A CHILD MENTAL HEALTH PROGRAM FOR PRIMARY CARE NURSES

by

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submitted in partial fulfilment of the requirements for the degree of Doctor of Philosophy (Community Psychology) in the Department of Psychology, University of Zululand

2003
Abstract

The state has committed itself to the integration of mental health and primary health care services in order to utilise resources more efficiently and to provide comprehensive care to the population. Primary health care nurses are generally lacking in mental health skills. The provision of training for them has been identified as being essential if integration is to succeed. The various provinces have differed from each other in their approaches to integration and training. In Kwa Zulu-Natal, no training programs had been introduced by the provincial health authorities until recently.

This study aimed to provide a training program in child mental health for primary health care nurses in the Ugu region. A group of fourteen nurses were trained in the diagnosis and management of four frequently occurring child mental health problems. Their knowledge prior to training was assessed and compared to that of a group of psychiatric nurses and a group of primary care nurses undergoing training in a general mental health program conducted by the Department of Health. Their attitude towards integration was also compared to that of the group of psychiatric nurses.

It was found that prior to training, both groups of primary care nurses knew significantly less about these conditions than did the group of trained psychiatric nurses. After training, the group that had been trained in the writer's program were found to have improved their knowledge to a level similar to that of the psychiatric nurses. The group undergoing training in the department's program made no significant gains in knowledge when compared to the other two groups. It was concluded that the department's program may be deficient in certain aspects and needs to be reviewed.

Both primary health care nurses and trained psychiatric nurses anticipate various problems related to the proposed integration of services. It is argued that for integration to be successful these concerns and issues need to be urgently addressed.
ACKNOWLEDGEMENTS

I am deeply indebted to several people without whom this work would not have been completed. In particular, I wish to express my gratitude to:

Professor Steve Edwards, Head of the Department of Psychology at the University of Zululand, for his guidance and encouragement.

Professor Anthony Pillay of the Sub-Department of Medically Applied Psychology, N.R. Mandela School of Medicine, for his support, suggestions and invaluable help.

Colleagues Siva Penchaliah, Gugu Nyawose, Dr A.H.S. Kajee and Dr A.S. Kathrada, for their help and support.

All the participants in this study for their time and effort.

My wife, Hyacinthia; and children, Nishlan, Divesh and Thashin, for their help, encouragement, patience and sacrifices.

Marshall and Nokia without whom none of this would have been possible.

My parents, sisters and aunts who have always been there for me.
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CHAPTER 1

Introduction

Although the term 'mental health' has no single definition or meaning, to most people, including professionals, it is often defined as being the absence of mental illness (Armstrong, 1992; The Clifford Beers Foundation, 1996). Defining a term by the absence of its opposite has been described as a "sleight of hand" by Tudor (1996; p.21). Nevertheless, this is a popular definition and it forms the basis of the mental health model of Community Psychology. This model holds that the primary role of the Community Psychologist is to provide expert, professional advice to individuals and organizations involved in the treatment and prevention of mental disorders (Ahmed & Pretorius-Heuchert, 2001).

In this model, the goal of intervention is to reduce the incidence and prevalence of mental disorders and the disability associated with them. This is achieved by engaging in illness prevention activities, health promotion and rehabilitation. Traditionally, such services have been provided in mental health centres or psychiatric clinics located within geographically defined communities (Mann, 1978).

1.1 Mental health services for children

The provision of mental health services in developing countries has generally been inadequate (Nikapota, 1991; Jacob, 2001; Pillay & Lockhat, 2001). Mental health is usually regarded as a low priority in these countries as physical needs and physical illness takes precedence. Infectious diseases and malnutrition are the major causes of mortality and morbidity and therefore governments are reluctant to divert limited resources to services which appear to provide little visible impact (de Silva et al; 1988; Jacob, 2001).

This stance appears to compromise the provision of mental health services for children in particular. Children comprise 40 - 50% of the population of developing countries yet, until recently, there has been little focus on mental health issues affecting them (Minde & Nikapota, 1993). In South Africa, it is estimated that 45% of the population is younger
than 20 years of age and that in rural areas this proportion is higher (Bradshaw, 1997). Referring specifically to Africa, Olawatura (1988), attributes the absence of adequate mental health services for children on the continent to reasons advanced earlier: namely, the diversion of scarce resources to combat the major causes of morbidity and mortality.

This is a rather narrow perspective as there is growing evidence that disability resulting from mental health problems is increasing (Murray & Lopez, 2000). They estimate that it will account for 15% of all disability adjusted life years (one disability adjusted life year or 'DALY' is the equivalent of one lost year of healthy life) by 2020. Considering that Dawes et al., (1997) have estimated that 15% of South African children have mental problems and that 20% of all child contacts at primary care clinics are probably related to mental health problems (WHO, 1996); it is perhaps imperative that more attention be focussed on the early detection, treatment and prevention of mental health problems in children. This is necessary so that the burden of disability in later life can be reduced.

South Africa, notwithstanding its status as one of Africa’s more prosperous and developed countries, is unfortunately not an exception to the problem of an inadequate provision of mental health services for children. This was acknowledged as early as 1988 in a report commissioned by the Department of National Health and Population Development on child mental health services (NHPD, 1988). Subsequently, Landman (1992) and Vogel (1996), among others, have further highlighted deficiencies in mental health service provision to children.

Pillay and Lockhat (2001) are of the opinion that it is primarily economically disadvantaged, rural children in this country that are the most likely to be deprived of services. Along with Chabalala (1997), they argue that urban populations are relatively well serviced by professional health workers but that rural populations are grossly neglected. A similar situation is reported to prevail in other developing countries such as Nigeria (Gureje, 1995) and India (Murthy, 2000).
In addition to a wide variation in service provision between urban and rural areas in developing countries, other problems include the tendency for such services to be closely linked to adult psychiatric facilities. One implication of this is that there may thus be a paucity of personnel who are properly trained in child mental health. This phenomenon is evident in South Africa as well. Not only are most children seen at adult clinics, Acuda (1993) and Vogel (1996), also report on a scarcity of appropriately trained personnel at these sites. For example, while the World Health Organization suggests a norm of Child Psychiatrists to population of 1: 35 000, in South Africa, the ratio in 1992 was 1: 1 000 000 (Landman, 1992). Kwa Zulu- Natal appears to be even worse off as there are at present no Child Psychiatrists in full time state employ in this province. Data extracted from PERSAL (a data management system for state employees) indicates low ratios of health workers to population in other mental health professions as well. At the end of November 2001, there were only 38 Clinical Psychologists and 57 Occupational Therapists on the provincial payroll. This represents ratios of 0.48 and 0.7 per 100 000 people respectively (Day & Gray, 2001). Nursing was better represented with 9058 members translating into a ratio of 114.4 nurses per 100 000 people. The specific number of nurses engaged in mental health activities could not be ascertained.

1.2 Factors affecting the provision of services

These already low ratios of mental health workers to population are further threatened by HIV/AIDS and migration. No exact data on the impact of HIV/AIDS on mental health professionals was located, but reports indicate relatively high infection rates amongst nurses in particular. A representative of the Hospital Association of South Africa is quoted as saying that nearly 20% or 35 000 registered nurses are HIV positive (Nursing Today, 2000). A drop in nursing enrolment from 12 282 in 1996 to 10 389 in 1999 was cited as evidence of the impact of the disease on the profession. Although the accuracy of these figures as been disputed, there is consensus that HIV/AIDS is having an impact on the number of people entering the profession as well as on mortality rates amongst existing personnel.
As with information on HIV/AIDS, no accurate data on the migration of specific groups of health professionals could be located. However, the acknowledgement by the Minister of Health that the state’s efforts to improve public health services is being threatened by the migration of health personnel, (Daily News, 25 October 2002); as well as ex-President Mandela’s request to Commonwealth states to cease recruiting South African health workers, is indicative of the extent of the problem. Geyer (2001) quotes figures released to the London Sunday Times by the British government showing that in 2000, at least 1640 nurses had left South Africa to take up employment in Britain. Anecdotal evidence indicates that there may be significant numbers of other professionals, including Psychologists, Psychiatrists, Social Workers, Occupational Therapists and Speech Therapists, emigrating or leaving the country at least temporarily to seek employment. Personal knowledge is that, in the past year, a number of psychiatric nurses have left state employ to take up appointments in England and the Republic of Ireland.

The loss of skilled personnel through migration and HIV/AIDS is likely to have a major impact on health services in general in this country. Years of education, training and experience have been lost and perhaps the full impact of this has yet to be felt. As mental health personnel are amongst those leaving, it follows that mental health services too will be affected. One possible solution to this problem would be to redefine what can be achieved with fewer personnel and to readjust health training to meet new demands (Nursing Update, 2002). This suggestion is of course not new.

1.3 Integration of mental health and primary health care services

The concept of Primary Health Care originated specifically in response to an awareness that the health needs of developing and underdeveloped nations were not being met because of a lack of both financial and personnel resources (Denhill et al., 1995). At a conference convened by the World Health Organization and UNICEF at Alma Ata, Russia, in 1978, strategies to optimise health care in these countries were discussed. These strategies form part of the primary health care concept and they take into account factors such as a lack of infrastructure, skills, trained personnel and financial resources. In brief,
primary health care was envisaged as affordable, accessible and essential health care based on scientifically sound and socially acceptable methods (Denhill et al., 1995).

Initially, no specific reference to the integration of mental health and primary health care services was made, but the World Health Organization (1990) recognized that primary care nurses could be trained to provide such services. The advantages of an integrated service included savings in cost through the sharing of infrastructure, a reduction in the stigmatization associated with mental illness, and an increase in the rate of detection and treatment of mental health problems (World Health Report, 2001).

Various programs were introduced in developing countries to train primary care nurses to detect mental disorders, to provide basic counselling and to refer more severe cases to specialized mental health personnel. Examples of such programs include those in Sri Lanka (de Silva et al., 1988; Nikapota, 1993), India (Srinivas & Murthy, 1986) Lesotho (Meursing & Wankin, 1988) and Zimbabwe (Hall & Williams, 1987; Reeler, Williams & Todd, 1994).

In South Africa, the decision to integrate primary care and mental health services was only formalised in the post apartheid era. The National Health Plan (ANC, 1994), committed the new government to the implementation of a primary health care system that would ensure a more equitable provision of services to the population. The aim was to eliminate the fragmentation of services and to provide comprehensive care. The plan emphasised the prevention of disorders by identifying and targeting high-risk groups and children.

The National Health Plan provided a framework within which health services were to be restructured, and like the White Paper for the Transformation of Health Systems (Dept of Health, 1997), it did not specify details on how this was to be achieved. The District Health System was identified as the vehicle through which primary health care was to be implemented but individual provinces had the option of choosing between the establishment of health authorities or exercising control through their municipalities. This option, together with delays in the passing of the National Health Bill which was only
published for comment in November 2001, has led to there being little uniformity amongst the provinces in both the pace of and approach to integration.

The Gauteng Health Department has had a primary mental health care training manual and training program in place since 1997. In Kwa Zulu-Natal it has only been in the latter half of 2002 that the Department of Health has begun to formally address the mental health training needs of its primary care nurses. This is despite statements by the coordinator of the integration process that integration must occur by January 2003 (Mkhize, 2002). The training program that has been adopted locally is based on a training manual developed by Gmeiner and van Wyk (2002 a) for the National Department of Health. As a preliminary step, a group of psychiatric nurses were trained over a 5 day period in the use of the manual and on the principles of training. Using a cascade model, this group has since begun training the first groups of primary care nurses at various locations in the province. On completion of training, these nurses are being expected to then train their colleagues at the centres where they are employed. A disturbing aspect of this program is that while Gmeiner and van Wyk (2002 b) recommended that training be conducted ideally over fifteen days, this was reduced to eight days for the first groups of primary care nurses. At the time of writing, the Deputy Director of Mental Health had indicated that this period was to be further reduced to four days for groups that are to follow. Informal discussions with some of the trainers reveals that there is much scepticism about the efficacy of the program given the wide range of topics that have to be covered in the time available. The section on the mental health of children comprises approximately two thirds of one module and in a training program extending over eight days, is being covered in about six hours. In a four day program this is likely to be reduced to three hours.

1.4 Statement of the problem
The current study was initiated at least a year and a half before the start of the Kwa Zulu-Natal Department of Health’s training program. This was in response to an awareness that although an integration of mental health and primary care was imminent, there had been little effort to prepare nurses for such a process. While there had been programs for
primary care nurses in other parts of the country, for example those by Vogel (1996) in Gauteng, and Uys and Sokhela (1996) in the Transkei, there was only one documented description of such a program in this province. Pillay and Lockhat (1997) had conducted a brief training program on child mental health for a group of interested professionals that included primary care nurses in the Natal midlands. In the lower South Coast region (Ugu), no such initiative had been undertaken. This is an area with a population of over 700 000 people and is considered to be one of the 13 most disadvantaged municipalities in South Africa. It has therefore been declared an Integrated Sustainable Rural Development Site and receives the direct attention of the State President’s office (Barron & Bennet, 2001). It is also poorly provided for in terms of mental health services. Psychiatric nurses are stationed at Umzinto and Port Shepstone, but in the outlying areas, no such services are available. Psychologists and Psychiatrists from outside the region provide services on an itinerant basis at the two main centres but there are no state Occupational Therapists, Speech Therapists or Social Workers rendering services.

Data obtained over a period of a year from clinic attendance at these centres showed that there was a significant demand for psychological services for children and that waiting times of up to six weeks was not uncommon. The majority of the children seen presented with Mental Retardation, Learning Disorders, Attention Deficit Hyperactivity Disorder or Conduct Disorders. Most referrals were from school principals or Social Workers attached to non-governmental organisations. The absence of referrals from primary care nurses seemed to suggest that findings in other parts of the world showing that they are poor at detecting mental health problems in children (Minde, 1975; Reeler & Todd, 1994), were probably applicable here as well. It was felt that a training program to help improve their ability to detect, manage and refer children with mental health problems would address this deficit. Mental health promotion was considered important as the region lacked resources such as special schools, remedial teaching facilities, and specialist health personnel who could provide the intervention necessary. Training nurses to empower the parents of these children would help to reduce or overcome the disability associated with the children’s problems.
A second concern was that although both primary care and psychiatric nurses were aware of moves to integrate their functions, there appeared to be much anxiety about the merger. Psychiatric nurses were uncertain about the role they were going to play in the new dispensation while the primary care nurses expressed reservations about working with psychiatric patients as they feared for their safety. They were also concerned about an increase in their workload. It was felt that a better understanding of both groups of nurses' anxieties, expectations and attitudes towards an integrated service would be useful in preparing them for the process.

A third factor motivating the study was the lack of detailed evaluations of previous programs. Uys and Sokhela (1996), Vogel (1996) and Pillay and Lockhat (1997) had presented programs to primary care nurses but had not objectively measured how much learning had taken place. This measure is important as it can indicate whether a program is achieving its objectives and is worth repeating with other groups. As the primary care nurses are being expected to perform many of the functions of the psychiatric nurses after integration, the knowledge level of the latter group was regarded as the benchmark against which the performance of the former could be assessed.

1.5 Aims of the study

The primary aim of the study was to address the child mental health training needs of a group of primary care nurses stationed in the Ugu region of Kwa Zulu-Natal. They were to be trained in the detection, management and referral of children presenting with mental health problems. There was to be a special emphasis on mental health promotion activities as it was hoped that the nurses would thereby be able to empower parents and caregivers to minimise the disability associated with their children's problems. A secondary aim was to assess whether the program was resulting in significant learning and to compare it to the program being run by the provincial Department of Health. Other aims included assessing nurses' attitudes and concerns about integration so that their needs and anxieties could be addressed.
1.6 Hypotheses

The following hypotheses were formulated:

- Significant differences in the knowledge of primary care nurses and psychiatrically trained nurses about child mental health problems exist.
- Following this intervention, there will be a significant improvement in primary care nurses' knowledge of child mental health problems.
- At the completion of training, primary care nurses participating in this program will have a significantly better knowledge of child mental health problems than nurses who participate in the program being conducted by the Department of Health.
- Both primary care and psychiatric nurses will report various concerns about the integration of services.

1.7 Summary

Although children form a substantial proportion of the population in South Africa, mental health services for them are generally under provided. The training of primary care nurses in mental health has been identified as one of the mechanisms by which the lack of services and service providers can be remedied. This study describes an attempt that was intended as a possible model for future training within this province.

The rest of this thesis is organised as follows:

In the Chapter 2, frequently used terms such as 'mental health' and 'mental health promotion' are discussed. Related literature and background information which help contextualize this study are also presented. The method by which this study was conducted will be discussed in Chapter 3 and the results will be presented in Chapter 4. These results and findings will be discussed in Chapter 5 and the work will be concluded in Chapter 6.
CHAPTER 2

2. Review of related literature

2.1 Mental Health

Definitions of mental health are linked to definitions of health in general. In its constitution, the World Health Organisation referred to health as being a state of complete physical, mental and social well being (WHO, 1946). This represented a significant shift away from earlier definitions that regarded health as being merely the absence of disease. In the period preceding the Second World War, the medical profession had tried to achieve optimal health by seeking scientific solutions to problems of disease. Following the war, there was an increase in awareness that the physical, mental and social aspects of health were inter-linked and that they impacted on each other (Walt & Rifkin, 1990; Tannahill, 2000). It was gradually acknowledged that good health depended not only on the provision of medical services but also on a community's political and social development and on individuals' life circumstances. Health came to be viewed as being synonymous with a better quality of life, and in order for it to be improved, the work, living and environmental conditions of individuals had to be transformed so that they were sources of health and not illness (Stark, 1992). These three facets of an individual's life could either encourage health-enhancing behaviours or they could predispose the individual to health damaging behaviour and physical pathology. Aspects of mental health such as stress management and the development of coping skills thus became important components of efforts to achieve optimal health.

Mental health itself has a multitude of definitions. Each definition reflects personal, subjective views and suggests different perspectives of looking at the concept. In a policy paper published by the European Centre for Mental Health Promotion (Clifford Beers Foundation, 1996) three conceptual models of mental health were identified:
In the **continuum model**, mental health and mental illness are seen as the ends of the same continuum and therefore mental health is regarded as being the absence of mental illness. In his review of various definitions, Tudor (1996) concludes that the term has become a euphemism for mental illness, and that when people speak of mental health, they are in fact referring to mental illness or the absence of it. This type of usage is apparently evident in legislation, social policy, medicine and sociology. An example of this is the international tendency for psychiatric services to be described as mental health services despite the continued focus on manifest illness and the use of traditional methods of intervention (Barker, 1999). Nevertheless, this is a useful definition as, by implication, the mental health of a community can be improved by reducing the incidence of mental illness. Thus many programs targeted at preventing mental illness include strategies to promote mental health (Clifford Beer’s Foundation, 1996).

The **positive model** of mental health holds that certain human qualities should be promoted not because they can prevent disease, but rather because they are desirable and worthy of promotion in their own right. One of the reasons why this model has gained favour is that it acknowledges that mental disorders are not preventable at present and that a more realistic goal would be to promote qualities indicative of good mental health. This would include the development of life skills, self esteem, assertiveness and spiritual well being. The presence of these characteristics is considered important as they enable individuals to live rich and fulfilling lives. However, no one characteristic can be considered to be evidence of good mental health and neither does the absence of any one indicate mental illness.

In the **functional model**, certain psychological characteristics are promoted because they are regarded as being protective factors that lead to emotional resilience and personal growth. By encouraging the development of social competence, problem solving skills, self-esteem, an internal locus of control and a supportive social network, individuals can be protected against the development of mental disorders. These characteristics enable individuals to cope with life despite its adversities (Health Education Authority, 1996 a). Their presence is also thought to be associated with a reduction in delinquency, a
dependence on social welfare programs and in-patient mental health care, and with an increase in school success and productivity at work (Clifford Beer's Foundation, 1996).

The above models all appear to define mental health in terms of the elements that are thought necessary for individuals to achieve a sense of emotional well being and resilience. The Health Education Authority (1996 a; 1996 b) therefore refers to mental health as a state in which individuals are able to enjoy life, survive pain, disappointment and sadness; initiate, develop and sustain mutually satisfying personal relationships and have a sense of self worth and belief in others.

In this thesis, mental health is defined by synthesising the continuum and functional models. The term is used to refer to both the absence of mental illness as well as to the presence of emotional resilience and coping skills that enable individuals to function at optimal levels even when they may have psychological problems. This definition has been adopted as it reflects the situation in South Africa where it is difficult to separate the roles of mental health workers into distinct categories of service provision to the mentally ill, mental health promotion and mental illness prevention activities.

2.2 Mental Health Promotion

As with the term ‘mental health’, mental health promotion has also been described as being difficult to define and open to a number of interpretations (Tannahill, 1985; Loeb et al., 1998). It is dependent on definitions of general health promotion which, according to the Ottawa Charter for Health Promotion (WHO, 1986), is the process whereby people are enabled to increase control of their health and improve it so that they can achieve their fullest health potential. Naidoo and Wills (1998) refer to it as an umbrella term that includes all activities undertaken to prevent disease, improve health and to enhance well being. This is accomplished by engaging in a number of action areas such as formulating appropriate public health policy; creating supportive environments; strengthening community actions; reorienting health services and developing personal skills.
According to Loeb et al. (1998) mental health promotion, in addition to not having a widely accepted definition, has no universally accepted range of target areas or indicators of effectiveness. Goals are varied and depend on the perspectives of individuals concerned. For example, for Tannahill (1985) and Tudor (1996) the goal of mental health promotion should be to enhance the general social and psychological well being of individuals. In their opinion, this is important as good mental health is the basis for the promotion of general health. In order to achieve this, Tannahill suggests that promotion efforts be directed at individuals’ life circumstances with a specific emphasis on related health topics and changes in lifestyle. Brogen (1985) feels that one of the goals of mental health promotion should be the reduction of the fear and misunderstanding associated with mental illness while Greenerak et al., (1994), feel that the goal should be to help individuals manage life events. Hosman (1994) and Childs (1994) believe that preventing mental disorders and relapses are target areas worthy of attention.

A combination of diverse intervention strategies may be used to achieve these goals. Health education, which attempts to increase knowledge and information; the promotion of changes in individual behaviour through counselling, and changes to the environment, are the key methods (French, 1990; Downie et al., 1990; Childs, 1994; Kok, 1999). At an individual level, strategies include developing self-esteem, improving life skills, teaching stress management, encouraging autonomy, promoting relationships, increasing social support, teaching child rearing competencies and encouraging medication compliance (Bogat et al., 1993; Greenerak et al., 1994; Hosman, 1994; Childs, 1994; Tudor, 1996; Tannahill, 2000). Action on the part of national and local governments to address the financial and housing needs of the mentally ill, mass media education and co-ordinated action by the health sector, industry and non-governmental organizations, are some examples of macro level approaches. These strategies reflect interventions at one or more of the three levels of mental illness prevention:

- **primary prevention** aims to reduce the incidence of disorders. Health promotion campaigns directed at making expectant mothers aware of the consequence of substance abuse for their unborn children is one such example as this may help to reduce the incidence of Fetal Alcoholic Syndrome.
. **Secondary prevention** efforts are directed at reducing the prevalence of a disorder by early detection and intervention. The identification of learning disorders and the provision of remedial education are examples of this.

. **Tertiary prevention** the focus is on reducing the amount of disability associated with disorders. This is exemplified by the teaching of self-help skills to mentally retarded children so that their dependence on caregivers is reduced.

In this study, mental health promotion refers to any intervention that aims to reduce the incidence or prevalence of mental disorders or enables individuals to overcome or reduce the disability associated with their condition.

### 2.3 The mental health of children

Mental and behavioural disorders are common in childhood and adolescence. The World Health Report (WHR, 2001) estimates that although there is a wide variation in prevalence, between 10 and 20% of children have at least one or more mental or behavioural problems. They refer to various studies that have identified children with mental health problems severe enough to cause some level of impairment and warranting special attention. These conditions may not necessarily correspond to a definite psychiatric diagnosis but intervention is indicated. Unfortunately, for a variety of reasons, less than 20% of these children actually receive treatment.

The prevalence of childhood mental health problems in less developed countries is believed to be higher than the estimates given above (Kramer, 1992; WHR, 2001). Children are thought to be more vulnerable in these countries because of factors such as poverty, poor nutrition and changes in family structure owing to urbanization, divorce and parental loss through AIDS. Urbanization in developing countries has resulted in the creation of slums in which there are overcrowding and increased exposure of children to substance abuse, violence and crime. Another consequence has been a breakdown in the extended family system as many families migrate to urban areas without taking along non-nuclear family members. This has been reported to contribute to an increase in child
mental health problems (Kramer, 1992). In a 15 year longitudinal study of 3 villages that comprise present day Khartoum, Sudan; Rahim and Cederblad (1984) found that increasing urbanization was associated with an increase in conduct disorders, hyperactivity and aggressive behaviour amongst both boys and girls. Over this period, the percentage of boys presenting with problems increased from 46% to 64% while the percentage of girls with problems increased from 31% to 43%. They attributed this increase to urbanization occurring without extended family involvement.

These findings were supported in another study in the Sudan conducted by Al Awad Ameh and Sonuga-Barke (1992). They reported that children raised in extended families presented with fewer behavioural problems and concluded that the involvement of a grandmother in child rearing was a protective factor against the development of psychological problems. Many of the families that had migrated to urban areas had done so without taking along grandparents and it was these families that tended to report mental health problems in their children.

Migration also has an effect on rural areas as it tends to leave behind populations that have a disproportionate number of children and adults suffering from physical, mental and social problems. These people have limited resources and end up being trapped in cycles of poverty, malnutrition and disease (Kramer, 1992).

More detailed and accurate data on the incidence of mental health problems in developing countries is lacking (Nikapota, 1991; Bradshaw et al., 2000). Epidemiological data is important as it provides the basis upon which services and intervention can be planned and resources utilised (Falloon et al., 1987; Shepherd, 1990). However, it is not always possible to establish the prevalence of disorders in developing countries as many lack the resources and expertise necessary to conduct scientific research.

Much of the research that has been conducted appears to have used questionnaires and checklists such as the Child Behaviour Checklist (CBCL) and the Reporting Questionnaire for Children (RQC) to classify children as presenting with mental health
problems. These can provide useful data but their findings need to be treated with caution as they may not necessarily be supported by clinical data (WHR, 2001).

Using the Reporting Questionnaire for Children and the Follow up Interview for Children, Giel et al., (1981) found that the prevalence rate for mental health problems among 5 to 15 year old children was 12% in Sudan, 15% in the Philippines, 22% in India and 29% in Colombia. No reasons for the wide variations were advanced.

Kangethe and Dhadphale (1991) reported that 20% of children aged 5 to 15 years had significant and definable psychiatric disorders when assessed on the same instruments as those used by Giel et al., (1981). This study was conducted at a clinic in Nairobi, Kenya.

Gureje et al., (1994) found that 19.6% of 990 children aged 7 to 14 years in Ibadan, Nigeria, could be classified as presenting with psychiatric morbidity on the basis of data obtained on the Child Behaviour Questionnaire and the children’s version of the Schedule for Affective Disorders and Schizophrenia (K-SADS-P). A total of 194 children were found to present with at least one DSM III R diagnosis. Conduct Disorders (61%) were most prevalent while Depressive Disorders and Attention Deficit Hyperactivity Disorder accounted for 6% and 1% respectively of the identified cases.

Nikapota (1991) concluded that while there was little data from community based epidemiological studies in developing countries, there was sufficient evidence to indicate significant morbidity from child psychiatric disorders. The burden of these disorders has not been calculated but their impact is likely to be substantial as they can be precursors to more disabling disorders during later life (WHR, 2001). Similarly, Visser et al., (2000) are of the opinion that mental health problems in childhood are highly predictive of further problems in adulthood. Hyperkinetic disorders, conduct disorders and emotional disturbances are but a few of the problems that emerge in childhood and that can persist into adulthood (WHR, 2001).
2.3.1 The mental health problems of children in South Africa

Reliable epidemiological data on the nature and prevalence of mental health problems in South Africa are also lacking. Data that is available is usually based on studies conducted at clinics. Petersen and Parekh (1994) argue that prevalence rates based on clinic attendance are inaccurate because they do not reflect the full spectrum of morbidity as they only include those persons who deliberately seek help. The first ever national epidemiological study assessing the extent of mental illness in South Africa began in 2000 but the results are not as yet available (Strachan and Clarke, 2000).

Epidemiological data on the mental health problems of children in this country is even more sparse and we are totally reliant on estimates and clinic based studies to give us an indication of the nature and extent of problems:

Dawes et al., (1997) used international data to arrive at an estimate that 15% of children in South Africa are likely to have mental health problems. They did not specify the type and severity of problems we are likely to expect. Lazarus, Dartnall and Sibeko (1996) estimated that the prevalence of mental disorders in the population under the age of 18 years ranged between 10 and 20%. According to them, common mental health problems in children include intellectual disability, learning problems, conduct disorders, depression, child abuse, parasuicide and posttraumatic stress disorders.

Kromberg et al., (1997) screened a total of 4581 children between the ages of 2 years and 9 years in the Bushbuckridge, Mpumalanga region for intellectual disability. They found that 152 children or 3.3% of the sample had some degree of intellectual disability. In clinic samples, intellectual disability appears to constitute a much higher proportion of the total number of children seen. Pillay, Naidoo and Lockhat (1999) reviewed the attendance of children at certain psychiatric clinics in urban and rural areas in KwaZulu-Natal over a 5 year period. They report that children with mental retardation accounted for 19.2% of all children seen. This was the largest single diagnostic category. Other significant problems included poor school progress (10.9%) and posttraumatic stress.
disorder (11.5%). The number of children presenting with posttraumatic stress is likely to have declined since then as political violence, which was responsible for much of the trauma experienced by children in certain areas, has declined substantially since the study was conducted.

Only two other local references indicating of the extent of child mental health problems were located. Strachan and Clarke (2000) briefly mention that 19% of children aged 6 to 16 years in Khayalitsha, Cape Town, present with mental disorders but they do not provide any further details. An unpublished document by Mkhize (2002) examined the diagnostic classification of all children that had attended the psychiatric outpatient clinic at King George V Hospital in Durban during 2001. He found that 50% of the children seen had been diagnosed as presenting with Attention Deficit Hyperactivity Disorder, 30% with Mental Retardation and 10% with Conduct Disorders. The remainder was diagnosed as presenting with Mood Disorders (5%), Substance Abuse Disorders (4%) and Psychosis (1%).

In spite of the absence of adequate epidemiological data, there seems to be consensus amongst researchers that the incidence of mental health problems amongst children in South Africa will increase in the foreseeable future. Faul (1992) expressed the view that intellectual disability and conduct disorders will increase because of poverty, poor hygiene, violence, substance abuse and the uprooting of communities. Acuda (1993) and Bradshaw et al., (2000) predict that the loss of family and caregivers through AIDS, and other associated sequelae such as poverty, will result in the mental health burden increasing.

While more accurate data is awaited, assessing the current needs of a defined population in terms of the frequency and type of disorders encountered can be an initial step in providing services and making more appropriate use of resources (Falloon et al., 1987). As there is no epidemiological data available on the extent of child mental health problems in the area in which this study was conducted, local needs were assessed on the basis of clinic attendance at psychiatric clinics in the region. A review of the diagnoses
assigned to 237 children referred to the psychologist at Umzinto and Port Shepstone in 2000 indicated that the majority was seen because of Mental Retardation. This diagnostic category accounted for 47,2% or 112 children. Other significant problems encountered were Learning Disorders (16,8%), Conduct Disorders (11,4%), Attention Deficit Hyperactivity Disorder (10,5%), Adjustment Disorder (5%) and the victims of sexual abuse (4,2%). The remaining 4,6% comprised children who presented with other problems or who did not warrant a diagnosis. This distribution does not in any way reflect the prevalence of disorders in the region but it does give an indication of the type of problems that referring agencies have to deal with. It is possible that primary care nurses in the region encounter children presenting with disorders in a similar proportion. The program that was presented focussed on training them to manage the four most frequently occurring mental health problems identified in the above survey.

2.3.2 Specific child mental health problems

2.3.2.1 Mental Retardation

In recent years, the term intellectual disability has been used increasingly to describe sub-average intellectual functioning and mental handicap. However, as South Africa still uses the American Psychiatric Association's guidelines for the diagnosis of mental disorders, the terminology contained in their publication, 'The Diagnostic and Statistical Manual of Mental Disorders IV-TR' or DSM IV-TR (APA, 2000), will be used. DSM IV-TR refers to sub average intellectual functioning, accompanied by impairments in adaptive functioning, and occurring before the age of 18 years, as mental retardation. This condition is widely regarded as the commonest form of childhood disability (Stein, Belmont and Durkin, 1986). DSM IV gives the prevalence rate as being approximately 1%, but studies such as those by Stein, Belmont and Durkin (1987) describe rates that range from 3,5% in Zambia to 6,8% in Brazil and India. These differences may be due to varying definitions and classifications being used. The only known non-clinic study of prevalence rates in South Africa is the study by Kromberg et al., (1997) which reported a prevalence rate of 3,3% in the Bushbuckridge region. Clinic rates are substantially
higher. One of the reasons for this may be the introduction of the Care Dependency Grant by the Department of Social Welfare. Parents and caregivers are now aware that their children may qualify for financial assistance from the state if they are mentally retarded and meet certain other criteria. They then seek psychological services to establish their children's level of intellectual functioning.

Mental Retardation is due to a number of possible etiological factors but it may not be possible to pinpoint the exact cause in any given case. Hutt and Gibby (1979) state that 75% of all retardation may be due to environmental influences or other unknown conditions. Generally, though, it is accepted that the following are some of the known etiological factors:

**.pre-natal variables**: This refers to influences occurring between conception and labour. They include heredity or genetic factors that may result in conditions such as Downs' Syndrome or Turners' Syndrome; infections such as rubella and syphilis; placental insufficiency; poor maternal nutrition, and maternal exposure to toxins including alcohol and drugs.

**.perinatal variables** refer to factors that exert their influence during labour and delivery. Prematurity, prolonged labour and birth trauma are often associated with mental retardation.

**.post-natal factors** occur in the period after delivery. They include infections such as meningitis and encephalitis; trauma through accidents and assaults; poisoning; neglect and malnutrition.

The course of the disorder is life-long but its effects vary according to severity. Mildly retarded individuals, who constitute the largest group, are able to acquire limited academic skills and can achieve social and vocational skills adequate for minimum self-support. They may however, require supervision and guidance. Moderately retarded persons may develop skills in personal care but are unlikely to progress beyond the second grade at school and can usually work in sheltered employment. They will require supervision. Those that are severely retarded may be able to perform very simple tasks but generally require constant care or institutionalization. Generally, though, retarded
children experience problems to varying degrees in a number of areas. This includes self-care, self-direction, education, vocational functioning and interpersonal relationships. There may also be behavioural problems (Robinson & Robinson, 1976; Drew, Logan and Hardman, 1984; Robertson, 1996; DSM IV-TR, 2000).

The aim of intervention is to optimise the functioning of the child. Strategies that can be implemented include counselling parents on acceptance of the condition and training them to set realistic and achievable goals for their children. Training in self-care and self-direction and vocational training is encouraged. Preventive interventions include genetic counselling and counselling on topics such as smoking, alcohol intake and nutrition during pregnancy; planning for delivery; post natal care; accident prevention and child rearing.

2.3.2.2 Attention Deficit /Hyperactivity Disorder

The defining feature of this disorder is a persistent pattern of inattention and or hyperactivity that occurs more frequently and is more severe than is typical for children at a comparable level of development. Symptoms must be present before the age of 7 years and must occur in at least two settings. It is estimated that between 3% and 7% of school age children present with hyperactivity (DSM IV-TR).

The etiology of the disorder is not fully understood. Heredity factors, exposure to toxins, maternal smoking and alcohol consumption in pregnancy, infections such as encephalitis, and head injuries have all been implicated (Barkley, 1990). Zametkin (1987) suggested that a dysfunction in the pre frontal cortex played a significant role in its occurrence. The pre frontal cortex is that part of the brain that is thought to control impulsivity, aggression and over activity. There is little evidence to support the view that lead in the environment or food additives such as tartrazine are causative agents (Graham, 1991).

Children presenting with this condition can experience several negative sequelae. These include a low frustration tolerance, aggressive outbursts, demoralization, poor self-esteem
and rejection by peers. Academic performance is often affected. On average, children diagnosed with hyperactivity complete fewer years of schooling than their peers and tend to achieve less vocationally (DSM IV-TR, 2000). The parents of such children often report a disruption in the normal parenting process. They find their children difficult to manage and may end up being distressed (Anastopoulous, et al., 1993).

Although the disorder responds well to medication, behaviour modification and psycho-educational counselling are essential components of most treatment programs (Robertson, 1996). Specific non-medical intervention that can be taught to parents or caregivers include parenting skills, behaviour modification and accident prevention techniques, strategies for coping with schoolwork and the need for the establishment of a clear structure and a regular and consistent home routine.

2.3.2.3 Learning Disorders

This diagnostic category comprises Reading Disorder, Mathematics Disorder and Disorders of Written Expression. The diagnosis is made when a child’s achievement on standardized tests measuring any of the above is substantially below that expected for age, level of education and intelligence. These learning problems must significantly affect academic achievement or activities of daily living that require reading, writing or mathematical skills (DSM IV-TR, 2000).

Prevalence rates have been reported to vary from 2% to 10% depending on the criteria and definitions used. No rates for South Africa are available.

The etiology of the disorder is uncertain but a genetic predisposition, perinatal injury and various neurological conditions are associated with it. Underlying abnormalities in cognitive processing, including tasks of visual perception, linguistic processes, attention and memory have also been implicated (DSM-IV TR, 2000).
A number of psychological problems either result from or have been associated with learning disorders (Penchaliah, 1997). Children with this diagnosis are more likely to present with symptoms of depression than their peers (Hall and Haws, 1989; Penchaliah, 1997) and may be at a higher risk for suicide (Wright-Strawderman & Watson, 1992). Difficulties with interpersonal relationships (Carlson, 1987), peer rejection, low self esteem and poor social skills (La Greca and Stone, 1990; DSM IV-TR, 2000) have also been reported. Teachers have been found to perceive such children as being isolated, unhappy and lacking in social skills (Hatzichristou & Hopf, 1993). These children have a school drop out rate that is 50% greater than average and, as adults, experience more problems in employment and social adjustment than those children without learning disorders (DSM IV-TR, 2000).

According to Robertson (1996), mild learning disorders are amenable to intervention. Remedial education programs, improved learning techniques, supportive counselling and intervention with the family to improve the parent-child relationship can help to reduce problems associated with the condition (Lyman and Hembree-Kigen, 1994). It is also essential to encourage the development of alternate, non-academic skills so that the child can develop a sense of competence and self esteem (Robertson, 1996).

2.3.2.4 Conduct Disorder

Conduct disorders are diagnosed when children present with a repetitive and persistent pattern of behaviour in which the rights of others or age appropriate societal norms are violated. Transgressions in three of the following areas must occur: Aggression towards people or animals; destruction of property; deceitfulness or theft, and a serious violation of rules eg. truancy or absconding from home (DSM IV-TR, 2000).

A prevalence rate of 1% to 10% has been reported in the United States. In South Africa, up to one third of all referrals to psychiatric clinics are allegedly for this problem (NHPD, 1988). Parental rejection, inconsistent child rearing practices, harsh discipline, physical or sexual abuse, a lack of supervision, an absence of traditional support structures, and
family psychopathology, are all factors that may be responsible for the development of this disorder (Loeber and Dishion, 1983; Rahim and Cederblad, 1984; Graham, 1991; Minde and Nikapota, 1993; DSM IV-TR, 2000).

Mental health problems associated with the disorder include a low self-esteem, poor frustration tolerance, irritability, aggression, rejection by peers and problems with work adjustment. The child may also be more likely to sustain physical injuries in accidents or fights, have problems at school, engage in suicidal behaviour and participate in high risk activities such as reckless vehicle use or substance abuse. Legal difficulties often arise (DSM IV-TR, 2000).

This condition has a poor prognosis and is one of the most difficult to treat. When children with the disorder grow up, males often present with Antisocial Personality Disorders while females are likely to develop mood and anxiety disorders (Offord, 1989). A usually noxious home and social environment conspire against a positive outcome (Robertson, 1996). However, parent training programs with a focus on behaviour modification and improving self-esteem have been found to be useful in effecting change. The remediation of social skills deficits has been reported to help children come to terms with their disorder, to enhance their self concept and to improve their relationship with their peers and significant others (Stark et al., 1994).

2.4 Promoting the Mental Health of Children

In accordance with the definition of mental health employed in this thesis, mental health promotion in respect of children will consist primarily of measures to prevent mental illness; measures to reduce the disability associated with these illnesses when they do occur; and strategies to optimise children’s general functioning. Macro-level prevention strategies can include, for example, action on the part of the state to iodize salt so as to reduce the incidence of cretinism; or steps to ensure that children with special educational needs are catered for by providing special schools (WHR, 2001).
Prevention efforts are usually directed at parents and caregivers and will take the form of counselling on aspects such as genetics, nutrition, pre-natal care, substance use, parent-child relationships and child rearing practices. This is especially so at primary care level where there is little direct work with children (Lazarus, Freeman and Rispel, 1995).

The families of children with mental health problems often experience a number of stresses. Their ability to cope with these can either hamper or enhance efforts to optimise the child's level of functioning. For some, the post diagnosis period is crucial as it may be accompanied by anxiety and uncertainty. Initial reactions vary from shock and disbelief to relief. Providing information about the disorder, answering parents' questions and directing them to sources of help should be a priority. Parents, especially those with a low level of education or from a socially disadvantaged background, may not be aware of their children's present or future needs. They should be encouraged to understand these and to take steps to meet them (Darling, 1991; Fewell, 1991; Obuchowska and Obuchowski, 1992). Many psychological problems result from a lack of awareness among parents. They may, for example, be unaware that their child has a learning disorder and perceive the problem to be due to a lack of co-operation or effort. They may then resort to corporal punishment rather than seek remedial education (Nikapota, 1983; Goldstein and Goldstein, 1992). Psycho-education facilitates the early detection of disorders and the acquisition of skills to manage these conditions. It is thus one of the more important roles of mental health workers (Sawyer et al., 1996).

Behavioural problems are often a key concern of parents. Over the years, they may have become confused by the conflicting messages regarding discipline, child rearing practices and parent-child communication approaches that have been proposed. Novak and Broom (1999) conclude that authoritative rather than authoritarian or permissive parenting is most effective. This involves being flexible about rules and emphasises rational, issue related guidance by both parents. Donnenberg and Baker (1993) report that the parents of children with difficult behaviours experience extremely high levels of stress, and when they have inadequate coping skills, they may be at risk for developing abusive parenting...
practices. Teaching authoritative parenting, as well as basic behaviour modification techniques and time out strategies, can help reduce behavioural problems.

Haggert (2000) is of the opinion that family learning is also important to the development of the mental health of children. Here, family members learn together about roles, relationships, responsibilities and decision making. Parents can be trained to train their children to acquire the competencies they need in order to be independent and to lead fulfilling lives. For example, parents can be trained in the graded approach to teach basic self-care skills (Sawyer et al., 1996).

It is equally important that children develop emotional resilience so that they feel comfortable about themselves and are able to cope with the stresses of daily life. This requires adequate social and self help skills as well as the development of a positive self-concept. They need to be able to engage in mutually satisfying relationships, make decisions, accept responsibility, recover from disappointment, cope with different emotions and feel capable of dealing with most situations (National Council for Mental Health, 1992). Children with a variety of mental health problems have been shown to experience deficiencies in social skills (Schonfeld et al., 1988; Stark et al., 1994; Harrison and Sofronoff, 2002) and self-esteem (La Greca and Stone, 1990; Lyman and Hembree-Kigen, 1994; Sawyer et al., 1996). These aspects should therefore be key components in the promotion of the mental of children.

2.4.1 Role of the nurse in promoting the mental health of children

Nurses, by virtue of their widespread distribution and superior number in relation to other mental health professionals, are ideally placed to extend the provision of mental health services to previously underserved groups such as children. In developing countries, it is not always possible for those in need of services to travel long distances, and often at great cost, to seek help from professionals such as Psychiatrists and Psychologists. With proper training, nurses will be able to adequately assume these roles (Nikapota, 1991).
Perhaps one of the most important tasks nurses have to be trained in is that of making a reliable and valid diagnosis. This is a pre-requisite for appropriate intervention (WHR, 2001). In South Africa, the Diagnostic and Statistical Manual of Mental Disorders IV-Text Revision or DSM IV-TR (APA, 2000) is used to classify mental disorders in accordance with a universal definition of signs and symptoms. There is a significant body of research that indicates that primary care nurses are generally poor at detecting mental health problems. Rudd and McMaster (1996) quote World Health Organization data that suggests that up to 20% of child contacts with primary care clinics result from psychological problems. However, only a small percentage of these problems are actually detected. Hall and Williams (1987) estimate that 95% of the morbidity due to psychological problems is missed by primary care workers. This leads to mismanagement and wasteful expenditure as unnecessary investigations are carried out or medicines prescribed (Giel and Harding, 1976).

In a study conducted at primary care clinics in Zimbabwe, Reeler and Todd (1994) found that a large proportion of mental health problems went undetected. Using available data, they had expected the frequency of psychiatric disorders at these clinics to be 13% but discovered that less than 1% of patients received treatment for psychiatric problems. They attributed this discrepancy to the failure of nurses to detect these problems. Rudd and McMaster (1996) attempted to discover the rate at which primary care nurses were able to detect child mental health problems at a primary care clinic in Zimbabwe. Using the Reporting Questionnaire for Children, they had identified 49.6% of their sample as being ‘cases’ but nurses were only able to identify 1.5% of the sample as requiring help.

Various reasons for the inability of primary care nurses to detect mental health problems have been advanced. Diop et al., (1982) suggest that nurses receive training in the detection of major psychiatric disorders and are in fact able to diagnose problems such as psychoses. However, they miss out on minor disorders. Kangethe and Dhadphale (1991) feel that psychiatric morbidity is often disguised as somatic complaints and therefore treatment for these physical ailments is more likely to be offered. Minde (1975) believed that low rates of detection of child mental health problems are due to the fact that
children are seldom brought to clinics for psychological problems. This of course is contradicted by World Health Organization data reported by Rudd and McMaster (1996). It is clear that psychological problems do present in significant numbers at primary care clinics but they are seldom recognized. By training primary care nurses in detection and diagnosis, the mental health of patients can be improved (WHR, 2001).

Arriving at a clinical diagnosis is just one aspect of nursing assessment. Previously, nurses were trained to concentrate on the physical dimensions of patients’ needs. By making a diagnosis, they were able to provide relief for physical ailments. A review of nursing literature indicates that, in recent years, there has been a growing emphasis on holistic, comprehensive assessments. Instead of simply defining and identifying physical health problems, more attention is being paid to assessing the mood of patients, their ability to carry out activities of daily living, their occupational functioning and their level of social integration (Ross and Mackenzie, 1996).

Mental health nursing in particular requires nurses to concentrate their efforts on promoting patients’ growth and development so that they are able to overcome the problems associated with their disorders. No where is this more essential than when dealing with children. Owens et al., (2002) report that there are multiple barriers to accessing mental health services for children. In addition to a lack of service providers, there may be long waiting lists, financial considerations and difficulties with transport. More importantly, parents are often unable to identify a need for services or lack knowledge about resources. They may be overwhelmed by their children’s problems. Nurses can help by identifying children with problems, listening to the concerns of parents, reassuring them, providing information and directing them to sources of help (Srinivas and Murthy, 1986; Barber, 1987; Nikapota, 1991). Developing the ability of parents to train and manage their children is a form of empowerment as it enables them to gain a sense of control and influence over their children’s problems (Rappaport, 1987; Novak and Broom, 1999).
Douglas (1993) suggests that nursing intervention should include the early identification of problems through the screening of children on tests of vision, hearing and language, as well as on the basis of developmental and behavioural problems. When problems have been identified, nurses can facilitate the development of self-help and self-care by sharing experiences and coping strategies with caregivers. The creation of voluntary support groups should be encouraged. In this way, competency in parents can be built with minimal professional intervention. It is possible though, that families may reject outside help. Nurses should therefore be trained in basic counselling skills so that they can gain entry into a family and help mobilize its resources. Counselling skills are also useful in helping parents and children cope with the conflicts and stresses in their lives.

Burnard and Chapman (1988), Gates (1994) and Edelman and Fain (1998) identified advocacy as another important role of nurses. They express the view that patients have difficulties in expressing their needs and that one of the responsibilities of nurses should be to speak out on their behalf so that they can obtain what they need. In the field of mental health, lobbying for the provision of special schools, remedial teachers and sheltered employment facilities represent some of the ways in which nurses can act as advocates.

2.5 Mental health services in South Africa

Historically, mental health services in this country can best be described as ineffective. A curative model was followed, there was a lack of personnel and the referral system was poor (McLaren & Philpott, 1998). Services were fragmented along racial lines and were also kept separate from general health services. This led to the existence of unequal vertical structures, each with its own program. The promotion of mental health was given low priority and the human rights of patients were often disregarded (Gagiano, 1995; Allwood, 1997).
2.5.1 Integration of mental health and primary health care

With the demise of the apartheid government in 1994, the ANC began on a process of restructuring health services so that there would be a more cost effective, equitable and humane provision of services. In the White Paper for the Transformation of Health Services (Department of Health, 1997), the government formally committed itself to the implementation of a primary health care system by which this was to be achieved. The rationale was that such a system would overcome fragmentation, provide access to essential health care, make optimal use of resources and facilitate health promotion. Mental health services were to be provided at primary care level. The vehicle by which services were to be delivered was the District Health System. Statutory districts, each with its own health authority, were to be created through legislation. In the local government option, responsibility for health services was to be vested in its municipalities. These developments were dependent on relevant legislation being finalised. The National Health Bill, which will enable the establishment of the district health system, has been under review for the past 7 years and is only scheduled to reach parliament in 2003 (ANC, 2002). Provincial legislation to enable the creation of District Health Authorities and management structures, and clarification of funding mechanisms, is also still outstanding (Barron and Sankar, 2001).

In spite of these delays, there has been progress towards such a system. Municipalities have been demarcated and municipal elections have been held. There has also been a massive expansion in the number of primary care clinics since 1994. According to the World Health Report (WHR, 1998), 54.3% of all households in KwaZulu-Natal have access to a primary care clinic that is less than 5 kilometres away. However, in a review of the availability of services at primary care clinics, van Rensburg (2000) reports that immunisation, family planning, antenatal care, TB, sexually transmitted diseases and emergency medical care services are provided. There is not a single reference to the provision of mental health services.
It has only been in the past two years that the Kwa Zulu-Natal provincial health department has begun to take definite steps to integrate mental health and primary care services. Professor Dan Mkhize, head of the Department of Psychiatry at the Nelson Mandela School of Medicine, was tasked with submitting recommendations to the provincial Secretary for Health on how this was to be achieved. In an unpublished document, Mkhize (2002) proposed that by the end of that year, all initial contact with mental health patients, emergency care and the supervision and monitoring of stable patients had to occur at primary care level. Primary care nurses were to provide comprehensive care to the mentally ill. This entailed screening patients for mental health problems, initiating treatment as described in primary care guidelines, providing medication, and conducting psycho-education and crisis intervention. More complicated cases were to be referred to regional teams at Community Health Centres. These teams were to consist of Psychiatrists, Psychologists, psychiatric nurses, Occupational Therapists and Social Workers. Besides assessing problem cases, their role was to provide counselling services, to develop mental health programs, to provide support and consultation to primary care nurses, and to refer complex cases to the next level of care which is at the District Hospital. The document acknowledges that primary care nurses may be over extended but makes no reference to a training program for them.

2.5.2 Training primary care nurses in mental health care

Gagiano (1995) cautions against underestimating the lack of diagnostic and therapeutic skills at primary care level. He argues that the value of a comprehensive service will depend on these skills, but at present, intervention at this level consists primarily of pharmacological intervention. The National Health Plan (ANC, 1994), and the White Paper on Transformation (Department of Health, 1997) both acknowledge that skills deficiencies do exist and that personnel at various levels need further training. Strasser (1998) feels that basic nurse training in South Africa does not equip nurses to deliver primary care services. Nurses, in rural areas in particular, are expected to combine the knowledge and expertise of various professionals in order to render a service. Gwele (1998) states that although there has been an increase in training programs for primary
care nurses in the past 5 years, the needs of the country are still not being met. She suggests that vertical programs where specific skills to deal with specific problems are taught, may go some way to addressing this problem.

Lazarus (1994) suggested that for integration to be successful, the minimum requirement would be for nurses to be trained in the detection of mental illness and to render a basic counselling service. To this, Grazin (1998) added training in listening skills, the administration of psychotropic medication, the identification of signs of relapse and the use of referral protocols. Petersen et al., (1996) felt that primary care nurses also had to be able to provide emergency services, psycho-education, basic rehabilitation and follow-up of stable patients.

In Kwa Zulu-Natal, training programs in mental health for primary care nurses were not implemented by the provincial health authorities until September 2002. In that month, the Department of Health began training nurses in a comprehensive program developed by the National Department of Health. This program aims to train nurses in the detection and treatment of mental health problems as well as in mental health education activities. Specific topics include interviewing and communication skills, the Mental Health Act, the Mental State Examination, DSM IV classification of disorders, the major psychiatric disorders, disorders of children and the elderly, psychopharmacology, substance abuse, crisis management and dealing with the victims of violence and sexual assault (Gmeiner & van Wyk, 2002 a). It had been intended that the program be conducted over 15 days (Gmeiner & van Wyk, 2002 b) but this has now been reduced to 4 days. The efficacy of this program is yet to be evaluated.

2.6 Summary

An examination of related literature indicates that there are no universally accepted definitions of mental health or mental health promotion. The latter term, however, broadly refers to activities that aim at the development of emotional resilience, the
reduction of the disabling sequelae often associated with mental disorders, and the prevention of mental illness.

Child mental health promotion programs may be more effective than adult programs as they provide opportunities to intervene before mental health problems become entrenched. Developing individual competence, social skills, problem solving abilities, self esteem and the child rearing competencies of parents, may be some of the ways in which the mental health of children can be improved.

Plans for the integration of mental health and primary health care services in Kwa Zulu-Natal are well advanced but there are indications that primary care nurses are ill prepared for this move. Training in various aspects of mental health is required if integration is to be successful. The Department of Health has recently commenced training primary care nurses in such a program.

The author of this thesis had developed and implemented a training program in child mental health before the Department of Health had begun with its program. Chapter 3 provides further details on the delivery and evaluation of his training program.
Chapter 3
Methodology

3.1 Introduction

In order to test the hypotheses stated in Chapter 1, two distinct methods of research were employed.

Firstly, evaluation research was conducted to determine the effect of two training programs in child mental health on primary care nurses. The evaluation was done largely by using a group pre-test and post-test experimental design. The core group, (referred to as the Ugu group), underwent training in a program designed by the author of this thesis, while a second group, referred to as the Sisonke group, were evaluated after completing a module on child mental health as presented in the Department of Health's training program. The Ugu group was also asked to complete a detailed questionnaire evaluating the effectiveness of the program that they had participated in.

The second aspect of the research consisted of a survey to determine the attitudes of both primary care and psychiatric nurses towards the integration of services. This took the form of a questionnaire.

The Sisonke group was not asked to complete the questionnaire evaluating the effectiveness of their program or the questionnaire that would have determined their attitudes towards the integration of services. It had been intended that these would be completed but time constraints did not allow for this. Several members of the group had traveled from as far away as Kokstad and they did not have the extra hour that was needed to complete these.
3.2 Informed consent

Permission to conduct the study was obtained from the relevant authorities as well as from individual participants. Letters explaining the nature and purpose of the study were sent to Nursing Managers in the regions concerned. Once permission to continue with the study had been granted, the release of nurses to participate in the programs was negotiated by primary health care trainers. At the beginning of the training intervention, the voluntary nature of participation was emphasised to individual participants. They were at liberty to attend the program without having to complete the pre and post- test instruments or the evaluation questionnaires. However, all subjects comprising the Ugu and Sisonke groups agreed to participate and duly completed the relevant material.

A similar explanation was offered to the group comprising psychiatric nurses. Written consent was not obtained but the return of a completed questionnaire was interpreted as an indication that the individual had consented to participate in the study.

3.3 Subjects

The total sample in this study consisted of 47 nurses, all of whom where chosen on the basis of availability. When permission to conduct this study was granted, the trainers in the respective regions undertook to arrange for the release of staff so that they could attend the training program. The actual selection of those that attended varied according to region. This will be discussed in the relevant sub-sections.

The sample was further subdivided into 3 naturally occurring groups. Hereafter, these will be referred to as the Ugu Group, the Sisonke Group and the Community Psychiatry Group.
Figure 1: Map indicating areas of study

KwaZulu-Natal
District Municipal Boundaries
3.3.1 The Ugu Group

This group is the focus of the study as its members participated in and evaluated the program presented by the writer. It was drawn from the Ugu region, which following consultations with primary care trainers, had been identified as being in urgent need of mental health skills development. Figure 1 is a map of KwaZulu-Natal that shows the regions in which this study was conducted. The actual training of this group occurred at the G.J. Crookes Hospital, Scottburgh.

A group size of 20 participants had been suggested to trainers but work commitments and logistical problems resulted in 15 people attending the first session. This number was reduced to 14 for the rest of the course as one person had to leave to attend to other matters.

No sample selection was involved. The District Health Office at Scottburgh had circulated a brief description of the program on offer to all clinics in the region and had called for volunteers. Of those who responded in the affirmative, those who could be released from their duties were granted permission to attend. This can therefore be regarded as an example of accidental or availability sampling. All 14 were primary care nurses who where stationed at various centres in the region. Five were attached to fixed primary care clinics, 3 to mobile clinics, 4 to community health centres and 2 to a School’s Health team. Most of the sample had had some training in mental health as 8, or 57% of the group, had completed the 4 year Diploma in Nursing which requires a 6 month placement at a psychiatric hospital. Of the others, none had had any training in psychiatry or allied disciplines. They were in possession of either the B. Cur degree or the 3 year Diploma in Nursing. Neither qualification includes any aspect of psychiatric nursing. On average, participants from this group had 11.5 years nursing experience of which 6.3 years was in primary health care. Seven participants reported having some experience in psychiatry. This averaged out at two years for each person.
All the participants were females and ranged in age from 26 to 53 years. The mean age was 39 years. The majority (12) were Zulu speaking while one each had English or Xhosa as a home language.

The comparative distribution of all three groups in respect of certain characteristics is presented in tabular form after section 3.3.3. Table 1 shows the distribution of the sample by gender, mean age and home language while Table 2 indicates the number and percentages of participants that have received training in Psychiatry. Table 3 illustrates the distribution of the sample by mean years of total, primary care and psychiatric experience.

3.3.2 The Sisonke Group

After the writer had completed the training program that he had devised for the Ugu group, the Department of Health began implementing its training program in various regions in Kwa Zulu-Natal. He then received a request from primary care trainers in the Sisonke region (see Figure 1 for location) to present a module on child and adolescent health, based on the manual by Gmeiner and van Wyk (2002a; 2002b), to primary care nurses in that region. As this was an opportunity to compare the two programs, this was agreed to. Training in this region took place at the community health centre in Ixopo.

This group consisted of 17 primary care nurses, all of whom had been nominated by their supervisors to attend the course. Informal discussions suggested that some would not have attended voluntarily as they had no interest in mental health nursing.

Of the 17, nine were based at fixed primary care clinics, 6 at hospitals and 2 at community health centres. Seven had a 4 year nursing diploma as a basic qualification while the rest (10) had a 3 year diploma. This meant that the majority (64,8%) did not have any psychiatric training (Table 2). The group reported having an average of 11,4 years of nursing experience. This was similar to the Ugu group who had 11,5 years experience. However, their experience in primary care was lower at 4,2 years on average.
Three members had had some experience in mental health. The group average was 1.7 years of experience in psychiatry (Table 3).

The ages of the participants ranged from 25 to 53 years with the mean age being 36.7 years. There were 14 females and 3 males. Home language was again predominantly Zulu (10), with 5 speaking Xhosa and 2, English (Table 1).

### 3.3.3 The Community Psychiatry Group

This group consisted of 16 nurses, all of whom had been trained in psychiatry and currently worked at community psychiatric clinics in the Ugu, eThekwini and Ilembe regions. They had been included primarily to serve as a benchmark against which the knowledge of the primary care nurses prior to and after training could be measured. It was assumed that because they had all been trained in psychiatry and they had several years of experience, their level of knowledge of child mental health problems would be a good indication of what training programs should be trying to achieve. Their attitude towards integration was also assessed as it was felt that this would give an indication of the problems that were likely to be encountered. Questionnaires were handed out to all 23 nurses working in Community Psychiatry. Of these, 16 were completed and returned timeously to be included in this sample.

The basic qualifications of this group consisted of those with a 3-year Diploma in Psychiatric Nursing (2); a 3-year Diploma in Nursing (8); and the 4-year Diploma in Nursing (6). Excluding the two individuals who had no general nursing qualification and who had trained exclusively in Psychiatry, the remaining 14 had all completed the year long Diploma in Psychiatry. Generally, this group had more years of nursing education than the other two groups. They had, on average, acquired 6.1 years of nursing related qualifications whereas the Ugu group had 4.6 years and the Sisonke group 3.6 years of qualifications (Table 4).
Relative to the other two groups, they also had more years of total experience (19.9) and, as was to be expected, more years of experience in psychiatry (14.6). The average age of the sample was 41.7 years with the age range being 26 to 55 years. There were 4 males and 12 females. The majority was English speaking (13) while 3 had Zulu as their home language.

Table 1: Distribution of the sample by gender, mean age and home language

<table>
<thead>
<tr>
<th>Group</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
<th>Mean Age</th>
<th>Language</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Zulu</td>
</tr>
<tr>
<td>Ugu</td>
<td>0</td>
<td>14</td>
<td>14</td>
<td>39</td>
<td>11</td>
</tr>
<tr>
<td>Sisonke</td>
<td>3</td>
<td>14</td>
<td>17</td>
<td>36.7</td>
<td>10</td>
</tr>
<tr>
<td>Community Psychiatry</td>
<td>4</td>
<td>12</td>
<td>16</td>
<td>41.7</td>
<td>3</td>
</tr>
</tbody>
</table>

Table 2: Distribution of the sample by training in psychiatry

<table>
<thead>
<tr>
<th>Group</th>
<th>4yr Diploma (%)</th>
<th>3yr Diploma in psychiatry (%)</th>
<th>Diploma in psychiatry (1 year) (%)</th>
<th>None (%)</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ugu</td>
<td>8 (57.1)</td>
<td>-</td>
<td>-</td>
<td>6 (42.8)</td>
<td>14</td>
</tr>
<tr>
<td>Sisonke</td>
<td>6 (35.2)</td>
<td>-</td>
<td>-</td>
<td>11 (64.8)</td>
<td>17</td>
</tr>
<tr>
<td>Community Psychiatry</td>
<td>6 (37.5)*</td>
<td>2 (12.5)</td>
<td>14 (87.5)</td>
<td>-</td>
<td>16</td>
</tr>
</tbody>
</table>

*The total excludes this figure as these nurses had also completed the 1 year Diploma in Psychiatry.
Table 3: Distribution of the sample by mean years of experience

<table>
<thead>
<tr>
<th>Group</th>
<th>Total years of experience</th>
<th>Primary Care experience</th>
<th>Mental Health experience</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ugu</td>
<td>11,5</td>
<td>6,3</td>
<td>2</td>
</tr>
<tr>
<td>Sisonke</td>
<td>11,4</td>
<td>4,2</td>
<td>1,7</td>
</tr>
<tr>
<td>Community Psychiatry</td>
<td>19,9</td>
<td>-</td>
<td>14,6</td>
</tr>
</tbody>
</table>

3.4 Data Collection

Different interventions were carried out with each of the groups and hence there were variations in the nature of the data collected. The biographical inventory (Appendix A), and the instrument assessing participants' knowledge of 4 childhood mental health problems (Appendix C), were the only sets of data obtained from all 3 groups.

3.4.1 Ugu Group

The main aim of the program conducted with this group was to improve their knowledge and intervention skills in respect of child mental health problems. The first step therefore was to assess their knowledge, prior to any intervention taking place, of four child mental health problems most frequently encountered in this region. This was done by using an instrument designed by the writer. Details are provided in Section 3.5 and a copy of the instrument appears as Appendix C. Scores obtained on this instrument served as a baseline indication of participants’ knowledge. They then completed a child mental health program that was also designed by the writer. A total of 18 hours was spent on this program which was held on 3 consecutive Fridays. In the final session, the instrument that had been administered prior to intervention was re-administered. It was hypothesized that statistically significant differences between pre and post-test scores would be an indication of whether learning had taken place.
As previous research had indicated that primary care nurses were apprehensive about taking on mental health work, participants were also asked to complete a questionnaire that examined this and related issues (Appendix B). In addition, on completion of the training period, they were requested to complete a detailed evaluation questionnaire that was intended to identify strengths and deficiencies in the program so that it could be improved. This questionnaire appears as Appendix E.

3.4.2 The Sisonke Group

This group was seen for a single 6-hour session in Ixopo. According to trainers who had undergone training in the Department of Health's program, they had been told that each module of the training manual would have to be completed in a day. This would normally have meant an 8-hour day, but as several of the participants had traveled from afar, this was reduced to 6 hours. As stated earlier, this did not permit the writer to administer a questionnaire on attitudes toward integration (Appendix B) or a questionnaire evaluating the presentation on child mental health (Appendix B). It should be noted, however, that the Department of Health has made provision for the entire course to be evaluated by participants.

In view of the above, the only data that was collected from this group was biographical information (Appendix A) and pre and post-test measurements of their knowledge of child mental health problems (Appendix C).

3.4.3 The Community Psychiatry Group

Data was collected from this group by first explaining the nature and purpose of the study and then handing out questionnaires to prospective participants with the request that these be returned when completed. It was not possible to assemble the participants at a single venue to obtain information under controlled conditions. Some participants took up to a fortnight to return questionnaires. The amount of time available to them and the fact that
they could have obtained help to complete the questionnaires were variables that were considered when analysing the data. They were required to complete the biographical inventory (Appendix A), the pre-test instrument (Appendix C) and the questionnaire assessing their attitude towards integration (Appendix D).

3.5 Content of training programs

3.5.1 Ugu Group

The program presented to this group consisted of a variety of presentations, case studies and group discussions on topics that had been identified as being relevant in the course of the review of literature. Specific topics included an overview of mental health and mental health promotion, interviewing and listening skills, history taking, basic counselling skills, child development, the DSM IV-TR classification of child disorders and detailed presentations on Mental Retardation, Learning Disorders, Attention Deficit Hyperactivity Disorder and Conduct Disorders. Identification of disorders, prevalence rates, etiology and intervention were discussed. Special emphasis was placed on nursing interventions that could lead to a prevention of disorders and techniques that could be taught to caregivers to optimise children's functioning. This included topics on behaviour modification, discipline, self-esteem, life skills, developing vocational competencies and interpersonal skills, accident prevention and coping with school related problems. The role and function of various mental health professionals was discussed as was when and how to refer to these and other resources. A resource list indicating centres where help could be obtained was included in an information pack. This list included the names and addresses of welfare agencies, special schools, residential care facilities and clinics where psychiatric services were available. Information on eligibility for and application procedures to access state financial assistance was also provided. The importance of support groups and the need to lobby on behalf of patients was discussed.
3.5.2 Sisonke Group

The content of the course that was presented to this group varied significantly from that presented to the Ugu group. This was due to the fact that guidelines as laid down in the Department of Health's Training Manual (Gmeiner and van Wyk, 2002 a) and the Trainer's Manual (Gmeiner and van Wyk, 2002 b) had to be followed. One of the most significant differences was that the module did not focus exclusively on child mental health. It included sections of genograms, the mental health problems of the elderly, the management of delirium and dementia, psychopharmacology, the rehabilitation and management of chronic illness, adolescent problems such as eating disorders and early onset Schizophrenia and Mood Disorders. Topics related to children included emotional, social and cognitive development, assessing children and their families, the child psychiatric interview, mental state examinations, children's drawings, enuresis, encopresis, Learning disorders, Mental Retardation, Attention Deficit Hyperactivity Disorder, Depression and Conduct Disorders. With regard to disorders, their diagnosis, etiology and management had to be discussed. However, management strategies appeared to focus largely on pharmacological intervention or referral to psychiatric services. Few suggestions were made regarding what should be done if these resources were not available. It should also be noted that although there were frequent references to the Essential Drug List, the manual which is supposed to guide primary care nurses in the prescription of medication (Standard Treatment Guidelines and Essential Drug List, National Department of Health, 1998) makes no reference to mental health other than a single chapter in which delirium, depression and acute psychosis are discussed. There is no reference to the treatment of children.
3.6 Instruments

3.6.1 Biographical Inventory (Appendix A)

This was completed by all participants. The inventory established the age, sex, qualifications, experience, home language and places of employment of subjects. Details of training and experience in mental health was also requested.

3.6.2 Instrument assessing knowledge of child mental health problems (Appendix C)

This instrument was compiled by the writer and consists of 4 vignettes that describe Mental Retardation, Attention Deficit Hyperactivity Disorder, Learning Disorders and Conduct Disorders. According to Sawyer et al., (1996), vignettes are a valuable aid in problem based learning as they help participants identify and understand the experiences of persons who have similar problems. These vignettes were drawn up on the basis of DSM IV criteria as well as on personal experience. Questions were formulated with the intention of eliciting a diagnosis, possible etiology, knowledge of whom to refer to, and appropriate home based interventions.

The validity of the vignettes and the questions was established by submitting them to two colleagues for scrutiny. Both agreed that they were valid and fulfilled their objective.

3.6.3 Questionnaire administered to primary care nurses (Appendix B)

This questionnaire was developed with the intention of establishing participants' current exposure to mental health problems, their perception of their own skills and abilities and their feelings on integration among other issues. The rationale behind these questions is that they all relate to issues that had been identified in a review of related literature. For example, they attempt to determine whether nurses are willing and able to engage in mental health promotion activities as proponents of integration have stated that this is one of the main objectives of integration.
3.6.4 Questionnaire administered to psychiatric nurses (Appendix D)

There has been much disquiet amongst psychiatric nurses about integration as some of them do not believe that it will succeed. They have, for example, expressed the view that primary care nurses lack the capacity to cope with psychiatric patients. This questionnaire was designed to establish some of the problems they anticipate as well as possible solutions to these problems.

3.6.5 Scoring and analysis of data

3.6.5.1 Biographical Inventory

All ages, years of experience and education were recorded to the nearest whole year. The means were then calculated and presented in the relevant sub-sections and tables.

3.6.5.2 Assessment of knowledge of child mental health problems (Appendix C)

Correct answers were assigned a nominal value of 1 and incorrect answers a value of zero. These were then tallied to yield a total which was interpreted as an indication of that participant's knowledge of child mental health problems. A maximum score of 16 could be obtained.

Differences between pre and post-test scores were analysed statistically by using the t test or Students' t (Downie and Heath, 1974). This is a test that establishes whether there are significant differences between means. Variations of the test are used depending on whether that data is correlated or uncorrelated. In this instance, pre and post-test analysis for the same subject was treated as correlated data but comparisons between groups was regarded as uncorrelated data. All computations were done manually as the sample was relatively small.
3.6.5.3 Questionnaires administered to the Ugu group (Appendix B), the Community Psychiatry group (Appendix D) and the Evaluation Questionnaire (Appendix E)

These questionnaires consisted primarily of open-ended questions. Responses were read repeatedly and those that were similar were clustered together. A large number of scoring categories was used so as to capture the essence of responses. Broader categories would have resulted in vaguely similar responses being grouped together and these may then have been overlooked in the interpretation.

The results of the above analyses are presented in Chapter 4.
Chapter 4

Results

The demographic data of participants in this study has already been presented in Chapter 3 under the heading 'subjects'. In this chapter, inferential data from pre and post-test comparisons, both within and between groups; as well as an analysis of responses to the questionnaires administered to the Ugu and Community Psychiatry groups are presented.

4.1 Comparison of pre and post- test scores on instrument assessing knowledge of child mental health problems

The raw scores obtained by the Ugu, Sisonke and Community Psychiatry groups on this measure are presented in Appendices F, G and H respectively. The mean scores are presented in Table 4 below:

<table>
<thead>
<tr>
<th>Group</th>
<th>N</th>
<th>Pre test Mean*</th>
<th>Post test Mean*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ugu</td>
<td>14</td>
<td>14.28</td>
<td>15.5</td>
</tr>
<tr>
<td>Sisonke</td>
<td>17</td>
<td>14.12</td>
<td>14.53</td>
</tr>
<tr>
<td>Community Psychiatry</td>
<td>16</td>
<td>15.38</td>
<td>**</td>
</tr>
</tbody>
</table>

* The maximum score possible was 16.

** The Community Psychiatry group did not participate in any intervention and hence were not re-assessed.

4.1.1. Comparison of pre and post test scores

In the following table, \( X_D \) refers to the mean difference between scores and \( S_D \) to the standard error of the means.
The above data indicates that there was a significant difference between the pre and post test scores of the Ugu group at the 1% level. However, there was no significant difference in the performance of the Sisonke group after the program had been completed.

4.1.2. Pre and post test comparisons between Ugu and Sisonke groups

Table 5

<table>
<thead>
<tr>
<th>Group</th>
<th>$X_D$</th>
<th>$S_D$</th>
<th>df</th>
<th>t</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ugu</td>
<td>1,21</td>
<td>0,3</td>
<td>13</td>
<td>4,03</td>
<td>P&lt; .01</td>
</tr>
<tr>
<td>Sisonke</td>
<td>0,41</td>
<td>0,23</td>
<td>16</td>
<td>1,78</td>
<td>Not significant</td>
</tr>
</tbody>
</table>

The two groups were similar in their level of knowledge prior intervention. However, on completion of the program, their level of knowledge was found to be significantly different.

4.1.3. Comparison of pre test scores with scores of the Community Psychiatry group.

In this table, $SD_X$ refers to the standard error of the difference between 2 means:

Table 6

<table>
<thead>
<tr>
<th>S$_{DX}$</th>
<th>df</th>
<th>t</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre test</td>
<td>0,41</td>
<td>29</td>
<td>0,39</td>
</tr>
<tr>
<td>Post test</td>
<td>0,36</td>
<td>29</td>
<td>2,69</td>
</tr>
</tbody>
</table>

4.1.3. Comparison of pre test scores with scores of the Community Psychiatry group.

In this table, $SD_X$ refers to the standard error of the difference between 2 means:

<table>
<thead>
<tr>
<th>Group</th>
<th>$SD_X$</th>
<th>df</th>
<th>t</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ugu</td>
<td>0,33</td>
<td>28</td>
<td>3,33</td>
<td>P&lt; .001</td>
</tr>
<tr>
<td>Sisonke</td>
<td>0,32</td>
<td>31</td>
<td>3,94</td>
<td>P&lt; .001</td>
</tr>
</tbody>
</table>
This indicates that, prior to intervention, both the Ugu and the Sisonke groups' knowledge of certain child mental health problems was significantly different from that of the Community Psychiatric nurses'.

### 4.1.4. Comparison of post test scores with scores of the Community Psychiatry group.

<table>
<thead>
<tr>
<th>Group</th>
<th>SDX</th>
<th>Df</th>
<th>T</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ugu</td>
<td>0.26</td>
<td>28</td>
<td>0.46</td>
<td>Not significant</td>
</tr>
<tr>
<td>Sisonke</td>
<td>0.32</td>
<td>31</td>
<td>2.66</td>
<td>P &lt; .05</td>
</tr>
</tbody>
</table>

After training, there was no significant difference between the knowledge of the Ugu group and the Community Psychiatry group. However, there was a difference between the knowledge of the Sisonke group and the Community Psychiatry group at the 5% level of significance.

### 4.2 Questionnaire administered to primary care nurses

This questionnaire was only administered to the 14 nurses comprising the Ugu group. It consisted of 20 questions, most of them open ended, and was intended to establish the current experiences, attitudes and feelings of primary health care nurses about undertaking mental health work. The data obtained from this questionnaire is presented below.

#### 4.2.1 Frequency of contact with patients suspected of having mental health problems:

This question was subdivided to determine contact with adults and children separately. An equal number of nurses (4 or 28.6%) reported having either daily or weekly contact with adult patients. Six nurses (42.8%) reported that on average, they only came into contact with adult mental health patients once per month.
Contact with children with mental health problems was reported to occur on a daily basis by 3 nurses (21.4%) and on a weekly basis by 2 nurses (14.3%). The majority (9 nurses or 64.3% of the sample) reported seeing such children on 1 occasion each month.

4.2.2 Attitude to working with patients with mental health problems

Most nurses (9 or 64.3%) stated that working with patients with mental health problems made them anxious. Two individuals reported that they felt uncomfortable and afraid. At the same time, 8 (57.1%) attributed their anxiety to a lack of knowledge and skills in dealing with mental health problems. Four nurses (28.6%) reported that they were comfortable working with these types of problems and actually found the experience “interesting”. A further 2 (14.3%) felt that if they were equipped with better skills, they could find the work “fulfilling.”

4.2.3 Attitude towards integration

All 14 (100%) expressed the view that this was a good idea but only 9 (64.3%) gave a reason why they thought this. Of these, 2 (14.3%) felt that integration would provide holistic care or would result in cost savings to patients. One person (7.1%) saw integration as being able to help in alleviating the shortage of nurses.

In all, 5 nurses qualified their approval of the integration of services with the proviso that further training in mental health needs to occur (3 nurses or 21.4%) or that additional staff needs to be employed to take on the increased work load (2 nurses or 14.3%).

4.2.4 Suggestions on how integration can best be achieved

A total of 10 nurses (71.4%) felt that training primary care nurses in mental health was essential if services were to be integrated. Two (14.3%) believed that trained psychiatric nurses or doctors had to be attached to primary care clinics for integration to succeed.
They did not elaborate on the roles they envisaged for these professionals. The need for additional staff was emphasised by 2 (14.3%) nurses while another 2 suggested that only nurses who were committed to or interested in mental health service provision should engage in these activities.

4.2.5 Possible problems resulting from integration

The majority of nurses (8 or 57.1%) were concerned that their workload would increase significantly after integration, while 7 (50%) expressed concerns about their own safety and that of other patients. They perceived mental health patients to be dangerous or destructive and as being capable of causing “chaos”. Four (28.6%) did not foresee any problems if staff received appropriate training.

4.2.6 Suggested solutions to problems

Four nurses (28.6%) did not record any answer to this question. Attending to the training needs of primary care nurses was seen as a possible solution by 6 nurses (42.8%) while 3 nurses (21.4%) felt that additional staff had to be employed to cope with the anticipated increase in workload. Another 3 nurses (21.4%) felt that within primary care clinics, patients with mental health problems should only be attended to by personnel chosen and trained specifically for this purpose. These should be people who are motivated to undertake such work but they should also be given special incentives.

4.2.7 Role of the psychiatric nurse in an integrated service

This question either failed to elicit a response or produced an unintelligible answer from 5 nurses (35.7%). For example, two nurses simply wrote down the word “yes” while one person wrote down“Yes. Nurses safety towards violent and psychiatric clients” (sic). Of the others, 5 (35.7%) saw psychiatric nurses in the role of consultants while 4 (28.6%) believed that they should continue to function as specialist personnel by see psychiatric patients at primary care clinics.
4.2.8 Self rating on knowledge of mental health

Four aspects were examined in this question. These were primary care nurses' general knowledge of mental health, their ability to identify mental health problems, their ability to counsel patients and their ability to appropriately refer patients to other resources.

Eight nurses (57,1%) rated their general knowledge of mental health and psychiatry as being “fair”; 4 (28,6%) rated their knowledge as being “good” while 2 believed that their knowledge was “poor.”

As regards their ability to identify mental health problems in adults, 2 again said that they were “poor”, 4 (28,6%) reported that they were “fair” while 8 (57,1%) felt that they were “good” at this. When it came to problems in children 3 (21,4%) felt that they were “poor” at identification. Six nurses (42,8%) reported that they were “fair” while 5 (35,7%) considered themselves to be “good” in this aspect.

Most (8) rated their ability to counsel patients and their families as being “fair.” Five nurses (35,7%) felt that they were “good” at this and one person thought that they were “poor.”

When it came to referring to patients to appropriate sources of help, the majority (10) reported that they were “fair” at this. Two persons each believed that their skills were either “good” or “poor.”

4.2.9 Knowledge about mental health professionals

This question attempted to determine whether participants were aware of the roles of various mental health professionals, where they could be found and when it was appropriate to refer to them. The majority (12 or 85,7%) reported that they knew about the roles and functions of psychiatric nurses and where they could be located. An equal number (11 or 78,6%) were familiar with the same information about Psychiatrists,
Psychologists and Social Workers but only 8 (57.1%), knew about Speech Therapists and Audiologists or Occupational Therapists (5 nurses or 35.7%).

4.2.10 Previous referrals to mental health professionals

Eight nurses (57.1%) reported having made referrals to Psychiatrists, 7 (50 % ) to Social Workers, and 6 each (42.8%) to Psychologists and Psychiatric nurses. Only 3 nurses (21.4%) had made a referral to an Occupational Therapist and the another 3 had referred to a Speech Therapist /Audiologist.

4.2.11 Reasons for not referring patients to mental health workers

Five participants did not respond to this question. Of those who did, 4 (28.6%) had not referred because they were not sure about what some of these people did while 6 (42.8%) did not know where these professionals could be found. One person had not made any referrals as they did not believe that help would be provided.

4.2.12 Referrals to traditional healers

The overwhelming majority of nurses (13 or 92.8%) had not referred any patients to traditional healers. Only 1 person had done so.

4.2.13 Role of the traditional healer in mental health

More than half the sample (8 or 57.1%) did not see traditional healers as playing any role in the treatment of mental health problems. They felt that they were either unable to help as they did not have appropriate skills and knowledge to treat these problems, or that they engaged in practices that were detrimental to the patient. This included requesting patients to engage in expensive rituals or being harsh and abusive towards them. Three nurses (21.4%) were uncertain about their role. However, a further three nurses believed
that they could be of use in certain cases, for example in the treatment of hysteria or where patients believed that they had been bewitched.

4.2.14 Definitions of health

The majority (13 or 92.8%) made reference to the World Health Organization (1946) definition of health which states that health is not merely the absence of diseases but is a state of complete physical, mental and social well being. The remaining individual listed a range of activities that were required to ensure good health eg. exercise, proper nutrition etc.

4.2.15 Definition of mental health

The absence of mental illness was reported as an indication of mental health by 8 nurses (57.1%). Four (28.6%) did not offer any definition while the remaining two referred to mental health as a state in which individuals are able to cope with problems, think constructively or act in a responsible manner.

4.2.16 Definitions of health promotion and of mental health promotion

Two participants said that they did not know what health promotion was. The majority (12 or 85.7%) believed that it referred to health education or providing advice to patients so as to prevent illness or to assist in rehabilitation.

Four nurses (28.6%) did not know what mental health promotion was. Of the rest, 6 (42.8%) believed it consisted of health education activities to prevent mental illness and 4 (28.6%) thought that it referred to efforts to promote the optimal functioning of patients.

4.2.17 Training in health promotion and prevention

An equal number of participants (10) reported being trained in health promotion and illness prevention activities. Four (28.6%) did not receive training in either aspect.
4.2.18 Frequency of promotion and prevention activities

General health promotion was reportedly carried out “often” by 8 (57.1%) of nurses while 4 (28.6%) said that they only engaged in this “sometimes.” One person did not do any health promotion at all.

Ten nurses (71.4%) stated that they “often” carried out illness prevention activities. Four did this “sometimes.”

4.2.19 Willingness to undertake mental health promotion and prevention activities

All 14 nurses (100%) reported that they were willing to carry out these activities if they received appropriate training.

4.2.20 Identification of mental health training needs

Half the sample (7 nurses) stated that they required training in all aspects as they knew very little about mental health. Three participants (21.4%) requested training in the detection of mental health problems and 2 (14.3%) in counselling skills. Other requests were for training in conducting mental state examinations and in dealing with mentally retarded persons.

4.3 Questionnaire administered to psychiatric nurses

This questionnaire consisted of 12 questions that attempted to determine the way in which community psychiatric nurses perceived the proposed integration of services. An analysis of the responses of the 17 individuals who responded is presented below.
4.3.1 Proposed integration of services

Only 3 participants (17.6%) saw the merger in a positive light while 2 (11.8%) were ambivalent about it. Those who saw this as being a step forwards, felt that it would benefit patients as it would provide them with holistic care. One person each said the move would result in a reduction of costs for patients or it would help de-stigmatize mental illness.

Those who were ambivalent felt this way because, while they could see that there would be less inconvenience for patients and they would receive comprehensive care, they believed that they would be marginalised in a primary care clinic.

The majority, (12 nurses or 70.6%) were unhappy about integration and believed that services should be kept separate. One of their main concerns was that psychiatric patients would be neglected or mismanaged for a variety of reasons. The chief concern of 8 nurses (47.1%) was that primary care nurses were not properly trained in mental health care. In particular, they felt that there had to be a strong, trusting relationship between patient and nurse that would allow for a sharing of information and for monitoring the mental state of individual patients. In a primary care set up, they anticipated that the large volume of patients would result in psychiatric patients being seen by different personnel on each occasion and that little time would be spent on consultation. Patients who were relapsing would escape detection and those who were in crisis would fail to get the necessary attention. Three nurses stated that as psychiatric patients could be violent or disruptive, the functioning of clinics would be affected. Two nurses believed that these patients posed a threat to women and children and that a large number of people, especially children and crying babies, would be a source of irritation to them.

Just as one nurse felt that integration would de-stigmatize mental illness, 2 others believed stigmatization by patients requiring general health services would increase.
4.3.2 Suggestions on how integration could be effected

There was an outright rejection of integration by 3 (17.6%) respondents, while 7 others (41.2%) stated that integration should only occur at a physical level. By this they meant that psychiatric clinics should be provided at the same physical location but that the services should be rendered by specialist personnel.

Of those who accepted the principle of integration, 7 (41.2%) believed that primary care nurses would have to receive extensive training first. Two others suggested that integration occur gradually, with stable patients being transferred to primary care clinics first and more problematic patients following after skills had improved.

4.3.3 Problems anticipated by psychiatric nurses

The most frequently stated concern was that psychiatric patients could be aggressive and disruptive in a general health care set up. Nine nurses (52.9%) believed that patients who were psychotic or had a low frustration tolerance would not be able to cope with crowds, long queues or noise. Five of them (29.4%) anticipated longer waiting times and predicted that as psychiatric patients were generally impatient, they would default on treatment thereby leading to more frequent relapses.

Concerns about the mismanagement of patients because of a lack of expertise on the part of primary care nurses was expressed by 6 nurses (35.3%) while 5 others (29.4%) believed that the high volume of patients would result in a failure to monitor high risk patients. Three nurses (17.6%) felt that the behaviour of patients when acutely ill would lead to them being stigmatized by both staff and general patients.
4.3.4 Suggested solutions to problems

The majority of psychiatric nurses (11 or 64.7%) believed that integration should be restricted to the sharing of premises. The actual service should be rendered by specialist personnel. More than half (9 or 52.9%) said that psychiatric services should be provided in a separate section of the hospital or clinic or that there should be a separate waiting room. Other suggestions were that priority be given to psychiatric patients so that they spent less time in queues or that specific days be set aside for them to be attended to.

An increase in the training for primary care nurses was suggested by 3 participants (17.6%).

4.3.5 Role of the psychiatric nurse

The majority of nurses (14 or 82.4%) stated that they wished to continue in their roles as specialists. They believed that they should be allowed to attend to psychiatric patients in primary care. However, 5 of them (29.4%) believed that they could act as consultants by offering training and help to primary care nurses. They also felt that they could focus on mental health promotion activities or on conducting home visits.

4.3.6 Referrals to traditional healers

Only 3 nurses (17.6%) had referred patients with a mental health problem to a traditional healer while the majority (14 nurses or 82.4%) had not.

Six nurses (35.7%) felt that referral was not necessary either as traditional healing and psychiatry where contradictory practices or that the use of pharmacological intervention was the best practice. Four others believed that referral was unnecessary as patients usually consult traditional healers prior to seeking psychiatric help. Other reasons given included the belief by 2 participants that only Black patients believed in traditional healers and that as they mostly saw persons of other race groups, they had had no reason
to make referrals. Three nurses (17.6%) stated that while they would not make referrals, they would not discourage patients from seeking such help.

4.3.7 The role of traditional healers in mental health

Two participants were of the opinion that traditional healers had no role to play at all. Ten others (71.4%) believed that with appropriate training, they could be an important source of referrals to psychiatric services and that both herbal and formal approaches to treatment could co-exist. In terms of patient care, 3 nurses felt that traditional healers would be able to provide supportive services to patients depending on their beliefs.

4.3.8 Definition of health

An integrated definition of health was offered by 16 respondents (94.1%). They saw it as being a combination of physical, mental and social well being. Only one person defined it as being the absence of illness.

4.3.9 Definition of mental health

This was defined as referring to “mental well-being” or “mental stability” by 6 nurses (35.7%). The ability to cope with stress was listed by 6 respondents while a further 5 thought that it referred to functioning at an optimal level. Having insight, a high self-esteem and good interpersonal relationship skills were listed as some indicators of mental health.

4.3.10 Definition of health promotion

Three respondents failed to provide an intelligible answer. The remainder believed that it referred to efforts to improve the general health of the population. This included encouraging lifestyle changes and education on aspects such as nutrition and exercise. Four nurses said that health promotion included illness prevention activities.
Mental health promotion

This was interpreted as referring to strategies to improve spiritual and emotional well-being by 5 nurses (29.4%), and as efforts to help persons cope with stress by 5 others. Activities to prevent mental illness were listed by 4 respondents. Others saw mental health promotion as consisting of activities aimed at improving specific aspects of a person's functioning, for example, their self-esteem, their ability to be assertive and their ability to manage their anger.

4.3.11 Training in mental health promotion and illness prevention

More than half the respondents (53%) had not received any training in either aspect. Only 8 nurses (47%) reported that they had been trained in some aspect.

4.3.12 Frequency of mental health promotion and illness prevention activities

One person reported that they did not engage in either activity. Responses by the remaining 16 nurses was identical for both activities. Fourteen (82.3%) said that they engaged in health promotion and illness prevention activities “often” and 2 (11.8%) said that they did this “sometimes.”

4.4 Results of evaluation questionnaire

These questionnaires were completed at the end of the training program by the 14 primary care nurses in the Ugu group.
4.4.1 Evaluation of presenter and program

In this section the nurses were first asked to rate the presenter and the program on 4 aspects and to then elaborate on their answers.

4.4.1 a) Content of program

This was considered to be “appropriate” to their current duties by all participants.

Most nurses (10) felt that they had frequently encountered the problems discussed in the course of their work or in the communities they lived in but had previously overlooked these or had been unaware of how to manage them. Discussion on practical strategies to cope with these problems was thought to be particularly useful by five nurses (35.7%). Three nurses reported that what they had learnt was useful in coping with their own children.

b) Method of presentation

This was found to be “effective” by all respondents. The use of examples, case studies and vignettes was found to be an effective learning tool as it enabled participants to obtain a clear understanding of subject matter. They also felt that the presenter encouraged discussions and questions and this enhanced their understanding.

c) Knowledge of presenter

All participants rated the presenter as being “knowledgeable”. Six participants (42.8%) were of the opinion that the presenter was highly experienced and that this was evident in his ability to answer all questions clearly and simply. His awareness of resources in local communities and use of examples to illustrate certain aspects was also evidence of him being knowledgeable.
d) The use of case studies

These were found to be “helpful” by all participants. Case studies were reported to help by creating a detailed picture that illustrated the problem being discussed. Participants said that it was a practical way of helping them to understand a particular disorder and that it encouraged critical thinking.

4.4.2 Aspect of program most likely to be applied

Eight nurses (57.1%) found that their new found ability to counsel the families of children would be most useful while 5 each (35.7%) stated that their overall improved understanding of the various disorders and their ability to diagnose and refer these conditions, would prove useful. Advising families of behaviour modification techniques was an important new skill to 3 nurses.

4.4.3 Aspects of the program that were unlikely to be of use

The majority (12 or 85.7%) found all aspects to be useful. However, one person felt that everything was unlikely to be of use as she did not come across any of the conditions discussed in the clinic in which she worked. Another participant felt that the section on working with families would be of little use as there was no time to engage in such activities.

4.4.4 Attitude towards working with children

All participants reported that their feelings about working with children had changed and that they were now more confident.

For 11 of them (78.6%), the information they had acquired had led them to believe that they were now more knowledgeable. They reported feeling empowered and said that they could now counsel caregivers and teachers. For the others, they felt confident in their
ability to refer children to appropriate sources of help. One person said that the program had aroused her interest in working with children.

4.4.5 Self-rating on skills acquired

All participants reported that, after training, they would be able to make a diagnosis and refer appropriately. However, only 13 felt that they could counsel parents and caregivers while one person was unsure.

4.4.6 Suggestions on how the program could be improved

The most frequent request were for further training in other aspects of child mental health and for the opportunity to visit special schools, clinics and institutions to see real examples of problems that had been discussed. Three nurses requested ongoing support and consultative services as they implemented what they had learnt. They were also suggestions that the program be extended, that group discussions be encouraged and that a certificate be provided at the end of the course.

4.4.7 Areas of further interest

In respect of child mental health, most requests were for additional training in the diagnosis and management of depression, substance abuse and parasuicide. Other requests were for skills to counsel the children themselves and information on how to cope with parental violence.

There were also requests for help in other aspects of mental health. This included the diagnosis and management of schizophrenia, dementia and organic brain disorders, how to manage stress, and on how to handle treat patients experiencing the side-effects of medication.
Chapter 5
Discussion

5.1 Demographic data

The composition of the three groups in this study varied on a number of aspects although the significance of some of these variations is uncertain. For example, there was a preponderance of female nurses (Table 1) in 2 groups while one group was exclusively female. There were no indications in the literature that gender played a significant role in influencing any of the variables examined.

The variation among the groups in respect of mean age (Table 4) and mean years of mental health nursing experience (Table 3) may have had some bearing on the findings. The Community Psychiatry group tended to be older, to have more years of training and to be more experienced than the other 2 groups. Along with their specialist training in Psychiatry (Table 2), this may account for their higher scores on the test evaluating knowledge of child mental health problems as well as for differences in their responses to the questionnaire assessing their attitude towards the integration of services. This will be discussed further in the relevant section.

The difference between the groups in respect of home language (Table 1) may also have influenced some of the findings. Most of the participants in the Ugu and Sisonke groups spoke Zulu or Xhosa as their home language while the Community Psychiatry group was predominantly English speaking. The questionnaires assessing knowledge were presented in English as was the rest of the training course. It is therefore possible that the scores of non-English speaking participants may have been negatively affected by the use of English. The overall poor quality of responses to the questionnaires administered to the Ugu group may also be due to participants not having English as their first language.
5.2 COMPARISONS OF PRE AND POST-TEST ASSESSMENT

5.2.1 Pre-test assessment

The Community Psychiatry group had the highest mean score on the test assessing nurses' knowledge of four frequently occurring mental health problems of children. Statistically, there was a significant difference between their scores and that of nurses in the Ugu and Sisonke groups ($p < .001$; Table 4.1.3). They emerged as having a significantly better knowledge of these conditions than nurses in the other two groups. This was to be expected as they had all completed specialized training in psychiatry and had more years of experience in working with children with mental health problems. With the exception of one participant, their failure to answer all questions correctly was due to their belief that tartrazine played a role in hyperactivity. This is of course a commonly held belief that is not supported by scientific evidence (Graham, 1991).

A comparison of the Ugu and Sisonke groups' knowledge prior to intervention did not reveal any significant differences between them (Table 4.1.2). This suggests that although they differed from each other in terms of mean age, years of training and experience, they were similar in their knowledge of children's mental health problems. This implied that differences in their knowledge following training would have to be due largely to the effects of the training programs they participated in.

5.2.2 Comparison of pre and post-test scores

Following training, both the Ugu and Sisonke groups were reassessed. The Ugu group was found to have performed significantly better following training ($p < .01$; Table 5) but there was no significant difference between the pre and post-test scores of the Sisonke group. This meant that participants in the Ugu group had increased their knowledge during training but those in the Sisonke group had not. Possible reasons for this finding are advanced later in this section.
The post-test scores of both groups were then compared to that of the Community Psychiatry group. The scores of the Community Psychiatry group had been used as a benchmark indicator of what nurses' knowledge of these conditions should be. No difference between the scores of this group and that of the Ugu group was found. This suggests that the training program that had been implemented with the Ugu group had been successful in improving their knowledge of certain child mental health problems to a level equivalent to that of trained Community Psychiatry nurses.

However, after implementation of the Department of Health’s training program, there was still a significant difference between the knowledge of the Sisonke and Community Psychiatry groups ($p < .05$, Table 4.1.4). The Sisonke group still knew less about these conditions than did the psychiatric nurses. The implication of this is that the Department of Health’s program may not be as effective in improving primary care nurses’ knowledge of child mental health problems to the extent where it approximates the knowledge of psychiatrically trained nurses.

By implication, these results also suggest that the training program implemented with the Ugu group was more effective than that conducted with the Sisonke group. Further support for this conclusion can be found by comparing the post-test scores of these groups with each other. Prior to training, there was no evidence of a significant difference in knowledge between the groups but following training, a significant difference was found to exist ($p < .05$; Table 4.1.2).

A variation in the content of the programs that nurses participated in may be a significant factor that has contributed to this finding. The assessment instrument was designed to ascertain participants’ knowledge of diagnosis, etiology, referral and nurse based interventions in respect of certain conditions. Although these conditions were discussed in both groups, the Department of Health’s program did not cover these aspects in much detail. As indicated in the description of this program in section 3.5, the module that was presented to the Sisonke group was not confined to the mental health of children. Time was also spent on presentations on the mental health of adolescents and the elderly and
on genograms and other topics. This left a little over four hours to discuss 11 topics related to child mental health. The sheer volume of the material that had to be covered did not allow for detailed presentations or for much time to be spent on discussions, case studies and questions. This is in spite of the compilers of the Department of Health’s training manual stating that these are essential components of learning (Gineiner & van Wyk, 2002a). It is possible that important material is being overlooked or that participants are being fatigued because of the intensity of this program. It is clear that the program needs to be thoroughly evaluated before any definite conclusions about its efficacy can be drawn.

5.3 PRIMARY CARE NURSES’ ATTITUDES TOWARD INTEGRATION

Although the data obtained in the questionnaires used in this study was presented separately for each question, for discussion purposes the answers to related questions have been combined in the sections that follow.

5.3.1 Frequency of contact with patients with mental health problems

Most nurses reported that they had infrequent contact with patients with mental health problems. Relatively small percentages (28.6% and 21.4% respectively) reported having daily contact with adults and children. This may well be a true reflection of the local situation in that patients with mental health problems are simply not turning up at primary care clinics. While this may give credence to the belief of Minde (1975) that children are rarely brought to primary care clinics for mental health problems, it may also support the view of other researchers that a large percentage of morbidity due to psychological problems is missed by primary care workers. Hall and Williams (1987) and Rudd and McMaster (1996) have reported that nurses in primary care generally fail to detect mental health problems when they do present. Improved detection skills may therefore lead to an increase in the frequency with which nurses report contact with patients with mental health problems. This aspect requires further investigation.
5.3.2 Attitude to working with persons requiring mental health services

More than a quarter of the sample (28.6%) reported feeling comfortable about working with patients with mental health problems. While none stated that they were unwilling to work with these patients, the majority did report being anxious or uncomfortable. This is consistent with the findings of Strachan and Clarke (2000) who report that primary care nurses are sometimes reluctant to undertake mental health work because of their fears surrounding mental illness. In this sample, participants acknowledged that their fears and anxiety were related to a lack of skills and knowledge about mental illness. This implies that with adequate education and training, these anxieties should dissipate.

The attitude of nurses in this sample does not necessarily reflect the attitude of primary care nurses in general. These nurses had volunteered to participate in this training program and may therefore already have been favourably disposed towards working with patients with mental health problems. Other nurses may be more reluctant to undertake such work. This may be an important consideration when selecting nurses for training as poorly motivated individuals are unlikely to fulfil the objectives of the program.

5.3.3 Attitude towards integration, possible problems and suggested solutions

The entire sample supported plans to integrate mental health and primary health care services. This is in contrast to other reports which indicate that primary care nurses are reluctant to integrate either because they are anxious about working with mental health patients or because they are wary of an increase in their workload without receiving additional incentives (SAHR, 1998; Strachan & Clarke, 2000).

The willingness of this group to integrate is again perhaps due to the fact that they were volunteers and that they already had a positive attitude towards mental health work. They were keen on integration but expressed concerns about their safety, an increased workload and a lack of knowledge and skills. This is similar to the findings of Grazin (1998) who surveyed primary care nurses in the Lower Orange District.
The perception that psychiatric patients are dangerous and pose a threat to the safety of nursing staff may be exaggerated. Acutely ill or psychotic patients are sometimes destructive and aggressive but by providing adequate training, for example, on how to handle aggressive patients, anxieties can be allayed.

On the other hand, the fear that nurses may be overburdened may in fact be real. At present, primary care nurses at fixed clinics each see an average of 25 patients per day and those at mobile see in excess of 41 per day (van Rensburg et al., 2000). The Centre for Health Policy at the University of Witwatersrand surmises that even a basic mental health service at primary care level will make significant demands on nurses’ time (Lazarus, 1994). The provision of additional staff may be one way in which to address this problem.

Nurses in this sample suggested that trained psychiatric nurses should be retained to deal specifically with mental health problems. This, however, is contrary to the principle of primary health care which requires that all primary care nurses be generalists and that they undertake mental health work. Local proposals (Mkhize, 2002) are for psychiatric nurses to function as consultants at secondary care level, for example at community health centres. Five participants (35.7%) concurred with this suggestion. Unfortunately, an equal number failed to provide an intelligible answer and hence there is no clear indication as to what role they would prefer psychiatric nurses to have in the new dispensation.

5.3.4 Knowledge of mental health and mental health professionals

The majority of nurses rated their knowledge of mental health, their ability to identify mental health problems, to counsel patients and to refer patients appropriately, as being either ‘fair’ or ‘good.’ Less than 29% felt that they were ‘poor’ on any aspect. This reflects relatively high levels of confidence in their abilities. This confidence may be related to the fact that more than half of them (57.1%) did have a qualification in which
they had completed 6 months of training in mental health or that they had on average, two years experience in working with patients with mental health problems. If this sample is representative of primary care nurses in general, and if their self-assessment is accurate, then it is possible to tailor a skills upgrading program that need not teach basic concepts and skills. The program can be shortened or can focus only on skills that have been identified as lacking.

5.3.5 Referrals to health professionals

Although more than three quarters of the participants knew about the roles of psychiatric nurses, psychiatrists, psychologists and social workers, the number of referrals to these professionals was low. Speech Therapists and Occupational Therapists were even less well known and fewer nurses made use of their services. Reasons advanced included being unaware of what these people did and where they could be found. Providing information to primary care nurses on these aspects is necessary if they are to make appropriate use of resources.

5.3.6 Role of the traditional healer in mental health

Although the vast majority (92.8%) of the sample was either Zulu or Xhosa speaking more than half (57.1%), did not see traditional healers as playing a role in the treatment of mental health problems. Participants believed that referral to these practitioners was not necessary as they were not able to help or caused further problems for the patient.

Although few culture specific syndromes amongst children have been reported in sub-Saharan Africa, certain behaviours may be interpreted in terms of traditional beliefs involving ancestors and evil spirits (Roberston, 1996). Local studies such as that by Petersen et al., (1995) have reported that a large number of patients attending clinics do consult traditional healers for their mental health problems. The nurses in this study have been trained in western approaches to healing but they need to be made aware of the necessity of taking the values and cultural beliefs of their patients and their families into
account when treating mental illness. Patients have to be understood in terms of the context from which they come and their belief patterns may need to be incorporated into their care plan (Edelman & Fain, 1998; Allwood et al., 2001).

5.3.7 Definitions of health and mental health

Most nurses appeared to understand the comprehensive nature of health and the fact that it includes physical, mental and social aspects. Such an understanding is important as it emphasizes the need to focus on all three aspects in patient care rather than only on disease prevention. This would also suggest that these nurses would be more likely to be aware of the need to pay closer attention to the mental health needs of their patients. However, participants were less clear about what constituted mental health. The majority felt that it referred to the absence of mental illness. There appeared to be little awareness of positive mental health or for the need to encourage patients to develop skills so that they could function optimally.

5.3.8 Health promotion and mental health promotion

The majority of participants saw health promotion as consisting of providing information or education to patients to prevent illness. More than a quarter did not know what mental health promotion was and of the rest, 42.8% believed that it only involved illness prevention education. The general impression was that participants did not fully understand the nature of both general and mental health promotion activities in spite having undergone training in the former. As the new integrated service requires a greater emphasis on promotion activities, this is another area that needs to be emphasised in training. It was encouraging to note that all nurses are willing to undertake such activities if properly trained.
5.3.9 Training needs of primary care nurses

Participants generally indicated that their knowledge of mental health was inadequate and that they required extensive training. Half of them requested training in all aspects while three requested training in detection skills and two in counselling skills. This was confusing as when asked earlier to rate themselves on their knowledge of mental health, their detection skills and their ability to counsel patients and their families, the majority (79.7%) rated themselves as being either ‘fair’ or ‘good.’ Fair is usually taken to mean ‘satisfactory’ or ‘abundant’ (The Concise Oxford Dictionary, 1973). In light of this, one would have expected them to be more specific about their training needs but it is possible that they wished to improve on their mental health knowledge and skills in general and therefore responded by requesting training in “everything.” Specific requests for training in detection and counselling skills are in keeping with what innovators of training programs such as Nikapota (1993), Lazarus (1994), Sawyer et al., (1996) and Pillay and Lockhat (1997) have identified as being important.

There is considerable debate about whether the training of primary care nurses should consist of a general training course (as with the Department of Health’s training program) or whether specific skills should be taught (Gwele, 1998). Ideally, training in mental health should form part of all nurses’ basic training but where specific skills are lacking, in service programs, informal training and selective training have been used. This approach has been criticised as some have argued that nurses have difficulty integrating what they have learned in the various programs (Strasser, 1998). At the same time, these stand alone programs have been found to be invaluable in improving nurses’ skills and the quality of care. The amount of time available for training may be a crucial factor in determining which is the better option. Where ample time is available, a comprehensive program may be feasible but where time is limited, high priority conditions should be targeted in brief but intensive courses.
5.3.10 Summary of findings on questionnaire administered to primary care nurses

The key findings of this questionnaire were that primary care nurses in this sample are willing to undertake mental health work in spite of reservations related to their lack of knowledge, their anxieties about working with psychiatric patients and fears of an increase in their workload. They anticipate that most of these problems can be resolved by an increase in training and staff members.

A second major finding was that although they are being expected to place greater emphasis on mental health promotion activities, few of them are aware of what this entails and are thus ill prepared for this aspect.

5.4 QUESTIONNAIRE ADMINISTERED TO PSYCHIATRIC NURSES

5.4.1 Attitude of Community Psychiatric nurses towards integration

In contrast to the primary care nurses, the majority of the psychiatric nurses (70.6%) were unhappy about the proposed integration of services. Their main concern was that primary care nurses are inadequately trained to undertake mental health work and that as a result of this, patients will experience a deterioration in services. They appear to have overlooked the fact that primary care nurses are in the process of being trained and that some of the problems they anticipate may not materialise.

However, they did highlight the personal nature of patient-nurse contact in mental health care and may have valid concerns about whether primary care nurses are going to have the time to establish trusting relationships with individual patients. They consider this to be an important part of their work as it enables them to monitor high-risk patients for signs of relapse. It also gives patients the opportunity to express their fears and concerns to someone they trust and who may be able to help. A possible solution to this would be to ensure that patients have contact with the same nurse on each visit.
The suggestion that psychiatric services continue to run independently at the same location as primary care services is untenable as this too is not in keeping with the objectives of primary health care. It reinforces the existence of vertically structured services and does little to address the problems of staff shortages and a lack of skills.

Concerns about mental health patients having a low frustration tolerance, being disruptive or defaulting because of long waiting times may well reflect the personal experience of psychiatric nurses. These are not insurmountable problems as solutions have been suggested by some of their colleagues. Giving priority to psychotic or emotionally disturbed patients and providing training on how to handle these types of patients are some of the strategies that can be implemented to address these issues.

5.4.1 Role of the psychiatric nurse

The answer of the majority of nurses to this question was in keeping with their unhappiness at the prospect of integration. Most (82.4%) still believed that they should continue in their roles as specialists and appeared to be unwilling to accept that services were about to be integrated or that their roles would have to change. Relatively few of them expressed the desire to act as consultants to primary care nurses, a role envisaged for them by those tasked with effecting integration.

Previous studies, for example that by Grazin (1998), have focussed on addressing the concerns of primary care nurses toward integration but none have examined the perceptions of psychiatric nurses. This study seems to indicate that psychiatric nurses do have major concerns about integration and that these concerns also need to be addressed. It is apparent that by virtue of their years of experience and training, they are familiar with problems that are likely to occur once integration takes place but these concerns and suggested solutions are perhaps being ignored. For integration to be successful, attention needs to be paid to their concerns as psychiatric nurses constitute a significant proportion of mental health care workers.
5.4.2 The role of the traditional healer in mental health

As was the case with primary care nurses, few psychiatric nurses reported that they had referred patients with mental health problems to traditional healers. This may be due partially to nurses working largely with patients whose beliefs are not consistent with seeking such help. However, the belief expressed by the majority of nurses (71.4%) that traditional healers could play an important role in mental health service provision is encouraging as it appears to take cognisance of patients' personal and cultural beliefs. This is in contrast with the views expressed by primary care nurses who have relatively little experience working with mental health patients and who perhaps need to learn to respect the value systems and beliefs of their patients. The training manual being used in the Department of Health's training program makes no reference to traditional healers and this aspect may also need to be looked at more closely.

5.4.3 Mental health and mental health promotion

The definition of health offered by the majority of participants was similar to that offered by primary care nurses. Definitions of mental health though, tended to be vague with terms such as 'mental well-being' and 'mental stability' being used frequently. This seems to suggest that "mental health" is an elusive concept even for psychiatric nurses. However, they did appear to understand some of the goals of mental health promotion. The majority (82.3%) reported engaging in mental health promotion and illness prevention activities 'often' despite less than half of them receiving training in this aspect. Unfortunately, the question failed to elicit details of exactly what they do to promote mental health or to prevent mental illness. Given their difficulty in defining these terms, it is possible that if they are to act as trainers or consultants to primary care nurses, they will require further training in this area.
5.4.4 Summary of findings on questionnaire administered to psychiatric nurses

This questionnaire revealed that there were a number of differences between the way in which psychiatric nurses and primary care nurses perceived integration. One of the main differences and concerns is that psychiatric nurses do not appear to be willing or ready to give up their roles as specialists. Just as primary care nurses are being prepared for integration, indications are that psychiatric nurses too need to be prepared for the new dispensation. Their anxieties and concerns need to be addressed, their roles must be clearly defined and they may require further training to fulfill these roles. For example, if they are to act as consultants, then they too need to be trained in mental health promotion as few of them have acquired such training.

5.5 EVALUATION OF PROGRAM

5.5.1 Evaluation of content and method of presentation

Although participants had indicated earlier that they had infrequently encountered children with mental health problems, on completion of the program they reported that these problems were in fact common but that they had been overlooked. They asserted that the content of the program had increased their ability to detect these problems and had made them aware of practical strategies to cope with them. The program can therefore be considered to have achieved its main objectives of improving nurses' skills in the detection and management of children with mental health problems.

The selection of frequently occurring conditions rather than rare disorders may have contributed to their perception of the content as being relevant to their work. In a time-limited program, it may be essential to focus on commonly encountered problems so that there are opportunities for whatever is learned to be put into practice. Ideally, decisions on the content of programs should be related to epidemiological data, but if these are absent, then data obtained locally can be used.
Gmeiner and van Wyk (2002a) state the principles of adult education should be followed when designing a learning package for nurses. They suggest that teaching should be problem oriented and include short presentations and ample time for discussion and questions. These basic principles were followed in the presentation of this course and this may have contributed to all participants declaring the program to have been effective. The problem oriented approach was evident in the use of case studies which ensured that relevant and realistic information was presented.

5.5.2 Knowledge of the presenter

Participants in this program rated the presenter as being knowledgeable and experienced. These are essential qualities of persons engaged in adult education as they have to be able to answer questions and to encourage discussion. The Department of Health intends using a cascade model to teach primary care nurses about mental health but in view of the shortened duration of the training program, this may be a cause for concern. Those who are being expected to teach may not be acquiring sufficient knowledge and expertise during an abbreviated course to effectively pass on what they have learned. This is another aspect of the Department’s program that needs scrutiny.

5.5.3 Relevance of the program and self rating of skills acquired

The general consensus was that all aspects of the program were relevant and useful and that they had contributed to an improvement in participants’ ability to detect, manage and refer mental health problems in children. Participants reported that their attitude towards working with children had changed and that they were now more confident, is further subjective evidence that the program had succeeded in achieving its objectives.

5.5.4 Suggested improvements to program

Most participants did not feel that any major changes were necessary. Some did request the opportunity to have access to patients who presented with the problems described but
this aspect had not been considered when drawing up the program. Provided that the logistical problems associated with field trips can be sorted out and patients give consent to be presented, this can be looked into. An alternative would be to obtain video material that illustrates these conditions and to show these instead.

Another suggestion was that ongoing support be provided to participants in the period immediately following the completion of the program so that participants would have access to some form of help should problems arise. The wide geographic distribution of participants did not allow for personal visits to nurses at their work stations but they were given the contact details of the program presenter so that he could be accessed when necessary. When integration does become a reality, psychiatric nurses can assume this role.

Requests for further training were varied and may reflect the personal experiences of participants. The diagnosis and management of Adjustment Disorders and related problems such as parasuicide and Substance Abuse had been considered in the original program but had been excluded because of time constraints. It had been intended that there would be a follow-up training program but the introduction of the Department of Health’s training program has created uncertainty about whether there will be a need for this.

5.5.5 Summary of findings on evaluation questionnaire

The program that had been presented was well received by all participants and was reported to have succeeded in achieving its objective of improving the diagnostic, management and referral skills of primary care nurses. The content was considered to be relevant and the method of presentation conducive to significant learning taking place. Although minor improvements were suggested, comments of participants indicate that the program could have played a significant role in improving primary care nurses’ knowledge of child mental health problems. It appears to have been worth repeating with other groups of nurses and could perhaps have been extended to include other topics in
which nurses require training. Although the Department of Health has since introduced its program, its efficacy has yet to be assessed. It is possible that independently run programs targeting specific skills deficiencies may still have a role to play in the training of primary care nurses in mental health.
Chapter 6
Conclusion

6.1 Summary of findings

The main aims of this study were to implement a training program in child mental health for primary care nurses in the Ugu region; to compare the effectiveness of the program to that being run by the Department of Health; and to assess nurses’ attitudes and concerns about the integration of services. Four main hypotheses were formulated. All of these were confirmed by the study:

Primary care nurses and psychiatric nurses differed significantly in their knowledge of child mental health problems prior to intervention. Following intervention, these differences no longer existed and the primary care nurses’ knowledge of these conditions was found to be similar to that of the psychiatrically trained nurses.

A second group of primary care nurses from the Sisonke region differed from the Community Psychiatry group both prior to and after participating in the program run by the Department of Health. They were also found not to have made significant gains in knowledge when compared to the Ugu group which had participated in another program on child mental health. It was concluded that factors such as differences in the content of the programs and the time limited nature of the Department of Health’s program had resulted in less significant learning taking place.

Various concerns and anxieties about integration were expressed by both primary care nurses and psychiatric nurses. Primary care nurses’ concerns about a lack of knowledge, an increase in workload and the potential danger posed by psychiatric patients was similar to that found in other studies. However, this study indicated that psychiatric nurses too have concerns about integration and that these are perhaps not being addressed satisfactorily. Their chief concern revolved around their role in the new dispensation and
fears that an integrated service will not permit close regular contact with patients so that a trusting relationship can be established and patients monitored for signs of relapse.

6.2 Limitations of the study

One of the main limitations of the study is the relatively small size of the samples. The group that was exposed to the writer’s training program was confined to 14 individuals while the other groups were slightly larger. This is advantageous when programs require intensive participation by way of questions and discussion. The disadvantage, however, is that generalizations based on data obtained from small sized samples may be limited in their validity. Hence, the findings of this study may not be applicable to other groups of primary care or psychiatric nurses. More than one group of nurses should have been used in each category.

A second factor that affects our ability to generalize from this study is the fact that participants in the Ugu and Community Psychiatry groups were all volunteers. The former group may have agreed to participate in the program because they have an interest in mental health. This would have influenced some of their responses. For example, their attitude towards undertaking mental health work may have been more positive than that of colleagues who had not volunteered to participate. Similarly, those community psychiatry nurses that had volunteered to participate tended to have negative feelings about integration. They may have viewed this study as an opportunity to ventilate their feelings.

Findings on the learning that had taken place during training also need to be treated with caution. A 16 item multiple choice questionnaire was used to assess knowledge prior to and after training. A brief questionnaire of this nature is unlikely to provide a comprehensive indication of knowledge that has been acquired over a three day period. Also, child mental health consists of more than just four diagnosable conditions. Although interview and counselling skills and other aspects had been taught, no attempt was made to assess whether participants had acquired these skills. It may also have been
unfair to use the same questionnaire with participants exposed to a different training program. The questionnaire had been designed to determine whether basic knowledge had been acquired, but the originators of the respective programs may have had different ideas about what constitutes basic knowledge of the conditions discussed. Perhaps the true success of the program can only be gauged by determining whether participants actually implement what they have learned when they return to their places of employment.

Generally, the quality of responses to the open-ended questions was poor. Several questions were left unanswered or elicited unintelligible responses. This may have been due to questions being poorly framed or to participants having difficulties with English. Whatever the reason, the responses to some questions had to be analysed without there being a full complement of answers. This, together with the already small size of the sample, resulted in there being relatively few responses to analyse. In retrospect, the questionnaire method may not have been appropriate to certain aspects of the study. Focus groups may have been more useful in eliciting the information required.

Despite these problems, this study did produce valuable information which can be used to modify training efforts directed at improving the mental health skills of primary care nurses. It also illustrated how Community Psychologists can play a significant role in improving the mental health of communities by engaging in research, teaching and training.

6.3 Conclusion

As the Department of Health has now introduced its own training program for primary care nurses, it is uncertain whether there will still be a need for a program such as this to be offered concurrently. The Department’s training program is comprehensive and does have the potential to equip primary care nurses with most of the skills they require to engage in mental health work. However, two problems are apparent. The first is that the Department of Health’s program may be deficient in that it contains a number of
suggestions regarding the management of conditions that revolve around referral to other 
mental health professionals. As has been discussed earlier, there is a dearth of such 
professionals in rural areas in particular. It is therefore possible that nurses’ detection 
skills will be improved but they will have few resources to refer to. In most instances 
they will be limited to providing pharmacological intervention. By placing greater 
emphasis on training in practical, home based interventions, it may be possible to 
improve the mental health of children presenting with a range of problems.

A second problem appears to be the manner in which the Department’s training program 
is being implemented. It was intended to be presented over 15 days but this was then 
reduced to 8 days and now four. As it is a comprehensive program, it is unlikely that 
nurses will be able to learn much in such a short space of time. Those in charge of the 
program appear to be overambitious in their expectations. The problem is compounded 
by the fact that many of those undergoing training are doing so involuntarily. Their 
possible lack of motivation, coupled with the volume and pace of the course, may lead to 
the program failing to achieve its objectives. It therefore appears that there is an urgent 
need for the program to be scientifically evaluated. Informal discussions with participants 
and trainers indicate that they share the same reservations about the program and unless 
their concerns are addressed, the value of the course may be diminished.

If the Department does persist with its program without making any changes, then this 
may be construed as another example of developments in mental health care being driven 
by government policy rather than by research. There is certainly a need for mental health 
care to be integrated into primary health care but we should be wary of rapid solutions 
and attempts to achieve instant success (van Balen, 1996; Gask, Sibbald and Creed, 
1997).
REFERENCES


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APPENDIX A

Biographical Inventory

NAME: .................................................................

AGE: .................................................................

HOME LANGUAGE:

- Zulu
- English
- Other: ..........................................................

STATION (please tick one):

- Mobile
- Hospital
- Psychiatric Clinic
- Health Centre
- OTHER (please state) ........................................

BASIC TRAINING:

- 3 yr Diploma
- 4 yr Diploma
- B Cur
- 3 yr Diploma in Psychiatry
- Other (please state) ........................................

Please list other post basic training you have completed eg. Diploma in Midwifery, Psychiatry, etc

- ..............................................................................
- ..............................................................................
- ..............................................................................

EXPERIENCE

Total: ..............yrs

PHC: .............. yrs

Psychiatry .............. yrs.
APPENDIX B

(Questionnaire administered to primary care nurses)

Please complete the following questions which will enable us to better understand your training and exposure to mental health care and psychiatry.

1. At present, how often do you see patients you suspect of having mental health or psychiatric problems?
   
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<th>Daily</th>
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<th>Monthly</th>
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<td>ADULTS</td>
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<tr>
<td>CHILDREN:</td>
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2. How do you feel about working with patients with mental health or psychiatric problems?

3. There are proposals for primary health care and mental health services to be integrated. What are your feelings on this?

4. How do you think the integration of services can best be achieved?

5. What problems do you foresee should services be integrated?

6. What are some of the possible solutions to these problems?

7. In what role would you like to see Psychiatric nurses functioning when PHC and mental health services are integrated?
8. Please rate yourself on the following:

(a) your knowledge of mental health and psychiatry in general:  
   Good  Fair  Poor
(b) your ability to identify mental health / psychiatric problems in:
   Adults: Good  Fair  Poor
   Children: Good  Fair  Poor
(c) your ability to counsel the above patients or their families
   Good  Fair  Poor
(d) your ability to refer the above patients to appropriate sources of help:
   Good  Fair  Poor

9. Please indicate your knowledge of what the following professionals do and when referrals should be made to them by ticking the appropriate column:

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<th>PROFESSIONALS</th>
<th>KNOW</th>
<th>DON'T KNOW</th>
<th>UNSURE</th>
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<tr>
<td>Psychiatric Nurses</td>
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<tr>
<td>Social Workers</td>
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<tr>
<td>Speech Therapists / Audiologists</td>
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10. If you have referred patients with mental health or psychiatric problems to any of the above professionals, please place a cross (X) next to their names.

11. If you have not referred patients to those listed in 10. above, is it because: (please tick)

(a) you don't know what they do
(b) you don't know where they can be found
(c) you don't think they can be of help

12. Have you referred any patients with mental health or psychiatric problems to traditional healers

   YES    NO

13. Describe the role you see traditional healers playing in the treatment of mental health or psychiatric problems.

   ................................................................................................................................................
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   ................................................................................................................................................
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   ................................................................................................................................................

14. Please explain what you understand by the term “health”

   ................................................................................................................................................
   ................................................................................................................................................
   ................................................................................................................................................
   ................................................................................................................................................
   ................................................................................................................................................
15. What do you understand by the term “mental health”?

16. What do the following terms mean to you:

health promotion

mental health promotion

17. Have you received any training in:
   a) health promotion
      YES  NO
   b) Prevention
      YES  NO

18. How often do you engage in the following activities: (please tick one)
   general health promotion:
      Often  Sometimes
      Never
   general health prevention:
      Often  Sometimes
      Never

19. Would you be willing to undertake mental health promotion and prevention activities after training?
      YES  NO

20. What aspects of mental health and psychiatry would you like to be trained in?

Thank you for your cooperation.
APPENDIX C

Pre Test

Name ......................................................................................................................

The following four paragraphs describe typical problems presented by children which parents seek help for. Please read through them and then answer the questions that follow by circling the answer that you think is the most appropriate.

A. A ten-year old boy, Vusi, is brought to the clinic by his mother. She is concerned because he has failed Grade 1 twice and his teacher says he is going to fail again because he can’t write his name properly, read simple words or do any sums.

He is cheerful and playful but prefers being with children much younger than himself. Everyone considers him to be ‘slow’ because he has difficulty following simple instructions and he is not able to bath or dress without help.

1. Vusi is: a. schizophrenic 
   b. mentally retarded

2. The above condition may have been caused by:
   a. birth complications
   b. him joining children younger than himself

3. It would be more appropriate to refer him to:
   a. A psychiatrist
   b. A psychologist

4. His family should:
   a. take over bathing and dressing him as he will not learn
   b. be encouraged to be more patient in training him to care for himself.

B. Zanele is 10 years old and is not coping at school. She has failed Grade 4 mainly because she is unable to read, and on spelling tests, she usually gets one or two out of ten. However, she always participates in class discussions and gives some very good answers.

She travels to school on her own by taxi; goes to the shop for her mother; is able to cook simple meals and can be trusted to look after her younger brother and sister.

1. Zanele is: a. mentally retarded 
   b. learning disabled

2. Current thinking is that problems like hers may be due to:
   a. difficulties in processing information
   b. laziness.

3. She should: a. have her hearing and vision assessed
   b. be referred to the Dept of Social Welfare for assistance with a Care Dependency Grant application
4. At home, her parents should:
   a. encourage her to spend every possible moment studying
   b. give her more opportunities to do the things that she shows an interest in eg cooking and sewing.

C. Sizwe’s teacher has complained repeatedly about his behaviour at school. He is considered to be a clever child but he does not sit at his desk for long and he disrupts lessons by being fidgety and talking to others. His school work is rarely completed.

His mother reports that at home he gets up very early, goes to bed late and generally runs about or climbs all day. He is unable to watch TV or concentrate on any games or activities for longer than a few minutes.

1. Sizwe is:
   a. just naughty
   b. hyperactive

2. There is considerable evidence that this condition may be due to:
   a. genetic factors
   b. food additives such as tartrazine

3. He may benefit from:
   a. a hiding
   b. medication

4. He can be helped by:
   a. providing a structured routine
   b. punishing him each time he is disruptive or misbehaves.

D. A 11 year boy with flu is brought to the clinic by his mother. He looks as though he has been recently assaulted. When you ask about what had happened, you are told that his mother had hit him because she was extremely angry. She complains that he truants from school, steals money, returns home late in the evening and suspects him of smoking and sniffing glue. The neighbours complain about him swearing at and bullying their children.

1. This is an example of:
   a. A Conduct Disorder
   b. Depression in childhood

2. It is more likely to be due to:
   a. An environment in which there are social problems such as parental conflict, violence and alcohol abuse
   b. poverty

3. He should be referred to:
   a. a social worker
   b. an occupational therapist

4. His parents should be advised to:
   a. use behaviour modification techniques to change his behaviour
   b. take him to a doctor for some medication
APPENDIX D

(Questionnaire administered to psychiatric nurses)

It will be appreciated if you could please take a few minutes to answer the following questions:

1. There are proposals for primary health care and mental health services to be integrated. What are your feelings on this?

2. How do you think the integration of services can best be achieved?

3. What problems do you foresee should services be integrated?

4. What are some of the possible solutions to these problems?

5. In what role would you like to see Psychiatric nurses functioning when PHC and mental health services are integrated?

6. Have you referred any patients with mental health or psychiatric problems to traditional healers [YES] [NO]

If “NO,” could you please explain your reasons for not doing so

________________________________________________________________________
________________________________________________________________________
7. Describe the role you see traditional healers playing in the treatment of mental health or psychiatric problems.

8. Please explain what you understand by the term “health”

9. What do you understand by the term “mental health”?

10. What do the following terms mean to you?

   “health promotion”

   “mental health promotion”

11. Have you received any training in:

    a) mental health promotion
    b) mental illness prevention

12. How often do you engage in the following activities: (please tick one)

   Mental health promotion:
   
   Often  Sometimes  Never

   Mental illness prevention:
   
   Often  Sometimes  Never

   Thank you for your cooperation.
APPENDIX E

(Administered to primary care nurses: UGU group)

EVALUATION

It will be appreciated if you could please provide some feedback on the program you have just attended. This will help determine how it can be improved and whether its objectives have been achieved.

1. Do you think that:
   a) The content (ie. the topics covered) were:
      [ ] APPROPRIATE  [ ] INAPPROPRIATE
      Please explain

   b) The method of presentation was:
      [ ] EFFECTIVE  [ ] NOT EFFECTIVE
      Please explain

   c) The presenter was:
      [ ] KNOWLEDGEABLE  [ ] NOT KNOWLEDGEABLE
      Please explain

   d) The use of case studies were:
      [ ] HELPFUL  [ ] NOT HELPFUL
      Please explain

2. Which aspects of the program do you think you will be most likely to apply in the course of your work?

   Please explain
3. Which aspects do you feel are unlikely to be of much use to you?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

4. Have your feelings about working with children with mental health problems changed in any way?
   YES [ ] NO. [ ]

Now, do you feel:

   MORE CONFIDENT  SAME AS BEFORE  LESS CONFIDENT

Please explain.

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

5. If a child presents with one of the mental health problems discussed, will you be able to: (Ring one)
   a. make a diagnosis [ ]
   b. refer to appropriate sources of help [ ]
   c. counsel parents/caregivers on home-based interventions [ ]

6. Could you please suggest some ways in which the program can be improved.

________________________________________________________________________
________________________________________________________________________
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7. List 2-3 other mental health topics that you would like to learn about.

________________________________________________________________________
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THANK YOU FOR YOUR CO-OPERATION.
**APPENDIX F**

Pre and post test scores: (UGU group)

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APPENDIX G

Pre and post test scores: (SISONKE GROUP)

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APPENDIX H

Pre test Scores: Community Psychiatry Group.

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