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THE INTEGRATION OF DIAGNOSIS, TREATMENT
AND REHABILITATION OF PSYCHIATRIC
PATIENTS INTO PRIMARY HEALTH CARE IN THE
EASTERN CAPE.

BY

EFFIE NOBESUTHU SOKHELA.

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IN THE EASTERN CAPE**

by

EFFIE NOBESUTHU SOKHELA (nee Sikuza)

SUPERVISOR : PROFESSOR L. R. UYS

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Department of Nursing, University of Natal, Durban.

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PREFACE

The whole of the thesis, unless specifically indicated in the text, is the original work of
Effie Nobesuthu Sokhela

N.E. Sokhela

N.E. Sokhela

DEDICATION

This study is dedicated to all the psychiatric patients and Primary Health Care nurses, my mother, Norah Sikuza, brothers and sisters, Edward, Cecilia, Temperance, Nompucuko, Makaya, Mandlenkosi, Lungisani Churchill as well as my children and grandson, Nomcebo, Simiso, Sizwe and Phila, sisters in-law Pumla, Noxolo and Nombulelo.

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ABSTRACT

The purpose of this study was to design and implement the two phases of a three-phased approach to the integration of the psychiatric component into the PHC system in the Eastern Cape.

The study included an educational approach in which the PHC nurses were trained to diagnose, treat and rehabilitate psychiatric patients.

Case studies and surveys were used to collect data. A sample of six clinics in which twenty registered nurses were trained was conveniently selected. Nurses had to volunteer so that 50% of the registered nurses would take part in the study. Each clinic was seen as a case in which a record review and questionnaires were used to collect data.

The data revealed that, given the training in the diagnosis, treatment and rehabilitation, nurses could provide the first line of psychiatric care efficiently if there is a backup support from a team of consultants at the secondary health services and a support and supervision from an advanced psychiatric nurse.

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CHAPTER 1 : INTRODUCTION

1.1. BACKGROUND OF THE STUDY

Health care has developed along the hospital-based approach in South Africa for a long time, in which health problems were mainly handled in hospitals. One aspect of this centralised health care was in the form of medication and specialised services to outpatients, resulting in outpatient services being popular and overcrowded. Hospital facilities were found mainly in urban areas far from the rest of the community. Those which were in rural areas provided the same services but to a very large population. Although hospitals were meant to provide secondary health care, clients travelled long distances for problems that could have been handled in Primary Health Care (PHC) services. PHC is the initial care given to a client in a clinic or health centre in South Africa closer to where the patient lives and regarded as the first contact between the client and health services. It is within walkable distance so that even those who cannot pay for travelling, have access to it. As stated above this focus led to overcrowded hospitals and poor community care (Freeman, 1989a).

The secondary health services in South Africa have failed to prevent and solve health problems that result from environmental factors within the patient's community but provided treatment for the existing health symptoms (Freeman, 1989a). This led to the development of a more sophisticated and specialised service for specific conditions at hospital level, an approach that has proved expensive in all countries of the world (Freeman 1989a). Health care at hospital level is provided only to the clients who can afford to travel to hospital, thus the rest of the clients are not provided with adequate accessible service. This picture still exists in most developing countries like South Africa, especially in rural communities (Gagliano, 1992).

In an effort to address health problems, various countries e.g. Bangladesh and other African countries (Walt and Vaughan, 1981) adopted the 1978 World Health Organisation (WHO) recommendation that PHC is the strategy for effective provision of health to a wider population. The aim of this strategy was to provide access for everyone to the minimum health care. The PHC approach was designed so that it could be easily used by any country,

poor or rich, according to the health needs and economy of that country. This was made possible through the principles which served as guidelines. Within the South African context presently the services are provided by the generalist nurse allocated to work in a given clinic. About 60% of health problems are handled at this level (Freeman, 1992).

Services range from assessment, treatment of minor ailments, prescription of medication, antenatal care and under 5 clinics. An effective referral system is necessary from this service to hospital so that problems outside the generalist nurse's scope are referred to hospital for further management. To enable contact between the PHC clinic and the secondary health service, roads, transport and an effective communication system is necessary. A consultation service is also necessary to prevent unnecessary referral and also to act as an education and support system to the generalist nurse at the PHC clinic.

The current system of PHC in South Africa differs from the recommendations of the WHO(1978) in the following ways.

- * The available clinics are few and far from the bulk of the communities served to an extent that most clients have no access to the service.
- * PHC services are understaffed with no equipment, insufficient medical supplies and no security measures. This leads to services opening only during the day. Clients have to seek their own means to get health care in a hospital far from home.
- * Some clinics do not have an effective communication system.
- * Essential drugs are not always available, which leads to a loss of confidence in the service.
- * Services that should be at this level are specialised and found in hospitals such as the supply of maintenance drugs for chronic conditions such as hypertension and tuberculosis.

- * The secondary health services are overcrowded due to increased demand for outpatient care by communities who have no primary health service (Freeman, 1989).
- * With the current policy of "Free Health Care to larger populations" (ANC 1994a), the present PHC services are inadequate for the many clients who need the care due to an increased need for the provision of effective PHC services.

In South Africa the present PHC services have been offering a variety of services to some communities according to their needs. The WHO (1978) in its definition takes into consideration the physical, social and psychological aspects of health. As the understanding of health developed and communities demanded services, a need arose for the care of other conditions which had previously not been catered for, such as the psychiatric conditions. The previous focus of the WHO was on communicable diseases and non communicable diseases such as hypertension. Mental illness did not receive the attention it needed as it was seen as a specialist care. Indeed in South Africa, the psychiatric services developed slowly and in isolation from the rest of health services due to lack of focus by health authorities on these conditions.

Although there are reliable studies examining the incidence of mental illness in South Africa, statistics concentrate on inpatient population and do not give a clear picture of the whole South African population. Gillis, Sandler, Jakoet & Elk, (1986 a&b) reports the rate of admissions and re-admissions to the psychiatric hospitals while Benatar and Saven, (1985) report on the mobility in medical wards. It is important to note that some patients are treated by traditional and faith healers and never present themselves to health care services. Freeman (1992) reports that at least one in every five people seeking health do so as a result of mental health problem. Various statistics done account for only patients who present themselves to either outpatients departments and hospitals. Uys (1992) reports that the prevalence of psychiatric disorders in clients who visit the primary health care clinics in South Africa ranges between 20% to 50%. There are indicators which suggest that there are probably at least the same number of people who require mental health services in this country as in other countries (Oliver, 1989; Gagliano, 1992).

Statistics available in the South African National Council for Alcohol and Drug Dependence reveal that in 1992, 10000 people received psychiatric service of whom 1800 were blacks (Freeman 1992). The mental health statistics published by the Directorate of Mental Health in 1993 from studies done in Cape Town and Durban reveal a steady decrease in hospital admissions (including State patients) from 16 536 in 1977 to 11395 in 1991, and an increase in clinic visits from 468 610 to 841 167 in 1991/92. If this be the case, the incidence remains high although the trend of care has shifted from hospital to community care.

The trend in other developing countries is not different to this picture. The incidence of mental illness in South Africa is reflected by the different authors in the following table:

Table 1.1 : Incidence of categories of mental illness according to authors.

CONDITION	REELER (1987)	IHEZUE (1986)	GAGIANO (1992)	KHANDELWAL (1988)
SCHIZOPHRENIA	6.3%	59.6%	8.7%	8.14%
MOOD DISORDERS	48.6%	18.2%	22.4%	8.84%
ANXIETY	30%	2.5%	14.7%	53.38%
SUBSTANCE ABUSE	18.7%	-	-	0.80% (Alcohol)
DEMENTIA	-	11.3%	-	1.11%
MENTAL RETARDATION	-	1%	-	1.15%
DEPRESSION	-	-	12.5%	Included in mood disorders

In addition Ihezue, Kumaraswamy & Onuora, (1986) reported that the incidence of mental illness was higher amongst lower socio-economic income group, a factor that is so common amongst the South African community, especially Blacks. Amongst the causes mentioned by Townsend (1993) nutritional deficiencies, infections, congenital defects, brain trauma and substance abuse are responsible for the development of dementia. These causes are common in the South African situation.

The report by the World Mental Health problems and priorities (Desjarlas, Eisenberg, Good

& Kleinman, 1995) reveals that in developing countries the following picture of psychiatric morbidity emerges amongst adults: 8.1% suffer from a psychiatric disorder in the following order of prevalence:

- Depression
- Alcohol abuse
- Epilepsy
- Psychosis
- Drug abuse
- Traumatic disorder

In this list only epilepsy cannot be handled by the PHC nurse. In this report it is estimated that in the whole world the total number of persons with schizophrenia will increase from 16.7 million in 1985 to 24.4 million by the year 2000 - a 45% increase. Depression and Anxiety have been found to constitute between 9.3% for females and 3.2% for males (Gagiano,1992).

Dersjalais et al (1995) reported that, in general, the prevalence of dementia doubles with every 5 year increase in age from about 60 year to 90 years. With the envisaged increase in the lifespan of most populations in South Africa dementia will be a problem. This information is supported by the study done at Shanghai in which it was reported that the rates for dementia were much higher in education than those with little education, a factor that increases the risk of dementia.

Mental retardation rates are 3-5 times higher in low socio-economic income groups compared to industrialized countries. Maddison & Kellehear (1985) reports that the incidence is about 2-3% of the total population while Kaplan & Sadock (1988) reports an incidence of 1% in his study. Townsend (1993) in discussing the factors that lead to mental retardation report that 30% are due to alcohol abuse during pregnancy while 20% are due to nutritional deficiencies. South Africa presently is faced with poverty and unemployment, factors known to contribute to alcoholism and poor nutrition especial in the low socio-economic income group. This therefore sheds the light of the possibility of higher percentages of mental

retardation than is recorded hither to. Due to these statistics it was necessary to select these conditions as apriority for care in this study.

When appropriately diagnosed and treated, the suffering these conditions cause is possible to alleviate, thus preventing chronicity for the individual and reduce cost for the health care system. South Africa has the similar problems mentioned as contributal to mental illness and demands an urgent attention as it is known that psychiatric illness incapacitates and is difficult to rehabilitate once chronic.

In the Netherlands, as quoted by Pillay & Subedar (1992), the incidence varies from 15 to 46% whereas in Sudan it is 10,6% and India 17,7%. Studies in Kenya reveal that 20-30% of people who visit PHC services suffer from mental illness. Reeler (1987a) reports an incidence between 10 to 30% of psychological problems in clients who report to clinics, although it has been shown that about 80% of such patients are not detected. Various studies from Kenya and other Eastern parts of Africa indicate that in general around 20-50% of all people who attend general outpatient services suffer from psychological disorders (Mustafa, 1974; Otsyyla and Rees, 1972).

The causes of mental illness are multiple and range from genetic, developmental, political and socio-economic and others. In addition, South Africa has a number of high risk factors of mental illness such as violence, poverty, family disorganisation due to migrant labour, poor maternal child health services and fast social change. Due to these risk factors it can be expected that South Africa would fall at the higher limits of the range. Freeman (1992) reports that the number of psychiatric beds in South Africa are double the recommended services. This demonstrates that psychiatric/mental health care is provided at a secondary health care level, and only limited rehabilitation services are provided to support those recovering from illness. Rehabilitation in South Africa should be part of the duty of the nurses, especially in rural areas where most of the clients are, to make community care as therapeutic as possible. Various models have been developed for rehabilitation but these are still not well established in South Africa and there are no clear guidelines in the health policy. Many authors believe that the present community care should be based on attempts

to return the patient to the highest level of functioning (Anthony, Cohen & Farkas;1990). The absence of rehabilitation at community level has led to a high relapse rate in clients who do not receive aftercare services.

Pillay and Subedar (1992) report a treatment rate of 15% in South Africa. This means that if South Africa both the developed and developing sectors of society is taken into account, the treatment rate is the same as in the developed countries, and underreported for underdeveloped societies. This is not acceptable especially if one takes into account that a higher percentage of the population is at risk. This further indicates that a higher percent of people who need treatment do not receive it.

As stated above, the WHO (1978) has recommended PHC as the key approach to the world health problems and a mechanism to achieve Health for all. Despite some development of primary health care in this country, however, mental health care has remained a specialised service, generally centralised in hospitals or special units. South Africa has adopted the Alma Ata declaration which provides the reasons for the existence of primary mental health in order for the physical, social and mental well being of the individual to be met (Pillay & Subedar, 1992).

The present system of offering psychiatric care in South Africa differs from all the recommendations by the WHO and other authors in South Africa (Freeman, 1989a; Gagliano,1992; Uys, 1992) in the following ways.

1. In most settings psychiatric services are provided by a specialised psychiatric team which visits primary health care clinics on specific days and times scheduled for those clients. This team consists of psychiatrically trained nurses and sometimes a physician and a social worker. This team is based in the psychiatric hospital.
2. In other settings, community health nurses offer the psychiatric service but at specific times. Not all these nurses have psychiatric training and no other training has been given.

3. The service provided consists of supplying the patient with medication and organising admissions when necessary. The social worker may assist in obtaining a disability grant for deserving patients. Clients who have previously been admitted to a psychiatric hospital are often sent to the magistrate's office by their relatives for certification and admission to a psychiatric hospital if they relapse because the psychiatric service is not always available for emergency cases. There is no case finding, rehabilitation and primary preventive activities involved.
4. If the patient comes outside the times set for psychiatric service, the nurse will decide whether it is possible to attend to the patient or not. Clients are made to wait for long periods or are often turned away to come at a scheduled time.
5. In Transkei when a new client comes to the clinic he/she is referred to hospital from where she may be sent to one of the psychiatric hospitals in Transkei or put on medication by the hospital physicians. This may involve travel of 120km from an outlying area to Umtata or long hospitalisation in a hospital far from home.

Changes are expected in this method of providing mental health care as observed in the National Health Policy which puts emphasis on integration of mental health care into the PHC approach (ANC, 1994a). This is in line with recommendation of the WHO (1984), that governments should take all necessary steps to improve mental health care at every organisational level, especially at community level, provided by more skilled personnel and referral services being available for the more difficult types of cases.

If the National Health Policy puts emphasis on improved integration at primary level, this integration should be clearly defined. Aboidum (1990) outlines various benefits of this approach for developing countries with the support from Freeman (1992) in relation to the cost, personnel, accessibility. Ngubane and Uys (1994) add family involvement in rehabilitation as another benefit. There are no clear guidelines on how integration should be done in the National Health Policy. Gagliano (1992) has recommended a model for this approach in the Orange Free State as an example for all South Africans.

1.2. PROBLEM STATEMENT

Although the PHC model has been accepted universally as the answer to health care crisis, it is still not clear how the care of severely and persistently mentally ill fit in this model. This component of care was included in the latter WHO (1984) documentation of primary health care as cited in Walt and Vaughan (1981). Reeler (1987) reports that in looking around developing countries, there seems to be very few countries in which psychiatric care has been fully integrated into the PHC system.

Psychiatric care has always been seen as a specialist service. Generalist practitioners were deemed to be inadequately prepared to deal with complexities of the problems of psychiatric illness. Studies have shown that the debility and suffering caused by psychiatric illness are amongst the highest of all chronic illness. It has always been shown that psychiatric patients are amongst the most difficult to rehabilitate successfully. The question is therefore whether the PHC model can be used for the treatment of severely and persistently mentally ill patients. Is it effective, or is this a model which is only aimed at minor ailments, normal pregnancy and prevention.

1.3. AIMS AND OBJECTIVES OF THE STUDY

The aims of this research were to design, implement and evaluate the first two phases of a three phased approach to integrating the comprehensive psychiatric/mental health care service into the PHC system in the Eastern Cape. The two Phases are :

Phase I- Diagnosis and Treatment of psychiatric conditions

Phase II - Rehabilitation.

In view of the on-going restructuring of health services according to the PHC model it was envisaged that the research would serve to inform health service managers and planners.

1.4. RESEARCH QUESTIONS

Specifically, this study sought to address the following research questions :

1. What are the barriers and strengths which influence the process of integration ?

2. What is the quality of the psychiatric diagnosis, prescriptions and referrals made by PHC practitioners ?
3. Is there an increase in utilisation of services in the shift from secondary to PHC ?
4. Is there a decrease in hospital admissions and re-admissions and a decrease in patients who terminate treatment on their own as a result of the integration of psychiatric diagnosis, treatment and rehabilitation into PHC ?
5. What is the extent of improvement in consumer satisfaction with the service provided after the implementation of the intervention ?
6. What are the qualities of the rehabilitation diagnosis and rehabilitation plans made by PHC practitioner ?
7. Is there an improvement in the vocational rehabilitation level of clients after implementation of the second phase ?

1.5. EXPLANATION OF KEY CONCEPTS USED IN THE STUDY

PRIMARY HEALTH CARE

The Oxford Reference Dictionary of Nursing describes primary health care as the person's point of entry into a comprehensive health care system, the first element of continuity health care process provided through an integrated network of services covering the treatment of common illness and injuries, maternal and child health problems, the care and rehabilitation of people with long and short term handicaps and disabilities and health education. (Walt & Vaughan, 1981).In this study this refers to the care given at clinics.

PRIMARY HEALTH CARE PRACTITIONER

According to Dorland's Pocket Medical Dictionary, 24th edition, a PHC practitioner is one

who has complied with the requirements and who is engaged in the practice of medicine. In this study a PHC practitioner is a registered nurse providing PHC in a clinic (Freeman, 1992).

COMPREHENSIVE COMMUNITY PSYCHIATRIC/MENTAL HEALTH CARE

This is an integrated and holistic approach to the provision of mental health care at community level. In this study it refers to the provision of mental health care with the components of primary health care in a clinic (Pincus, 1980).

REGISTERED GENERAL NURSE

A person registered under section 16 of Act no. 50 of the S.A. Nursing Act of 1978 as a general nurse and midwife.

A CLIENT

In this study it refers to person who receives treatment for psychiatric/mental health problems.

REFERRAL

A system set up for sending clients from the clinic to an appropriate service such as a hospital. In this study it is a system of sending clients from the clinic to the psychiatric unit of the Umtata General Hospital.

PRESCRIPTION

A process of prescribing drugs or other regimen and of providing an action to be followed either in writing or verbally for purposes of improving a client's problem. In this study is a process of prescribing medication and nursing action by a primary health care practitioner.

CONSULTATION

A process of using the knowledge/advice and skills from a consultant. This may be verbal or telephonic (Pincus 1980). In this study consultation refers to the use of skill and advice from the psychiatrists, psychologists, social workers, psychiatric nurse at Umtata General Hospital

and psychiatric nurse specialist at the University of Transkei.

PSYCHIATRIC DIAGNOSIS

A diagnosis given according to the DSM IV classification published by the American Psychiatric Association in 1994 (Buntting, 1996).

UTILIZATION OF A SERVICE

The use of the health service for the purpose of receiving treatment, education, advice and support.

SECONDARY HEALTH CARE

The care provided in a specialised health service such as the hospital, in this study Umtata General Hospital.

HOSPITAL ADMISSION

A process of receiving and treatment of client while kept in hospital. In this study this refers to clients received and treated at Umtata General Hospital psychiatric unit, Komani Hospital and Umzimkulu Hospital.

READMISSION

A client admitted to hospital for the second and subsequent times. In this study clients admitted in Umzimkulu hospital, Umtata General Hospital psychiatric unit and Komani Hospital.

TERMINATE TREATMENT

To stop the treatment on the client's own volition, without the suggestion of a medical professional.

CONSUMER SATISFACTION

The satisfaction of the person who uses the service. In this study it refers to community members, relatives of psychiatric patients and psychiatric patients.

REHABILITATION PLAN

A series of proposals of activities decided by the client, family and health provider for the rehabilitation of the client aimed at the achievement of set goals.

VOCATIONAL REHABILITATION LEVEL

This is the level of functioning possessed by the client on assessment.

EFFORT EVALUATION

This is the description of the level of implementation of change. In this study it is as a result of the implementation of the integration of psychiatric care into the PHC system.

CHAPTER TWO : LITERATURE SURVEY

2.1. PRIMARY HEALTH CARE

The WHO defines health as "a state of complete physical, mental and social well being" (WHO 1978). It is therefore evident that Primary Health Care has been designed as a tool to achieve this state. The aim of the WHO is to ensure that the provision of basic health is achieved by all countries. This declaration was adopted in 1978 in the Alma Atta, outlining PHC as the important method of achieving Health For All by the year 2000 (Pillay and Subedar, 1992).

2.1.1. CHARACTERISTICS OF A PRIMARY HEALTH CARE SERVICE

A further description of PHC by the WHO is clearly explained to have the following principle (WHO, 1988).

- * It must be within reach and cost the community and country can afford.
- * Should be available 24 hours round the clock.
- * Must be accepted by the community it serves.

The community must be more actively involved in decision making so that the service is designed to meet the health needs of that community (Walt & Vaughan, 1981 ; Ebrahim & Ranken, 1988).

- * The service must be more equally accessible not neglecting rural and isolated populations of post-urban dwellers.
- * The main focus should be to provide preventive and promotive service rather than curative services.
- * Health must be seen as only part of total care, with nutrition, education, water supplies and shelter as essential minimum requirements to the well being of communities.

- * It should form an integral part of both the country's health system of which it is a fundamental focus, and of the overall social and economic development of the community.

Hospital oriented services focus on diseases whereas PHC is aimed at distinguishing health from health care of a conventional type. Health is a product of many things of which health care is one. Many other factors need to be taken into consideration. In order to improve health, a multisectoral approach between the service and the community activities is necessary to correct inequalities that exist. The multidisciplinary approach has been implemented in countries like China, Cuba, Tanzania and India (Ebrahim & Ranken, 1988).

While the definition of health by the WHO (1978) distinctly includes the mental well being of the individual, mental health has been a much neglected discipline in the whole world. Ochola and Kisubi (1992) remark that this worldwide neglect has been demonstrated by an increase in poor scholastic performance, suicide and substance abuse with no clearly defined services for these groups. Psychiatric illness has not received much attention from governments and other health personnel as some of the debilitating diseases, which led to a shift of focus away from these conditions.

2.1.2. ROLE PLAYERS IN PHC

PHC requires change in the concept and ways of thinking, enough national commitment and active involvement of various sectors of the relevant government departments, and non-governmental organisations. This includes re-allocation of the available resources between the competing government organisations (Ebrahim & Ranken, 1988). Central to this concept of PHC is that individual families and communities take the major responsibility for their own health. The role of health professionals and health systems should be to assist and support this system. This therefore demands new roles from health professionals who have for years provided the care. The approach should start from the community up to health providers for setting targets and identify needs. If this is expected of health professionals, the government has to be committed to assist in this change. This change should include activities to change methods of implementation and attitudes of health personnel at the primary health level. (Freeman, 1992)

2.1.3. IMPLEMENTATION OF PHC

Although the concepts of PHC were intended to apply to all countries, both poor and rich, the extent to which these concepts apply differ from country to country. Turya (1990) remarks that each country should decide on how the future health of the country should be made better and acceptable than the present and decide on what changes are necessary and how these changes must be implemented. This, therefore, indicates that there will be some differences in the provision of PHC without changing the basic concepts laid down by the WHO. Some countries have made a clear differentiation between PHC and Community Medicine by naming it Community Oriented PHC (Reeler 1987a). This was aimed at implementing the principles of PHC in the presence of community medicine. Mention is also made that the successful implementation in countries will also depend on the authorities responsible for PHC on behalf of the government. WHO (1988) reports that unless the government is committed to the allocation of resources to PHC, success will not be achieved.

The role of the hospital in the PHC service needs a change in the hospital culture from receiving interesting and difficult cases to encourage flow of information and technical support. Several countries are now concentrating on building up the district health system in keeping with the PHC system (Ebrahim & Ranken, 1988).

In 1990 the WHO published a document with recommendations on the introduction of a mental health component into PHC. It is clear from this document that although PHC was evaluated as a success in many countries, mental health had been neglected. The relationship between physical complaints commonly presented by clients in primary health services and the emotional and psychological problems was highlighted. These are the patients who complain of vague physical ailments and it is important for the health worker to recognise the psychological distress without wasting health resources. This involves skilful application of psychological principles by all health workers. It is therefore important that psychological care be included in all activities for the promotion of health and mental health receive special attention and be included in primary health. The type of care needed at this level is not only health promotion but also diagnosis, treatment and rehabilitation.

Primary prevention of psychiatric/mental illness cannot be done in isolation from social and environmental change which is fundamental to the success of PHC. The WHO (1984) stresses the general improvement of the general health system and, socio-economic development in order to decrease mental health problems, leading to the improvement in the general quality of life through early identification of problems. More emphasis is put on early identification of conditions and complaints that would lead to mental illness. Davies and Janosik (1991) add that in the primary prevention of mental illness, risk factors to specific vulnerable groups such as adolescents who are affected by high suicide rate and depression be prevented.

Gagiano (1992) reports that nearly 50% of patients who consult medical practitioners suffer from psychiatric disorder. Of this number only 2% are referred to the psychiatrist and the rest are treated with medication with no attention given to unresolved stress and conflicts, and no correction of pathological family systems or improvement of coping skills. This is the same in health services that are run by nurses who work at PHC centres because they are not skilled in the diagnosis of mental illnesses. A remark by the Centre for Study of Health Policy indicate a concern about lack of skills in diagnosis and treatment of psychiatric/mental illnesses at primary level (Freeman 1992). Solombela (1990) in her study reports that in the area of the Transkei, the relapse rate of patients discharged from Umzimkulu is very high. Out of 175 patients discharged 35 patients never reported to clinics, 40 patients relapsed and were re-admitted.

Various studies have been conducted to look at how psychiatric care can be provided at PHC. One study by WHO (as cited in Meursing & Wankiri, 1988) recommended that generalist nurses who have no psychiatric training, working in clinics be trained in diagnosis and treatment of mental disorders. These nurses have received training as medical and surgical nurses as well as midwives. In this study various countries were involved and the length of training varied from country to country. The results were that about 90% of patients requiring priority treatment could be treated in the clinics.

It is therefore important that the general nurses working in the clinics should be more competent to fulfil an overall health function including diagnosis and treatment of mental health problems with primary prevention as an integral part of PHC. In this way the WHO (1984) estimate that at least 50% of mental health problems in developing

countries could be avoided through public health action.

While the WHO (1986) puts emphasis on the primary prevention of mental illness, there is also a need for secondary and tertiary prevention to reduce the duration of disorders that do occur and to reduce the impairment as a result of the disorders. Warner (1986) argues that treatment and prevention go hand in hand. Early treatment prevents mild illness from becoming serious if people are helped recognize many of their common health problems and treat them early, much needless suffering can be prevented.

International studies have been done, such as the WHO Collaborative Study, to detect whether the clinic nurses could provide mental health care and prescribe a limited range of psychotropic drugs. The result has been that given a form of training, nurses with only two years of high school and 18 months training can diagnose and treat specific priority disorders. This programme was implemented and evaluated in India where after sixty hours of training nurses could diagnose and treat correctly 28 out of 30 cases in the PHC services. It was also implemented and evaluated in Lesotho where 76% out of 60 cases were correctly diagnosed and treated after 18 hours of training. Recommendations from this study are that to achieve success an effective consultation service provided by the multi-professional team based in hospital must be set up (Essex & Gosling, 1983). All the studies used to evaluate these programmes have shown that the results are acceptable and efficient. Essex and Gosling (1983) recommend that a new problem oriented method could be used by developing countries as it allows for variations and local constraints. An example of this is the use of algorithmic processes to determine the sequence of observations that must be made to decide on the appropriate management. The editorial comment of the East African Journal (1988) agreed that in developing countries there is need for training of PHC professionals in the diagnosis and treatment of mental illness with the support of consultants and a referral system for clients who cannot be handled at this level.

Gagiano (1992) reports on a study done in South Africa in which general nurses were trained at primary level to provide psychiatric care in areas where there were no psychiatrically trained district nurses and hospital based personnel. Visits by the hospital based team were done to give support to the nurses at primary level health centres. Therapy resistant patients were referred to hospital for admission. This prevented

overcrowding of the secondary services for problems that could be handled at the primary level and allowed the patients the chance to be treated nearer home, thus economic. Freeman (1992) puts emphasis on the need for an efficient telephone system for consultation with the psychiatric team and an efficient referral system to enable clients to be referred. In this study done in the Orange Free State as reported by Freeman (1992) the model used is appropriate for rural communities, even in the absence of a mobile team if the telephone and referral systems are efficient. (Gagiano 1990)

2.1.4. IMPORTANCE OF PHC

The WHO (1984) has proved from research and experience that PHC is the most successful strategy in providing health where each country can use the available resources to improve the quality of life. The WHO collaborative studies implemented in various studies such as in India and Lesotho, have shown that in spite of technological advances in health care throughout the whole world, the mental health problems of the populations have not shown any significant improvement (Walt & Vaughan 1981), thus an approach that would be more affordable had to be decided for all countries of the world. The implementation of PHC in various countries has indicated that it encourages communities to develop decision making and self dependency as they learn from their participation in PHC initiatives. It has also been observed that the presence of primary health care in communities increases their awareness and the need for health care (Ochola and Kisubi, 1992). History reveals that the past policies which did not include the communities in the identification of health needs, planning methods of intervention and involvement in implementation, led to overdependence on the government and under utilisation of services (WHO, 1990).

Developing countries are mostly rural with poor health status especially at the family level. This makes it difficult for all families to benefit from the expensive specialised health care. This is made worse by the fact that these services are situated in the urban areas while the bulk of the population lives in rural areas (Freeman, 1989a).

PHC is designed to meet the total wellbeing of an individual, in line with the WHO's definition of health as "a state of complete physical, mental and social well being (WHO, 1990). This holistic approach will benefit all aspects of the individual with no indication

that any one of these aspects should have precedence over the others (WHO, 1978).

When psychological problems are identified within PHC services, simple forms of treatment can be of value and scarce health resources are thus not wasted. Without proper attention to factors that may lead to mental illness within the general setting the cost of PHC will keep on rising, without any improvement in the health to those affected (WHO, 1990). The key to the improvement of health is therefore seen as early identification of factors which may lead to psychological imbalances, some of which are presented by clients as mild complaints in PHC services or as social, physical and emotional disturbances. Some of these factors are found within the environment in which the person lives.

Pillay and Subedar(1992) argue that health care does not focus on health only but involves a wide variety of activities aimed at improving health, such as economic, social, educational and political dimensions of communities. This is also in line with the ANC (1994a) Health Policy's vision of improving health for all citizens through the achievement of equitable social and economic development through employment, education, improvement of housing and others. In this document, the ANC also emphasize that clients will not be passive recipients but will work with health providers in planning and implementing the health care needed. This is planned to reduce inequalities in access to health services in rural and disadvantaged communities. It is therefore important for PHC workers to recognise the importance of the holistic approach to the patient's problems at the point of entry of the client to the health service. The government of National Unity has adopted this strategy as recommended in the ANC health policy (ANC, 1994a).

Ochola and Kisubi (1992) explain that communities have been paralysed by agents who have delivered goods for a long time. To improve this, they recommend that communities must be empowered from personal understanding to group action. This will improve confidence, awareness and competence which are needed for change. Therefore, PHC is an important change agent which will help people take positive action towards their well being. At the primary health level the client and his/her family are to be encouraged to take some steps to modify and improve some factors in their lives, identify areas that

need to be changed by them and to work with health care providers in making improvements in their lifestyles (Ochola & Kisubi, 1992).

2.1.5. INCORPORATION OF PSYCHIATRIC SERVICES INTO PHC

The development of psychiatric care from custodial care was influenced by the development of the mental health movements in the 1950's which led to a change from hospital based care to community care. This led to more people being cared for at home than in hospitals.

While the hospitals opened their doors for psychiatric patients to move to community care, the services were not adequately prepared to provide this care especially in rural communities. The outpatient care in South Africa reflects a decrease in hospitalised patients from 16,536 in 1977 to 11 395 in 1991 and an increase of patients in community services from 486,610 in 1988 to 841 167 in 1992. This increase alone demonstrates the need for improved psychiatric care at community level. The nature of services provided presently varies from administration of medication and assessment of the patient's progress to counselling of the client and family available mostly in urban areas (Uys, 1992).

The WHO (1984) in its recommendation put emphasis on the integration of PHC. If one looks at how the various countries have provided PHC using the principles of the WHO, it is obvious that the same principles apply to the psychiatric component in PHC. The nature of mental/psychiatric illness needs to be diagnosed early and managed, given the suffering it causes to the individual, family and the community. The causes of psychiatric/mental illness can be controlled within the community by identifying factors which are likely to lead to psychological disturbances. This does not need additional staff but that PHC workers in conjunction with schools, social services and other sectors can be equipped to identify these factors. Communities are educated to avoid and prevent illness-inducing factors. Clients who already suffer from psychiatric illness are diagnosed and treated in the clinic nearer home involving the family and the community in which the clients live so that they partake in their family roles, with the support of the family.

Rehabilitation is a modern approach in which clients and relatives take an active part in the provision of health care. Changes are needed in the present approach in order to focus on community care (Uys, Middleton and Vermaak, 1997). Rehabilitation is aimed at the prevention of relapse process while the patient is on treatment. The areas affected by the illness such as social skill, coping skills, and vocational skills restrict the patient from performing in the way regarded as normal by the society and these areas should be the focus of rehabilitation.

The process of rehabilitation starts with assessment to determine the patient's level of functioning followed by the identification of symptoms known to be an indication of relapse by the patient and the family. The family and the client is educated on how to deal with these troublesome symptoms. Further the client and family is assisted to identify which skills he needs to learn or re-learn in order to function better in his environment. Goals are set around these skills and are arranged into short and long term. Dates on which these goals should be achieved are set and clearly defined. The activities aimed at the achievement of the set goals are clearly discussed with the clarification of who should do what. In this way the family takes over the role of health provider and teacher within the home (Uys, 1991).

Rehabilitation of psychiatric patients needs a multidisciplinary approach as these clients may need to be retrained to learn new skills which they can use for employment. Sheltered workshops are necessary in the rehabilitation so that patients are taught certain skills in order for them to make a living. This decreases the dependence of the patient on his/her family. When clients are employed their socio-economic income is improved at family level, thus, being enabled to fulfil the goals of PHC. Clients who cannot be employed are equipped with skills that will help them lead a partially independent life within their families without being a burden. Throughout the process of rehabilitation an evaluation of the goals achieved is done. Some clients recover through this process to a level where they can be employed (Uys, 1991).

While prevention and promotion of mental health are needed in any society, the need for this is particularly important in South Africa, given the attendant violence, social instability and unemployment (Freeman; 1992). With more violence experienced by communities in which the public is usually a victim as in taxi wars and political wars the

incidence of mental illness as a result of violence is likely to increase (Madel, Poggenpoel, 1993). In this study it was concluded that communities suffer from stress which leads to mental illness. This study corresponds with other studies on violence done in South Africa (Mc Kendrick & Hoffman, 1990; OASSAD, nd) The risk of an increase in suicide is 5% for every 1% increase on unemployment in adults (Davies & Janosik, 1991).

Specialist psychiatric services are far from the bulk of people at risk which increases the need for the first line care to be brought to the people. There is every proof that psychiatric/mental health services are inadequate in developing countries and that those available are mostly in urban communities (Gillis, 1985). The WHO (1984) stresses that the aim of the integration is important so that a large part of this care is rendered by general health workers.

The priority given to treating the severely mentally ill is seen as a strong point in services of developing countries. Chronic mental illness can be treated in the community through the use of community resources while services are delegated to PHC centres (Lefley 1990; WHO 1984: 12). Vocational rehabilitation is a problem amongst Black patients as reported by Uys, Dlamini, Mabandla & Fish (1993) who report that 5% of rehabilitated clients were employed and 60% received disability grants although the number of patients on disability grant in the Transkei is 17% as compared to the other studies reported. Rehabilitation services need more attention so that fewer patients depend on the social services. As part of rehabilitation of clients, re-education of the family and the community be included to assist the patient to resume his/her family and community roles with the support of families and communities in which they live.

It has been established that social factors and living environment are associated with relapse rates (Newton, 1992). One of the factors known to be effective in reducing relapse is maintenance medication. A study reported by Newton (1992) reveals that intensive behavioural intervention including education, stress management and goal setting for both the family and client done over a period of nine months reduces the relapse rate of schizophrenic patients. This concept is the basis of the rehabilitation model in the treatment of psychiatric patients in the community.

In the community setting, it is important to meet the needs of psychiatric patients which are often not taken into account by the medical and psycho dynamic approaches . These needs are similar to the needs of other patients as mentioned by Kraus and Slavinsky, (1982) such as:

- * A need to be taken care of.

This need plays a large role in the illness of psychiatric patients due to its nature and severity coupled with lack of social resources. The carers need to have social resources mobilised to assist them in dealing with the variety of symptoms.

- * A need for social interaction.

Chronic mental illness is known from documentation that it leads to an inability to form and sustain a close and rewarding relationship with parents, children and spouses. This is due to poor problem solving skills, timidity in seeking social interaction outside and within the home, low self esteem and the degree of impairment and symptom difficulty. Social isolation dominates the life of the patient whether he live alone or with the family.

- * A need for relief from psychiatric symptoms.

Psychiatric symptoms are distressing and leave the patient with a degree of impairment and symptoms difficulty which can be stabilized with medication. There is need for health professionals in the community to assist the client and the family to find relief from effects of troublesome symptoms which sometimes remain and can be stabilised by medication.

- * A need for basic life necessities.

Psychiatric patients have necessities like any other persons such as need for food, clothing and shelter. The traditional institutional care was designed to meet these needs when clients and their relatives were not able to fulfil such needs. When there is a shift from hospital to community care as is recommended by the PHC approach (WHO, 1984), there must also be a shift of resources to assist these families.

- * A need for hope.

Although mental illness is chronic mental health professionals must mobilize support for

the client and family who always feel rejected and hopeless. This brings hope in the face of an uncertain prognosis with efforts to rehabilitate and arrest the progress of the disease.

* The needs of others.

The concerns and difficulties experienced by the families of the mentally ill clients must be considered. The dangers and risks associated with mental illness must be taken into consideration if the client is to be cared for at home.

In view of the needs mentioned above the mentally ill is best be treated within the community with only severe forms of cases treated in hospital so that the needs of these patients are met within the environment in which the client lives. An integrated approach into health care would be a solution so that psychiatric care is not isolated from the PHC approach used in this country and other countries. This would also be of benefit to all forms of illness prevalent in each community.

According to Aboidum (1990) and Freeman (1992) if mental health services are integrated into Primary Health this would have the following benefits :

- * It will improve coverage of the population
- * The cost of health care will be reduced as the psychiatric care will be provided by the existing clinic nurses.
- * Mentally ill patients will receive care without being identified as mentally ill thus the stigma attached is avoided.
- * The service will be nearer to the consumers and therefore more accessible and economical to them.
- * The treatment of psychological, behavioral and physical illness will be provided within the same setting, thus, treating an individual in totality.
- * The services will be decentralised, thus reducing overcrowding of the currently

used services.

- * The rehabilitation of patients will be improved since it will allow for families to be involved in the treatment of their members (Ngubane & Uys, 1994).
- * It will provide for early diagnosis and treatment (Reeler 1987a)

2.1.6. IMPLEMENTATION MODELS

It is clear from the literature that although the recommendations of the WHO (1992) that mental health be integrated into PHC were welcomed, it is not clear how this integration should be done. Various countries have implemented models suitable to their countries and have experienced different implementation problems. Pincus (1980) devised some of the models which are suggestions aimed at assisting various countries to choose and modify according to the situation and available resources of each country, as well as the levels of health care available. A few of these models are presented.

Triage model

The PHC service makes a written agreement to refer patients who are thought to be psychologically disturbed to the specialist psychiatric care or transfer them for treatment. While the patient is in the care of the specialist team, feedback is given to the PHC team on the form of treatment and management given. In other cases, consultation is done in relation to diagnosis treatment and management of the client while the patient is treated in the PHC setting. This arrangement involves finance, as grants have to be allocated for specialists who are involved in handling consultations, referrals and transfers although both services are under one administration (Pincus 1980).

Consultation service model

The specialist service provides consultation to the PHC personnel as a means of equipping them with skills in dealing with psychological problems and to transfer severe

problems to specialist personnel. There is no formal contract on flow of patients and for referral. The important factor is education of PHC personnel so that only clients with severe problems should be sent to specialist teams.

Supervision and education

This model is similar to the consultation service as it puts emphasis on the education aspect of health workers at PHC services. The only difference is that unlike the consultation service model there must be formal contracts signed. PHC workers with no psychiatric training refer clients who need specialist care. The important element is that non- psychiatrically trained personnel are provided with the skills to assess, treat and manage psychiatric problems and refer those who are beyond the ability of the PHC workers to specialist service which provides backup services. The example given is related to the training of generalist medical practitioners in psychiatric centres so that they are able to deal with first line clients in their practice.

Another model recommended by Freeman (1992) is an example of an attempt to provide mental health care in South Africa implemented in the Orange Free State as follows : Psychiatric teams visit the clinics on specific days per month to provide psychiatric care in the form of medication from a psychiatric hospital. In other areas, PHC nurses assess, diagnose, treat and refer clients to the specialist team if the condition is beyond their ability. These PHC nurses are non-psychiatrically trained but receive inservice education from the specialist team to be able to handle psychological problems at PHC level. A 24 hour telephonic consultation service has been set up and an efficient referral system used so that the clinic nurses get the advice and support of the back-up team in a psychiatric hospital whenever necessary. Complicated cases are either referred to the specialist mobile team or the psychiatric team in the hospital. After referrals patients from the specialists team are sent back to the clinics for continuity of care.

Gous (1992) in supporting this model emphasises the importance of consultation and liaison as seen in this model. He further recommends that the success of the model depends on the way in which the support, liaison and consultation works between the teams. This idea is supported by Hart (1992) and Schubert (1989).

2.1.7. DISCUSSION OF THE MODELS

There are similarities and differences in some of these models. The models can easily be used in a variety of settings and modified to fit each situation. Consultation services, supervision and education can be used where the PHC setting is in close proximity to the specialist service so that there is easy contact between the two teams. The problem is that specialist services are in urban areas far from the rural primary health centres where most skills are needed. Difficulties can arise if the communication system is poor, as in most clinics in South Africa. Transport is another problem where patients need to be taken to hospital, especially during the night. The contact between the two services has financial implications and is not cost effective.

Although the Free State model seems to have some problems related to the legislation, enabling nurses to prescribe medication used for the treatment of psychiatric conditions, it is best suited for rural communities even in the absence of the visiting psychiatric team. Backup services can be provided by the psychiatric team in hospitals through referrals and consultations. Whenever patients who cannot be cared for in the community come or when there are problems in prescription and management, clients can be handed over to the psychiatric team. This will ensure a greater coverage of psychiatric services without increasing the health costs as the existing services will be used. Consultation services of the psychiatric nurse who is a member of the mobile team are used by some clinics whenever she is available. Problems will arise in areas where transport and communication systems are poor. Since this is in the process of improvement with the new government policy, there is hope that these problems will fast disappear. In addition, this model will provide coverage of more clients visiting the PHC setting where transport and availability of the specialist care is a problem as in most rural communities.

2.1.8. THE CURRENT MENTAL HEALTH CARE IN SOUTH AFRICA

Mental health care is provided through health and welfare organisations, education, industry, religious organisations, and the community to a lesser formal way. Freeman (1988) reports that within the health sector mental health care is provided by the State and the private sector in the form of curative services. The preventive mental health services are available only to urban communities.

Private organizations that provide mental care such as Life Care Group are profit making and have a contract with the state. Although these organisations cost less than the state institutions, per patient per day, this does not justify their use for the care of psychiatric patients. There is growing suspicion that because this is the only private organisation, it is not possible to compare the care provided against the profits made (Freeman, 1989a).

The State budget for community and preventive care for the mentally ill in 1992 constituted 7% of the budget, with more money spent on services which cater for the small group of people. In the private organisation the budget for mental health care was only 3% (Freeman, 1989a).

The mental health services in South Africa as described by Freeman (1989) and Uys(1992) are centralised in overcrowded hospitals. This type of service is not appropriate for a country like South Africa with the largest number of people still live in rural areas. An example Freeman (1988) gives is an area with 1,5 million people served by 3 hospitals. These hospitals do not have a psychiatrist and psychologist, and have no counselling services. Genetic services are only found in big cities. The available services to psychiatric patients are limited and poor in quality.

Reeler (1987a) criticised the South African government for continuing to use the medical approach in the treatment of psychiatric patients as a treatment of choice. Solombela (1990) argues that the relapse of patients who are maintained on drugs in the absence of community care is high. The relapse rate in developed countries is low. In South Africa, families bear the burden of caring for discharged patients without receiving any information and support from PHC workers. Often there is no continuity of care in Transkei as pointed out by Solombela (1990) and Magadla (1991). When a client is discharged from hospital, relapses and readmitted, it increases the burden on the state funds as patients are discharged and lost only to reappear when they relapse. The Mental Health Act No. 18 of 1973 allows involuntary admission to patients who cannot be treated at home. Kaliski, Koopowitz & Reinach (1990) reports that 60% of patients admitted at Sterkfontein were certified and Dlamini as quoted in reports that 82% of the patients studied were certified. There is no clear reason for this pattern. In developed countries, as well as in South Africa the reason the client is certified is when the client is a danger to himself and others. This has led to overcrowding in hospitals whose care is inadequate.

Clients do not need to be certified unnecessarily but kept and cared for in the community (Uys, Dlamini, Fish & Mabandla, 1993).

There are various problems encountered in the provision of psychiatric care as illustrated by Poggenpoel (1993).

- * The rising cost of care without efficient provision of mental health care to the whole community.
- * A high rate of relapse in patients who received community care.
- * Patients travel long distances to receive mental health services which led to a large percentage of defaulters. This had economic implications and if the patient had no money, the treatment would be discontinued.

In areas where psychiatric care was provided in clinics, the attitude of the health professionals was negative and increased the stigma to mental illness (Mavundla : 1993).

Uys (1992) reveals that the level of knowledge about mental health among community members is low. Communities do not utilise the services because they are not educated about where to go when they experience psychological problems.

Compounding the problems encountered in the provision of mental health care is the limited availability of mental health professionals. There is only 1 psychologist and 1 psychiatrist per 304 000 and 276 000 in developing countries respectively, as opposed to 1 psychologist and 1 psychiatrist per 4 000 and 1 400 population, respectively in developed countries. The available human resources reported by Freeman (1992) in South Africa are in the following ratio :

Psychiatric nurses	-	1:5 400 population
Social workers	-	1:5 200 population
Psychiatrists	-	1:130, 500 population
Clinical Psychologists	-	1:35, 800 population

These figures do not reflect the real distribution but are an estimation of personnel in the public sector. Personnel inequalities exist between urban and rural communities as well. The South African Nursing Council in 1993 reported that only 12,4% of registered nurses have a registration in psychiatric nursing and not all these are allocated to the care of psychiatric patients. A high percentage of these nurses were trained in hospitals and have no skills for community care (Poggenpoel : 1993). Legal limitations in the practice of PHC is a problem. A study done in South Africa in 1994 revealed that the scope of practice of PHC was very limited and recommended amendments to the legislation (Bierman & Muller, 1994).

Volgeman (1988) reports that psychiatric services in South Africa are provided along racial lines. Blacks receive inadequate and sometimes hazardous care. More funds are allocated to racially privileged groups who benefit from preventive services, such as counselling and rehabilitation.

Freeman (1989a) further states that there are no statistics to measure the morbidity of mental illness in South Africa as a result of lack of the dividing line between healthy but unhappy persons and the mentally ill. At the PHC level, preventive and promotive measures do not exist, hence mental health problems are not identified. PHC workers have limited background in mental health.

Most suggestions and proposed solutions are found in Freeman (1989b) as guidelines for rendering of mental health services. Additional recommendations have been made by (Freeman, 1989; Solombela, 1990; Ngubane & Uys, 1994; Uys, Dlamini, Mabandla & Fish, 1993,).

- * PHC is the only holistic care that will provide a more comprehensive service and coverage to all patients;
- * Mental health care should be a priority as other aspects of care within the PHC service using an integrated approach;
- * The policy on the provision of mental health should clearly explain what structural changes should be done;

- * There should be a multi-sectoral approach which should include agriculture, defence, recreation, communication system, industry, education and human resources with close co-operation between government departments;
- * Mental health care should be made available to all;
- * People with psychiatric/mental health problems should be treated nearer their homes and rehabilitation should form the focus of mental health (Middleton & Uys, 1997).
- * PHC workers should be equipped with skills needed to provide PHC.

The ANC health policy (1994a) puts emphasis on the need for political will on the part of the government, and commitment from communities and other health sectors as a measure to sustain PHC. These recommendations are in line with the vision of the ANC in its National Health Policy (ANC, 1994a) in respect of mental health with emphasis on the following :

- * Empowerment of the people and communities
- * Awareness of mental health and mental illness
- * Multi-sectoral and integrated approach
- * Promotion of healthy lifestyle and prevention of mental illness

4 Further, as quoted in Uys, Dlamini, Mabandla & Fish, (1993) recommends that all nurses must be involved in community care at grassroots level supported by Chavanduka in Reeler (1987a) that there must be appropriate health care facilities to study the development of psychological disorders overlooked by the present mainstream of treatment centres.

In order to deal with the problem of involuntary admission. Reeler (1987a) and Kaliski (1990) suggest that there should be an interim facility set up within the community to stabilise acutely ill and dangerous patients before a final decision can be made.

In view of the results in various studies on differences in hospitalisation rates where more

Blacks are hospitalised that Indians, Uys (1992) recommends that the psychiatric component be integrated into PHC so that more patients are treated at primary health centres. This would be cheaper compared to the cost of hospitalised patients in terms of cost and quality care.

The above recommendations can be implemented within the proposed PHC approach in South Africa, using the existing resources. Although the number of clinics need to be increased in order to make services accessible, the cost of psychiatric care will decrease (Freeman, 1992).

If the PHC nurses in clinics are equipped with the skills necessary to enable them to diagnose, treat, refer and consult, as well as to be guided, and supported by the psychiatric team, the secondary health services will reduce the load of providing PHC. This also requires that the referral system be improved, communication system upgraded to enable consultation to be possible. A more complicated aspect will be to determine the legislation needed to enable general nurses to prescribe (Gous, 1992).

The current scope of practice regulation of the South African Nursing Council (R2598 as amended up to 1991) does not prohibit nurses from diagnosing and prescribing. However although these regulations have been promulgated their provision has not been implemented during the time of this report. The Medicines Related Substances Control Amendment Act (1492 of 1991) makes provision for regulations to be made authorising nurses to diagnose and prescribe.

Due to the limited literature available on the integration of psychiatric component from other countries it was difficult for the researcher to obtain more information from examples of other countries and to compare the implementation results and problems from various countries. It is believed that the use of the WHO (1990) guidelines will assist in the development of more programmes in different countries.

CONCLUSION

The adoption of the principles of PHC is seen as the method of improving access of health services to all communities. All government sectors, communities and individuals are role players in PHC although each country decides how the services should be made accessible which leads to the existing differences in the model of implementation. Mental health has not been part of PHC in the past and services for these clients have been offered as a specialist in hospitals. At PHC centres only maintenance medication was available for psychiatric patients. The recent recommendations found in the ANC health policy are in line with the WHO recommendations found in the later documentation (WHO, 1990). The present psychiatric services in South Africa are inadequate as are rehabilitation and welfare services and far from the bulk of communities who need these services (Gillis, 1986b). It is therefore important for the country to bring the services for psychiatric care closer to most communities. To make this change, a change is necessary to influence policy makers to effect a shift of resources to the care of the mentally ill persons.

There is need to improve the skills and attitudes of workers through short courses and orientation at clinical settings as a part of the re-orientation of all nurses towards the importance of the PHC approach as recommended by Hart (1992). Furthermore, it might be difficult to convince policy makers of the importance of re-allocation of additional resources into psychiatric/mental health care, as this is not always seen as a priority in comparison to the popular causes of mortality and morbidity such as the prevention of sexually transmitted diseases like AIDS. Therefore if this integration is important, it is essential to develop, test and implement plans in this area which are in line with the country's health policy and with the recommendations of the WHO. Such plans should be implemented on a pilot basis so as to explore implementation problems and illustrate its worth.

Due to the limited literature available on the integration of psychiatric component from other countries it was difficult for the researcher to obtain more information from examples of other countries and to compare the implementation results and problems from various countries. It is believed that the use of the WHO (1990) guidelines will assist in the development of more programmes in different countries.

CHAPTER 3 : RESEARCH METHODOLOGY

3.1 INTRODUCTION

A case study incorporating a quasi-experimental design was used in this study. This is a health system research in which an educational approach was used to enable PHC nurses to implement Community Psychiatric Care into the primary health care system. The research consisted of the following steps:

1. A sample of six clinics from around Umtata was drawn (3.3.1.1)
2. Primary health care nurses from each clinic volunteered to take part in the training and implementation of the project.
3. The nurses were trained in primary mental health care in two block periods and then supervised in implementing each component of the psychiatric care into their clinics. The implementation of the first phase (diagnosis and treatment) started from April to September. The implementation of the second phase (Rehabilitation) started from October to March.
4. A case study of the implementation process and results of implementation was done on each clinic looking at:
 - * the process of implementation
 - * barriers to implementation
 - * effort evaluation

3.2 RESEARCH DESIGN

The study used case studies in different phases of the project using both qualitative and quantitative data. The population targeted for participation in the study included 20 clinics in the region of Umtata, 16 of which were in rural areas whereas the remaining 4 were in urban areas.

The method involved an intensive study of the process of implementation at each clinic and the problems encountered. The aim was to obtain information about the process under study to explore the effectiveness of change in the provision of psychiatric care.

Data collection for case studies was done through a series of visits to clinics, where unstructured interviews based on the case study protocols, as well as objectives based on the protocol were done. The rationale behind the use of case studies was that this method was appropriate in the investigation of real life events in each clinic. In addition, case studies were relevant to answer the research questions and to deal with a variety of events. Case studies would also be useful in the study of a unit of analysis, in this case a clinic (Yin, 1990). Further Imenda (1996) recommends the use of case studies when an insight concerning previously unsuspected relationship was suspected.

3.2.1 Sampling for case studies

Six (6) clinics were purposively chosen to form the sample because they were within the supervision distance of the researcher, and also represented urban and rural clinics. Abdellah & Levine, (1979) recommend purposive sampling to be used for the purposes of convenience.

The criteria for inclusion of the clinics was that:

- * clinics belonging to the local authority have not been offering psychiatric services, sending all their patients to the Umtata General Hospital outpatient department. Including these clinics would offer a comparison of services which would shed some light on the different implementation problems encountered where psychiatric care has never been offered at primary health care levels, compared to where some follow-up care had been given. Only one clinic was included in the study from this group.
- * in the remaining clinics follow-up of psychiatric patients was already done by the primary health care nurses where packets of psychiatric medication were dispensed to them. This means that this is an accepted part of the work of the PHC nurses. The increased work-load would therefore not be a primary barrier which may influence implementation.

Case study designs involve an intensive exploration of a single unit of study. Within the content of this study each clinic was seen as a case, and was studied to obtain descriptive information from a variety of sources of information collected on each concept leading to better understanding of the situation under study.

3.2.1.1 Salient features of the selected clinics

1. Clinic AA1

Setting

This is an urban local authority clinic situated south east of the town serving a population of about 16 000 people dwelling in a township and informal settlement areas. Three high schools and nine primary schools increase the population to about 25 000. The population is not stable as a result of the fast development of squatter camps around the township. This clinic was included to represent those PHC settings not currently offering psychiatric care.

Building

It is a modern clinic with five consulting rooms, a dispensary, three offices, a kitchen, store room and a big waiting room, a social worker's office and a doctor's office. The outside building has a common room for domestic workers and watchmen. The clinic is in the process of extension by Kellogg in order to have more consulting rooms, an X-ray room and a laboratory. It is electrified and has an efficient telephone system. Ambulance services are provided whenever needed from the Municipality offices in town. The security, in addition to the two watchman on duty during the day and at night, is increased by the presence of a police station 100m from the clinic. The health services are rendered for 24 hours.

Staff

Enrolled Nursing Assistant (ENA)	- 4
Enrolled Nurse (EN)	- 2
Professional Nurse (PN)	- 3
Senior Professional Nurse (SPN)	- 1
Chief Professional Nurse (CPN)	- 1

Two registered nurses were included in this study from this clinic.

The patient attendance for this clinic in the three months before the study for both general and psychiatric patients is shown below:

Table 3.1 Clinic AA1 Patient Attendance 1995

	January	February	March
General patients	1016	996	1008
Psychiatric patients:	-	-	-

Barriers

Due to policy issues psychotropic drugs are not available in the drug list of this Municipality health service. Unless an agreement was reached on the supply of these drugs by the Umtata General hospital, it was difficult for clients to get medication in clinic as prescribed. Clients were sent to collect medication from hospital or drugs were collected for them from hospital through the use of a prescription card.

2. Clinic AA2

Setting

This is a rural clinic about 16km east of Umtata which serves a population of about 65 000 people living in scattered rural villages and dwellings.

Building

The clinic is accommodated in an old church building within the church yard. The building is made out of mud bricks and plastered with mud. The windows are small which makes it dark inside. It has 3 spacious rooms

- 1 used as a waiting room and treatment room.
- 1 used as a consulting room and ANC room.
- 1 used as a dressing room and office.

Staff

Senior Professional Nurse	- 4
Senior Enrolled Nurse	- 1
Senior Enrolled Nursing Assistant	- 1
Enrolled Nursing Assistant	- 1
Cleaner	- 1
Gateman/Watchman	- 1

Two registered nurses were included in the project.

The attendance of patients three months before the implementation of the study is shown in Table 3.2 below:

Table 3.2 Clinic AA2 Patient Attendance 1995

	January	February	March
General patients	554	443	540
Psychiatric patients	14	16	13
Defaulters	2	0	3
Relapses	-	-	2
Home visits	-	3	3

Barriers

There is no communication system between this clinic and the hospital. No two way radio has ever been installed. Nurses have to drive in their cars to get help from Umtata Hospital. Drugs are not easily available unless collected by nurses through the use of the patient's prescription card.

3. Clinic AA3

Setting

A rural clinic about 58km north of Umtata, serving a population of about 30 000 people living in scattered rural dwellings and villages.

Building

Presently the clinic is accommodated in a prefabricated building with 3 rooms.

1 waiting room

1 treatment room/consulting room

1 maternity room

There are 4 flats used as a nurses home. The clinic is to be moved into a new complex - a community hospital (Health Centre) built by Kellogg in a new site about 500m from the present clinic. The centre is completed and furnished but is still awaiting the official opening.

Staff

Professional Nurse	- 3
Enrolled Nurse	- 1
Enrolled Nursing Assistant	- 2
General Assistant	- 2
Gateman/Watchman	- 2

One registered nurse was included in the project.

Table 3.3 shows the attendance of all patients in the first three months of 1995 before the implementation of the study.

Table 3.3 Clinic AA3 Patient attendance 1995

	January	February	March
General patients	765	700	830
Psychiatric patients	26	17	18
Defaulters	-	-	-
Relapses	-	1	-
Home visits	2	2	2

Communication is available through a two way radio, but not always functioning.

Barriers

Roads are bad and dangerous on rainy days. Drug supply is a problem and due to distance from Umtata General Hospital, nurses collect patient's supplies on their own.

4. Clinic AA4

Setting

A rural clinic about 24km north of Umtata with a particularly high intake of psychiatric patients, serving a population of about 63,000 people living in scattered rural villages and dwelling.

Building

1 three - roomed prefabricated building

- 1 used for consultation and maternity.
- 1 used for treatments and dressings

- 1 used as a waiting room

A four - roomed flat built of cement blocks is used as a nurses home.

A one - roomed prefabricated room is used as a store room.

Staff

Senior Professional Nurse - 2

Professional Nurse - 2

Enrolled Nursing Assistants - 2

General Assistant - 1

Watchman - nil

Two registered nurses were included in this project.

The patient attendance in this clinic three months before the implementation of the project is shown in table 3.4

Table 3.4 Clinic AA4 Patient Attendance 1995

	January	February	March
General patients	800	961	1062
Psychiatric patients	35	48	56
Defaulters	-	2	2
Relapses	-	-	-
Home visits	2	1	1

Communication through a two way radio is available and works efficiently.

Barriers

Home visits to clients far from the clinic were very difficult as the area is very wide. No transport was available for home visits except on foot or if possible through the use of nurses' cars. Some roads do not have bridges across the rivers and need the use of 4x4 vehicles which are not available.

5. Clinic AA5

Setting

A rural clinic situated 33km south of Umtata, serving a population of 31 000 people living

in scattered rural villages and dwellings with a steady rise in relapses and defaulters. Provides a comprehensive service which includes deliveries, antenatal care, treatment of minor ailments, maintenance of chronic diseases, immunisations, demonstrations to mothers of under 5. Health education done to individuals, and to groups when possible. Home visits done when possible, but hampered by transport shortage. The clinic is fenced with net wire and has lockable steel gates.

Building

- each has a zinc water tank.
- 2 two - roomed prefabricated building was used as:
 - treatment room
 - maternity room
 - waiting room
 - consulting room
- 2 two - roomed prefabricated building used as nurses home.

Staff

Professional nurse	- 4
Staff Nurse	- 2
Nursing Assistant	- 2
General Assistant	- 1
Gateman/Watchman	- 1

Two registered nurses were included in the project.

Records in this clinic showed the following patient attendance three months before the implementation of the study :

Table 3.5 Clinic AA5 Patient Attendance 1995

	January	February	March
General patients	1592	1647	1595
Psychiatric patients	15	10	10
Defaulters	2	1	3
Relapses	2	3	4
Home visits	2	4	6

Barriers

Communication is bad as the two way radio is out of order most of the time. Medicine supplies are inadequate and most drugs not always available. Patients' cards were collected for at least a week so that drugs can be obtained from the hospital at the end of each week. Home visits only to surrounding villages were done on foot only due to the absence of transport.

6. Clinic AA6**Setting**

A rural clinic situated 31km from Umtata, serving a population of about 45 000 people living in scattered rural villages and dwellings. This clinic also has high statistics of patients on psychiatric medication. It provides comprehensive service which includes treatment of minor ailments, immunisations of under 5 children, maintenance of chronic diseases like TB and hypertension, health education and home visits done only when possible.

Building

2 prefabricated buildings and 1 mud building. Both prefabricated buildings have two rooms.

- 1 room used as waiting room and dressing room and the second used as consulting room.
- 1 prefabricated building used as a nurses home with 1 bedroom, a combined kitchen and dining room.

1 old mud building used as a nurses home with the following rooms:

- 1 bedroom
- 1 store room to store clinic equipment
- 1 zinc room for Gateman

The clinic is fenced with razor wire and has a steel gate. Each building has a zinc water tank.

Staff

Senior Professional Nurse	- 2
Professional Nurse	- 2
Senior Staff Nurse	- 2
Senior Enrolled Nursing Assistant	- 2
General Assistant	- 2
Gateman	- 2

Two registered nurses were selected to participate in the study.

The clinic statistics collected revealed the information showed in Table 4.6 on the patient attendance three months before the implementation of the study.

Table 3.6 Clinic AA6 Patient Attendance 1995

	January	February	March
General patients	279	756	755
Psychiatric patients	14	14	10
Defaulters	7	7	12
Relapses	-	-	-
Home visits	-	-	-

Barriers

Communication is by a two way radio which is at times out of order. Nurses travel by public transport with the client from the clinic to hospital. At times nurses use their own transport to hospital when a client is referred for further management. It was not easy to conduct home visits due to the long distance to be travelled. Nurses had to use their cars for this.

In the rest of the clinics under study the communication is by two way radio between the clinics and between each clinic and hospital. None of these clinics has electricity which makes it impossible and unsafe to work at night. These clinics open from 7h00 till 17h00. No ambulances are available for each clinic except by request from Umtata General

Hospital. This ambulance system is not always available.

Emergency services are not adequate to meet the needs of all clinics. Clinics with a two way radio have a direct communication with this service but due to distances and the shortage of vehicles delays do occur.

3.2.2 Educational Programme

The programme was characterized by :

- * a skills based approach with only the theory necessary to master the skills.
- * methodologies which sought to promote attitude change.

The programme consisted of three phases each of which started with a 10 day workshop followed by 6 months implementation, supervision and support. Books of reading for students giving objectives for each unit and a facilitator's guide with objectives and methods of teaching were developed for each phase and workshopped with the secondary health service staff for their comment. Each book used by students consisted of the objectives to be achieved for each unit, the literature from different books and the content to be studied was developed by Uys (1995a & 1995b). No textbooks were used. The books were developed in line with the other two courses developed in Cape Town and in Free State and also in accordance with the training manuals developed by WHO used in the training of health professionals in Columbia and by PHC nurses in Zimbabwe (Reeler, 1987).

3.2.2.1 Teaching Methods

Lessons were conducted in the form of workshops where the topic was introduced in the form of a limited lecture, followed by group discussions of 3-5 students in a group. Case studies were used for each clinical condition in order to increase the awareness and ability to identify the concepts needed. Role plays were used by participants in each group in which one played the role of client, one played the role of health worker and the other played the role of relative. The activity was subsequently evaluated by the rest of the class. Where necessary video tapes and films were played in order for participants to appreciate the live situations in the care of psychiatric patients. Report backs from group discussions enabled the participants to learn from each other, to identify their

weakness and to argue their decisions in order to come to a consensus. Three visits to the Psychiatric departments of Umtata Hospital, each lasting for half a day were conducted in order to expose participants to implement certain skills taught, which were needed in their day to day care of patients. These included consultation, writing a referral letter, taking history from new clients, making a diagnosis, prescribing treatment and giving psycho-education to clients and family under the guidance of the researcher and the secondary health service staff. Some of the activities encountered had earlier been role played in the workshops.

3.2.2.2 Course Content

PHASE 1

The phase started with a 10 day workshop in which the theory on secondary prevention of psychiatric disorders was discussed. Only the following 6 conditions were studied : Schizophrenia, mood disorders, anxiety disorders, mental retardation, organic disorders (dementia and delirium) and substance abuse.

Motivation for the course content

The six conditions were selected based on numerous African research studies done which indicate high prevalence as shown by Fish (1988), Gillis (1986), Kaliski (1990) and Reeler (1987).

The researcher decided to start with the diagnosis and treatment (Secondary prevention) due to the following reasons:

- * the priority of patients who are already affected and need care.
- * literature reveals that a higher percentage of psychiatric patients are not diagnosed correctly at the PHC services due to the lack of skills (Reeler, 1987). It was important to prevent more clients incorrectly diagnosed and becoming chronic.
- * screening psychiatric services is a skill that PHC need in order to deal with psychiatric patients.
- * in many areas which were previously homelands nurses have already been handling psychiatric patients within the PHC setting as part of their daily work. It was therefore important to train them in the skill they need to be effective at their workplace.

- * clinic records revealed lack of specificity in diagnosing psychiatric patients as they were recorded as "psych".
- * psychiatric patients were made to wait for long periods in some clinics or referred unnecessarily. To alleviate this, nurses needed to be trained in the nature of the illness, diagnosis and treatment so that they would not be reluctant to deal with psychiatric patients.
- * the myths about mental illness affects the care nurses give to psychiatric patients. Increased knowledge changes the attitudes of care givers as they learn to understand the conditions as in physical illness.
- * as some clients were difficult, nurses needed support from the secondary health service staff in order to build their skills and confidence through consultation and referral of difficult patients.

As an introduction the myths about mental illness were discussed in order to assist participants to deal with their own attitudes. At the end the guidelines for consultation, referral and counselling were discussed in relation to the theory, and practised in class.

In this phase the participants were trained to:

- * take a complete psychiatric history using the correct interviewing skills.
- * make a DSM IV diagnosis on the 6 common conditions.
- * prescribe treatment on the first visit of the client.
- * review medication and maintain the client on the long term medication.
- * identify when referral is necessary and the procedure for referral.
- * do psycho-education of patients and their families about the condition and its treatment

PHASE II

This phase started with a 10 day workshop in which the theory on tertiary prevention of mental illness was taught and discussed. The rehabilitation programme consisted of the following :

1. Orientation to psychosocial rehabilitation and the policy of rehabilitation at present.
2. Making a rehabilitation, diagnosis and planning a rehabilitation programme with the client and the family.

3. Skills teaching.
4. Relapse prevention through symptom monitoring.
5. Vocational rehabilitation of people with severe mental illnesses.
6. Giving long term support and psycho-education to client and family of a person with mental illness.

3.2.2.3 Evaluation Methods

Continuous evaluation was done on the skills needed and according to the objectives of each unit. Two tests were written in each 10 day workshop. The first test was written at the end of the first 5 days and marked in class by participants. No definite marks were allocated but there were discussions centred around the weak areas identified by the participants in their performance. At the end of the two weeks a test covering all the work done during the 10 days were given.

The skills were practised through role of modelling, based on simulated situations and case studies. Peer evaluation of each group of students was done to enable participants to practise the skill needed daily. At the end of the block the skills were implemented in the psychiatric department and evaluated by the researcher and marks were allocated. Participants were also asked to conduct one interview with a new client in her clinic, tape record and fill in the assessment form and submit the two for marking.

Case histories were given and participants required to make rehabilitation diagnosis. Role plays of given case histories were done by each group in order for participants to play the roles in determining what needed to be included in the rehabilitation programme according to:

- * what the client wanted to be able to do.
- * what the relatives wanted the client to be able to do.
- * job seeking skills and how to start a small business.

3.2.3 Instrumentation and Data Collection

A total of six instruments were used for data collection. Research studies may employ a

single method or a combination of methods for data collection. In these case studies a combination of clients' records and questionnaire was used to gather more interpretative depth and to enhance precision of data.

(a) Diagnosis and treatment evaluation

Each record was expected to have a full history taken by the participant, a DSM IV diagnosis given and the treatment given on the first visit and any changes on subsequent visit. Photostat copies of client records with names erased were sent to two independent psychiatrists for evaluation. A rating scale (see Annexure A) was developed to measure the registered nurses' performance in diagnosis and treatment was used.

The rating schedule consisted of:

- 5 closed ended items to evaluate the correctness of the history and diagnosis with the rating from 1-5. Categorical response scale was used in rating medication with a scale from 1-3.
- 4 open ended items eliciting qualitative data.

Validity and Reliability

Literature was used to identify the core constructs for the instrument. Core constructs were used to guide the development of the history taking form as well as the mental status evaluation form. These were used by the registered nurses in the assessment and treatment of psychiatric patients. Although the actual tool was not tested for validity, an inter-rater reliability was tested during the research by using two raters for the first evaluation and found to be 0,6171. The instrument was consistent in measuring the history, diagnosis and long-term treatment.

Each record was expected to have a full history taken by the participant, a DSM IV diagnosis given and the treatment given on the first visit and any changes on subsequent visit. Photostat copies of client records with names erased were sent to two independent psychiatrists for evaluation.

As nurses needed to learn new skills a period of 3 months elapsed during which participants were supported and supervised. Client files were then collected from each clinic from the 6th month of implementation. All psychiatric patient files at sampled clinics were used at the following periods:

After 6 months - 1st evaluation of diagnosis and treatment

After 1 year - second evaluation of diagnosis and treatment

The diagnosis and treatment instrument accompanied the patients' files so that each independent evaluator (psychiatrist) evaluated each file independently on the same aspects.

(b) Referral records evaluation

A standard hospital referral form (see Annexure B) was used to measure the registered nurses performance in referring psychiatric patients where indicated by the patient's health status.

Items in this instrument were:

- referral clinic
- date of referral
- rating scale of referral
- name of patient

There were four responses aimed at determining whether the referral was appropriate and accepted.

- rating the referral for the amount of information provided
- rating the referral for motivation done by the referral person
- rating the referral for the appropriateness
- rating the referral for acceptance by the secondary health service

Three responses were used in this item to detect whether there was some missing information or not.

- all information given
- some information missing
- lots of information missing

Validity and reliability

This is the regular standard instrument used by the general hospitals to refer clients to the psychiatric services. On face validity it was seen to be suitable to collect data that was needed.

All referral forms from the six clinics sent to the Umtata General Hospital were collected from the third month of implementation of Phase I, until 30 referral forms were available for analysis. For each client referred the registered nurse in each clinic completed the form for the client to take to hospital. The back up team who were also members of the psychiatric team and formed the secondary health support service to the programme were required to complete this form in order to evaluate the quality of referrals.

The completed referral instruments accompanied the files to the independent evaluators so that each psychiatrist evaluated each file independently on the same aspects. The same procedures that were used for collecting data diagnosis and treatment were used by the independent evaluators for reviewing referral records.

©Programme evaluation by staff : PHC nurses

A tool was developed by Uys (1995a; see Annexure C) to evaluate the perception of the participants about the programme. There were 4 items directed to specific areas of the programme and to the feelings of the participants. A combination of Semantic differential and Likert scales and two open ended questions were used.

ITEM I : This is a semantic differential scale with two opposite adjectives or descriptive phrases with a seven point scale between them. Eleven such opposites were used. The positive and negative poles were randomly varied, so that they did not all fall on the same side. This scale was used to evaluate the feelings of the participants about the integration of the psychiatric component into PHC.

ITEM II : A Likert scale was used with varying degrees of ratings to check the level of satisfaction from Very Satisfied to Very Unhappy. The various aspects evaluated were:

- the training programme
- supervision

- consultation service
- reaction to your referral
- ability to take history
- ability to make a diagnosis
- ability to prescribe medication
- ability to do psycho-education to patients
- ability to do psycho-education to families
- support of the programme in the clinic
- response of the clients

The rest of the instrument was designed to obtain qualitative data about the positive and the negative aspects of the integration process.

Pilot Testing

Pilot testing of this instrument was done with the purpose of ascertaining its clarity and feasibility. The pilot test respondents were requested to respond to each question in order to examine the style, language and clarity. It was also possible to note the time required to complete the instrument. Validity and reliability could not be ascertained because there was no similar programme running in the country at the time and therefore there was no appropriate avenue for testing.

The first evaluation of the educational programme was done at the end of the first ten day workshop. The questionnaire was distributed in class and participants asked to fill them in, in the presence of a research assistant and placed in a sealed box. In the second evaluation the questionnaire was distributed to the various clinics by the research assistant. Each participant was given 1 hour to complete the questionnaire, independently, and deposit it in a sealed box. This was aimed at preventing discussions between participants. All the clinics completed the evaluation on the same day.

(d) Rehabilitation record evaluation

In order to measure the registered nurses performance in rehabilitation planning, a rating scale was designed by Uys (1995b; see Annexure D). This instrument was used to

evaluate the quality of the rehabilitation plans. There were 6 closed ended questions to evaluate the following aspects:

- the ability of participants to identify target symptoms
- clarity and appropriateness of the plan for the patient and for the family.
- clarity of rehabilitation goals
- appropriateness of the steps to achieve the goals
- the level of vocational rehabilitation

Content validity

Content covered all major aspects of rehabilitation as demonstrated in the table below. Extensive literature review on rehabilitation was undertaken. The instrument used for measuring the registered nurses’ performance in planning rehabilitation was designed based on this information. Table 3.7 shows content areas that formed the focus of the evaluation. The extent to which the registered nurses included these areas in terms of the aspects discussed above formed the criteria for evaluation. No reliability testing was done.

Table 3.7 Areas covered by content on rehabilitation

Areas covered in the programme	Items
1. Rehabilitation Diagnosis	4
2. Rehabilitation Plans	5
3. Skills teaching	not evaluated within 6 months
4. Relapse prevention	1, 2 & 3
5. Vocational rehabilitation	6
6. Psycho-education	ongoing

Data was collected from each client file on the ability of the registered nurse to perform the skills as identified in Annexure D. Data was collected after one year and after eighteen months, using the same data collection procedures used for collecting data on diagnosis and treatment.

(e) Consumer satisfaction

The consumer satisfaction evaluation instrument (see Annexure E) is a modified version of the instrument developed by WHO (1993) used to evaluate approaches in mental health. However it was necessary to modify the instrument to ensure relevance for the present study. The instrument had Section A which dealt with the demographic information of the consumer. It consisted of 10 closed ended questions. Section B comprised a series of 5 point rating scales to assess various aspects of access of the psychiatric service, such as:

- . distance
- . technical quality of care
- . communication between nurses and consumers
- . the attitudes of nurses
- . access when the client has no money to travel
- . assistance with transport when ill
- . assistance with tasks of daily living
- . ability to make a choice of treatment and rehabilitation
- . the action of the staff when the client missed the visit
- . an aspect to assess negative attitudes which could discourage the client from making use of the clinic such as favouritism, wrong number of tablets given, nurses discussing clients with other clients and positive aspects such as home visits.

Validity and Reliability

The WHO (1993) argued for the content validity of the instrument based on extensive literature survey. According to the developers of this instrument, it was designed in such a way that it discriminated between the negative and positive response of the service. For this present study no psychometric tests were done.

A research assistant visited the clinics one year post implementation, distributed the questionnaire to any client found in the clinic and any relative of a psychiatric patient who received treatment at that clinic until 2 patients and 2 relatives were evaluated per clinic to a total of 24 evaluations. Questionnaires were used on both clients and their families to fill.

A small number of consumers (n = 24) participated in this aspect of the study in order to examine their perception of the service before and after the implementation of the changes. Consumers who were literate were given the form to fill on their own. Clients who could not read were assisted by the research assistant to complete the form.

3.2.4 Data Analysis Techniques

Illustrations using descriptive statistics in terms of frequencies and percentages were used for the quantitative data. These manifested themselves mainly in the form of pie charts and bar graphs drawn on the Harvard Graphics Computer Programme. Selectively inferential statistics in the form of t-tests were used to test for differences in overall performance in all aspects ie. on diagnosis, referrals, long-term and stat medication between the first and second evaluations. Both the descriptive and inferential statistics were computed using the SAS statistical package available on the University of Transkei's main frame computer system.

Data obtained from the qualitative explanatory statements as well as the patients data on history taking were analysed qualitatively so as to identify patterns from which categories were derived. Once categories were derived frequencies were and percentages were computed.

3.3. ETHICAL CONSIDERATION

Written permission was obtained to conduct the research and to use the files from the Department of Health in Bisho, Department of Health Umtata, Umtata General Hospital and Umtata Municipality (See annexure 6). Although client files were used code names were used for each file for confidentiality. Clinic committees gave permission for implementation of the project in their settings. To maintain anonymity names of participants and clinics used in the study will not be mentioned. Anonymity in responses was maintained as there were no names in all instruments used for evaluation. Individual consent was obtained from each client or a family member, but registered nurse participating in each clinic, based on the full explanation given to the patient and /or family member about the nature of the study.

For each patient seen, a copy of the file was sent to the psychiatrist that formed part of

the backup team within a period of three to four days. Changes were made for safety of the clients but the original file with the initial diagnosis and treatment was sent for evaluation to the evaluators.

The backup team used in this study consisted of the two clinical psychologists, two social workers, two psychiatrists and two psychiatrically trained registered nurses. This team was found in the psychiatric clinic and unit in hospital. A reasonable representative of this team was found after hours in the form of persons on call so that they could be used when there was need. The backup team was responsible for ensuring that errors in diagnosis, and treatment were detected and corrected timeously.

CHAPTER 4 : RESULTS

4.1. INTRODUCTION

In this chapter the results of all case studies and surveys will be given and explained. The results will be presented according to the research questions.

4.2. CASE STUDIES

4.2.1. Introduction

All together six cases are described. Each case has been presented in detail and in terms of information judged to be pertinent to the research questions of this study. The description of cases is made in terms of what Yin (1990:134) refers to as "multiple-case report" containing "multiple narratives. In keeping with this mode of cse study reporting, a "cross - case analysis" (Yin, 1990: 134) is subsequently made following the presentation of all the six cases.

4.2.2 History, Diagnosis and Treatment

4.2.2.1. Sample realization

A total of 54 files were collected in a period of 6 months for the first evaluation and 54 files after one year for the second evaluation. The overall performance in taking history is shown in Figure 4.1. This would enable a comparison of the perfomance of registered nurses over a period of time.

4.2.2.2. Appropriateness of history taken (N=54)

Table 4.1 shows the comparison of performance on first and second evaluation.

Table 4.1. Quality of history taken.

	FIRST EVALUATION	SECOND EVALUATION
All information needed	2%	33%
Minor omissions	34%	56%
Major omissions	56%	11%
Not rated	8%	0%

From the data of the first evaluation 2% of the information collected in history was correct, with 34% of the information having minor omissions; 56% had major omission by the end of 6 months. The results of the second evaluation after 1 year reflect an improvement in the ability of participants to take history. Fifty-six percent of the histories had minor omissions and 33% had all the essential information, thus acceptable histories on which a diagnosis could be made were 33%+56%=89%. This information is further shown in Figure 4.1

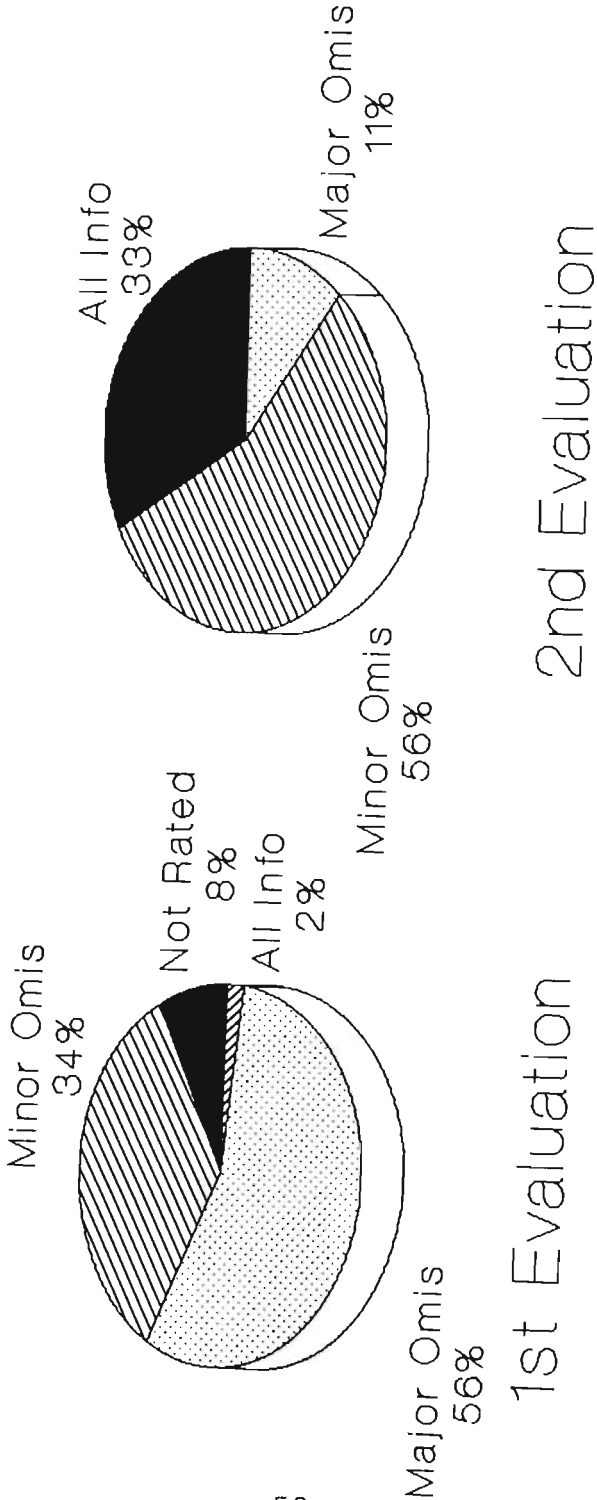


Fig 4.1 Appropriateness of Histories Taken (N=54)

A t-test was performed to ascertain whether or not there was a statistically significant difference in the respondents' performance between the first and second evaluation. In carrying out this comparison the categories of "All information" and "Minor omissions" were combined to indicate the respondents' level of performance. The outcome of comparison is given in Table 4.2

Table 4.2 Statistical comparison on Taking Histories between the first and second evaluation for all respondents across the six participating clinics (N=54)

COMPARISON	MEANS(%)	DIFFERENCE	t_0	t_c	RESULT
First Evaluation	36	52	9.82	2.70	significant (alpha=0.01)
Second Evaluation	89				

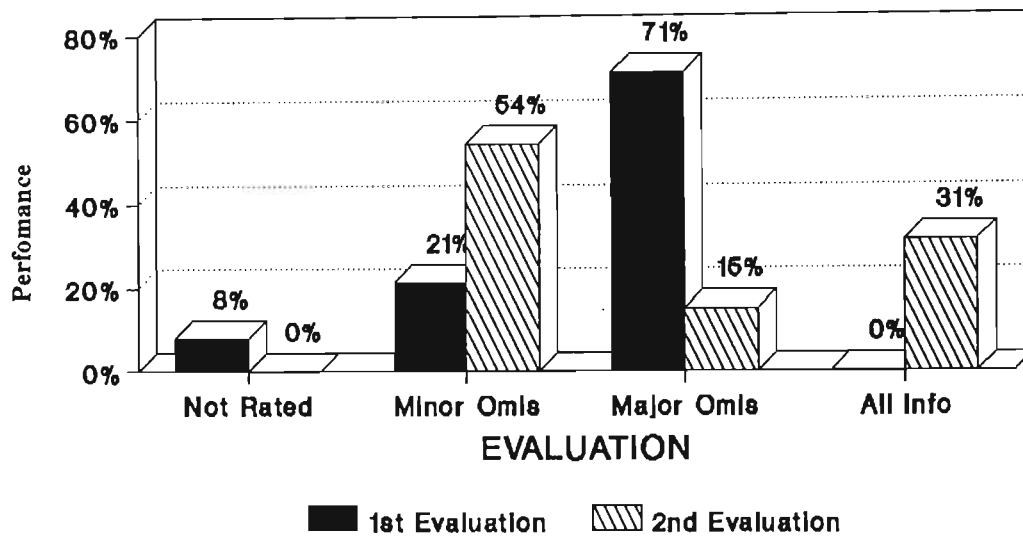
The result indicates that the improvement shown by the respondents between the first and second evaluation was statistically significant at the 99% confidence interval ie. $\alpha=0.01$: and degrees of freedom [df] =52. Overall therefore this indicates that the programme was effective in developing the participants' skills and abilities in taking history from psychiatric patients.

The major omissions in the first evaluation were further analysed qualitatively and categorised into the following aspects as shown in Table 4.3 below:

Table 4.3. Major omissions from history

	PERCENTAGES
Duration of symptoms	27%
Mental state evaluation	25%
Response to previous treatment	7%
Nature and content of hallucinations	5%
Drugs abused	4%
Recent Stressors	4%
Nature of seizures	4%
Previous admissions	3%
Commencement of medication	3%
Previous diagnosis	2%
Compliance to treatment	2%
Duration of symptoms after mentioned incidence	2%
Others which include (functioning between episodes, age, frequency of fits and reasons for operation	12%

The files which were not rated had no information provided. The information in Figure 4.1 is summarised in Table 4.1. It was necessary to analyse the data further in order to determine the performance of individual clinics in history taking as is shown in Figure 4.2. The performance per clinic was analysed and each clinics' performance analysed qualitatively. The results per clinic are shown in Figures 4.2 to 4.7. During this period it was evident that very few patients were ever informed about their diagnosis and even when they are, it is difficult for illiterate people to grasp the medical terms. All these illnesses are classified in traditional terms as mental illness. This was the reason why clients did not know the previous diagnosis which, amounted to 2% of the major omissions. This was taken into account during psycho-education in order to enable the client and his/her family to get a better understanding of the medical terms used to describe their illnesses. Furthermore, clients were advised to keep their records in which the diagnosis and treatment were written so that when a need arises for this information to be given it should be easy to do so.



**Fig 4.2 Appropriateness of Histories taken (N=13)
(Clinic AA1)**

The reason for the performance of individual clinics with poor performance were as follows:

Clinic AA1 had never handled psychiatric patients in the past and needed more time to utilize the interviewing skills to gather information from psychiatric patients. Their attitudes were changing from negative but found it difficult to deal with psychiatric patients. Major omissions were 71% and had 21% minor omissions. None of the files had a complete history taken. During the second evaluation much improvement was shown in the performance. Although minor omissions increased to 54%, major omissions decreased to 15%. Records with all information amounted to 31%.

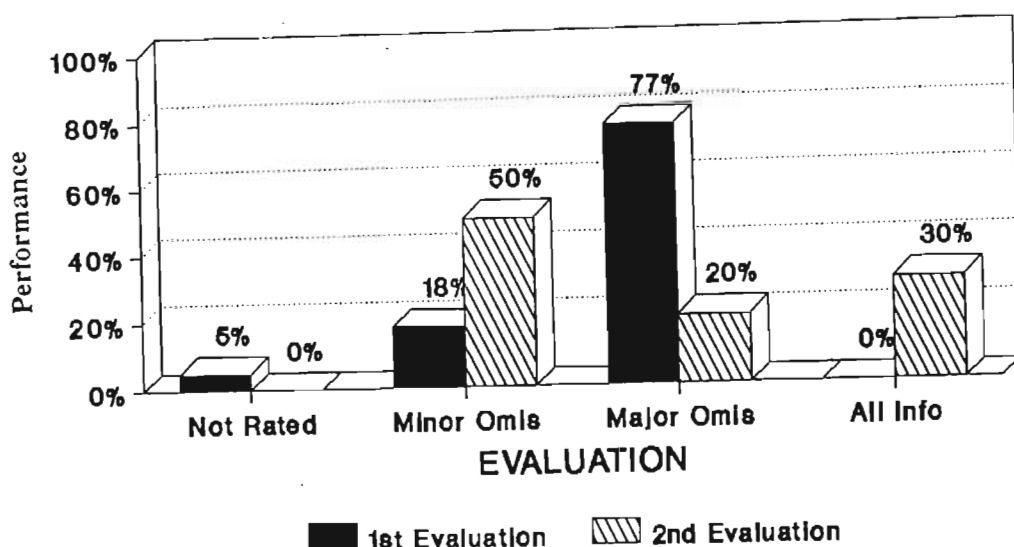


Fig 4.3 Appropriateness of Histories Taken (N=10)
(Clinic AA2)

Clinic AA2

The clinic was grossly understaffed at the time of this study due to transfers of one registered nurse without replacement. The frequent visit of the supervisor was believed to have drawn large numbers of clients to the clinic, which increased the workload of existing staff. This had an effect on the time taken to gather information from clients perceived as difficult. In the first evaluation this clinic had 77% of major omissions, 50% of minor omissions and no complete history was taken.

The second evaluation carried out one year after the commencement of the training is shown in Figure 4.3. The percentage of all information collected increased to 30% and major omissions decreased to 20% while minor omissions increased to 77%. This therefore shows that the total acceptable percentage of history taken increased to 97% within a year. These results were used as the basis of further support by the researcher in the absence of consultations with the hospital due to communication problems. All clinics were given more support to enable participants to increase their confidence as this was a new task to all participants. Clinics were visited once a week to reinforce the skill with the theory needed. The results per clinic after 1 year of implementation reveal much improvement second evaluation as shown in Figures 4.2, to Figures 4.7 .

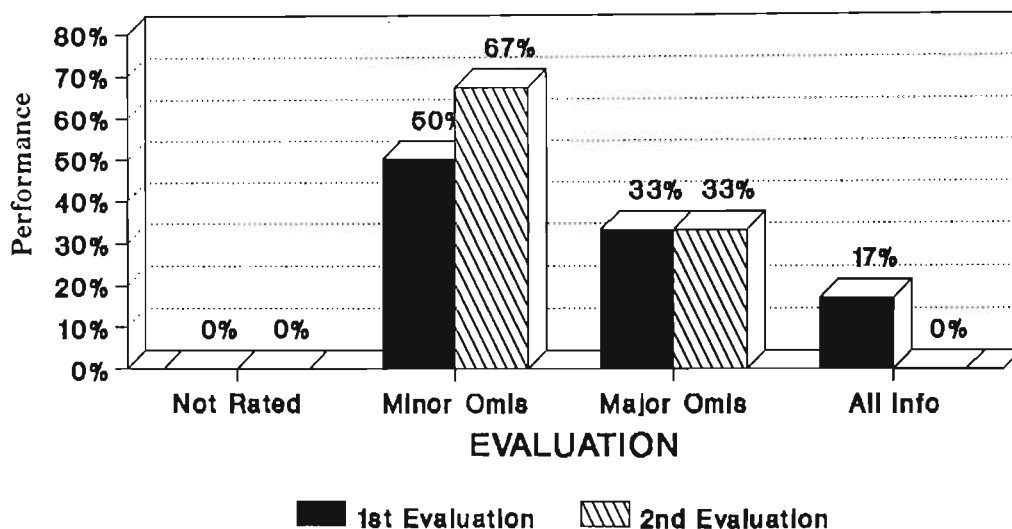


Fig 4.4 Appropriateness of Histories Taken (N=6)
(Clinic AA3)

This clinic performed fairly with 50% of the minor omission on first evaluation which increased to 67% on second evaluation. Major omissions remained 33% for both first and second evaluation. The files in which the information was complete were 17% on the first evaluation. As the minor omissions increased in the second evaluation there was no complete information obtained

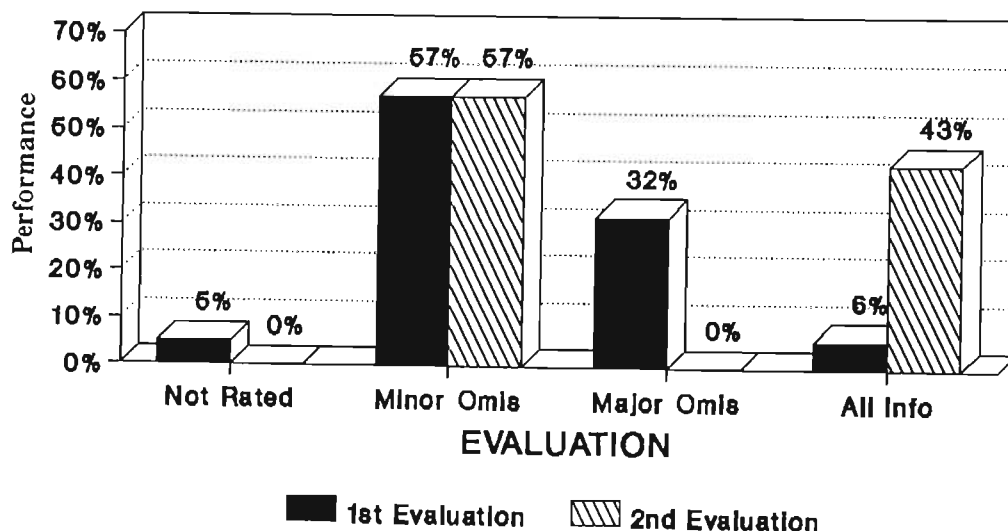


Fig 4.5 Appropriateness of Histories Taken (N=7)
(Clinic AA4)

Major omissions were 32% in the first evaluation and there were no major omissions in the second evaluation. Minor omissions remained 57% in both evaluations. the complete information obtained was 6% in the first evaluation and increased to 43% in the second evaluation. This was regarded as a good performance in the light of the effect of major omissions in the future care of the client.

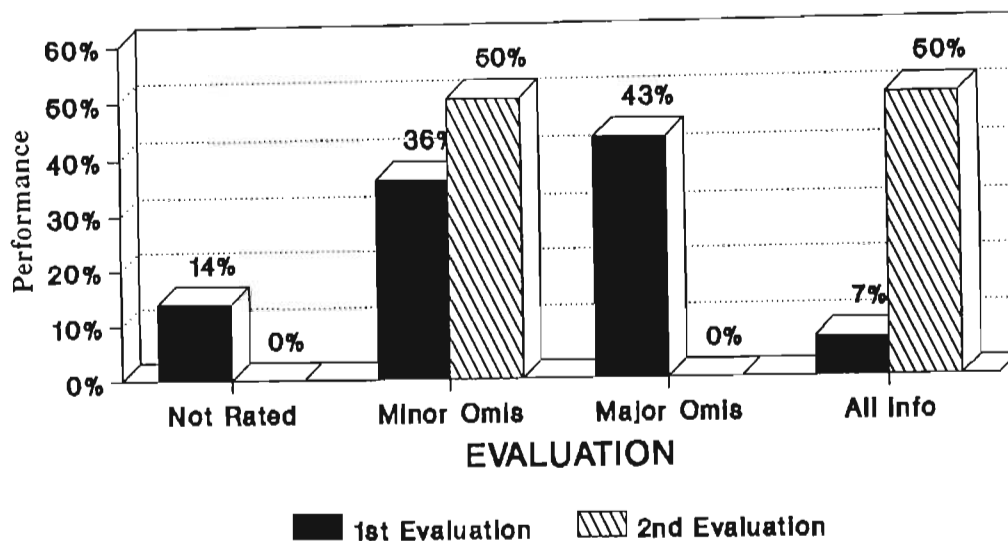


Fig 5.6 Appropriatenes of Histories Taken (N=6)
(Clinic AA5)

Clinic AA5

Major omissions on the first evaluation were 43% of the files evaluated, shown in Figure 4.6. Participating nurses experienced a lot of negative practises from their colleagues. There were complaints about the length of time participants spent on each client. As a compromise for the time, they were not comfortable enough to give more time to their clients. Meetings with the rest of the staff by the researcher increased the staff understanding on the nature of the psychiatric history and its importance in the future management of a clients. This support was very effective on the ability of the participants. After one year no major omissions were found in the histories taken.

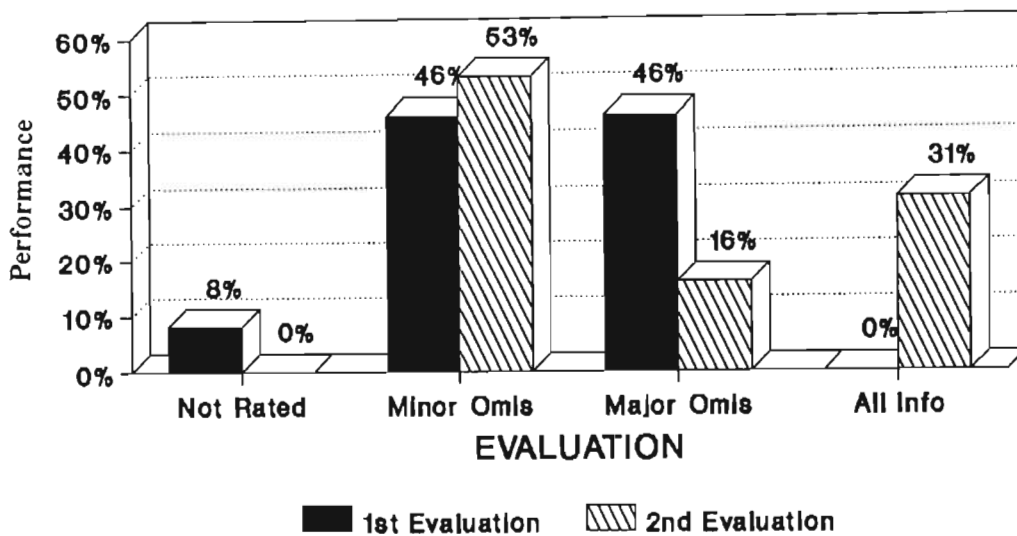


Fig 4.7 Appropriateness of Histories Taken (N=13)
(Clinic AA6)

Clinic AA6

Major omissions as shown in the results in Figure 4.7, amounted to 46% of the files reviewed. The major problem identified in this clinic was the high rate of absenteeism amongst the enrolled nurses and nursing assistants which increased the workload of participants. They were expected to attend to physically ill patients first before attending to psychiatric patients - a practice they rejected from the suggestion of their colleagues. One of the registered nurses not involved in the project had a plaster of paris as a treatment from the potts fracture, a factor that prevented her from functioning effectively. Increased support and consultations made an improvement and contributed to the decrease of major omissions to 16% in one year. The correct diagnosis depends on the quality of the history taken. Poor and insufficient history led to incorrect diagnosis from the results shown. Vague history does not give enough grounds for a diagnosis to be given. Participants demonstrated a good ability to give a diagnosis according to the DSM IV criteria, in 78% of the files in one year. This made it easy for participants to treat both physical and psychiatric condition.

4.2.2.3. Appropriateness of Diagnosis according to 5 Axes

This refers to the correct information recorded under each axis according to the history of the patient.

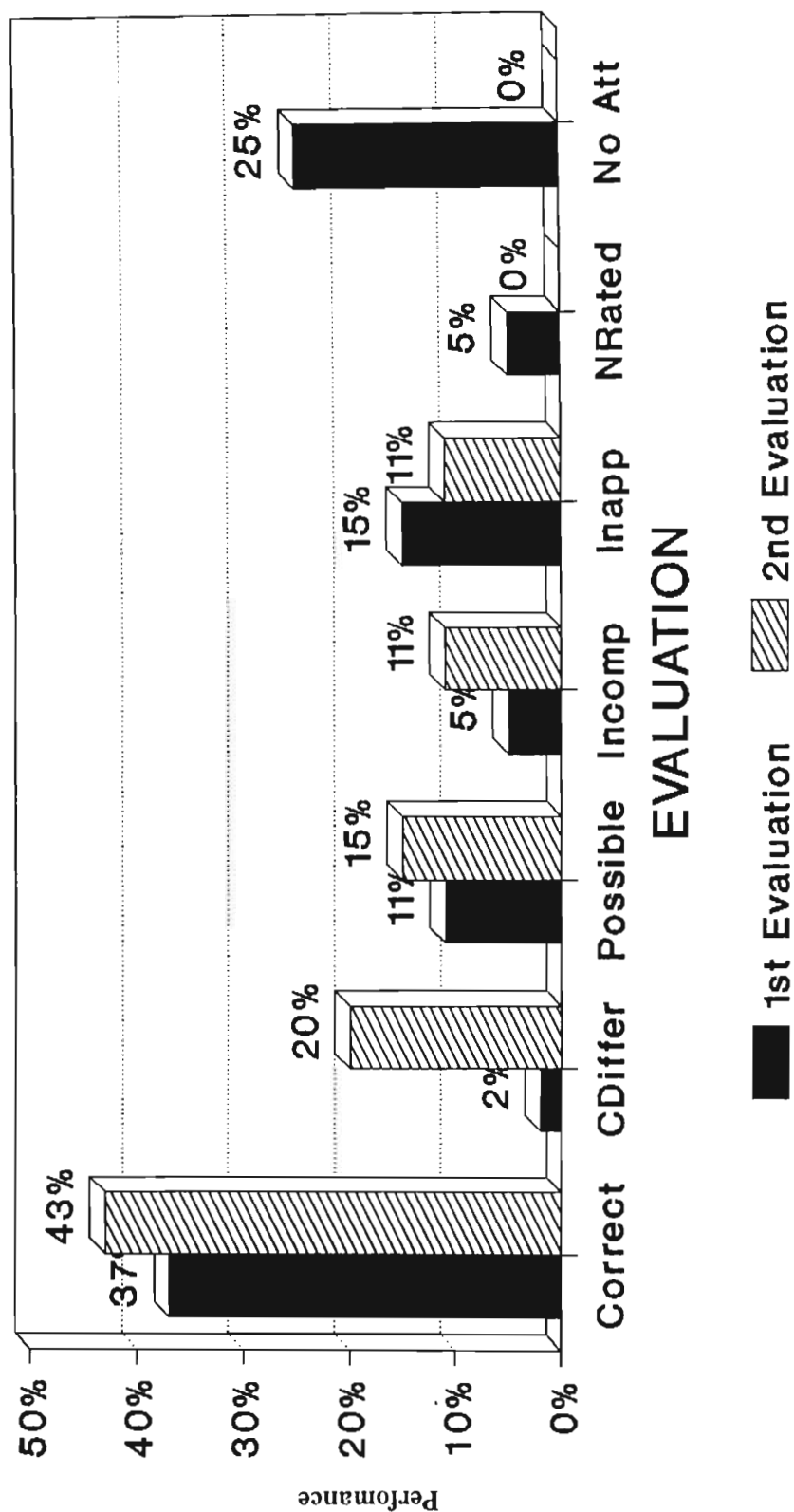


Fig 4.8 Overall Performance on all Axes (N=54)

The overall performance of all clinics in the first evaluation demonstrated that 37% of the diagnosis given were Correct; 2% Could Differ but were correct, 11% were Possible, although there were insufficient grounds to warrant the diagnosis. The total correct diagnosis was 50%. A further 5% had incomplete information to make a diagnosis; 15% of the diagnoses given were inappropriate; 5% were not rated by the evaluator and 25% were not attempted as shown in Figure 4.8. Further analysis of the inappropriate diagnoses revealed that on all incomplete histories it was difficult to give a correct diagnosis. From further analysis of the files not attempted, it was revealed that when participants were not sure of the diagnosis per axis they left the space blank.

In the second evaluation the percentage of correct diagnosis increased to 43% with 20% Could Differ and 15% Possible to a total of 78% acceptable diagnosis. Only 11% were not appropriate. This information is shown as second evaluation in Figure 4.8.

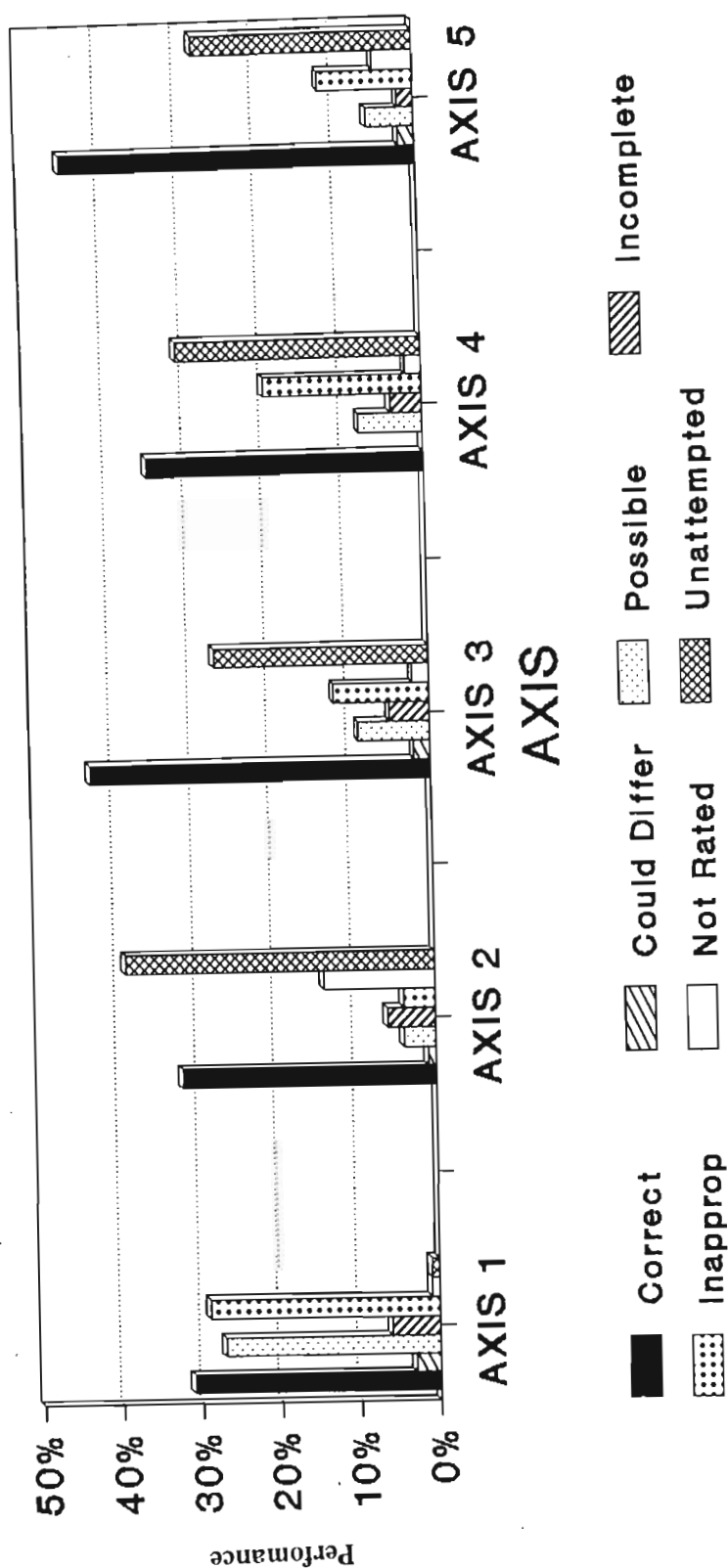


Fig 4.9 Performance on Each Axis (N=54)
First Evaluation

The performance of all respondents on each axis demonstrates that the overall performance in Axis 3 and 5 was better than the rest of the axes as shown in Figure 4.9. The information reported reflects the performance of respondents on each axis. This

information shed light on which axes were well understood and those that were problematic to the participants.

The performance of each clinic is shown in Figure 4.10 to Figure 4.14 in which the performance is shown according to each axes. Some participants gave vague incomplete and unsupported diagnosis. Participants left 25% of files not attempted in various areas of the DSM IV diagnosis while the evaluator left 5% of files not rated.

The second evaluation shows an increase in the correct diagnosis given from 37% to 43%. Diagnosis that could differ increased to 20% and possible 15% as compared to the first evaluation. There was a decrease in the inappropriate diagnosis from 15% to 11%. All files had been attempted by participants and rated by the evaluator as shown in Figure 4.8 second evaluation.

A t-test was performed to compare the respondents acceptable level of performance on all the five axes taken together between the first and second evaluations. As stated above, the acceptable levels of performance were those rated in the three categories of **correct**, **could differ** and **possible**. The outcome of this comparison is presented in Table 4.4.

Table 4.4 Statistical comparison between the first and second evaluations on all axes (N=54)

COMPARISON	MEANS(%)	DIFFERENCE	t ₀	t _c	RESULT
First Evaluation	50	52	6.43	2.70	significant (alpha=0.01)
Second Evaluation	78				

Table 4.4 shows that there was a statistically significant difference between the first and second evaluation. this indicates a statistically significant improvement in the participants' skills and abilities across the five axes taken together. This is an important finding in that it suggest that the programme significantly enhanced the development of the necessary skills of the participants.

Much details were important to be able to analyse all the individual axis to determine the strenghts and weakness of the participants in rating the diagnosis according to the 5 axis.

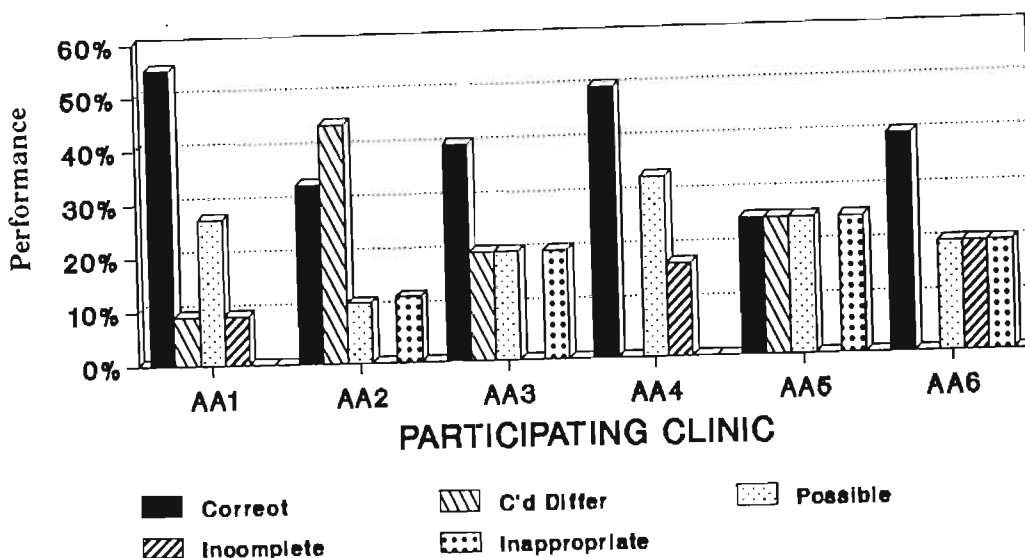


Fig 4.10 Performance on Axis 1 (N=54)
Second Evaluation

Axis I

This is a clinical syndrome and participants were expected to specify the clinical syndrome identified. In the first evaluation 31% of the respondents gave a correct diagnosis while 29% gave an inappropriate diagnosis as shown in Figure 4.9.

Performance of individual clinics was evaluated as a means of identifying which case had which problem in giving a diagnosis according to the 5 axes in the first and second evaluations. This was aimed at looking at the individual cases instead of all cases taken together. Cases improved differently. The overall performance of all cases on Axis I revealed a poor performance as compared to their performance on other axes. The diagnostic criteria was further re-inforced as participants lacked specificity in giving the clinical syndromes. An example of this was the tendency to give mood disorder or schizophrenia as a clinical syndrome without explaining the specific type. Inappropriate diagnosis was as a result of poor history. In Axis 1, second evaluation, Clinics AA5 and AA2 performed poorly at 25% and 32%, respectively. Through consultations during the researcher's visits these two clinics gained more information.

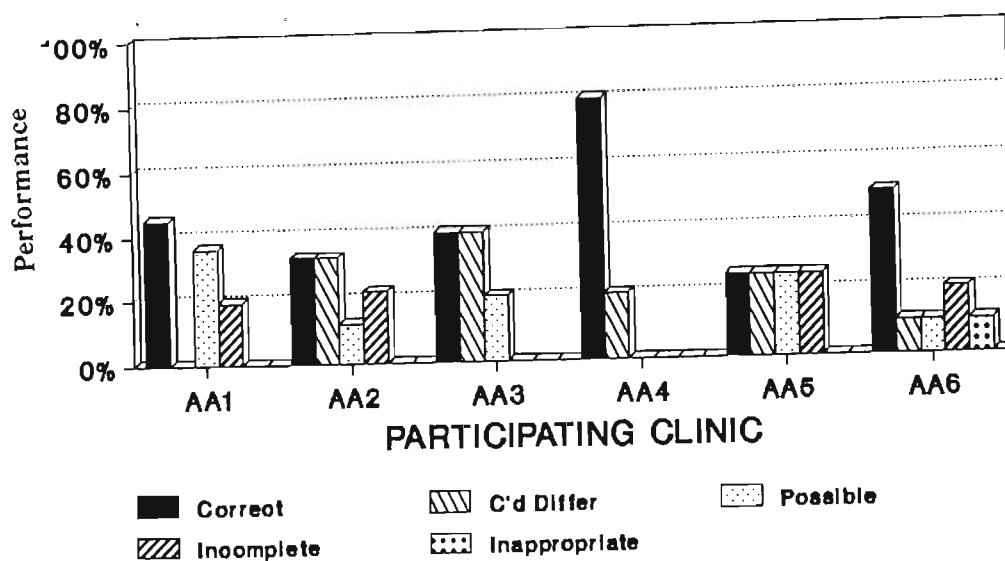


Fig 4.11 Performance on Axis 2 (N=54)
Second Evaluation

Axis II

32% of the diagnoses were Correct, 39% were not attempted by the participants while 14% were not rated by the evaluator. Participants identified mental retardation correctly but had a problem in diagnosing personality disorders. The high percentage of unattempted diagnoses is a result of poor recording. Where the history of the client did not reveal the presence of either mental retardation or personality disorder, participants left a blank space. A significant percentage left this part blank when there were no signs of personality disorders or mental retardation, giving rise to a rating of "unattempted". To correct this, participants were asked to indicate whenever this was not applicable. The results are shown in Figure 4.9. It was shown in the qualitative analysis of Figure 4.9 that most participants had a difficulty in identifying behaviours related to this axis.

On the second evaluation each clinic was analysed. Clinics AA3, AA2 and AA5 performed poorly at 40%, 27% and 23%, respectively. An exceptional performance was shown by Clinic AA4 at 80%. Clinics AA6 and AA1 performed fairly at 46% and 42%, respectively. This information is shown in Figure 4.11.

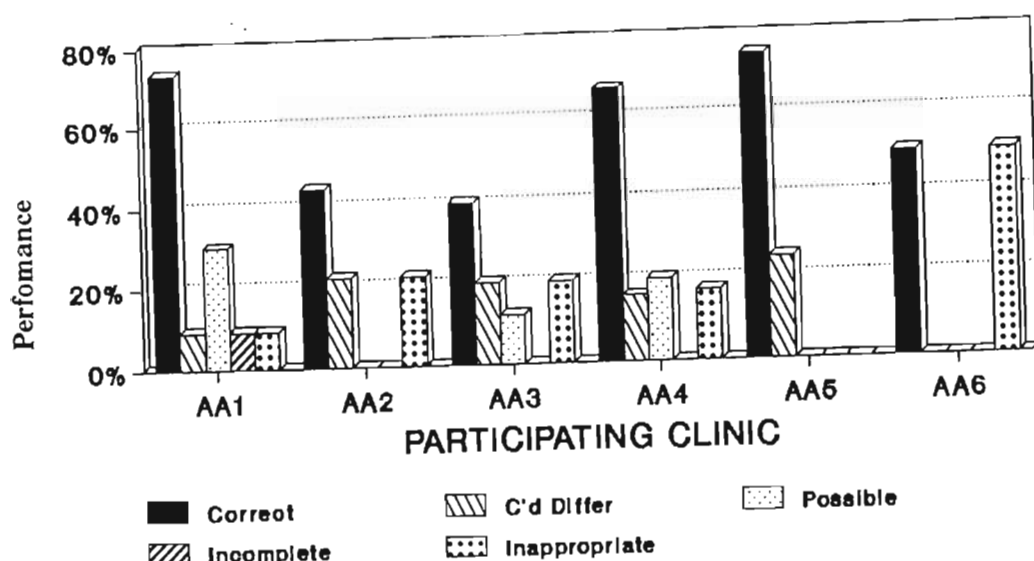


Fig 4.12 Performance on Axis 3 (N=54)
Second Evaluation

Axis III

This was fairly done as all participants were general nurses and were therefore, able to identify a physical illness. Figure 4.9 shows that 42% of the participants gave a correct diagnosis. This is a result of the participants previous experience in diagnosing physical illness. This performance was reinforced through supervision and consultation by the researcher. Since participants were all general nurses, it was easier for them to develop insight into the existence of physical illness, either as a result of mental illness or with mental illness. Their difficulty was mainly in prescribing medication for fear of untoward reactions from combined medications. Pamphlets from the pharmaceuticals which specified which drugs may not be given together were provided to participants. In Axis III Clinics AA3 and AA2 performed more poorly than the rest of the clinics at 40% and 42% respectively; Clinic AA6 performed at 45% and Clinic AA4 at 63%; both Clinic AA5 and AA1 performed at 72%. This information is shown in Figure 4.12.

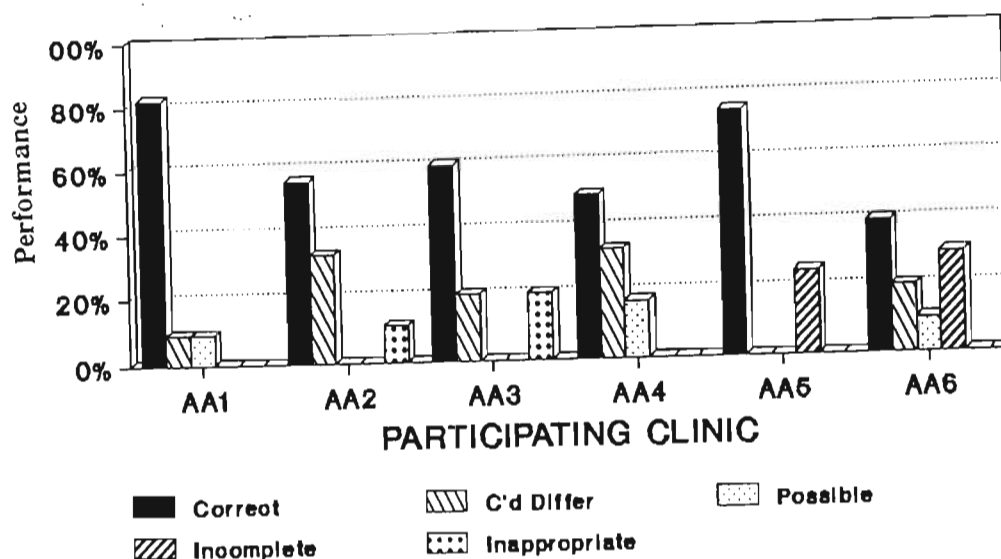


Fig 4.13 Performance on Axis 4 (N=54)
Second Evaluation

Axis IV

The results show that 35% files were correct and 20% were inappropriate. Participants did not relate the illness with a recent stressor but with a stressor occurred long before the illness. The identified stressors were in the form of loss of a loved one through death separation or divorce. Work related stressor and school performance related stressors were not identified. Information on stress and its effects was discussed. It was also important for participants to look for factors from the patients environment that may trigger the illness. Although participants could identify psychosocial stressors, 20% of inappropriate diagnosis were based more on the past stressors that had nothing to do with present attack and ignored recent stressors. The 31% of participants left this part blank when they failed to identify stressors in the clients life. Clinic AA6, AA4 and AA2 performed poorly than the rest of the clinics at 40%, 50% and 48%, respectively. The rest of the clinics performed above 60%. This information is shown in Figure 4.13

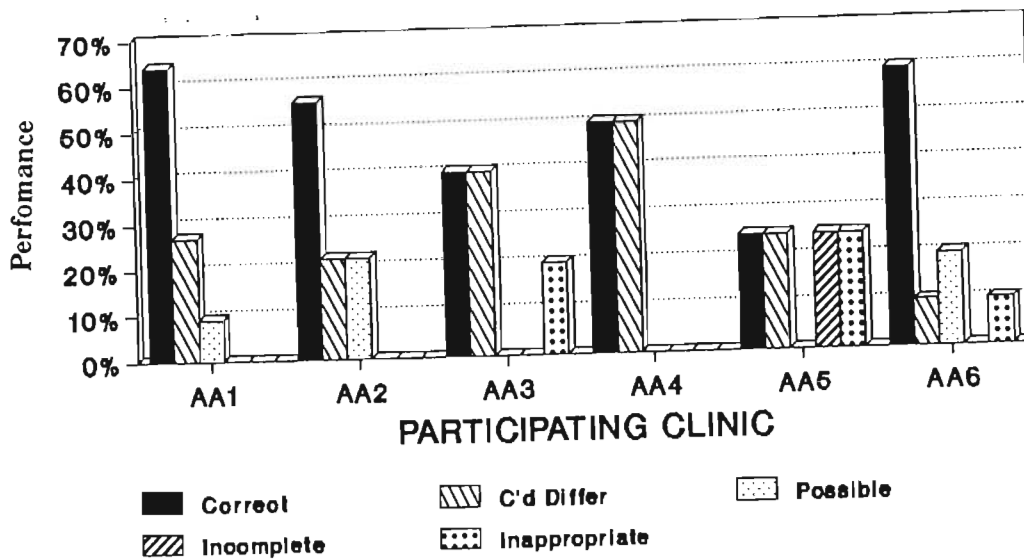


Fig 4.14 Performance on Axis 5 (N=54)
Second Evaluation

Axis V

Of all the Axes this was fairly done at 45% - a good basis for rehabilitation, although 28% of the respondents made no attempt to rate the level of functioning. Clinics AA5 and AA3 performed at 25% and 40%, respectively, while Clinic AA4 performed at 50%. The remaining clinics performed well at between 55% and 65%. This information is shown in Figure 4.14.

Finally the performance of individual clinics on each axis revealed the areas of concern per clinic. Remedial education and support enabled the participants to deal with their areas of concern. As the participants learnt more about giving a diagnosis their confidence was increased.

4.2.2.4. Appropriateness of Stat Medication

Stat medication is the prescribed drug and dose at the beginning of the treatment until it is reviewed. Stat medication depends on the correct and complete history taken to give an appropriate diagnosis so that a sound choice of a drug is made. Figure 4.15 shows that in the first evaluation 11% of the files had a correct stat medication, 25% could be better, 21% were inappropriate and 43% were not stated. All incorrect diagnoses were due to insufficient histories taken and had an inappropriate medication prescribed. Only 2 files

had a correct diagnosis but inappropriate medication. Prescriptions that could be better were either sub-therapeutic but correct or were an alternative in the absence of the drug of choice. An example is the prescription of largactil when according to history the patient could benefit better from fluanxol. Most of the psychotropic drugs suggested as preferable in the initial stages of treatment were not available even at the central pharmaceutical suppliers. Accordingly participants prescribed what was easily available and commonly used. In the 43% of the cases in which stat treatment was not stated - the diagnosis was mental retardation and no medication had been prescribed for behaviour problems. In addition when there were both physical illness and mental illness no provision was made for the treatment of the physical condition, e.g. addition of vitamins in the presence of avitaminosis common in the patients who wander from place to place with poor nutrition.

From the above data it may be said that $25\% + 11\% = 36\%$ was acceptable stat treatment. The 21% incorrect stat medication was due to either an incomplete history taken leading to an incorrect diagnosis or inability to give a diagnosis. Participants' performance could be improved from 25% higher. This percentage was due to the fact that most nurses prescribed a correct drug but a small dose. General nurses are not used to the large doses of psychotropic drugs used in the treatment of psychiatric illness and tend to prescribe sub therapeutic doses. With improved confidence the ability to make sound treatment decisions and knowledge about the therapeutic doses and side effects of these drugs the performance improved dramatically as shown in Figure 4.15 first evaluation.

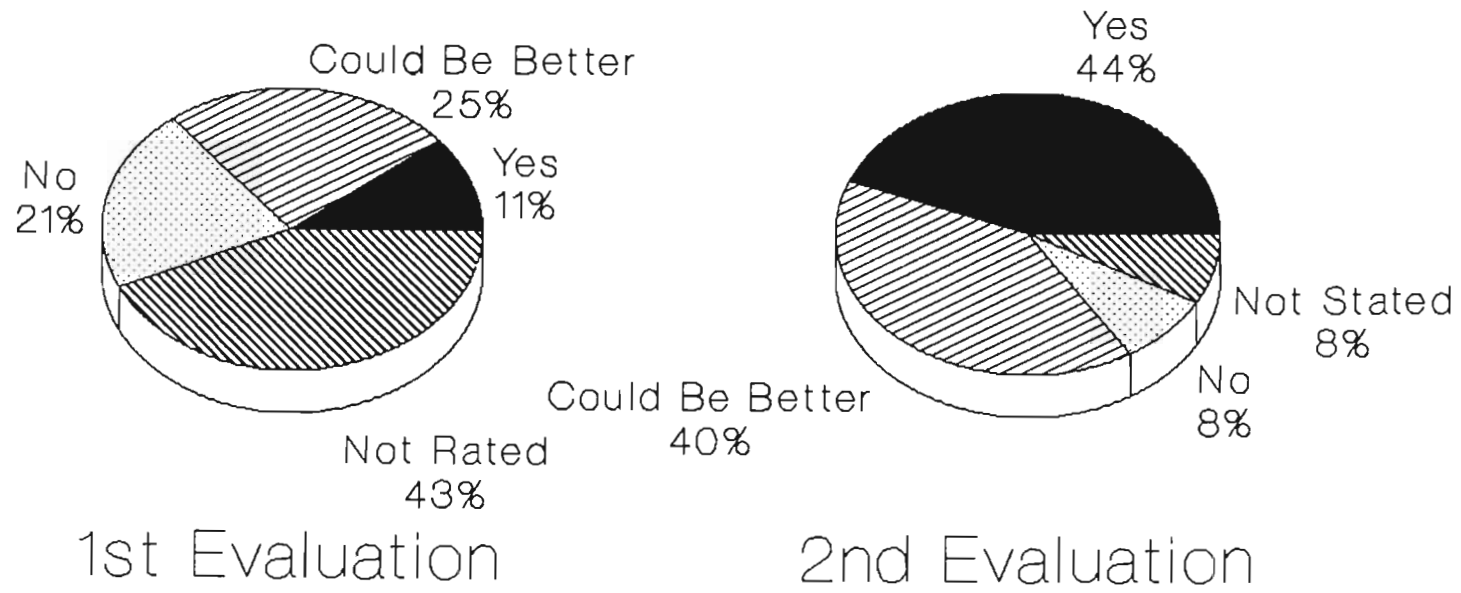


Fig 4.15 Appropriateness of Stat Medication (N=54)

During remedial teaching to individual cases it was also discovered that participants prescribed what was available to them as there were not enough drug supplies especially phenothiazines. Clinics received one type of phenothiazines, e.g. Largactil in the tablet form or Modecate while others were supplied with melleril and modecate. It was therefore difficult for the participant to make an informed choice. The only antidepressant commonly available was Tophranil. This was due to the process of integration of the previous three Departments of Health (Transkei, Ciskei and Eastern Cape), as well as other administrative problems inherited from these previous Departments.

This picture improved a year after, as nurses gained more skill and knowledge from the referrals and from individual consultations, as shown in Figure 4.15 : second evaluation in which 44% of stat medication was correct, 40% could have been better giving a total of 84% acceptable stat medication. Only 8% was not appropriate. This is shown as second evaluation in the same figure

There was a dramatic decrease of medication not stated from 43% in 6 months to 8% in 1 year. Many factors were taken into consideration such as:

- * the appropriateness of the reason given for change.
- * the appropriateness of the change.
- * whether the change that was supposed to be made was made at.

The improvement in the prescription of stat medication was subjected to a statistical test for significance yielding the findings in Table 4.5.

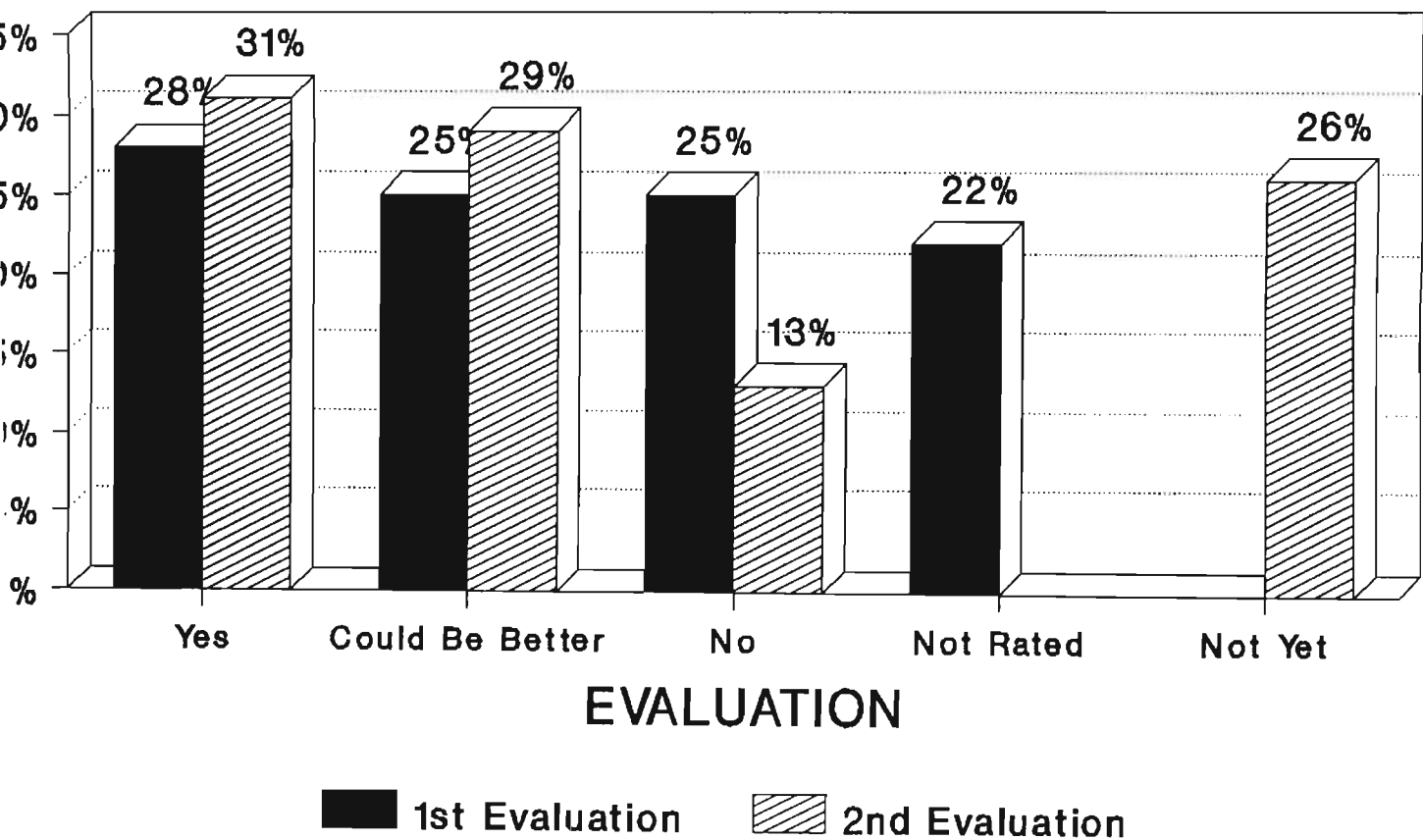
Table 4.5 Improvement in prescription of Stat Medication between the first and second Evaluations

COMPARISON	MEAN(%)	DIFFERENCE	t_c	t_c	RESULT
First Evaluation	36	52	15.28	2.70	Significant (alpha=0.01)
Second Evaluation	84				

Indeed, the above findings indicate a statistically significant improvement in the participants' skills by the time the second evaluations were conducted as compared with their level of performance at the beginning of the programme.

4.2.2.5 Appropriateness of long term medication

Participants were expected to adjust the treatment to a drug dose on which the client could be treated on long term. Figure 4.16 shows the overall performance of all clinics on first and second evaluations. The inappropriate long term medication resulted from incomplete history, leading to incorrect diagnosis and incorrect long term medication. As drug supplies continued to be unavailable, participants prescribed what was easily available. This increased the percentage of Could Be Better from 25% to 29% with little change in the correct long term medication on the first evaluation from 28% to 31% on second evaluation. Not Rated refers to files which were records in which the treatment was not due for adjustment, which constituted 22% of the total files as compared to 26% in the second evaluation recorded as "not yet".



Appropriateness of Long-term Medication (N=54)

As a result of the previous experience of most participants in managing clients on long term treatment it was easier to maintain clients on an appropriate dose. Therefore the performance of each case on the choice of a type of maintenance drug was influenced by the availability of that specific drug. It was difficult to evaluate the ability of participants on the choice of the drug.

In the overall performance of all clinics it was evident that participants were used to long term doses of medication since all clients in their care were on maintenance dose. The performance as seen in Table 4.6 shows the following information:

Table 4.6 Appropriateness of long term medication

Rating	% gained
Correct	28%
Could be better	25%
Not rated	22%
Incorrect	25%
Total acceptable	53%

In the case of "Not Yet" as shown in Figure 4.16 the evaluator supported the decision from the history and the progress of the client that it was still premature for treatment to be adjusted. The 25% of the sample recorded as " could have been better" indicated that participants reduced the dose to either slowly or drastically according to patients progress. The performance of individual clinics demonstrates the difficulty experienced by participants in getting appropriate drugs for long term treatment shown by the percentage of "could be better " in the first six months (Fig 4.17) and in one year (Fig 4.18).

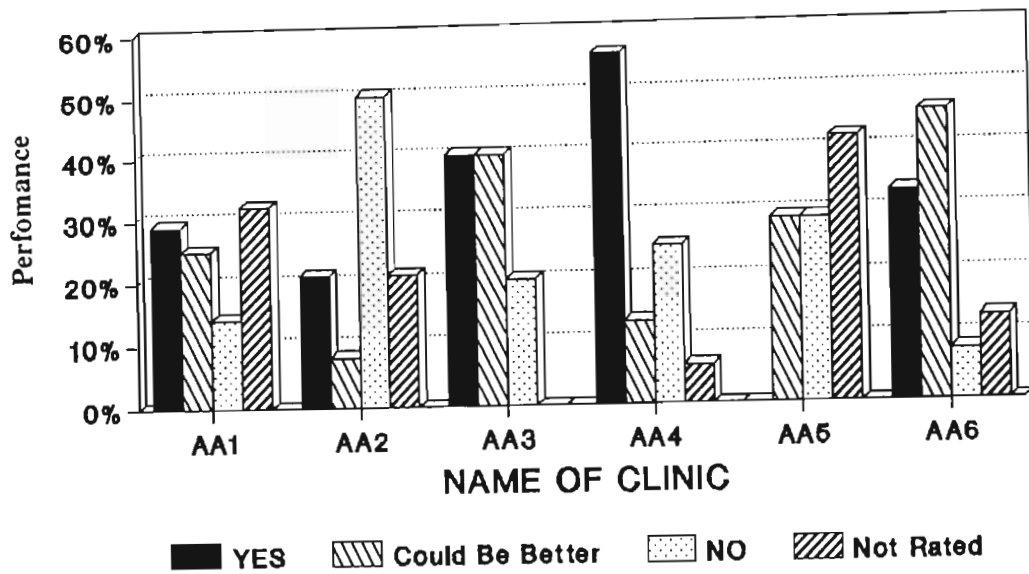


Fig 4.17 Appropriateness of Long-term Medication (N=54)
First Evaluation

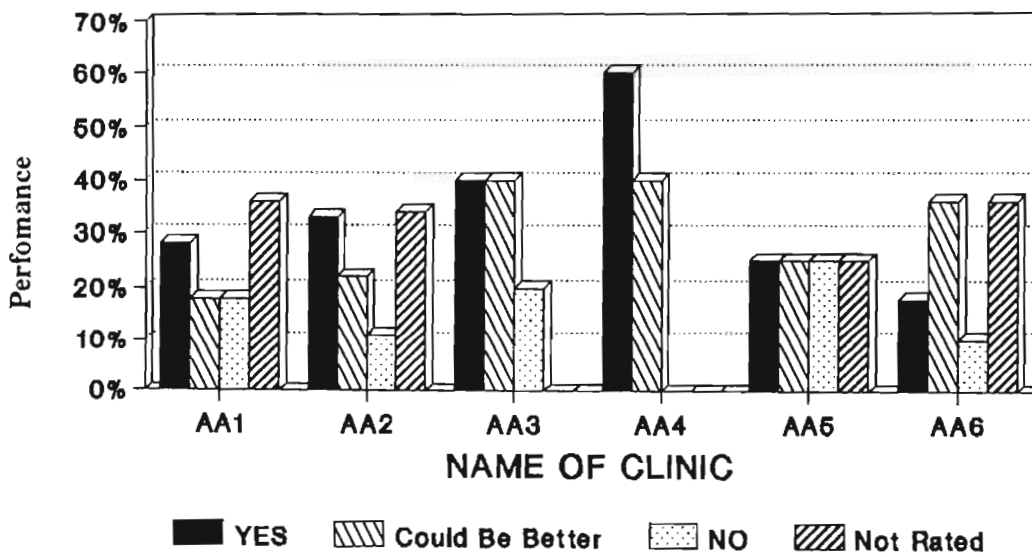


Fig 4.18 Appropriateness of Long-term Medication (N=54)
Second Evaluation

4.2.3 Quality of referrals

Sample description

A total of 27 referrals were collected to form a sample in the first 6 months. This was possible as participants were not yet confident of themselves. In the second evaluation only 12 referrals were obtained over a period of 9 months. Table 4.7 shows the number and percentage of referrals for the first six months and second six months.. This table shows that the number of referrals decreased as the participants gained confidence and skill in dealing with psychiatric patients.

Table 4.7. Quality of referrals

1ST EVALUATION (N=27)			2ND EVALUATION (N=12)		
TOTAL = 27	FREQUENCY	%	TOTAL = 12	FREQUENCY	%
Correct	23	85	Correct	11	92
Acceptable	2	7	Acceptable	1	8
Inappropriate	2	7	Inappropriate	0	-

In Figure 4.19 first evaluation, 86% of the referrals were correct while this percentage increased in the second evaluation to 92%. Only 7% of the referrals were inappropriate in the first evaluation while all the referrals were correct in the second evaluation.

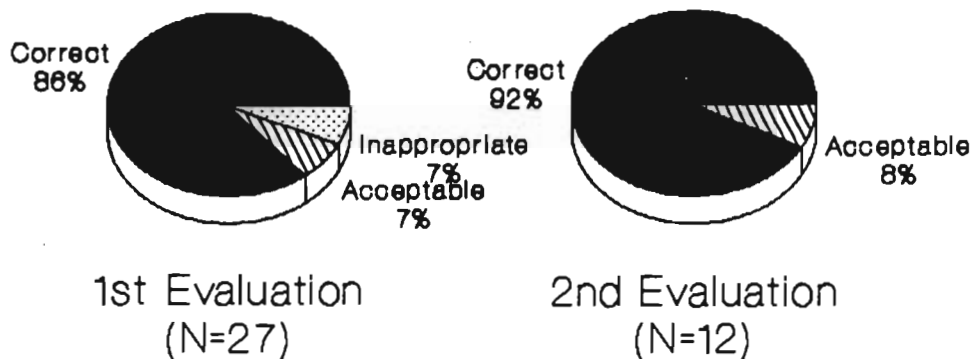


Fig 4.19 Quality of Referrals

The inappropriate referrals resulted from:

- * failure to give a clear reason for referral.
- * referral for an incorrect reason which could have been solved through consultation.
- * referral to a wrong person e.g. referring a mentally retarded person to a psychiatrist for I.Q. assessment.

The reasons for referral of clients were the following:

- * To apply for disability grant from the social worker
- * When the nurse was unsure of the diagnosis of the client
- * When the nurse unsure of symptoms
- * Epileptic clients with psychosis
- * Alcoholic patients for detoxification
- * Mentally retarded persons for I.Q. assessment in preparation for decisions on rehabilitation
- * Children who displayed childhood disorders
- * Cases of depression with suicidal ideas
- * Clients with acute aggressive episodes

The following sources and numbers of referrals were identified in the first and second evaluation are shown in Table 4.8

Table 4.8. Sources and numbers of referrals

FIRST 6 MONTHS	SECOND 6 MONTHS
Clinic AA1 = 17	Clinic AA3 = 3
Clinic AA2 = 2	Clinic AA1 = 4
Clinic AA3 = 3	Clinic AA6 = 3
Clinic AA4 = 3	Clinic AA4 = 1
Clinic AA5 = 2	
Clinic AA6 = 2	

The respondents' performance on the quality of referrals between the first and second evaluations did not yealed the statistically significant gains. These findings are summarised in Table 4.9.

Table 4.9 Quality of Referrals (N=39)

COMPARISON	MEAN(%)	DIFFERENCE	t _c	t _c	RESULT
First Evaluation	86	37	2.23	2.75	not significant (alpha=0.01)
Second Evaluation	92				

This picture confirms the explanation given on the performance of the registered nurses in the first evaluation that the referrals have been part of the registered nurses' work even before the project in both the Municipality clinics as well as the government clinics. The tool that was used is the original form they used on daily basis. Few areas needed to be improved in their ability such as making decisions on which client to refer and to whom to refer.

4.2.4. Qualities of rehabilitation diagnosis and rehabilitation plans

4.2.4.1 Sample

A total of 42 files formed the sample. These files were purposively selected from files of clients who visited the clinic regularly for rehabilitation and review. Most clients were not consistent due to problems experienced with medication supplies. Rehabilitation was discussed with the client and family during the clients' visit to clinic for review and with relatives. Relatives gave the report of the clients' progress on every visit.

4.2.4.2 Identification of Target Symptoms

From the first visit, participants identified the first indicative symptoms of the illness with the client and family. The family and client were educated to continually observe for the appearance of these symptoms as an indication the relapse of the client. These symptoms were the target on which the rehabilitation plans were centred. The first evaluation was done after 1 year of implementation of phase 2 (March 1996) and the second evaluation at 6 month after the first evaluation (October 1996).

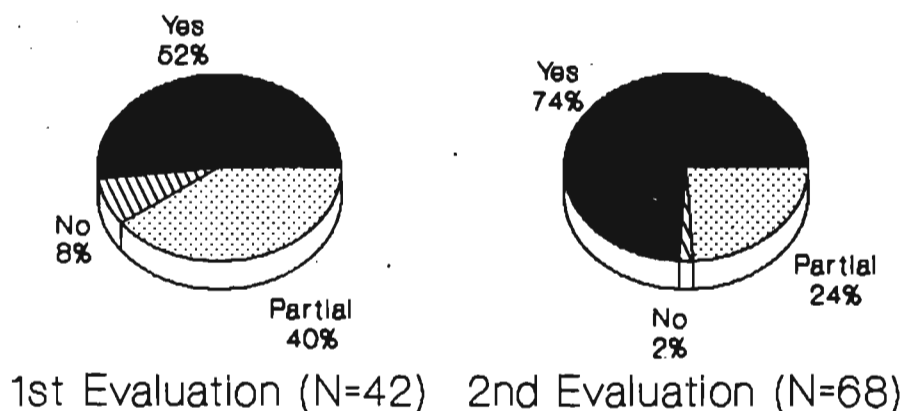


Fig 4.20 Performance on the Identification of Symptoms

The results as shown in Figure 4.20 reflect that in 52% of the files target symptoms were clearly identified and in 40% of the files the target symptoms were partially identified. Only 8% had incorrectly identified target symptoms. In these files participants could not obtain sufficient information in order to make rehabilitation plans. In the second evaluation 74% had clearly identified target symptoms while in 24% target symptoms were partially identified.

4.2.4.3 Plans for the patient retarget symptoms

Participants were expected to set out a clear plan for the patient to follow when target symptoms appeared. It was emphasized that these plans must be realistic, practical and implementable. This was a difficult task for all nurses. The plans set were not clear and did not target the symptoms presented. With more exposure and exercises participants could develop a better plan to assist the family. Plans involved steps to be taken if symptoms appeared at night or at work. This enabled the clients to identify unacceptable behaviours they presented, and planned for better methods of dealing with target symptoms. The overall results show that 43% of the files had a clear plan for the patient,

45% had an incomplete plan while only 12% had an incorrect plan in the first evaluation. Nurses were encouraged to revise the rehabilitation plans with the family and client on every visit. The second evaluation shows that 75% of the records had a correct plan for the patient, 23% had a partially complete plan while only 2% had an incorrect plan. This information is shown in Figure 4.21.

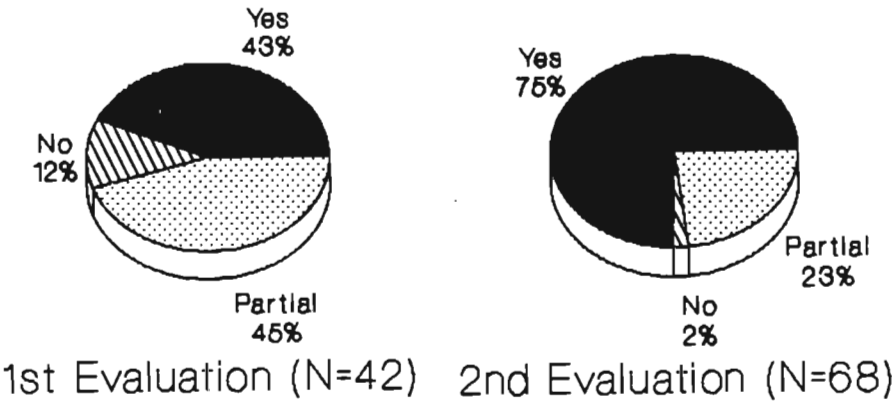


Fig 4.21 Plan for the Patient - re-target symptoms

4.2.4.4 Plan for the family retarget symptoms

Family members are the caregivers in a home. Families caring for the mentally ill persons need to be equipped enough to deal with the distressing symptoms of mental illness. To achieve success, a team consisting of the client, family and health care providers must be set for each client. Psycho-education and counselling assist the family to develop awareness of the nature of the clients' illness. Questions asked by the family must be clearly answered to deal with conflicts and concerns related to the care and rehabilitation. Expectations of the family must be discussed in details and unrealistic expectations clarified with the client and family. This demands a lot of courage and support so that the families are enthusiastic in taking over the caring role. Plans set must be aimed at assisting the family in times of stress and on a day to day basis. Family strengths are developed and their weakness strengthened through psycho-education and counselling.

The overall performance as shown in Figure 4.22 shows that 51% of the files had a correct plan for the family while 43% had a partially correct plan and only 6% had an unrealistic plan.

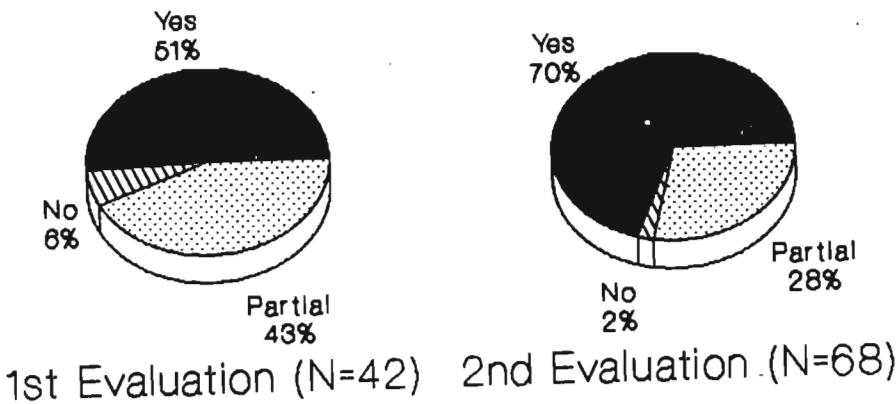


Fig 4.22 Plan for Family - re-target symptoms

4.2.4.5 Setting rehabilitation goals

Nurses were expected to set realistic goals with the client and the family. The goals were determined on the basis of what the client wanted to achieve and what the relatives wanted the patient to achieve. These goals were aimed at assisting the client to be able to function within the environment in which he/she lives. The level of independence depended on what the client was able to learn from his/her relative and his/her environment. Steps to achieve the set goals were determined by the patient and relatives, supported and guided by the nurse. It was clear that goal setting was a difficult task for the nurses. To prevent unrealistic expectations from relatives, nurses started with goals related to meeting basic needs such as cleanliness of self and the environment, food preparation and eating habits and then extended to household work. Clients who did not need this skill were taught how to look for work, work - related behaviours, working in a group, developing vocational skills and management of money.

Figure 4.23 shows that only 14% of the files had clear goals set while 77% had partially set goals and only 9% had incorrect goals in the first evaluation. There was a great improvement shown in the second evaluation in the same figure. 78% had clearly set goals with only 21% displayed partially set goals.

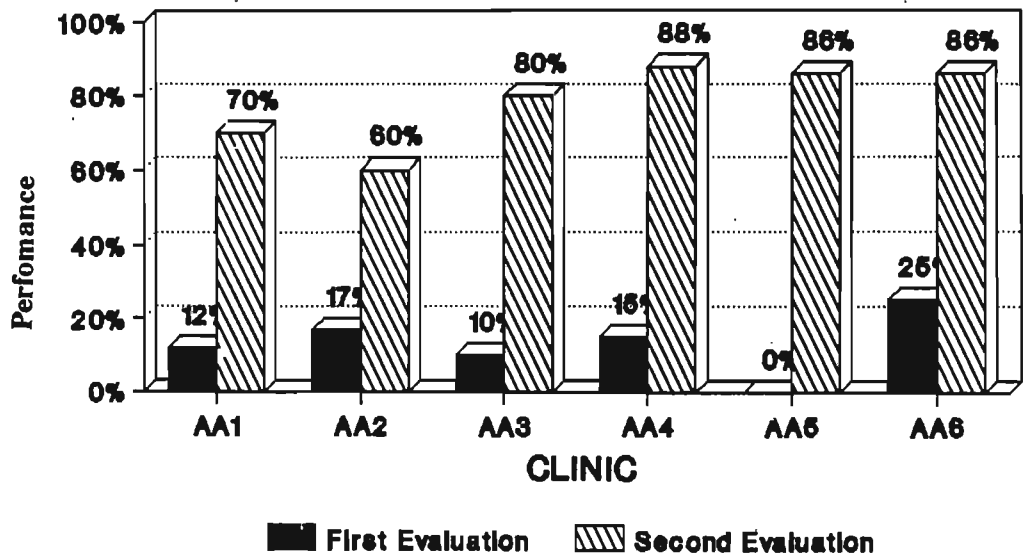


Fig 4.23 Goal Setting Skills Per Clinic

The ability of each clinic in setting goals was of importance due to the poor performance as shown in Figure 4.23. In all clinics in the first evaluation this skill was poorly performed ranging between 12% and 25%.

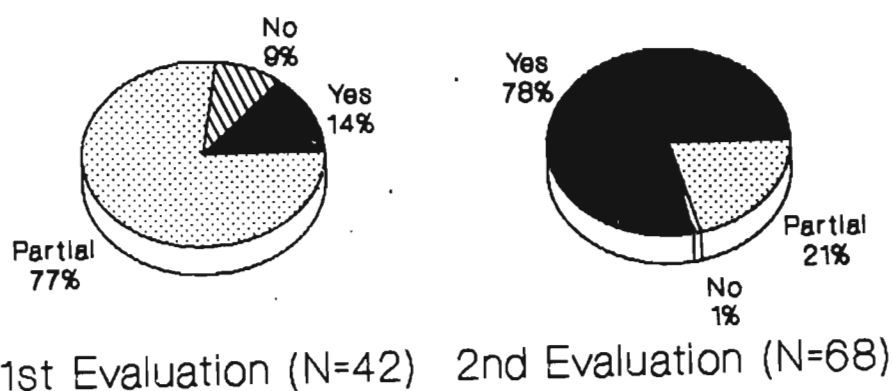


Fig 4.24 Goal Setting Skills - Overall Performance

Remedial education and consultation improved the performance of participants as shown in Figure 4.24 with the lowest performing clinic obtaining 60% of correctly set goals and the highest obtaining 88% correctly set goals

4.2.4.6 Steps to achieve the goals

Goal setting was followed by determining steps to be taken to achieve the set goals. Nurses worked with the client and relatives to decide on the steps needed. The evaluation was aimed at assessing the ability of the nurses to determine with the client and family the steps to be taken to achieve goals. The results on the overall ability of all nurses in this regard is shown in Figure 4.25.

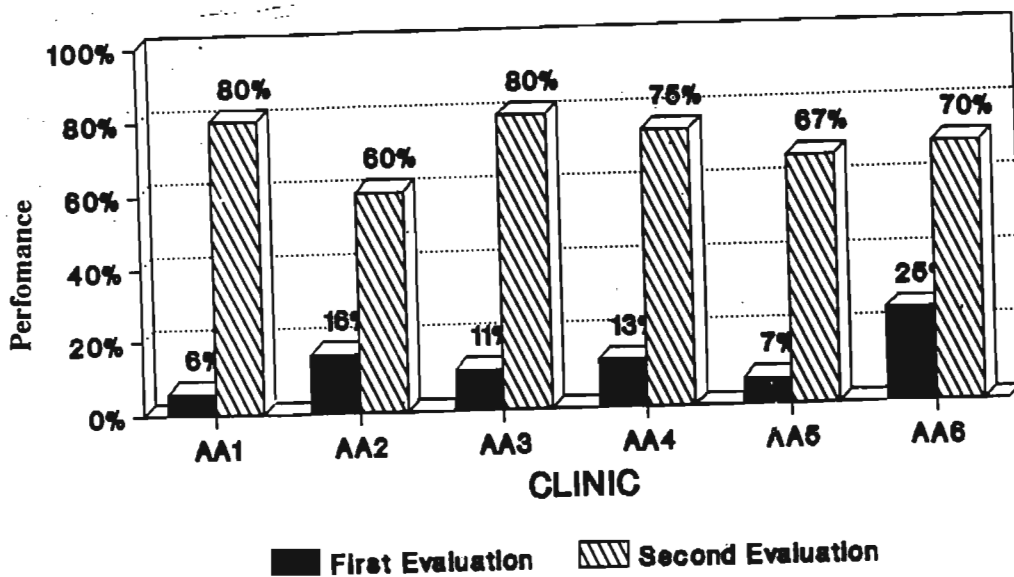


Fig 4.25 Steps to Achieve Goals Per Clinic

Results in Figure 4.25 show that 16% of the files had clear steps to achieve set goals, 71% had incomplete steps to achieve goals and 13% had incorrect steps to achieve goals. Participants experienced a problem in deciding on the steps as seen in the above results. For the three goals set the performance varied in the steps to achieve each one. Most cases determined the steps incompletely. This exercise needed re-education and re-inforcement of the participants. Time had to be allowed to assist participants and families to review the goals set and to change them if they were not achievable, or decide new steps to achieve the existing goals. This helped participants to practise goal setting and planning of steps to achieve the goals. In the second evaluation, 72% of the files contained clear steps to achieve goals and only 26% had unclear steps. The information on the first and second evaluations is shown in Figure 4.25

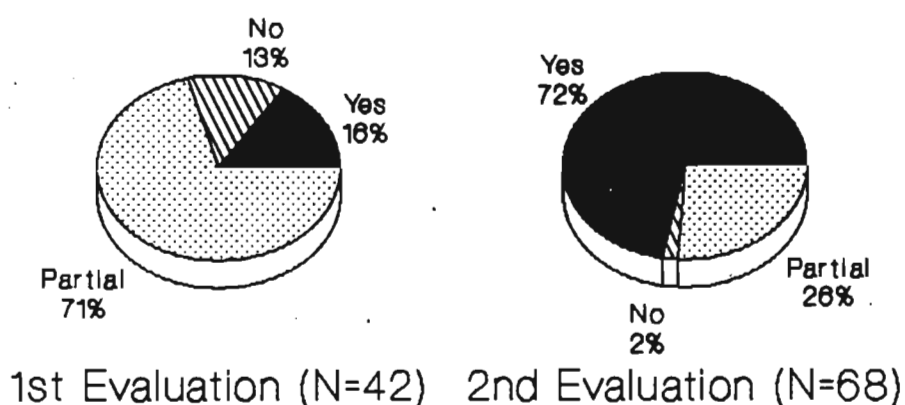


Fig 4.26 Steps to Achieve Goals - Overall Performance

In order to assist individual clinics further analysis of the results per clinic was done for the first and second evaluations. The improvements in the performance of clinics as shown in the second evaluation as shown in Figure 4.26 was as a result of the review of the goals set and replanning with the client and family.

4.2.4.7 Level of vocational rehabilitation

For each client the level of rehabilitation was calculated. Scores of patients were added and reflected as the level of rehabilitation achieved for the clients by each case. For each client the level of functioning at the beginning was rated and given a score ranging from 0 to 7 according to what the client was able to do. The results in Figure 4.27 show the level of rehabilitation for each case.

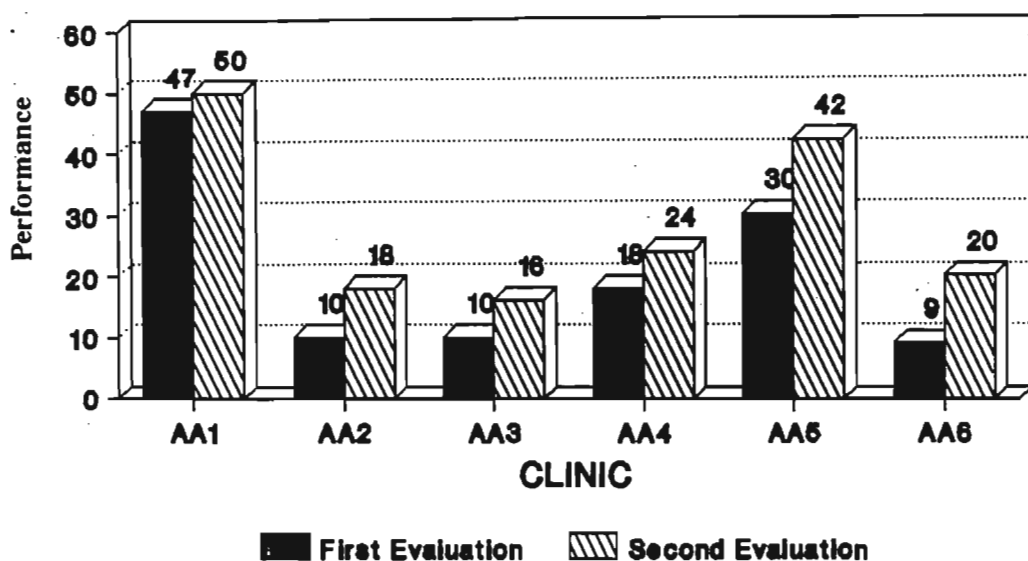


Fig 4.27 Level of Vocational Rehabilitation Per Clinic

Clinic AA1

This clinic had better facilities to enable rehabilitation of clients. The clinic is close to the location and participants could supervise their clients and families in the achievement of goals. Relatives came for advice on how to deal with problems as they arose. Patients' relatives formed support groups from which they learnt from each other. Independence of the clients was stressed in these groups. This had good results as seen in the level of rehabilitation achieved. This clinic achieved 47% on the level of rehabilitation on the first evaluation and 50% on the second evaluation.

Clinic AA5

Although very few clients were evaluated this clinic achieved a reasonable level of vocational rehabilitation. In addition to the basic life skills achieved, clients were introduced to the vocational rehabilitation club that exists within the clinic yard which is used for the rehabilitation of the physically handicapped males and females. This occupied most of the unemployed psychiatric patients who had improved enough to benefit from vocational rehabilitation and had achieved all the goals on basic life skills. The first evaluation reflects a 30% level and a 42% level was achieved on the second evaluation.

Clinic AA4

This case had achieved 18% in the level of vocational rehabilitation. It was difficult to supervise vocational rehabilitation on clients far from the clinic. To encourage families to do their best in teaching the client to fit within the family and community first, clients were required to furnish the household routine without supervision before they could join the small rehabilitation club started by the clinic on gardening, knitting, sewing and carpentry. The difficulty was in getting an appropriate accommodation. As part of rehabilitation some clients were employed by the road construction company on the recommendation of the participants. The level of rehabilitation increased to 24% in the second evaluation.

Clinic AA2, AA3 and AA6

These three cases achieved between 9% and 10% progress on the level of rehabilitation. Clinics AA2 and AA6 had no transport to visit clients far from the clinic. The families were educated to continue the rehabilitation and to report to the clinic any problems experienced. Clients within reach were visited and families supported. The environment in which the client lived was used as a basis of setting goals. This enabled families to identify the abilities clients had and to encourage clients to utilize the existing skills.

Home facilities were used in developing skills that could be used at work. Such skills included brick laying and plastering, gardening, sewing and knitting. Two clients in Clinic AA3 were employed in the Kellogg project building the clinic. Other clients were encouraged to look for work in town while selling fruit and vegetables in the local market. In the second evaluation these three clinics improved slightly to 18%, 16% and 20% respectively.

Although relatives had unrealistic expectations of sick members, they had courage to assist them in terms of realistic and achievable goals clients could achieve. It became clear that mental illness affected clients differently. Community members were able to identify the different facilities that could be of benefit to the clients for rehabilitation. Although rural communities do not have factories and other resources that could employ persons for the purpose of rehabilitation, small funded projects could be started to meet the vocational needs of clients. Psychosocial rehabilitation in the PHC approach must be

seen as part of treatment and be started at the beginning of the treatment to enable clients to be fully integrated within the society in which they live. Given the social skills and the skills for daily living, such clients can live independently. Vocational rehabilitation is important for clients who are able to work outside the home. The income generated by the client should be used as decided by the client and relatives.

4.2.5 Programme evaluation by P.H.C. nurses

Sample realization

All participants (N=20) were included in the sample.

General attitude

It was important to evaluate the feelings of the participants about the integration as this was important during the implementation of the programme. Negative feelings would have a bad effect on the success of the integration. All participants were given the tool to complete in a classroom on the last day of the workshop. Information provided was confidential and no one was allowed to open any discussion during this period. The results in Table 4.6, 4.7, 4.8 and 4.9 reflect the feelings of the nurses in various aspects of the integration.

Table 4.6 Perceptions of participants about the programm

	Mean	Remark	Standard Deviation
Valuable - Worthless	5.85	Positive	0.09
Heavy - light	2.3	Negative	5.17
Fast - slow	3.85	Positive	4.21
Difficult - easy	4	Positive	2.95
Helpers - powerful	4.9	Positive	1.25
Challenge - threat	5.75	Positive	0.30
Neccessary - waste	5.55	Positive	2.06
Tense - relaxed	3.75	Positive	5.04
Small - big	4.35	Positive	3.40
Frantic - steady	3.7	Positive	5.27
Disaster - achievement	5.5	Positive	0.47
0 - 6 \bar{x}	4.25	\bar{x}	1.95

The standard deviations indicate only minor variations in the respondents' evaluation of the programme. This indicates that, overall, there was a reasonable level of agreement amongst the respondents in their evaluation of the programme with a standard deviation of 1.95. This is a good finding because wider variations would have indicated significantly varying impressions about the programme. One would therefore say that, overall the programme made identical impressions on the respondents.

In the case of Semantic Defferential, three different components made up the total attitude. This will now be analysed separately. Table shows the evaluation of the programme on activity criteria by the 20 participants.

Table 4.7. Rating of programme on activity (N=20)

PERCENTAGE	RATING
3%	Extremely active
14%	Highly active
28%	Active
12%	Neutral
22%	Not active
13%	Very inactive
8%	extremely inactive
\bar{x} 14.4	

The above information is further illustrated in Figure 4.28.

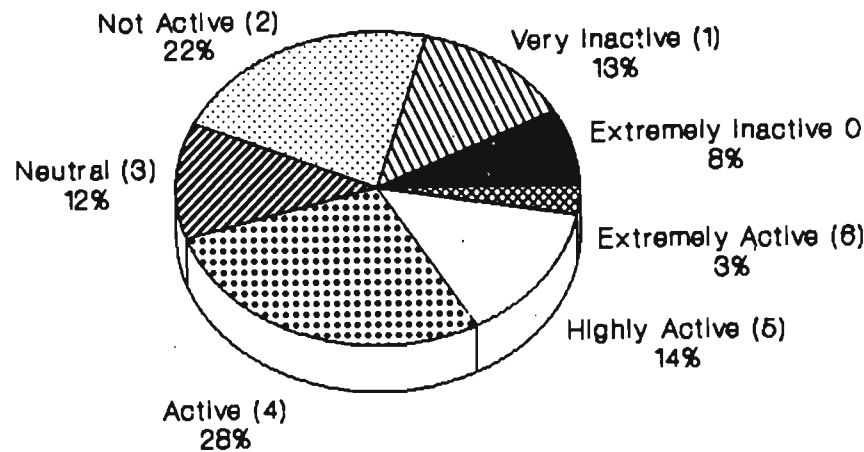


Fig 4.28 Overall Ratings on the 7-Point Scale - Activity (N=20)

The total percentage of participants who rated the programme positively on Activity is 45% as compared to those who rated the programme as inactive (42%). The other 12% participants were neutral.

Table 4.8. Rating of programme on Evaluative (N=20)

PERCENTAGE	RATING
65%	Extremely positive
28%	Highly positive
5%	Positive
2%	Neutral
x 255	

The total percentage of participants who rated the programme as Evaluative was 98% while 2% were neutral. This information is further shown in Figure 4.29

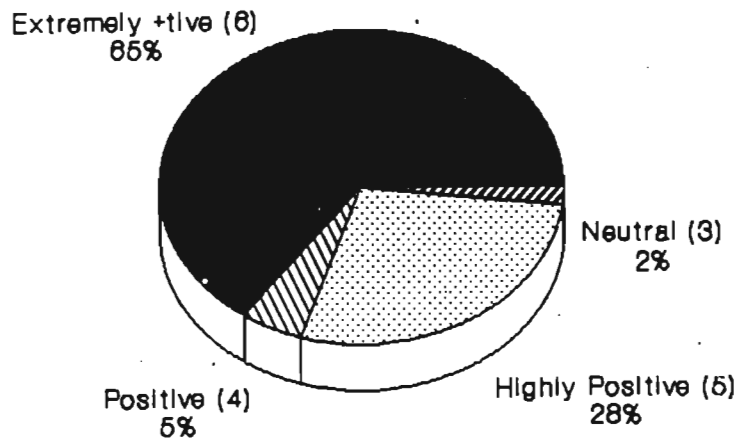


Fig 4.29 Overall Ratings on the 7-Point Scale - Evaluative (N=20)

Table 4.9 Rating of programme on Potency criteria (N=20)

PERCENTAGE	RATING
7%	Extremely potent
26%	Highly potent
26%	Potent
14%	Neutral
14%	Ineffectual
9%	Highly ineffectual
4%	Extremely ineffectual

Table 4.9 shows the scores on Potency. Of the 20 participants 59% rated the programme as potent against 27% who rated the programme as ineffectual. The 14% neutral respondents were due to the belief that at the time of evaluation it was not yet clear whether the programme would effect change or not. The information in Table 4.9 is further illustrated in Figure 4.30.

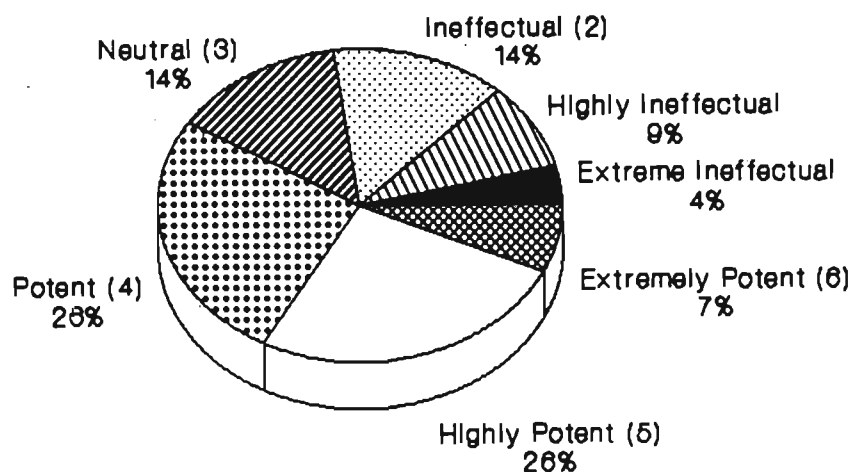
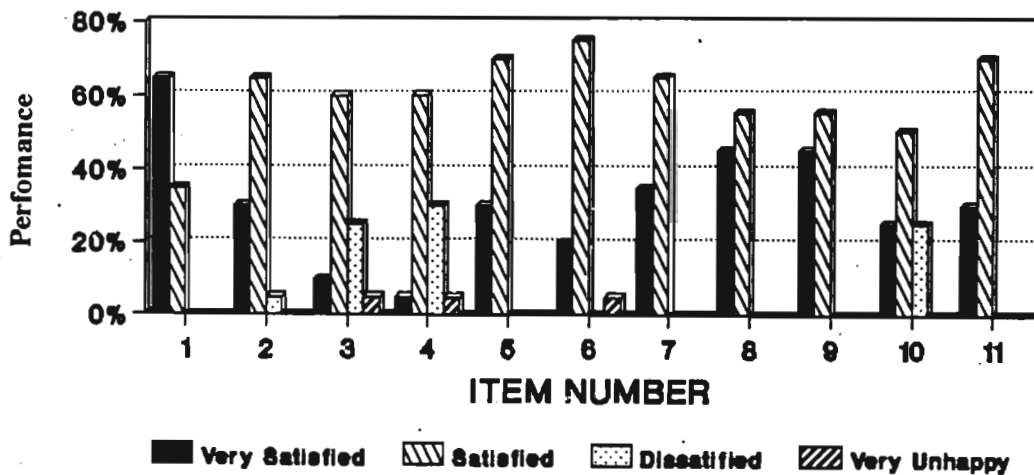


Fig 4.30 Overall Ratings on the 7-Point Scale - Potency (N=20)

4.3.2. Degree of Satisfaction

The degree of satisfaction was evaluated on the 11 variables of the programme. The information in Figure 4.31 reflects the results at the end of the 10 day block. Figure 4.32 shows the results after one year of implementation. The first evaluation done after 1 month of implementation revealed that participants were dissatisfied with the consultation service. It was reported that this was not possible due to communication problems between the secondary health service and the clinics. Only about 3% managed to consult. The 60% that were satisfied found it frustrating to be unable to do so frequently in order to get support from the secondary health services.



**Fig 4.31 Participants' degree of Satisfaction with the Programme
First Evaluation (N=20)**

In Figure 4.31 Item 4 referred to the referral system. Only 5% of participants referred were given feedback on the first month as compared to 65% in the second evaluation. There was no feedback on what had been done to a referred client in this first evaluation. Most nurses had to find this information from relatives days after the patient had been referred. Item 10 referred to the support the participants received from their colleagues in the clinic. Due to negative attitudes towards the care of mentally ill patients, very little or no support was given in most clinics which amounts to 30% while 45% reported that they were supported fairly and 25% were not supported. It was interesting to find that items 5, 6, 7, 8, 9 and 11 were aimed at self evaluation of the participants on the specific skills needed, i.e. history taking, making a diagnosis, prescription of medication, as well as giving psycho-education to patients and relatives. Participants were confident that as they applied the skills in practice, there would be some improvement in their performance. Item 1 was the evaluation of their satisfaction with the programme. From the first workshop 31% of the participants were **Very Satisfied** and 60% were **Satisfied**. The second evaluation as shown in Figure 4.32 reflects a total change in the degree of satisfaction of the participants in all aspects of the programme. There was also an improvement in their satisfaction in consultation due to the services provided by the researcher.

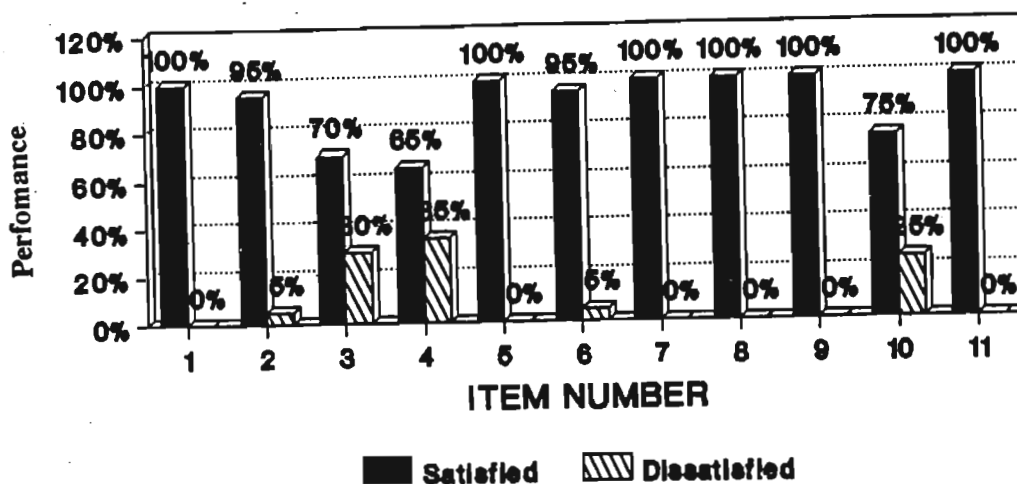


Fig 4.32 Participants' degree of Satisfaction with the Programme
Second Evaluation (N=20)

Statistical analysis revealed no significant change in the participants' overall level of satisfaction with the programme between the first and second evaluations. This statistical test is given in Table 4.9

Table 4.9 Overall change in the levels of satisfaction with the programme

COMPARISON	MEAN (%)	DIFFERENCE	t_o	t_c	RESULT
First Evaluation	90.73	18	0.01	2.86	not significant (alpha =0.01)
Second Evaluation	90.91				

The areas in which nurses were dissatisfied were the consultation service, the reaction to the referrals by the backup team and their ability to make a diagnosis in the first evaluation. While the ability to make a diagnosis improved as seen in the second evaluation the consultation service and the reaction to their referrals was beyond the scope of the clinic nurses. Both factors were related to poor transport and the reaction to referrals was related to absence of an efficient referral and communication system

4.3.2.1 Nurses' perceptions about benefits of integration

Benefits perceived by the nurses were analysed and categorised as shown in Table 4.8. These were the positive aspects which motivated them to sustain the programme. These results amounted from qualitative analysis of the responses given.

Table 4.10 Nurses' perceptions of major benefits (N=20)

PERCENTAGE OF RESPONDENTS	BENEFITS
12%	Consumers get health care from programme.
11%	Participants, clients and families gained skills.
7%	Mental health care was made accessible.
6%	The programme can be extended to all clinics.
5%	The integration programme perceived as economic.

This information is further shown in Figure 4.33.

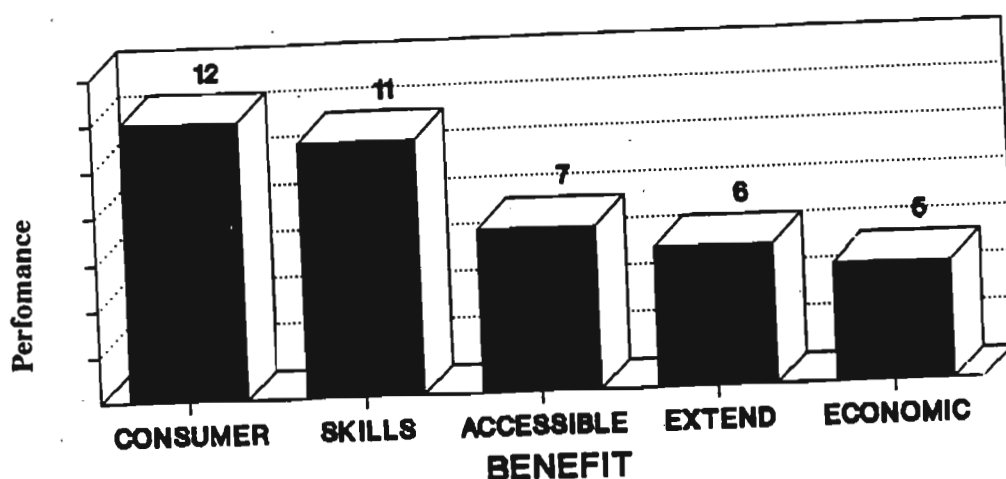


Fig 4.33 Participants' Perceptions of the Major Benefits of Integration (N=20)

In this figure the number of respondents who mentioned each aspect are reflected. It did appear that consumer benefits were seen by most participants (12) as a benefit, followed by the skills learnt in the programme (11). Accessibility of the service was mentioned by 7 respondents while 6 believed that the programme would be of benefit to the other nurses. Five respondents believed that the programme was economic to the government and the clients.

4.3.2.2 Participants' perception of the problems of integration

It was important to obtain information on the problems perceived by the participants regarding integration. These problems were seen as negative forces against the principle of integration. Out of the list drawn as shown in Table 4.11, from the information qualitatively analysed shortage of drugs came first having been mentioned by 19 participants. the respondents further remarked that the absence of drugs made it difficult for them to prescribe what they believed was suitable. It was not possible to get from the dispensary, even the commonly available drugs such as Largactil and Modicate. Fears of complete breakdown of the service for the care of the physically ill and pregnant women were expressed by all respondents as staff shortage and longer time were needed for each

client, as compared to physically ill patients. Transport was perceived by 11 respondents as an obstacle in assisting clients in need of emergency care and delivery of supplies to clinics. Although stationary shortage seemed a problem, as mentioned by 9 respondents, nurses tried all possible means to get file covers, treatment cards, history forms and used scrap papers. Clinics which have no two-way radios perceived poor communication as an obstacle, as was seen by 5 participants.

Table 4.11 Participants perception of major problems (N=20)

PERCENTAGE RESPONDENTS	PROBLEM
19%	Shortage of drug supplies.
11%	Transport.
9%	Absence of stationery.
8%	Staff shortage for the workload.
7%	Longer time needed for each client.
5%	Poor communication between hospital and clinics for effective consultation

This information is further shown in Figure 4.34.

The identified problems had a negative impact on the provision of psychiatric care and should be seen in the light of barriers. Most of them form the backbone of the success of the integration process. The evaluation of the above aspects reflect the differences in the perception of participants in the various clinics. Some clinics were used to not having transport and stationery while some needed an improvement in the mentioned aspects as they percieved them as obstacles in their effectiveness to providing the needed care.

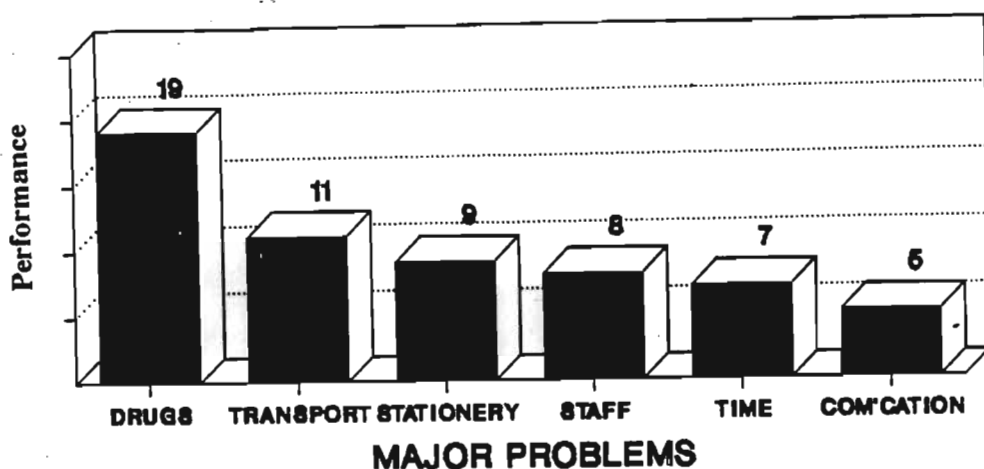


Fig 4.34 Participants' Perceptions of the Major Problems with Integration (N=20)

4.2.6 Consumer Satisfaction

The sample consisted of two clients and any two relatives conveniently selected by an independent research assistant from each clinic, giving a total of 24 respondents. Interviews were done in clinics. Themes that were evaluated in the questionnaire were

*** Access**

Access refers to the convenience of the location, the service hours when the clinic was opened. Access to care in times of emergency was also included. Access also included the length of time spent while waiting, and whether clients' general health was monitored. The availability of drugs and whether clients received prompt help or not when symptoms increased at home, were considered.

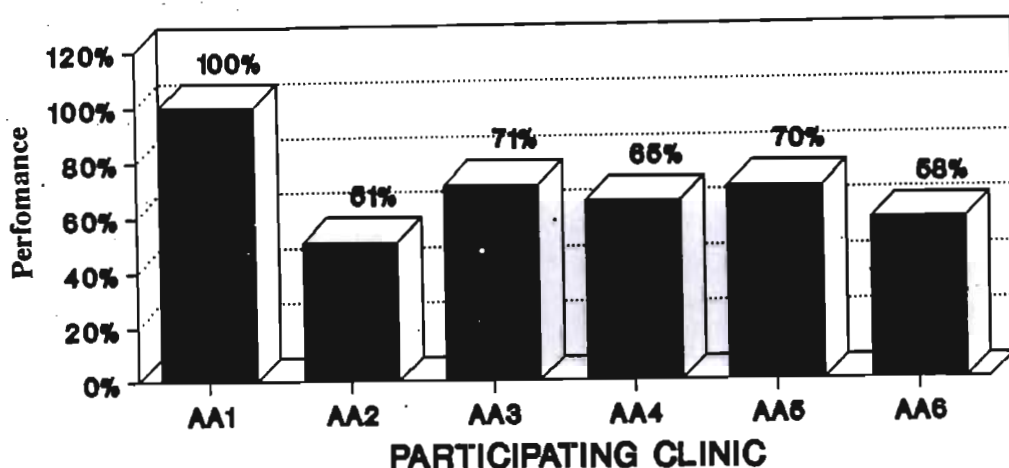


Fig 4.35 Consumer satisfaction with Access Per Clinic
(N=24)

Access to clinic AA1 was rated as 100%. This clinic has better resources than all other clinics. Another advantage was its close distance to the community it served. Furthermore the presence of a Police Station about 100m from the clinic provided security.

Clinics AA3 and AA5 were rated at 71% and 70%, respectively. Various factors were identified in the differences in access between these clinics and AA2, AA4 and AA6 as discussed in the case study protocol. The distance travelled by clients in some clinics, e.g. AA2 and AA4 was longer. Due to the absence or poor security measures and previous criminal acts against the clinic staff, as well as the absence of electricity, all made it very unsafe to work at night. Clinic AA2 did not have accommodation for nurses. Consequently nurses live far from the clinic and work only during the day. The staff of Clinic AA4 can only provide service to clients after 18h00 if accompanied by a member of the clinic committee, known by community member sand clinic staff. Although this arrangement does help in emergency cases it is difficult for relatives who bring clients with conditions perceived as less serious by committee members.

Although Clinic AA1 is rated as 100% accessible drugs are never available in this clinic. Community members were educated on reasons why psychotropic drugs are not available. To them the contact with nurses who use the clinic transport to collect drugs for their clients is a better service than clients paying for collecting drugs.

Those who collect drugs feel helped, as compared to standing for a long period to see the secondary health service staff for review of treatment. Many methods have been used by clients from this clinic to avoid going through the psychiatric clinic by reporting that they have already been seen in the clinic but have come to collect drugs only. This has worked for many but not for all. This happens in spite of the evidence of the date recorded in the card and the information that the client has been reviewed at the clinic. This information is shown in Figure 4.35

*** Finances**

Hardships arise when psychiatric /mentally ill clients have to travel by taxi or bus to the health service. This has been identified as the reason for high defaulters (Solombela 1990). Clients were expected to make some input on whether they were protected from hardship due to medical costs and whether any arrangements were made them to get medicines without without being faced with financial problems.

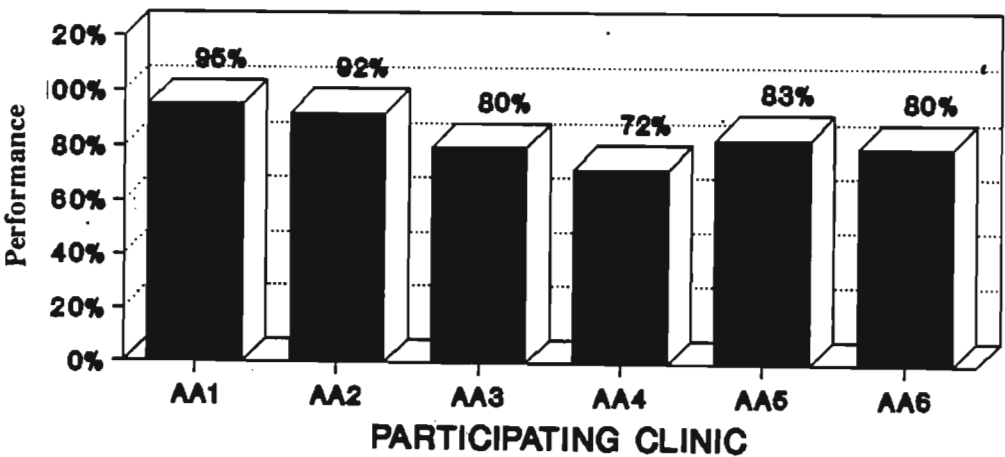


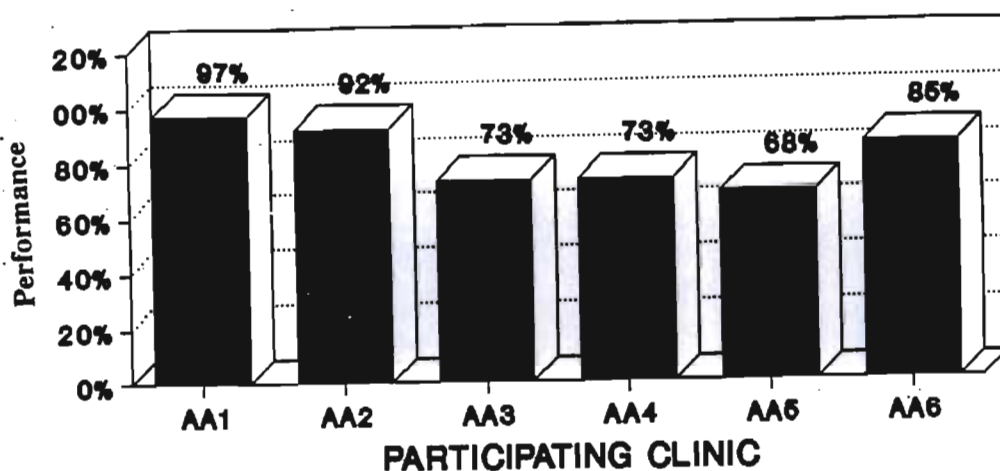
Fig 4.36 Consumer satisfaction with Finance Per Clinic
(N=24)

Clinics AA1 and AA2 were rated at 95% and 92%, respectively with respect to financial assistance. Clinic AA1 was able to make an arrangement for financial assistance through the social worker for deserving clients when a need arises for clients to travel in the absence of the ambulance. Clinic AA2 is not far from hospital and clients willingly pay the taxi fare of less than R1.00. If clients have no money, nurses either collect drugs not available in clinic for the clients or transport the clients during their routine visit to hospital for administration duties to collect treatment. Clients make use of the nurses visits to hospital which is done weekly or occasional visit to bring supply to clinic by the transport from mobile services. Clinic AA3 and AA6 rated between 80% and clinic AA5 rated at 83%. Clinic AA4 is rated the lowest at 72%. This clinic is 33km from hospital and patients pay R10.00 return. People who have no income find it difficult to travel to hospital. Nurses collect treatment on own cars or wait for the transport that delivers supply to clinic.

Finance does not seem to be a problem that can prevent clients from getting medical care presently. It is not clear what will happen in future as nurses may not be in a position to transport clients or to continue to collect drugs for clients.

*** Technical Quality**

This refers to accurateness of nurses in giving a diagnosis making use of skills taught and treatment decisions. Making a diagnosis was not a matter of concern to consumers as long as clients and relatives were informed that the person suffered from mental illness, this was due to the to the level of education which made it difficult to understand the different classes of mental illness in medical terms. Those who were able to understand these terms knew their clinical diagnosis. Clients showed interest in learning their diagnosis and in choosing the type of treatment e.g. they prefer an injection better and rate injections as a better treatment.

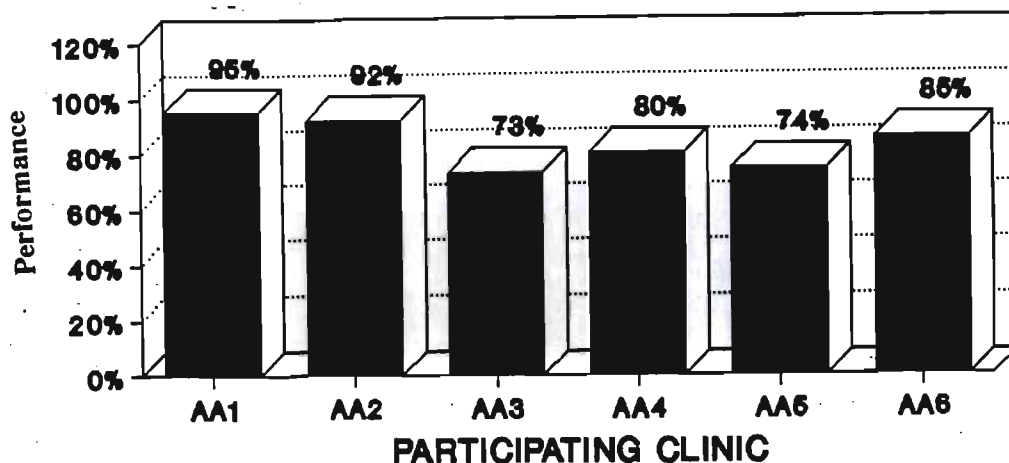


**Fig 4.37 Consumer satisfaction with Technical Quality
Per Clinic (N=24)**

Clinic AA1, AA2 and AA6 consumers were better satisfied with the technical quality at 97%, 92% and 85% respectively. Clinic AA3 and AA4 at 73% while clinic AA5 followed at 68%.

*** Communication**

This referred to the communication between the client and relatives with the nurse on explanation of the diagnosis, understanding of clients point of view related to treatment and rehabilitation. It also includes feedback of client and relatives and involvement of client and family in the care.

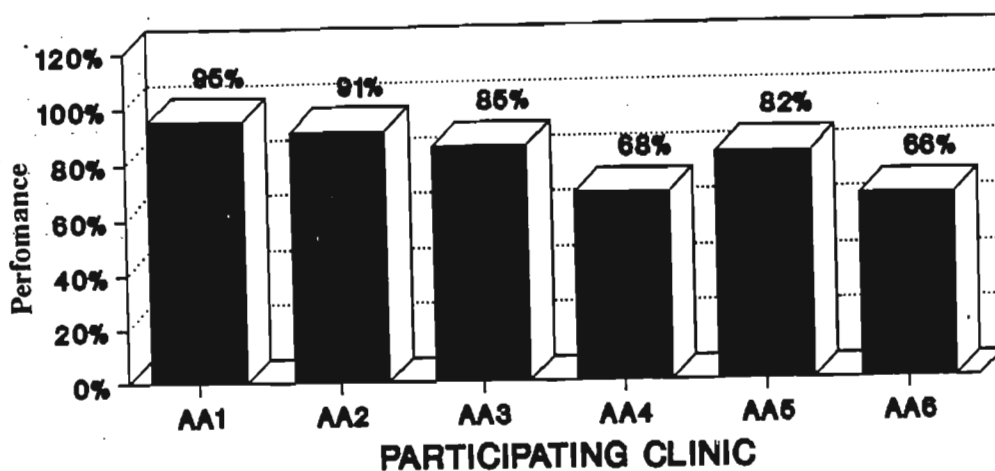


**Fig 4.38 Consumer satisfaction with Communication
Per Clinic (N=24)**

Clinic AA1 and AA2 were rated the highest at 95% and 92% respectively. This demonstrate the difference in the ability of nurses to communicate to their clients. Clinic AA6 and AA4 were rated at 85% and 80% respectively with AA5 and AA3 at 74% and 73% respectively. In the space given for additional information six respondents out of the 24 respondents appreciated the explanations given on the illness and what relatives should do to assist the clients at home. One client reported that he has identified what could be 2the cause of the illness and is prepared to change his lifestyle.

*** Staff attitudes**

Figuree 4.39 shows the results of the evaluation of the nurses attitudes by the consumers in each clinic. The attitude of the staff in each clinic was evaluated in terms of friendliness, courtesy, personal interest of staff on clients problems, respect shown to client and family member. Acceptance shown to alternative approaches to treatment.



**Fig.4.39 Consumer satisfaction with Staff Attitude
Per Clinic (N=24)**

Clinic AA1 and AA2 were rated to have excellent attitude towards clients and their relatives at 95% and 91% respectively. Clients in clinic AA1 remarked that since the project started nurses have shown a different attitude than when they did not want psychiatric patients to be brought to clinic.

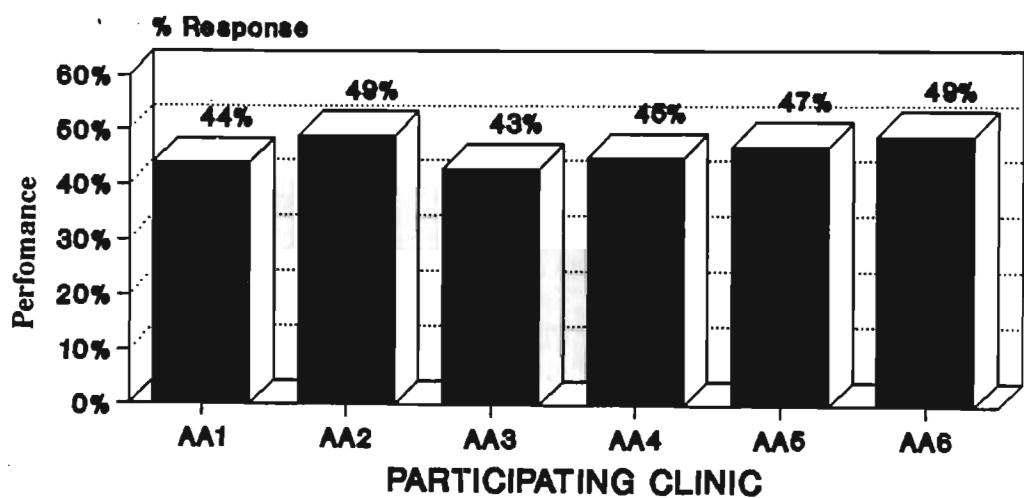
Participants in clinic AA2 reported that psychiatric patients before this project were not cared for and always advised to go to hospital even when they complained of physical illness because most nurses were afraid of them. It was surprising to them to find that they are now given time to talk about their problems.

Clinic AA3 and AA5 were rated at 85% and 82% respectively while clinic AA4 and AA6 were rated at 68% and 66% respectively. Participants in clinic AA3 remarked that they like coming to clinic now than in the past. One relative suggested that if this project is able to do what it has done to change nurses attitudes let it be continued to help all the nurses in other clinics.

Participants in AA4 reported that only the nurses in the project have good attitude towards all clients in clinic which has been observed since the time of the strike. Other nurses not included in the project need to be taught how to deal with people especially psychiatric patients. In clinic AA6 clients remarked that they do observe a difference between how psychiatric patients were treated before and now. Respondents hoped for greater improvement in the attitude of all nurses.

*** Negative incidents**

Aspects included were discussing the patient with another, favouritism, wrong number of tablets given, home visits and assistance of seriously ill patients with tasks of living and with transport when needed. The above information is shown in figure 4.40



**Fig 4.40 Consumer Perceptions of Negative Incidence
Per Clinic (N=24)**

It was evident that clients were not discussed with other clients and no favouritism had been identified. However, assistance of patients with transport was seen as negative, as very few nurses made such an attempt, particularly at night. The evaluation of negative incidents ranges between 43% and 49% in all six clinics. This demonstrated a need for the service at night.

Because of relatively lower numbers of psychiatric patients compared to other category of patients, consumer satisfaction was limited to only two psychiatric patients and two

relatives of patients per clinic, a total of four consumers. This made it impractical to engage inferential statistics aimed at comparing levels of satisfaction between two clinics at a time. This would have been tantamount to comparing four respondents against another four respondents. Such low numbers are not recommended for inferential statistics (Tukey, 1949), (Anastasy, 1954), (Cochran, 1957).

4.2.7 Utilization of the Service

It was difficult to determine the rate at which clinics were utilized due to the problem of drugs in the first 6 months. As soon as nurses decided to work with clients in obtaining medication, it was easier to determine how each client utilized the service. It was also difficult to record patient attendance, as most clients went to hospital for review of their medication. However, only clients who went through the clinic to hospital could be recorded. Participants kept track of their clients through home visits and educated their relatives to send the clients to clinic even if they preferred to collect medication on their own. This was successful in some clinics but failed in others. Statistics obtained from the clinics between September 1995 and March 1996 had gaps as a result of poor recording during the nurses industrial action.

Clinic AA1

Nevertheless, records revealed a high detection rate of new clients and decrease of defaulters in clinics. Clinic AA1 recorded the following information on new clients:

Table 4.1.2 Detection rate AA1

Year	Month	No. of New Patients	Year	Month	No. of New Patients
1995	April	4	1996	January	5
	May	5		February	6
	June	4		March	6
	July	6		April	9
	August	3		May	4
	September	5		June	10
	October	1			
	November	5			
	December	8			

Clinic AA2

The records demonstrate the following information on the quarterly statistics of this clinic:

Table 4.1.3 Attendance record: AA2

Year	Month	No. of Patients Attended
1995	June	13
	September	21
	December	17
1996	March	28

There is a steady increase of psychiatric clients who received health care in this clinic. The increase is a result of home visits where the mentally retarded persons who had been neglected were discovered. This neglect was as a result of ignorance and the belief that they could not benefit from medical care. Some clients were wondering about and travelled daily between this area and town. Participants requested relatives to consider the rights these clients had to mental health care. Persuasion and education led to the community is awareness about the service as clients were brought for assessment of I.Q. and for treatment and advice.

Clinic AA3

In this clinic it was agreed that even if the client collected medication from hospital the maintenance card be brought to clinic. Not all clients complied with this, but relatives reported to clinic each month the client collected medication from hospital. All these clients were seen at home during home visits. The utilization rate obtained from the clinic statistics was irregular as a result of the industrial action but showed the following information :

Table 4.1.4 Attendance record: AA3

Year	Month	N. of patients Attended
1995	April	18
	May	22
	June	17
	August	12
	September	18
	October	18
	November	26
1996	March	22

Clinic AA4

Records in this clinic revealed a decrease in patients who were on psychiatric medication in April 1995 from 56 to 44. All epileptic patients were recorded as psychiatric patients before this study. Records were reviewed and clients who had no psychotic condition were removed from this list. The community in this area had an efficient transport to town which enabled clients to collect medication from hospital as they travelled to work in town. With the assistance of the clinic committee clients who were on the clinic records reported to clinic with their cards. Some were found to be in the Umtata psychiatric clinic records, where it was easy for them to obtain the treatment prescribed for them. This led to fluctuation of clients recorded in the monthly review book in the following way :

Table 4.1.5 Attendance record: AA4

Year	Month	No. of Patient Attended
1995	April	56
	May	44- 1 transferred, relapsed and re-admitted
	September	38
	December	21
1996	March	40

Eight reported defaulters were found to be collecting medication from the hospital psychiatric clinic. This clinic was hard hit by the nurses industrial action between November and February 1996. Participants during this period distributed the medication

in clients' homes. Clients who were able to collect medication on their own were allowed to do so and a record was kept.

Clinic AA5

The distance from town to this clinic, and the nature of roads were advantages to the process of implementation of the study during the period of the nurses' unrest. Participants had sufficient time to visit the homes of the clients to do psycho-education and counselling without any pressure from the other duties. Although nothing was recorded in November and December all clients returned to the service in January with a clear evidence that treatment had been collected from hospital. Numbers fluctuated as most clients lost faith in the service during the strike period but gradually, they returned back to the clinic. Records reflect the following pattern of attendance at quarterly intervals :

Table 4.1.6 Attendance record: AA5

Year	Month	No. of Patients Attended
1995	April	28
	June	14- 4 clients incorrectly diagnosed in 1994
	September	26
	December	14
1996	March	28

Clinic AA6

Clients from this clinic have poor transport facilities and depend on the clinic staff for medication. Poverty and unemployment is high. When clients need to be referred to clinic in most cases nurses use their transport to save lives. It is very difficult for clients to make use of the ambulance due to bad roads and poor communication system. Medicines were collected by the nurses from the hospital dispensary during the strike period but no records were kept as the clinic opened only for few hours for fear of intimidation by the staff from other health centres. The records show the following pattern of attendance :

Table 4.1.7 Attendance record: AA6

Year	Month	No. of Patients Attended
1995	April	20 - 3 defaulters
	June	30
	September	36
	December	nil
1996	March	38

It is of importance to describe how difficult it had been for participants to follow clients who did not report to the clinic for review. This service cost the nurse a lot of time. Clients had a freedom of choice between the clinics and the psychiatric clinic at Umtata General Hospital. If the peripheral clinics had all the medication supplies, no clients would travel such long distances for only medication. Clients wanted to benefit from psycho-education and counselling, provided in clinics, they also wanted to be maintained on a drug which they believed was most effective. Most of these drugs were not always available for clients due to poor delivery, or the drugs being out of stock. Another factor was that at the hospital dispensary, priority was given to those clients who presented themselves either from the psychiatric clinic or from far clinics. Insufficient drugs were set aside for clinics during the period of integration of the previous health administrations as there was fear that hospital services might run out of medical supplies before the health structures were in place to meet the needs of each health institution. It was hoped that as administration problems were gradually solved the problem of transport, delivery of supplies to clinics and communication facilities would improve. The monthly attendance reflects that of the new clients detected and referred to hospital for collection of treatment, all clients had to go through the psychiatric clinic. This was a duplicate of the service as no information on psycho-education and counselling was recorded on the treatment card by the clinic. The same process was done in the psychiatric clinic. The role of the psychiatric clinic confused most of the clients. Some believed that this hospital clinic was better - as drugs were available while some believed that long que consumed a long time. This was the picture in all clinics when drugs were not available.

The psychiatric clinic situated in hospital serves as a primary health service for psychiatric patients as it serves patients who came on their own without a prior visit to another

P.H.C. clinic and also serves as a secondary health service that received patients from the outlying clinics, referred for a specific reason. It was confusing to discover that at times the dispensary required that clients reviewed in clinic and referred only for collection of medication were required to go to this clinic for further review a duplication of service.

Cross Case Analysis

Clinic AA1 could not keep statistics of the total number of clients as they used the referral system for medication collection more than the other clinics. Statistics in this clinic reflected mostly new clients. Most of the clients knew that the clinic did not supply them with the drugs needed and therefore did not keep their appointments with this clinic but went to the hospital clinic. Some came on the appointed date for rehabilitation evaluation and were referred. Some clients who came in the absence of the participants were not recorded and therefore the statistics on old clients in this clinic were not reliable. Clinic AA2 had an increase in clinic visits by old clients due to the recovery of defaulters during home visits especially the mentally retarded. The strategy used to keep clients from defaulting in Clinic AA3 was an agreement between the client, his family and the clinic that even if the client collected medication from hospital the treatment card should be brought after this visit to keep the clinic staff informed. This practice was possible on clients around the clinic but not to clients who were far.

Clinic AA4 had about 56 patients recorded in 1995, April which decreased gradually between September and December. The decrease of these patients was due to the discovery that epileptic patients were recorded under psychiatric patients. A second factor was the availability of better transport to town than to the clinic which made it better for clients to collect their medication in the hospital clinic. In Clinic AA5 fluctuations were recorded between September and December but figures became steady in the following months. In this clinic epileptic patients were recorded as psychiatric patients also. Clinic AA6 was utilized better than the other five clinics due to the long distance to hospital, nature of roads and the economic states of most consumers made them depend on the clinic for their health problems in general. A common feature in all these clinics was the absence of psychiatric drugs and irregular supplies when drugs were available.

A conclusion on the rate at which the six clinics were utilized was that:

- * the clinics situated in areas closer to the hospital clinic had access to the hospital clinic, utilized their clinics less due to the absence of drugs. The other programmes such as rehabilitation and psycho-education were not sufficiently utilized by all clients. This is the area common in all the clinics. Most clients view medication supplies as the only treatment and that counselling, psycho-education and rehabilitation as not very important.
- * clinics distant from town are better utilized than those closer to the hospital clinic as this is the only available health service in the area. These clients have a narrow choice of health service due to the nature of roads, expensive means of travelling for clients who have no income. clients in the Municipality clinics utilized both their clinic and the hospital clinic due to the referral policies that had been followed between the Municipality health centres and the Government health services that if a client has been to these clinics a referral letter be written to allow the client access to the hospital clinic. Government clinics could not be fully utilized in the absence of medication which increased the cost of health care. When medication was available the utilization rate increased.

4.2.8 Rate of defaulters, Admissions and Re-admissions

AA1

All clients were new in this clinic. The turnover ranged between 1 and 9 new clients per month. Only 1 client who was transferred to a clinic nearer home, on relatives request and could not be traced due to his unstable place of abode ended up admitted in the psychiatric ward as referred from one of the clinics which are not in the project.

Defaulters = nil

Transferred = 1 relapsed and admitted after transfer

AA2

The last client to default in this clinic was in April 1995 during the first workshop. Home visits increased to at least 6-7 per month with increased involvement of the family. No

relapses have been recorded since April 1995. Due to close proximity of the clinic to the hospital some clients collect treatment from hospital but come to the clinic on scheduled return dates. There were no supplies of drugs in November, December and January, and nurses sent clients to hospital during this strike period.

AA3

Although records reveal an irregular monthly attendance from August 1995, clients who were thought to be defaulters were found to be collecting their treatment from Umtata General Hospital psychiatric clinic, from the time before the strike and continued even after this, due to absence of drugs in this clinics. Home visits maintained the contact for psycho-education and counselling. No clients have been admitted from this clinic. There was an increase in clients in March to 22 as compared to August where there were 12 clients in the records. Possibly this was as a result of the end of the nurses' strike. Patients had hoped to get all medicines and also wanted to benefit from the education and rehabilitation provided by the participating nurses.

AA4

The record of defaulters reflected the following information:

Table 4.12 Record of defaulters 1995

February	2	April	3
March	2	May	1
		Thenafter	none

Out of the 8 defaulters reported, 1 was admitted in May and others returned after increased home visits, family and community awareness.

AA5

Home visits were done before the project. No defaulters were recorded and patient attendance was regular. Clients transferred nearer home were recorded. Some clients were found to be incorrectly diagnosed and did not need psychiatric care. No clients were admitted from this clinic.

AA6

Statistics revealed the following pattern of defaulters:

Table 4.13 Record of defaulters 1995

March	2
April	3
May	2
Thenafter	none

From June onwards, there were no defaulters. Home visits had not been done before the project due to transport problems. As home visits started and communities became aware of the service, no clients defaulted treatment. No admissions from this clinic were found in all referral hospitals.

In conclusion only two patients were admitted to hospital from these 6 clinics over the previous 18 months.

4.2.8 Cross Case Analysis

Setting

Five clinics were negatively affected by the setting in terms of electricity, roads, telephones and transport. Clinic AA2 was further affected by the absence of the nurses' residence which led to nurses living very far from the clinic.. Only clinic AA1 was accessible in terms of hours of service, transport, telephone, roads and space. All the other clinics were difficult to reach from town and also for consumers. Clinic AA2 was reasonable accessible in terms of roads but not accessible in terms of communication.

Buildings

One clinic had adequate accommodation built with a durable building material and has electricity. All the other clinics used inadequate prefabricated buildings and poorly ventilated mud buildings with no electricity. Clinic AA2 was affected by the absence nurses' residence closer to the service as compared to the other clinics.

Process of implementation

The activities implemented were similar in all cases ranging from advertising the service, diagnosing new clients and prescription of treatment. Clients who were outside the nurses

capacity were referred. Only clinic AA1 could consult with the secondary health service and the researcher by telephone. The other clinics used the consultation service only when the researcher visited the individual clinic once a week. Rehabilitation and home visits were done by all clinics but to varying numbers of clients. In five clinics home visits increased to between six and eight per month. In clinic AA4 which had no home visits previously, only two to three home visits were done per month. Clinic AA1 had more referrals due to the absence of medication, this picture still continues. In other clinics there were more referrals in the first six months but gradually decrease. Case finding and counselling was a common feature in all the clinics. Rehabilitation was started for all clients although there were differences in the implementation of rehabilitation. Clinic AA1 had access in a development project where most of the clients were sent for the development of vocational skills. Clinic AA5 had a community project running in the clinic in which the physically disabled persons and unemployed community members were taught skills in sewing, brick making, baking, etc. The other clinics had no group projects and were in the process of motivating for a community project for the benefit of both physically and the mentally handicapped persons within the principles of the Reconstruction and Development Plan (Mandela, 1994) (ANC, 1994).

Barriers

One clinic belonging to the municipality had a unique problem of drug supplies as a result of policy issues between the Municipality and the Department of Health. The rest of the clinics had a similar problem related to the delivery of drugs to the clinics. All the cases had a difficulty in keeping consistent statistics of clinic attendance. Clinic AA2 had no communication with the hospital and other clinics. Clinics AA3, AA4, AA5, and AA6 had an unreliable communication through a two-way radio. Roads and transport had a bad effect on the delivery of drug supplies to clinics AA3, AA4, AA5 and AA6. Clinic AA2 had a problem of transport and was not affected by roads.

Effort Evaluation

The statistics in all clinics reflected a clear picture of more new clients per month. Clinic AA1 had a high incidence of new clients ranging between 1 to 6 per month while the rest of the clinics had a steady increase of clients on treatment in the area as a result of efforts to trace clients who had discontinued treatment on their own as well as new clients. On average, rural clinics were seeing approximately 1 to 2 new psychiatric patients per month.

4.2.9 Staff establishment

The ratio of patients per registered nurse per month varied as a result of differences in the numbers of patients who utilized the services of each clinic. Of the six clinics, clinic AA1 had a ratio of one registered nurse per 203 patients. Clinic AA3 had a ratio of 279 patients per registered nurse while clinic AA5 had 413 patients per registered nurse. Clinic AA2 and AA6 ranged between 147 patients per registered nurse and 133 patients per registered nurse respectively. Two cases had a ratio of one registered nurse per 200 patients. One of these clinics is the Municipality clinic. Two clinics had a ratio of between 1 registered nurse per 263 and 279 patients.

CHAPTER 5 : SUMMARY, DISCUSSION, CONCLUSIONS, RECOMMENDATIONS AND LIMITATIONS

5.1 INTRODUCTION

In this chapter, the results and their implication to practice will be discussed. A summary of the findings will be given. Research questions will be used to guide the discussion. The limitations of the study and suggestions for further research will be explained. Recommendations will be made, based on the results.

5.2 SUMMARY

This study used case studies and surveys to collect qualitative and quantitative data. The purpose of the study was :-

- * to design and implement the first two phases of a three phased approach to the integration of the psychiatric component into the PHC in the Eastern Cape. Only the diagnosis, treatment and rehabilitation were included.

The study was divided into two phases. Each phase started with a ten day workshop, followed by 6 months of implementation. Phase 1 consisted of the diagnosis and treatment of the six common psychiatric conditions identified as common in the world, based on the literature. Phase two consisted of the rehabilitation of each client. Clinics were purposively chosen because they were within supervision distance. Six clinics were selected to form a sample. Each clinic was seen as a case and cross case analysis was done. The six clinics represented the urban and rural health services. A total of twenty registered nurses working in these clinics were trained to take the psychiatric history, give a diagnosis according to the DSM IV classification, make treatment decisions and prescribe medication for stat and long-term care. Furthermore, the nurses were expected to make a rehabilitation diagnosis with the client and family, educate, supervise and give support to the client and family in the rehabilitation process.

The registered nurses from each of the six clinics were requested to volunteer to participate in the study. At least 50% of registered nurses from each clinic participated.

Clients diagnosed on any six of the following conditions were treated in the clinic:

- * schizophrenia
- * mood disorders
- * mental retardation
- * anxiety disorders
- * substance abuse
- * organic disorders (dementia and delirium)

Clients who fell out of the above list were referred to the secondary health service with a clear reason for referral and to a specific member of the multidisciplinary team.

The project consisted of a skills based educational approach in which participants were trained on the skills needed in a 10 day workshop for each phase. They were allowed to implement the skills under supervision for a period of six months. Their ability to perform the skill was evaluated at the end of six months through a record review. Surveys and case studies were used to collect qualitative and quantitative data. Data were analysed by computer, using the Harward Graphics programme. Perceptions and attitudes of the participating nurses on the programme were evaluated. The study had strengths and limitations. Barriers were identified and handled during the course of the project. The results were presented in the form of tables and charts on each area evaluated.

5.3 LIMITATIONS OF THE STUDY

This study had limitations which should be taken into account.

- * the sample for the case studies was not a representation of all clinics in the Eastern cape but a representation of rural urban settings sampled from 20 clinics in the Umtata region.
- * The sample of consumers was convenient and may not represent the client population in each clinic. For this reason the findings may not be a true reflection of the entire region., and generalisation of the finding should be made at the utmost discretion of the reader.
- * The literature from countries in which the integration of psychiatric component has been implemented and evaluated was very limited with examples only from Lesotho and Orange Free State.

5.4 DISCUSSION

The research questions will be used as a guideline for the discussion of results.

5.4.1 Barriers and strengths that influence the process of integration.

5.4.1.1 Strengths

The results on the evaluation of the perception of participants about the programme during the first month of implementation of phase one revealed that participating nurses perceived the integration as economic which is in line with the report by WHO (1990). In addition, participating nurses were used to screening, diagnosing and prescribing for physically ill patients in clinics and this integration of psychiatric care was seen as an extension of the existing service. The positive attitude of the participating nurses after the first workshop and the support they received from the supervisor and from each other enabled them to be dedicated to the implementation of change. The willingness to give support to a client and family which resulted from the increased awareness about the needs and rights of clients and the nature of mental illness, removed myths and the stigma participants previously held about mental illness. WHO (1990) reports that in countries that have a PHC system should be able to incorporate mental health care in their everyday activities. This is an agreement with the results of the study done in the Orange Free State (Gagiano, 1992) which was found to be cost effective as it will be provided by the existing nurses in clinics (Aboidum, 1990) and (Freeman, 1992)

The stigma attached to mental illness is a known factor to professionals who do not understand the nature of mental illness as reported by Mavundla (1993) that about 90% of nurses have a negative attitude towards the care of mentally ill. Ayonrinde (1987) suggested that any form of training used must be designed to give the less specialised health professionals a support to work in areas seen as uncomfortable. This has been proved to motivate these professionals to accept training aimed at increasing their ability to function in isolated areas of work.

Another strength was the fact that the existing human resources in each clinic were utilized so that the staff of the clinic perceived the integration as part of the normal work. Although more time was needed for each client, nurses believed that there was no need for a special person for psychiatric care but that the staff establishment be improved and

all nurses trained to be able to work with psychiatric patients (Aboidum, 1990 and Freeman, 1992)

Community awareness and evaluation, increased recognition of nurses who took part in the project. The nurses' confidence and status were also increased by their participation in this study. Furthermore appreciation from clients and families about the service provided improved their morale.

5.4.1.2 Barriers

Drugs

- * Poor delivery and shortage of psychotropic drugs in the clinics and the limited range of medicines, made it difficult for participants to make sound treatment decisions. This also led to an increase in the cost of health care as clients had to pay for travelling to collect their medication supplies. Participating nurses had a difficulty in keeping a clear record of the client turnover in their clinics because clients had a dual entry point into the health care system. Some went to the clinic and were referred to the Umtata General Hospital, others went to the Hospital without being referred. All these clients went to Umtata General Hospital to collect medication. According to the Essential Drug Programme compiled in 1996 for PHC, phenothiazines like chlorpromazine in tablet form, fluphenazine decanote in injection form, phalapheridol injection, lorazepan injection, orphenadrine tablets, zuclopenthixicol injection, amtriptyline tablets and fluoxetine capsules should be available in every PHC clinic. This list is still under review and may be increased when the situation demands.

Policy issues

There were difficulties in getting psychotropic drugs by the municipality clinic without a written agreement between the Department of Health and the Municipality. So all the patients seen in the municipality clinic had to be referred to collect their medication from Umtata General Hospital after every consultation and review by the nurses.

Industrial Action

The nurses's strike between November, 1995 and January, 1996 made the health service unavailable in all clinics, resulting in the loss of faith on the PHC services. Psychiatric patients were considerably affected because of their dependence on the support of the service for their day to day life.

Transport

Transport problems prevented participants from conducting home visits as the situation demanded. Koch and Gillis (1991) in their study concluded that after care services reduce the incidence of relapse. Availability of transport could have solved the problem of poor delivery of drugs. It was an unfair practise for the nurses to use their own personal transport to deliver health care without remuneration. Absence of transport had a negative effect on aftercare and on medication supplies and supported by studies done by Krauss, Slavinsky (1982).

Communication

Consultation was not possible in the absence of a telephone connection between the clinic and the backup psychiatric team. Nurses used the services of the researcher who visited the clinic once a week which was in itself not adequate enough to give advice and support to the participating nurses. The referral system was used when there were problems that could have been solved through consultation. As mentioned in the study done in Orange Free State (Gagiano,1990), (Freeman, 1992) that the success of the integration of the psychiatric component into PHC demands an efficient consultation and liason and a clear referral system, the absence of this service had a negative effect on the support needed by the nurses. referral was used unnecessarily due to the absence of communication system for consultation.

Time

The utilization of more time for psychiatric care was not a result of more clients visiting the clinic but as a result of efforts to provide adequate service to psychiatric patients in the absence of resources. The time used for collecting medication from the hospital dispensary, home visits on foot to trace defaulters and conduct psycho-education and counselling, all increased the time used in the care of psychiatric patients. This time could have been used to improve the quality of care given through the improvement of the skills in handling aspects related to care. This time also refers to the time used by the clients in duplicating the health care by visiting the clinic for prescription, psycho-education and counselling, and then travelling to collect drugs when they were not available in the clinic. In one clinic with a staff ratio of 1:400 the problem of time had an impact on the rate of home visits. It can be argued that the time factor could be solved if transport and drugs were available for these clinics.

In conclusion PHC nurses need constant updating of their skills and knowledge so that they are not isolated from the mainstream of health professionals. The rural clinic with its poor facilities should be given a support service of more qualified personnel who should be used as consultants, teachers and counsellors to the PHC nurse.

5.4.2 Quality of psychiatric diagnosis, prescription and referrals

Diagnosis - History Taking

The results revealed that out of the 54 files received for the quality of history taken on the first evaluation, 2% of the participants were able to collect all needed information to make a diagnosis in the first 6 months of implementation. This figure increased to fifty six percent in one year. The history taken had major omissions that affected the diagnosis given in the first 6 months but improved as nurses identified the important aspects in the psychiatric history as compared to ordinary questions asked on patients who visit the clinic for physical illness. At the end of 6 months only 11% of the patients' files had major omissions. From this practice nurses were able to obtain a comprehensive history from clients and relatives that would enable them to give a DSM IV diagnosis and be able to handle both physical and psychiatric illness within the same patient. Even

clients who needed to be referred had sufficient information to enable the secondary health service staff to manage the client easily. There was an increase in co-operation between the clinic and Secondary Health Service staff in patient management.

The ability to collect relevant and sufficient information is the vital function of registered nurses. Registered nurses have performed this function since the beginning of their nurse training. The key factor was to enable them to identify which information was needed.

The time taken for each patient, and lack of skill in the identification of important issues in the history, led to poor and insufficient information obtained. As they discovered how important history taking was, in relation to the diagnosis and treatment, their skill of interviewing improved and the information important for the management of the client was adequately collected. Privacy was identified as a crucial aspect in history taking.

Given the necessary knowledge and skill, the PHC nurses are a good source of information related to the patient's illness on each visit. The relationship between the clients and the nurse is strengthened by the nurses ability to understand the client within his/her environment. The nurses observation of events surrounding the client and his/her family on a continuous basis revealed important information related to the client's family dynamics. If the client is removed from his/her usual environment it is difficult to identify cues related to his/her illness.

History taking is a crucial information source which enables the information to be comprehensive enough to arrive at a diagnosis. Old files with vague complaints that had been presented by patients assist the nurses to follow the pattern of the illness and be able to treat the psychiatric condition before it becomes chronic. The results of this study revealed that 34% of the patients' files had minor omissions in the first 6 months. In the second evaluation, one year later there was a shift from 34% to 56% minor omissions. Major omissions decreased to 11. % from 56%. This had no harmful effects on the diagnosis given because minor omissions resulted from lack of sufficient knowledge from the client and family about the type of drugs previously used, as well as the previous diagnosis and the duration of symptoms after a mentioned incidence. Illiteracy prevented clients and families from giving reliable information about these issues in the absence of records.

Clients are seldom informed about their diagnosis and therefore, do not know the type of mental illness they suffer from. Patient education about medication is usually vague and does not equip the client with information he/she can use in future. Relatives are often not involved in the care of the patient while in hospital and sometimes never visit the patient in hospital. It is therefore difficult to obtain information about the previous treatment and diagnosis. The relationship between mental illness and a stressor is a known factor amongst clients and relatives but how long the stressor has been experienced in relation to the beginning of symptoms is usually ignored. Estimation of time may be done and is usually unreliable. Nurses needed to be equipped with the skill on taking history about psychiatric illness as it is an important step into the correct diagnosis and treatment. This has proved to be possible from the results and will improve as participants gain more experience. To improve this skill in all the nurses will need strategies such as workshops and inservice education.

Major omissions listed in Table 4.2 affected the diagnosis given and therefore, the treatment decisions made. As soon as the client did not demonstrate improvement, the history was reviewed within two weeks and if in doubt the researcher was consulted on her weekly visit to the clinic. All new client files were sent to hospital and incorrect diagnosis were picked up easily by the psychiatrist who was part of the research team. Within a period of one year of practise the history taken improved.

The role of the backup team in the effective functioning without endangering the client is of importance. The presence of a consultation service to support the PHC was seen as vital. Literature in the Free State model, Gagiano (1990) support the need for the backup team of a multidisciplinary team. If this team is not accessible when needed by the PHC nurse referrals were used unnecessarily. This therefore demonstrates that a supervisor is needed, who in the recommendations is an advanced psychiatric nurse to handle some of the difficulties experienced by PHC nurses who have less skill in handling difficult patients. The PHC nurse should handle only clients suitable to be treated in the community. If the psychotropic drugs are dispensed at community level, PHC nurse must be trained on the dangers of each drug, the doses that are effective, and the indication for each drug in terms of symptoms evident in mental illness. Not all nurses will be experts in this function and therefore client safety must be maintained.

If there were no consultation and supervision services in the study, clients whose diagnosis and prescription were incorrect could have been incorrectly treated, suffered the effects of the incorrect drug and the chances of recovery diminished. This is an important area that needs to be decided by health authorities in areas where access to consultation and supervision is poor before the psychiatric component is integrated completely at PHC.

Appropriateness of Prescription

Stat medication:

Incorrect prescriptions were as a result of an incorrect diagnosis that resulted from an insufficient history taken. Subtherapeutic doses were prescribed due to the nurses' previous experience on common appropriate doses usually prescribed for physically ill patients, not aware that doses of psychiatric drugs are usually high. At the end of one year 44% of the prescriptions were correct as compared to the 11% of the first evaluation. As in incorrect diagnosis the subtherapeutic doses were identified by the psychiatrist who was part of the research team.

The opportunity of the nurses to select an appropriate drug was very limited. Drugs were not available in clinics. Various factors influenced the drugs supplies such as the policy on which drugs should be made available to the PHC settings is the most influential aspect. Drugs that could be effective according to the patients' histories such as fluanxol, were not kept in clinics. All Schedules 5 and 6 drugs could only be sent to the clinic by prescription cards. There was no provision for drugs of these schedules to be kept for clients who were diagnosed for the first time. This led participants to collect new prescriptions on their own or use various means of obtaining drugs to prevent clients from paying to travel to hospital to collect their supplies. This problem will be solved as soon as the recommendations of the Essential Drug List for PHC (1996) is implemented.

The shortage of drugs in clinics was an area of concern. The data on the perceptions of major problems revealed that 19% of the participants identified shortage of drug supplies as the highest on the list. Regulations and drugs protocols must be clearly defined if the psychiatric component is to be effectively integrated into PHC. It is necessary to put policies on the types of drugs to be kept in clinics. Their delivery, control, storage must

be clearly documented. Provision should be made for clients who need treatment for the first time. The scope of practice of general nurses in relation to prescription of schedules 5 and 6 must be revised to enable them to prescribe and dispense drugs to all clients without discrimination of psychiatric patients. If psychiatry is moved from being a specialist care, as is the case today, all that goes with it should be modified to enable the primary objective to be achieved - "health for all". The organisation of the district health system should enable drugs that cannot be stored in clinics due to specification of the Pharmacy Act be made easily available to clients without an increase in the cost by travelling.

Long - term Medication :

Clients maintained on long-term medication may continue to live on the treatment throughout their lives. Most of these patients are not on any grant, be it a disability grant or some form of family income, and are therefore a burden to their families. Some families are so poor and have inadequate income that the basic human needs are not easily met. Clients default treatment due to lack of funds to travel to the health service far from home. The availability of a service closer to where people live is the recommendation of the Alma Atta declaration of 1978 as a solution to the problem of access and cost.

Long-term medication was included as part of rehabilitation in this study. Client and family education enabled the clients and the relatives to learn to identify side effects of psychotropic drugs and what to do when side effects occurred. Clients were taught to identify the maintenance treatment so that whenever they visited the doctor they could either carry the tablets or be able to name them.

The results of this study revealed that the participants had insight into the doses on which clients could be maintained. Participants who had been providing maintenance treatment to psychiatric patients before the study were better able to make treatment decisions. The problem identified in keeping the client on a drug of choice was due to the availability of a very narrow range of drugs. Participants were compelled to maintain the client on a drug that would be easily available but not necessarily the best choice for the clients condition. Clients who were likely not to comply with treatment and needed supervision were maintained on long acting phenothiazines intramuscularly given once a month. When the intramuscular injections of modocate were not available clients were given

Largactil orally as a substitute. This practice led to dissatisfaction in most clients. Some clients were referred to collect their medication from hospital where it was possible for them to get the correct drug. Participants struggled to keep the image of the service offered by collecting medication for the clients from hospital using the clients' prescription cards when transport was available. Changes are expected after the publication of the Essential Drug Programme (1996) which gives a wider range of psychotropic drugs that should be available at the PHC centres.

The problem of shortage of drug supplies has to be addressed urgently at regional level. It has been observed that the cost of travelling from home to a clinic and from a clinic to a hospital dispensary far from home to collect medication increases the cost of health care for psychiatric patients.

The administrative problems experienced by the Municipality health service need a standing agreement between Department of Health and the Municipality offices so that in the process, clients do not suffer from the division of finances for use by the two offices. All efforts must be made to ensure that clients do not use different entry points to the health service. The role of the psychiatric clinic attached to the hospital should be clearly defined. This service would be better utilized for clients referred from the peripheral PHC services and would give the backup support for the PHC clinics. This would serve as a consultation service for all clinics. A major obstacle is the absence of a reliable telephone system in all the other clinics, except for the municipality clinic. Clinics connected to a two-way radio are connected to the outpatient department where no psychiatric team is available to support the nurses dealing with psychiatric patients. If this communication service could be of use for both physically ill and psychiatric care, very few clients would need to be referred unnecessarily.

Referrals

This was part of the PHC practitioner even before this study. The workshop improved the participants' ability to specify the problem clearly and to explain what needed to be done for the client. The results of the study showed that from the beginning of the project 86% participants could refer clients with a clearly specified reason to an appropriate service. This improved to 92% within one year. In addition to the

recommendations of the study done in Free State Sawyer et al (1996) and Gous (1992) add the emphasis on the need for an efficient referral system.

The referral system was used more in the first 6 months but few clients were referred during the last six months of the first year of implementation. These results are in line with the WHO (1984) results that about 90% of the priority conditions can be treated at the PHC centres. The referrals in addition to clients who could not be treated in the community were increased by a shortage of medication. Participants discovered new ways of solving the problem of shortage of medication other than referring clients. The decrease in the numbers of referred clients in the second evaluation as seen in Figure 4.3, second evaluation, reflects the confidence participants gained in making treatment decisions, making it unnecessary to refer for confirmation of the diagnosis or because the symptoms were vague. Clients were now only referred for such reasons as the assessment of the I.Q., alcoholic for detoxification, childhood disorders, depression with suicide. Other clients were referred due to the presence of psychotic symptoms with severe aggression that made it difficult for the client to live within the family. Table 4.5 shows the sources of referrals. The clinic that had never handled psychiatric patients before had 17 referrals in the first 6 months and only 4 in the last 6 months of the year of study. Two clinics did not refer any client in the later half of the implementation of phase one. Other clinics referred between one to three clients in the last six months.

An efficient referral system forms the pillar of the PHC approach. This service needs to be strengthened between the clinic and the backup service by replying to the service that referred the clients to inform them of what has been done to the client referred. This will enable the PHC and secondary health services to keep a good track of the patients' progress as they moves from one service to another. Primary health practitioners use the referral system during case management and therefore need all the information related to the patient to be kept in one file. In this way, a comprehensive record is kept by the PHC service where the client receives treatment.

PHC nurses work independently far from the hospital and need to be skilled to handle a variety of medical conditions unassisted. The service provided should be sufficient enough to handle at least 80% of cases, thus prevent overcrowding of secondary health services by clients who can benefit from a less sophisticated service. If the PHC

practitioners are not equipped with the skills needed to be able to diagnose all forms of illness and act appropriately to solve the clients problems they are likely to suffer from burnout as a result of poor productivity. In addition, clients have a right to benefit fully from a health service provided close to where they live. Those clients who need beyond what the service provide be referred to the right resource. Few patients will utilize the secondary health service unnecessarily and will save the use of the taxpayer's money uneconomically.

Therefore from literature, other studies in South Africa and the results of this study, the PHC forms the backbone of a service that is provided to the greatest number of clients. The support from the psychiatric team, or specialists in the care of psychiatric patients, is most crucial. The PHC nurses should be equipped with the skill needed for them to perform the duty they are expected to perform. To allocate registered nurses in the PHC service without the skill will lead to frustration and an inability to identify psychological elements in the patients history. Incorrectly diagnosed clients move from service to service without a correct treatment until they are chronic. Early identification of psychiatric conditions and prompt treatment is what is required.

The success of this service depends on personnel skilled to do so. Such personnel need not be highly trained but skilled to perform the duty. This training can take between few hours as seen in the Lesotho study to about 60 hours as shown in the study done in India (WHO, 1984) and in OFS (Gagliano, 1990). Another example given by Ayonrinde (1989) from an experience in Nigeria reflects that nurses and doctors working in isolated areas are receptive to additional information which would equip them with skills needed in their work environment.

The existing psychiatric nurses could be used after inservice, to improve the skills needed, as consultants and as specialists. The above attempts to improve the ability to take history demonstrates that, if psychiatric care is integrated with other forms of health care there must be levels of supervision that will give support to the nurses involved in the care of psychiatric patients, or an improvement in the communication system between the clinic and the psychiatric team to enable consultation to occur. Absence of an efficient telephone system and supervision can lead to a total breakdown of this important service.

In order for psychiatric care to be effectively integrated into PHC literature reveals that an efficient referrals system be put in place. Aboidum (1990) and Freeman (1992) reveal that amongst the benefits the cost is included. If the cost of health care is increased by travelling to collect medicines, clients tend to default the treatment which may lead to relapse. The referral system should include an efficient transport system to assist clients who cannot travel on their own means to hospital.

Rehabilitation has not been used as an approach in S.A. The nature of rehabilitation services for blacks especial in rural community care is poor (Uys,1991). This integrated approach will be able to meet the needs of psychiatric patients listed by (Kraus et al 1982). This non-sophisticated service should be used by each community for persons with all forms of handicap. Projects must be community driven so that they generate income that will be used to support each project. Such projects can be developed in line with the projects financed by the Reconstruction and Development Plan of the Government of National Unity (ANC, 1994) and be managed by trained community members. In turn when clinets have been fully rehabilitated and trained they should be supported to start their own income generating projects, supported and evaluated from time to time. The disability grant that clients receive should be used to start such small buisnesses (Uys, 1991).

THE ROLE OF THE CLINIC FOR PSYCHIATRIC CARE IN HOSPITAL

The role of a clinic at a hospital will have to be clarified. This service was a duplicate of the services offered by the PHC services in the community as well as a referrals secondary health care service for psychiatric patients. There was confusion when clients used the service for problems that could be handled in a PHC clinic without being referred. Clients came from all walks of life to get the services of the specialist team without any referral. Most clients took advantage of the absence of a clear policy on how this clinic should function. This service could administer some long-term drugs that were not available to the PHC centres, mostly favoured and appropriate for other clients like fluanaxol and at times modecate, making it impossible for these clients to receive their treatment from anywhere either than from this clinic. This was evident when most drugs were out of stock in the dispensary which supplies all clinics except in this clinic.

5.4.3 Quality of rehabilitation diagnosis and rehabilitation plans

Rehabilitation has proved from this study to be an important pillar in the recovery of psychiatric patients within the community. Rehabilitation involves the family, the client and the health professional in setting the goals and in planning the steps to be taken in the management of the client. The health professional gives education and support to the family and the client while the family takes over the educational role of the client. The family sets goals which they would like the patient to achieve while the patient has his/her own goals. Both sets of goals should be realistic and achievable according to the patients' condition. Priority goals are selected and agreed upon and steps to achieve goals are discussed.

Care must be taken to prevent unrealistic expectations from the client and family through discussions about each goal and its importance in the patients' life. The principle of positive re-inforcement should be taught to the family in order to use it to encourage and support the client in the achievement of set goals. Rehabilitation must be taught to all primary health care nurses as part of their daily work so that clients are given the chance to learn new skills, re-learn old skills that were lost due to illness and to utilize the remaining abilities in the day to day activities of the client. This will prevent overdependence of the client on the family.

When clients have lost their productivity, it is important to support the family in the restoration of the clients' work ability to those clients who can benefit vocational rehabilitation. Other clients may only be able to learn basic life skills. Communities should be motivated to start small projects from which disabled clients can learn work related skills and behaviour. These projects can also generate income for use by the clients and their communities.

Social services must be sensitised into the need for financial assistance of the chronic mentally ill so that the rehabilitation needs and personal needs are met. There is great need for the education of the family into the correct use and objective of the disability grant. A policy must be set up in which rehabilitation of disabled clients in the community will be included in order to guide the communities in continuing rehabilitation as a community responsibility. A multi disciplinary approach into the training of disabled persons within these rehabilitation projects must be clearly defined.

5.4.4 Utilization of service

The results of this study show that all the clinics were better utilized than before with one clinic seeing an average of five new clients per month while others had an average of one new client per month. This increase in utilization is as a result of the community awareness of the availability of the service and what it offered for the mentally ill as well as the increase in home visits to trace old clients who had defaulted on their treatment. Access in terms of distance and the availability of service any time between 8h00 and 16h00 without discrimination of psychiatric patients also played a role in the better utilization of the service.

Psychiatric care will have less stigma if provided in a PHC setting within the other services provided. Care must be taken to avoid separating psychiatric patients from the mainstream of health care. If psychiatric patients are seen as they come the service will be better utilized. Clients reported that in other clinics not included in the study, patients were made to wait for a long time to be seen last. This was the practice in most clinics before the study. It would be a good service if all nurses were equipped to deal with psychiatric patients so that clients are not discriminated when their turn to be seen comes. Let the clients benefit from the service with all the other clients. If more time is needed for them because of the nature of their illness, provision must be made so that they are not kept in the clinic longer than necessary.

Various factors affected the ability of the cases to reflect a clear pattern of utilization. Patient attendance varied depending on the strategies used by the service to influence clients to visit the clinic. There was a general problem of shortage of all types of drugs which led to most clients utilizing the hospital clinic for treatment. Clinics were unable to cater for large numbers of physically ill clients including psychiatric patients. Consumers lost faith in some clinics while those who could not do without treatment were assisted with transport, or the nurses collected medication for them. These clients included patients on diabetic treatment, psychiatric care, hypertension and tuberculosis. It was unfortunate that during this period the health services had many problems and that in the Eastern Cape this was a period of transition aimed at the integration of health

services. This resulted in dissatisfaction of consumers with the health services in general.

It is believed that more clients in need of psychiatric care could be screened from the communities. The rate of unemployment, poverty, loss of jobs and violence are known to be prevalent today. These factors have been shown from literature to contribute to mental illness. The increase in the use of alternative care, such as faith and traditional healers, is as a result of clients seeking all available means to get help from distressing symptoms of mental illness. Mental health care should therefore be made available for all clients to make a choice on which service to use for which problems. The information shown by the statistics reflects the need to increase the services for the care of psychiatric patients in all clinics. Resources need to be increased where there is most need. Since rural health services serve a larger population it is important to equip these services with adequate resources that will prevent unnecessary utilization of secondary health services.

For utilization of services to improve, factors such as the hours of service, medicine supplies, increased support of the rehabilitation programmes for each family and provision of transport for referred patients must be improved so that the needs of clients are met closer to where they live. The problem of safety of nurses in clinics needs to be addressed together with the need for proper accommodation for all PHC professionals.

5.4.5 The Rate of Defaulters, Admissions and Re-admission :

Statistics collected from the psychiatric ward at Umtata General and Umzimkulu hospitals were not clear. No clients were admitted in Umtata General Hospital from the clinics in the project. One client from clinic AA1 was transferred to a clinic nearer home not included in the project, defaulted treatment and was admitted at Komani hospital.

The reason for the decrease of defaulters in clinics and absence of defaulters in others was due to the support the families received from the clinics under study. Psycho-education gave most relatives advices on how to handle different situations related to the care of their relatives at home. The common practice of sending the patients for admission on the grounds of poor personal habits, walking about aimlessly and undressing in public and other common behaviours were included in the education given to families. Communities were asked to identify tangible reasons for which patients could

be hospitalised. In the presence of a health service that gave support it was not necessary to send patients for hospitalisation who could be treated within the family.

Clients in other cases used alternative treatment when symptoms recurred and continued to use the health service when medication was available. The skill of identifying symptoms of relapse assisted families to report any change in the clients' behaviour so that nurses could increase or change the treatment as desired. Monitoring symptoms became a family practice to most families and the care of the patient is a shared role.

Families have not been supported by the health services in the care of patients in the past. So, the service provided by this project was received with great appreciation especially by families whose relatives had been on treatment for a long time. Responsibility was given to, and rehabilitation plans made with, the client and family so that the health providers did not take over the family role. This increased the willingness of the family to learn to care for their ill members. Some families were resistant to change and wanted their relatives to be hospitalised unnecessarily. Such families were educated, home visits increased and relatives encouraged to accompany the client on his/her next visit to the clinic in order to give a report on his/her progress according to the family observations and expectations. Families were supported on all difficulties experienced as nurses were case workers for each client.

The role of traditional and faith healers must be understood by the health professionals. These alternative treatment personnel should be educated about the treatment methods used by health professionals vice-versa so that an informal referral system is opened between these two types of health care since most of the rural clients still believe in traditional health care.

To maintain a psychiatric patient in the community, family involvement was used. Education and persuasion provided the needed support.

5.4.6 Consumer satisfaction

A small sample of consumers, two from each clinic were interviewed to evaluate their satisfaction about the service provided.

The results showed that of the themes evaluated there were differences in the performance of the various cases as evaluated by the client and one relative.

Access

There were differences in access in all clinics. One clinic was reasonably accessible for 24 hours and evaluated as good by consumers while in most clinics services were available between 08h00 and 16h00 hours and was regarded as fair. Only clients who utilized the clinic that was accessible for 24 hours were satisfied with the service offered. All clients believed that the services for psychiatric patients were necessary the whole day and night. According to WHO (1978) the services at the PHC level should be made accessible in terms of distance and hours of service. The PHC services in these clinics were not accessible even before the project. Therefore, to correct the problem of accessibility the nurses in the PHC services should offer services to clients anytime they come to the clinic. In order for this to be possible, all clinics should have adequate accommodation for nurses, adequate security measures for their safety, electricity to make it possible for nurses to work at night. Clients who are far from the clinic should be provided with a clinic within walkable distance so that there is less travelling.

Finance

Financial problems varied from the need for assistance to requisites necessary for daily leaving. Consumers evaluated one clinic higher and satisfactory than the others due to the presence in this clinic of a social worker who handled financial needs of various clients. The rest of the clients were rated slightly lower but fair on the understanding of what each clinic could offer. These clinics did not have a social worker attached to the service but the nurses had to take over this role. The absence of a transport service for the clinic was seen to be the biggest problem that increased the need for financial support of most clients when they were expected to collect medication from the hospital dispensary.

Clients were advised to collect their medication at least a week before they run out of supplies so that whenever drugs were not available, means were made to bring the supply before the client was completely out of treatment. Not all the clients complied with this agreement as some came late.

Finance was a major problem amongst psychiatric patients. Participants dealt with problems of budgeting with families for clients who were on a grant and made all means to refer the client to apply for a disability grant. Families who had a reasonable income were educated on the provision of funds for the clients' health needs and to avoid depending on the clinic staff for this part of care. Communities were motivated to make all necessary recommendations to the health administrators for better delivery of drugs supplies to clinics in order for the service to be efficient in the delivery of health care.

In addition social workers and PHC nurses should educate clients on the intended use of the disability grant and a system set up to evaluate the use of such grants by the family members. Some clients report that family frictions and quarrels occur around the use of these grants by the clients. If this grant is correctly utilized the burden at community level, of meeting the needs of chronic patients will be improved (Kraus, 1982)

Technical Quality

Consumers were expected to evaluate the ability of the participants in making a diagnosis, prescription of medication, giving information to the client and relatives about the illness, as well as the involvement of the family and client in making treatment decisions. The degree of satisfaction with this service depended on the consumers' understanding of the importance of this information. Consumers were already sensitized to learning about the nature of mental illness and its management at home.

In 3 clinics consumers were satisfied with the way in which nurses explained to them all aspects of the illness. Even the illiterate patients were educated on their right to be informed about the illness and to request a form of medication they believed was suitable unless it was contra indicated to the patient. Reasons why a patient may not receive modocate intramuscularly or another form of treatment chosen by the patient were explained. All the above clinics were evaluated at 97%, 92% and 85% respectively and therefore good according to consumers. Differences were as a result of the consumers perception about the specific aspects mentioned. Two clinics were rated as fair at 73% while the last clinic followed at 68%. The feedback on how each case was rated was aimed at developing insight into how the consumer evaluated the care given so that the various aspects of concern would be improved at clinic level.

Communication

With respect to Communication, the results of this study illustrate how important it is to allow clients and relatives to ask all questions related to the illness and treatment. Consumers remarked about the vast change that had occurred since the implementation of the project. Consumers could give a clear account of the treatment and what to watch for. Even illiterate clients could explain what they were suffering from in medical terms. This information was necessary for all clients so that they were able to give full information about their illness or the illness of their relatives.

Consumers could give feedback on what they believe would best suit them. This open communication enabled the clients and relatives to develop a trusting relationship with the participants. A comparison was made by most consumers and they were very critical about the breakdown of communication between the health service and consumers. The reason why the hospital-based clinic was criticised by clients was in relation to the absence of telephone system to summon an ambulance when a serious patient needed hospitalisation. Consumers complained about the absence of telephones in the government clinics as compared to the Municipality clinics. Suggestions were made that telephone lines be connected to the existing lines in the local shops. There is however hope that in the improvement of the telecommunication system in the whole country especial in rural areas, clinics will also benefit. Clients wanted to be given a chance to discuss issues of concern even if the discussion was interrupted by psychotic symptoms. Participants satisfied the consumers on the above aspects although they were not rated equally. From the data collected consumers were prepared to take the necessary steps to improve their lifestyles which were identified in their discussion with the participants as contributing to mental illness.

Negative incidents

Negative incidences included an aspect of assistance of patients with tasks of living and with transport. Consumers explained how they suffered because of transport problems. Home visits could not be made due to lack of transport and clients could not be sufficiently assisted in travelling to hospital. Clients described this as the most negative aspect of the care in clinics and suggested that an efficient ambulance system be put in place. This was the general feeling in all clinics. All clinics were evaluated between 43% and 49% on Figure 4.40. The improvement of the state of roads to all health services is

the responsibility of the government to enable public transport to be used to health centres. There is need for a durable type of a transport in every clinic for use on home visits and for other services between the clinic and other health centres.

5.5. CONCLUSION

In conclusion this study has shown that, if given the necessary training and supervision with the support of a backup system the registered nurses in clinics can :

- * diagnose and treat psychiatric conditions
- * refer clients appropriately
- * teach clients and relatives to identify target symptoms and take appropriate steps to handle them
- * make rehabilitation plans with the clients and family
- * improve vocational rehabilitation of each client.

To implement this approach support for PHC nurses is necessary.

The service provided by this project has brought satisfaction of consumers as the service was brought closer. This system of treatment was able to prevent defaulting of treatment and increased the communication and family participation in the care of psychiatric patients and limited the rate of hospital admissions.

There were specific barriers which made the provision of an adequate PHC service difficult. These included weakness in :

- . drug supplies
- . transport
- . communication
- . security measures

There were specific strengths which supported the process of integration, such as :

- . the training offered to the registered nurses in clinics
- . the support provided by the researcher, and to other clinics by the nursing staff.
- . the backup team in the secondary health service

5.6 RECOMMENDATIONS

The model followed in this study for the integration of psychiatric component into PHC seems to be effective enough to warrant general implementation in the Eastern Cape provided the following are taken into consideration :

- * Government of the Eastern Cape to facilitate the integration of psychiatric component into PHC according to the recommendations of WHO and ANC.
- * transport for the clinics to be improved so that the referral system is efficient
- * drug supply be improved with a clear policy on drug supplies so that the nurses can prescribe the treatment for psychiatric conditions that can be managed in the PHC setting
- * communication be improved to enable consultation between the secondary health service and the clinic to be possible
- * backup of the secondary health care system facilitate in the implementation of the integration of the psychiatric care into PHC
- * the placement of an advanced psychiatric nurse at district health service level for supervision of psychiatric care and to give support to nurses at PHC level
- * security for PHC service be stepped up and accommodation for nurses be provided.
- * a policy be developed for the integration of the Municipality clinics into the general PHC system, and this process should be speeded up.

5.7 IDEAS FOR FUTURE RESEARCH

Further research will be needed in order to determine the applicability of the results in the urban areas other than rural communities and semi urban health services as there may be difference in the setting from the area of the present study.

The role of mobile health care in relation to the integration of psychiatric care was not included in this study yet mobile health services still form part of the present PHC

service. The researcher believes that if this service has to provide aspects of psychiatric care, a study needs to be undertaken to determine which activities could be included in a mobile psychiatric care. The time taken by a mobile service, the referral system to be used and how rehabilitation service will be offered are all matters which require further clarification and articulation.

The list of conditions used in the theoretical background were determined according to the mental health priority list. Further study is needed to look into the treatment of other conditions, such as child and adolescent psychiatry in the PHC setting. These other conditions may be prevalent in other areas. Further research could also be undertaken to examine the major forces affecting mental care and the welfare of psychiatric patients.

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PHASE 1 : DIAGNOSIS AND INITIAL TREATMENT EVALUATION

RECORD NUMBER: _____

1. Please rate the history taken by ticking one of the following:

All the necessary/possible information is given
There are minor omissions
There are major omissions

List the specific omissions:

2. Please rate the diagnosis by giving a mark to each of the five axes according to the following rating scale:

	Rating
I concur with this diagnosis	5
There is ample evidence for this diagnosis, but I would have made a different diagnosis	4
There is some support for this diagnosis, but not enough to warrant making it	3
The information is so incomplete that a diagnosis is impossible/very difficult	2
The diagnosis is inappropriate	1

	Rating
Axis 1 :	
Axis 2 :	
Axis 3 :	
Axis 4 :	
Axis 5 :	

Comments:

3. Is the stat medication appropriate?

Yes	1
Yes, but it could have been better	2
No	3

If you choose 2 or 3, please explain:

4. Is the long-term medication appropriate?

Yes	1
Yes, but it could have been better	2
No	3

If you choose 2 or 3, please explain:

PHASE 1 : TREATMENT ADJUSTMENT EVALUATION

RECORD NUMBER: _____

1. The motivation for the change of medication is clear: Yes
No

2. The reason is appropriate: Yes
No

3. The change is appropriate:

Yes	: 1
Yes, but it could have been better	: 2
No	: 3
The patient should have been referred	: 4

If you choose 2, 3 or 4, please explain:

4. A change which should have been made, according to the data in the file, was not made

Yes (Nr of times)

No

If yes, please explain:

PHASE I : REFERRAL RECORD

INSTRUCTIONS:

- * A form like this should be filled in for every patient you see from the clinics involved in the study.
- * Please ensure that you fill in every item, and then put the completed form in the research mail box in the central office for the researchers to collect every week.

FORM:

1. Referral clinic : Ngangelizwe Mbekweni
 Tabase Baziya

2. Date of referral :
 Date of outpatient visit:

3. Please rate the referral by ticking ONE of the following:

Totally appropriate
 Acceptable, but could have been prevented by consultation
 Poorly motivated
 Inappropriate

Any comments ? _____

4. Please rate the referral letter/form by ticking ONE of the following:

All necessary information is given
 Some information missing
 Lots of information missing

Any comments ? _____

5. Patients information: Name: _____

OPD Number: _____

6. Referring person: _____

7. Diagnosis: _____

8. Treatment: _____

9. Reasons for referral: _____

PHASE 1 : CONSULTATION RECORD

INSTRUCTIONS:

1. Please fill in this form every time you get a call or a letter of consultation from one of the PHC nurses involved in the project.

2. Please make sure that you fill in every item, and then place the form in the research mail box in the central office, where it will be collected every week by the researcher.

FORM:

1. Name of consulting nurse: _____

2. Area of consultation: (Tick one or more of the following:)

2.1 History

2.2 Diagnosis

Axis 1 :

Axis 2 :

Axis 3 :

Axis 4 :

Axis 5 :

2.3 Referral or not

2.4 Stat treatment

2.5 Long-term treatment

2.6 Handling of side-effects

2.7 Adjustment of medication

2.8 Psycho-social problem

3. Was the consultation by letter? Yes _____ No _____

If "yes", which date was it written? _____

4. Could you help?

Definitely

To some extent

Not really

5. How long did the consultation take? _____

6. Did the nurse have the necessary information available?

If not, what was missing? _____

7. Date: _____

8. Time: _____

9. Consultant: _____

REHABILITATION PLAN RATING SCALE

1. Clear target symptoms identified.

YES	NO	PARTIAL

2. Plan for patient clear and appropriate.

YES	NO	PARTIAL

3. Plan for family clear and appropriate.

YES	NO	PARTIAL

4. Rehabilitation goals set clearly.

	YES	NO	PARTIAL
1.			
2.			
3.			

5. Steps to achieve goals clear and appropriate.

	YES	NO	PARTIAL
1.			
2.			
3.			

6. Level of vocational rehabilitation.

FIRST	LAST

PHASE 1 : PROGRAMME EVALUATION BY STAFF : PHC NURSES

1. PLEASE INDICATE YOUR GENERAL FEELINGS ABOUT THE INTEGRATION OF PSYCHIATRIC CARE IN YOU PRIMARY HEALTH CARE CLINIC AT THIS STAGE ON THE SCALE BELOW.

THERE IS NO RIGHT ANSWER, SO DO NOT TRY TO FIGURE IT OUT. JUST GIVE YOUR FIRST FEELING.

FOR EXAMPLE, A PERSON'S FEELING ABOUT "rain" MIGHT BE:

happy 1____1____1____1____1____1____1 sad
destructive 1____1____1____1____1____1____1 healing

Now indicate your feelings about the integration. Please mark every line:

valuable 1____1____1____1____1____1____1 worthless
heavy 1____1____1____1____1____1____1 light
fast 1____1____1____1____1____1____1 slow
difficult 1____1____1____1____1____1____1 easy
helpless 1____1____1____1____1____1____1 powerfull
challenge 1____1____1____1____1____1____1 threat
necessary 1____1____1____1____1____1____1 waste
tense 1____1____1____1____1____1____1 relaxed
small 1____1____1____1____1____1____1 big
frantic 1____1____1____1____1____1____1 steady
disaster 1____1____1____1____1____1____1 achievement

2. Rate your satisfaction with the different aspects of the integration programme on the following scale:

1. Very satisfied
2. Satisfied
3. Dissatisfied
4. Very unhappy

Rating

- 2.1 The training programme
- 2.2 The supervision
- 2.3 The consultation service
- 2.4 The reaction to your referral
- 2.5 Your own ability to take a history
- 2.6 Your own ability to make a diagnosis
- 2.7 Your own ability to prescribe medication
- 2.8 Your own ability to give psycho-education to patients
- 2.9 Your own ability to give psycho-education to families
- 2.10 The support for this programme in the clinic
- 2.11 The response of the clients

3. What do you see as a best thing about the integration programme?

4. What do you see as the biggest problem about the integration programme?

QUESTIONNAIRE FOR CONSUMERS: PATIENTS OR FAMILY MEMBER

Section A: Demographic Information

Circle the option which is most appropriate:

1. Do you yourself have a mental illness? Yes/No
2. If No, What is your relationship to the mentally ill person?
Mother/Father
Wife/Husband
Sister/Brother
Daughter/Son
Friend/Other relation
3. Your age: _____
4. Marital status: _____
5. Race: _____
6. Level of Education: _____
7. Diagnosis you or your family member have: _____
8. When was the first attack of illness?: _____
9. Have you/your family member ever been hospitalised for mental illness Yes/No
10. If yes how many times?: _____

Section B: Your psychiatric Health Care

1.1. ACCESS: Arranging and getting care

Make a cross over one number on each line

Poor=1 Fair=2 Good=3 Very good=4 Excellent=5

1.1.1. Convenience of location of the psychiatric clinic/outpatients.	1	2	3	4	5
Before					
After					
1.1.2. Hours when the clinic is open.	1	2	3	4	5
Before					
After					
1.1.3. Access to care in an emergency.	1	2	3	4	5
Before					
After					

1.1.4. Length of time spent waiting at the clinic to be seen.	1	2	3	4	5
Before	1	2	3	4	5
After					
1.1.5. Access to assistance whenever it is needed.	1	2	3	4	5
Before					
After					
1.1.6. Monitoring of general health.	1	2	3	4	5
Before					
After					
1.1.7. Prompt help when symptoms increase at home.	1	2	3	4	5
Before					
After					
1.1.8. Availability of drugs when needed.	1	2	3	4	5
Before					
After					

1.2. FINANCES

1.2.1. Protection you have against hardship due to medical expenses.	1	2	3	4	5
Before					
After					
1.2.2. Arrangements for you to get the medical care needed without financial problems.	1	2	3	4	5
Before					
After					

1.3. TECHNICAL QUALITY

1.3.1. Thoroughness of examination and accuracy of diagnosis.	1	2	3	4	5
Before					
After					
1.3.2. Skill, experience and training of staff.	1	2	3	4	5
Before					
After					
1.3.3. Thoroughness of treatment.	1	2	3	4	5
Before					
After					

1.4. COMMUNICATION

1.4.1. Explanation of diagnosis and treatment.	1	2	3	4	5
Before					
After					
1.4.2. Attention given to what you have to say and feedback is given.	1	2	3	4	5
Before					
After					
1.4.3. Choice in terms of treatment and rehabilitation option.	1	2	3	4	5
Before					
After					
1.4.4. Being kept informed.	1	2	3	4	5
Before					
After					
1.4.5. Teaching to monitor and deal with symptoms.	1	2	3	4	5
Before					

After					
1.4.6. Involving family actively in care.	1	2	3	4	5
Before					
After					

1.5. STAFF ATTITUDES

1.5.1. Friendliness and courtesy shown to you by staff.	1	2	3	4	5
Before					
After					
1.5.2. Personal interest in you and your problems.	1	2	3	4	5
Before					
After					
1.5.3. Respect shown to you.	1	2	3	4	5
Before					
After					
If you are a family member:					
1.5.4. Respect shown to you as a family member.					
Before					
After					
1.5.5. Acceptance shown to alternative approaches to treatment, eg. traditional healers.	1	2	3	4	5
Before					
After					

1.6. INCIDENTS

How often does the following incidents occur in psychiatric services according to your own experience?

1=Never 2=Seldom 3=Sometimes 4=Often 5=Very often

1.6.1. Discussing one patient with another.	1	2	3	4	5
Before					
After					
1.6.2. Favouritism from staff to some patients.	1	2	3	4	5
Before					
After					
1.6.3. Wrong number of tablets in envelopes handed out at clinics.	1	2	3	4	5
Before					
After					
1.6.4. Home visits.	1	2	3	4	5
Before					
After					
1.6.5. Medication reviewed in order to decrease it.	1	2	3	4	5
Before					
After					
1.6.6. Clinic staff assists seriously ill patients with transport when needed.	1	2	3	4	5
Before					
After					
1.6.7. Clinic staff assist seriously ill persons with more general tasks of living, not just strictly medical treatment.	1	2	3	4	5
Before					
After					

1.6.8. Patients have a choice in terms of treatment and rehabilitation options.	1	2	3	4	5
Before					
After					
1.6.9. Family have a choice in terms of treatment and rehabilitation options.	1	2	3	4	5
Before					
After					
1.6.10. Missed clinic visits are followed.	1	2	3	4	5
Before					
After					
1.6.11. Clinic staff refuse to help or treat a patient.	1	2	3	4	5
Before					
After					
1.6.12. Patients are seen at clinics in the order in which they arrive.	1	2	3	4	5
Before					
After					

ANY COMMENTS:

.....

.....

.....

.....

.....

.....

.....



University of Transkei
Faculty of Medicine and Health Sciences
Department of Nursing Science

Private Bag X1 UNITRA Umtata Eastern Cape South Africa
Tel: (0471) 302 2111 - Fax: (0471) 26820/25747 - Tel. Add.: UNITRA Telex: 734TT

Reference No.:

03.04.94

Director General For Health
Department of Health
Bisho

Dear Sir

RE : PERMISSION TO UNDERTAKE THE STUDY

I hereby request permission to undertake a research project in the six following clinics in the region of Umtata :

Ngangelizwe
Tabase
Baziya
Mpunzana
Ntshabeni
Qokolweni

The study is on the Integration which will take a period of 18 months. I do also request that a meeting be held in which I will be able to explain all issues related to the study.

N.E. Sokhela
Yours faithfully
Mrs N.E. Sokhela

PROVINCE OF THE EASTERN CAPE

ISEBE LEZEMPILO NENTLALONTLE MINISTRY OF HEALTH AND WELFARE

Referensi : *MC*
Ref. No. :

Ingxowa Eyodwa X0033
Private Bag X
BISHO

13/05/96

Imibuzo : *G. N. Nkomo*
Enquiries:

Fax: (0401) 951205 \ 91625

Telephone: *994111*

TO : *Mrs. S. S. S. S.* FAX NUMBER *0471 - 26820*
FOR ATTENTION: *Mrs. S. S. S. S.*
FROM : *Mrs. S. S. S. S.*
NUMBER OF PAGES (including this page): *2*

MESSAGE

*Appointment - Integration of Psychiatric
Component into Primary Health Care*

G. N. Nkomo
for Mrs. S. S. S. S.

(If you do not receive all the pages clearly please phone or telefax us)

HAVE A NICE DAY !!

PROVINCE OF THE EASTERN CAPE
ISEBE LEMPILO NENTLALONTLE
MINISTRY OF HEALTH AND WELFARE

In: ferensi : PHC
Ref No. :

Ingxowa Eyodwa X0038
Private Bag X
BISHO

Inibuzo : Mrs S Siwahla
Enquiries:

13 MAY 1996

Fax : (0401) 951205 \ 91625 \ 993765


Telephone: 0401- 994101

Mrs N E Sokhela
University of Transkei
Nursing Science Department
Private bag X1
UMTATA

INTEGRATION OF THE PSYCHIATRIC COMPONENT INTO PRIMARY HEALTH CARE IN THE EASTERN CAPE.

Please be advised that the Director for Primary Health Care (Mrs S Siwahla) and the Psychiatric Regional Co-ordinators will be able to meet you and Prof. L. Uys on 30 May 1996 at 14H00.

The team is looking forward to the discussions.


PERMANENT SECRETARY
DEPARTMENT OF HEALTH AND WELFARE
tcf/yek.15