

**A PROGRAMME TO FACILITATE THE IMPLEMENTATION OF MENTAL HEALTH CARE
ACT 17 OF 2002 BY MEDICAL DOCTORS IN VHEMBE DISTRICT OF LIMPOPO PROVINCE,
SOUTH AFRICA**

By

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DECLARATION

I, **Muvhango Rachel Ramovha** declare that

**A PROGRAMME TO FACILITATE THE IMPLEMENTATION OF MENTAL HEALTH
CARE ACT 17 OF 2002 BY MEDICAL DOCTORS IN VHEMBE DISTRICT OF
LIMPOPO PROVINCE, SOUTH AFRICA**

Research is my own work and that all the sources I used or quote were indicated and acknowledged by means of complete references.

RAMOVHA M.R

Abstract

The Mental Health Act is the law which sets out when you can be admitted, detained, and treated in hospital against your wishes. It is also known as being “sectioned”. For this to happen, certain people must agree that you have a mental disorder that requires a stay in hospital. In South Africa, the Mental Health Act of 1973 was noted to have many gaps. Due to all the shortcomings, in 2004 the Mental Health Care Act No. 17 of 2002 came into being in order to protect human rights of the mental health care users.

This study sought to determine the knowledge and explore the experiences of medical doctors regarding the implementation of Mental Health Care Act No. 17 of 2002. Secondly, based on the findings, to develop a programme to facilitate the implementation of the Mental Health Care Act No. 17 of 2002 by medical doctors in Vhembe District.

The population of this study consisted of all medical doctors working in Vhembe District Hospitals with mental health units and at a specialized mental health hospital as well as all documents completed by medical doctors during admission, care and discharge of mental health care users were purposively sampled.

The study was conducted in two phases. In phase 1, where quantitative and qualitative designs were followed to do situational analysis. In phase 2, the programme was developed using results from phase 1, the theoretical framework and approaches outlined by Dickoff, James and Wiedenbach (1968); Chinn and Krammer (1999); Walker and Avant (1995).

Individual in-depth interviews and questionnaires checklist were used to collect data which was analysed through opened coding method and SPSS.

The findings of this study indicate that medical doctors have knowledge and skills deficit regarding implementation of the Mental Health Care Act No. 17 of 2002 during the admission, care, and discharge of mental health care users. Based on these, a programme to facilitate the implementation of the Mental Health Care Act No. 17 of 2002 by medical doctors during admission, care and discharge of mental health care users was developed.

The study concludes that this is a significant contributor in supporting the vision of the National Department of Health to ensure improved mental health for all in South Africa.

The study recommends a longitudinal study, tracking the impact of a developed programme, the knowledge of medical doctors regarding the implementation of Mental Health Care Act No. 17 of 2002, and its contribution to the improvement of mental health for all should be conducted over a period of 5 (five) to 10 (ten) years.

Key words- Programme, Mental Health Care Act, medical doctors, implementation, experts, hospital, mental health care users, Mental Health Review Board.

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ABBREVIATIONS/ACRONYMS USED

HOD	Head of Department
IPHC	Integrated Primary Health Care
MEC	Member of the Executive Council
MHCA	Mental Health Care Act
MHCP	Mental Health Care Practitioner
MHCS	Mental Health Care Service
MHCU	Mental Health Care User
MHE	Mental Health Establishment
MHRB	Mental Health Review Board
S A	South Africa
WH O	World Health Organisation

CHAPTER 1

1. ORIENTATION TO THE STUDY

1.1 INTRODUCTION AND BACKGROUND

The Mental Health Care Act is the law which sets out when you can be admitted, detained and treated in hospital against your wishes. It is also known as being 'sectioned'. For this to happen, certain people must agree that you have a mental disorder that requires a stay in hospital. The Mental Health Care Act provides for the treatment, care, and rehabilitation of the mentally ill.

Most countries have legislation regarding the treatment of mental health care users and their services. Narayan, Narayan and Shikha (2011) found that in India, social stigma remains an obstacle to helping Indians cope with mental illness. The attitude towards mental health in India is very different from the one in the West. This is supported by Shanoor (2013), when arguing that in India there is mention of safeguarding the human rights of mentally ill persons too. It is alleged to be concerned mainly with the legal procedure of licensing mental hospitals, regulating admission in these hospitals, and guardianship matters of the persons with mental illness. Human rights issues and mental health care delivery are not properly addressed in this Act. Licensing of mental hospitals is presumably for the purpose of ensuring quality of services in these hospitals.

In England, the Mental Health Act of 1983 provided legislation to ensure a consistent and comprehensive approach to the compulsory admission of mentally ill persons (Wall, Hotopf, Wessely & Churchill, 1999). Wall et al. (1999) revealed that proper implementation of the Mental Health Care Act of 1983 led to closure of certain hospitals and the introduction of care in the community programme. The Approved Mental Health Professionals have a lead role in coordinating Mental Health Act Assessments and this ensures that mentally ill persons are admitted appropriately (Wall et al., 1999).

Mental Health in America is reported to have the federal mental health parity law which is fully effective and is a leader in mental health support (America: 2014). It is regarded

to be a powerful voice for change that is made up of thousands of individuals who take an active role in protecting America's mental health. Through several seminars and comments, they have continued to advocate and educate on systems for navigators and other peer services, such as, associations, family voices, university collaboratives, community initiatives like community Anti-drug coalitions of America (America:2014).

In 1994, the South African democratic government noted that the Mental Health Act 18 of 1973 did not have an individual rights concern. Rather, its primary focus was on patient control and treatment, along with the 'welfare and safety' of the society. The fact that this Act was propelled during the apartheid era cements the view that the human rights of the patients were not necessarily a priority. The democratic government in 1994 promulgated the new Mental Health Care Act No. 17 of 2002. Based on the Mental Health Care Act No. 17 of 2002, the Mental Health Review Board has been appointed in Vhembe District Limpopo Province in 2012 to ensure that the Mental Health Care Act No. 17 of 2002 is implemented as prescribed.

According to the South Africa Federation for Mental Health, while the Mental Health Act of 1973 was in existence, it facilitated disproportionate mental health care based on race, with blacks receiving the least care. In addition, the Mental Health Act of 1973 did not promote personal autonomy, dignity or justice for individuals with mental illness. Instead, it highlighted a paternalistic principle which allowed mentally ill patients to be alienated, stigmatized and disempowered. It became apparent that Mental Health Act of 1973 needed to be reconsidered and changed.

Due to all those items listed above, Mental Health Care Act No.17 of 2002 came into being, to protect human rights of the mental health care users (McCrea, 2010).The objects of this Act are to:

Regulate the mental health care in a manner that makes the best possible mental health care, treatment and rehabilitation services available to the population equitably, efficiently and in the best interest of mental health care users within the limits of the available resources; co-ordinate access to mental health care, treatment and rehabilitation services to various categories of mental health care users; Integrate the provision of mental health care services into the general health services environment;

Regulate access to and provide mental health care, treatment and rehabilitation services to voluntary, assisted and involuntary mental health care users and patients, State patients and mentally ill prisoners; Clarify the rights and obligations of mental health care users and the obligations of mental health care providers; Regulated the mental health care in a manner in which the property of persons with mental illness and persons with severe or profound intellectual disability may be dealt with by a court of law (S A, 2002).

Furthermore, the Mental Health Care Act No. 17 of 2002 provides for the care and administration of the property of mentally ill persons. It also prohibits against unfair discrimination of people with mental disorders. The Mental Health Care Act No.17 of 2002 recognizes the person and property of a person with a mental disorder. In addition, it has set out different procedures to be followed in the admissions care and discharge of such persons. Finally, it established the Mental Health Review Boards in respect of every hospital and laid down its functions.

In South Africa, based on the Mental Health Care Act No. 17 of 2002, the Mental Health Review Board has been appointed in all districts in 2012 to ensure that the Mental Health Care Act No. 17 Of 2002 is implemented as prescribed. In 2014, the Mental Health Review Board in the Vhembe district reported to be encountering documents indicating poor implementation of the Mental Health Care Act by medical doctors. This study proposes to investigate the implementation of the Mental Health Act 17 of 2002 by medical doctors in hospitals in the Vhembe District of the Limpopo Province, South Africa.

1.2 PROBLEM STATEMENT

In the Vhembe district, the Mental Health Review board meets every Tuesday to assess and audit mental health care user's admission, care and discharge documents and to then compile a report. All their reports indicated the following problems are encountered:

- The Mental Health Care Act forms are not completed properly;
- Assessment forms used to assess are not completed correctly and some are left with gaps and there may be litigation by mental health care users or their families

when realizing that correct measures of assessment leading to their admission were not done. Again because of inadequate or failure to assess the user before admission, leading to poor management of care for the user.

- Mental health care users are sometimes sent for admission without forms while they are not voluntary patients; and this may mean that there was illegal admission, infringement of right to freedom of movement yet they were not bound by the law as their next of kin or themselves may have not consented. Also that their admission may have not been done with best interest to benefit the user as legal documents were not completed, assessment not done, sorting out reasons for submitting such a user for admission.
- Mental health care users are discharged without proper clinical diagnosis by doctors and may lead to litigation when the user discover that no proper diagnosis was attached, leaving the institution and the department having to pay for such litigation.
- While doctors are not completing legal (MHCA) forms correctly, it is not clear if doctors have knowledge and skill or lack knowledge on the mental health legislation or not clear on policies guiding the implementation.
- These reports conclude that there is non-compliance in the implementation of the Mental Health Care Act No. 17 of 2002 by medical doctors. No scientific report was found about the knowledge and experiences of medical doctors in Vhembe District regarding the implementation of Mental Health Care Act No. 17 of 2002. Furthermore, there is no programme to facilitate the implementation of Mental Health Care Act No. 17 of 2002.
- This study sought to determine the knowledge and explore the experiences of medical doctors regarding the implementation of Mental Health Care Act No. 17 of 2002 by medical doctors. Secondly, based on the findings, to develop a programme to facilitate the implementation of the Mental Health Care Act 17 of 2002 by medical doctors in Vhembe District.

1.3 PURPOSE

The purpose of the study was to explore the experiences and determine knowledge of medical doctors in implementation of Mental Health Care Act No.17 of 2002 and develop a programme to facilitate the implementation of the Mental Health Care Act No 17 of 2002 by medical doctors in the Vhembe district hospitals which included a mental health unit and a specialised mental hospital.

1.4 RESEARCH QUESTIONS

Based on the problem statement, the researcher formulated research questions to address the stated problem. The following questions emerged:

- What knowledge do doctors have of the implementation of Mental Health Act No 17 of 2002 during admission of mental health care users?
- What are the experiences of doctors regarding the implementation of the Mental Health Care Act?
- What kind of a programme is required to facilitate the implementation of the Mental Health Act No 17 of 2002 among doctors?

1.5 OBJECTIVES

The objectives of this study were to:

- Determine knowledge of doctors about the implementation of the Mental Health Act No 17 of 2002 during admission of mental health care users;
- Explore the experiences of medical doctors regarding the implementation of the Mental Health Care Act No 17 of 2002; and
- Develop a programme to facilitate the implementation for the Mental Health Care Act No 17 of 2002 based on the findings.

1.6 SIGNIFICANCE OF THE STUDY

This study might inform the authorities on the experiences of medical doctors when implementing the Mental Health Care Act No 17 of 2002, in case of any flaws authorities will take steps in order to avoid litigations brought about such flaws and that will boost the economy of the country.

This study may also inform policy makers of the challenges facing mental health care users and providers leading to the development of relevant policies addressing such challenges.

Medical doctors were provided with the platform to talk about their experiences, perceptions and challenges when implementing the Mental Health Care Act No. 17 of 2002. Mental health care users will be assessed, findings written appropriately in order to complete legal documents as required by the Act. When study findings are implemented, the context shall enhance quality patient care since medical doctors will be able to admit, care and discharge mental health care users according to Mental Health Care Act No. 17 of 2002 leading to reduced length of stay as appropriate management of skill will be implemented. Hospitals shall contain quality competent medical doctors with knowledge and skills required to respond to national and regional development imperatives regarding Mental Health Care Act No. 17 of 2002. It is envisaged that the litigations regarding illegal admissions of mental health care users will be reduced if not prevented. Further it is hoped that while implementing the findings of this study medical doctors will acknowledge that the context belonged not to them but rather to the multidisciplinary team, team work is the key.

The study findings were utilised to develop a program to facilitate the implementation of the Mental Health Care Act No.17 of 2002.

The findings of the study were used to develop a programme which will add to the body of knowledge on the implementation of the Mental Health Care Act No. 17 of 2002 in the Limpopo Province, since no scientific document was found.

1.7 DEFINITION OF THE KEY CONCEPTS

1.7.1 Programme

A programme is a series of actions or events that are planned to be done or a list of planned events or activities, a leaflet giving details of a play (Collins English dictionary). In this study, 'programme' refers to a set of events that will be drawn and must be done to implement Mental Health Care Act No 17 of 2002.

1.7.2 Implementation

The carrying out, execution, or practice of a plan, a method, or any design for doing something. Implementation is the action that must follow any preliminary thinking for something to actually happen (Rouse: 2007). In this study 'implementation' refers to admission, care and discharge of a mental health care user as stipulated by the Mental Health Act 17 of 2002.

1.7.2 Medical doctor

A person who has been educated, trained, and licensed to practice the art and science of medicine (Medical Dictionary for the Health Professions & Nursing, 2012). In this study, medical doctors are doctors employed by the Department of Health in the Limpopo Province working in the Vhembe District hospitals.

1.7.4 Mental Health Care Act 17 Of 2002

The legislation developed by the Parliament of South Africa to guide the care to be provided to the mental health care users. In this study it refers to the Mental Health Care Act No 17 of 2002

1.7.5 Mental Health Care User

A person receiving care treatment and rehabilitation services using a health services at a health establishment aimed at enhancing the mental health status of a user, state patient and a mentally ill prisoner (S. A: 2002).

1.7.6 Mental Health

A successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change, cope with adversity and successfully contribute to a community or society (United States Public Health Service: 2001).

1.8 PARADIGMATIC PERSPECTIVE

A paradigm is a worldview or ideology. A paradigm implies the standards or criteria for assigning value or worth to both the processes and the procedures of the discipline, as well as to the methods of knowledge development within a discipline (Chinn & Kramer, 1999). A paradigm is also defined as a set of beliefs that constitutes the researcher's perceptions regarding the nature of reality of the world as well as the researcher's perceptions of where he/she stands in the reality of the world (De Vos; Strydom; Fouché; Delport, 2011). The following paradigmatic perspectives are described.

1.8.1 Meta-theoretical assumptions

Meta-theory is defined as assumptions about reality (Brink, 2012). The researcher's point of departure was the assumption that medical doctors are responsible for their own personal and professional development. Secondly, grounded on the fact that medical doctors are not implementing the Mental Health Care Act No. 17 of 2002 accordingly. This implies that a programme to facilitate the implementation of Mental Health Care Act is required.

Every person has the ability to become whole. Wholeness is important at the hospital for medical profession to develop and implement the Mental Health Care Act No.17 of 2002 appropriately. Medical doctors' professional development depends on the interaction with his internal and external environment. External environment amongst others involves the experts. The researcher believes that experts are needed to aid in the professional development of medical doctors. Experts should have knowledge and skills in the implementation of the Mental Health Care Act No. 17 of 2002.

1.8.1 Theoretical assumptions

This study was conceptualized within Bloom's taxonomy theory of teaching and learning. The theory takes into consideration the higher forms of thinking in education, such as analysing and evaluating concepts, processes, procedures, and principles, rather than just remembering facts (rote learning). This theory is based on a fact that attainment is the product of learning. The author further contends that the product of learning is dependent on the following concepts: Taxonomy of educational objectives; Context and Mystery learning. These are discussed below.

1.8.2.1 Taxonomy of educational objectives

The Mental Health Act requires medical doctors who are at higher levels of critical thinking because it deals with the law as well as human life and protection of human rights. The taxonomy referred to above is a classification of different objectives and skills that educators set for learners. In this the experts in mental health will divide their educational objectives into three domains, that is, affective, psychomotor and cognitive when they empower medical doctors. Taxonomy is said to be hierarchical, meaning that learning at the higher level is dependent on having attained prerequisite knowledge and skills at lower level. In this study, medical doctors have been trained in assessment of patients and this is their prerequisite knowledge required for entry in learning about Mental Health Care Act. This is focusing on all three domains to create a more holistic form of education for whole learning in theory, procedures and the skill of implementing the Mental Health Care Act accordingly.

1.8.2.2 Context

Context is a powerful optimistic conception of the possibilities that education can take place as described in Bloom's taxonomy of teaching and learning (2001). In this study, the researcher is optimistic that medical doctors can attain the necessary knowledge and skills needed to implement the Mental Health Care Act No. 17 of 2002 at the hospital which is the context where the Mental Health Care Act No. 17 of 2002 is applied. Both the experts and medical doctors work in an integrated and interactive manner within the hospital context.

Bloom wanted the world to focus on target attainment, of which this study is aiming at developing the programme to facilitate the implementation of the Mental Health Care Act. No. 17 of 2002. According to Bloom (2001), teachers need to shift their role from inventing ways to optimize human aptitude into activities mainly concerned with matters of identification and selection. In this study the knowledge of doctors will be determined and their experiences will be explored regarding the implementation of Mental Health Care Act. Furthermore, Bloom (2001) states that attainment is the product of learning, and learning is influenced by opportunity and effort. In this study opportunity was created for medical doctors to share their knowledge and experiences regarding Mental Health Care Act No. 17 of 2002 implementation.

1.8.2.3 Mastery learning

According to Bloom (2001), mastery learning is an optimistic approach to realization of educational goals. The optimistic approach consists of the knowledge and cognitive dimension with the aim of increasing student awareness to self as well as self-assurance. In this study, the medical doctors' knowledge and experiences was explored, based on the findings, the programme was developed.

1.8.3 Methodological assumptions

Methodological assumptions are concerned with the nature and structure of the science of research, and include the preferences and assumptions of the research (Mouton & Marais 1996; Mouton, 2002). The methodological assumptions, which guided this study, are in line with Botes, Nolte, and Poggenpoel (2004) functional approach, which implies

that research, should be functional and should contribute to the body of knowledge and the improvement of the quality of life.

The documents review and in depth individual interviews produced data that provided an understanding of knowledge and experiences of medical doctors regarding the implementation of Mental Health Act No. 17 of 2002 during admission, care and discharge of mental health care users in the Vhembe district, of the Limpopo Province. A programme was developed based on the data, the developed programme would assist experts with how to teach, mentor, role model, support, peer coach and supervise medical doctors.

Medical doctors would have an opportunity to learn and be capacitated with what was not covered in their curriculum during their study years. This may increase the implementation of the Mental Health Care Act during admission, care and discharge of mental health care users. As a result, mental health care users will be admitted legally, their rights will be protected and litigations will be reduced.

1.9 RESEARCH APPROACH.

This study approach was in two phases. Phase 1 involved a situational analysis and phase 2 involved the development of a programme. Table 1.1 indicate the phases.

Table1.1 Phases of this research.

PHASE	OBJECTIVE	DESIGN
1	To determine the knowledge of doctors in implementation of mental health Care Act during admission, care and discharge of mental health care users. Explore the experiences of medical doctors regarding the implementation of the Mental Health Care Act 17 of 2002. Analyse data derived from participants and control against relevant literature.	Quantitative, documents review using questionnaire Checklist Qualitative interviews, exploratory, descriptive and contextual.
2	Develop a programme to facilitate the implementation for the Mental Health Care Act 17 of 2002 based on the findings.	Develop a conceptual framework and programme based on conceptual framework of Dickoff and Wiedenbach. Evaluate the programme according to Chinn and Kramer.

1.9.1 Phase 1: Situational analysis

1.9.1.1 Design and Methods

The study design was both quantitative and qualitative and is described in chapter 3.

1.9.1.1.1 Quantitative design

A quantitative design was used in reviewing documents submitted by hospitals to the MHRB, to determine the knowledge of doctors in implementation of mental health Care Act during admission, care and discharge of mental health care users.

- Population

Polit and Beck (2008) and Burns and Grove (2011), describe a population as the aggregate or totality of all objects, subjects, or members that conform to a set of

specification. In this study, to answer objective number 1, documents completed by medical doctors during admission, care and discharge of mental health care users were reviewed.

- Sample

A sample is a subset of measurements drawn from the population in which the researcher is interested, it is a small fraction of the population (Polit & Beck, 2008; De Vos, 2011; Burns & Grove, 2011). The sample of this study was 200 documents which were sampled from the records submitted to the Mental Health Review Board by district hospitals with a mental health unit and specialized mental health hospital in Vhembe District for documents review to answer study objective 1.

- Sampling Method

Sampling is the process of selecting a sample from the population to obtain information regarding a phenomenon in a way that represents the population of interest (De Vos, 2011; Polit & Beck, 2008; Burns & Grove, 2011). Non probability Random sampling was used to sample documents in this study. According to Polit and Beck (2008), and Shaughnessy et al., (2014), non-random sampling gives every member of a population an equal chance/probability of being included. This is fully described in chapter 3.

- Data collection

Data collection is described to be the process of gathering information from the selected subjects needed to address a research problem (Polit & Hungler, 2013; Burns & Grove, 2011). The documents were selected as described above until a sample of 200 was reached. The researcher then reviewed each document using a pretested questionnaire (checklist). This is fully described in chapter 3.

- Data analysis

Data analysis is the process that is conducted to reduce, organize and give meaning to the collected data. It is the selection of appropriate statistical techniques to analyse the

study data (Burns & Grove, 2011). In this study, a computer loaded with the IBM Statistical Package for Social Science (IBM SPSS statistics) version 23 programme was used to analyse quantitative data from the checklist as it is more powerful and accessible on the personal computer.

- Validity

Validity refers to the degree to which an instrument measures what it was supposed to measure, what it was designed to measure, the extent to which the instrument actually reflects the abstract constructs being examined (Speziale & Caperter, 2007; Burns & Grove, 2011). In this study pre-test of the questionnaire was administered to increase validity. This is elaborated in chapter 3.

- Reliability

Reliability refers to the consistency with which the instrument measures the attributes. The accuracy or precision of an instrument, as the degree of consistency or agreement between the two independently derived sets of scores, as the extent to which independent administration of the same instrument yield the same results under comparable conditions (Polit & Hungler, 2013). In this study the checklist questionnaire consisted of items designed to determine the knowledge of medical doctors regarding implementation of Mental Health Care Act during admission, care and discharge of mental health care users. The researcher developed the checklist questionnaire guided by the National Mental Health Review Board Guidelines.

1.9.1.1.2 Qualitative design

Burns and Grove (2011) describe qualitative research as a systematic, subjective, approach used to describe life experiences and give them meaning. Within this qualitative design, descriptive, exploratory, and contextual design was utilised (Mouton, 2002). The research design is discussed in detail in chapter 3.

- Exploratory

The aim of the exploratory research is to get facts, gather new data and determine if there are interesting patterns in the data. The method is typical when a researcher examines a new interest or when the subject of the study is relatively new. Exploratory design gains broad understanding of a situation, phenomenon, community or a human being (Mouton & Marais, 1996; Babbie & Mouton, 2011). In Vhembe district, there is no information regarding the experiences of medical doctors as they implement Mental Health Act No. 17 of 2002.

In this study, the researcher selected the exploratory method to gain new insight, discover new ideas and increase knowledge about the implementation of the Mental Health Care Act by medical doctors in the Vhembe district. The researcher used in-depth interviews of which personal experiences of medical doctors as they implement the Mental Health Care Act were explored. The dimensions of Mental Health Care Act No. 17 of 2002 were explored with regard to how implementation of Mental Health Care Act could be facilitated. Literature was also explored extensively during literature control and programme development.

- Descriptive design

Descriptive research accurately portrayal of particular individuals or real life situations for purposes of discovering new meaning, describing what exists and categorising information. People's perceptions or stories reflect their understanding about what is going on in a service situation (Mouton & Marais, 1996; Polit & Hungler, 2013; Burns & Grove, 2011).

The information was gained through in-depth individual interviews where medical doctors described their experiences as they implemented the Mental Health Care Act No. 17 of 2002. The documented information on the phenomenon was analysed and classified to provide new insights into it. To obtain a holistic understanding of the data collected, an in-depth description of the identified attributes was made. Furthermore, an in-depth description of experiences of medical doctors with regard to how implementation of the

Mental Health Care Act could be facilitated in the Vhembe district hospitals was made. An accurate description of the program and guidelines for operationalizing were also made

- Contextual

Mouton and Marais (1996) describe “contextual” as an ideograph research, in that it is uniquely descriptive within the context of the individual setting. This study was contextual because the researcher tried as far as possible to study people in their natural setting in order to understand the dynamics of human meaning as fully as possible. It is believed that human behaviour is influenced in many ways by the environment or setting in which it occurs (De Vos, 2011). This study was contextual in that individual interviews were conducted with medical doctors in the Vhembe district hospitals and specialised hospitals in their cubicles where they are consulting patients. The researcher took into account their work setting as well as their professional and work ethical backgrounds.

According to Babbie and Mouton (2011), the researcher can claim to understand the phenomenon if he/she understands it against the background of the whole context, and such context confirms the meaning of the phenomenon concerned. This study was conducted in the Vhembe District of the Limpopo Province and medical doctors outside the selected study area were not included in this study. The study only focused on the implementation of the Mental Health Care Act No. 17 of 2002 by medical doctors. Other Health Care Acts and professionals were not considered.

Population and sampling

- Population

Population is described as the entire group of persons or objects that is of interest to the researcher or that meets the criteria the researcher is interested in studying (Burns & Grove, 2011; & Brink, 2012). This study population were all medical doctors working in the Vhembe district hospitals with mental health units and those working at a specialised mental hospital in the Vhembe district of the Limpopo Province.

- Sampling Method

A sampling method is described as the process of selecting a sample from the population in order to obtain information regarding a phenomenon in a way that represents the population of interests (Burns & Grove, 2011; Brink, 2012).

Non- probability convenient and purposive sampling was used in this study. The purposive sampling method is based on the judgment of the researcher regarding subjects or objects that are typical or representative of the topic being studied or who are especially knowledgeable about the question at issue (Brink, 2012). Sampling occurred in two stages namely; sampling of hospitals and sampling of participants. This is fully explained in chapter 3.

- Data collection

Data collection is the precise, systematic gathering of information relevant to the research purpose or specific objective, questions, or hypothesis of the study (Burns and Grove, 2011). In this study data collection involved data collection instrument; preparation, data collection and the role of the researcher. These are discussed in chapter 3.

- Data analysis

Qualitative data analysis involves working with a wealth of rich descriptive data (Mouton, 2002). Analysis means reconstructing the inherently significant structure and the self-understanding of individuals by staying close to the subject. The coherence and meaning of data are more important than the meaning of specific parts. Data analysis is more holistic, synthetic and interpretative (Mouton, 2002). In this study the researcher developed structure and meaning from the volume of data generated during the interviews. Data analysis was done simultaneously with data collection (Creswell, 2009). In this study data was analysed according to Tesch's (in Creswell, 2009) eight steps of analysis. Detailed discussion of the steps is given in Chapter 3.

- Literature control

This process was done after data analysis to develop a theory which would be in line with the research objectives. This ensured that there would be a good fit between data and relevant literature, providing a link between previous and the present research (Mdluli, 2005). Literature control was done to confirm the results of the investigation and the description of the life experiences of medical doctors regarding implementation of Mental Health Care Act No. 17 of 2002. Previous research was used to establish similarities as well as to determine the uniqueness of the present study during data analysis.

1.9.2 Phase 2: Programme development

The data generated in phase 1 served as the foundation for developing a programme for facilitating implementation of the Act by medical doctors. In developing the programme, certain aspects need to be considered such as situational analysis (phase 1) which provided information regarding the knowledge and experiences of medical doctors during implementation of the Mental Health Act No. 17 of 2002. This was followed by the theoretical framework for the development of the programme which was informed by the elements of the practice theory (Dickoff, James & Wiedenbach, 1968). The programme was developed in an interactive interventive manner using the theoretical framework and approaches outlined in Chinn and Krammer (1999) and Walker and Avant (1995). These are fully described in Chapter 3.

1.10 MEASURES TO ENSURE TRUSTWORTHINESS

Guba's model (Lincoln & Guba 1985) for ensuring and assessing trustworthiness was used for this study. Trustworthiness is a method of establishing rigor in qualitative research without sacrificing relevance. This was to ascertain that the outcomes of this study could be trusted and were reproducible. The four criteria that were used to ensure trustworthiness as identified by Guba were the following and are fully described in chapter 3.

- Truth value (credibility)

Truth value asks whether the researcher has established confidence in the truth of the findings from the participants and the context in which the study is undertaken (Lincoln & Guba, 1985).

- Applicability (transferability)

Applicability refers to the degree to which the findings can be applied to other contexts and settings or with other groups (Lincoln & Guba, 1985).

- Consistency (dependability)

Consistency of the data considers whether the findings would be consistent if the inquiry were to be replicated with the same subjects or similar context (Lincoln & Guba, 1985).

- Neutrality (conformability)

Neutrality refers to the degree to which the findings are a function of the participants and conditions of the research and not of other biases, motivations and perspectives (Lincoln & Guba, 1985).

1.11 ETHICAL CONSIDERATION

Ethics is a branch of philosophy that deals with morality. It contains a set of propositions for the intellectual analysis of morality and a means of striving for rational ends (Burns & Grove, 2011). Ethics in research ensures that the rights of participants are observed, protected and respected (Polit & Beck, 2008). In this study the researcher made sure that the protection of the rights of the participants were ensured. This is discussed in detail in chapter 3.

1.12 LIMITATIONS OF THE STUDY

This study was restricted to hospitals in the Vhembe district only out of the five districts of the Limpopo province. The study data does not represent all practitioners involved in the implementation of the mental health care Act No. 17 of 2002.

1.13 DISSEMINATION OF FINDINGS

The findings of this research project will be disseminated by the following methods:

- presentation of papers at national and international conferences, seminars and workshops;
- publications in accredited journals;
- presentation to the participants; and
- presentation to department of health.

1.14 OUTLAY OF CHAPTERS

CHAPTER 1: Orientation to the study

CHAPTER 2: Literature review

CHAPTER 3: Research methodology

CHAPTER 4: Data analysis and interpretation

CHAPTER 5: Programme development

CHAPTER 6: Guidelines to operationalise the programme

CHAPTER 7: Evaluation, justification, limitations, conclusion and recommendations.

1.15. SUMMARY

This chapter introduced the overview of the study, the background, rationale of the study as well as the problem statement, research question and objectives were discussed. The paradigmatic perspective followed guiding the study as well as the description of research design and methods. This research aims to investigate the practicability and applicability of implementing the Mental Health Care Act No. 17 Of 2002 as described by doctors. Chapter 2 present the literature review.

CHAPTER 2

2. LITERATURE REVIEW

2.1 INTRODUCTION

Chapter 1 presented the introduction to this study. This chapter presents conceptual framework and literature reviewed on implementation of the Mental Health Care Act. The first part of this chapter provides a conceptual framework of the study. This is followed by the presentation of literature reviewed on the Mental Health Care Act. The literature reviewed is presented guided by the objectives of the study. This study, therefore present literature reviewed on:

- Mental Health Act globally
- Experiences regarding the implementation of the Mental Health Act globally
- The similarities and differences in different countries regarding Mental Health Act
- Programmes for implementation

2.2 THE MENTAL HEALTH ACT GLOBALLY

Wall, Hotopf, Wesseley and Churchill (1999), indicated that Mental Health America is having centralized mental health equality law supporting mental health. They regard it as a powerful voice for change. Eu commission (2001) reveals a good point of sharing ideas and comments on the website. This Act advocates and teaches other peer services like family voices, associations and university collaborative to name a few. In the United States of America, the Act seems to have assured domestic rights of MHCUs.

The concept of Mental Health Care Act in India, as reported by Narayan et al. (2011) was started as Indian Lunatic Asylum Act 1858, then changed to Indian Lunacy Act 1912. Though in India Mental Health Act has a long history: 1858, then 1912 (2011), it appeared not to be well established with, no officially approved Mental Health Policy, mental health human resource e.g. psychiatrists at 0.3 per 100,000 (World Health Organization's Mental Health Atlas 2011). It is clear that if countries do not have an officially approved mental health policy they lack clear guidance on how to provide mental health care service.

Shanoor, (2013) reported that the Mental Health Care Bill was introduced in parliament however was not passed yet. The report further says that it was the first step in expanding India's mental health infrastructure. The bill was to protect rights and improve mental health access to treatment through creation of central and state mental health experts. Further Shanoor (2013) reported the approach of India towards mental health as diverse from the one in the west because it is said that they say if something is wrong with you it is your fault, instead of saying this is a medical problem and can be treated. Assessment of both physical and mental leads to a diagnosis and lastly correct treatment.

The concept of personal freedom for the mentally ill, is reported by Narayan et al (2011), that there was concern from human rights advocates questioning the constitution about restriction of movement for the MHCU without proper review by legitimate authorities dealing with legal matters. The fact that freedom of movement for MHCUs must be guided by the law is important because no one can just make someone to be admitted without the reason for either treatment and or safety of the person and others. Should there be need for change, it should involve the judiciary to look at the need for change and how it will affect human rights.

According to Wall et al (2011), in England, the availability and outlining of approved Mental Health Act 1983 made it possible that steady and holistic approach in the provision of services be improved. Again, correct norms and standards were made available, followed appointment of qualified mental health professionals to give direction on how to assess for proper and or appropriate admissions.

It is further reported by Wall et al (2011) that, there were clear guidelines for stakeholders to understand the part they are to play in order to protect MHCU's rights leading to appropriate admissions. Again the Mental Health Act in British Columbia is reported that it had principles to ensure least restrictive freedom of movement, that MHCUs get the best possible care, yet receiving care within professionally accepted standards, protecting rights, dignity and respect of the user.

Further the Mental Health Act 1983 was reported to have included principles such as the lawful outline for the assessment and treatment of MHCUs, hopefully this was to prevent abuses of MHCUs where they may be taken for admission when a person want to remain

abusing users property. Again the Act also covered aspects such as treating physical illnesses leading or causing mental illness or even if is unrelated or Users refusing treatment of such illness (Mental Health Act British Columbia, 1983).

2.2.1 Mental Health Act in African Countries

In the report by Njenga, (2002), Mental Health Act was slowly developed in African countries. This is so even though Uganda, Kenya and Tanzania were colonies of British Empire. Treatments were mainly sedation and nurses were overworked. Njenga (2002), further reported changes in political sphere that led to more freedom for people who had mental illness. Authorities started concentrating on refurbishing hospitals. The Act was enacted leading to the appointment of the controlling board to check the implementation of the very Act. The enactment of this Act to the countries cited above clarified the place of mental illness, destigmatized and showed that mental illness is not a crime. Deployment of psychiatric nurses in general hospitals started welcoming mentally ill people in their institutions including financing psychiatric hospitals.

Kigozi, Ssebunya, Kizza, Cooper and Ndyanabangi, (2007) reported that despite the availability of the Mental Health Act, it is only known by the minority, meaning that it is known by those in the field of mental health service. Report further says development of their Act did not follow the basic principles of the World Health Organisation. The Act has not been marketed, no workshops, seminars, campaigns to conscientise communities and other professionals.

Kigozi and Ssebunnya (2009) reported of the incorporation of mental health into primary health care. Incorporation guaranteed equality and entry to reasonable mental health resources under limited supply. The inception of integration led to legislative guideline development, development of guidelines, monitoring tools, medication delivery and other therapies, public education and empowerment of MHCUs in their own care. That is involving them in their own care by making it known to them.

Kleintjies, Lund and Flisher (2010) also noted that the mental health care Act in Uganda led to enhanced resource mobilization, and a holistic approach to patient care. They supported that provision of mental health services within the general health care setup

should be by health workers who are adequately trained in mental health care, psychotropic medication and appropriate services in the community.

World Health Organisation (2011) reported that mental health in Zimbabwe is specifically mentioned in the general health policy. An Act of parliament, Zimbabwe Mental Health Act 1996 is available and the mental health plan exists and was approved or most recently revised in 2009. An officially approved mental health policy exists and was approved or most recently revised in 2005 with timelines for the implementation. The National mental health strategic plan 1997-2007 is available and its components include:

Funding allocation for the implementation of half or more of the items in the mental health plan. Shift of services and resources from mental hospitals to community mental health facilities. Integration of mental health services into primary care. Legal provisions concerning mental health are also covered in other laws (e.g., welfare, disability, general health legislation etc.).

WHO (2011) reported that Mozambique does not have a mental health policy nor a specific legislation on mental health. However, Law No 1/99 controls and regulates access of youngsters to the night clubs as well as projection of certain videos and also controls the sale of alcohol and tobacco. A national mental health programme is present. The programme was formulated in 1990. The draft National Mental Health Strategic Plan is available though not approved yet. Mental health is part of primary health care system.

WHO (2011) further reported that Lesotho does not have an officially approved mental health policy, no mental health plan although a mental health policy has been drafted. Dedicated mental health legislation was said to be available and initiated. Mental health is said to be guided by current versions of mental health legislation. Mental health service is reported to be available at primary health level where primary health care nurses are allowed to prescribe medicines of mentally ill.

Seloiwe and Thupayagale-Tshweneagae reported that in Botswana, mental health system is under the Ministry of health, administered by the local government through local authorities with district hospitals and primary health care. Psychiatric outpatient clinics are run by psychiatric nurses and the visiting psychiatrist who visit on monthly basis. Botswana's mental health system has shifted from institutional care to community

based care. The primary, district and referral hospitals are administered by Ministry of Health at central government level.

2.2.2 Mental Health Care Act in South Africa

Burns (2008) reported that in South Africa, Mental Health Act 18 of 1973 allowed MHCU to be admitted to a mental health institution when a rational account of suspicion was provided, that would be enough to deny a person freedom and be subjected to an institution based preconceptions of people with no assessment done by those qualified to assess. It is said that the Act was sometimes used to isolate people for political reasons as a way to make them keep quiet. It is this very Act that provided unequal mental health service based on the color of people degrading blacks and giving whites the best services.

Burns (2008), further reported that Mental Health Act 1973 facilitated mental health service that was isolative, promoting stigmatization and not empowering. Mental Health Care Act No. 17 of 2002; and McCrea (2010) reported the value noted on the new Act, that it followed the World Health Organization principles. They were concerned that if it is not known and applied by mental health care practitioners including the medical doctors it may not protect human rights for mentally disabled.

Mental Health Act No. 17 of 2002 provides for 72 hour observation/assessment at district hospitals. Mental health policy framework and strategic plan 2013-2020 in South Africa is available, but since its adoption by National Health Council in 2013 very little has been implemented.

2.3 EXPERIENCES REGARDING THE IMPLEMENTATION OF THE MENTAL HEALTH ACT GLOBALLY

2.3.1 Experiences in India

The concept of improved MHA 1987 for India was narrated as being too ambitious leading to Psychiatric Society recommending realistic goals which should be attainable. The realistic goals were indicated as follows:

Realistic goals recommended were that mental health is essential to overall health, mental health care is consumer and family driven, disparities in mental health service are eliminated, early mental health screening, assessment, and referral to services be common practice, excellent mental health care is delivered, and research is accelerated, technology is used to access mental healthcare and information.

The changes in the unique assets for Indian psychiatry helped in bringing psychiatry to the correct path.

Furthermore, concepts of advance directive and nominated representative were discussed and found to be good in principle, but not easy to apply in India yet to be introduced. It was reported that clarity of terms and definitions as well as commendable introductions were important for without guidance, nothing goes right.

2.3.2 Experiences in British Columbia

Dutta and Oration (2011) reported that despite many advances in models, care, policies and laws, undesirable perception and stigma still continued in England with provincial frameworks for mental illness and addiction included. The reports further indicate that there was disintegration of services despite the presence of the policies, the Act and other advances of care. Dutta et al. (2011), continued to report that systems were difficult to follow even by MHCUs and service providers themselves. It was also impossible to monitor mental health services and addiction treatment other than those provided by hospitals or primary health care providers.

Dutta et al. (2011) further reported that the concept of children and adolescent mental health service developed slowly as it was an addition to the services of adults. Mental

health policies had focused on treatment for adults with no promotive, preventive and early interventions services (Dutta & Oration, 2011).

2.3.3 Experiences in South Africa

The study by Lund (2007) identified that Mental Health Care Act No. 17 of 2002 brought about challenges to health services due to lack of resources for mental health care yet the plan is there. Lack of resources led to under diagnosis and treatment for mental illness. The document so well designed following all the guidelines of the World Health Organization, remains a prompt to decision makers since most of the guidelines seem impossible to implement due to lack of funding in mental health service and is further reflecting the ancient inheritance for not funding mental health services.

Lund (2007) further reports the problem of poor development of mental health information systems in South Africa. Improvement of quality assurance measures for mental health is another problem for general hospitals and psychiatric hospitals. National Department of Health has already developed the National Standards of Care for severe psychiatric disorders. The direction on utilizing such standards needs to be emphasized and check current accreditation of health facilities.

Burns (2008) revealed the difficulty in implementing the Act as it required the generalist to actively participate in providing mental health services at community, primary health care and district. Further, the concept of 72-hour observation was reported to be difficult, because the mentally ill, need to be observed in a general medical environment so that exclusion of medical behavioural or psychiatric disturbance can be ruled out. Further, Burns (2008) reported that the difficulty is on the real application of Act.

Burns (2008) further stated that grave problems emerged with the provision of the 72-hour assessments at district hospitals that contributed to unfavourable levels of care and tragedies. He explained that users are poorly assessed, insufficiently sedated, no provision for routine examinations and investigations as well as failure at district hospital level to complete MHCA forms. In addition, Burns (2008) reported that there is lack of appropriate type of rooms to observe users in general wards and lack of skills possessed by health workers in dealing with psychiatric patients, lack of understanding

of the MHCA 2002 as well as the applicable forms, insufficient medications, lack of treatment protocols, guidelines and knowledge of referral options and the unclear roles of South African Police Services (SAPS) and Emergency Medical Rescue Services (EMRS) in the management of MHCUs as well as their (SAPS and EMRS) are regularly unhelpful (Burns, 2008).

The personal observation of the researcher is that the mental health policy framework and strategic plan 2013-2020 in South Africa is available, but since its adoption by National Health Council in 2013 very little has been implemented such as there is no directorate for mental health in most provinces and many other things.

It is for this reason that this study intends to develop a programme for facilitation of implementation of the Mental Health Care Act No. 17 of 2002 by medical doctors.

2.4 THE SIMILARITIES AND DIFFERENCES IN DIFFERENT COUNTRIES REGARDING IMPLEMENTATION OF THE MENTAL HEALTH ACT

2.4.1 Similarities

The following Researchers, Commonwealth Secretariat, (2007) reported that the following researchers: Chodoff, (1984); Bolis, (2002); Dhanda, (2005); Faunce, (2005); Watchirs, (2005); Jones, (2005); reported that countries in association known as Commonwealth of Nations with 53 countries, share the same common-law basis for legal systems. Jones (2005) reflected that those countries, their mental health legislations lack attention to the human rights of people with mental disorders as they reflect the following: shortage of the necessary economic resources. Most countries want to use the approach of deinstitutionalization and community mental health care which is cheaper.

2.4.2. Differences

The following researchers: Fistein, Holland, Clare, and Gunn(2009) reported that the council of Europe (1997) reported that they grounded their mental health on the European Convention on Human Rights (also derived from the UDHR) and the *Convention on Human Rights and Biomedicine* (Council of Europe, 1997), hence they

integrated an evaluation process, an analytical threshold, a therapeutic aim, and a fixed risk threshold.

According to Fulford (2004) their mental health Act had differences in value judgements regarding underlying principles, attitudes to mental disorder, and resource availability.

2.5 PROGRAMMES TO FACILITATE IMPLEMENTATION OF THE ACT BY MEDICAL PRACTITIONERS IN SOUTH AFRICA

2.5.1 National Mental Health Policy Framework and Strategic Plan 2013-2020

The National Department of Health developed National Mental Health Policy Framework and Strategic Plan 2013-2020. The purpose for the policy is to give instruction to provinces for mental health promotion, prevention of mental ill health, therapies and rehabilitation. The instruction is a plan, directed to all mental health stakeholders. The reason behind the policy is for South Africa to provide an all-inclusive mental health both in scope. The comprehensive mental health care is for all age groups and all mental disorders as well as co-morbid intellectual disability and substance abuse. The Policy Framework does not outline the implementation of the Mental Health Care Act by medical doctors.

2.5.2 Mental Health Care Act No. 17 of 2002

This is the latest Act applied in South Africa regarding mental health services. The Act provides a set of policies and procedures to be followed in the admission, care, rehabilitation and administration of property for MHCU. Furthermore, it outlined in the following guidelines and procedures: On 72-hour assessment of involuntary mental health care users; seclusion of mental health care users, Mental Health Review Board, Electro convulsive therapy, and the guidelines for best practice in child and adolescent mental health. The available policies and guidelines are silent about the programme to facilitate implementation of the Act by medical doctors.

2.5.3 Principles of implementation of Mental Health Care Act (2002)

In (2008) Burns conducted a study, developed and suggested the following principles in practice regarding mental health care. The principles covered are: Infrastructure, Human resources, education and training and others.

- **Infrastructure:** In a general ward, the percentage of beds, type and number of rooms and dedicated outpatient clinic.
- **Human Resources:** Human resource for mental health service as follows: Type of staff, whether full time or part time and outreach services by regional and tertiary services by MHCPs.
- **Education and Training:** Regular updates for district and community health workers, treatment protocols, Allocation of medical doctors in tertiary psychiatric hospitals regularly and local SAPS and EMRS personnel regular basis.

Literature search conducted on the implementation of Mental Health Care Act by medical doctors in South Africa revealed that there is a gap on guidelines, protocols, principles, models, strategies and programmes regarding implementation of the Act by medical doctors. This is also supported by Ramlall and Chipps (2012) in their study where they indicated that in South Africa there are policies without implementation plans.

2.6. SUMMARY

This chapter detailed the literature of the study. The literature search done was for international countries, African countries, as well as nationally, in order to understand how other countries are doing in terms of Mental Health Act implementation. Most studies had no information on the compliance of medical doctors to Mental Health Act. This research aims to investigate the practicability and applicability of implementing the mental health care Act 17 Of 2002 as described by doctors. Chapter three will elaborate on the design and methods used in this study.

CHAPTER 3

3. RESEARCH METHODOLOGY

3.1 INTRODUCTION

The previous chapter gave a detailed description of the reviewed literature of the study. In this chapter, a detailed discussion and reasons for the used research approach is given. This study was done in two phases. The first phase was situational analysis, where quantitative and qualitative designs were used. The second phase was the development of a programme to facilitate the implementation of Mental Health Care Act No. 17 of 2002 by medical doctors.

3.2 STUDY SETTING

This study was conducted in the Vhembe district, among the medical doctors working at District hospitals with a mental health unit as well as doctors at a specialised mental hospital. There are five district hospitals with mental health units and one specialised mental hospital in Vhembe District which is one of the districts that form the Limpopo Province. The Vhembe District is divided into four municipalities which are Makhado, Mutale, Musina and Thulamela municipalities. District Hospitals are located within the Makhado, Musina and Thulamela municipalities. The map in Figure 3.1 portrays the four municipalities and location of hospitals.

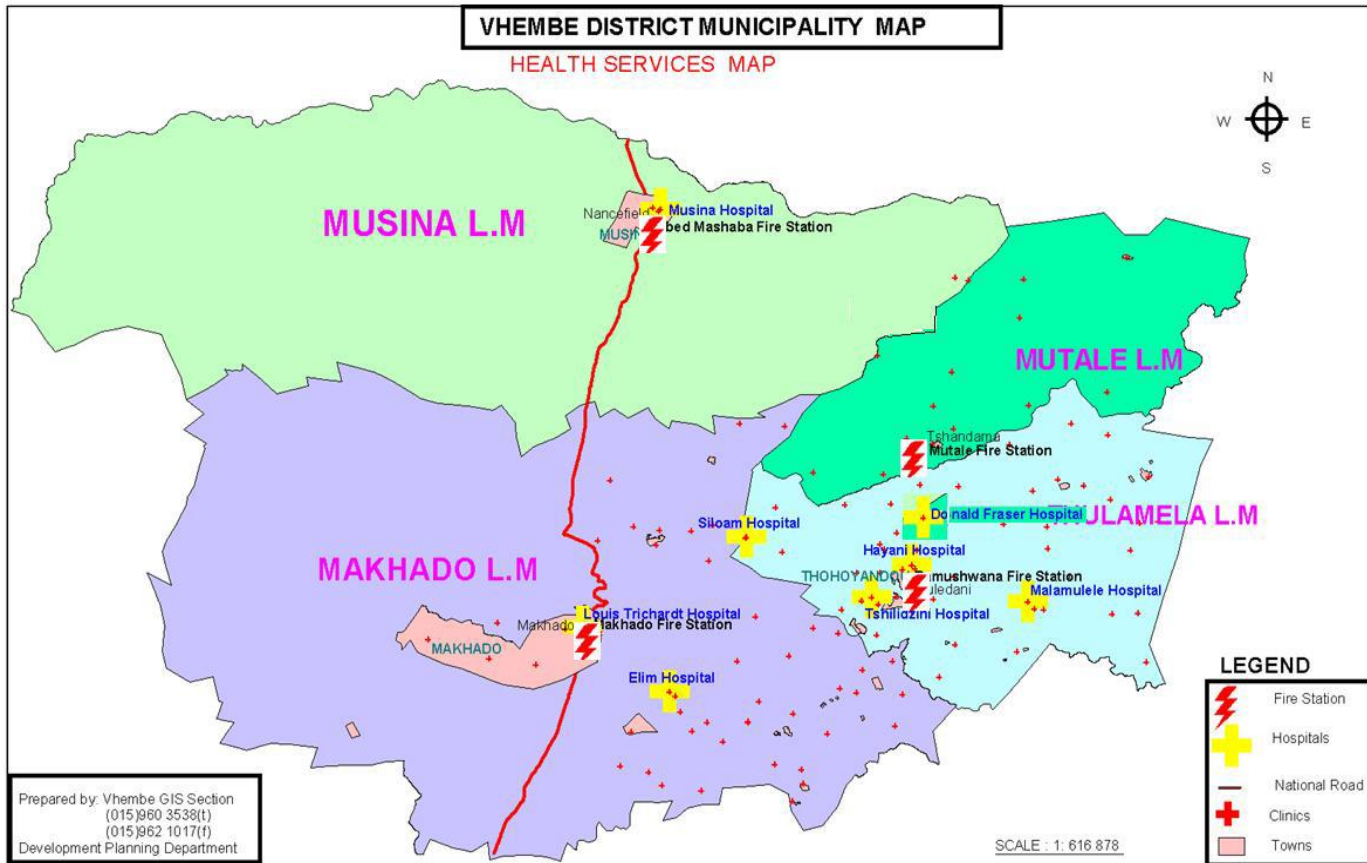


Figure 3.1: Vhembe district Hospitals and a specialised hospitals in mental health

3.3. RESEARCH APPROACH

The study was conducted in two phases, namely, Phase 1: situational analysis, and phase Phase 2: programme development. Figure 3.2 below presents the schematic illustration of the phases, which is followed by the full description of each phase.

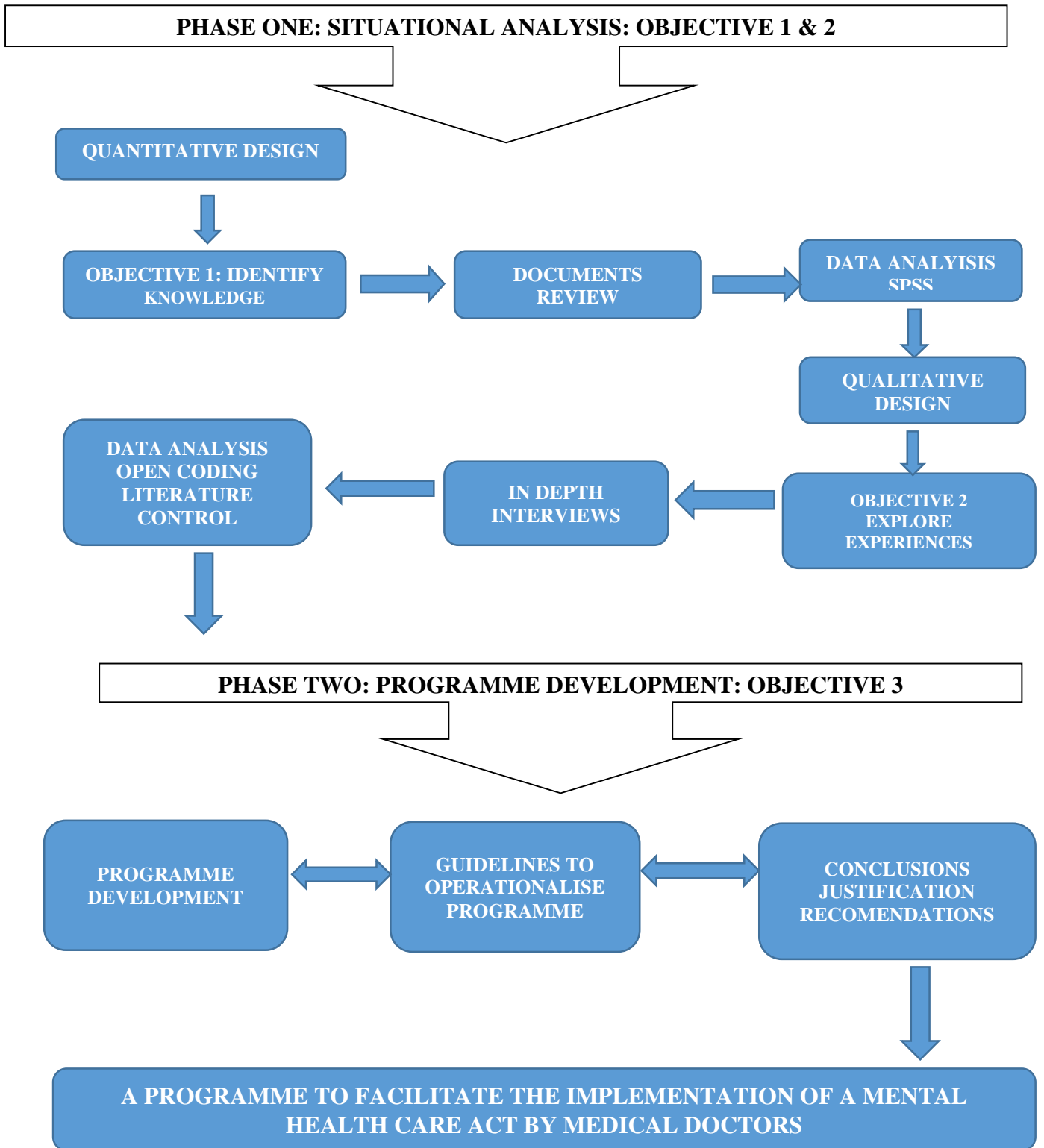


Figure 3.2: Schematic illustration of the phases

3.3.1 PHASE 1: SITUATIONAL ANALYSIS

For the decision to be made on what programme to develop, a situational analysis was done to explore and describe what should be contained in the programme for facilitation of the implementation of the Mental Health Care Act No. 17 of 2002. Quantitative and qualitative designs were used.

3.3.1.1. Quantitative design

Objective 1: To determine the medical doctors' knowledge regarding the implementation of the Mental Health Care Act No. 17 of 2002, during admission, care and discharge of mental health care users.

Quantitative research is defined or explained as a formal, objective, systematic process in which numerical data can be utilized to obtain information about the world. It is also indicated that this research method is used to describe variables, examine relationships among variables and to determine the cause and effect interaction between variables (Cresswell, 2009; Burns & Grove, 2011). The reason for choosing quantitative research was that the researcher used documents submitted by hospitals, reviewed in order to determine the knowledge of doctors in completion of the legal documents which is the study objective 1.

3.3.1.1.1 Population and sampling

Polit and Beck (2008), and Burns and Grove (2011), described population as the aggregate or totality of all objects, subjects, or members that conform to a set of specification. The population to answer objective number 1 for this study was documents completed by medical doctors, who were chosen because it was their area of operation; they assess and admit mental health care users and were expected to implement the Mental Health Care Act No.17 of 2002, during such process. It was the legal documents they completed that were reviewed.

The criteria for participation was legal documents completed by medical doctors working in the Vhembe district hospitals with mental health units and those working at a specialised mental health hospital in the Vhembe District of the Limpopo Province. The

documents ought to have been sent for auditing by the Mental Health Review Board (MHRB).

3.3.1.1.2 Sample

A sample is a subset of measurements drawn from the population in which the researcher is interested, it is a small fraction of the population (Polit and Beck, 2008; De Vos, 2005; Burns and Grove, 2011). All documents submitted to the MHRB that were completed by medical doctors in hospitals with mental health units and those working at a specialised mental hospital in the Vhembe district of the Limpopo Province were sampled.

3.3.1.1.3 Sampling Method

Sampling is the process of selecting a sample from the population to obtain information regarding a phenomenon in a way that represents the population of interests (De Vos, 2005; Polit & Beck, 2008; Burns & Grove, 2011). Non-probability purposive random sampling was used in this study. All documents that were completed by medical doctors during 1st April 2015 to 31 March 2016, in hospitals with mental health units and those working at a specialised mental hospital in the Vhembe district of the Limpopo Province were purposively sampled. This was done to determine the knowledge of doctors in completion of the legal documents which is objective 1.

Non-probability purposive random sampling was used to sample documents. According to Polit and Beck (2008), and Shaughnessy et al., (2014), random sampling gives every member of a population an equal chance/probability of being included. A total of 1430 documents were submitted in 2015 that is, from April 2015 to 31 March 2016, to the MHRB. The documents at the MHRB were totalised every quarter ending, from the first quarter to the fourth of the year 2016. For every quarter, 50 documents were sampled as follows: The first document was picked then, two and three were skipped and the fourth was picked until 50 was reached then go to the second, third and fourth quarter batches were sampled in the same way. The sample then was 200 documents which were picked for documents review to answer objective 1. Table 3.1 below provides the statistics of the documents population. All documents submitted to the MHRB by district hospitals, such copy of documents are filled whilst the MHRB return the non-approved report for hospitals to correct and resubmit so they can compare if indeed the corrections

were done and are correct and in line with the comments of the MHRB. From such records the sample of documents were drawn.

Table 3.1: Documents population statistics

Quarter	1st	2nd	3rd	4th	Total
Submissions	271	420	368	371	1430
Submissions approved	6	53	15	7	81
Submissions rejected	265	367	353	364	1349
Discharges	0	458	336	479	1273
Transfer out	0	0	0	0	0

3.3.1.1.4 Instrument

- The self-constructed and pre-test questionnaire was administered to increase validity. It was pretested with four documents (one per quarter) to identify flaws and ambiguities while ensuring that the items were clear and easy to answer. Outcome of the pretest questionnaire was not yielding the results determining the knowledge of doctors in implementing the Mental Health Care Act No. 17 of 2002 e.g. questioning about the qualification of the doctor. The questions were then realigned and checked again with the supervisors and such checklist is the tool that was used for this study consisting of items designed to determine the knowledge of medical doctors regarding implementation of Mental Health Care Act No. 17 of 2002 during admission, care and discharge of mental health care users. The items are dates; signatures; relevant forms; documentation; management and approval. Each item was ranked in a yes or no response. (ANNEXURE G)

3.3.1.1.5 Data collection

Data collection is described to be the process of gathering information from the selected subjects needed to address a research problem (Polit & Hungler, 2006; Burns & Grove, 2011). After obtaining permission from the relevant authorities, the researcher had access to the documents. The documents were selected as described above until a sample of 200 was reached. The researcher then reviewed each document using a pretest questionnaire (checklist). All items in the checklist were marked against the information in the document and then ranked as yes or no depending on the findings. This was done to answer objective 1.

3.3.1.1.6 Data analysis

Data analysis is the process that is conducted to reduce, organize and give meaning to the collected data. (Burns & Grove, 2011). In this study, a computer loaded with the IBM Statistical Package for Social Science (IBM SPSS statistics) version 23 programme was used to analyse quantitative data from the checklist as it is more powerful and accessible on the personal computer.

3.3.1.2 Qualitative design

Objective 2: to explore and describe the experiences of medical doctors when implementing the Mental Health Care Act No. 17 of 2002.

To answer the above objective, qualitative, explorative, descriptive and contextual design was adopted as described by Mouton and Marais (1996); Babbie (2011), De Vos (2005) and Burns and Grove (2011).

- Qualitative

Qualitative research is a systematic, subjective approach used to describe life experience and give it meaning. It is exploratory and descriptive (Burns & Grove, 2011). In this study, qualitative design was used to explore and describe the depth, richness and complexity inherent in the lived experiences of medical doctors in implementing the Mental Health Care Act No. 17 of 2002. Secondly, the study used qualitative design to gain a richer understanding of how implementation of the Mental

Health Care Act during admission, care and discharge of mental health care users by medical doctors could be facilitated.

- Exploratory

According to Mouton and Marais (1996) and Babbie (2013), the aim of the exploratory research is to get facts, gather new data and determine if there are interesting patterns in the data. Furthermore, exploratory method is typical when a researcher examines a new interest or when the subject of the study is relatively new. In this study the researcher selected the exploratory method to gain new insight, discover new ideas and increase knowledge about the experiences of medical doctors as they implement Mental Health Act No. 17 of 2002. The researcher used in-depth interviews of which personal experiences of medical doctors as they implement the Mental Health Care Act was explored. Secondly, the dimensions of mental health care were explored with regards to how implementation of the Mental Health Care Act could be facilitated. Literature was also explored extensively during literature control and programme development.

- Descriptive design

Descriptive research is the accurate portrayal of particular individuals or real life situations for purposes of discovering new meaning, describing what exists and categorising information (Burns & Grove, 2011). The study data was gained through in-depth individual interviews where medical doctors described their experiences as they implemented the Mental Health Care Act No. 17 of 2002.

The transcribed data was analysed and classified to provide new insights into it. To obtain a holistic understanding of the analysed data, an in-depth description of the identified attributes was made. Again an in-depth description of experiences of medical doctors with regard to how implementation of the Mental Health Care Act could be facilitated was made. Accurate description of the program and guidelines for operationalizing were also made.

- Contextual

According to Babbie (2011), the researcher can claim to understand the phenomenon if he/she understands it against the background of the whole context, and such context confirms the meaning of the phenomenon concerned. This study was contextual in that individual interviews were conducted with medical doctors in the Vhembe district hospitals and specialised hospitals in their cubicles where they consult patients. The researcher took into account their work setting as well as their professional and work ethical backgrounds.

The programme developed would facilitate the implementation of Mental Health Care Act No. 17 of 2002 by medical doctors in Vhembe district hospitals.

3.3.1.2.1 Population and sampling

Population

Population is described as the entire group of persons or objects that is of interest to the researcher or that meets the criteria the researcher is interested in studying (Burns & Grove, 2011 & Brink, 2012). This study population were all 76 medical doctors working in the Vhembe District hospitals with mental health units and those working at a specialised mental hospital in the Vhembe district of the Limpopo Province. Medical doctors, were chosen because in their area of operation, they assess and admit mental health care users and are expected to implement the Mental Health Act No. 17 of 2002 during such process.

Sampling Method

A sampling method is described as the process of selecting a sample from the population to obtain information regarding a phenomenon in a way that represents the population of interests (Burns & Grove, 2011; Brink, 2012). Non- probability purposive and convenient sampling was used in this study. The purposive sampling method is based on the judgment of the researcher regarding subjects or objects that are typical or representative of the topic being studied or who are especially knowledgeable about the

question at issue (Brink, 2012). Sampling occurred in two stages namely; sampling of hospitals and sampling of participants.

Sampling of hospitals

Six Vhembe district hospitals with mental health units including the specialised hospital in mental health were purposively sampled as they are the hospitals where mental health care users are admitted.

Sampling of participants

To answer study objective 2, fifteen (15) medical doctors (including community service) working in the Vhembe district hospitals were non-probable purposively and conveniently sampled because of their experience in implementing the Mental Health Care Act No.17 of 2002, when admitting, caring and discharging mental health care users. It was convenient because, of the nature of their work, medical doctors who were found in their cubicles and gave consent to participation were included in the sample. Doctors were from the six hospitals. 2-3 doctors per hospital were interviewed on a one to one basis.

3.3.1.2.2 Data collection

Data collection is the precise, systematic gathering of information relevant to the research purpose or specific objective, questions, or hypothesis of the study (Burns and Grove, 2011). In this study data collection involved preparation; data collection instrument; and the role of the researcher. These are discussed now.

Preparation

The researcher invited medical practitioners to participate in the study and explained that the reason for interviewing them is that they are experts in the topic of the study as well as that it is providing a platform for them to talk about their experiences when implementing the Mental Health Care Act No.17 of 2002.

Participants were informed that they were under no obligation to participate in this study, but if they do so, they have the right to withdraw at any stage of the study. Interested medical doctors are to be interviewed at venues that will be identified by them and the

researcher. The researcher explained that an audio tape was to be used as well as how to operate it, so that participants know in case they want to stop it for some reason.

Data collection instruments

Data was collected through in-depth individual interviews. This was a one-to-one interview between the researcher and the participants. Medical doctors working in the Vhembe district hospitals with mental health units were interviewed using this methods because it was difficult to get them together at once due to the nature of their work schedule. The interview was free-flowing with its structure limited to the focus of the research. This was the In-depth accounts which presented a lively picture of the participants' reality were densely presented in words as narratives, using individual quotes. The raw data of in-depth interviews were recorded in non-numerical form as alluded by Du Plooy (2009). An audiotape recorder was used during the interview and the data collected was transcribed (using the verbatim method). The interview was directed by the following two broad questions which was followed by probing.

- What are your experiences as you implement Mental Health Care Act No.17 of 2002 when you admit, care and discharge mental health care users?
- What type of a programme do you need to facilitate the implementation of Mental Health Act No.17 of 2002? (ANNEXURE H)

These broad questions made it possible for the researcher to get a better understanding of the doctor's experiences regarding implementation of Mental Health Care Act No. 17 of 2002 as they admit and manage MHCU. The interviews were conducted in English. An audiotape was used as explained above and data was later transcribed verbatim for analysis purposes.

The role of the researcher

The role of a researcher was that of being a human tape video-tape recorder as indicated by Le Compte and Pressle (1993). The researcher was the main research instrument for data collection and observed, interviewed, recorded, analysed, and interpreted as faithfully as possible what participants said and did as she interacted with them during data collection. The researcher started by establishing rapport and trust where she

displayed an attitude of unconditional acceptance, respect, empathy, honesty, openness and modesty.

Furthermore, researcher explained that they must feel free to explain their experience and that no name is to be mentioned during interview. That there is no right or wrong answer, but differing points of view. Made conscious attempt to appear relaxed, as natural as possible. When participants were relating their experiences, made it a point that her none verbal responses were consistent with the flow of the story. The researcher as a data collection instrument used effective communication skills to facilitate interview as described by Babbie (2013); De Vos, (2005); Brink (2012):

- Listening: The researcher applied her listening skills, paying attention throughout the interview process and study.
- Probing: Probing questions were asked, emanating from the participants answers, to allow participants to give more clarity.
- Minimal verbal responding: Minimal verbal respond by nodding the head, saying “mm, “Yes”, “continue” to allow free flow of information and to encourage participants to talk. This made participants to feel more relaxed and more willing to talk about their experiences.
- Clarifying: Always sought clarification on statements that I did not understand in order to avoid assumptions.
- Reflecting: Reflected by repeating the statement as mentioned by the participant in a question form in order for the participant to expand more on the specified points. Researcher reflected back to the participant in her own words to understand what is being said when need arose.
- Focusing: Participants were given full attention as they were deliberating about their own experiences to help them focus. This was demonstrated by the way of sitting arrangement done by the researcher, where the researcher ensured that, where interview is conducted chairs are the same with no table between the

researcher and the participant. The researcher maintained a non-threatening environment throughout the interview to enable participants to relate their stories without fear. All interviews were conducted at the time that was convenient to participants. The interviews were conducted in a private, comfortable place accessible to the participants in their consulting rooms as agreed. The researcher was respectful towards the participants; all these kept participants focused to the interview.

- **Paraphrased:** The researcher rephrased the participant's words in another form but with the same meaning. This encouraged the participant to give more information. Furthermore, she paraphrased the responses from the participants before asking the next question.
- **Validating:** The researcher observed the participants and interpreted their non-verbal communication such as vocalization, facial expression and body gestures and transcribe them for analysis. In this study, all non-verbal communication collected during interviews as field notes were transcribed and analysed to give collected data more meaning.
- **Using Silence:** The researcher used silence by keeping quiet and observed all the deliberations to allow the participant to think and continue to talk at own pace without interference. The researcher maintained eye contact, remained silent demonstrating to participants that she is there listening to them. Demonstrated awareness and hearing. The researcher listened actively and attentively to what the participants were saying both verbally and non-verbally. This involved perceiving another person's body movements, facial expressions and quality and tone of voice.
- **Establishing a trust relationship:** The researcher immersed self in the participant's life world to better understand their experiences while implementing the Mental Health Care Act No. 17 of 2002. Mutual trust was ensured to gain cooperation of the interviewee, and also improve the quality of collected data. The researcher responded in a manner that showed that the interviewees were worthy of their

disclosure and did not condemn or oppose the interviewees. Pleasant interpersonal relationship was maintained through the interviews/study.

An audiotaped data was later transcribed verbatim for analysis purposes (ANNEXURE I).

3.3.1.2.3 Data Analysis

According to Streubert and Carpenter (2011), as interviews were conducted, records were kept, and were constantly reviewed to discover additional questions that needed to be used or to offer descriptions of what would be found. In this study, eight steps as described by Tesch, following Creswell (2009) were applied as follows:

- Step one: Get sense of whole: The researcher read through all the transcripts carefully, to get a sense of the whole several times, to acquaint the researcher with data collected and jotting down some ideas which came to mind.
- Step two: Pick one document: The researcher picked the most interesting document which was also short and read through it again, to make sense out of it. The researcher underlined thoughts that came out and wrote in the margin. They were later used to group similar topics together.
- Step three: List the topics: When the researcher had completed the task for several participants a list was made for all the topics. Similar topics were clustered together to form columns, which arrayed as major, unique and left overs topics, different colour pens were used to simplify the task.
- Step four: Go back to data: The researcher took the list and went back to the data. The researcher abbreviated the topics as codes and wrote a code next to the appropriate segment of the text. Thereafter, the researcher tried to preliminarily organise scheme to see if new categories and codes could emerge.
- Step five: Describe the topics: The researcher tried to find the most descriptive wording for the topics and turned them into categories or themes and sub-themes. The researcher tried, by all means, to reduce the total list of categories by

grouping topics that relate to each other and drew lines between the categories to show interrelationships.

- Step six: Abbreviate categories: A final decision was made on the abbreviation for each category and codes, and they were arranged alphabetically. This was done after going through the codes several times making sure that all codes were noted.
- Step seven: Assemble data: Data material belonging to each other were assembled and a preliminary analysis was done. These made it easier for the researcher to come up with the themes and sub themes based on the grouping.
- Step eight: Recording: The researcher recorded existing data to ensure that no data was left out.

Literature control

After data was analysed, the experiences of medical doctors in implementation of Mental Health Act No.17 of 2002 was identified and literature control supported the findings. Literature control Mdluli (2005) ensures that there would be a perfect fit between data and relevant literature, providing a linkage between past and present research.

3.3.1.3. Ethical consideration

According to Burns and Grove, (2011) and Brink (2012), ethics refers to a branch of philosophy that deals with morality. It contains a set of propositions for the intellectual analysis of morality and a means of striving for rational ends. Therefore, in research, ethics ensures that the rights of participants are observed, protected and respected. In this study the researcher ensured that the following are observed.

Permission to conduct the study

The researcher requested permission to conduct this study from the following:

- University of Venda Research Ethics Committee. A proposal was presented to the Higher Degree's Committee of the School of Health Sciences. An ethical clearance certificate and permission to conduct the study was given by the University of Venda through the Higher Degree's committee (see annexure A).
- The Limpopo Province Department of Health Research Ethics Committee (see annexure B and C)
- The Vhembe District Department of Health (see annexure D)

Informed consent

Informed consent involves informing the participants about the type of information needed, their degree of understanding and the fact that the participants have the choice of whether or not to give consent (Brink, 2012). Information regarding the aim of the study and the information needed was explained and how data will be collected and used and then a written consent was sought from participants. All this was done to ensure free will to participation being informed (ANNEXURE E & F)

Coercion

Essack and Juwah (2007) asserted that the research involving the medical doctors as they practice is an ethical issue, which is the reason it was necessary that special attention be given to the potential for coercion, undue influence, power disparities as well as being fair when selecting medical doctors to participate in the study. In this study, the likelihood that medical doctor's participation might be the results of unintended undue influence was carefully thought out. The researcher was conscious of her position as a mental health practitioner in one of the district hospitals where the research was to take place. To avoid any coercion that might arise, the following was done:

The letter to request permission from Chief Executive Officers of district hospitals was submitted to seek permission to undertake the study in their institution. A note was then

sent to all district hospitals with a mental health unit and a specialised mental hospital for them to paste at their noticeboards and doctors conference rooms.

The right to self-determination

Self-determination is based on the ethical principle of respect for person, it means that human beings are capable of controlling their own destiny therefore they should be treated as autonomous agents who have the freedom to conduct their lives as they choose without external controls (Burns & Groves, 2011). This was ensured by allowing participants to decide whether or not to participate in the study and they have a right to withdraw from the study if they do not wish to continue to participate. An announcement was made at doctors' meetings, there after individual doctor's names and the notice for research were sent to different hospitals to let the medical doctors read on their own then make a choice about participating in the study.

Principle of beneficence

Beneficence means that the researcher is required to do well and above all do no harm (Brink, 2012). The well-being of participants was secured and protected from discomfort and harm. It was explained that there were no legal implications as a result of them giving their opinion about the implementation of the Mental HealthCare Act No. 17 of 2002.

Principle of justice

This principle is concerned about fair selection of participants and treatment (Burns & Grove, 2011). Participants were selected fairly and randomly and they were treated fairly. Their participation was voluntary.

Right to anonymity

The process of ensuring anonymity refers to the researcher's act of keeping the subjects identities a secret with regards to their participation in the study (Brink, 2012). The use of real names of participants was prohibited in this study, each participant was provided

with a number. The number was used when discussing data. A master list of participants and matching number was kept in a safe place

Confidentiality

The process of ensuring confidentiality refers to the researcher's responsibility to prevent data gathered from being divulged or made available to any person. In case the information is requested for use in another study, the researcher must inform the participants and ask for permission for the use of data in another study (Brink, 2012). In this study participants' names were never mentioned during an interview. Data gathered during the study was made available only to persons directly involved with the study. It will only be published for the benefit of the researcher and the Department of Health. Anonymity will be protected.

3.3.1.4 Measures to ensure trustworthiness

Lincoln and Guba (1995) posit that trustworthiness of a research study is important in evaluating its worth. Trustworthiness refers to the degree of confidence qualitative researchers have in their data assessed using the criteria of credibility, transferability, dependability, confirmability and authenticity (Polit & Beck, 2008). These are described below

Credibility (Truth value)

Credibility is defined as truth-value which will be obtained from the discovery of human experiences as they are lived and perceived by the researcher's participants (Lincoln & Guba, 1985). In this study credibility was achieved by ensuring that the population is accurately identified and especially knowledgeable about the phenomenon being studied. Data was transcribed as the direct quotations from the participants.

Furthermore, credibility was ensured through prolonged engagement, persistent observation and member checking.

Prolonged engagement

Prolonged engagement refers to the investment of sufficient time during data collection to have an in-depth understanding of the phenomenon under study, thereby enhancing credibility (Polit & Beck, 2008). In this study prolonged engagements and persistent observation with participants allowed for identification of recurring patterns, themes, and values for the validation of perspectives. The researcher as a coordinator of mental health in the Vhembe district met with the participants while preparing for the interviews, in order to establish rapport and build trust. The researcher also met them individually at their hospitals to present to them the interview transcript and the interpretation derived from the interviews, in order to confirm the accuracy and credibility of the findings. The participants were interviewed to the point at which there was data saturation.

The credibility of this study was further enhanced by consensus discussion with experts in qualitative research as promoters of this study are qualitative researchers themselves as well as experts in programme development. They also played an active role of acting as “devil’s advocate while challenging my research questions in relation to objectives, data sets, analysis and interpretation as a way of making me to be more focused and in direct engagement with my study. Triangulation of quantitative and qualitative design was used to enhance the probability that interpretations were credible.

Persistent observation

Persistent observation refers to the researcher’s focus on the aspects of a situation that is relevant to the phenomenon being studied (Polit & Beck, 2008). The researcher observed the participants as they were being interviewed, probe for clarity on issues raised by participants and focus on elements that are most relevant to the problem. During the interviews, the researcher utilised time to listen and observe them as they are interviewed.

Member checking

The member check means that the researcher provides feedback to study participants about emerging interpretations and obtains their realities (Polit & Beck, 2008). In this

study, member checking was done throughout the interview by deliberate probing. The preliminary findings of the researcher were discussed with the participants. After data has been fully analysed the researcher went back to participants for final member check to determine if what is transcribed is what they meant.

Transferability (applicability)

In the naturalistic paradigm, the transferability of a working hypothesis to other situations depends on the degree of similarity between the original situation and the situation to which it is transferred. Transferability refers to the degree to which the findings can be applied to another context or with other groups (Polit & Beck, 2008). In this study transferability was ensured by densely describing the background information of participants. The research context and setting was also described, so as to allow others to assess how transferable the findings are. The purposive sampling technique was used to select participants who fit the criteria described.

Dependability (Consistency)

The concept dependability implies traceable variability, which is variability that can be ascribed to identify sources (Lincoln & Guba, 1985). In this study the researcher coded the data and waited for a certain period and returned to recoded tape of the same data to ensure accuracy.

Confirmability (Neutrality)

Confirmability refers to the criteria for evaluating the quality of data by referring to objectivity or neutrality. Neutrality refers to the degree to which the findings are a function solely of the participants and conditions of research and not biases, motivations and perspectives (Lincoln & Guba, 1995). In this study confirmability was ensured by playing back the tape-recorded interviews to participants to check if what they had said is what they meant. Furthermore, a researcher tried to be non-judgmental, and strives to report what is found in a balanced way.

3.3.2 PHASE 2: Programme development

Objective 3: To develop a programme to facilitate the implementation for the Mental Health Care Act No.17 of 2002 based on the findings.

Phase 2 of this study comprised of the programme development. In developing the programme, certain aspects needed to be considered such as situational analysis (phase 1), which provided information regarding the knowledge of doctors on the implementation of Mental Health Care Act No.17 of 2002 during admission, care and discharge of mental health care users; and their experiences regarding the implementation of the Mental Health Care Act No.17 of 2002. The programme was developed in an interactive interventive manner using the theoretical framework and approaches outlined by Dickoff, James and Wiedenbach (1968). Chinn and Kramer (1999); Walker and Avant (1995). These are discussed below.

3.3.2.1 The theoretical framework for the development of the programme

The theoretical framework for the development of the programme was informed by the elements of practice theory outlined by Dickoff, James and Wiedenbach (1968). These are agents, recipients, context, process, dynamics and outcomes. These are briefly explained below and fully described and applied in Chapter 5.

Agent: Who or what performs the activity? An agent is any person whose activity leads to the realization of the goal (Dickoff, et al., 1968). In this study the agents were Psychiatrist, Mental Health Review Board Members, Academic specialists and Mental Health coordinator. They are the experts in implementation of the Mental Health Care Act No. 17 of 2002.

Recipient: Who or what is the recipient of the activity? Recipients are all those persons who receive action from agents and benefit from the activity (Dickoff et al., 1968). In this study the recipients were medical doctors who were empowered by the mental health experts and the main goal of empowerment was to give valuable skills and knowledge to the medical doctors about Mental Health Care Act No. 17 of 2002 and its implementation.

Context: In what context is the activity performed? The context is viewed from the aspect of the matrix of activity; it is seen in relation to other things, including persons and other activities, and to see the interrelation of these other factors as constituting an organism, unity, or total context of activity (Dickoff, et al., 1968). The context within which this study was conducted was hospital environment.

Process: What is the guiding procedure? The process involves the steps to be taken towards accomplishment. The process aims at providing sufficient information to enable the activity to be carried out. It safeguards the agent, recipient and the institution in that it provides knowledge and therefore lessens liability to criticism (Dikoff, et al., 1968). The implementation of the mental health care act by medical doctors could be enhanced by the following activities, namely: situational analysis; planning; implementation and evaluation. Both experts and medical doctors should participate in the process.

Dynamics: What is the energy source of the activity? Dynamics involve the power sources for that activity. These are the energy sources that motivate agents to pursue their activity without getting discouraged (Dickoff, et al., 1968). The dynamics required to implement the Mental Health Care Act are the agents and recipients' willingness, commitment, effective communication, mutual trust, participation, collaboration and reflective feedback.

Outcomes: What is the end point of the activity? This involves defining an activity from the perspective of an end point or its accomplishment (Dickoff, et al., 1968). The outcomes of this study representing the elements of context, agents and recipients in implementation of the Mental Health Care Act No. 17 of 2002.

3.3.2.2. Approaches outlined in various authors

The programme was developed in an interactive interventive manner using approaches outlined in Chinn and Kramer (1999), and Walker and Avant (1995); namely, analyzing, derivation and synthesizing. Through deductive analysis, synthesis and derivation, relational statements with regards to each element of practice theory in Dickoff et al., (1968) made to make meaningful claims about the mental health programme. The approaches are:

- Analysis

According to Walker and Avant (1995); Chin and Kramer (1999), analysis is useful in areas in which there is an existing body of theoretical literature. It involves the examination, clarifying, refining or sharpening of concepts, statements, or theories. Furthermore, the whole was dissected into its component parts for better understanding. In this study, analysis was done in the refinement of the programme.

- Synthesis

Synthesis combines isolated pieces of information that are not connected theoretically. It aids in sifting out important factors and relationships from data without an explicit theoretical framework (Walker & Avant, 1995; Chin & Kramer, 1999). In this study, the effect of synthesis was located as theoretical framework was constructed out of inputs of medical doctors, structuring and development of a programme.

Derivation

Derivation is described as the third approach to theory building which provides a means of the theory building through shifting the structure or terminology from one context to another (Walker & Avant, 1995). In interpreting the inputs of participants in phase 1 of the study, derivation was used to draw from other contexts on how the Mental Health Care Act implementation programme can be employed. Also, derivation, according to Chin & Kramer, (1999), may be used in areas in which no theory base exists or the existing theories have become outdated and new innovative perspectives are needed. In this study, the medical doctors brought new perspective about their experiences in implementing Mental Health Care Act as they provide mental health care. The purpose of theory derivation was to acquire a means of explanation and prediction about the experiences of medical doctors when they implement the Mental Health Care Act that is currently poorly understood, or for which there is no present means to study it.

3.3.2.3 Programme Evaluation

An evaluation of the programme was conducted using Chinn and Kramer's (1999) questions relating to the programme's clarity, simplicity, generalizability, accessibility and value and are as follows:

- How clear is the programme?
- How simple is the programme?
- How general is the programme?
- How accessible is the programme?
- How important is the programme?

These are fully described in Chapter 5.

3.4 SUMMARY

This chapter presented the research methodology, followed by data collection, data analysis, methods of ensuring trust worthiness and ethical considerations. Here a description on how the study was conducted was done in detail. A description on programme development were also provided though a detailed description of is detailed in Chapter 5. Study findings and literature control are presented in the chapter following here after.

CHAPTER 4

4. DATA ANALYSIS AND INTERPRETATION

4.1. INTRODUCTION

In this study, the researcher used the Bloom's taxonomy theory of teaching as a conceptual framework which is detailed in chapter 1. The data collected enabled the researcher to evaluate the variables, which included MHCU admission status as well as the approval status by MHRB in the participated mental health institutions at Vhembe district of Limpopo province.

The previous chapter presented the research approaches and methodology used for the study. This chapter discusses the data analysis and interpretation of the admission documents perused for this study in the quantitative methods. The statistical information was derived from a sample of 200 documents that formed part for the study. The percentages were calculated on the number of information received from the sampled documents to each item (valid percent). This was done as a function of the SPSS version 23 programme on the advice of Mrs. T. Mulaudzi from the Department of Statistics at the University of Venda.

Demographic information was obtained from the documents submitted to the Mental Health Review Board for compliance audit of the legal documentation to contextualise the information about the implementation Mental Health Care Act No. 17 of 2002.

Data analysis was done by Mrs. T. Mulaudzi, a statistician at University of Venda, using the SPSS version 23 programme.

The following statistical tests were applied in the data analysis:

Frequency distributions were compiled to arrange data belonging to the same category (Straussner and Spiegel (1996); Valanis, 1999). Frequencies, percentages and total percentages were used to describe different variables and allow for the clear presentation of data in figures and frequency tables. The results were discussed separately as quantitative and qualitative.

4.2 QUANTITATIVE DESIGN RESULTS

Objective 1: To determine the medical doctors' knowledge regarding the implementation of mental health Act No. 17 of 2002 during admission, care and discharge of mental health care users.

The quantitative results are presented in two sections, namely, demographic information and knowledge of medical doctors regarding the implementation of Mental Health Care Act No. 17 of 2002 during admission, care and discharge of mental health care users.

4.2.1 Demographic information

The demographic characteristics of the 200 reviewed documents are addressed in this section. The variables, which include MHCU admission status and Approval status by MHRB are presented and discussed.

- Mental Health Care User admission status

The admission status of mental health care users indicate that more than half (56, 5%) of the admitted Mental health care users were admitted involuntarily. On the other hand, less than half (43%) were admitted as assisted MHCUs. Table 4.1 illustrates the admission status.

Table 4.1 Results from the documents of admission status from MHRB

MHCU	Frequency (N)	Percentage
Assisted	87	43%
In voluntary	113	56,5%
Total	200	100%

- Outcomes of Mental Health Review Board

Table 4.2 below shows the distribution of the outcome status from MHRB. The study assumes that all admissions are approved by the MHRB as prescribed by the Mental Health Care Act No. 17 of 2002 as amended. There are however, MHCU admission status that are not approved by the MHRB. Results show that majority 179 (89, 5%) of admissions were rejected by MHRB. This indicate that the Mental Health Care Act was not implemented accordingly by medical doctors.

Table 4.2. Outcome of Mental Health Review Board

Status	Frequency (N)	Percentage
Approved	21	10.5%
Rejected	179	89,5%
Total	200	100%

4.2.2 Knowledge of medical doctors regarding the implementation of Mental Health Care Act No. 17 of 2002 during admission, care and discharge of mental health care users.

Results and discussions

In order to answer the above objective 1, data was collected through checklist questionnaire in document review as fully discussed in chapter 3. The checklist questionnaire consisted of items designed to determine the knowledge of medical doctors regarding dates; signatures; relevant forms; documentation; management and approval as they admit, care, and discharge mental health care users. Each item is ranked in a yes or no response. The data collection took 30 to 35 minutes per document. The frequency tables were used to organise the data and is shown in table 4.2 to table 4.6. Furthermore, each table is followed by the analysis and discussion.

4.2.2.1 Dates

Dates written that contribute towards implementation of the Mental Health Care Act (raw percentage) based on the yes and no responses are shown in Table 4.3.

Table 4.3 Rank order of dates

Items	YES	%	NO	%
Was the document submitted to the Mental Health Review Board within seven days?	150	75.0	50	25.0
Is the document having different dates on assessment form?	67	33,5	133	66,5
Date changed/ Overwriting?	150	75.0	50	25.0
Date omitted?	40.0	20.0	160	80.0
Is date legible?	50	25.0	150	75.0

In this study majority of the documents 179 (75.0%) of the 200 documents sampled were submitted within seven days after the decision of the HHE. In this study institutions that submitted in time contributing to the 179 (75.0%) are credited for best practices. Similar findings were reported by the study conducted in South Africa by Ramlall and Chipps (2010) who showed that 24 hospitals of the 50 designated hospitals (66.7%) reported that their staff were reasonably proficient in completing these forms although 16 hospitals which is 44.7% is not forwarding forms. In Vhembe District submissions indicated above, revealed the remaining 21 (25.0%) which is a concern because all documents need to be submitted in time as per the prescripts of the Mental Health Care Act and its regulations as well as the guidelines. The 67 (33.5%) of such documents had different dates yet 133 (66.5%) had same dates. Another observation was overwriting over dates which showed 150 (75.0%) of documents were overwritten and 50 (25.0%) with no overwriting, in 40 (20.0%) of documents date was omitted yet 160 (80.0%) had dates, although 150 (75.0%) of such date were not legible and 50 (25.0%) legible. Overwriting over dates of assessment as well as application (MHCA) forms and is also a concern, especially on legal documents as it makes the reviewer not to be sure of the correct date because 150 (75.0%) of those documents were not legible and 50 (25.0%) of documents dates were legible.

The date on which the document was written in this case is very important because there are prescriptions by the Mental Health Care Act No. 17 of 2002 that the head of the health establishment (HHE) must within seven (7) days of his or her decision made under section 27 (9) submit documents to the Review Board, and within 30 days of receipt of documents referred to subsection (1), the Review Board must conduct an investigation using dates as the land mark (South Africa, 2002).

In this study, minority of the documents of 50 (25.0%) which seems to be low in terms of submission was a concern as it leaves MHRB with no knowledge regarding when the decision was taken. It is the same with 133 (66.5%) of assessment forms with no date indicating when assessment was done. Legibility on legal document is very important because legal opinion need to be taken with the best interest of users in the least restrictive environment (Freeman, 2002).

The study revealed that majority of doctors 160 (80.0%) observe and write the dates accordingly on the documents. Although omission of the dates in some documents were found to be low 40 (20.0%), it is high on legal documents since Mental Health Review board members will check if all the requirement for the procedure prescribed in the Act and regulations have been met, such as all the necessary documentation being available and correctly completed, having time periods met as required. Review Board may not know when the decision was taken by the HHE and procedural obligations by MHRB such as time periods to conclude reviews or arrange hearings will not be possible (South Africa, 2013).

4.2.2.2 Signatures

Documents were checked for medical doctors' signatures to show the issues that contribute to accountability for implementation of the Mental Health Care Act. These are presented in Table 4.4 in rank order.

Table 4.4 Rank order of signatures

Items	YES	%	NO	%
Are there different signatures on one form?	51	25.5	149	74,5
Omitted signatures?	160	80.0	40	20.0
Cancellations not accounted for?	101	50,5	99	49,5
Is the declaration having the commissioner's signature and names?	88	44.0	112	56.0
Is thumb print with owner's names? (total 56)	27	48.2	29	51.7

Signature is one of the most important item in showing who the author of such writing is, and that shows that whoever the author is, is indicating that he/she is accountable and responsible or is answerable for the script.

In this study findings revealed that the minority document 51 (25.5%) of the documents, signatures were omitted in some of the pages, yet 149 (74.5%) had signatures. The majority of documents 160 (80.0%) had different signatures in one form and 40 (20.0%) with omitted signatures. It was found that some documents 101 (50.5%) had cancellation which were unaccounted for yet 99 (49.5%) did not have any cancellation that was not accounted for if ever there were cancellations. This made the reviewer to wander as to who then is accountable for such cancelling on a signature of an assessment or document writing to the ones cancelled with no one's accounting signature. There were 112 (56%) of documents were declaration did not have the signature of the commissioner with names although 88 (44.0%) had a signature and names as well. The applications MHCA 04 which belong to the applicants who cannot write accounting to 29 (51.7%), had a thumb print which did not indicate to whom the thumb print belongs, as there were no names attached. The study findings showed that 27 (48.2%) had no names of the owner of such a thumb print (total applications with thumb print were 56)

According to the Mental Health Review Board Orientation Guideline and Procedure Manual (2007), during the review process the Review Board review each entry in the register, not repeat entries (same user, same practitioner) check signatures and track patterns across entries.

4.2.2.3. Relevant forms

The ratings of relevant forms that must be put together during admission, care and discharge of a mental health care user were recorded into six items and rank order. Table 4.5. presents the results in ranked order according to raw percentages.

Table 4.5 Rank order of relevant forms

Items	YES	%	NO	%
Is there form MHCA 08 when applying for an extension of admission as involuntary after 72 hours?	78	39.0	122	61.0
Is the application form MHCA 04 available and well completed?	156	78.0	44	22.0
Availability of MHCA 05 x 2, and fully completed?	32	16.0	168	84.0
Availability of MHCA 06, and fully completed?	161	80,5	39	19,5
Availability of MHCA 07 and well completed?	21	10,5	179	89,5
If user was brought by SAPS, was form MHCA 22 completed? (85)	13	15.3	72	84.7

The study revealed that 122 (61.0%) documents did not have MHCA 08 for extension of admission as involuntary after 72 hours neither did they reclassify the MHCUs, those who completed did not complete fully, yet 78 (39.0%) applied or reclassified their users. This study found that 156 (78.0%) of MHCA 04 for application was well completed which was good, but 44 (22.0%) of such documents were not duly completed. The findings of this study revealed that 168 (84.0%) of assessment forms were not fully completed yet 32 (16.0%) were fully completed. Most of the (MHCA) form 06, 161 (80.5%) were fully completed and a lesser number of 39 (19.5%) thereof were not fully completed. The question therefore, arises whether MHCUs were observed/assessed? The study further found that MHCA 07 i.e. 179 (89.5%) was not well completed, and only 21 (10.5%) were well completed. Realizing that this was the form giving authority for admission, it means all the users admitted using MHCA 07 which were not fully completed were admitted illegal.

Furthermore, findings of the study identified that there was a high percentage of assessment forms and MHCA 8 that were not fully and well completed plus reclassification was not done as well. Ultimately, the whole admission process were faulty therefore illegal according to the prescripts of the Act. The MHCU who were

brought by police to the hospital of a total of 85 had 72 (84.7%) MHCA 22 were not completed by SAPS, yet 13 (15.3%) was completed well. MHCA 22 is very important as it informs the institution of the condition of the MHCU when he/she was brought to the institution. The Review Board also checks if the necessary documentation/forms are available and correctly completed and adhered to the time periods prescribed (South Africa, 2007) hence relevant documentation was checked in this study because it was the procedure prescribed by the Act. According to Van Rensburg (2007), filling forms correctly is to protect MHCUs, if not done it means failure to uphold their rights.

4.2.2.4. Documentation

The manner in which the information is documented in mental health care users' files by medical doctors was assessed into eight items then ranked.

Table 4.6 illustrates this documentation.

Table 4.6. Rank order of documentation

Items	YES	%	NO	%
Were cancellations on the forms accounted for?	101	50,5	99	49,5
Are there different handwritings in one form?	96	48.0	104	52.0
Was legibility of writings compromised?	115	57,5	85	42,5
Is there copying from each other?	128	64.0	72	36.0
Did the doctor indicate the name of the Head Health Establishment in MHCA 07?	21	10,5	179	89,5
Is MHCP serving as an assessor?	26	13.0	174	87.0
Is MHCP serving as a commissioner?	26	13.0	174	87.0
Has the complete profile of the applicant been included?	31	15,5	169	84,5
Was the physical examination done? (e.g. condition looks good not allowed, but to write findings)	29	14,5	171	85,5

The findings of this study revealed that almost half of the documents the 101 (50.5%) had cancellation that were accounted for, and 99 (49.5%) unaccounted for, making reviewers unclear of whose cancellation the reviewers were presented with. MHCA

forms are legal forms, if a cancellation was not accounted for, such documents are considered not authentic.

The documents of 96 (48, 0%) MHCA had different handwritings in one form which lead to conclusion of possible forgery, yet 104 (52.0%) had one hand writing which was considered authentic. As many as 115 (57.5%) of documents, legibility was compromised though 85 (42.5%) legibility was not compromised, to documents were legibility was compromised, that made it difficult for MHRB members to see what is written in the documents. Copying from one another was noted in 128 (64.0%) of the documents where some even copied names and credentials, and 72 (36.0%) did not copy. The doctors amounting to 89.5% did not indicate the name of the HHE yet only 10.5% indicated who the accounting officer of the institution is, as he/she is the one who appointed the one filling the form. Doctors amounting to 26 (13.0%) served as assessors and commissioners, however majority of doctors 174 (87.0%) did not play both roles. According to the best practice one doctor cannot serve as both assessor and commissioner at the same time.

The profile of the user in some forms, such as, name, age and gender in this study were excluded. In the findings of the study 169 (84.5%) of the documents excluded particulars of the profile of the MHCU and 31 (15.5%) included everything of the profile of the users. The information omitted prevents proper registration of mental health care user into data base. Omission of this information is associated with poor practice since such information forms part in the best practice which declares completion of records. Physical examination of MHCU was done well in 29 (14.5%) of documents but 171 (85.5%) of documents had physical assessment not reflected yet in others condition looks good was written, not reflecting the real findings. It is worrying to find that in 171 (85.5%) of the documents physical examination was not taken as serious and HHE can only take a decision whether to treat, care and rehabilitate after checking the findings of two mental health care practitioners (South Africa, 2002). Another problem is that of MHCP copying from one another yet the guideline requires independent reports from MHCP (South Africa, 2007).

Medical doctors are obliged by the Health Profession Act No. 56 of 1974 to practice with conscience, ethically correct and not copy from others and take responsibility for own actions by assessing on their own.

4.2.2.5. Management

Management by the head of Health Establishment in the admission of mental health care users was determined by two items and ranked as indicated in Table 4.7.

Table 4.7 Rank order of management

Items	YES	%	NO	%
Findings of the MHCPs not concurring, if so is there a third assessor appointed by HHE?	71	35,5	129	64,5
Was authorisation for the admission by the HHE completed correctly?	36	18.0	164	82.0

In as many as 129 (64.4%) of the documents showed that the findings concurred with each other for both assessors yet 71 (35.5%) of documents, findings did not concur with each other. The HHE is to complete MHCA 07 correctly after taking a decision or else it will be taken as though the patient was admitted illegally because they are contrary to the Act (South Africa,2007)). The findings of the documents review showed that only 36 (18.0%) of the MHCA 07 was completed correctly yet 164 (82.0%) was not completed correctly. According to the Mental Health Care Act No. 17 of 2002, authorisation for admission is given by the HHE by filling MHCA 07 after having checked the findings of two assessment forms – that is, MHCA 05 if the findings concur with each other and if they do not concur with each other, the HHE shall appoint the other Mental Health Care Practitioner to assess the mental health care user (South Africa, 2002).

4.2.2.6. Approval

Approval of documents completed by medical doctors during admission, care and discharge of mental health care users by Mental Health Review Board were assessed and ranked in yes and no as illustrated in Table 4.8

Table 4.8 Rank order of Approval

Items	YES	%	NO	%
Is the document approved by the MHRB?	21	10,5	179	89,5

Approved forms were very minimal, only 21 (10.5%) of the documents yet 179 (89.5%) were rejected because they had one or more mistakes which were identified by the Review Board. According to the Mental Health Review Board Orientation Guideline and Procedure Manual (2007), the review board must check documents for completeness and return incomplete or incorrect documents for correction because illegal admissions are not allowed by the MHRB since those who implemented with mistakes are contrary to the Mental Health Care Act No. 17 of 2002.

4.3 Qualitative Data

Objective 2: To explore and describe the experiences of medical doctors when implementing the Mental Health Care Act No. 17 of 2002.

4.3.1 Description of demographic profile of the sample

The sample of this study comprised of fifteen (15) participants. Amongst them were male and female doctors, different ranks, for example, the clinical manager, medical officers and community service doctors. Individual interviews were conducted to 7 medical doctors, 3 clinical managers and five (5) community service doctors. Table 4.9 below illustrates sample profile:

Table 4.9 Sample profile

Rank	Number	Gender	
Clinical managers	3	1 F	2 M
Medical officers	7	3 F	4 M
Community service doctors	5	2 F	3 M
Total	15	6	9

4.3.2 Results

The experiences of medical doctors regarding implementation of the Mental Health Care Act No. 17 of 2002.

Results from qualitative data have been presented through Table 4.10 below; the following section presents an analysis and discussion of these results.

Table 4.10 Findings of qualitative

THEMES	CATEGORY	SUB-CATEGORIES
1. Lots of paper work	<ul style="list-style-type: none"> • Mental Health Act 17 of 2002 legal forms 	<ul style="list-style-type: none"> • In one Act many forms, it is too much for us • Complaint about instruction written at the bottom of form 07 • Stressed the word forms with anger (tapping the table) • filling forms for formality, Just made to fill forms, which are confusing and not going anywhere • Do not see any reason for clinical managers appointed as HHE in filling form 07 • Every mental health care provision is filling of forms
2. Increased workload	<ul style="list-style-type: none"> • General patients 	<ul style="list-style-type: none"> • General patients are also to be seen by us (doctors) • Outpatient department full of general patients
	<ul style="list-style-type: none"> • MHCU 	<ul style="list-style-type: none"> • Every patient care for mental health care users is filling forms • Assessing patients, fill doctor's notes and again fill the many forms • Assessment of one person by two people • Psych patients treated so special.
3. Knowledge deficit regarding Mental Health Care Act No. 17 of 2002.	Lack of orientation	<ul style="list-style-type: none"> • No workshops • Lack of explanation about forms for psychiatric patient/MHCU's • Doctors do not know how to fill forms • Forms dropped to doctors

		<ul style="list-style-type: none"> • Not knowing that there are two forms MHCA 05 to compare if findings concur with each other • Does not understand the use of the Act, unaware it is to protect MHCU • Forgetting what was taught at school
4. Impact/implications	Poor patient/quality care	<ul style="list-style-type: none"> • Copying from nurse and vice versa • Copying from one another doctor from nurse and vice versa • Not examining the patient, but just feeling forms
5. Burnout	Medical doctors frustrations	<ul style="list-style-type: none"> • Frustrated by filling forms • It feels like it is a punishment • Fear to be laughed at • Refusal of allocation • Lack of ownership • Lack of responsibility • Lack of willingness • Poor attendance to related meetings • Lack of interest in working in MHC unit
6. Recommendations	Capacity building	<ul style="list-style-type: none"> • Need for mentorship • Need for explanation of the Mental Health Care Act No.17 2002 • Need for more workshops for doctors • Need for exposure/allocation of every community service doctor in psychiatry/mental health units • Need for rotation of medical doctors in mental health units • Need for continuous in-service training

4.3.3. Discussion

Table 4.8 reflects the summary of themes, category and sub categories

From the analysed data, six themes emerged with categories and sub-categories. The themes that emerged are reflected in Table 4.10 as follows: lots of paper work, increased workload, knowledge deficit, impact/quality care, burnout and recommendations.

4.3.3.1. Theme 1: Lots of paper work

During interviews, participants described theme one which is lots of paper work as the main challenge making implementation of Mental Health Care Act No. 17 of 2002 unbearable.

It was noted with concern that doctors complained of managing MHCU using lots of paper work through filling many forms. Further, doctors complained about the instruction written at the bottom of MHCA 07, forms are filled for formality and the very forms themselves are confusing and cause frustration.

Further doctors indicated that they did not see any reason for clinical managers to be appointed in filling MHCA 07 as they do not see the patient, that they are overwhelmed by the prescripts of the Act and that every mental health care provision is filling of forms. One category was identified: Mental Health Care Act No. 17 of 2002 legal forms

Category: Mental Health Care Act No. 17 of 2002 legal forms

Doctors complained of filling many forms for mental health care users whereas other general patients do not have this many forms. In addition, the many forms are only filled for mental health care users throughout their care.

Narratives told around filling of MHCA forms by medical doctors' is that they felt implementing the Mental Health Care Act impossible, it is too much for them because the forms to be filled are too many and are confusing. Doctors indicated that from one Act there are many forms to be filled.

One participant said: *"I am just frustrated by the forms to be filled, but only for mental health patients, because other general patients do not have the legal forms they only*

have necessary admission forms, treatment sheet and consent form in case of surgical procedure and other investigations. Forms for psychiatric patients are so many. It looks like is one Act but there are lots of forms, and I mean forms. ...And yet one still need to fill admission forms like those of general patients on top of the MHCA form 07”.

Another participant said: “I usually do not want to talk about this Act and its forms because we are just made to fill many forms, and they end up not going anywhere: Why don’t we fill for other patients (general)? General patients have no forms to be filled but only the necessary admission forms, treatment sheet and consent form in case of surgical procedure and other investigations; where do these forms go? I am not prepared to look stupid. A rongo vhuya rafunzwa hezwi zwithu (during our time, this were never taught) during our time.

It looks like it is easy, but there are so many forms; and those forms need a lot of information to be filled, it’s too much for us, they will lead us into cheating.

Mmm!

There are forms like form number 05 and form number 07 filled by the Head of Health institution and many others”.

Another participant said: “Forms themselves are confusing, they are too many and need a lot of concentration to fill them. It is a hell lot of Job, especially when outpatient department is full. We are not coping with this forms really”.

Another participant said: “This is not a good experience for doctors, I am very worried about these forms. I think we must be given a platform to talk for ourselves. And I am concerned that we are filling forms, just for formality. With so many doctors involved really. Why are the psychiatric patients treated so special? I do not understand?”

According to the World Health Organisation (2005), dishonesty, when filling MHCA legal forms will not be entertained by the independent Ombudsmen appointed, according to the Mental Health Act, filling forms is one of the prescripts put in place in to protect the rights of mental health care users. Health professionals who think of cheating must know that it is punishable by law because MHRB are appointed to check that as well.

The concern of lots of papers was also found in another study by Ramlall et al. (2010) conducted in KwaZulu Natal Province, where it is reported that health managers

complained of too much paper work, and indicated that it leads to confusion and frustration to their staff members and that their staff do not have time to fill forms.

Doctors from a report by Edwards (2013) indicated that doctors are worried that they spend most of their time about 2/3, twice as much time on paper work, such as doing administration and management meetings about 17hours a week compared to 7hours spent on patients. This statement supports what doctors are relating in terms of filling forms although they are disregarding the importance of filling such forms.

According to Health professions council of south Africa (2014) it is a misconduct if South African health practitioners are found with ignorance such as failure to keep proper records, it a is a serious offence leading to disciplinary action and MHCA legal forms form part of patient records, meaning that if doctors fail to fill them or are found to have cheated, they are to face a disciplinary action.

Lee (2016) reported in support that doctors waste over 49, 2% of their time doing paperwork, which is two thirds of their time. According to Lee (2016), doctors say there is too much paperwork, taking their time to be with patients. This supports the narratives by medical doctors who disregard the fact that in the case of Mental Health Care Act forms, doctors are expected to fill them as they examine, or conduct such procedure that warrants them to fill according to the prescripts.

4.3.3.2. Theme 2: Increased workload

Increased workload was noted by participants, they indicated that since the inception of the Mental Health Care Act No. 17 of 2002 and its implementation in terms of admitting a mental health care user, Analysis of data revealed that two categories emerged from the theme:

- ✓ General patients
- ✓ Mental Health Care Users

Category one: General patients

Medical doctors' work is to assess patients who come to the hospital for consultations with different kinds of illnesses some of which are mental disorders. Discussions during interviews with participants described what was understood to be complains regarding

increased workload as they say there are other general patients to be seen in outpatient department, which is always full of general patients to be seen by them as well, yet mental health care users are to be admitted using a lot of MHCA forms, and also involving more than two medical doctors.

One participant said: *“Imagine with OPD full of general patients and mental health care users, and you sit with one patient assessing, writing doctor’s notes and thereafter patient’s notes and then mental health legal forms, it’s a lot of work really”*.

Another participant said: *“Our patients come to OPD without being referred either from the clinics or GP, they come in as much as they fall sick and want to see a doctor; majority don’t have money to go to the private doctors hence they come to our hospitals leaving our OPD full at all times and this calls for a lot of work; then with such a burden you are still expected to attend to mental health users”*.

Data indicated that medical doctors complained that they are overburdened because they are expected to see general patients of which outpatient department is always full. Doctors indicated that it feels like it is a punishment as they are yet expected to also assess mental health care users, write doctors notes and thereafter patients’ notes and again fill so many forms to admit a mental health care user. To medical doctors filling of forms has increased their workload.

In their study Chacko and Prabhavalkar (2014) indicated that doctor patient ratio differed according to shifts schedule, though catering clinical need which is likely to be the case in the context where this study was conducted, because doctors say their outpatient department is always full with medical patient. Average patient doctor numbers where Chacko and Prabhavalkar (2014) conducted their study were as follows: 8am-1pm, 3.5 patient is to 2 doctors, 1pm-5pm 10.5 patients to 3 doctors, 5pm -9pm 7 patients to 5 doctors, and lastly 9pm-8am 12patients to 2 doctors and in this study doctor patient ratio was not checked as it was not one of the objectives of the study.

Xu, Xie, Wu, Guo, Guo, and Feng (2016) are in support of the findings of this study as well as the study by Chacko and Prabhavalkar (2014) who reported that doctors’ workload is excessively high because they do clinical work, teaching, research and administrative tasks and that extra research work worsens the workload which already

is very heavy. Further they say excessive high workload leads to very little time for patient care and unsafe practice.

Gyorffy, Dweik, and Girasek (2016) also are in support of the findings as narrated by medical doctors in this study although doctors in this study did not indicate the issue of difficult work related situations. Gyorffy et al.(2016) reported that there is increased workload with less job satisfaction, leading to stress and difficult work related situations leading to mental health related symptoms and burnout to female physicians.

Category two: Mental Health Care Users

Participants were complaining that the job is too much for them because they are expected to see general patients, yet outpatient department is always full. They say they are to assess patients, fill doctor's notes and again fill the many forms. They expressed their dismay to say that every patient care for mental health care users is filling forms. Also, that assessment of one person meaning a mental health user is done by two people yet they both fill forms. Majority of doctors had a concern as to why psychiatric patients are treated so special.

One Participant said: *"This is not a good experience for doctors, I am very worried about these forms. I think we must be given a platform to talk for ourselves. And I am concerned that we are filling forms, just for formality. With so many doctors involved really. Why are the psychiatric patients treated so special? I do not understand?"*

Another Participant said: *"It is amazing that every patient care for mental health care users is filling forms. Also that assessment of one person meaning a mental health user is done by two people yet they both fill forms, isn't it too much? How come? I think people who wrote this Act did not apply their minds well, it does not work with lots of forms like this. So many people are made to be involved in one admission"*

According to what has been described by doctors, filling forms for every patient care in mental health care service is not justified. Also, that they assume they are just made to fill forms that are not going anywhere because to them the law is treating psychiatric patients so special and for what reason? They do not understand the reasons behind this.

The experience of doctors which they cited above, the many forms are increasing their workload. It felt too much for medical doctors to assess users, fill doctors' notes, and again fill the legal forms which, according to participants they are too many and difficult to understand.

Mental Health Care Users are treated according to the prescripts of the Mental Health Care Act No. 17 of 2002, as amended which provides for the following:

- That the prescribed requirements need to be met, and such requirement means filling forms according to classification in Mental Health Regulations (2002).
- It provides for the treatment, care, and rehabilitation of the mentally ill.
- It has set out different procedures to be followed in the admissions of such persons (South Africa, 2002).

Mkizei and Kometsi (2008) are in support that health professionals have high workload as they indicted that high workload for PHC workers fail them to cater for people with mental disorders.

According to Jeanne (2015) specialties such as internal medicine and psychiatry emphasise extensive exhaustive detailed history taking, systems or problem based assessments and plans, managing difficult patients with co-morbidities increasing more writing, now with added legal forms for mental health medical doctors feel that filling forms is overburdening them, and has increased their workload as well as involving so many doctors in the admission of one person, they feel it is unfair, and they do not say anything about the protection MHCUs rights.

4.3.3.3 Theme 3: Knowledge deficit

While continuing with interviews the theme cited above emerged from the data and it reflected that doctor's knowledge is limited with regards to filling MHCA forms when admitting and caring for mental health care users. Data from doctors' description yielded one category: Lack of orientation.

Category: Lack of orientation

Doctors described that they have not been consulted when the Act was put in place for implementation and they have not been workshopped on filling of such forms for mental health care users. The Mental Health Care directorate was cited as being unfair to them in that they did not orientate them yet it expects them to fill so many forms. They say forms were just dropped to them, not explained to them, no workshops, and they do not understand the use of the Mental Health Care Act No. 17 of (2002). They did not know the Act was put in place to protect the rights of mental health care users, and did not know that there are two MHCA 05 to compare findings if they concur. They were worried that there are no workshops and most of them say they have forgotten what was taught at school. The discussion I had with doctors described their experience of not having been workshopped as unkind/unpleasant to them.

One participant said: *“Illegal admission? How illegal? Is these for real that police can be called to arrest me to go and appear before the board? Why? I am not aware that this is mandatory. No, I do not want to work in psych, I do not want to work with the mental patients, that is not my area, Anhiswitivi swa le Psych (I do not know what is done in Psych). I am afraid”.*

Ohm! *“Are the form 05s two? I did not know that they are two, and that they are to be compared. I only wanted the reason why they brought the patient and the recommendation in that one form 05. Another thing is that instruction in form 07 which is written at the bottom of the form, lead us into making mistakes when you did not see that you have to erase or delete. It must be written on top and be bolded so that it can be easily seen before you start filling the form. Why are the psychiatric patients treated so special? I do not understand?”*

Another participant said: *“I was not aware that it is to protect the patients, because I once came across a woman who brought her son for admission, but the son looked well and answering questions well and accurately”. The mother complained that they did not give him the correct injection that makes him to just sit and quiet demonstrating by curling forward. The patient asked the mother if really she wants him to remain that way, and it was indicated that he is only given only ten (R10, 00) from his disability grant, so they want him admitted and remain eating his money”.*

Medical doctors described their experiences of lack of orientation to the Mental Health Care Act, indicating that forms were just dropped to them with no explanation, no workshops hence they do not see any reason to fill them. Medical doctors say they do not know how to fill them, some of them who sometimes act as HHE say they did not know that for one to take a decision on whether to admit or not, did not know they have to compare the findings from two MHCA form 05 filled by two mental health care practitioners. Doctors claim that there was no explanation about the forms, they were just dumped to them. Based on the findings, doctors do not understand the use of the Act and that it is used to protect MHCU. They also claim that they have forgotten what they were taught at school about mental health.

Furthermore, another doctor was not aware that the mother who said the doctor did not give his son the correct medication, indicating the correct injection that it is the one that make his son to just sit quietly, he did not realise that the mother wanted son to be admitted so that she remains eating his grant.

Jelinek, Weiland, Mackinlay, Gerditz, and Hill (2013) reported lack of knowledge and confidence in managing mental health related presentations, as barriers to implementation of mental health legislation among nurses and doctors working in Australia. Lack of knowledge in drawing care plans, assessing mental status of users, assessing self-harm and pharmacological management. The statement above is supporting lack of knowledge which was also the case in this present study as doctors reported that they were not orientated, they forgot what they were taught as well as forms where just dropped to them hence the development of a programme to capacitate them.

In their study Nugent, Hancock and Honey (2017) reported that occupational therapists corrected their identified lag in implementation by consciously, actively develop and putting in place orientation in their mental health practice. This statement shows that occupational therapists identified a gap, in their stream especially in mental health practice. It is clear that in mental health service provision, occupational therapists had a problem with it and so is our doctors in terms of knowledge of Mental Health Care Act No. 17 of 2002 and the skill of filling legal forms.

4.3.3.4 Theme 4: Impact/implications of non-compliance/not implementing

This theme emerged from information that was described as interviews continued with medical doctors. The discussions showed that actions impacted negatively on the quality

of patient care for MHCU. The following category emerged from the theme above: Poor patient care.

Category: Poor patient care

Doctors described their experiences which reflected that they did not examine the patients, but just filled the forms, they copied information from nurses and vice versa. They said these forms may lead them to dishonesty sometimes because they are many. As interviews continued, there were different ways of managing mental health care users when they are to be admitted in outpatient department. Other doctors indicated that they copied from one another i.e. from nurses and vice versa meaning that they copy assessment done by others without them assessing which is cheating. This kind of behaviour led to poor patient care. There were other doctors who indicated that the forms are too many such that they may lead one to dishonesty.

One participant said: "It makes us not to be honest sometimes, and copy from one another, because we are just filling the forms just for formality, because we do not see the patient, and one just check one form 05 and not see the patient, fill the forms for the sake of complying without understanding and even examining the patient. No one explained anything about the forms."

He further said "when I have to consult I am not honest sometimes, sometimes we do not see the patient really, copying what the nurse has written, and one just check one form 05 and not see the patient, fill the form 07 for the sake of complying without understanding and even examining the patient. No one explained anything to us about the forms, we forget what we were taught, and no one has interest in psych, yes I am talking specifically about myself"

Another participant said: Ok, but I am not responsible for mental health, the doctor allocated must see that forms are filled, we just admit. I do not know what to fill and what not to fill because the forms are too many, and is a lot of writing. There are forms like form number 05 for doctors and nurses and form number 07 filled by the Head of Health institution.

Health Professions Council of South Africa indicate that health care professionals registered with their council are required to uphold prescribed standards of professional and ethical behaviour. And such standards include insufficient care towards patient, like failure to assess and copy findings from others. They encourage users to lodge a complaint regarding such conduct (www.hpcsa.co.za).

Alegria, Canino, Rios, Vera, Calderon, Rush, and Ortega (2002) indicated that their specialty care was discriminatory, looking at ethnicity, income and wealth to allow a person to access and use mental health service, blacks receiving less than the poor non-whites. In the case of this study, it is clear that majority of doctors do not want to work with mental health care users nor be responsible in their care, and sometimes they do not assess them they just copy from one another impacting negatively to mental health care. This study revealed that doctors have no knowledge of Mental Health Care Act No.17 of 2002 and the legal forms thereof.

In a study by Jonsson, Moosa, and Jeenah (2009) their findings concur with the findings in this study in that they reported only 9.9% of records which were found to have been recorded physical condition by MHCP on arrival after MHCU were brought by police. Researchers reported that it may be the high workload or that MHCP were not examining MHCU.

Edwards (2013) is in support that due to lots of paper work, doctors do not have time with their patients, which in the case of mental health opposite is the case because doctors are expected to assess their patients as they fill forms. The researcher above reported that 44% of doctors believed that the standard of patient care will drop in the next 5 years because doctors do not have much time with their patients.

4.3.3.5 Theme 5: Burnout

Medical doctors' explained their experiences of frustrations when consulting mental health care users in outpatient especially where they are to be admitted. They expressed how difficult it felt when they were to fill admission forms for a mental health care user because they did not want to be involved. As interviews continued, data that described this difficulty was analysed, one category emerged: Medical doctors' frustrations.

Category: Medical doctors' frustrations

Medical doctors described how they became frustrated when the forms were dropped to them to fill and realised that they were expected to fill for every health care provision for mental health care users, including the very admission. They said they refused allocation, poor attendance of mental health related meetings, lacked interest in working in mental health care unit nor own it, did not want to be responsible for mental health care service, they feared that they will be laughed at on making mistakes.

Doctors described their experiences which reflected that they did not examine the patient, but just filled the forms, they copied information from nurses and vice versa. They said these forms may lead them to dishonesty sometimes because they are many. They indicated that they started to refuse whenever clinical managers allocate them to work with mental health care users. No one agreed to own mental health care unit such that users could not be seen if the ward doctor at that time is on leave. Doctors indicated that they did not have any interest in mental health care service and they were not prepared to compromise. Senior medical doctors feared that if they fill such forms wrongly they will look stupid and be laughed at by young doctors.

One participant said: *"No one is willing to take ownership, nor responsibility. If ward doctor who agreed to work in psych is not there, mental health care users may not be seen whilst in the ward. Doctors are not interested; they are not prepared. Doctors do not know how to fill those forms"*.

Another participant said: *I mean the curricula is ok, we just don't have interest in psych, and there is need to increase time: These things are not meant for us, and mmm! By things I mean the explanation about the Mental Health Act"*.

I am just frustrated by filling these forms (stressed aggressively the word forms) for psychiatric patients. Because other general patients do not have the forms to be filled but only the necessary admission forms, treatment sheet and consent form in case of surgical procedure and other investigations.

Listening to participant's lack of interest and responsibility made the researcher to ask oneself whether participants are aware of existence of the Mental Health Care Act (2002) because according to Wall et al. (1999) the key changes in the 2005 Guide were rewritten in plain language to ensure that communities, Review panels, police, physicians and

hospital staff understand their roles in order to protect patients' rights and appropriate admissions as well as leave of absence.

A study by Ramlall et al. (2012) conducted in KwaZulu Natal province, supported the findings of this study as they reported that health managers complained of too much paper work, that it leads to confusion and frustration and that staff do not have time to fill forms. The statement above were narrated by medical doctors as they explain their experiences during implementation of the Act. They indicated that they are frustrated, they are not interested and do not want to be responsible.

Gyorffy et al. (2016) support the findings in this study where doctors stress their frustrations to an extent of refusing to be allocated to a mental health care unit indicating burnout. The above researcher reported that burnout is a leading challenge among female physicians of late because of increased workload and work related challenges. Lee (2016) indicated that many doctors were not satisfied while using electric health record and became frustrated and burnout, which may be because of high volume of electric health record or lack of understanding.

4.3.3.6 Theme 6: Recommendation

Medical doctors expressed different ways through which they are likely going to understand and have a skill for implementing the Act. Data collected during interviews revealed from the theme has only one category: Capacity building

Category: Capacity building

Doctors described the need for explanation of the Mental Health Care Act No. 17 of 2002. They felt that there is need for exposure/allocation for every community service doctor in mental health units. Rotation for doctors was also emphasised. It was expressed by doctors that they must take adequate responsibility in matters of mental health. They described failure to be explained about the MHCA forms and the Act as errors that needed to be mend by means of workshops, mentorship and supervision.

One participant said: *“That instruction at the bottom of form 07 must be written on top and be bolded because it guides us. Also I think there is need for more workshops and explanation about this Act to us doctors. I was not aware that it is to protect the patients, because I once came across a woman who brought her son for admission, but the son*

looked well and answering questions well and accurately. The mother complained that they did not give him the correct injection that makes him to just sit and quiet demonstrating by curling forward. The patient asked the mother if really she wants him to remain that way, and it was indicated that he is only given ten (R10, 00) from his disability grant, so they want him admitted and remain eating his money”.

Another participant: “Forms were not explained, it would not feel like is an extra job and filling forms just for formality and I was unaware it is to protect the mental health care users...Ohhh! ..“Is Ok, I was not aware, these things need to be explained to doctors, because I did not know what you have just explained, doctors need to be workshopped on this matter. We would not feel as if it is an extra job”.

The National department of health developed and passed the Mental Health Care Act No. 17 of 2002 and its regulations, which is the law which sets out when one can be admitted, detained and treated in hospital against your wishes. It is also known as being sectioned'. It is the one on which medical doctors must be workshopped. Also the department developed guidelines and procedure manual for the Review Board which will aid to guide the experts who are to workshop medical doctors. Mental Health Review Board Orientation Guideline and procedure Manual will also guide on the procedures/prescripts to be followed on completion of documents and checking documents before submission to the board (South Africa, 2007).

Nugent, Hancock and Honey (2017) reported of the orientation of occupational therapists in order to capacitate their professionals after realizing the gap identified. It is also the plight of the researcher that medical doctors be capacitated in order to close the gap of knowledge deficit as they verbalise issues of lack of explanation of the Act and lack of awareness that Mental Health Care Act is to be implemented in order to protect the rights of mental health care users hence the development of the programme to facilitate implementation of the Mental Health Care Act by medical doctors.

4.4 SUMMARY

The chapter presented and discussed the findings of this study. Presented the quantitative and qualitative results in tables of which findings were in percentages. In this study the researcher found that doctor's experiences are that there is increased workload, Mental Health Care Act and its forms were not explained to them. The findings revealed that there was lack of orientation leading to knowledge deficit making doctors to have fear in managing and or providing mental health care service. The researcher realised that there is need to close the knowledge deficit gap and frustration of doctors by developing a programme to facilitate implementation of the Mental Health Care Act No.17 of 2002 in order to enhance protection of the rights of mental health care users.

CHAPTER 5

5. PROGRAMME DEVELOPMENT

5.1. INTRODUCTION

Chapter four presented the results of the data collected concerning the knowledge and lived experiences of medical doctors when implementing the Mental Health Care Act No. 17 of 2002. In this chapter, attention will be given to the theoretical framework for the development and description of the programme to facilitate implementation of the Mental Health Care Act No. 17 of 2002 by medical doctors. Dickoff et al.'s (1968) survey list was used to integrate results of phase one of the study (the situational analysis) and this gave the structure for the theoretical foundation. This survey list was utilized to ensure logical development of the programme.

The study objective 3: To develop a programme to facilitate the implementation of the Mental Health Care Act No. 17 of 2002 based on the findings.

5.2. THE THEORETICAL FRAMEWORK FOR THE DEVELOPMENT OF THE PROGRAMME

The theoretical framework for the development of the programme was informed by the elements of practice theory outlined by Dickoff, James and Wiedenbach (1968). In this study the elements of practice are agents, context, recipients, process, dynamics and outcomes.

5.2.1 Context

The context is viewed from the aspect of the matrix of activity; it is seen in relation to other things, including persons and other activities, and to see the interrelation of these other factors as constituting an organism, unity, or total context of activity (Dickoff, et al.,

1968). In this study the context is the out-patient department of district hospitals designated as 72-hour assessment institutions, or those with a mental health unit, as well as a specialised hospital for mental health in the Vhembe District. This outpatient context operate within the following legislations: Health Professions Act, National Health Act 61 of 2003, Constitution of S. A Act 108 of 1996, Mental Health Care Act No. 17 of 2002 as amended, National core Standard for Health Care Service in South Africa 2011, Medicines and related substances amendment Act 2014. Bathopele principles in South Africa as well as National Mental Health Policy Framework and Strategic Planning 2013-2020. The analysed data revealed some elements within the entire context where implementation of the Mental Health Care Act No. 17 of 2002 should take place. The elements are: knowledge deficit, lots of paper work, increased work load, and burnout out. These elements influence the magnitude to which implementation of Mental Health Care Act is carried out by medical doctors and should also be taken into consideration. Fig. 5.1below illustrates the context.

OUT PATIENT CONTEXT



Figure 5.1 Illustration of the context.

5.2.2 Agents

An agent is any person whose activity leads to the realization of the goal (Dickoff et al., 1968). It emanates from the analysed data and literature reviewed to this point that the agents for the implementation of the Mental Health Care Act are mental health coordinator, psychiatrist, academic specialists, and mental health review board members. These agents are experts in mental health and have knowledge of the Mental Health Care Act and completion of the legal documents (MHCA forms) required by the Mental Health Act No.17 of 2002, when admitting, caring and discharging mental health care users. This is supported by Rycroft-Malone J, Harvey G, Seers K, Kitson A, McCormack B, Titchen A (2004) when they argue that agents are persons with specialty in the field with appropriate skills and knowledge to help individuals, groups and organisations apply evidence into practice. Fig 5.2 indicates the agents of this study. The agents should create an environment conducive for medical doctors to learn. The roles played by the agents need to be defined so that each one is aware of the duties of self and of the other to avoid conflict. They must be resourceful and comprehensive with skills and information required to support medical doctors and assist them towards the implementation of the Mental Health Care Act No. 17 of 2002.



Figure 5.2 Agents

5.2.3 Recipient: Who or what is the recipient of the activity?

Recipients are all those persons who receive action from agents and benefit from the activity (Dickoff et al., 1968). The findings in phase one of this study revealed that medical doctors have a knowledge and skills deficit regarding the implementation of the Mental Health Care Act No. 17 of 2002, thus recipients in this study are medical doctors. Medical doctors need to acknowledge the knowledge deficit that they have regarding the Mental Health Care Act No. 17 of 2002. Furthermore, they should take responsibility to learn as the agents will be capacitating them. They should learn that they need to be active in by interaction, participation and authentic collaboration with the agents. Medical doctors have a responsibility towards their own professional development.

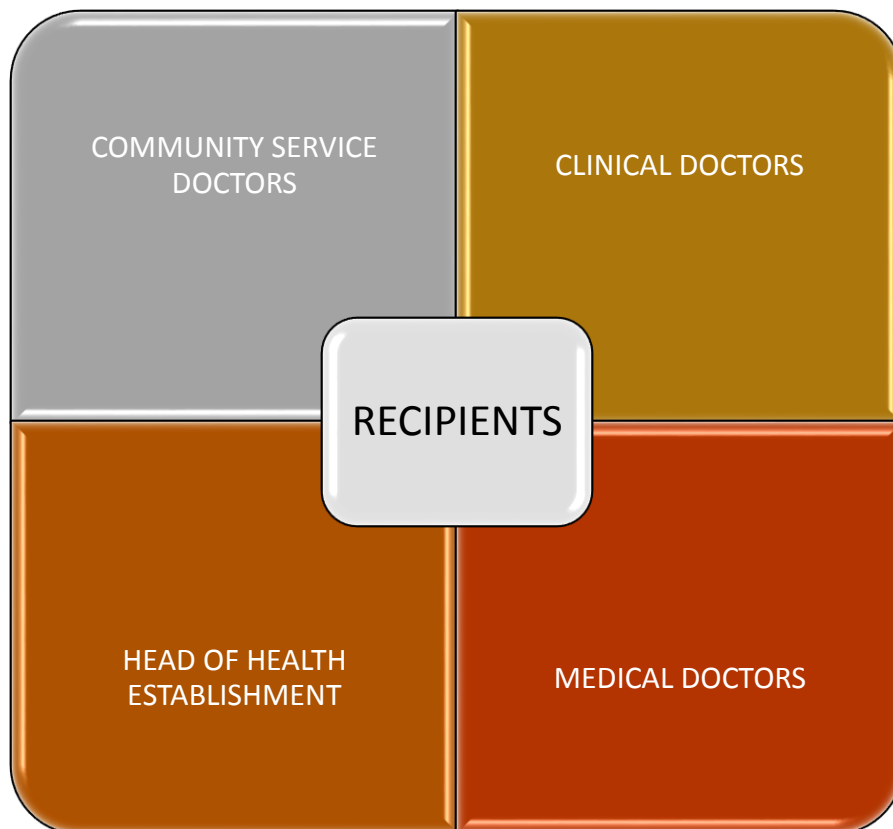


Figure 5.3 Recipients

5.2.4 Dynamics: What is the energy source of the activity?

Dynamics involve the power sources for that activity. These are the energy sources that motivate agents to pursue their activity without getting discouraged (Dickoff et al., 1968). The findings of this study indicate that medical doctors feel overwhelmed by the Mental Health Care Act. They experience the Act to involve lots of paperwork and an increased workload. Furthermore, the results reveal that medical doctors lack knowledge regarding the Mental Health Care Act. Medical doctors recommended that they be capacitated on the Mental Health Care Act in the form of in-service training, orientation and workshops. The dynamics of the programme are the agents and recipients' willingness, commitment, effective communication, mutual trust, participation, collaboration and reflective feedback. The dynamics are psychologically based, through interactive processes of self-awareness, relationship building and trust. Figure 5.4 indicates the dynamics. These dynamics are discussed below.

- Willingness and commitment

Medical doctors should be willing to be guided and empowered. They should also be willing to work towards self-development with the help of experts. They must be willing to consult when they need help. It is also very important for the experts to be willing to commit time and energy to capacity building activities. For empowerment to take place, agents and recipients must see the need for empowerment to be able to do something towards it. Both should be willing and committed to the process.

- Communication

The key to successful capacity building is the ability to communicate appropriately (Turner, 2006; Benner, 2008). The findings of this study reveal that doctors just saw forms dumped on their desks without any explanation about them. The experts can best understand the messages that the medical doctors convey by developing interactive listening skills, which involves clarifying, verifying and reflecting. One of the main components for learning and education should be learning how to communicate. There must be at all times, a two-way communication between the experts and medical doctors.

- Participation and collaboration

Both experts and medical doctors should feel obliged to actively participate in the capacity building activities, they need to commit themselves and be eager to see the empowerment working for the best results. Participation on the part of medical doctors, entails availing themselves for orientation, support, training and help when necessary.

Participation on the experts' entails realising their professional and moral responsibility towards the professional development of a medical doctor. There should be collaboration between the experts and medical doctors and such should receive acknowledgment of each other's responsibility.

- Reflection and feedback

Reflection and feedback analysis are essential dynamics of capacity building (Salami, 2008). In this study, it involves discussing what has gone right, starting with the medical doctor's views regarding Mental Health Care Act No. 17 of 2002 followed by the expert's views, and then discussion of what needs to be improved, again starting with medical doctors' views followed by those of the experts.

The above discussed dynamics are reflected by the hands holding together indicates meaningful interaction, willingness, commitment, effective communication, mutual trust, participation, collaboration and reflective feedback between experts and medical doctors in Figure 5.4 below.



Figure 5.4 Dynamics

5.2.5 Process: What is the guiding procedure?

The process involves the steps to be taken towards accomplishment. The process aims at providing sufficient information to enable the activity to be carried out. It safeguards the agent, recipient and the institution in that it provides knowledge and therefore lessens liability to criticism (Dikoff et al., 1968). The findings of this study reveal that 89.0 % of mental health care users were illegally admitted by medical doctors which could lead to litigations. Majority of medical doctors lacked knowledge regarding the Mental Health Care Act. Furthermore, the findings from situational analysis indicated that the developed programme to facilitate the implementation of the Mental Health Care Act by medical doctors could be enhanced by the following activities, namely: situational analysis; planning; implementation and evaluation. Figure 5.5 illustrates the process implementation.



Figure 5.5 Process

These activities in figure 5.5 are now discussed.

- Situational analysis

In this study, situational analysis is regarded to be the first step of the programme as it is a full and open communication with everyone affected. It is the interactive process by both the experts and medical doctors.

Experts prepare for the initial step of the operationalization of the programme where medical doctors's knowledge gaps and needs are identified regarding the Mental Health Care Act and the recognition for the quest for empowering them. Both experts and medical doctors enter into the interactive awareness process with clear objectives and goals. The focus is engagement, interaction and self-awareness of both parties, as described by Tobin (2007).

- Planning

The experts will define and communicate information regarding Mental Health Care Act, together with medical doctors set goals and strategies for implementation. The medical doctors should also come up with strategies as to how they are going to deal with problems or dynamics. Roles should be discussed as this may have adverse impact on individuals. These activities prepare the medical doctors for activities on the capacity building. The aim of the planning is to influence personal and professional development on the medical doctors' point of view to be willing to commit themselves. Through interaction, it is envisaged that experts and medical doctors will recognize, acknowledge and reach consensus about a problem situation and its intrinsic drivers, including programs' expected contribution.

- Implementation

At this level, intensive participation by experts and medical doctors is observed. The study findings revealed that medical doctors need to be orientated, workshopped, in-service trained and mentored regarding the Mental Health Care Act No. 17 of 2002 for them to be able to implement it accordingly. Experts mobilise resources to orientate, in-service train and provide workshops to medical doctors regarding Mental Health Care Act.

Experts, guided by Blooms Taxonomy Theory, create an informative and enabling environment in which sharing of knowledge occur among experts and medical doctors.

The experts create an enabling environment in which medical doctors learn reflective skills where cognitive (thinking), affective (feeling), and psychomotor (acting) domains of learning are examined. Each domain has behavioural competences that lead to the development of competencies.

Furthermore, the experts utilize the learning steps and the behavioural components to enhance reflecting on the learning of medical doctors. The learning steps are knowledge, comprehension, application, analysis, synthesis and evaluation. Medical doctors are engaged in dialogical discussions with creativity and open-mindedness and the experts being available for the medical doctors.

Evaluation

This is a very crucial stage where reflection process occurs. Medical doctors demonstrate self-reinforcing and self-enhancing through feedback, and learning as recommended by Tobin (2007). Intense discussions of identified knowledge acquired occur with feedback from individual medical doctor and expert takes place. The study findings indicate that medical doctors experience burnout regarding mental health care Act. At this stage, medical doctors internalize professional values through feedback that enhances change in behaviour for positive outcomes. This feedback leads to improved performance of individuals and meets goals and predetermined standards, which impacts on behaviour and performance. Salimi (2008) claims that during the reflection process, technical reflection and practical reflection are applied. In this study, medical doctors obtained knowledge and skills from experts and such is used to implement Mental Health Care Act when need arise.

The medical doctors and experts review practices and look back on their past experiences while learning and reflecting on the meaning. These individuals will begin to undertake some initiatives that indicate a certain level of empowerment with self-managed feedback that facilitate dealing with identified knowledge deficit. The above discussed process is illustrated in Figure 5.5 below.

5.2.6 Outcomes: What is the end point of the activity?

This involves defining an activity from the perspective of an end point, or its accomplishment (Dickoff et al., 1968). It is envisaged that the outcomes of this study representing the elements of recipients, agents and context, will be as follows:

Recipients: Outcomes for the recipients are competencies in implementing the Mental Health Care Act No. 17 of 2002.

Agents: For the agents, the outcomes are that they shall acquire lifelong learning in the form of teaching skills, responsibility and mentoring skills which enable them to be responsible, mentally sound and competent citizens.

Context: The quality patient care will be enhanced since medical doctors will be able to admit, care and discharge according to the Mental Health Care Act No. 17 of 2002.

It is envisaged that the litigations regarding illegal admissions of mental health care users will be reduced if not prevented. Secondly, hospitals shall contain quality mentally sound medical doctors with knowledge and skills required to respond to national and regional development imperatives regarding the Mental Health Care Act No. 17 of 2002.

5.3. PROGRAMME DEVELOPMENT

Based on the findings in Chapter four of this study, and the explanation given in the classification of elements of practice according to Dickoff, et al. (1968), the programme to facilitate the implementation of the Mental Health Care Act is discussed. The discussion is under the following headings as described by Chinn and Kramer (1999): the purpose of the programme, the theoretical departure assumptions of the programme, the relation statement and the nature of structure.

5.3.1. Purpose of the programme

The purpose of programme is to provide the experts in mental health population with the tools and mechanisms to cognitively capacitate and empower medical doctors for them to professionally manage their work in an effective way that contributes towards implementation of the Mental Health Care Act as prescribed.

5.3.2 Theoretical departure and assumptions of the programme

This programme departs from Bloom's Taxonomy of educational objectives (2001) as it advocates the cognitive processes when work with knowledge and the level of expertise required to achieve each measurable student outcome as described in chapter 1 of this study.

In this instance, it is acknowledged that knowledge is complex, can be overturned and is a process of reasoning based on empirical evidence. Therefore, based on the findings in chapter four, the focus should be orientation, workshops, in service training, peer coaching and mentoring of medical doctors regarding the Mental Health Care Act No. 17 of 2002.

It is assumed that with the programme to facilitate the implementation of Mental Health Care Act in place, experts will be able to empower medical doctors accordingly. Medical doctors will admit, care and discharge patients in a manner that does not compromise their profession, thus, improving quality care and prevent litigations.

Furthermore, patient care would be provided economically and efficiently, thus, realizing the concept of 'value for money' as explained in the Batho Pele Principles document (South Africa, 1995).

5.3.3 Relational statement of the programme

This is a description, explanation, or prediction of the nature of interaction between the concepts of the theory (Chinn & Kramer, 1999). The following relational statements are formulated for the programme to facilitate the implementation of a Mental Health Care Act by medical doctors:

- Implementation of the mental health programme is influenced by the context within which it exists; in this case, the context being the hospital.
- It involves interaction and participation between agents who are experts, recipients as medical doctors, and engages both in a responsible, meaningful and challenging action.
- It allows for those with needs to define those needs.
- Dynamics that drove the process of information sharing between experts and medical doctors willingness, commitment, effective communication, mutual trust, participation, collaboration and reflective feedback.
- The process to be taken towards implementation of the mental health care act are situational analysis; planning; implementation and evaluation.

5.3.4 The structure of the programme

According to Chin and Kramer (2008), the structure of the programme gives overall form to the conceptual relationships within it.

The structure of the programme was determined by bringing together the elements of practice identified and discussed in 5.2 above of this chapter. The structural form of the programme is the graphic illustration of how the elements of the programme relate to one another. The structure is reflected predominately on two graphic forms, namely, linear and rectangle. The arrows show how one element relates to the other. The rectangles represent unity, professionalism and team effort between agents and recipients. The different colours used in the diagram are meant to simplify the diction of elements and has no significant meaning attached to it. Figure 5.6 presents the structure of the programme to facilitate the implementation of the Mental Health Care Act by medical doctors.

HOSPITAL CONTEXT

OUT PATIENT CONTEXT

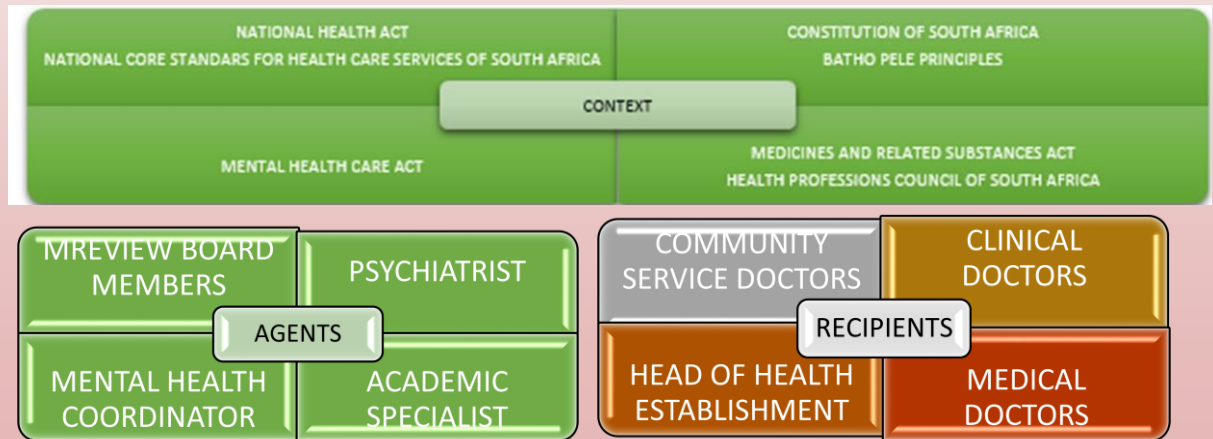


Figure 5.6. The structure of the programme to facilitate the implementation of the Mental Health Care Act No. 17 of 2002.

5.4 EVALUATION OF THE PROGRAMME

An evaluation of the programme was conducted in accordance with guidelines in Chinn and Kramer (2014). The criteria for programme evaluation by Chinn and Kramer (2014) were selected because the programme is based on empirical evidence. The five critical questions necessary for evaluation of the programme are as follows: How clear is the programme? How simple is the programme? How general is the programme? How accessible is the programme? How important is the programme?

5.4.1 How clear is the programme?

Six elements of the practice model according to Dickoff. *et. al.* (1968), that is context, agents, recipients, dynamic, procedure and purpose, were used as a basis for describing the programme. The major and related concepts formed the structure of the programme and therefore the structural clarity and consistency was met. The concepts within the programme are well connected and easy to understand as illustrated in different diagrams. In the structure, the relationship between concepts are clearly indicated in figure 5.6.

5.4.2 How simple is the programme?

The programme simplicity was achieved by keeping to the major and related concepts of the study. These concepts are Mental Health Care Act, implementation, empowerment, and capacitate. The researcher did not add new concepts as this would cause confusion. The number and differentiation of concepts is minimal, but sufficient to structure theoretic relations.

5.4.3 How general is the programme?

The programme was described as a response to the need for experts to empower medical doctors regarding the implementation of the Mental Health Care Act No. 17 of 2002. This study results indicate that medical doctors have knowledge deficit regarding the Mental Health Care Act No. 17 of 2002 during the admission, care and discharge of mental health care users. The programme was therefore developed to facilitate the

implementation of the Mental Health Care Act No. 17 of 2002 by medical doctors during admission, care and discharge of mental health care users. The developed programme can be applied to all hospitals that render care to mental health care users in South Africa. However, it can only be applied to mental health care users not general patients.

5.4.4 How accessible is the programme?

The programme would be made accessible to the hospitals where data was collected through workshops that would be conducted by the researcher where the programme would be implemented and evaluated. Workshops would be conducted with teachers at schools where the study was conducted. The district mental health directorate would be involved so that it would be easier to access other districts in the province. It would be possible to access the programme through library search, publications in accredited journals, attendance of seminars, and national and international conference presentations.

5.4.5 How important is the programme?

South Africa's government developed, passed and promulgated Mental Health Care Act No. 17 of 2002, which is the law which sets out certain procedures that must be followed by certain persons when one can be admitted, detained and discharged in hospital. Secondly, protection of people with mental illness and intellectual disability is a national priority.

Medical doctors were found to have knowledge and skills deficit regarding the implementation of Mental Health Care Act No. 17 of 2002 during care, admission and discharge of mentally ill patients. The programme would close the identified knowledge and skills deficit.

It is hoped that with the implementation of the Mental Health Care Act programme in operation that:

- The mental health experts would have a resource to refer and guide them regarding how to empower medical doctors regarding Mental Health Care Act.

- Medical doctors shall receive the necessary knowledge and skills required for them to admit, care and discharge mental health care users.
- Mental health care users shall be treated with respect and dignity, their rights protected and get the best quality mental health care.
- In addition, the hospital staff would have a resource to refer to regarding how implementation of the Mental Health Care Act by medical doctors could be facilitated.

The developed programme adds value to mental health practice and nursing and mental health research. Finally, the developed programme creates the gap for other researchers to conduct research when implemented.

5.5 SUMMARY

This chapter focused on the description of the programme to facilitate the implementation of the Mental Health Care Act No. 17 of 2002 by medical doctors. Emphasis was given to the description of the overview, purpose and structure of the programme. The structure of the programme included assumptions on which the programme was based, formulation of relation statement, the nature of the structure and the description of the process. The programme was evaluated in accordance with the criteria set out in Chinn and Kramer (2014). Chapter 6 presents the guidelines to 100 operationalize the developed programme.

CHAPTER 6

6. GUIDELINES TO OPERATIONALISE THE PROGRAMME

6.1 INTRODUCTION

The previous chapter focused on development and evaluation of the programme to facilitate the implementation of Mental Health Care Act No. 17 of 2002 by medical doctors during admission, care and discharge of mental health care users. The purpose of this chapter is to describe the guidelines to operationalise the programme.

6.2 GUIDELINES TO OPERATIONALISE THE PROGRAMME

The final step in programme development is the application of the programme (Chinn & Kramer, 1999). Application of the programme involves a description of guidelines to the programme is to be operationalised. The guidelines for programme to facilitate the implementation of Mental Health Care Act No. 17 of 2002 by medical doctors during admission, care and discharge of mental health care users is described according to the six elements of the practice programme as presented in chapter 5 of this study. The six elements of the practice programme are as follows:

- Guidelines pertaining to context
- The agents and recipients
- The procedure and dynamics and
- Outcomes or purpose.

6.2.1 Guidelines for the context

The following guidelines were derived from the data analysis as discussed in chapter 4. Data indicated that the context where implementation of the programme was expected to take place was the hospital.

- Hospital share professional knowledge and skills related to Mental Health Care Act by all stakeholders.
- Within hospital, professionals should also engage each other in a knowledge and skill clarification workshop where knowledge and skills are assessed for competency regarding implementation of Mental Health Care Act No. 17 of 2002 according to Blooms Taxonomy. These knowledge and skills influence the magnitude to which implementation of Mental Health Care Act is carried out by medical doctors and should so be taken into consideration.
- Acts and regulations should be applied in all health care services in hospital setting as prescribed by the law.
- The hospital as a unit should collectively inquire and look for information. Inquiry with regard to Mental Health Care Act issues should never be left to one profession as this may make that profession stop participating as sometimes the profession might feel overwhelmed.
- Participation at the outpatient and ward level should be all-inclusive and promote active participation by professionals.
- Strategies for strengthening the programme should be developed to ensure sustainability.
- Clear guidelines should be set for involving people with expertise during workshops to gain more current knowledge about Mental Health Care Act issues
- Collaboration with district mental health office at hospital level should be encouraged as they could be used as resource support at district level.
- The people who are in charge of support programmes for medical doctors should receive training through workshops about Mental Health Care Act No. 17 of 2002
- Collaboration with mental health experts within the hospital should be encouraged where medical doctors can go for assistance or information.

- The hospital should also coordinate with the district Mental Health Review Board to ensure that whatever the professionals are doing regarding mental health services are in line with the Mental Health Care Act.
- Hospital should also participate in district, provincial and national activities related to mental health. This will in turn ensure that hospital receive up-to-date information about mental health issues and implement mental health services correctly.
- The workload should be evenly distributed among medical doctors. The medical doctors responsible for mental health should have their allocation to other wards reduced as this makes them unproductive.

6.2.2 Guidelines for the agent and the recipient

The agents

- The agent who could be mental health coordinator, psychiatrist, academic specialists, and mental health review board members, should be aware of his/her own knowledge and skills about mental health care Act No. 17 of 2002.
- The agents should create an environment conducive for medical doctors to learn how to implement Mental Health Care Act without feeling overworked.
- The roles played by the agents in empowering medical doctors regarding Mental Health Care Act need to be defined so that each one is aware of the duties of self and of the other to avoid conflict.
- Agents must be resourceful and comprehensive with skills and information required to support medical doctors and assist them towards the implementation of a Mental Health Care Act No. 17 of 2002 as supported by Bloom's Taxonomy.
- The agents should take it upon themselves to look for more information about issues of Mental Health Care Act so that during capacitating medical doctors they have enough information to resolve misunderstandings that medical doctors might have and when agents display a high level of knowledge the medical doctors might learn to trust them.

- The agents should continuously support the medical doctors during admission, care and discharge of mental health care users to cover a wide range of issues related to implementation of Mental Health Care Act. Continuity would also stimulate more interest and understanding on mental health which would be beneficial to both the medical doctors and agents.

The recipients

- Medical doctors as recipients need to acknowledge the knowledge deficit that they have regarding the Mental Health Care Act No. 17 of 2002.
- Medical doctors have a responsibility towards their own professional development.
- Medical doctors they should take responsibility to learn as the agents will be empowering them
- They should learn that they need to be active by interaction, participation and authentic collaboration with the agents

6.2.3 Guidelines regarding the dynamics of the programme

The dynamics of the programme are the agents and recipients' willingness, commitment, effective communication, mutual trust, participation, collaboration and reflective feedback. The guidelines to operationalise these dynamics are described as follows:

Willingness and commitment

- Medical doctors should be willing to be guided and empowered.
- They should also be willing to work towards self-development with the help of experts.
- They must be willing to consult when they need help.
- Experts should be willing to commit time and energy to capacity building activities.
- For empowerment to take place, agents and recipients must see the need for empowerment to be able to do something towards it.
- Both should be willing and committed to the process.

Communication

- The experts and medical doctors can best understand the messages that each other convey by developing interactive listening skills, which involves clarifying, verifying and reflecting.
- Bloom's Taxonomy argue that one of the main components for the learning and education should be learning how to communicate. There must be at all time, a two-way communication between the experts and medical doctors.

Participation and collaboration

- Both experts and medical doctors should feel obliged to actively participate in the capacity building activities.
- They need to commit themselves and be eager to see the empowerment working for the best results.
- Participation on the part of medical doctors entails availing themselves for orientation, support, training and help when necessary.
- Participation on the experts' entails realizing their professional and moral responsibility towards the professional development of a medical doctor.
- There should be collaboration between the experts and medical doctors and such should receive acknowledgment of each other's responsibility.

Reflection and feedback

- Both experts and medical doctors should engage in discussing what has gone right, starting with the medical doctor's views regarding Mental Health Care Act No. 17 of 2002 followed by the expert's views, and then discussion of what needs to be improved, again starting with medical doctors' views followed by those of the experts.

6.2.4 Guidelines regarding the process

The programme to facilitate the implementation of the Mental Health Care Act No. 17 of 2002 by medical doctors could be enhanced by the following process, namely: situational analysis; planning; implementation and evaluation. These activities are discussed.

Situational analysis

- The first step of the programme is a full and open communication with everyone affected.
- Experts prepare for the initial step of the operationalization of the programme where medical doctors' knowledge gaps and needs are identified regarding the Mental Health Care Act and the recognition for the quest for empowering them.
- Both experts and medical doctors enter into the interactive awareness process with clear objectives and goals. Through interaction, it is envisaged that experts and medical doctors will recognize, acknowledge and reach consensus about a problem situation and its intrinsic drivers, including programs' expected contribution.

Planning

- The experts will define and communicate information regarding Mental Health Care Act No. 17 of 2002.
- Experts and medical doctors set goals and strategies for implementation. The aim of the planning is to influence personal and professional development on the medical doctors' point of view for them to commit themselves
- The medical doctors should also come up with strategies as to how they are going to deal with the challenges or dynamics.
- Roles should be discussed as this may have adverse impact on individuals. These activities prepare the medical doctors for activities on the capacity building.

Implementation

- At this level, intensive participation by experts and medical doctors is observed.
- Experts mobilise resources to orientate, in-service train and provide workshops to medical doctors regarding Mental Health Care Act.

- Experts create an informative and enabling environment in which sharing of knowledge occur among experts and medical doctors.
- The experts create an enabling environment in which medical doctors learn reflective skills where cognitive (thinking), affective (feeling), and psychomotor (acting) domains of learning are examined.
- The experts utilize the learning steps and the behavioural components to enhance reflecting on the learning of medical doctors. The learning steps are knowledge, comprehension, application, analysis, synthesis and evaluation.
- Medical doctors are engaged in dialogical discussions with creativity and open-mindedness and the experts being available for the medical doctors.

Evaluation

- Medical doctors internalize professional values through feedback that enhances change in behaviour for positive outcomes. This feedback may lead to improved performance of individual medical doctors regarding implementation of Mental Health Care Act No. 17 of 2002.
- The medical doctors and experts review practices and look back on their past experiences while learning and reflecting on the meaning.
- Medical doctors should begin to undertake some initiatives that indicate a certain level of empowerment with self-managed feedback that facilitate dealing with identified knowledge deficit.

6.2.5 Guidelines in terms of the outcome of the programme

It is envisaged that the outcomes representing the elements of recipients, agents and context, will be as follows:

- Recipients are competent in implementing the Mental Health Care Act No. 17 of 2002.
- Agents shall have acquired lifelong learning in the form of teaching skills, responsibility and mentoring skills which enable them to be responsible mentally sound and competent citizens.

- Context shall enhance quality patient care since medical doctors will be able to admit, care and discharge mental health care users according to Mental Health Care Act No. 17 of 2002.
- It is envisaged that the litigations regarding illegal admissions of mental health care users will be reduced if not prevented.
- Hospitals shall contain quality competent medical doctors with knowledge and skills required to respond to national and regional development imperatives regarding Mental Health Care Act No. 17 of 2002.

6.3 SUMMARY

Chapter 6 discussed the operationalisation of the programme. The guidelines to operationalise the programme were described in accordance with the elements of the practice model as described by Dickoff, et al (1968). Chapter 7 focuses on evaluation, justification, limitations, conclusion and recommendations.

CHAPTER 7

7. EVALUATION, JUSTIFICATION, CONCLUSION AND RECOMMENDATIONS

7.1 INTRODUCTION

The previous chapter presented the guidelines to operationalize the programme to facilitate the implementation of the Mental Health Care Act No. 17 of 2002. In this final chapter, focus is on the evaluation of the study in terms of its ability to meet the objectives as set out in Chapter 1. Furthermore, justification of the study as to its original contribution to the body of knowledge and conclusion is described.

7.2 EVALUATION OF THE STUDY

The study is evaluated against its purpose and objectives as set out in Chapter 1.

7.2.1 The purpose of the study

The purpose of the study was to develop a programme to facilitate the implementation of Mental Health Care Act No. 17 of 2002 by medical doctors in Vhembe district hospitals with a mental health unit and a specialised mental hospital.

The knowledge of doctors was determined and their experiences were explored regarding the implementation of Mental Health Care Act No. 17 of 2002 during admission of mental health care users.

- Programme development

The findings of situational analysis (Phase1), literature review and the theoretical framework for the development of the programme formed the basis of the development of the programme. The programme was developed in an interactive interventive manner. The programme was developed according to Dickoff et al.'s (1968) framework as the practice survey list.

- Programme evaluation

The programme evaluation was conducted using Chinn and Kramer's (2014) questions relating to the programme's clarity, simplicity, generalisability, accessibility and value.

7.2.2 The objectives of the study

The objectives of this study was to:

- determine knowledge of doctors on the implementation of Mental Health Care Act No. 17 of 2002 during admission of mental health care users
- explore the experiences of medical doctors regarding the implementation of the Mental Health Care Act No. 17 of 2002.
- develop a programme to facilitate the implementation for the Mental Health Care Act No. 17 of 2002 based on the findings.

The study approach was done in two phases. Phase one was situational analysis and Phase two was the development of a programme. In Phase one, the situational analysis was done by means of a quantitative and qualitative designs. In Quantitative design, document review using checklist was adopted as an instrument to collect data in order to answer objective 1. Data was analysed through the SPSS statistical and ranked in frequency tables and percentages.

In qualitative design, data was collected through in-depth individual interviews with medical doctors and analysed according to Tesch's open coding method in order to

answer objective 2. Data was provided from which the themes, categories and sub categories emerged.

Dense descriptions on the findings were also done against relevant literature. Central to the results elicited from the participants, it was identified that medical doctors lack knowledge regarding the implementation of the Mental Health Care Act No. 17 of 2002. The study identified that there is a need to empower medical doctors in a form of orientation, workshops and training for them to implement the Mental Health Care Act accordingly.

In Phase 2, the results of the situational analysis and literature gave direction to the development and description of the programme. The survey list of the practice model of Dickoff et al., (1968:434) was used as a framework for programme development. The developed programme was piloted and evaluated to assess its effectiveness. Chinn and Kramer's (2014) criteria were used to describe and evaluate the programme. This was done to answer objective 3 of the study.

7.3 LIMITATION OF THE STUDY

This study was restricted to hospitals in the Vhembe district only out of the five districts of the Limpopo province. The study data does not represent all practitioners involved in the implementation of the mental health care Act No. 17 of 2002.

7.4 ORIGINAL CONTRIBUTIONS OF THE RESEARCH FINDINGS TO THE BODY OF KNOWLEDGE

This study was conducted at the time when the protection of the rights of people living with mental illness in the department of health was a primary objective as it relates with

national priority. This study identified and explored the knowledge gap dimension of empowerment required by medical doctors to render quality patient care.

The findings reveal that there are expert's silos in the knowledge regarding implementation of Mental Health Care Act No. 17 of 2002. There is no deliberate focus on enhancement empowerment of medical doctors. Secondly, the efforts of each expert do not complement each other.

The findings suggest that a deliberate team effort should be made looking at all dimensions of capacity building of the medical doctors. It further suggests that such effort should be interdisciplinary and should be coordinated so that the impact thereof should be measured.

Capacity building of medical doctors regarding Mental Health Care Act No. 17 of 2002 is not accommodated within the current medical doctors' support programmes. The feasibility and the development of a programme of facilitation in Vhembe district have not been explored before. Based on the findings from participants, a programme to facilitate the implementation of the Mental Health Care Act No. 17 of 2002 by medical doctors was developed which proposes capacity building and team work.

7.5 CONCLUSION

From the study, it was confirmed from other authors that more often than not, medical doctors are not aware of the how to implement Mental Health Care Act No. 17 of 2002. District is dealing with substantial challenges posed by illegal admission, care and discharge of mental health care users. The study participants recommended that medical doctors should be empowered regarding the implementation of Mental Health Care Act. Furthermore, they indicated that empowerment should be in the form of ongoing workshops, orientations and in service training by the mental health experts.

Based on the findings, it was important to develop a programme to facilitate the implementation of the Mental Health Care Act by medical doctors. The developed programme reinforces the philosophy that medical doctor knowledge on mental health

issues should be a shared concern and responsibility within the district mental health experts.

This is a significant contributor in supporting the vision of national department of health to ensure improved mental health for all in South Africa.

7.6 RECOMMENDATIONS

The recommendations of this study are discussed according to research and practice.

7.6.1 Recommendations for further study

The following are recommendations for further study:

- A longitudinal study, tracking the impact of a developed programme the knowledge of medical doctors regarding the implementation of the mental health care Act No. 17 of 2002, and its contribution to the improvement of mental health for all should be conducted over a period of 5 to 10 years.

7.6.2 Recommendations for Practice

It is recommended that implementation of Mental Health Care Act No. 17 of 2002 should be packaged in the medical doctor support programme. The hospital medical doctors' orientation programmes should deliberately include an objective designed to familiarize medical doctors with the Mental Health Care Act No.17 of 2002.

Orientation, in service training, workshops and mentoring regarding the implementation of the Mental Health Care Act should all be ways in which mental health experts capacitate medical doctors.

Positive rapport may be built by having mental health experts and medical doctors interact on a professional network forum. Purposeful and strong efforts are needed to break down professional silos as all of these disciplines serve mental health care users. Experts and medical doctors should operate in a collaborative complementary manner towards the improvement of quality of life of mental health care users.

7.7 SUMMARY

This chapter provided conclusions of the study. An account of how the overall purpose and objectives of the study were achieved was given. Justification in terms of the study original contribution to the body of knowledge and recommendations of the study were also given. In the final analysis the study found that the set of objectives were relevant in the study. The formulated programme will actually enhance compliance with the Mental Health care Act No. 17 of 2002. The Mental health care Users will be care for better than before. It is believed that the implementation of the programme will benefit the Department of Health, doctors, and mental health care users not only from Vhembe District but South Africa in general.

8. LIST OF REFERENCES

Algeria, M., Canino, G., Rios, R., Vera, M., Calderon, J., Rusch, D., Ortega, A. N. (2002). *Mental Health Care for Latinos: Inequalities in use of Specialty Mental Health Services among Latinos, African Americans, and non-Latino whites*. American Psychiatric Association Publishing.

America (Republic) 2014. *Regulations impacting community ... Fact Sheet on America's College Promise Act, Community College Legislative Priorities (Green Sheet)*. Government printer. <https://www.acct.org/fact-sheets-and-summaries>.

Anderson, L.W. & Krathwohl, D.R. (2001). *A taxonomy for learning, teaching, and assessing: a revision of Bloom's taxonomy of educational objectives*. New York: Longman.

Babbie, E. R. (2013). *The Basics of Social Research 6th Edition*. Cengage Learning.

Babbie, E. R. & Mouton, J. (2001). *The practice of social research*. Oxford University Press. Cape Town.

Bolis, M. (2002). *The impact of Caracas Declaration on the modernization of mental health legislation in Latin America and the English-speaking Caribbean*. Pan America Health Organization.

Botes, A.C, Nolte, A. G. C, & Poggenpoel, M. (2004). *Research Methodology*. Johannesburg: Rand Afrikaans University.

Brink, H.I. (2012). *Fundamentals of Research for Health Care Professionals*. Cape Town: Juta & Company Ltd.

British Columbia (Republic). *Mental Health Act (1983)*.

https://www.cqc.org.uk/sites/default/files/mental_health_act_1983_20a_201507.pdf.

Burns, K.J. (2008). *Implementation of Mental Health Care Act (2002) at district hospitals in South Africa: Translating Principles into practice*.

www.Ajol.info/index.php/samj/article/download/13944/58747, 2008, Vol.98, No.1 SAMJ.

Burns, N. & Grove, K. S. (2011). *The practice of nursing research*. St Louis Missouri: Saunders.

Catalano, R.F., Hawkins, J.D., Berglund M.L., Pollard J.A. & Arthur, M.W. (2002). *Prevention science and positive youth development: competitive or cooperative frameworks?* Journal of Adolescent Health, December 2002 Volume 31, Issue 6, Supplement, Pages 230-239.

Chacko, S & Prabhavalkar, S. (2014). *Doctor-Patient Ratios and Acute Medical Admissions: A Simple Solution for Important Problem!* UMJ, published By the Ulster Medical Society.

Chinn, P. L. & Krammer, M.K. (1999). *Theory and Nursing: A systematic approach*, 5th edition. St. Louis: Mosby Company. Commonwealth Small States: *Issues and Prospects*. Association 2007- Commonwealth Secretarial.

Chinn, P. L. & Krammer, M.K. (2014). *Knowledge development in Nursing: Theory and process*. Elsevier, Health Sciences, Copyright.

Chodoff, P. (1984). *Involuntary hospitalization as a moral issue*. Am J Psychiatry 141(3) 384-389.

Creswell, J.W. (2009). *Research design 3rd Edition* University of Nebraska-Lincoln: Sage.

Dhanda, A. (2005). *The right of treatment of persons with psychosocial disabilities and the role of the courts*. International Journal of Law and psychiatry 28 (2) 155-170.

De Vos, A. S, Strydom, H, Fouché, C. B, Delport, C. S. L. (2011). *Research at grass roots: For the Social Science and Human services Professions*. Pretoria. Van Schaik.

De Vos, A.S. (2011). *Research at grass roots: for the social sciences and human services professions*. Van Schaik Publishers. Pretoria. 4th Edition.

De Vos, A.S. (2005). *Research at grass roots: for the social sciences and human services professions*. Van Schaik Publishers. Pretoria.

Dickoff, J., James, P. & Wiedenbach, E. (1968). *Theory in a practice discipline*. Part 1: Practice Oriented Theory. Nursing research, 17(5): 415-435.

DU Plooy G. M. (2009). *Communication research, Techniques, Methods & application*, Cape Town. Juta.

Dutta, A. B. & Oration S. (2011). *The Long March of Mental Health Legislation in Independent India. L. P., Stand of Indian psychiatric society on the Draft of Mental Health Care Act, delivered at IPS-WZ Conference at Goa*, published by Goa Psychiatry Society. 2001.

Essack, S. & Juwah, C. (2007). Peer facilitated mentoring in higher education: Enhancing the quality of learning for the first-year students. *International Online journal of Learning and teaching in Higher Education*, 1 (1):48-67.

Edwards, A. (2013). *Doctors spend more than twice as much time on Paper work than patients...and almost a third do not see a future for MHS*, <http://www.dailymail.co.uk/news/article-2431296/Doctors-spend-twice-time-paperwork-patients-THIRD-future-NHS.html>.

European Union commission (2001).

Faunce, T.A (2005). *Will international human rights subsume medical ethics? Intersections in the UNESCO Universal Bioethics Declaration*. *Journal of medical ethics*, 31(3): 173-178.

Fistein, E.C., Holland, A.J., Clare, I.C. H. & Gunn, M.J. (2009). *A comparison of mental health legislation from diverse Commonwealth jurisdictions*. *International Journal Law Psychiatry*. 2009 May; 32(3): 147–155.

Freeman, M. (2002). *New mental health legislation in South Africa –principles and practicalities: A view from the Department of Health*. *South African Psychiatry Review*, 5(3):4-8.

Georffy, Z., Dweik, D. & Girasek, E. (2016). Work-load, Mental Health and Burnout indicators among female physicians. *Human Resource for Health* 14:12

Hall, L. M & Duval, M. (2004). *Neurosemantic coaching for the next generation Executives.HR Future*, January 2004: 46.

Health Professions Council of South Africa, (2008). *Guidelines for good practice in the health care professions ethical and professional rules of the health professions council of South Africa*, Government gazette r717/2006, Pretoria.

Howe, B (1993). *Psychological Skills and Coaching. Sport Science Review*, 2(2), 1993:3047.

Jeanne, T. (2015). *How much paperwork do doctors do after seeing a patient?* <http://www.Quora.com/How-much-paper-work-do-doctors-do-after-seeing-patients/answer/Tom-Jeane#>.

Jelinek, G.A., Weiland, T.J., Mackinlay, C., Gerditz, M. and Hill, N. (2013). *Knowledge and confidence of Australian emergency department clinicians in managing patients with mental health-related presentations: findings from a national qualitative study. International Journal of Emergency Medicine*.6 (2) <http://doi.org/10.1186/1865-1380-6-2>.

Johnson, G., Moosa, M.Y.H, & Jeenah, F. Y. (2009). *The Mental Health Care Act: Stake holder compliance with section 40 of the Act. South African Journal of Psychiatry* 15(2): 37-42.

Kigozi, F., Ssebunnya, J., Kizza, D. & Ndyabangi, S. (2008). *A situational analysis of the mental health system in Uganda*. Unpublished research report www.psychiatry.uct.ac.za/mhapp.

Kigozi, F.N & Ssebunnya, J. (2009). *Integration of mental health into primary health care in Uganda: opportunities and challenges*. *Mental Health Family Medicine*. Vol. 6 (1): 37-42.

Kleintjies, S, Lund C & Flisher A. J. (2010). *A situational analysis of child and adolescent mental health services in Ghana, Uganda, South Africa and Zambia*, www.ajol.info/index.php/ajpsy/article/download/54360/42879, *African Journal of Psychiatry* 54360-88159-1-PB.pdf.

Le Compte, M.D. & Preissle, J. (1993). *Ethnography and Qualitative Design in Educational*, London: Academic Press.

Lee, B. Y. (2016). *Doctors Wasting over Two Thirds of Their Time Doing Paper work*, *Pharma & Healthcare /#Medicine*. Forbes.

Lund C., Stein D. J., & Flisher, A. J. (2010). *Challenges faced by South African health services in implementing the Mental Health Care Act*, *South African Medical Journal*, www.samj.org.za/index.php/samj/article/download/738/226.

Licoln, Y.S. & Guba E.G. (1985). *Naturalistic enquiry*. London: Sage Publication.

Lund, C. (2007). *Challenges faced by South African health services in implementing Mental Health Care Act*, www.samj.org.za/index.php/samj/article/download/738/226.
McCrea, N. L. (2010). *An Analysis of South Africa's Mental Health Legislation*. *National Law Forum*.
http://digitalcommons.wcl.american.edu/cgi/viewcontent.cgi?article=1006&context=stusch_winners.

Medical Dictionary for the Health Professions & Nursing (2012). © Farlex.

Mkizei, N. & Kometsi, M. (2008). *Community Access to Mental Health Service: Lessons and Recommendations*. http://www.hst.org.za/uploads/files/chap7_08.pdf.

Mouton J. (2002). *Understanding Social Research*. Van Schaik, Publishers.

Mouton, J. & Marais, H, C. (1996). *Basic concept in methodology of Social Science*. Johannesburg: Human Research Council.

Mdluli, M. (2005). *A psycho-educational model for facilitation of self-discipline for educators in rural township schools*. Unpublished Doctoral Thesis. UJ.

Narayan, C. L., Narayan, M., & Shikha D. (2011). *The ongoing process of amendments in MHA-87 and PWD Act-95 and their implications on mental health care*. *Indian Journal of Psychiatry* 2011 Oct-Dec 53(4): 343-350. http://doi.org/10.4103/0019_5545.91910.

Naughton, J. (2002). *The coaching boom*. *Psychotherapy Networker*, July/August 2002:2433.

Njenga, F. (2002). *Focus on psychiatry in East Africa. The British Journal of Psychiatry*, 354-359.

Nugent, A., Hadock, N., & Honey, N. (2017). *Developing and sustaining recovery-Orientation in Mental Health Practice: Experiences of Occupational Therapists*. The University of Sydney, Cumberland Campus, 74 East St., Lidcombe, NSW 2141, Australia.

Polit, D. F & Hungler, B.P. (2013). *Nursing Research: Principles & methods*, 6th ed. Philadelphia, Lippincott.

Polit, D. F & Beck, C. T. (2008). *Nursing Research: Generating and Assessing Evidence for nursing practice*. Lippincott Williams & Wilkins.

Ramlall, S & Chipps, J. (2012). *Impact of the Mental Health Care Act No. 17 of 2002 on designated hospitals in Kwazulu-Natal: Trials and triumphs*. 2002- 2012.

Rouse, D.P. (2007). 'Computer-assisted instruction: an effective instructional method', *Teaching Learning in Nursing*, Vol. 2, pp.138-143.

Rycroft-Malone J, Harvey G, Seers K, Kitson A, McCormack B, Titchen A. (2004). *An exploration of the factors that influence the implementation of evidence into practice*. *Journal of Clinical Nursing*, Nov; 13(8):913-24.

Salami, S.O. (2008). *Psychological factors as predictors of mentoring among nurses in Southwestern Nigeria*. *Journal of Workplace Learning*, 20(5):348-365. www.emeraldinsight.com/1366-5626.htm.

Sameed, S. (2014). *A presentation on Mental Health Acts India*. Published on Mar 19, 2014 www.slideshare.net/saminsameed/mental-health-acts-india-drsamin-sameed.

Seloilwe, E.S & Thupayagale-Tshweneagae (2007) *Community mental health care in Botswana: Approaches and opportunities*. *International Nursing Review* 54, 173-178.

Shanoor, S. (2013). "*India's Mental Health Challenge*" *The Wall Street Journal*: viewed 26 May 2014, from <http://blogs.wsj.com/indiarealtime/2013/10/21/indias-mental-health-challenge> (*Indian J Psychiatry*, v.53 (4); Oct-Dec 2011).

South Africa (Republic) (2002). *Mental Health Care Act No. 17 of 2002*. Pretoria: Government Printer.

South Africa (Republic) (1995). *White Paper on Transforming Public Service Delivery*. Pretoria: Government Printer.

South Africa (Republic) (1996a). *Constitution of the Republic South Africa Act, of 1996*. Pretoria: Government Printer. 108

South Africa (Republic) (2007). *Mental Health Review Board Orientation Guideline and Procedure Manual: 2007*. Pretoria: Government Printer.

Speziale, H.J.S. & Carpenter, D.R. (2007). *Qualitative Research in Nursing, Advancing the Humanistic Imperative*. 4th Edition. Philadelphia: Lippincott Williams and Wilkins.

Straussner, S.L.A., & Spiegel, B. R. (1996). *An analysis of 12-step programs for substance abusers from a developmental perspective*. *Clinical Social Work Journal*, 24 (3), 299-309.

Streubert, H.J. & Carpenter, D.R. (2011). *Qualitative Research in Nursing. Advancing the humanistic imperative*. Philadelphia: JB Lippincott.

Tesch, J. (1994) (in Creswell, J W 1994). *Research design: Qualitative and quantitative approaches*. London: Sage.

Tobin, M.J. (2007). Will that be one mentor or two? A cross-sectional study of women's mentoring during college. *Mentoring and Tutoring*, 12(6):111-120.

Turner, F. (2006). *Social work Treatment Interlocking. Theoretical Approaches*. New York: The Free Press.

United States Public Health Service. (2001)
http://publications.europa.eu/com/COM_2001_524.

Turunen, M., Tayinbo, O., Putus, T., Nevalainen, A., Shaughnessy, R. & Shaughnessy, U. (2014). *Indoor environmental quality in school buildings, and the health and wellbeing of students*. *International Journal of Hygiene and Environmental Health*. Volume 217, Issue 7, September 2014, Pages 733-739.

Valanis, B.G., Glasgow, R.E., Mullooly, J., Vogt, T.M., Whitlock, E.P., Bole, S.M., & Kimes, T.M. (2002). *Screening HMO women overdue for both mammograms and pap test*. *Preventive Medicine*, 34 (1), 40-50.

Van Rensburg A. B. R. (2007). *A framework for current public mental health care practice in South Africa*, www.researchgate.net/...A...in.../e0b4951b478cb76d59, African Journal of Psychiatry 2007; 10:205-209.

Wall, S., Hotopf, M., Wessely, S. & Churchill, R. (1999). *Trends in the use of Mental Health Act*. England, 1984-96. *Bmj*, 318(7197), 1520-1521

Walker, O.L. & Avant, K.C. (1995). *Strategies for Theory Construction in Nursing*. Appleton & Norwalk, CT: Appleton & Lange.

Waterman, H., Boaden, R., Burey, L., Spence, M. (2015). Academic paper: Facilitating large-scale implementation of evidence based health care: Insider Accounts from a cooperative inquiry 60 https://www.researchgate.net/.../274736526_large-scale_implementation.

World Health Organization, *Mental Health Atlas (2011)* - Department of Mental Health and Substance Abuse. Geneva.

WHO. World Health Organisation, (2009). *Mental Health for All*. The WHO Strategy. Geneva.

World Health Organization, (2005). *Mental Health Policy and Service Guidance Package. Mental Health Legislation & Human Rights*. World Health Organization, Switzerland. <http://www.healthnettpo.org/en/1103/mental-health-and-psychosocial-support.html>.



Xu, W., Xie, J., Wu, H., Guo, Z., Guo, L. & Feng, X. (2016). *The Association between Chinese Doctor's Workload and Medical Disputes*, Journal of Psychology & Pvh.



ANNEXURES A: ETHICAL CLEARANCE FROM UNIVEN

PLEASE TURN OVER FOR ANNEXURE A

ANNEXURE: B Permission request

P.O Box 269
Thohoyandou
0950

Enquiries: Ramovha MR
Cell: 083 948 1876
Work contact: 015 962 1001/

Requisition for permission to conduct research: Limpopo Province Department of Health Ethical Committee

I RamovhaMuvhango Rachel a PHD student at the University of Venda request permission to conduct research at the district hospitals in Limpopo Province.

The title of the study is **“A programme to facilitate the implementation of Mental Health Care Act No.17 of 2002 by medical doctors in Vhembe District of Limpopo province, South Africa”**

The purpose of the study

The study aims to investigate the practicality and applicability of implementing the mental health care act as described by doctors based on the findings to develop a program. This will be achieved through exploring and describing the experiences of medical doctors in the implementation of mental health care act, compliance audit when completing the legal forms required during admission of mental health care users and describing an improvement plan to improve compliance and impact on the quality care of mental health users.

The significance of the study

One of the core principles of the Mental Health Care Act No.17 is to protect the human rights for mental health care users, therefore proper implementation of the Act will ensure that the rights of the users are protected. This study will inform the authorities about the experiences of medical doctors when implementing the Mental Health Care Act No.17 of 2002.

Medical doctors will be provided with the platform to talk about their experiences and challenges when implementing the Mental Health Care Act legal admission forms.

These findings will be utilised to develop a program to facilitate the implementation of the Mental Health Care Act No.17 of 2002.

No study has been conducted on the implementation of the Mental Health Care Act No.17 of 2002 in Limpopo Province.

If you have any queries on the matter which is not reflected in this correspondence, the contact details are as follows:

Promoter: DrMaluleke Mary

Cell number: 076 394 752

Co-promoters: Prof Netshandama V O

Cell number: 0828960501

Prof Netshikweta ML

cell number: 072 493 3694

Researcher: Mrs Ramovha MR

Cell number: 083 948 1876

Work contact:

015 962 1001/015 962 2273

Thanking you in anticipation

RESEARCHER: _____



ANNEXURE: C PERMISSION LETTER FROM THE PROVINCE AND DISTRICT

PLEASE TURN OVER FOR ANNEXURE C

ANNEXURE D: PERMISSION REQUEST IN THE HOSPITAL

P.O Box 269
Thohoyandou
0950

Enquiries: Ramovha M R
Cell: 083 948 1876
Work contact: 015 962 1001/

Requisition for permission to conduct research Limpopo Province Hospitals

To: The Clinical Manager (Hospitals of Limpopo)

I **Ramovha Muvhango Rachel** a PHD student at the University of Venda request permission to conduct research at the district hospitals in Limpopo Province.

The title of the study is **“A programme to facilitate the implementation of Mental Health Care Act No.17 of 2002 by medical doctors in Vhembe district hospitals of Limpopo province, South Africa”**

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The study aims to investigate the practicality and applicability of implementing the mental health care act as described by doctors based on the findings to develop a program. This will be achieved through exploring and describing the experiences of medical doctors in the implementation of mental health care act, compliance audit when completing the legal forms required during admission of mental health care users and describing an improvement plan to improve compliance and impact on the quality care of mental health users.

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These findings will be utilised to develop a program to facilitate the implementation of the mental health care Act No.17 of 2002.

No study has been conducted on the implementation of the Mental Health Care Act No.17 of 2002 in Limpopo Province.

If you have any queries on the matter which is not reflected in this correspondence, the contact details are as follows:

Promoter: Dr Maluleke Mary

Cell number: 076 3949752

Co-promoter: Prof NetshandamaVhonani

Cell number: 0828960501

Researcher: MrsRamovha M R

Cell number: 083 948 1876

Work contact: 015 962 1001

Thank you in anticipation

ANNEXURE E: PARTICIPANT INFORMATION SHEET

Title: A programme to facilitate the implementation of Mental Health Care Act No. 17 of 2002 by medical doctors in Vhembe district of Limpopo Province, South Africa

Purpose:

The study aims to investigate the practicality and applicability of implementing the mental health care act as described by doctors based on the findings to develop a program. This will be achieved through exploring and describing the experiences of medical doctors in the implementation of mental health care act, compliance audit when completing the legal forms required during admission of mental health care users and describing an improvement plan to improve compliance and impact on the quality care of mental health users.

Objectives:

The objectives of this study are to:

- Identify, explore and describe the experiences of medical doctors when implementing the Mental Health Care Act No. 17 of 2002.
- To determine knowledge of doctors on the implementation of mental health Act 17 of 2002 during admission of mental health care users.
- Based on the findings, to develop a program to facilitate the implementation for the Mental Health Care Act No.17 of 2002.

Significance of study

One of the core principles of the Mental Health Care Act is to protect the human rights for mental health care users therefore proper implementation of the Act will ensure that the rights of the users are protected. This study will inform the authorities about the experiences of medical doctors when implementing the Mental Health Care Act No. 17 of 2002.

Medical doctors will be provided with the platform to talk about their experiences and challenges when implementing the Mental Health Care Act legal admission forms. These findings will be utilised to develop a program to facilitate the implementation of the Mental Health Care Act No.17 of 2002. No study has been conducted on the implementation of the Mental Health Care Act No. 17 of 2002 in Limpopo Province.

What are the risks?

There are no risks anticipated except that you may get tired as I interview you leading to some discomforts as you share your experiences when implementing the Mental Health Act No.17 of 2002 practically.

What are the benefits?

As you share your experiences, answers leading to proper implementation of the Act may be found, thereby protecting our mental health care users.

Whom you should contact

Your participation in this project is appreciated, if you have any queries, please contact the researchers at the numbers listed below:

Promoter: Dr Maluleke Mary

Cell number: 076 394 752

Co-promoters: Prof Netshandama V O

Cell number: 0828960501

Prof Netshikweta M L

cell number: 072 493 3694

Researcher: Mrs Ramovha M R

Cell number: 083 948 1876

Work contact:

015 962 1001/015 962 2273

Thanking you in anticipation

ANNEXURE: F

INFORMED CONSENT

I _____ on this the _____ days of _____ 2016 hereby consent to:

1. Being interviewed by _____ on the topic “a programme to facilitate the implementation of Mental Health Care Act No.17 of 2002 by medical doctors in Vhembe District of Limpopo province, South Africa”
2. The interviews will be audiotaped, I also understand that:
 1. I am free to end my involvement or to recall my consent to participate in this research any time; Information given up to the point of my termination of participation could however still be used by the researcher; No reimbursement will be made by the researcher for information given or my participation in this project; I may refrain from answering questions should I feel these are an invasion of my privacy.
 2. By signing this agreement I undertake to give honest answers to reasonable question and not to mislead the researcher. I hereby acknowledge that the researcher/interviewer has:
discussed the purpose and objectives of this research project with me;
informed me about the content of this agreement; informed me about the implications of signing this agreement .

As I sign this agreement the researcher undertake to:

Maintain confidentiality, and privacy regarding the interviewee’s identity and information given by the interviewee; Arrange in advance a suitable time and place for an interview to take place; and Safe guard the duplicate of this agreement.

(Interviewee) _____ DATE: _____

(Interviewer) _____ DATE: _____

ANNEXURE G

QUESTIONNAIRE CHECKLIST

Dates		
Items	YES	NO
Was the document submitted to the Mental Health Review Board within seven days?	<input type="checkbox"/>	<input type="checkbox"/>
Is the document having different dates on assessment form?	<input type="checkbox"/>	<input type="checkbox"/>
Date changed/ Overwriting?	<input type="checkbox"/>	<input type="checkbox"/>
Date omitted?	<input type="checkbox"/>	<input type="checkbox"/>
Is date legible?	<input type="checkbox"/>	<input type="checkbox"/>
Signatures		
Items	YES	NO
Are there different signatures on one form?	<input type="checkbox"/>	<input type="checkbox"/>
Omitted signatures?	<input type="checkbox"/>	<input type="checkbox"/>
Cancellations not accounted for?	<input type="checkbox"/>	<input type="checkbox"/>
Is the declaration having the commissioner's signature and names?	<input type="checkbox"/>	<input type="checkbox"/>
Is thumb print with owner's names?	<input type="checkbox"/>	<input type="checkbox"/>
Relevant forms		
Items	YES	NO
Is there form MHCA 08 when applying for an extension of admission as involuntary after 72 hours?	<input type="checkbox"/>	<input type="checkbox"/>
Is the application form MHCA 04 available and well completed?	<input type="checkbox"/>	<input type="checkbox"/>
Availability of MHCA 05 x 2, and fully completed?	<input type="checkbox"/>	<input type="checkbox"/>
Availability of MHCA 06, and fully completed?	<input type="checkbox"/>	<input type="checkbox"/>
Availability of MHCA 07 and well completed?	<input type="checkbox"/>	<input type="checkbox"/>
If user was brought by SAPS, was form MHCA 22 completed?	<input type="checkbox"/>	<input type="checkbox"/>

Documentation

Items	YES	NO
Were cancellations on the forms accounted for?	<input type="checkbox"/>	<input type="checkbox"/>
Are there different handwritings in one form?	<input type="checkbox"/>	<input type="checkbox"/>
Was legibility of writings compromised?	<input type="checkbox"/>	<input type="checkbox"/>
Is there copying from each other?	<input type="checkbox"/>	<input type="checkbox"/>
Did the doctor indicate the name of the Head Health Establishment in MHCA 07?	<input type="checkbox"/>	<input type="checkbox"/>
Is MHCP serving as an assessor and as the commissioner?	<input type="checkbox"/>	<input type="checkbox"/>
Has name, age and gender of the applicant been included?	<input type="checkbox"/>	<input type="checkbox"/>
Was the physical examination done? (e.g. condition looks good not allowed, but to write findings)	<input type="checkbox"/>	<input type="checkbox"/>

Management

Items	YES	NO
Findings of the MHCPs not concurring, if so is there a third assessor appointed by HHE?	<input type="checkbox"/>	<input type="checkbox"/>
Was authorisation for the admission by the HHE completed correctly?	<input type="checkbox"/>	<input type="checkbox"/>

Approval

Items	YES	NO
Is the document approved by the MHRB?	<input type="checkbox"/>	<input type="checkbox"/>

ANNEXURE: H

UNSTRUCTURED INTERVIEW GUIDE

- What are your experiences as you implement mental health Act no. 17 of 2002 when you admit, care and discharge mental health care users?
- What type of a programme is do you need to facilitate the implementation of Mental Health Act no.17 of 2002?

ANNEXURE: I

INDIVIDUAL INTERVIEW (UNSTRUCTURED ONE TO ONE INTERVIEW)

Key: Researcher = R

Participant = P

POPULATION: Medical doctors

R. Good day

P. Good afternoon

R. How are you in this cold weather?

P. Cool weather is better because we are busy here, outpatient is always full. So today's weather is the best. I enjoy it

R. It is that time for our interview, how do you want us to start our meeting, by a prayer? And what language do you prefer?

P. English, but I may mix with vernacular though mostly I will use English. A prayer is also good so that God may give me power to work hard. Who prays me or you?

R. Thank you for asking, let it be you, please pray.

P. Let us pray,
Prayed.....Amen

R. Thank you for allowing me to come to your consulting room for this meeting. Allow me to remind you about this study and the role. This study is intended to develop a programme to facilitate the implementation of Mental Health Care Act No. 17 of 2002 by medical doctors in Vhembe district. So I am here to conduct interviews with

you so that I get to understand your experiences about implementing or application of mental health care Act No. 17 of 2002 as amended when caring for mental health care users.

I brought with me a tape recorder to be used during the interview in order not to miss your valuable information you are to give. During this interview I may write some notes during the interview (field notes). When transcribing I will omit your name for anonymity sake. If you want to say something that you do not want to be tape recorded, you press this button (pointing at the button) to stop the tape recorder.

R. Any questions?

R. It is that time for our interview, can we start?

P. Yes, I am ready

R. What are your experiences about the implementation of mental health care Act 17 of 2002 with regard to admission of patients?

P. Ohh! "I am just frustrated by the forms to be filled, but only for mental health patients, because other general patients do not have the legal forms they only have necessary admission forms, treatment sheet and consent form in case of surgical procedure and other investigations. Forms for psychiatric patients are so many. "It looks like is one Act but there are lots of forms, and I mean forms". "And yet one still need to fill admission forms like those of general patients on top of the MHCA form 07".

R. Hmmmm, and then?

P. I am frustrated by filling these forms (stressed aggressively the word (forms) for psychiatric patients. It looks like is one Act but there are forms, and I mean forms.

R. Hhmmm

P. What I am saying is that there are lots of forms to be filled for psychiatric patients. There are forms like form number 05 and form number 07 filled by the Head of Health institution and other forms which are filled like form 04 with a declaration form.

I do not see any reason of the clinical manager filling form 07 because they do not even see the patient.

R. You say you do not see any reason for filling the forms you mentioned i.e. form MHCA 05 and MHCA 07 by Clinical Managers, can you elaborate more?

P. I do not see any reason of Clinical Managers filling form 07 because they do not even see the patient. This forms were not explained to us and we are made to fill them.

R. Hhmmm

P. During our time when I was studying we were not taught about this. I do not know these forms, my colleagues as well. Imagine with OPD full of general patients and mental health care users, and you sit with one patient assessing, filling doctor's notes and thereafter patient's notes and then mental health legal forms, it's a lot of work really".

R. How does the mental health care Act requirements influence the way in which you render care to mental health care users?

P. "Are the form 05s two? I did not know that they are two, and that they are to be compared. I only wanted the reason why the patient was brought to the hospital and the recommendation in that one form 05". "Another thing is that instruction in form 07 which is written at the bottom of the form, lead us into making mistakes when you did not see that you have to erase or delete". "It must be written on top

and be bolded so that it can be easily seen before you start filling the form”. “Why are the psychiatric patients treated so special? I do not understand?”

And

It makes us not to be honest sometimes, and copy from one another, because we are just filling the forms just for formality, because we do not see the patient, and one just check one form 05 and not see the patient, fill the forms for the sake of complying without understanding and even examining the patient. No one explained anything about the forms.

R. Hhmmm

P. Another thing is that instruction in form 07 which is written at the bottom of the form, it lead us into making mistakes when you did not see that you have to crash. The very forms are confusing, is not easy to understand what you must write. The other day another doctor was nearly beaten by a psychiatric patient. Had it not been the presence of the male nurses at that time, I don't know what could have happened.

R. Hhmmm

P. It must be written on top and be bolded so that it can be easily seen before you start filling the form. Why are the psychiatric patients treated so special? I do not understand? And all this forms? Honestly, this forms, where do they go. Is there any one checking them really? There is no one who can sit for this forms, this is too much for us. I do not think relatives are aware that we are delaying them because of this. May be we should have a clerk to fill this forms.

R. This may not be a good time to answer all the questions but amongst many other reasons, it is for the protection of the rights of mental health

care user, as anyone can bring patient for admission yet the patient is not sick but because they want to remain gaining access into the patient's assets.

P. Ok, I was not aware, these things need to be explained to doctors, because I did not know what you have just explained, or have a workshop on this matter. We would not feel as if it is an extra job because for now, I tell you all the doctors are complaining about this forms.

R. What do you mean by "these things?"

P. I mean the forms that we are supposed to fill for mental patients. The way they are so many, you can call them anything.

R. What do you think must be done to improve the implementation of the mental health care Act?

P. That instruction at the bottom of form 07 must be written on top and be bolded because it guides us. Also I think there is need for more workshops and explanation about this Act to us doctors because there is no teaching us.

R. Hhmmm

P. I was not aware that it is to protect the patients, because I once came across a woman who brought her son for admission, but the son looked well and answering questions well and accurately.

R. And then?

P. The mother complained that the doctors did not give him the correct injection that makes him to just sit and quiet, demonstrating by curling forward. The patient asked the mother if really she wants him to remain that way, and he indicated that he is only given only ten (R10, 00) from his disability grant, so they want him admitted and remain eating his money.

R. Hahhh

P. I did not know who to believe, but ended up giving the patient treatment to take home. The mother left very angry.

R. Did the curriculum used during your training include mental health as a module and for how long?

P. Yes it had a module but not in a bigger portion, just for few months, six months or less like eye and ear problems, and with them we refer to specialists.

R. Tell me more!

P. It would be good if curriculum consider increasing the module and time, because when listening to junior doctors present cases, they are better may be it has been increased.

R. Hmmm

P. I feel very happy that you explained these things to me, I have learned a lot, Thank you.

R. What things are you talking about?

P. I mean the explanation about the mental health Act.

R. Ohh, is that so? I am happy that you learnt something.

R. As I conclude, you said you are frustrated by the forms that they are too many, confusing, is not easy to understand, not explained to you doctors, OPD is always full of general patients who need your attention and this feels like is an

extra job. You also said you feel doctors must be explained about the forms and be workshopped as you do not understand the use of the forms, where they go and what you must write, and that why psychiatric patients are treated special. I hope you told me everything about this forms. Let me thank so very much for availing yourself and share your experiences with me during this interview. If there is a need I may come back again to sort clarity in case there are some answers you gave that I do not follow well. I hope it is fine with you. Thank you.

P. Thank you, I will always be available for you. I will make time, I want to know more about mental health.

R. We have prayed as we start with this interview. Shall we pray again?

P. Sure let us pray
Prayed.....Amen.

R. Thank you once more.