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Care for patients with psychiatric disorders: the attitude and role of primary health care medical doctors towards integration of mental health into primary health care in Soweto

Mavie-Shibanda, Nokuthula Mavis

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CARE FOR PATIENTS WITH PSYCHIATRIC DISORDERS: THE ATTITUDE AND ROLE OF PRIMARY HEALTH CARE MEDICAL DOCTORS TOWARDS INTEGRATION OF MENTAL HEALTH INTO PRIMARY HEALTH CARE IN SOWETO

by

Nokuthula Mavis, Mavie-Shibanda

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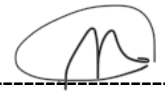
SUPERVISOR: DR MVUYISO TALATALA

South Africa

2021

Declaration

I declare that the dissertation titled **"Care for patients with psychiatric disorders: the attitude and role of primary health care medical doctors towards integration of mental health into primary health care in Soweto"** hereby submitted to University of Witwatersrand for the degree of Master of Medicine (Psychiatry) by me for a degree at this university is my work in design and in execution, and that all material contained herein has been duly acknowledged. I understand what plagiarism is and I am aware of the department's policy in this regard.



---------- Dated: 26/09/2021

M. N. Mavie-Shibanda

Dedication

I dedicate this work to my family.

Thank you for your ongoing prayers, love and support.

Acknowledgements

I wish to express my sincere thanks, and appreciation to:

- **My supervisor:** Dr Mvuyiso Talatala, for his involvement, and motivational support in investigating an area that needs special attention – the role and attitude of PHC Doctors towards the integration of mental health into PHC.

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- **Public Health Practitioner**: Dr Perpetua Modjadji for advice on revising the dissertation and final data analysis.

- **Department of Psychiatry, Faculty of Health Science, Wits University**: For allowing me to conduct this unique research project.

Abstract

Introduction: Mental health is an integral part of health. However, health systems have not been able to respond adequately to the burden of mental health. There is a wide gap between the mental health needs of the community and the available mental health services in Soweto. Therefore, integration of mental health into primary health care (PHC) services is one solution to the treatment gap. This requires task shifting from mental health specialists to a range of non-specialist health workers including doctors providing PHC service.

Aim of the study: To determine the perception, attitude and role of medical doctors working in PHC regarding caring for patients with mental illness and barriers towards integration of mental health care into PHC. The objectives of the study were (1) to describe the demographics of PHC doctors, (2) to assess the level of understanding of mental illness among PHC doctors, (3) to determine the attitudes and role of PHC doctors in caring for patients with mental illness, and (4) to assess the barriers towards integration of mental health care into PHC.

Methods: This is a cross sectional study using a quantitative approach among doctors working in PHC clinics in Soweto. The study was conducted in Lillian Ngoyi PHC, a facility where doctors meet every Friday morning for in-service training. A self-administered questionnaire was used to collect data on the basic demographics and practice employment history, respondents' feelings regarding psychiatric disorders and views on how the disorders should be treated. Data was also collected on tasks in the acute and long-term phase, care for family, self-experienced competencies, and need for continual professional training and development in mental health to enable doctors to communicate with psychotic patients. Attitudes towards mental health care provision and perceptions regarding the barriers towards the successful integration of mental health care programs into PHC were also determined. Data were analyzed using STATA 14.

Results: The total number of doctors working in the PHC clinics in Soweto in December 2015 to January 2016 was 67. However, a total sample of 30 doctors was obtained for the study. Males were nine (30%) and females were 21 (70%). The results showed that 14 (46.7%) of the respondents were aged ≤30 years while 16 (53.3%) were aged above 30 years. Most of the respondents with work experience ≤20 years were females (n=19) representing 63.3% of the study sample while only 10.5% (n=2) of these females had work experience over 20 years. PHC doctors did not have a negative attitude to mental illness but were opposed to full integration of psychiatric patients in the PHC clinic. They suggested that psychiatric patients should be separated from patients with other medical conditions attending the PHC clinics. Doctors were also aware of their roles in terms of supporting the patients and their families but did not think that they had a role to play in the care of chronic psychiatric patients, which could be due to the lack of skills and exposure to psychiatry. The identified barriers to the integration of mental health services into PHC included lack of training, overcrowding, lack of resources and lack of support. Doctors were willing to be upskilled in order for them to be able to treat some of the mental illnesses at PHC.

Conclusion: Ongoing in-service training, mentoring and support of PHC doctors are a priority. Improvement of collaboration between PHC and secondary psychiatric services will also enhance integration. The success of integration also requires increased consensus, commitment and political will within the government to place mental health on the national agenda and secure funding for the sector.
Keywords: Primary Health Care, Doctors, Soweto, integration, mental health

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LIST OF ABBREVIATIONS

AFFIRM:	Africa Focus on Intervention Research for Mental Health
AIDS:	Acquired Immunodeficiency Syndrome
CMHS:	Community Mental Health Services
CPD:	Continued Professional Development
CRPD:	Convention on the Rights of Persons with Disabilities
DALYs:	Disability Adjusted For Life Years
GP:	General Practitioner
HIV:	Human Immunodeficiency Virus
LE:	Life Esidimeni Health Care
mhGAP-IG:	mental health Gap Action Programmed Intervention Guide
NGOs:	Non-Governmental Organizations
NHI:	National Health Insurance
NMHPF & SP:	National Mental Health Policy Framework and Strategic Plan (2013-2020)
PC:	Primary Care
PHC:	Primary Health Care
PRIME:	Program for Improving Mental Healthcare
SASH:	South African Stress and Health
WHO:	World Health Organization
YLDs:	Years Lived with Disabilities

CHAPTER 1

INTRODUCTION AND BACKGROUND

1.1 Introduction

Mental health problems are very common in primary care clinics.[1] Mental illness has a significant direct and indirect burden and represents 5 of the 10 leading causes of disability in the world, and affects as many as 500 million people worldwide.[2] The World Health Organization (WHO) estimates that globally, 154 million people suffer from depression, 25 million from schizophrenia, 91 million are affected by alcohol use disorders and 15 million by other substance use disorders.[3] It is believed that by 2030, non-communicable diseases including psychiatric conditions, will be among the top ten disorders globally, with depression being the leading cause of disease burden.[3] There remain many barriers to access mental health care, including limited resources.[2]

Primary Health Care (PHC) doctors play vital roles, both directly and indirectly, in mental health care. Approximately 40% of patients seeking help for mental health problems are seen only by PHC doctors.[4,5] PHC doctors are the first point of contact for people dealing with mental illness.[6-9] However, challenges continue to exist in detection and treatment of mental illness.[10-12] PHC doctors often report difficulties in accessing mental health specialists for consultations or referrals.[9,13,14] Evidence suggests that those with psychiatric problems might receive better care in secondary mental health care settings compared with primary care settings,[15] but there is a scarcity of secondary mental health care facilities.

There are several factors that influence PHC workers' willingness to provide mental health care and these include lack of skills concerning treatment of mental health disorders as well as stigma about psychiatric disorders.[16] People suffering from mental illness commonly present to PHC clinics because mental

illness frequently overlaps with physical illness.[17] Therefore, integration of mental health care with PHC can lead to prompt detection and treatment of common mental disorders, management of stable psychiatric patients, and timeous referral to relevant specialties.[3] Other benefits of an integrated health care include training of primary care workers to apply psychosocial and behavioural science skills to improve overall health outcomes.[18]

With integration of mental health into PHC, doctors working in PHC are expected to competently assess and treat mental illness and manage stable chronic psychiatric patients. Studies have shown that competence and positive attitudes influence clinical practice in the care of patients.[3] Unfortunately, in the past there were limited learning opportunities or exposure to psychiatry during the undergraduate training of medical doctors in South Africa.[19]

South Africa has made progress in the development of policies and implementation of programs of mental health care at national and provincial levels. Mental health and substance abuse are being prioritized at all levels of care.[20] In 2013, the National Mental Health Policy Framework and Strategic Plan (NMHPF & SP) was developed with its objectives intended to be implemented in the period 2013-2020.[21] The first objective was to scale up decentralized integrated primary health services, which include community-based care, PHC and district hospitals.[21]

1.2 Problem statement

South Africa has multiple psychosocial risk factors for mental illness and disability such as unemployment, poverty, violent crimes, inequality, urbanization and substance and alcohol use.[22,23] There is also a high prevalence of the Human Immunodeficiency Virus and Acquired Immunodeficiency Syndrome (HIV/AIDS) in South Africa.[24] HIV/AIDS leads to an increased burden of

psychiatric conditions such as depression, anxiety, psychosis and major neurocognitive disorders.[25]

Mental health services in South Africa are poorly resourced despite South Africa's progressive mental health legislation. This has resulted in poor development of community mental health services and consequently, the psychiatric hospitals remain the entry level to the mental health care system.[26] There is also a challenge in providing human resources to deliver essential mental health services in the public sector.[27] WHO Mental Health Atlas in its profiling of South Africa reported that there are 0,4 public sector psychiatrists per 100,000 populations,[27] but has no figures for the other mental health care work-force including medical officers, psychologists, nurses, occupational therapists, and social workers.

1.3 Aim of the study

- To determine the perceptions of medical doctors working in PHC in Soweto towards integration of mental health care into PHC, as well as their attitudes in caring for patients with mental illness.

1.4 Research questions

- What is the level of understanding of mental illness among PHC doctors?
- What are the attitudes and the roles of PHC towards caring for patients with mental illness?
- What are the barriers towards integration of mental health care into PHC?

1.5 Objectives of the study

- To describe the demographics of PHC doctors in Soweto.
- To assess the level of understanding of mental illness among PHC doctors.

- To determine the attitude and role of PHC doctors on caring for patients with mental illness.
- To assess the barriers towards integration of mental health care into PHC.

CHAPTER 2
LITERATURE REVIEW

2.1 Introduction

This chapter on literature review will illustrate that integration of mental health care into primary health care is possible, as it has been implemented successfully in other parts of the world. The burden of mental illness in South Africa, and the importance of integration of mental health care in general health care will be discussed. The progress that has been made in South Africa and globally towards integration, and the models of care that have been implemented successfully in other parts of the world, will be discussed. The chapter will also discuss possible obstacles to successful integration.

2.2 An overview of mental health in South Africa

The most common disorders in PHC are depression, anxiety disorders, harmful alcohol use, dependence and somatization.[28] Although mental disorders are widespread in PHC, they are usually not detected and treated resulting in suffering, disability and economic loss[29] despite the success in their treatment if diagnosed. Integrating psychiatric services into PHC is one of the effective methods of ensuring that people receive holistic care that they need.[30] The challenge is that health care providers are not properly trained to deal with psychiatric disorders as the undergraduate training programs previously focused on a biomedical model of care outside a bio-psycho-social model.[31]

The need for a comprehensive mental health care system is enshrined in the declaration of ALMA ATA, which emphasizes the importance of achieving health for all.[32]

According to the Global Burden of Disease Study (2010) "mental disorders and substance use disorders were among the leading causes of disease burden.[33] They were responsible for 7.4 percent of global Disability Adjusted for Life Years

(DALYs) and 22.9% of global Years Lived with Disability (YLDs), making them the fifth-leading cause of DALYs and the leading cause of YLDs".[33]The disorders that frequently cause disability globally are self-inflicted injuries, depressive disorders, anxiety and alcohol use disorders.[33]

Prior to 1994, in Gauteng Province and other parts of the country, most patients suffering from mental illness were admitted to chronic care facilities. Most of the acute beds were located in specialized mental health hospitals and there were limited beds in general hospitals. The institutionalization of patients violated their human rights and dignity.[34] In 1994, the National Health Care Plan was developed with the aim of providing a comprehensive, equitable and integrated national health system.[35] In 1997 the White Paper[36] and Mental Health Care Act no. 17 of 2002 (MHCA)[37] were developed which provided for respect of human rights and dignity. Section 8 of the MHCA made provision for de-institutionalization as it states that people with mental illness should be treated in primary health clinics.[37]

The MHCA, the National Mental Care Plan, and the White Paper highlighted changes that needed to be addressed in order to achieve the respect for human rights for people with mental illness as well as equitable and accessible care, including deinstitutionalization. Deinstitutionalization in South Africa was scheduled to be done over several years and was supposed to follow after the strengthening and capacitation of community psychiatric services.[21,34] Long-stay hospital beds were reduced from 70 beds per 100 000 population in 1994 to about 35 beds per 100 000 population in 2004[26]. By 2008, it became impossible to reduce long-stay beds further to the targeted 10 beds per 100 000 population because of the "revolving door" phenomenon where patients were being readmitted due to relapse after being discharged.[26]

Some of the long-term stay beds were outsourced by the Gauteng Provincial Department of Health to a private facility – Life Esidimeni Health Care (LE). Despite the planned and cautious approach to deinstitutionalization and the

revolving door phenomenon, in March to June 2016, 1442 patients with severe mental illness were transferred from LE facilities to non-governmental facilities (NGOs).[38] The NGOs were unlicensed and poorly prepared for the sudden increase in the number of psychiatric patients and others were transferred to psychiatric institutions that were more costly than the LE facilities.[38] 143 patients died mostly in the NGOs, following serious violation of human rights, despite the fact that in 2007 South Africa became a signatory to the United Nations Convention on the Rights of Persons with Disabilities (CRPD).[26] The CRPD[26] states that mental health care users should have equal rights similar to the general population.

2.3 The magnitude of mental illness in South Africa

Few epidemiological studies have been conducted on prevalence of mental illness in South Africa. The Stress and Health Study (SASH)[39] showed that in South Africa, "the most prevalent class of lifetime disorders was anxiety disorders (15.8%), followed by substance use disorders (13.3%) and mood disorders (9.8%). The most prevalent individual lifetime disorders were alcohol abuse (11.4%), major depressive disorder (9.8%) and agoraphobia without panic (9.8%)".[39]National epidemiological studies for severe mental illnesses like schizophrenia and bipolar disorder are not available in South Africa.[40]

Mental disorders account for considerable suffering, which affects both the individuals and their families. The loss of social and occupational functioning associated with mental disorders results in increased burden to the families and the society. The rates of poverty, complex trauma due to violent crimes and intimate partner violence are associated with increased 12 month and lifetime prevalence of mental disorders.[41]

Research suggests a high prevalence of mental disorders among people living with HIV (PLWHIV).[40] This is of particular concern because of high prevalence of

HIV in South Africa.[42] There is a growing evidence of increased risk of HIV infection for people living with mental illness as well as increased prevalence of mental illness in PLWHIV. Mental disorders in HIV positive patients should be identified and treated aggressively as they usually affect compliance,[40] consequently increasing morbidity and mortality rates.

In response to the overwhelming burden of mental illness, South Africa's Ministry of Health committed to increasing the number of people assessed and treated for mental disorders by 30% in 2030, and to reduce alcohol consumption by 20% per capita in 2020.[43] Unfortunately, the financial commitment to mental health has not been proportionate to this commitment because only three percent of the health budget is used on mental health.[26] Mental health services share funds with general health services and there is poor collection of information on the incidence and prevalence of mental disorders to guide appropriate budgeting for mental health.[44]

2.4 Mental health integration into general health care in South Africa

Integrating mental health care into PHC is a global priority.[45] It is an evidence-based intervention,[46] providing comprehensive community-based care that is easily accessible, equitable and less stigmatizing. This strategy of integration is intended to mitigate the increasing burden of mental illness with limited resources.[44]

In South Africa, mental health care remains fragmented and limited to specialist psychiatric care for severe mental illness,[26] and the specialist services remain the entry level of care for many patients.[39] There is also skewed distribution of mental health services with a bias towards mainly urban based, institutionalized services with few specialist psychiatric services in the rural areas, despite policies that prescribe less restrictive care to patients based in PHC.[44] Legislation and policy clearly show that moving mental health care from specialist level to community-based services is a necessity for South Africa and has several

benefits. PHC is a decentralized form of health care delivery with several benefits for patients, families and governments.[3] These benefits include improved quality and outcomes of medical care, accessibility to patients and families, the ability of patients to maintain their daily activities and have the support of their families. Further benefits include the ability of health workers to provide health education to families, reduction of stigma associated with mental health and affordability for governments because of low costs involved.[47]

Medical conditions like diabetes mellitus, cardiovascular conditions, cancer and HIV are commonly interwoven with psychiatric disorders.[36] Life expectancy in people living with mental illness is less than in the general population.[48] Therefore, integrating mental health into primary health optimizes the opportunity for screening for physical conditions. People with chronic physical illness like diabetes, cardiovascular disease, cancer and chronic respiratory illnesses are likely to have comorbid depression and anxiety disorders.[49] These mental illnesses if left undiagnosed and untreated compromise the individual's ability to cope with co-morbid illness, and to participate effectively in recovery process.[46] Most patients with psychosomatic conditions present to primary care settings with symptoms that cannot be explained.[50] This can lead to unnecessary referrals and treatment plans if not diagnosed and managed appropriately, and might further impose a financial burden on the already constrained finances.[44] Patients with severe mental illness often have comorbid physical conditions such as obesity, hypertension and diabetes mellitus which reduce their life expectancy.[51,52] Integrating their care into PHC will improve the screening and management of these comorbid conditions.

People suffering from mental disorders must be assessed periodically to exclude physical illness, and people with chronic physical conditions must be assessed for mental illness.[53,54] Comorbidity between mental health and general health requires a holistic approach.[50] Integration of mental health care into PHC is likely to improve patient outcomes.[55] In other parts of the world, integration has been

implemented successfully resulting in the improvement of the collaboration between the psychiatrist and PHC doctors.[3] With improvement of knowledge on mental illness, stigmatizing attitudes are also reduced, and the burden is taken off the costly specialist care.[44,46]

2.5 Attitudes towards mental health

An attitude in psychology, defines a set of emotions, beliefs and behaviors towards a particular person, object, thing or event. While attitudes can have a powerful influence over behaviour, attitudes can also be changed.[56] It is believed that a doctor's knowledge of mental illness influences his/her ability to interact effectively and to form therapeutic alliances with patients.[58] Much as that is the case, a study conducted in Kenya showed that knowledge of mental disorders does not reduce negative attitudes towards patients with mental illness.[16]

There are beliefs that health professionals do not have negative attitudes towards mental illness.[57] It is instructive to point out that positive and negative attitudes are formed routinely, and members of different health care disciplines are as susceptible to experiencing the same negative attitudes as members of the general population.[58] Mental health care users (MHCUs) are considered unpredictable and dangerous, and consequently get discriminated against resulting in them receiving inferior care than the general public.[58] The attitudes of health professionals in South Africa have been studied among nurses, with one study finding that the majority of nurses had a negative attitudes towards mentally ill patients.[58]

2.6 The role perspective

Integration has highlighted the important role of primary care practitioners in the management of psychiatric illnesses, in collaboration with community mental health services. Integration offers personalized, low stigma and cost-effective care.[46] International studies reveal varied understandings by the general

practitioners (GPs) of their role in the management of patients with mental illness in PHC.[1,59-63] In the first world countries like Canada, GPs accept the integrated care and are confident in their knowledge of mental illness. The GPs with easy access to specialist care are even more satisfied.[62]

Clatney et al[1] found that GPs viewed their role as follows: "monitoring treatment plans, participating in ongoing patient management, early detection and prevention of relapse, management of general health and referral to psychiatric special services". According to Kendrick et al.,[61] the GPs were willing to be responsible for physical care of their patients but were not willing to provide structured psychiatric follow up. In other studies, GPs viewed their role as limited to writing repeat script of psychotropic drugs. In the study conducted by Roberts et al.[62] most of the health professionals felt that the care for people with mental illness was too specialized for PHC. According to Marian Oud et al.[60] the GPs agreed that their role in acute phase was to assess the patients' condition and refer them to mental health care centers or prescribe the psychotropic drugs. Regarding the chronic phase, opinions of GPs differed, with the majority indicating that their role was limited to monitoring physical health.[63]

There are varied opinions of GPs across the world on their role in the assessment and treatment of mental illness. For integration to be successful in South Africa, the role perspective of South African GPs about the management of mental illness must be established.

2.7 Progress made towards integration in South Africa

Progress towards integration of mental health into general health has been slow, despite progressive and enabling policies and legislation.[20,44] Approximately 80-85% of the population in South Africa is dependent on the state for their health needs, with 16% of the population purchasing care from the private sector through medical schemes and out of pocket payments.[44] In 2019, South Africa released the National Health Insurance (NHI) Bill confirming its commitment to

Universal Health Coverage, aimed at providing equitable health care, without incurring financial difficulties at the point of service for all South Africans, including people with disabilities.[39]

The Intervention of WHO and the NMHPF & SP model for provision of mental health care clearly outlines that community based mental health services are the mainstay of psychiatric care with the hospitals providing acute relief.[21] In the NMHPF & SP it is envisaged that community mental health services will be reorganized in a way that facilitates task sharing and collaborative care.[39] This will enable the smooth transition to integration, as the psychiatric specialist will be enabled to provide training and mentoring of primary care doctors while managing the difficult patients.[64]

Despite these reforms in policies, integration of mental health care into PHC in Gauteng Province has not taken place. PHC practitioners have been trained by the Community mental health services (CMHS) psychiatrists and psychiatric nurses in the assessment and management of psychiatric disorders.[64] Specialist District services already exist in Gauteng Province, provided by the University of Witwatersrand, through Psychiatric registrars and medical officers supervised by a psychiatrist. The psychiatric registrars and medical officers assess, diagnose and manage all patients referred to the mental health clinics. The nursing staff is in charge of community mental health clinics, reviewing patients and issuing monthly repeat medications. Few stable patients have been down referred to PHC and PHC nurses only supply repeat medication. The psychiatric medical officers or registrars review the patients at six monthly intervals.

There are few examples of successful integration of mental health into general health throughout the country. A few examples include integration in Ehlanzeni District in Mpumalanga Province and Mooreesburg District in Western Cape Province and these may have happened out of necessity.[3] Additionally, there is the involvement of a district psychiatrist.

Mpumalanga Province has three districts, which are Ehlanzeni, Gert Sibande and Nkangala with a population of 4,3 million in 2016.[65] In Ehlanzeni district, the patients are managed by Professional nurses, but the model of care varies from clinic to clinic.[3] One of the models used is such that psychiatric patients are managed like all other patients attending the clinic. The nurses assess and treat patients with common mental health problems and refer patients that have severe mental illness to the district psychiatrist. They also intervene in a crisis and make referrals to complementary services if available. The other model is designed such that a designated Professional nurse sees patients. The psychiatric patients do not wait in queues with other patients. They visit the clinic per appointment. Both models work collaboratively with the district mental health coordinator i.e. a trained psychiatric nurse, and medical doctor. There are general nurses who are also trained to detect mental illness and refer to the psychiatric nurses.[3]

Mooreesburg District in Western Cape Province is another example where some integration has taken place. Professional nurses manage psychiatric patients in primary care clinics and refer complicated cases to the psychiatric nurse. The psychiatric nurses also initiate treatment in consultation with the regional psychiatrist. The psychiatrist visits the clinic once in three months to see patients who are unstable.[3]

In an attempt to address the mental health gap and align themselves with WHO, mental health Gap Action Programmed intervention Guide (mhGAP-IG), Program for Improving Mental health care (PRIME) was formed in 2011.[66] The aim of PRIME is to generate evidence on the implementation and scaling up of integrated packages of care for priority mental health disorders in primary and maternal care contexts in Ethiopia, India, Nepal, South Africa and Uganda.[67] In South Africa, quality improvement initiatives from PRIME were to facilitate transition to patient -centered care, and management of chronic disease in PHC

clinics.[68] In settings where specialist staff is scarce, technology platforms such as the internet can be used to facilitate specialist support.[39]

In another bid to close the gap in mental health delivery the Africa Focus on Intervention Research for Mental Health (AFFIRM) was conducted in South Africa and Ethiopia.[69] The aim of AFFIRM was to build capacity of individuals and institutions to participate in research projects in mental health by providing them with research skills.

2.8 State of integration in other parts of the world

In countries like Canada, Argentina in the Neuquén District, Australia, Chile, Brazil, India and Saudi Arabia, most PHC doctors diagnose, treat and rehabilitate patients with severe mental illness. Mental health disorders are managed like other health problems. They use the collaborative care model. Over time, the PHC physicians have become competent.[3]

Collaborative care model is one of the effective approaches used to deliver integrated mental health in PHC.[70] PHC doctors, professional nurses and the community mental health psychiatrists work together to provide mental health care and monitor patient progress. Collaborative care involves coordination of care, regular monitoring using evidence-based medicine, and regular and systematic reviews and consultation for patients who do not show clinical improvement.

2.9 Models of care in the integrated health care

Collaborative models with their origins in Britain are some of the models of care that have been implemented in integrated health with significant benefits for mental health care. In a collaborative model there is accessibility, stigma is reduced, treatment adherence improved, knowledge and skills transfer to the family physician can be achieved. Collaborative models can lead to early detection of mental illness, early intervention and improved outcomes and better

use of limited psychiatric resources.[71] The collaborative model can be used effectively in Soweto to achieve integration.

Craven et.al.[71] conducted a study in Ontario to assess the interaction between the psychiatric departments and family medicine. The family physicians in most provinces reported that they had problems in accessing psychiatric specialist services, experienced poor communication between psychiatric services and family physicians, and lack of continuity of care.[71]

MHPF&SP in South Africa outlines how integrated care will be implemented. Mental health training programs for general health staff will be conducted at PHC level, thereafter ongoing mentoring and support will be done by the specialist mental health teams. The protocols for management of mentally ill patients will also be formulated.[21]

The shifted model of care is frequently used and it entails the secondary psychiatric services within the PHC facility instead of the hospital site. In this model, the psychiatrist works with the psychiatric nurses to provide care to patients. There is minimal contact between the psychiatrist and the primary care physician.[72] The shifted model cannot work in South Africa as there are only 600 psychiatrists for a population of about 55 million.[26]

The consultation-liaison model is a model, where the psychiatrist sees patients that are referred by the family physician. In the consultation-liaison model, there is optimal interaction with the family physician and skills can be transferred. The physician and the psychiatrist work together to formulate a treatment plan, therefore support for the family physician with difficult cases, and reinforce continuity of care.[73]

WHO[73] described task shifting as the training of non-specialist health workers by the specialist health care personnel in order to optimize the human resource to

compensate for the shortage of specialists and to close the gap in the provision of health care. Task sharing enables the transfer of skills like screening, diagnosis, treatment of common mental disorders and counseling.[55] The benefits of task sharing are that it is cost effective, it improves accessibility of mental health care and reduces the stigma of mental disorders.[3] The limitation of task shifting and task sharing is that available studies have not tested their effectiveness.

World Health Assembly adopted the WHO Comprehensive Mental Health Plan 2013-2020,[74] which called for provision of a comprehensive, integrated and responsive mental health care based in community. In South Africa, one of the strategies that can be used to achieve a comprehensive and integrated mental health care is through task sharing because of shortage of mental health specialists, both psychiatric nurses and psychiatrists.[75] Studies have evaluated the feasibility and acceptability of task sharing. Research like AFFIRM[69] was conducted to provide evidence-based effectiveness of task sharing in lower and middle-income countries. Maconick, et al.[55] conducted a study on task sharing in Conville Community Health Centre in the Eden district, and discovered that it was feasible but longer-term training, follow up and support was necessary.[55]

CHAPTER 3
RESEARCH METHODOLOGY

3.1 Introduction

The research methodology provides an entire strategy and defines structures within which the study is implemented.[76] This study used a cross sectional design with a quantitative approach. The main aim of the study was to determine attitudes and the role of medical doctors working in PHC in Soweto towards integration of mental health care into PHC. This chapter presents a detailed description of the methods used in the study. First, the design and the approach employed are discussed. Second, procedures used in sampling method and selection of the study population are well explained. Third, the data collection tools, and the procedures and processes for data analysis, as well as strategies regarding validity, reliability, and bias are explained. The study adhered to ethical considerations as discussed below.

3.2 Research design and method of approach

3.2.1 Study design

Burns and Grove[77] define a research design as a blueprint for conducting a study. It maximizes control over factors that could interfere with the validity of the findings or the entire strategy from identification of the problem to final plans for data collection. This study used a descriptive cross sectional design to determine the perceptions, attitudes and understanding of medical doctors working in PHC in Soweto towards integration of mental health care into PHC. The study was conducted between December 2015 and January 2016.

3.2.2 Method of approach

The study employed a quantitative method. Quantitative research is defined as a formal, objective, systematic process in which numerical data are used to obtain information.[77] The approach is used to describe variables, examine relationships

among variables and to determine cause-and-effect interactions between variables.[77] This study only described the variables. A structured questionnaire with close-ended questions, and minimal open-ended questions, was administered to medical doctors working in PHC in Soweto.The questionnaire was adapted from study that was conducted in Netherlands in 2009, on the care for patients with severe mental illness was administered to medical doctors working in PHC in Soweto.[60]

3.3 Study population

The study population and the setting used in this study are described in this subsection.

3.3.1 Population

According to Brink, “a population is defined as the entire group of persons or objects that is of interest to the researcher, meeting the criteria needed to achieve the objectives of the study.”[78] The population of interest in this study was medical doctors working in PHC in Soweto.

3.3.2 Study Setting

The study setting is defined as a physical, social and cultural area where data is collected.[79] The study was conducted in Soweto, the biggest township in South Africa, situated in of the City of Johannesburg Metropolitan Municipality in Gauteng Province. Soweto is inhabited by over two million people.[80] There are two public hospitals, namely, Chris Hani Baragwaneth Academic hospital, a central hospital and Bheki Mlangeni Hospital, a district hospital. There are also two private hospitals that provide specialist care. There are 17 PHC clinics, which are divided into sub district D1 and D2, and only 10 of these clinics offer mental health care services. The study focused on PHC services, which have 67 doctors

and was conducted in Lillian Ngoyi PHC, a facility where all doctors in PHC in Soweto meet every Friday morning for in-service training.

3.4 Sampling

Sampling is defined as the process of selecting a portion of the population to represent the whole population.[81] The study used a non-probability sampling method, defined as the sample population selected in a non-systematic process that does not guarantee equal chances for each subject in the target population.[82,83]

3.4.1 Sampling and recruitment

Convenience sampling was used to select respondents. Convenience sampling is the most applicable and widely used method in clinical research. In this method, the investigators enroll subjects according to their availability and accessibility.[84] The advantage of this sampling method is that it is quick, inexpensive, and convenient. It is called convenient sampling as the researcher selects the sample elements according to their convenient accessibility and proximity.[82,85] During the time of the study, the researcher recruited doctors while attending their in-service training. Forty-one (n=41) medical doctors from the two in-service training meetings were recruited to participate in the study and all of them gave written consent.

3.4.2 Sample size

A sample is a subset of a population consisting of those selected to partake in a study.[81] There were 67 doctors working in the PHC clinics in Soweto in the period from December 2015 to January 2016. In this study, the sample was drawn from the population of doctors who attended in-service training in Lillian Ngoyi PHC and 41 were available and accessible at the time of the study, but only 30 doctors were legible to participate and eventually 30 participated.

3.4.3 Inclusion and exclusion criteria

Burns and Grove[77] define the criteria for inclusion into a study as a list of characteristics essential for eligibility in the target population. All medical doctors working in the PHC in Soweto, both part-time and full-time were included in the study. The study excluded doctors who were doing their internship and community service doctors, as well as medical doctors who did not consent to participate.

3.5 Data collection

Data collection is the process of choosing research subjects and collecting data from them. It involves the steps, procedures and strategies for gathering as well as analysing data in a research investigation.[77]

3.5.1 Data collection tool

The researcher developed a questionnaire based on available literature in English on the subject. The questionnaire was self-administered considering the busy schedules and levels of literacy of medical doctors. This study established a standardized six-page English self-administered questionnaire, based on a five-point scale to collect data from the relevant respondents. The author developed the questionnaire by adapting a questionnaire of a study that was conducted in Netherlands in 2009, on the care for patients with severe mental illness, focusing on the general practitioners' role perspective.[60] An attempt was made to obtain permission to use the Netherlands questionnaire by writing emails to the authors. The questionnaire was made up of the following sections (Appendix II):[60]

- Characteristic title consisting of eight sub elements such as the basic demographics and practice employment history, respondents' feelings regarding psychiatric disorders and views on how they should be treated.

- Tasks in the acute and long-term phase, how chronic psychiatric patients ought to be treated, whether they think it is their job to monitor medical comorbidity in chronic psychiatric patients or not.
- Care for family which consisted of two sub elements.
- Self-experienced competencies consisting of five sub elements to test whether the respondent feels competent enough to treat mentally ill patients or not.
- Need for continual professional training and development in mental health to enable doctors to communicate with psychotic patients. This tested for the respondents' knowledge of mental health, and self-perceived competence in providing mental health care to their patients.
- Attitudes towards mental health care provision.

The questionnaire has a five-point scale with agree, strongly agree, neutral, disagree, and strongly disagree variables. Attitudes towards mental health were examined by asking respondents to agree or disagree with a series of attitudinal statements to test doctor's mental health literacy. This section has nine (9) elements testing whether the respondents believe that medication given to patients results in improved mental stability or not, whether they think mentally ill patients might need some counselling or not.

The last section has two open ended questions soliciting the respondents' opinion regarding the barriers towards the successful integration of mental health care programs into PHC and secondly, their recommendations to improve the program to suit the needs of the patients or community members. The adaptation of open-ended questions to some functions in quantitative surveys for which they have not previously been used, or used only rarely, tends to result in more respondent-focused surveys and more accurate and useful data. First, the researcher explained the purpose and the rules of the study to the selected respondents gathered in one place and an information leaflet containing all

necessary information (Appendix I) was distributed. Second, written consent was obtained before the questionnaire was distributed and the questionnaire was distributed to the doctors after the in-service training meeting. Finally, a box was provided into which the respondents were requested to drop their completed questionnaires. The questionnaire was self-administered and took 20-30 minutes to complete. Duplication of respondents was avoided by using identification codes. The researcher collected the boxes with questionnaires from the facility for capturing and analysis.

3.5.2 Pilot study

According to Polit and Beck,[81] a pilot study is a small version or trial done in preparation for a major study. It serves the purpose of identifying any problems with the design, sequence of questions, and procedure for recording responses. With reference to this research, the pilot study enlightened the researcher about the duration of each interview and the appropriateness of the setting as well to the need to establish adequacy of study methods and procedures.[86] The questionnaire used in this study was pretested to five (5) medical doctors who were conversant with mental health care services but not working in Soweto PHC where the study was conducted. The outcome of this pilot study was not included in the results of the main study, but informed subsequent efforts to improve and refine the practical aspects of the main study.

3.6 Reliability, Validity and Bias

Brink[78] mentioned that rigour is a principle of truth-value concerning the research outcome and strives for excellence through precision and accuracy. Accuracy is comparable to validity in that it addresses the extent to which the instrument measures what it is intended to in a study, while precision is the degree of reproducibility of measurements made with physiological instruments and is comparable to reliability.[76] This study adhered to the standard procedures of data collection to ensure that the tool produces stable and consistent results (i.e.

reliability) and it measured what it was supposed to measure (i.e. validity). Bias is defined as any tendency, which prevents unprejudiced considerations of sampling or data collection.[76]

3.6.1 Reliability and validity

In this study, the researcher established specific measures to ensure reliability of the data collection instrument. The self-administered questionnaire was tested and retested before the main study was conducted, while for validity, face and content validity were applied. Face validity refers to whether the instrument appears to be measuring the target construct[81] and this was ensured through experts' judgement to make sure that the questionnaire will measure what it intended to measure. Content validity examines the extent to which measurement includes all the major elements relevant to the construct being measured[81] and it was achieved by making use of experts in the field and reference to the literature review.

3.6.2 Bias

Potential selection bias was unavoidable since the number of medical doctors in the selected facility was small. Information bias was minimized by administering the same questionnaire to all respondents. Potential recall bias, which refers to the phenomenon in which the outcomes may be confused by the respondents' inability to recollect events accurately, was reported in the limitations of the study since the respondents might not have been able to recall some of their involvement, encounters and experiences on duty in the past days, weeks, months or years. The questionnaire was self-administered, which might have also introduced bias. Nonetheless, respondents were advised to keep information confidential and not discuss with colleagues.

3.7 Data analysis

Data analysis is a consolidation of information by systematically applying statistical and logical techniques to describe, illustrate and evaluate data to present a clear picture, but without disclosing the implications (Rebar et al, 2011). After data collection, all data were captured on a Microsoft Excel spreadsheet 2013. The researcher cleaned, validated and coded the collected data. Data were imported into small STATA (Intercooled Stata® Version 14) for statistical analysis. Descriptive analysis included the mean [standard deviation (SD)] for numerical values, while the continuous variables were studied through frequencies (n) and percentages (%). A five-point scale with agree, strongly agree, neutral, disagree, and strongly disagree variables was used. The scale was collapsed into three, i.e. agree, disagree and neutral during data analysis. Although a sample of 30 is sufficient for a statistical analysis, inferential statistics, especially comparing respondents by gender could not be done due to some cells having five or less entries.

Quantitative content analysis is the classical method of analysing responses to open-ended questions. One or more coders code the open responses based on a predefined categorisation scheme. The procedure can be outlined only in brief here.[87] In this case, the open-ended questions were analysed through content analysis to group the perceptions of respondents on barriers towards integrating mental health care into PHC.

3.8 Ethical considerations

The Human Research Ethics of the University of Witwatersrand granted ethics clearance [M151027]. Permission to conduct the study was also obtained from District Research Committee.

The researcher designed a comprehensive information sheet in English concerning the study. The risks, benefits, and the rights of the subjects, were

explained to all respondents. **Written consent** was obtained from the respondents prior to distributing the questionnaire. The researcher maintained **confidentiality and anonymity** by making sure that respondents' identity remained protected at all stages of the research. The study's unique codes were not linked to names and surnames. To maintain ***privacy***, patients were only approached to participate in this research in a separate room where there was privacy and individualised attention.

3.9 Summary

In this chapter, the researcher explained the use of a descriptive cross-sectional study design and a quantitative approach to determine the attitudes and the role of medical doctors working in PHC in Soweto towards integration of mental health care into PHC. The section described the study setting and population in detail. Furthermore, the sample size, sampling procedure, recruitment, data collection tool and procedures were discussed. Quality assurance of the study was maintained through validity, reliability, and minimizing bias. Descriptive statistics (i.e. data analysis) was computed through STATA software and content analysis grouped the perception of respondents on barriers towards integration of mental health care in PHC. The ethical principles adhered to in this study were discussed

CHAPTER 4
RESULTS

4.1 Introduction

A cross sectional design was used in the study and a quantitative method was employed. The aim of the study was to determine the perception, attitude and roles of medical doctors towards integration of mental health care into PHC. The study was conducted in Lillian Ngoyi PHC, Soweto. Data were collected on the basic demographics, tasks in the acute and long-term phase, care for family, self-experienced competencies, need for continual professional development, attitudes regarding mental health care provision and perceptions on the barriers towards the successful integration of mental health care programs into PHC. Data analysis was done using STATA 14 for the descriptive (i.e. frequency and percentages) and inferential statistics (i.e. chi-square test) for comparison.

4.1.1 The objectives of the study and results presentation are as follows:

- To describe the demographics of PHC doctors (**Section A**).
- To assess understanding of mental illness by PHC doctors (**Section B**).
- To assess the attitude of PHC doctors and their role in caring for patients with mental illness (**Section C**).
- To determine the perceptions on barriers towards the successful integration of mental health care programs into PHC (**Section D**).

SECTION A

4.2 Demographic characteristics

This section presents the demographic characteristics of respondents on age, gender, and practice employment history, respondent's feelings regarding psychiatric disorders and views on how they should be treated.

4.2.1 Gender distribution

Figure 4.1 shows the distribution of respondents by gender.

A total sample of 30 medical doctors was obtained for the study. Males were nine (30%) and females were 21 (70%).

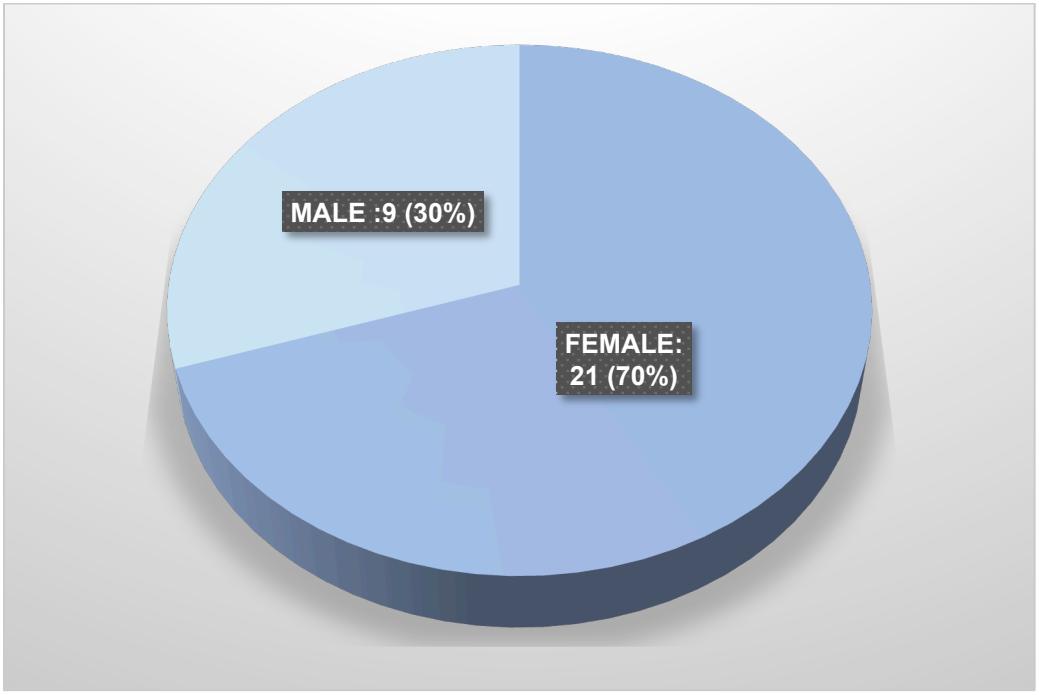


Figure 4. 1: Gender distribution of respondents

4.2.2 Age distribution

Figure 4.2 shows the distribution of respondents by age. Two age groups were created; ≤30 years and >30 years. The results showed that 14 (46.7%) of the respondents were aged ≤30 years while 16 (53.3%) were aged above 30 years.

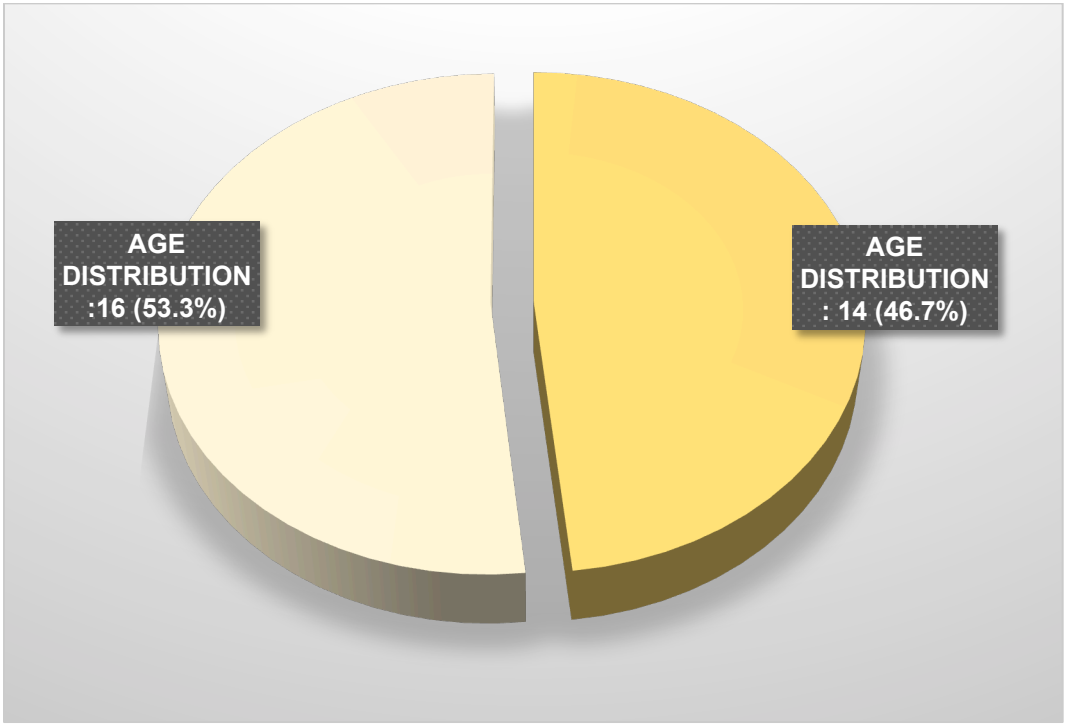


Figure 4. 2: Distribution of respondents by age groups

4.2.3 Distribution of work experience by years

Figure 4.3. shows the distribution of work experience by years. The results show that 23 (77%) of the respondents had work experience of ≤20 years while seven (23%) had worked for over 20 years.

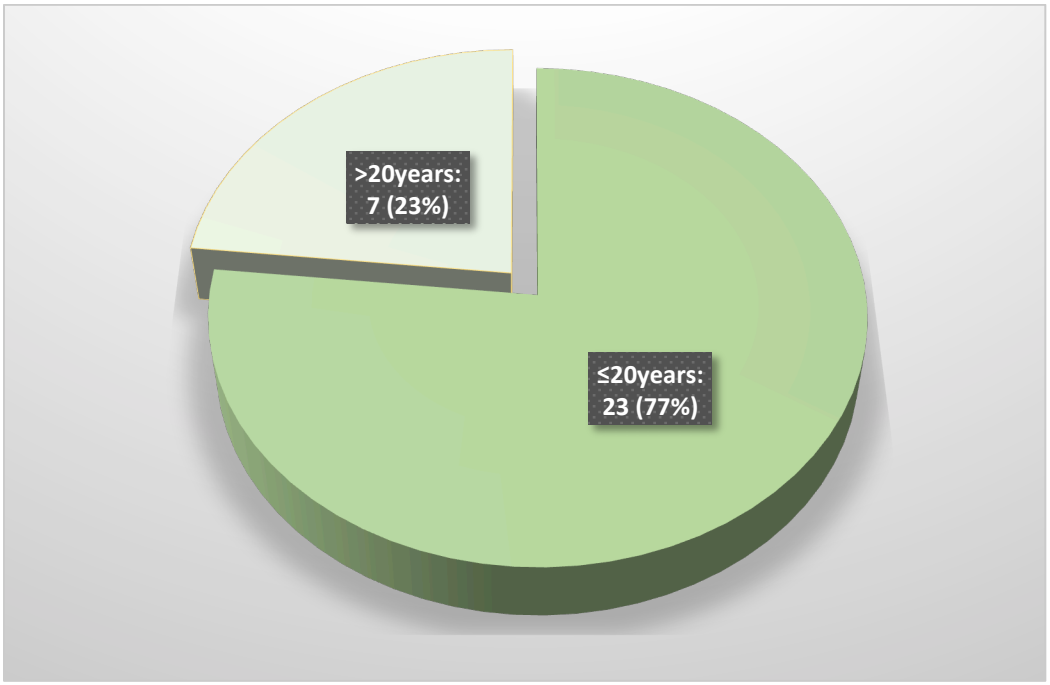


Figure4. 3: Distribution of work experience by years

4.2.4 Work experience by age and gender

Most of the respondents with work experience ≤20 years were females (n=19 or 82.6% of this group) while only 8.7% of females (n=2) had work experience of over 20 years. For males 44% (n=4) and 56% (n=5) had work experience of ≤20years and above 20 years, respectively.

Figure 4.4. shows work experience by age groups. All respondents aged ≤30years, that is 14 of them, had worked for ≤20 years.

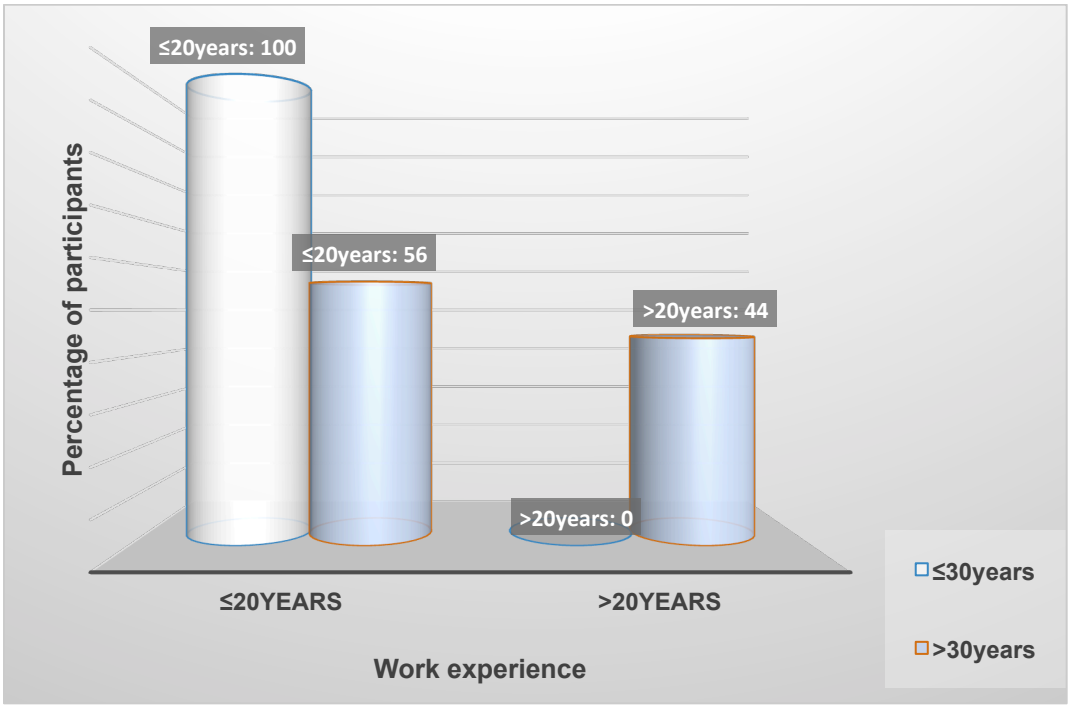


Figure 4.4: Work experience by age groups

4.2.5 Knowledge of psychiatric conditions

Table 4.1. shows the doctors' knowledge of psychiatric conditions. Results are presented as frequency (n) and percentage (%). When respondents were asked about adequate knowledge on psychiatric disorders, 53% (n=16) said they did have adequate knowledge, while 47% (n=14) said they did not. All respondents 100% (n=30) thought that psychological factors can influence the origin of physical illnesses. 73%(n=22) indicated that they treated some psychiatric patients in a clinic. Almost all Medical Doctors, (97%) indicated that they had referred some psychiatric patients to psychiatrists

Table 4.1. Knowledge of psychiatric conditions

Questions	n	%
Do you have adequate knowledge of psychiatric disorders?		
Yes	16	53
No	14	47
Do psychological factors influence origin of physical illnesses?		
Yes	30	100
No	0	0
Do you treat some psychiatric patients in your clinic?		
Yes	22	73
No	8	27
Do you refer some psychiatric patients to psychiatrists?		
Yes	29	97
No	1	3

SECTION B

4.3 Understanding of mental illness

This section presents the results on tasks in the acute and long-term phase of patient care, care for family, self- experienced competencies and need for continual professional development.

4.3.1 Tasks in the acute and long-term phases of patient treatment

This section presents the tasks in the acute and long-term phases of treatment of patients in the PHC setting.

4.3.2 The GP as a first contact for acute confusion

The results showed that 63% (n=19) of the respondents agreed that the GP is the first contact for acute confusion. However, 20% (n=6) of the respondents disagreed while 17% (n=5) were neutral (figure 4.5).

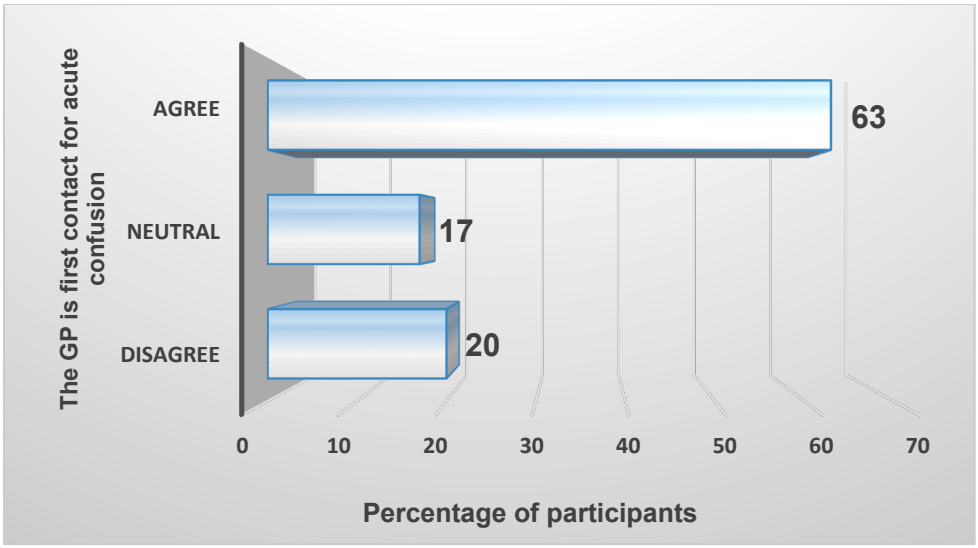


Figure 4.5: The GP as a first contact for acute confusion

4.3.3 Responsibility for the care of chronic psychiatric patients

Figure 4.6 shows that 30% (n=9) of respondents felt responsible for the care of chronic psychiatric patients in PHC while 43% (n=13) disagreed and 27% (n=8) were neutral.

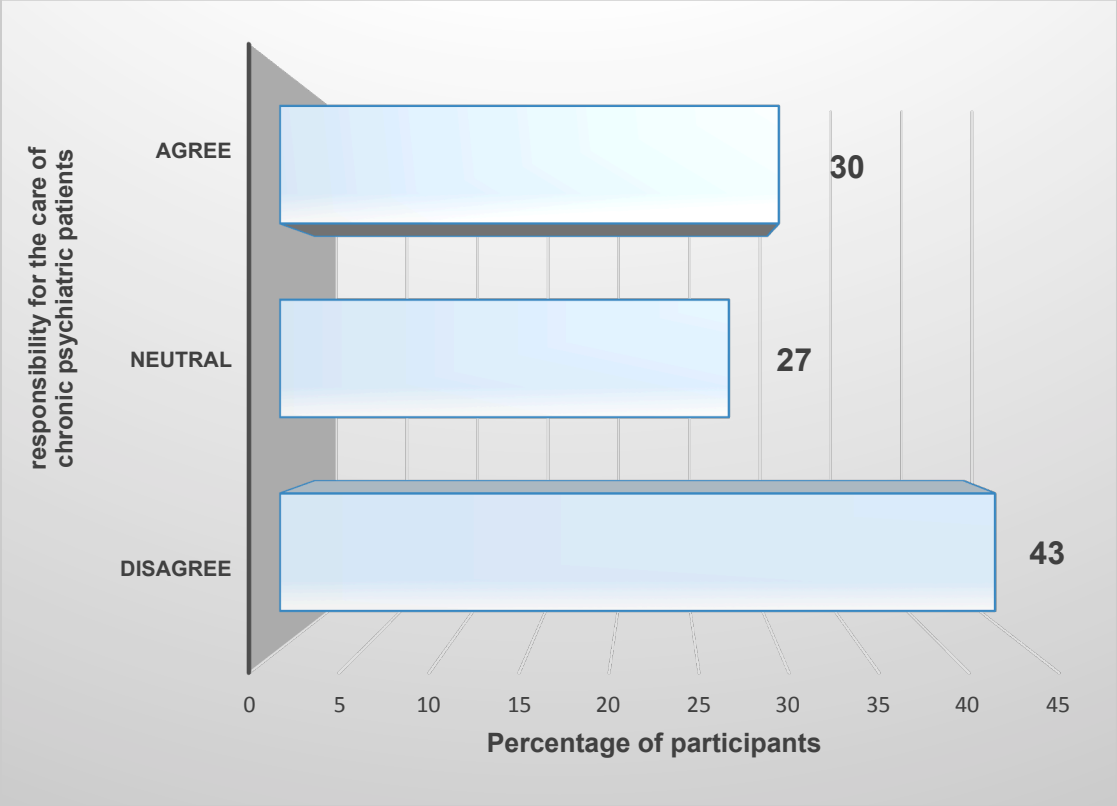


Figure 4.6: Responsibility for the care of chronic psychiatric patients

4.3.4 Psychiatric patients' ability to take care of themselves

The results showed that 30% (n=9) of the respondents agreed that it was their responsibility to check on a psychiatric patients' ability to care of themselves while 43% (n=13) disagreed and 27% (n=8) remained neutral (figure 4.8).

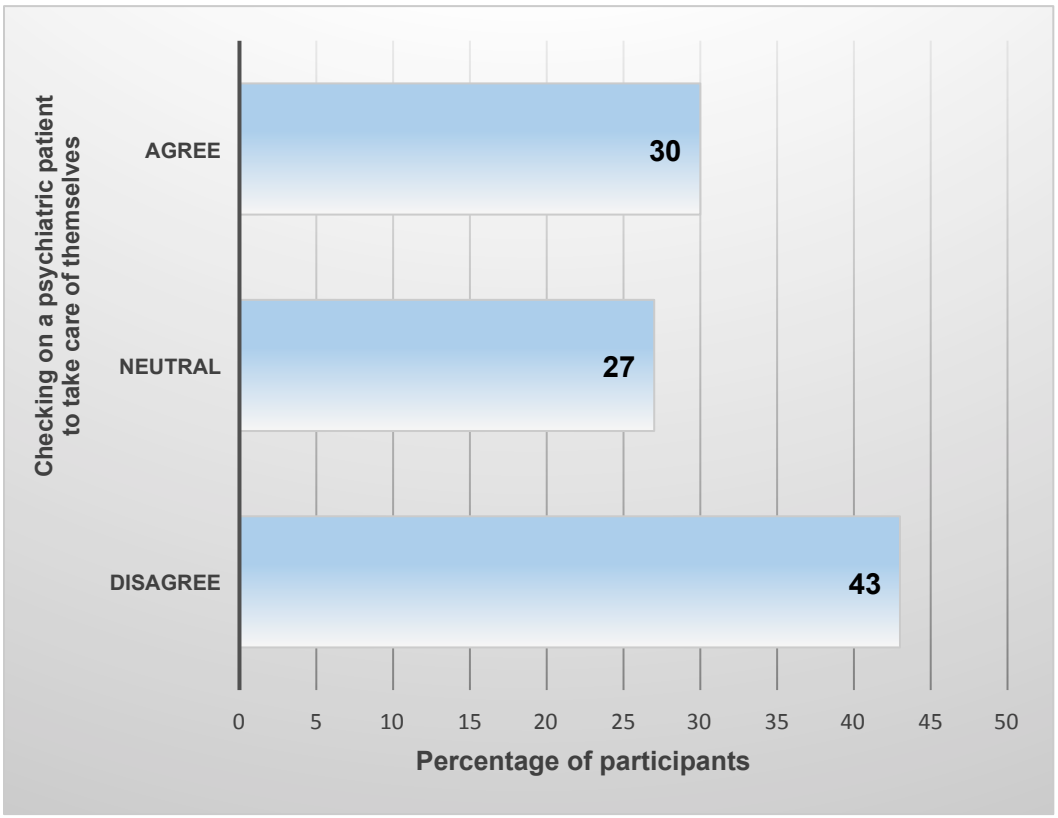


Figure 4.7: Psychiatric patient's ability to take care of themselves

4.3.5 Supporting the family of a chronic psychiatric patient

Figure 4.8 shows the perceptions of the respondents on their roles and responsibilities in supporting families of a chronic psychiatric patient. Results revealed that 56% (n=17) agreed that they considered it their responsibility to support the family of a chronic psychiatric patient. However, 17% (n=5) of the respondents disagreed with the assertion while 27% (n=8) were neutral.

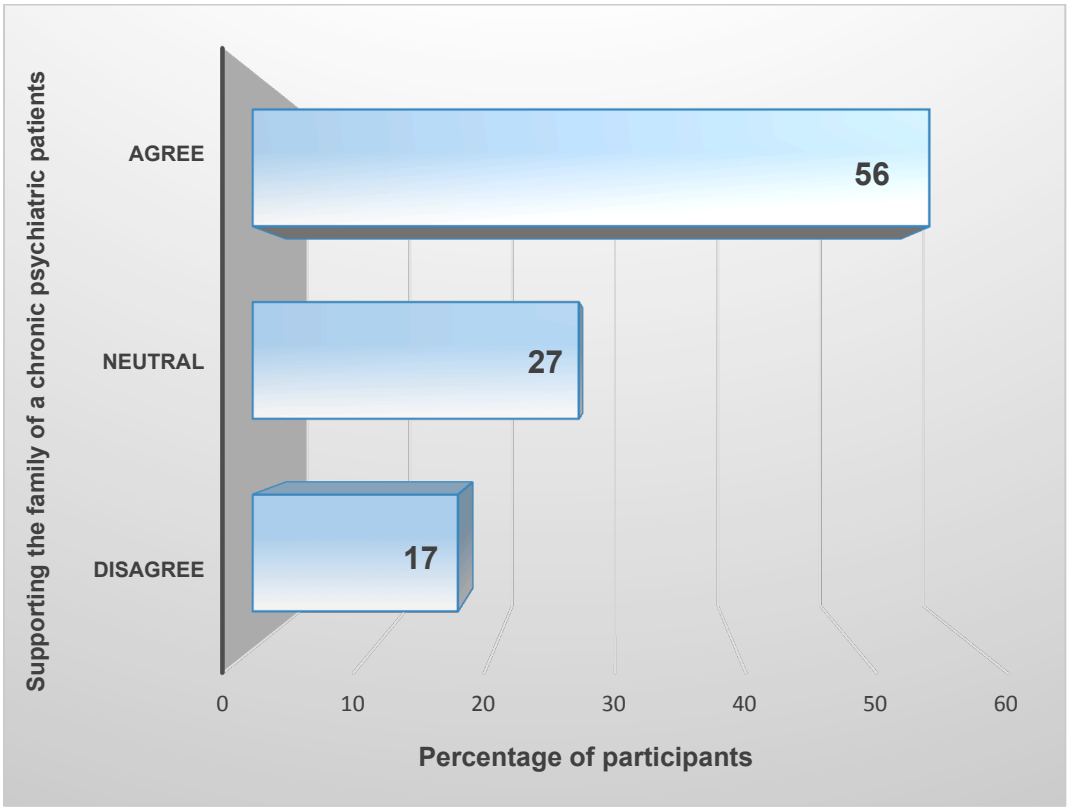


Figure 4.8: Supporting the family of a chronic psychiatric patient

4.3.6 Managing somatic comorbidity in chronic psychiatric patients

Figure 4.9. shows that 27% (n=8) agreed to managing somatic comorbidity in chronic psychiatric patients while 53% (n=16) of respondents disagreed and 20% (n=6) were neutral.

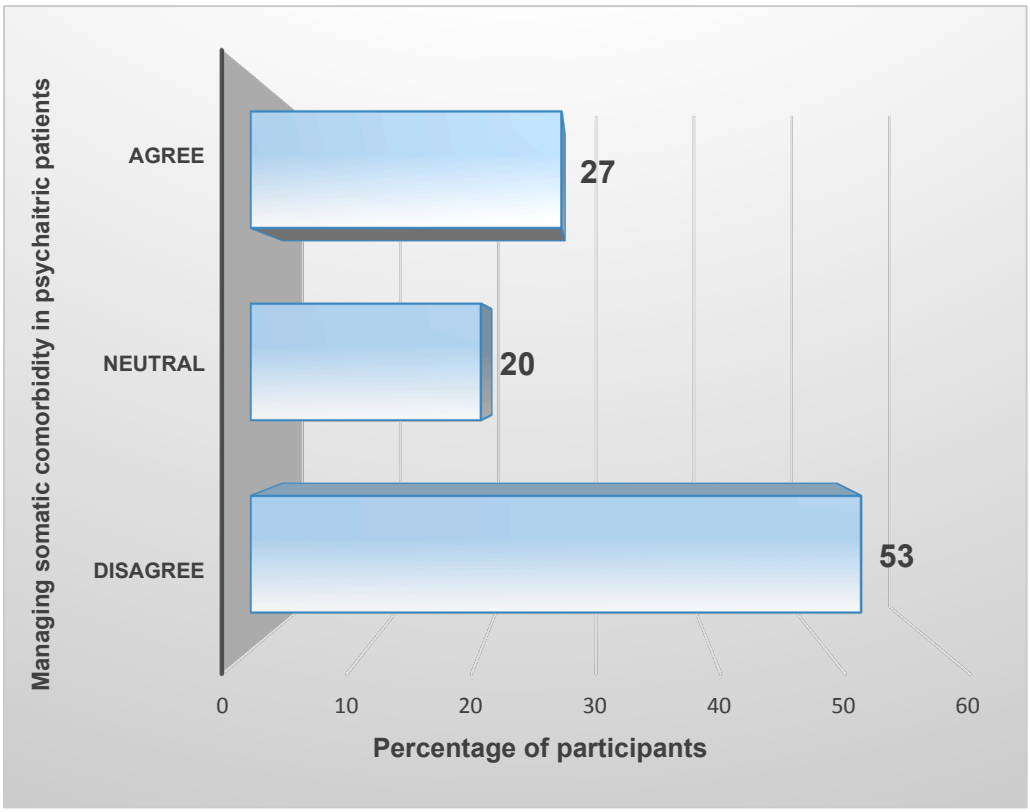


Figure 4.9: Managing somatic illnesses in chronic psychiatric patients

4.3.7 Care for the family

Under family care, respondents indicated that they considered providing information on the condition of the patient to the family of a chronic psychiatric patient. In addition, they were also willing to support the families of patients with chronic psychiatric conditions.

4.3.8 Providing information to family on condition of the patient

Figure 4.10 shows that 72% (n=22) of the respondents agreed that it was their responsibility to provide information on the condition of a chronic psychiatric patient to the family. However, 14% (n=4) of the respondents disagreed while 14% (n=4) remained neutral.

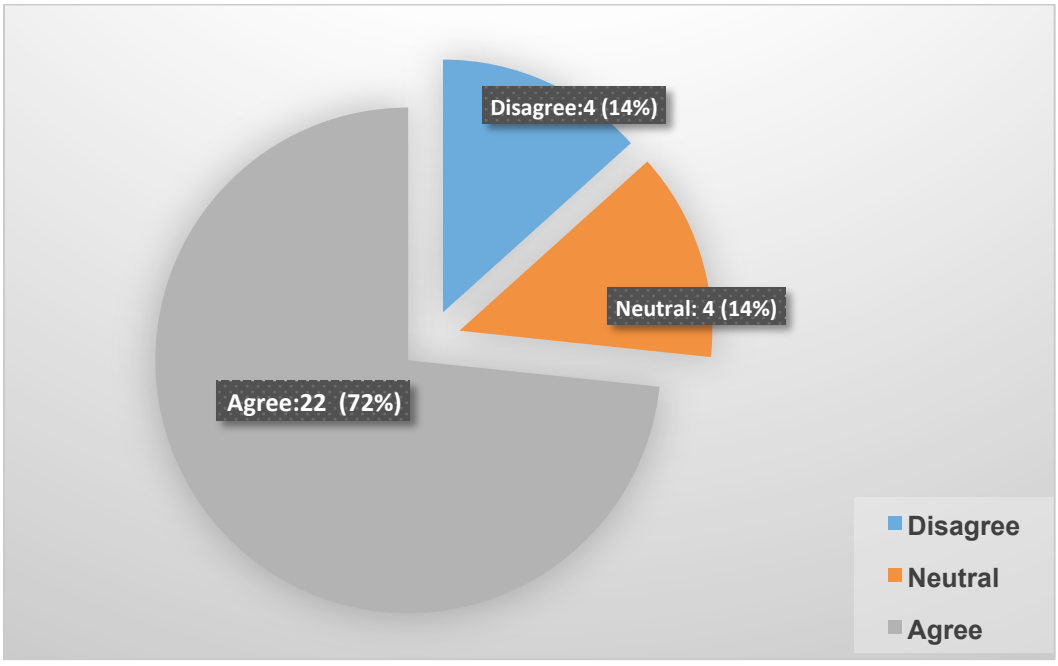


Figure 4.10: Providing information to family on clinical condition of patients

4.3.9 Supporting the family of a psychiatric patient

Results on supporting the families of a chronic psychiatric patient are presented in figure 4.11. The findings showed that 56% (n=17) of the respondents agreed with this assertion while 17% (n=5) disagreed and 27% (n=8) were neutral.

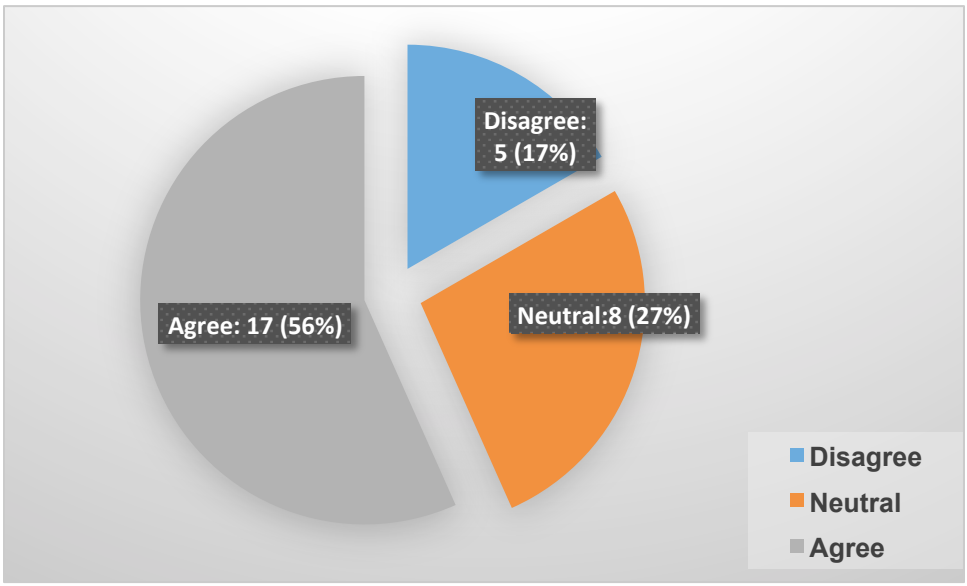


Figure 4.11: Supporting the family of a psychiatric patient

4.3.10 Self-experienced competencies

Table 4.2. shows self-experienced competencies of respondents. Half of respondents (50% or n=15) indicated that they felt competent in making contact with patients in a psychiatric crisis, while 43% (n=13) indicated they felt competent to intervening in crisis and 60% (n=18) said they felt competent in communicating with family in a psychiatric crisis. Over half [53% (n=16)] of the respondents felt that they were not powerless in psychiatric crisis, 27% (n=8) reported that they felt powerless, while 33% (n=10) reported that they felt unsafe near an acute psychotic patient.

Table 4.2. Self-experienced competencies of respondents

Statements on self-experienced competencies	n	%
I feel competent in making contact with a patient in a psychiatric crisis		
Agree	15	50
Neutral	10	33
Disagree	5	17
I feel competent in intervening in crisis		
Agree	13	43
Neutral	12	40
Disagree	5	16
I feel competent in communicating with the family in a psychiatric crisis		
Agree	18	60
Neutral	7	23
Disagree	5	16
I feel powerless in a psychiatric crisis	8	26
Agree	6	20
Neutral	16	53
Disagree		
I feel unsafe near an acute psychotic patient		
Agree	10	33.3
Neutral	10	33.3
Disagree	10	33.3

4.3.11 Need for continual professional development

This section presents the need for a continual professional development (CPD) and results are shown in Table 4.3. Sixty-three percent [63% n=19)] of respondents indicated that they needed a CPD for training and guidance on communicating with psychotic patients, 77% (n=23) on interventions in a psychotic crisis, and 77% (n=23) on antipsychotic pharmacotherapy.

Table 4.3. Need for continual professional development

Statements on need for CPD	n	%
I need CPD training and guidance on communicating with psychotic patients		
Agree	19	63
Neutral	6	20
Disagree	5	17
I need CPD training on interventions in a psychotic crisis		
Agree	23	77
Neutral	4	13
Disagree	3	10
I need CPD training on antipsychotic pharmacotherapy		
Agree	23	77
Neutral	6	20
Disagree	1	3

SECTION C

This section presents the attitude of respondents towards integration of mental health care services into PHC.

4.4 Attitudes regarding mental health care provision

The respondents were presented with statements to elicit their attitude towards mental health service provision in the community. Most respondents [77% (n=23)] indicated that the number of patients presenting with signs and symptoms of mental health problems is increasing. Respondents further indicated that an underlying biochemical abnormality (63%) is at the basis of severe mental health problems, and not personal weakness (80%). Half (50%) of the doctors indicated that working with patients with mental illness was difficult. Respondents (66%) felt that they had sufficient knowledge to care for patients with mental illness and over half (56%) felt that counseling for mental health problems should be left for specialists.

Table 4.4 Attitudes regarding mental health care provision

Attitudes regarding mental health care provision	n	%
The number of patients presenting with signs and symptoms of mental health problems is increasing		
Agree	23	77
Neutral	6	20
Disagree	1	3
The majority of mental health problems that I see originate from patient's recent misfortune.		
Agree	9	30
Neutral	12	40
Disagree	9	30
An underlying biochemical abnormality is at the basis of severe mental health problems		
Agree	19	63
Neutral	7	23
Disagree	4	13

Medication is more beneficial than counseling for patients with mental health problems		
Agree	9	30
Neutral	9	30
Disagree	12	20
Mental health problems are a sign of personal weakness		
Agree	3	10
Neutral	3	10
Disagree	24	80
Working with patients with mental illness is difficult		
Agree	15	50
Neutral	10	33
Disagree	5	17
PHC doctors have little to offer patients with mental illness		
Agree	5	17
Neutral	5	17
Disagree	20	66
Counseling for mental health problems should be left for specialists		
Agree	8	27
Neutral	5	17
Disagree	17	56

SECTION D

To be able to get the perception of respondents, open ended questions were used in this section and content analysis was done to group the opinions. Respondents were ask about the barriers towards the successful integration of mental health care programs into PHC.

4.3 Perception on barriers towards the successful integration of mental health care programs into PHC

The most cited barriers were overcrowding in the PHC clinics, complexity of assessing a psychiatric patient, including time taken, as well as lack of resources such as human resources and medication, and lack of training.

Table 4.5. Perception on barriers of successful integration of mental health care into PHC

The perception of respondents
Overcrowding in the PHC clinics
Complexity of assessing a psychiatric patient including the time taken
Lack of resources including human resources and medications
Lack of training
Lack of support to deal with complicated psychiatric cases
Stigma

CHAPTER 5
DISCUSSION

5.1 Introduction

This study determined the attitudes and the role of doctors towards integration of mental health care services into PHC. The study used a cross sectional design with a quantitative approach. The study was conducted among 30 doctors after two in-service training meetings in Lillian Ngoyi facility with a set inclusion and exclusion criteria. A self-administered questionnaire was used, and data were analyzed using STATA. This study adhered to the guidelines laid down in the Declaration of Helsinki for human subjects. This chapter elaborates on the findings in relation to other studies in South Africa and beyond.

5.2 Demographic details of respondents

There were more female than male respondents and the former were also younger compared to their male counterparts. Working experience varied by age groups with younger doctors having work experience of less than 20 years while the older doctors had worked for over 20 years. Most of the females had less work experience while work experience among males was spread between those with the least and most experience. Younger doctors indicated that they had adequate knowledge on psychiatric disorders compared to older doctors. This finding of adequate knowledge of psychiatric disorders amongst the younger doctors may be indicative of the improved undergraduate curriculum of South African medical schools with a greater emphasis on psychiatry. Compared to 53% reported in the current study, a study conducted in Chile, found that 35.5% of doctors indicated that they had adequate knowledge of psychiatric disorders.[88]

Literature documents participation in research as dominated by males than females in general, and mostly with average work experience of 18 years.[60, 75] In South Africa, there is a change of demographic profile of people trained to become doctors. The overall demographic profile of selected students is

beginning to reflect the diversity of the population groups in SA.[89] There has also been a change in the curriculum of training undergraduate students from a biomedical model of care in psychiatry to a bio-psychosocial model, in the recent years.[89]

5.3 Respondents' knowledge on mental disorders and sense of responsibility

Although majority of respondents in the current study indicated that they had adequate knowledge on mental disorders, contrary results have been reported in other studies.[1,75] In a study by Clatney,[1] the majority of respondents indicated dissatisfaction with their knowledge of mental disorders, while in a study by Cowen,[75] a third of respondents had no knowledge of mental disorders.

The majority of respondents acknowledged that they were the first point of contact with mentally ill patients. Nonetheless, they did not feel responsible for care of stable chronic psychiatric patients. This finding is indicative of the problems with the training doctors receive in South African medical schools as well as the kind of exposure to psychiatry doctors receive in their internship training. The training is done in regional and tertiary hospitals and these hospitals emphasize acute psychiatry with limited exposure to community psychiatry. The majority of respondents were willing to support the family and provide psychoeducation to families of chronically ill patients but they did not think that it was their responsibility to care for chronically ill psychiatric patients. Doctors in this study agreed that it was their responsibility to provide information on the clinical condition of a chronic psychiatric patient to the family. The findings further showed that a large proportion of PHC doctors were reluctant to manage somatic comorbidities in psychiatric patients.

In other countries, doctors saw themselves as having a shared responsibility in early detection and relapse prevention[1,16,62,90], which is contrary to the current study. Other studies suggested that even though the perceived role of the doctors is to manage patients with chronic psychiatric illnesses holistically,

physical care of patients with psychiatric disorders is suboptimal.[62] Furthermore, supporting family and psychoeducation has been viewed as the role for mental health care staff,[90] which is similar to the findings of this current study. This is confirmed in other studies where doctors were positive about managing psychiatric patients.[16,59,90]

5.4 Need for training on mental illness

This study further found that the majority of doctors felt that they needed more training in communicating with psychotic patients, managing patients in a psychotic crisis and on pharmacotherapy. The important finding in this report was that although females reported more knowledge of mental illness, fewer males (33% of the respondents) expressed interest in CPD. Most males were older and had less exposure to psychiatry during internship and this could have resulted in them having less interest in learning psychiatry. Effective and evidence-based targeted training in mental health for PHC practitioners is critical to ensure effective integration of mental health into PHC settings. A study conducted in India indicated the importance of adequate training among doctors, emphasizing diagnosis and management of priority mental disorders.[91]

Half of the respondents in this present study felt that they were competent in managing psychotic patients. These results could mean that although the PHC doctors accept their role as the first point of contact for psychiatric patients, they are concerned about their safety around acute psychiatrically ill patients as well as their skills in managing acute and chronic patients. Doctors, in addition to nurses and other workers at the emergency and psychiatric services, are at higher risk of any form of violence compared to other health care staff.[92,93] In America, 40% of psychiatrists reported being assaulted physically by psychiatric patients.[92] Another study carried out in a psychiatric hospital in Nigeria revealed that about half (49.5%) of mental health care providers had experienced physical assault by patients at least once within their employment period in the psychiatric facility, and 33.7% had been physically assaulted in the past 12 months.[93]

Results of this current study showed that doctors did not have a negative attitude towards patients with mental illness. These findings are similar to studies that were done in the Middle East.[94,95] Negative attitudes towards psychiatry and psychiatric patients have been reported among physicians in countries such as Saudi Arabia and Nigeria.[94,96]

The lack of skills in handling psychiatric patients is valid and was revealed in the findings of this study. The study showed that lack of training is a barrier to integration of mental health care into PHC. Respondents further proposed adequate training as one of the solutions to meet the needs of patients and community. The findings of this study therefore support a proposition that doctors should be trained in community psychiatry at medical school and in their internship in order to improve their competence in psychiatry and their willingness to participate in the integration of mental health care into PHC. Respondents felt that they had a role in caring for psychiatric patients but they were of the view that managing psychiatric patients was difficult and time consuming.

5.5 Integration of mental health into PHC

Integrating mental health services into PHC is among the most viable means of closing the treatment gap and ensuring that people get the mental health care they need.[97,98] However, the respondents in this study were of the opinion that PHC clinics were overcrowded with long queues and faced lack of skills, support, resources and medications. These factors combined with stigma around mental illness would make integration of mental health into PHC very difficult. Similar to the current study, others have highlighted resource-related barriers and limited resources for service delivery concerning integrating mental health services into PHC.[99-101] Furthermore, lack of in-service training in mental health care was reported as another barrier.[102,103] Inadequate training in the use of mental health

screening tools and current evidence-based treatment were also identified as barriers to integration.[99,104]

In general, literature has summarised the barriers to integration of mental health services into PHC as originating from (1) the attitudes regarding programme acceptability, appropriateness, and credibility; (2) knowledge and skills; and (3) motivation to change. These factors are closely linked and are prerequisites to behaviour change. Factors mentioned under health systems constraints were divided into those related to (1) management and/or leadership and (2) financial resources.[105] Literature documents that policy of integration of mental health into PHC has been carried out in various countries but in South Africa there is still lack of integration of mental health into PHC.[105] The key factors to integration of mental health services into PHC include primary care providers' attitudes regarding program acceptability, appropriateness and credibility, knowledge and skills, motivation to change, management and/leadership, and financial resources.[105]

CHAPTER 6
CONCLUSION

PHC doctors in this study did not have a negative attitude to mental illness but they were opposed to full integration with psychiatric patients in the same queue with all patients attending the PHC clinic. They suggested that psychiatric patients should be separated from other patients within the PHC. Doctors were also aware of their roles in terms of supporting the patients and their families but did not see their role in as extending to the care of chronic psychiatric patients, but that could be a reflection of their lack of skills and exposure. Doctors acknowledged the importance of patient care and its complexity.

The identified barriers to integration of mental health services into PHC included lack of training, overcrowding, lack of resources and lack of support. The study found that doctors were willing to be upskilled in order for them to be able to treat some mental illness at PHC level. Ongoing in-service training, mentoring and support of PHC doctors are a priority. Improvement of collaboration between PHC and secondary psychiatric services will also improve integration. Also required is increased consensus, commitment and political will within the government to place mental health on the national agenda and secure funding for the sector.

However, the study was not without limitations. The study was relatively small in scope and only collected data from one sub-district, and therefore the results cannot be generalized outside of this district. Only the doctors who attended the Friday meetings were included in the study. The nurses and community care workers who are important in the integration of mental health were not included in the study.

CHAPTER 7
RECOMMENDATIONS

The study recommends the following:

- For the integration of mental health care to be realized in Soweto, the government should commit more human and financial resources. This should include employment of more doctors and nurses.

- Task shifting from the mental health specialists to PHC doctors and nurses through ongoing in-service training and mentoring is important, as the training of doctors is not adequate to prepare them to take over the care of stable patients with mental illness, as well as to identify mental illness and treat those with common mental illness.

- Medical Interns to be placed in community psychiatric clinics to learn about psychiatric conditions in primary health care.

- De-stigmatizing mental illness should be a priority through educating health care workers at all levels of care as well as community.

- The recommendations of the NMHPF & SP need to be implemented in order for community mental health specialist services to be established which must then support the PHC doctors.

- Further studies on integration and development of community based mental health services need to be undertaken.

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APPENDIX A: INFORMATION LEAFLET

Dear colleagues

My name is Dr Nokuthula Mavie-Shibanda. I am a registrar in the Department of Psychiatry at the University of Witwatersrand. I would like to invite you to participate in a research study entitled: *Care of patients with psychiatric disorders: the role and attitudes of medical officers towards integration of mental health into PHC*.

The study we are conducting will focus on the exploration of your attitudes and role perspective towards integration of mental health care into PHC. The goal of this research is to understand the feasibility of integration in your setting. Please take time to read the following information carefully.

Please read the following information, which will provide you with an explanation of the study and the reason for conducting the study, prior to agreeing to participate:

- If you have any question don't hesitate to ask me
- If you decide to participate, you will be asked to sign the document to confirm that you understand the study. You will be given a copy of this information leaflet.
- The study is being performed as a partial fulfillment for the degree of Master of Medicine in Psychiatry.
- It will take 20 to 30 minutes to complete the questionnaires.

Purpose of the study:

According to the directive from the department of health, it is envisaged that mental healthcare be integrated into primary health to ensure holistic care and de-stigmatize mental illness.

Procedure.

The researcher among the doctors in primary health clinics will distribute questionnaires in the morning and they will be collected two days later.

Rights to participate in this study

Confidentiality

All information obtained from the questionnaires will be kept strictly confidential. Only the investigator and the supervisor will have access to the data obtained. Data may be reported on in scientific journals and will not include any evidence that identifies you.

APPENDIX B: DATA COLLECTION SHEET

Directions: Please read each question carefully and mark with a cross the most appropriate response to the question

STUDY NUMBER		
CHARACTERISTICS OF MEDICAL DOCTORS		
Please indicate your gender	Male	Female
Please indicate your age	21-30	
	31-40	
	41-50	
	51-60 61-70 >70	
Are you part time/full time employed	Part time	Full time
State the number of years working as a general practitioner	0-10 11-20 21-30 31-40 41-50 >50	
	Yes	No
Do you feel you have adequate knowledge of psychiatric disorders?		
Do you think that psychological factors can influence the origin of		

physical illnesses?		
Do you treat some psychiatric patients in your clinic?		
Do you refer some psychiatric patients to psychiatrists?		

TASKS IN THE ACUTE AND LONG-TERM PHASE	**Strongly disagree**	**disagree**	**neutral**	**Agree**	**Strongly agree**
For acute confusion, the GP is the first contact					
I feel responsible for the care of chronic psychiatric patients in PHC setting					
I think it's my job to check on psychiatric patients' ability to take care of themselves					
I think it's my job to support the family of a chronic psychiatric patient					
I think I should monitor somatic comorbidity in chronic psychiatric patients					
Care for family					

I think it's my job to provide information on the clinical condition to the family of a chronic psychiatric patient					
I think it's my job to support the family of a chronic psychiatric patient					
Self- experienced competencies					
I feel competent in making contact with the patient in a psychiatric crisis					
I feel competent in intervening in a crisis situation					
I feel competent in communicating with the family in a psychiatric crisis					
I feel powerless in a psychiatric crisis					
I feel unsafe near an acute psychotic patient					
Need for continual professional development					

I need CPD training and guidance in communicating with psychotic patients					
I need CPD training on interventions in a psychiatric crisis					
I need training on antipsychotic pharmacotherapy					

Attitudes regarding mental health care provision					
Medications usually produce satisfactory results in patients with mental health problems					
The number of patients I see presenting with signs and symptoms of mental health problems is increasing.					
The majority of mental health problems that I see originate from patients' recent misfortunes					
An underlying biochemical abnormality is at the basis of severe mental health problems					

Medication is more beneficial than counseling for patients with mental health problems					
Mental Health problems are a sign of personal weakness					
Working with patients with mental health problems is difficult					
PHC doctors have little to offer patients with mental health problems					
Counseling for mental health problems should be left to a specialist					

APPENDIX C: ETHICAL CLEARANCE

R14/49 Dr Nokuthula Mavie-Shibanda

HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL)

CLEARANCE CERTIFICATE NO. M151027

NAME: (Principal Investigator)	Dr Nokuthula Mavie-Shibanda
DEPARTMENT:	Psychiatry Lilian Ngoyi, Soweto
PROJECT TITLE:	Care for Patients with Psychiatric Disorders : The Attitude and Role of Primary Health Care Medical Doctors Towards Intergration of Mental Health into Primary Health Care in Soweto
DATE CONSIDERED:	30/10/2015
DECISION:	Approved unconditionally
CONDITIONS:	
SUPERVISOR:	Dr Mvuyiso Talatala
APPROVED BY:	Professor A Dhai, Co-Chairperson, HREC (Medical)
DATE OF APPROVAL:	15/12/2015

This clearance certificate is valid for 5 years from date of approval. Extension may be applied for.

DECLARATION OF INVESTIGATORS

To be completed in duplicate and **ONE COPY** returned to the Secretary in Room 10004, 10th floor, Senate House, University.

I/we fully understand the conditions under which I am/we are authorized to carry out the above-mentioned research and I/we undertake to ensure compliance with these conditions. Should any departure be contemplated, from the research protocol as approved, I/we undertake to resubmit the application to the Committee. **I agree to submit a yearly progress report**.

Principal Investigator Signature

Date 16/12/15

PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES

APPENDIX D: PLAGIARISM REPORT

