PERCEPTIONS OF NURSES ON THE SIGNIFICANCE OF INTEGRATING MENTAL HEALTH INTO PRIMARY CARE IN THE DR KENNETH KAUNDA DISTRICT

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DECLARATION

I ....declare that:

The research reported in this dissertation, except where otherwise indicated, is my original work.

This dissertation has not been previously submitted for any degree or examination at any other university or higher institution of learning.

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ABSTRACT

Due to the huge burden of mental health especially in low- and middle-income countries, there is an increasing shift in mental health policy and practice towards a more comprehensive and integrated health care system. This includes task-shifting whereby non-specialists and other health care resources are leveraged for more effective mental health care service delivery. Central to the success of any comprehensive mental health care which integrates mental health into primary health care is the role of nurses and community health workers who are the backbone of such systems. Thus, it is important to understand their role, experiences and attitudes towards task-shifting and integration of mental health into primary healthcare. This is an area with very limited coverage in research literature. Therefore, this study aimed to investigate the attitudes of health care workers towards integration and the ways this could expand their roles through task-shifting. It also examined the level of knowledge about mental health disorders among nurses, with a focus on psychotic disorders, depression, maternal depression, and alcohol use disorder.

The study involved in-depth interviews conducted with nurses in selected clinics at the Dr Kenneth Kaunda district of the North West province of South Africa as part of the **PR**ogramme for **I**mproving **M**ental Health Car**E** in South Africa (PRIME-SA) intervention. Results show that nurses generally had positive and receptive attitudes towards the idea of task-shifting and integration, which they believed had several advantages. They also showed strong willingness and interest in working with mental health patients. However, the nurses had generally rudimentary and inadequate knowledge of mental health disorders. Within the framework of this limited knowledge, they knew less about psychotic disorders than they did about depression, maternal depression and alcohol use disorders. They also knew less about alcohol use disorders than they did about depression.

The study also shows that participants felt that they had insufficient training on mental health care and that this impacted negatively on their ability to assist mental health patients. It is suggested that a further large-scale study is required to better understand the issues highlighted by this study.

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List of Abbreviations

AFFIRM: Africa Focus on Intervention Research for Mental Health

CHWs: Community health workers

CMD: Common mental disorders

CBT: Cognitive-behaviour therapy

DALYs: Disability-adjusted life years

DNHPD: Department of National Health and Population Development

DoH: Department of Health

ICDM: Integrated Chronic Disease Management

LMICs: Low- and Middle-Income Countries

IPT: Interpersonal therapy

MHCUs: Mental health care users

MNS: Mental, neurological and substance use disorders

NHI: National Health Insurance

PHC: Primary Health Care

PRIME: Programme for Improving Mental Health Care

PTSD: Post-traumatic stress disorders

SASH: South African Stress and Health Study

WHO: World Health Organization

YLLs: Years lost to premature mortality

YLDs: Years lived with disabilities

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CHAPTER ONE
GENERAL INTRODUCTION

1.1 Introduction

This chapter offers a general introduction to the study. It presents the background to the research, the research problem, and outlines the research questions, aims and objectives. The scope of the study is also presented, and the chapter concludes with an outline of the structure of this research report.

1.2 Background

Half the world's population live in low-income or middle-income countries where, on average, there is one psychiatrist to serve 200 000 or more people and an extremely limited number of general and specialized health workers dealing with mental health interventions (World Health Organization (WHO), 2015). Thus, there is an increasing move among mental health practitioners and policymakers towards the use of non-specialist health workers and other professionals with health care roles to assist in the delivery of mental health services; this is seen as a key strategy for closing the mental health treatment gap (van Ginneken et al., 2013). This is in line with the broader efforts towards enabling people with mental disorders to live 'normal' and dignified lives. The United Nations Secretary-General Ban Ki-moon, on World Mental Health Day in October 2015, declared that "Everyone is entitled to their hopes and dreams – to work, enjoy family and friends, go about their life without stigma and discrimination, and participate in decisions that affect them". This highlights the imperative to see people presenting with various mental illnesses and psychosocial disabilities as deserving to live with the dignity that is fundamental to a healthy and fulfilling life. In line with this assertion, the United Nations Organization's Sustainable Development Goals (UN, 2017) formulated targets related to the prevention, promotion and treatment of mental illness. The agenda arising from these goals is to reduce premature mortality from non-communicable diseases by one-third and to strengthen the prevention and treatment of substance abuse by the year 2030.

Within this trajectory of change in worldwide perceptions of mental health, a number of important reforms have taken place in mental health policy and legislation. In South Africa, the *White Paper for the Transformation of the Health System* was published following the election of the first democratic government at end of the apartheid era (Department of Health, 1997). According to Petersen et al. (2015), this document, accompanied by draft Mental Health Policy Guidelines, set out the provisions of a new mental health system based on primary health care (PHC) principles. This was a significant transformation and a major departure from the past. It set the platform for the promulgation of the Mental Health Care Act (No. 17 of 2002) in 2004 (Department of Health, 2004). Essentially, the new legislation was aimed at preserving the human rights of people with mental disorders; improving access by making PHC the first point of contact of mental health care users with the health system; and promoting the integration of mental health care into general health services and the development of community-based services (Petersen et al., 2015). According to the new South African *National Mental Health Policy Framework and Strategic Plan 2013-2020* (Department of Health, 2012), mental health was intended to be integrated into all aspects of general health care, particularly those identified as priorities.

Several efforts have been made toward the implementation of such policies and the strategy of integrating mental health into PHC. The Programme for Improving Mental Health Care in South Africa (PRIME-SA), for example, has implemented projects to better mental health care in Africa within the framework of integration and task-sharing. As the literature shows, this process is marked by both successes and challenges that call for further investigation and continuous refinement and improvement of such efforts. It is against this backdrop that this study examined the perceptions and attitudes of nurses towards task-sharing and integration of mental health care into PHC. This data was collected during a PRIME-SA study in the Dr Kenneth Kaunda district of the North West province of South Africa.

1.3 Research problem

This research sought to respond to the need for a critical understanding of the context and stakeholders in task-sharing and integration of mental health into PHC. This is important for successful and effective implementation. Petersen and Lund (2011), in a systematic review of

mental health literature from 2000 to 2010, concluded that although progress has been made in the decentralization of mental health service provision, substantial gaps in service delivery remained. Thus, they argued that intervention research is needed to provide evidence of the mix of requirements for organizational and human resources, as well as the cost-effectiveness of a culturally appropriate, task-shifting and stepped-care approach for severe and common mental disorders at the PHC level. This is substantiated by the *National Mental Health Policy Framework and Strategic Plan of 2013-2020*, which indicates that although most provincial services recognize the importance of integrating mental health into PHC, there is limited implementation and progress in this regard (Department of Health, 2012).

It is not enough to have an understanding of the advantages and value of integration, or that non-specialist based mental health workers have the capability to deliver mental health services. It is also crucial to take into consideration their perceptions regarding the integration of mental health into their scope of practice. This is because resistance on their part could serve as a barrier to the implementation of any training received in mental health care and could thus significantly jeopardize efforts. Receptivity on their part could also positively inform the process of integration. There may also be system-level issues that need to be addressed in order to provide a more enabling platform and to improve their receptivity to expanding their roles to include providing mental health care.

Moreover, nurses are the backbone of the PHC system. It is through them that PHC services are delivered to communities and they are the primary non-specialists on whom much of the burden of execution of integrated mental health care lies. Thus, they are central to the system and success of integrated mental health care (Dube & Uys, 2016). Despite the importance of understanding the attitudes of nurses, there have not been many studies on the perceptions of mental health care workers regarding integration of mental health care into PHC in low- and middle-income countries (LMICs). This study, therefore, aimed to evaluate the perceptions of nurses about the integration of mental health into PHC and the expansion of their roles to accommodate this integration, with the aim of informing intervention at a district level.

1.4 Research questions

The research questions addressed in this study include the following:

1. How do PHC nurses understand mental health disorders in the context of increasing preference for and shifts towards more comprehensive community-based health care?
2. What are the attitudes of PHC nurses towards task-shifting and integration of mental health into PHC and the expansion of their roles to include the provision of mental health care?
3. What challenges do PHC nurses face in dealing with mental health disorders?

1.5 Aims and objectives of the study

The study aimed to provide insight into the attitudes of health care workers (i.e. nurses) towards integration of mental health care into PHC and the ways this could possibly expand their roles through task-shifting. The specific objectives of this study are:

1. To examine PHC nurses' understanding of mental health disorders in the context of policy shifts towards a more comprehensive community-based health care system and developments.
2. To explore PHC nurses' attitudes towards task-shifting with respect to the integration of mental health into PHC and expanding their roles to include the provision of mental health care.
2. To investigate the challenges faced by nurses' in dealing with mental disorders.

1.6 Context and scope of the study

According to Patel and Thornicroft (2009), the world's poorer and less-resourced countries face a significant burden of mental, neurological, and substance use (MNS) disorders. Patel and Thornicroft's assertion suggests that an evaluation of a country's percentage of people living in poverty is crucial in determining the country's burden of mental illness. The current study analyzed data collected as part of the PRIME study located in the Dr Kenneth Kaunda district of the North West province of South Africa. This is because the Dr Kenneth Kaunda district is the pilot site of the PRIME-SA study in South Africa. It was the preferred site by the South African Department of Health for the development of the model for integrated mental health care in the

country. The district is also the National Health Insurance (NHI) and the PHC re-engineering pilot site, as well as one of three pilot sites for the Integrated Chronic Disease Management (ICDM) project in South Africa.[1]

According to the Department of Health (2012), the percentage of people living in poverty in the North West is between 71% and 100%. Although the number of outpatient clinics in the province is 448 and there are two mental hospitals, there are no community residential facilities, no child and adolescent outpatient clinics and no psychiatric inpatient units. The North West is expected to have a high burden of mental disorders (Patel & Thornicroft, 2009). Moreover, the number of clinics in relation to the number of mental hospitals makes this location ideal for the purposes of the current study.

The focal area of this study is the Dr Kenneth Kaunda district which covers 14 767 square kilometers and has a total population of 80 252, with a density of 54.7 per square meter. Dr Kenneth Kaunda district comprises four sub-districts. Two of these sub-districts, namely Matlosana and Tlokwe, are peri-urban and most of the population resides here; the other two, Ventersdorp and Maquassi Hills, are rural. The main language spoken in the district is seTswana, followed by Afrikaans and Sesotho. The Dr Kenneth Kaunda district houses two district hospitals both of which are situated in the rural areas of the province.

The scope of this study was limited to the analysis of qualitative data collected during a study by PRIME-SA. PRIME-SA conducted the study to understand the obstacles to successful implementation of integrated health care by nurses it had previously trained at the Dr Kenneth Kaunda District of the North West province of South Africa, as part of its Mental Health Care Plan in the Province. Thus, no primary data source was used besides the interview transcripts from the PRIME-SA study.

1.7 Outline of chapters

This research report is organized into five chapters. The first chapter offers a general introduction and background to the study, providing details on the study questions, objectives

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[1] http://www.prime.uct.ac.za/prime-south-africa

and scope. Chapter Two includes a thematic review of literature on mental illness and integration of mental health into PHC. Chapter Three explains the methodology of the research. The findings of the study are presented in Chapter Four, and Chapter Five discusses these findings in light of existing literature, offers a conclusion to the study and makes recommendations.

CHAPTER TWO
LITERATURE REVIEW

2.1 Introduction

This chapter includes a review of the development of mental health services in South Africa to this point, the burden of mental health in South Africa, historical shifts in mental health policy towards a more comprehensive and inclusive health system, evidence and effectiveness of task-sharing in low- and middle-income countries such as South Africa, and the challenges associated with the integration of mental health care into PHC.

2.2 The burden of mental health in South Africa

The most recent estimation of the burden of disease globally, shows that in 2010, mental disorders, neurological disorders and alcohol use disorders (MNS) were the prominent causes of this burden globally (Whiteford, Ferrari, Degenhardt, Feigin & Vos, 2015). Thus, 10.4% of global disability-adjusted life years (DALYs) were accounted for by MNS disorders, and mental disorders alone account for 56.7%, which is the largest DALYs proportion (Whiteford et al., 2015). In addition, 2.3% of global years lost to premature mortality (YLLs) and 28.5% of years lived with disability (YLDs) globally (Whiteford et al., 2015). The World Health Organization (2008) reports that 16.6% of neuropsychiatric disorders are accounted for by middle-income countries and 8.8% by low-income countries.

In South Africa, mental health scholarship reviewed in this chapter appears to generally accept and use 16.5% as the most representative figure of adults with a common mental disorder (CMD) in the country; this includes depression, substance use disorders and anxiety disorders. This is based on the South African Stress and Health (SASH) study which is considered by these scholars to be the first and best representative epidemiological psychological data for mental illness. Lund et al. (2008) observed that 17% of children and adolescents also suffer mental health disorders. The abuse and trauma of apartheid is also said to have significantly affected mental health in the country (Lund, Keintjes, Kakuma and Flisher, 2010).

In low- and middle-income countries (LMICs), depression is ranked as the seventh major cause of disease burden (Moussavi et al., 2007). These countries, and the poorer communities of the world, also have a significant MNS disorder burden (Patel & Thornicroft, 2009). In South Africa, maternal depression is prevalent with a range of 18% to 47% in the case of antenatal depression and 32% to 35% for postnatal depression; this has major consequences such as premature delivery and/or other related complications, increased suicide risk, alcohol and substance abuse, and non-adherence with medical treatment (Schneider et al., 2016). High rates of mental disorders have also been observed in people living with HIV/AIDS (PLWHA), and tuberculosis (TB) (Schneider et al., 2016). The high rate of HIV and TB in South Africa makes this a very important statistic, especially as evidence increasingly shows that people with mental disorders have a high risk of HIV infection, while there is a rising prevalence of mental disorders in PLWHA (Schneider et al., 2016). Furthermore, neuropsychiatric conditions were ranked third in terms of contribution to disease burden in South Africa, after HIV and AIDS (Lund et al., 2010)

In terms of the contributory social factors to mental health disorders, people who live in poverty have been shown to have an increased risk of mental health problems because of increased stress levels, limited or lack of access to social capital, malnutrition, exclusion, and a higher likelihood of being exposed to violence (Schneider et al., 2016). At the same time, people with poor mental health have more likelihood of descending into poverty as a result of social and economic exclusion and cost of treatment (Schneider et al., 2016). Lund et al. (2010) further confirm that, based on evidence from LMICs, there is a strong relationship between poverty and several aspects of social depression. Patel et al. (2013) also associate mental health with several other economic and social issues such as unemployment, teenage pregnancy, impaired family functioning and domestic violence. These studies show that mental health disorders cannot be adequately engaged with in isolation, and thus require approaches that recognize the wider contextual and societal issues.

The burden of mental health in South Africa is also highlighted by the findings of the South African Stress and Health study, according to which lifetime prevalence of mental disorder in South Africa was 30.3%. The most prevalent lifetime disorders were anxiety disorders (15.8%), substance use disorders (13.3%) and mood disorders (9.8%). Alcohol abuse, major depressive

disorder and agoraphobia without panic are the most prevalent individual lifetime disorders. The Western Cape has the highest rate of lifetime prevalence (42%), while the Northern Cape has the lowest (29%) (Herman et al., 2009). The study also investigated 12-month prevalence, which showed anxiety disorders, substance use disorders, and mood disorders, respectively, to be the most prevalent (Herman et al., 2009). Furthermore, it showed that regarding socio-demographic correlates of the 12-month disorder prevalence, increased severity was associated with being female. There was also increased prevalence among those between 35 and 49 years, compared to those 65 years and above. Low average income individuals had decreased risk of disorders compared to those with high incomes. The widowed, separated, and divorced had increased risk of severe disorders and any disorders compared to married people. Being female was more associated with mood and anxiety disorders, and being male with substance use disorder. (Herman et al., 2009).

In their examination of mental health in public health, Lund et al. (2008) observed that, despite the progress made with SASH, the disease prevalence figures do not take into account the impact of poor mental health on overall health outcomes. Mental health, they argue, also contributes to the development of multiple adverse health outcomes including diabetes mellitus, accidental injury, substance misuse, tobacco use, HIV infection, violence and cardiovascular disease.

2.3 Policy shifts in mental health care from the hospi-centric curative system towards comprehensive primary health care

Given the burden of mental health in South Africa, major policies have been issued over the years to help tackle mental health disorders. This has seen significant progress in policy development post-apartheid, which continues to move the public health sector away from a hospi-centric and curative system and closer to a fully integrated and comprehensive health care system. In 1991, the Department of National Health and Population Development (DNHPD) issued a document called the "The Organization of Mental Health Services in the Republic of South Africa". The document noted that the mental health system at that time was limited because it was hospi-centric and curative, and rendered all mental health services at tertiary and secondary levels, with almost no service at the PHC level. The document also observed that the mental health service at that time led to increased stigmatization, was costly and did not include

preventative measures at the basic level (Pillay & Freeman, 1996). The DNHPD proposed a new policy that sought to offer different mental health services at different care levels; these comprised preventative, promotive and rehabilitative care at the primary level, specialized mental health care at the secondary level and the delivery of tertiary health care at academic health centres. The DNHPD also proposed a 'gradual shift' from the existing institutional care to community-based care (Pillay & Freeman, 1996).

This turning point in mental health policy in South Africa was followed by discussions held two years later at a workshop, convened by the Department of National Health and Population Development, to discuss the problem of mental health services in South Africa. At this stage, there was no evidence of implementation of the 1991 White Paper. Several models of mental health integration into PHC were discussed and participants were in favour of combining different approaches to integration rather than the adoption of a single model (Pillay & Freeman, 1996). Pillay and Freeman (1996) noted that no mention of the 1991 policy was made during this workshop. Perhaps this lack of evidence of continuity or progressive reference to previous policies was a setback to policy development in South Africa. Nonetheless, further developments in terms of policy continued to take place in the country.

A White Paper on the Transformation of the Health System, issued in 1997, devoted Chapter 12 to mental health (Department of Health, 1997). The White Paper stipulated that a mental health service that is comprehensive and community based should planned and executed at all levels – national, provincial, district and community. This service, it said, should be integrated with other health services. This was a major departure from policies previously defined by apartheid values and institutionalization. The Department of Health further provided a framework for the development of mental health policies by provinces through a guideline it also issued in 1997: the Mental Health Policy Guidelines. While these guidelines were limited in their focus on severe psychiatric conditions, they offered a good policy backbone for research and other developments that explored broader mental health issues.

Another landmark in the policy shift towards comprehensive health care was the release in 2004, of the Mental Health Care Act No. 17 of 2002. It took seriously international human rights

standards and tools, as well as guidelines by the World Health Organization (WHO). It also set up the Mental Health Review Boards and other systems, for the protection and promotion of the rights of mental health care users (MHCUs) (Lund et al., 2012). Part of the Mental Health Care Act was the legislation of a 72-hour emergency management and observation period for MHCUs at certain general hospitals in the different regions of the country before they are referred to tertiary care. The goal was to cut down on unnecessary referral of care users to psychiatric hospitals and to make mental health services more accessible and available at local levels (Petersen & Lund, 2011).

Another significant policy event for the shift towards a comprehensive health care was the series of mental health summits convened by the Minister of Health between February and March of 2012. More than four thousand people involved in mental health care and related practices attended from different parts of the country. The summits aimed to determine the policy priorities for South African mental health and led to a national summit in April 2012. This was a demonstration of refreshed commitment to the pursuit of optimum mental health within the context of an integrated and comprehensive health system. Part of the outcome of these summits was the establishment of a task team to draft the National Mental Health Policy Framework and Strategic Plan which would factor in mental health research as well as the recommendations that emerged from the summits.

The National Development Plan recognizes the need to utilize professionals towards the treatment and care of psychological health issues. In 2013, the National Mental Health Policy Framework and Strategic Plan was adopted by the National Health Council. The plan expressed the willingness and readiness of the South African government to pursue integrated mental health care in South Africa and reduce the treatment gap. The policy committed to comprehensive health care, integration of mental health into the South African health system, protection of the rights of MHCUs, as well as addressing socio-demographic and socio-economic factors associated with mental health. In other words, it aimed for a more holistic approach to mental health.

Schneider et al. (2016) observed that there are still concerns about the feasibility and sustainability of these plans, and about whether such policies need to be supported by other policies and activities in order to achieve full mental health integration. Furthermore, the literature reviewed earlier, especially those studies written after the policy was promulgated, highlighted challenges that indicate a poor and/or inadequate implementation of the policy. Schneider et al. (2016) also noted that a key impediment to implementation is a lack of human and financial resources, as well as few available evidence-based protocols for treatment. It seems that in terms of policy, much has been achieved, while the major challenges for mental health care are related to implementation. In addition, poor implementation limits the ability of evaluations to identify significant evidence-based data for future policies.

2.4 The nature of mental health services in the past decades

With the increasing academic and policy attention to mental health both locally and internationally, mental health services in South Africa have gone through several stages of revision and development in the past two decades. A systematic review of research on mental health services in South Africa between 1967 and 1999 was conducted by Rita Thom (2000), who highlighted the inefficiencies of the centralized care systems that emerged from the apartheid era. She advocated for more decentralized and community-based services that are not removed from human rights concerns. These concerns do not only indicate the limitations of mental health services at that time, they constitute a significant proportion of the issues that subsequent scholarship on mental health care services studies and seeks to address.

In their study of mental health service delivery in South Africa over the decade that followed Thom's (2000) review, Petersen and Lund (2011) observed that a primary concern of the majority of publications between 2000 and 2010 focused on demonstrating mental health care status as well as user experience and perception. Articles on inpatient care at the tertiary level indicated that there was a high rate of readmission largely because adherence to treatment was poor and there were problems of defaulting and substance abuse, as well as bed shortages which led to early discharge of patients. The quality of inpatient care was also reported to be inadequate. The study also showed that while psychotropic medication was available and largely accessible at both in- and outpatient facilities, there were problems with infrastructure, limited

specialists to implement the 72-hour emergency management and observation, and PHC staff did not have sufficient training. Thus, the provisions of the Mental Health Care Act and the Mental Health Review Board created to protect the human rights of MHCUs suffered from poor implementation.

Additionally, the results of Petersen's and Lund's (2011) study suggested that psychotropic medication was generally available in PHC clinics across South Africa, although PHC nurses were able to comfortably manage symptoms of chronic severe mental disorders. Identification and treatment of common mental disorders (CMD) at the level of PHC were shown to be inconsistent and irregular as a result of inadequate training and time limitations of PHC workers, as well as referral channels that were poorly developed. There were also gaps in community-based mental rehabilitation programs, especially in rural areas. Other findings included that simultaneous or sequential use of both western public health facilities and traditional systems of healing by MHCUs with severe mental disorders was common; stigmatization and discrimination against MHCUs due to traditional explanatory models of illness in South Africa was reported; and co-morbidity of HIV and AIDS and mental health illnesses was a problem, as a high proportion of CMD are linked with HIV, including alcohol abuse, suicide risk and post-traumatic stress disorder (PTSD). Petersen and Lund (2011), based on reviewed literature, suggested that some progress had been made with regard to decentralization of health care, but several setbacks were evident including the lack of sufficient development of community-based care to utilize task-shifting and self-help approaches.

Lund et al. (2012) approached the question of the nature and status of mental health services in South Africa by analysing such services at three distinguishable levels, namely, primary, secondary and tertiary care. At the level of primary care, they argued that disorders such as bipolar mood disorder and schizophrenia are managed primarily at a symptomatic level with follow-up medications. PHC staff and facilities are often ill-equipped for these needs. There is also very limited community-based psychosocial rehabilitation to help MHCUs easily re-integrate and find support in their communities, with the exception of NGO-provided rehabilitation. Lund et al. (2012) also reported that identification and treatment was not consistent at the PHC level. At the secondary level, the study supported that of Petersen and

Lund (2011) that psychotropic medication was generally available at inpatient and outpatient psychiatric units in general hospitals. However, the problem of inadequate infrastructure and personnel, especially for the provision of the 72-hour emergency management stipulated by the Mental Health Care Act was noted. The problem of the 'revolving door', already highlighted by Petersen and Lund (2012) and other scholars, constitutes a major problem with the de-institutionalization process, whereby discharged MHCUs from tertiary health facilities are readmitted regularly because of poor, or a lack of, community care. Lund et al. (2012) also highlighted language and class differences as impediments to psychological assistance, as well as the failure to implement norms calculated for community-based and inpatient mental health services.

Another study by Lund et al. (2010) applied a comparative approach to mental health systems in the public health sector across South African provinces. The study showed, for instance, that as part of the integrated health service goal in the country's public health sector, South Africa (at the time of study) had 3 460 general health outpatient facilities that provided services for mental health, although such service provision was not monitored. The use of such services, based on data from four provinces, showed that 1 660 people per 100 000 general population used the services annually (Lund et al., 2010). There were 80 daycare facilities, which treated 3.4 users per 100 000 general population, also available in South Africa. In addition, the study showed that South Africa had 23 mental hospitals nationally, which provided 18 beds per 100 000 general population, and that there was a 7.7% decrease between 2000 and 2005 in the number of hospital beds. While provinces such as the Eastern Cape, Limpopo and the Western Cape saw dramatic decreases in bed numbers during this period, others such as the Free State saw a slight increase (Lund et al., 2010).

In terms of PHC, Lund et al. (2010) observed that several PHC nurses and doctors had received training in mental health, although the number of such personnel varied according to province. The study also showed variation in the availability of protocols for assessment and treatment of mental health disorders in these provinces as indicated in Table1 below:

Table 1 Availability of assessment and treatment protocols for key mental health conditions in primary health care clinics

Province	% with protocols	
	Physician-based PHC clinics	Non-physician-based PHC clinics
Eastern Cape	21–50	51–80
Free State	51–80	51–80
Gauteng	0	1–20
KwaZulu-Natal	51–80	21–50
Limpopo	0	81–100
Mpumalanga	0	0
North West	Unknown	51–80
Northern Cape	0	81–100
Western Cape	1–20	81–100

Source: Lund et al. (2010, p. 399)

Lund et al. (2010) corroborated Petersen and Lund (2011) on the availability of psychotropic medicines. They noted that 80% of the PHC clinics in three provinces where a physician was based had one or more psychotropic medicine of each therapeutic category. In four provinces with non-physician-based clinics, an 81-100% availability was reported.

In terms of education, Lund et al. (2010) noted that in South Africa, the Department of Health was the body tasked with coordinating and overseeing mental health and mental disorders awareness and education campaigns. While the lack of resources limited the campaign activities of this department, it was supported by several NGOs including the South African Depression and Anxiety Group, the South African Federation for Mental Health and other groups and individuals.

These studies are indicative of the state of mental health services in South Africa and they report some laudable progress in the strides towards a comprehensive health practice which includes mental health as part of PHC. However, the studies also suggested that much still needs to be achieved, and several challenges still need to be addressed. Recent studies such as Schneider et al. (2016) highlighted the same progress and challenges but observed that there is a mental health

treatment gap. For instance, 75% of people with a mental health disorder in South Africa do not receive relevant services, and as the study by Seedat et al. (2008) showed, a majority of South Africans with a mental health disorder of 12 or more months duration have unmet treatment needs.

2.5 Evidence of task-sharing of psychological treatment interventions in low- and middle-income countries

Petersen, Ssebunya, Bhana and Baillie (2011) observed that in contexts where resources and specialists are limited, task-shifting has been integrated into stepped-care approaches as an effective way to scale up services for common mental disorders, especially in LMICs. Task-shifting is a strategy that utilizes non-specialists, under the supervision of mental health specialists, to provide psychopharmacological and psychosocial treatments (Petersen et al., 2011). Lund et al. (2010) agreed with this assertion and noted that international evidence increasingly confirms the existence and possibility of interventions that are cost effective. Developments in the past four decades, for instance, have made available drugs that could effectively enable people with mental disorders such as bipolar mood disorder and schizophrenia to live a relatively satisfactory life. The same applies to common mental disorders like anxiety disorder and stress (Lund et al., 2010).

Moreover, Lund et al. (2010) held that there had been similar progress with regard to psychosocial interventions, and while the evidence for these interventions came largely from western contexts and environments, they have also been effective in LMICs where they were applied, African countries included. For example, Lund et al. (2010) pointed to increasing evidence from LMICs which shows that community health workers (CHWs), within a task-shifting framework, can successfully deliver Cognitive-Behavior Therapy (CBT) and Interpersonal Therapy (IPT). Patel and Thomicroft (2009) concurred that most evidence was from developed and high-income countries; however, replications in LMICs have also proven to be effective, demonstrating that such models are applicable across cultures.

These studies corroborated arguments made by Patel et al. (2007), who observed that evidence shows that mental disorders such as depression can be treated effectively in LMICs with low-

cost medication and intervention through stepped-care models that allow effective integration of psychological treatments and drugs. The study also showed that community-based rehabilitation systems assist with low-cost and integrative care for adults and children with chronic mental disorders.

The WHO developed methodologies based on the WHO framework of 1996; South African health service literature and guidelines as well as data from current provincial services, to produce an estimate of the community mental health service needs of adults with a range of mental disorders. The WHO models utilized for conducting mental health needs assessments can be adapted to various settings by adjusting variables such as: population size, age distribution, prevalence, comorbidity, levels of coverage, staff profile etc., in order to calculate mental health service resources for CMHS (WHO 2003b).Additionally, according to Lund et al. (2000) this model has been utilized in the development of the norms for mental health services for South Africans with severe psychiatric conditions in a hypothetical population of 100 000 people. It was adapted for use in the study by Petersen et al. (2011) which carried out the calculation and costing of a hypothetical human resources combination needed for a district mental health service for adults, using a task-shifting framework. The population targeted by this study was in rural northern KwaZulu-Natal. This study makes use of a spreadsheet model which is derived from the model developed to calculate human resource requirements for community mental health services in South Africa. its development aids in estimating the minimum and maximum human resources required for packages of care at the various levels within the district mental health system for a nominal population of 100 000. These estimates for minimum coverage were calculated by Lund and Flisher (2009), and are based on a range of scenarios in consultation with provincial mental health co-coordinators and the national Directorate in Mental Health and Substance Abuse in South Africa. The study found that PHC for a 100 000 size population would require a staffing package that would include: a mental health counselor position or equivalent; 7.2 posts for community mental health workers in order to cover an estimated 50% service for bipolar affective disorder and schizophrenia as well as 30% service for post-traumatic stress disorder and maternal depression. This would cost about 28 457 Euros per 100 000 population. at the time the time Peterson et al (2011) study was published in Feb 2011, the Euro to South African Rand exchange rate was 1EUR: 9,606062 ZAR. The cost would

therefore be 273 358,51 South African rands per 100 000 population. Based on the foreign exchange rate The authors argued that this cost could be significantly reduced by cutting down the number of personnel required at primary level so as to close the service gap through the adoption of task-shifting.

Schneider et al. (2016) cited examples of task-shifting interventions used to manage mental disorders such as substance abuse, anxiety and depression. They cited, for example, the Programme for Improving Mental Health Care (PRIME) which is a research project involving five LMICs, namely India, Ethiopia, Nepal, Ugandan and South Africa. In this project, a district site for demonstration is established in each country which aims to develop and implement a plan for mental health care and to consult with local stakeholders. In South Africa, this site is located at the Dr Kenneth Kaunda district in the North West province. The PRIME in South Africa (PRIME-SA) has worked closely with the Department of Health to develop and implement a plan that is integrated into the chronic disease management strategy of the department. This includes intervention packages at the facility and community levels of the health care organization, and provides mental health care for people with depression, alcohol use disorder and psychosis. The PRIME-SA has gone through several stages of implementation, monitoring and evaluation, and has been shown to address the integration of mental health care services into PHC health care by training and supporting PHC nurses, and also by finding ways to scale up mental health services.

Other examples of integration include the trauma intervention model used for treating substance use disorder in the Western Cape, which has sought to identify and treat mental disorders in the emergency department services. The focus of the program is evidence-based treatment that can be scaled up in emergency departments to address substance use disorders at all hospitals (Schneider et al., 2016). In addition, the Africa Focus on Intervention Research for Mental Health (AFFIRM) has tested the effectiveness of a manual-based counseling intervention for depression among pregnant women, provided by trained counselors at Khayelitsha Midwife Obstetric Units in Cape Town. The research is seeking to address the need for developing task-sharing interventions for depression among pregnant women that can be scaled up at antenatal care services (Schneider et al., 2016). Several other examples exist of intervention projects,

research and services in South Africa that seek to integrate mental health care into various aspects of PHC, and some of these studies, although still being developed, are already showing evidence of effective task-sharing (Schneider et al., 2016).

2.6 Conclusion

The literature reviewed thematically in this chapter shows that a significant number of empirical and literature-based studies have been conducted on mental health care policy and practices, within a broad framework of community psychology. These studies have largely focused on investigating the challenges and possibilities of comprehensive and integrated mental health care in South Africa, models of cost-effective and accessible mental health – such as those that adopt the task-sharing/shifting concepts, and issues surrounding policy implementation. The various challenges highlighted point to several areas open for further research in order to further inform research and practice in the field. Particularly missing in the literature is a comprehensive engagement with health care personnel in order to understand their attitudes towards integrated mental health care, as they are an important part of the process. This study aims to contribute in this regard.

CHAPTER THREE
RESEARCH METHODOLOGY

3.1 Introduction

This chapter explains the various component of the methodology employed in this study. The research design is explained, which includes a restating of the research aims and objectives, as well as the qualitative method employed and method of data analysis. Additionally, the chapter also discusses the steps taken to ensure that the research was ethical, as well as steps taken to achieve validity, reliability and rigour of the research. The chapter concludes with a brief discussion of some of the limitations of the study.

3.2 Research aims and objectives

This study aimed to examine how PHC nurses in Dr Kenneth Kaunda district perceive the move towards integrating mental health services into PHC, in light of recent policy and practice shifts in this direction and the value and significance attached to it. More broadly, the study also sought to understand the nurses' level of knowledge about mental health disorders, if and what their experiences of working with mental health patients have been, whether they experience some challenges, and what these challenges are. Thus, the study focused on the following objectives:

1. To examine PHC nurses' understanding of mental health disorders in the context of policy shifts towards a more comprehensive community-based health care system and developments.

2. To explore PHC nurses' attitudes towards task-shifting with respect to the integration of mental health into PHC and expanding their roles to include the provision of mental health care.

3. To investigate the challenges faced by PHC nurses in dealing with mental disorders.

3.3 Research Design

3.3.1 Qualitative methodology

The ontological and epistemological orientation of the research aims and objectives, and the phenomenon investigated – nurses' attitudes – pointed to a qualitative approach as the most suitable research methodology. This is because, within a qualitative framework, the focus is on describing and interpreting the lived experience of human beings (Terre Blanche, Durrheim & Painter, 2006). The qualitative approach seeks to obtain detailed information on, and to understand, attitudes, behavior and the ways in which people make sense of, and interpret their experiences and their life, as well as how they view their world and reality. Thus, it is a subjective endeavor, which views reality as socially constructed, subjective and interpreted by individuals based on their history, experiences of life, situations and other factors (Kelly, 2006). This is unlike quantitative methodology which views reality as objective and singular, and suggests a distance between the researcher and the research phenomenon. The qualitative approach sees meaning as multiple because reality is subjective; informed by their cultural, social, and historical position and context, people produce multiple meanings about reality (Creswell, Plano Clark, Guttman & Hanson, 2003).

3.3.2 Data

Within a qualitative framework, this study involved analysis of qualitative data collected during a study by the Programme for Improving Mental Health Care in South Africa (PRIME-SA). One of the objectives of the PRIME-SA study was to understand the challenges and obstacles to successful implementation of integrated mental health care by nurses. This study uses data that was collected through interviews with PHC nurses to meet this objective.

3.4 Study site

The sites for the study were three clinics, namely Grace Mokhomo, Orkney and Kanana clinics located in Orkney town and Kanana Township in the Dr Kenneth Kaunda district, North West province. According to the National Health Policy Framework's (2013-2020) statistics, the percentage of people living in poverty in the North West is between 71% and 100%. With a population of 3.7 million people (about 7% of South Africa's population, as at 2015), the

province depends heavily on platinum mining, and to a lesser extent, agriculture, manufacturing and construction (Provincial review 2016: North West, 2016). The province is bordered by the Limpopo, Gauteng, Northern Cape and Free State provinces, and Botswana. It is the sixth largest province in South Africa and covers about 116 320 Km^2, that is 9% of South Africa (Walmsley & Walmsley, 2002). Figure 1 provides a map of South Africa illustrating the North West province in green.

Figure 1: North West province
Source: Walmsley and Walmsley (2002, p. 9)

The focal area of this study, Dr Kenneth Kaunda district, covers 14 767 square kilometers and has a total population of 807 252 with a density of 54,7 per square meter. Dr Kenneth Kaunda district comprises four sub-districts. Two of these sub-districts (Matlosana and Tlokwe) are peri-urban and most of the population reside here; the other two (Ventersdorp and Maquassi Hills) are rural. The main language spoken in the district is seTswana, followed by Afrikaans and seSotho. The Dr Kenneth Kaunda district houses two district hospitals, both of which are situated in the rural areas of the province.

Efforts to revise the expensive hospi-centric health care system have seen several changes in the health care systems of the North West province, as with other provinces in the country, which also seek to comply with the Mental Health Care Act of 2002 (Department of Health, 2004) and the National Mental Health Care Policy Framework and Action Plan 2013-2020 (Department of Health, 2013) which embraces integration of mental health care into PHC as a mechanism to increase access to mental health care. It is towards this broader objective that the PRIME-SA project sought to contribute. The project implemented a plan in the Dr Kenneth Kaunda district which makes available care packages for depression, schizophrenia and alcohol use disorders. Part of this was the training of PHC workers on a Primary Care 101+ (PC101+) package to enable them to identify and refer patients suffering from depression, alcohol use disorder and schizophrenia.

3.5 Participants

The study selected nine participants who were PHC nurses working in Orkney clinic (two participant), Kanana clinic (three participants), Manana clinic (two participants) and Grace Mokhomo clinic (three participants) in the Dr Kenneth Kaunda district of the North West province. Eight of the participants were females and one was a male, and in terms of race, eight were black and one was white.

The study used non-probability, purposive sampling to select participants. The criteria the study used included being staff at one of the four PHC clinics in Klerksdorp, North West province, and being a PHC nurse or facility manager who had received training in primary care (PC101+). PC101+ was a training program received by nurses on how to identify and refer patients with depression, alcohol use disorders and schizophrenia to doctors or lay counselors. Table 2 presents details of participants as identified in the transcripts.

Table 2: Research participants

Pseudonym	Gender	Clinic	Position	Occupation	Training
Participant 1	Female	Grace Mokhomo		Professional nurse	Mental Status Exam (MSE)
Participant 2	Female	Kanana		Professional nurse	General nursing (community, psychiatry, midwifery)
Participant 3	Female	Grace Mokhomo		Nurse	Community, psychiatry
Participant 4	Female	Kanana		Professional nurse	General nursing, (community, midwifery, psychiatry)
Participant 5	Female	Kanana	Operational manager	Registered nurse and midwife	Primary health care, PALSA PLUS, midwifery, HIV management, nursing education
Participant 6	Female	Majara		Professional nurse; clinician	General nursing (psychiatry, midwifery, community, primary health care)
Participant 7	Female	Orkney	Team leader in PHC field work (PHC re-engineering)	Professional nurse; clinician	Psychiatry, community, midwifery, clinician, primary health care
Participant 8	Female	Majara	Working with Integrated Chronic Diseases Management (ICDM); traditional healer	Professional nurse	Primary health care, midwifery, psychiatry, PEC
Participant 9	Male	Grace Mokhomo	Mental health sub-coordinator	Professional nurse	Psychiatry

3.6 Method of data collection

The study collected data through semi-structured interviews. The interview schedule included both open-ended and closed-ended questions. The interview included questions about the

qualification and training of participants, their experiences of working with mental health patients, and their knowledge of psychotic disorders, depression, maternal depression, and alcohol abuse disorders, as well as implementation of the PRIME intervention. Participants were also asked questions about the challenges they face while working with mental health patients, their willingness to work with mental health patients, the training they believed they needed for such work, and their feelings about the training of PHC workers to assist with provision of mental health care. The interviews took place in parts of the clinics where the participants were comfortable; they were conducted in English and recorded with the permission of interviewees. Afterwards, they were transcribed for analysis and the audio files were deleted from the recorder.

3.7 Method of data analysis

The analysis of the transcripts was carried out using thematic analysis based on the guidelines provided by Braun and Clarke (2006). This made it possible for the results presented in the study to closely reflect the raw data as themes were allowed both to emerge from the data as well as being established a priori based on the research objectives. The analysis was done using NVivo 11 Pro qualitative data analysis software. The researcher did an initial reading of all the transcribed data to familiarize herself with the data and to identify broader emerging issues. Individual interview questions, and in some cases a group of questions, emerged from this reading as helpful topics or tentative themes around which to code the data. The data was coded into nine broad themes (nodes) in NVivo. A closer line-by-line and word-by-word reading of the data resulted in several sub-themes. This phase of reading ensured that the researcher developed a more careful and detailed understanding of the data and the issues that emerged from it. During this stage, coding was also undertaken. This involved the assigning of words, phrases or symbols to capture larger meanings (Yin, 2011).

3.8 Ethical considerations

Doing research requires the observance of acceptable ethical standards of behavior that are important for the integrity of the research and the protection of research subjects. Yin (2011) observed that it is an ethical requirement that research be conducted responsibly. This involves the avoidance of harm to the research subjects, respect for their well-being, avoiding deception or misrepresentation of the subject or the field of study, openness and truthfulness. The author

also added that it is important to protect and respect the values, self-worth and dignity of the research population, and to be fair and honest with them. Participants in the original study were duly informed about the study, that participation was voluntary and that they were free to withdraw from the study without any negative consequences.

The present study obtained permission from the PRIME-SA project. Ethical clearance was also obtained for this study from the University of KwaZulu-Natal Ethics Committee. (*HSS/2224/017M*). The researcher maintained the anonymity of the research participants, referring to them as Participant 1 to 9 rather than using their actual names. No one else, besides the researcher and the supervisor, had access to the raw data since it was acquired for the purpose of this research. The data and experiences of participants were treated with respect by ensuring that interpretation was done with awareness of the research context, and reflexively engaging with the research process. Thus, the researcher was aware and took note of her own biases and opinions, and the potential ways they could affect interpretation. This awareness enabled her to deliberately manage such interference with findings.

3.9 Validity, reliability and rigour

Validity, reliability and rigour are concerned with quality control of research whether qualitative or quantitative (Yin, 2011). Thus, the validity of a study addresses issues around the manner in which data were collected and interpreted, and whether the conclusions drawn from such data accurately represent and reflect the phenomenon studied. Thus, it raises questions about whether the conclusions arrived at are true or false. The related concept of reliability relates to whether the study and its methods are trustworthy, and rigour refers to the thoroughness with which the research was carried out (Yin, 2011).

Some of the steps taken in this study included thorough, careful and multiple readings of the data to ensure that the data was properly and deeply understood, and that any misrepresentation of the participants or their experiences and opinions was avoided. While analysing the data, the researcher ensured that themes were not arbitrarily imposed on the data but that some of them were allowed to emerge within the parameters of the research objectives and others were framed a priori, drawing on the research objectives. These steps also ensured that the study was rigorous

and increased its reliability. Additionally, the conclusions of the study were consistently checked to ensure they accurately reflected the experiences and opinions of nurses in Dr Kenneth Kaunda district and that the coded text used in the report to illustrate such experiences adequately captured the themes and adequately represented what they were meant to represent.

CHAPTER FOUR
RESULTS

4.1 Introduction

In this chapter, the results of the study are presented. The analysis of the data was carried out thematically using Braun and Clarke's (2006) guide to thematic analysis described in the methodology section.

4.2 Participants, their training and experience

Participants were asked questions about themselves in the introductory parts of the interview. The two main and distinct questions which each participant was asked inquired about 1) their training (education, professional), and, 2) the experience they had which 'qualified' them to work with mental health patients. The responses of participants regarding training/education is represented in Table 3 below: The terms that the participants themselves used to refer to their training/qualifications were retained.

Table 3: Participants' training

Training	Number of participants
General nursing	4
Psychiatry	6
Midwifery	5
Community	6
Primary health care	4

Mental health status examination	1
Nursing education	1
PC 101+	2
PALSA PLUS	1
HIV management	1
PEC	1

As illustrated in Table 3, six out of the 9 participants said they had training in psychiatry, six were trained in community nursing, five in midwifery, four in general nursing and four in PHC. Two of the participants said they were trained in PC 101+ which they described as protocols, guidelines or steps to follow in attending to patients. One participant also said she had training in nursing education and one in PALSA PLUS[2], which she described as training on how to use new guidelines at the clinic. Furthermore, one mentioned being trained in HIV management and one in PEC[3]. All participants had a combination of these aspects of training and none had only one training aspect.

Besides the training in PALSA PLUS (Participant 5) and mental status examination (Participant 1), all the training/qualifications listed appear to have been acquired during the participants' training towards becoming professional nurses. Only two participants were asked follow-up questions that specifically sought to establish whether they had further training after their professional nursing education and they both said "No". Additionally, two participants listed their training as including psychiatry, midwifery and community nursing as part of their comprehensive training in general nursing, while others did not indicate such a relationship.

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[2] PALSA PLUS is the Practical Approach to Lung Health and HIV in South Africa guidelines. It was developed originally by the WHO's Knowledge Translation Unit as part of the Practical approach to Lung Health (PAL) strategy. The program gives health care workers the necessary skills for the diagnosis and management of respiratory diseases in the setting of primary care. The guideline has been expanded to include HIV, and common chronic conditions such as hypertension and diabetes, and several nurses in South Africa have received training in the use and application of the guideline (knowledgetranslation.co.za).

[3] What PEC stands for is not stated in the data. However, given the context and participant, it possibly refers to the Principles of Emergency Care training.

Thus, while the data that the present study is re-using targeted nurses who had received training in PC 101+, only two participants mentioned being trained in PC 101+. This could be an oversight, or that they had not received the training at the time of interview.

Regarding the second question which asked about the experience participants had which 'qualified' them to work with mental health patients, nurses responded differently. However, their responses can be grouped into two categories. In the first set of responses, nurses gave their opinion on qualities they believed a nurse should have when dealing with mental health patients, based on their contacts and interactions with such patients, and on what they experienced in such contacts. For example, Participant 1 responded thus:

> *What I know about mental illness patients is that when they talk, you need to pay attention and listen to them and be patient with them.*

Participant 4 said:

> *I think as a professional, you just need to know mental health patients and how to manage and handle them.*

In the second set of responses, participants highlighted the limitations or challenges of dealing with mental health patients, both in the clinics and in the communities. For example, Participant 2 said:

> *The experience that I have from basic training until the one I have for mental health now is that mental health patients ... don't get enough intervention.*

Participant 9 observed:

> *My experience is that most of the clients with depression and psychosis are among the community but they are not diagnosed in time and they are not getting the right medications.*

Thus, participants spoke mainly about attitudes and skills or the importance of these in assisting mental health patients, rather than recounting previous work or professional experience that enriched them with such skills. They also highlighted the limitations in the systems established

to assist mental health patients, such as Participant 2's excerpt above which indicated that patients do not receive enough attention, and the issue of late diagnosis raised by Participant 9.

4.3 Contact with mental health patients

Participants' contact with mental health patients at their workplaces was a key theme in the data. Questions around this theme sought to find out how frequently participants saw mental health patients, what disorders such patients presented with and how they attended to such patients. However, relevant responses came from only five out of the ten participants, as not all participants responded to this issue.

4.3.1 Frequency of seeing mental health patients

Participants did not all see mental health patients, and those who saw them did not all specify how many or how frequently they saw them. One participant said she saw few mental health patients at the clinic; another said she did not usually see them because she did not work in a department that allowed her to meet them. However, another participant, when asked whether and how often she saw mental health patients, said:

> *Yes, I do see patients on daily basis from Monday to Thursday, according to our booking system. With the appointments that I have with them, they are also integrated because I will also see mental health.* (Participant 8)

It is not clear from this response, whether this participant meant that she saw mental health patients daily, or that she saw patients generally but, since there is integration, she is also able to see mental health patients.

Participant 3 indicated that the integration of mental health with other health visits at the clinic might have increased the frequency with which participants saw and attended to mental health patients. She observed that, prior to the integration, mental health patients had their own day at the clinic. However, with the integration, the nurses do not see them separately, so they are more likely to be seen at any time. Thus, integration might have increased how frequently nurses met with mental health patients, since they could visit any day like every other patient. However, Participant 3 also highlighted a limitation of integration, saying:

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I think it was better when we were seeing just them because we were able to monitor them and we can see who came and who missed their treatment; but now when they are mixed with other patients, we can't trace them and see if they didn't come.

Thus, integration was perceived to limit the participants' ability to monitor mental health patients and to follow them up, although the participant also highlighted that they can see from the clinic book/record who came and who did not, but it seemed easier when mental health patients visited separately.

Participant 10, however, indicated that she never saw mental health patients, but only provided repeat medication. She said:

Mental health patients just come here for treatment…. I just ask them if they are here to collect treatment and whether the pills are treating them okay. Then I would go and get medication for them. (Participant 10)

The data thus suggested that integration had impacted negatively on participants being able to track and confidently estimate the frequency of contact with mental health patients. Also, it emerged that not all participants worked or interacted with mental health patients in the same capacity; while some only provided repeat medication, others had closer interaction.

4.3.2 Presenting disorders of mental health patients

When asked what disorders the patients they had seen presented with, participants mentioned mental retardation, bipolar disorder, schizophrenia, psychosis, and depression. None of the participants who responded to this question had seen alcohol abuse disorder patients at the clinic where they worked at that time. Participant 1, for example, said she had only encountered people with substance abuse-related problems at the clinic where she previously worked.

4.3.3 How participants attend to mental health patients

Participants generally indicated that attending to mental health patients involved doing some initial diagnosis and then referring patients to the doctor. Two participants described the process as 'diagnosis' because it involves some amount of listening to determine what a patient might be

presenting with. However, one participant indicated that she did not make a diagnosis but rather a recording of the patient's health history, so that the doctor is able to do the final diagnosis and sometimes further referral. In most cases, participants indicated that they refer only to the doctor and it is the doctor who refers to the psychologist or psychiatrists. They also pointed out that they have written protocols to guide them in this process. Two participants specifically mentioned PC 101+ and one mentioned Essential Drugs List (EDL) as books that offer guidelines for what they should do on certain occasions. However, one participant also added that they also depend on their knowledge and discretion at times. The following excerpt from Participant 8 offers a general sense of how participants attend to mental health patients

> *... you'll just see the presenting signs and ask questions like why are you feeling like this because they will be feeling like they cannot sleep* [insomnia]*, sometimes they over eat or not eat at all* [loss of appetite] *and cry all the time; they will also isolate themselves. Those are the signs that I see and then I continue asking questions so that I can diagnose the patient. If I see that it is depression, I'll refer the patient to the doctor for further management and then from the doctor sometimes the doctor will refer and I can also refer the patient to maybe a social worker or a psychologist depending on the presenting problem.*

For all participants who spoke about this subject, the process of identification seemed to be clear, with sufficient guidelines that are complemented by their own knowledge, previous experience and some level of discretion. However, nurses are not allowed to initiate/prescribe medication, as noted by Participant 9:

> *When it comes to prescription of medication, we are not covered in the protocol. We are only allowed to issue the medication.*

Nurses are also not trained to offer counselling to patients, although two nurses indicated that they do provide supportive counselling to patients. This is reflected in the following excerpt:

> *...We assist, not necessarily doing the counselling, we just give the patient a time to talk about whatever the problem is and empathize with the patient and then, if you do see that this is really serious, then you refer to a psychologist.* (Participant 6)

Thus, to attend to mental health patients, participants needed to be able to listen and probe the patient as a way of supporting them, but also to identify signs and symptoms so that they could refer them to the doctor or psychologist where necessary.

4.4 Knowledge about mental disorders

Participants were asked a series of questions that sought to establish how much they knew about mental disorders. These questions specifically asked about psychotic disorders, depression, maternal depression and alcohol abuse disorders. Among other things, participants were asked what they knew about these illnesses, whether/how they can be cured and challenges in dealing with patients who present with these disorders. The study shows that while participants had varying degrees of knowledge about and familiarity with these disorders, their knowledge was rather vague and rudimentary, and some participants were not confident about their knowledge.

4.4.1 Psychotic disorders

Understanding of psychotic disorders

Participants' understanding of psychotic disorders was elementary. Some participants were able to say psychotic disorders refer to severe mental illnesses and were able to give examples. As Table 4 below shows, schizophrenia was the most mentioned example (four participants), followed by bipolar disorder while one participant mentioned "major depression" as an example.

Table 4: Participants' examples of psychotic disorders

Disorder	No of participants
Schizophrenia	4
Bipolar disorder	2
Major depression	1

Most participants named symptoms of different psychotic disorders or described the behavior of someone suffering from psychosis. For example, when asked what psychotic disorders were, Participant 6 responded:

> *Psychotic, I think is someone who behaves abnormally, not in a way like any other person would. He may be violent and talking some things that we don't understand.*

Basically, most of the time they are violent and they just fight; they would tell you they
see and hear things that other people don't.

As exemplified in the above quote by Participant 6, violence, hallucinations, delusions, unintelligible speech and abnormal behavior are the most common symptoms mentioned by participants. Participants also mentioned withdrawal and wandering around as symptoms. Furthermore, two participants viewed psychotic disorders, especially schizophrenia, as hereditary/genetic, two said they could be caused or aggravated by alcohol and drug abuse, and one participant thought unattended stress and depression could cause psychotic disorders.

Curing psychotic disorders

Participants were further asked whether, in their view, psychotic disorders can be cured and what would be the best way to cure such disorders. Three of the ten participants felt that psychotic disorders can be cured if detected early and the right treatment is provided. For example, Participant 3 said:

If psychosis could be detected earlier, yes I believe a person could be cured.

One participant felt that some psychotic disorders can be cured, such as psychosis due to depression, stress or PTSD, but others cannot. However, half of the participants (five) felt that psychotic disorders cannot be cured, but that they can only be managed or controlled, and the patient can be stabilized or the symptoms managed with the right medication. This group believed that patients with psychotic disorders can live normal lives with the right treatments but could not be entirely healed. Participant 7, for example, observed that:

I don't think they can really get 100% healed; they can be stabilized, then they can live a
normal life when they are taking their medication.

Regarding the best way to treat or cure psychotic disorders, participants shared several ideas that could be broadly categorized as support (three participants), counseling (three participants) and education (three participants). These are reflected in the following excerpts:

The best ways to help psychotic patients is to give them support, show them that you care
for them, be friendly towards them, give them love and [provide] *psycho-education* [for]

their family members about their illness so that they can treat them just like any other normal person. (Participant 1)

Counseling, and we can also give them treatment such as anti-psychotic. Counseling include[s] *friends, family and the patient because you educate the family about the client's condition and the client also has to have an idea what disorder she has and how she can manage it.* (Participant 4)

The data generally indicates that giving support meant several things to participants including being friendly to psychotic patients, caring for them in different ways, showing them love, and helping them receive and maintain the required treatments. In terms of education, participants emphasized the need to educate the patient about their conditions, their families and members of the community. This would allow the community and family to offer the necessary support and to accept mentally challenged people as normal people rather than reject them. For participants, education also included training the patient on necessary lifestyle change that could help them live a normal life. Counseling was also cited by three participants as useful for helping patients suffering from psychotic disorders, and as suggested by Participant 4 in the above quote, the counseling process could include friends and family as a way of educating them about the condition.

Challenges in dealing with psychotic patients

While one nurse said she did not think there were any challenges in her dealings with mental health patients, the other nine had several challenges. Some of the challenges related to the behavior and attitude of patients and others came from other practitioners such as nurses, doctors and the South African police. Challenges from patients included refusal to take medication, violence, and being loud and uncontrollable. This was perceived to be worsened by the lack of knowledge about the illnesses on the part of their family and community members, who could assist with bringing them to the clinic and with the treatment process, but who instead were afraid of the mentally ill. Sometimes, the police needed to be involved as well because some patients become difficult to transport as a result of their violence. However, Participant 9 observed that, like other community members, the South African Police Service (SAPS) personnel did not understand the protocols of helping to bring mentally patients from the

community to the clinic, and of their obligations to assist as stipulated in the Mental Health Care Act.

Furthermore, integration was highlighted as a challenge in that it limited participants' ability to focus on mentally ill patients and give them special attention. Moreover, patients suffering psychotic disorders were reported to become frustrated and aggressive while sitting and waiting with other patients, as the following quote shows:

> *I think it was better* [when there was not integration] *but now it's not working because some of them think sitting there is too frustrating, whereas some of them become aggressive.* (Participant 8)

Two participants felt that their work was affected by their inability to recall what they learned during training, having never previously worked in hospital departments that allowed them to apply such aspects, and felt unable to adequately assist patients when necessary. Participant 7, for example, suggested that they need refresher courses. She said:

> *...refresher courses to be reminded because we study for exams and if you have to practice that; like now I've forgotten a lot of things but I'm a psychiatric nurse.* (Participant 7)

Additionally, Participant 9 observed that the doctors in the clinic do not always follow procedures, and this constituted another challenge. For example, they do not prescribe for an adequate duration and do not always conduct assessments every six months to determine whether treatments should continue or change. The participant notes:

> *The doctors in the facility prescribe the medication for one month, whereas most of mental conditions are chronic conditions. That is basically the problem that I'm faced with right now.* (Participant 9)

Thus, this participant believes that doctors also need refresher courses to help them with procedures as well as their confidence in dealing with psychotic disorders; this is because some of them, mostly intern doctors, do not have the skills to deal with such patients.

In terms of psychotic disorders, participants displayed a general and basic understanding of what they are, and what some of the symptoms are, but the majority of them did not think people with such disorders can be healed; rather, they believed the patients can be assisted to live a normal life through proper management of the disease. Participants also highlighted several challenges in their experiences of working with mental health patients. Overall, only about three participants seemed to have a reasonably good working understanding of psychotic disorders; the rest of the participants' knowledge of psychotic disorders was very limited and clearly inadequate.

4.4.2 Depression

While participants generally appeared to have better understanding of, and familiarity with, depression than they did with psychotic disorders, they also tended to conflate stress with depression. This is seen in the responses to questions about what depression is, causes of depression, curing depression and the challenges they encounter with depressed patients.

Understanding of depression

Two participants described depression as a mood disorder and another as a disease of the mind which has different degrees of manifestation – mild, moderate or severe. However, four participants defined depression as stress; one of these saw it as severe stress and another as unmanaged stress, as shown in the following quote:

> *Depression, I think is that somebody has been having stress and she has not been able to manage that stress.* (Participant 8)

In terms of the causes of depression, participants were quick to point out that there are many causal factors. The examples of causes given by participants included family issues (two participants), divorce (two participants), financial problems (two participants), work-related problems (four participants), loss of a loved one or bereavement (three participants), social problems (two participants), and relationship problems (one participant). The following quote from Participant 4 offers an example of how participants talked about the causes of depression:

> *...let me say bereavement. Maybe you have lost a family member and cannot cope with the loss of a close one because you are in denial and it happens that you don't get counseling after you went through that, then you might end up being depressed.*

Like a few other participants, this participant suggested that factors such as bereavement in themselves do not immediately cause depression, but can lead to depression if steps such as counseling are not taken to address them. Generally, the factors highlighted by participants indicate that participants think about stressors (painful and emotionally demanding situations) when they think about depression and its causes.

Curing depression

Participants all had an appropriate understanding of treatments for depression and that it would, at least, involve counseling and/or medication. On whether or not depression can be cured, most participants (six) were positive that it can be cured once there is medication and/or counseling, as noted by Participant 6:

> *Yes, I think they can, with medication and continuous counseling, they can get healed.* (Participant 6)

One of these six participants further mentioned that it would require the patient to cooperate and show interest in getting healed. Two participants felt that not all cases of depression can be cured. One of the two felt that mild and moderate depression can be cured but severe cases can only be managed, while the other participant said it depends on how effective the treatment is. She observed:

> *Some people can be cured depending on the effectiveness of psychosocial rehabilitation and treatment.* (Participant 1)

In other words, if the treatment and rehabilitation process are effective, the patient can be cured. Only one participant was of the opinion that depression cannot be cured at all, that patients can only be helped to accept and live with the condition.

Regarding the best way to treat depression, counseling was mentioned by seven participants, referral to a specialist by two participants, support by two participants and consistent medication by two participants. Other ways to cure depression mentioned include early diagnosis,

intervention by social workers, psychosocial rehabilitation, support and support groups. The following quote typifies participants' opinion:

> *Counseling is the best remedy for a person who's presenting with depression and the other important thing is to refer the person to a doctor for treatment and social support. The other thing that would be helpful for a person who's presenting with depression would be psychosocial rehabilitation.* (Participant 1)

It is interesting that medication did not receive as much emphasis as counseling, and participants who mentioned medication also gave the impression that it is helpful for managing moods and stabilizing patients rather than curing depression on their own. Most participants did not suggest only one form of treatment but rather a combination of treatments as indicated in the above quote by Participant 1. Moreover, two participants saw counseling as the best approach because it would help the patient accept their condition and develop positive attitudes, and this they viewed as important to healing.

Challenges in assisting people with depression

The challenges participants faced when dealing with depressed patients were almost as varied as the number of participants. One participant had no challenges. She said:

> *I don't think there are challenges when helping people with depression because we have hospitals where we refer clients who present with depression and there's availability of people who can help them.* (Participant 2)

Another participant said the challenge was that sometimes nurses are not able to assist due to the nature of the causes of the depression, and also that social workers who could help are not available at times. She said:

> *Like I already mentioned that for some patients with depression it might be due to social problems so it would be hard to give intervention in such instances and sometimes when you refer her to the social workers, she doesn't even go see them or sometimes social workers are not always available at the clinics, so you end up telling the person to come back again on Monday.* (Participant 3)

These reflect some of the difficulties participants encountered individually as they attend to patients presenting with depression. Other challenges highlighted included a lack of understanding of depression by family and colleagues of patients who are, therefore, unable to offer support and assist the patient accept their situation. Instead, this contributes to worsening the situation. Other challenges included self-pity and a feeling of hopelessness by patients which affect their consistency at therapy sessions, and the fact that nurses sometimes forget how they were trained to assist patients because of lack of opportunities to practice. Participant 8 specifically mentioned 'mute' patients who cannot speak and are therefore unable to communicate and share their experiences in ways that most people would understand. This slows down their healing processes, as sharing and being listened to assist with healing.

Participants showed more knowledge, familiarity and experience with patients presenting with depression than they did with psychosis. Nonetheless, their knowledge is perhaps not as would be expected of professional nurses, several of whom had had training in psychiatry.

4.4.3 Maternal depression

Understanding of maternal depression

All participants understood maternal depression to be due to issues related to pregnancy. They primarily spoke of it as associated with teenage, unplanned or unwanted pregnancy (e.g. as a result of rape); or lack of interest and support from the father; and the pregnant women's fears about their ability or readiness to be parents and take care of the child, which can also lead to hatred of the child. The following quote reflects participants' responses:

> [I] *would say teenage pregnancy, unplanned pregnancy and people who were raped can have maternal depression.* (Participant 5)

Three participants explicitly associated maternal depression only with the period after birth, but more implied the same. For example, Participant 7 said:

> *Yes, it is depression after delivery…*

Support of people with maternal depression

Participants were asked their opinion about the kind of support maternal depression patients should receive. While only one participant specifically mentioned counselling, most responses suggested support practices that involved conversation that allowed the patients to express themselves, talk about their situation, to be listened to and for supporters to be able to determine how to help them. Thus, two participants suggested the establishment of support/discussion groups for pregnant women, and three participants suggested interviewing/talking to them to better understand their situation. This is exemplified in the following quote:

> *I think during assessment, if we could have a specific portion to interview the client holistically about her pregnancy, questions such as "Was your pregnancy planned?", "How did you fall pregnant?" and the consequences of falling pregnant, "How would you raise the child?", "Do you have a social support?", etc. I think these questions could help us a lot.* (Participant 2)

This participant suggests that a holistic interview approach would seek to thoroughly understand the patient and different issues relevant to her pregnancy and upbringing of the child. One participant advocated training for maternity patients on how to deal with stressors, and two participants suggested that family is the most important support because the patients spend most of their time with their families, and therefore families should be educated about maternal depression and how to assist. As Participant 1 observed:

> *We can give them support at the clinic but the most important support should come from the family because she spends most of the time with family. She spends little time at the clinic.*

When people with maternal depression should receive support

A majority of participants (six) believed that maternal depression patients should receive support during pregnancy and after delivery. These participants suggest that, whether or not the depression comes during or after pregnancy, different kinds of support, including counselling, are needed by patients. Participant 9, for example, said:

> *Because in maternal or in any ANC* [antenatal care] *issues… the time during pregnancy and the time after pregnancy is most important. This is because during pregnancy you*

might be having maternal depression, after pregnancy you might be having preparal[4]
[sic] psychosis whereby you literally rejects the baby, you want to hurt the baby, you are
lost and you don't actually, don't know what's going on due to undiagnosed depression
that you had during your pregnancy period. (Participant 9)

The quote highlights how this nurse viewed it as crucial for patients to receive support during
and after pregnancy, as unresolved depression during pregnancy could lead to something worse
and life threatening to the child after childbirth. The importance of prenatal interventions was
supported by two other participants. For example, Participant 6 said:

I think they need help the most during pregnancy; you'll find that sometimes some of
them rejects the baby. I think it is better before than after…. Talking about whatever the
problem they have and maybe it will be resolved by the time the baby is born rather than
after having the baby and she realize that the problems are getting even worse.
(Participant 6)

Thus, participants agreed on the need for support for pregnant women suffering depression but
three think such support should be prioritized during pregnancy and six participants think it
should be provided both during pregnancy and after childbirth.

CHWs being trained to counsel women presenting with maternal depression
Participants were asked their thoughts on the idea of training community health workers (CWHs)
to give counselling to women presenting with maternal depression. All participants felt that it
was a good and important idea which has several advantages. One of the participants, for
example, said:

I don't have a problem if counsellors who are sent to those homes are trained because
many people are unable to access clinics due to lack of transport. People with depression
don't like walking long distances; they rather stay indoors so it's best if these counsellors
go see them in their homes and bring feedback about the difficulties encountered and
refer them to the clinics. (Participant 5)

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[4] Most likely referring to 'puerperal' which means occurring at the time of/immediately after birth, and used to
qualify several conditions and illnesses that affect women during or shortly after birth (WHO, 2015).

This participant sees that training CHWs to offer counselling will increase access to such services which are limited by factors such as lack of transport and unwillingness of depressed persons to walk long distances. Other advantages highlighted by participants include: that it would offer the opportunity to counsel women in their own environment where they can be advised based on what the CHW can observe. Since CHWs spend most of their time in the communities with the people and sometimes are the ones who identify abnormality in patients, they are best situated to assist with counselling. Participants also felt that this could help demystify counselling and depression by educating and creating awareness in communities, and changing the view that counselling is only for privileged people. Additionally, four participants emphasized the need for such CHWs to receive the required training before being involved in counselling; one participant, however, expressed scepticism because of the level of education of some CHWs. She said:

> *Maybe they should be trained; it would help but now I'm wondering because some of the CHWs don't have matric, so I don't know how they will go about doing that training.* (Participant 8)

Overall, the responses of nurses indicated a positive attitude towards task-sharing and integration in so far as it pertains to maternal depression and ensuring that affected patients access required treatment.

Who would be allowed to visit maternal depression patients?

Related to the question of CHWs bringing counselling services to the homes of patients is the question of preferences, restrictions and cultural issues relating to the identity of health workers who could visit patients in their homes. This has to do with whether or not the race, gender and age of a health worker matters in such visits. All participants said that the race, gender and age of a counsellor usually do not matter, although one participant observed that in her maternity ward, most women do not allow younger counsellors without giving any reasons for this. Another participant also said it depends on the culture and preferences of the families. The following excerpts demonstrate participants' views on this issue:

I don't think they will have a problem about who is coming. I think what matters would be the attitude of the person and how he/she talks with them, whether they are caring or not. I think they will prefer the person who will be able to speak the same language as them. (Participant 6)

*No, I think it will depend on their family's culture and that's why I emphasize that these counsellors should get training because there are taboos (*ngwana wa ilelwa*) in different families especially when it comes to a new born baby, and you'll find that they will say a baby can only be seen by the outsiders after six weeks so the new mother can only be seen after that six weeks has elapsed.* (Participant 2)

These participants highlighted important issues in such visits, such as the attitudes of the person; how respectful they are of the cultures and preferences of the patients, families and communities they are visiting; how much they understand and are aware of these; and whether or not they are able to communicate in the language the patients and their families understand. Nonetheless, these participants also explained this is usually not a major problem as long as the patients, families and communities are warned beforehand and understand why such counsellors are visiting. Thus, one participant observed, based on previous experience, that:

...before the counsellors are sent, there is community dialogue to alert people about the visits of counsellors. (Participant 5)

Community members do not seem to see such visits as an intrusion into their cultural spaces. Two participants, however, made exceptions for gender by highlighting that some cultures do not allow males, especially soon after delivery. She noted:

Females would be welcomed especially if the woman had just given birth. I know in my culture, we don't allow that but in this case males won't be allowed; they would rather allow females like I said. (Participant 8)

Yet, responses generally suggest that even in such situations highlighted by Participant 8, patients and community members are not rigid and sometimes make allowances for any counsellor as long as they are informed and understand the purpose of the visits.

Moreover, one cultural practice that was identified that could inform restrictions on visits is the '*botsoetsi*'. This is the practice of secluding women for a set period of time after childbirth, where they are seen only by a very limited number of family members, excluding husbands. Participants did not share their sentiments on whether or not they considered this a good or bad practice; they only spoke on whether or not it affected access to patients by HCWs. While some participants believed that HCWs could be allowed into such homes to attend to such women despite the culture, some believed access would have to be negotiated. However, overall, this tradition did not seem to constitute a major challenge in the district being investigated. This is illustrated in the following excerpt:

> *Yes, previously it was not okay but now I'm thinking people are becoming modernized and we tell them that after three days, there are people who will come visit. But they are those that you find that they are real...real....real.....accustomed traditional. 95 % really the* botsoetsi *is really facing away.....* (Participant 7)

Participants generally demonstrated a reasonably good and appropriate understanding of maternal depression and the several challenges associated with it at individual, family, community and health care levels. They also demonstrated a positive attitude towards task-sharing and indicated that community members and their cultures are not a challenge to the process.

4.4.4 Alcohol abuse disorders

Regarding whether the participants knew of any mental disorders caused by alcohol consumption, six participants mentioned psychosis or alcohol-induced psychosis, two participants mentioned addiction, which one participant said could lead to psychosis, one participant mentioned schizophrenia and foetal alcohol syndrome, and one participant added that sometimes it is alcohol and cannabis rather than alcohol alone that affects people. One participant said she did not know of any and another said she could not remember any. Here, participants demonstrated limited knowledge of examples and other manifestations of alcohol use disorder beyond psychosis and addiction.

Best way to help patients with disorders due to alcohol consumption

Out of the five participants who responded to questions on the best way to help patients suffering from alcohol use disorders, two suggested education on the dangers of abusing alcohol and awareness campaigns, one participant suggested 'non-drug management', namely methods that do not involve the use of drugs such as counselling and sending patients for rehabilitation. Another participant, in addition to rehabilitation, suggested continuous monitoring and counselling. Participant 7 was elaborate in her suggested approach:

> *I think if you are doing one-on-one session, the person can understand you but if you are going to call* imbizo [awareness campaign] *and have the pamphlets and people who come to address the issue of alcohol, that includes different topics that can be helpful. Young people are drinking and I think if there could be pamphlets that are distributed at schools that address this matter and there should be a speaker who went through the same thing to share with them that this is what happened.*

This participant highlighted what almost all other participants hinted at - that alcohol consumption is a major problem in the communities, and that sometimes clients even come to the clinic drunk when visiting for other purposes. This highlighted the need to tackle the problem at a preventative and community level by addressing the problem of alcohol consumption generally.

Challenges in trying to help people with alcohol use disorders

The following challenges were mentioned by four participants when asked about the challenges they experienced in dealing with people presenting with alcohol use disorders. These included lack of support groups to assist patients with recovery, patients refusing or being unable to stop drinking after receiving help, patients' loud and aggressive behaviour when they come to the clinic which makes it hard to assist them, and denial. On the latter, Participant 7 notes that:

> *The major problem is that people are in denial and they take rehab as some sort of holiday.*

This shows that challenges vary for each participant. It also shows, as some participants confirmed, that they are not directly involved in working with people presenting with mental health problems resulting from alcohol abuse. They had more to say, generally, about patients who come to the clinic drunk and the level of alcohol use in their communities than about alcohol use disorders.

4.5 Attitudes towards working with mental health patients

In the foregoing presentation of findings, it has been highlighted that participants were generally positive about task-sharing in terms of welcoming the idea of training CHWs to provide counselling for women suffering maternal depression in the communities where they work. This section presents participants' own feelings about being involved in mental health care and which training, if any, they think they need to further equip them to work effectively with mental health patients. On these issues also, participants were very positive, as the following paragraphs will show.

4.5.1 Feelings about working with mental health patients

All participants responded positively to questions regarding how they felt about working with mental health patients and expressed their willingness to support such patients by indicating that they are comfortable and willing, or have no problem at all, in working with mental health patients. Only one participant said she was afraid they might hurt her, but nonetheless has no problem working with them. Participant 9, for example, said:

> *Yes, I'm happy. I'm happy to give them counselling, and treatment.*

Two participants also indicated that they were happy to work with mental health patients because of the pleasure it gave them to see such patients improve. One of them said:

> *Yes, I'm willing, basically I'm so happy because now I have three or four clients who were roaming around in the location and I think their parents felt that they were helpless. I was talking to community health workers that it's so nice to see people who come in a certain state and later leaves looking good.* (Participant 4)

4.5.2 Further training to work with mental health patients

The data indicated that six participants responded directly to this question and all of them showed interest in further training and skills to equip them to better assist mental health patients. This is exemplified by Participant 5, who said:

> *I would like to be trained to assess mental health patients and how to manage them, especially when they are aggressive, because I see nurses who were trained are able to handle them. We can't handle them at the clinic because there is no one who was trained to manage them but when you get to their wards in hospitals, the nurses are doing a good job in managing them. You'll find that the mental health patients are so calm, including the ones who are known to be aggressive.*

Participant 5 is one of two participants who wanted training that could help them handle patients who are particularly violent and aggressive. One participant wanted training in different kinds of mental disorders and their treatments as well as on the mental status examination (MSE). Another participant wanted training that would reinforce what she had already learned, another on the latest treatments and methods for assisting psychiatric patients, and one showed interest in going abroad to pursue clinical psychology.

4.6 Traditional/faith healing

Eight participants reported that community members and patients apply traditional explanatory systems to mental health issues and, thus, several patients combine traditional healing with their medical treatments, and sometimes they prioritize their traditional healing. Some patients were reported to go first to traditional or faith healers and only come to the clinic when the problem becomes uncontrollable. This is because mental ill-health is causally associated with witchcraft. The excerpts below offer examples:

> *The elders believe it is witchcraft, so they take them to traditional healers.* (Participant 4)

> *We've got others who seek help on both sides, I've got two clients and before they come to the clinic, they go to Lesotho to collect whatever and they will also come to the clinic to collect medication. If we ask why you didn't honour your appointment, she would say*

"I had to go to Lesotho to collect my things before I can even come here. This treatment won't help if I didn't start at Lesotho". So they have that in mind. (Participant 7)

Another participant suggested that this was not much of a problem because some traditional healers have the necessary training to be able to identify and refer mental health patients to the hospital. She said:

Yes, because some traditional healers had been trained so they understand that when a person has mental illness, they should refer him/her to the hospital. (Participant 1)

One of the participants, who was both a professional nurse and a traditional healer, observed that she had not experienced any conflict between the two responsibilities, and that she had not encountered the same patient in both settings. She observed;

No, I don't. I think to me it's an advantage that I'm a professional nurse trained in psychiatry. I think it's a bonus because I will know better on how to treat the patient traditionally…. When I'm here, I work as a professional nurse and even the ancestors know that now I'm going to work with my hands so they don't bother me. (Participant 8)

Participants did not give any impression that holding onto traditional explanatory systems or visiting traditional healers in themselves were bad. They only seemed to think that some of the consequences were negative, such as patients missing appointments at the clinic or allowing the mental illness to worsen because of time spent using traditional healing methods. However, they indicated that this is a common practice among communities that perhaps calls for negotiation rather than discounting.

4.7 Discrimination and stigma

All the nurses interviewed said they had not experienced stigma or discrimination directed against them as nurses for working with mental health patients. However, they observed that mental health patients experience discrimination in communities and families. One participant noted that:

Most of the people have, like you'll find that person is not being treated nicely, but not in the facilities, maybe somewhere on the streets, he/she will be treated like he/she is not a person. He/she is just something else. (Participant 6)

Another participant suggested that even at the facilities, mental health patients did not always receive the best of treatments or priorities. She laments:

We are treating them like, I don't know because I don't want to say like they are not important.... We don't have the support group for the mental health patients, but in the clinic we do have support groups for the ARVs and for the diabetes patients and I don't know why we don't have any for the mental health patients. I think maybe it's because these people have mental illness, therefore they cannot treat them as normal people. (Participant 7)

4.8 Support mechanisms

Participants did not necessarily speak about whether or not they felt supported; rather they spoke about what systems are in place to provide such support. What stood out in participants' discussion of whether or not they had support mechanisms to help them in their work with mental health patients is the existence of mental health coordinators. They were supposed to be able to contact their mental health coordinators when they needed support and these coordinators should generally monitor mental health work in the clinics by visiting the clinics. Seven participants, however, reported not really having close interaction or regular communication with their coordinator, saying that they do not see her regularly as she barely visited. The following are excerpts from participants:

You know in this district, we have a coordinator who usually comes when there's a need and I don't know after how long. It will be her and she will tell us to choose about three clients with different diagnoses and, on that day, there will be those clients, the coordinator, the social worker, the psychiatrist and the psychologists, and they would have a meeting. Just out of the blue…. There's no support, she will come once in a while. (Participant 7)

Those are administrative issues but she doesn't come here more often unless I call her with a problem or there's a programme that she needs to go out and do it. (Participant 8)

Thus, participants suggested that the mental health coordinator does not adequately and efficiently carry out her responsibilities because she was not always there, and they did not have the ideal type of interaction. However, one participant had a much more positive experience with her mental health coordinator. She narrated:

Yes, we do have Sr. S who comes to the clinic on [a] *monthly basis and when she can't make it she sends another sister to come and check how we are coping…. she checks the registers, files, and we also tell her about the challenges we have encountered. Yesterday, I was with her and I told her about the challenge I had with a patient because we do not have psychiatry training. When there is a patient in the community, people come seek help from us. I even asked her about the protocol and she said we should look at* [the] *mental health act. I haven't looked at it as yet but I will make time to look at it. She told me some steps to follow; she said we should call the police because we can't call an ambulance. The nurse will help to stabilize the patient and the police should call the ambulance.* (Participant 5).

CHAPTER FIVE
DISCUSSION

5.1 Introduction

In this chapter, the results presented in the previous chapter are discussed in relation to existing literature. The overarching goal of the study was to evaluate nurses' perceptions of, and attitudes towards, integrating mental health care into PHC. The results of the study generally indicate that nurses had positive perceptions and attitudes towards integration, while some of them highlighted a few challenges. This is illustrated in the discussions below on the findings of the study on the various issues relating to the objectives of the study.

5.2 Training and contact with mental health patients

The results show that, beyond their training and education towards professional nursing qualifications, nurses hardly had any other training. Only two participants said they had any post-qualification training. The study data did not reveal any reasons why this was the case; however, it could be that further training was not considered a priority by management and, perhaps, by the nurses themselves. Yet, the study also showed that some nurses were concerned that their work was affected by the lack of additional training and their inability to recall relevant lessons from their nursing education. Additionally, nurses were further affected by the fact that they did not work in hospital departments that offered them the opportunities to apply the knowledge and skills training they had received about mental health during their professional training. For these reasons, nurses felt they were unable to adequately assist patients presenting with mental health issues, and that refresher courses would go a long way to prepare them to work better with mental health patients.

These findings show that for a more effective response and delivery of services to mental health patients, regular post-qualification training is important and likely to be very useful to nurses. This is because they are presently working with these patients; in addition, their experiences at work are more likely to enrich their learning, and their learning to enrich their work. Learning as full-time students has limitations as for some, it is learning to simply pass exams and get a job, which decreases the likelihood of retention of knowledge and skills after graduation. However, training on the job will very likely have a more significant and positive impact on nurses. Previous research shows that PHC workers and doctors have already been undergoing training as part of the move towards integration in South Africa. Lund al. (2010) noted that, because all health services in South Africa seek to comply with the integration of mental health policy, several PHC nurses and doctors have received relevant training. However, they also noted that there are provincial variations. Some provinces, such as KwaZulu-Natal, do not have proper records on the number of nurses that have been trained, but in places such as the Northern Cape, an estimated 80% of nurses had received training. Schneider et al. (2016) also observed that the PRIME-SA initiative has implemented several stages of their strategy to address the integration of mental health care services into PHC, including the training and support of PHC care nurses. Thus, the question of training is being addressed, although clearly more could be done in this regard.

In terms of contact with mental health patients, the study shows that integration of mental health into PHC had both negative and positive impacts. On the positive side, integration increased the likelihood of seeing mental health patients, as well as the frequency with which participants attended to such patients. This also implies that patients could receive needed attention earlier and on any day rather than waiting for a specific day in the week to be seen. Chances of some illnesses worsening are reduced by this, as well as the likelihood of discrimination, because mental health patients are mixed with other patients and do not stand out.

However, integration negatively impacted nurses' ability to track and confidently estimate the frequency of the clinic's contact with mental health patients. The reason for this is not clear from the data, but could be that the administration of attending to mental health patients as a specific

group on a specific day made it easier to keep (separate) records and to recall one's contact with them. In other words, dealing with people presenting with different kinds of illnesses at the same time, perhaps made it more difficult to isolate and track cases specific to mental health. It is also probably an indication that nurses are responding positively to the spirit of integration whereby everyone is simply a patient in their mind, and no special track is needed to be kept of mental health patients.

The positives of integration highlighted by participants are consistent with previous evidence-based studies and hypothetical grounds for integration and task-shifting. Patel et al. (2013) highlighted some of the advantages such as the leveraging of limited resources and mental health specialists to enable more patients to access care. Patel et al. (2013) also observed that despite being a noble endeavour, integration can have negative outcomes too. They noted, for example, that a purely integrated approach to mental health also carries the risk of neglecting some types of mental illnesses that cannot be addressed within such integrated platforms. Petersen (2000) had also argued that a comprehensive PHC requires more than simply adding mental health care to PHC. She noted that it will require changes on many fronts, especially a paradigm shift on the notion of care, and a more holistic approach to care and health. The present study further suggests that, additionally, tracking patients and their contact with health care workers could be another challenge for integration, and possibly signals important issues that need to be attended to for a more comprehensive health care to be attained.

Regarding the disorders that patients presented with, participants had only encountered mental retardation, bipolar disorder, schizophrenia, psychosis and depression. None of the participants reported meeting (at their current place of work) a patient with any illness relating to alcohol use. Yet, alcohol misuse is a major concern highlighted by nurses as a problem in communities in the region of study. Nurses even mentioned cases of patients coming to the clinic drunk. One would expect alcohol use disorder to be among the mental illnesses that are more frequently presented, given the high level of alcohol consumption suggested by the study participants. Literature suggests a larger prevalence and variety of mental disorders in South Africa than participants had encountered. Burns (2011) observed that maternal and perinatal mental illnesses are the most common mental disorders in LMICs. Schneider et al. (2016) also noted that in South Africa,

maternal, antenatal and postnatal depression are common with high prevalence rates. Additionally, Herman et al. (2009) indicated that anxiety disorders, substance use disorders and alcohol abuse disorders are among the most prevalent mental disorders in South Africa. The fact that nurses had not encountered some of these illnesses could have several possible explanations, including variations in regional prevalence, that such patients do not seek help, or that the nurses did not want to identify alcohol use disorders, among other things.

The results show that participants had clear protocols and guidelines for identifying mental health patients and referring them to specialists. The nurses also complemented this with their own knowledge, previous experience and some amount of discretion. This suggests that while protocols and guidelines may be detailed, there is a possibility of cases that are partially or entirely not covered by such guidelines, or situations that require nurses to think beyond guidebooks. This further highlights the significance of in-service training, which can support nurses to apply more confidently their knowledge and discretion in situations and cases where laid-down protocols are not sufficient.

Participants do not have training to give counselling to patients, and there is no indication that they counsel patients. However, a very small number of participants (two) said they offer supportive counselling, including listening to and probing patients, as a way to identify symptoms, make referral decisions and support patients. The study by Lund et al. (2010) showed the existence of varying degrees of availability of protocols for assessing and treating mental health disorders in South Africa's provinces. They showed that 21-50% of physician-based PHC clinics and 51-80% of non-physician-based PHC clinics in the Eastern Cape Province had protocols for assessment and treatment of key mental health conditions. In addition, while provinces such as Mpumalanga had none, others such as the Western Cape had a higher percentage of 81-100% in the non-physician based clinics and 1-20% in the physician-based clinics. Yet, Schneider et al. (2016) suggested that the availability of only a few evidence-based protocols for treatment is a challenge for providing mental health care.

5.3 Knowledge about mental health disorders

The study results show that that overall, participants' knowledge about mental illnesses was not outstanding but rather vague and anywhere between rudimentary and average. Participants appeared to know less about psychotic disorders than they did about depression, maternal depression and alcohol use disorders. They also seemed to have more appropriate and better knowledge about depression and maternal depression than they did about alcohol use disorders. Moreover, participants did not generally demonstrate confidence in their knowledge of mental health illnesses.

Participant's' understanding of psychotic disorders was basic. They were able to point out that the term refers to severe mental illness and mentioned schizophrenia more frequently than bipolar disorder and depression as the three examples of psychotic disorders. These were accurate examples but indicated limitation in the scope of their knowledge. It is not clear why these three illnesses are the most commonly known among participants, but it could also suggest that these are the more generally known severe mental health conditions in participants' environments. It is also possible that participants used the names of these three illnesses to refer to a wider range of mental disorders. They were also able to name some of the more generally known manifestations. Participants did indicate familiarity with hallucinations and delusions in relation to psychosis. However, they did not, for example, demonstrate clear understanding of psychosis as loss of contact with reality or as itself a symptom or feature of a range of mental illnesses, sometimes collectively known as psychotic disorders, or several other aspects that could be described about psychosis and psychotic disorders (Cuthbert & Insel, 2010).

Participants demonstrated a better knowledge, familiarity and experience with depression than psychosis, even if this was also relatively poor knowledge. The data also show a tendency to conflate stress with depression. This reduces depression to stress which, although there could be a causal relationship, are not the same thing. There was generally an indication in the data that participants had a fair and appropriate knowledge of maternal depression and the challenges associated with it at individual, family, community and health care levels. They identified causes as related to teenage, unplanned or unwanted pregnancy.

It is not clear from the data why participants had a better, albeit poor, understanding of depression and maternal depression than they did of psychotic disorders and alcohol abuse disorders. Depression appears to be a generally more well-known and talked-about condition that South Africans, irrespective of their level and type of education, are more likely to be familiar with. Moreover, it does not demand more than the knowledge of the meaning of the word 'maternal' to deduce that maternal depression has something to do with pregnancy, childbirth or being a mother. Perhaps, psychotic disorders and alcohol abuse disorders are less well-known and familiar, and their meanings not as easily worked out. Also, the fact that alcohol abuse disorders sometimes co-occur with other psychotic disorders (Burns, 2011) could increase the chances of them been missed or misinterpreted. Unless nurses had previously diagnosed or learned carefully about some of these mental illnesses, it would be difficult for them know much about them beyond basic knowledge or the remnants of their previous education on the illness. Nonetheless, nurses' knowledge of mental illness is not consistent with their qualifications and position as nurses. It is comparable to, and not better than, what would be expected of a lay person.

Most participants believed that psychotic disorders cannot be cured, but that patients can be assisted to live normal lives through proper management; only a few (three) felt that such patients can be cured. However, with depression, the majority (six) of participants were positive that it can be cured through medication and/or counselling. These positions were stated only as beliefs and not as informed positions based on adequate knowledge or experience. This further indicates that participants did not have adequate scientific knowledge about these illnesses, nor knowledge of current advancements in the treatment of mental health illnesses. Literature shows that psychotic disorders do not have a cure-all formula, but that several treatment options are available for people who suffering from psychotic disorders (Kane, Leucht, Carpenter & Docherty, 2003; Rössler, Salize, van Os & Riecher-Rössler, 2005). Also, since such disorders are manifested differently in different patients, treatments would vary, and one cannot simply generalize, as participants did, on whether or not psychotic disorders can be cured as this would depend on the specific condition.

The results also show an adequate understanding of treatments for depression, maternal depression and alcohol use disorders, as involving at least medication and/or counselling. Counselling was the most highlighted treatment for mental health disorders. Medication did not emerge strongly as an option and the few times it emerged, it was presented as complementary to counselling and support, and more helpful for managing moods and stabilizing patients, especially in the case of depression. Data also shows a strong belief in and use of the term 'support' for mental health illnesses. The data generally indicate that giving support meant several things to participants including being friendly, showing care, expressing love, assisting them to access and maintain treatments, educating them, their families and communities, and creating support groups. This suggests that effective treatments of mental illnesses were viewed in more holistic terms. This implies that it would require different approaches comprehensively working together to complement each other. Thus, while counselling allows the patient to be attended to by the specialist directly, medication stabilizes them and helps them manage their moods, while different kinds of support provide the right environment and conditions for them to heal and/or live a normal life.

5.4 Challenges

Nurses face several challenges in working with mental health patients. Results of this study show that some of these challenges relate to the behavior and attitude of patients, while others concern the response of practitioners such as the nurses, doctors and officers of the South African Police Service. Patients sometimes refuse to take their medications, and can be violent, loud and uncontrollable. This could indicate a deteriorated condition, and that patients are probably not brought to the clinic at the early stages of the manifestation of their illnesses, when they are more controllable. The results suggest that nurses perceived the situation to have been worsened by the responses of family and community members to mental illnesses. Communities are not adequately educated about mental illnesses, thus family and community members who could assist in bringing patients to clinics and with the process of treatment become afraid of the mentally ill and isolate them or treat them badly.

The study also indicates that members of the SAPS are expected to assist with transportation of patients who are otherwise difficult to transport due to their violence. However, these officers do

not seem to understand the protocols of assisting the transport of patient to clinics. This is likely to worsen the situation or make it harder for the nurses receiving the patients at the clinic. These challenges show that mental health care is a process that involves different people and expertise, and is not limited to the health care specialists alone. Moreover, inefficiency of any of the persons involved could have a negative impact on the process of assisting mental health patients, and this could aggravate their conditions and their willingness to engage in the treatment process.

Furthermore, integration of mental health into PHC was viewed as limiting the participants' ability to focus on mentally ill patients and offer them special attention. The participants who considered this a challenge imply that mental health patients need special and focused attention that cannot be provided adequately when such patients have to be attended to alongside other patients. A possible consequence is the reduction in the quality of service mental health patients received as they may have to share time, space and resources with other patients. While some of these challenges might not have been recorded, they also indicate, as literature also shows, that the process of integration of mental health has several challenges. Petersen and Lund (2011), based on reviewed literature, suggested that some progress with decentralization of health care has been made but several setbacks were still to be surmounted; these included the lack of sufficient development of community-based care to utilize task-shifting and self-help approaches. Additionally, they observed that identification and treatment of common mental disorders (CMDs) at the level of PHC were inconsistent and irregular as a result of inadequate training and time limitation of PHC workers, as well as poor referral channels.

5.5 Community health workers (CHWs) being trained to counsel women with maternal depression

The results of this study show a positive attitude towards task-sharing and integration regarding maternal depression and ensuring that affected patients access required treatment and support. Thus, participants were highly receptive to the idea of training CHWs to offer counselling to depressed maternity patients. Participants tended to further highlight advantages of such training when expressing their appreciation of the idea. Thus, they noted that training CHWs to offer counselling would demystify the illness and treatment process; take advantage of the knowledge

CHWs already had about their communities and patients, and enable a better service because the patients would be counselled in their own environments.

Given the participants' profession and experience of working in these communities, their feelings about task-shifting could be a strong positive indication of the likelihood of its success. They arguably understand the workload and the needs of their communities very well. The concern that the lack of sufficient educational background among some CHWs could be a challenge to training them in counselling is an important one, however, although it was expressed by only one participant. Lack of formal educational qualifications may not necessarily imply a lack of aptitude for, or ability to learn practically useful counselling skills. However, it may require more time and more creative ways of training such CHWs that are different to styles meant for people with experience of formal education.

There is evidence in the literature, however, that CHWs and other non-specialists can successfully provide services such as screening, referral and counselling to depressed maternity patients (Chowdhary et al. 2014; Rahman, Surkhan, Cayetano, Rwagatere & Dickson, 2013). Rahman et al. (2013) offered an example of successful scalable interventions from non-mental health specialists such as nurses, midwives and health visitors in programs such as the Thinking Healthy Programme in Pakistan and the Perinatal Mental Health Project in the Western Cape, South Africa. The latter wove the intervention into the routine work of CHWs, making it appear not to be an additional burden but part of their regular responsibilities. The project trained midwives to screen women routinely for maternal mood disorder and refer patients with positive indicators to counselors who are also case managers. One key observation in such literature was that the integration of mental health care responsibilities of nurses into their regular routine made it easier to achieve success (Chowdhary et al., 2014; Rahman et al., 2013).

While the positive attitudes of nurses discussed here concern maternal depression specifically, it is also an indication of a positive attitude towards integration in so far as it offers patients more and better access to quality assistance. This is because the reasons the nurses gave show that they cared more about the patients and were concerned that they receive the required treatment at the right time, by the right people and in the right environment. Even when participants expressed

preference for the pre-integration visiting arrangements for mental health patients, their concern appears to have been driven by a positive desire to serve mental health patients better. Thus, it could be argued that beyond maternal depression, nurses are welcoming of integration and task-sharing when they perceive it, or aspects of it, to be in the best interest and benefit of mental health patients.

These findings offer insights into nurses' own attitudes towards integration. This is important considering the significant role they play as health care workers and as part of the process of integration. A positive response from them means an increased likelihood of success. The findings also highlight advantages of integration that add to and corroborate those already highlighted in literature. Patel et al. (2013), for example, argued that the leveraging of limited resources such as the limited number of mental health specialists to serve as supervisors of counsellors will strengthen the capacity of PHC in settings where there is no specialized service for mental healthcare. They further argued that integration provides an opportunity for treatment of the patient as a whole rather than treating one aspect of the individual; it is patient-centered and more effective in not only treating mental health, but in chronic physical health issues, pain problems and reproductive health. Integrated mental health care is also more appealing to patients and their families as the general or specialized health care context of such treatments addresses concerns about stigma attached to MHCUs. In addition, integration of mental health can further speed up the process of achieving goals of sustainable development through leveraging of already existing platforms for addressing other health problems, such as HIV and AIDS (Patel et al., 2013).

With specific reference to maternal depression patients, results of this study show that the race, gender and age of HCWs were not considered obstacles to provision of mental health services in the homes of patients. While the study highlighted the existence of practices such as the *botsoetsi*, which restricts contact between a woman who recently delivered and others, especially men, participants suggest that when it comes to maternal depression, this is less likely to constitute a problem. In their view, the patients and community members are not rigid but would prefer that they are informed prior to visits, and that the purpose of such visits be clearly explained to them.

Overall, there was no indication that culture would be a significant impediment to accessing maternal mental health patients. This is another indication of a positive attitude towards integration of mental health into PHC and a higher likelihood of success in task-sharing. It also shows that communities are not blind followers of culture, but are able to recognize the value of efforts that may require them to yield their cultural values and practices. It also shows that, with proper information and education, cultural challenges to the integration of mental health can be surmounted because the target population is very likely to be receptive and cooperative when properly informed. This study has further highlighted the importance of understanding the culture of patients, respecting such cultures and the preferences of communities in relation to their cultural practices. This is important even in cases, such as the current site of study, where certain cultural practices are not a significant obstacle to provision of service to maternal health patients in their homes.

5.6 Feelings about working with mental health patients

As already highlighted, all participants showed a positive attitude towards working with mental health patients. Results show that participants were comfortable, happy, and willing to work with and support mental health patients. Even the single participant who expressed a fear of being hurt by such patients, responded positively about working with them. Additionally, participants displayed willingness to undergo further training to assist them work with mental health patients. The literature suggests that with adequate training, support and supervision, mental health interventions by non-specialists are comparable to services delivered by specialists (Thornicroft & Tansella, 2004; WHO, 2011). However, it is crucial to the success of integration and task-sharing with non-specialists that their attitudes and feelings towards such a project, which is likely to expand their scope of practice, be taken into consideration. Resistance from practitioners could slow down progress and negatively impact expected positive outcomes. There may also be system-level issues that need to be addressed in order to provide a more enabling platform and to improve their receptivity to expanding their roles to include providing mental health care. Results of this study shows that health care workers in the Dr Kenneth Kaunda district are positively inclined towards task-sharing and expanding their roles and capacity to work with mental health patients.

5.7 Traditional explanatory systems

The results of this study are consistent with previous studies which show that patients and community members apply traditional explanatory systems to mental health issues. Thus, some patients combine traditional healing with their medical treatments, and sometimes they prioritize their traditional healing methods. This is because mental ill-health is causally associated with witchcraft in these systems. Some patients were reported to go first to traditional or faith healers and only come to the clinic when the problem becomes uncontrollable. The results of the present study suggest that traditional and western medicine are not viewed as incompatible, and that some traditional healers are trained to identify and refer mental health patients.

Participants did not give any impression that holding onto traditional explanatory systems or visiting traditional healers in themselves were bad. This is probably because it is part of their culture and socialization, which cannot be easily changed through formal education. They only seemed to think that some of the consequences were negative, such as patients missing appointments at the clinic or allowing the mental illness to worsen because of time spent using traditional healing methods. Considering that this is a common practice, it calls for negotiation rather than being discounted. The fact that some traditional healers already have training on identification and referral suggests that some form of negotiation and interaction is already taking place. Traditional healers could be included as part of the process of integration and the task-sharing model could benefit by providing a space for them.

Previous studies by Petersen and Lund (2011) already hinted at this need in their identification of the several cross-cutting issues that provide a fuller picture of mental health services in South Africa. Some of these include simultaneous or sequential use of both western public health facilities and traditional systems of healing, as well as stigmatization and discrimination of MHCUs due to traditional explanatory models of illness in South Africa. This shows that traditional explanatory and healing systems have been a significant part of the mental health experience of South Africans, and that this has been part of the challenge to mental health care. However, it can also be utilized for better outcomes if intervention models consider it as opportunity rather than obstacle.

5.8 Stigma

The study results show that nurses had not experienced stigma or discrimination directed against them for working with mental health patients. However, mental health patients were reported to experience discrimination in communities and families. While the study did not indicate that health care workers were observed explicitly to discriminate against mental health patients, there was a suggestion that patients did not always receive the best treatment at the mental health facilities. Health care workers could have internalized misconceptions and negative attitudes towards mental health from their communities and demonstrated this at their workplace. The finding of this study, generally, is not consistent with observations of scholars such as Schneider et al. (2016), who highlighted stigmatization by health care workers in South Africa as a challenge which also affects the behavior of such patients.

5.9 Support mechanisms

Nurses had very limited support in their work with mental health patients. The only form of support they could identify was the existence of a mental health coordinator who is supposed to oversee their activities and provide them with the necessary support. However, this was not a functional system for most of the participants, as they had no close interaction or regular communication with their coordinator. This implies that the mental health coordinator system was not very effective, as the coordinators do not adequately and efficiently carry out their responsibilities, and are not always there. Thus, the nurses did not have an ideal or expected type of interaction with their coordinators. Thus, assigning a mental health coordinator was an insufficient support mechanism for nurses. This is worsened by the fact that, as the data suggest, these coordinators oversee several clinics, are not able to visit regularly, and some are not in touch with the nurses they supervise.

Health care workers need constant support in various forms to increase their job satisfaction, output and willingness to continue to stay. Support can come in different forms and have different levels of impact on nurses. While there was not enough from the data to measure the extent to which the poor support mechanisms affected them personally and their work, findings of studies such as Acker (2004) and Collins and Long (2003) suggested the possibility of

negative impact. Acker (2004) examined the relationship between the working conditions of mental health social workers, and their job satisfaction and intention to leave their jobs. The author found that organizational conditions such as role conflict and ambiguity, social support and opportunity for further professional development played significant roles in the intention of nurses to leave, as well as in their job satisfaction. Moreover, as Collins and Long (2003) observed, mental health care workers could be negatively affected by their work with mental health patients, which could manifest in stress and other forms of mental pressure. Thus, the poor support mechanisms identified by the present study could be a major challenge to integration, as this possibly impacts nurses in ways that negatively affect their performance and the overall objectives of integration and task-shifting.

5.10 Limitations of the study

While the researcher was able to analyse rich data on nurses' attitudes and experiences with mental health care, the conclusions have limited generalizability beyond the ten nurses interviewed and their immediate health care environment. The researcher also acknowledges the possibility of bias in the analysis of data. However, the qualitative interpretivist paradigm within which the research was conducted makes allowance for the researcher to be a part of the research and acknowledges the possibility that the researcher's subjectivity could inform their research process and conclusions.

5.11 Conclusion

Overall, the study shows that nurses are receptive and positive about task-sharing and integration, although they highlighted a few challenges that deserve attention. They indicated strong willingness to care for mental health patients, and interest in further training to better equip them to attend to mental health patients. Although their knowledge of depression and maternal depression was better than their knowledge of psychotic and alcohol abuse disorders, this knowledge was hardly more than basic common knowledge and was inconsistent with what might be expected of professional nurses

The positive response and attitudes of nurses towards task-shifting is a potential indication of the likelihood of success in so far as they are concerned. It is an indication that significant progress

could be achieved if such nurses are further equipped and educated about integration, including what it involves and what their roles are in it. Their perceived limitations, particularly about mental health patients visiting clinics on the same days as other patients, are worth further investigation and attention because this could highlight other challenges that are not currently apparent. Overall, task-sharing and integration were viewed as worthwhile pursuits, and this study has shown that even at the level of health care workers, its advantages are immediately tenable and the process supported.

Based on the findings of this study, it is recommended that, firstly, further more large-scale, research is needed to further establish the perceptions and attitudes of nurses and other health care workers towards integration and role-expansion within this framework. This will give a clearer and broader picture of some of the issues highlighted in this study and may yield further issues. Secondly, it seems that having trained as a professional nurse, even if that includes training in psychiatry, is not sufficient for nurses to fully participate in caring for mental health patients. Thus, integration projects should prioritize further training and refresher courses for PHC workers. Such training should not only be about teaching them how to follow protocols and guidelines, it should also educate them about mental illnesses. As the study shows, sometimes nurses need to apply discretion beyond protocols, and such training will be valuable in informing their decisions.

REFERENCE LIST

Acker, G. M. (2004). The effect of organizational conditions (role conflict, role ambiguity, opportunities for professional development, and social support) on job satisfaction and intention to leave among social workers in mental health care. *Community Mental Health Journal*, *40*(1), 65-73.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77-101.

Burns, J. K. (2011). The mental health gap in South Africa: A human rights issue. *The Equal Rights Review*, *6*(99), 99-113.

Chowdhary, N., Sikander, S., Atif, N., Singh, N., Ahmad, I., Fuhr, D. C., . . . Patel, V. (2014). The content and delivery of psychological interventions for perinatal depression by non-specialist health workers in low and middle-income countries: A systematic review. *Best Practice and Research Clinical Obstetrics and Gynaecology*, *28*(1), 113-133.

Collins, S., & Long, A. (2003). Working with the psychological effects of trauma: Consequences for mental health-care workers – a literature review. *Journal of Psychiatric and Mental Health Nursing*, *10*(4), 417-424.

Creswell, J. W., Plano Clark, V. L., Gutmann, M. L., & Hanson, W. E. (2003). Advanced mixed methods research designs. In A. Tashakkori, & C. Teddlie (Eds.), *Handbook on mixed methods in social and behavioral research* (pp. 209-240). Thousand Oaks, CA: Sage.

Cuthbert, B. N., & Insel, T. R. (2010). Toward new approaches to psychotic disorders: The NIMH Research Domain Criteria project. *Schizophrenia Bulletin*, *36*(6), 1061-1062.

Department of Health. (1997). White paper for the transformation of the health system in South Africa. *Government Gazette*, *382*(17910).

Department of Health. (2004). *Mental Health Care Act No. 17 of 2002*. Pretoria: Department of Health. Retrieved from http://www.info.gov.za/ gazette/acts/2002

Department of Health. (2013). *National mental health policy framework and strategic plan 2013-2020.* Retrieved from https://www.health-e.org.za/.../National-Mental-Health-Policy-Framework-and-Strateg...

Dube, F. N., & Uys, L. R. (2016). Integrating mental health care services in primary health care clinics: A survey of primary health care nurses' knowledge, attitudes and beliefs. *South African Family Practice*, *58*(3), 119-125.

Durrheim, K., & Painter, D. (2006). Collecting quantitative data: Sampling and measuring. In M. Terre Blanche, K. Durrheim, & D. Painter (Eds.), *Research in practice: Applied methods for the social sciences* (2nd ed., pp. 131-159). Cape Town: UCT Press.

Herman, A. A, Stein, D. J, Seedat, S., Heeringa, S. G., Moomal, H. & Williams, D. R. (2009). The South African Stress and Health (SASH) study: 12-month and lifetime prevalence of common mental disorders. *South African Medical Journal*, *99*(5), 339-344.

Kane, J. M., Leucht, S., Carpenter, D., & Docherty, J. P. (2003). The expert consensus guideline series. Optimizing pharmacologic treatment of psychotic disorders. Introduction: methods, commentary, and summary. *Journal of Clinical Psychiatry*, *64*(Supp. 12), 5-19.

Kelly, K. (2006). From encounter to text: Collecting data in qualitative research. In M. Terre Blanche, K. Durrheim, & D. Painter (Eds.), *Research in practice: Applied methods for the social sciences* (2nd ed., pp. 285-319). Cape Town: UCT Press.

Lund, C., Kleintjes, S., Campbell-Hall, V., Mjadu, S., Petersen, I., . . . Flisher, A. J. (2008). *Mental health policy development and implementation in South Africa: A situation analysis. Phase 1. Country report*. Retrieved July 10, 2017 from http://www.dfid.gov.uk/r4d/PDF/Outputs/MentalHealth_RPC/SA_report.pdf

Lund, C., Kleintjes, S., Kakuma, R., & Flisher, A. J. (2010). Public sector mental health systems in South Africa: Inter-provincial comparisons and policy implications. *Social Psychiatry and Psychiatric Epidemiology*, *45*(3), 393-404.

Lund, C., Tomlinson, M., De Silva, M., Fekadu, A., Shidhaye, R., Jordans, M., . . . Patel, V. (2012). PRIME: A programme to reduce the treatment gap for mental disorders in five low- and middle-income countries. *PLoS Medicine*, *9*(12), e1001359. https://doi.org/10.1371/journal.pmed.1001359.

Moussavi, S., Chatterji, S., Verdes, E., Tandon, A., Patel, V., & Ustun, B. (2007). Depression, chronic diseases, and decrements in health: Results from the World Health Surveys. *Lancet*, *370*(9590), 851-858.

Patel, V., Araya, R., Chatterjee, S., Chisholm, D., Cohen, A., De Silva, M., ... van Ommeren, M. (2007). Treatment and prevention of mental disorders in low-income and middle-income countries. *The Lancet*, *370* (9591), 991-1005.

Patel, V., Belkin, G. S., Chockalingam, A., Cooper, J., Saxena, S., & Unützer, J. (2013). Grand challenges: Integrating mental health services into priority health care platforms. *PloS Medicine*, *10*(5), e1001448. https://doi.org/10.1371/journal.pmed.1001448

Patel, V. & Thornicroft, G. (2009). Packages of care for mental, neurological and substance use disorders in low and middle income countries. *PLoS Medicine*, 6(10), e100016. doi:0.1371/journal.pmed.1000160

Petersen, I. (2000). Comprehensive integrated primary mental health care for South Africa. Pipedream or possibility?. *Social science & medicine*, *51*(3), 321-334.

Petersen, I., Fairall, L., Bhana, A., Kathree, T., Selohilwe, O., & Brooke-Sumner, C. (2015). Integrating mental health into chronic care in South Africa: The development of a district mental healthcare plan. *British Journal of Psychiatry*, *208*(Supp. 56), 29-39. doi:10.1192/bjp.bp.114.153726

Petersen, I., & Lund, C. (2011). Mental health service delivery in South Africa from 2000 to 2010: One step forward, one step back. *South African Medical Journal*, *101*, 751-757.

Petersen, I., Ssebunnya, J., Bhana, A., & Baillie, K. (2011). Lessons from case studies of integrating mental health into primary health care in South Africa and Uganda. *International Journal of Mental Health Systems*, *5*(1), 8. doi: 10.1186/1752-4458-5-8

Pillay, Y., & Freeman, M. (1996). Mental health policy and planning: Continuing the debates. *Psychology in Society*, *21*, 60-72.

Rahman, A., Surkan, P. J., Cayetano, C. E., Rwagatare, P., & Dickson, K. E. (2013). Grand challenges: Integrating maternal mental health into maternal and child health programmes. *PLoS Medicine*, *10*(5), e1001442.

Provincial review 2016: North West. (2016). *The Real Economy Bulletin.* Retrieved August 15, 2017, from https://www.tips.org.za/images/The_REB_Provincial_Review_2016_North_West.pdf

Rössler, W., Salize, H. J., van Os, J., & Riecher-Rössler, A. (2005). Size of burden of schizophrenia and psychotic disorders. *European Neuropsychopharmacology*, *15*(4), 399-409.

Schneider, M., Baron, E., Breuer, E., Docrat, S., Honikman, S., Onah, M., . . . Skeen, S. (2016). Integrating mental health into South Africa's health system: Current status and way forward. *South African Health Review*, *2016*(1), 153-163.

Seedat, S., Stein, D. J., Herman, A., Kessler, R., Sonnega, J., Heeringa, S., . . . Williams, D. (2008). Twelve-month treatment of psychiatric disorders in the South African Stress and Health study (World Mental Health Survey Initiative). *Social Psychiatry and Psychiatric Epidemiology*, *43*(11), 889-897.

Terre Blanche, M., Durrheim, K., & Painter, W. (2006). *Research in practice: Applied methods for social sciences* (2nd ed.). Cape Town: UCT Press.

Thom, R. (2000). Mental health services: A review of southern African literature, 1967-1999. Johannesburg: Centre for Health Policy, University of the Witwatersrand.

Thornicroft, G., & Tansella, M. (2004). Components of a modern mental health service: A pragmatic balance of community and hospital care. Overview of systematic evidence. *British Journal of Psychiatry*, *185*(4), 283-290.

van Ginneken, N., Tharyan, P., Lewin, S., Rao, G. N., Meera, S. M., Pian, J., . . . Patel, V. (2013). Non-specialist health worker interventions for the care of mental, neurological and substance-abuse disorders in low- and middle-income countries. *Cochrane Database Systematic Review*, *19*(11), CD009149. doi:10.1002/14651858.CD009149.pub2

Walmsley, D., & Walmsley, J. (2002). North West province state of the environment report: Overview. Retrieved May 2, 2017, from http://soer.deat.gov.za/dm_documents/19_Full_Overview_Print_zWCET.pdf

Whiteford, H. A., Ferrari, A. J., Degenhardt, L., Feigin, V., & Vos, T. (2015). The global burden of mental, neurological and substance use disorders: An analysis from the Global Burden of Disease Study 2010. *PloS One*, *10*(2), e0116820.

World Health Organization (WHO). (1948). *Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June, 1946*. Geneva: World Health Organization.

World Health Organization (2015). Mental health action plan 2013-2020. Geneva: WHO.

World Health Organization (2008). *Integrating mental health into primary care: a global perspective*. World Health Organization.

World Health Organization (WHO). (2011). *Global burden of mental disorders and the need for a comprehensive, coordinated response from health and social sectors at the country level*. Retrieved from www.who.int/gb/ebwha/pdf_files/EB130/B130_R8-en.pdf

Yin, R. K. (2011). *Applications of case study research* (3rd ed.). Thousand Oaks, CA: Sage.

Appendix 1: PRIME Study Ethics Committee Approval Letter

UNIVERSITY OF KWAZULU-NATAL

INYUVESI YAKWAZULU-NATALI

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14 September 2011

Professor I Petersen (3106)
School of Psychology

Dear Professor Petersen

PROTOCOL REFERENCE NUMBER: HSS/0880/011
PROJECT TITLE: PRIME-SA: PRogramme for Improving Mental Health CarE in South Africa
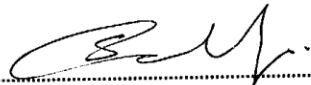
EXPEDITED APPROVAL

I wish to inform you that your application has been granted Full Approval through an expedited review process:

Any alteration/s to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form, Title of the Project, Location of the Study, Research Approach and Methods must be reviewed and approved through the amendment/modification prior to its implementation. In case you have further queries, please quote the above reference number. PLEASE NOTE: Research data should be securely stored in the school/department for a period of 5 years.

I take this opportunity of wishing you everything of the best with your study.

Yours faithfully

Professor Steven Collings (Chair)
HUMANITIES & SOCIAL SCIENCES RESEARCH ETHICS COMMITTEE

cc. Dr Arvin Bhana
cc. Dr Lara Fairall
cc. Dr Beverly Draper
cc. Dr Crick Lund
cc. Dr Mark Sibanyoni
cc. Nomvula Sibanyoni

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Appendix 2: Letter of Support from the Department of Health

FAX COVER SHEET

Republic of South Africa

TO: SCHOOL OF PSYCHOLOGY

FOR ATTENTION: Prof I Peterson

FAX NO: 031 260 2618

NO OF PAGES: 03
(including this one)

DATE: 23/01/12

	For your information
X	For your urgent attention
	Please circulate
	Please reply

SUBJECT:

REQUEST FOR SUPPORT FOR THE PROJECT "PROGRAMME FOR IMPROVING MENTAL HEALTH CARE IN SA"

MESSAGE:

Kindly receive the attached above-mentioned letter.

Thank you

Ms Phindile Masuku
Snr Admin Officer
Fax No: 0866323902
Tel No: 012 395 8022
E-Mail: MasukP@health.gov.za

DIRECTOR GENERAL
HEALTH
REPUBLIC OF SOUTH AFRICA

Private Bag X828, PRETORIA, 0001, 19TH Floor, Civitas, Cnr Struben & Andries Street, PRETORIA, 0001 Tel (012) 395 8402 Fax (012) 395 8422
Private Bag X9070, CAPE TOWN, 8000, 4TH Floor, 120 Plein St, CAPE TOWN, 8001 Tel (021) 461 2040 Fax (021) 461 6884

Prof I Petersen
Principal Investigator: PRIME SA
School of Psychology
Howard College
University of KwaZulu Natal
DURBAN
4000

Dear Prof Petersen

REQUEST FOR SUPPORT FOR THE PROJECT "PROGRAMME FOR IMPROVING MENTAL HEALTH CARE IN SOUTH AFRICA"

Your request for support for the above-mentioned project refers.

Research forms part of the 10 point plan of the Department of Health. Studies such as these will assist us generate knowledge, provide evidence and inform strategies and interventions as we transform and strengthen the health system

Mental health is central to improving the health of the nation. Local research findings show that there are unmet needs for those requiring mental health care. In this regard provision of mental health care at the primary health care level will assist us to improve access to mental health services and ensure that mental health problems are identified and managed early.

The Department of Health supports this initiative as it supports the Department of Health 10 point plan and the four priority outputs as outlined in the Negotiated Service Delivery Agreement.

I have also requested the Head of Health in the North West Province to support this project.

Yours sincerely

MS MP MATSOSO
DIRECTOR-GENERAL: HEALTH
DATE: 23 / 12 / 2011

Additional sites in other
provinces to be included
and this must be locally
driven under the leadership
of the Dept of Health

Appendix 3: PRIME Information Sheet and Informed Consent

Information Sheet and Consent for Service Providers

To participate in a study to evaluate the PRIME-SA mental health care programme

You will be given a copy of this information sheet

Date:

Dear Service Provider,

You are being invited to participate in a study that involves research about the mental health care programme implemented at your primary health care clinic that is aimed at improving the identification and management of depression and alcohol misuse in patients with chronic conditions. Before agreeing to take part in this research study, please read the information below so that you understand what the study will involve. Please read this carefully and feel free to ask me if there is anything that is not clear or if you have any questions about your participation. The PRIME-SA project and the current study are funded by the Department of International Development (DFID) in the United Kingdom.

What is the purpose of this study?

The aim of this research study is to evaluate how well the programme that has been implemented at your clinic is working for you as health care providers, and for the patients at your clinic who have been involved in the programme. The goal of this programme was to improve the identification and management of depression and alcohol misuse in patients with chronic conditions, including HIV/AIDS. During this programme, we used new guidelines to train nurses in identifying and referring patients with depression to the counseling service at your clinic, and we trained the counsellors to help patients who were found to be suffering from depression.

The study we are asking you to participate in now is to test how well this programme is working. We want to learn what worked and didn't work in the testing of the new programme so that we can improve on the training provided to health care providers and counsellors, the training materials, the supervision and support provided, the quality of care provided to service users and any systems issues that may have interfered with the implementation of the intervention.

Who are we asking to participate?

This study will be taking place at four primary health care clinics, including yours, in the the Kanana Township outside of Klerksdorp in the Dr Kenneth Kaunda district of the North West province. Participants will include the facility manager, primary health care nurses trained in PC101+, primary health care doctors, counsellors trained in the depression counselling guidelines and patients who have been identified as having depression or alcohol use disorder and who were referred by the primary health care nurse to the doctor and/or counsellors. We would like to include in this study all the primary health care personnel exposed to the PC101+ and counselling training at each facility, as well as a range of patients. We aim to include between 12 and 20 primary health care staff and counsellors from each clinic.

What will participation in the study involve?

If you decide to participate in this study, the duration of your participation will be approximately 20-40 minutes, during which you will be asked a number of questions about your experience of the training you received in diagnosing, referring or treating depression and alcohol misuse, as well as your experiences of how well the programme worked or did not work at your clinic. The interview will be conducted by myself. With your permission, I will audiotape the interview and the audio recordings will be transcribed later. The audio recordings will be deleted as soon as they have been transcribed.

Will my information remain confidential?

Yes. Should you agree to take part in the study, all the information collected from you will be seen by the study researchers only. Information and results of the study that are shared with other researchers will not contain any identifiable (personal) information such as names or contact details. Every effort will be made to keep your information confidential. Although we will try to conduct this interview in a private room, it might happen that, during the course of your interview, another clinic staff member or patient comes into the room. We are unable to guarantee the confidentiality of your participation in this study should this happen. The posibility also exists that, despite the absence of identifying data, the clinic could be identified as the research site due to a process of deduction from the public information about the PRIME project. This does not mean that you yourself will be identified but that the aggregate data from the study may be linked back to your facility.

The transcript from your interview will be stored on a computer and protected with a password. The audio recording of your interview, if you consented to it being recorded, will be destroyed immediately

after it has been transcribed. Your interview data will be stored under password protection for up to five years on the PRIME-SA computers.

What are the possible benefits of participating in this study?

There are no direct benefits to you for participating in this study. You will be asked to give 20-40 minutes of your time in participating in this study. You will receive no remuneration for your time. We hope that the study results will help us to improve the programme at your clinic so that service provision and treatment for patients will depression and alcohol misuse will be improved. The information that we get from this study will also help us to identify any issues that need to be addressed before we implement the new programme in other primary health care clinics.

What are the possible drawbacks or discomforts of participating in this study?

The only cost to you of participating in this study is your time. If you agree to participate in this study, you will be asked a number of questions about your experience of the PC101 and counselling training, and about your experiences in implementing the programme at your clinic. The interview should take approximately 20 to 40 minutes of your time. If you experience any discomfort or distress during the course of this interview, you can contact (name of independent psychologist / counsellor in the area) for to speak about your concerns.

Do I have to participate in this study?

It is your choice whether you want to participate in this study or not. If you decide not to participate, you will not be prejudiced in any way, and your decision will not affect your position at the clinic you work at. If you decide to take part, you are still free to withdraw from the study at any time and without giving a reason. Should you decide not to take part, or if you withdraw from the study, this will in no way affect your position at the clinic. Should you agree to participate, we will ask you to sign the attached consent form.

How will we report this research?

We will report our results and other aspects of the study in scholarly journals, conferences and to the Department of Health via policy briefs and other reporting structures.

This study has been ethically reviewed and approved by the UKZN Biomedical research Ethics Committee (approval number BE372/13).
In the event of any problems or concerns/questions you may contact

For questions related to the study	For Your rights as a research participant
The Principal Investigator, Professor Inge Petersen	**BIOMEDICAL RESEARCH ETHICS COMMITTEE**
Department of Psychology	**Research Office, Westville Campus**
Howard College	**Govan Mbeki Building**
Privat Bag X 54001	**Private Bag X 54001**
Durban	**Durban**
4000	**4000**

KwaZulu-Natal, SOUTH AFRICA	KwaZulu-Natal, SOUTH AFRICA
Tel: 27 31 260 7970	Tel: 27 31 2604769 - Fax: 27 31 2604609
Email: Peterseni@ukzn.ac.za	Email: **BREC@ukzn.ac.za**

Consent Form for Service Providers

Participation in the study to evaluate the PRIME-SA mental health care programme

Please complete this form after you have been through the information sheet and understand what your participation in this study entails.

Thank you for considering taking part in this study. If you have any questions arising from the information sheet, please ask before you decide whether to take part. You will be given a copy of the information sheet and consent form.

I, (write your name here), _____ have been informed about the study to evaluate the PRIME-SA mental health care programme conducted by Professor Inge Petersen and One Selohilwe.

I understand the purpose and procedures of the study.

I have been given an opportunity to ask questions about the study and have had answers to my satisfaction.

I declare that my participation in this study is entirely voluntary and that I may withdraw at any time without affecting my position at the facility I work at.

I have been informed about any available compensation or medical treatment if injury occurs to me as a result of study-related procedures.

If I have any further questions or concerns or queries related to the study, I understand that I may contact the researcher at 031 260 7970 or peterseni@ukzn.ac.za.

Tel: 27 31 2604769 - Fax: 27 31 2604609
Email: BREC@ukzn.ac.za

Please tick
or initial

I understand that if I decide at any time during the study that I no longer want to take part, I can notify the researchers and withdraw without having to give a reason.

I consent to the processing of my personal information for the purposes explained to me.

I agree to my interview being audio recorded.

I agree that the research team may use my data (information) for future research and understand that any such use of identifiable data would be reviewed and approved by a research ethics committee. In such cases, as with this project, data would not be identifiable in any report.

_____   _____

Signature of Participant   **Date**

_____   _____

Signature of Witness

(Where applicable)   **Date**

Appendix 4: PRIME Research Instrument

Process Evaluation Interview Schedule for PC101+ / PRIME-SA intervention for depression and alcohol misuse in chronic care users: <u>Facility managers</u>

We would like to know about your experiences of implementing the enhanced PC101+ for identifying, referring and treating chronic care patients with symptoms of depression and alcohol misuse in your facility.

1. After the PC101+ do you think that the nurses are more comfortable to identify and refer chronic care patients with symptoms of depression to the counsellor and the PHC doctor? *Probe for reasons why they may not identify and refer patients with depression to the counsellor and PHC doctor.*

2. In practice, how do you think the referral system to the PHC doctor is working?
   Probe for:
   - *What is working and not working and why.*
   - *Reasons why patients with depression referred to the PHC doctors do not follow up on these referrals.*
   - *Suggestions for how the process can be improved.*

3. In practice, how do you think the referral system to the counsellors is working?
   Probe for:
   - *What is working and not working and why.*
   - *Reasons why patients with depression referred to the counsellors do not follow up on these referrals.*

  o *Suggestions for how the process can be improved.*

4. After the PC101+ do you think that the nurses are more comfortable to identify patients with alcohol misuse and provide brief advice?
 Probe for reasons why they may not identify and provide brief advice to patients who misuse alcohol.

5. Has the training and referral system for depression and alcohol misuse been helpful in the improving the service provided to patients by your clinic?
 Probe for:
  o *Whether it has helped to promote more holistic care.*
  o *Any evidence that patients perceive the quality of care provided to be more comprehensive and better.*

6. Has the additional training and services provided for depression and alcohol misuse improved mental health literacy of patients attending the clinic?
 Probe for:
  o *Any evidence that patients are more aware of depression and alcohol misuse and that the clinic now offers services for these conditions.*

7. What challenges have you encountered in referring depressed patients or patients with alcohol use disorders?

8. If you could change any aspect of the programme, which aspects would you change?

Now we would like to know about your experience of the implementation of the ICDM and the PRIME intervention for depression.

9. How has a typical workday changed since the implementation of the ICDM including the PRIME intervention for depression?
 Probe for:
  • *Whether this has affected the way they work*
  • *Whether this has affected their attitudes to their work and patients*

- o *Probe for whether they have adopted a different approach to patient care in line with holistic person centred care and patient self- management*
- *How they feel about having to deal with the whole patient including their emotional difficulties*
  - o *Probe for how they cope with dealing with the emotional issues of their patients during the consultation as well as after*
  - o *Whether this has led to increased levels of stress*

10. What demands do the patients place on you?
    Probe for:
    - *What patients expect from you*
    - *Why they have these expectations*
    - *How they think that the clinic is meeting the needs of the community*
    - *How patients expectations need to change in line with the ICDM*
    - *Possible interventions to help change patient expectations towards patients taking more responsibility for their health*

11. What is the purpose of the clinic?
    Probe for:
    - *Probe for how they see their role as a nurse in fulfilling the objectives of the clinic*
    - *Promoting the health of the community*
    - *Chronic care including mental health*

12. What values guide the management of the clinics?
    Probe for:
    - *What is the decision making process in the clinic*
    - *How do their managers relate to them*
    - *Do they feel supported by their managers to work within a patient centred approach*
      - o *If not – how do they feel management could change to make it easier to work within this approach*

13. If you/the nursing staff are unhappy, what is the procedure for voicing this?
    Probe for:
    - *Are nurses comfortable reporting if they are unhappy*
    - *In what ways do the nursing staff feel empowered to voice their needs in order to be able to do their job better*

14. Do you have any ideas on how the system can be improved to support the implementation of the ICDM?

15. You have recently completed Change Management Workshops called ReMmogo. How was this experience for you?

> If positive probe:
> What impact have the skills that you were exposed to during the workshop had on your interaction with your patients?
> What has been the most useful skills for you as a professional nurse?
>
> If negative probe:
> What was challenging about the workshop?
> How can we make the workshop more beneficial for you?

Process Evaluation Interview Schedule for PC101+ / PRIME-SA intervention for depression and alcohol misuse in chronic care users: <u>Nurses</u>

We would like to know about your experiences in using PC101+ (PRIME version) to identify and refer patients with symptoms of depression, and to identify and provide brief interventions for patients with alcohol misuse.

DEPRESSION

1. **What was your experience of diagnosing depression after being trained in PC 101+?**

   Prompting questions:

- Do you feel that you are now able to recognise when a patient is clinically depressed, compared with simply "having a hard time"?
- How useful did you find the depression algorithm on page 81 in helping you to decide whether or not someone depressed?
  - *Probe for whether they used this algorithm or not. If they did, probe for whether they worked through it while they were with the patient.*
- What signs and symptoms alert you to the fact that a patient might be depressed?
  - *Probe for particular symptoms, other problems like non-adherence to medication for other conditions, patients who appear down.*
- What things make it difficult for you to diagnose depression as per the PC 101+ guideline?
  - *Probe for:*

- o *Issues of time or privacy. If yes to either time or privacy, prompt for how this impacts on their ability to provide routine chronic care more generally e.g. for hypertension or HIV.*
- o *Other demands or clinical issues to attend to that seem more pressing than depression.*
- o *Whether they feel confident or unconfident to diagnose and refer depression.*
- o *Attitudes towards depression as a 'real' clinical problem that can be addressed with counselling interventions.*
- o *Whether there are issues referring patients to the counsellors or primary health care doctor.*
- What could the training and guidelines better help you to recognise and diagnose depression?

2. What was your experience of referring patients with depression to the counsellors?

- If they seem to be positive about referring patients to counsellors, prompt for how they experienced the referral process.

  Probe for:
  - o *Whether it was easy to arrange.*
  - o *Whether they got any feedback from the counsellors.*
  - o *Whether they got any feedback from the patients themselves.*

- If they seem reluctant to refer patients to counsellors, prompt for why this is the case.

  Probe for:
  - o *Uncertainty about what the counsellors do.*
  - o *Lack of confidence in counsellors or counselling services.*
  - o *Whether they would prefer to help the patient themselves.*
  - o *Issues about counsellor availability to accept referrals.*
  - o *Reluctance on part of patients to see the counsellors.*
  - o *Requires too much extra effort in limited space of time.*

3. What was your experience of referring patients to the primary health care doctor for their depression?

- If they seem positive about referring to the doctor, probe for how this process went.

Probe for:

- o *How soon patients were seen by the doctor.*
- o *Whether they got any feedback from the doctor and whether they saw patients again after they had been seen by the doctor.*

- o *Whether the doctor prescribed antidepressants and, if not, whether they know why not.*

- If they seem reluctant to refer to the doctor, probe for why this is the case.

  Probe for:
  - o *Doctor is too busy? Wasn't sure whether the referral was really necessary? Patient was not keen to have to see the doctor?*

4. How did your patients respond to being told that you thought that they might be depressed?

Probe for:

- *Relief at having an explanation for symptoms; confusion or lack of understanding about what depression is.*
- *How patients reacted to being advised to see the counsellor for this problem.*
- *How patients reacted to being advised to see the doctor for this problem.*

5. Care for depression is a team effort, requiring you as nurses to recognise and diagnose it, the counsellors to offer the counselling, and the doctor to prescribe medication if necessary. How did you experience working as part of a team like this?

- How did you experience your own role within the team?
- Do you think the counsellors are a useful addition to the team, or would you prefer to be trained to provide the counselling yourself?
- Do you think it would be more or less effective if you were able to prescribe the medication to patients yourself, rather than referring to the doctor?
- Do you think the training prepared you well enough for this role as the 'gate-way" to care? What could be done to better prepare you for this?

ALCOHOL USE DISORDERS

1. **What was your experience of diagnosing risky alcohol use after being trained in PC 101+?**

- How useful did you find the training and guidelines in helping to identify risky alcohol use?
- Has the training made you more aware of the problem of alcohol misuse among patients?

  Prompt for:
  - *Whether they consider alcohol misuse a serious issue (as opposed to somewhat normative).*
  - *Whether or not they believe that alcohol misuse is a problem among their patients.*
  - *Whether they believe that alcohol misuse is too big a problem to solve.*
  - *Whether they are concerned about patient reactions to hearing that he/she has a problem with alcohol.*

- How easily were you able to establish the amount of alcohol a patients drinks per week or in a session?

  Prompt for:
  - *If they found it difficult, what were the challenges?*

- How could the training better prepare you to diagnose risky alcohol use?

2. **What was your experience of managing risky alcohol use after being trained in PC 101+?**

- Did you feel confident about providing brief advice to a patient with risky alcohol use following the PC101+ training?

  Prompt for:
  - *Whether they found the advice on page 83 of the training manual helpful*

- How did the patient react to the advice?
- Did you have an experience of diagnosing someone with dependent alcohol use? If yes, can you tell me what happened?

Now we would like to know about your experience of the implementation of the ICDM and the PRIME intervention for depression.

1. How has a typical workday changed since the implementation of the ICDM including the PRIME intervention for depression?
   Probe for:
   - *Whether this has affected the way they work*
   - *Whether this has affected their attitudes to their work and patients*
     - *Probe for whether they have adopted a different approach to patient care in line with holistic person centred care and patient self- management*
   - *How they feel about having to deal with the whole patient including their emotional difficulties*
     - *Probe for how they cope with dealing with the emotional issues of their patients during the consultation as well as after*
     - *Whether this has led to increased levels of stress*

2. What demands do the patients place on you?
   Probe for:
   - *What patients expect from you*
   - *Why they have these expectations*
   - *How they think that the clinic is meeting the needs of the community*
   - *How patients expectations need to change in line with the ICDM*
   - *Possible interventions to help change patient expectations towards patients taking more responsibility for their health*

3. What is the purpose of the clinic?
   Probe for:
   - *Probe for how they see their role as a nurse in fulfilling the objectives of the clinic*
   - *Promoting the health of the community*
   - *Chronic care including mental health*

4. What values guide the management of the clinics?
   Probe for:
   - *What is the decision making process in the clinic*
   - *How do their managers relate to them*
   - *Do they feel supported by their managers to work within a patient centred approach*

> > o *If not – how do they feel management could change to make it easier to work within this approach*

5. If you/the nursing staff are unhappy, what is the procedure for voicing this?
   Probe for:
   - *Are nurses comfortable reporting if they are unhappy*
   - *In what ways do the nursing staff feel empowered to voice their needs in order to be able to do their job better*

6. Do you have any ideas on how the system can be improved to support the implementation of the ICDM?

7. You have recently completed Change Management Workshops called ReMmogo. How was this experience for you?

> If positive probe:
> What impact have the skills that you were exposed to during the workshop had on your interaction with your patients?
> What has been the most useful skills for you as a professional nurse?
>
> If negative probe:
> What was challenging about the workshop?
> How can we make the workshop more beneficial for you?

Appendix 5: Ethical Clearance Certificate

UNIVERSITY OF ™
KWAZULU-NATAL

INYUVESI
YAKWAZULU-NATALI

6 February 2018

Ms Qaqamba Madikizela 206518354
School of Applied Human Sciences
Howard College Campus

Dear Ms Madikizela

Protocol reference number: HSS/2224/017M
Project Title: An evaluation of perceptions of nurses on the significance of integrating mental health into primary care in the Dr Kenneth District

Full Approval – Expedited Application

In response to your application received 24 November 2017, the Humanities & Social Sciences Research Ethics Committee has considered the abovementioned application and the protocol has been granted **FULL APPROVAL**.

Any alteration/s to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form, Title of the Project, Location of the Study, Research Approach and Methods must be reviewed and approved through the amendment /modification prior to its implementation. In case you have further queries, please quote the above reference number.

PLEASE NOTE: Research data should be securely stored in the discipline/department for a period of 5 years.

The ethical clearance certificate is only valid for a period of 3 years from the date of issue. Thereafter Recertification must be applied for on an annual basis.

I take this opportunity of wishing you everything of the best with your study.

Yours faithfully

Dr Shamila Naidoo (Deputy Chair)
Humanities & Social Sciences Research Ethics Committee

/pm

cc Supervisor: Professor I Petersen
cc. Academic Leader Research: Professor Jean Steyn
cc. School Administrator: Ms Ayanda Ntuli

Appendix 6: Gatekeeper's letter

health
Department of
Health
North West Province
REPUBLIC OF SOUTH AFRICA

2ND Floor Tirelo Building
Dr. Albert Luthuli Drive
Mafikeng, 2745
Private Bag X2068
MMABATHO, 2735

Tel: (018) 387 5757
Fax: (018) 392 6710
kshogwe@nwpg.gov.za

POLICY, PLANNING, RESEARCH, MONITORING & EVALUATION DIRECTORATE

FAX COVER PAGE

To	: PRIME-SA
Att	: Caire Van Derventer
FAX	: 086 6461 789
FROM	: Keitumetse Shogwe
TEL	: 018 387 5747
CELL	: 076 3135 861
FAX	: 018 392 6710

1

Healthy Living for All

POLICY, PLANNING, RESEARCH, MONITORING AND EVALUATION

To : Prof I Petersen
    University of KwaZulu-Natal

From : Policy, Planning, Research, Monitoring & Evaluation

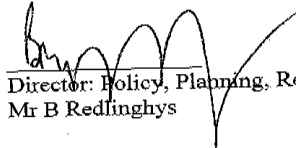Subject: **Approval Letter- Programme for Improving Mental Health Care in South Africa**

The Subject matter above bears reference

Purpose

To inform your good selves that permission to undertake the above mentioned study has been granted by the North West Department of Health. The researcher is expected to issue this letter as prove that the Department has granted approval to the districts or health facilities that form part of the study.

Arrangements in advance with managers at district level or facilities shall be facilitated by the researcher and the department expects to receive the final research report upon completion.

Kindest regards

Director: Policy, Planning, Research, Monitoring & Evaluation   Date
Mr B Redlinghys

17/10/11

DEPARTMENT OF HEALTH
PRIVATE BAG X2068

2011 -10- 1 7

SUPERINTENDENT GENERAL

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H e a l t h y   L i v i n g   f o r   A l l

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