often includes exposing a Mentally Ill person to the risks of relapse and failure.	Recovery for MHCUs is possible.	To meet MHCUs individualized needs and aspirations.	Recovery of MHCUs.

3.6. The instrument's Validity and reliability

The validity (Cronbach's $\alpha=.68$) and reliability (test-retest ICC=.92) of the Psychiatric Rehabilitation Beliefs, Goals, and Practices (PRBGP) scale was tested in New Jersey and Pennsylvania. The scale was shown to have stability (Casper, Oursler, Schmidt, & Gill, 2002). In addition the scale was able to differentiate between the unified body of psychiatric rehabilitation beliefs, goals, and practices; and distinct academic degree ($F=10.11$; $df=3,267$; $p<.001$; $\eta^2=.32$), role ($F=6.31$; $df=1,269$; $p<.02$), discipline ($F=11.12$; $df=2,212$; $p<.01$; $\eta^2=.23$), and field experience (PSR leadership read: $R=.63$; $Beta=.59$ and PSR conferences attended: $r=.29$). Whilst there was no results available for the relationships between the subscale scores and the overall scale score, each scale item was compared to the overall scale score and the experience, role and psychiatric rehabilitation readings domains made significant contributions to the multiple correlation of .49 (Casper, Oursler, Schmidt, & Gill, 2002; Casper, 2005).

3.7. Data analysis

Questionnaires were coded to facilitate data analysis. Data was entered into SPSS version 18 and Descriptive Analyses of the data was carried out. The demographic data (Annexure D, Section 1, p. 70) was used to describe the sample and its representativeness. Descriptive statistics was applied to data in the PRBGP scale (Annexure D, Section 2, p. 71). Frequency distribution; measures of central tendency which included mean, median and mode; measures of dispersion which included range, percentiles, skewness statistic and standard error of

skewness were determined. Histograms with a distribution curve were computed to confirm skewness and percentiles requested. The determinations of whether the data were normally distributed helped decide whether parametric or non-parametric tests were employed for further analysis. Measures of associations were computed between the five subscale scores and the demographic variables. Inter-correlations were computed between subscale scores.

3.8. Ethical considerations

This study proposal was submitted for approval to the research ethics committee of the University of KwaZulu Natal. Only when that approval had been granted were the gatekeepers at the Department of Health for KwaZulu Natal approached for permission to ask the registered nurses working in Primary Health Care clinics to participate in that study (Annexure A1, p. 63 and A2, p. 64). The participants' rights (as discussed hereafter) were protected during the course of that study (Emanuel, Wendler, Killen, & Grady, 2004; Burns & Grove, 2005). Those rights were indicated in the information sheet (Annexure B, p. 68) and the informed consent sheet (Annexure C, p. 69).

3.8.1. Respect for persons: The participants were informed in writing and verbally of the proposed study and they were allowed to voluntarily choose to participate or not. In addition, participants were informed of their right to withdraw from the study at any time before depositing the questionnaires into the sealed box, without any detrimental effect. This study did not use coercion, covert data collection or deception. Thus there was no violation of the respect for persons. The study participants were adults without diminished autonomy and we therefore assumed that they were able to protect their own rights.

3.8.2. Right to privacy and confidentiality: The participants' right to remain anonymous was ensured through the coding of questionnaires, participants' names or identifiable data such as dates of birth, telephone and fax numbers were not recorded. All returned demographic and study questionnaires were placed in a sealed box at the workplace so that the participants' identity was kept anonymous. There were no negative consequences personally or professionally associated with responses recorded on the questionnaire. This study did not require the participants to be re-identified. Therefore the list of clinics visited was destroyed and not kept for future use.

3.8.3. Benefits and risks: The benefits of this study were linked to improvement in evidence-based clinical practice. That would be beneficial to nurses and the mental

health care users as this study would inform future training of nurses and the integration of mental health into primary health care. The results of the study were made available at the University of KwaZulu Natal library, to any of the participants who wished to have access. There were no risks attached to this study since the identities of participants' were protected at all times. The study attempted to prevent interfering with essential health services to health care users seeking help at those clinics. In addition, this study satisfied the requirements for the coursework masters programme of the researcher.

3.8.4. Informed consent: The participants were registered nurses who were adults capable of making informed choices. All participants were provided with an information sheet (Annexure B, p. 68) that outlined the aims of the study, any risks and benefits and assurances of their right to voluntary participation and withdrawal from the study. In addition participants were offered the opportunity to ask any questions to clarify those aims if they so desired before signing the informed consent form (Annexure C, p. 69).

3.9. Summary

An interpretivist approach using the PRBGP scale was utilized to conduct a quantitative cross-sectional survey. The SPSS statistical package was used to describe the PSR beliefs, goals and practices of registered nurses working in PHC clinics in the eThekweni District in KwaZulu Natal. Informed written consent was obtained from participants.

CHAPTER FOUR

DATA PRESENTATION AND ANALYSIS

4.1. Introduction

Data was entered into SPSS, version 19, using a code book. Demographic data was entered; the continuous age variable was collapsed into five categorical age groups (22 to 29 years, 30 to 39 years, 40 to 49 years, 50 to 59 years and 60+ years). The PRBGP scale (Appendix D, section 2, p. 71) items 7 to 14 and 20 to 23 were reversed scored; a score of 1 converted to 4, 2 converted to 3, 3 was converted to 2, and a score of 4 converted to 1. In addition to individual PRBGP item scores being captured subscale scores and total scores were also calculated and coded. Several questionnaires were spoilt, participants failing to complete one or more items, the specific number changing for section 1 (demographic data) and section 2 (PRBGP). A decision was taken to use the 'exclude cases pairwise' option so that cases were excluded only if they were missing data that was required for that particular analysis. This was done to ensure that the sample size did not decrease even further (Pallant, 2010).

Descriptive statistics included frequencies, percentages, measures of central tendency (mean for continuous variables, median and mode for categorical variables) and dispersions (skewness and kurtosis for continuous variables, minimum, maximum, range and percentiles for categorical variables).

The decision to use parametric or non-parametric tests was based on whether the data (continuous variable) was normally distributed as determined by the; skewness statistic (indication of symmetry of the distribution), Kurtosis statistic (indication of 'peakedness' of the distribution) and the Kolmogorov-Smirnov statistic (assesses the normality of a distribution with a significance value greater than .05 seen as a non-significant result and indicating a normal distribution of scores) (Pallant, 2010). Positive skewness values indicate a clustering of scores at the low end, a negative skew indicating clustering of scores at the higher end of possible scores, the skewness statistic reaching significance when it was twice the value of the standard error of skewness. Positive kurtosis values indicate a clustering of scores in the centre with or without thickening in the tails due to outliers, a kurtosis statistic reaching significance when it was twice the value of the standard error of kurtosis. Histograms were used to confirm distribution (Pallant, 2010). Due to the significant

skewness, kurtosis and Kolmogorov-Smirnov statistics for most demographic variables and the small sample size (N = 41), non-parametric tests that have less stringent assumptions regarding normality were used to determine associations between the demographic variables and subscale scores, and to determine inter-correlations between the subscale scores, and finally between the total scale scores and demographic variables. and scale scores (Pallant, 2010, p 112).

This chapter begins with a description of the sample and its representativeness, followed by descriptive statistics of participants' total scores. The next section includes associations between demographic variables and: contact with MHCUs and subscale scores. Lastly inter-correlations are presented between each subscale score; and between subscale scores and total score.

4.2. Description of the sample

The sample was drawn from five sites and a total of 41 participants (n = 41) completed the questionnaire. Due to time constraints related to gatekeeper approval or non-response to telephonic calls to clinics it was not possible to approach participants within all the intended 113 clinics and achieve the proposed target sample (N = 100). Thirteen questionnaires were spoilt, with participants failing to complete one or more of the sections. The missing data is summarized in Table 4.1., the first column on the left indicating the demographic data, the middle column the number of participants who responded and the right hand column the number of participants who did not respond, missing data.

Table 4.1: Summary of participants' response rate

Demographic Data	Number of participants who responded	Number of participants who did not respond
Gender	41	0
Age	39	2
Years practicing	38	3
Academic qualification	41	0
SANC registration as Psychiatric Nurse	40	1
SANC registration as PHC nurse	40	1
PSR training	36	5
Contact with MHCU	40	1

The sample is described through the creation of nominal scales, frequency counts, and cross tabulations of numbers and percentages of participants: gender, age, years of practice, academic qualification, SANC registration as Psychiatric Nurse, SANC registration as PHC Nurse, PSR training and contact with MHCU.

All participants (n = 41) indicated their gender. Only 1 participant was male (n = 1, 2.4%), the remaining 40 were female (n = 40, 97.6%). This is in keeping with international and national trends. Males make up less than 6% in Canada (Rajacich, Kane, Williston, & Cameron, 2013), 6.2% in the US (American Association of Colleges of Nursing, 2013), 10% in Australia (Australian Bureau of Statistics, 2013), and 5.8% to 7.97% in South Africa (Wildschut & Mqolozana, 2008; South African Nursing Council, 2013). Of the 39 participants (n = 39, 95%) who provided their age the median was 43 years and there were multiple modes (24 years: mo = 4; 51 years: mo = 4). As displayed in Table 4.2 (p. 28) the largest proportion of participants were in the middle age groups; 40 to 49 years (n = 11, 26.8%) and 50 to 59 years (n = 11, 26.8%), followed by the ages 22 to 29 years (n = 9, 22%), 30 to 39 years (n = 7, 17.1%) and finally 60+ years (n = 1, 2.4%). The age group 22-29 years reported the majority of contacts with MHCUs (n=7, 18.4%), followed by the age group 50-59 (n=6, 15.8%), then the age group 40-49 years (n=4, 10.5%) and finally the age group 30-39 years reported the least contacts with MHCUs (n=3, 7.9%).

Only 38 participants (93%) provided the number of years in practice. The mode was 1 year of practice (mo = 1) and included six participants (n = 6, 15.79%). The next commonly occurring number of years of practice was 22 years (n = 4, 10.53%). Years in practice ranged widely from 1 to 36 years as confirmed by the variance, skewness and significant kurtosis statistics (me = 15.55, SD = 10.407, variance = 108.308, Skewness=.093, standard error of skewness = .383, kurtosis = -1.192, standard error of kurtosis = .750).

All the participants indicated academic qualifications (n = 41). The majority of participants had achieved a Diploma qualification (n = 31, 75.6%), 9 had a Bachelor degree (n = 9, 22%), none of the participants had an Honours degree, and only 1 had a Master of nursing degree (n = 1, 2.4%).

Nurses with a Diploma had the majority of contacts with MHCUs (n=16, 40%), followed by nurses with a Bachelor degree (n=5, 12.5%) and finally the nurse with a Master of nursing degree (n=1, 2.5%). SANC registration status was reported by 40 participants, the majority were registered general nurses with a primary health nursing qualification (n = 26, 63.4%), followed by registered general nurses with a psychiatric nursing qualification (n = 25, 61%). Only 39 participants indicated whether they had both psychiatric nursing and primary health nursing qualifications. Of these, 14 (35.9%) had both qualifications and 4 (10.3%) had neither qualifications.

Table 4.2: Summary of Demographic Characteristics of Participants

Gender	Males	1 (2.4%)
	Females	40 (97.6%)
Age in years	22- 29	9 (22%)
	30 – 39	7 (17.1%)
	40 – 49	11 (26.8%)
	50 – 59	1 (2.4%)
	60+	Nil
Years in practice	1	6 (15.79%)
	8	3 (7.89%)
	10	3 (7.89%)
	15	3 (7.89%)
	22	4 (10.53%)
	25	3 (7.89%)
	27	2 (5.26%)
Academic Qualifications	Diploma	31 (75.6%)
	Bachelors	9 (22%)
	Honours	Nil
	Masters	1 (2.4%)
SANC registration as Psychiatric Nurse		25 (61%)
SANC registration as PHC nurse		26 (63.4%)
SANC registration as Psychiatric and PHC Nurse		14 (35.9%)
PSR training		11 (30.6%)
Contact with MHCU		22 (55%)

In addition, the majority (n = 25, 69.4%) had no PSR training. Of the 11 (30.6%) participants that indicated they had PSR training (with SANC Psychiatric registration: n = 8; without SANC Psychiatric registration: n = 3), only 9 indicated the duration of their training with the mode being 6 months (me = 3.130, std. error of mean = .923, SD = 2.769, variance = 7.670, skewness = .160, std. Error of skewness = .717, kurtosis = -2.449, std. Error of kurtosis = 1.400). All nurses who had PSR training (n=11, 30.6%) had contact with MHCUs, and they accounted for 50% of participants reporting contact with MHCUs. Finally, of the 40 participants who indicated whether they had contact with MHCUs, 22 did have contact with MHCUs (n = 22, 55%) and 18 did not have contact with MHCUs (n = 18, 45%).

4.3. PRBGP Scale Items, Subscale (Factor) scores and Total Scores

The reliability of the PRBGP scale was calculated with Chronbach's alpha coefficient above .7 considered as acceptable, otherwise the mean inter-item correlation was reported (and should have an optimal range of .2 to .4) (Pallant, 2010). The Cronbach's alpha coefficients for the subscales: Factor I 'Consumer Driven Approach' was .77, Factor II 'Staff Directed Approach' (reverse scored) was .71, Factor III 'Evidence Based Approach' was .64 (mean inter-item correlation was .25 with a range of -.26 to .72), Factor IV 'Standardized Services Approach' (reverse scored) was .73, and Factor V 'Recovery Mission Approach' was .75. In addition the Cronbach's alpha coefficient for the total scale was .51 (mean inter-item correlation was .02 with range of -.66 to .73). This coefficient is below the acceptable .7 alpha value. However, when the score was divided by the number of items in the scale (26 items) to produce a score that related more closely to the Likert scale used (which ranged from 1 to 4), as Pallant (2010) suggests may sometimes be done (Pallant, 2010, p. 87), the Cronbach's alpha coefficient for the total scale reached an acceptable value of .81. It is not clear from the original article whether this was done when the PRBGP Scale was used by Casper et al. (2002).

Descriptive statistics were done for each individual item within each of the five subscales (factors); the total subscale scores for each of the five subscales (factors); and total PRBGP scale scores to determine whether the responses represented a normal distribution. Descriptive statistics for the PRBGP scale thus included individual subscale items (Factor I = items 1 to 6, Factor II = items 7 to 14, Factor III = items 15 to 19, Factor IV = items 20 to 23, and Factor V = items 24 to 26), and subscale scores (Factor I = 'consumer driven

approach to care', Factor II = 'staff directed approach to care' , Factor III = 'evidence based approach to care', Factor IV = 'standardized services approach to care', and Factor V = 'recovery mission approach to care'). The presentation of the data will refer to these as factor scores. As indicated in the introduction to this chapter (point 4.1, p. 26) reverse scoring was employed for certain items to facilitate data analysis by ensuring that higher scores indicated a more favourable PSR response. Eighteen questionnaires were spoilt, with participants failing to complete one or more of the items within one or more of the subscales within the PRBGP.

The Kolmogorov-Smirnov statistical test was calculated for the factor scores and total scores. Only Factors I and IV had normally distributed scores (Factor I: $p = .200$, $df = 34$, Factor IV: $p = .122$, $df = 40$) with the remaining three factor scores not normally distributed (Factor II: $p = .046$, $df = 38$, Factor III: $p = .031$, $df = 39$, Factor V: $p = .011$, $df = 41$). The factor scores are therefore considered to be, in general, not normally distributed. The total scores are normally distributed ($p = .200$, $df = 32$). This is confirmed by the 5% trimmed mean, non-significant skewness and kurtosis statistics and normal probability plots (Normal Q-Q Plot) (me = 69.69, std. error of mean = .763, 5% trimmed mean = 69.60, skewness = .274, std. error of skewness = .414, kurtosis = -.187, std. error of kurtosis = .809). Although the total scores are considered to be normally distributed, non-parametric tests were used to determine associations between the demographic variables and subscale and total scores due to the significant skewness and kurtosis statistics and the small sample size ($N = 41$) (Pallant, 2010, p 112).

Tabulated representation of the statistical results for factor scores and total scores is attached as Annexure F (pp.74-77).

4.3.1. Factor I: Consumer Driven Approach to Care

Results on Factor I (Annexure F, p. 74) indicated the extent of a consumer driven approach adopted by participants and included items 1 to 6 (Table 4.3, p. 32). All item scores indicated a significant negative skew being more than double the standard error of skewness (item 1: Skewness = -.564, std. error of skewness = .383; item 2: skewness = -.613, std. error of skewness = .378; item 3: skewness = -.650, std. error of skewness = .378; item 4: Skewness = -1.277, std. error of skewness = .369; item 5: skewness = -1.078, std. error of skewness = .374; item 6: skewness = -.766, std. error of skewness = .374). The negative skew suggesting

that scores are clustered towards the higher scores indicating a consumer driven approach and thus a significant positive PSR response. No significant kurtosis was noted indicating there was no clustering of values in the middle or the extreme tails of the distribution.

Table 4.3: Item statements 1 to 6

Item Number	Item Statements
1	I like to have a client's preferences & choices direct every aspect of the rehabilitation process, including where and when I intervene.
2	When exploring potential residences, I rely on the person's housing preferences to direct the search.
3	A mentally ill person's housing, work and education should be in the same settings as persons who do not have the illness.
4	An overall goal of Psychiatric Rehabilitation is to assist mentally ill people in developing their preferences and skills, in reference to where they want to live, work and socialize.
5	If given the opportunity, people with a mental illness would choose the same kinds of things any of us would want.
6	I prefer a situational assessment rather than a global one to plan a client's skill training program.

Item 1 indicated that most participants (n = 27, 65.9%) allowed MHCU's preferences and choices to direct the process (md = 3, mo = 3, 75th percentile = 4). This practice was confirmed by item 2 (md = 3, mo = 3, 75th percentile = 3) where 26 participants agreed (somewhat agree = 22, 53.7%, totally agree = 4, 9.8%). However, participants did not agree totally with item 2 (75th percentile = 3, n = 22, 53.7%). Item 6 had a significant skewness statistic (-.766) with the 50th percentile equal to 4 thus supporting the findings of strong "PSR" practice in this subscale (md = 4, mo = 4, 50th percentile = 4). The majority of participants agreed with item 3 (n = 28, 68%) indicating a strong PSR belief (md = 3, mo = 4, 75th percentile = 4). This strong "PSR" belief was confirmed in item 5 by the median, mode and 50th percentile reaching the maximum value (md = 4, mo = 4, 50th percentile = 4). A majority of participants (n = 35, 85.3%) agreed with the goal of PSR (item 4) and this was confirmed by the median, mode and 50th percentile reaching a maximum value of 4 (md = 4, mo = 4, 50th percentile = 4). Thus participants agreed that their focus should be the MHCU.

4.3.2. Factor II: Staff-directed Approach to Care

Factor II (Annexure F, p. 74) measured the extent to which participants held beliefs and goals in their practices that reflected a consumer-directed agenda. It included items 7 to 14 (Table 4.4, p. 34). All of the items except item 13 (md = 3, mo = 3, skewness = -.308, std. error of skewness = .369, kurtosis = -.528, std. error of kurtosis = .724, 75th percentile = 3) had positive skews indicating that participants did not favour an agenda led by consumers.

Table 4.4: Item Statements 7 to 14 (Reverse Scored)

Item Number	Item Statements (Reverse Scored)
7	Psychiatric Rehabilitation is a consultative process in which the client should always discuss his/her decisions with the counsellor before making them.
8	A good rehabilitation plan identifies the person's greatest problems and weaknesses.
9	One consequence of having a mental illness is that people tend to lack personal preferences.
10	People with mental illness need more protection from society than help to participate in it.
11	Making choices for a person suffering from schizophrenia is not the same as making choices for a person who is not sick.
12	Because of the stress associated with it, working competitively should probably not be a goal for many mentally ill people.
13	I'm not comfortable with a client that I serve joining a consumer-run self-help group.
14	Competitive employment is a proper goal so long as the person has had prior competitive experience.

Although only items 8 ($md = 1$, $mo = 1$, skewness = 1.845, std. error of skewness = .374, kurtosis = 3.507, std. error of kurtosis = .733, 75th percentile = 2) and 11 ($md = 1$, $mo = 1$, skewness = 1.084, std. error of skewness = .369, kurtosis = .512, std. error of kurtosis = .724, 75th percentile = 2) reached significantly large skewness values that were more than twice the value of the standard error of skewness. The large, significant kurtosis for item 8 (kurtosis = 3.507, std. error of kurtosis = .733) indicates that most participants' responses were clustered around the lower scores, again lending support to the idea that most participants ($n = 37$, 90.3%) did not favour consumer directed agendas.

4.3.3. Factor III: Evidence-based Approach to Care

Factor III (Annexure F, p. 75) elucidated the use of research evidence to guide the practice of participants. Of the five items (items 15 to 19, Table 4.5, p. 35) that made up this subscale, four items (15, 16, 17, 18) had significantly large negative skewness and four items (15, 17 and 18) had significantly large positive kurtosis (item 15: $md = 4$, $mo = 4$, skewness = -2.262, std. error of skewness = .374, kurtosis = 5.897, std. error of kurtosis = .733, 50th percentile = 4; item 16: $md = 3$, $mo = 3$, skewness = -.780, std. error of skewness = .374, kurtosis = -.402, std. error of kurtosis = .733, 75th percentile = 4; item 17: $md = 4$, $mo = 4$, skewness = -2.173, std. error of skewness = .369, kurtosis = 6.532, std. error of kurtosis = .724, 50th percentile = 4; and item 18: $md = 4$, $mo = 4$, skewness = -4.057, std. error of skewness = .369, kurtosis = 18.773, std. error of kurtosis = .724, 25th percentile = 4).

Table 4.5: Item Statements 15 to 19

Item Number	Item Statements
15	A rehabilitation plan to help a mentally ill person go to work should always include gradual, incremental steps in order to reduce stress and maximize skill acquisition.
16	Living alone in one's home if one wants that, is only a proper Psychiatric Rehabilitation goal for persons whose symptoms are completely stable.
17	Psychiatric Rehabilitation professionals should be as concerned with client's quality of life as with their symptoms.
18	Educating Mentally Ill people about their illness, its symptoms, and their medication's benefits and side effects, is the best way to encourage cooperation with treatment.
19	Having a mental illness means in part that the capacities to learn and grow are greatly diminished.

This implies a strong agreement with evidence from literature since most participants selected higher scores for these statements (item15: somewhat agree n = 9 (22.0%), totally agree n = 29 (70.7%); item 16: somewhat agree n = 15 (36.6%), totally agree n = 15 (36.6%); item 17: somewhat agree n = 12 (29.3%), totally agree n = 28 (68.3%); item 18: somewhat agree n = 4 (9.8%), totally agree n = 36 (87.8%)) with items 15, 17 and 18 in particular having extremely large skewness and kurtosis values indicating that a significant majority (item 15: n = 29 (70.7%); item 17: n = 28 (68.3%); item 18: n = 36 (87.8%)) were in complete agreement with evidence from literature. Item 19 did not have a significant skew but it did have a significant negative kurtosis statistic (kurtosis = -1.280, std. error of kurtosis = .724) indicating that participants' responses were widely, almost equally distributed with 85.4% selecting responses that ranged from totally disagree (n = 15, 36%), to disagree (n = 9, 22%) and agree (n = 11, 26.8%).

4.3.4. Factor 1V: Standardized Services Approach to Care

The flexibility of participants to adjust services to meet the unique needs of MHCUs was determined in Factor IV (Annexure F, p. 75), items 20 to 23 (Table 4.6, p.36). Only item 22 had a significant positive skew (md = 1, mo = 1, skewness = 1.397, std. error of skewness = .374, kurtosis = 1.145, std. error of kurtosis = .733, 75th percentile = 2). In addition, items 20 and 21 had significantly negative kurtosis statistic values (item 20: kurtosis = -1.000, std. error of kurtosis = .724; item 21: kurtosis = -.973, std. error of kurtosis = .724) indicating a wide distribution of scores which included the extreme responses of totally disagree (item 20: n = 6, 14.6%; item 21: n = 34.1%) and totally agree (item 20: n = 9, 22%; item 21: n = 6, 14.6%).

Table 4.6: Item Statements 20 to 23 (Reverse Scored)

Item Number	Item Statements (Reverse Scored)
20	The outcomes achieved from individualized Psychiatric Rehabilitation services are often not worth the high cost and extreme complexity of providing them.
21	Providing supports to the mentally ill in their jobs or residences should be time limited so that they don't become too dependent on the supports.
22	When developing a Mentally Ill person's rehabilitation plan & goals I am guided primarily by a good assessment of their mental status.
23	I can usually judge how well a client will do at work or school settings by how well he/she does in his/her residence.

These were in keeping with the other items in this subscale (all had a positive skew although not significant) with the 75th percentile reaching a maximum of 3 for items 20, 21 and 23. Most participants selected low scores (item 20: md = 2, mo = 2, 75th percentile = 3; item 21: md = 2, mo = 1, 75th percentile = 3; item 22: md = 1, mo = 1, 75th percentile = 2; item 23: md = 2, mo = 2, 75th percentile = 3) indicating a lack of flexibility when dealing with the unique needs of MHCUs.

4.3.5. Factor V: Recovery Mission Approach to Care

Factor V (Annexure F, p. 76) comprised of items 24 to 26 (Table 4.7, p. 36), with scores widely distributed for item 24 between somewhat disagree (n = 6, 14.6%), somewhat agree (n = 20, 48.8%) and agree (n = 15, 36.6%), as confirmed by the significant negative kurtosis (kurtosis = -.814, std. error of kurtosis = .724) and the non-significant skewness (skewness = -.317, std. error of skewness = .369).

Table 4.7: Items 24 to 26

Item Number	Item Statements
24	Support development and environmental modifications may be more important than skill training in the long run for helping Mentally Ill persons achieve success in community integration.
25	Helping Mentally Ill persons fashion a new, positive self image is a viable, long-term goal for Psychiatric Rehabilitation.
26	Real recovery often includes exposing a Mentally Ill person to the risks of relapse and failure.

The significant negative skewness values for items 25 and 26 (item 25: skewness = -.726, std. error of skewness = .369; item 26: skewness = -.437, std. error of skewness = .369) together with the significant negative kurtosis for item 26 (kurtosis = -.888, std. error of kurtosis =

.724) indicates that participants favoured the Recovery Mission even though the responses were more spread out amongst the choices (somewhat agree and totally agree) for item 26 (n = 27, 65.8%) and more clustered for item 25 (n = 40, 97.5%).

4.4. Associations

Presented in this section are the associations which were computed between demographic variables and contact with MHCUs. For these analyses the demographic variable of 'contact with MHCUs' was seen as the independent variable in association to the other demographic 'dependent' variables. In addition associations were computed between demographic variables and subscale scores on the PRGPB.

The non-parametric Chi-square Test for Independence (Pallant, 2010, p. 217) was used to explore relationships between two categorical variables (contact with MHCUs: gender, age groups, SANC PHC registration, SANC Psychiatric registration, SANC PHC and Psychiatric registration, Qualifications and PSR training. No tests were done to explore relationships between contact with MHCUs and PSR duration because all nurses who had PSR training had contact with MHCUs) with results reaching significance when the p value was less than .05. The effect size (phi coefficient ϕ) was calculated and Cohen's (1988) criteria of .10 for small effect, .30 for medium effect and .50 for large effect were used (Pallant, 2010, p. 220). The Man-Whitney U Test was used due to the small sample size to test for differences between a continuous variable, for example, number of years in practice or the median of the total scores, and two independent groups such as contact with MHCUs. Again Cohen's (1998) criteria were used to determine the effect size ($r = z/\sqrt{N}$) (Pallant, 2010, p. 230). Spearman Rank Order Correlation (ρ) was used to determine the strength (r) (again using Cohen's (1998) criteria, Pallant, 2010, p. 134) and direction between continuous variables (total scores and: PSR Duration, age of participants and years in practice). Kruskal-Willis H Test was done to determine any differences between the total scores and qualifications (Pallant, 2010). In addition the Kolmogorov-Smirnov statistic which assesses the normality of a distribution, with a non-significant result (i.e. significance values greater than .05) indicating a normal distribution was .127, $p = .126$, $df = 38$) was calculated to add to the robustness of the study (Pallant, 2010).

4.4.1. Associations between Contact with MHCUs and Demographic Variables

There were no significant associations between contact with MHCUs and: gender (χ^2 (1, n = 40) = .01, p = .919, ϕ = -.18), age groups (χ^2 (4, n = 38) = 4.318, p = .365, ϕ = .337), SANC PHC Nurse registration (χ^2 (1, n = 39) = .000, p = 1.000, ϕ = -.05), having both SANC Psychiatric and PHC registrations (χ^2 (1, n = 38) = .581, p = .446, ϕ = .178), and Qualifications (χ^2 (2, n = 40) = .853, p = .653, ϕ = .146), . There was no significant difference in the number of years in practice between participants who had contact with MHCUs (me = 16.81, n = 21) and those who did not have contact with MHCUs (me = 21.88, n = 16), $U=122.000$, $z=-1.415$, p = .157, r = .233.

There was a significant association of medium effect size between SANC Psychiatric Nurse registration and contact with MHCUs (χ^2 (1, n = 39) = 4.139, p = .042, ϕ = .379). The majority of contacts with MHCUs were by nurses with a SANC Psychiatric registration (n = 17, 81%) and the majority of no-contacts with MHCUs were by nurses without a SANC Psychiatric registration (n = 10, 55.6%), suggesting that when a MHCU presents at the clinic the nurses with the psychiatric qualification are called to complete the consultation. There was also a highly significant positive association with large effect size between PSR Training and contact with MHCUs (χ^2 (1, n = 35) = 8.193, p = .004, ϕ = .548). This is in keeping with the previous finding (SANC Psychiatric Nurse registration and contact with MHCUs) and indicates that nurses who had previous PSR training had the majority of interactions with MHCUs in the clinic.

4.4.2. Associations between Subscale Scores and Demographic Variables

There was a medium, statistically significant negative relationship between Factor II scores and age of participants (ρ = -.416, n = 36, p = .012) with 17.3% shared variance (coefficient of determination = .173, Pallant, 2010). The older participants were less likely to allow MHCUs' needs to direct the interaction. There was also significant negative associations with small effect size between Factor III scores and PSR training (md = 15, n = 11) and no PSR training (md = 17, n = 24), $U = 67.500$, $z = -2.323$, $p = .020$, $r = .159$. Those participants who had PSR training were less likely to use evidence from literature to guide their interaction with MHCUs.

There were no other significant relationships or associations between any of the remaining subscale scores and demographic variables. (Annexure F, p. 74-77).

4.4.3. Associations between Total Scores and Demographic Variables

There were no significant associations between total scores and demographic variables (gender, SANC Psychiatric registration, SANC PHC registration, SANC Psychiatric and PHC registration, PSR training, PSR training duration, contact with MHCUs, age of participants, years in practice and qualifications) (Annexure F, p. 77).

4.5. Inter-Correlations between the Subscale Scores

Spearman Rank Order Correlation (ρ) was used to determine the strength (r) (using Cohen's (1998) criteria of small ($r = .10$ to $.29$); medium ($r = .30$ to $.49$); and large ($r = .50$ to 1.0) (Pallant, 2010, p. 134)) and direction between continuous variables (Subscale Scores and: PSR Duration, age of participants and years in practice). The coefficient of determination was also calculated to describe the shared variance between the variables (Pallant, 2010, p. 134).

As illustrated in Table 4.8 (p. 40) inter-correlations for the five factors were calculated. There was medium positive inter-correlation between Factor III scores and Factor V scores, with nurses' agreement with the PSR recovery mission reflected in their evidence based practice ($\rho = .326$, $n=39$, $p<.05$); large negative inter-correlations between Factor I scores and Factor II scores ($\rho = -.459$, $n = 32$, $p < .01$); and between Factor I scores and Factor IV scores ($\rho = -.592$, $n = 34$, $p < .01$), indicating a conflict between the claims of nurses' consumer driven approach and allowing MHCUs to actually direct the process including personalizing the services to meet the needs of MHCUs; large negative inter-correlation between Factor II scores and Factor III scores ($\rho = -.579$, $n = 37$, $p < .01$), which indicates a significantly large disagreement between claims that nurses used PSR evidence from literature and the actual process of allowing consumers' needs to direct this process; and large positive inter-correlation between Factor II scores and Factor IV scores ($\rho = .584$, $n = 37$, $p < .01$) indicating that nurses who agreed that consumers' needs should direct the process also individualized services to meet the unique needs of MHCUs.

Table 4.8 Spearman Rank Order Correlation between Subscale Scores

	Factor I	Factor II	Factor III	Factor IV	Factor V
Factor I Consumer Driven	-	-.459**	.145	-.592**	.050
Factor II Staff Directed	-	-	-.579**	.584**	-.209
Factor III Evidence Based	-	-	-	-.292	.326*
Factor IV Standardized Services	-	-	-	-	-.103
Factor V Recovery Mission	-	-	-	-	-

*= medium correlations

**= large correlations

4.6. Summary of the chapter

The sample was drawn from five sites and a total of 41 participants. The Cronbach's alpha coefficient for the total scale reached an acceptable value of .81. Participants agreed that their focus should be the MHCU with the use of PSR evidence from literature and a Recovery Mission approach. Those who agreed with the PSR recovery mission approach also agreed with the PSR evidence in literature and nurses who agreed that consumers' needs should direct the process also individualized services to meet the unique needs of MHCUs. Nurses with a SANC Psychiatric Nurse registration or PSR Training had significantly more contact with MHCUs. However most participants did not favour consumer directed agendas and lacked flexibility when dealing with the unique needs of MHCUs. The age of participants was inversely related to the likelihood to allow MHCUs' needs to direct the interaction; and nurses with PSR training were less likely to agree with evidence-based practice. There was conflict between the claims of nurses' use of the consumer driven approach and allowing MHCUs' needs to actually direct the process including personalizing the services to meet the needs of MHCUs. Disagreement also existed between claims that nurses used PSR evidence from literature and the actual process of allowing consumers' needs to direct this process. The tabulated summary of all the results is available in Annexure G (p. 78)

Chapter Five

Discussion and Recommendations

5.1. Introduction

The findings of this study are discussed with particular focus on differences found in relation to previous research. The limitations and recommendations of the study are also noted. This study's aim was to describe PSR beliefs, goals and practices of registered nurses working in PHC in the eThekweni District.

Nurses are generally trained in PHC using the biomedical rather than a social model, which does not use a PSR or empowerment approach to care (Petersen, 1999, 2008; Naledi, Barron, & Schneider, 2011). In addition nurses who have no psychiatric training have the same negative stereotypes and prejudices as the general population (Chambers, Guise, Valimaki, Botelho, Scott, Staniuliene & Zanotti, 2010; Schafer, Wood, & Williams, 2011). Specifically, nurses from general hospital settings are reported to subscribe to negative stereotypes associated with MHCUs, compounded by their (the nurses) lack of exposure to MHCUs post acute treatment phase and thus positive outcomes of recovery that MHCUs may experience. (Saunders, Hawton, Fortune, & Farrell, 2012; Boekel, Brouwers, van Weeghel, & Garretsen, 2013). Within this biomedical context nurses working in integrated mental health and primary health care settings are unable to provide psychosocial rehabilitative mental health care services.

5.2. Discussion

Although South Africa has made some gains in decentralization and integration of mental health into primary health care (Petersen, Lund, Bhana, & Flisher, 2010) there is no evidence of the PSR practices in PHC and the beliefs, goals and practices of registered nurses working in PHC have not been examined empirically in the South African context.

5.2.1. Nurses understanding of PSR beliefs, goals and practices

Nurses could clearly articulate the rhetoric of PSR and empowerment in this study as indicated by the large negative skewness statistics (consumer driven, p. 32; evidence based, p. 34; and recovery mission, p. 36) and the 75th percentiles reaching a value of 3 (agree) or 4

(strongly agree) but there was no evidence of implementation of these in practice as indicated by the positive skewness statistics (staff directed, p. 33 and standardized services, p. 35). Results indicating that effective nurse-MHCU collaborative relationships that allow MHCUs to participate in clinical decisions are important to successful mental health outcomes (Galon & Graor, 2012) but is lacking. This discordance between discourse and practice is interpreted as social desirability (van de Mortel, 2008) and is not unusual when the political history of South Africa which includes dealing with extremely unfair, discriminatory legislation and practices (African National Congress, 2011) is considered. This history has included the dismantling of apartheid legislation and practices and the institution of more equitable legislation as described in the constitution of South Africa (Government Gazette, 1996). Most citizens in South Africa appear to be able to use discourse that is socially appropriate and desirable, as is evident in the ability to use appropriate language in official documents produced such as the Batho Pele principles (Department of Health KZN, 2001b) that describe an ideal standard of care. Yet it is still possible to find patients who are dissatisfied with the quality of services rendered that clearly fall short of this articulated ideal (Peltzer, 2009). The use of language to describe the ideal services provision does not necessarily equate to performance of this ideal.

Performance and practice may also be closely related to ability. The results of this study indicate that nurses do not implement consumer driven, individualized approaches to care. Data indicates that practice choices may be related to the qualifications of participants and one advanced nurse with masters qualification participated in this study (n = 1, p. 29) and the majority had diplomas or Bachelors degrees (n = 40, p. 29). This link to qualifications, specifically advanced qualifications, is referenced in current literature. There are studies that indicate that nurses can and do provide quality integrated primary mental health care services that are based upon PSR principles, but these nurses were advanced practice nurses (Marion, Brauns, Anderson, McDevitt, Noyes, & Snyder, 2004). Even when qualified staff could utilize appropriate tools such as an assessment of MHCUs' health needs, the provision of treatment was however not optimal (Sacks, Chaple, Sirikantraporn, Sacks, Knickman, & Martinez, 2013, p. 492). Existing structures found in PHC may not facilitate the use of evidence-based PSR interventions (Saraceno, et al., 2007; Eaton, et al., 2011) because the constant training and supervision which are required is not accommodated in the PHC service plan resulting in no motivation to provide continuous, appropriate mental health care (Eaton, et al., 2011). Though mental health policy exists and staff acquire adequate PSR skills,

mechanisms of implementation may be inadequate (Eaton, et al., 2011). In addition, “less enthusiasm for readying the organization to serve...clients” may also be relevant (Sacks, Chaple, Sirikantraporn, Sacks, Knickman, & Martinez, 2013, p. 492).

5.2.2. Younger nurses would allow consumers’ needs to direct treatment interactions and would individualize services

The medium, significant negative association (p. 38) between the age of participants and Factor II (Staff-directed approach- reverse scored) and large, positive inter-correlations (p. 39) between Factor II and Factor IV (Standardized services approach- reverse scored) indicate that younger nurses were more likely to allow consumers’ needs to direct treatment interactions and would individualize services to meet MHCUs’ needs. This does not mean that these nurses’ actual practice allowed MHCUs’ needs to direct treatment interactions or adapted services to meet the specific needs of their patients but it simply indicates an intention to do so. This result is in keeping with the curriculum changes experienced in nurse training with older nurses having received training with a strong focus on secondary care (Butterworth, 1995; Uys, Subedar, & Lewis, 1995) where interaction with chronically mentally ill patients would create a negative perception regarding recovery for these patients. In a systematic review conducted by Saunders, Hawton, Fortune, and Farrell (2012) the influence of the age of staff on attitudes towards MHCUs was not clear. Another study indicated that age was not a significant predictor of attitudes towards MHCUs (Schafer, Wood & Williams, 2011). However, Johnson, et al. (2009) found that healthcare providers were not providing optimal support for clients and the mean age of participants was 44.2 years; whilst Schafer, Wood, and Williams (2011) found more positive attitudes related to contact with MHCUs in their study which had participants in the age group 17-29 years (67% of that sample). This current study supports the conclusion that age does have an influence on attitudes towards MHCUs and the approach used to determine clinical care.

5.2.3. Nurses with PSR and Psych registration more likely to interact with MHCUs

The significant association with medium effect between SANC psychiatric registration and contact (81%) with MHCUs (p. 38) and the highly significant association with large effect size between PSR training and contact with MHCUs (p. 38) should be a welcome result. It indicates that MHCUs are being seen by appropriately qualified nurses. The results for PSR training and contact with MHCUs is initially surprising since some of the nurses that had PSR training did not have SANC psychiatric registration (n = 3, p. 31). This would seem to

indicate that PSR training itself resulted in more positive attitudes towards MHCUs (O'Neill, Moore, & Ryan, 2008) as well as more interactions with MHCUs. Significant improvements in self-reported attitudes and confidence were reported with active training for staff (Saunders, Hawton, Fortune, & Farrell, 2012). Other research shows that nurses with a psychiatric qualification, or those who have had personal experience or interacted with someone who has had a personal experience with mental illness were more likely to have a positive attitude towards MHCUs (Schafer, Wood, & Williams, 2011; Boekel, Brouwers, van Weeghel, & Garretsen, 2013). This however does not necessarily mean that nurses with psychiatric registrations and PSR training actively engaged MHCUs, but rather this interaction could be due to MHCUs being directed to nurses with psychiatric registrations or PSR training whilst nurses without psychiatric registration or PSR training only interacted with MHCUs when a nurse with psychiatric registration or PSR training was unavailable (Glover & Smith, 2013, in print).

Nurses with PSR training did not agree with the PSR evidence in literature as indicated by the significant negative associations with small effect size between PSR training and Factor III (Evidence-based approach) (p. 38). This is not in keeping with previous research (O'Neill, Moore, & Ryan, 2008; Schafer, Wood, & Williams, 2011; Boekel, Brouwers, van Weeghel, & Garretsen, 2013) and may indicate that 'PSR training' may not have been based on the core PSR literature on which the PRBGP scale is constructed. Although not examined further because it was not within the scope of this study, the validity of the content and practical applications demonstrated in workshops on PSR may have been based on other models of rehabilitation. Training that was often "short, theoretical, and without sufficient follow-up" (Saraceno, et al., 2007, p. 1170) did not enhance skills and knowledge and are largely ineffective (Saraceno, et al., 2007; Wiley-Exley, 2007) with education also having a counter-productive role in influencing attitudes when there is low role support from colleagues (Boekel, Brouwers, van Weeghel, & Garretsen, 2013) and these could also be possible reasons for this study's findings. In addition the demands of providing PHC to MHCUs was seen as an additional task by PHC nurses that could not be realistically met because they were already overburdened (Petersen, Ssebunnya, Bhana, & Baillie, 2011). The lack of adequate structures for health professionals to support MHCUs has been reported by other studies (Boekel, Brouwers, van Weeghel, & Garretsen, 2013) and could also account for the disagreement with PSR evidence in literature.

5.3. Limitations of this study

The small, convenience sample used is not representative of the population being studied. These results therefore cannot be generalized to the population of nurses working in PHC. The study also did not actively involve males and nurses working in rural PHC. The ideological or theoretical perspectives of participants were also not identified in this study and these responses may really only reflect what participants' considered to be appropriate rather than what they actually believed or practiced (Fydi, et al., 2011).

5.4. Recommendations

This study brings the practice of PSR in PHC settings in South Africa into sharp focus and its findings suggest future research needs to occur with specific areas of focus. In an attempt to improve mental health care outcomes future research is suggested to focus on ; the differentiation between the ideological stance of nurses and their actual beliefs to inform and facilitate programmes such as PSR training. It would be futile to offer training that enables nurses to articulate what is considered to be appropriate language for PSR discourse without actual changes in beliefs regarding MHCUs occurring. Secondly, the best intentions of nurses can be nullified if there is no support for PSR from organizational structures and colleagues. The characteristics of effective organisational and collegial support for effective PSR implementation must be determined so that interventions can be appropriately directed. Lastly, PSR training has been shown to positively influence the attitudes of nurses (Saunders, Hawton, Fortune, & Farrell, 2012). Yet the content of PSR programmes in South Africa have not been assessed and may have resulted in this study's findings which included participants responses indicating disagreement with evidence from PSR literature. It is clear that the appropriate PSR philosophy and content must be taught in order to achieve the positive attitude and reflective practice changes required in nurses working with MHCUs. Future research that examines whether PSR training alone of PHC nurses will improve nurses' active engagement of MHCUs, whether the age of nurses without the influence of PSR training or SANC psychiatric registration influences the attitude of nurses towards MHCUs and whether advanced nurses have a more positive attitude towards MHCUs should be done.

5.5. Conclusions

Nurses working in PHC have the potential to adopt a PSR approach to care that facilitates MHCUs that attend their clinics to achieve optimal health. They are able to articulate PSR beliefs, goals and practices that acknowledge MHCUs' needs should direct the treatment

agenda based on a recovery mission focus using evidence-based practice. However they were unable to translate this into their actual practice settings but made choices for MHCUs from standardized treatment options available in PHC. The age of nurses was inversely related to both their willingness to allow MHCUs' needs to direct treatment options and to individualize services to meet unique needs of MHCUs. Nurses with SANC psychiatric registration or who had PSR training were more likely to interact with MHCUs although this did not necessarily mean that this contact was initiated by these nurses. PSR training in itself was also no guarantee that nurses used evidence-based practice.

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Annexures

Annexure A1: Letter to Gatekeepers: District Office

Thank you for your time. I am requesting the participation of registered nurses working in Primary Health Care clinics in a research study.

I am Ashley Govender and am a master's student at the University of KwaZulu Natal - School of Nursing. This study is part of the requirements for completion of the master's programme. My supervisors are Ms Amanda Smith (University of KwaZulu Natal – School of Nursing) and Dr Lyn Middleton (Regional Nursing Advisor, ICAP Nurse Capacity Initiative).

The recent change to the way healthcare is practiced in primary health, specifically the inclusion of mental health, is the reason for this study. With the emphasis on integration of mental health services in the primary health clinic, many nurses find themselves taking care of mental health care users.

This study seeks to determine the knowledge registered nurses have regarding the provision of psychosocial rehabilitation services to mental health care users.

The identities of these registered nurses are not required in this study. They will not record their names or the names of their clinics. All answers provided will be treated as strictly confidential. The designs of the questionnaires do not include any information that can be used now or in the future to identify them. You are therefore completely assured of these registered nurses remaining anonymous. I will be contacting clinic managers to arrange for the appropriate date and time for these appointments.

We assume that the registered nurses are adults who are able to make informed choices regarding their participation in this study. They can choose to join the study or they can refuse to join the study with no consequences, personally or professional. If they join the study, their participation will provide valuable information that could improve the clinical practice offered to mental health care users. They can choose to withdraw from the study while completing the questionnaire. However once the questionnaire has been posted in the box provided it is not possible to withdraw as we will not be able to identify which questionnaire is theirs. The findings of the study will be available from the University of KwaZulu Natal – School of Nursing and will be published in an academic journal within one year of the studies' completion.

If they choose to participate in this study, they will need to complete the Informed Consent form. As part of the requirements for informed consent, we will encourage them to ask any questions that they may have and to clarify any concerns that may have arisen.

The demographic questionnaire and PRBGP scale questionnaire will be completed by these registered nurses during the afternoons when the clinics are quieter and will be placed into the sealed box provided. They should not require more than half an hour to complete the questionnaires.

Please find the copy of the research proposal attached for your perusal.

Annexure A2: Letter to Gatekeepers: PHC Clinic Managers

Thank you for your time. I am requesting the participation of registered nurses working in Primary Health Care clinics in a research study.

I am Ashley Govender and am a master's student at the University of KwaZulu Natal - School of Nursing. This study is part of the requirements for completion of the master's programme. My supervisors are Ms Amanda Smith (University of KwaZulu Natal – School of Nursing) and Dr Lyn Middleton (Regional Nursing Advisor, ICAP Nurse Capacity Initiative).

The recent change to the way healthcare is practiced in primary health, specifically the inclusion of mental health, is the reason for this study. With the emphasis on integration of mental health services in the primary health clinic, many nurses find themselves taking care of mental health care users.

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We assume that the registered nurses are adults who are able to make informed choices regarding their participation in this study. They can choose to join the study or they can refuse to join the study with no consequences, personally or professional. If they join the study, their participation will provide valuable information that could improve the clinical practice offered to mental health care users. They can choose to withdraw from the study while completing the questionnaire. However once the questionnaire has been posted in the box provided it is not possible to withdraw as we will not be able to identify which questionnaire is theirs. The findings of the study will be available from the University of KwaZulu Natal – School of Nursing and will be published in an academic journal within one year of the studies' completion.

If they choose to participate in this study, they will need to complete the Informed Consent form. As part of the requirements for informed consent, we will encourage them to ask any questions that they may have and to clarify any concerns that may have arisen.

The demographic questionnaire and PRBGP scale questionnaire will be completed by these registered nurses during the afternoons when the clinics are quieter and will be placed into the sealed box provided. They should not require more than half an hour to complete the questionnaires.

Please find a summary of the research proposal attached for your perusal.

Summary of Research:

Topic:

EXPLORATION OF MENTAL HEALTH PSYCHOSOCIAL REHABILITATION BELIEFS, GOALS AND PRACTICES OF REGISTERED NURSES' WORKING IN PRIMARY HEALTH CARE CLINICS WITHIN THE ETHEKWINI DISTRICT

Aim/ Purpose:

The purpose of this study is to describe psychosocial rehabilitation beliefs, goals and practices of registered nurses' working in Primary Health Care clinics in the eThekweni District.

Objectives:

1. To describe the treatment approach/s inherent in the beliefs, goals and practices of registered nurses working in PHC clinics.
2. To determine if there are relationships between different treatment approaches to care.
3. To describe associations between demographic and service variables and specific treatment approaches to care.

Research Questions:

The research questions are related to the three research objectives.

Research objective one.

1. What are the PSR beliefs, goals and practices of registered nurses working in PHC clinics?
2. What is the treatment approach that registered nurses working in PHC clinics more or less subscribe to; consumer driven; staff driven, evidence based practice, standardised disease and or recovery?

Research objective two.

3. Are there relationships between the approaches to care (consumer driven, staff directed, evidence based practice, standardised disease orientation, and recovery mission orientation)?

Research objective three.

4. Are there associations between the demographic variables (gender, age, experience, qualification, and training in PSR) and each of the approaches to care (consumer driven, staff directed, EBP, standardised disease orientation, and recovery mission orientation)?
5. Are there associations between the service variables (Rural or urban setting and exposure to MHCU) and each of the approaches to care (consumer driven, staff directed, EBP, standardised disease orientation, and recovery mission orientation)?

Research Tool:

The Psychiatric Rehabilitation Beliefs, Goals, and Practices (PRBGP) scale will be used to collect data from participants. The scale has twenty six (26) items that measure mental health

practitioner's knowledge of current beliefs, goals and practices in psychiatric rehabilitation (Casper, 2005).

Ethics:

1. Respect for persons: The participants' will be informed in writing and verbally of the proposed study and they will be allowed to voluntarily choose to participate or not. In addition, participants' will be informed of their right to withdraw from the study at any time before depositing the questionnaires into the sealed box, without any detrimental effect. This study will not use coercion, covert data collection or deception. Thus there will be no violation of the respect for persons. The study participants' are adults without diminished autonomy and we therefore assume that they are able to protect their own rights.

2. Right to privacy and confidentiality: The participants' right to remain anonymous will be ensured through the coding of questionnaires, participants' names nor identifiable data such as dates of birth, telephone and fax numbers will not be recorded. Any other means of identifying participants' will be de-identified if they are discovered during the course of the study. All returned demographic and study questionnaires will be placed in a sealed box at the workplace so that the participants' identity is kept anonymous. There will be no negative consequences personally or professionally associated with responses recorded on the questionnaire.

This study does not require the participants' to be re-identified. Therefore the list of clinics visited will be destroyed and not be kept for future use.

3. Benefits and risks: The benefits of this study are linked to improvement in evidence-based clinical practice. This will be beneficial to nurses and the mental health care users as this study will inform future training of nurses and the integration of mental health into primary health care. The results of the study will be made available at the University of KwaZulu Natal library, to any of the participants who wish to have access. There are no risks attached to this study since the identities of participants' will be protected at all times. The study will attempt to prevent interfering with essential health services to health care users seeking help at these clinics. In addition, this study will satisfy the requirements for the coursework masters programme of the researcher.

4. Informed consent: The participants' are registered nurses who are adults capable of making informed choices. All participants' will be provided with an information sheet (Annexure B) that outlines the aims of the study, any risks and benefits and assurances of their right to voluntary participation and withdrawal from the study. In addition participants' will be offered the opportunity to ask any questions to clarify these aims if they so desire before signing the informed consent form (Annexure C).

5. Limitation of the study: The sample size will limit the generalizability of the findings. Respondents may also provide responses whilst filling the self-report questionnaire, that they perceive to be socially or professionally acceptable and may not necessarily reflect the actual beliefs, goals or practices of registered nurses working in PHC clinics. Their responses will not be verified. The completion of the questionnaire will be during normal clinic times and may conflict with other duties that need to be completed by these nurses. Participants may have emergencies to attend to and will be allowed to return to complete the questionnaires. That may result in uncompleted questionnaires or inappropriate responses given to get back to these duties.

Data Collection Plan:

1. Contacting the PHC clinics
 - a. Once permission is granted from the eThekweni district office the 113 PHC clinics (KwaZulu Natal Department of Health, 2009) will be contacted per telephone followed by a written request (Annexure A) for support via fax to the staff of the clinic via fax. The request will indicate the purpose and requirements and will also indicate that the researcher will be contacting them telephonically within the following week.
 - b. This will be followed up with a phone call to the PHC clinic manager to confirm date, time, and the availability of an office in which to administer the self-report questionnaire.
2. Appointments
 - a. Appointments will be made with registered nurses working at the PHC clinic to administer the self-report questionnaire.
 - b. All appointments will be made from 12h00 onwards as these are quieter times at the clinics with minimal booked cases. Nurses are usually engaged in administrative duties and recording, while being available for emergency unscheduled appointments.
 - c. Data collection at each clinic will be completed in a single afternoon.
3. Pre-commencement of the self-report questionnaire
 - a. The researcher will give a verbal and written explanation (information sheet-Annexure B) to each participant. This will include
 - i. Guarantees of anonymity,
 - ii. Expected date of written report / feedback,
 - iii. Feedback will focus on all clinics and not be specific to individual clinics,
 - iv. Who else will receive feedback.
 - b. Time will be given for questions and reassurances.
 - c. An explanation of the data collection process including the expected length of time required to complete the self-report questionnaire will be given.
4. The participant will be required to sign an informed consent form before the data collection begins (Annexure C).
5. During the self-report questionnaire
 - a. The researcher will remain available to read the self-report questionnaire to the participants to ensure that each participant understands what is required.
 - b. The researcher will define any terms that the participants request. Requests for definitions will be noted as will any hesitation, ambivalence, or requested explanations as a possible defect of the tool.
 - c. Questions will not be explained to participants but reassurance will be given that there is no right or wrong answer and therefore no personal or professional risk associated with choosing a response.
 - d. No assistance or guidance will be given to participants regarding answers selected.
6. On completion of the self-report questionnaire
 - a. Participants will be asked not to discuss the contents of the questionnaire with staff from other clinics for twelve weeks, until the data collection process is completed.
 - b. Completed self-report questionnaires will be deposited by the participants at the clinic into a sealed box which will be opened at the end of the data collection process to facilitate coding of questionnaires per clinic.

Annexure B: Information Sheet

Thank you for your time. I am requesting your participation in a research study. I am Ashley Govender and am a master's student at the University of KwaZulu Natal - School of Nursing.

This study is part of the requirements for completion of the master's programme. My supervisors are Ms Amanda Smith (University of KwaZulu Natal – School of Nursing) and Dr Lyn Middleton (Regional Nursing Advisor, ICAP Nurse Capacity Initiative).

The recent change to the way healthcare is practiced in primary health, specifically the inclusion of mental health is the reason for this study. With the emphasis on integration of mental health services in the primary health clinic, many primary health nurses find themselves taking care of psychiatric clients.

This study seeks to determine the knowledge primary health nurses have regarding the provision of psychosocial rehabilitation services to psychiatric clients.

Your identity is not required in this study. You will not record your name or the name of your clinic. All answers provided will be treated as strictly confidential. The designs of the questionnaires do not include any information that can be used now or in the future to identify you. You are therefore completely assured of remaining anonymous.

We assume that you are an adult who is able to make an informed choice regarding your participation in this study. You can choose to join the study or you can refuse to join the study with no consequences, personally or professional. If you join the study, your participation will provide valuable information that could improve the clinical practice offered to psychiatric clients. You can choose to withdraw from the study while completing the questionnaire. However once the questionnaire has been posted in the box provided it is not possible to withdraw as we will not be able to identify which questionnaire is yours. The findings of the study will be available from the University of KwaZulu Natal – School of Nursing and will be published in an academic journal within one year of the studies' completion.

If you choose to participate in this study, you will need to complete the Informed Consent form. As part of the requirements for informed consent, we encourage you to ask any questions that you may have and to clarify any concerns that may have arisen.

The demographic questionnaire and PRBGP scale questionnaire will be completed by you now and placed into the sealed box provided. You should not require more than half an hour to complete the questionnaires.

Annexure C: Informed consent Form (Adapted from Polit & Beck, 2008, p. 179).

I understand that I am being asked to participate in a research study conducted by Mr Ashley Govender, a master's student from the University of KwaZulu Natal – School of Nursing. This study will collect information about registered nurses' knowledge about beliefs, goals and practices regarding psychosocial rehabilitation of psychiatric clients in PHC clinics.

If I agree to participate in the study I will complete the demographic questionnaire and complete the PRBGP scale questionnaire. No personally identifying information will be included in these forms. I understand that there are no known risks with this study and that there is no payment for participation in this study.

I realize that the knowledge gained from this study may help improve the clinical services provided to psychiatric clients.

I realize that my participation in this study is entirely voluntary, and I may withdraw from the study at any time before putting my completed questionnaire in the sealed box provided. If I decide to discontinue my participation in the study, I will continue to be treated in the usual and customary fashion as at present. I understand that all study data will be kept confidential. However, this information will be used as completion of a master's student course requirements, and will be used in nursing publications or presentations.

If I need to, I can contact Ms Amanda Smith at UKZN- School of Nursing at any time during the study.

The study has been explained to me. I have read and understood this consent form. All of my questions regarding this study have been answered, and I agree to participate. I understand that I will be given a copy of this signed consent form if I request it.

Signature of Subject

Date

Signature of Witness

Date

Signature of Researcher

Date

Annexure D

SELF REPORT QUESTIONNAIRE

Please note the following

- Do not write your name anywhere on this questionnaire
- Answer all the question items by indicating your choice with a cross (X)
- Place the completed questionnaire in the sealed box provided

SECTION 1

1. Are you Male
 Female
2. What was your age at your last birthday? _____
3. State the number of years you have been practicing as a registered nurse _____
4. Indicate by placing a cross (X) next to your highest academic qualification in nursing?

Diploma	<input type="checkbox"/>
Bachelor's degree	<input type="checkbox"/>
Honours degree	<input type="checkbox"/>
Masters degree	<input type="checkbox"/>

	YES	NO
5. Are you registered with SANC as a psychiatric nurse?		
6. Are you registered with SANC as a PHC nurse?		
7. Have you had any training in Psychosocial Rehabilitation? If yes, how long was the training?.....		
8. Do you currently have contact with MHCUs (psychiatric patients)		
9. Are there specific policies or guidelines that direct your clinical practice? If yes, please list which policies or guidelines.....		

SECTION 2

Please read the following 26 statements and indicate by placing a cross (X) whether you:

1. Totally disagree
2. Somewhat disagree
3. Somewhat agree
4. Totally agree

	Items	1	2	3	4
1	I like to have a client's preferences & choices direct every aspect of the rehabilitation process, including where and when I intervene.				
2	When exploring potential residences, I rely on the person's housing preferences to direct the search.				
3	A mentally ill person's housing, work and education should be in the same settings as persons who do not have the illness.				
4	An overall goal of Psychiatric Rehabilitation is to assist mentally ill people in developing their preferences and skills, in reference to where they want to live, work and socialize.				
5	If given the opportunity, people with a mental illness would choose the same kinds of things any of us would want.				
6	I prefer a situational assessment rather than a global one to plan a client's skill training program.				
7	Psychiatric Rehabilitation is a consultative process in which the client should always discuss his/her decisions with the counsellor before making them.				
8	A good rehabilitation plan identifies the person's greatest problems and weaknesses.				
9	One consequence of having a mental illness is that people tend to lack personal preferences.				
10	People with mental illness need more protection from society than help to participate in it.				
11	Making choices for a person suffering from schizophrenia is not the same as making choices for a person who is not sick.				
12	Because of the stress associated with it, working competitively should probably not be a goal for many mentally ill people.				
13	I'm not comfortable with a client that I serve joining a consumer-run self-help group.				
14	Competitive employment is a proper goal so long as the person has had prior competitive experience.				
15	A rehabilitation plan to help a mentally ill person go to work should always include gradual, incremental steps in order to reduce stress and maximize skill acquisition.				
16	Living alone in one's home if one wants that, is only a proper Psychiatric Rehabilitation goal for persons whose symptoms are completely stable.				
17	Psychiatric Rehabilitation professionals should be as concerned with client's quality of life as with their symptoms.				
18	Educating Mentally Ill people about their illness, its symptoms, and their medication's benefits and side effects, is the best way to encourage cooperation with treatment.				
19	Having a mental illness means in part that the capacities to learn and grow are greatly diminished.				
	Items	1	2	3	4
20	The outcomes achieved from individualized Psychiatric Rehabilitation				

	services are often not worth the high cost and extreme complexity of providing them.				
21	Providing supports to the mentally ill in their jobs or residences should be time limited so that they don't become too dependent on the supports.				
22	When developing a Mentally Ill person's rehabilitation plan & goals I am guided primarily by a good assessment of their mental status.				
23	I can usually judge how well a client will do at work or school settings by how well he/she does in his/her residence.				
24	Support development and environmental modifications may be more important than skill training in the long run for helping Mentally Ill persons achieve success in community integration.				
25	Helping Mentally Ill persons fashion a new, positive self image is a viable, long-term goal for Psychiatric Rehabilitation.				
26	Real recovery often includes exposing a Mentally Ill person to the risks of relapse and failure.				

Annexure E

Clinics per PHC area

List received from Deputy District Manager: Monitoring and Evaluatuion-07/02/2011

North 1	North 2	North 3	North 4	North 5	North 6
Glen Earle	Goodwins	Besters	Inanda C CHC	Amaoti	Hambanathi
La Lucia Clinic	KwaMashu B Clinic	KwaMashu Mob 1	Inanda Seminary	Caneside	Matikwe
Newlands East	KwaMashu Chest	KwaMashu Mob 2	Newtown A CHC	Grove End	Oakford
Newlands West	KwaMashu Poly	KwaSimama	Newtown YC	Ottawa	Redcliffe
Redhill		Lindelani	Inanda C CHC	Phoenix CHC	Trenance
Sandsonke (BT)		Ntuzuma		Starwood	Verulam
Sea Cow Lake		Rydalvale		Stonebridge	Waterloo
Umhlanga					Tongaat CHC

West 1	West 2	West 3	West 4
Halley Stott	Fredville	Clermont	Pinetown
Maphephetheni	Mpumalanga	Kloof	Queensburgh
Molweni	Msunduze Bridge	KwaNdengezi	Reservoir Hills
Ngcolosi	Ntshongweni	Mariannridge	Westville
Qadi	Hlengisizwe CHC	Mpola	
Waterfall		Mzamo	
Wyebank		New Germany	
Kwadabeka CHC		Peaceville	
		St Anne's Clinic	
		Tshelimnyama	
		Zwelibomvu	

South 1	South 2	South 3	South 4	South 5	South 6	South 7	South 8
Amanzimtoti	Adams Mission Clinic	Austerville	Addington Gateway	Ekuphileni (Uml L)	Umlazi AA	Bayview	Chatsworth Centre
Athlone Park Hall	Folweni	Bluff Clinic	Beatrice Str	Osizweni (Uml Q)	Umlazi G	Lamontville	Klaarwater
Craigieburn	Luganda	Isipingo	Chesterville Clinic	Prince Mshiyeni Gate	Umlazi K		Nagina
Danganya	Nsimbini	Merebank	Chesterville Prov	Umlazi D	Umlazi N		RK Khan Gateway
Kingsburgh	Odidini		Clare Estate	Umlazi U21	Umzomuhle		Shallcross
KwaMakhutha	Umbumbulu Clinic		Commercial City FP	Umlazi V			Welbedacht Clinic
			Lancers Road				
			Overport Clinic				
			Prince Zulu CDC				
			Sydenham Heights				
			Cato Manor CHC				

Annexure F

Statistics for Factor I: Consumer Driven Approach to Care

		S1	S2	S3	S4	S5	S6	F1SubTotal
N	Valid	38	39	39	41	40	40	34
	Missing	3	2	2	0	1	1	7
Mean		2.87	2.59	3.05	3.29	3.30	3.43	18.47
Median		3.00	3.00	3.00	4.00	4.00	4.00	19.00
Mode		3	3	4	4	4	4	15
Std. Deviation		.935	.910	.972	.901	.911	.675	3.570
Skewness		-.564	-.613	-.650	-1.277	-1.078	-.766	-.641
Std. Error of Skewness		.383	.378	.378	.369	.374	.374	.403
Kurtosis		-.383	-.465	-.633	1.016	.155	-.470	.342
Std. Error of Kurtosis		.750	.741	.741	.724	.733	.733	.788
Minimum		1	1	1	1	1	2	9
Maximum		4	4	4	4	4	4	24
Percentiles 25		2.00	2.00	2.00	3.00	3.00	3.00	16.50
Percentiles 50		3.00	3.00	3.00	4.00	4.00	4.00	19.00
Percentiles 75		4.00	3.00	4.00	4.00	4.00	4.00	21.25

Statistics for Factor II: Staff Directed Approach to Care (Reverse Scored)

		S7R	S8R	S9R	S10R	S11R	S12R	S13R	S14R	F2SubTotal
N	Valid	41	40	40	40	41	40	41	39	38
	Missing	0	1	1	1	0	1	0	2	3
Mean		1.56	1.50	2.30	2.53	1.63	2.00	2.73	2.08	16.42
Median		1.00	1.00	2.00	2.00	1.00	2.00	3.00	2.00	16.00
Mode		1	1	2	2	1	2	3	2	17
Std. Deviation		.634	.784	.939	.987	.799	.847	.895	.839	3.446
Skewness		.687	1.845	.325	.264	1.084	.799	-.308	.695	.229
Std. Error of Skewness		.369	.374	.374	.374	.369	.374	.369	.378	.383
Kurtosis		-.445	3.507	-.664	-.993	.512	.468	-.528	.318	-.339
Std. Error of Kurtosis		.724	.733	.733	.733	.724	.733	.724	.741	.750
Minimum		1	1	1	1	1	1	1	1	10
Maximum		3	4	4	4	4	4	4	4	23
Percentiles 25		1.00	1.00	2.00	2.00	1.00	1.00	2.00	2.00	14.00
Percentiles 50		1.00	1.00	2.00	2.00	1.00	2.00	3.00	2.00	16.00
Percentiles 75		2.00	2.00	3.00	3.00	2.00	2.00	3.00	2.00	18.25

Statistics for Factor III: Evidence-based Approach to Care

		S15	S16	S17	S18	S19	F3SubTotal
N	Valid	40	40	41	41	41	39
	Missing	1	1	0	0	0	2
Mean		3.65	3.00	3.63	3.83	2.20	16.31
Median		4.00	3.00	4.00	4.00	2.00	17.00
Mode		4	3 ^a	4	4	1	17
Std. Deviation		.662	1.013	.623	.543	1.100	2.002
Skewness		-2.262	-.780	-2.173	-4.057	.303	-.490
Std. Error of Skewness		.374	.374	.369	.369	.369	.378
Kurtosis		5.897	-.402	6.532	18.773	-1.280	.392
Std. Error of Kurtosis		.733	.733	.724	.724	.724	.741
Minimum		1	1	1	1	1	11
Maximum		4	4	4	4	4	20
Percentiles							
	25	3.00	2.25	3.00	4.00	1.00	15.00
	50	4.00	3.00	4.00	4.00	2.00	17.00
	75	4.00	4.00	4.00	4.00	3.00	18.00

a. Multiple modes exist. The smallest value is shown

Statistics for Factor IV: Standardized Services (Reverse Scored)

		S20R	S21R	S22R	S23R	F4SubTotal
N	Valid	41	41	40	41	40
	Missing	0	0	1	0	1
Mean		2.49	2.15	1.65	2.20	8.48
Median		2.00	2.00	1.00	2.00	8.00
Mode		2	1	1	2	6
Std. Deviation		1.003	1.062	.921	.843	2.396
Skewness		.269	.484	1.397	.660	.344
Std. Error of Skewness		.369	.369	.374	.369	.374
Kurtosis		-1.000	-.973	1.145	.192	-.414
Std. Error of Kurtosis		.724	.724	.733	.724	.733
Minimum		1	1	1	1	4
Maximum		4	4	4	4	14
Percentiles						
	25	2.00	1.00	1.00	2.00	6.00
	50	2.00	2.00	1.00	2.00	8.00
	75	3.00	3.00	2.00	3.00	10.00

Statistics for Factor V: Recovery Mission Approach to Care

		S24	S25	S26	F5SubTotal
N	Valid	41	41	41	41
	Missing	0	0	0	0
Mean		3.22	3.56	2.90	9.68
Median		3.00	4.00	3.00	10.00
Mode		3	4	4	9
Std. Deviation		.690	.550	.995	1.540
Skewness		-.317	-.726	-.437	-.082
Std. Error of Skewness		.369	.369	.369	.369
Kurtosis		-.814	-.567	-.888	-.932
Std. Error of Kurtosis		.724	.724	.724	.724
Minimum		2	2	1	7
Maximum		4	4	4	12
Percentiles					
	25	3.00	3.00	2.00	9.00
	50	3.00	4.00	3.00	10.00
	75	4.00	4.00	4.00	11.00

Statistics for Total Scale Items

	N		Median	Mode	Skewness	Std. Error of Skewness	Kurtosis	Std. Error of Kurtosis	Range	Minimum	Maximum	Percentiles		
	Valid	Missing										25	50	75
S1	38	3	3.00	3	-.564	.383	-.383	.760	3	1	4	2.00	3.00	4.00
S2	39	2	3.00	3	-.613	.378	-.465	.741	3	1	4	2.00	3.00	3.00
S3	39	2	3.00	4	-.650	.378	-.633	.741	3	1	4	2.00	3.00	4.00
S4	41	0	4.00	4	-1.277	.369	1.016	.724	3	1	4	3.00	4.00	4.00
S5	40	1	4.00	4	-1.078	.374	.155	.733	3	1	4	3.00	4.00	4.00
S6	40	1	4.00	4	-.766	.374	-.470	.733	2	2	4	3.00	4.00	4.00
S7R	41	0	1.00	1	.687	.369	-.445	.724	2	1	3	1.00	1.00	2.00
S8R	40	1	1.00	1	1.845	.374	3.507	.733	3	1	4	1.00	1.00	2.00
S9R	40	1	2.00	2	.325	.374	-.684	.733	3	1	4	2.00	2.00	3.00
S10R	40	1	2.00	2	.264	.374	-.893	.733	3	1	4	2.00	2.00	3.00
S11R	41	0	1.00	1	1.084	.369	.512	.724	3	1	4	1.00	1.00	2.00
S12R	40	1	2.00	2	.789	.374	.488	.733	3	1	4	1.00	2.00	2.00
S13R	41	0	3.00	3	-.308	.369	-.528	.724	3	1	4	2.00	3.00	3.00
S14R	38	2	2.00	2	.685	.378	.318	.741	3	1	4	2.00	2.00	2.00
S15	40	1	4.00	4	-2.262	.374	5.897	.733	3	1	4	3.00	4.00	4.00
S16	40	1	3.00	3 ^a	-.780	.374	-.402	.733	3	1	4	2.25	3.00	4.00
S17	41	0	4.00	4	-2.173	.369	6.532	.724	3	1	4	3.00	4.00	4.00
S18	41	0	4.00	4	-4.057	.369	18.773	.724	3	1	4	4.00	4.00	4.00
S19	41	0	2.00	1	.303	.369	-1.280	.724	3	1	4	1.00	2.00	3.00
S20R	41	0	2.00	2	.269	.369	-1.000	.724	3	1	4	2.00	2.00	3.00
S21R	41	0	2.00	1	.484	.369	-.973	.724	3	1	4	1.00	2.00	3.00
S22R	40	1	1.00	1	1.397	.374	1.145	.733	3	1	4	1.00	1.00	2.00
S23R	41	0	2.00	2	.680	.369	.192	.724	3	1	4	2.00	2.00	3.00
S24	41	0	3.00	3	-.317	.369	-.814	.724	2	2	4	3.00	3.00	4.00
S25	41	0	4.00	4	-.726	.369	-.587	.724	2	2	4	3.00	4.00	4.00
S26	41	0	3.00	4	-.437	.369	-.888	.724	3	1	4	2.00	3.00	4.00

Annexure G

Summary of Statistical Analyses for All Factors and Total Score

	Gender	Psych Registration	PHC Registration	Psych +PHC	PSR
Factor I	no significant differences in Factor I subscale scores between male (md = 18, n = 1) and females (md = 19, n = 33), $U = 13.500$, $z = -.308$, $p = .758$, $r = .053$	no significant differences in Factor I subscale scores between SANC Psychiatric registration (md = 19, n = 20) and without SANC Psychiatric registration (md = 19, n = 13), $U = 124.000$, $z = -.222$, $p = .824$, $r = .039$	no significant differences in Factor I subscale scores between SANC PHC registration (md = 18, n = 21), and without SANC PHC registration (md = 19.50, n = 12), $U = 84.500$, $z = -1.562$, $p = .118$, $r = .272$	no significant differences in Factor I subscale scores between SANC Psychiatric and PHC registration (md = 17.50, n = 10) and without SANC Psychiatric and PHC registration (md = 19, n = 22), $U = 90.000$, $z = -.818$, $p = .414$, $r = .145$	no significant differences in Factor I subscale scores between PSR training (md = 19, n = 10) and no PSR training (md = 18, n = 20), $U = 88.000$, $z = -.532$, $p = .595$, $r = .097$

	PSR Duration	Contact	Age	Years in Practice	Qualifications
Factor I continued	no significant relationship between Factor I subscale scores and PSR training duration and Factor I subscale scores ($\rho = -.056$, $n = 8$, $p = .895$) with 3% overlap (coefficient of determination = .003)	no significant difference in subscale scores between contact with MHCUs (md = 19, n = 18) and no contact with MHCUs (md = 18, n = 15), $U = 121.000$, $z = -.509$, $p = .611$, $r = .089$	no significant relationship between Factor I subscale scores and age of participants ($\rho = -.110$, $n = 33$, $p = .542$) with 1.21% overlap (coefficient of determination = .012)	no significant relationship between Factor I subscale scores and years in practice ($\rho = -.286$, $n = 31$, $p = .119$) with 8.18% overlap (coefficient of determination = .012)	no significant differences in subscale scores between participants' qualifications (Diploma: n = 25; Bachelors: n = 9), ($\chi^2(1, n = 34) = .154$, $p = .695$)

	Gender	Psych Registration	PHC Registration	Psych +PHC	PSR
Factor II	no significant differences in Factor II subscale scores between male (md = 16, n = 1) and females (md = 16, n = 37), $U = 16.500$, $z = -.184$, $p = .854$, $r = .030$	no significant differences in Factor II subscale scores between SANC Psychiatric registration (md = 16, n = 24) and without SANC Psychiatric registration (md = 17, n = 13), $U = 143.500$, $z = -.400$, $p = .689$, $r = .066$	no significant differences in Factor I subscale scores between SANC PHC registration (md = 16, n = 24), and without SANC PHC registration (md = 17, n = 13), $U = 145.000$, $z = -.352$, $p = .725$, $r = .058$	no significant differences in Factor II subscale scores between SANC Psychiatric and PHC registration (md = 17, n = 13) and without SANC Psychiatric and PHC registration (md = 16, n = 23), $U = 146.500$, $z = -.099$, $p = .921$, $r = .017$	no significant differences in Factor II subscale scores between PSR training (md = 17, n = 11) and no PSR training (md = 16, n = 23), $U = 101.500$, $z = -.927$, $p = .354$, $r = .159$

	PSR Duration	Contact	Age	Years in Practice	Qualifications
Factor II continued	no significant relationship between Factor II subscale scores and PSR training duration and Factor II subscale scores ($\rho = -.040, n = 9, p = .919$) with .1% overlap (coefficient of determination = .001)	no significant differences in subscale scores between contact with MHCUs ($md = 17, n = 22$) and no contact with MHCUs ($md = 16, n = 15$), $U = 108.000, z = -1.776, p = .076, r = .292$	significant medium relationship between Factor II subscale scores and age of participants ($\rho = -.416, n = 36, p = .012$) with 17.3% shared variance (coefficient of determination = .173, Pallant, 2010)	no significant relationship between factor II subscale scores and years in practice ($\rho = -.304, n = 35, p = .076$) with 9.20% overlap (coefficient of determination = .092, Pallant, 2010)	no significant differences in subscale scores between participants' qualifications (Diploma: $n = 28$; Bachelors: $n = 9$; Masters: $n = 1$), ($\chi^2(2, n = 38) = 1.925, p = .382$)

	Gender	Psych Registration	PHC Registration	Psych +PHC	PSR
Factor III	no significant differences in Factor III subscale scores between male ($md = 18, n = 1$) and females ($md = 16.50, n = 38$), $U = 7.000, z = -1.081, p = .280, r = .173$	no significant differences in Factor III subscale scores between SANC Psychiatric registration ($md = 16, n = 13$) and without SANC Psychiatric registration ($md = 17, n = 24$), $U = 150.500, z = -.178, p = .859, r = .029$	no significant differences in Factor III subscale scores between SANC PHC registration ($md = 17, n = 25$), and without SANC PHC registration ($md = 17, n = 13$), $U = 161.500, z = -.031, p = .975, r = .005$	no significant differences in Factor III subscale scores between SANC Psychiatric and PHC registration ($md = 16, n = 13$) and without SANC Psychiatric and PHC registration ($md = 17, n = 24$), $U = 150.500, z = -.178, p = .859, r = .029$	significant medium differences in Factor III subscale scores between PSR training ($md = 15, n = 11$) and no PSR training ($md = 17, n = 24$), $U = 67.500, z = -2.323, p = .020, r = .159$

	PSR Duration	Contact	Age	Years in Practice	Qualifications
Factor III continued	no significant relationship between Factor III subscale scores and PSR training duration and Factor III subscale scores ($\rho = -.195, n = 9, p = .615$) with 3.8% overlap (coefficient of determination = .038)	no significant difference between contact with MHCUs ($md = 16, n = 21$) and no contact with MHCUs ($md = 17, n = 17$), $U = 124.500, z = -1.608, p = .108, r = .261$	no significant relationship between Factor II subscale scores and age of participants ($\rho = .092, n = 37, p = .589$) with .8% shared variance (coefficient of determination = .008, Pallant, 2010)	no significant relationship between Factor II subscale scores and years in practice ($\rho = .046, n = 36, p = .792$) with .2% overlap (coefficient of determination = .002, Pallant, 2010).	no significant differences in subscale scores between participants' qualifications (Diploma: $n = 28$; Bachelors: $n = 9$; Masters: $n = 1$), ($\chi^2(2, n = 39) = 2.488, p = .288$)

	Gender	Psych Registration	PHC Registration	Psych +PHC	PSR
Factor IV	no significant differences between male (md = 13, n = 1) and females (md = 8, n = 39), $U = 1.500$, $z = -1.575$, $p = .115$, $r = .249$	no significant differences between SANC Psychiatric registration (md = 8, n = 24) and without SANC Psychiatric registration (md = 8, n = 15), $U = 149.500$, $z = -.889$, $p = .374$, $r = .142$	no significant differences between SANC PHC registration (md = 9, n = 25), and without SANC PHC registration (md = 8, n = 14), $U = 163.500$, $z = -.340$, $p = .734$, $r = .054$	no significant differences between SANC Psychiatric and PHC registration (md = 9, n = 13) and without SANC Psychiatric and PHC registration (md = 8, n = 25), $U = 128.000$, $z = -1.072$, $p = .284$, $r = .174$	no significant differences between PSR training (md = 9, n = 11) and no PSR training (md = 8.50, n = 24), $U = 110.000$, $z = -.789$, $p = .430$, $r = .133$

	PSR Duration	Contact	Age	Years in Practice	Qualifications
Factor IV continued	no significant relationship between PSR training duration and total scale scores ($\rho = -.141$, $n = 9$, $p = .717$) with 2% overlap (coefficient of determination = .020)	no significant differences between contact with MHCUs (md = 8, n = 21) and no contact with MHCUs (md = 8, n = 18), $U = 158.500$, $z = -.868$, $p = .385$, $r = .139$	no significant relationships between Factor IV subscale scores: age of participants ($\rho = -.272$, $n = 38$, $p = .099$) with 7.4% shared variance (coefficient of determination = .074)	no significant relationship between years in practice ($\rho = -.114$, $n = 37$, $p = .501$) with 1.3% overlap (coefficient of determination = .013)	no significant difference in Factor IV subscale scores between participants' qualifications (Diploma: n = 30; Bachelors: n = 9, Honours: n = 0, Masters: n = 1), ($\chi^2(2, n = 40) = 1.296$, $p = .523$)

	Gender	Psych Registration	PHC Registration	Psych +PHC	PSR
Factor V	no significant differences between male (md = 9, n = 1) and females (md = 10, n = 40), $U = 14.000$, $z = -.517$, $p = .605$, $r = .139$	no significant differences between SANC Psychiatric registration (md = 10, n = 25) and without SANC Psychiatric registration (md = 10, n = 15), $U = 163.500$, $z = -.682$, $p = .495$, $r = .108$	no significant differences between SANC PHC registration (md = 10, n = 26), and without SANC PHC registration (md = 9, n = 14), $U = 137.500$, $z = -1.287$, $p = .198$, $r = .203$	no significant differences between SANC Psychiatric and PHC registration (md = 10, n = 14) and without SANC Psychiatric and PHC registration (md = 9, n = 25), $U = 146.500$, $z = -.850$, $p = .395$, $r = .136$	no significant differences between PSR training (md = 11, n = 11) and no PSR training (md = 9, n = 25), $U = 110.500$, $z = -.943$, $r = .157$

	PSR Duration	Contact	Age	Years in Practice	Qualifications
Factor V continued	no significant relationship between PSR training duration and Factor V subscale scores ($\rho = .217$, $n = 9$, $p = .575$) with 4.7% overlap (coefficient of determination = .047)	no significant differences between contact with MHCUs ($md = 9.50$, $n = 22$) and no contact with MHCUs ($md = 9.50$, $n = 18$), $U = 176.500$, $z = -.596$, $p = .551$, $r = .094$	no significant relationships between Factor V subscale scores: age of participants ($\rho = .205$, $n = 39$, $p = .210$) with 4.2% shared variance (coefficient of determination = .042)	no significant relationship between years in practice ($\rho = .065$, $n = 38$, $p = .698$) with .4% overlap (coefficient of determination = .004)	no significant difference in Factor V subscale scores between participants' qualifications (Diploma: $n = 31$; Bachelors: $n = 9$; Honours: $n = 0$; Masters: $n = 1$), ($\chi^2(2, n = 41) = 4.889$, $p = .087$)

	Gender	Psych Registration	PHC Registration	Psych +PHC	PSR
Total Scale Scores	no significant differences between male ($md = 74$, $n = 1$) and females ($md = 70$, $n = 31$), $U = 4.000$, $z = -1.252$, $p = .210$, $r = .221$	no significant differences between SANC Psychiatric registration ($md = 70$, $n = 19$) and without SANC Psychiatric registration ($md = 69.50$, $n = 12$), $U = 175.000$, $z = -.693$, $p = .488$, $r = .124$	no significant differences between SANC PHC registration ($md = 70$, $n = 19$), and without SANC PHC registration ($md = 69.50$, $n = 12$), $U = 113.000$, $z = -.041$, $p = .967$, $r = .007$	no significant differences between SANC Psychiatric and PHC registration ($md = 71$, $n = 9$) and without SANC Psychiatric and PHC registration ($md = 70$, $n = 21$), $U = 79.500$, $z = -.683$, $p = .495$, $r = .125$	no significant differences between PSR training ($md = 69.50$, $n = 10$) and no PSR training ($md = 70$, $n = 18$), $U = 82.000$, $z = -.386$, $p = .700$, $r = .073$

	PSR Duration	Contact	Age	Years in Practice	Qualifications
Total Scale Scores continued	no significant relationship with small effect size between PSR training duration and total scale scores ($\rho = -.289$, $n = 8$, $p = .487$) with 8.4% overlap (coefficient of determination = .084)	no significant differences between contact with MHCUs ($md = 70$, $n = 18$) and no contact with MHCUs ($md = 68$, $n = 13$), $U = 76.500$, $z = -1.631$, $p = .103$, $r = .293$	no significant relationships between total scale scores: age of participants ($\rho = -.318$, $n = 31$, $p = .081$) with 10.1% shared variance (coefficient of determination = .101)	no significant relationship between years in practice ($\rho = -.335$, $n = 29$, $p = .075$) with 11.2% overlap (coefficient of determination = .112)	no significant difference in total scale scores between participants' qualifications (Diploma: $n = 23$; Bachelors: $n = 9$), ($\chi^2(1, n = 32) = .054$, $p = .817$)