EVALUATION OF PRIMARY MENTAL HEALTH CARE IN NORTH WEST PROVINCE

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CONTENTS

LIST OF TABLES

EXECUTIVE SUMMARY

Introduction

The majority of patients with mental disorders are managed in primary care. In line with national policy, North West province uses the so-called supermarket approach in caring for patients in primary care, including those with mental illnesses. The impact of this on patient care is unclear. The aim of this research was to evaluate clinic-based mental health services in North West province.

Methodology

A cross-sectional study was conducted in 2005, with both quantitative and qualitative components.

A random sample of four clinics in each of the four districts in North West province was selected. Clinic registers over one month and 10 consecutive patient records on one day were reviewed in each clinic.

Focus group interviews were conducted with patients and caregivers at the clinics, as well as the provincial mental health coordinators. Individual interviews were conducted with professional nurses and doctors in the clinics.

Findings

A review of the mental health care documented in 142 patient records was conducted, and details of 584 patients with mental conditions in the clinic registers were noted. No diagnosis was recorded for patients in 23 records (16.2%) and in

115 register entries (19.7%). Other patients were given non-specific diagnostic labels such as “psychiatric patient” and “psychosis”. Formal diagnoses were thus not available for 63 of the patient records studied (44.4%) and for 375 of the patients in the clinic registers (64.2%). Of the patients who were given a diagnosis, 50 (63%) were labelled as having schizophrenia in the records and 120 (57.4%) in the registers. Almost 30% of the patients had been diagnosed more than 12 years ago while approximately 40% had been diagnosed in the last 5 years.

Of the 19 medications listed in the patient records, fluphenazine decanoate was most frequently prescribed (22.6%), followed by orphenadrine (19.5%), chlorpromazine (14.9%) and haloperidol (14.5%), together accounting for 71.6% of the medication prescribed. Most patients were on more than one medication; 17 (12.2%) were receiving only one. About 50% of the patients (64) had been on their current medication for less than 2 years, whereas almost 18% (23) had been on the medication for more than 5 years.

Information about the health professional who last reviewed the patient was noted in the patient records for 70 patients (49.2%); in most patients this was a mental health nurse, with 17% being doctors, of whom half were psychiatrists. The time since the last review could be calculated for 81 patients; 52 (64%) had been seen for review within the preceding 6 months.

Six focus group interviews were conducted with patients and caregivers, posing the question, “what do you feel about the treatment and care that you receive at this clinic for your problem?” The majority of patients and caregivers in these groups communicated general satisfaction, and most described nurses as friendly and dedicated. Communication was raised as a particular problem, as well as the lack of continuity due to staff turnover. Long waiting times were mentioned as a significant problem. A number of medication problems were raised, such as medicine going out of stock and difficulty accessing treatment when mental health coordinators were not present. The groups expressed a desire for a more specialised service in the form of special clinics and dedicated staff for care of mentally ill patients, and noted a need for more staff, particularly doctors.

Free attitude interviews were conducted with five professional nurses and three doctors, posing the question "what do you feel about managing mentally ill patients in your clinic?" The professional nurses feel competent in what they are doing, and believe they are offering a good service to mentally ill patients. Doctors feel that the psychiatric-trained nurse is the backbone of the service and essential for good mental health care. A mental health care system with a designated person was described as the ideal. Compliance was said to improve with having a designated doctor; they feel patients prefer this and it decreases waiting times. In contrast, the supermarket approach was seen as not being appropriate for mental health care. Problems raised with the service included patients not being reviewed regularly as required, the lack of observation facilities, the short time spent in hospitals when patients are referred there, and lack of communication between levels of care. A need for more staff (nurses, doctors and mental health nurse specialists) and for better training was expressed repeatedly.

Finally, a focus group discussion was held with the mental health coordinators in the province, posing the question, "what do you feel about the management of mentally ill patients in your sub-district?" These coordinators believe patients in the clinics often get very inadequate care, and that there are lots of problems with prescribing in the clinics. Clinic staff are said to be inadequately trained for the job; the mental health coordinators themselves also expressed a need for training. There is a lack of human resources, with few doctors and trained mental health nurses, and no psychologists and psychiatrists. There are negative attitudes towards mental health patients, and managers are not supportive, leading to feelings of isolation. Many primary care clinicians are not aware of the Mental Health Care Act and all its requirements.

Discussion

The most significant finding was poor record-keeping, both in terms of patient records and clinic registers. There is no standard format for history taking, examination, data entry, recording of diagnosis and management, etc, in patient records. A simple, easy-to-use, and appropriate patient chart for mental health care

is urgently required.

The extent to which diagnoses are not available is worrying, because adequate treatment cannot be provided without accurate and appropriate diagnosis. Schizophrenia is the commonest diagnosis, raising the question whether any form of psychosis has a tendency to be labelled “schizophrenia”. On the other hand, the low rate of diagnosis of certain mental health problems, particularly depression and other mood disorders, is also of concern.

The use of medication reflects the availability of drugs in clinics as per the Essential Drugs List, as well as the range of diagnoses, with anti-psychotic agents being the major drugs being used, but the appropriateness of some prescriptions is questionable. The extent of use of orphenadrine needs to be investigated.

Mental health nurses bear a major burden in terms of caring for these patients; 83% of patients were last reviewed by a nurse. This is done on top of the load normally carried in terms of all the other primary care patients that need to be seen. It is thus not surprising that the national standard of 6-monthly review for all patients on psychiatric medication is not being met.

It is encouraging that the patients and their caregivers who were interviewed were generally satisfied and feel the nurses are sincerely interested in their welfare. However, communication problems need to be addressed. It is clear that patients are not always sure when they should come, and often find the process confusing. Similarly there is a problem of communication between clinics and hospitals, particularly referral hospitals.

Patients and caregivers struggle with a lack of continuity, seeing different staff members each time, and with the length of time spent waiting, both in the clinics and at hospital. To address these and other concerns, they plead for a specialised service for mentally ill patients. This is echoed by doctors and nurses.

Limited human resources featured strongly in all interviews.

Recommendations

The problem of mental health care should be taken seriously, and incorporated into provincial strategic plans.

There should be reorganisation of care in a way that does not exclude patients with mental health conditions from the system, but rather integrates them into a comprehensive approach to chronic care. The organisation of chronic care in general in clinics needs to receive special attention and a coordinated provincial strategy to address this is required.

A standardised system of documentation for all chronic patients in general and mental health patients in particular, should be developed and implemented, as part of this re-organisation.

Community based services need to be augmented with more formalised support groups and better cooperation with NGO's and CBO's.

Staff at all levels need training, with the aim of improving the detection and diagnosis of common psychiatric illnesses, as well as the comprehensive care of such patients.

Conclusion

This study highlights a number of strengths and weaknesses in the primary mental health care system in North West province. A coordinated effort is required to tackle issues systematically in order of priority, with re-organisation of chronic care, proper documentation and record-keeping, and further training and support of staff being early interventions.

INTRODUCTION

The de-institutionalisation of mentally ill patients and the community based care of these patients is a central element of mental health policy in South Africa. For the care of these patients to be effective the community based mental health care system and mental health care as a part of primary care needs to be effective and supportive.

Nationally, and especially within the North West province, the so-called supermarket approach to patients in primary care has been introduced whereby there are no specialised clinics within the general primary care clinics and no special days for treating particular problems but any patient is able to present on any day for treatment. Mentally ill patients are supposed to be treated in the same way. Thus these patients have to wait in the queue alongside anybody else, and they are seen by whoever happens to be consulting patients on that day whether or not they have particular expertise in mental health. There is no particular organised follow-up of such patients. They compete in terms of time with the general load of patients. The impact of this on the care of the mentally ill has not been assessed.

It is well-documented internationally that the majority of patients with mental disorders are managed in primary care (Mash, 2000). In the South African context it is suggested that up to 25% of patients in primary care might have a mental disorder (Mash, 2000).

It has been our impression from working in the primary care context that mentally ill patients do not get well cared for and are often neglected by the system. A survey of psychiatric community services in the North West province in 2000/1 confirmed this impression: there was no consistency of assessment, little dedicated mental health care or medical input, and lack of record keeping, amongst others (Wilma Roos, personal communication). A study in one sub-district of the province, Moretele, reported a wide range of problems identified by users of mental health services (patients) and their families, with much unhappiness being expressed (Modiba et al, 2000). There is lack of understanding on the part of health service providers about

the referral system, the role of the psychiatric institution, and the place of specialist psychiatrists in the system, which adds to the problems.

Furthermore, there was no standardisation regarding integration of services in North West province. The policy had changed to one of integration. However, in some districts, mental health services were largely still run by mental health coordinators and not by the clinic PHC nurses, whereas in others integration had occurred.

There are four districts in North West province – Southern, Bophirima, Central and Bojanala. All have a network of primary care clinics, health centres and district hospitals; all but Bophirima have regional hospitals. The province has the lowest public service doctor-to-population ratio in South Africa (National Department of Health, 2005). Mental health care service delivery is not uniform across these districts. There is one recognised psychiatric hospital (Bophelong Hospital, in Mafikeng, Central district), with only one specialist, and one rehabilitation centre (Witrand hospital, in Potchefstroom, Southern district) with one full time psychiatrist.

The aim of this research was to evaluate clinic based mental health services in North West province. We did this by:

1. Assessing the clinic-based records of patients with mental health problems.
2. Auditing the management of mental health patients in these clinics.
3. Ascertaining the attitudes and perceptions of clinic nurses and sub-district mental health coordinators regarding the care of mental health patients in the clinics.
4. Exploring the feelings of mental health patients themselves about the treatment received in these clinics.

LITERATURE REVIEW

Limited research has been done on the issue of non-adherence to treatment in mental health (Lowry, 1998). It is assumed that psychiatric patients, especially those with schizophrenia, paranoia and personality disorders will show greater non-adherence than other categories of patients (Haynes, 1979). There is evidence from a number of studies that this is indeed the case (Young et al, 1986; Koch & Gillis, 1991; Razali & Yahya, 1995). It is postulated that this is due to the additional challenges faced by schizophrenics, where the treatment is not curative, the patients easily become demoralised and there is often impaired judgement associated with the disease (Kane, 1997). There is frequently lack of insight into the illness and poor understanding of the chronic nature of the illness (Koch & Gillis, 1991; Bartko et al, 1998; Lin et al, 1979; MacPherson et al, 1996). Side effects of psychotropic medication compound the problem (Koch & Gillis, 1991; Nageotte et al, 1997; Ruscher et al, 1997; Gillis et al, 1987; Conrad 1985). However it is not just schizophrenics who struggle with adherence; depression is also associated with a great measure of non-compliance (Bebbington, 1995; Johnson and Freeman, 1972)

The issue is complicated by patients' belief systems where mental illness is often considered to have a spiritual cause (Seape, 1997) in which case medication is contraindicated. There is also a lack of confidence in and understanding of western treatment approaches (Gillis et al, 1987).

What seems be even more true is that there has been little focus on the health system as a possible cause of non-adherence. Patient satisfaction and meeting patients' expectations are important elements of compliance (Morris & Schultz, 1992; Yasin, 1998; Nageotte et al, 1997; Conrad, 1985). Inadequate information has been shown in the Western Cape to be a major cause of non compliance (Gillis et al, 1987). Koch & Gillis (1991) found that patients on disability grants in South Africa were more likely to comply with follow up, possibly because regular review is a condition of the grant.

In free attitude interviews with 6 patients suffering from psychiatric illness in the Mmametlhake Health District, Shariff (2000) notes that 3 patients complained about

not being reassessed, with 2 of these claiming they were not mentally ill, but had never been adequately reassessed. The problem of disorganised service delivery was highlighted by all patients interviewed, raising anger and frustration. One patient mentioned that his file was missing every time he arrived at the clinic, and that he saw a different health worker on each occasion. Patients also complained about a paternalistic approach on the part of nurses, even to the extent of receiving injections against their will, and non-involvement of them and/or their families in treatment. Poor communication between the different levels of care was also highlighted.

These problems are probably far more widespread than have been reported. They raise the issue of the restructuring of the health service and the best model to follow for mental health care delivery. The South African Department of Health has pursued a policy of integration. Whatever its theoretical advantages, it creates serious challenges for mental health care delivery, placing additional burdens on primary health care staff already feeling overburdened by their general primary health care work. In addition, more psychiatric patients are entering the primary health care system through deinstitutionalisation, early discharge, not having been admitted, through absconding, or through greater reliance on formal health care on the part of those who were previously marginalised. These patients increase the load on the general primary health care system (Swartz and MacGregor, 2000). Many of these patients are seen by primary health care staff to be problematic, both because of obvious psychiatric symptoms, and inexperience on the part of staff (Swartz and MacGregor, 2000). This in turn leads to inadequate care.

Swartz and MacGregor (2000) describe two cases which illustrate the problems faced by ‘chronic stable’ mentally ill patients: in one, severe side effects of medication are overlooked, and in the other, a major upheaval in the patient’s life is not identified. Part of the problem is the idea that chronic psychiatric illness is similar to other chronic illnesses, which raises significant difficulties in an overstretched and narrow biomedically focussed system (Swartz and MacGregor, 2000).

We know from previous research, such as cited above by Shariff (2000), Modiba et

al (2000) and Swartz and MacGregor (2000), that users of the service are unhappy, but it is not clear what they believe would change their situation. Furthermore, how health care providers themselves perceive this problem, and what they think could be done to improve it, is also unknown. These gaps together are a major rationale for this research.

METHODS

Study design: A cross-sectional study with both quantitative and qualitative components.

Study Population: Patients and staff of primary care clinics in the North West province.

Sample: Stratified random sample. All clinics in the province were allocated a number at random and stratified into the four districts. A random sample of four clinics per district was then taken, using a random number table, continuing to select clinics randomly until there was one health centre together with 3 functioning clinics included in each district. (See appendix A for the list of facilities assessed.)

Definition of variables: For the purposes of this study, mental health patients referred to those suffering both from chronic and major psychiatric conditions such as schizophrenia, depression, bipolar disorder, dementia, etc, and from acute and common problems such as anxiety disorders, stress reactions, etc. Epilepsy, which is commonly (and incorrectly) defined in primary care clinics as a mental health problem, was excluded, unless there was a concomitant psychiatric diagnosis (e.g. epileptic psychosis). Patients could have more than one diagnosis. Common problems requiring counselling such as spouse abuse, HIV, sexual difficulties, etc, were also excluded. Mental retardation, as a primary diagnosis, was also excluded

Data collection: Five separate methods were followed:

1. <u>Record reviews</u>

   This had 2 components:

   i) The clinic registers in each of the sampled clinics were analysed over one month between July and September 2005 to ascertain the number of mental health patients according to the patient register, the conditions being treated, and the details recorded regarding the diagnosis and management of these patients. Both the mental health registers and the general clinic registers were examined.

ii) A review of the care of ten consecutive patients with mental health problems seen in the clinic was done. A family physician spent one day at the clinic reviewing the diagnosis and management of ten patients on the basis of the patients' clinic cards (patient held records) or any other available records. They recorded whether or not the following information was available and the detail thereof:

- the diagnosis,
- level of control of symptoms,
- the drugs given,
- the length of time the patient has been on treatment,
- any note regarding compliance,
- any notes regarding substance abuse,
- social or family history,
- contact with the family,
- anything about disability grants,
- admissions (where, how long, etc) and referrals
- when the last review was done,
- who did the last review,
- when the patient was last seen by a specialist/specialised mental health professional, and
- any side effects recorded.

2. Focus group interviews with patients and caregivers. Six focus group discussions were conducted, 2 with patients, 2 with caregivers and 2 with a mix of patients and caregivers (family members or relatives who assist in patients' care). These depended on the availability of sufficient patients at a site at one time, and for this reason took place largely at the health centres. The researchers sought to obtain a range of responses through the mix of patients (both in terms of demographics and their conditions). The assistance of local clinic staff was obtained to invite appropriate patients (and their caregivers) who were sufficiently well to be able to give informed consent , to return on a set date and time to participate in the interview. The choice was based on the professional nurse's opinion and the patient's ability to understand the purpose of the research. The focus group discussions

were conducted by research assistants from the Madibeng Centre for Research. The initial exploratory question posed was "what do you feel about the treatment and care that you receive at this clinic for your problem?" Once saturation was reached, a follow up question was asked, "What do you think can be done to improve the care that you receive at this clinic?" The focus group interviews were conducted in Setswana and English. The discussion was audiotaped. The interviews were transcribed and, in the case of the Setswana ones, translated into English for the purpose of data analysis.

3. Free attitude interviews.

This again had 2 components:

i) Five professional nurses in 3 of the districts (Bojanala, Southern and Bophirima) were interviewed using free attitude interview techniques. The initial exploratory question asked was "what do you feel about managing mentally ill patients in your clinic?" A follow up question was asked "what do you think can be done to improve the management of these patients in your clinic?" The nurses interviewed were the senior primary health care nurses available at each of the clinics visited in 3 of these districts, who gave consent at a time when the family physician-researcher was present at the clinic. They were purposively chosen in terms of demographic factors, to ensure coverage of the range of clinics. The interviews were conducted in English. They were audiotaped and transcribed verbatim.

ii) Three doctors, each working in one of the clinics visited in the above-mentioned districts, were interviewed using free attitude interview techniques. The same initial and follow up questions were asked. The interviews were conducted in English. They were audiotaped and transcribed verbatim.

4. Focus group discussion with the mental health coordinators. At one of the meetings of the mental health coordinators from all the sub-districts in the province, 8 volunteers were invited, to ensure coverage of the districts and the demographics of the province, to join a focus group interview, conducted by a family physician. This was done as in a "fish bowl" arrangement, with the focus group being conducted in the middle of the room, and the other

coordinators observing the process. The initial exploratory question was, "what do you feel about the management of mentally ill patients in your sub-district?" A follow up question was asked, "What do you think can be done to improve the management of these patients in your sub-district?" The focus group was conducted in English. Due to malfunctioning equipment, notes were made by the interviewer and an observer, which were then triangulated and compiled into a record.

The research team had a day long planning meeting at the outset to standardise data collection methods and to ensure a common approach in interviewing.

Data Analysis:

Quantitative data was recorded on data collection sheets designed by the team and then entered on computer using EpiInfo. Provisional analysis was then discussed in a research team meeting, when corrections were made and decisions around discarding poor quality information, grouping and re-categorisation of data, were made.

In terms of the qualitative data, transcriptions of the interviews/focus group discussions were used. Content analysis was done in order to develop lists of issues emerging from each set of data, individually and then together (the patients and caregivers, the professional nurses and doctors, and the mental health coordinators respectively). The research team together then agreed on common cross-cutting themes, taking note of areas of agreement and discordant voices. Representative quotes were then used to illustrate the themes using the cut and paste process.

ETHICAL CONSIDERATIONS

The protocol received approval from the Committee for Research on Human Subjects of the University of the Witwatersrand and from the Research Committee of the North West Provincial Department of Health.

Clinics were informed of the project through the District Managers. An information letter explaining the process and detailing approval was sent to each of the clinics sampled. Personal arrangements were made by the researchers with the clinics prior to visiting them.

The informed consent of all people interviewed, individually or in focus groups, was obtained. No names or identifying details of patients or staff are used in reporting the results.

RESULTS

Quantitative results

A. Patient Record Reviews

a) Clinics

The clinics from which patient records were examined are shown in Table 1. The sample of patient records was to have consisted of 10 patient records from each of 16 clinics. However records were received from only 15 clinics due to data not having been collected from one clinic, in Central District. At three clinics, less than 10 records were examined yielding a total of 142 records.

Table 1. Clinics and patient record numbers

District	Clinic	Frequency	%
Bojanala	Bakubung	10	7
Southern	Botshabelo	10	7
Bophirima	Huhudi	10	7
Central	Itekeng	10	7
Bojanala	Kgabo	10	7
Central	Masutlhe 1	8	5.6
Bophirima	Mocweding	10	7
Southern	S Mogaetsho	7	4.9
Central	Montshioa town	10	7
Bophirima	Morokwaneng	10	7
Bojanala	Pitsedisulejang	10	7
Bojanala	Sesobe	10	7
Southern	Stilfontein	10	7
Bophirima	Taung gateway	7	4.9
Southern	Top City	10	7
	Total	**142**	**100**

b) Age group

The age groups of patients are shown in Table 2. The age of the patients was recorded in 134 of the 142 records (94.36%). The mean was 44.05 years, the median 42.5 years and the range 19 – 77 years. Only patients 18 years or older

were included in the study and so for the sake of convenience, the one 19 year old patient was included in the 20 – 29 year age group. As can be seen, just over 70% of patients were aged below 50 years with the single largest group being the 40 – 49 year olds.

Table 2: Age groups of patients

Age group	Freq	%	Cum %
20 – 29 yrs	17	12.7	12.7
30 – 39	33	24.6	37.3
40 – 49	44	32.8	70.1
50 – 59	20	14.9	85.1
60 – 69	15	11.2	96.3
70 - 79	5	3.7	100.0
	134	100.0	100.0

c) Gender

The gender of 141 patients was recorded. Of these, 61 (43.3%) were female and 80 (56.7%) male, which is a significant difference (p= 0.0063). Table 3 gives the breakdown of gender by age group. (Ages were available for only 133 patients for whom gender was recorded.)

Table 3. Gender by Age Group of Patients

Age	**Female**		**Male**		
	Freq	**%**	**Freq**	**%**	**Total**
20 – 29	4	23.5	13	76.5	17
30 – 39	9	28.1	23	71.9	32
40 – 49	19	43.2	25	56.8	44
50 – 59	12	60.0	8	40.0	20
60 – 69	9	60.0	6	40.0	15
70 – 79	5	100.0	0	0.0	5
Total	**58**	**43.6**	**75**	**56.4**	**133**

d) Ethnicity

Of the 140 patients for whom ethnicity was recorded, 129 (92.1%) were black and 11 (8.0%) white.

e) Diagnosis

i) Range of diagnoses

As shown in Table 4, of the 142 patients, no diagnosis was recorded for 23 (16.2%) patients. Of the remaining 119 patients, in 20 instances the diagnosis was given as "psychiatric patient" and in 17 as "psychosis"; in 3 more only symptoms were given. Thus in effect no diagnosis was available for 63 (44.4%) of the patients studied. Of the 79 patients who were given a diagnosis, 50 (63%) were labelled as having schizophrenia.

Table 4. Diagnoses of patients

Diagnosis	Freq	%
Schizophrenia	50	35.2
No diagnosis	23	16.2
"Psychiatric patient"	20	14.1
Psychosis	17	12.0
Epileptic psychosis	7	4.9
Depression	5	3.5
Substance abuse	5	3.5
Symptoms only listed (roaming, hearing voices, hallucinations, flight of ideas)	3	2.1
Anxiety/ panic attack	2	1.4
Dementia	2	1.4
Suicidal	2	1.4
Brief psychosis	1	0.7
Intermittent explosive disorder	1	0.7
Organic mood disorder	1	0.7
Post partum psychosis	1	0.7
Schizoaffective	1	0.7
Social problems	1	0.7
Total	**142**	**100.0**

ii) Date when diagnosis was made

Of the 142 patients, information about when the diagnosis was made was available in 110 cases including those instances when terms such as "psychiatric patient" or "psychosis" were used. Although dates were given, it is evident that in several cases it could not be stated with certainty that the date referred to the day of diagnosis; for example, in some cases the date when medication was started was used to indicate the date of diagnosis. Also in many instances only a year but no

month or day was given. This section of the data must therefore be interpreted with caution. Bearing this in mind, the dates in 3 year periods when diagnoses were made is shown in Table 5. One notes that almost 30% of the patients had been diagnosed more than 12 years ago while approximately 40% had been diagnosed in the last 5 years.

Table 5. Years when diagnoses were made

Years	Freq	%	Cum %
76 – 78	4	3.6	3.6
79 – 81	2	1.8	5.4
82 – 84	4	3.6	9.0
85 – 87	2	1.8	10.8
88 – 90	4	3.6	14.4
91 – 93	16	14.5	28.9
94 – 96	11	10	38.9
97 - 99	24	21.8	60.7
00 - 02	21	19.1	79.8
03 - 05	22	20	99.8
Total	**110**	**100**	**100**

Iii) Person who made the diagnosis

Information about the health professional who made the diagnosis was available for 86 patients. Although the accuracy of the data should be treated with caution, it appears that 74 (86%) of the diagnoses were made by doctors of whom at least 19 (22%) were psychiatrists, and the remaining 12 (13.9%) were made by nurses (variously called mental health nurses, mental health sisters, mental health coordinators, professional nurses or clinic sisters).

f) Medication

i) Medication used

The medication prescribed for 139 of the 142 patients is shown in Table 6. Of the 19 medications used, fluphenazine decanoate was most frequently prescribed (22.6%), followed by orphenadrine (19.5%), chlorpromazine (14.9%) and haloperidol (14.5%). These 4 medications accounted for 71.6% of the medication prescribed. Most patients were on more than one medication: of the 139 patients, 17 (12.2%)

received only 1 medication, 86 (61.8%) received 2, 29 (20.8%) received 3, and 7 (17.9%) were prescribed 4 medications.

Table 6. Medication prescribed

Medication	Freq	%
Fluphenazine decanoate	59	22.6
Orphenadrine	51	19.5
Chlorpromazine	39	14.9
Haloperidol	38	14.6
Oxazepam	13	5.0
Flupenthixol	12	4.6
Thioridizine	9	3.4
Carbamazepine	6	2.3
Amitriptyline	6	2.3
Sodium valproate	5	1.9
Fluoxetine	4	1.5
Zuclopenthixol decanoate	4	1.5
Trifluoperazine	2	0.8
Clozapine	2	0.8
Phenytoin	2	0.8
Clonazepam	2	0.8
Clothiapine	1	0.4
Imipramine	1	0.4
Lithium	1	0.4
Sulpiride	1	0.4
Diazepam	1	0.4
Thiamine	1	0.4
Biperiden	1	0.4
Total	261	100

ii) Time on medication

Information about the length of time patients had been on their current medication was available for 131 patients (see Table 7). As can be seen from table 7, about 50% (64) of the patients had been on their current medication for less than 2 years. However, almost 18% (23) had been on the medication for more than 5 years.

Table 7. Time on medication

Time		Freq	%	Cum %
1 year	0 – 6 mths	23	17.6	17.6
	7 – 12 mths	14	10.7	28.3
2 years	13 – 18 mths	13	9.9	38.2
	19 – 24 mths	14	10.7	48.9
3 yrs		19	14.5	63.4
4 yrs		12	9.2	72.6
5 yrs		14	10.7	83.3
6 yrs		8	6.1	89.4
7 yrs		1	0.8	90.2
8 yrs		5	3.8	94.0
9 yrs +		8	6.1	100
Total		131	100.0	100

iii) Side effects

Of the 142 patients, information about side effects was available for 38 (26.7%). Of the 38 comments, 4 were to the effect that the patients had experienced no side effects, and the remaining comments indicated that extra-pyramidal side effects (EPSE) had been noted or there was a brief mention of side effects such as rigidity, sleepiness and headaches. Note that the absence of recorded comments in patient notes does not indicate an absence of side effects.

iv) Compliance

Of the 142 patients, information about compliance was available for 111 patients (78.16%). However the quality of the information was very variable and can be summarized as follows: in about 66 records (60%) “good”, “fair” or “regular attendance” was noted; in about 33 records (33%) “defaulting” of some kind was noted.

v) Blood levels

Blood level information for specific drugs was noted for only 7 patients. However as shown in Table 6, lithium had been prescribed only once and of the other medications prescribed only phenytoin and carbamazepine require regular blood levels to be done.

g) Reviews by health professionals

i) Review by health professional

Of the 142 patient records, information about the health professional who last reviewed the patient was noted for only 70 patients (49.2%) as shown in Table 8. The last review of most patients was done in most cases by mental health nurses with only 17% by doctors, of whom half were psychiatrists.

Table 8. Last review by health professional

Professional	Freq	%
Mental Health nurse	58	82.9
Medical Officer	6	8.6
Psychiatrist	6	8.6
Total	70	100

ii) Date of last review by a health professional

The time since the last review was done by a health professional could be calculated for 81 patients and is shown in Table 9. As can be seen most patients (64%; 52) had last been seen for formal review (rather than repeat prescription) by a health professional within the preceding 6 months. Of the 81 patients, just over three quarters had been seen within the last year. Six patients had last been seen for review by a health professional more than 4 years previously.

Table 9. Time since last review by health professional

Time	Freq	%	Cum %
Same month	13	16.0	16.0
1 – 3 mths	1	1.2	17.2
4 – 6 mths	38	46.9	64.1
6 - 12 mths	10	12.3	76.4
1 – 2 yrs	8	9.9	86.3
2 – 3 yrs	4	4.9	91.2
3 – 4 yrs	1	1.2	92.4
4 – 5 yrs	1	1.2	93.6
5 – 6 yrs	2	2.5	96.1
7 – 8 yrs	3	3.7	99.8
Total	81	100	100

There is no statistically significant relationship between the time of last review by a

health professional and gender (p = 0.471) nor for age group (p = 0.967). The breakdown for clinic and time of last review is shown in Table 10.

Table 10. Time since last review by clinic

Months	**0**	**1-3**	**4 -6**	**6 - 12**	**1 – 2 yrs**	**2- 3**	**3 – 4**	**4 -5**	**5 -6**	**7 - 8**
Bakubung	1	0	6	1	0	0	0	0	0	0
Botshabelo	0	1	6	2	0	0	0	0	0	0
Huhudi	0	0	1	0	2	0	0	0	2	1
Itekeng	0	0	0	0	1	0	0	0	0	1
Kgabo	1	0	5	1	0	0	1	0	0	0
Masutlhe 1	0	0	2	0	1	2	0	1	0	0
S Mogaetsho	0	0	4	0	1	0	0	0	0	0
Montshioa	0	0	0	3	2	2	0	0	0	0
Morokwaneng	0	0	0	0	1	0	0	0	0	0
Sesobe	5	0	5	0	0	0	0	0	0	0
Stilfontein	0	0	8	2	0	0	0	0	0	0
Top City	6	0	1	1	0	0	0	0	0	1
Total	**13**	**1**	**38**	**10**	**8**	**4**	**1**	**1**	**2**	**3**

iii) Date of last review by doctor

In 87 of the 142 records it was possible to determine when the last review specifically by a doctor had been done. The results are shown in Table 11. As can be seen, 25% (22) had seen a doctor in the preceding 6 months; 60% (53) of the patients had been reviewed by a doctor in the last 2 years. Just over 20% (18) had last been seen by a doctor 5 years or more ago.

Table 11. Time since last review by doctor

Time	Freq	%	Cum %
1 – 6 mths	22	25.28	25.28
7 – 12 mths	17	19.5	44.78
13 – 18 mths	7	8.04	52.82
19 – 24 mths	7	8.04	60.86
25 – 30 mths	5	5.74	66.6
31 – 36 mths	4	4.59	71.19
4 yrs	7	8.04	79.23
5 yrs	2	2.29	81.52
6 yrs	6	6.89	88.41
7 – 14 yrs	10	11.49	99.9
Total	87	100	100

h) Admissions

Of the 142 patients, 72 were noted to have had previous admissions. As one would expect the admissions had been to: Bophelong, Taung, Witrand, Weskoppies and George Stegman Hospitals. Unfortunately for many of the 72, only a date of admission was recorded but not the place.

i) Disability grants

Information was available for 51 of the 142 patients (36%) concerning disability grants. However the information was so incomplete that it is not possible to state with any certainty what the situation was. Usually the information briefly referred to a disability grant application having been completed, sometimes several times, but very rarely was there any follow up information about the success of the application. It therefore cannot be ascertained from the records reviewed how many of the patients were actually in receipt of a disability grant.

j) Drug use/abuse

Of the 142 patients, information about illicit drug use/abuse was available for 28 (19.7%) patients[1]. The information for the 28 patients was not detailed and in most cases simply noted a substance abuse problem – with no indication of duration or extent. As would be expected, alcohol and dagga were the substances noted with one mention of glue and two of tobacco. In only one case (of the 28) did the record reflect that the patient "did not" use any substances.

k) Social history

Of the 142 patients, some mention of a social history was available for 43 (30.5%). The comments were very brief and usually referred to a history of mental illness in the family. It is difficult to interpret the comments because of a lack of standardization in supplying the information i.e. an absence of recorded information

[1] Note that this does not mean that the remaining 114 patients did not use or abuse illicit drugs; it simply means that there was no information available in their files.

about mental illness in the family does not necessarily mean that there was no such history.

l) Family contact

Of the 142 patients, information about contact with the patient's family was available for only 45 patients (31.6%). The information which does exist was extremely brief and usually simply noted a visit by a family member or relatives. One home visit was noted with all the other contacts being made when accompanying the patient to the clinic.

m) Home visits

Of the 142 patients, there was a record of only 8 patients (5.6%) receiving home visits. Very little information apart from a date is available about these 8 visits.

B. Clinic Register Review

a) Site of study

The clinics at which clinic registers were examined are shown in Table 12. The sample was to have consisted of registers from 16 clinics but registers from only 14 were received yielding a total of 584 patients.

In addition to the absence of data cited above, at another clinic (Top City), the records were kept electronically by the mental health coordinator and a computer crash meant these could not be obtained i.e. the patient information was all lost.

Table 12. Clinics where registers were examined

District	Clinic	Frequency	%
Bojanala	Kgabo	160	27.4
Bophirima	Taung gateway	126	21.6
Bophirima	Huhudi	81	13.9
Southern	Stilfontein	43	7.4
Central	Itekeng	27	4.6
Bojanala	Pitsedisulejang	26	4.5
Southern	S. Mogaetsho	22	3.8
Bojanala	Sesobe	20	3.4
Bophirima	Mocweding	17	2.9
Bojanala	Bakubung	14	2.4
Southern	Botshabelo	14	2.4
Bophirima	Morokwaneng	14	2.4
Central	Montshioa town	12	2.1
Central	Masutlhe 1	8	1.4
Total		**584**	**100**

b) Age group

The ages of 542 patients were available and are shown in Table 13. The mean age was 45.85 years; the median was 45 years and the range 18 – 81 years. Only patients 18 years or older were included in the study and so for the sake of convenience, the two 18 year old patients were included in the 20 – 29 year age group. As can be seen, patients under the age of 60 years accounted for more than 80% of the sample.

Table 13. Age groups of patients

Age group	Freq	%	Cum %
20 – 29	64	11.	11.8
30 – 39	117	21.6	33.4
40 – 49	144	26.6	60.0
50 – 59	123	22.7	82.7
60 – 69	72	13.3	95.9
70 – 79	18	3.3	99.3
80 - 89	4	0.7	100.0
	542	**100**	**100.0**

c) Gender

Of the 574 patients for whom gender was recorded, 44.9% (258) were female with 55.1% being male.

d) Diagnoses

The diagnoses for the 584 patients are shown in Table 14. Diagnoses were not stated at all for almost 20% of the patients (115). In addition the "diagnosis" for another 260 patients was simply a meaningless label: "psychosis" (184; 31.5%), "psych" (31; 5.3%), "mental illness" (32; 5.5%) and "psychiatric" (13; 2.2%). There was thus no real diagnostic information in the clinic registers for 375 (64.2%) of the patients. Of the 209 patients who were given some kind of diagnosis, 120 (57.4%) were said to have schizophrenia.

Table 15 gives a breakdown of those clinics which used the "no diagnosis" label. As can be seen, 6 clinics gave all their patients a "no diagnosis" label and with the exception of Huhudi, Montshioa and Stilfontein clinics, all the rest gave at least 50% of the patients no diagnosis.

Table 14. Diagnoses from clinic registers (n= 584)

Diagnosis	**Freq**	**%**
Psychosis	184	76.7
Schizophrenia	120	20.5
Not stated	115	19.7
Depression	38	6.2
“Mental illness”	32	5.5
“Psych”	31	5.3
Substance abuse	16	2.6
“Psychiatric”	13	2.2
Epileptic psychosis	11	1.9
Anxiety	8	1.0
Insomnia	4	0.7
Dementia	4	0.7
Bipolar	3	0.5
Aggression	1	0.2
Confusion	1	0.2
Delirium	1	0.2
“Explosive disorder”	1	0.2
Hysterical reaction	1	0.2
Organic brain disorder	1	0.2
Organic mood disorder	1	0.2
Organic psychosis	1	0.2
Paranoid disorder	1	0.2
Schizoaffective disorder	1	0.2
Total	**589**	**100.0**

Table 15. “No diagnosis” by clinic

	Total patients	“No diagnosis”	% of patients per clinic	% of “no diagnosis”
Bakubung	14	14	100	3.7
Botshabelo	14	7	50.0	1.9
Huhudi	81	17	21.0	4.5
Itekeng	27	20	74.1	5.3
Kgabo	160	79	49.4	21.1
Masuthle 1	8	5	62.5	1.3
Mocweding	17	17	100	4.5
Montshioa	12	4	33.3	1.1
Morokwaneng	14	11	78.6	2.9
Pitsedisulejang	26	26	100	7.0
S Mogaetsho	22	22	100	5.9
Sesobe	20	20	100	5.3
Stilfontein	43	6	14.0	1.6
Taung Gateway	126	126	100	33.7
TOTAL	584	374	64.0	100

There were significant differences between the percentages of males and females on a number of the most common diagnosis, as shown in Table 16. This was particularly notable in terms of depression, schizophrenia and substance abuse.

Table 16. Gender by diagnosis

	FEMALE		**MALE**	
	Freq	%	Freq	%
Depression	29	80.6	7	19.4
Epileptic psychosis	7	63.6	4	36.4
Not stated	49	44.1	62	55.9
Psychiatric/ Psych/ Mental illness	30	41.1	43	58.9
Psychosis	81	44.0	103	56.0
Schizophrenia	40	33.6	79	66.4
Substance abuse	3	20.0	12	80.0

e) Medication

The medication prescribed for 527 patients according to the clinic registers is shown in Table 17. Medication information was not stated for 37 patients and for a further 20 was not available for a number of reasons: the writing was not legible, the medication was out of stock, the patient was referred, the patient defaulted, no medication was given, etc.

From Table 17 one notes that of the 793 prescriptions, the most frequently prescribed medications were Haloperidol (23.2%), followed by Fluphenazine (16.5%), Orphenadrine (16.1%) and Chlorpromazine (15.2%) together accounting for 71% of prescriptions.

Table 17. Medication from Clinic registers (N = 793 prescriptions)

Medication		%
Haloperidol	184	23.2
Fluphenazine decanoate	131	16.5
Orphenadrine	128	16.1
Chlorpromazine	121	15.2
Flupenthixol	32	4.0
Amitriptyline	34	4.2
Zuclopenthixol decanoate	25	3.2
Fluoxetine	23	2.9
Carbamazepine	19	2.4
Trifluoperazine	16	2.0
Oxazepam	13	1.6
Thioridazine	9	1.1
Clozapine	6	0.8
Imipramine	7	0.9
Sulpiride	7	0.9
Clonazepam	5	0.6
Hydroxyzine	4	0.5
Sodium valproate	4	0.5
Lithium	3	0.4
Phenytoin	3	0.4
Risperidone	2	0.3
Hydrochlorothiazide	2	0.3
Nicotinamide	2	0.3
Vit B Co	2	0.3
Diazepam	2	0.3
Thiamine	2	0.3
Clothiapine	2	0.3
Lorazepam	1	0.1
Phenobarbitone	1	0.1
Promethazine	1	0.1
Paracetamol	1	0.1
Propranolol	1	0.1
Total	793	100.0

This data was then analysed in terms of patients rather than prescriptions. In Table 18 the most frequently prescribed medications given to the 527 patients is shown. The prescriptions thus mean that almost 35% of patients received haloperidol, and almost a quarter received fluphenazine, orphenadrine and chlorpromazine respectively.

Table 18. Most frequent drugs in relation to numbers of patients (n= 527)

Medication	Freq	%
Haloperidol	184	34.9
Fluphenazine decanoate	131	24.9
Orphenadrine	128	24.3
Chlorpromazine	121	23.0
Flupenthixol	32	6.0
Amitriptyline	34	6.5
Zuclopenthixol decanoate	25	4.7
Fluoxetine	23	4.4
Carbamazepine	19	3.6
Trifluoperazine	16	3.0

f) Orphenadrine

According to the clinic register review, orphenadrine was the third most frequently prescribed medication comprising 128 of the 793 (16.1%) prescriptions. Almost one quarter of the patients received a prescription for it. An attempt was made to clarify its usage in terms of diagnosis and other medications prescribed.

The medications with which orphenadrine was prescribed are shown in Table 19.

Table 19. Medications prescribed with orphenadrine

Medication prescribed	Freq	%
Amitriptyline	1	0.6
Carbamazepine	5	3.3
Chlorpromazine	25	16,5
Diazepam	1	0.6
Flupenthixol	5	3.3
Fluphenazine decanoate	34	22.5
Haloperidol	63	41.7
Phenobarbitone	2	1.3
Phenytoin	2	1.3
Sodium Valproate	1	0.6
Trifluoperazine	3	1.9
Zuclopenthixol acetate	9	5.9
TOTAL	151	100

As can be seen, 86.8% of the orphenadrine was prescribed together with anti-psychotic agents, viz. chlorpromazine, fluphenazine decanoate, haloperidol, and

zuclopenthixol. It should be remembered that up to four medications were prescribed for patients so the medications below do not stand in a 1:1 relationship with orphenadrine. Thus the diazepam, phenytoin, phenobarbitone, carbamazepine were in prescriptions together with haloperidol; the amitriptyline was together with fluphenazine.

The diagnoses for which orphenadrine was prescribed are shown in Table 20.

Table 20. Diagnoses and Orphenadrine

DIAGNOSIS	ORPHENADRINE			
	YES		NO	
	Freq	%	Freq	%
Aggression	0	0.0	1	100
Anxiety	0	0.0	6	100
Bipolar	1	33.3	2	66.7
Delirium	0	0.0	1	100
Dementia	0	0.o	3	100
Depression	0	0.0	37	100
Epileptic Psychosis	1	10.0	9	90.0
Explosive Disorder	0	0.0	1	100
Hysterical Reaction	0	0.0	1	100
Insomnia	0	0.0	4	100
Mental Illness	3	11.1	24	88.9
Not stated	8	8.7	84	91.3
Organic brain Disorder	0	0.0	1	100
Organic Mood Disorder	0	0.0	1	100
Organic psychosis	1	100	0	0.0
Paranoid Disorder	0	0.0	1	100
Psych	6	30	14	70.0
Psychiatric	2	20.0	8	80.0
Psychosis	84	47.2	94	52.8
Schizo-affective disorder	0	0.0	1	100
Schizophrenia	18	15.4	99	84.6
Substance abuse	4	30.8	9	69.2
	128	24.2	401	75.8

As would be expected, the very large number of non specific diagnoses predominates: thus of the 128 prescriptions for orphenadrine, 97 (75.7%) of these carried a “diagnosis” of “mental illness”, “psych”, “psychosis” or “psychiatric” . The next most frequent diagnosis was schizophrenia with 18/ 128 (14%) of orphenadrine prescriptions. However among the 97 “non specific” labels one label “psychosis” clearly predominates: 84 of the 97 “orphenadrine” patients were given the

diagnosis “psychosis”. As was noted earlier, the label “psychosis” was used most frequently by Taung Gateway Clinic and indeed if orphenadrine usage is cross tabulated with the medication/patient per clinic, it can be seen that more than half (56.35) of the patients receiving orphenadrine came from this clinic. The breakdown is shown in Table 21.

Table 21. Orphenadrine prescription by Clinic

	Total patients	Orph. Rx	%	% of total patients
Bakubung	8	1	0.8	12.5
Botshabelo	12	4	3.1	33.3
Huhudi	79	16	12.5	20.3
Itekeng	27	5	3.9	18.5
Kgabo	150	5	3.9	3.3
Masuthle 1	8	0	0.0	0.0
Mocweding	17	5	3.9	29.4
Montshioa	12	4	3.1	33.3
Morokwaneng	12	8	6.3	66.7
Pitsedisulejang	10	2	1.6	20.0
S Mogaetsho	22	5	3.9	22.7
Sesobe	8	0	0.0	0.0
Stilfontein	38	1	0.8	2.6
Taung Gateway	126	72	56.3	57.1
TOTAL	529[2]	128	100	24.2

As can be seen the use of orphenadrine was not evenly distributed among the clinics but was centred in Taung Gateway clinic. Just over 56% of patients were prescribed orphenadrine, the next highest being Huhudi with 12.5%, then Morokwaneng with 6.3% and all the rest being less than 5%. Admittedly Taung Gateway clinic had a considerably larger number of psychiatric patients (121) than most of the other clinics and Morokwaneng used it in a higher percentage of its patients (66.7%). But it is interesting to note that Kgabo clinic which had 150 patients, recorded only 5 (3.3%) orphenadrine prescriptions.

[2] Note that this total reflects only those records for which drug information was available and is therefore less than the actual number of patients (584).

Qualitative results

Patients and caregivers

Description of focus groups:

Six focus group discussions were conducted with patients and caregivers, as described below.

Stilfontein Clinic

The Stilfontein Clinic is located right in the town of Stilfontein and caters for all categories of patients. It has a mental health coordinator who visits twice a month. The interview was conducted with a group of six mental health patients and one caregiver who responded to the clinic sister's invitation. All the participants were white, Afrikaans-speaking people. The language medium was thus English and Afrikaans.

The initial plan was to do two focus group interviews, one with mental health patients and one with their caregivers. Due to the fact that only one caregiver arrived, they were formed into one group. Further enquiry revealed that there are black patients who attend the clinic's mental health programme, with five being expected on the day of the interview. None were present to be included in the focus group, even after an hour's wait.

Unit 9, Mafikeng

Two focus groups were conducted at Unit 9 health centre Mafikeng, one with patients and one with caregivers. There were 9 patients (6 males and 3 females). All the patients were very attentive, and showed patience throughout the process. They all shared their different experiences and concerns. They appeared controlled from a psychosis point of view, except for one male patient who described auditory hallucinations. They did not know each other but were happy to meet in a group and to describe their experiences of care.

No caregivers had been specifically invited for the group. There were 4 caregivers who had accompanied their patient because they always do and they agreed to participate in the discussion. They were all female - mothers or wives of patients. They had little to say, indicating that they were happy with the service and treatment.

Kgabo Health Centre

This health centre is located in the Odi sub-district in Bojanala district. It serves a mainly rural population. It has 14 professional nurses, two of whom are trained in mental health. The two run the mental health facility within the clinic. Although the service is described as supermarket, mental health services are conducted in one room in the facility and patients are attended to every day. The PHC clinic is visited by the doctors twice per week. The doctor attends to general patients including mental health patients referred by the nurses. One focus group interview consisting of six patients and one care giver was conducted in seTswana. All patients had either schizophrenia or psychosis. Although one was dominant in the discussion, all had something to say about the care they received.

Huhudi Health Centre

Two focus groups interviews were conducted at Huhudi community Health Centre in Naledi Sub-district of Bophirima district. This is the only CHC in the sub-district and it is about 5km from Vryburg Town. There were six patients (4 females and 2 males) who responded to the sister's invitation and all six patients participated in the interview. The patients were fairly well controlled in terms of their mental status and they participated well in the interview, which was conducted in seTswana. There were only two female caregivers but it was decided not to combine them with the patients, so a separate interview was conducted with them, also in seTswana.

Results:

The themes arising from these focus group discussions are presented in tabulated form, in table 22.

Table 22: Themes from focus group interviews with patients and caregivers.

Major themes	Issues	Representative quotes
Satisfaction	Patients were satisfied with the care they received. They felt they receive good treatment and the care was clearly of a high standard. There was recognition by some of the responsibility they themselves have in getting good care.	"The treatment we get is first class" (Patient) "The treatment we receive is good." (Patient) "Personally this treatment made me to live better, even the injection made me better". (Patient) "Ah, right now since I take these tablets I have never experienced any problem". (Patient) "We are all happy. It is always a pleasure. We are always happy with this clinic" (Patient) "They treat us fine…they have understanding…they are kind and very forthcoming when coming to remedies". (Patient) "The treatment keeps me fine. I don't experience any problems. There is nothing that I can complain about, as I don't default." (Patient)

		"The treatment we get is good…it is not difficult for us to get the pills." (Patient) "I'm happy. If treatment is taken correctly you will have no problem and the doctor will not put you on an injection. My only problem is that I have anger and sometimes forgetful and as a result got lost especially at night. I find that I don't know where I am whether I'm from North or South, East or West even if I know the place or at the same place that I'm staying." (Patient)
Good nurses	Nurses were seen as being friendly and dedicated, and thus provided good care.	"Yes, the nurses take good care of us" (Patient) "Sometimes we come to the clinic very late and they are able to help us. We spend most of our time sleeping because of these tablets. We find ourselves coming very slowly and late but they are able to help us". (Patient) "They must be high, high. This clinic is always full of patients. They wake up early in the morning, these children, before sunrise even at tea time they don't eat even lunch" (Elderly patient) "They do care for them." (Caregiver) "They treat us fine." (Patient) "They have understanding." (Patient) "They are kind and very forthcoming when it comes to remedies." (Patient)
Dissatisfaction	Despite this general satisfaction, it was obvious that the process was not understood by some patients. A number of participants felt care could be improved.	"… the doctor will only ask you questions. Maybe is the way they are checking on patients, by asking questions." (Patient) "We are not checked by a doctor only the sisters will take BP even the psychiatric doctor will ask only questions about how you feel and he will only give medication." (Patient) "If the doctor could do an overall check up and not only ask you silly questions like what is today's date, which day is today and how do you feel and just give medication. He must check for other illnesses." (Patient) ""I will say the service in this clinic is weak…" (Patient) "…but sometimes these people who are helping us don't have that care." (Patient)
	Communication was raised as a particular problem needing to be addressed.	"If they could improve the communication, the way they communicate information is not good. Last week I was told while I was already at the clinic that my appointment is changed to Monday and it made me feel bad because I went back home and luckily I was still having medication." (Patient) "If the sisters could listen to the concerns that we tell them." (Caregiver)

	Lack of continuity due to staff turnover was noted, and distresses patients.	"Every week they change … they should keep them for four to five months so that they get used to us." (Patient)
Time issues	Long waiting times were mentioned as a significant problem. The time spent waiting for treatment or to see a nurse/doctor should be shortened. In some cases medication can be collected without having to see a health care provider	"If they could change the way they wait for treatment while being at the clinic. If they could also not wait for long time, they would be attended to immediately." (Caregiver) "… we stay on long queue for a long time and if you were out of medication you will be doing or saying nasty things and people will be laughing at you but if there was a special room other people will not see us. If it's only us we will not have to wait for such a long time. From 8 to 2, 3 or 4 is a long time and we became impatient." (Patient)
	The concern over waiting time extends to the hospital as well.	"If the doctors could check us at the clinic so that when we go for our check up at hospital the nurses and the doctors are given a report on how we are progressing and they take over for recommendations on our progress. That is going to be fast and we won't stay for a long time in the long queue." (Patient)
Special clinics	There was a desire expressed for specialised service in the form of special clinics and dedicated staff for care of mentally ill patients.	"They should also have a special doctor and room that they consult in or they should be given one, two or three days in a week and be told on those days that on their arrival they should go straight to that room." (Caregiver) "If there could be a separate room and instead of going to Bophelong for check up. It is expensive to go to Bophelong and again patient wait for a long time." (Caregiver)
More staff	A need for more staff was noted. Particularly they felt there was a need for doctors to help in the care of patients with mental health problems.	"The staff needs to be increased…one nurse can't attend general patients and maternity." (Caregiver) "Dentists and pensioners' doctors are the only ones that visit the clinic." (Patient) "Doctors don't care for us…when I am sick I go to the private doctor."(Patient) "I wish if there could be a doctor at clinic who could check us always on our monthly visits." (Patient)

Medication issues	A number of issues were raised around medication problems, such as medicine going out of stock, issuing of repeat medication, accessing treatment when mental health coordinators were not present, etc	"The service in this clinic is very weak…I am from Pretoria…since I started coming here, today is the 17th, I started to come here on the 11th …they were telling me the medication is not available." (Patient) "I wish our medication could be available every time so that we are not being sent to other clinics because they are far and you have to wait for medication if you don't have money and your problem will start. It will be best if there is a special room for our selves and our medication." (Patient)
	Patients also described concerns about particular treatment regimens.	"The treatment is fine except I have fear of an injection. I don't know if they can arrange for me to get pills instead of an injection." (Patient) "I have been taking my treatment for a long time, 30 years now. First it was from the hospital and later transferred to the clinic and I had never defaulted treatment but only check up because Bophelong is very far and transport is a bit costly. I was taking admiral [sic] 100 together with an injection and I talked with my doctor that I don't need an injection and he stopped it and now I'm using only the pills. I'm very much concern about the new treatment called latrine [sic] that is going to be used to replace admiral." (Patient) "I don't experience any difference. I'm given an injection and I don't like it, in fact it makes me not to come to the clinic because it's so painful that I'll spend 2 weeks having pain on the side that was injected and the side will be swollen. There is no difference. I am always listening to my father, God and people who died, the American, Persians, Germans and the Botswana's talking about me." (Patient)
Minor themes		
Comprehensive care	Care for physical problems should not be separated from mental health problems	"Again, this asthma just started. I am going to tell the sister today, that I think it is asthma. Will you try to help me and again check whether it is asthma or what?" (Patient)
Extended involvement of staff	The involvement of staff members beyond simple treatment was appreciated, the example being given of a party for patients.	"They throw also a party for us here. You will find all '*Weskoppies'** being here. We eat and become full". (Patient) [*'*Weskoppies'* is a term some patients use to describe themselves, in terms of being mentally ill. It derives from the mental health referral hospital in Pretoria of that name.]

Social issues	Patients felt their family and social problems were being addressed. However, social workers would help this.	"I am thinking too much because I was having problems at home. That my husband is not working." (Patient) "If there could be a social worker available at clinics because we are having problems that need their service at home but we cannot reach them because they are far away you have to pay to go and see them." (Patient)
	Caregivers believe family members are educated about the illness, but patients do not always see it the same way.	"We are being called to the clinic especially when your patient is not well looked; after they will tell us on how to take care and look after the mental patient. They need us to show love and care for them." (Caregiver) "We need people who could come and teach us about how to care for our selves and the importance of taking treatment and not only mental treatment things like abuse because some of us are abused by our families." (Patient)
	Patients have special needs which must be considered.	"The treatment is fine except for these days because I have a problem of getting lost. Like when I got here or going to town, I have to hold myself like this on the head and I will be fine. But if I don't, I get lost. This problem comes when I'm alone. My child is at school and I live alone." (patient)
	Money was raised as an important issue in respect of accessing treatment.	"We psychiatric, we don't work and you find that we travel to Bophelong and pay R17 sometimes we default check up because we don't have money." (Patient)
Community	Some patients felt that everyone was in it for themselves with no support amongst each other, while others felt they did meet together and support each other.	"I wish if we could have a support group where by we could come and share our ideas and experiences." (Caregiver) "It feels great to know and to see that we are not alone. It is for the first time [in this focus group discussion] we meet in such a group. I think we should form a support group and meet more often to discuss our problems and our experiences and to share ideas on how we cope with our problems. I cannot say we don't have support from the clinic because they don't know our needs and I think if we could form the support group then they will be able to support us." (Patient)
	The issue of stigma in the community was also raised – discrimination is a significant issue.	"They do discriminate against them…some they do beat and this makes me sick…our community needs to be educated about this issue of mental health." (Caregiver) "They treat us differently…they discriminate against us, so is the community." (Patient)

Doctors' and professional nurses' interviews

Description of interviews

Eight interviews were conducted with professional nurses in the clinics and doctors visiting the clinics.

- In Southern district, two professional nurses were interviewed. One had training in mental health and the other was a nurse dealing mostly with general patients. The doctor interviewed had done mental health as part of her family medicine rotation.
- In Bojanala district, one doctor and one professional nurse were interviewed. The doctor visited the clinic from the district hospital and attended to patients booked under the general primary care services and also those referred by the mental health trained nurses. The nurse interviewed was one of the two at the health centre trained in mental health.
- In Bophirima district, two professional nurses were interviewed. One had training in mental health and the other was the professional nurse in charge of the facility. The doctor who was interviewed had been working in the district for more than ten years.

Results:

The themes arising from these interviews are presented in tabulated form, in table 23.

Table 23: Themes from interviews with professional nurses and doctors.

Major themes	Issues	Representative quotes
Good care	The professional nurses feel competent in what they are doing, and feel they are offering a good service to mentally ill patients. The system – referring to the old approach of dedicated clinics – was seen as being very good and providing good care.	"I think we provide a very good service …its very broad" (Sr) "The care is very good." (Sr) "There's a lot in place" (Dr) "There is a good mental health service at [this] clinic".(Dr) "By treating them we are providing an essential service to the community".(Sr)
Dedicated service	The mental health system with a designated person was described as the ideal. In one case, this collapsed when a mental health coordinator died. Compliance is improved by having a designated doctor and clinic, or at least an interested doctor. It was felt that patients prefer this and it decreases waiting times. Having designated dates for mental health patients was seen to be important.	"There are many of them that want to talk to one particular person…they make contact with one person. It can be a problem when one goes on holiday…It's not a problem with medication - they take the medication, but if it's for conversation they come back." (Sr) " ..If they could be seen separately and isolated…if the nurses can be outside... it could be here [pointing to an open space behind the clinic]" (Sr) "Because they are psychiatric patients, you have to give them a date and they keep to that date. If there is any problem with that date, there is a terrible drama." (Sr) "There's actually just a small group of people who like this type of work. They care for their patients - the patients come back to them each time, they're compliant. …If you have such people it helps with compliance." (Dr) "Mental health patients get help on any day but the main day for them is Tuesday." (Dr) "When the coordinator died in 2004, there was no replacement and the mental health services collapsed" (Sr)

Supermarket approach	In contrast, the supermarket approach was seen as not being appropriate for mental health care. It may be fine for patients who are controlled, but not for those who are still symptomatic. It undermines compliance as well as group therapy. Mental health patients must be separated from the rest.	"The patients don't want to be mixed with them. They become aggressive. They want to be seen alone. There is name calling from the other patients. The patients don't want to wait in the queue."(Sr) "A psychiatric guy is not someone who can sit in a queue for hours. He comes to the front and says I am looking for you now." (Sr) "I would not suggest that the general sister sees these patients. It's a different type of patient... you can take a chance with a sore ankle for four years. But this type of treatment, they can get back a quality of life. …There must be a psychiatric sister." (Dr) "They could fit in coming a few a day." (Sr) "The supermarket approach has the problem of heavy workload. This is mainly with the general patients and the HIV patients. We get stuck with the HIV patients as one tends to take long to resolve their problems. This does not leave much room for the mental health patients".(Dr) "The problem is that now patients decide to come at their own time some early in the morning and others in the after noon. It is difficult to have a group for group therapy and health talk. The group also keeps changing so you have to individualise the care".(Sr) "[The supermarket approach] will not work because it will take a lot of time" (Sr) "Some sisters will not complete the special mental health register…they can't move from one room to another looking for the register" (Sr) "Patients are afraid of the waiting…it will increase defaulting" (Sr) "Supermarket approach is overloading us to such an extent that you can't even check the date on which the patient last came to the clinic, you tend to give the patient treatment even when it is not due." (nurse)
	There was, however, one respondent who felt strongly that the supermarket approach provides better care	"The supermarket approach works very well. We are trained in general nursing and psychiatry so we are able to see the patient holistically. When we had specialised clinic days we only concentrated on the mental problem and had to refer the patients to different clinic days for other problems. For now we treat even the asthma and hypertension in mentally ill patients in the same visit. This improves compliance".(Sr)

Problems with the service	Despite being generally positive, problems were raised with the service. These included the lack of observation facilities, the short time spent in hospitals by patients referred there, and lack of communication between levels of care.	"There is a referral service." (Sr) "The big problem is that patients default from treatment. One month you see one and then you do not see him again for the next three months. So when the patients come you have to start all over again and their condition is worse. We try to encourage the patient and relatives to come for treatment. Sometimes we even throw parties for them to encourage them".(Sr) "The patients we transfer to the psychiatric hospital are discharged very quickly and many of them relapse." (Dr) "We don't have any regular communication between the hospital and the clinics…we never had any workshop to share knowledge." (Dr) "We don't have a psychiatric unit…we see patients assaulting nurses, damaging hospital property…we need a secure unit." (Dr)
Psychiatric nurses	Doctors feel that the psychiatric-trained nurse is the backbone of the service and essential for good mental health care. The role of the doctor should be one of support.	"There must be a psychiatric sister." (Dr) "The nurses are managing well even though they don't have a specialist visiting the clinic". (Dr) "The service is mainly run by the professional nurses". (Dr) "There is one nurse trained in mental health and they offer a very comprehensive service".(Dr) "I feel adequate but there are some patients I do refer to doctors for assistance although sometimes the doctor does not give me feedback." (Sr)
Human resources	A need for more staff was expressed, in a number of ways – more nurses, more doctors, and more mental health nurse specialists. Doctors felt they and their colleagues are inadequately trained. Comments on the availability of mental health specialists depended on the location of the clinic – those near to a psychiatric hospital spoke positively about this, whereas those further away indicated this support was lacking.	"Before there were more psychiatric nurses…it was better." (Sr) "There is shortage of trained mental health sisters. One nurse is allocated to the mental health room per day. They should increase the PHC nurses to take off the load of general patients".(Dr) "We do not have a specialist visiting the clinic as it was in the past. The patients who need a specialist are first seen by the visiting doctor who refers to GaRankuwa. The doctors visit three times a week, so we are able to book the mental patients for the doctor and there is no delay. It would be nice to have a specialist visiting".(Sr) "There is only one sister trained in psychiatry [She had just qualified]. All the others are general PHC sisters and those with interest in psychiatry are allowed to work with the mental health patients. However we still go to help with the general queue"(Sr) "I am not really a psychiatric doctor…the other doctors also have limited psychiatric experience." (Dr)

Legal issues	The Mental Health Care Act is being followed in some areas, but not everyone is aware of all the issues and knows all the requirements. Some nurses indicated that they had not even read the Act. The process required by the Act is complicated and difficult.	"The whole legal system is working – the mental health act is utilized." (Dr) "It will only work if all the doctors really know how the new system works. (Dr) "I am not aware of the mental health act. I have never seen it but would like to. Apart from this we don't have any other challenges".(Dr) "The mental health act is very good. It is meant to protect the patient and also gives direction to those treating them. Without the act mental patients can get abused. The act also says that patients should be treated in the community and I agree with this. We are also protected by the act because it gives us guidelines on how to treat the patient".(Sr) "I didn't go through it…the one that I look for are the reports that the mental health coordinator is sending to us." (Sr)
No reviews	Patients are not being reviewed regularly as required. In some cases, patients have not been reviewed for more than 5 years.	"They make appointments. The doctor has had problems with trying to change treatment with some patients who we know have been at Tara or Weskoppies and….he wants to stop their disability grant…But we explain to him." (Sr) "Mentally ill patients are neglected" (Sr) "Reviews are not done…we have been raising this even in the reports." (Sr) "There is no real system…if the patients come back we see them, if they don't come back we don't know how they are." (Dr)
No diagnoses	Many patients do not have diagnoses made – they are simply treated on their symptoms.	"The term that many use is psychiatric patient." (Dr)
Cooperation with other agencies	There is a need to work with the police and with the emergency medical services in order to manage psychiatric patients. Good cooperation is generally reported.	"On the other hand there has been improvement in the ambulance services. In the past emergency services never went for mental patients. Now they fetch the patients so long as we accompany them to give sedation and the relatives are willing to accompany the patients. This is very good".(Sr) "The police say that it is not their duty to collect aggressive patients from their homes…and the EMS say it is not in their scope because the patients will break their equipment. If we have transport we go to the homes to sedate the patient but if we don't have transport we ask the family to bring the patient to the clinic." (Sr)

Family involvement	Differing views were expressed on the level of involvement of families, with some interviewees describing them as supportive and others saying they were not supportive and not involved, and even did not care,	"There are those that are supportive and there are those who want their patients all the time to be in the psychiatric institutions." (Sr)
Medication	Generally it was stated that there were few problems with medication supplies, although one doctor did indicate a problem with the supply of emergency drugs, and one nurse indicated there were drugs out of stock at times	"If the hospital says they don't have supplies or Mmabatho says they don't have supplies…it is absolutely unacceptable not to have medication for psychiatric patients. You know what happens if psychiatric patients don't get their medication – you can't say to a guy who uses camcolith [lithium] or modecate, I don't have your medication. This is very bad."(Sr) "If things change, it's a bit difficult because then the prescription will only change the following month. But they do have emergency stock." (Dr) "There is no problem except if we the sisters don't order on time." (Sr)
Emergencies	Protocols are available for these	"We don't have emergency drugs like etomine at the clinic. We would rely on manpower to handle the patient. For the confused patient, if I was in the hospital I would use serenace or diazepam. In the clinic I am not able to use any. Otherwise we have all other medications and the supply is regular. There are no problems with medication of specific patients".(Dr)
Home visits	Mostly home visits cannot be done because of lack of transport, but in some instances these are being done.	"And this [Mental health coordinator] actually has an ambulatory practice because they drive around to people's homes…we did home visits and went to get people's assistance and heard people's complaints about their children…so it's relatively accessible. It was very nice. You drive around and see how these people's whole little life system works, the context within which they work. Most people don't have transport to get to the services." (Dr) "Sometimes we do home visits but sometimes there is no transport." (Sr)
Community awareness	A need was expressed to create community awareness, and to facilitate destigmatisation. In some cases there is a level of community participation already	"This way they start understanding that mental illness is treatable. This also helps in taking the fear of mental illness from the community".(Sr) "We have volunteers that are doing DOTS support for TB, we send them to follow up the mental patients".(Sr) "Patients need to be treated where their families are as there are no homes in the hospitals or the mental institutions".(Sr)

		"The patients also like to be involved in other activities like soccer, so we organize games for them. The community seems to like these events as they can see that the patients are improving".(Sr) "There is a need to form a mental health forum…like cancer society…so that there is pressure from the community to improve the service." (Dr) "We should utilize the awareness month to mobilize the patients and community to do activities like sports…they will know that they belong to the society and not focus on their illness…this will reduce the dagga smoking and alcohol abuse." (Sr)
Minor themes		
Personal satisfaction	One interviewee described her involvement with mental health patients as a source of satisfaction and personal growth, obviously enjoying and taking pride in what she is doing.	"Managing mentally ill patients is very satisfying to me as they are patients like any other and they need care. It is very good when you help a patient who comes with severe mental illness behaving abnormally and you see him or her improving … We also learn a lot from these patients. Yes, the learning is both professional and personal. At personal level I learn a lot of things that I take home with me and use them in my family. For example the effects of stress and drugs. At personal level I try to avoid stress and drugs because I have seen what it can do to patients".(Sr)

Mental health coordinators

Description of focus group

One focus group discussion was conducted. There were 12 respondents out of a large group of provincial mental health coordinators who had gathered for a provincial meeting in Potchefstroom; the focus group was conducted as a "fish bowl" exercise, with the rest of the coordinators observing from the outside. The interview was captured on paper by two individual people and the notes triangulated afterwards as the tape recorder that had been arranged did not function. The inputs were also summarized for validation by the group.

Results:

The themes arising from this focus group discussion are presented in tabulated form, in table 24.

Table 24: Themes from focus group discussion with mental health coordinators.

Themes	Issues	Representative quotes
Inadequate care	Patients in the clinics often get very inadequate care. Resource issues (budgets) impact on this.	"A full evaluation is not done of patients at the clinics for example the mental status by the primary care nurses. They usually write 'psychiatric patient – for collection of treatment'." "Most nurses … don't take proper history." "Users of the system are not being assessed according to the Act." "The treatment of psychiatry patients is mostly still with first generation psychotropics … cheap treatment. Even risperdal needs a motivation. The cheapness is affecting patients and also affecting compliance. We need access to newer and better treatment." "There are budget constraints. We are not allowed to take blood levels for certain clients e.g. epanutin, tegretol, lithium (particularly in one sub-district), to contain the budget"

Resource issues	There is a lack of human resources. There are no psychologists and psychiatrists available. There are also few doctors to assist with patient reviews and few trained mental health nurses.	"It is not up to standard because of lack of resources… no psychologists, psychiatrists." "The lack of a psychiatrist especially with community psychiatry services in mind is a problem." "There is also a lack of GP's to review the patients. A lack of mental health trained professionals, for example a general sister has to do everything." "Staffing is a problem. Sometimes there is no psychiatrically trained nurse." "There should be an allocation of a psych nurse in each clinic – even those with psychiatry in undergraduate training.")
	Lack of transport prevents home visits from being done.	"There are transport problems if one wants to go and visit patients and do home visits."
Training issues	Clinic staff are inadequately trained for the job	"There should be training of PHC (clinic) nurses in psychiatric nursing. Some clinic nurses are using the 'white manual'. There are areas where there is no psychiatrically trained nurse."
	Mental health coordinators also need training	"Training on advanced psychiatry should be for all co-ordinators. We change the prescriptions when the doctor is wrong."
	Greater focus on training is needed, and support for implementation of what is learnt.	"The province needs to give the same recognition to advanced psychiatry as to advanced midwifery. This is not happening. If there is an allocation for training, many more other categories go than advanced psychiatry." "There is training but it is never being implemented. Implement small things and they will grow and grow."
Medication issues	There are lots of problems with prescribing – inappropriate prescribing is common.	"Most of the doctors at hospital are inexperienced… they prescribe for the sake of prescribing. We often have to change the prescription." "When a depressed patient comes they are being treated with a combination of antidepressants and psychotropics sometimes for many years. If there was depression as a diagnosis, it is something that can be healed but because of psychotropic drugs, the patient gets worse and worse." "There is a high defaulter rate because of side effects."
	Levels of care cause problems	"Then the treatment. We all know there is level 1, level 2 types of treatment with only level one at the clinics and these patients need to be referred if they are on level 2 treatment. They don't have money for the taxi."
Attitudes	There are negative attitudes towards mental health patients and a lack of interest in mental health	"Attitude is a problem. Most nurses don't come for mental health workshops. They don't take proper history." "Attitude is a big problem."

Role of mental health coordinators	The role of the mental health coordinators is often unclear and becomes focused on curative issues because of the lack of skills of staff in the clinics	"The mental health coordinator has to do all things and become curative rather than preventative. "There is a role clarification problem. We cannot deal with the sub-programmes… get stuck in curative care." [Clarification: The sub-programmes are suicide prevention, substance abuse and victim empowerment.]
	The managers are not supportive and do not understand the role and needs of mental health coordinators	"Managers don't know what the programme involves and what is needed." "Management should support the activities for example the other programmes get notice of a 2 week activity, with reports and they are supported. If the circular comes from the province, then there's support. We mostly initiate but the other programmes are initiated from the province." "Management needs to be trained. They attend meetings but when we have to implement they … don't even remember what was discussed."
	They feel isolated and carry the stigma of their patients.	"It is frustrating…isolated from information and stigmatized as psychiatric nurse. We are deprived of new knowledge and skills."
Team work	Team work is needed but does not often occur.	"The team means integrated services for example the school nurse sees the patient and sends to the clinic and then to the social worker, we should not be alone, it makes it simpler." "There is a high defaulter rate because of side effects and a lack of team approach." "Coming back to role clarification, the impact on management. There is a great deal of passing the buck. The patient has a social problem, is sent to social development who says this is a psychiatric patient and passes him back but he doesn't really belong."
Community involvement	There is a lack of community resources and a need for education of the community	"There is also a lack of community resources e.g. activities. People get grants, abuse them are readmitted; it is a vicious circle." "The education of the community is important. They are unused to the shift from institutions to the community and don't know how to handle them." "The NGO's and CBO's need to concentrate on the needs of mental health e.g. to get projects going for the clients. They need funding."
Legal issues	Patients are not being assessed according to the Mental Health Care Act	"The users of the system are not being assessed according the Act."

Attention to mental health	There needs to be recognition of mental health as a problem and political support for mental health care. Insufficient attention is paid to the problem. This should be addressed at a national level.	"There's a lot to be done … to recognize mental health as defined by WHO, with a focus on health and not on illness. There needs to be political will." "There are no facilities for children. It needs political recognition, this will help with things like facilities for children." "When one looks at the national and provincial strategic goals and priorities, there's a lot on HIV and TB and other areas but nothing on mental health. They build in details for the other programmes but no specifics for mental health. Just a few generalized words. It needs good national planning to correct this." "Even in the clinic supervision manual, there is nothing on mental health."
Co-ordination	There is a need for better coordination of services	"Better co-ordination of services. You make your plan, then there's something else and you have to cancel."
	Integration with other programmes is an important aspect of this.	"We need true integration of services …. Uniformity." "Programmes need to be integrated more."
Institutions	There are only two psychiatric institutions in the province. More facilities are needed	"There are only two institutions in North West province … Bophelong and Witrand. Moretele has a 72 hour stay facility, patients are discharged on high medication and often relapse at home because of the side effects. When they are referred to Bophelong for example, they only stay a week and back at home relapse easily. There should be some institution in each and every sub-district."

DISCUSSION

The results of the quantitative component are discussed first, followed by the qualitative findings, although there is cross-reference. The recommendations arise out of a synthesis of the two.

Limitations

Poor record-keeping was a major limitation of this study as well as being a major finding (see below); it meant that accessing data was difficult. The loss of data became an added problem. However, the fact that 142 patient records and 584 entries in the clinic registers were examined in all 4 districts of the province, provides a good basis for discussion. Furthermore, the number of patients and staff interviewed add weight to the findings. The consistency within the quantitative data, between patient records and clinic registers, and between the quantitative and qualitative findings, mean that many conclusions can be drawn with confidence.

This report endeavours to make recommendations on those issues which come through clearly and consistently despite any drawbacks in the data collected.

Quantitative findings

Record keeping

The major finding is the poor quality of record-keeping, both in terms of patient records and clinic registers. Where this might have been better, which was in one site where computerised data was collected, the loss of computerised data without back-up emphasises the need for a proper system. It is clear that there is no standard format for history taking, examination, data entry, recording of diagnosis and management, etc, in patient records. A simple, easy-to-use, and appropriate patient chart for mental health care is urgently required, as part of a systematic approach to improving care of mentally ill patients.

Some of the issues which should be addressed in every mentally ill patient, and may have been in these patients, but for which there was little or no evidence to be found include fundamental ones such as side effects of medications, adherence, disability grants, drug and alcohol use and abuse, family and social history, etc. Such information is important given the finding, for example, that disability grants can improve adherence (Koch & Gillis, 1991).

Incomplete medical records may relate to the scarcity of clerks and lack of appropriate training of clinic sisters. Because of the supermarket approach, referred to many times in the interviews, mental health patients are not usually seen by a health worker with special interest or training in this area. Clinics frequently concentrate on seeing acute patients and dispensing treatment to them, and repeating prescriptions for chronic patients. Thus poor record-keeping may be a casualty of the supermarket approach, or may reflect the absence of a functional system for recording care for all chronically ill patients. Patients with chronic illness cannot be managed adequately without good record-keeping (Couper, 2003); this points to a wider problem, beyond just mental health patients, which needs to be addressed as part of improving management of chronic patients in general and mental health patients in particular.

Demographics

The racial demographics of the patients whose records were reviewed reflect the profile of the province according to the 2001 census, which indicated that North West has 89.6% black African and 8.4% white inhabitants (Statistics SA, 200l). This confirms that the sampling was appropriate.

Gender differences were clear in both patient records (57% male) and clinic registers (56% male), as opposed to a provincial proportion of 50.3% male in the general population; the predominance of men amongst the population of mental health patients fits with the literature only perhaps in terms of schizophrenia (Gold, 1998; McGrath et al, 2004), whereas women predominate in most other mental

disorders (Dennerstein, 1995; Gold, 1998) – possibly because of an increased prevalence of greater use of health care services (Rhodes & Goering, 1994). Modiba et al (2000) found similar proportions in their study in Moretele district within the province. The question must be raised to what extent this reflects an issue of labelling and/or access to care, versus an actual difference in the prevalence of mental illness in men versus women.

No conclusions can be made regarding mental illness in adolescents, as people under 18 years were deliberately excluded from the study. It is interesting that 70% of patients whose records were reviewed and 60% of patients in the register were under 50 years old. This is similar to what is found elsewhere in terms of psychotic disorders (Gold, 1998; Rössler et al, 2005). Thus the prevalence of mental illness does not increase as people get older – whether this is due to genuine epidemiological differences such as in schizophrenia which is more common in people under 30 years of age (Daubenton & van Rensburg, 2001), or due to other factors such as premature death, substance abuse, lack of access to care, or "burning out" can be no more than speculation.

Diagnoses

Many concerns are raised by the information obtained regarding diagnoses of patients within the province. The extent to which diagnoses are not available, either because nothing is recorded or because non-specific terms are used such as "psych patient", "mental illness" and "psychiatric", is worrying. Adequate treatment cannot be provided without accurate and appropriate diagnosis – yet 44.4% of patients' records did not have a diagnosis that could be determined. Clinic registers not surprisingly revealed an even greater proportion of absent diagnoses (64%); while these may not have the same direct influence on patient care, they are included in any statistics collected in clinics and health centres, and thus determine the data presented to the provincial (and national) department of health, which forms the basis for planning and decision-making.

In some instances, this arose because clinic nurses made the initial diagnosis and

patients had not had the chance of seeing a doctor, hence the perpetuation of the label of “psychiatric patient” without a definite psychiatric condition, which indicates the shortage of doctors in the province, which has the lowest doctor-to-population ratio in the country (Health Systems Trust, 2004), and particularly the shortage of doctors trained or working in the field of mental health. It is also argued in the United Kingdom that the way patients present with mental problems in primary care, the understanding of mental illness at that level and the paradigm with which patients are approached may all contribute to under-diagnosis (Lester et al, 2004)

It is notable that the lack of diagnosis is particularly high in certain clinics, with 6 of them (40% of the sample) giving no specific diagnosis to 100% of their patients. This calls for urgent intervention at these sites, but also for a review of this issue in all clinics, given the fact that this is a sample. In 3 clinics it is conversely lower, approaching an acceptable standard; is it training in these sites which makes the difference? Further investigation is needed.

Schizophrenia is given as the diagnosis in 35.2% of patient records examined, and 20.5% of patients in the clinic registers, representing 63% and 57% respectively of patients for whom diagnoses were available. This is surprisingly high, and begs the question whether any form of psychosis has a tendency to be labelled “schizophrenia”, or whether this is indeed indicative of a true prevalence in the province. A similar problem was noted in an earlier study in Moretele sub-district (Modiba et al, 2000), where all the patients whose records were reviewed were labelled as having either schizophrenia or epilepsy.

On the other hand, the low rate of diagnosis of certain mental health problems, in the light of what is expected based on international and local prevalence data is worrying. This is particularly the case in terms of depression and other mood disorders (not a single person in the patient records had a diagnosis of bipolar disorder and only 3 in the clinic registers), substance abuse and anxiety-related disorders. In Europe, depression, phobias, somatoform disorders and alcohol dependence are the most common psychiatric disorders (Wittchen & Jacobi, 2005). In fact the distribution approaches what is expected in the clinical setting, where schizophrenia, bipolar disorder, cognitive disorders, substance-related disorders

and personality disorders are said to constitute 75% of diagnoses (but is still skewed in relationship to this), whereas one would assume it would be closer to what is expected at community level where depressive illness and anxiety states apparently make up about 90% of mental illness (Kaliski, 2001). It is suspected that these disorders are simply being missed and that patients either do not present with them or, more likely, they are being misdiagnosed, or treated symptomatically only. Internationally, mental disorders are thought to be missed by primary care providers in more than half of all patients suffering from such problems, with the figures being much higher in South Africa (Mash, 2000).

Diagnoses are made largely by doctors, but seldom by psychiatrists, which is not surprising given the shortage of psychiatrists in the province. However, the proportion of patients with major psychiatric disorders suggests that a greater number should have been sent to mental hospitals for evaluation and diagnosis. This accords with the finding that only 72 patients out of 142 were noted to have had a previous hospital admission.

This would not necessarily solve the problem. It is noted that during down referral from mental health institutions, the discharge summaries with correct diagnoses are often not available, for a range of reasons – being lost by patients or clinic staff, being sent to the wrong clinic, patients changing clinics, not having been written or sent, etc.

Health professionals are often overwhelmed by the workload, and furthermore often feel uncomfortable managing mentally ill patients, so often do not take a detailed history whenever patients visit the clinic, preferring simply to continue what was done before. Doctors and nurses indicated their uncertainty and lack of confidence in managing mental health conditions and their need for further training. This may also have contributed towards the non-specific diagnoses.

One has also to raise the question whether in fact the diagnostic categories that are used are in fact appropriate. There is a whole debate around the usefulness of standardised diagnoses to define mental disorders at community level in the South African context (Mash, 2000).

In many areas, community service doctors assist the clinics and the turnover of doctors is high. This break in continuity of care on the part of the doctor is a reality which undermines good quality of care and attention to important details such as establishing proper diagnoses.

Also, there are no formalized standards of documentation in clinics and it is very easy for clinic staff to omit information.

Medication

The use of medication reflects the availability of drugs in clinics as per the Essential Drugs List, as well as the range of diagnoses, with anti-psychotic agents being the major drugs being used. The range of drugs is similar to that found in Moretele (Modiba et al, 2000)

The extent of use of Orphenadrine for extra-pyramidal side-effects, especially when these were seldom recorded, needs to be investigated, and clear protocols implemented in this regard. The high use in one particular clinic emphasises that this is most likely due to training and/or habit, and needs correction.

The limited knowledge of psychiatry in general among nurses and doctors, referred to by a number of the respondents and the mental health coordinators in particular, leads to repetition of previous scripts instead of proper review.

Any mental health drug which has been prescribed by a specialist can be motivated for and ordered per patient name from the local hospital and down referred to the nearest clinic. There is therefore no theoretical limit to good drugs. However, such patients need to get a prescription renewed 6 monthly, which requires good systems to be in place. This is where district psychiatrists are needed to look at outreach programmes to prevent transport and other access issues from leading to non-adherence.

During the time of the study, the manufacture of thioridazine was terminated, the provincial medical store was depleted of the drug and clients were changed to other drugs. There was also a moratorium in some districts on blood tests relating to certain drugs e.g. lithium, phenytoin and carbamazepine, due to budgetary constraints, which would have impacted on blood monitoring of these drugs, but this cannot fully explain the virtual absence of blood level monitoring for patients on these agents.

Patient review

Mental health nurses bear a major burden in terms of caring for these patients; 83% of patients were last reviewed by a nurse. This is done on top of the load normally carried in terms of all the other patients that need to be seen, and thus it accounts for many of the issues raised above.

It is also not surprising, given this load and given the absence of a proper system, that so many patients are not being reviewed regularly. The standard set by the National Department of Health (2002) of 6-monthly review for all patients on psychiatric medication is not being met, with 35.8% of patients having last been reviewed more than 6 months before, and 23.5% over a year before – with the data not obtainable in many records, so that these figures are likely to be much higher. The data is worse if one looks at when the last review by a doctor was done, let alone a psychiatrist, with 20% of patients last having been seen by a doctor more than 5 years before. This is, not surprisingly, more of a problem in some areas than others, which relates to distribution and availability of staff in the particular district.

Treatment is often repeated in absentia as doctors do not visit some of the clinics studied regularly, indicative of additional systemic problems. It is possible for 6 monthly reviews to be done by doctors if the visits are scheduled to be included with those of other chronic patients at clinics, which speaks to the organisation of care for these patients. Obviously this depends on regular doctors' visits to clinics, which is far from being a norm in the province.

In in-depth interviews with 6 patients suffering from Psychiatric illness in the Mmametlhake Health District, Shariff (2000) notes that 3 patients complained about not being reassessed, with 2 of these claiming they were not mentally ill, but were never adequately reassessed. This highlights the importance of such reviews.

At the same time it must be recognised that the long-term ongoing attendance by many patients indicates that they are getting something positive out of the system to keep them coming back.

Qualitative findings

Despite the problems noted, it is encouraging that patients and their caregivers are generally satisfied and feel they receive a good standard of care, with nurses who are sincerely interested in their welfare. Modiba et al (2000) similarly found that a high proportion (77%) of patients and caregivers interviewed by them in Moretele sub-district perceived the clinic service to be helpful. In contrast to the study by Shariff (2000), where dissatisfaction with the service in a district in Limpopo province led to poor patient care, the patients interviewed in this province were mostly positive about their health care. Staff themselves feel they are generally giving good care to mental health patients. It is also very clear that nurses are the backbone of the service, and that doctors are quite peripheral. Any intervention which does not take that into account will not succeed.

There are important issues of concern that were raised by all groups. Communication problems are one such. It is clear that patients are not always sure when they should come, and often find the process confusing. Similarly there is a problem of communication between clinics and hospitals, particularly referral hospitals, which adds to the general lack of information that is evident in responses of interviewees, borne out by the quantitative findings.

Patients and caregivers struggle with a lack of continuity, seeing different staff members each time, and with the length of time spent waiting, both in the clinics and at hospital. To address these and other concerns, they plead for a specialised

service for mentally ill patients. This is echoed by doctors and nurses who argue that specialised services are needed due to the skills required, the difficulty of ensuring adherence to treatment, the importance of continuity, the long waiting times for patients, etc. There is a strong feeling amongst staff generally that the supermarket approach is not appropriate for mental health care. Patients do not get adequate attention and there is not time to see them properly. Although one interviewee felt that it is important that everything is treated together, as envisaged in the supermarket approach, members of at least one focus group discussion felt they do not get care for their other problems despite the policy.

It is recognised that the problem is not the supermarket approach per se but rather the process of de-hospitalisation instead of comprehensive de-institutionalisation. The absence of the social dimension of mental health care and rehabilitation has wrongly placed all responsibility of care on primary care generalists who too often rely on a medical model of intervention. Reorganisation of care should therefore focus not only on changing the system to control patients' illness but also on addressing their needs to enable them function as full citizens with minimal disability.

Limited human resources featured strongly in all interviews and focus group discussions. There are, according to patients, insufficient staff, especially doctors. This is echoed by nurses and doctors. Mental health coordinators add that it is not only doctors, especially psychiatrists, who are too few, but also psychologists, social workers and other members of the mental health care team, a lack also noted in the earlier study in Moretele (Modiba et al, 2000).

Different suggestions are made to deal with the problem. A range of models for offering mental health services need to be explored, such as the four main models currently being used in the National Health Service in the United Kingdom, viz. community mental health teams that provide increased liaison and crisis intervention; psychiatrists that operate clinics within health centres; community psychiatric nurses, designated to work with those with mental health problems in a primary care setting; and provision of advice and skills to primary care teams from specialist mental health services (Lester et al, 2004).

Apart from an absolute lack of staff, there is also a shortage of specialised skills in mental health care, and thus a need for more training, for nurses and doctors. One particular area of training that is needed is in regard to the Mental Health Care Act (Act 17 of 2002), in terms of which there was much ignorance expressed. It seems nurses are generally more familiar with its provisions than doctors.

The stigma that patients feel in the community is often felt by nurses who therefore do not want to get further training in mental health care, for fear of having to work exclusively in that field. Although one respondent was enthusiastic about her role in mental health care, negative attitudes are a problem raised by mental health coordinators and reflected in some of the responses in the interviews, such as the reasoning behind specialised care for mental health patients offered by some respondents. “If they could be seen separately and isolated…if the nurses can be outside... it could be here [pointing to an open space behind the clinic]” (Nurse). This accords with the assertion by Swartz and Macgregor (2002) that psychiatric patients continue to be stigmatized by primary health care staff. Mental health coordinators believe that greater coordination and integration of services can assist this.

Patients express a need for support – by the service and by fellow sufferers. This highlights the need expressed for greater involvement in social issues, such as extending care into patients' homes (limited both by time and transport), the need for social workers and the lack of education of families and community members around mental illness. Modiba et al (2000) noted that community involvement was viewed by informants in Moretele sub-district as key to providing community based mental health services to people with mental illness. Participants identified involvement of mental health service providers in community meetings and providing education on mental illness as essential. Certainly elsewhere such community based mental health care is seen to be critical in dealing with the issue of stigma and discrimination (Rössler et al, 2005).

It is noted by staff that patient reviews are not done frequently enough, confirming what was found in the record reviews. Mental health coordinators also raised the

issue of diagnostic problems.

Generally the referral system is seen as problematic, with poor communication (as noted above) and a feeling that patients are admitted for too short a time before being sent back to level one facilities. Mental health coordinators felt that there is generally good coordination at district level, although at the same time they feel that there is poor team work.

The role of the mental health coordinator is obviously one that needs clarification – better job descriptions, supportive managers and debriefing in the light of the stigma they too feel could assist this.

Conclusions

There is much focus in the literature on the patient as the one to blame for non-compliance – the very term suggests that – in one way or another, either because of their disease or because of their responses to the medication they must take (Johnson and Freeman, 1972; Haynes, 1979; Lin et al, 1979; Conrad 1985; Young et al, 1986; Gillis et al, 1987 ; Koch & Gillis, 1991; Bebbington, 1995; Razali & Yahya, 1995; MacPherson et al, 1996; Kane, 1997; Nageotte et al, 1997; Ruscher et al, 1997; Bartko et al, 1998); there has been little focus on the health system as a possible cause of non-adherence. Yet our findings suggest a system in which there is every reason for non-adherence, from insufficient and unskilled staff, to inadequate or absent records, to poor communication and referral pathways, to poor prescribing, to irregular and inadequate reviews.

It is clear from the literature that, just as there is no scientific evidence favouring the use of hospital services alone for mental health care, there is also no evidence that community services alone can provide satisfactory and comprehensive care (Thornicroft & Tansella, 2004); both are needed and ways of ensuring they work together and support each other, such as the models described above in the UK, are critical. Bower and Gilbody (2005) argued that the involvement of primary care clinicians in mental health care provides a link between quality improvement and

goals such as access and equity, thus models of care provision that put greater focus on increasing the abilities of primary care clinicians, and thus on training and equipping them, have the greatest potential impact on access and equity.

Van der Walt and Swartz (1999, 2002) have shown how high case loads in public facilities in South Africa, together with the emotional demands of the work, often leads to a routinised, administrative approach to patient care, which seems to be behind many of the problems described here, both in the quantitative and qualitative data, with lack of reviews and repetition of medication. The debate is what the solution should be. Swartz and MacGregor (2002) have eloquently summarised the debates around integration and the consequences for mental health patients. It is not the place in this report to enter those debates. However, one point is of importance to this discussion. Swartz and MacGregor argue strongly against the idea that chronic psychiatric illness can be treated in the same way as other chronic illnesses in an overstretched and biomedically focused system. This may be true – and certainly the concerns raised in this study reveal the need for greater specialisation – but we would also argue that the problem is a broader one: chronic illnesses in general are not being managed well, and overhauling chronic illness care, through the introduction of sound principles and appropriate systems, including adequate training and record-keeping, would go a long way to dealing with the problems in mental health care as well.

Such an approach may also assist in avoiding the dichotomy of defining a patient's problem as physical or mental, and thus maintain the integration between medical and mental health care at primary care level (Lester et al, 2004).

This study has highlighted a number of strengths and weaknesses in the primary mental health care system. If there is a coordinated effort to tackle issues systematically in order of priority, with systematic organisation of chronic care, proper documentation and further training and support of staff being early interventions, it is foreseen that it will result in a major improvement in care of the mentally ill in North West province.

RECOMMENDATIONS

Recommendations are made in relationship to systems, structures, staff and skills. Critical to the success of all of these recommendations is active political backing and managerial support, taking the problems of mental health seriously, including mental health care into the provincial strategic priorities, and providing the necessary resources for this.

1. Systems

1.1 The challenges posed by the **supermarket approach** with particular reference to the care of mental health patients need to be addressed. Participants in this study acknowledged the value of the supermarket approach for general patients but also the difficulties of managing mental health patients in such a structure. Specialised mental health clinics should be accommodated within the supermarket format for optimal benefit of the patients and the system. Sub-district mental health coordinators can play a consultancy role, but need to be part of an active team, which includes doctors working in the clinics.

1.2 The **organisation of chronic care** in clinics needs to receive special attention and a coordinated provincial strategy needs to be put into place in this regard, which would include mental health patients. The opportunity provided by the ARV roll-out to address the needs of all patients needing ongoing management should not be lost.

1.3 Thus **reorganisation of care** should be done in a way that does not exclude patients with mental health conditions from the system, but rather integrates them into a comprehensive approach to chronic care, which not only addresses their medical need for control of their illness but also their psychosocial needs

1.3 There is an urgent need to institute a **systematic approach** to the diagnosis and review of all mentally ill patients in the province, as well as to create greater

awareness of a range of mental health problems, amongst staff and communities.

1.4 The province should provide **standard of care guidelines** and protocols for mental health. Manuals for primary mental health care in South Africa should be made available. At the same time, staff should be encouraged the use of existing EDL guidelines and appropriate referral systems.

1.5 An appropriate formalised and standardised **system of documentation** for all chronic patients in general and mental health patients in particular, should be developed and implemented, as part of the organisation of care referred to above. As part of this, all patients should have standard prescription charts with the diagnosis and other information at the top, with these being reassessed by a doctor every 6 months.

1.6 Along with this, simple **service monitoring and evaluation tools**, which are not available in the Clinic Supervisors Manual, need to be developed. Regular audits should be arranged by the provincial mental health team in conjunction with of sub-district mental health teams.

1.7 A process must be put in place to ensure **regular clinic visits by doctors** as well as visits to clinics by the sub-district pharmacist at least annually.

2. Structures

2.1 There is need for **specialist support** of the mental health services at primary care level. This can be implemented through structured visits by a district psychiatrist (or mental health specialist team) to the primary care facilities. Posts for psychiatrists or family physicians with experience in mental health care in the province need to be created and filled.

2.2 At a sub-district level, **meetings** between hospitals and sub-district management teams should address the issue of doctors' visits to clinics, to ensure that the standards are met in this regard and that the required transport is available, either

through use of government vehicles or through subsidy of doctors' own vehicles.

2.3 The sub-district **Drugs and Therapeutics Committees** need to play an active role in monitoring the use of and discussing issues related to psychiatric medication.

2.4 Home based care and **community based services** need to be augmented. There is a need for resource people, accessible at community level to families and patients at all times, that can intervene effectively at time of crisis, such as housing problems, domestic violence, running out of medication, problems at work, etc. This could use existing structures such as the network of health promoters. It could also be integrated into other community driven processes such as the DOTS support system. More formalised support groups can also help towards this, as well as better cooperation with non governmental and community-based organisations (NGO's and CBO's).

2.5 **Vehicles** should be made available for mental health coordinators to do community follow up and home visits.

3. Staff

3.1 Appropriate numbers of **clerks** must be appointed and allocated to clinics to relieve senior nurses of clerical duties.

3.2 Hospitals must support **sub-district mental health teams** by appointing clinicians in the multidisciplinary team. Sub-district or clinic doctors should be part of these multidisciplinary teams.

3.3 There is a need to appoint **mental health champions** in each clinic and ensure coordination of sub-district mental health activities by interested and qualified person. District psychiatrists and family physicians, mentioned above, would support these activities.

3.4 **Social workers** in each sub-district should also be involved in the care of

mental health patients.

3.5 **Psychologists** can play an important supportive role, both of patients and of staff. In regard to the latter, Employee Assistance Programme practitioners also have an important role to play.

3.6 Participation of hospital staff in **community activitie**s must be part of their key performance areas and rewarded accordingly.

4. Skills

4.1 A process of **training** and re-training of staff is required. While this is needed for most clinic nurses and doctors, particular focus should be given to those who have an interest in this area, with suitable inducements, and also to clinics which have been identified as problematic. In-service and external training and qualifications should be recognized and rewarded by appropriate rewards/ certification/ appraisals. As stated by Modiba et al (2000), the aim of this training should be to improve the detection and diagnosis of common psychiatric illnesses.

4.2 A South African modification of the **WHO programme** Mental Disorders in Primary Care, which focuses on the recognition and management of mental disorders, provides a potentially useful educational programme (Mash, 2002). This should be explored for possible implementation in the province.

4.3 **Outreach visits** by psychiatrists or appropriately experienced doctors for the more complicated patients, to assist in diagnosing and managing them, are essential. This necessitates the appointment of more psychiatrists or at least doctors with additional experience in mental health care.

4.4 Each mental health coordinator should be sent for **advanced psychiatry training**.

4.5 Ongoing **training on the Mental Health Care Act** is essential particularly for

medical officers, including community service doctors, and nurses not having specific training in mental health. Managers must also be trained on their responsibilities according the Act, as a common understanding of the Act will assist proper implementation of and respect for the rights of mental care users.

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APPENDIX A

List of facilities at which the research was conducted.

Central District
1. Unit 9 CHC
2. Itekeng
3. Masutlhe 1
4. Montshioa Town

Southern District
1. Botshabelo CHC
2. Stilfontein
3. Top City
4. S Mogaetsho

Bophirima District
1. Huhudi CHC
2. Mocweding
3. Morokwaneng
4. Taung Gateway

Bojanala Platinum District
1. Kgabo CHC
2. Pitsedisulejang
3. Sesobe
4. Bakubung