THE INTEGRATION OF MENTAL HEALTH CARE SERVICES INTO PRIMARY HEALTH CARE SYSTEM AT KING SABATA DALINDYEBO MUNICIPALITY CLINICS

by

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ABSTRACT

Introduction: Primary Health care refers to care which is based on the needs of population. Mental health care provided within general primary care services is the first level of care within the formal health system. There is no research in King Sabata Dalindyebo, carried out on issues around integration of mental health with primary health care. The present study is initiated to overcome this gap.

Aim of the study: The aim of the study was to investigate the level of knowledge, implementation and barriers of integrating mental health care services into primary health care system at King Sabata Dalindyebo clinics, in Mthatha region.

Methods: This descriptive cross-sectional study was conducted at King Sabata Dalindyebo Clinics, between January 2010 and December 2011. A 10% random sample of all health professionals from King Sabata Dalindyebo was interviewed concerning their demographic characteristics, education/ qualifications, general and further training in psychiatry, awareness about Mental Health Care Act 17 of 2002 and mental health care services characteristic related to the integration of mental health care services into primary health care system. For data analysis, the means of continuous variables across 2 groups were compared using Student-t test. The proportions (%) of the categorical variable across 2 groups were compared using Chi-square test.

Results: A total of 52 health professionals (40.4% males, 59.6 females, 59.6 married, 3 doctors, 49 nurses, mean age 36.9± 8 years range 23 years-52 years), were surveyed. The participants were characterized by low level of qualification in specialization, further training in psychiatry, and by very low awareness about Mental Health Care Act 17 of 2002. Furthermore, there was no implication of expects (Regional psychiatrist, psychologist, social worker) and co-ordination of mental health care services.
Working in remote and disadvantaged area, health workers with lower education qualification, absence of co-ordinator for mental health care services and absence of workshop on Mental Health Care Act 17 of 2002 were determinants of lower awareness about Mental Health Care Act 17 of 2002. However, there was a good to excellent framework for potential implementation of mental health care services into primary health care system. The government support in infrastructures, drugs availability, transport and equipment was evident. Patients were helped within abroad based ethical**,** human rights and psycho-social framework.

Conclusion: There is a lack of improving human capacity for mental health in terms of continuous training in mental health issues, policies, organization and development. Globally, the integration of mental health care service in King Sabata Dalindyebo is non-optimal.

DECLARATION

I, **Dlatu Ntandazo**, Student Number **201613646**, solemnly declare that this mini-dissertation entitled "**The integration of mental health care services into primary health care system at King Sabata Dalindyebo Municipality O.R Tambo District, Eastern Cape**" is my original work. All sources used or quoted in the study have been indicated and acknowledged by way of complete references.

Name: Dlatu Ntandazo

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SIGNATURE:

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DEDICATION

I dedicate this study to my beautiful wife, Noluntu Dlatu for being so supportive while I was working hard throughout my entire degree as well as giving me a chance to finish what I've started. To my children Siyakha and Sinako I thank them by understanding that everything I do, I am doing it for them to have food on the table and bright future. To my parents as well as extended family for their prayers and to my in-laws for their support.

DEFINITION OF TERMS

Health: It is the extent to which an individual or a group is able to realise aspirations and satisfy needs; and on the hand, to change or to cope with the environment. Health is, therefore, seen as a resource for everyday life, not an objective of living; it is a positive concept emphasising social and personal resources, as well as physical capabilities (World Health Organization, 1984).

Mental Health: Is a state of well-being in which individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully and is able to make contribution to his or her community (Elizabeth Amstrong, 2000).

Quality: The degree to which health care services for individuals and populations Increase the likelihood of desired health outcomes and are consistent with current professional knowledge (Institute of Medicine, 2001). A quality service would have six elements: it would treat patients and service users with dignity, creating the right environments for them to recover from illness and being guided by their views on how services should develop; it would recognise the skills of families acting as carers, routinely welcoming them into plans of care and responding when they were worried; it would link service activity to need, ensuring that acutely ill people received urgent access to care and that people with a broad range of health and social needs received a comprehensive package of care; it would make the best and most effective treatments available; it would emphasise the safety of patients themselves, because every year in England there are over 1000 suicides by people currently or recently under mental health care, and also of families, staff and the general public; and it would be delivered by a skilled and motivated workforce (British Journal of Psychiatry, 2000 177: 290-291).

Integration: The term "integrated health care" includes integration of screening, prevention, early intervention and treatment of diseases at primary health care level (Harris and Barrowclough 1998, Mentality 2003, Phelan et al, 2001).

CHAPTER 1 INTRODUCTION

1.1 Background

World Health Organization (WHO, 2006), report that hundreds of millions of people, including man, woman, children, poor and rich, are affected by mental disorders (World Health Organization and World Organization of Family Doctors (WONCA, 2008) Integrating Mental health into Primary Care. A global perspective, WHO and WONCA, 2008). Depression, Schizophrenia, Suicide, Alcohol Abuse, Alzheimer's disease, Epilepsy and Dementia are the most frequent (Revised Global Burden of Disease(GBD)2002estimates.Geneva,WHO,2004). (http://www.who.int/healthinfo/bodgbd2002revised/en/index.html,accessed 31 March 2008), (Neurological disorders: public health challenges. Geneva, World Health Organization, 2006. World Health Report 2003). Shaping the future. Geneva, World Health Organization, 2003. Many data related to mental disorders are also reported in sub-Saharan African Countries including South Africa (Africa).

Mental illness is the major cause of morbidity as well as some mortality particularly among citizens at risk in South Africa. The latter refers specifically to communities which have for decades, been ravaged by the state neglect and abuse. Generally, mental health promotion and provision of services to South African communities have been neglected in the past (Lund C, Flisher AJ, 2006).

Primary Health care is about providing 'essential health care' which is universally accessible to individuals and families in the community and provided as close as possible to where people live and work. It refers to care which is based on the needs of population. It is decentralized and requires the active participation of the community and family (WHO, 1978: Declaration of Alma-Ata). There are many plausible policy interventions, which may be expected to indirectly affect mental health, for which evidence appears to be absent ((Lund C, Flisher AJ, 2006). As an approach to care, primary health care includes a range of services, accessible through self-referral, including the promotion of health, prevention of disease, diagnosis, treatment, rehabilitation and personal social services.

Mental health care provided within general primary care services is the first level of care within the formal health system. The essential services at this level include early identification of mental disorders, treatment of common mental disorders, management of stable psychiatric patients, referral to other levels where required, attention to the health needs of people with physical health problems and mental health promotion and prevention. As a setting for mental health promotion, primary health care has the advantage of being an accessible community-based service delivery by health workers who know the local community. It also acts as gateway to specialist services, therefore, has a key role to play in terms of ensuring access to community supports and appropriate referral for the sizeable amount of people with mental health problems. Therefore, a strong case to be made for ensuring that the promotion of mental health is incorporated in a more holistic manner into the standard delivery of health care for physical conditions. People with severe mental disorders have been identified as being one of the most excluded and vulnerable population groups, with poorer physical health and significantly raised standardised mortality ratios than the general population (Harris and Barrowclough 1998, Mentality 2003, Phelan et al, 2001). Where mental health is integrated into primary health care services, the following advantages offered are (WHO, Globally):

- reduced stigma for people with mental disorder and their families,
- improved prevention, early detection and treatment of mental illness and of co-morbid physical conditions,

- reduced chronicity and improved social integration

1.2 PROBLEM STATEMENT AND RATIONALE

Articulated as such, primary health care services have an important role to play in promoting mental health, in both social as well as health focus to service provision. Its aim of an integrated service effectively links community health care with specialist services.

However, what constitutes primary health care services varies considerably across countries and to date, mental health has been relatively neglected in the delivery of primary health care service in many countries (World Health Organization, 2004). Indeed, over the last decade, african countries have embarked on translating principles into legislative action and practice as well as on a radical transformation mechanism aimed at creating a well functioning, cost-effective and equitable district health care system (World family doctors, caring for people, World Health Organization: Integrating mental health into primary care, A global perspective).

In South Africa, many municipalities such as King Sabata Dalindyebo are systematically disadvanged by mental health system that was inherited from the colonial and apartheid government (A. Flisher and H. Subedar, Mental Health Programme, Provincial Administration of the Western Cape, 2003). King Sabata Dalindyebo is located in Eastern Cape Province, the poorest province of South Africa (Petersen I., Bhana A., Campbell-Hall V., Mjadu S., Lund C., Kleintjies S. etal. Planning for district mental health services in South Africa: a situation analysis of a rural district site. Health Policy Plan.2009;24(2):140-50.doi:10.1093/heapol/czn049.[Pubmed]. Despite this achievement many impediments to the integration of mental health care service into primary health care are reported in South Africa (South Africa.info. Gateway to the nation. International Marketing Council of South Africa (http://www.SouthAfrica.info/ess-info/sa glance, accessed 17 April 2008). These barriers to full mental health integration include:

- a lack of clear definitions and goals on the part of both mental health management and service providers regarding the nature of a transformed mental health service;
- a lack of support by general health service managers at all levels, from facility managers to district managers;
- shortage of mental health professionals to provide ongoing supervision and support to primary health care practitioners;
- restrictions that prohibit primary health care nurses from prescribing common psychotropic medications;
- a lack of funding to support and sustain mental health services in primary health care;
- a poor infrastructure, inadequate pharmacy facilities and services, inadequate transport, a lack of clinic space, poor staff/ patient ratios and lack of time;
- insufficient ongoing training of primary health care staff who deliver mental health services, including training in counselling;
- incorporation of budget for psychiatric hospitals and primary care services within different management structures.

It has been evident that mental health users coming from surrounding areas of King Sabata Dalindyebo Municipality (tertiary referral psychiatric service in Mthatha) have a high rate of re-admission due to unavailability of treatment (WorldHealthStatistics,2007,WorldHealthOrganization(http://www.who.int/whosis/whostat2007/en/index.html, accessed 9 April 2008). In most cases they travelled long distances to access mental health care services including continuation treatment after discharge from Mental Health Hospital.

There is a need to generate evidence of the effectiveness of interventions operating at different levels of KSD (Petersen I. et al, 2009).

There is no research in King Sabata Dalindyebo, carried out on issues around integration of mental health with primary health care. The present study is initiated to overcome this gap by raising the research question and defining the objectives.

1.3 RESEARCH QUESTIONS

The research questions were raised to determine whether mental health care services are integrated into primary health care system in King Sabata Dalindyebo Sub-district clinics.

This study answers the following research sub-questions:

- what is the level of integration of mental health care services into primary health care in King Sabata Dalindyebo?
- what are the health professional's views about mental health integration into primary health care?

1.4 AIM OF THE STUDY

The aim of the study was to investigate the level of knowledge, implementation and barriers of integrating mental health care services into primary health care system at King Sabata Dalindyebo clinics, in Mthatha region.

1.5 OBJECTIVES OF THE STUDY

The following specific objectives were assigned to achieve the aim of the study:

- to describe the demographic characteristics of the participants;
- to assess health care worker's level of qualification in rendering mental health care services;
- to assess the quality of health care rendered to mental ill;
- to assess the attitudes of health care workers towards mental ill patients;
- to assess the availability of special health care personnel, drugs, equipment and infrastructure;
- to determine the level of the awareness about mental health care Act 17 of 2002;
- to characterise outreach programmes for mental health users;
- to formulate recommendations for policy implementation, training, research and information that will move King Sabata Dalindyebo in the direction of community-wide access to mental health services.

1.6 CONCEPTUAL MODEL AND HYPOTHESES

Figure 1: describes the conceptual framework as a diagram which describes the study process in terms of auditing the element for integrating mental health services into primary health care system in King Sabata Dalindyebo. In this model, the level of integration of mental health services with primary health care is considered the dependent variables on the right of diagram. The independent variables located on left of the diagram, explain the level of components of integrating mental health into primary health care system.

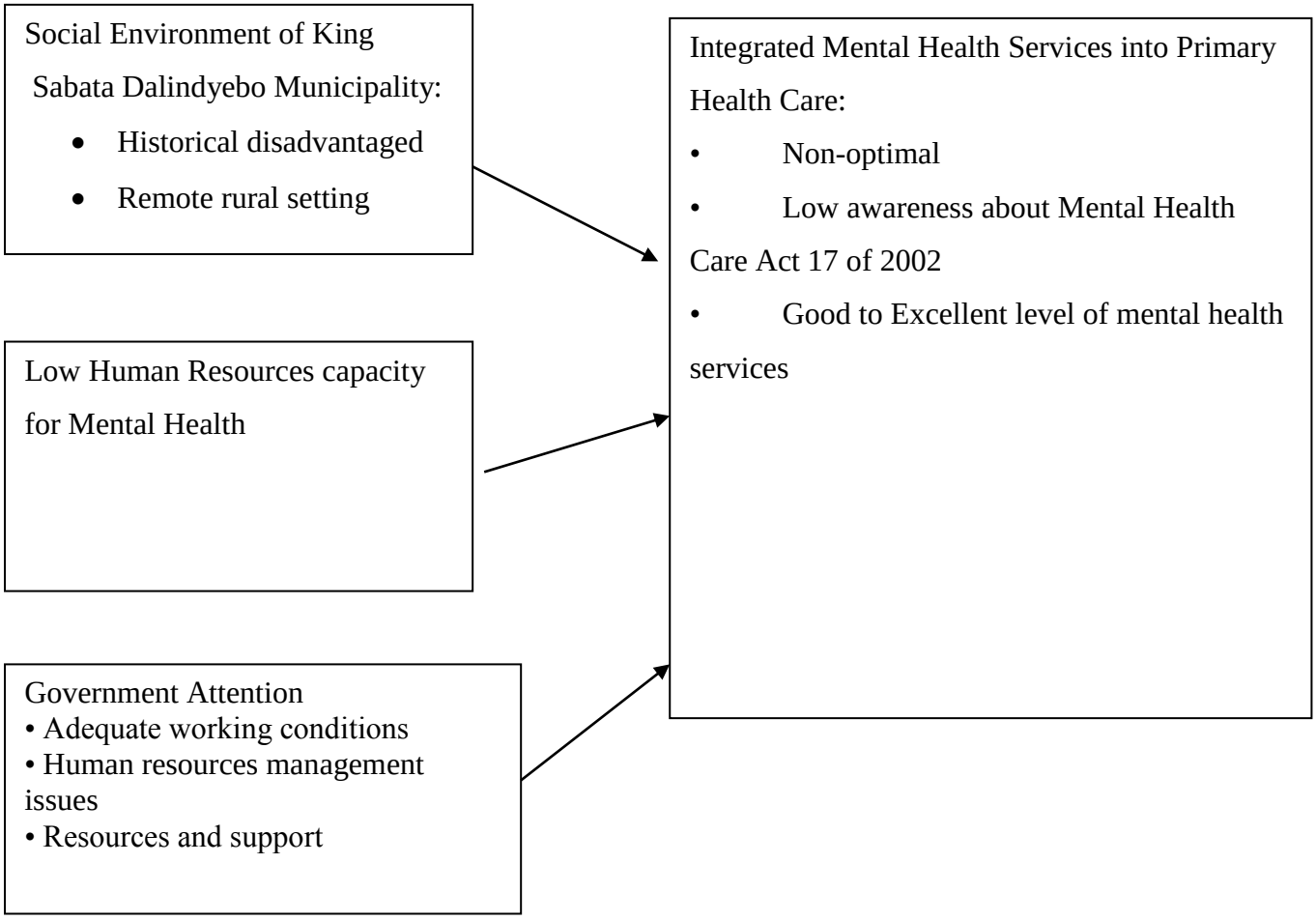

Figure 1: Conceptual Model of integration of Mental Health Services into Primary Health Care in King Sabata Dalindyebo Municipality.

Thus, the study hypotheses are stated from the conceptual model as follows:

- integration of mental health services into primary is not optimal because of social, environmental and historical aspects as well as low human resource capacity for mental health, low government supervision and lack of interventions regarding implementation of legislature ;
- awareness of the Act 17 of 2002 is poor;
- the mental health services are characterized by a good to excellent level for implementation.

1.7 SIGNIFICANCE OF THE STUDY

The study will be useful to health service planners in that, it will provide critical and objective information which will help to develop appropriate services, with the allocation of resources and decision-making on priorities of mental health.

The present study will offer insights into how mental health services could be better integrated into primary health care system in King Sabata Dalindyebo and other municipalities.

When mental health care services integrated into primary health care system, people will access mental health care services closer to their homes, thus keeping their families together and maintaining their daily activities.

Primary health care for mental health facilitates community outreach and mental health promotion as well as long-term monitoring and management of affected individuals.

The services will be affordable as compared to services in psychiatric hospitals for users and communities. In addition, users and families will avoid indirect costs associated with seeking specialist care in distant hospitals.

People with mental disorders treated in primary health care setting by psychiatric trained nurses and doctors will have good outcomes, particularly when linked to services at secondary level.

By integration process of mental health care services into primary health care system, all the mental health care services will be available at primary health care level and improvement of service delivery in King Sabata Dalindyebo and Provincial Department of Health, Eastern Cape.

CHAPTER 2 LITERATURE REVIEW

This chapter reviewed critically the relevant information to integration of mental health care into primary health care. This was done to avoid information biases. Doing so, only studies published in English and reported following websites: Pub med/ Medline and Google Scholar. Monographs edited by WHO, WONCA, Ministry of South African government were also consulted.

2.1 Primary Health Care

Primary care for mental health is an essential component of any well-functioning health system. Therefore to be fully effective and efficient, primary health care for mental health must be complemented by additional levels of care. These include secondary care components to which primary health care workers can turn for referrals, support and supervision. Understanding and appreciating these relationships is crucial to understanding the role of integrated primary mental health care within the context of the overall health system, (Integrating mental health into primary care: A global perspective, WHO and WONCA, 2008).

In the past, mortality figures were the most common indicators of estimating the seriousness of a condition. Mental illness was not considered important, even when a person committed suicide because of depression or schizophrenia; it was not documented as morbidity of depression or schizophrenia but was reported under the heading "suicide" (Desjaire, Eisnberg, Good and Klienman, 2003). The health services of this country are going through a major change due to the new Health Act 61 of 2004, which provides for the establishment of what is generally known as a District Health System (WHO, 2007*)*.

In this system, mental health care is incorporated into the primary health care. Another point of focus is that the (World Health Organization report, 2001) points the fact that more than 450 million people suffer from mental disorders worldwide and one in four people develop mental disorder through out their lifetime. On that note, the main focus of primary health care tends to be on physical health and many primary health care workers do not have mental health orientation (WHO, 2001).

One example is from the Ehlanzeni District of Mpumalanga Province, which demonstrated how primary care for mental health can be provided using two distinct service models. In the first model, a skilled professional nurse sees all patients with mental disorders, within the primary care clinic. In the second model, mental disorders are managed as any other health problem and all primary care workers treat patients with mental disorders. Importantly, clinics have tended to adopt the model that best accommodates their available resources and local needs.

By the end of 2002, 50 percent of clinics in the Ehlanzeni District were delivering mental health services and by early 2007, 83 percent of clinics were delivering these services. Primary care nurses and patients are generally satisfied with the integrated approach. These achievements are noteworthy because in 1994 at the end of apartheid rule, the Mpumalanga Province had no mental health services whatsoever. Yet within 10 years, it had developed and implemented primary care for mental health throughout the region (DR Williams et al. Twelve-month mental disorders in South Africa: prevalence, service use and demographic correlates in the population based South African Stress and Health Study (World health statistics 2007.World Health Organization).

2.2 Challenges experienced in integrating of Mental Primary Health Care Services

Poor infrastructure hinders the provision of mental health services at the primary level of care and this is particularly so in the rural areas. This is perhaps; because that compared to other areas of health, mental health services remain low on the priorities of most governments in low and middle income countries, South Africa included. There is a shortage of vehicles, meaning that mental health workers are unable to visit patients at home and they also encounter difficulties in transferring patients between the clinics and the hospital. Telephones and communication equipment are inadequate, for an efficient referral system and on the part of community members reporting mental health related issues.

Integration into primary health care requires investment in the training of staff to detect and treat mental disorders. Within the context of training, primary health care workers may be uncomfortable in dealing with mental disorders; therefore in addition to imparting skills, training also needs to address the overall reluctance of primary health care workers to work with people with mental disorders. The issue of availability of time also needs to be addressed. In many countries, primary health care staffs are overburdened with work as they are expected to deliver multiple health care programs (Integrating mental health into primary care: A global perspective, WHO and WONCA, 2008).

Governments cannot ignore the need to increase the numbers of primary health care staff, if they are to take on additional mental health work. Adequate supervision of primary care staff is another key issue which need to be addressed if integration is to succeed. Mental health professionals should be available regularly to primary health care staff to give advice as well as guidance on management and treatment of people with mental disorders. Furthermore the absence of good referral system between primary and secondary care can severely undermines the effectiveness of mental health care delivered at primary health care level.

Revisions were made to the Mental Health Act (Act 17 of 2002) to ensure that the human rights of mental care users were protected, in line with the South African constitution. The changes to the Act were meant to also ensure that mental care users received the best possible care, treatment and rehabilitation services. The South African legislation also advocates for a rehabilitative, community-based model of health care, an approach that will mean also to reduce the stigma attached to mental illness. It is envisaged that de-institutionalisation will free resources, which will in turn be channelled to residential care and ambulatory services at the community level. The most common mental disorders in South Africa are Schizophrenia, Epilepsy, Depressive Affective Disorder, Substance Induced Psychosis, Mental Retardation, Anxiety Disorders, Organic Brain Syndrome and Senile Dementia (Integrating mental health into primary care: A global perspective, WHO, WONCA, 2008).

2.3 Prevalence and Incident Rates of Mental Health Problems

The burden of mental health and neurological disorders on society is immense. The 2001 WHO World Report estimated that, measured in disability – adjusted life years (DALYs) mental and behavioural disorders accounted for 12 % of the global burden of diseases in 2000. The report projects that this figure will increase to 15% by 2020.

In the 15- 44 year age group, the health burden resulting from unipolar depression is currently second to HIV/ AIDS. In terms of years of life lost to disability (YLDs) alone, it is estimated that in 2000 mental and neurological disorders accounted for around 31% of YLDs, with depression contributing 12% of all disability across all age groups and 16% at the age category of 15-45years old. Therefore neuropsychiatric disorders have been calculated to account for around 18% of all YLDs (WHO, 2001).

In South Africa there is renewed political commitment to improve mental health and mental health services (South African Harsard, 2001). Services are in the process of being transformed into integrated and decentralised primary health care approach. The notion of all mental health problems being synonymous with severe mental illness and responsive only to medical intervention is also changing (Department of Health, 1997).

South Africa also lacks national epidemiological studies (Parry, 1996; Robertson and Berger, 1994) but several valuable local studies have been conducted. A community study of 6-16 years old in an informal African settlement in Cape Town yielded a prevalence rate of psychiatric disorders of 18.8% (Ensink K. et al 1997). Anxiety and depression were the most common, while rates of attention-deficit hyperactivity disorder and post-traumatic stress disorder (PTSD) were unusually low.

2.4 Mental Health Budget and Other Resource Allocation

The new government has many challenges, including the need to revise political ideas and expensive mistakes have been made by ministers attempting to reconcile their humanitarian goals with shrinking budgets. Prior to 1990, 60% of the health budget was allocated to academic hospitals for service provision, with consequent development of first-class specialised services but neglect of community care. Mental health services were even more institution-based; with psychiatric hospitals spending 93% of the mental budget and community psychiatric services only 3% (Ensink K. et al, 1997). Thus health services were inordinately concentrated in large hospitals in major centres and although theoretically available to everyone irrespective of income, they were relatively inaccessible to those who needed them most.

Furthermore, mental health services were not available at the secondary care level and individuals with mental problems presenting at primary health care services were usually referred directly to specialised facilities.

2.5 Access to resources in mental health using appropriate technology

Mental Health Services, like all other health services have been fragmented and ill equipped to intervene effectively (Milne and Robertson, 1998). The available services are neither appropriate nor accessible to majority of the population, especially in rural areas. Success in improving and promoting psychosocial well-being of all communities is essential ingredient in the implementation of the Reconstruction and Development Programme
(RDP). South Africa has the advantage of a strong NGO presence and other social formations like the concerned and committed business community, the church groups, organised children, youth and women's associations which with proper co-ordination could play major role in mental health promotion. Relative to other services, mental health is neglected and is afforded a very low priority, especially as regard to the allocation of technological resources (Milne et al, 1998).

2.6 Implications of Legislation Governing Mental Health Services and Practice

Mental health over many decades acquired the unwelcomed reputation of being stepchild of the health services. According to (Thulani, 2000) this was partly because it was narrow understood as psychiatric illness, an area of concern for psychiatrists, psychiatric nurses, patients and their families. However, the past three to four years has been mental health care steadly moving out of this quarantine, towards mainstream health care. Also mental health care has begun to address issues that distress South Africans on a day to day basis such as crime violence and HIV/ AIDS.

This is starting to change people's perceptions of mental health as an abstract, mysterious set of interventions; to an understanding that this component of health that addresses issues of general psychological well being and problem of day to day living (Thulani, 2000).

2.7 Mental Health Bill of 1999

The transformation of mental health care in South Africa started with the Draft Mental Health Bill of 1999 which was published for public comment in the Government Gazzett on 4 February 2000. The Bill was an important milestone which provides the legislative framework for the provision of mental health care in human manner based on the individual rights espoused by our constitution and resonant with the times in which we live (Thulani, 2000).

2.8 The Mental Health Care Act (Act 17 of 2002)

"The prohibition of discrimination against mental health care users who are now entitled to the same level of care as non-mental health changing the ethos of mental health care", says Kurt Worall-Clare Legal Advisor for the Hospital Association of South Africa (HASA).

The Mental Health Care Act (Act 17 of 2002) was promulgated with immediate effect on 15 December 2004 along with the associated General Regulations published on the same day. The positive language in both the Act and Regulations help to address the stigma traditionally attached to mental health care users and their health care services providers. The Act also contains the Mental Health Care user's rights among others include the following:

- the person, human dignity and privacy of every mental health care user must be respected;
- a health care provider or health establishment may provide care, treatment and rehabilitation services to or admit a mental health care user only if the user has consented to the care;
- a mental health care user may not be unfairly discriminated against on the grounds of his or her mental health status;
- every person, body, organisation or health establishment providing care, treatment and rehabilitation services to mental health care user must take

steps to ensure that users are protected from exploitation, abuse and any degrading treatment;

- a person or health establishment may not disclose any information which a mental health care user is entitled to keep confidentiality in terms of any other law;
- every health care provider must, before administering any care, treatment and rehabilitation service, inform a mental health user in an appropriate manner of his or her rights, unless the user has been admitted under circumstances referred to in section 9(1c) The Mental Health Care Act (Act 17 of 2002);
- The above mentioned rights also include all patient's right and human rights general.

The main premise of the Act appears to be grounded in ensuring that mental ill patients receive the least restrictive and intrusive intervention. These interventions will be administered through the implementation of clear protocols that are outlined in the Act which govern the state; the individuals or medical practitioners may intervene in the lives of mentally ill or detain these patients without the consent for the purposes of appropriate treatment.

The Act also provides the greater involvement of mental health care patients in the care they receive. Mental Health Review Boards have also been established to ensure that patients are correctly identified and treated. The net results are that medical practitioners will, as of now be compelled to consider mental health care establishments and ultimately psychiatric hospitals, as a last resort.

2.9 Policy Issues, Models and Care

The recommendations of World Health Organization (WHO, 1984) that 'governments should take all necessary steps to improve mental health care at every organizational level, especially at community level through integration with the primary health care system, supervision being provided by more skilled personnel and referral services being available for more difficult types of cases' clearly advocate the integration of psychiatric care into primary health care (PHC).

2.10 WHO perspective about mental health care services and its integration

Mental health according to World Health Organization (WHO,2001) can be conceptualize as a state of well-being in which individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully and is able to make contribution to his or her community (WHO, 2001).

The Ottawa Charter (WHO, 1986) provides a socio-ecological framework for mental health promotion as it draws attention to a systems approach, spanning individual, social and environmental factors that influence health. The Ottawa Charter outlined five key areas for action to promote health:

- to build health public policy;
- to create supportive environments;
- to strengthen community action;
- to develop personal skills and reorientate health service.

Building health public policy puts mental health promotion on the agenda of all policy makers and calls for co-ordinated action across health economic and social policies for improved mental health. Building health public policy includes diverse approaches such as investment in government and social policy, the implementation of legislation and regulations, organisational change and partnerships.

Creating supportive environment moves mental health beyond an individualistic focus to consider the influence of broader social, physical, cultural and economic environments in different countries (Burns JK, 2008)(Flannigan CB, 1994). This action area emphasises the importance of the interaction between people and their environments also highlight the importance of mediating the structures such as homes, schools, communities, workplaces and community settings as key context for creating and promoting positive mental health.

Strengthening community action focuses on the empowerment of communities through their active engagement and participation in identifying their needs, setting priorities, planning and implementation action to achieve better health and take control of their daily lives. Community development approaches strengthen public participation and lead to the empowerment of communities and improve mental health at the community level.

Developing personal skills involve enabling personal and social development through providing information, education and enhancing life skills. Improving people's knowledge and understanding of positive mental health as an intergral part of overall health forms an important part of this action area highlighting the need for improved mental health literacy.

Developing personal skills such as self awareness, improved self-esteem, sense of control and self-efficacy, relationship and communication skills, problem solving and coping skills have been shown to improve mental health and facilitate people to exercise more control over their life and their environments (Margaret M. Barry, Rachel Jenkins, 2007).

Reorienting health services requires that mental health services embrace promotion and prevention activities as well as treatment and rehabilitation services. This calls for a health care system, which contribute to the pursuit of health as well as treatment of illness. In terms of mental health, this emphasises the important role of primary health care and mental health services in promoting mental health across different population groups such as children, young mother, people with chronic health problems and mental health service users and their families. Reorienting health services to promote mental health requires greater attention to the organisation, structure of health services, training and education of health professionals.

According to (WONCA, WHO 2008: A global perspective), the care rationale for integrating mental health care services into primary health care advantages are to:

- reduce Stigma for people with mental disorders and their families;
- improved Access to care;
- improved Prevention and Detection of Mental Disorders;
- treatment and follow-up of Mental Disorders;
- better physical accessibility;
- better financial accessibility;
- better acceptability;
- reduced chronicity and Improved Social Integration;
- human Right Protection;
- better Health Outcomes for people treated in Primary Health Care;
- improving Human Resource Capacity for Mental Health.

CHAPTER 3 RESEARCH DESIGN AND METHODOLOGY

3.1 Study Design and Period

A descriptive cross-sectional approach design was used when conducting this study. This design described important characteristics of the identified participants in the study during the time of the study starting from January 2010 and December 2011.

3.2 Research Setting

The study was conducted at King Sabata Dalindyebo Sub-district Clinics (Figure 2); Mthatha, Eastern Cape; South Africa.

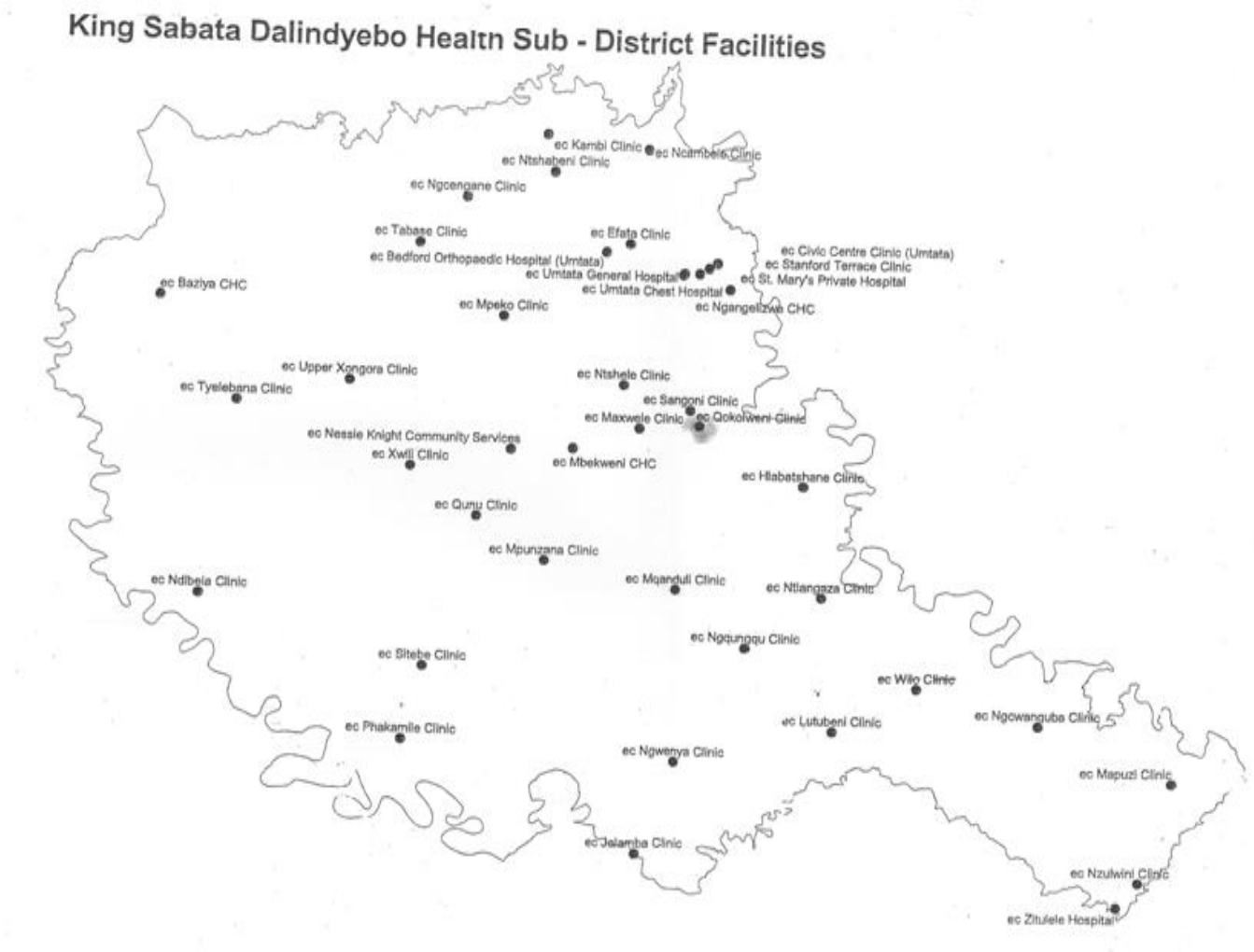

Figure 2 King Sabata Dalindyebo Sub-district Facilities.

King Sabata Dalindyebo is one of seven local municipalities located within OR Tambo District Municipality in the Eastern Cape Province. It comprises four (4) amalgamated entities comprised of both Mthatha and Mandela urban and rural magisterial areas. It measures approximately 3019km square in extent and approximately has 430 000 people in the municipal area, the majority of whom reside in rural settlements. The city of Mthatha is an important regional service centre and tourism gateway city. Mqanduli is subsidiary node, with other nodes and development areas along the coast, N2 and mountain region to the north.

The population is primarily dependant on welfare and pensions for their survival due to widespread of poverty and unemployment. The municipality has forty seven (47) health facilities referring to one Mthatha Hospital which comprises of general hospital and within mental health unit, Nelson Mandela Academic Hospital and Bedford Orthopaedic Hospital. These health facilities consists of forty two (42) clinics, four (4) community health centres and one(1) mobile clinic.

3.3 Study Population

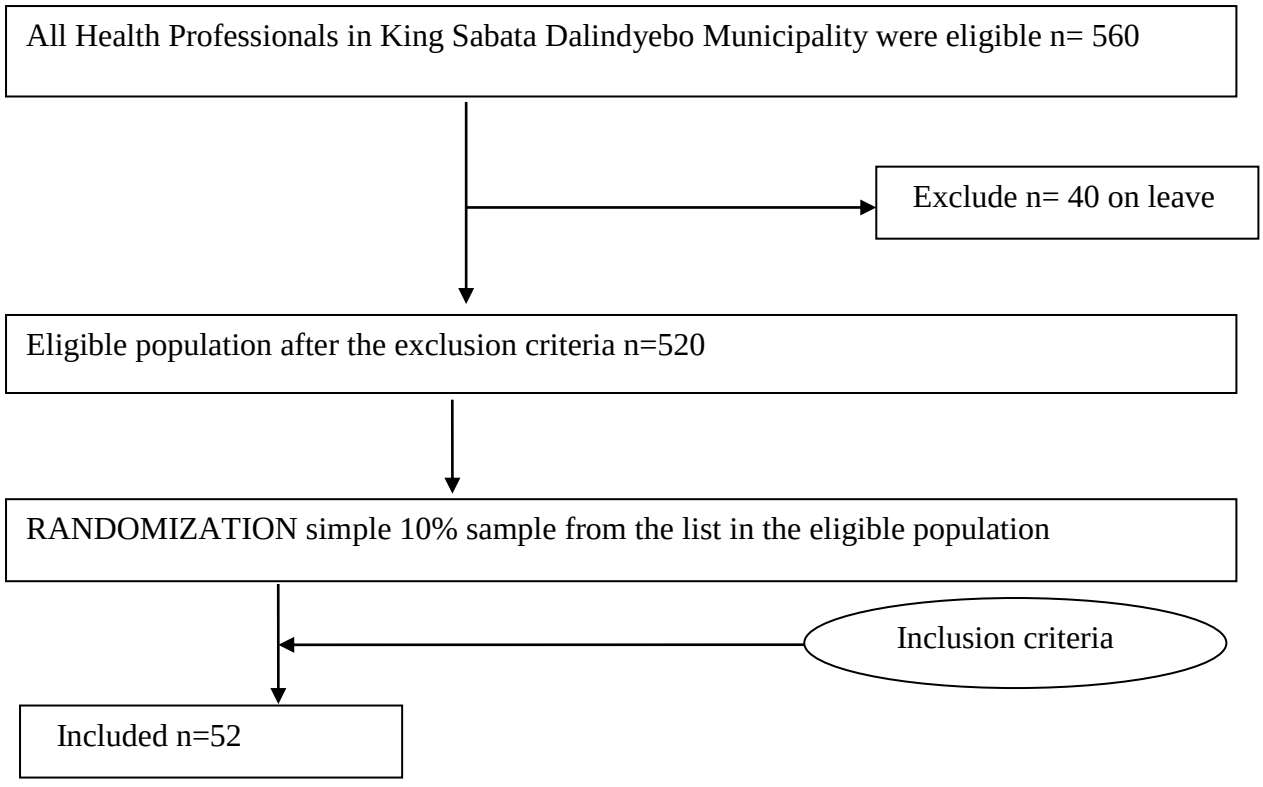

Figure 3. summarizes the flow chart of the sampling.

All health professionals from King Sabata Dalindyebo Sub-district clinics (n= 560) were eligible to participate in the study.

3.4 Population Sample

The health providers included as simple random sample (10% representatives drawn from the list of 520 health professionals not on leave) responded to the following inclusion criteria:

- verbal and informed consent;
- effective presence during the survey.

The exclusion criteria comprised of the following:

- refusal to participate;
- absence at work due to leaves holidays and sickness.

3.5 Data Collection

Pre-tested, Pre-coded, Structured and standardized closed ended questionnaires were used and administered during 30 minutes as tool to collect data on each participant (appendix1). The questionnaire was piloted on 10 health professionals. Based on the findings from the pilot, the questionnaire was adapted and revised. The language used was English spoken by participants.

Forty three questions, administered, dealt with socio-demographic data, knowledge of the Act 17 of 2002, training capacity, availability of drugs and transport, condition of infrastructure, specialised personnel and attitudes of health professionals towards mentally ill.

3.6 Data Analysis

Before and during the data processing, quality control checks were performed and data collected was analysed using Statistical Package for the Social Sciences (SPSS) to save time and maintain accuracy of the results. For data analysis, the means of continuous variables across 2 groups, were compared using Student-t test. The proportions (%) of the categorical variable across 2 groups, were compared using Chi-square test.

3.7 Validity and Reliability

The correct procedures and quality of measurement procedures have been applied to find the answers to a question for example the tools were tested to the participants but they gave same responds twice. The interview schedules were done by the researcher himself for clarity to the respondents. The tools also were further handed over to research champions to identify if all aspects pertaining to the topic were addressed and relevant for the study.

3.8 Reduction of biases

To reduce selection, information and biases that are due to confounding, the researcher has informed the participants to ensure continued participation as well as prevention of participant and researcher exhaustion.

3.9 Ethical and Legal Consideration

The researcher has been given permission to conduct the study by Sub-district Manager of King Sabata Dalindyebo and Eastern Cape Department of Health (appendix C). On approval by ethical committee, the informed consent letters were sent to the participants explaining about the study. Some of the participants of the study signed the consent form letters voluntarily and others have agreed to participate on the study by verbal consent (appendix B).

Confidentiality of information of the participants and the clinics was maintained and kept anonymously.

CHAPTER 4 RESULTS

4.1 Introduction

This chapter begins with presentation of the biographical data information relating to the respondents, the presentation of findings. In total, 52 health professionals were surveyed.

4.2 Demographic characteristics

Gender and Ages

Out of all the participants (Figure 2), 40.4 % (n= 21, and 59.6% (n=31) were males and females, respectively.

The sex ratio was almost 2 females: 1 male.

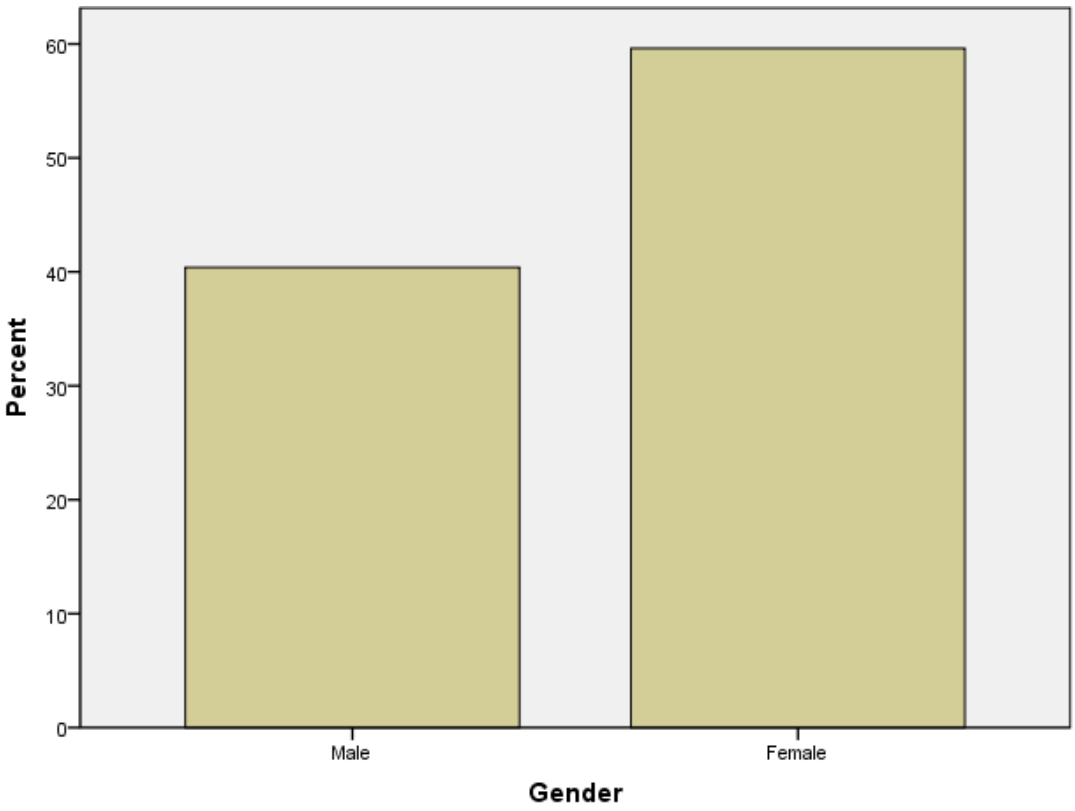

Figure 3. Distribution of participants according to gender.

The mean age of the study samples was 36.9±8years (ranges of 23 years and 52 years). Females were older (39.7±7.1 years, P= 0.002) than males (32.8± 7.7 years).

4.3 Marital Status

Married professionals (59.6% n=31) were commoner than not married professionals (40.4% n=21) (Figure3).

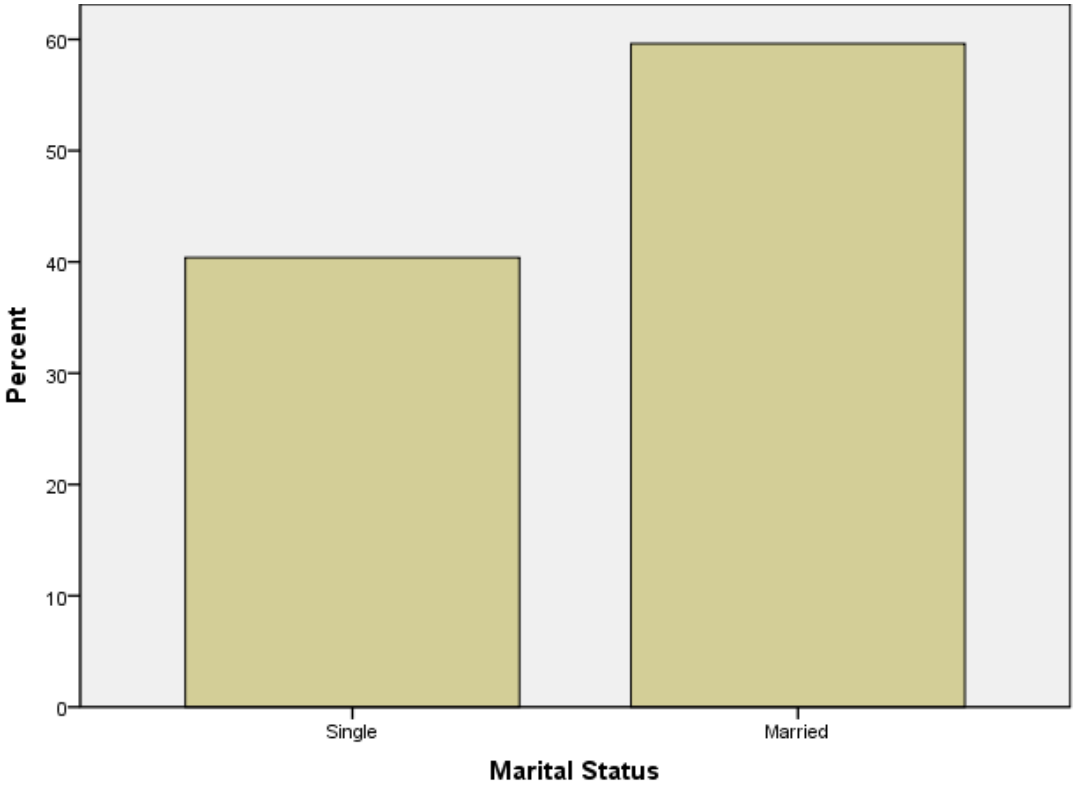

Figure 3. Distribution of professionals by marital status.

4.4 Educational Qualification and Post qualification

Figure 4. describes the types of qualifications for general nursing and Bachelor of Medicine: over representation of undergraduate diploma (71.2 % n=37) in comparison with bachelor's degree (25% n=13), high school certificate (1.9% n=1), and postgraduate diploma (1.9% n=1).

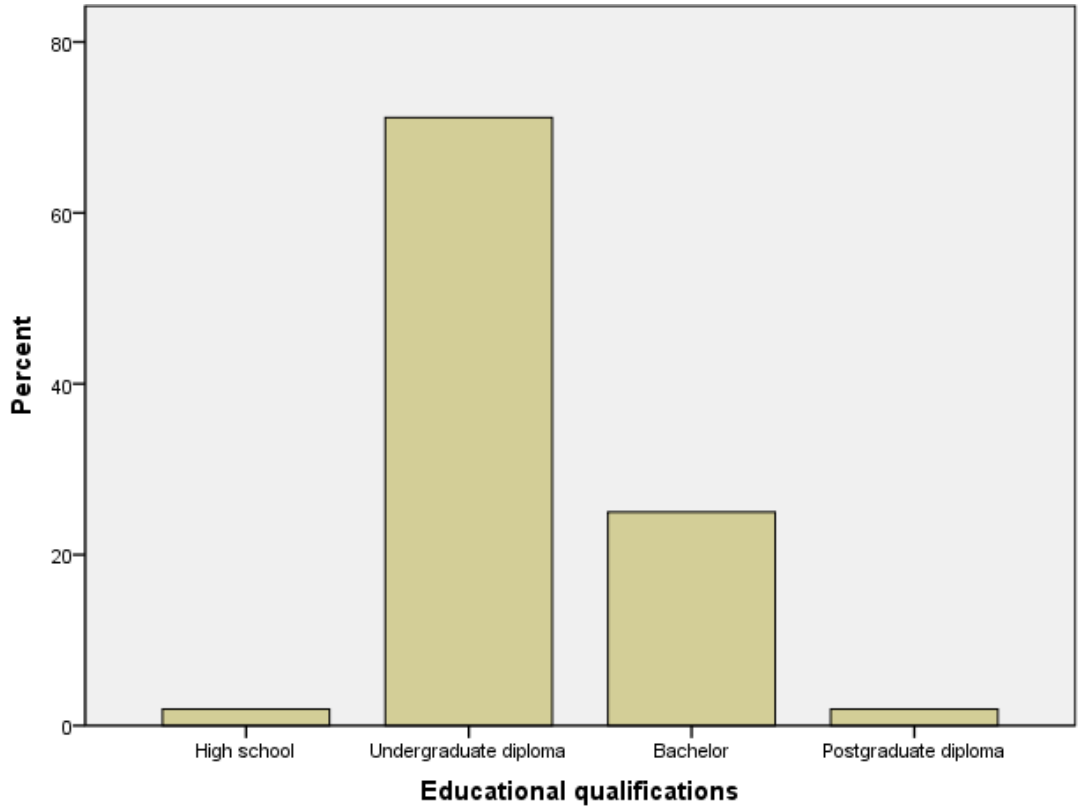

Figure 4. Qualification by general nursing.

At the post qualification level, more than 80% had only diploma (Figure 5)

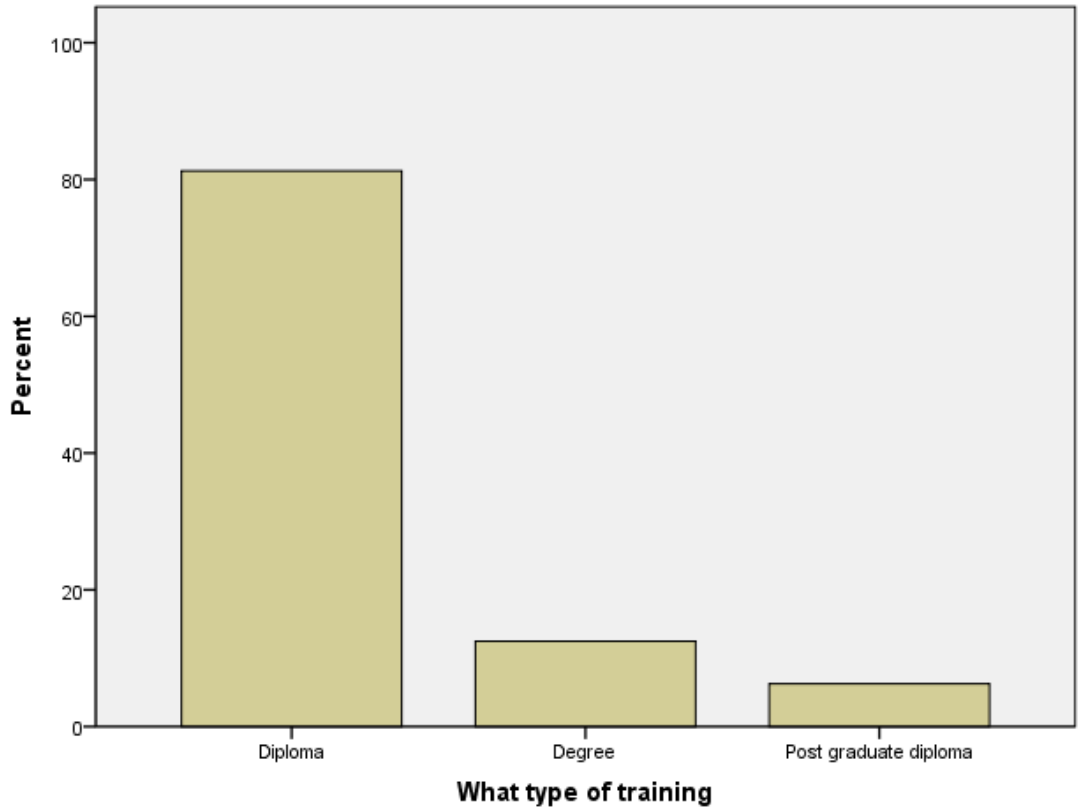

Figure 5. Postgraduate qualification of health professionals.

4.5 Job level and terms of employment

Table 1. summarizes the job level and terms of employment characteristics in the study samples. The majority were professional nurses (females), contrasting with 2 female medical doctors and 1 male medical doctor.

Table 1. Characteristics related to job level and terms of employment

Variables	n	%
Job Level		
Professional Nurse	45	86.5
Middle Management	4	7.7
Medical Doctor	3	5.8
Terms of employment		
Permanent		73.1
Contract		26.9

4.6 General and further training in Psychiatry

In the study, 16(30, 8%) surveyed health professionals had further training in psychiatry (Figure. 6), however, 38(73.1%) workers had qualification in general psychiatry (Figure.7).

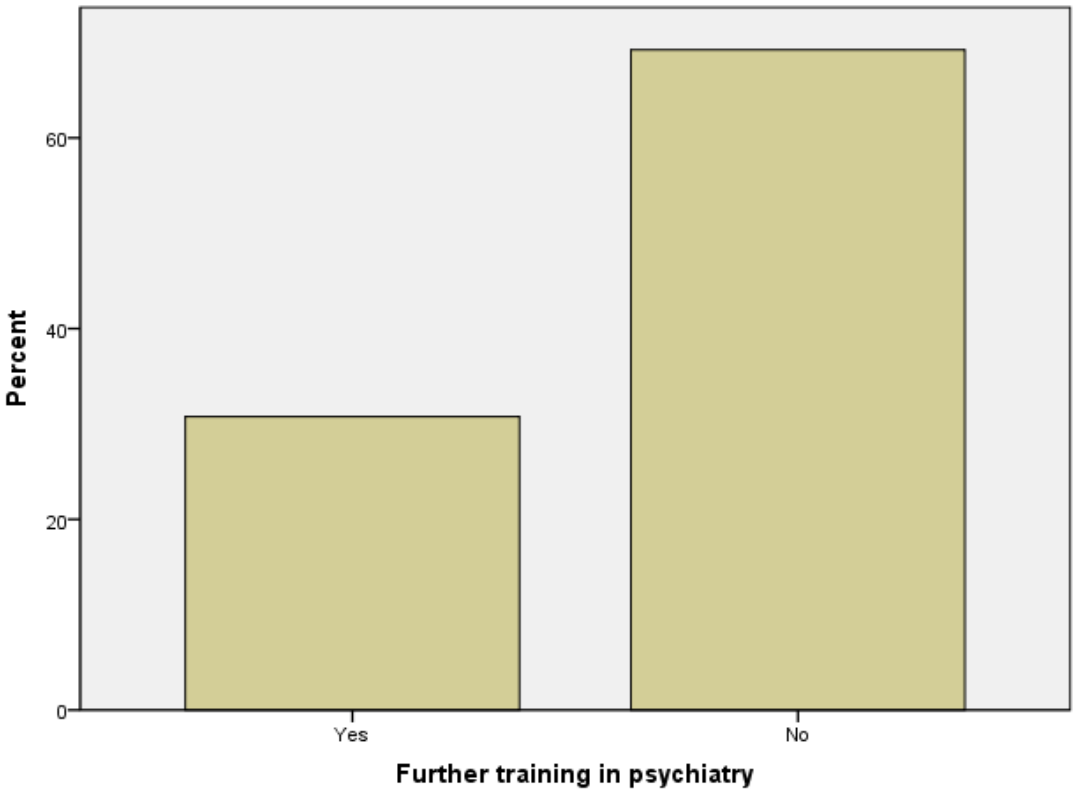

Figure 6. Further training in Psychiatry.

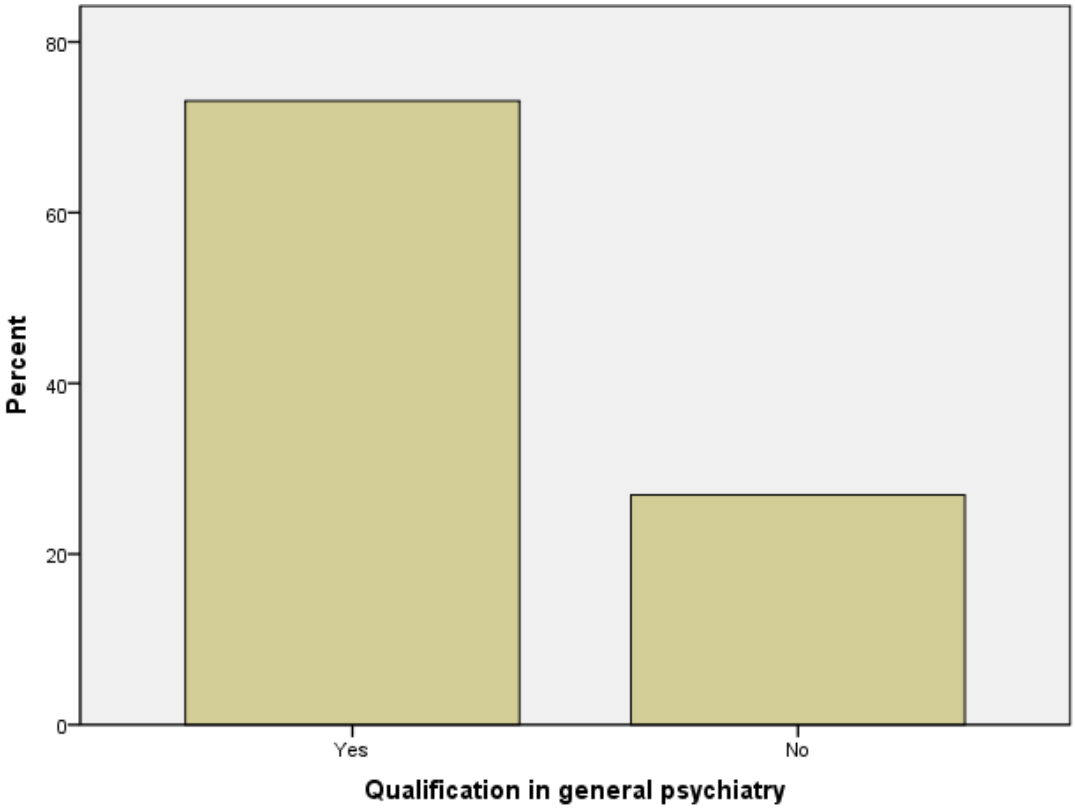

Figure 7. Qualification in general psychiatry.

4.7 Awareness about Mental Health Care Act 17 of 2002

Out of the study samples, 30(57.7%) were aware about Mental Health Care Act 17 of 2002.

4.3.1 Mental health care services characteristics rather fair to good

Tables 2 and 3 present the characteristics of mental health care services considered good to excellent.

Table 2. Components of good to excellent mental health care services as collected from workers.

Variables	%	n
Mental health care services acceptability to mental ill;	92.3	48
Mental health care services are Effective;	84.6	44
Mental health services equitable;	90.4	47
They are accessible;	88.5	46
Confidentiality and privacy;	90.4	47
Personal interaction and relationship;	88.5	46
Rights and legal protection;	96.2	50
Safety and risk management;	76.9	40
Treatment and support environment;	78.8	41
User care-giver participation.	76.9	40

Table 3. Other characteristics of mental health care services defined fair to good

Variables	%	n
Emergency care	78.8	41
Screening, assessment and Review;	80.8	42
Treatment, care and therapies;	80.8	42
Service management and Development;	84.6	44
Telephones and faxing machine for reporting cases of mental illness;	75	39
Resource management and Affordability;	84.6	44
Medication and other technologies	86.5	45
Psycho-social rehabilitation;	73.1	38
Language, culture and context;	86.5	45
Mental health promotion;	71.2	37
Community living;	75	39
Mental ill are treated fairly same as physical ill? Yes	98.1	51
Transport for mental ill referral? purposes? Yes	71.2	37
Collaboration well in achieving? objectives of mental health? Yes	82.7	43
Clinic days for mental ill same day as physical ill? Yes	75	39
Mental health care services efficiently? Yes	39	75

Worse characteristics

The levels of documentation (65.4% n=34), provider training and support (67.3% n=35), entry or admission (67.3% n=35), trained psychiatric sister for supervision of mental health services (63.5% n=33) were fair according to the operational definitions(Appendix 1)

4.8 Characteristics suggesting lack of integrated mental health care

Frequency of outreach programmes

The majority (73.1 % n=38) were not aware about how often are outreach programmes (Figure. 8). Furthermore, out reach programmes were reported weekly, once a month and every six months by 1.9 % (n=1), 9.6% (n=5), and 15.4(n=8) respectively (Figure. 8).

4.9 Outreach programmes for mental ill users

Outreach programmes for mental ill patients and users, was reported by only 28.8 % professionals (n=15).

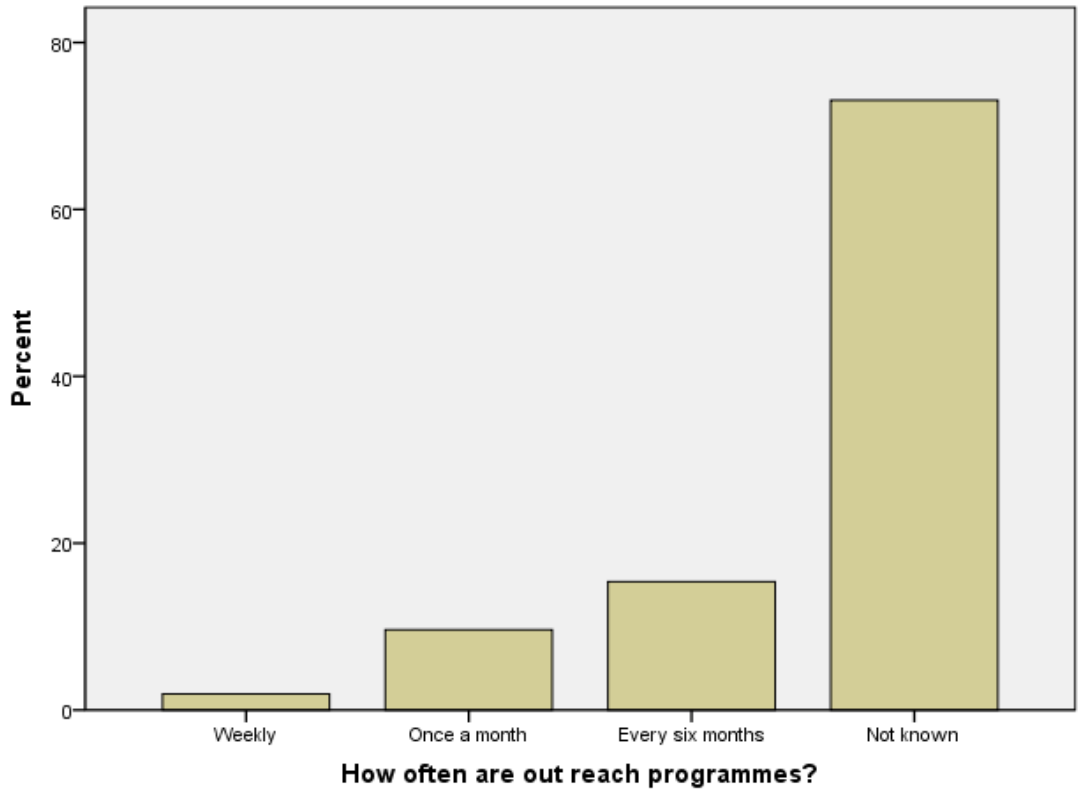

Figure 8. Frequency of outreach programmes on mental health Act 17 of 2002.

4.10 Referrals for mental health care users to tertiary levels

Almost all surveyed professionals (92.3% n=48) responded that mental health care users were referred to tertiary levels (Figure. 9).

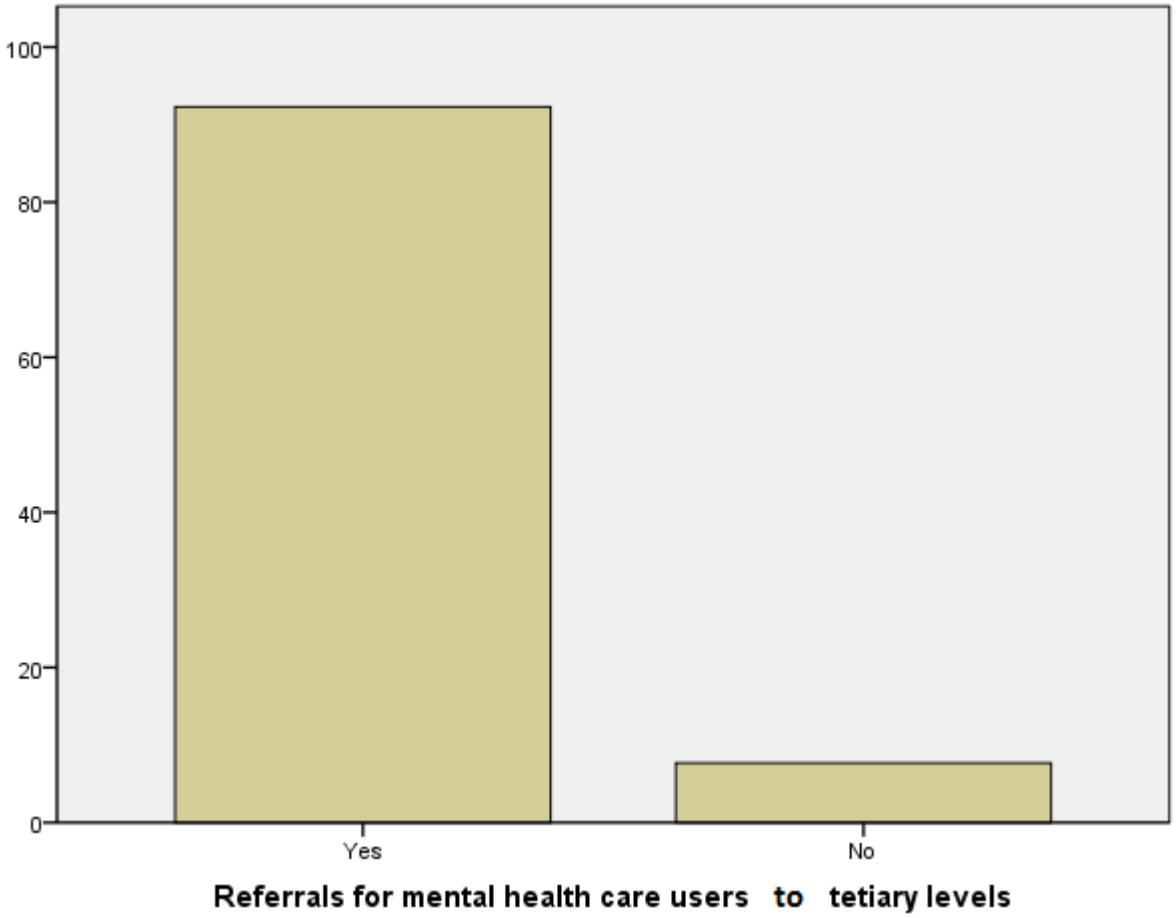

Figure 9. Referrals of mental health care to tertiary levels.

Mental health care services provided by Medical Officer

Almost ¾ of professionals (71.2% n=37) reported that mental health care services were provided by medical officer (Figure. 10).

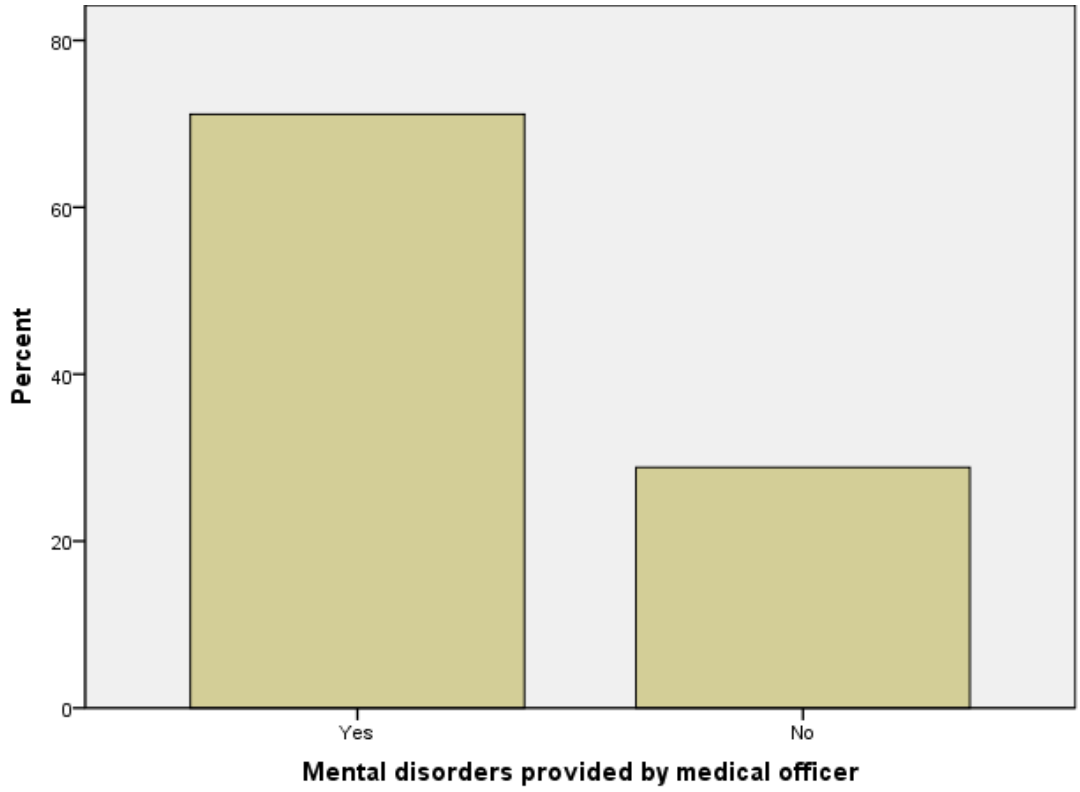

Figure 10. Mental health care services provided by Medical Officer

Implication of experts

Regional psychiatrist visits every three months were reported by only 5.8 % (n=3) professionals (Figure 11).

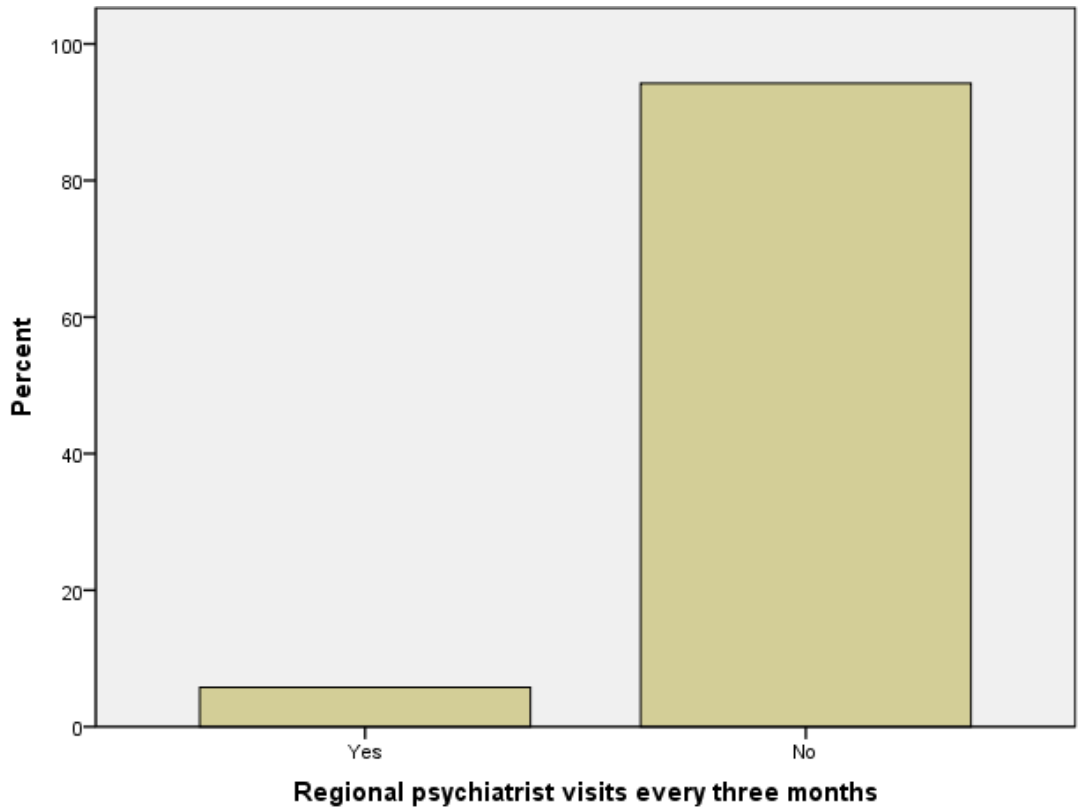

Figure 11. Regional psychiatrist visits.

Visits by mental health specialist every tree months (Figure.12), weekly Psychologist visits (figure.13), and Social worker presence (Figure.14) were reported by only 5.8% (n=3), 3.8% (n=2), and 5.8% (n=3), respectively.

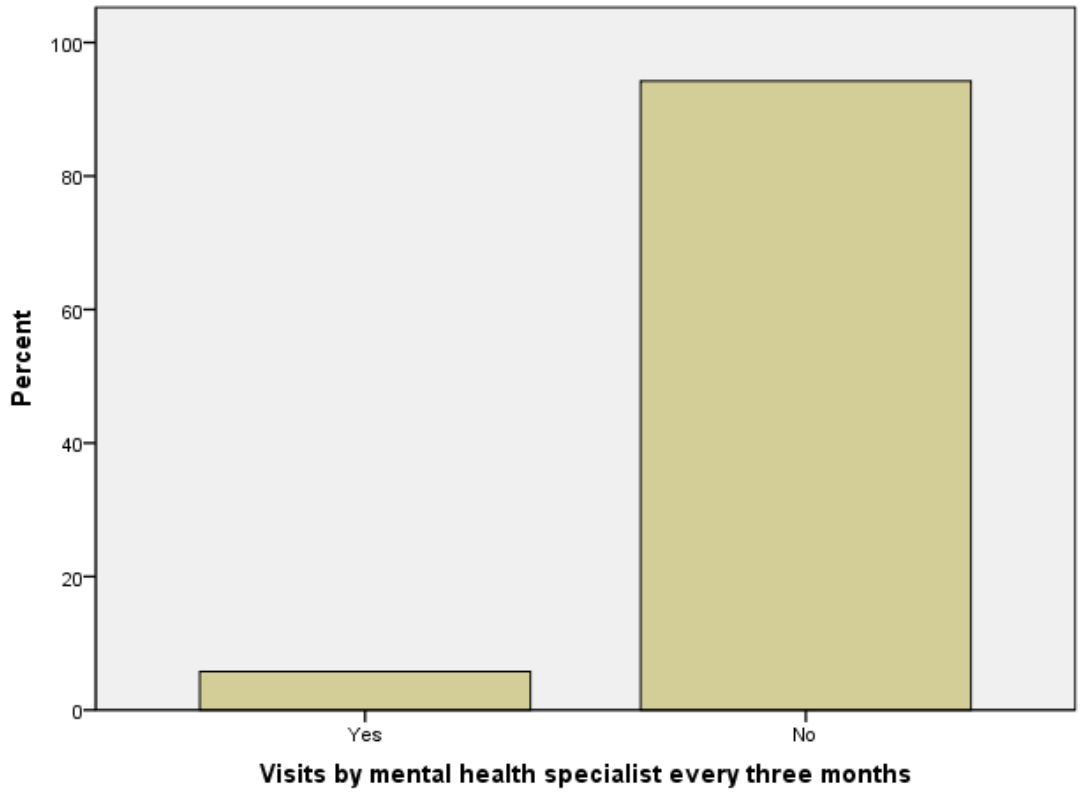

Figure 12. Visits by mental health specialist.

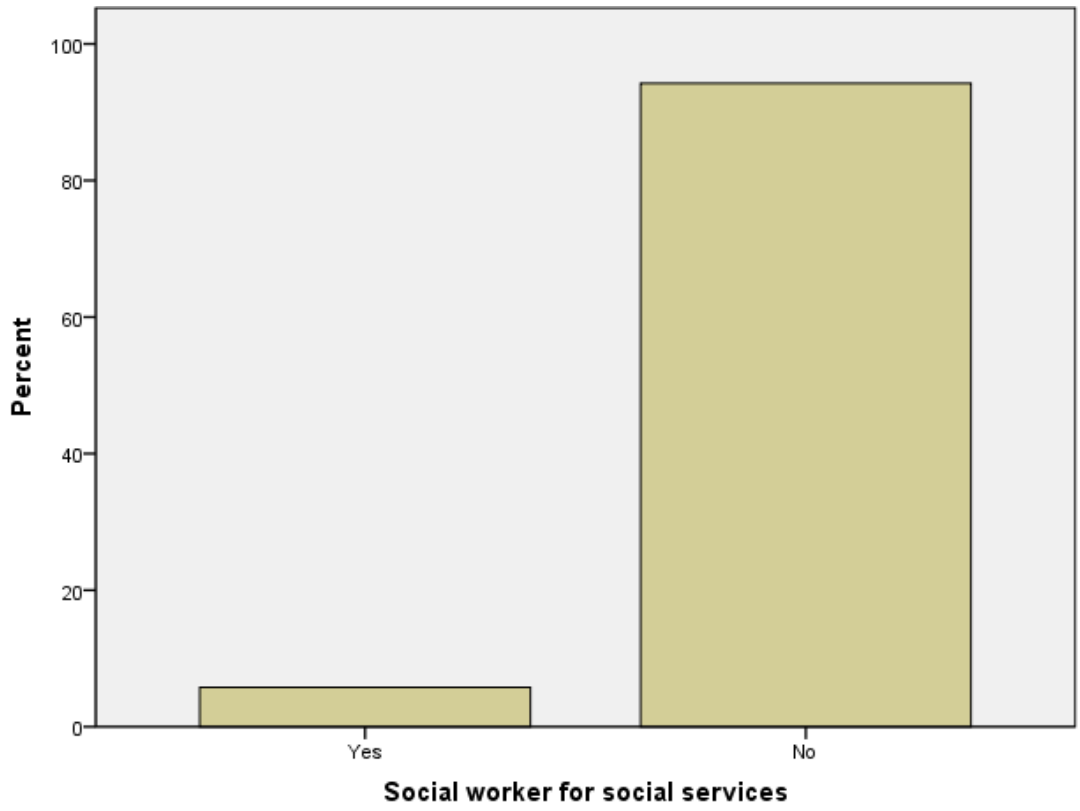

Figure.13 Social worker presence.

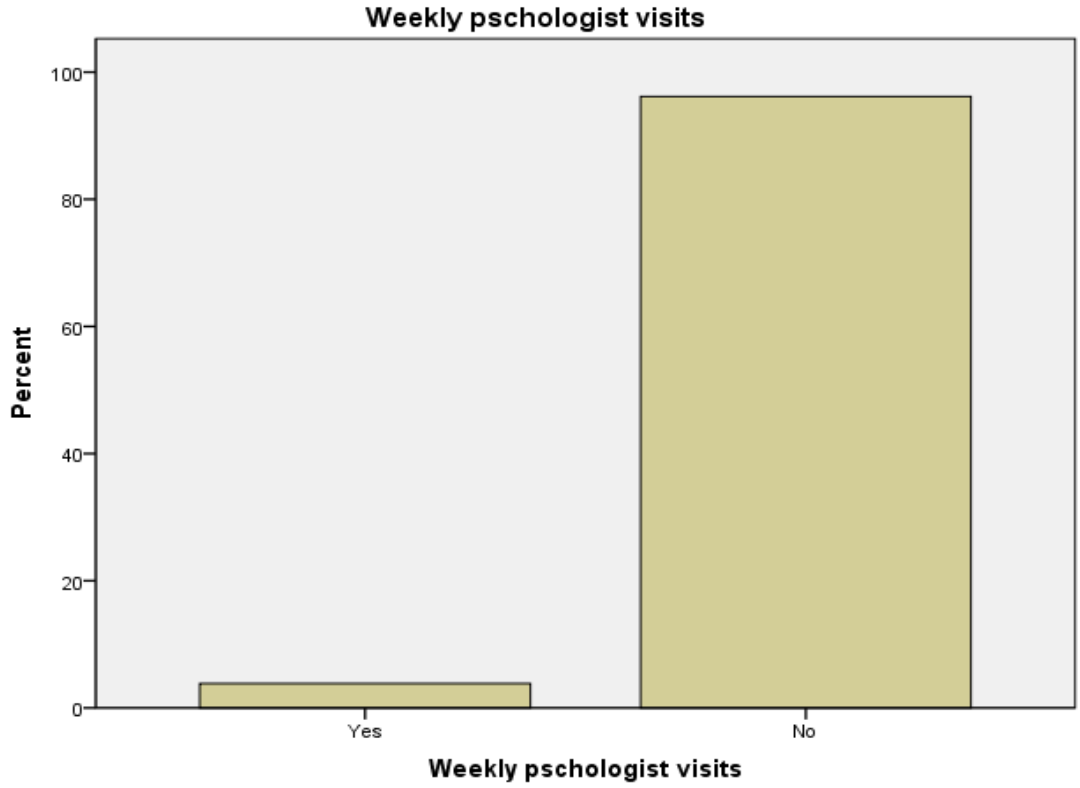

Figure.14 Weekly psychologist visits.

4.11 Involvement in services evaluation, workshops and participation between professionals and community

The workshops on Mental health care Act 17 of 2002 (61.5% n=32), mental health care users involvement in services evaluation (69.2% n=36) and participation between health care workers and community (57.7% n=30) were reported to not optimal.

4.12 Accessibility to Mthatha Hospital for tertiary level as assessed by workers during the data collection.

Table 4 presents the level of infrastructure and accessibility to tertiary level

Among the 14 clinics visited, 10 were far away (7, 50 km) from Mthatha Hospital (tertiary level), less equipped and inadequately supported.

Table 4 Level of accessibility of clinics visited by workers

Variables	n
Disadvanged Clinics	10
Ngqwara	29km
Ntlangaza	45km
Mahlungulu	55km
Zidindi	96km
Nzulwini	104km
Mapuzi	120km
Tshezi	127km
Ngcengane	21km
Xhongorha	80km
Ntshele	20km
Well Supported Clinics	4
Gateway	2km
Mbekweni	22km
Tabase	23km
Baziya	50km

4.13 Determinants of awareness about mental health care Act 17 of 2002

Professionals working in advantaged clinics were significantly more (90% n=18/20) (P<0.0001) aware about mental health care Act 17 of 2002 than their counterparts working in disadvantaged clinics (38% n=12/32).

Awareness about mental health care Act 17 of 2002, was significantly lower among workers with low education qualification (high school, undergraduate diploma and degree: 47% n=18/38, P=0.037) than in their counterparts with highest educational qualification with postgraduate diploma in psychiatry (86% n=12/14).

Workers who reported the presence of co-ordinator for mental health services were significantly more aware(72% n=18/25, P=0.044) about mental health care Act 17 of 2002 than those who did not reported (44.4% n=12/27).

Awareness about mental health care Act 17 of 2002 was significantly commoner(71.9% n=23/32, P= 0.009) among workers who reported the presence of workshop on mental health care Act 17 of 2002 than in those who did not (35% n=7/20).

The mean age was similar (P=0.545) in workers aware (37.7± 7.1 years) about mental health care Act 17 of 2002 (36.3± 8.7 years) and in workers not aware.

CHAPTER 5 DISCUSSION

This chapter outlines major findings of the study which will be discussed in relation to data literature. It shows how the study responded to the aims, objectives and hypothesis. Interpretations, explanations and limitation of the findings will be also handled.

This study asssesed the level of knowledge and implementation of mental health care services into primary health care system in KSD Sub-district municipality, OR Tambo District, Mthatha Eastern Cape Province of South Africa. Doing so, the study hypotheses were verified. In deed, the study showed that integration of mental health care services into primary health care system was not optimal.

5.1 Socio-demographic profile

5.1.1 Gender

In this study there was a female predominance (Sex ratio almost 2 females: 1 male). In South Africa, the demographics encompass about 50 million people of diverse origins, cultures, languages and religions. The sex ratio is almost 1 male: 1 female (CIA World Fact book, (en.wilkipedia.org/ wiki/List of countries) List of Countries by sex ratio, www.indexmundi.com, 2011).

It is important to recognise the profound implications of gender-based inequities in health. Evidence is emerging that integrating gender considerations into interventions has a positive effect on health outcomes across various domains (Boarder C., Santana D, Santilla`n D., Hardee K., Greene M. E., Schuler S. The "So What" Report: A look at Wheather Integrating a Gender Focus into Programs Makes a Difference to outcomes. Washington: Interagency Gender Working Group Task Force Report (IGWG); 2004).

However; the majority of female health workers were professional nurses and not at top level. Indeed, only woman were medical doctors. Implementation of South African affirmative policies and measures has resulted in better equity in gender representation in the public sector management (World Health Statistics 2007, World

HealthOrganization(http://www.who.int/whosis/whostat2007/en/index.html,accessed 9 April 2008).

Reasons for their dominance in the nursing and supplementary professions are historical and international phenomenal(World Health Statistics, 2007. World Health Organization).

In Zambia, Nurses are the frontline staff in delivery of mental health care in primary health care units in both long stay facilities and daily outpatient facilities (Mwape L et al, 2010. Integrating mental health into primary health care in Zambia: a care provider's perspective, International Journal of Mental Health Systems 2010, 4:21).

5.1.2 Age

Globally the participants were young adults. Moreover, females were older than males.

These mean ages are similar with that reported among Zambian mental health professionals (Mwape et al, 2010).

5.2 Barriers to mental health care integration in primary health care system in King Sabata Dalindyebo Municipality

The present study explored integration of mental health into primary health care from the perspective of health professionals in King Sabata Dalindyebo Municipality.

It identified the key barriers around integrating mental health care into primary health care as follows:

- under representation of further training in psychiatry (specialization);
- low awareness about mental health care Act 17 of 2002;
- low levels of documentation, provider training and support, entry or admission, training psychiatric sister for supervision of mental health care services;
- the majority not aware about how often out-reach programmes for mental health are organised;
- almost 100% of referrals to tertiary levels;
- mental disorders are provided only by medical officer;
- lack of implication of regional psychiatrist;
- lack of visit by mental health specialist, psychologist and social worker;
- poor accessibility to Mthatha hospital for tertiary level of majority of disadvantaged clinics;
- restrictions that prohibit primary health care nurses from prescribing common psychotropic medication (Mohlakoana S.P, 2003. Integration of mental health into primary health care. Johannesburg, University of the Witwatersrand, 2003), (World Mental Health Day, 2009, Mental Health in Primary Care: Enhancing treatment and Promoting Mental Health, 10 October 2009).

These main constraints of integrating mental health into primary health care system are not full taken into account worldwide (Mwape et al, Jenkins R., Strathdee G.,: The Integration of Mental Health Care with Primary Health Care. International Journal of law and Psychiatry, 2000, 23:277-291, A. Alem, L. Jacobsson, C. Hanlon, Community-based mental health care in Africa:

mental health worker's views, World Psychiatric Journal, 2008, Burns J.K, 2008; Implementation of the Mental Health Care Act 17 of 2002 at district hospitals in South Africa: Translating principles into practice).

The lack of awareness about the mental health care Act 17 of 2002 and other identified barriers could undermine the successful implementation of the mental health care integration into community mental health system (Burns J.K.; 2008, Implementation of Mental Health Care Act 17 of 2002 at district hospitals in South Africa: Translating principles into practice January 2008, Vol.98,No.1 South African Medical Journal). The determinants of the lack of awareness about mental health care legislation in South Africa were also identified in the survey. These determinants, related to poverty, lack of infrastructure, inadequate skills and training as well as poor support from the government, included:

- professionals working in disadvantaged clinics;
- health workers with low educational qualification;
- lack of co-ordinator for mental health care services;
- absence of workshops on mental health care Act 17 of 2002.

These findings witness that the South African mental health care Act 17 of 2002(Burns J.K 2008. Implementation of the Mental Health Care Act 17 of 2002 at district hospitals in South Africa: Translating principles into practice, January 2008, Vol.98, No.1 South African Journal), is no longer against apartheid legislature on mental ill patients (Act No. 18 of 1973) and against a backdrop of positive international developments in mental health legislature (Mental Health Care Act 17 of 2002 Pretoria: Department of Health.http//www.info.gov.za/gazette/act/2002 (accessed October 2007).

Apartheid for legislation was reinforcing the alienation, stigmatization and disempowerment of mental ill patient in South Africa. To reduce this gap, Burns offered the solution of translating principles into practice (JK. Burns 2008. Implementation of the Mental Health Care Act 17 of 2002 at district hospitals in South Africa: Translating principles into action, January 2008, Vol.98, No.1 South African Medical Journals).

5.3 Potential factors to implementing integration of mental health into primary health care system

The present survey showed relevant factors with potential implementation of integrated mental health care into primary health care system. Indeed, the characteristics of mental health care services were reported by health workers to be good to excellent.

The retention of the surveyed health professional within the remote areas of King Sabata Dalindyebo, possible related to high proportion of married health professionals, should the cornerstone of integration of mental health services into primary health care system.

These characteristics constitute the rationale for integrating mental health care service into primary health care system with the following advantages (Integrating Mental health into primary care: A global perspective, WONCA, World Mental Health Day, 2009):

- decreased stigma in mental patients;
- improved of accessibility to mental health care services and comorbity physical conditions;
- respect of confidentiality and human rights;
- effectiveness of mental health care services;
- availability of treatment, support environment, emergency care;
- screening, service management and development;
- mental health promotion, psycho social rehabilitation;
- language, cultural context, community living;
- telephone, fax machines, medication;
- transport offered to patients.

5.4 Implications and perspectives for public health

The present data will impact in rendering integrated primary mental health services as complementary with tertiary and secondary level of mental health care services in King Sabata Dalindyebo and other developing Sub-districts.

Of the World Health Organization, proposes the development of community based mental health services worldwide (A. Alem, L. Jacosson, C. Hanlon, Community-based mental health in Africa: mental health workers'views). Even in developed countries, primary health care based mental health services are preferred in contrast to more hospital based services (A. Alem et al., 2008. Community-based mental health in Africa: mental health worker's views).

This study will have implication for health care provision and use (making mental health care service available, accessible and acceptable in King Sabata Dalindyebo), implication for health policies (enhancement of current South African mental health policy can be successful integrated into primary health), and implications for further research (mental health services and mental health economies, perceptions of health workers, predisposing, enabling factors associated with successful integration of mental health into primary health care system).

The present data will serve to break the vicious cycle of human poverty and mental ill-health, in order to generate lessons provided by poor setting (Mwape L., Flischer A.J, Lund C., Funk M., Banda M., Bhana A., Doku V, 2007: Mental health policy development and implementation in four African countries. Journal of health Psychology, 2007 12:505-516).

The present information emphasises on the importance of effective mental health services as South Africa is facing a burden of diseases arising from mental health issues (World Health Organization- Choice, 2003). Cost-effectiveness of interventions for reducing the burden of mental disorders: A global analysis (WHO-CHOICE,2003). GPE Discussion Paper (prepared by Chisholm D), Geneva, World Health Organization.

CHAPTER 6 Recommendations

The recommendation from the present study towards national, provincial and regional policy makers as well as to researchers, health professionals, patients and Community including Walter Sisulu University, will facilitate the strengthening of the integration of mental health into primary health system in South Africa.

The national government and provincial government of the Eastern Cape should make substantial efforts directed towards integration of mental health care into primary health care as follows:

- mental health to become a vital component in strategic planning;
- availability of national minimum health care package;
- centralization of health care services delivery;
- increasing investment in mental health care, infrastructure, human resources and research;
- to train and increase capacity of mental managers in planning for, and implementing mental health services;
- increase in recruitment of specialised mental health professionals at district level;
- increase in number of primary health care professionals, subsequently receiving continuous training in mental health care, providing a mental co-ordination officer at district level;
- commitment and political will for strengthening mental health care.

Health professionals should at least have skills and competencies to provide mental health interventions. The community should be embarked in prevention and education, organised by policies, interventions and research related to health promotion to tackle raising the burden of mental illness. Only collaboration of all stakeholders with best of private and public services partnership will accelerate achievement integration of mental health.

According to these study findings, primary care for mental health in KSD should function being inspired by the WHO model for Service Organization Pyramid for optimal Mix of Services for Mental Health (Funk M. et al. Mental health policy and plans: promoting an optimal mix of services in developing countries. International Journal of Mental Health, 2004, 33:4-16). The WHO model is based on the principle that no single service setting can meet all population mental health needs (Integrating mental health services into primary health: A global perspective). Furthermore, the integration of mental health services into primary care is essential, but must be accompanied by the development of complementary services in general and at secondary levels in particular. This requires leadership and long time commitment of health managers and health professionals at service levels.

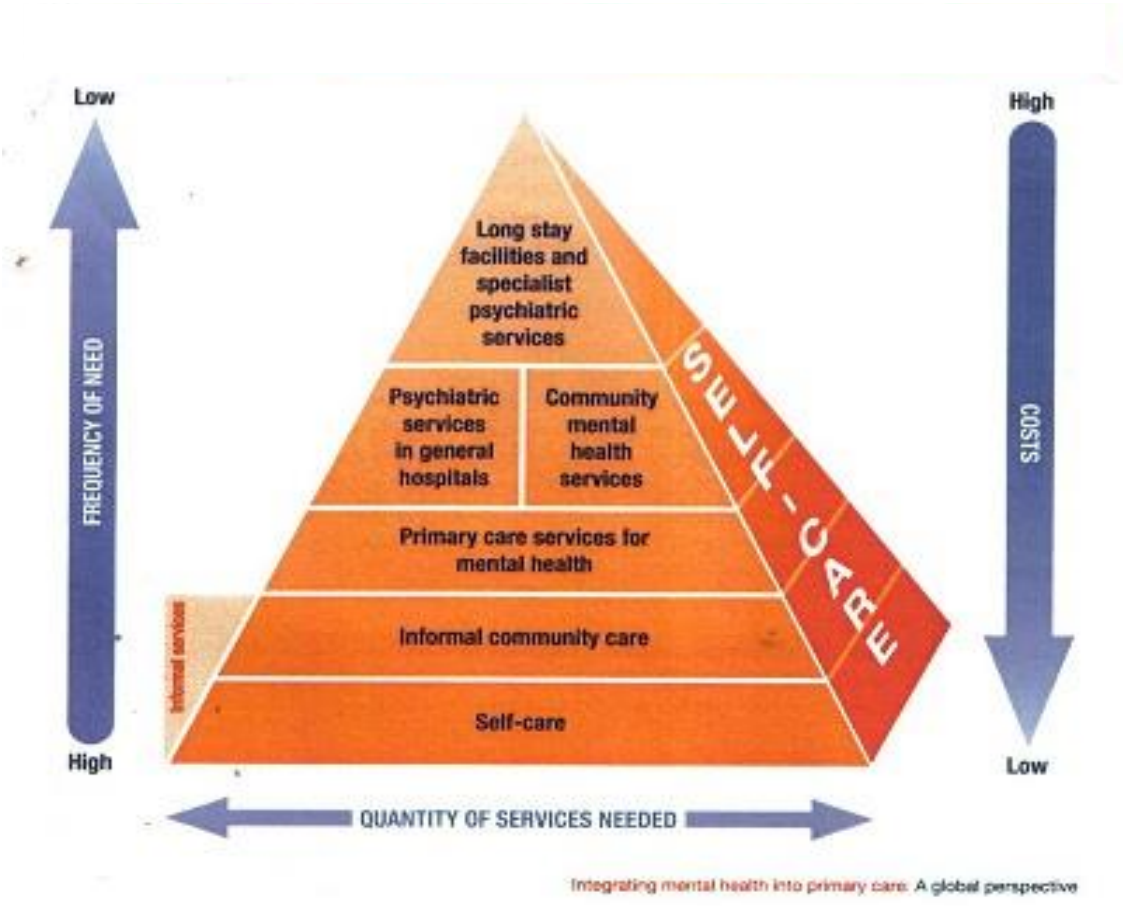

Figure 15. Organization Pyramid for optimal Mix of Services for Mental Health

The mental health managers in KSD are invited to learn from the success in integrating primary care service and partnership from several developing settings out and within South Africa (South Africa. info. Gateway to the nation. International Marketing Council of South Africa (http://www.southafrica.info/ess-glance, accessed 17 April 2008) Health care in South Africa. International Marketing Council of South Africa (http://www.southafrica.info/ess-info/sa-glance/health/health.htm,accessed 17 April 2008) World health Statistics 2007. Geneva, World Health Organization 2007. Williams DR et al. Twelve-month mental disorders in South Africa: prevalence, service use and demographic correlates in the population-based South African Stress and Health Study. Psychological Medicine, 2008, 38:211-220. Mpumalanga Province. International Marketing Council of South Africa (http://southafrica.info/about/geography/ mpumalanga.htm, accessed 18 April 2008). Mohlakoana SP. 2003, Integration of mental health into primary health care. Johannesburg, University of the Witwatersrand, 2003.

6.1 Conclusion

The present study demonstrated the presence of a good to excellent framework for potential implementation of mental health care service into primary health care system in KSD. The government support in infrastructures, drugs availability, transport and equipment is evident. Patients are helped within abroad based ethical**,** human rights and psycho-social framework.

The awareness about the mental health care Act 17 of 2002 was low. To close this gap, urgent interventions on the determinants of low awareness are needed. The factors associated with awareness legislative action about mental health care system are: remote and disadvantaged working area, lower education attainment/ qualification, lack of co-ordinator for mental health service, and absence of workshops on mental health care Act 17 of 2002.

There is a lack of improving human capacity for mental health in terms of continuous training in mental health issues, policies, organization and development. Globally, the integration of mental health care service in King Sabata Dalindyebo is non-optimal.

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Appendix A

THE INTEGRATION OF MENTAL HEALTH CARE SERVICES INTO PRIMARY HEALTH CARE SYSTEM IN MTHATHA CLINICS

Date : _____/_____/_____

Respondent number: _____

Name of researcher : _____

Name of place where questionnaire administered

_____

Health Professionals Questionnaire

General information

1. Gender: 1. Male _____

2. Female _____

2. Age: _____

3. Marital: 1. Single _____

2. Married _____

3. Widow _____

4. Divorced _____

4. Qualification 1. High school qualification _____

2. Bachelor's degree _____

3. Undergraduate diploma _____

4. Postgraduate Degree _____

5. Postgraduate Diploma _____

5. Population group : 1. African _____

2. White _____

3. Indian _____

4. Coloured _____

6. Home language : 1. English _____

2. Xhosa _____

3. Zulu _____

4. Afrikaans _____

5. Other _____

7. Nationality : 1. South African _____

2. Other _____

8. Province of upbringing: 1. Eastern Cape _____

2. Gauteng _____

3. Western Cape_____

4. Limpopo _____

5. Free State _____

6. Mpumalanga _____

7. Kwazulu Natal_____

8. Northern Cape_____

9. North West _____

9. Environment : 1. Rural _____

2. Urban _____

Work Experience

10. Name of Health care centre : _____

11. Job Level : 1. Top Management _____

2. Middle Management_____
3. Professional _____
4. Doctor _____

12. Number of years employed :_____

13. Terms of employment : 1. Permanent _____
2. Contract _____
3. Casual _____

14. Do you have qualifications in general psychiatry?
1. Yes _____
2. No _____

15. Do you have a further training in psychiatry?
1. Yes _____
2. No _____

17. If yes, what type of training: 1. Diploma _____
2. Degree _____
3. Postgraduate Diploma_____

18. Are there mental health care services available in this clinic for instance psychotic drugs like largactils etc…, monthly injections like modecate, clopixol depot etc… for mental disorders?
1. Yes _____
2. No _____

19. Are you aware of the new Mental Health Act (Act 17 of 2002) and its procedures for mentally patient?

1. Yes_____
2. No_____

20. Do you have a co-ordinator for mental health care programmes in this clinic?

1. Yes_____
2. No_____

21. Do you have a psychologist who visits weekly the clinic for sessions with mental ill clients?

1. Yes_____
2. No_____

22. Do you have a social worker for people with mental disorders that need assistance in social services for instance disability grants?

1. Yes_____
2. No _____

23. Are you regularly visited by mental health specialist on monthly basis for overall supervision of primary health care practitioners on integration of mental health care services into other programmes at this clinic?

1. Yes_____
2. No_____

24. Do you have a regional psychiatrist visiting every three months at this clinic for supervision of doctors in mental health services?

1. Yes_____
2. No_____

25. Are physical health care of people with mental disorders provided by a Medical Officer on daily basis to promote integration of mental health in this clinic?

1. Yes_____
2. No_____

26. Do you have workshops that are being conducted on new mental health act (Act 17 of 2002) and its procedures in relation to mental illness and patients?

1. Yes_____
2. No_____

27. Do you think mental health care services in your clinic are efficient for instance are they covering the whole catchment area as intended for mental health care patients?

1. Yes ____
2. No ____

28. Do you think that mental health services in your clinic are equitable for instance all mental ill patients have access to services?

1. Yes ____
2. No_____

29. Do you involve mental health care patients in their services evaluation in your clinic?

1. Yes_____
2. No _____

30. Do you think that mental health services offered in this clinic are acceptable to the mental ill patients?

1. Yes_____
2. No_____

31. Rate your service delivery at the clinic for mental ill patients:

1. Good_____
2. Fair _____
3. Poor_____

32. Do you think that these services offered to mental ill are effective for instance are serving the intended purpose?

1. Yes_____
2. No_____

33. Do you have clinic days for mental health services in the same proportion as for physical health clients?

1. Yes_____
2. No_____

34. Do you render outreach programmes in connection with mental health services?

1. Yes_____
2. No_____

35. How often do you have outreach programmes?

1. Once in a month
2. After every three months
3. Every six months
4. Not known

36. Does the clinic receive down referrals for Mental Health clients from tertiary hospitals?

1. Yes ____
2. No_____

37. Do you think that as health workers and community members of this area, you are actively involve enough in achieving good quality mental health care service ?

1. Yes ____
2. No_____

38. Do you think that mental ill clients are treated fairly as in same relation to physical ill clients in your clinic/ health centre?

1. Yes _____
2. No _____

39. Do you think that good steps are taken to improve the implementation of integration of the mental health care services into primary health care system for instance mental ill clients are getting all their services in your clinic?

1. Yes ____
2. No ____

40. Do you think mental ill patients should be separated to the physical ill patients?

1. Yes___

2. No___

41. Do you think that they should locked away from other people?

1. Yes____

2. No____

42. Do you have a transport for mental ill patients for transportation of patients to peripheral hospitals when referred and home visits for them?

1. Yes____

2. No____

43. Do you have a telephone for community and the clinic to report cases of mental illness and for effective referral purposes?

1. Yes____

2. No___

A tool to measure of the standards for mental health care in South Africa (WHO, 2004)

Name of Clinic :

Standards

1. Rights and legal protection	
2. Safety and risk management	
3. Access	
4. Confidentiality and privacy	
5. Personal interaction and relationships	
6. Treatment and support environments	
7. User and care-giver participation	
8. Community participation and	

development	
9. Community living	
10. Mental health and promotion	
11. Language, culture and context	
12. Resource management and affordability	
13. Service management and development	
14. Documentation	
15. Provider training and support	
16. Entry or admission	
17. Emergency care	
18. Screening, assessment and review	
19. Treatment, care and therapies	
20. Medication and other technologies	
21. Psycho-social rehabilitation	

Filled by:	Signature:

Standard Description

1. The rights and legal status of people affected by severe psychiatric conditions (SPCs) are upheld by services within the ethos of care, equity and respect for human rights

2. The services' activities and environment are safe for users, care-givers, providers and the community

3. The services are accessible to the population of the district or catchment area, and users with severe psychiatric conditions in particular

4. The services ensure confidentiality and seek optimum privacy for users with SPCs and their care-givers

5. The services promote and provide care for users, which is based upon humane and respectful interaction and relationships and the need for social integration and support

6. The environment and structure in which treatment and support occurs should promote mental health goals, community integration and service accessibility

7. Users and care-givers should be involved in the planning, implementation and when possible, the evaluation of their treatment and the services

8. The service promotes community participation and development that benefits and addresses the needs of users and their care-givers

9. The service emphasises and facilitates the ongoing living, support, care and empowerment of users and their care-givers in the community

10. The services work with users, care-givers, providers and the community to promote positive and informed awareness of severe psychiatric conditions, reduce disabling and stigmatising practices, and provide prevention, early detection and care of SPCs and its associated impairments

11. The services strive to ensure equity and acceptability through the prioritisation of language, and culturally and contextually sensitive practices to users, their care-givers and communities

12. The services seek to offer acceptable and equitable mental health services to users with the best utilisation of available resources, and in the most cost-effective manner

13. The policy, structure and management processes of the health services facilitates the delivery of the best possible care for users in all health care levels and settings

14. There is accurate documentation of clinical information to assist with the delivery of care, management of services and public education for users

15. Providers are adequately trained, supported and supervised in order to offer the best possible care to users and care-givers

16. The process of entry or admission into the services occurs at the appropriate care level in and accessible, timely and rights-sensitive manner

17. The services ensure that users have access to the acceptable emergency mental health care in a range of care settings

18. All users are screened for severe psychiatric conditions, and users receive a comprehensive timely socio-culturally sensitive and accurate assessment and regular review of progress

19. Treatment, care and therapies are provided in a manner that promotes efficacy, participation, safety and maximum possible quality of life for users

20. These are provided in a manner which promotes efficacy, choice (within the available range), safety and maximum possible quality of life for users with severe psychiatric conditions

21. This is provided as an integral component of all types and levels of service provision, and promotes their highest level of personal and economic independence, self esteem and quality of life for users and care-givers

Appendix B Informed Consent letter for participants

FACULTY OF HEALTH SCIENCES

DEPARTMENT OF COMMUNITY MEDICINE

SCHOOL OF PUBLIC HEALTH

Nelson Mandela Drive, Private Bag x 1, WSU Mthatha 5117
Eastern Cape, South Africa Tel: 0475022723/2250 Fax: 0475022595

To Whom It May Concern

Re: Request to participate in research study on: Integration of mental health care services into primary health care system in King Sabata Dalindyebo Municipality Clinics.

I write to request your participation in the above mentioned research study to be conducted during my studies .The study is being conducted as part of a Masters Degree pursued at Walter Sisulu University. I appeal for your support towards the success of this worthwhile study, which aims at understanding and explaining integration of mental health services into primary health care system as the purpose to improve service delivery and job success as strategy for poverty reduction and development in the region. Such support may include: responding to questionnaire accompanied by this letter, being part of a focus group discussion: granting permission for the study to be conducted in your health centre, identifying potential interviewees.

In line with the ethical standards of research, the information you provide in questionnaire and interviews will be used for purpose of this study, anonymously and strictly confidential.

Your co-operation in this regard will be highly appreciated.

Yours sincerely
Ntandazo Dlatu (Mr)
Tel: 0475024179
Cell: 0731630498

WSU
Walter Sisulu University

FACULTY OF HEALTH SCIENCES
POSTGRADUATE EDUCATION, TRAINING, RESEARCH AND ETHICS UNIT

HUMAN RESEARCH COMMITTEE
CLEARANCE CERTIFICATE

PROTOCOL NUMBER	:	0086/009
PROJECT	:	THE INTEGRATION OF MENTAL HEALTH CARE SERVICES INTO PRIMARY HEALTH
INVESTIGATOR(S)	:	N DLATU
DEPARTMENT	:	COMMUNITY MEDICINE
DATE CONSIDERED	:	28 JANUARY 2010
DECISION OF THE COMMITTEE	:	APPROVED

N.B. You are required to provide the committee with a progress or outcome report of the research after every 6 months. The committee expects a report on any changes in the protocol as well as any untoward events that may occur at any time during the study as soon as they occur.

Professor CD Mwesigwa-Kayongo
CHAIRPERSON

22/01/2010
Date

DECLARATION OF INVESTIGATOR(S)
(to be completed in duplicate and one copy returned to the Research Officer at Office L311, 3rd Floor, Old Library Building, NMD Campus, WSU)

I/We fully understand the conditions under which I am/we are authorized to carry out the abovementioned research and I/we guarantee to ensure compliance with these conditions. Should any departure to be contemplated from the research procedure as approved I/we undertake to resubmit the protocol to the Research Ethics Committee. I/We agree to a completion of a yearly progress report.

N. Dlatu

24/02/2010

N.B. Please quote the protocol number in all enquiries.

ENDORSEMENT ROUTE SHEET

DRAFT PROPOSAL	LETTERS	SUBMISSIONS	MEMORANDUM

SUBMISSIONS

REQUEST APPROVAL FOR MR BLATU TO CONDUCT A STUDY ON MENTAL HEALTH SERVICES IN PRIMARY HEALTH CARE

(See attached documents)

No	Route	Action	Date
1.	SUB DISTRICT MANAGER	For your information/ comments/approval and return to compiler	26/02/10
2.	DISTRICT MANAGER	For your information comments / approval, return to compiler or forward to-	01/03/2010
3.	GENERAL MANAGER PHC	For your information comments / approval, return to compiler or forward to-	
4.	DEPUTY DIRECTOR GENERAL	For your information comments / approval, return to compiler or forward to-	2010/05/06.
5.	SUPERINTENDENT GENERAL	For your information comments / approval, return to compiler or forward to-	4/6/10

Contact Number : 0833781467

01/06/2010

Superintendent General
Department of Health, Private Bag x0038
Dhlisko, EC
Tel: 040 608 3869

DEPARTMENT OF HEALTH
OFFICE OF THE CHIEF DIRECTOR
EC
2010 -06- 09
RECEIVED

APPENDIX K

WALTER SISULU UNIVERSITY

DIRECTORATE OF POSTGRADUATE STUDIES

MANDATORY CONSENT FORM: ELECTRONIC THESES & DISSERTATIONS (ETD) AND PLAGIARISM REQUIREMENT (For postgraduate research outputs from 2009 September)

TEMPLATE FOR THE STUDENT AND SUPERVISOR CONSENT FOR PUBLICATION OF ELECTRONIC RESEARCH OUTPUT ON INTERNET AND WSU INTRANET

FACULTY:

_____

QUALIFICATION NAME:_____**ABBREVIATION:**_____**YEAR:** _____

STUDENT'S FULL N_____**STUDENT NUMBER**_____

TYPE OF RESEARCH OUTPUT: RESEARCH PAPER/MINI-DISSERTATION/DISSERTATION/THESIS (TICK ONE)
TITLE OF THE RESEARCH OUTPUT:

_____

CONSENT: I HEREBY GIVE MY CONSENT TO WALTER SUSULU UNIVERSITY TO PUBLISH MY RESEARCH OUTPUT FOR THE QUALIFICATION ABOVE ON THE WSU INTRANET AND INTERNET. I CERTIFY THAT TO THE BEST OF MY KNOWLEDGE, THERE IS NO PLAIGARISM IN THE RESEARCH OUTPUT AS SUBMITTED. I HAVE TAKEN REASONABLE CARE TO ENSURE THAT THE RESEARCH OUTPUT MEETS THE QUALITY LEVEL EXPECTED FOR THE PRESENT QUALIFICATION LEVEL BOTH IN TERMS OF CONTENT AND TECHNICAL REQUIREMENTS. I FULLY UNDERSTAND THE CONTENTS OF THIS DECLARATION.

_____ _____

SIGNATURE OF STUDENT **DATE**

ENDORSEMENTS BY:

SUPERVISOR:

FULL NAME:

_____**SIGNATURE:**_____**DATE:**_____

CO-SUPERVISOR(S):

1 FULL NAME:

_____**SIGNATURE:**_____**DATE:**_____

2. FULL NAME:

_____**SIGNATURE:**_____**DATE:**_____