THE OUTCOMES OF IMPLEMENTING THE DEPARTMENT OF HEALTH MENTAL HEALTH CLINICAL GUIDELINES FOR THE MANAGEMENT OF PSYCHIATRIC PATIENTS AT PRIMARY HEALTH CARE CLINICS

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DECLARATION

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ACRONYMS AND ABBREVIATIONS

Acronym	**Interpretation**
PHC	Primary Health Care
WHO	World Health Organization
KZN	KwaZulu-Natal

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ABSTRACT

Background: The South African (SA) government recognizes that the first step towards improving mental health and wellbeing of the people is to develop effective guidelines .After guidelines have been developed, there is a need for transferring them to the implementing settings. It has been noted that mental health guidelines are important tools for enhancing framework of the mental health system.

Objectives: The objectives for the study were: (1) To analyse the process inherent in the implementation of the guidelines in PHC settings in KZN based on action research; (2) To analyze the awareness, knowledge, perceptions and implementation practices of Primary Health Care Nurses of the treatment guidelines for common mental health conditions in their primary health care practice; and (3) To evaluate the readiness for a change management programme for the sustainable implementation of appropriate clinical guidelines in selected primary health care practice contexts.

Method: A survey was conducted amongst nurses working in PHC clinics in order to determine the outcomes of implementing the Department of Health mental health clinical guidelines for the management of psychiatric patients at primary health care clinics. Qualitative and quantitative methods were used.

Results: The study found that quality of care was compromised when the implementation of a mental health policy was flawed in all seven major implementation themes. Services for psychiatric patients were only available daily in four of the sites (66.7%). Patients attending the other two sites (33.3%) were seen by a psychiatrically trained nurse on a dedicated day once a month. PHC nurse's attitudes and beliefs toward people with mental illness were positive, but did not have adequate knowledge to manage psychiatric patients.

Conclusion: The identified a number of gaps in the implementation of Standard Treatment Guidelines for Common Mental Health conditions in primary health care settings as an example of the policy implementation process in rural areas.

CHAPTER 1

1.1 BACKGROUND

1.1.1 History of Mental Health in South Africa

The transition that occurred in South African history, that is, moving from apartheid era to a democratic era in 1994 brought about changes in the provision of mental health. There was a realisation during the twentieth century is South Africa that hospital-based mental health care is not effective in promoting recovery for psychiatric patients. The World Health Organization's strategy of integrating mental health into primary health care (PHC) was then adopted (World Health Organization (WHO), 2008). Integration of mental health into primary health care (PHC) was seen as an important strategy since research has proved that there is relationship between mental health and physical health problems (Saxena & Skeen, 2012).

1.1.2 Mental Health service delivery in PHC clinics

The high prevalence of mental health disorders at a community level strongly warrants the provision of integrated mental health at a primary health care clinic (Roca, Gili, & Garcia-Garcia et al., 2009). In South Africa, the primary health care clinic is the point where the patient first presents herself / himself for care (Cullican, 2006). According to Ssebunnya et al (2010), PHC implies providing universal accessible care to individuals and families near to where people live and work. The vision for the PHC approach is that every citizen must have better health and thus a better life at the level of the community (Power, 2009). PHC clinics are managed by professional nurses with training in mental health while others do not have training in mental health (Cullican, 2006). In PHC clinics, nurses are not permitted to initiate psychiatric treatment but refer the patient to the medical doctor for this (Cullican, 2006). These practices interfere with integration of mental health into primary health care and act as a stumbling block to accessibility of mental health in the primary health care setting (Dussault, 2008). This also raises a concern because most hospitals have general doctors who are not as experienced as psychiatric nurses in mental health (Schierenbeck, Johansson, Anderson & van Rooyen, 2013). According to Schierenbeck et al (2013), psychiatric patients have a right to interventions that are known to be effective and are delivered by knowledgeable nursing staff. In a study conducted by WHO (2008) in Ehlanzeni District in

Mpumalanga Province, South Africa, 99% of nurses interviewed felt that patients with mental illnesses should receive care like any other patient in the PHC setting and most nurses felt comfortable in attending to mentally ill patients.

1.1.3 Why Mental Health clinical guidelines?

The South African (SA) government recognises that the first step towards improving mental health and wellbeing of the people is to develop effective guidelines (Durlak & DuPree, 2008). After guidelines have been developed, according to Durlak and DuPree, (2008), there is a need for transferring them to the implementing settings. It has been noted that mental health guidelines are important tools for enhancing framework of the mental health system (Morris, Lora, McBain, & Saxena, 2012). It is an official document of the National Department of Health which conveys organised set of values, principles, objectives and areas for action to improve delivery of mental health to the communities (Morris et al., 2012). According to Morris et al. (2012), mental health guidelines in PHC cover issues which include, amongst others, access to mental health care, integration of mental health into general health and provision of quality mental health care. Development of guidelines and plans that are linked to the people's health and recognition of their rights is important to the achievement of quality mental health care (Dugeon et al., 2014).

Improved communication where there are meetings between primary care and secondary care to discuss mental health service delivery is seen to be an important tool in facilitating integration of mental health into PHC (Jenkins, 2007). Interpersonal relationships in health care settings which are achieved through communication have different goals (Bakic-Miric & Bakic, 2008). The goals as indicated by Bakic-Miric and Bakic (2008) are creation of good interpersonal relations, discussing and taking collaborative decisions about nursing care and giving information. Bakic-Miric and Bakic (2008) recommended that good rapport with the patient can be established through non-verbal communication like smiling, eye contact, head nodding and touch. This conveys security and comfort to the patient (Bakic-Miric & Bakic, 2008).

1.1.4 Barriers to provision of Mental Health Care at PHC clinics

Research has shown that long distances to the primary health care facility are having an impact on the patients not attending the clinic for early health assessment (Schierenbeck et

al., 2013). Most patients coming to the clinic have mental problems but most mental illness in PHC is not detected because of negative attitudes and lack of primary health care workers to mental health (Schierenbeck et al., 2013). Another factor that affects detection of mental health in primary health care services is incomplete history given by the patient because of the stigma attached to mental illness (Schierenbeck et al., 2013).

Shortage of human resources and lack of supervision of PHC health workers has been identified by Saraceno et al. (2007) as one of the barriers in the provision of mental health in the PHC clinics. Although in South Africa there is an increasing number of nurses that are trained in a four year Nursing Diploma that includes training on mental health, it is difficult to attract these nurses to the rural clinics where they are most needed (Awenva, et al., 2010). Awenva et al. (2010) further maintain that lack of health care workers with training in psychosocial care and rehabilitation is also a barrier towards integrated mental health care in PHC. The reluctance of primary care workers to work with people with mental health conditions has also resulted in poor integration of mental health into PHC (Kigozi, 2007).

Lack of knowledge about the resources required for integration of mental health in low- and middle-income countries is a hindrance to the smooth integration of mental health into PHC (Lund & Flisher, 2009). Human resources in PHC facilities must be provided with training in mental health in order to be able to assess and treat mental health problems (Hlahane, Greeff, & du Plessis, 2006). Supervision of PHC workers has also been identified as an important activity for integration as they are provided with strategic leadership and this helps the PHC practitioners to refer patients appropriately to the specialist (Munyewende & Rispel, 2014).

1.1.5 Determinants of mental illness

The decentralisation of mental health care to PHC in South Africa was aligned with social, economic and social domains (Plagerson, 2014). Poverty in the South African context is a key contributory factor for mental disorders (Sorsdahl, Stein, & Lund, 2012). People who are poor, unemployed, less educated and those who are faced with economic hardship due to unemployment are at greater risk of developing mental health disorders (Patel, 2007; Myer, et al., 2008).

The poor may be vulnerable to mental ill-health because of social marginalisation, a large number and high intensity of stressors, reduced access to social capital, malnutrition and obstetric risks (Flisher et al., 2007).

1.2 CONCEPTUAL FRAMEWORK

The use of a framework, according to Harrison, Legare, Graham and Fervers (2010), provides a strategy for the effective implementation of guidelines by clinicians. The conceptual framework that informs this study assumes that the desired outcomes of implementing mental health clinical guidelines depend on a number of interrelated factors.

The study attempts to draw a mapping of these factors that contribute to effective implementation of mental health clinical guidelines in PHC clinics in figure 1. Commitment by the implementers to a particular policy guideline, training on policy, conviction, positive attitudes and beliefs have been identified as factors in the successful implementation of clinical guidelines (Brynard, 2009). Brynard (2009) further maintains that effective planning, allocation of resources for mental health which includes human and financial resources, and supervision of PHC nurses will lead to positive outcomes in the implementation of mental health policy.

Figure 1.1: Factors influencing successful implementation of mental health policy.

Source: Brynard (2009)

The illustration above shows the interrelationship of factors that contribute to the success of policy implementation. Commitment as illustrated in Figure 1. is defined as the visible will to deliver the policy and it helps overcome individuals' resistance (Brynard, 2009). This stage involves motivating people and preparing them for change. This stage should clarify which aspects of the problem the intervention will address and make clear the outcomes and impacts it seeks to produce (Rogers, 2014). In order to have highly skilled health care workers with positive attitudes and beliefs towards mental health in PHC clinics, there is a need for continuous training on mental health and effective PHC supervision (Brynard, 2009; Naledi, Barron & Schneider, 2011). Individual characteristics such knowledge of beliefs and attitudes towards guidelines plays an important role at this stage. Activities such as development of training materials and provision of training to the implementers are done at this point of the programme and the individuals develop new attitudes and behaviours because of exposure to training (Rogers, 2014). The allocation of resources requires effective planning and deployment of skilled and motivated human resources (Brynard, 2009). Research has shown that positive attitudes, beliefs and confidence of PHC nurses change their practice behaviour in the management of people with mental disorders (Vadlamudi et al., 2008). Objective number one and research questions number one and three in the study cover the aspect of commitment. Objective number two and research questions number two, three and four in the study address the issues of training which will change PHC nurses' attitudes, knowledge and perceptions which are important factors to achieve the desired health outcome. In this study, objective number three and research question number six deal with the outcomes. There can be improvement in the management of psychiatric patients in PHC clinics due to change. Change in staff attitude towards psychiatric patients will be an important measure for the outcome.

This conceptual framework was used in conjunction with the method to evaluate policy implementation as discussed by Bhuyan, Jorgensen and Sharma (2010) which is discussed in detail in article three.

1.3 PROBLEM STATEMENT

Despite the availability of mental health guidelines for management of psychiatric patients, quality and outcomes for persons with mental disorders remain suboptimal (Kilbourne, 2014). Although research has proved that social and economic determinants play a major role

in the mental health status of the society, mental health remains low on the public health agenda (Bird, et al., 2011). Several studies revealed that identification and treatment of mental disorders at PHC clinics is poor (Petersen et al., 2009; Lund et al., 2010; Sorsdahl et al., 2010).

In 2006 the National Department of Health published Standard Treatment Guidelines for Common Mental Health Conditions in order to improve management of psychiatric patients. However, in a survey conducted by KwaZulu-Natal Provincial Department of Health in 2008 for Mental Health Services in the KZN Province which has eleven districts, they found that, the process of integrating mental health services into PHC has been partially implemented. It is also not clear to what extent these guidelines are known and used by nurses in PHC settings, or how appropriate they are for this level of practice.

The study aimed to study the process and outcomes of implementing the Department of Health Mental Health Clinical Guidelines at primary health care clinics.

1.4 OBJECTIVES AND RESEARCH QUESTIONS

The aim of the study was to address three major objectives and to answer five research questions:

1.4.1 OBJECTIVES

1. To analyse the process inherent in the implementation of the guidelines in PHC settings in KZN based on action research.
2. To analyze the awareness, knowledge, perceptions and implementation practices of Primary Health Care Nurses of the treatment guidelines for common mental health conditions in their primary health care practice.
3. To evaluate the readiness for a change management programme for the sustainable implementation of appropriate clinical guidelines in selected primary health care practice contexts.

1.4.2 RESEARCH QUESTIONS

1. What implementation practices are being employed in the management of psychiatric clients at primary health care clinics?

2. What are the awareness, knowledge and perceptions about the care of psychiatric patients at PHC level amongst nurses?
3. How ready is the PHC system for the implementation of clinical guidelines for the management of psychiatric patients?
4. What are the barriers and facilitators in implementing the guidelines in PHC settings?
5. What are the outcomes to participation in and exposure to the ability to conduct assessment of a psychiatric patient, ability to provide diagnosis, ability to provide management of the psychiatric condition?

1.5 DEFINITION OF TERMS

1.5.1 Outcomes of implementation

Outcomes of implementation refers to achieving the expected functionality required by an identified stakeholder (Brynard, 2009). In this study the outcomes of implementation will mean the extent to which the implementation of guidelines for the management of psychiatric patients has contributed towards improving management of psychiatric patients at PHC clinics. The observable improvement can be (1) improved clinical skill of PHC nurses (2) improved management of psychiatric patients which can be determined by improved service utilization, improvement in symptoms and in client satisfaction with the service and (3) change of attitude of PHC nurses towards psychiatric patients.

1.5.2 Psychiatric client

Psychiatric client refers to a person receiving care, treatment and rehabilitation services aimed at enhancing the mental health status of that person (National Department of Health, 2010).

1.5.3 Mental Health guidelines

Mental health guidelines are systematically developed statements to assist health practitioners about appropriate mental health care. They are tools for improving quality mental health care by ensuring that provision of mental health care is standardized (Forsner, *et al.* 2010).

1.5.4 Primary Care clinics

Primary Health Care clinics refer to settings that provide the first level of contact for individuals seeking health care (National Department of Health, 2010). For the purpose of this study Primary Health Care clinics refers to the health care facility where patients are managed nearest to their homes and health care services are provided by trained professional nurses.

1.5.5 Professional Nurses

Professional nurses are individuals who have undergone formal training in nursing at a recognized institution of higher learning and are registered with the South African Nursing Council as professional nurses. These individuals are responsible for the management of patients in PHC clinics

1.5.6 Rural Clinics

Rural clinics are clinics that provide health services outside urban centres where there is no ready access to specialist and or high technology care and where resources, both human and material are lacking.

1.5.7 Deep Rural Clinics

For the purpose of this study, deep rural clinics means clinics that are 200km further away from urban areas and the infrastructure and human resources are extremely limited.

1.5.9 PHC Model of Care

PHC model of care is the philosophy of attaining equitable health care that governs all levels of care within the health system and responsible for delivering improvements in the social determinants of health (Naledi et al., 2011).

1.6 CONCLUSION

People with mental health conditions have a higher chance of a speedy recovery if they are treated in an environment with committed staff that are highly skilled to manage mental health problems, health workers with positive attitude towards people with mental health

problems (Clark, 2011). The system should support the PHC by providing resources required for integration of mental health into PHC. World Health Organization Mental Health Atlas (2011) results indicate that there is still a long way to go towards integration of mental health into PHC services. Training on mental health issues is not done in PHC clinics (World Health Organization, 2011). This was affirmed by the results of the study conducted by Morris et al. (2012*)* who found that only 22% of PHC nurses had received in-service education on mental health within the last five years.This study focuses on nurses in the management of people with mental health conditions because they form the bulk of health professionals providing mental health (Saxena & Skeen, 2012).

There is dearth of human resources in rural clinics because of their rural nature (Mohale & Mulaudzi, 2008). Nurse patient ratio in these clinics is 1:44 (Department of Health, 2009). This simply means one professional nurse attends to 44 patients per day which is above the norm of 1:38 (Department of Health, 2009).

1.7 THESIS LAYOUT

In line with the PhD by publication, the thesis was structured as follows:

Chapter 1

Chapter 1 provided the background, research problem and the objectives of the thesis.

Chapter 2

Chapter 2 provided a literature review which included a survey of the literature.

Chapter 3

Chapter 3 discussed the research methodology that was used for the study. It included a report of how the researcher actually carried out the research. It also presented how participants were selected.

Chapter 4

Chapter 4 dealt with the presentation of three overarching articles which were submitted for publication.

Chapter 5

Chapter 5 presented summary of the problem, the main findings, conclusion and recommendations.

CHAPTER 2
2.1 LITERATURE REVIEW

2.1.1 Introduction

The aim of this chapter was to review literature related to policy and guidelines implementation and other articles related to factors that affects policy implementation. The review included, Sabinet, Medline, EBSCO host, Pubmed and Google Scholar.

Primary sources were used to enable thorough and relevant review. The inclusion criteria are those papers, articles published within ten years (2006 to 2014) unless they are considered as providing historical perspective. Key terms were used such as "policies", "plans" "guidelines", "integration", "Primary Health Care", "mental health and mental illness", "community mental health", "district mental health", "mental health guidelines", "mental health in South Africa" It was then possible to limit the search to mental health in primary health care when using combination of these words.

2.1.2 What are clinical guidelines?

Clinical guidelines are a tool for promoting quality in the management of patients but their outcomes in practice in health care settings are variable. There is a gap between what is recommended by the guidelines and the actual delivery of care based on the guidelines. Surveys on the implementation of guidelines have identified some of the major barriers in the implementation of guidelines which are related to health practitioner, patient. organisational and environment (Franke, Smit, de Veer & Mistiaen, 2008; Schierenbeck et al., 2013; Abera, Tesfaye, Belachew & Hanlon, 2014).

Qualitative studies explored health workers' attitudes on the implementation of guidelines. They identified that lack of trust in the guidelines by clinicians and negative attitudes are the contributory factors (Carlsen, Glenton, & Pope, 2007; Carisen & Norheim, 2008). These results motivated the researcher to explore further the outcomes of implementing mental health clinical guidelines in PHC clinics.

2.1.3 Factors influencing the implementation of clinical guidelines

Most studies have identified that lack of human resources for mental health especially in rural areas had an negative impact in the implementation of clinical guidelines (Jacob et al., 2007; Medina, Kullgren, & Dahlblom, 2014). In most studies, health workers reported that they lack knowledge in the management of patients (Friedman et al., 2006; Talor, Hawton, Fortune, & Kapur, 2009). Poor health provider-patient relationship was also found to be a barrier in the implementation of guidelines (Talor et al., 2009). Negative attitudes and unfavourable perceptions of health workers were found to adversely affect the implementation of clinical guidelines (Suokas, Suominen, & Lonngvist, 2008).

2.1.4 Integration of mental health into PHC internationally

In developed countries, primary mental health care is mainly provided by doctors unlike in South Africa where primary health care is provided by primary health care nurses (World Health Organization, 2008).They then refer to the specialist psychiatrist when there is a need (World Health Organization, 2008). There were challenges that were identified in this model in Argentina where it was found that the standards of care received by a person with physical conditions were not the same for the psychiatric patient (World Health Organization, 2008).

2.1.5 Integration of Mental Health in Africa

The results of a study that was conducted in 2010, in Uganda, revealed that mental health is not integrated into PHC and there were no plans at that time for the integration to take place (Ssebunnya et al., 2010). Shortage of staff for mental health, and lack of training on mental health was a major problem identified by studies conducted in Uganda and Ghana (Ssebunnya et al., 2010; Awenva et al., 2010).There was no support supervision from the regional hospitals (Ssebunnya et al., 2010). Frequent out-of-stock psychiatric medication was also found as a challenge in integrating mental health services into PHC (Ssebunnya et al., 2010). The findings in Uganda and Ghana are that mental health policy is not a priority in providing quality mental health (Ssebunnya et al., 2010; Awenva et al., 2010).

2.1.6 Integration of mental health into PHC in South Africa

There have been developments in South Africa in the integration of mental health into PHC since the South African Mental Health Policy and the new Mental Health Care Act No. 17 of 2002 put emphasis on this (National Department of Health, 2002) However, authors like Lund, et al., (2010) maintain that although there are developments in South Africa regarding integration of mental health, psychiatric hospitals which existed before the promulgation of Mental Health Care Act, are still providing psychiatric services.

Mental health in South Africa has been provided in an era of transition and political differences and because of these, South Africa has a high number of mental disorders compared to other countries in sub-Saharan Africa (Williams et al., 2008).

South Africa is divided into nine provinces. All these provinces have primary care facilities that range from community health centres to clinics that open on a twenty-four hour basis and on an eight-hour basis, but integration of mental health into PHC is characterised by poor policy implementation (Lund et al. 2010).

Integration of mental health into PHC differs in provinces in that in some PHC clinics mental health services are provided as routine care and, in some, mental health services are provided by a psychiatric-trained nurse on dedicated days, (Lund et al., 2008). In the latter approach, psychiatric patients become used to their psychiatric nurse as the only person who can provide best mental health services(Lund *et al.*, 2008). It was found that in PHC clinics where patients join the general queue, they complained about daily changes of the attending PHC nurse and long waiting times (Lund et al., 2008).

2.1.7 Implementation of Guidelines to improve provision of Mental Health Care at PHC Clinics

The success of guidelines depends on how well they were understood and implemented by the implementers (Durlak & DuPree, 2008). Durlak & DuPree (2008) advised that the outcomes of implementing guidelines could be interpreted when implementers know what aspects of guidelines were delivered and how well they were implemented. According to Aarons, Hurlburt and Horwitz (2011), implementation becomes part of the way where

implementers understands the problem. Proctor et al. (2010), maintain that implementation outcomes serve as preconditions for attaining desired changes in the service.

2.1.8 Challenges in Improving Mental Health Services in PHC Clinics

Lack of supervision of PHC health workers has been identified as a major challenge towards improving quality mental health services (Naledi et al., 2011). This is despite the supervision policy that was developed by the Department of Health which clearly states that PHC clinic must be supported by the Primary Health Care manager at least once a month (National Department of Health, 2009). Regional hospitals with specialist psychiatric teams also do not conduct outreach psychiatric services to PHC clinics (Naledi et al., 2011). Shortage of trained staff in mental health at PHC clinics also affects provision of quality mental health services(Naledi et al., 2011). Omar et al. (2010) identified that knowledge and understanding of mental health amongst health care workers was generally poor.

Mental health guidelines are not effectively implemented because of lack of commitment by the implementers at PHC clinics (Omar et al., 2010). Staff shortages in PHC facilities are a threat to integration of mental health into PHC (Frenk, 2009). Nurses in a study conducted by Petersen et al. (2009) raised a concern that assessing a psychiatric patient needs extra time. The stigma attached to mental illness was found to be an inhibitor in the implementation of mental health clinical guidelines by PHC nurses (Omar et al., 2010). There is a need for improved communication where there are meetings between primary care and secondary care to discuss mental health service delivery. This is an important tool in facilitating integration of mental health into PHC (Jenkins, 2007). Lack of knowledge about the resources required for integration of mental health in low- and middle-income countries is a hindrance to the smooth integration of mental health into PHC (Lund & Flisher, 2009).

2.1.9 Strategies to Overcome Barriers

Training and capacity building would enhance implementation of mental health clinical guidelines in PHC clinics (Ssebunnya et al., 2010). For mental health to be fully integrated into PHC, there must be a shift of attitudes from PHC nurses and they must see this process of integration as ‘business unusual’ (World Health Organization, 2008). Petersen and Lund,

(2011) recommend that PHC health care workers need to implement a strategy which will assist in the identification and prompt referral of people with mental health disorders.

2.2 CONCLUSION

There is an assumption that thoughts, feelings and behaviours have influence on each other. Application of change theory in this study is based on the assumption that effective implementation of mental health clinical guidelines depends on knowledge, attitudes and on perceptions of an individual towards the guidelines. Training with an external stimulus enforces change that influences adherence to guidelines. Knowledge, attitudes, skills and beliefs play a major role in the implementation of clinical guidelines (Baiardini, Braido, Bonini, Compalati & Canonica, 2009).

CHAPTER 3

3.1 RESEARCH METHODOLOGY

3.1.1 Research Design

The researcher used the case study approach. The case study method was used by early Chinese philosophers and was revived by Christopher Langdell in 1880s (Clark, 1999). In this study, the researcher adopted Yin's method of case study and each clinic will be a case (Yin, 2009).This study used holistic, multiple case design with explanatory and exploratory focus. The design was a mixed method design including both qualitative and quantitative data and was used in order to explain and explore the health outcomes of implementing Department of Health Mental Health clinical guidelines in PHC settings.

The case study has both strengths and weaknesses. Some of the advantages are that the case study concentrates on studying the behaviour of one person or a small group. In that way the researcher is able to get detailed information from one person compared to many participants; this is called thick description (Duff, 2008). Gilbert (2008) argues that the case is studied in a more detailed way. Another advantage of the case study is that it is unique or atypical in that it provides room to study the background or behaviour of a person that is considered atypical or unique (Duff, 2008). Two major drawbacks for case study have been identified. The first one is lack of generalisability (Duff, 2008). Duff (2008) argues that it is impossible to generalise from a sample of one. Nevertheless, social constructionists view reality as being constructed by people through their activity and they interpret their situations differently (Saunders, Lewis, & Thornhill, 2003). These interpretations at times have a role in their interactions with other people (Saunders et al., 2003). For Saunders et al (2003), people share their interpretations as they have socially constructed their environment. The second drawback is that case studies produce a lot of data from different sources. Analysing this data is time consuming and needs a lot of hard work (Duff, 2008).

3.1.2 Setting

The study was conducted in uThungulu Health District in the Northern Area of Kwa-Zulu Natal Province. This district is the third largest district in KwaZulu-Natal Province with a population of 979,513 (Department of Health, 2013). The population is composed of

Africans, Whites and Asians. UThungulu district was selected to be the site of the study because of its rural nature with no urban primary health care clinics. There is shortage of human resources in primary health care clinics which impacts negatively on integration of mental health into primary health care. The site was selected for representation of the rural scenarios. There is no study that was previously conducted in the district that looked at practices of PHC nurses in their management of psychiatric clients at PHC clinics.

3.1.3 Unit of analysis

Cases in this study were the six Primary Health Care clinics**.** As has been mooted by Scholz and Tietje (2002), case studies are divided into holistic case studies versus embedded case studies, and single versus multiple case studies. Holistic case studies are qualitative in nature and deal with a case as a whole in its environment. Embedded case studies use qualitative and quantitative methods and involve more than one unit. Single case studies were chosen because of their uniqueness or their appropriateness to the topic under investigation.

This study used holistic, multiple case design with an explanatory and exploratory focus. The design was a mixed method design including both qualitative and quantitative data (Gravetter & Forzano, 2006). According to Gravetter and Forzano (2006), a case study provides a researcher with a chance to identify unique situation that will lead to intervention of the situation under investigation.

3.1.4 Population and Sampling

Six clinics were purposively selected based on their geographical location so that the level of support, which decreases as rurality increases, is well covered in the sample. Four clinics fell into the rural category and two fell into the deep rural category, making a total of six clinics for the study.

Case A was in a rural area. The mental health workload per month was 57 patients. Patients attended the clinic once a month and health records were patient-held. The clinic provided a twenty-four hour service. It was staffed by seven professional nurses and seven enrolled nurses. The doctor visited the clinic twice a week and the social worker visited the clinic once a month.

Case B was situated in a rural area. Monthly mental health workload was 80 patients. Health records were clinic-held. Patients visited the clinic on a dedicated day once a month. The clinic had ten professional nurses and seven enrolled nurses that provided twenty-four hour services.

Case C was situated in a rural area with a monthly mental health workload of 42 patients. Psychiatric patients were attended to daily and health records were patient-held. There were three professional nurses and three enrolled nurses that provided an eight-hour day clinic. Visits by the doctor and Social Worker to the clinic were once a month.

Case D was situated in a rural area with a monthly mental health workload of 36 patients. Psychiatric patients were attended to daily and health records were patient-held. There were three professional nurses and three enrolled nurses that provide an eight-hour day clinic. The doctor and social worker visit the clinic once a month.

Case E was situated in a deep rural area with a monthly mental health workload of 20 patients. Psychiatric patients were attended to monthly and health records were patient-held. There were three professional nurses and three enrolled nurses that provided eight-hour on-call services. The clinic was visited by a doctor once a month.

Clinic F was situated in a deep rural area with a monthly mental health workload of 22 patients. Psychiatric patients were attended to monthly and health records were patient-held. There were three professional nurses and three enrolled nurses that provided an eight-hour day clinic. The doctor visited the clinic once a month.

3.2 PHASES FOR THE STUDY

This study was divided into three phases, which were description of the current situation, evaluation of guidelines and readiness to implement them and lastly is the implementation of the guidelines and measuring of the outcomes. Table 3.1 provides the details.

Table 3.1: Phases of Study

Phases	Activity
Phase 1: January 2012-August 2012	1) Seeking permission to conduct the study from health authorities Entering the field and establishing relationship with research participants 2) Baseline Data collection
Phase 2: August2012- January 2013	1) Implementation strategies
Phase 3: January 2013-June 2013	1) Post implementation data collection
Phase 4: June 2013-December 2013	1) Writing report and articles

3.3 DATA COLLECTION

3.3.1 Data Collection Instruments

3.3.1.1 Questionnaires

A questionnaire was used to collect quantitative data. The questionnaire (Appendix 1) was adapted from the PHC Supervision Manual for the purpose of collecting quantitative data from the registered nurse in charge at each of the selected PHC clinics. The questionnaire had five sections with 24 items, 19 of which addressed the implementation practices in the management of psychiatric patients in PHC clinics. Section 3 of the questionnaire involved reviewing clinic-held patient records for three months. The criterion for record selection was that the record should be of clients who were accessing treatment for at least three consecutive months. Entries in patients' medical records were reviewed to assess whether patients' medication had been reviewed in the last six months (1), whether patients were assessed before they are given treatment (2), whether education on medication and side effects was given to the patient (3) and whether a medical examination had been conducted in the last two years (4). Clear documentation was given a score of 1 and absence of data was scored 0. The average service utilization for the clinics for three months, that is, October 2011 to December 2011 was also noted.

A second questionnaire (Appendix 2) was used to collect quantitative data to measure PHC nurses' knowledge, attitudes and perceptions data from nurses on their current practices on the management of mental health conditions in primary health care clinics. After seeking permission from the researchers who developed the questionnaire, it was adapted from the Mental Illness: Clinicians' Attitude Scale (MICA v 4) which is a Likert scale questionnaire with six points (strongly agree to strongly disagree).The tool was developed in English and there was no translation done since the participants used the English language as a medium of communication. The tool was tested for reliability and it was found to have internal validity (Kassam et al., 2010). The researcher tested the tool by conducting a pilot the study. Content validity was further ensured by experienced researcher who further examined the questionnaire.

3.3.1.2 Interviews

An interview schedule (Appendix 4) with five semi-structured questions was used to collect data on the management practices of PHC nurses.

3.3.1.3 Action Research

The researcher used action research in order to strengthen the change processes in the implementation of guidelines and evaluate the plan for improving the management of psychiatric patients in PHC clinics (Appendix 5).

3.4 Data collection process

The researcher used multiple methods of collecting data. The advantage of using different kinds of data sources according to Yin, (2009) is that it gives the researcher different kinds of evidence where she can base her argument. Scholz and Tietje (2002) and Yin (2003) are of the opinion that use of data from different sources provides sufficient cues and improves organisational or group performance and bias is avoided from a single source of data.

The disadvantages of using mixed methods as posited by Johnson and Onwuegbuzie (2004) are that (1) it can be difficult for a single researcher to conduct both quantitative and qualitative research; (2) the researcher has to learn about multiple methods and must have understanding of mixing the methods; and (3) it can be time-consuming and expensive. The qualitative method that was used in this study was interviews.

Each case (clinic) was visited on a separate date and notice of the visit was provided. The researcher collected data personally in order to ensure that this was done systematically. Interviews were conducted in September 2012 at the workplace of the respondents. Each interview took approximately 35-40 minutes and was audio-recorded with participants' consent for later transcription. On a convenient basis, the researcher invited health care workers present at the clinic during data collection visit to participate. All health care workers who are not registered as psychiatric nurses were included because the clinics had limited staff and it is therefore possible that these health care workers often have to manage mental health patients. Evident from the information gathering through interviews with the nurses, data saturation occurred with the first 12 interviews as the same information was repeated by the participants, data collection continued with the remainder 3 nurses. Ten professional nurses and five staff nurses from six study sites out of a total of 32 professional nurses and 15 staff nurses allocated to these clinics participated in the study.

Probability sampling using systematic random sampling was used to sample the records, every 2nd record was sampled. Records were randomly selected, until saturation was reached. Saturation was reached after perusing 100 records. Selection of records continued and 10 records selected from the remaining records. After reaching 110 records, the selection was discontinued as the remaining records were having the same gaps and were not meeting the selection criteria. Table 3.2 below provides the details.

Table 3. 2: Clinic records used

Clinic	Available records	Usable records
A	161	33
B	35	8
C	23	9
D	68	18
E	64	24
F	64	18

The self-administered questionnaires were distributed to the clinics under study and were personally collected by the researcher to minimise the non-response rate. The semi-structured

interview schedule with five questions was also used to address the issues of practices in the management of psychiatric patients in primary health care clinics.

Table 3. 3: Types of data collected and data collection instruments used

Research question	Data to be collected	Data collection instrument
What implementation practices are being employed in the management of psychiatric clients at primary health care clinics?	Data that was collected was from patients' records and from self-reports by nurses	Patients' record review for three months (Appendix 1); Service utilisation for three months (Appendix 1); Interviews with professional nurses and staff nurses (Appendix 4)
What are the awareness, knowledge and perceptions about the care of psychiatric patients at PHC level amongst nurses?	Data was collected from patients records, interviews and observation by the researcher	Awareness, Knowledge and Perceptions of all nurses at each clinic (Appendix 2)
How ready is the PHC system for the implementation of clinical guidelines for the management of psychiatric patients?	Readiness to change	Attitude survey for nurses (Appendix 2).
What are the barriers and facilitators in implementing the guidelines in PHC settings?	Bi-monthly meetings with professional nurses at each clinic.	Patient record review; Interviews with two registered psychiatric nurses and one staff nurse per clinic. (Appendix 4); Patient record review (Appendix 1)
What are the outcomes to participation in and exposure to the ability to conduct assessment of a psychiatric patient, ability to provide diagnosis, ability to provide management of the psychiatric condition?	Interviews	Attitude survey for nurses (Appendix 2); Service utilization (appendix 1)

3.5 Data analysis

Quantitative data was entered in the computer and analysed using SPSS (version 22) for Windows (spss-t2). Simple descriptive analysis was used. Cross-tabulation in record review was done in order to ascertain whether there was any relationship between the geographical area and the management of the psychiatric patients.

Qualitative data was generated from the tape recorded interviews by transcribing the interviews verbatim. Data were analysed by coding, categorisation and theme generation. This process helps to produce meaningful findings from the case under study (Wong, 2008).

Concept mapping was used as a tool to clarify relationships between themes and sub-themes. Names for the interviewees were not used but the responses from registered nurses were labelled as 'RN1 to RN10' from case A to case F and responses from staff nurses were labelled as 'EN 1 to EN 5'. Triangulation of data from three data sources was used in order to facilitate comparative analysis of participant's responses.

3.6 DATA MANAGEMENT

Field notes were locked in a cupboard while the researcher was still continuing with data collection.

3.7 TRUSTWORTHINESS

According to Lincoln & Guba(2013), there are four aspects to trustworthiness in qualitative research, namely credibility, transferability, dependability and conformability.

3.7.1 Credibility

Credibility is the tangible evidence that the study intends to produce(Lincoln & Guba, 2013).

In this study, the researcher ensured credibility through prolonged engagement, building trust with the respondents and use of multiple sources of data. Triangulation is another technique that can be used in rendering credibility to the research findings (Lincoln & Guba, 2013).

3.7.2 Transferability

In transferability, the researcher uses thick description to come to the conclusion whether transfer can be thought to be possible (Lincoln & Guba, 2013).The recommendation by Lincoln & Guba (2013) is that the researcher must provide a range of information for inclusion in thick description. The researcher must provide data base so that transferability is possible.

3.7.3 Dependability

Lincoln & Guba(2013) argue that where there is credibility there is also dependability. Dependability is determined by the extent to which the findings of the study would be

consistent if the enquiry were conducted with the same subjects in the same context(Lincoln & Guba, 2013). Prolonged engagement increased the dependability of the research.

3.7.4 Conformability

The researcher examined the data, interpretations and findings and confirmed that they were supported by data collected(Lincoln & Guba, 2013). The researcher had first to check whether the findings were based on the data collected and not on the researcher's personal interpretations(Lincoln & Guba, 2013). An audit was done by giving the recorded data to the thesis supervisor to listen to the recordings, and review the interpretations and recommendations.

3.8 RELIABILITY

Reliability is the degree to which the study yields the same results when repeated. Pilot study was conducted amongst 15 nurses who did not form part of the study. Test- retest reliability was applied by distributing the questionnaire to 15 nurses who did not form part of the study. The questionnaire yielded same results after it was administered to the same nurses a month later.

3.9 VALIDITY

Validity in case studies, according to Scholz and Tietje (2002), refers to the degree to which the findings are not influenced by accidental characteristics of research. To ensure construct validity, the researcher used multiple sources of evidence and established chain of evidence. the researcher used pattern matching in order to ensure internal validity during data analysis as recommended by Voss, Tsikriktsis and Frohlich (2002). The survey instrument was tested to ensure accuracy in collecting data.

The researcher selected three clinics from the bigger semi-urban local municipality and three clinics from five small local municipalities so that there was equal distribution and the findings could then be generalised for the whole district.

Table 3. 4: Content validity of the instrument

Item	Objective	Item in questionnaire	Instrument number
Awareness	2	6-12	Appendix 2
Knowledge	2	6-12	Appendix 2
Perceptions	2	13-15	Appendix 2

3.10 TRUSTWORTHINESS AND CREDIBILITY

The researcher used interviews and focus group discussions. The quantitative and qualitative instruments had semi structured questions for qualitative data that ensured trustworthiness and credibility of data.

3.11 ETHICAL ASPECTS

3.11.1 Permission to conduct the study

The study was approved by the University of KwaZulu-Natal Ethics Committee, reference number: HSS/0653/011D (Appendix 6), and by the KwaZulu- Natal Department of Health (Appendix 7). Permission was sought from uThungulu District Office Management and from the Chief Executive Officer of the hospital to which the clinics were attached (Appendix 8). When clinics were visited for data collection, participants were briefed about the study and informed consent obtained at the start of each clinic visit. Participants were advised of the confidentiality and anonymity of their responses and that they would withdraw at any time without prejudice. Participation in the interview was considered to be consent to participate

3.11.2 Anonymity

To maintain anonymity, no names or identification details of PHC nurses have been used when reporting results. Names of clinics were not mentioned but alphabet letters A to F were assigned to the seven clinics.

3.11.3 Confidentiality

Data collected was kept confidential and was used for research purposes only. During record reviews, patients' names were not be used. All information obtained was treated privately.

3.11.4 Vulnerable participants

As the researcher was reviewing records for psychiatric patients, prior approval was sought from the hospital authorities and the proposal was presented to their Hospital Research Ethics Committees.

3.11.5 Researcher being the nurses' employer

The participants were given assurance that the information was collected for research purposes only and would not be used against the participants.

CHAPTER 4

THREE ARTICLES

4.1 INTRODUCTION

In line with the PhD by publication, the candidate produced three overarching articles which will be submitted for publication. These articles examine the existing mental health services and programs that are provided in PHC clinics in one of the districts in KwaZulu-Natal. The focus is to assess the effectiveness and efficiency of mental health clinical guidelines in the management of people with mental health conditions. These are listed and displayed below.

ARTICLE 1:

Portable Document Format (PDF)

The PDF file you selected should load here if your Web browser has a PDF reader plug-in installed (for example, a recent version of Adobe Reader). Alternatively, the PDF file will download to your computer, where it can be opened using a PDF reader.

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Primary health care nurses' management practices of common mental health conditions in KwaZulu-Natal, South Africa

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Background: Psychiatric conditions contribute to 13% of the global burden of diseases and account for one third of years lost because of disability (YLD). Despite the high prevalence of mental health problems, primary health care (PHC) services remain ineffective in managing patients with mental health conditions.

Objectives: The aim of the study was to determine the practices of PHC nurses in the management of psychiatric patients in primary health care clinics in one of the rural districts in South Africa.

Method: A survey was conducted amongst nurses working in several PHC clinics in KwaZulu-Natal (KZN) in order to determine their practices in the management of psychiatric patients. Mixed methods were used to determine the PHC nurses practices in the management of psychiatric patients.

Results: The findings revealed that in five sites (83.3%) treatments are not reviewed every six months, there were no local protocols on the administration of psychiatric emergency drugs, and none of the study sites provided psychiatric patients with education on their medication and its possible side effects.

Conclusion: Based on the results of this study it is evident that psychiatric patients at PHC clinics in the district where the study was conducted do not receive quality treatment according to institutional mental health guidelines.

Introduction

Despite the high prevalence of mental health problems, primary health care (PHC) services remain ineffective in managing patients with mental health conditions. Psychiatric conditions contribute to 13% of the global burden of diseases and account for one third of years lost because of disability (YLD) (World Health Organisation [WHO] 2008a). An epidemiological study conducted in South Africa revealed that 16.5% of South African adults suffered from common mental disorders (Williams *et al.* 2008:4). The high prevalence of psychiatric disorders in South Africa can be attributed to exposure to violence and crime, the high prevalence of HIV infection and substance abuse (National Department of Health 2013b).

Prior to 1994, there was little consideration for primary mental health care and the policy of mental health services was to treat mentally ill people with medication and admission to psychiatric hospitals (Petersen *et al.* 2009). However as PHC clinics are generally the first point of contact patients seeking treatment (National Department of Health 2010), a mental health policy based on primary care principles was adopted in 1997 (WHO 2008b).

The mission for the South African National Department of Health is to ensure that all South Africans have access to good quality, affordable health care (WHO 2008b). Although the National Department of Health is responsible for developing mental health policy and guidelines, delivery of services is the responsibility of the provincial and district health departments (WHO 2008b). Therefore, with the promulgation of the *Mental Health Care Act* (17 of 2002) (National Department of Health 2002), it was the responsibility of provincial and district health services to integrate mental health services into PHC services (WHO 2008b).

In 2006, the National Department of Health released guidelines on the management of psychiatric patients at PHC level. The Standard Treatment Guidelines for Common Mental Health Conditions outline the following seven principles:

- Treatment begins with diagnosis, meaning a PHC nurse is obliged to take adequate history from the patient, relatives and other professionals who are treating the patient.

- Remember the person, meaning that any medical intervention should be made with the person as a whole in mind.
- Keep the treatment regimen simple so as to improve patient acceptability and adherence.
- Begin low, go slow, but reach high and long, meaning that the right dose of medication should be used for the correct duration.
- Antidepressants can be good for patients with any of the 10 common psychiatric diseases, such as schizophrenia, major depression and generalised anxiety disorder.
- Monitor side effects carefully.
- Consult when it is necessary (National Department of Health 2006).

However, despite the release of these guidelines, gaps still exist in the management of psychiatric patients in PHC clinics (Petersen *et al.* 2012) as de-institutionalisation was introduced without the necessary community based services, especially in rural areas (Department of Health 2013b). Petersen *et al.* maintain that psychosocial rehabilitation programmes are not provided in rural clinics, there is insufficient support for PHC clinic nurses in the management of psychiatric patients and poor identification and treatment of common mental disorders persist (Petersen *et al.* 2012). PHC services prioritise the control of chronic diseases that decrease life expectancy above diseases that cause disability (Grandes *et al.* 2011). Failure to diagnose mental health conditions may increase the rate of healthcare service utilisation (WHO 2008b).

Some psychiatric patients require continuity of care. They get psychiatric treatment every month from the PHC clinic and are reliant on the nurses who deliver the care. As a result of staff shortages in some PHC clinics, patients may be attended to by a registered nurse who has had no psychiatric training (Lund *et al.* 2008). The danger of this practice is that such nurses may misdiagnose a relapse in mental illness because of a lack of knowledge (Mwape *et al.* 2010).

Problem statement

The National Mental Health Summit held on 12 and 13 April 2012 in Ekurhuleni, South Africa, was attended by representatives from government departments, non-governmental, research and user organisations, the WHO, academic institutions, professional bodies, traditional health practitioners, and clinicians. The Ekurhuleni Declaration on Mental Health (2012) that emanated during the summit concluded that integrating mental health services into primary health care, which is the foundation of the health care system, would increase prevention, screening, self-care, treatment and rehabilitation of patients with mental disorders and thus reduce the number of psychiatric patients referred for secondary and tertiary health care services. Even before the summit PHC nurses have been responsible for promoting mental health, detecting and treating people with common mental health conditions, ensuring an efficient referral system for patients requiring specialist care (Saxena *et al.* 2006) and providing follow-up treatment for patients who are stable (Petersen *et al.* 2009).

However, despite the strategies set out above, mental health in South African PHC clinics has a low priority and people with mental health disorders do not receive the care they deserve (Draper *et al.* 2009; Williams *et al.* 2008). Studies have found that nurses in PHC clinics are poor at detecting and managing mental health conditions (Naledi, Barron & Schneider 2011) and are not delivering psychosocial rehabilitation programmes, especially in rural clinics (Petersen *et al.* 2012).

There is shortage of human resources in PHC clinics which impacts negatively on integration of mental health into PHC. Awenva *et al.* (2010) maintain that one of the major challenges affecting the quality of mental health care services in PHC clinics is that primary health workers do not have the necessary time to provide quality mental health care. Furthermore, a South African study conducted by Van Deventer *et al.* (2008) revealed that PHC nurses do not have the necessary expertise to manage people with mental health conditions. Patients in the same study complained of seeing different health care workers every time they required follow-up treatment. Although psychiatrists should be available to supervise psychopharmacological care (National Department of Health 2013a), there are few available in the district where the research was conducted. There were only four full time psychiatrists based at the tertiary hospital providing specialist mental health services, which supports three districts with a population of 2 million (Department of Health 2014a). It was not clear how patients with psychiatric disorders were managed in the district.

Significance of the study

Lack of support, training and supervision of health care providers to provide quality mental health care have been identified as contributing factors for poor detection of mental health conditions and poor management of people with mental health conditions (Naledi *et al.* 2011). As no previous studies have been conducted to investigate PHC nurses' management of psychiatric clients in the context under study, the results of this study may contribute to improving the quality of care provided to people suffering from mental health conditions.

Objective

The aim of the study was to determine the practices of PHC nurses in the management of psychiatric clients in PHC clinics in one of the rural districts in South Africa.

Research question

The research question was: 'What practices are adopted and implemented by PHC nurses in the management of psychiatric clients at PHC clinics in one of the rural districts in South Africa?

Research method and design

A survey was conducted amongst nurses working in PHC clinics in a rural district in South Africa in order to determine their practices in the management of psychiatric patients. Mixed methods were used. For the qualitative aspect, semi-structured interviews, using an interview schedule with open questions, were conducted with PHC nurses. For the quantitative aspect, a questionnaire was used that included principles of supervision policy, which are continuity and accessibility.

Whilst some management issues were explored, the seven principles of the Standard Treatment Guidelines for Common Mental Health Conditions served as the basis for both the interviews and the questionnaire. However, principles 3 and 5 were excluded as nurses do not prescribe medication. Principle 4 was included because nurses monitor medication use and distribute the medication (see Table 1).

Setting

The study was conducted in uThungulu Health District in the northern area of KwaZulu-Natal. This is the third largest district in the province with a population of 979 513, which is composed of Africans, white people and Asians (Department of Health 2013b). UThungulu district was selected as the site of the study because it represents a semi-urban and rural scenario (see Table 2).

Population and sampling

All clinics selected were public institutions providing the full PHC package as prescribed by the National Department of Health. The clinics were under the supervision of the hospitals attached to them in accordance with government recommendations that they be visited once a month by a PHC supervisor for mentoring and guidance (National Department of Health 2009). However, as a result of poor terrain which makes it difficult for the PHC supervisor to access them, the supervision rate for clinics in deep rural areas is 60%, which is far below the norm of 100% (Department of Health 2014a).

Whilst some clinics are semi-urban and therefore easily accessible, others are more rural, situated outside of towns or cities, where there is poor infrastructure. Those which are deep rural are at least 200 km away from urban areas and have extremely limited infrastructure and human resources (Department of Health 2014b). There were no urban areas in the health district in which the study was carried out.

Each clinic was visited on a separate date and had been advised of the visit. Convenient sampling was used whereby the researcher invited the health care workers present at the clinic to participate in the study. All health care workers were included, also those who were not registered as psychiatric nurses because it is possible that they would have to manage mental health patients because of limited staff. The sample therefore consisted of PHC nurses and staff nurses who were available during the visits.

The registered nurses in charge of the clinics (clinic managers) were purposely selected to complete the questionnaires as it required a self-report from them. Only 10 professional nurses and 5 staff nurses from six study sites from a total of 32 professional nurses and 15 staff nurses allocated to these clinics participated in the study as they were the only category of staff available during data collection at the clinics. Interviews were audio recorded for later transcription with participants consent.

Section three of the questionnaire involved reviewing patient records at the clinics. The criterion for inclusion of records was that the patient had to have been attending the clinic for three consecutive months without interruption. Records were randomly selected, and 110 of 415 met the criterion for inclusion. Entries in patients' medical records were reviewed to assess the following:

- If patients' medication had been reviewed in the six months prior to the study.
- If patients had been assessed before they were given treatment.
- If patients had been given education on their medication and possible side effects.
- If a medical examination had been conducted in the two years prior to the study.

TABLE 1: Principles that were evaluated in the study.

Number	Principle
1	Treatment begins with diagnosis/adequate assessment
2	Remember the person
3	Simple treatment regime
4	Medication dose as low as possible
5	Antidepressants for anxiety
6	Monitor side effects
7	Consult when necessary
8	Continuity of care
9	Accessibility
10	Management of care

TABLE 2: Classification and services in uThungulu District.

Local municipality	District hospital	Total number of PHC clinics	Number of clinics selected as cases	Number of psychiatric patients per month (average)
uMhlatuze (semi-urban)	0	$N = 9$	3	304
uMlalazi (rural)	3	$N = 12$	0	203
Mthonjaneni (rural)	1	$N = 2$	0	22
uMbonambi (rural)	0	$N = 7$	1	171
Ntambanana (deep rural	0	$N = 5$	1	53
Nkandla (deep rural)	2	$N = 18$	1	423

Source: World Health Organisation, (WHO), 2008b, *Integrating mental health into primary care: A global perspective*, World Health Organisation, Geneva
PHC, primary health care.

Clear documentation was given a score of 1 and absence of data was scored 0. The average service utilisation for the clinics for three months, from October 2011 to December 2011 was noted.

Research method and design

Data collection process

The following instruments were used to collect data on the practices of PHC nurses in the management of psychiatric patients in primary health care clinics in one of the rural districts in South Africa:

- **A questionnaire:** The questionnaire was adapted from the PHC Supervision Manual for the purpose of collecting quantitative data from the registered nurse in charge (clinic manager) at each of the selected PHC clinics on the manner in which mental health conditions were managed at the particular clinic. The questionnaire had five sections with 24 items, 19 of which addressed the implementation practices in the management of psychiatric patients in PHC clinics. For the 19 items see Table 3.
- **Record review:** Section three of the questionnaire involved reviewing the previous three months' clinical information recorded on clinic-held patients' records. There were five items which addressed the clinical quality of mental health care provision to psychiatric patients.
- **Interviews:** An interview schedule with five semi-structured questions was used to collect data on the management practices of PHC nurses to determine how psychiatric clients were being managed.

The researcher collected the data, transcribed the recordings and analysed the data.

Data analysis

Quantitative data were analysed according to simple descriptive analysis. Data were entered in the computer and analysed using SPSS (version 19) for Windows (spss-t2). A cross tabulation of the record review was carried out in order to ascertain whether there was any relationship between the geographical area and the management of the psychiatric patients.

Qualitative data were generated from the audio-recorded interviews by transcribing the interviews verbatim. Thematic analysis was used because of its benefit of flexibility (Braun & Clarke 2006). The researcher used Braun and Clarke's guide to the six phases of conducting thematic analysis which are: becoming familiar with the data, generating initial codes, searching for themes, reviewing themes, defining and naming themes, and producing the report.

Ethical considerations

Ethical permission was sought from the University of KwaZulu-Natal Research Ethics Committee (reference number HSS/0653/011D) and from the KwaZulu-Natal Department of Health. Permission was also sought from uThungulu District Office Management and from the Chief Executive Officer of the hospital to which the clinics were attached. Participants were informed about the study and informed consent was obtained at the start of each clinic visit. Participants were informed that participation in the research project was voluntary. They were advised of the confidentiality and anonymity of their responses and that they could withdraw at any time without prejudice. The researcher conducted the interviews personally and ensured that the participants were at ease. A time for reflection was provided after the interview session.

Names for the interviewees were not used at any time. The responses from registered nurses were labeled as 'RN1' to 'RN10' and responses from staff nurses were labeled as 'EN1' to 'EN5'. Data were coded by an independent coder to ensure trustworthiness.

Reliability and validity

Data were triangulated from three data sources in order to facilitate comparative analysis of participants' responses. This was carried out to ensure validity of the findings by cross checking the quantitative data with the qualitative data (Wilson 2014). Pattern matching was then performed in order to ensure internal validity (Voss, Tsikriktsis & Frohlich 2002).

Results and discussion

Results from the questionnaire are summarised in Table 4 and the findings from the record review are summarised in Table 5.

Demographic information of nurses who completed the questionnaire

Six female registered nurses in charge of the six clinics completed the questionnaire. Three of the registered nurses were aged between 51 and 60 years, one was between the ages of 31 and 40 and one between the ages of 41 and 50. Two of the nurses had a four year nursing diploma, one had a diploma in psychiatric nursing and three had general nursing only.

Demographic profile of nurses who took part in the interviews

Interviews were conducted with 10 registered nurses and 5 staff nurses. All nurses who took part in the interviews were female. One registered nurse was aged between 51 and 60 years and had a qualification in General Nursing with Psychiatric Nursing; four were between 41 and 50 years, two of whom had a qualification in General Nursing with Psychiatric Nursing and two had completed a four year Diploma in Nursing; and five were between 21 and 30 years and had a four year Diploma in Nursing. One staff nurse was aged between 51 and 60 years, one was between 31 and 40 and three between 21 and 30 (see Table 3).

Demographic profile of record review

The 110 records reviewed revealed that the highest percentage (97.4%) of patients was treated in rural clinics as compared to semi-urban (1.8%) and deep rural areas (0.9%). Most patients from semi-urban (n = 36) and rural (n = 38) study sites were single. Statistics showed no significant difference in unemployment rate between semi-urban (n = 38) and rural areas (n = 41). The educational status was low in deep rural areas, with 21% of participants being recorded as having no education (see Table 5).

TABLE 3: Demographic profile of nurses who took part in the interviews (N = 15).

Qualification	Age Range	N = 15
General Nursing with Psychiatric Nursing	21–30	0
	31–40	0
	41–50	2
	51–60	1
Completed 4 year Diploma in Nursing	21–30	5
	31–40	0
	41–50	2
	51–60	0
Staff Nurse	21–30	3
	31–40	1
	41–50	0
	51–60	1

Findings from the questionnaire

The findings revealed that policies and guidelines on the *Mental Health Care Act* (17 of 2002) were not available in 66.7% of the clinics surveyed. Participants indicated that patients in emotional crisis, patients requiring counselling and patients referred from hospitals were attended to daily in all the study sites.

Written referral criteria and routes were not available in any of the study sites and a client in a current crisis could not receive continuity of care from the same practitioner. People with symptoms of mental illness were not given a full physical examination, including an examination of the neurological system, blood glucose tests and assessment for signs of substance abuse. Medication was available to patients as on the PHC Essential Drug List (EDL) and routine monitoring of drug levels was carried out in all study sites. Sixty seven percent of study sites did not have support groups for people with mental health conditions. Feedback informing the PHC facilities of their role in continuation of care was only received by 66.7% of the clinics.

Results from interviews

Themes relating to the practices of PHC nurses were generated based on the interview schedule that was used to collect data. The results are reported according to the themes.

TABLE 4: Results from PHC nurses in-charge (N = 6).

Number	Items	Response	Frequency	Percentage
1	Are the policies and guidelines on mental health and Act available?	Yes	2	33.3
		No	4	66.7
2	Are services available daily: Known psychiatric patients?	Yes	4	66.7
		No	2	33.3
3	Are services available daily: People in emotional crisis?	Yes	6	100
4	Are services available daily for people requiring counselling?	Yes	6	100
5	Are services available daily for mental health care users referred from hospital to the PHC facility?	Yes	6	100
6	Does a mental health team visit this facility to consult and attend to referred patients?	Yes	1	16.7
		No	5	83.3
7	Are records of attendance of psychiatric patients kept to enable follow-up of defaulters?	Yes	4	66.7
		No	2	33.3
8	Are written referral criteria and routes available?	No	6	100
9	Could a client in a current crisis receive continuity of care from the same practitioner?	No	6	100
10	Are people with symptoms of mental illness, given a full physical examination including neurological system, blood glucose, signs of substance abuse?	No	6	100
11	Is medication available to patients who require medication on PHC EDL?	Yes	6	100
12	Does this facility take routine blood from patients requiring monitoring, e.g. patients on lithium, clozapine, tegretol, etc?	Yes	6	100
13	Is emergency treatment for side effects available?	Yes	5	83.3
		No	1	16.7
14	Are there local protocols on the administration of psychiatric drugs for psychiatric emergency?	Yes	1	16.7
		No	5	83.3
15	Is it possible for a psychiatric patient to see the same health worker, to provide continuity of care?	No	6	100
		No	6	100
16	Are there support groups for patients and their families?	Yes	4	66.7
		No	2	33.3
17	Are written annually updated referral protocols in line with the mental health care available?	Yes	4	66.7
		No	2	33.3
18	Is feedback received, informing the PHC facility of their role in continuation of care?	Yes	4	66.7
		No	2	33.3
19	Are written signed emergency treatment/management protocols for psychiatric patients in place?	Yes	3	50
		No	3	50

TABLE 5: Record review according to geographical area (N = 110).

Variable	Geographical area and frequency			Percentage
	Semi-urban	Rural	Deep rural	
Age of patient				
15–25	2	10	1	11.8
26–35	11	10	6	24.5
36–45	11	15	6	29.1
46–65	16	7	12	31.8
66 +	1	0	2	2.7
Gender categories				
Female	19	13	19	46.4
Male	22	29	8	53.6
Marital status				
Married	5	4	8	15.5
Single	36	38	18	83.6
Widowed	0	0	1	0.9
Employment history				
Employed	3	1	0	3.6
Unemployed	38	41	27	96.4
Educational status				
Primary	10	16	4	27.3
Secondary	15	15	2	29.1
None	16	11	21	43.6
Questions, Yes/No				
Has the medicine required been reviewed in last 6 months?				
Yes	2	0	0	1.8
No	39	42	27	98.2
Has a medical exam been carried out in the last 2 years?				
Yes	0	0	1	.9
No	41	42	26	99.1
Has an in-depth interview been carried out in last 2 months?				
No	41	42	27	100
Was education given in last 6 months?				
No	41	42	27	100
Was education on side effects given?				
No	41	42	27	100

Data from the survey and the record review have also been integrated into each theme.

Theme 1: Treatment begins with diagnosis

During interviews nurses indicated that psychiatric patients are given a full physical examination, including blood glucose tests as evident in the excerpt below:

> 'We also assess them the mental symbol whether he is well oriented, is he relapsing, some of them are having fits, assess how often do the fits occurred, how are they, how do they look. Are they oriented, are they responding or not responding.' (RN1)

This was not consistent with the findings of the document review which indicated that people with symptoms of mental illness had not been given a full physical examination which included the neurological system, blood glucose tests and assessment for signs of substance abuse in any of the study sites (Table 4).

Findings revealed that in-depth interviews had not been held with patients at two month intervals as prescribed, but that critical information had been evaluated when the patient came to collect treatment. This was confirmed by one of the nurses who said:

> 'Though it is a summary but you do that general appearance of a client, do orientation, memory as you remember [RN1]. But I have always seen summary being done.' (RN5)

Theme 2: Remember the person

Participants indicated that patients who are seen to be restless in the queue are attended to first:

> 'We do fast-track those we know cannot wait.' (RN5)

In some clinics, interviewees indicated that patients are treated with courtesy by greeting them before they are attended to.

Theme 3: Medication dose as low as possible

In 98.2% of the cases, the record review revealed that medicine required by the psychiatric patients had not been reviewed in the six months prior to the study (Table 5). It was observed in the patients' records that some patients were receiving the same treatment that had been prescribed six years previously. There was no evidence whether patients had been given education about their treatment in the six months prior to the study.

Theme 4: Monitor side effects

Nurses in all study sites indicated that they take blood samples from patients whose drug levels need monitoring. This was confirmed during the interviews:

> 'Bloods are taken in six months and they then go to the doctor.' (RN6)

Whilst emergency treatment for side effects was available in five of the study sites, it was not available in one site.

Theme 5: Consult when necessary

Referral criteria and routes were not available in the clinics where the study was conducted and it is therefore not clear what procedures are followed when PHC nurses refer patients to the next level of care. During interviews participants indicated that they refer patients who are due for treatment review and monitoring of lithium levels. They also indicated that they consult the psychiatric trained nurse who is based at the hospital psychiatric clinic when they are not sure of what to do:

> '… Then we consulted, and ask about bloods and about policies, what is needed so as to have direction of what to do in order to improve care of psych.' (RN2)

Nurses indicated that they also consult other stakeholders, such as police officers, if they are faced with a patient who is violent. Patients with a first episode of mental illness and patients who show signs of aggression are transported to the hospital with the help of police officers, if necessary:

> 'If a new patient coming from home telling us that she has delusions for the first time, we first check whether she is on any treatment. If he is too violent, we give him injection so that he becomes calm and we call an ambulance. If he becomes way beyond the ambulance we call the police and they do respond.' (RN1)

Theme 6: Continuity of care

Table 4 shows that nurses in all six study sites indicated that it is impossible for a patient in crisis to receive continuity of care from the same practitioner. This was affirmed by one of the nurses who said:

> 'It's not one sister who attends to them. It's like daily allocation. If I am not in someone else do attend to them …' (RN1)

To ensure continuity of care, nurses recommended that:

> 'There must be a person who must be solely responsible for them so that she can even attend workshops and be updated with new things that are happening in psych.' (RN3).

Nurses in four of the sites (66.7%) indicated that continuity of care is a challenge because they do not receive feedback when a patient has been referred to hospital.

Theme 7: Accessibility of care

Nurses at all the study sites reported that services for people in emotional crises and those requiring counseling were available on a daily basis as well as services for psychiatric patients who had been referred to PHC from hospital. However, services for psychiatric patients were only available daily in four of the sites (66.7%). Patients attending the other two sites (33.3%) were seen by a psychiatrically trained nurse on a dedicated day once a month. One of the interviewees said:

> 'When they come to the clinic, they come in groups. We attend to them in the morning when they come. We have a nurse who attends to them every first Friday of the month.' (RN)

The participant added, however, that if the dedicated registered nurse is off duty on that day, another professional nurse is allocated to attend to patients:

> '… But if I am not in someone else do attend to them.' (RN)

In the clinics where services are available on a daily basis, patients join the general queue and are seen by the registered nurse who happens to be on duty on that day:

> 'They are attended by the sister who is available. If we see there is a problem, we refer.' (RN10)

This is consistent with the findings of the questionnaire where the nurses in charge at all study sites (100%) indicated that patients are seen by whichever nurse is on duty on the day rather than by the same nurse on subsequent visits (Table 4). Participants indicated that psychiatric patients are promptly attended to if they become restless whilst in the queue:

> 'There are two or three clients who do not want to sit down. So you just check them and not make him to wait.' (RN5)

Theme 8: Management of care

The findings revealed that mental health guidelines, including the *Mental Health Care Act* (17 of 2002), were not available in four of the study sites (66.7%). Furthermore, five (83%) of the study sites were not visited by the mental health team. Only one site reported being visited once a month by the mental health team from the mother hospital.

Records of attendance to enable tracing of patients defaulting treatment were not available in four sites (66.7%). Nurses put the blame on the system for introducing integration of service:

> 'Since the integration of mental health was implemented, and it was said the clinic must be every day, Aii!, you see that is where we started to have defaulters.' (RN6)

They expressed that it was not easy to identify patients who had not come for treatment:

> 'Like now as they are coming at any time, you are not able to see who has come, who has not come. If you have specific day you will know that you have seen all 10 patients.' (RN8).

There were no local protocols on the administration of emergency psychiatric drugs in five of the sites (83.3%). Moreover, none of the study sites had support groups for psychiatric patients and their families or referral protocols. One of the interviewees acknowledged the fact that they are not managing the psychiatric patients properly by saying, 'We

have not been well established in attending to them the correct way. But we have just started to take care of them' (RN1).

Theme 9: Problems impacting on quality mental health provision

In four of the study sites (66.7%) staff had received in-service education provided by the mother hospital, but none of the study sites had programmes of in-service training on mental health planned for the year. This was consistent with the findings of the interviews where some of the nurses indicated that they needed in-service education:

> 'But we need a person who will update us and tell us what is expected so that patients can get total nursing care. Most of the nurses last have the information during their training and we are not sure what to do.' (RN2)

Nurses indicated that they do not provide quality mental health because they experience shortages of staff:

> 'Due to shortage of resources, we tend to do things routinely. We summarise as I have just said that we are now doing summary.' (RN5)

Discussion

The study explored the practices used in the management of psychiatric clients at selected PHC clinics by looking whether PHC nurses implemented the principles of the Standard Treatment Guidelines for Common Mental Health Conditions. The discussion is in accordance with the principles.

Principle 1: Treatment begins with diagnosis

Although psychiatric patients should be given a full physical examination which includes assessment of the neurological system, blood glucose and signs of substance abuse before a diagnosis are made, the results revealed no evidence that any thorough assessment or any psychosocial interventions were being implemented. This could be attributed to PHC nurses' lack of knowledge and skills with respect to psychiatric patients, or, as in a study conducted by Petersen *et al.* (2009) where nurses verbalised that assessing a psychiatric patient needs extra time.

None of the study sites had a programme for in-service training on mental health although such training would enable PHC nurses to provide quality mental health care and thus meet the medical and psychological needs of the patients (Collins *et al.* 2010). Saraceno *et al.* (2007) recommend that nurses in PHC facilities be provided with training in mental health to enable them to assess and treat mental health problems.

Training and capacity building of PHC nurses must be an ongoing process because new nurses who have not been trained in mental health are continually being allocated to PHC facilities.

Principle 2: Remember the person

The Patients' Rights Charter (Department of Health 2001) clearly states that patients have a right to privacy and confidentiality. In a study conducted by the WHO (2008b:155), in Ehlanzeni District in Mpumalanga Province, South Africa, 99% of nurses interviewed felt that patients with mental illness should receive the same care as any other patient in the PHC setting. The findings of the current study revealed that patients in all of the study sites were treated with respect and dignity. Each patient was afforded time to be alone with the health care provider in the consulting room.

The PHC clinics have a duty to establish support groups for psychiatric patients and their families, but it was found that there were no support groups for psychiatric patients and their families in any of the sites. Offori-Atta, Read and Lund (2010) are of the opinion that support groups would assist families in caring for their family members suffering from mental health conditions.

Principle 3: Start medication dose as low as possible

The patients' treatment was not monitored. For a person with a psychiatric condition, the need to take medication for a long time may affect compliance (Serobatse, Du Plessis & Koen 2014).

Principle 4: Antidepressants for treatment of anxiety

This principle was excluded as nurses do not prescribe medication and treatment for newly diagnosed patients it is prescribed by the doctor.

Principle 5: Monitor side effects

Side effects were not monitored by nurses (Table 4) and education on side effects was not given. This is consistent with the findings of the study conducted by Hetrick *et al.* (2011) who found that nurses only became aware that patients were experiencing side effects if this was brought to their attention by these patients. The care provided at the clinics seems to be dictated by routine, based only on providing medication.

Principle 6: Consult when necessary

Findings revealed that nurses did seek advice when they need guidance in the management of psychiatric patients, but this consultation was not guided by any criteria. PHC nurses are not responsible for initiating treatment (Petersen *et al.* 2009).

Principal 7: Continuity of care

Findings showed that there were variations on how psychiatric patients were being managed in the different study sites. In some clinics, services for psychiatric patients were offered daily, whilst in others, services were only offered once a month on a dedicated day. Patients attending the clinics which offer a daily service joined the general queue and were seen by whichever nurse was on duty at the time. There is, therefore, no continuity of care. Clients, health care workers and policy makers consider continuity care as an effective strategy in the management of long term psychiatric disorders (Burns *et al.* 2009). The findings of the study conducted by Green *et al.*

(2008) revealed that continuity of care was associated with good recovery and better quality of life.

Limitations of the study

One of the limitations identified in this study was that it did not investigate whether the patients were satisfied with the service they received from the study sites. According to Westaway *et al.* (2003), a satisfied patient is free to utilise the health service and comply with the treatment plan. They advise that patient satisfaction can be measured by getting to know the patients' experiences regarding health care.

Recommendations

The researcher recommends that PHC mental health services should be scaled up by offering services that are based on scientific evidence and by adhering to available mental health guidelines and protocols (Eaton *et al.* 2011). Psychosocial rehabilitation at clinic level should be strengthened to ensure that psychiatric patients are managed holistically (Petersen *et al.* 2009).

It is also recommended that mental health care in primary health care clinics be revived through retraining of PHC nurses on mental health care. Mentoring and supervision of PHC nurses should be carried out so that they provide quality mental health services (Saraceno *et al.* 2007). In terms of improving the mental health care, it is recommended that support groups for psychiatric patients and their relatives be established because they not only provide a recovery-oriented treatment that is not provided through medication, but also help to reduce stigma (Goldstrom *et al.* 2006). Psychosocial rehabilitation programmes should be implemented in PHC clinics as part of management of psychiatric patients (Petersen *et al.* 2012).

Conclusion

Based on the findings of the study, it is evident that psychiatric patients do not receive the quality mental health services they deserve. The study identified a lack of knowledge and skills amongst PHC nurses as contributing factors to the poor management of psychiatric patients in the study sites. Staff shortages in PHC clinics are a barrier towards provision of quality mental health care, especially in rural clinics because these clinics are overburdened with multiple programmes and high patient workloads (Sareceno *et al.* 2007). It became apparent that principles 1 (assessment), 4 (lowest dose) and 6 (management of side effects) are not being adhered to in PHC clinics. This is the result of both a lack of adequate preparation of the nurses doing the work, lack of support by other health care providers, such as psychiatrists, as well as the lack of adequate guidance on the guidelines provided.

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Competing interests

The authors declare that they have no financial or personal relationship(s) that may have inappropriately influenced them in writing this article.

Authors' contributions

F.N.D. (University of KwaZulu-Natal, Durban) contributed to the conceptualisation of the study, data collection and analysis, interpretation of the findings and the drafting of the manuscript. L.R.U. (University of KwaZulu-Natal, Durban) supervised the study and critically reviewed the content.

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ARTICLE TWO

TITLE: **INTEGRATING MENTAL HEALTH CARE SERVICES IN PRIMARY HEALTH CARE CLINICS: A SURVEY OF PRIMARY HEALTH CARE NURSES' KNOWLEDGE, ATTITUDES AND BELIEFS.**

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INTEGRATING MENTAL HEALTH CARE SERVICES IN PRIMARY HEALTH CARE CLINICS: A SURVEY OF PRIMARY HEALTH CARE NURSES' KNOWLEDGE, ATTITUDES AND BELIEFS.

Background: Since nurses are the main providers of care at Primary Health Care (PHC) clinics, the high incidence of mental health problems at these clinics means that PHC nurses are important providers of mental health care. The Primary Health Care nurses' knowledge for provision and identification of mental health problems has been shown to be poor, and, as a result, mental health problems are not optimally detected at PHC clinics.

Aim: The study aimed to investigate the knowledge, attitudes and beliefs about the care of psychiatric patients at PHC level amongst nurses.

Setting: The study was conducted in uThungulu Health District in the Northern Area of Kwa-Zulu Natal Province. Six clinics were purposively selected based on their geographical location.

Methods: The study used quantitative method.Simple descriptive analysis and one-way ANOVA were used to analyse data

Results: The study revealed that the 39% of nurses were between the ages of 41-50 years and 92% were females. The association between past experience in working with psychiatric patients and positive attitude of nurses was found to be significant. Nurses' attitudes towards mental illness were generally positive but they lacked knowledge to manage psychiatric patients**.**

Conclusion: An environment with knowledgeable and skilled staff at primary health care clinics may encourage people to seek help thus reducing the incidence of mental health conditions.

Key words: attitudes, knowledge, beliefs, change, integration, primary health care clinics.

Introduction

In South Africa, mental health promotion, prevention of mental disorders and provision of mental health curative care are basic services that are provided in primary health care (PHC) clinics.[1] It is estimated that one in four people in the world suffer from mental health conditions during their life span and mental health conditions are the leading cause of disability.[2] About 23% of people attending primary health care suffer from mental health disorders.[3] Despite the high number of people with mental health conditions, mental health has a low priority in South Africa and people with mental health disorders do not receive the care they require in PHC clinics.[4]

Despite the important role PHC nurses play in the provision of health to the general population, their attitudes toward people with mental illness are often negative.[5,6,7] and provision and identification of mental health problems by PHC nurses has been

shown to be poor.[8,9] In a study by Nordt, Rössler and Lauber,[10] health care workers ratings for negative attitudes were higher than for the general public and the desire for social distance was greater.[11] Sartorius[12] identified PHC nurses' negative attitudes and perceptions as a major reason for patients with mental health conditions receiving poor mental health care. The usage of stigmatising terms and psychiatric labelling by health professionals has led to the development and maintenance of stigmatisation.[12,13] Results of the study conducted by Pietrzak, Johnson, and Goldstein, et al. [14] among veterans who screened positive for mental health disorders revealed that negative beliefs about mental health care and decreased perceptions were associated with increased stigma and barrier to care. Stigma directed to a person with psychiatric illness is due to lack of knowledge about mental health, negative attitudes towards mental health and discrimination against people with psychiatric conditions.[15] The stigmatising attitudes may vary according to gender or whether someone knows a person with mental illness.[16] Thornicroft et al.[15] recommended interventions which will bring about behaviour change to reduce negative attitudes towards people with mental illness.

Given the high prevalence of mental health conditions in South Africa, there is a need for integrated mental health services at primary health care clinics.[17] Integration of mental health services into PHC is supported by the World Health Organization [WHO] on The Optimal Mix of Services for Mental Health because the person can be treated as a whole and seeking care is less stigmatised.[18] Integration of mental health into general PHC services ensures that all PHC health workers involved in the management of a psychiatric patient have a shared understanding of the patients' progress and compliance with medication regimens.[19]

Problem statement

Mental disorders account for four of the 10 leading causes of health disability.[20] There is a relationship between mental disorders and physical disorders.[20] Mental health policies emphasise the concept of integrated mental health care with other general health services especially at PHC level.[20] In spite of the growing global burden of mental disorders, PHC nurses are ill-equipped to address mental health needs.[20]

Research shows that stigma around mental disorders is more predominant in rural settings than in urban settings.[21] The purpose of the study was to examine the PHC nurses' knowledge, attitudes and beliefs in the integration of mental health care services in primary health care settings in rural environments. The study addressed the following research question: What is the knowledge, attitudes and beliefs about the care of psychiatric patients at PHC level amongst nurses'?

Theoretical framework

Integration of mental health services into primary health care services was used as a framework for the study. The model is based on WHO's ten principles[22] of successful integration where mental disorders are managed like all other health problems, and patients are treated by all primary health care workers.

WHO[22] developed ten principles which are crucial for integration to be successful, as shown in Table 1 below:

Table 1: WHO's Ten Principles of Integration

Principle	What it entails
1. Policy and plans need to incorporate into primary care for mental health	There must be commitment from the government to integrate mental health care that must be guided by the policy and legislation.
2. Advocacy is required to shift attitudes and behaviour	Information can be used strategically to influence behaviour change.
3. Adequate training of primary care workers is required	Continuous in-service training of primary health care workers is essential for mental health integration.
4. Primary care tasks must be limited and doable	Primary health care workers' functions must be limited and doable so that they function at their optimal level.
5. Specialist mental health professionals and facilities must be available to support primary care	Integration of mental health care into primary health care must be accompanied by secondary care to which primary health care workers can refer to.
6. Patients must have access to essential psychotropic medication in primary care	Availability of essential psychotropic medications is essential for the successful integration of mental health into primary care.
7. Integration is a process, not an event	Integration takes time and involves a series of developments.
8. A mental health service coordinator is crucial	Mental health coordinator is essential in facilitating the integration process.

9. Collaboration with other government non-health sectors, nongovernmental organizations, village and community health workers, and volunteers is required	Collaboration with government and non-governmental sectors can help patients become more functional and decrease their need for hospitalization.
10. Financial and human resources are needed	Financial resources are required to establish and maintain the service.

WHO maintains that integration of mental health services into primary health has benefits for the people with mental disorders. These benefits are that if mental health services are integrated into general health care, the burden of mental health is reduced in the community; people are treated holistically; the treatment gap is reduced; access to mental health services is enhanced; there is respect for human dignity and good health outcomes.[22]

Petersen, et al.[23] recommended that district management authorities should be educated on what integration entails so that they develop political will power to strengthen mental health services provision in PHC clinics. They also supported the implementation framework of task-shifting where psychiatric trained nurses from the hospital are deployed to work in PHC clinics in order to improve mental health care services.[23]

Research method and design

Research design

A survey was conducted among nurses working in PHC clinics order to assess their knowledge, attitudes and beliefs regarding integration of mental health care services in PCH clinics.

Setting

The study was conducted in uThungulu Health District in the Northern Area of Kwa-Zulu Natal Province. This district is the third largest district in KwaZulu-Natal Province with a population of 979,513.[24] The population is composed of African, Whites and Asians. UThungulu district was selected to be the site of the study because of its rural nature where patients have to travel more than 5 kilometers to the primary health care clinic. There is shortage of human resources in PHC clinics which impacts negatively on integration of mental health into primary health care as indicated by the nurse patient ratio of 1:44 instead of 1:38 which is a national norm.[24] The site was selected for representivity of the semi-urban and rural scenarios. No study that looked at integrated mental health care services in relation to nurses' knowledge, attitudes and beliefs has previously been conducted in the district.

Population and Sampling

The survey was done in PHC nurses from six clinics that were purposely selected based on their geographical location so that the level of support, which decreases as rurality increases, is well covered in the sample. Two clinics fell in each of the following categories: rural and deep rural. Rural clinics are geographically situated outside of towns or cities, where there is poor infrastructure. Deep rural clinics are 200 kilometres away from urban areas and the infrastructure and human resources are extremely limited.[25] Urban clinics were excluded because the health district in which the study was done has no urban areas. All clinics selected were public institutions and were attached to hospitals attached to them which provided supervision of the nursing staff, and all were providing the full Primary Health Care Package as prescribed by the National Department of Health. All nurses present in the PHC clinics during the data collection visits were included in the survey. The sample is described in Table 2 below.

Table 2: Description of sample

Clinic	Service hours	Number and type of staff	Number of staff with PHC*** training
A	24 hour service	7 RN*	4
		7 EN**	
B	24 hour service	3 RN	3
		7 EN	
C	8 hour service	3 RN	1
		3 EN	
D	8 hour service	3 EN	1
		3 EN	1
E	8 hour service	3 RN	1
		3 EN	
F	8 hour service	3 RN	3
		3 EN	

Key: *Registered Nurse
**Enrolled Nurse
***Clinical Diagnosis, Assessment, Treatment and Care

Data collection

Data collection instrument

A previously developed questionnaire was used to measure nurses' knowledge, attitudes and beliefs after seeking permission from the researcher who developed the tool. The tool was developed in the United Kingdom, and has been used widely around the world. It was developed in English and there was no translation done since the participants were using English as a language of communication in the workplace. The Mental Illness: Clinicians' Attitude Scale (MICA v 4) uses a Likert scale with four points (strongly agree to strongly disagree) (see table 4 for items). It was tested for reliability by using a sample of 39 medical students who completed the 16-item MICA scale 2 weeks apart with no specific training related to reducing stigma of mental illness.[26] The scale yielded an internal consistency of $a = 0.79$ which

was good. A reliability coefficient of .70 or higher is considered "acceptable" in most social science research situations.[27] The MICA v4 scale only aimed to measure attitudes and beliefs.[28] As the researcher also wanted to assess nurses' knowledge in the provision of mental health care, in section B of the questionnaire, items addressing knowledge and practices were added to assess the practice of health care workers in relation to their attitudes. Section A on demographic characteristics of the sample was included in the scale as demographic characteristics play a role in the knowledge and attitudes of health care workers in their practice. One item in the original MICA scale was omitted because it asked about attitudes towards colleagues with mental health disorders whereas the study purported to measure attitudes towards patients with mental health disorders. A pilot study in which fifteen nurses participated was conducted in two clinics that did not form part of the main study. Participants saw the scale for the first time and there was no prior information given to them concerning the scale. The final tool was organized around 15 items with four points (strongly agree to strongly disagree) and had three sections. The tool was self-administered. Tables 3 and 4 provide the details of the items that were tested.

Data collection

Questionnaires were personally distributed and collected by the researcher from the clinics in order to minimize the number of missed questionnaires. Data was collected from the six clinics that were selected for case study for the major study. The nurses were given three weeks to complete the questionnaire. Three weeks was appropriate so as to allow nurses who were off duty and on leave to voluntary participate in the survey. The total population was 55 nurses. Thirty six questionnaires were returned out of fifty questionnaires that were distributed which was 76% response rate which was acceptable. The number returned was dependent

on the number of nurses at the clinics who were available during the data collection period, as some of them were on leave. The researcher personally collected the questionnaire after three weeks which was the set date for return of the questionnaires. Those who were on leave were excluded from the study because the researcher feared that by prolonging the time, the questionnaires could be misplaced by the PHC nurses.

Data analysis

Quantitative data was entered analysed using Statistical Package of Social Sciences (SPSS) version 22 for Windows (spss-t2). Simple descriptive analysis was used on the quantitative data. A person's score is the sum of the scores for individual items. For items 1, 2, 4, 6, 7, 8, 11, 12, 13, 14 and 15, the scoring was as follows: Strongly agree = 1; Agree =2; Disagree =3; strongly disagree =4. Items 3, 5, 9, and 10 were reversed as follows: Strongly agree =4, Agree = 3; Disagree = 2; Strongly Disagree =1. The scores for each item were summed to produce a single overall score. The average marginal score for knowledge and attitudes was set at 2.5. A score higher than the marginal score indicated negative attitudes and the score below the margin indicated positive attitudes. For example, scores higher than 2.5 for items (4, 6, 9, 10, 11, 12, 13 and 14) indicated a high degree of lack of knowledge, and lower scores indicated better knowledge.

The scores for individual items were calculated, as well as the average scores for the two subsets (attitude; knowledge). A one-way ANOVA was also calculated between demographic factors and the scores.

Ethical considerations

Before conducting the study, ethical permission was sought from University of KwaZulu-Natal Ethics Committee, reference number: HSS/0653/011D and from the

KwaZulu- Natal Department of Health. Permission was also sought from uThungulu District Office Management and from the Chief Executive Officer of the hospitals where the clinics are attached. When clinics were visited for data collection, participants were briefed about the study and informed consent was obtained at the start of each clinic visit. Participants were advised of the confidentiality and anonymity of their responses and that they could withdraw at any time without prejudice. Participation in the interview was considered to be consent to participate.

Reliability

Participants were informed that they were not forced to participate in the study. This was done to ensure that only participants who were genuinely prepared to take part in the study would provide data freely.

Results and discussion

Sample

The participant's characteristics are presented in Table 3. Thirty nine percent (39%) of the respondent were between the ages of 41-50 and there were 33 females (92%) and 3 males (8%). There were differences in educational level. The participants mainly (66%) were having a 4 year Diploma in Nursing, 17% were having General Nursing with Psychiatry and few (14%) were having general nursing only. Majority of the participants (36%) had 5 years past experience working with psychiatric patients. A greater proportion of respondents (78%) had reported to have personal contact with someone with mental illness.

Table 3: Demographic Characteristics of Respondents N=36

Item	Attribute	Frequency	Percentage
Age	21-30	6	17%
	31-40	11	30%
	41-50	14	39%
	51-60	5	14%
Gender	male	3	8%
	female	33	92%
Nurisng Qualification	4 year diploma in nursing (i.e. general nursing , midwifery , community health and psychiatric nursing)	24	66%
	3 year diploma in General Nursing only	5	14%
	3 year diploma in General Nursing and 1 year qualification in psychiatric nursing	6	17%
	Enroleld Nurse	1	3%
Years of Practice	0-1 year	2	5%
	2-5 years	10	28%
	6-10 years	15	42%
	11-15 + years	9	25%
Past Experience working in psychiatric nursing	none	7	19%
	2 years	8	22%
	5 years	13	36%
	More than 10 years	8	22%
Know someone other than patient with psychiatric conditon	Yes	28	78%
	No	8	22%

Nurses' attitudes to mental illness

Table 4 shows that the average score for nurses' attitudes was 2.326. This means that nurses had a relatively positive attitude to mental illness, since it is below the score of 2.5 and a score above that would indicate negative attitudes. The average score for knowledge and skill was 2.8 as shown in Table 4. Since this score is slightly above the 2.5 cut-off, this indicates that nurses perceive themselves to have a slight lack of knowledge in the management of psychiatric patients

Three attitude items (4, 6, & 8) had a score that indicated negative attitudes, while five of the knowledge items (11 to15) indicated negative perceptions about their own knowledge.

Table 4: Scores for Attitudes and Knowledge

Number	Item	N	Mean
1	I just learn about mental health when I have to and would not bother reading additional material	36	2.6389
2	People with mental illness can never recover enough to have a good quality life	36	2.9167
3	People with mental illness are dangerous®	36	2.8056
4	It is important for any health professional supporting a person with mental illness to also ensure that their physical health is assessed	36	1.4722
5	PHC nurses should not be expected to complete a thorough assessment for people with psychiatric symptoms because they have been referred to the psychiatrist ®	36	2.8056
6	I have a responsibility to identify patients with mental health problems	36	1.4444
7	For the majority of mental health conditions, counselling is a waste of effort	36	2.9444
8	I have a responsibility to intervene with patients who have mental health related problems	36	1.5833
	Average for Attitudes 2.326		
9	I do not have enough clinical skills to care for psychiatric patients ®	36	2.5833
10	I do not have enough clinical skills to care for patients psychotropic drugs side effects ®	36	3.2222
11	I include a detailed mental health history in my psychiatric patients nursing assessment	36	1.7778
12	I provide information about mental health to patients	36	1.8333
13	I assess my patients for physical problems related psychotropic drug use	36	1.8611
14	I assess my patients for psycho-social problems	36	1.6667
15	People with mental illness tend to improve with treatment	36	1.5
	Average for Knowledge 2.8		
	R= Reversed Scored Items		

Characteristics associated with nurses' attitudes towards mental illness

One -way ANOVA was carried out to test whether nurses' socio-demographic characteristics had an impact on their attitudes towards mental illness. Six socio-demographic variables (age, gender, health qualification, years in practice, past experience of working with psychiatric patients and knowing someone other than patients with a psychiatric condition) were each tested separately. P- Value was set at 0.05. Table 5 only highlighted characteristics that were found to be significant to nurses' attitudes and knowledge.

When the ANOVA was done between the demographic factors and the total score on the MICA scale, none of the demographic factors made a significant difference; the *f* value for age was 7.409, *f* value for professional qualifications 8.024 and *f* value for work experience working with psychiatric patients 3.689. However, when the demographic factors were correlated with individual items, it was found that health qualifications made a significant difference in six items, while age and past experience with psychiatric patients made a significant difference in one item each (see Table 5).

Table 5: Characteristics associated with nurses' knowledge, attitudes and beliefs towards mental illness

Number	Item	N	Mean (SE)	F	p- Value
1	I have a responsibility to identify patients with mental health problems	36			
	Health Qualification		4.027	7.113	0.003
2	For the majority of mental health conditions, counselling is a waste of effort	36			
	Health Qualification		4.027	7.113	0.003
3	I do not have enough clinical skills to care for psychiatric patients ®	36			
	Health Qualification		5.879	12.879	0
4	I do not have enough clinical skills to care for patients psychotropic drugs side effects ®	36			
	Past experience of working with psychiatric patients		82.479	3.689	0.022
5	I assess my patients for physical problems related psychotropic drug use	36			
	Age		4.803	7.409	0.002
	Health Qualification		4.371	8.024	0.001
6	I assess my patients for psycho-social problems	36			
	Health Qualification		3.474	6.837	0.001

DISCUSSION

This study explored knowledge, attitudes and beliefs of PHC nurses towards mental health provision in PHC clinics. The present findings showed that age, professional qualification, past experience in working with psychiatric patients are associated with participants' general positive attitudes towards persons with mental illness.

The majority of nurses with a 4 year Diploma in Nursing indicate that PHC clinics are well covered with nurses who have psychiatric nursing training. The availability of psychiatrically trained nurses in PHC clinics is necessary to ensure that mental health conditions are appropriately identified and managed.[29] The association with past experience in working with psychiatric patients and positive attitude of nurses was found to be significant. These findings are consistent with the findings of the study conducted by Couture and Penn.[30] The interesting finding was that the staff have had a personal contact with someone with mental health problems but this was not found to have any significance in this study. The findings differ with the findings of the study conducted by Schafer et al.[31] where they found that knowing someone with mental illness was significant.

Nurses' attitudes towards mental illness were generally positive. These results were supported by the findings from the study by Chambers, et al.[32] and Mwape, et al.[8] where they found that nurses held positive attitudes towards management of mental health disorders.

The three items that showed negative results all have to do with the role of the nurse in caring for patients with psychiatric problems. They had negative scores in areas such as assessment, providing health information, providing information on side effects of drug use, psycho-social problems and a feeling that treatment did not make a difference. This might indicate a lack of clarity about the role of the PHC

nurse in this type of care and should be attended to in policy guidelines and continuing education. According to the study by Avarniti et al.[33] nurses with increased educational levels have more positive attitudes towards patients with mental illness.

The findings regarding positive attitudes in this study are encouraging as it shows that with continuing education and supervision, nurses are likely to promote mental health in PHC settings. According to Chambers et al.,[32] nurses with positive attitudes are more likely to influence patients to take control of their lives and take better decisions about their mental health care.

Although nurses showed relatively positive attitudes towards psychiatric patients, the findings of this study revealed that nurses felt they lacked knowledge to manage psychiatric patients. The findings are consistent with what was found by van Deventer et al.[34] who found that primary health care nurses did not have the skill to manage patients with mental health disorders. In the study by van der Kluit & Goossens[35] they found that lack of knowledge and skill was associated to negative and unfavourable attitudes.

Lack of training and supervision by the hospital mental health teams was also identified as the cause of lack of knowledge in managing patients with mental disorders which negatively affects integration of mental health care into PHC.[36] This aligns with the findings in the WHO report[22] that most health care workers working in PHC clinics do not receive adequate training on mental health care. According to Siddiqi & Siddiqi[2] nurses' lack of knowledge in managing patients with mental health disorders has led to poor detection of most mental health conditions in PHC. Continuing education may be needed for dissemination of information and guidelines and practice-based education.[37] This will help improve skill in diagnosing and psychological therapy for the psychiatric patient.[37] The researcher is of the

opinion that further research is needed to ascertain the type of training required to equip the nurses in order to provide quality mental health care services. A larger study is required to investigate the factors that would lead to behaviour change of nurses working in PHC clinics with regard to the provision of mental health services.

Recommendations

Continuous staff development is recommended so that PHC nurses gain necessary knowledge of providing integrated mental health care services.

Conclusion

In general, PHC nurse's attitudes and beliefs toward people with mental illness were positive. It is of great concern that nurses in PHC clinics do not have adequate knowledge to manage psychiatric patients. It is evident that most of them do not have the opportunity to be exposed to refresher courses related to mental health.

An environment with knowledgeable and skilled staff at primary health care clinics may encourage people to seek help thus reducing the incidence of mental health conditions.

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Competing interests

The authors declare that they have no financial or personal relationship(s) that may have inappropriately influenced them in writing this article.

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ARTICLE 3

TITLE: THE IMPLEMENTATION OF A MENTAL HEALTH CARE POLICY IN A RURAL DISTRICT IN KWAZULU-NATAL

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ABSTRACT

Background: Mental health policies are essential tools for ensuring that mental health framework is implemented. Priority for policy implementation must be set in order to ensure that rural primary health care (PHC) clinics contribute meaningfully to the provision of quality mental health care. Policy implementation involves development of policy plans, strategies, activities and identification of resources required for the policy to be effectively implemented.

Methods: The study involved three phases of data collection- two surveys and one action research project - and then a final phase to evaluate the state of policy implementation based on the findings of all three parts, based on seven policy implementation principles.

Results: Implementation gaps were identified in all seven themes. Quality of mental health care services provided to people with psychiatric conditions was compromised as nurses did not have the required skills.

Conclusion: Lack of empowerment in decision making at district health level be addressed strategically. It might be necessary for provincial leadership to train Mental Health Forums in order to equip them to plan for and monitor policy implementation. District- based implementation plans should be developed for mental health policies and should have the support of the Mental Health Forums.

Key Words: implementation, mental health care, policy, rural.

1. INTRODUCTION

Mental health policies are essential tools for ensuring that mental health framework is implemented. [1] Priority for policy implementation must be set in order to ensure that rural primary health care (PHC) clinics contribute meaningfully to the provision of quality mental health care.[2] According to Ajulor policy implementation involves development of policy plans, strategies, activities and identification of resources required for the policy to be effectively implemented. [3] Weaver argues that implementation is important for the success of the policy especially in health care settings.[4] Implementation problems must be identified as many indications are that policy implementation falls far short of policy enactment.[4]

Neuropsychiatric disorders contribute about 30% of the total burden of noncommunicable diseases. [5] According to Prince, mental health conditions account for most of disability-adjusted life years.[6] A high burden of neuropsychiatric disorders is mostly found in low and middle income countries[5] Based on these statistics, there is a need for mental health care services to be organised so that they are accessible and rendered with high quality to enable a better quality of life for mental health care users.[7].

The Standard Treatment Guidelines for Common Mental Health Conditions that there were published in 2006 were in line with Alma Ata Declaration of 1978 that advocates for equity in health care and particularly, for a broad range of basic health care services accessible to and affordable for all communities. [8] These guidelines were developed as a simple strategic plan for clinicians to implement the Mental Health Care Act no 17 of 2002 using limited resources in PHC settings. [9] There was a need to develop these guidelines considering the fact that neuropsychiatric disorders are ranked third in their contribution to the burden of diseases in South Africa after HIV & AIDS and after infectious diseases. [10] Primary Health Care (PHC) nurses are important providers in supporting mental health care services users and their families. However, primary health care clinics are overloaded with multiple programmes; as a result, PHC nurses do not have the necessary time to implement mental health policies in the management of psychiatric patients. [11]

Although mental health policy and guidelines were developed through wide consultation, there are still difficulties with its implementation in primary health settings in provinces and districts. [12] Training given to Primary Health Care (PHC) staff, mainly nurses, on the integration of mental health into PHC did not lead to significant improvement in the provision of mental health in PHC services. [12] In most PHC clinics in KwaZulu-Natal, if not the whole country, patients with mental health problems will be seen only by nurses and no specialist services such as a doctor or psychiatrist are provided. The question could therefore be asked how this reality is dealt with in the guidelines and how the PHC nurses deal with patients with common mental health conditions. Despite the high burden of mental health conditions, there are still inequities in access and provision of quality mental health care to people with mental health conditions. [6]

It is important to evaluate policy implementation since it promotes accountability by holding policy makers and implementers accountable for achieving stated goals and by reinvigorating commitment.[13] The aim of the study was to examine the process and outcomes of policy implementation process in rural health care clinics in order to improve policy implementation process. The purpose of the study was to answer three questions that were: (1) what were the barriers and facilitators in implementing the mental health policy in PHC settings?; (2) what was the level of implementation of the policy?; and (3) what are the policy implications of the interventions and their results in order to improve the management of psychiatric patients in PHC clinics?

2. METHODS

The study used overarching results from the Practice Survey and Knowledge, Attitudes and Perceptions (KAP) survey that was conducted by Dube and Uys. [14,15] Data was collected in three phases. In phase one, the researcher collected data from Practice Survey results. [14] In phase two, data was collected from Knowledge, Attitudes Perceptions (KAP) survey results. [15] In phase three, the researcher used action research to collect data. Data was collected in 2012. The study was conducted in uThungulu Health District in the Northern Area of Kwa-Zulu Natal Province, in South Africa.

The study sample involved eight PHC nurses from six clinics, one Registered Nurse with a Diploma in Advanced Mental Health Nursing from the Regional Hospital, the Provincial Deputy Manager for Mental Health and was purposely selected.

A thematic qualitative analysis was used to analyse data from the three studies and information from the 2006 Department of Health document. Quantitative data was coded and categorised according to the themes that were developed in thematic qualitative analysis. Pattern matching was done in order to ensure internal validity. In this analysis, the seven criteria suggested by the USAID instrument were used as the themes around which to use the qualitative data to address the factors influencing implementation of this policy. [13] Before conducting the study, ethical permission was sought from University of KwaZulu-Natal Ethics Committee, reference number: HSS/0653/011D and from the KwaZulu-Natal Department of Health. Permission was also sought from uThungulu District Office Management and from the Chief Executive Officer (CEO) of the hospital to which the clinics are attached. Detailed information was provided to participants concerning participation. Participation was voluntary and informed consent was obtained.

3. RESULTS

The aim of this study was to study the process and outcomes of implementing the Department of Health Mental Health Care policy at primary health care clinics. In the analysis, the current practice survey will be referred to as Practice Survey, the Knowledge, Attitudes and Perceptions survey as KAP and the action research by (Action Research) tag.

3.1 Theme 1: The policy, its formulation, and dissemination

USAID pointed out that policy formulation process and the extent it is disseminated influences its implementation. [13] This theme refers to the policy content, the nature of the formulation process and the degree of dissemination.

3.1.1What was the process?

The Standard Treatment Guidelines for Common Mental Health Conditions were commissioned by the South African National Department of Health. Experts in the field of psychiatry from diverse geographic regions, multiple disciplines and patient advocates participated in an expert consensus meeting. Participants completed questionnaires to rate first choice intervention and formal methods previously used to facilitate expert consensus. Participant ratings and previously published evidence-based guidelines were discussed and debated at the stakeholder meeting. Draft guidelines were compiled for feedback that was incorporated into the final version of the guidelines. Guidelines were also circulated to several professional societies in South Africa for their feedback. [9]

After consideration of which psychiatric disorders to focus on, it was decided to begin with those that are commonly seen in the state psychiatric hospitals and in primary health care clinics in South Africa. [9]

3.1.2 How was the policy disseminated?

Dissemination of the policy at a national level was done by sending the policy to the Provinces who then sent it to districts. However in the Practice Survey, it was found that the policy was not available at PHC clinic level.

3.2 Theme 2: Social, political and economic context

This theme deals with the various social, political and economic factors outside of the policy process that can either enhance or hinder effective implementation. Depending on the nature and scope of the policy, social norms such as gender inequality and governing processes such as decentralisation and other factors can affect policy implementation.

3.2.1 What is the influence of attitudes towards mental illness/health on policy implementation?

In the KAP survey, the majority of nurses held positive attitudes towards mental illness; for example, the majority (61%) did not agree that (1) people with mental illness can never recover enough to have a good life; (2) people with

mental illness are dangerous; and that (3) nurses learn about mental health when they have to and would not bother reading additional material. The low level of stigma and high levels of acceptance should have contributed towards policy implementation. [14]

3.3 Theme 3: Leadership for policy implementation

Leadership for policy implementation recognises that strong leadership and commitment are essential to ensure the flow of resources and accountability needed for putting policies into practice. However, the leaders responsible for policy formulation might find their attention diverted elsewhere once the policy is adopted or the responsibility for leading implementation might shift to new individuals and groups.

3.3.1 How effective was leadership for mental health provincially?

Certain activities identified in the implementation plan developed during the Action Research needed provincial support; for example, the referral system and the creation of posts for Advanced Psychiatric nurses at PHC clinics. While the creation of new posts might have been impossible due to resource constraints, the development of reliable reference systems demands leadership and planning.

3.3.2 How effective is leadership for mental health policy implementation at district level?

The District Offices in all the Provinces in South Africa act as authorities responsible for providing information and guidance. At a district level, there is a District Mental Health Coordinator (DMHC) who is responsible for amongst other things: (1) coordinating the training of general staff in mental health; (2) providing information to staff and solve mental health related problems; (3) developing an operational plan for mental health service delivery; and (4) monitoring the implementation of the mental health policy. Most of the activities identified in the Action Research that were supposed to be implemented by the District Mental Health Coordinator and clinic nurse in-charge were successfully implemented within three months.

3.4 Theme 4: Stakeholder involvement in policy implementation

Stakeholder involvement in policy implementation recognises that policy formulation is increasingly a multi-sectoral endeavour, yet this engagement might not continue during the policy implementation stage.

3.4.1 What is the effectiveness of involvement of stakeholders in this policy implementation?

This policy was not discussed by the Mental Health Forum before it was promulgated. The first consultative meeting of stakeholders that dealt with this policy happened as part of this research, which was 7 years after the promulgation of the policy. There seems to be lack of focus on policy implementation and evaluation by the Mental Health Forum which deals mainly with solving of operational challenges experienced by PHC nurses in the management of psychiatric patients and coordination of trainings on mental health.

3.5 Theme 5: Planning for Implementation and Resource Mobilization

Planning for implementation and resource mobilization considers the planning resources and capacity needed to facilitate policy implementation.

3.5.1 Does an implementation plan exist at the district level?

Before the consultative meeting with stakeholders, there was no implementation plan for the district (Action Research). There were no protocols available at PHC clinics in order to guide nurses in the management of psychiatric patients and nurses experienced this as a major barrier to implementation. [15] Nurses expressed the expectation that a mental health expert team would visit them to manage complicated problems identified by PHC nurses, but this team had long been discontinued due to staff shortages. [14]

3.5.2 Was a skill assessment done before implementation and how was skill shortage dealt with?

It is not documented as to whether skills assessment was conducted before implementation of the Standard Treatment Guidelines for Common Mental Health Conditions. In the Practice Survey, nurses indicated that they need in-service education in the management of psychiatric patients as they have outdated information. [14] This was supported by the findings of KAP survey, where it was identified that nurses lacked skills in the management of psychiatric patients. [15]

3.6 Theme 6: Operations and services

Operations and services refer to the coordination mechanism, operational systems and capacity of individuals and organisations charged with delivering services outlined in the policy.

3.6.1 What was the nature of the policy?

The policy is vague in certain issues, for example, referral criteria and the availability of a specialist team. [14] Some of the policy principles, such as principle number one (assessment), four (lowest dose) and six (side effects) were not adhered to by PHC nurses. [14].

3.6.3 What are the challenges?

3.6.3.1 Quality of care

Patients were not assessed when they come to collect their monthly treatment at the clinic. The review of patients at six months was not done where a full mental status examination should be done and blood tests before treatment is renewed. [14]

3.6.3.2 Availability of client information

Record keeping for clinic-held patient records was a challenge as there was no filing system in place. There was no system for follow up as a result the clinics had high defaulter rate. [14]

3.6.3.3 Continuity of care

Patients that were down-referred by the hospital to the clinics were often without a diagnosis. Side effects for patients on psychiatric treatment were not monitored. Continuity of care in some clinics was a problem as psychiatric patients were seen by any nurse who is in the consulting room irrespective whether the nurse is psychiatric trained or not. [14]

3.6.4 What positive changes have resulted from this policy? What positive changes have resulted from the research?

3.6.4.1 Accessibility

During the Action Research, copies of mental health guidelines were distributed for each clinic and the Primary Health Care Managers and Supervisors had to account for the guidelines. A dedicated Registered Nurse with psychiatric training was allocated to provide mental health care services at each clinic. A filing system for each clinic was developed to improve access to patients' records (Action Research). Thirty two percent of patients who attended the clinic were aged between 46and 65 years and they were mostly males (53.6%). The total number of psychiatric patients that were seen at PHC clinic during data collection period was 1176 and only two were referred for admission. [14]

3.6.4.2 Counselling

There were no support groups for people with mental health conditions in all the clinics. Two clinics out of the six from the case study established a support group for psychiatric patients and their families (Action Research).

3.7 Theme 7: Feedback on progress and results

Feedback on progress and results recognises the importance of regularly gathering, disseminating information and using feedback to assess progress toward achieving results.

3.7.1 Is the consumer perspective reflected in the feedback?

At a district level, monitoring is done by collecting data using the District Health Information System (DHIS). This programme provides feedback to the policy implementers as to whether the policy is being implemented according to the directives by the people in authority or not.

Psychiatric indicators like (1) number of mental health clients under 18; (2) number of mental health client 18 years and older; (3) number of clients on the mental health register; and (4) number of mental health defaulters, do not address components of policy issues. Additional criteria such as (1) each patient has a diagnosis; (2) patient satisfaction; (3) scheduled revision of medication; (4) change of medication based on side effects; and (5) level of consultation or referral, would more directly address this policy.

3.7.3 Are records available for feedback?

Records of attendance from all six study clinics were not available. [15] Records should enable the health workers to trace defaulters and to monitor whether there is improvement in patient condition or not.

4. DISCUSSION

This study aimed at improving the policy implementation process in rural areas. The seven areas for policy implementation developed by USAID were used in order to analyse the process of implementation of the Standard Treatment Guidelines for Common Mental Health Conditions. [13]

The formulation process of Standard Treatment Guidelines for Common Mental Health Conditions was identified as deficient because it did not include any nurses or specialists from the rural areas or patients as consumers of mental health care. [13] Bhuyan, *et al.* advised that the patients who should benefit from the new policy must be made aware of the new provisions. [13] The greatest result of these omissions was probably that the guidelines did not address who should do what in rural areas and how referrals should work. These problems have still not been solved.

The main social issue affecting the implementation of the policy was the culture within the health system that predisposed districts to wait for leadership from the provincial office, even when they had the power to act independently. In a study on the effect of decentralisation in Uganda health services, it was found that decentralisation does not guarantee fast and efficient implementation. [16] Decentralisation of policy implementation is intended to ensure that psychiatric patients receive integrated mental health services in PHC clinics as opposed to the centralisation of mental health services. [17]

The District Mental Health Forum seems to be the ideal platform for the involvement of stakeholders in the implementation of mental health policy, but this does not seem to happen. According to Spratt interaction between implementers and policy enforcers is the key factor in the success of the policy implementation. [18] Spratt points out that interaction takes the form of cooperation where implementers actively participate because they share a common goal with policy enforcers. [18] However, participation can be passive as there can be opposition to the policy implementation. [18]

For the guidelines under study no implementation plan was developed and there were no additional human resources provided for the implementation of the policy in the district. The implementation of the Standard Treatment Guidelines for Common Mental Health Conditions was decentralised to the districts but there was no mobilisation of resources and training was not provided for implementation of the policy. Spratt advised that before people can implement a policy, they must first be exposed to training so that they become knowledgeable.[18] Furthermore Petersen, *et al.* have recommended task shifting which they defined as training of non-specialist health care workers to provide mental health care in order to bridge the gap of staff shortages in rural clinics. [19]

When the policy was developed, there were no concomitant objectives against which implementers could measure themselves with regard to whether they are implementing the policy as required. The data regularly collected by the clinics with regard to mental health care is very limited and does not address quality issues such as continuity of care, patient satisfaction or treatment revision. The District Mental Health Forum which meets on a quarterly basis has a limited agenda.

5. CONCLUSION

The study has identified a number of gaps in the implementation of the South African Mental Health Care Act No. 17 of 2002 and Standard Treatment Guidelines for Common Mental Health conditions in primary health care settings as an example of the policy implementation process in rural areas.

Nurse-led PHC services can be very successful [20] , but in this case, it was found that quality of care was compromised when the implementation of the mental health policy was flawed in all seven major implementation themes. One limitation was identified in the study. The study was conducted in one province of South Africa where as South Africa has nine provinces. The findings cannot be generalised to other parts of the country.

Based on the findings, the study recommended that lack of empowerment in decision making at district health level should be addressed strategically. District-based implementation plans should be developed for mental health policies and should have the support of the Mental Health Forums. The mental health indicators for PHC should be extended and that these be discussed on a routine basis at the meetings of the Mental Health Forums in order for them to adapt plans or formulate new ones. Further research related to the influence of culture within the health system and policy implementation needs to be undertaken.

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4.2 CONCLUSION

Article1 looked at the practices are adopted by PHC nurses when managing the psychiatric patients at PHC clinics. The practices are influenced by knowledge, attitudes and perceptions about the particular programme. The implementers' knowledge and capacity has to be taken into account when implementing the policy. Article 2 looked at the knowledge attitudes and perceptions of the PHC nurses towards the implementation of the policy. Article 3 was then looking at the outcome of implementing the policy after the gaps in the management practices and knowledge, attitudes and perceptions have been identified and corrected through the development of action plan.

CHAPTER FIVE

5.1 CONCLUSION

5.1.1 Introduction

It is important to evaluate policy implementation since it promotes accountability by holding policy makers and implementers accountable for achieving stated goals and by reinvigorating commitment. It also enhances effectiveness because understanding and addressing barriers to policy implementation can improve programme delivery and foster equity. In addition, effective policy implementation can establish minimum standards for quality and promote access, reducing inconsistencies among service providers and regions. Mental health care services are to be organised so that they are accessible and rendered in high quality to enable a better quality of life for Mental Health Care Users. The Mental Health Care Act number 17 of 2002 provided for instructive guidelines to be developed intended to improve mental health care services for rural communities. The Standard Treatment Guidelines for Common Mental Health Conditions were published by the Department of Health in 2006 to guide the management of patients with psychiatric diseases at the Primary Health Care (PHC) level of care. The guidelines were in line with Alma Ata Declaration of 1978 that advocates for equity in health care and particularly, for a broad range of basic health care services accessible to and affordable for all communities (World Health Organization, 1978). The policy prescribed how psychiatric patients must be managed in health care facilities and consisted, amongst other things, of integration of mental health care into primary health care services, accessibility and availability of mental health services regardless of race, sex or geographical area, treatment of psychiatric patients in their communities nearer their families, emphasis on the promotion of mental health and prevention of mental illness, balance between mental health and other health services in terms of allocation of human and financial resources and training and on-going supervision to facilitate the integration of mental health care.

5.1.2 Main findings

The study has identified a number of gaps in the implementation of Standard Treatment Guidelines for Common Mental Health conditions in primary health care settings as an example of the policy implementation process in rural areas. The study found that quality of care was compromised when the implementation of a mental health policy was flawed in all seven major implementation themes. At the 2012 Mental Health Summit, The National MEC

for Health, Dr Motsoaledi stressed the importance of integrating mental health into Primary Health Care Services (Lund et al., 2012).

However, it seems that much more careful planning is necessary to make this happen efficiently and effectively. This can only be achieved by having PHC nurses who are skilled in managing psychiatric patients. Psychiatric patients do not receive quality mental health services they deserve. The priority at PHC clinics is on other programmes rather than mental health. Nurses' attitudes towards mental illness were generally positive but they lacked knowledge to manage psychiatric patients. Age of respondents, their professional qualifications and past experience in working with psychiatric patients were found to be significant characteristic in influencing nurses' attitudes and knowledge in the management of psychiatric patients

5.1.3 Recommendations and implications for Nursing practice

It is recommended that mental health care in primary health care clinics be revived through retraining of primary health care nurses on mental health and ensuring mentoring for them. There must be support from the district authorities so as to identify their priorities and allocated appropriate resources for integration to be successful. Supervision of PHC clinics must be the priority and to be done regularly in order to support nurses working in PHC clinics. The mental health indicators from PHC should be extended and these should be discussed on a routine basis at the meetings of the Mental Health Forums in order for them to adapt plans or formulate new ones.

5.1.4 Recommendations and implications for Nursing education

There is a need for training of non-mental health trained primary health care workers on mental health, strengthening basic training for mental health trained personnel and continuing education on management of a psychiatric patients. Lack of empowerment in decision-making at district health level should be addressed strategically. The use of expert teams to address this issue of lack of knowledge from PHC nurses and the support of the DMHC by using a mentor or consultant should be considered.

It might be necessary for provincial leadership to train Mental Health Forums in order to equip them to plan for and monitor policy implementation.

5.1.5 Conclusion

The study has identified a number of barriers in the implementation of Standard Treatment Guidelines for Common Mental Health conditions in primary health care settings as an example of the policy implementation process in rural areas. The starting point to increase implementation of mental health clinical guidelines in PHC clinics is to review the allocation of adequate health workers to PHC clinics to diagnose and treat mental health conditions. Periodic supportive supervision by mental health professionals will also enable PHC nurses to effectively implement the guidelines.

Provision of opportunities of ongoing feedback between management and PHC nurses will improve communication and address issues of difficulties that guidelines may create. This will ensure that guidelines are effectively implemented.

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APPENDICES

APPENDIX 1

Box 540

Empangeni

3880

Consent form

You are kindly requested to participate in the study being conducted in your clinic. I am a student at the University of KwaZulu-Natal, School of Nursing & Public Health. The study is conducted as the fulfilment of the requirement for the completion of my doctoral degree. The title of my study **is " The outcomes of implementing the Department of Health (DoH) mental health clinical guidelines for the management of psychiatric patients at primary health care clinics**". The information that will be obtained from the study will be used to improve management of psychiatric patients in PHC clinics.

Conditions for participation in the study are:

1. The researcher is conducting the study as a requirement for completion of her degree.
2. Your participation in the study is voluntary.
3. All the information obtained will be rendered anonymous after analysis and instruments will be kept safe for a period of five years after completion of the study before being destroyed.
4. Names for the participants or clinics where participants are employed will not be divulged to maintain anonymity and confidentiality.
5. You can withdraw from participation in the study at any time .
6. There are no incentives attached to participation to the study but there will be benefit of improvement in the service and personal growth.
7. The study carries no risk to the participants.

If you have any further questions about the study, please contact me at Uthungulu Health District Office at 035-7870631.

Thank you.

____

Nana Dube (Ms) Student

I hereby consent to participate in the study. I have read and understood all the information contained in the consent form.

---   ** **---

Participant signature   **Date**

I have explained this study to the above participant and have sought his/her understanding and informed consent.

---   **---**

Researcher's signature   **Date**

APPENDIX 2

QUESTIONNAIRE FOR THE REGISTERED NURSE IN CHARGE AND RECORD REVIEW

CASE NO. [ ]

[✓] Tick appropriate box

Availability Of Services

Question	Y	N
1. Are the Policies and Guidelines on mental health as well as the Act available?	Y	N
2. Are the services available daily for known psychiatric patients	Y	N
3. Are the services available daily for people in crisis?	Y	N
4. Are the services available daily for people requiring counselling?	Y	N
5. Are the services available daily for mental health care users referred from hospital to the PHC facility?	Y	N
6. Does a mental health team visit this facility to consult and attend to referred patients?	Y	N
7. Are records of attendance of psychiatric patients kept to enable follow up of defaulters?	Y	N
8. Are written referral criteria and routes available?	Y	N

Early detection

Question	Y	N
9. Could a client in a current crisis receive continuity of care from the same practitioner?	Y	N
10. Are People with Symptoms of mental illness, give a full physical examination and history including neurological system, blood glucose, signs of substance abuse?	Y	N
11. Is medication available to patients who require medication on PHC EDL?	Y	N
12. Does this PHC facility take routine blood from patients requiring monitoring, e.g. patients on Lithium, Clozapine, Tegretol etc?	Y	N
13. Is emergency treatment for major side effect available?	Y	N
14. Are there local protocols on (written and signed) on the administration of Psychiatric drugs for psychiatric emergency?	Y	N
15. Is it possible for a psychiatric patient to see the same health worker, to provide continuity of care?	Y	N
16. Are there support groups for patients and their families?	Y	N

Referral System

17. Are written annually updated referral protocols in line with the Mental Health Care available?
18. Is feedback received, informing the PHC facility of their role in continuation of care?
19. Are written signed emergency treatment /management protocols for psychiatric in place?

Y	N
Y	N
Y	N

RECORD REVIEW

Patients' Demographic and Geographic details

Age group

15-25	
26-35	
36-45	
46-65	
66+	

Gender

Female	
Male	

Marital status

Married	
Single	
Widowed	

Employment history

Employed	
Unemployed	

Educational status

Primary	
Secondary	
None	

Geographical area

Semi-urban	Rural	Deep rural

NB. .Under take a card audit: Select clinic based cards of Mental Health Users until saturation is reached.
Answer Y for Yes and N for No.

Case	Has the Medicine required been reviewed in last 6 Months?	Has a Medical exam been done in last 2 years?	Has an in-depth interview been done in last 2 months?	Was education on medication given in last 6 months?	Was education on side effects given?
1					
2					
3					
4					
5					

Adapted from PHC Supervisors Manual, 2008.

APPENDIX3

Knowledge, beliefs and perception scale for health professionals.

Dear Respondent.

I am student at the University of KwaZulu-Natal. I am conducting the study on the topic "**THE OUTCOMES OF IMPLEMENTING THE DEPARTMENT OF HEALTH (DoH) MENTAL HEALTH CLINICAL GUIDELINES FOR THE MANAGEMENT OF PSYCHIATRIC PATIENTS AT PRIMARY HEALTH CARE CLINICS"**

Kindly complete this questionnaire. All information provided will be treated confidentially. Please do not write your name on the questionnaire. Results of research will be made available to you. For any information regarding this study, please feel free to contact Nana Dube at 035-787-0631.

Thank you.

SECTION A

Instructions: please put a tick (√) in the box provided.

Demographic characteristics:

1.Age:

	21-30 years
	31-40years
	41-50years
	51-60+years

2. Sex :

	Male
	Female

3. Health qualification:

	4 year diploma/degree in nursing
	General nursing only
	General nursing with psychiatric nursing
	Enrolled nurse
	Doctor
	Social Worker

4. Years in practice:

	0-1year
	2-5 years
	6-10 years
	11-15+years

5. Past experience of working with psychiatric patients:

	none
	2 years
	5 years
	More than 10 years

6. Know someone other than patients with a psychiatric condition?

	yes
	no

Section B

Instructions: Please respond to question by ticking one box only.

Key: SA-strongly agree, A-Agree, D- Disagree, SD- Strongly Disagree

	SA	A	SD	D
1. I just learn about mental health when I have to and would not bother reading additional material				
2. People with mental illness can never recover enough to have a good quality of life				
3. People with mental illness are dangerous				
4. It is important for any health professional supporting a person with a mental Illness to also ensures that their physical health is assessed				
5. PHC nurses should not be expected to complete a thorough assessment for people with psychiatric symptoms because they can be referred to the psychiatrist				

6. I have a responsibility to identify patients with mental health problems				
7. For the majority of mental health conditions, counselling is a waste of effort.				
8. I have a responsibility to intervene with patients who have mental health related problems.				
9. I do not have enough clinical skills to care for psychiatric patients.				
10. I do not have enough clinical skills to care for patients psychotropic drugs side effects				
11. I include a detailed mental health history in my Psychiatric patients Nursing Assessment.				
12.I provide information about mental health to patients				
13. I assess my patients for physical problems related to psychotropic drugs use.				
14. I assess my patients for psycho-social problems				
15. People with mental illness tend to improve with treatment				

Thank you.

APPENDIX 4

INTERVIEW SCHEDULE

1. When a repeat or known psychiatric patient comes to the clinic, what is the procedure?
   Why do you do that?
   Who is attending to the psychiatric patient?
   Why by this person?

2. What do you think of this procedure?
   Why do you think like that?

3. When a new patient with psychiatric problem comes to the clinic, what is the procedure?
   Why do you do that?
   Who is attending to the psychiatric patient?
   Why by this person?

4. How do you think could this practice be improved?

5. When family members come to the clinic with a problem about the patient with psychiatric illness, how is this handled?
   By whom?

APPENDIX 5

EVALUATION PLAN

Priority	Challenge and baseline	Key activities and actors	Results
1	Patients not properly assessed due to lack of skills.	Conduct one day training on mental health for PHC nurses and members of multidisciplinary team (District Mental Health Coordinator).	One day training conducted which included PHC, Social Workers, Occupational Therapists and Clinical Psychologists
	Psychiatric patients are not given full physical examination.	Reinforce use of guidelines and ensure availability of guidelines in the consulting rooms of all clinics (District Mental Health Coordinator and Clinic Incharge)	Copies of guidelines were for each clinic were distributed during training and were accounted for by the PHC Managers and Supervisors.
2	The treatment of patients are not reviewed In-depth interviews were not conducted when the patient is coming to collect treatment	Allocate dedicated Registered Nurse for mental health services (Clinic Incharge)	Dedicated Registered Nurse allocated to provide mental health services in clinics
3	Poor management of follow up patients. In some clinics, services for psychiatric patients are offered daily and in some there is a dedicated day.	Provide mental health services on a dedicated day to ensure continuity of care (Clinic Incharge).	Mental health services provided on a dedicated day
	High defaulter rate	Allocate Community Care Givers(CCGs) to trace defaulters in the community (Clinic Incharge)	CCG's attached to clinics to trace defaulters
	There are no support groups for psychiatric patients and their families	Establish support groups for psychiatric patients (Clinic Incharge)	Two clinics had established support groups for psychiatric patients
	Side effects were not monitored by nurses and education on side effects was not given.	Reinforce management of side effects (District Mental Health Coordinator)	One day training conducted
4	No referral notes from the hospital Patients come with pink card only without notes	Improve referral system (District Mental Health Forum)	System inconsistence as hospitals are getting new doctors without in-service education on mental health
5	Mind-set/ negative attitudes.	Provide in-service education to PHC nurses on customer care	In-service education conducted

	Treatment for patients controlled on psychiatric medication is not reviewed at six months	Educate service providers about the rights of psychiatric patients (District Mental Health Coordinator)	Training provided on the rights of psychiatric patients
	Inservice education program for all clinics did not have inservice training on Mental Health.	Provide integrated in-service education program for the clinic (Clinic Incharge)	In-service education program included a topic on mental health
6	Patients without diagnosis	Motivate for creation of posts for Advanced Psychiatric trained nurses (Provincial Mental Health Directorate).	Submissions forwarded to higher authorities for creation of Advanced Psychiatric Trained Nurses at PHC clinics
7	Limited referral of patients to other disciplines	Market services for other disciplines (District Mental Health Coordinator)	Services for other disciplines were marketed
	Patients are not referred to other disciplines like Occupational Therapists & Clinical Psychologists		
8	Poor record keeping.	Proper filing of patients files at the clinics(Clinic Incharge)	Alphabetical filing of patients' files done
	In some clinics, files are patient held and there is no filling system	Develop filing system for each clinic (Clinic In charge)	Filing system for each clinic in place
9	Lack of research projects around mental health	Support research initiatives (PHC Nurses)	Currently there is no study pertaining to mental health taking place in the district.

APPENDIX 6

Research Office (Govan Mbeki Centre)
Private Bag x54001
DURBAN, 4000
Tel No: +27 31 260 3587
Fax No: +27 31 260 4609
Ximbap@ukzn.ac.za

2 August 2011

Ms. FN Dube (201507705)
School of Nursing

Dear Ms. Dube

PROTOCOL REFERENCE NUMBER: HSS/0653/011D
PROJECT TITLE: The outcomes of implementing the South African Department of Health (DoH) mental health clinical guidelines for the management of psychiatric patients at Primary Health Care Clinics.

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. Supervisor – Prof. L Uys
cc. Dr. L Middleton
cc. Mr. S Reddy

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health

Department:
Health
PROVINCE OF KWAZULU-NATAL

APPENDIX 7

Health Research & Knowledge Management
10 – 103 Natalia Building, 330 Langalibalele Street
Private Bag x9051
Pietermaritzburg, 3200
Tel.: 033 – 395 2895
Fax.: 033 – 394 3782
Email.: hrkm@kznhealth.gov.za
www.kznhealth.gov.za

Reference : **HRKM 128/11**
Enquiries : **Mr X. Xaba**
Telephone : 033 – 395 2805

Dear Ms N. Dube

Subject: Approval of a Research Proposal

1. The research proposal titled **'The outcomes of implementing the South African Department of Health (DoH) mental health clinical guidelines for the management of psychiatric patients at primary health care (PHC) clinics'** was reviewed by the KwaZulu-Natal Department of Health.

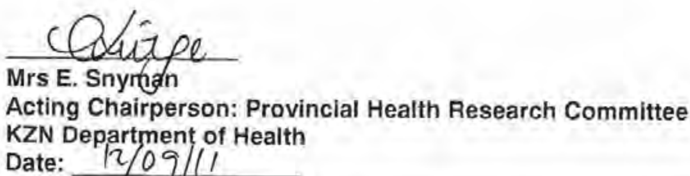
   The proposal is hereby approved for research to be undertaken at Six PHC clinics in uThungulu District.

2. You are requested to take note of the following:
   a. Make the necessary arrangement with the identified facility before commencing with your research project.
   b. Provide an interim progress report and final report (electronic and hard copies) when your research is complete.

3. Your final report must be posted to **HEALTH RESEARCH AND KNOWLEDGE MANAGEMENT, 10-102, PRIVATE BAG X9051, PIETERMARITZBURG, 3200** and e-mail an electronic copy to hrkm@kznhealth.gov.za

For any additional information please contact Mr X. Xaba.

Yours Sincerely



Mrs E. Snyman
Acting Chairperson: Provincial Health Research Committee
KZN Department of Health
Date: 12/09/11

uMnyango Wezempilo . Departement van Gesondheid

Fighting Disease, Fighting Poverty, Giving Hope

APPENDIX 8

HEALTH
KwaZulu-Natal

MEMORANDUM

No2 Lood Avenue, Cnr Chrome & Crescent Avenue Empangeni Rail
Private Bag X 20034, Empangeni, 3880
Tel.: 035 7870631/3/4/5/6/7/8/9, Fax: 035 7870644/0865176012
Email: Nokuthula.Nyawo@kznhealth.gov.za
www.kznhealth.co.za

OFFICE OF THE DISTRICT MANAGER

Enquiries: MM ZUNGU

TO	:	**Ms FN Dube**
Fax	:	
FROM	:	**DISTRICT MANAGER**
DATE	:	**19 August 2011**
SUBJECT	:	**Permission to Conduct Research at Uthungulu District: The Outcomes of Implementing the South African Department of Health Mental Health Clinical Guidelines for the Management of Psychiatric Patients at PHC Clinics**

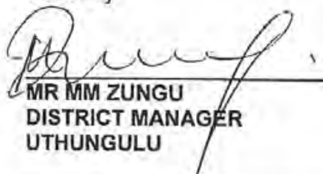
I have pleasure in informing you that permission has been granted to you by the District Office to conduct research on "**The Outcomes of Implementing the South African Department of Health Mental Health Clinical Guidelines for the Management of Psychiatric Patients at PHC Clinics".**

Please note the following:

1. Please ensure that you adhere to all the policies, procedures, protocols and guidelines of the Department of Health with regards to this research.
2. This research will only commence once this office has received confirmation from the Provincial Health Research Committee in the KZN Department of Health.
3. Please ensure this office is informed before you commence your research.
4. The District Office will not provide any resources for this research.
5. You will be expected to provide feedback on your findings to the District Office.

Thanking you

Sincerely



MR MM ZUNGU
DISTRICT MANAGER
UTHUNGULU

uMnyango Wezempilo . Departement van Gesondheid

Fighting Disease, Fighting Poverty, Giving Hope

NB: KINDLY RETURN ALL DOCUMENTATION WHEN REPLYING!!

APPENDIX 9

health

Department:
Health
PROVINCE OF KWAZULU-NATAL

NGWELEZANE HOSPITAL
OFFICE OF THE ACTING CHIEF EXECUTIVE OFFICER
Private Bag X20021
EMPANGENI
3880
Thanduyise Road
Ngwelezane Township
EMPANGENI
3880
Tel: 035 - 9017105, Fax: 0865102898
Email: Thandeka.khanyile@kznhealth.gov.za
www.kznhealth.gov.za

Enquiries : Dr M Phaff
Date : 23 March 2012

Ms FN Dube
UThungulu District Office

RE: APPROVAL TO CONDUCT RESEARCH AT UTHUNGULU DISTRICT – THE OUTCOME OF IMPLEMENTING THE SOUTH AFRICAN DEPARTMENT OF HEALTH MENTAL HEALTH CLINIC GUIDELINES FOR THE MANAGEMENT OF PSYCHIATRIC PATIENTS AT PHC CLINICS

Dear Ms Dube,

As discussed at the Ngwelezana Hospital Ethics Committee meeting held on the 27 February 2012. Permission is hereby granted for you to conduct the above named research. We are happy to inform you that we fully support your application.

We wish you the best of luck with this study. Please keep us updated with any further progress, and your findings.

Yours faithfully,

....

DR TT KHANYILE
ACTING CHIEF EXECUTIVE OFFICER
NGWELEZANA HOSPITAL

uMnyango Wezempilo . Departement van Gesondheid

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APPENDIX 10

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29 October 2015

Declaration of professional edit

THE OUTCOMES OF IMPLEMENTING THE DEPARTMENT OF HEALTH MENTAL HEALTH CLINICAL GUIDELINES FOR THE MANAGEMENT OF PSYCHIATRIC PATIENTS AT PRIMARY HEALTH CARE CLINICS

by

Faith Nana Dube

I declare that I have edited and proofread this thesis. My involvement was restricted to language usage and spelling, completeness and consistency, referencing style and formatting of headings, captions and Tables of Contents. I did no structural re-writing of the content.

Sincerely,

Baumgardt

Dr Jacqueline Baumgardt
Member, Professional Editors Guild

Professional EDITORS Guild

1