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IMPLEMENTATION OF THE 72 HOUR ASSESSMENT POLICY OF INVOLUNTARY MENTAL HEALTH CARE USERS AT GENERAL HOSPITALS IN VHEMBE DISTRICT, LIMPOPO PROVINCE

By

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A mini-dissertation submitted in partial fulfilment of the requirements for the degree:

Master of Public Health (MPH)

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DECLARATION

I, Mubvafhi Norman Lufuno, declare that the study titled "Implementation Of The 72 Hour Assessment Policy Of Involuntary Mental Health Care Users At General Hospitals In Vhembe District, Limpopo Province" is my original work and that all the sources that I have used or cited have been duly indicated and acknowledged by means of complete references, and that this work has not been submitted previously for a degree at any other higher educational institution.

.....
Signature

03-05-2016
.....
Date Signed

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DEDICATION

I dedicate this work to all mental health care providers who are working tirelessly providing mental health care services to all mental health care users, in the midst of all challenges they are faced with in South Africa.

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ACKNOWLEGMENT

- To God be the glory for the strength to complete my study.
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ABSTRACT

Purpose: The aim of this study was to evaluate the implementation of the 72 hour assessment policy of the involuntary Mental Health Care Users at general hospitals in the Vhembe District Limpopo Province.

Methodology: The study adopted a quantitative, cross-sectional, descriptive approach. The study was conducted in all general hospitals in Vhembe District. All professional nurses working in general wards and psychiatric units, implementing 72 hour assessment policy of the involuntary Mental Health Care Users were involved in the study by completing the questionnaires. The research data was captured using Microsoft Excel and then analyzed using the Statistical Package for Social Sciences, version 22.

Results: Results were presented descriptively in tables and charts. The study revealed that 59.4% of the participants strongly agree that their infrastructure does not meet the requirements for listing facilities to conduct 72 hour assessment policy. The majority of the participants (89%) indicated that they admit patients for 72 hour assessment. These findings reveal that there are still general hospitals that are not implementing the policy. Results indicated that 88.1% of the participants agree on commencement of treatment during admission. However, there are some requirements that are not available in the units such as: monitoring tools for suicide (37%) and only 11.9% affirmed that they indeed refer patients for detoxification. This finding reveals that there is lack of supervision and support by supervisors in general hospital regarding the implementation of the policy.

Recommendation: More training needs to be provided to general nurses in order to acquire skills to manage Mental Health Care Users. Infrastructure should be improved to meet the required standard in order to implement the policy properly.

Keywords: Mental health, General hospital, Implementation, Policy, Nurse

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CHAPTER 1

OVERVIEW OF THE STUDY

1.1 Introduction

The 72 hour assessment policy for mental health care users has been in place since 2004 (Mental Care Act, 2002), as an amendment to the Mental Health Care Act no.17 of 2002. It is being implemented in most of the general hospitals in South Africa and, in most of the countries whereby patients are treated in open units within the general hospitals.

1.2 Background to the study

Two of the main objectives of the Act are to clarify the rights and obligations of the Mental Health Care Users and the obligations of the health care providers. It also promotes the integration of mental health care services into the general health services environment (Mental Health Care Act, 2002). This innovation was established with the intention to integrate mental illness with other health problems, reduce detention of the patients' prior thorough assessment and preventing isolation of the mental illness from other conditions in the hospital (Petersen & Lund, 2011).

Based on the Mental Health Care Act, Matsoso (2012) published a guideline to assist with the implementation of the 72 hour assessment of involuntary Mental Health Care Users, with the following objectives:

- To guide provincial heads of health on requirements for listing of facilities to conduct 72 hours assessment.
- To provide procedures to be followed when conducting the program.
- To provide clinical management guideline on assessment and treatment of mental health care user.

Mental illness should be regarded as a serious issue in South Africa. It has been found that 1 in 3 women in Khayelitsha had postnatal depression. In KwaZulu-Natal 4% of pregnant women are depressed (Ssebunnya, Kigozi, Lund,Kizza & Okello, 2008).

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Millennium Development Goals revealed that 43% of people with HIV in South Africa had mental disorders in 2012. In South Africa, 75% of people who live with mental disorders do not receive the needed care. To address this growing burden and reduce the gap in treatment, there is a need to develop evidence-based and culturally appropriate mental health services that can feasibly be delivered within available resource constraints (Lund et al., 2012).

Despite legal, economic, social, medical, methodological and other factors that affect the care of the mentally ill in the past four years, there has been significant improvement towards implementation of the procedures to manage involuntary mental health care users. However, there is still a crucial need for the education of public and health professionals, as well as financial investment by the Department of Health to improve human resources and infrastructure (Ramlall, 2012).

Health care providers working at general hospitals seem to be facing numerous challenges with regard to the implementation of the 72 hours assessment policy of involuntary mental health care users. This seems to result from inadequate infrastructure and staff, a high administrative load, and a low level of contact with Review Board (Ramlall, 2010).

Ramlall (2012) has identified numerous challenges such as:

- Lack of adequate facilities.
- Bed shortages.
- Shortage of nurses, psychiatrists, occupational therapists, social workers and psychologists.
- Completing of Mental Health Care Act forms.
- Availability of psychotropic medication.
- Poor community support post discharge.
- Difficulties with the South African Police Service.
- Mental Health Review Boards: not functional, poor communication between Board members and health professionals.

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These challenges affect health care providers, resulting in poor morale among the mental health care providers. As a result, health care providers experience stress and depression due to the increased number of patients to be managed in a minimum resourced environment, with some of the staff members going on sick leave, absenting themselves from work or simply quitting.

A thorough evaluation of the programme needs to be conducted in order to assess the utilization of the resources efficiently and to bring production on the health care services rendered to mental health care users. Government needs to secure mental health care services in hospitals and also at the community level (Lund, Stein & Flisher, 2007).

1.3 Problem statement

Despite good mental health care legislation, South Africa is still facing numerous challenges with regard to proper implementation of the 72 hour assessment policy of the involuntary mental health care users. The institutions for mental health care users have not improved due to the shortage of staff and lack of further training for health care providers. This exposes health care providers to serious dangers when providing mental health care service in a poorly resourced environment, resulting in poor management of mental health care users and burn out to the health care providers. Mental health services urgently need to be scaled up and further work is needed to determine what possible measures will work best in South Africa (Lund, Petersen, Kleinjes, & Bhana, 2012).

It becomes clear that the legislation was passed without due consideration of the financial implications regarding the funding of the policy. In his study Van Rensburg (2007), observed that previous patterns of clinical practice and factors determining management decisions in the public sector service continued as before. The shortage of health care providers and poor infrastructure remained critical.

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1.4 Rationale of the study

This study was focused on the evaluation of the 72 hour assessment of the involuntary mental health care user. It was necessary to conduct it because it is a new program being initiated in all general hospitals around Vhembe district. Currently, health care providers seem to be struggling with the implementation of the policy and it has been observed that not much has been done on the evaluation of the programme (Mabena, 2010).

The Mental Health Care Act needs to be urgently reviewed with the amendment of the Act and its regulations. Failure to address the challenges faced by health care providers may result in a negative impact on their ability to provide patient care. Improper implementation of the policy may also hinder patients from receiving optimum health care services.

1.5 Significance of the study

This study may contribute knowledge towards improving the quality of health care services rendered to mental health care users in Vhembe district and across the country. It may also enable most of the staff members to have a better understanding in executing the policy.

The outcomes of this study may also assist in the amendment of the policy. It may assist in improving the training of the health care providers on the implementation of the 72 hour assessment policy in general hospitals. This study further aims to assist in the development and the implementation of the current policy. It will also orientate community members with regard to the new program of the 72 hour assessment of involuntary mental health care users.

1.6 Purpose of the study

The purpose of the study was to evaluate the implementation of the 72 hour assessment policy of involuntary mental health care user, at general hospitals in the Vhembe District, Limpopo Province, South Africa.

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1.7 Specific objectives

The objectives of the study were to:

- To assess compliance of the general hospitals with regard to requirements for listing facilities to conduct 72 hour assessment of involuntary mental health care users.
- To examine the procedures being followed in conducting the 72 hour assessment of involuntary mental health care users.
- To assess the clinical interventions and treatment available to Mental Health Care Users, during the72 hour assessment.
- To evaluate the challenges faced by health care providers in the implementation of the 72 hour assessment program of involuntary mental health care users.

1.8 Definitions

Implementation Is defined as making something that has been officially decided start to happen (Hornby, 2006). For the purpose of study, implementation refers to providing mental health care services in general hospitals under the 72 hour assessment guidelines.

Evaluation According to Hornby (2006), evaluation it refers to a form of opinion on the amount, value or quality of something after thinking about it carefully. In this study evaluation is the assessment of the implementation of the program.

Mental health Is defined as a state of well-being in which every individual realizes his or her own potential and can cope with the stress of life (WHO, 2014). In this study mental health is defined as the acceptable state of mind and behaviour by the individual in the community.

Mental illness Is defined as the condition which causes serious disorder in person's behaviour and thinking (Oxford dictionary, 2016). For the purpose of this study, mental illness refers to unacceptable state of mind and behaviour in individuals that may lead to self harm or other people in the community.

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CHAPTER 2

LITERATURE REVIEW

2.1 Introduction

Literature review entails systematically evaluating studies related to the present study. It reviews the data, research and scientific analysis on what have already been done on the 72 hours assessment policy of the involuntary mental health care users. This Includes: facilities for admission of the involuntary mental health care user, Mental health care in South Africa, procedures to be followed when conducting the 72 hour assessment of involuntary mental health care users and challenges on implementation of the 72 hour assessment of involuntary mental health care users

2.2 Data based literature

Bloom (2013) indicated that a total of two billion rands in legal claims and R1.6 billion in the 2011/2012 financial year where spent of managing medico-legal hazard. All these claims were from 1,002 medico-legal cases that claimed a total amount of R3.415 billion, due to loss from the department concerning medical negligence court cases in the past three years. These claims indicate the urgency of raising the standard of health care so that medical mistakes are minimized. However, due to the passion of health care providers, they still provide optimum health care services despite poor resources in the working environment.

Lund et al. (2012) noted that there is scarcity of studies on intervention and economic evaluation. However, the priority is being focused on health policy and system research. The study further identified the scarcity of knowledge on basic neuroscientific and behavioural mechanisms. Few studies have been done on an effective system of implementation strategies to improve mental health. Statistics indicate 16.5% of South Africans suffer from common mental disorders such as depression, anxiety, somatoform disorders, schizophrenia and bipolar mood disorder (Lund, Kleintjies, Campbell-Hall,

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Mjadu, Petersen, Bhana, Kakuma, Mlanjeni, Bird, Drew, Faydi, Funk, Green, Omar & Flisher, 2008).

According to Lund et al. (2012), "There is no health without mental illness." Collaboration between policy makers and other stakeholders should be emphasized in order to achieve effective goals. There should be evidence based policy in psychiatric and mental health.

In South Africa, there is a shortage of health care providers, a limited number of hospital beds where mental health care users can be assessed and monitored for a stipulated time in order to come out with the correct findings to assist in the decision as to whether the patient has to be discharged or needs further care, and for treatment and rehabilitation in the designated institution (Lund, Stein & Flisher, 2007). Due to lack of human resources and inappropriate infrastructure, patients end up being mistreated. They are detained or admitted in the assessment room for more than 72 hours while waiting to be seen by the medical practitioners, who in most cases are general practitioners.

This is because psychiatrists are rarely found in the district hospitals. Due to overcrowding of patients in the wards and the increased flow of admissions from casualty or emergency room, health care providers working in the wards usually discharge patients before fully recovery. In most of the cases, the referral hospitals also experience a large turnout of patients beyond their capacity. This brings a serious challenge to the family members since they are used to the old system whereby mental health care users on admission are detained for longer periods in the acute ward within the general hospital.

Mokallik (2012), reported on the higher number of young people who are being admitted to the hospitals around Cape Town and occupying hospital beds to full capacity in the mental health care facilities. This was due to the use of substances such as: TIK drug (Methamphetamine), cannabis and alcohol. The study also indicated a greater need for the state to intervene in alleviating the situation as mental health service is still underfunded by the state.

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Ramlall (2012) conducted a study in KwaZulu Natal (KZN) where he noted that the cost of stress at workplace was three billion rands a year in South Africa and $ 200 billion a year in United State of America (USA). This was due to absenteeism, lower productivity, staff turnover, workers' compensation, medical insurance, mistakes, reduced creativity and other stress related expenses. The global epidemic is 60% of lost workdays and 80% of health visits. It is highly impossible to provide health care service in a very limited resource environment.

2.3 Facilities for admission of the involuntary mental health care user

Mental illness is posing a serious threat to the world, number of patients being admitted in the hospital is increasing tremendously. The high proportion of involuntary mental health care users in relation to the total psychiatric patients (92%) indicates an excessive coercive system (Bola, Park & Kim, 2011). Involuntary hospitalization in Korea rose from 117 to 132 (per 100,000) between 2000 and 2006. Korea's involuntary hospitalization is three times that of the highest European Union (EU) country. This high rate results from underdeveloped voluntary psychiatric services and culturally mandated family referrals resulting in involuntary hospitalization (Bola, Park & Kim, 2011). WHO (2006), published a report on Mental Health System which indicated that Korea had a large proportion of involuntary mental health care users compared to other developed countries.

Most of the mental health care users are still being treated at the long term mental health institutions, whereas there are community mental health facilities. Six percent of the health care funds are directed to mental health care services, where a large proportion is directed to long term stay facilities. A large proportion of the human resource is composed of professional nurses; there is no occupational therapist, 0.01 psychiatrists per bed in community-based psychiatric inpatient units and in mental hospitals. Poor prioritization of the community-based inpatient mental health care services, leading health care workers to work under strenuous environment, where the facility is inappropriate due to insufficient funds to sustain mental health care services at the community level.

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A study on changing patterns in emergency involuntary admissions, conducted in England between 2000-2004 shows higher rates of involuntary admission. There is an increased admission of patients with dementia (59%), other organic mental disorders (40%) and substance abuse (36%) (Mulder, Uiteng, Broer, Lendemeijer, Veldhuizen, Tilburg, Ielliot & Wierdsma, 2008).

The number of patients admitted in the mental health care units as involuntary mental health care users is higher than patients admitted as voluntary and assisted mental health care users. In Ireland, there is high rate of involuntary mental health care users, The Irish rate of involuntary admissions is almost triple that of Italy and 50% higher than that of England and Wales. The commonest reasons for admission include depressive disorders (30% of all admissions), schizophrenia (19%), and alcoholic disorders. In addition, 30% more men than women were admitted for alcoholic disorders, but 30% more women than men were admitted for depressive disorders (Birchard, 2000).

England seems to be doing well with regards to the provision of mental health services at the community level due to adequate human resources made up of community mental health nurses, clinical psychologists and psychiatrists. The country has a team of professionals dealing with different age groups of people with mental illness. Most of the patients are treated at the community clinic level and hospitals as day care visits. Those who are dangerous to themselves and others are the ones to be taken to the hospital for admission under the Mental Health Act (Buchanam, 2013). However, at the hospital level the country is facing numerous challenges. The British Brodcasting Company (BBC) News and Community care magazine revealed that more than 1,500 mental health beds have been reduced from the hospitals (Buchanam, 2013), hence, the higher statistics of insufficient space at the hospitals leaves patients and the health care providers in a stressful position.

In a study conducted to address the criteria for admitting and assessing in which involuntary mental health care users, for 72 hours in the emergency room, the following qualifying factors for the detention of the involuntary mental health care user were indicated:

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- Dangerous to himself or herself.
- Dangerous to others.
- Gravely disabled and that the person's condition is due to a mental disorder.

Two assessments should then be made, but if the criteria couldn't be defined, the legislation clearly stated that determination should be guided by clinicians' judgment (Segal, Watson & Nelson, 2011).

In Canada, the law provides for three types of confinement namely:

- Preventive confinement.
- Temporary confinement.
- Regular confinement.

Preventive confinement allows the physician to exceptionally confine a person for up to 72 hours. The physician may decide that if the mental state of the person presents danger to himself or others (Marchildon, 2013). However, despite the implementation of the law, the country received complains and a number of reports, showing that some hospital workers had difficulties, affecting negatively the rights of the citizens.

Moosa (2008) described the 72 hour assessment and involuntary admission as a service provided without the consent of people who are likely to inflict serious harm on themselves or others, protection of the financial interest or reputation of the users and for those who are incapable of making an informed decision on the need for care, treatment and rehabilitation. This procedure is done with the purpose of assessing the patient every 24 hours for underlying medical illnesses and to provide treatment such that the patient will gain insight and good judgment to be able to give consent for further treatment.

2.4 Mental health care in South Africa

In 1913 a committee was established in Cape Town to look after people with intellectual disabilities. The committee's mandate was extended to mentally ill people. The committee worked on the development of the legislative provision for the management of psychiatric patients. This led to the promulgation of the Mental Disorder Act of 1916. In 1920 the committee was called the National Council for Mental Health, where it

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developed services such as Child Guidance Clinics, Training Centers for Intellectual disabilities and Juvenile Courts (Uys & Middleton, 2009).
In 1909 psychiatric institutions were transferred from the Department of Health to Department of Internal Affairs, but in 1943 they were returned to the Department of Health. The psychiatric hospitals were treated in isolation from the medical hospitals and this stopped in 1958 when the psychiatric hospitals were brought under the provincial administrations (Uys & Middleton, 2009).

Recently WHO conducted a study to assess mental health care service in South Africa. The study shared disparities within provinces in terms of allocation of the budget. There were also a high number of people expecting to receive mental health service; whereas there are only 41 psychiatric inpatient units located in general hospitals with a total of 28 beds per 100,000. Regarding human resources the total number of employees working in the department of health facilities was 9.3 per 100,000 populations, 0. 28 being psychiatrists, 7. 45 nurses, 0. 13 occupational therapists, 0. 32 psychologists and 0.4 social workers per 100,000 (WHO, 2007).

Petersen and Lund (2011) conducted a study in South Africa aimed at investigating the policy level interventions. The findings depicted a significant burden of mental illness, being ranked 3rd in the contribution to the burden of disease, after HIV/AIDS and other infectious diseases. However, despite constituting a significant burden mental health has not been accorded the priority it deserves.

WHO (2007) report, indicated that the rate of monitoring and studies regarding mental health was 2% (78/3374) in the last five years. This observation indicates the country's negligence regarding mental health despite an increasing number of newly diagnosed mental health care users on daily bases. In the same report WHO recommended the need to develop a national mental health policy, mental health information system, building of community mental health services, including community residential care centres, day services and out patient services.

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Ramlall (2012) published a study indicating the burden and risk factors for mental disorders and the challenges for local mental health services and research, emphasizing mental disorders and existing services needed to be scaled up. The study recommended the need for new research to determine what interventions are best for South Africa. A12-months prevalence data indicated that 16.5% of adults suffered a common mental disorder in the past year. However, only 25% of the individuals received treatment. Although mental illness is a more serious condition than physical conditions, it is 10 times less likely to be treated.

South African morbidity data indicates that mental disorders are the third highest contributor to the local burden of diseases. Interpersonal violence was highly prevalent in South Africa and was associated with major psychiatric morbidity. Both HIV and substance use had an on extremely important association with mental disorder (Lund et al., 2012). The Mental Health Care Act of 2002 is a new legislation that has regarded care, treatment and rehabilitation to be provided to mental health care users at household and community level. Through this Act, provision has been made for the first time to treat involuntary mental health care users as outpatient care, treatment and rehabilitation. It has promoted the involvement of South African Police Service (SAPS), during the management of the involuntary patients or abscondment and monitoring maximum security facilities. South Africa has initiated the 72 hour assessment of the involuntary mental health care users in general hospitals with the aim of avoiding unnecessary admissions to psychiatric units (Moosa, 2008).

It is a good way of treating people in the community in order to reduce unnecessary stigma attached to Mental Health Care Users. However, there is an urgent need for the adjustment of the infrastructure, equipment and human resources in order to ensure comprehensive implementation of the policy. The new establishment of the Review Board previously referred to as hospital board assesses the implementation of the legislation. It has also reduced the stigma on mentally ill patients, as they are now referred to as mental health care users and not patients in the community. It also

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stipulates the free health care service to involuntary mental health care users (Uys & Middleton, 2009).

According to Ramlall (2012), the Act improved mental health care through the protection of rights, treated patients in a less restrictive environment and also reduced the discrimination of the users. There is an improved accessibility of care through compilation of treatment guidelines, outreach teams and mental health forum (Ramlall, 2012). When compared to the previous ways of managing mental health care users it is a significant stride that South Africa has made with regards to mental health care services. Mental health care users were being dehumanized and abused in psychiatric hospitals before the introduction of the Act.

According to the Mental Health Care Act (2002), the following objectives were outlined

- To provide the care, treatment and rehabilitation of the mentally ill patients.
- To describe the procedure to be followed during the admission of the mental health care user.
- To establish a Review Board and determine its powers and functions in terms of providing care and administration of the property, the mental health care user and revise the old mental health Act (Mental Health Care Act, 2002).

2.5 Procedures to be followed when conducting the 72 hour assessment of involuntary mental health care users

The KwaZulu-Natal province developed a Treatment Protocol for Mental Health Disorder (Burns, King & Saloojee, 2007), indicated the steps to be followed during the admission of involuntary and assisted individuals under the Mental Health Care Act.

STEP 1 Friends/family to complete application for admission form 04.

STEP 2 Person to be assessed by 2 mental health care practitioners (MHCP) and examination and findings to be recorded on form 05.

STEP 3 MHCP must submit forms 04 and 05 to Head of Health Establishment (HHE).

STEP 4 HHE to decide on whether or not to provide further care and to give notice of consent to such care on form 07.

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STEP 5 Person can now be admitted/treated for 72 hours without his/her consent.

STEP 6 Person to be assessed everyday 24 hours for 72 hours.

STEP 7 2 MHCP re-assess person after 72 hours have elapsed and examination and findings recorded on form 06.

STEP 8 MHCP submit form 06 to HHE.

STEP 9 HHE decides whether person needs to be further treated as an outpatient (09), inpatient (08), or to be discharged (03) and gives notice to Review Board.

STEP 10 If further treatment is required as an inpatient, person must be transferred to a Psychiatric Hospital, HHE to complete form 11.

The Mental Health Care Act (2002) has outlined the procedure of admission and discharge of the voluntary, assisted and emergency admission/involuntary users, as shown in Table 1.1:

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Table 2.1: Voluntary, assisted and involuntary admission of involuntary mental health care users

PROCEDURE	PROCESS
Voluntary admission	Patient or anyone older than 18 years or guardian of the patient younger than 18years. Superintendent decides patient requirement.
Discharge	Doctor discharges patient.
Assisted Admission	Guardian, spouse, relative or registered health worker applies. Examination two MHCPs. Superintendent decides. Superintendent reports to Review Board within 07 days. Review Board report to the province.
Discharge	A person who applied for admission may apply. Doctor evaluates fitness for discharge and decides. If fits for discharge, patient is released.
Emergency/72 hour Admission	Taken to the nearest clinic or health facility for treatment. The clinic should refer immediately if necessary. The involuntary admission process is used.

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Table 2.2: The 72hour assessment procedure of involuntary mental health care users

Admission	Written application by spouse, next of kin, partner, associate, parent or guardian, if possible or health care practitioner MHCA 04 ↓ Two MHCPS examine user submit findings to HHE x2 MHCA 05 ↓ HHE decides(inpatient or outpatient care) and gives notice to the applicant MHCA07 ↓ Admission and continue with 72 hour assessment ↓ Within 24 hours after expiry of 72 hours assessment, MHCPs record the findings and outcome of 72 hours assessment MHCA 06 ↓ User is discharged if recovered MHCA 03 OR Transferred to psychiatric hospital if still very ill MHCA 11

Table 2.2 indicates a standard procedure as outlined on the policy guideline on 72 hour assessment of involuntary mental health care user (Matsoso, 2012).

Ramlall, Chipps and Mars (2010) reported that 83.3% of participants stated that the Act improved mental health care for mental health care users through the protection of rights, provision of least restrictive care and reduction of stigma. However, it was found that designated hospitals were not satisfied with the administration required by the Act. The Mental Health Review Board visited 80.6% of the hospitals within six months and designated hospitals were operating with inadequate infrastructure and staff, high administrative load and low level contact with the Review Board.

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2.6 Challenges on implementation of the 72 hour assessment of involuntary mental health care users

The Mental Health Care Act No.17 of 2002 marks a significant step forward in addressing mental health issues and protecting the human rights of people with mental illness in South Africa. The legislation is important for monitoring mental health services, implementing the human rights of people with mental disorders through compliance with the law. The challenge is to implement the legislation through the delivery of appropriate mental health services at provincial and district levels (Lund, Stein & Fisher, 2007).

Most of the patients being admitted in the observation units are aggressive and violent, requiring special care and facilities to manage them. De-escalation, physical restraint, sedation, mechanical restraint, seclusion or transfer strategies are applied to calm the situation. In case of physical restrain or mechanical restrain four staff members are required to assist in the process of calming down the patient. In case of sedation enough staff members are also required.

A staff member should be assigned to check vital signs every 5 – 10 minutes in the first hour and then every 15 minutes until recovery (Burns, King & Saloojee, 2007). It is impossible to implement this policy or follow the guide-lines in a limited resource unit where two staff members are left to provide health services in the unit. In some instances, seclusion may be the best clinical intervention required. However, in a unit with poor infrastructure it is not possible to provide the appropriate clinical intervention.

In order to systematically address the lack of resources for mental health care beginning with the planning and appropriate services. The Mental Health Act provides an opportunity to remind decision-makers of the importance of mental health and ensures that appropriate resources are allocated to improve the quality of mental health services and protect the human rights of people with mental disorders now and in the future (Lund, Stein & Fisher, 2007).

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The health service institutions are to develop information systems to monitor the mental health services that they deliver and to become transparent and accountable in this regard. South Africa also needs to improve the quality assurance measures for mental health care in both psychiatric and general hospitals. The National Standard of care needs to be used to assess the current quality of care needs, to be employed in health facilities through accreditation agencies or Review Boards. The National Department has also commissioned and adopted a set of standard treatment guidelines for common mental health conditions. In the Western Cape Province, out of 19 hospitals it was found that only 6 were in possession of the Standard Treatment Guidelines (Lund, Stein & Fisher, 2007).

The call for the provision of financial and human resources to support the implementation of the MHCA has been a common request. South Africa is facing a serious challenge regarding the allocation of adequate funds in the country's budget to cater for mental illness and such discriminatory practices have negatively affected the prognosis for mental health in the country (Lund, Petersen, Kleintjes & Bhana, 2012). The integration of mental health into general health has precipitated an infrastructural crisis. The implementation of the MHCA in South Africa has resulted in hospitals being left to manage potentially dangerous patients in open wards. A study conducted in KZN indicated that more than 66% of hospitals did not have adequate facilities, 41% admitted Mental Health Care Users in general medical or surgical wards and only 27.8% had dedicated psychiatric units. Common complains were related to the insufficient number of beds, seclusion rooms and staff to accommodate the clinical demand and the challenges of managing the disruptive patient in the general hospital setting (Lund, Petersen, Kleintjes & Bhana, 2012).

A study conducted by van Rensburg (2011), in one of the hospitals around Gauteng Province (Helen Joseph hospital), indicated that to implement the MHCA without violating the human rights of mental health care users will require specific adjustments of the infrastructure in the hospitals. This hospital was approved to provide 72 hours psychiatric assessment in 2005 and had 30-beds, acute adult assessment units. It

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receives patients from all over the city through direct or self referral of users and those who were brought as emergency cases by the Police Service. After the completion of assessment and stabilization, patients were transferred to other psychiatric hospitals such as Tara, the H. Moross Centre and Sterkfontein psychiatric hospital.

There is an increased rate of readmission and interrupted care and treatment after discharge from the acute units. Another serious challenge faced by the hospital was lack of the proper structure to provide patient care to involuntary mental health care users, since the voluntary and assisted mental health care users need a less restrictive environment unlike to involuntary mental health care users (van Rensburg, 2011).
Lund et al. (2012) confirmed the shortage of infrastructure and specialist personnel in order to provide 72 hour observation in general hospitals. Patients were discharged from the psychiatric hospital before full recovery, due to shortage of beds and an increased number of patients being transferred from the general hospital and primary health care. As a result, there is a high rate of re-admissions of the mental health care users. Since the implementation of the MHCA began the number of psychiatric hospitals has remained the same with the same capacity of beds. Patients are still experiencing human right abuse in these facilities.

The Mental Health Care Act was promulgated in South Africa in line with international developments. Its core principles focused on the human rights of users, decentralization and integration of mental health care at primary, secondary and tertiary levels of care, focused on care, treatment and rehabilitation. The implementation of the Act at community and district hospital level is a problem. The 72 hour observation is difficult to implement across the country, due to workload, inadequate resources and poor infrastructure. A study conducted in KwaZulu-Natal province indicated less improvement on the funds to be provided for mental health care service. There are inadequate facilities and significant shortages of mental health professionals (Ramlall, Chipps & Mars, 2010).

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2.7 Summary

This chapter discussed data based literature. It has also examined the procedures implemented in general hospitals across South Africa. The next chapter will discus the research methodology.

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CHAPTER 3

RESEARCH METHODOLOGY

3.1 Introduction

This chapter outlines the research method that was used in this study. The study design, study settings, population, data collection method and ethical considerations are also discussed in this chapter.

3.2 Study design

A quantitative, cross-sectional, descriptive approach was employed in this study to evaluate the implementation of the 72 hour assessment of involuntary mental health care users, in general hospitals around Vhembe district (Biemer & Lyberg, 2003). Since it emphasises precise objectives and generalises findings (Rubin & Babbie, 2010). A cross-sectional design allows for an entire population to be selected and data collected in order to achieve specific objectives (Biemer & Lyberg, 2003). According to Burns and Groves (2003), descriptive studies acquire more information about specific phenomenon.

This descriptive quantitative design assisted in providing the picture of the mental health care services provided in the hospitals around Vhembe district regarding involuntary mental health care users (Burns & Grove, 2011).

3.3 Study settings

The study was conducted in medical wards at all general hospitals in the Vhembe District, since the required number of the population is small. Tshilidzini, Malamulele, Elim, Makhado Memorial, Donald Fraizer, Siloam and Musina hospitals were utilised in the study. Vhembe district is located in the Northern part of Limpopo province and it shares borders with Zimbabwe in the North, Botswana in the South-West and Mozambique in the South-East through the Kruger National park. The Limpopo River forms the border between the district and its international neighbours. It is comprised of four local municipalities namely: Musina, Mutale, Thulamela and Makhado. The geographical area is predominantly rural and economical growth depends on

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agriculture, tourism and mining. The population is 1 294 722 and comprises of Venda, Tsonga and Sotho speaking people (Wolmarans & Asia, 2013).

3.4 Study population

In this study, the target population included all professional nurses who are working in medical wards implementing the 72 hour assessment policy of involuntary mental health care users, from all the general hospital in Vhembe District. Target population is described as the population to which the researcher will to generalise (Polit & Beck, 2012).

3.5 Sample

Due to their small number involved, all professional nurses working in medical ward and psychiatric unit at general hospitals in Vhembe district were requested to complete the questionnaire (Table 3.3).

Table 3.3: Sample frame

HOSPITALS IN VHEMBE DISTRIC	No of participants
Donald Fraser	14
Elim	08
Makhado Memorial	08
Malamulele	06
Musina	08
Siloam	12
Tshilidzini	15
TOTAL	71

3.6 Data collection instrument

The study used a questionnaire to collect data. The questionnaire contains closed and open ended questions to evaluate the implementation of the 72 hour assessment policy of involuntary mental health care users at general hospital in Vhembe district.

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The questionnaire was written in English and was divided into five sections: Section 1 - Demographic Data: Section 2 – The requirements for facilities to conduct 72 hour assessment: Section 3 – The procedure to be followed when conducting 72 hours: Section 4 – The clinical intervention and Section 5 challenges faced by health care providers with regard to implementation of the 72 hour policy. It was consisted of 33 questions see (Appendix: 6).

3.7 Reliability and Validity of the Research Instrument

Reliability was done using a test-retest method and the same questions were asked to all participants with the alterative answers.

Face validity was done by arranging the order of the questions according to the objectives of the study and the instrument was taken to an expert in the Department of Health in the Vhembe district and other local districts for their opinions and to be scrutinized to ensure a higher degree of face validity.

To ensure content validity of the instrument, a provisional version of the instrument was presented to experts in the field for comments and inputs before finalizing the instrument. This includes the Department of Public Health at the University of Venda and also to the fellow MPH students for their evaluation of its content validity. It was addressed by extensive review of literature on similar studies conducted locally and internationally in order to identify the domain of the construct before developing the questionnaire.

3.8 Pre-test

A pre-test was conducted at Nkhensani hospital, located in Mopani district in Limpopo Province by involving 10 professional nurses working in observation units providing 72 hour assessment programme. This hospital did not form part of the study. It was done to check if the questions on the checklist are easily understood by the participants, whereby the tool was amended until it was well understood (Pilot & Beck, 2012).

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3.9 Data collection method

Data collection is the gathering of information to address a research problem (Point & Beck, 2004). The questionnaires were completed by the participants. Participants were followed in their working environment within the hospital. The completion of the questionnaires was conducted in a quiet room, and where necessary the researcher was also request to confirm or to explain some of the items requested in the questionnaire. A thorough explanation of the procedures was done before they started filling in the questionnaire. The questionnaires were completed on site to reduce non-responses.

3.10 Data analysis

Data from the questionnaire were coded using a code sheet and entered into an MS excel worksheet program. The data was analyzed using statistical package for social sciences (SPSS) version 22. Descriptive statistic and frequencies were used to describe the data and Chi-square test for comparisons if there are any missing data from the collection forms. The results were presented in the form of tables and charts.

3.11 Ethical consideration

3.11.1 Approval to conduct study

Approval to conduct the study was obtained from the University Higher Degrees Committee, at the University of Venda.

3.11.2 Ethical clearance

Ethical clearance was obtained from the Research Ethics Committee, at the University of Venda.

3.11.3 Permission to conduct a research

Permission to conduct the study was obtained from the Department of Health in Limpopo province.

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3.11.4 Informed consent

Consent forms were given to every participant to complete (Appendix 5). Each of the participants was informed that their participation is voluntary. The following essential information was included as part one of the consent form to enable the participants to make an informed decision before signing the consent forms: the purpose of the study, a description of the risk or discomfort, the benefits of the study and confidentiality.

3.11.5 Confidentiality

Information provided by the subjects was treated as confidential and under no circumstances was the information divulged or made available to any third party except as reports and publications.

3.11.6 Anonymity

The participants did not write their names or any identification in the questionnaire. In order to ensure complete anonymity such instructions were appearing at the beginning of the questionnaire. The subject's identities were not made available in reports and research publication. The signed informed consent forms was not stapled to the instrument but were kept under lock and key. Each subject's questionnaire was kept under lock and key. The data was analyzed in groups and not individually to avoid identifying the participants by their responses.

3.11.7 Beneficence

In this study the principle of beneficence was observed. The questions were constructed carefully to avoid exploitation of participants' privacy. The participants were also allowed to discontinue participation in the study if they felt uncomfortable with the questions (Polit & Beck, 2012).

3.11.8 Justice

People should be treated fairly and receive what they deserve (Polit & Beck, 2012). This principle was observed by selecting available participants and not based on racial, social or cultural background.

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3.12 Summary

This chapter discussed the research methodology. It has also examined the ethical consideration. The next chapter describes data analysis, presentation and interpretation of the findings.

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CHAPTER 4

DATA ANALYSIS, PRESENTATION AND INTERPRETATION

4.1 Introduction

The purpose of this chapter is to present the results of the study. The results are presented in graphs and pie charts. It encompasses five sections from the questionnaire on the evaluation of the 72 hour assessment of the involuntary mental health care user in general hospitals in Vhembe District Limpopo. The results are divided into demographic information, compliance of the general hospitals, procedures to conduct 72 hour assessment, intervention, challenges and association.

4.2 Demographic results

A total of 70 participated in this study, and of this figure 67.6% were females whilst the rest (32.4%) were males (Figure 4.1).

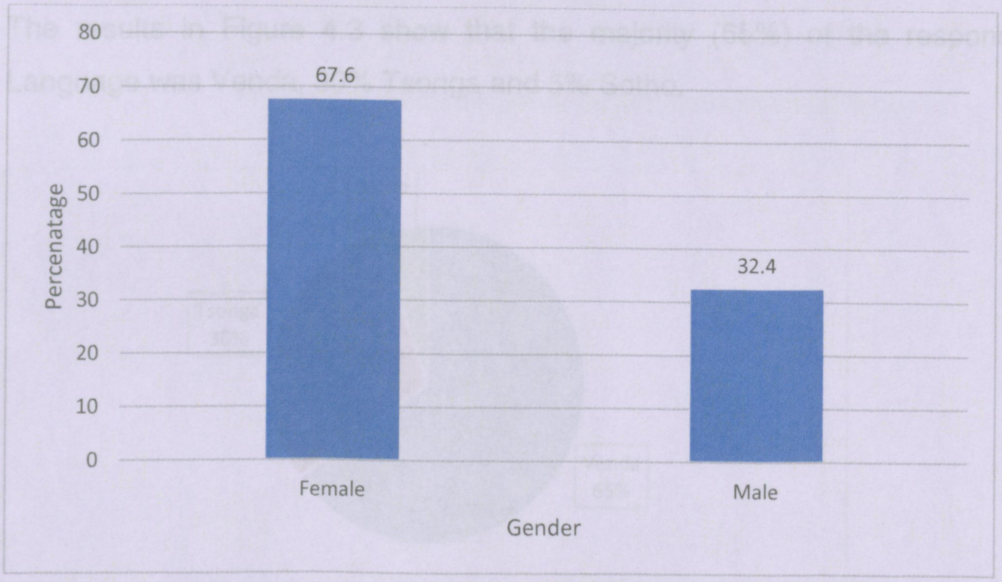


Figure 4.1: Distribution of respondents by gender

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The results in Figure 4.2 show that 18.6% of the respondents were aged between 19 to 25, 10.8% aged between 36 to 59, 67.6%, between 41 to 59 and 2.7%, were 60 and above. The majority of the respondents were aged between 41 to 59 years.



Figure 4.2: Distribution of respondents by age range

The results in Figure 4.3 show that the majority (65%) of the respondents' Home Language was Venda, 30% Tsonga and 5% Sotho.

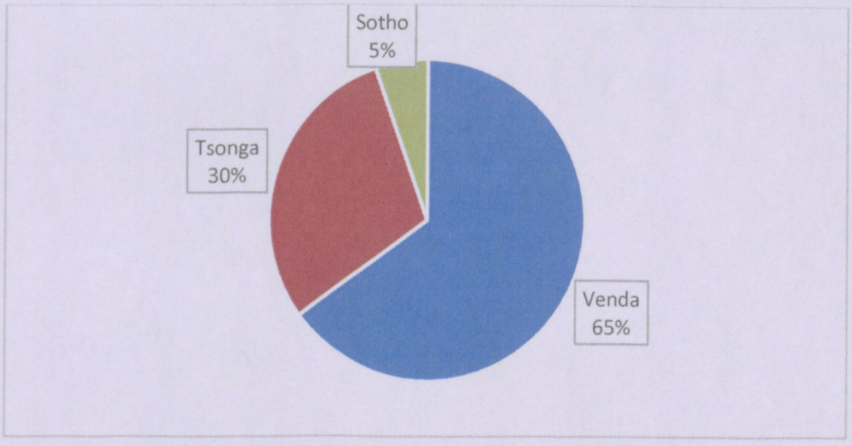


Figure 4.3: Distribution of respondents by Home Language

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The results in Figure 4.4 show that 67.6% of the respondents held a general nurse qualification, 13.5%-psychiatric nurse, and 18.9% held an advanced psychiatric nurse qualification.

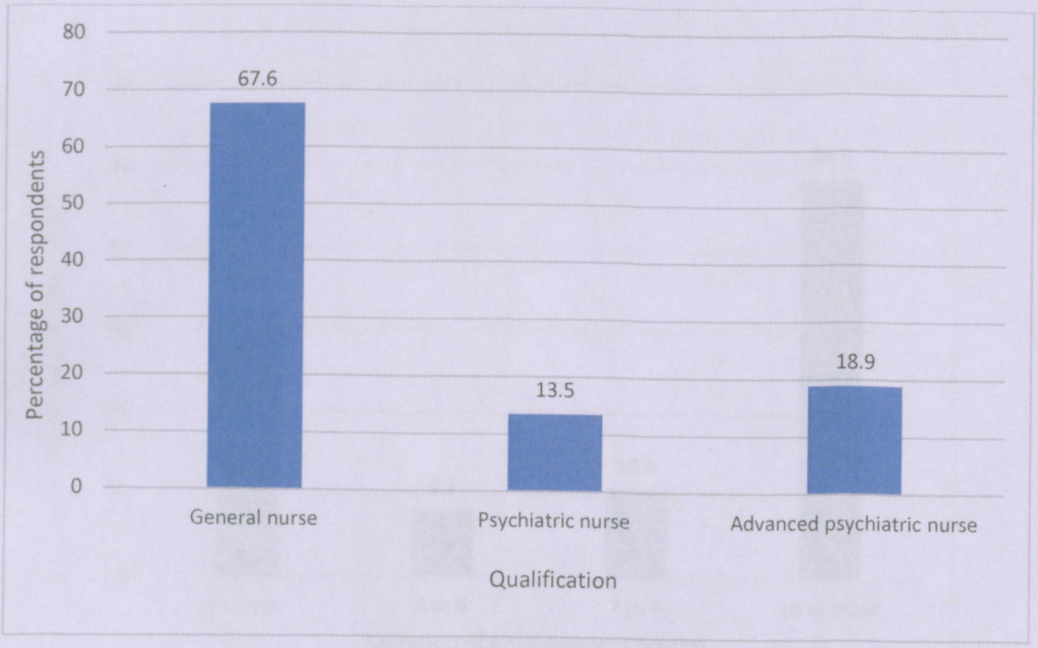


Figure 4.4: Distribution of respondents by qualifications

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As regards the question on the number of years of employment, 32.4% of the respondents indicated that they were employed for less than 4 years, 8.1% for - 4 to 6 years, 10.8% for - 7 to 9 years and 48.6% for - 10 or more years see (Figure 4.5).

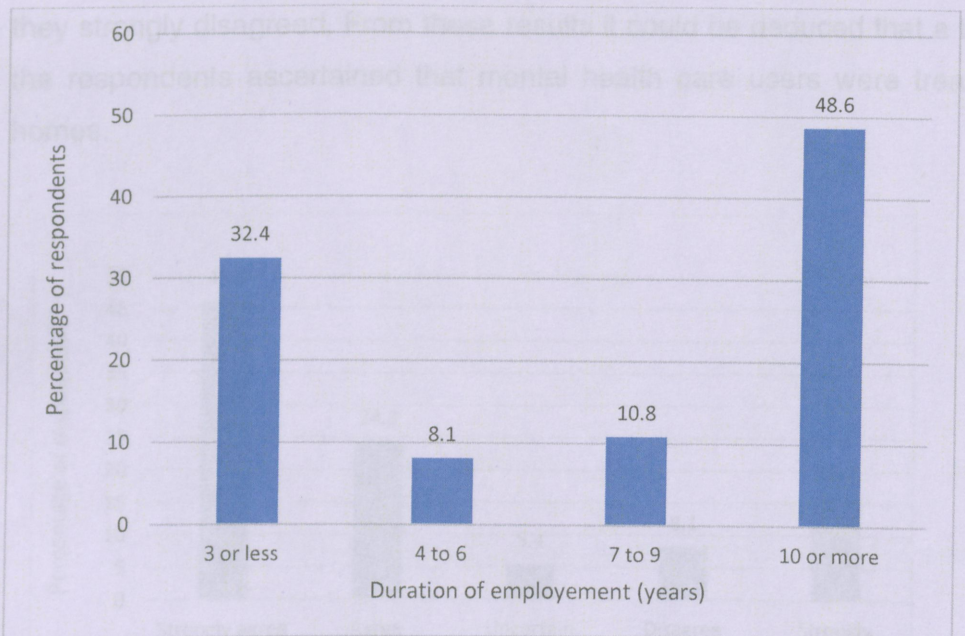


Figure 4.5: Distribution of respondents according to duration of employment

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4.3 Compliance of the general hospitals with regard to requirements for listing facilities to conduct 72 hour assessment of involuntary mental health care users

As indicated in figure 4.6 below - 45.9% of the respondents strongly agreed that mental health care users were treated nearer to their homes whilst 24.3% agreed. This was followed by 5.4% of respondents who were uncertain, 8.1% disagreed and 16.2 stated they strongly disagreed. From these results it could be deduced that a total of 70.2% of the respondents ascertained that mental health care users were treated nearer their homes.

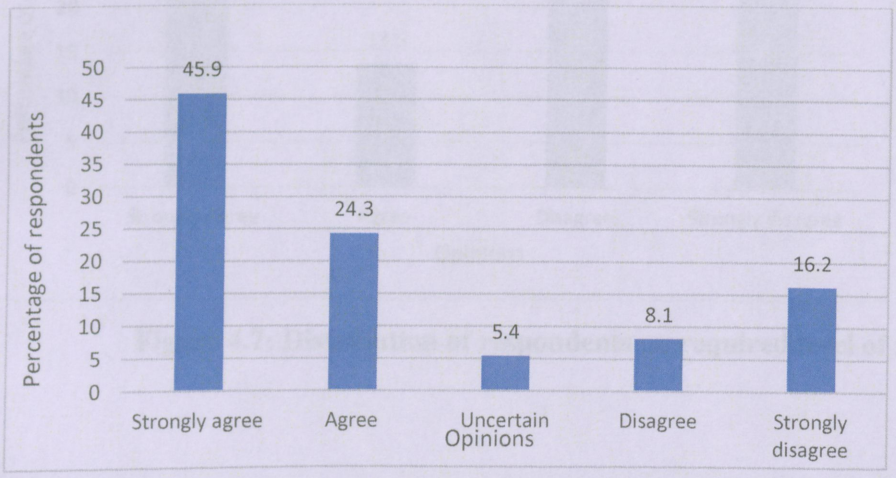


Figure 4.6: Distribution of respondents on whether mental health care users are treated nearer to their homes.

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Regarding the question on whether facilities met the required level of security, whist 21.6% of the respondents strongly agreed, 13.5%, 29.7% disagreed and 35.2% strongly agree (Figure 4.7). From the responses, a total of 64.9% of the facilities did not have the required level of security.

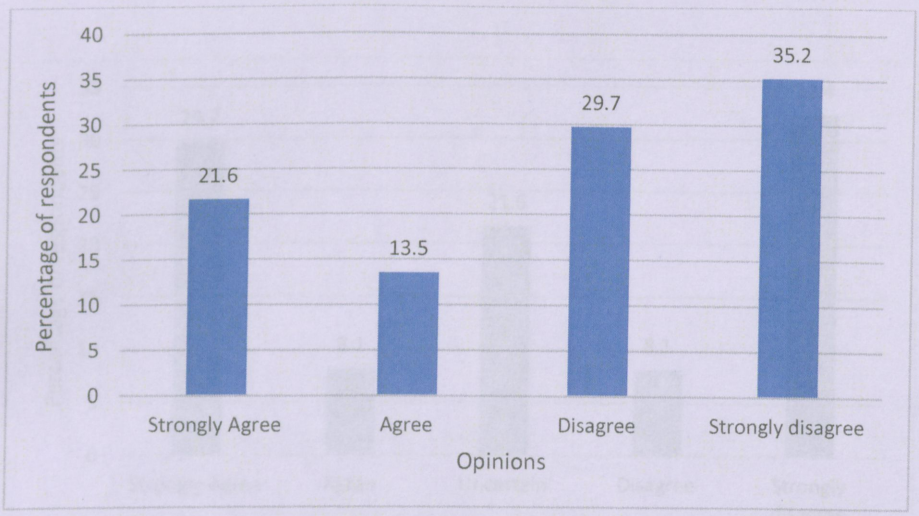


Figure 4.7: Distribution of respondents on required level of security

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The opinion of the respondents were also sought regarding the skills of health professionals in handling issues of mental health in Figure 4.8, 29.7% and 8.1% of the respondents stated that they strongly agree and agree respectively by affirming that allocated in their facilities had skills to assess mental disorders. But on the contrary, 21.6% were strongly uncertain while 32.4% strongly disagreed.

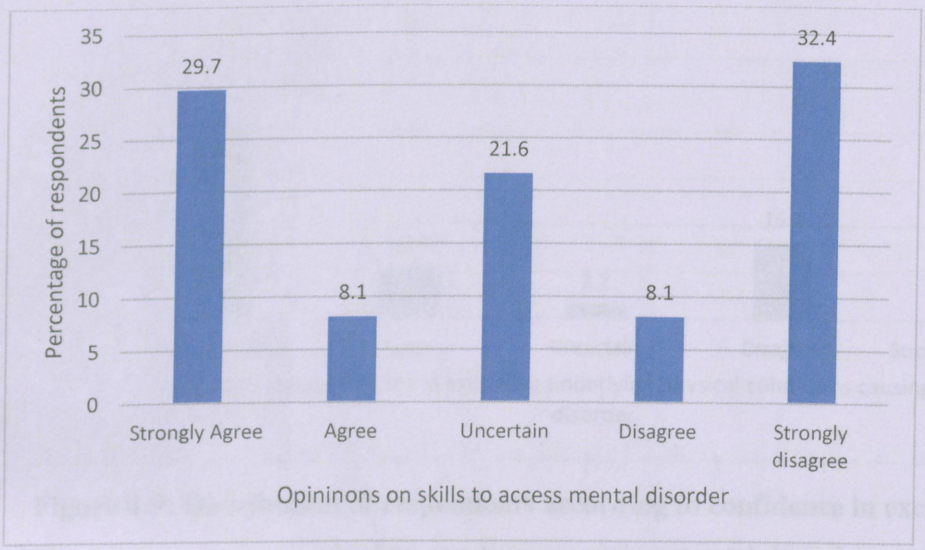


Figure 4.8: Distribution of respondents according staff allocation in skills to assess mental disorder

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Figure 4.9 below shows that, a total of 54% (43.2% strongly agree while 10.8% agree) were confident that excluding underlying physical conditions could have caused mental disorder. On the other hand, 43.3% (16.2% disagree and 27.1% strongly disagree) indicated that they were not confident in excluding underlying physical conditions which could caused mental disorder.

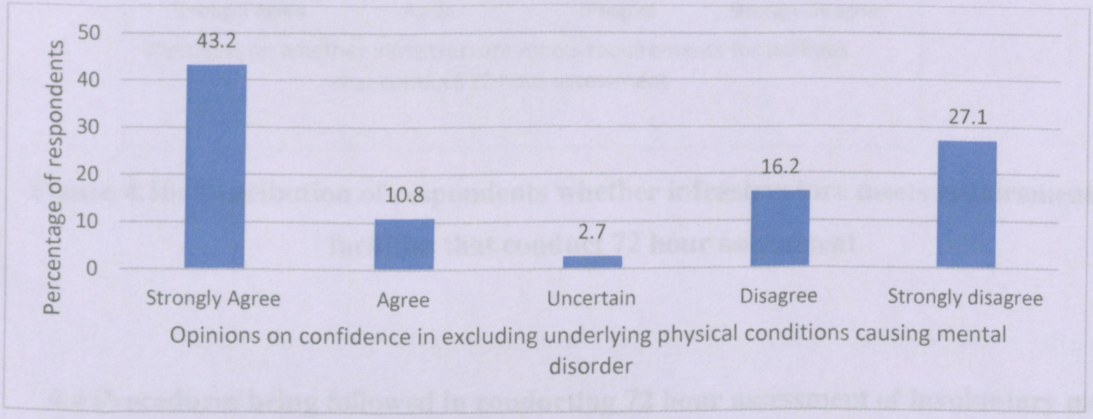


Figure 4:9: Distribution of respondents according to confidence in excluding underlying physical conditions causing mental disorder

As shown in Figure 4.10 below 40.5% (strongly agree 24.3% and agree 16.2%) of the respondents confirmed that their infrastructure met requirements for facilities that conduct 72 hour assessment whilst the rest either disagreed (16.2%).

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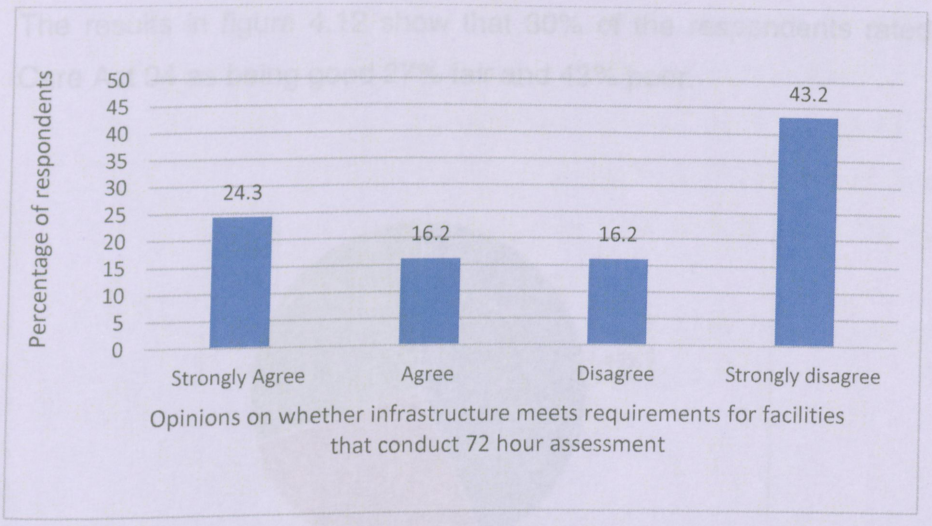


Figure 4.10: Distribution of respondents whether infrastructure meets requirements for facilities that conduct 72 hour assessment

4.4 Procedures being followed in conducting 72 hour assessment of involuntary mental health care users

Responses in relation to whether the procedural steps being followed in conducting the 72 hour assessment of involuntary mental health care are reported in this section. As shown in Figure 4.11 the majority (89%) of the respondents indicated that their facilities admitted patients for 72 hours while only 11% said they did not.

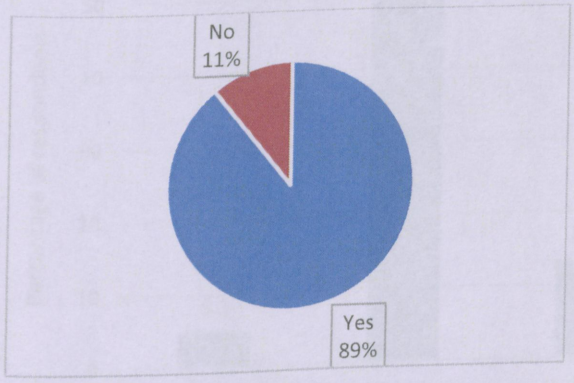


Figure 4.11: Admission of patients for 72 hours

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The results in figure 4.12 show that 30% of the respondents rated the Mental Health Care Act 04 as being good 27% fair and 43% poor.

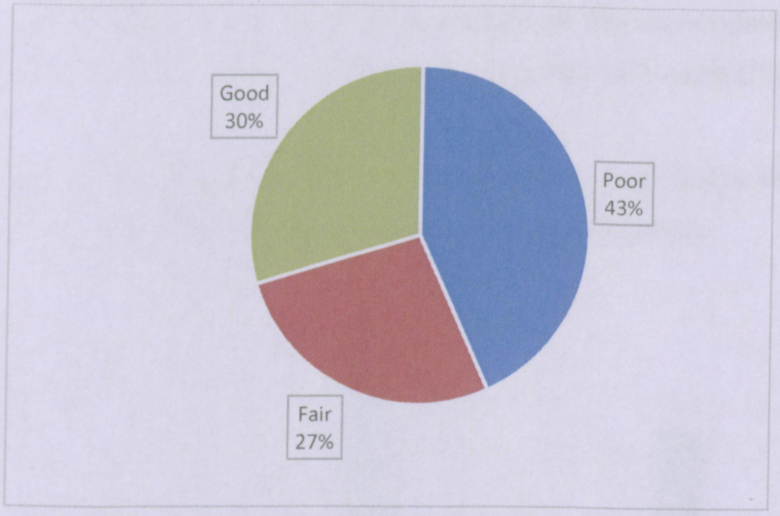


Figure 4.12: Ratings of the completeness of Mental Health Care Act 04 act on admission

Figure 4.13 reflect that the Mental Health Care Act 05 completeness on admission was rated as excellent by 5.1% of the respondents, good, 52.5%, fair 13.6% and poor 28.8%.

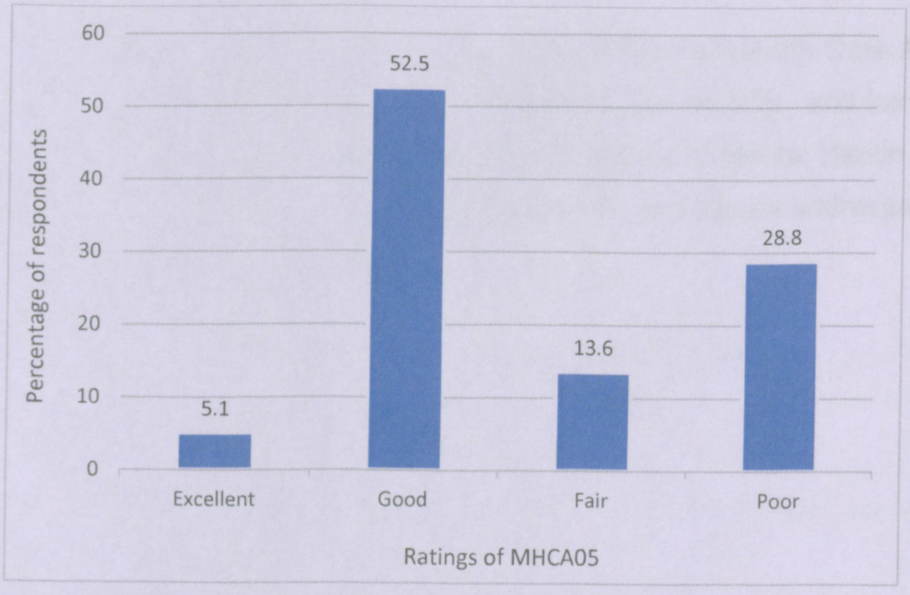


Figure 4.13: Ratings of the completeness of MHCA05 act on admission

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The results in figure 4.14 shows that 6.8% rated the Mental Health Care Act 07 completeness on admission as excellent, 49.2% rate it as being good, 8.5% fair and 35.6% poor. Although more than 50% of the respondents rated MHCA07 fair or good, the 35.6% is a large percentage to rate Mental Health Care Act 07 as poor.

Figure 4.15 results on the completeness of legal documents during the end of 72 hours assessment are shown in figures 4.14 to 4.16 below.

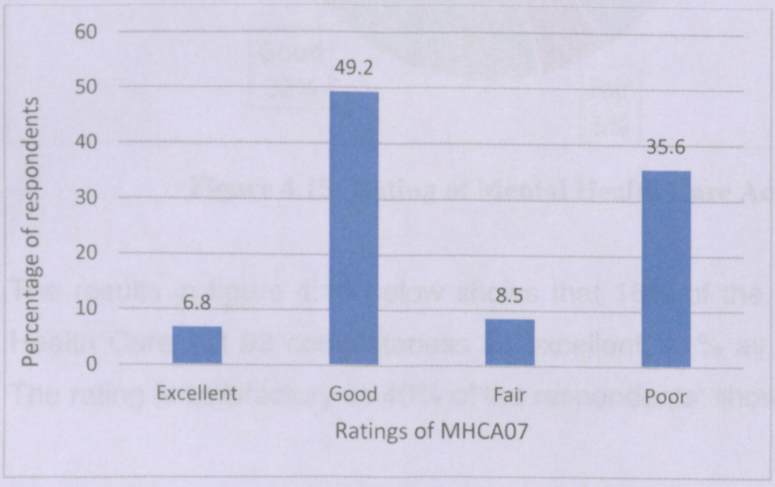


Figure 4.14: Ratings of Mental Health Care Act 07 completeness on admission

Figure 4.16 shows that the completeness of Mental Health Care Act 06 document was rated excellent by 22% of the respondents, good by 32%, and fair by 5%., 41% rated it as poor. The results show that the completeness of Mental Health Care Act 06 is fair to excellent as rated but there are concerns that need to be addressed as indicated by the 41% who stated it poor.

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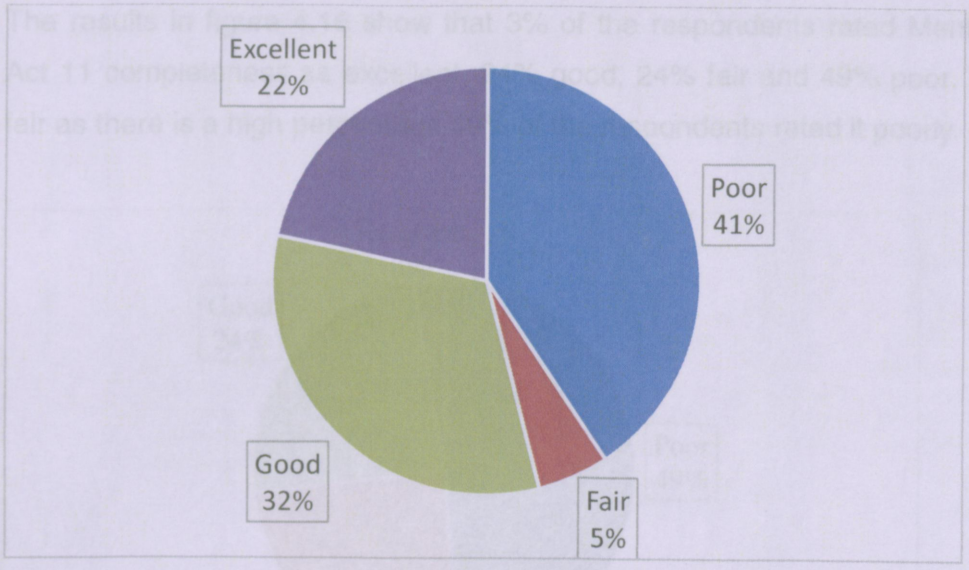


Figure 4.15: Rating of Mental Health Care Act 06 completeness

The results in figure 4.16 below shows that 16% of the respondents rated the Mental Health Care Act 93 completeness as excellent, 41% as good, 3% fair and 40% poor. The rating is satisfactory as 40% of the respondents' show that is poor.

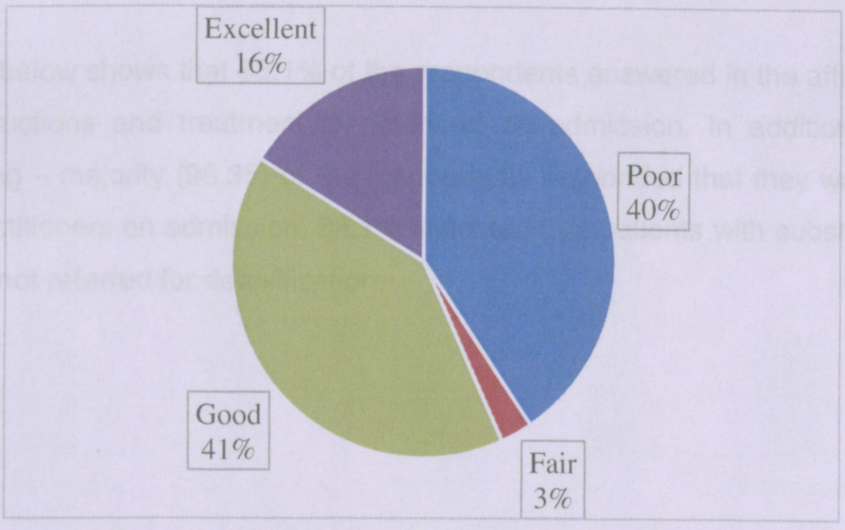


Figure 4.16: Rating on Mental Health Care Act 03 completeness

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The results in figure 4.16 show that 3% of the respondents rated Mental Health Care Act 11 completeness as excellent, 24% good, 24% fair and 49% poor. The rating was fair as there is a high percentage 49% of the respondents rated it poorly.

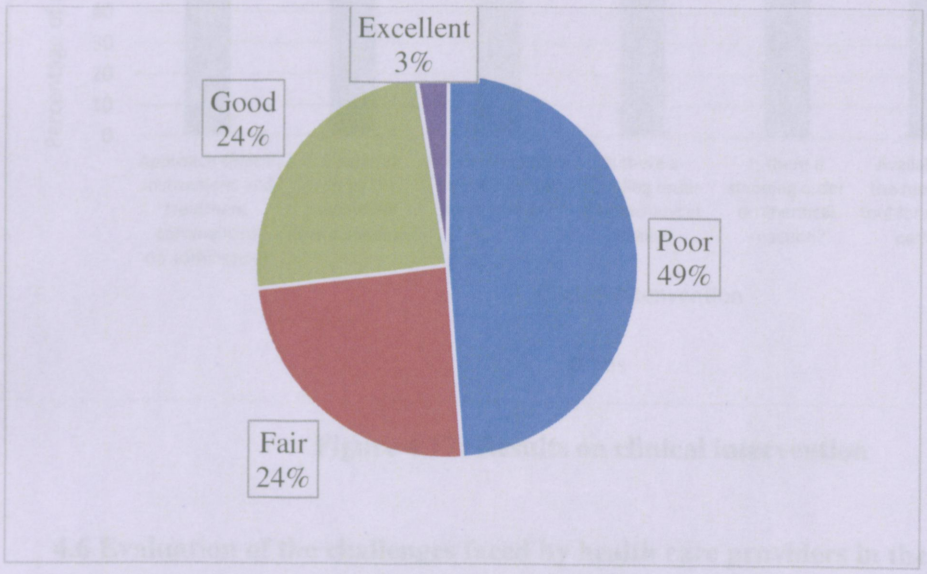


Figure 4.16: Rating of Mental Health Care Act 11 completeness

4.5 Clinical intervention

Figure 4.17 below shows that 88.1% of the respondents answered in the affirmative that clinical instructions and treatment commenced on admission. In addition, whilst an overwhelming – majority (98.35) of the respondents responded that they were seen by medical practitioners on admission, 88.1% indicated that patients with substance abuse cases were not referred for detoxification.

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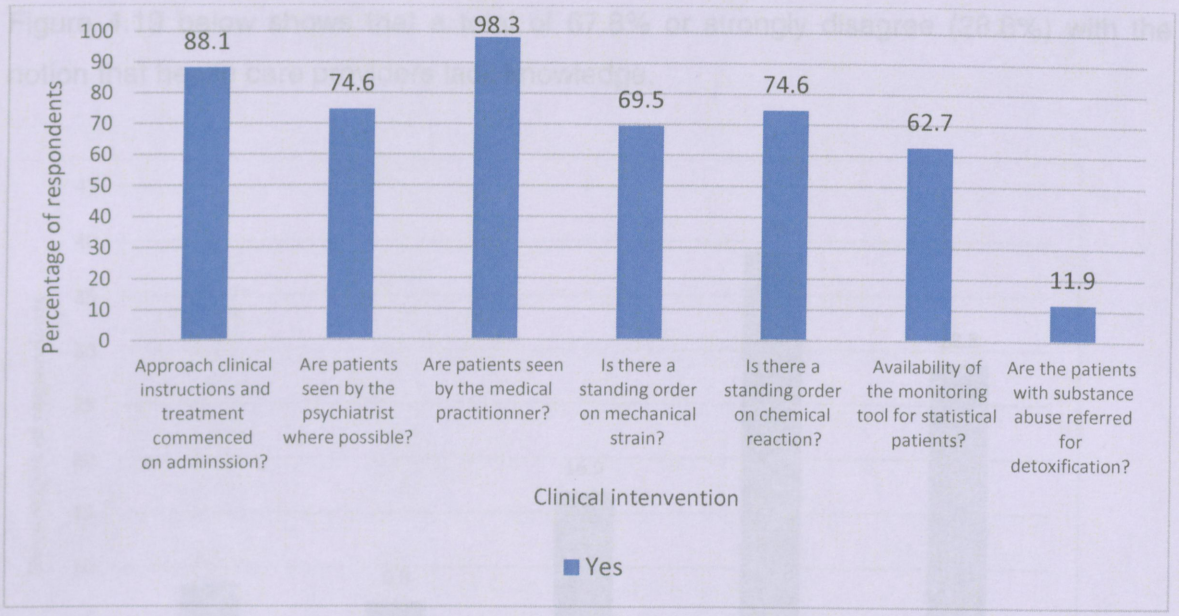


Figure 4.17: Results on clinical intervention

4.6 Evaluation of the challenges faced by health care providers in the implementation of the 72 hour assessment program of involuntary mental health care users

On the question regarding team work among health professional 32.2% strongly agree that there was lack of team work, 20.3% agreed, 27.1% disagreed (Figure 4.18).

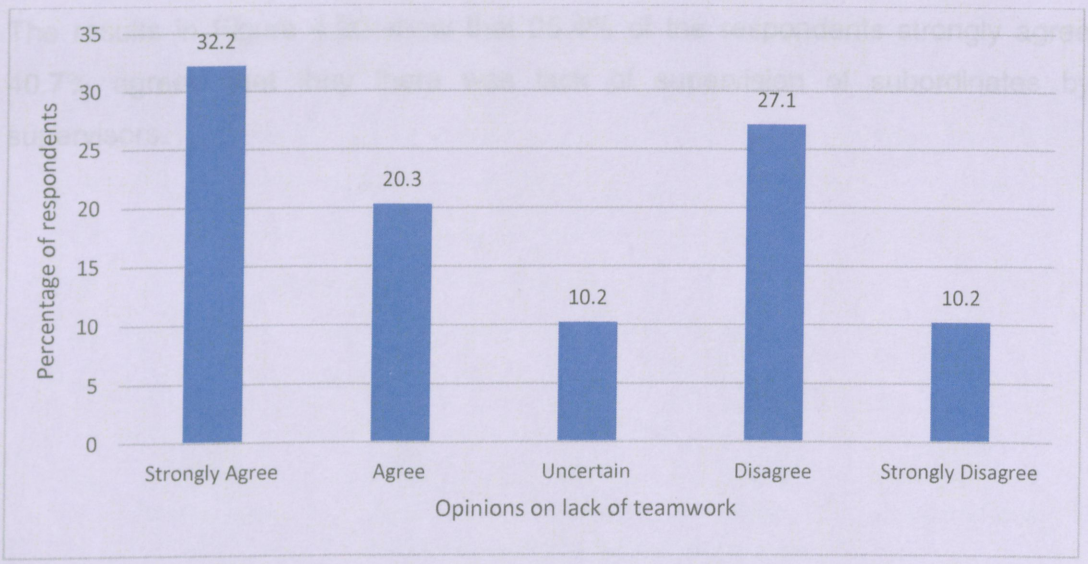


Figure 4.18: Distribution of respondents on lack of team work

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Figure 4.19 below shows that a total of 67.8% or strongly disagree (28.8%) with the notion that health care providers lack knowledge.

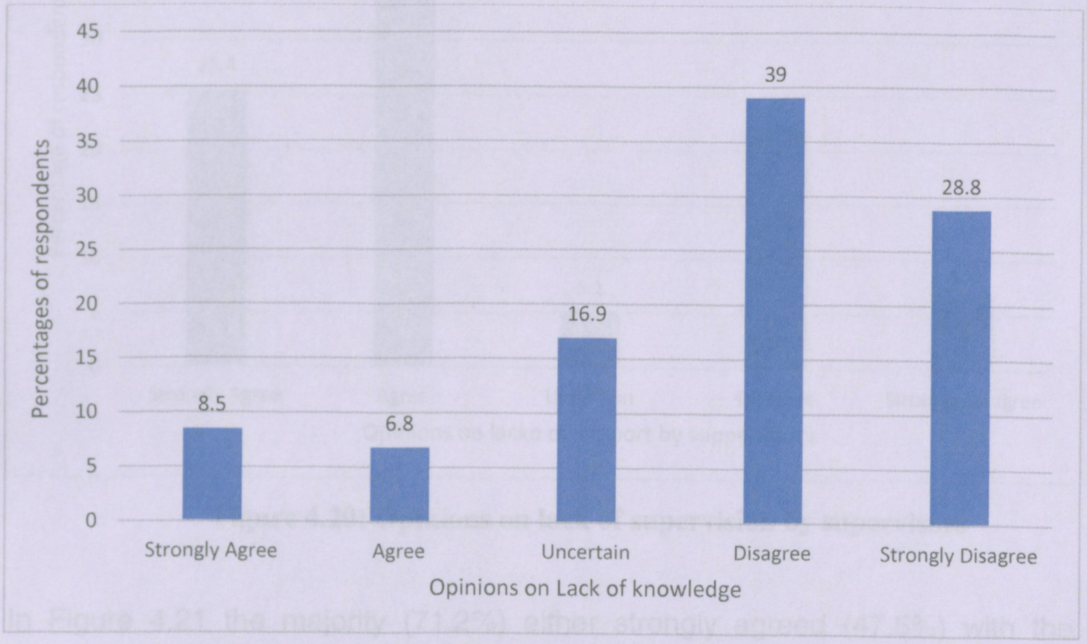


Figure 4.19: Distribution of respondents on opinions about lack of knowledge

The results in Figure 4.20 show that 25.4% of the respondents strongly agreed and 40.7% agreed that they there was lack of supervision of subordinates by their supervisors.

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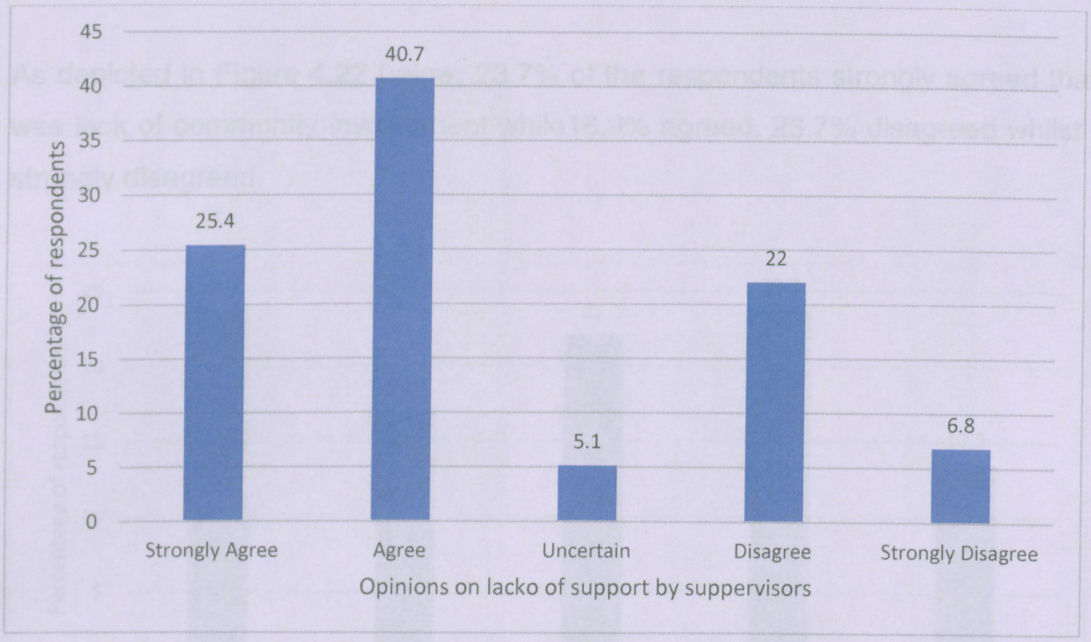


Figure 4.20: Opinions on lack of supervision by supervisors

In Figure 4.21 the majority (71.2%) either strongly agreed (47.5%) with the notion inadequacy of human resources at the health facilities.

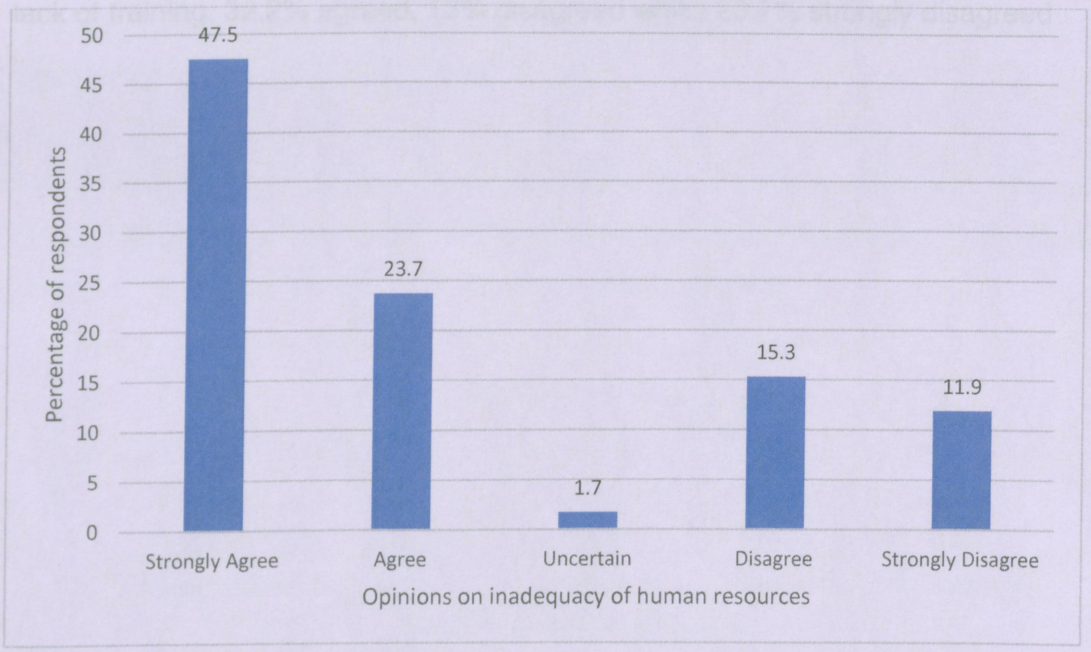


Figure 4.21: Opinions on inadequacy of human resources

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As depicted in Figure 4.22 below, 23.7% of the respondents strongly agreed that there was lack of community involvement while16.9% agreed, 23.7% disagreed whilst 13.6% strongly disagreed.

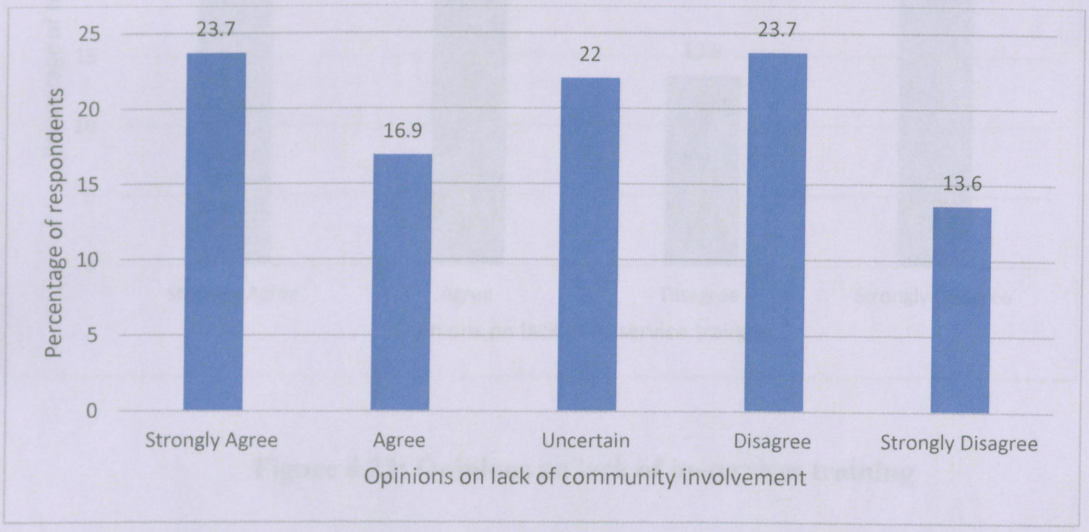


Figure 4.22: Opinions on lack of community involvement

Figure 4.23 the depicts that 30.5% of the respondents strongly agreed that there was lack of training, 32.2% agreed, 13% disagreed whilst 23.7% strongly disagreed

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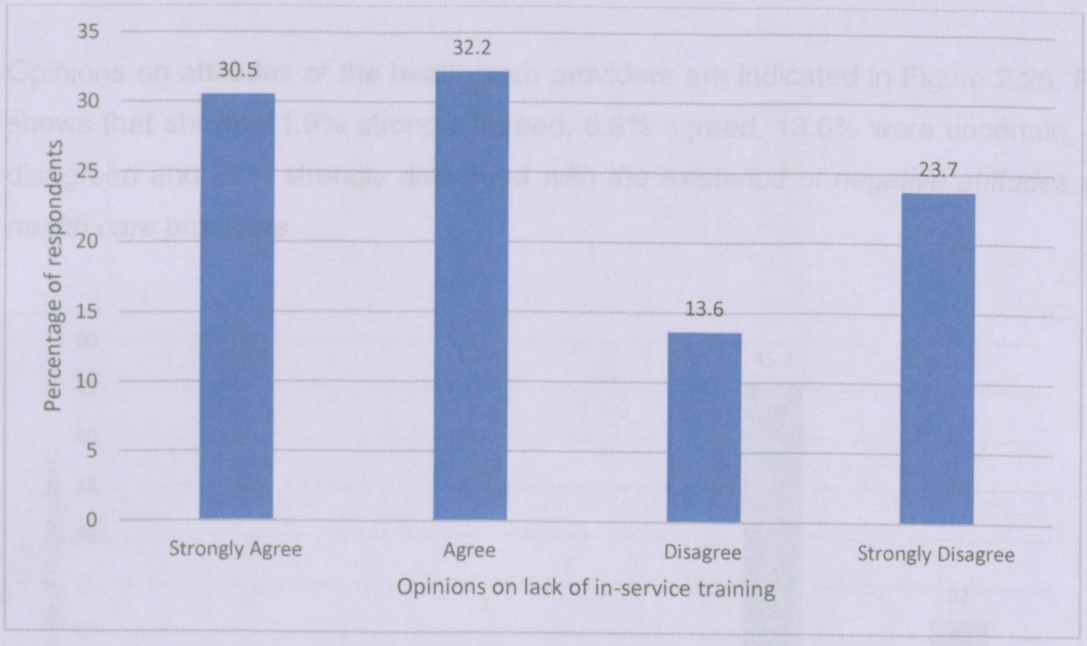


Figure 4.23: Opinions on lack of in-services training

Expressing their opinions on the shortage of equipment in mental health care facilities, majority of the respondents (62.7%) of the respondents strongly agreed that there was a shortage of equipment and only a negligible proportion (5.1%) were uncertain (Figure 4.24).

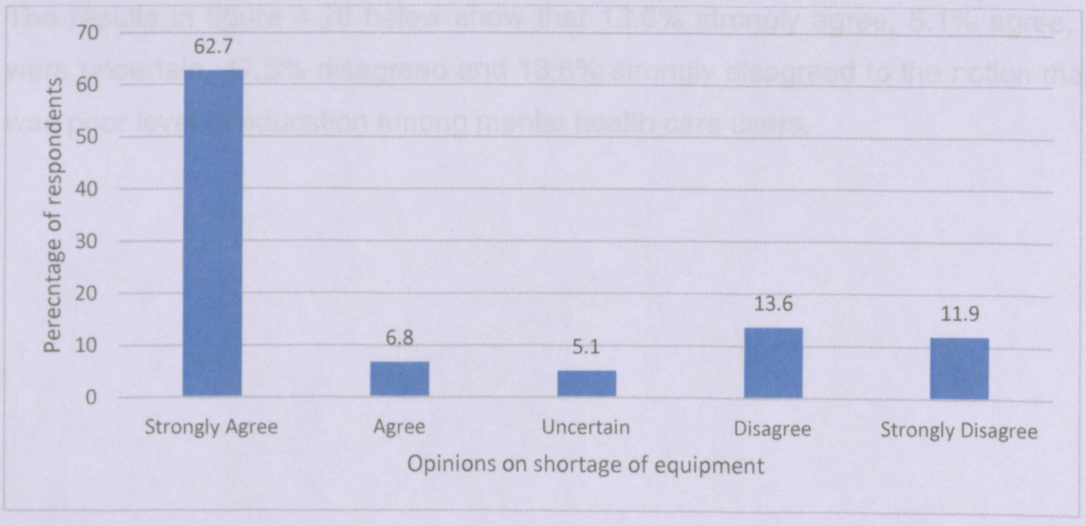


Figure 4.24: Opinions on shortage of equipment

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Opinions on attitudes of the health care providers are indicated in Figure 2.25. Results shows that shown 11.9% strongly agreed, 6.8% agreed, 13.6% were uncertain, 45.8% disagreed and 22% strongly disagreed *with the existence of negative attitudes among health care providers.*

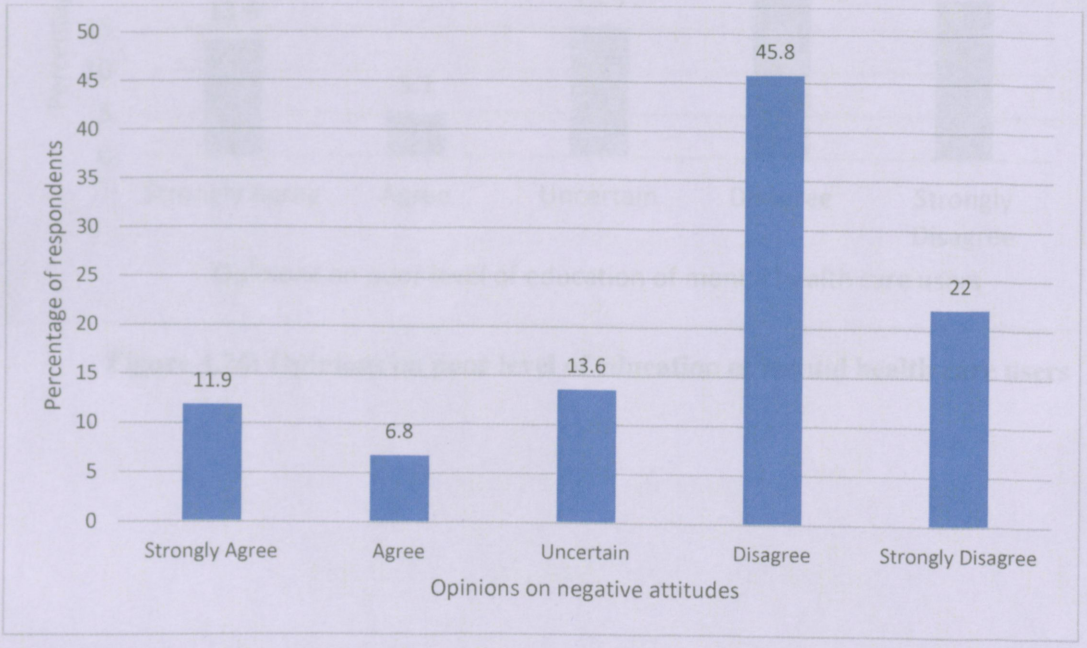


Figure 4.25: Opinions on negative attitudes

The results in figure 4.26 below show that 13.6% strongly agree, 5.1% agree, 15.4% were uncertain, 47.5% disagreed and 18.6% strongly disagreed to the notion that there was poor level of education among mental health care users.

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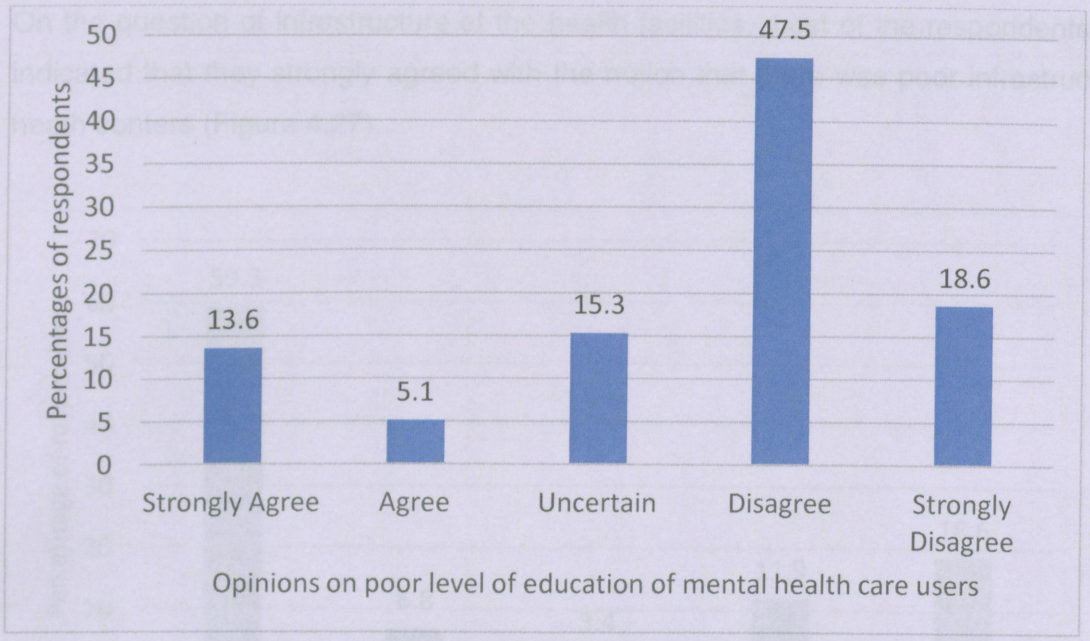


Figure 4.26: Opinions on poor level of education of mental health care users

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On the question of infrastructure at the health facilities, most of the respondents (59.3) indicated that they strongly agreed with the notion that there was poor infrastructure at heath centers (Figure 4.27).

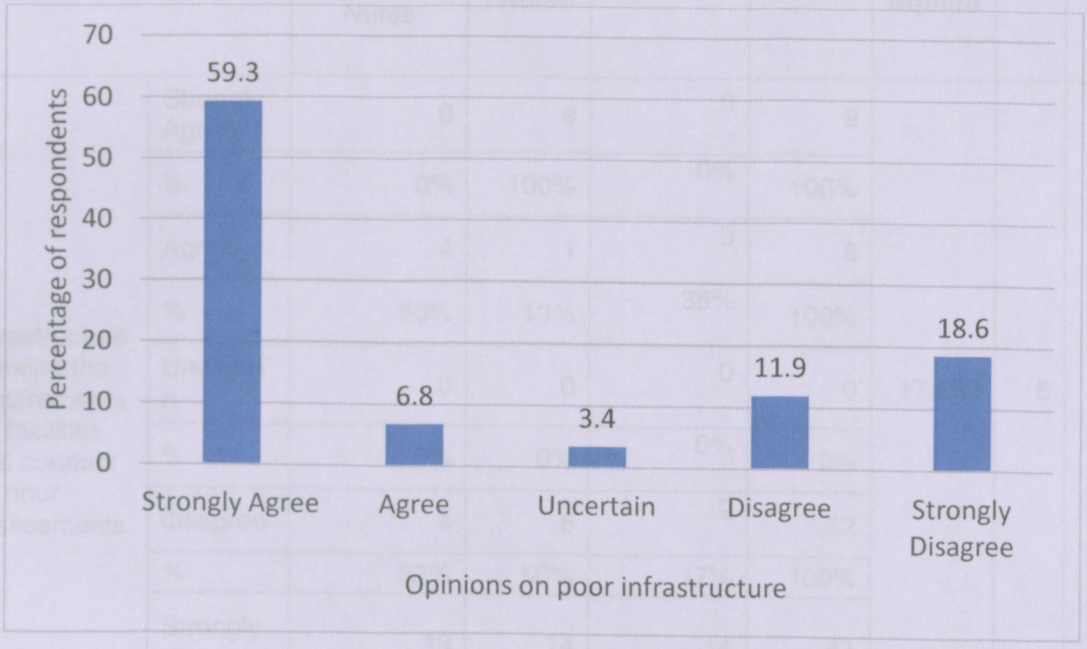


Figure 4.27: Opinions of poor infrastructure

4.7 Relationships between variables

This section presents results on the relationship between some key variables in the study.

In Table 4.4, X^2 (6, n=70) =17.282 and p=0.008. This is an indication that there was a significant association between qualification and knowledge of whether infrastructure meets the requirements or not.

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Table 4.4: Relationship between qualification and infrastructure meeting requirements

Response options		Qualification: Advanced Psychiatric Nurse	General Nurse	Psychiatric Nurse	Total	Chi-Square	Df	P-value Asymp. Sig. (2-sided)
Infrastructure meeting the requirements for facilities that conduct 72 hour assessments	Strongly Agree	0	9	0	9	17.282	6	0.008
	%	0%	100%	0%	100%			
	Agree	4	1	3	8			
	%	50%	13%	38%	100%			
	Uncertain	0	0	0	0			
	%	0%	0%	0%	0%			
	disagree	4	6	2	12			
	%	33%	50%	17%	100%			
	Strongly disagree	13	14	14	41			
	%	32%	34%	34%	100%			
Total	n	21	30	19	70			
	%	30%	43%	27%	100%			

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As shown in Table 4.5, X^2 (8, n=70) =17.011 and p=0.008; hence, there was a significant association between age-range of respondents and the completeness of MHCA07.

Table 4.5: Age range and Mental Health Care Act 07 completeness

		Age-range							
Response options		19 to 35	36 to 40	41 to 59	60 and above	total	Chi-Square	Df	P-value Asymp. Sig. (2-sided)
MHCA07 completeness	Excellent	0	0	1	0	1	17.011	8	0.008
	%	0%	0%	100%	0%	100%			
	Good	2	5	26	0	33			
	%	6%	15%	79%	0%	100%			
	Fair	5	0	6	1	12			
	%	42%	0%	50%	8%	100%			
	Poor	4	6	14	0	24			
	%	17%	25%	58%	0%	100%			
Total	n	11	11	47	1	70			
	%	16%	16%	67%	1%	100%			

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In Table 4.6, X^2 (6, n=70) =38.185 and p=0.000 show a significant association between qualification and the completeness of MHCA03. That is, the MHCA03 is likely to be complete from the respondent's' point of view when qualification categories of the nurses are present.

Table 4.6: Qualification and Mental Health Care Act 03 completeness

Qualification								
Response options		Advanced Psychiatric Nurse	General Nurse	Psychiatric Nurse	Total	**Chi-Square**	**Df**	**P-value Asymp. Sig. (2-sided)**
MHCA03 completeness	Excellent	4	2	2	8	38.185	6	0.000
	%	50%	25%	25%	100%			
	Good	17	8	17	42			
	%	40%	19%	40%	100%			
	Fair	0	1	0	1			
	%	0%	100%	0%	100%			
	Poor	0	19	0	19			
	%	0%	100%	0%	100%			
Total	n	21	30	19	70			
	%	30%	43%	27%	100%			

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Table 4.7 gives X^2 (2, n=70) =6.391 and p=0.001. This is an indication that there was a significant association between qualification and affirmation that appropriate clinical instructions and treatment commenced on admission of patient.

Table 4.7: Qualification and appropriate clinical instructions and treatment commenced on admission

		Qualification						
Response options		Advanced Psychiatric Nurse	General Nurse	Psychiatric Nurse	Total	**Chi-Square**	**Df**	**P-value Asymp. Sig. (2-sided)**
Appropriate clinical instructions and treatment commenced on admission?	Yes	19	23	19	61	6.391	2	0.001
	%	31%	38%	31%	100%			
	No	2	7	0	9			
	%	22%	78%	0%	100%			
Total	n	21	30	19	70			
	%	30%	43%	27%	100%			

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In Table 4.8, X^2 (8, n=70) =21.41, p=0.000. This shows that there is a significant association between qualification and inadequate human resources with.

Table 4.8: Qualification and inadequate human resources

Qualification								
Response options		Advanced Psychiatric Nurse	General Nurse	Psychiatric Nurse	Total	**Chi-Square**	**Df**	**P-value Asymp. Sig. (2-sided)**
Inadequate human Resource	Strongly Agree	10	5	15	30	21.41	8	0.000
	%	33.3%	16.7%	50%	100%			
	Agree	3	9	4	16			
	%	18.8%	56.3%	25%	100%			
	Uncertain	0	1	0	1			
	%	0%	100%	0%	100%			
	Disagree	8	4	0	12			
	%	66.7%	33.3%	0%	100%			
	Strongly disagree	0	11	0	11			
	%	0%	100%	0%	100%			
Total	n	21	30	19	70			
	%	30%	43%	27%	100%			

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The results in Table 4.9 give X^2 (8, n=70) =25.251 and p=0.000. It therefore, shows a significant association between qualification and lack of in-service training.

Table 4.9: Qualification and lack of in-service training

Qualification								
Response options		Advanced Psychiatric Nurse	General Nurse	Psychiatric Nurse	Total	**Chi-Square**	**Df**	**P-value Asymp. Sig. (2-sided)**
Lack of in-service training	Strongly Agree	7	6	8	21	25.251	8	0.000
	%	33.3%	28.6%	38.1%	100%			
	Agree	10	5	6	21			
	%	47.6%	23.8%	28.6%	100%			
	Uncertain	0	0	0	0			
	%	0%	0%	0%	0%			
	disagree	2	3	5	10			
	%	20%	30%	50%	100%			
	Strongly disagree	2	16	0	18			
	%	11.1%	88.9%	0%	100%			
Total	n	21	30	19	70			
	%	30%	43%	27%	100%			

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In Table 4.10, X^2 (8, n=70) =34.961 and p=0.000 which indicates that there is an association between qualification and poor infrastructure.

Table 4.10: Qualification and poor infrastructure

Qualification								
Response options		Advanced Psychiatric Nurse	General Nurse	Psychiatric Nurse	Total	Chi-Square	Df	P-value Asymp. Sig. (2-sided)
Poor infrastructure	Strongly Agree	14	10	15	39	34.961	8	0.000
	%	35.9%	25.6%	38.5%	100%			
	Agree	4	0	1	5			
	%	80%	0%	20%	100%			
	Uncertain	0	1	2	3			
	%	0%	33.3%	66.7%	0%			
	disagree	3	4	1	8			
	%	37.5%	50%	12.5%	100%			
	Strongly disagree	0	15	0	15			
	%	0%	100%	0%	100%			
Total	n	21	30	19	70			
	%	30%	43%	27%	100%			

4.8 Summary

This chapter described the data analyses and interpretation. It has also examined the demographic information. The next chapter discusses the discussion of the findings.

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CHAPTER 5

DISCUSSIONS OF THE FINDINGS

5.1 Introduction

This chapter discusses the findings of the study. The discussion is structured according to demographic data, compliance of the general hospitals with regard to requirements for listing facilities to conduct 72 hour assessment, procedures being followed in conducting 72 hour assessment of involuntary mental health care users, clinical intervention and challenges facing health care providers.

5.2 Demographic results

The study found that the majority of the nurses who work at the psychiatric units (67.6%) were females while males were the minority. These figures are consistent with the notion that nursing is a female dominated profession over the world as postulated by Duman (2012).

In terms of age, the study found that (67.6%) of the nurses in the psychiatric units were aged between 41 to 59 years. Very few young nurses were willing to work in the psychiatric units. These figures indicate that the majority of the nurses were mature and this was likely to affect the implementation of the 72 Hour Assessment Policy in these institutions. Age could play a crucial factor in the dispensation of duties in the unit, there by impinging negatively on the implementation of the policy (Mohs, 2016)

The majority of the people in Vhembe District speak Tshivenda and as a result, it was expected that the majority of the respondents' (65%), home language is Tshivenda. This means that the communication between the patients and the nurses could have been good as they used the same language.

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The percentage of nurses with a qualification in psychiatric was found to be low at (32.4%), implying that most of the nurses in these hospital were general nurses. This could have compromised the implementation of the 72 hour policy (WHO, 2007).

The sample in this study comprised manily of inexperienced nurses and highly expereinced nurses, less than 4 years (32.4%) and more than 10 years experience (48.6%.) With this relatively good balance of work experience, it would be expected that inexperienced nurses to get support from experienced nurses. However, most of the experienced nurses were general nurses.

5.3 Compliance of the general hospitals with regard to requirements for listing facilities to conduct 72 hour assessment

The results show that in Vhembe District, the majority of mental health care users were treated near their home as required by law and these constituted 70.2% of the respondents. There were also some users who were treated at places far away from their homes, meaning that they had to travel some distance to access the facilities. This has also had an effect on these patients as they could not get treatment regularly. This shows that not all hospitals complied with the requirements for listing facilities to conduct 72 hour assessment of involuntary mental health care users (WHO, 2007).

In terms of security level, the majority of the facilities (64.9%) did not have the required level of security putting the whole process of listing facilities in danger (Van Rensburg, 2012). For facilities dealing with psychiatric users, security should be in place. Facilities without security could have been compromising the 72 hour assessment of mental health care users. There could be cases where patients were improperly assessed or not assessed within 72 hours as a result of poor security in the facility.

From the demographic information, it was indicated that mental health care facilities were mainly staffed with general nurses who did not have the relevant skills to assess mental disorders among patients. Most of the mental health care facilities in Vhembe

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District might not have been able to comply with 72 hour assessment policy since most of the nurses in the hospital were not able to it. They could have been relying on other scarce psychiatrist specialists. In South Africa assessments of mentally ill patients are often done at district hospitals by general physicians who lack the skills and competency to do so and this usually results in inaccurate assessment of the need for involuntary treatment (Moosa & Jeenah, 2008; Mabena, 2010).

In terms of confidence in excluding underlying physical conditions which could have caused mental disorder (43.3%) of the respondents were found to be confident in performing this process. Only (57.7%) were somehow confident. This has an implication on the implementation of the 72 hour policy in that some facilities with "unconfident" nurses could have been delaying the process beyond the stipulated 72 hours or even referring the cases for assessment to other facilities. Moosa and Jeenah (2008) emphasise that it is difficult for physicians to make a diagnosis of mental illness from a brief evaluation of a mentally ill patient, let alone predict dangerousness. According to Gray, Spilling, Burgess and Newey (2009) mental health professionals require a range of competencies to help patients manage their medication effectively. Lack of key medical competencies, and nursing staff in mental health facilities could be the reasons leading to lack of confidence in performing their duties properly.

Infrastructure is a key component in health facilities if duties and services are to be discharged diligently and efficiently. The majority of the respondents (59.4%) in this study confirmed that their infrastructure hardly met the minimum requirements for facilities that conduct 72 hour assessment. This implies that many facilities in hospitals were not able to implement the 72 assessment policy due to lack of resources as they did not match the required standards. In South Africa, there are a limited number of specialized psychiatric hospitals, therefore, even district and regional hospitals are pressured into admitting these involuntary patients and conducting 72 hour assessments (Moosa & Jeenah, 2008). The issues of infrastructure and resource constraints at most of the designated institutions, that conduct 72 hour assessments

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integrally tied with further infringement of patients' rights, are common problem in South Africa (Moosa & Jeenah, 2008).

From the above observations hospitals seem to face a number of challenges in implementing the 72 hour assessment policy due to lack of nurses who specialized in psychiatry, lack of confidence by those nurses in such hospital and low standards in terms service delivery. According to Bateman (2012) it is worrisome that most South African provinces have not yet to meet the mandate and criteria of the new legislation of 72 hour assessment. Most of the nurses lack skills in performing duties related to psychiatric nursing. Mabena (2010) notes that general hospitals are designated to conduct 72 hour assessment on health care users who required admission to involuntary patients yet these hospitals often lack the infrastructure to accommodate such patients.

5.4 Procedures being followed in conducting 72 hour assessment of involuntary mental health care users

In terms of admission of patients in facilities, the majority of the respondents (89%) indicated that hospitals admitted patients for 72 hours while only 11% said they did not. The major constraint faced by hospitals was infrastructure and qualified psychiatrists. According to Mabena (2010), the MHCA makes legal provision for the protection of the rights of psychiatric patients and gives clear guidelines as to under which circumstances should patients be admitted involuntarily into specialized hospitals.

A number of documents need to be completed for mentally ill patients to be admitted and treated (De Marinis, Piredda, Pascarella, Vincenzi, Spiga, Tartaglini, Alvaro & Matarese, 2010). The reason is that documentation is essential for good clinical communication (Collins, Cato, Albers, Scott, Stetson, Bakken & Vawdrey, 2013), on which medical practitioners rely. Documentation encompasses all written and/or electronic entries reflecting all aspects of patient care communicated, planned, recommended or given to that patient (Collins, 2013). In all cases, documentation should be done before a patient is admitted unless under unusual situations. The

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completeness of MHCA04 was rated as being fair or bad by the majority of the respondents, while that of the MHCA05 and MHCA07 were rated as being fair and good. These disparities could have originated from the nature of the documents and the know-how by the nurses. Chi-square results for age range and MHCA07 completeness, X^2 (8, n=70) =17.011, p = 0.008 show significant association between age and completeness of MHCA07. Nurses below the age of 50 rated the completeness of MHCA07 as being good or excellent while few nurses whose age was above 50 viewed the completeness of MHCA07 as being poor.

The MHCA04 seems to have been difficult to complete and apparently general nurse did not complete it. The remaining two documents, MHAC06 and MHCA11 were also satisfactorily ranked for completeness. The implication is that most of the psychiatric patients could have been hospitalized without proper documentation due to the lack of skill by the nurses (Milligan, 2012; Boyd, 2008). These documents would require some training for nurses to understand how they are completed and also on their importance. Because an accurate history of past and current treatments and responses to them are a key ingredient to treatment planning, excellent documentation is of paramount importance. Especially critical, for example, is information about prior treatment efforts and clinical response (American Psychiatric Association Steering Committee on Practice Guidelines, 2010).

This study found that the qualification of nurses was a major determinant in the completeness of MHCAs forms. The chi-square results showed significant association between qualification and the completeness of all other MHCAs other than MHCA04 since it is mostly completed by relative, at p<=0.000. Nurses trained in psychiatry were likely to view the completeness of the documents as good while those not trained in psychiatric view it otherwise. These findings would mean that in facilities where there were no nurses trained in psychiatry, the general nurses could have been ignorant of the types of MHCAs to complete at each stage of the course of assessment, thereby compromising the 72 hours assessment policy.

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5.5 Clinical intervention

The majority (88.1%) of the respondents indicated that clinical instructions and treatment commences on admission. This implies that patients were timely treated following clinical instructions. However, considering the completion of documents, it would sound as if the patients which are embarked on treatment before the documents were not completely filled in for details a rare practice in hospitals. There was a significant association between qualification and appropriate clinical instructions and treatment commenced on admission with X^2 (2, n=70) =6.391, p=0.001.

Under normal circumstances treatment of patients was most likely to commence as soon as admission procedures were completed. According to Gray, Spilling, Burgess and Newey (2009) medication management includes discussing treatment choices, providing information about medication, monitoring the positive, negative and subjective effects of drugs, administering pills and giving injections.

Many patients with mental health require, and should receive, a variety of treatments, often from multiple clinicians. It is therefore incumbent on clinicians to coordinate their work and prioritize their efforts (APASCPG, 2010; Latha, 2010). The findings are consistent with suggestion made by Boy (2008) who recommends that a mental patient should be attended to immediately after admission to a facility. Neuman (2013) also observes that once a patient is admitted he/she should attended as soon as possible before he/she feels out of place and starts acting violently. Although hospitals are understaffed, it seems they are able to attend to situations within the confines of the medical practice stipulating how mental patients should be treated.

Under normal circumstances, a psychiatric patient should be assessed by two mental health care practitioners and a medical practitioner for 72 continuous hours (Boy, 2008; Mabena, 2010). As the results of this study indicate, the majority of the respondents (74.6%) affirmed that patients were seen by the psychiatrist as soon as they were admitted where possible, while 25.4% said the patients were not seen. The association

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between nurses' qualifications and whether patients were seen by the psychiatrist where possible was significant: X^2 (2, n=70) =14.771, p= 0.001. With 94% of nurses with a qualification in psychiatry likely to affirm this notion compared to 45% of the general nurses who disapproved, means that under normal conditions, a mental disorder patient was most likely to be examined by a psychiatrist when there was a need. Neuman (2013) posits that ideally, upon admission into a hospital, it brings the patient into a therapeutic community, every aspect of which is designed to have a beneficial effect on him. The patient is protected from those influences in the outside world that have caused him to become ill. Neuman (2013) also recommends psychiatrists to visit mental patients at their home to show a sign of seriousness towards their commitment in helping the patient. In this case, psychiatrists are expected to see the patient frequently to assess the progress.

The majority (98.3%) of the respondents indicated that the patients were seen the medical practitioner and 1.7% said they were not seen. According to Mabena (2010), the medical practitioner conducting the assessment determines the treatment program and the place within the health establishment where the patient will be kept during the assessment period to ensure the safety of the user and others. The findings of this study are consistent with Chaudhary and Mishra1 (2009) findings that about 88.7% of the practitioners they studied admitted seeing patients with mental health problems in their practice. This also consistent with a survey done on general practitioners in Jaipur city by Gupta and Kamalpreet (1992) that a medical practitioner was frequently in contact with their psychiatric patients. This is a common practice that patients have to be seen by a GP more frequently who assesses their progress (Neuman, 2013).

This study established that not all facilities in the Vhembe District had a standing order on mechanical restraint. Only 69.5% of the respondents indicated that there was a standing order on mechanical restraint in their facilities, while 30.5% indicated that there no standing order on medical restrain in their health centers.

Chi-square, X^2 (2, n=70) =28.901, p= 0.000 results also indicated a significant association between qualification and presence of a standing order on mechanical practitioner. 97% of nurses with qualification in psychiatry were most likely to affirm that

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the orders were in place while 54% of the general nurse said they did not exist. Considering that most of the respondents were general nurses, it would mean that some of the facilities did not have nurses with psychiatric specialists and were likely not to have standing orders in place in respect of mechanical restrain. Therefore, some of the health facilities do not adhere to the 72 hour assessment implementation guidelines when dealing with mental patients. However mechanical restraint should not be used as a punitive measure, but for the safety of the patient and the staff (Burns, King & Saloojee, 2007).

The study found that there were more facilities with a standing order on chemical restraint than those which did not have as indicated by the responses from the sample. In the Vhembe District, the results show that up to 74.6% of the facilities had a standing order on chemical restrain. However, the number without these orders was relatively high (25.4%). From chi-square X^2 (2, n=70) =16.781, p= 0.000, 95% of nurses with a qualification in psychiatry agree that there were standing orders on chemical restraint in their units and 54% of the general nurses indicated that they did not exist. This also shows that not all institutions were implementing the 72 hour policy as stipulated. Burns, King and Saloojee (2007), describe the stranding order on chemical restraint as oral medication should be considered first and then followed by intravenous or intra muscular injection in case the patient refused oral treatment.

According to Burns, King and Saloojee (2007), suicide is considered the third cause of death in adolescents (12%). Therefore, it becomes necessary to implement the monitoring tool for suicidal patients. The study found that there was a possibility of many facilities without monitoring tools for suicidal patients. The results show that 62.7% of the respondents confirmed that their institutions had a monitoring tool for suicidal patients while 37.3% indicated that their institutions did not have the tool. Also, chi-square X^2 (2, n=70) =31.411, p< 0.000, indicate an association between qualification and availability of the monitoring tool for suicidal patients. 89% of those nurses with a qualification in psychiatric were more likely to say that the instrument existed while 74% of general nurses said it did not exist. However, in this study there were fewer

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psychiatry specialists than general nurses in the facilities. This means that a number of units operated without a monitoring tool for suicidal patients, thereby flouting the 72 hour policy. Implicitly, it would mean that some of the psychiatric facilities did not monitor patients for suicidal incidences. These results are consistent with those by Temkin and Crotty (2010) who established that some facilities did not use monitoring tools for suicidal cases, where tools were used , they were either outdated or wrong information was recorded. McDowell, Lineberry and Bostwick (2011) observe that a number of self-administered tools for identifying depression are effective and rapidly administered.

Medical detoxification safely manages the acute physical symptoms of withdrawal associated with stopping drug use. However, medical detoxification is only the first stage of addiction treatment and by itself does little to change long-term drug use (McDowell et al., 2011).This study established that most of the psychiatry facilities in Vhembe District had a tendency of not sending patience with substance abuse for detoxification. This is evidenced by the majority of the respondents (88.1%) who indicated that patients were not referred for detoxification, but only a small number of respondents (11.9%) affirmed that they indeed referred patients. Detoxification can be done in the unit following the guidelines. However, in severe conditions, patients should be referred to various treatment settings (Burns, King & Saloojee, 2007).

5.6 Challenges

Lack of knowledge in dealing with psychiatric patients was not one of the major challenges affecting the implementation of the 72 hour policy. Only less that 18% of the respondents agreed that there was lack of knowledge among health worker while 67.8% disagreed with this view while, 16.9% were not certain. Generally, health care providers were knowledgeable in what they were practicing. These findings were in contradiction to those by Medina, Kullgren and Dahlblom (2014) who posit that Primary Health Care professionals acknowledged that they lacked sufficient knowledge and competence. Lack of knowledge could have been exhibited by those nurses who had no a qualification in psychiatry. Ngako, Van Rensburg and Mataboge (2012) conducted a

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study on "'Psychiatric nurse practitioners' experiences of working with mental health care users presenting with acute symptoms". The study confirms that there is lack of skills and competency with regard to managing mental health care users at the general hospitals.

Teamwork was another challenge which was found to have some influence in the implementation of the 72 hour policy as indicated by the results that 32.2% strongly agree that there was lack of team work, 20.3% agreed, 27.1% disagreed and 10.2% strongly disagreed. Generally, there seems to be lack of team work in most general units investigated. Fredheim, Danbolt, Haavet, Kjonsberg and Lien (2011) study in Norway, also found that several weaknesses in interaction and communication between General Practitioners (GP) and mental heath professionals, and can serve to support the national focus on improved coordination between primary and specialist levels of care. The study reports that mutual problems with accessibility were experienced because of lack of systematic model for collaboration with regular meetings between GPs and mental health professionals, common consultations and regular ambulatory services (Fredheim et al., 2010).

Pertaining to supervision, the study established that in most of the facilities there was lack of supervision as indicated by the findings that more than 66% of the respondents agreed hat they there was lack of supervision by supervisors. It follows that in most of the facilities; subordinates were not supervised and did work to their understanding at the expense of patients. This explains why the MHCA04 documents were not completed prior to treatment of the patients. This also links with lack of knowledge among the majority of none specialist who served in these facilities. These results indicate that the majority of the respondents were not being supervised. The study by Mendenhall, De Silva, Hanlon, Petersen, Shidhaye, Jordans, Luitel, Ssebunnya, Fekadu, Patel, Tomlinson and Lundl (2014) in Uganda, found that lack of supervision of general nurses in psychiatric clinics was prevalent, and in most cases caused stress among the nurses.

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Inadequate human resources were found to be prevalent in many mental facilities as indicated by the findings that, the majority of the respondents (71.2%) agreed that the there was inadequate human resource at their units. The study by Mendenhall et al (2014) also alludes that enormous scarcity and inequality in the distribution of specialist mental health professionals underscored the need for task-sharing mental health services. In this study the Chi-square results of Qualification and inadequate human resources: [X^2 (8, n=70) =21.41, p= 0.000] show a significant association between qualification and inadequate human resources, implying that 89% of those nurses with a qualification in psychiatry were more likely to recognise the shortage of psychiatric personnel, while 74% of general nurses refuted inadequacy. Sobekwa and Arunachallam (2015) conducted a study in Western Cape Province, indicating the shortage of staff and increased workload in psychiatric units.

Lack of training of nurses and staff at facilities was found to be prevalent as indicated by the results depicting that 67.7% of the respondents agreed that there was lack of training while (42.3%) agreed. Lack of training is also supported by large number of general nurses compared to psychiatric trained nurses. A number of studies show training, although a major component of the health profession was one of the most neglected areas (Fredheim et al., 2011; Medina et al., 2014; Mendenhall et al., 2014).In relation to infrastructure in mental health care the study has found that facilities had challenges in infrastructure as indicated by the results which show that (66.1%) of the respondents agreed that there was poor infrastructure in mental health care. Assisted and involuntary mental health care users are admitted at the general hospital despite inadequate infrastructure and staff (Ramlall, Chipps & Mars, 2010).

5.7 Summary

This chapter discussed the findings of the study. The discussion examined the demographic information, the 72 hour procedure, clinical intervention and the challenges. The next chapter focuses on the conclusion and recommendation.

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CHAPTER 6
CONCLUSIONS AND RECOMMENDATIONS

6.1 Conclusion

A number of conclusions can be drawn from this study regarding the implementation of the 72 hour assessment policy.

6.2 Demography

- **Age**: The majority of the nurses in the in the psychiatric clinics were aged between 41 to 59 years as very few young nurses were willing to work in the psychiatric units. The implementation of the 72 hour policy could be affected by the age of the nurses as the tendency to forget to do certain tasks increases with advance in age. A good case is completion of MHCA04 before admission of the patients.
- **Qualification**: The implementation of the 72 hour policy was affected by the qualification of the nurses in the general hospital as the majority of the nurses did not receive any training in psychiatry. Some psychiatric units were staffed with general nurses only due to shortage of psychiatric nurses.
- **Work experience:** There was a good balance of experience between inexperienced and highly expereinced nurses (32.4% and 48.6%). Experince was not a major factor in the implementation of the 72 hour policy.

6.3 Compliance of the general hospitals with regard to requirements for listing facilities to conduct 72 hour assessment of involuntary mental health care users

There was no strict compliance with the requirements for listing facilities to conduct 72 hour assessment of involuntary mental health care users because:

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- Some patients were treated far away from their homes after travelling long distances thus compromising regular treatment and exposing the community to dangers of these patients. Not all general hospitals complied with the requirement for listing facilities to conduct 72 hour assessment of involuntary mental health care users.
- Many facilities (64.9%) did not have the required level of security putting the whole process of listing in danger. Facilities without security compromised the 72 hour assessment of mental health care users. This could also result in cases of irregularities in assessment of patients and also that patients could not have been assessed within 72 hours.
- Mental health care facilities were mainly staffed with general nurses who did not have relevant skills to assess mental disorders among patients. Such facilities were unable to comply with 72 hour assessment policy as most of the nurses in the hospital were not able to perform the assessment.
- Due to lack of relevant expertise, some of the general nurses lacked confidence in performing the assessment, thereby compromising the 72 hour process. Lack of key medical competences, nursing staff in mental health facilities could be the reasons leading to the lack of confidence in performing their duties properly.
- There was a severe shortage of infrastructure in most of the facilities. Many facilities did not meet the minimum requirements of facilities that conduct 72 hour assessment. Lack of necessary resources and infrastructure meant that facilities were not able to implement the 72 assessment policy.

6.4 Examination of the procedures being followed in conducting 72 hour assessment of involuntary mental health care users

- Due to shortage of infrastructure and other resources, the majority of the hospitals were unable to admit patients for the 72 hours assessment; hence patients were treated from their homes.

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- Documentation prior to admission or treatment of patients was poorly done. Some of the documentation, such as MHCA04 was almost completely forgotten. Where it was completed; it was done by the assistance of nurses qualified in psychiatric nursing. In most units which were managed by general nurses, documentation was in shambles. Nurses found it more difficult to complete the MHCA04 than MHAC06 and MHCA11. This also means that hospitals did not have proper records for their psychiatric patients. Qualification was a major determinant of whether nurses completed documents or not as shown by the chi-square results of association which were significant at $p<0.05$, nurse trained in psychiatric were more likely to complete documents compared to those who were not trained.

6.5 Clinical intervention

- Most of the clinics started clinical instructions and treatment commences on admission. This took place at the backdrop of documentation. There was a significant association between qualification and appropriate clinical instructions and treatment commenced on admission with X^2 (2, n=70) =6.391, p=0.041. Under normal circumstances, the treatment of patients was most likely to commence as soon as admission procedures were completed, however, in some psychiatric units it did not.
- Patients were seen by the psychiatrist as soon as they were admitted where possible. It is in those units where there were psychiatric nurses where such practice was more likely to take place. The association between nurses' qualifications and whether patients were seen by the psychiatrist where possible was significant: X^2 (2, n=70) =14.771, p= 0.001.
- This general practice was adhered to in almost all general hospitals. Patients were seen by a medical practitioner who assessed and provided treatment.
- Not all units at General hospitals in the Vhembe District had a standing order on mechanical restraint. Chi-square, X^2 (2, n=70) =28.901, p= 0.000 results indicated a significant association between qualification and presence of a standing order on mechanical practitioner. It is in those facilities where there were psychiatric

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qualified nurses that these standing orders were noticed. It might that general nurse may not have been aware of these standing orders. This implies that some of the health facilities do not adhere to the 72 hour assessment implementation guidelines when dealing with mental health care users.

- Most of the facilities had a standing order on chemical restraint that required practice.
- A reasonable number of units seemed not to have monitoring tools for suicidal patients. Monitoring tools could have been found in those facilities where there were psychiatrists as confirmed by chi-square X^2 (2, n=70) =31.411, p= 0.000, that indicate an association between qualification and availability of the monitoring tool for suicidal patients. This means that a number of psychiatric units operated without monitoring tool for suicidal patients thereby flouting the 72 hour policy. Implicitly, it would mean that some of the psychiatric units did not monitor patients for suicidal incidences.
- Most of the psychiatric units studied had a tendency of not sending patience with substance abuse for detoxification.

6.6 Challenges

- Lack of knowledge in dealing with psychiatric patients was not one of the major challenges affecting the implementation of the 72 hour policy.
- Teamwork was challenge which was found to have some influence the implementation of the 72 hour policy as indicated by the results that 32.2% strongly agree that there was lack of team work, 20.3% agreed, 27.1% disagreed and 10.2% strongly disagreed. Generally, there seems to be lack of team work in most health psychiatric units investigated.
- Pertaining to supervision, the study established that in most of the facilities there was lack of supervision as indicated by the findings that more than 66% of the respondents agreed hat they there was lack of supervision by supervisors. It follows that in most of the facilities subordinates were not supervised and did work to their understanding at the expense of patients. These explain why the MHCA04 documents were not completed prior to treatment of the patients. This

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also links with lack of knowledge among the majority of the none specialist who served in these general hospital.

- Inadequate human resources were prevalent in many mental health care units as indicated by the findings that, the majority of the respondents 71.2% agreed that the human resource was inadequate at their centers. X^2 (2, n=70) =31.411, p= 0.000 results show a significant an association between qualification and inadequate human resources implying that those nurses with a qualification in psychiatric were more likely to recognise shortage of psychiatric personnel while 74% of general nurses refuted inadequacy.
- Lack of training of nurses and staff at unit was found to be another major obstacle in the implementation of the 72 hour policy as most general nurses lack key skills and knowledge in performing their duties in the facilities. Despite their poor insight with regard to lack of knowledge.
- Infrastructure shortage in mental health care was a key factor which constrained hospitals from admitting psychiatric patience. The existing infrastructure was said to be poor to match the expected standards.

6.7 Recommendations

The following recommendations were made as a result of the findings and conclusions of this study.

- Team work is a crucial aspect in nursing mental health care users; nurses should work as a team.
- Nurses should conduct in-service training within the mental health care units.
- General Nurses working at the general hospital should aim to train psychiatric nursing.
- Adequate budget should be provided to general hospital pertaining to nursing of the mental health care users.
- Adequate staff and infrastructure should be establish to ensure smooth implementation of the policy

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- Security to patients and staff members should be ensured at all general hospital units providing mental health care services.
- The policy should be revised to meet standards of the available infrastructure.
- Supervisors should provide necessary support and supervision to nurses proving mental health care services at general hospital.
- Standing orders and guidelines regarding implementation of the 72 hour assessment policy should be available at all general hospitals providing mental health care services.

6.8 Limitation of the study

The study was conducted among health care providers in only one district i.e. Vhembe district. This shows that the scope was limited. It did not represent the whole population of Limpopo Province. The results may however be vital in establishing a basis for comparing the level of practice regarding the handling of the involuntary mental health care user at the district level. In addition, some of the participants choose not to answer some of the questions posed in the instrument. This could also have a bearing on the study.



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APPENDIX 1

REQUEST FOR PERMISSION TO CONDUCT THE STUDY

Mr Mubvafhi NL
P.O.Box 164
Shayandima
0945
30/08/2014

Limpopo Province
Department of health
Private Bag x9302
Polokwane
0700

The Head of Department
Mental Health Care Manager

APPLICATION TO CONDUCT RESEARCH

I Mubvafhi Norman Lufuno, hereby request the Department of health to allow me to conduct a research at Vhembe district.

Research Topic:	Implementation Of The 72 Hour Assessment Policy of involuntary Mental Health Care Users At General Hospitals In Vhembe District, Limpopo Province.
Institution:	University of Venda
Researcher:	Mubvafhi Norman Lufuno
Study duration:	February 2012 to December 2015
Persal number:	83024913
Working place:	Vhembe District, Thulamela Municipality, Tshilidzini Hospital
Occupation:	Professional Nurse

I hope my application will be taken into consideration.

.....

Yours faithfully

Mubvafhi NL

Contact number: 0768910745
email address: mubvafhi@live.com

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APPENDIX 2

PERMISSION TO CONDUCT THE STUDY

LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

DEPARTMENT OF HEALTH

Enquiries: Latif Shamila

Ref:4/2/2

Mubvafhi NL
University of Venda
Private Bag X5050
Thohoyando
0950

Greetings,

RE: Implementation of the 72 Hour assessment policy of involuntary mental health care users at general hospitals in Vhembe District, Limpopo Province

The above matter refers.

1. Permission to conduct the above mentioned study is hereby granted.
2. Kindly be informed that:-
   - Research must be loaded on the NHRD site (http://nhrd.hst.org.za) by the researcher.
   - Further arrangement should be made with the targeted institutions.
   - In the course of your study there should be no action that disrupts the services.
   - After completion of the study, a copy should be submitted to the Department to serve as a resource.
   - The researcher should be prepared to assist in the interpretation and implementation of the study recommendation where possible.
   - The above approval is valid for a 3 year period.
   - If the proposal has been amended, a new approval should be sought from the Department of Health.

Your cooperation will be highly appreciated.

Head of Department

25/02/2015
Date

18 College Street, Polokwane, 0700, Private Bag x9302, POLOKWANE, 0700
Tel: (015) 293 6000, Fax: (015) 293 6211/20 Website: http\www.limpopo.gov.za

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APPENDIX 3

APPLICATION FOR ETHICAL CLEARENCE

Mr Mubvafhi NL
P.O.Box 164
Shayandima
0945
30/08/2014

University of Venda
Private Bag x5050
Thohoyandou
0950

Ethical clearance committee

University of Venda

APPLICATION FOR ETHICAL CLEARANCE

I, Mubvafhi Norman Lufuno, hereby request the University of Venda Ethical Clearance Committee to approve and authorise my research proposal.

RESEARCH DETAILS:

Research Topic: Implementation f The 72 Hour Assessment Policy of involuntary Mental Health Care Users At General Hospitals In Vhembe District, Limpopo Province.

Department: Public Health

School: Health sciences

Research Supervisor: Prof. A. M. Amosu

Co-Supervisor: Dr. A. Tugli

Study duration: 2014 and 2015

I hope my application will be taken into consideration.

.....

Yours faithfully

Mubvafhi NL

Contact number: 0768910745

email address mubvafhi@live.co

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APPENDIX 4

ETHICAL CLEARENCE CERTIFICATE

RESEARCH AND INNOVATION
OFFICE OF THE DIRECTOR

NAME OF RESEARCHER/INVESTIGATOR:
Mr NL Mubvafhi

Student No:
11540583

PROJECT TITLE: **IMPLEMENTATION OF THE 72-HOUR ASSESSMENT POLICY OF INVOLUNTARY MENTAL HEALTH CARE USERS AT GENERAL HOSPITALS IN VHEMBE DISTRICT, LIMPOPO PROVINCE.**

PROJECT NO: SHS/15/PH/01/1501

SUPERVISORS/ CO-RESEARCHERS/ CO-INVESTIGATORS

NAME	INSTITUTION & DEPARTMENT	ROLE
Prof AM Amosu	University of Venda	Supervisor
Dr A Tugli	University of Venda	Co-Supervisor
Mr NL Mubvafhi	University of Venda	Investigator - Student

ISSUED BY:
UNIVERSITY OF VENDA, RESEARCH ETHICS COMMITTEE

Date Considered: January 2015
Decision by Ethical Clearance Committee Granted
Signature of Chairperson of the Committee: .....
Name of the Chairperson of the Committee: Prof. G.E. Ekosse

University of Venda
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TELEPHONE (015) 962 8816/8313 FAX (015) 962 9060
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APPENDIX 5

INFORMED CONSENT FORM

I, Mubvafhi Norman Lufuno a post graduate student at the University of Venda Department Of Public Health.

I am conducting a research entitled Evaluation of the 72 hour assessment of the involuntary mental health care user by the health care providers in hospitals around Vhembe district.

I would like to request you to participate in the study. Information obtained from you will be treated as confidential. Your participation in this study is voluntary and you are free to withdraw at any time. Your decision to take part in this study will have no negative impact on your health or work. No remuneration that will be received by the participants for the purpose of being part of the research.

Researcher's signature.....Date.....

Participant

I.....have been thoroughly informed about the study and have read through the consent form and herby voluntarily consent to participate in this study. I am fully aware that I can withdraw my consent at anytime without jeopardizing any health care for the benefit of me and my family.

Participant's signature.....Date.....

For more information contact Mubvafhi NL (Researcher) on 0768910745 or mubvafhi@live.com

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APPENDIX 6

QUESTIONNAIRE

Evaluation of the 72 hour assessment of involuntary mental health care user, at general Hospitals in Vhembe District, Limpopo Province South Africa.

INSTRUCTIONS TO THE PARTICIPANTS

(The researcher will ask the participant if he/she is willing to answer a few questions. After reading the following introduction, the participant will be presented with the consent form)

Here are few details to be followed when completing the questionnaire.

- There is no need to record your name on the questionnaire, your participation is anonymous.
- There is no right or wrong answer.

SECTION 1

Kindly respond to the following questions by marking cross (X) over the appropriate boxes.

DEMOGRAPHIC DATA

1.1 Gender

- ☐ Male
- ☐ Female

1.2 Age range

- ☐ ≤ 18
- ☐ 19 – 35
- ☐ 36 – 40

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- ☐ 41 – 59
- ☐ ≥ 60

1.3 Home language

- ☐ Venda
- ☐ Tsonga
- ☐ Sotho

Other (specify).....

1.4 Qualification

- ☐ General nurse
- ☐ Psychiatric nurse
- ☐ Advanced psychiatric nurse

1.5 How long have you been working in this unit? (years)

- ☐ ≤ 3
- ☐ 4 – 6
- ☐ 7 – 9
- ☐ ≥10

SECTION 2

The statement below refers to requirements for facilities to conduct 72 hour assessment. Please evaluate each statement by using the following keys:

1=SA (Strongly agree)

2=AG (Agree)

3=UC (Uncertain)

4=DA (Disagree)

5=SD (Strongly disagree)

Place a mark with an X on the relevant answer

2.1 Mental health care users are treated nearer to their homes	1	2	3	4	5
2.2 The facility has a the required level of security	1	2	3	4	5
	1	2	3	4	5

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2.3 Staff allocated in this facility has the skill to assess mental disorders

2.4 As a professional nurse, I am confident in excluding underlying physical conditions which may have caused mental disorder

1	2	3	4	5

2.5 Infrastructure (e.g. building) meets requirements for facilities that conduct 72 hour assessments

1	2	3	4	5

SECTION 3

Question below refers to procedure to be followed when conducting 72 hours.

3.1 Do you admit patient for 72 hour assessment in your unit? (Please indicate with a cross (x) in the box bellow)

- ☐ YES
- ☐ NO

If answered NO, please describe how you manage mental health care users in your unit. (Use the space provided bellow and skip to Section 4)

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3.2 Rate the completeness of the following legal documents on admission. (Please indicate with a cross on the relevant block)

	POOR	FAIR	GOOD	EXCELLENT
a. MHCA 04				

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b. MHCA 05				
c. MHCA 07				

(MHCA = Mental health care act no)

3.3 Rate the completeness of the following legal documents during the end of 72 hour assessment. (Please indicate with a cross (x) on the appropriate block)

	POOR	FAIR	GOOD	EXCELLENT
a. MHCA 06				
b. MHCA 03				
c. MHCA 11				

SECTION 4

Questions below refer to clinical intervention. (Please indicate with a cross on the appropriate block)

	Yes	No	COMMENTS
4.1 Appropriate clinical instructions and treatment commenced on admission?			
4.2 Are patients seen by the psychiatrist where possible?			
4.3 Are the patients seen by the medical practitioner?			
4.4 Is there a standing order on mechanical restrain?			
4.5 Is there a standing order on chemical restrain?			
4.6 Availability of the monitoring tool for suicidal patients?			
4.7 Are the patients with substance abuse referred for detoxification?			

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SECTION 5

The statement bellow refers evaluation of the challenges faced by health care providers with regard to implementation of the 72 hour policy. Please evaluate each statement by using the following keys:

1=SA (Strongly agree)

2=AG (Agree)

3=UC (Uncertain)

4=DA (Disagree)

5=SD (Strongly disagree)

Place a cross (x) under the relevant answer

	1	2	3	4	5
5.1 Lack of team work					
5.2 lack of knowledge by the health care provider					
5.3 Lack of support by supervisors					
5.4 Inadequate human Resource					
5.5 Lack of community Involvement					
5.6 Lack of in-service training					
5.7 Shortage of equipments					
5.8 Negative attitude by health care providers					
5.9 Poor level of education by mental health care users					
5.10 Poor infrastructure					

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APPENDIX 7

CONFIRMATION BY LANGUAGE EDITOR

24th FEBRUARY 2016

TO WHOM IT MAY CONCERN

RE:EDITING OF MR NORMAN LUFUNO MUBVAFHI'S MASTERS DISSERTATION (STUDENT NUMBER 11540583).

This letter serves to confirm that I have edited **MR NORMAN LUFUNO MUBVAFHI'S** MASTERS DISSERTATION whose title is "IMPLEMENTATION OF THE 72 HOUR ASSESSMENT POLICY OF INVOLUNATRY MENTAL HEALTH CARE USERS AT GENERAL HOSPITALS IN VHEMBE DISTRICT, LIMPOPO PROVINCE"

My work entailed identifying and correcting grammatical, typographical, formatting and related editorial errors in the document.

I have recommended a number of corrections related to grammar, typographical errors and sentence construction.

Should there be any queries regarding the editorial aspects of the document please do not hesitate to contact me.

Yours sincerely

T. J Chari, Lecturer, Department of Communication and Applied Language Studies, University of Venda (BA (UZ), DMCS (UZ), MA (UZ))

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