Assessing the attitude of nursing staff working at a community health centre towards the mental health care user

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A mini- thesis in partial fulfilment of the requirements for the degree of Masters in Advanced Psychiatric Nursing in the School of Nursing in the Faculty of Community Health Sciences

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KEYWORDS

Attitude

Community Health Centre

Community Day Centre

Discrimination

Enrolled Nurse

Enrolled Nursing Assistant

Mental health

Mental Illness

Mental Health Care Provider

Mental Health Care Practitioner

Mental Health Care User

Nursing

Perception

Professional Nurse

Psychiatric Nursing

Stigma

ABSTRACT

The South African health care system shifted the focus of treating psychiatric disorders from institutional care level mental health services to facilitate this process of integration into the Primary Health Care (PHC) settings. All the provinces were thus engaged in improving mental health care services at community level by providing training for professional nurses in mental health at PHC settings. Consequently, mental health nursing has also changed considerably by shifting the focus of mental health care to the primary care level. It is however, suggested that the current revolving door syndrome experienced at psychiatric institutions was partly due to inadequate community-based psychiatric services. It was also suggested that the attitudes and knowledge of health professionals towards mental illness has a major impact on service delivery, treatment and outcome of mental illness.

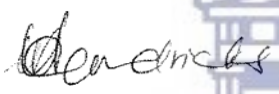
The aim of this research study was to assess the attitude of nursing staff working at a Community Health Centre (CHC) towards the mental health care user. A CHC was chosen that renders 24 hour services. The inclusive sample included all the different categories of nurses permanently employed at this CHC. The Attitude Scale for Mental Illness questionnaire was used to collect the data. Descriptive statistics: means, median and standard deviations were calculated for the following variables: separatism; stereotyping; restrictiveness; benevolence; pessimistic prediction and stigmatization.

In conclusion it can be said that the nursing staff with more experience irrespective of category of nurse has less of a stereotyping attitude towards mental illness. The

longer the nurse worked at the setting and irrespective of their nursing qualification the more positive their attitude towards the MHCU became.

DECLARATION

I, Michelle Dianna Hendricks, do hereby declare that the study entitled: *Assessing the attitude of nursing staff working at a Community Health Centre towards the mental health care user* is my work, that it has not been submitted for any degree or examination at any other University, and that all the sources I have used or quoted have been indicated and acknowledged by complete references.

Signed: 

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LIST OF ABBREVIATIONS

ASMI- Attitude Scale for Mental Illness

ANOVA- Analysis of variance

CDC- Community Day Centre

CHC- Community Health Centre

CDL- Chronic Diseases of Lifestyle

CNP- Clinical Nursing Practitioner

DOH- Department of Health

EN- Enrolled Nurse

ENA- Enrolled Nursing Assistant

MDHS- Metro District Health Services

MIDC- Medical Infectious Disease Clinic

MHCP- Mental Health Care Practitioner

MHCU- Mental Health Care User

PHC- Primary Health Care

PN- Professional Nurse

SANC- South African Nursing Council

SPSS- Statistical Package for the Social Science

USAID- United State Agency for International Development

WHO- World Health Organisation

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CHAPTER ONE: INTRODUCTION AND BACKGROUND

1. INTRODUCTION

This chapter provides an overview of the study. This includes background information on the attitude of nursing staff working at a community health centre towards the mental health care user, a problem statement, the purpose, as well as the objectives of the study, definition of key concepts and a brief discussion of ethics followed by a layout of the chapters.

1.1 BACKGROUND TO THE STUDY

Integrating mental health care into the South African health care systems has shifted the focus of treating psychiatric disorders in specialised institutions to community level mental health services (Nhlanhla & Molelekoa, 2010). All provinces became therefore engaged in providing mental health services at community level by integrating mental health into the Primary Health Care (PHC) system. Consequently, mental health nursing has also changed considerably by shifting the focus of mental health care to the primary care level. The intention is to promote and maintain holistic health for the different populations in the community (Frisch & Frisch, 2006). However, strategies to achieve holistic health should take into account that the mental health status of the population is intertwined with the biological, psychological, social, environmental and economic factors at all levels of society.

Interventions to promote health and reduce ill health should therefore include all services provided by the health care system, especially at the community level.

Pre 1997-mental health disorders weretreated in institutions and by psychopharmacological means (Nhlanha & Moletekoa, 2010:105). Since 1997, the South African government's integration of the different health systems into primary health care (PHC) was discussed. According to The White Paper (1997) on the transformation of health care systems has provided for mental health care users to access mental health care services closest to them. Its focus was thus on a community-based, population approach. This approach centres on the health services the community and population need by providing these services in a normal community setting close to where they live. As mental disorders and physical health are closely associated these services include assessment, screening, counselling, outpatient treatment, emergency help twenty-four hours a day, referral to appropriate resources and giving the client holistic treatment by tending to all aspects of his or her health. It is with this in mind that the treating of psychiatric disorders has been shifted from institutional care to community care level mental health services (Nhlanhla & Molelekota, 2010).

Current reports from psychiatric institutions of an increase in the relapse rate of chronically, mentally ill clients, who have been discharged into community-level care, suggest that this is, at least in part, due to the inability and incapacity of community-based psychiatric services to deal adequately with these patients (Van

Deventer et al., 2016; Du Plessis et al., 2004). Thornicroft et al (2010) suggested that factors like inadequate training and support for this additional responsibility places further strain on an already overburdened PHC system. They also argue that health professionals' whole outlook on mental illness combined with a lack of knowledge about it has a crucial effect on the quality of service that they will give mentally ill clients and thus on the treatment and outcome of the illness. These findings are substantiated by an earlier report of Reed and Fitzgerald (2005) who noted that professional nurses with limited training in mental health tended to fear and avoid mental health patients, whereas those with training in advanced mental health nursing had a robust confident way of dealing with such patients.

A Zambian study in 2011 of the discriminatory attitudes of PHC providers towards people with mental illness and their stigmatizing of these people reflects the South African experience. The study concluded by urgently recommending that all health care providers should undergo training and education programmes in care of the mentally ill in order to counteract and dispel prejudice against these patients (Kapumgwe et al., 2011).

These studies show that there is a relationship between the knowledge people have about mental illness and their attitudes towards it; and that when training in mental illness was incorporated into the training of health care providers, there was a positive shift in attitude towards mentally ill users.

1.2 RATIONALE FOR CONDUCTING THE STUDY

Mainstreaming psychiatric mental health nursing within the primary health care framework in South Africa is plagued by many challenges as nursing staff play a significant role in both the care and rehabilitation of the mental health care user (MHCU). Mental health has been integrated into Community Health Centres but the questions remain: Is it successful? Are the staff equipped to deal with mentally ill clients? Are the clients ready to go into the community? Is the community educated enough to accept these clients? Are there adequate resources? Finally, does the government supply financial support for the needs of the clients? The urgent necessity of answering these questions promptly is made clear by recent research.

According to Tomlinson and Lund (2013:3), "The lifetime prevalence of mental disorders has been estimated to be between 12.2% and 48.6% globally; More than 13% of the global burden of disease for mental disorders is due to neuropsychiatric disorders". The growth in the occurrence of mental illness brings sharply into focus the problems that beset those attempting to deal competently with the mentally ill (Mokgata, 2009). Poor knowledge, negative attitudes towards mental illness and poor understanding of mental illness by the public threaten the effectiveness of patient care and rehabilitation (Pelzang, 2008). Mohale (2009) expands on this view of the public by pointing out that attempts by health professionals to establish mental health care in the community were undermined in the past and continue even more strongly today, to be undermined by factors such as cultural beliefs,

stigmatization as well as myths about mentally ill people. Some of the core reasons for integrating mental health care into primary health care settings were to eradicate stigmatization, discrimination, institutionalization and to provide care to mentally ill clients at a health centre closest to home, hence providing holistic care to the client for physical as well as mental health problems.

1.3 PROBLEM STATEMENT

The researcher, a mental health care practitioner (MHCP) working in a Community Health Centre (CHC), observed that the general nurses in this setting tend to avoid interaction with clients showing signs of mental illnesses. In addition, these nurses are inclined to refer known MHCU's to the designated MHCP, even if the client was attending the CHC for a physical complaint. This observation is congruent with the findings of a recent study done in an Associated Psychiatric Hospital in the Western Cape by Basson et al., (2014).

The authors stated that nurses with more experience and longer work history have more positive attitudes towards mental health care users. This study determined if these findings are true for all categories of nurses who work on a permanent basis in this CHC.

1.4 SIGNIFICANCE OF THE STUDY

The findings of this study could stimulate further research with regard to formulating guidelines for the practice of holistic care for the mental health care user by raising awareness of the attitude of nursing staff towards the MHCU in 24-

hour Community Health Centres in the Western and Southern sub-structures of Metro-District Health Services (MDHS).

1.5 AIMS AND OBJECTIVES

The aim of this research study was to assess the attitude of nursing staff working at a Community Health Centre (CHC) towards the mental health care user. The following objectives were addressed to achieve the aim.

1. To describe socio-demographics of respondents.

2. To determine the negative attitudes of nurses employed in this CHC towards MHCU's (Stereotyping, Seperatism, Restrictiveness, Stigmatization and Pessimistic predictions).

3. To identify the positive attitudes displayed by nurses employed in this CHC towards MHCU's (Benevolence).

4. To determine factors that might influence attitudes of nurses towards the MHCU.

1.6 RESEARCH DESIGN AND METHODOLOGY

A quantitative research approach, with a descriptive design, was used to obtain information about the attitude of nursing staff towards mental health care users. The study population refers to all permanent nursing staff working at the CHC. Due to the small number and to accommodate for non-responses, an all-inclusive sampling method was used. An adapted version of the Attitude Scale for Mental Illness (ASMI) questionnaire was used to measure the attitude of nursing staff. The ASMI questionnaire was chosen as it measured all objectives of the study being stereotyping-, separatist-, benevolent-, restrictive-, stigmatisation attitude and

pessimistic predictions. The different attitudes and clarity why it was used will be discussed in chapter three. The design and methodology will be further discussed in chapter three. The Statistical Package for the Social Sciences (SPSS) V24 was used to analyse data collected and a more detailed description of data analysis is outlined in chapter three.

1.7 DEFINITION OF KEYWORDS

Attitude- a person's way of thinking that can be recognised in their behaviour, manner, disposition, feeling and position with regard to a person or thing; tendency or orientation, especially of the mind. Attitudes speak of a disposition towards a specific phenomenon, individual or thing and have cognitive, affective, and behavioural components (Van der Kluit, 2011). In this study attitude refers to the belief and behaviour of nursing staff towards mental health care users.

Community Day Centre is a community-based health facility that offers the same services as CHCs but only operates on an 8-hour basis.

Community Health Centre is a community-based health facility that operates on a 24-hour basis offering promotive, preventative, and curative care services, in contrast to a Community Mental Health Practitioner (CMHP) that operates only till 16h00. The trauma- and triage units of the CHC operates 24 hours, compared to the prep-, injection-, club room (CDL- chronic diseases of lifestyle) and Medical Infectious Disease Control (MIDC) clinic, hence they should be able to screen,

diagnose, provide emergency management of MHCU's and referral to the secondary level of psychiatric services.

Discrimination refers to unjust or prejudicial treatment of people due to their illness or circumstances (Browne 2010).

Enrolled Nurse – a person educated to practise basic nursing in the manner and level prescribed in the Nursing Act, 2005 and it's Regulation 30 (South Africa, 2005).

Enrolled Nursing Assistant – a person educated to provide elementary nursing care in the manner and level prescribed in terms of the Nursing Act. (South Africa, 2005).

Mental health –a state of well-being in which every individual realises his/her own potential, can cope with normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her/his community.(Mental Health Care Act, 2002).

Mental illness – refers to a wide range of mental health conditions- disorders that affect your mood, thinking and behaviour. A mental health concern becomes a mental illness when ongoing signs and symptoms cause frequent stress and affects the person's ability to function. This study of mental illness will be confined to conditions such as schizophrenia, bipolar, depression, suicidality, anxiety and personality disorders (Mental Health Care , 2002).

Mental Health Care Provider – refers to a person providing mental health care services to mental health care users and includes mental health care practitioners (South Africa, 2002). In this study the mental health care provider will be the nurse with additional qualifications.

Mental Health Care Practitioner – refers to a psychiatrist or registered medical practitioner or a nurse, occupational therapist, psychologist or social worker who has been trained to provide prescribed mental health care, treatment and rehabilitation services (South Africa, 2002). In this study the term MHCP refers to a nurse.

Mental Health Care User – refers to a person receiving care, care treatment and rehabilitation services or using a health service at a health establishment aiming at enhancing the mental health status of a user (South Africa, 2002).

Nursing – refers to all categories of nurses, meaning a caring profession of a person registered under Section 31, which supports, cares for and treats a health care user to achieve or maintain health (South Africa, 2002).

Perception – the way a person perceives and understands something or someone. A believe or opinion based on how things seem. (Browne 2010). In this study nurses' perception was measured towards the MHCUs.

Professional Nurse –A person who is qualified and competent to independently practise comprehensive nursing in the manner and to the level prescribed and who

is capable of assuming responsibility and accountability for such practice (South Africa, 2005).

Psychiatric Nursing is a speciality type of nursing concerned with the care and prevention of mental illness and the promoting of mental health of users of all ages (South Africa, 2002).

Stigma is regarded something associated with specific illness or circumstances as a mark of disgrace. In this study it relates to the stigma towards MHCU (Browne 2010).

1.8 ETHICS STATEMENT

Ethics approval was sought from the University of the Western Cape Ethics Research Committee. Permission was obtained from the Department of Health and the Head of Establishment from the institution to conduct the study. After permission was obtained from relevant committees, an information sheet pertaining to the research study was handed to each respondent. The research process and purpose was explained in detail and in the language respondents could understand. All respondents were given a consent form to complete but were given the option to do it anonymously and place it in the box provided. The researcher fully complied with the ethical standards whilst conducting the research. No harm was experienced by any person whilst conducting the study. Ethics will be discussed in detail in Chapter three.

1.9 OUTLINE OF THE STUDY

Chapter 1 introduces the background and rationale of the study, problem statement, aims and objectives, significance of the study and operational definitions of keywords and research design. The methodology and ethics are discussed briefly.

Chapter 2 discusses the literature review conducted on attitudes of nurses, education and training of mental health nursing, the factors that have an influence on their behaviour as well as the prevailing stigma towards mental illness.

Chapter 3 explains in detail the research design, methodology, sampling method used to recruit respondents,

Chapter 4 the findings of the study are presented as well as the study setting, data collection and instrument used data analysis and ethics.

Chapter 5 the results of the study are discussed

Chapter 6 concludes the study by highlighting the main findings, briefly discussing the limitations of the study and lastly making recommendations for practice.

CHAPTER TWO: LITERATURE REVIEW

2. INTRODUCTION

A literature review is a systematic reading of the important contributions in the field of study, which further leads to the development of research questions and research objectives (Sekaran & Bougie, 2010). In this second chapter, a review of the relevant literature is presented in order to contextualize the study. This has been discussed under the following subheadings:

- The education and training of psychiatric mental health nursing
- The training model for CMHP
- The Guangzhou model of community mental health
- The role of the CMHP
- Attitudes towards the mental health care users
- The stigmatising of mental illness.

2.1. EDUCATION AND TRAINING OF MENTAL HEALTH NURSING

The primary aim of nursing education and training is to provide adequate numbers of competent, caring nurses. Nursing education must involve strong collaboration between the higher education and health sectors and other relevant stakeholders to ensure success. Nursing education and training programs should be harmonized with health service delivery needs while ensuring that qualifications obtained are commensurate with the scopes of practice and relevant legislation (The national strategic plan, 2017). According to the United States Agency for International Development (2010), Many countries have few trained and available personnel,

staff competencies may not meet the population's needs or may be outdated the available personnel may not be used appropriately, and many of the staff may be unproductive or demoralized (USAID, 2010).

Moschovopoulou, Valkanos, Papastamatis, and Giavrimis (2011) defines continuing nursing education as a continuous process of knowledge and skills acquisition, a part of the initial education, aiming at the professional growth. Continuing nursing education according to American Nurses Association (ANA) refers to educational activities that provide knowledge, aiming at the improvement of provided services. The need for the training of psychiatric nursing staff became perceptible very early (1854) in Scotland, where the first system of education of psychiatric nurses was established. The World Health Organisation (WHO) (2005) highlighted that continuing education and training (CET) is in the interests of both the mental health service and the staff as lifelong learning is a cornerstone of continued fitness to practice and is closely tied with the quality of care and patient safety. (The United States Agency for International Development) (USAID) (2010) reported that for the service, it ensures up-to-date care, in line with available evidence for the most effective interventions. For the staff, it ensures that their occupation remains stimulating and that their working life can follow a trajectory of career-long professional development (USAID, 2010). The people forget what they were originally taught and a retention gap develops. A combination of the knowledge and retention gaps results in an ever-widening gap in knowledge and skills. The gap grows further if training does not continue after qualifying. Therefore, continuing education and training is the most effective way of bridging this gap (USAID, 2010).

According to the WHO (2005), the primary aim of mental health training is to serve the mental health needs of the society by producing workers competent to deliver care. There is often a phase lag, whereby clinical practice moves ahead of what training courses offer, as their curricula tend to change more slowly than clinical practice. Hence, in many countries, achieving training goals will require a change in the way in which mental health education and training is conducted. Therefore, it is necessary to update curricula where they have become outdated or are no longer consistent with new models of community-based care.

To address this lag, training must be conducted on the basis of the best available evidence for a particular practice or intervention, such as the use of the most cost-effective medications and psychosocial interventions, and the development of community-based care. Training is necessary to prepare workers who are competent to fulfill mental health service needs in the most relevant and efficient manner possible (WHO, 2005). There was a greater emphasis on outcomes-oriented training, multidisciplinary learning opportunities, and an integrated systems-oriented approach to the study of mental health that includes bio psychosocial elements. Because mental health training showed a move away from traditional, didactic or lecture-based methods towards more problem-focused, student centered, active learning methods. Recent developments in mental health training showed that. “Optimally, mental health training should employ a combination of training methods, such as didactic lectures, role-playing, practical experience, onsite training and supervision” (WHO, 2005).

Driving psychiatric nursing education and training in South Africa is the need to provide sufficient competent and caring nurses to meet the country’s needs. To

ensure that nursing education conforms to the requisite standards there must be collaboration between the health and higher education sectors in establishing nursing education and training programmes. As the National Strategic Plan for Nursing sums up "Nursing education and training programmes should be harmonised with health service delivery needs while ensuring that qualifications obtained are commensurate with the scopes of practice and relevant legislation" (South Africa, 2014).

The need for mental health training to serve the mental health needs of society by producing workers competent to deliver care emanates from WHO. Their *Mental Health Policy and Service Guidance Package* (2005) gives countries up-to-date guidance on the most effective ways of training mental health nurses and emphasizes new and crucial aspects of this training. For example, the WHO points out that mental health education and training is often affected by a phase lag when clinical practice is in advance of what training courses are offering. This is because clinical practice changes faster than educational programmes. To avoid training becoming out of phase with clinical practice or new models of community-based care, countries must constantly update their curricula, using evidence-based training. This is training "conducted on the basis of the best available evidence for a particular practice or intervention, such as the use of the most cost-effective medications and psychosocial interventions, and the development of community-based care" (WHO 2005:12).

To meet today's requirements of mental health workers, WHO recommend that the old traditional didactic lecture-based methods of training should be replaced "by problem-focused, student-centred, active learning methods. These involve changes

in the direction of outcomes-oriented training, multidisciplinary learning opportunities, and an integrated, systems-oriented approach to the study of mental health that includes bio-psychosocial elements" (WHO, 2005:13). To sum up, mental health training should involve a combination of training methods including "didactic lectures, role playing, practical experience, onsite training and supervision" (WHO 2005: 91).

Ammentorp, Sabroe, Kofoed and Mainz (2007) define self-efficacy as a belief of one's capability to perform a certain task and the expectation of being able to successfully perform certain behavior. The concept self-efficacy was introduced by Bandura and refers to a person's estimate of his or her ability to perform a specific task successfully. Ammentorp et al., (2007) further define Self-efficacy as an evaluation of the capability to perform a certain task. The concept self-efficacy refers to a person's estimate of his or her ability to perform a specific task successfully. Self-efficacy can change as a result of learning, experience, and feedback; and the magnitude of self-efficacy changes corresponds closely to changes in performance. Organizational research has also shown that self-efficacy can predict the performance of an individual. However, a variety of internal and external factors such as personal knowledge and skills, physical condition, self-esteem, interpersonal environment, available time, task complexity, stress, etc., can also influence self-efficacy and thereby behavior (Ammentorp et al., 2007). The health professionals that better respond to patients' problems are those with adequate skills and reasonable confidence in own abilities (Ammentorp et al., 2007). Numerous literature showed the more knowledge and experience a person

had the more positive and empathetic their behavior is towards MHCU's, hence the discussion on self-efficacy.

The importance of the strong organization of the education and training of nurses in South Africa and the awareness that training must be relevant and comply with South African scopes of practice and health service delivery needs is underlined by the United States Agency for International Development (2010). They point out that many countries which lack such organized training have few trained and available personnel; staff competencies may not meet the population's needs or may be outdated; the available personnel may not be used appropriately, and many of the staff may be unproductive or demoralized (USAID, 2010).

2.1.2 TRAINING MODEL FOR COMMUNITY MENTAL HEALTH PRACTITIONERS

Studies have shown that the level of education and training plays a major role in the attitude and perception of professional nurses towards mental illness. Findings indicate that professional nurses with more experience in the psychiatric field demonstrate a more positive attitude, therapeutic commitment and role competency than those with less experience in this field (Poreddi, Thimmaiah, Passhuba, 2014).

2.1.2.1. THE GUANGZHOU MODEL OF COMMUNITY MENTAL HEALTH

Li et al., (2015), point out that in order to improve the delivery of mental health services; the Guangzhou model in the field of community mental health was developed. This model is also known as Policy, Training, Services and Assessment (PTSA) curriculum and compromises of three modules. The first module mainly includes traditional courses, the second module is clinical practice, and the third module combines the public health perspective with stigma and discrimination, WHO guidelines, ICD-10, and current policies. Traditional courses used the first and second module, which were mainly clinical psychiatric textbooks and clinical practices as usual. The traditional training curriculum was based on an individual approach, but the public heath approach was lacking. Thus we could not develop effective community mental health services in real situations. This was problematic from a public health point of view because the clinical approach could not offer appropriate training courses for community mental health staff.

2.1.3 THE ROLE OF THE COMMUNITY MENTAL HEALTH PRACTITONER

Studies have shown that the level of education and training plays a major role in the attitude and perception of professional nurses towards mental illness. Findings indicate that professional nurses with more experience in the psychiatric field demonstrate a more positive attitude, therapeutic commitment and role competency than those with less experience in this field (Poreddi, Thimmaise, Passhuba, 2014).

The role of the Community Mental Health Practitioner (CMHP) is multi-faceted as it is that of the primary caregiver of the Mental Health Care User (MHCU). The CMHP's responsibilities are providing population-focused mental health, promotive and preventative care, community development, group, family and individual therapy as well as the treatment, management and rehabilitation of mental illness. In addition, the CMHP should be the voice, advocate and support system for the mentally ill. The CMHP must do individual-, family- and group therapy, evaluate treatment modalities and implement care plans that are beneficial to the client, be knowledgeable of psychopharmacology, assessment of medication side effects, do mental health examinations, have motivational interview skills and strategies to improve clients' adherence to treatment modalities and supervise and support general health staff with management of people with mental disorders. The CMHP must also be able to asses clients who were discharged from primary and secondary institutions assist with psychosocial rehabilitation and keep mental health statistics. She or he must be aware and knowledgeable of referral pathways and resources available in the community to assist clients with rehabilitation, provide continuous care when the client is discharged from psychiatric hospitals and do home visits if the client defaults on treatment. In addition to all this, the CMHP must be the facilitator of students and be able to see more clients than other health professionals due to the stigmatization and attitude of other health professionals.

2.2. ATTITUDES TOWARDS THE MENTAL HEALTH CARE USER

According to Bohner and Dickel (2011), an attitude is an evaluation of an object of thought. Attitude objects comprise anything a person may hold in mind. According to Kiriakidis (2015), the main conclusion for the definition of an attitude is that, an attitude is "a learned predisposition to respond to an object or class of objects in a consistently favorable or unfavorable way". Attitude is a construct not directly observable but precedes behavior and guides choices and decisions which can either be positive or negative. Ajzen, (2011) stated that attitude is also formed through experience which can be gained through family interaction, social environment and education. According to Seitz, Lord and Taylor, (2007) attitudes are often described as having three components: affective, cognitive, and behavioral. The affective component involves feelings, moods, and emotions that people have in relation to the attitude object. The cognitive component consists of beliefs about positive or negative attributes of the attitude object. The behavioural component involves actions and intentions to act toward the attitude object. The authors reported that individuals whose attitudes are more congruent with the cognitive component tend to be more persuaded by cognitive appeals, whereas individuals whose attitudes are more congruent with the affective component tend to be more persuaded by emotional appeals.

Hsiao, Lu and Tsai, (2015) highlighted that more importantly, the knowledge of attitudes possessed by mental health nurses towards people with mental illnesses is of utmost interest because these attitudes may affect nurses' interactions with patients and ultimately the quality of integrated nursing care provided. Because

mental health nurses are in a unique position to assist individuals with mental illness to successfully adapt. In addition, previous studies have reported various characteristics associated with attitudes of the general population and health care professionals towards people with mental illness. For example, people with mental illness are responsible for their own disorders. In other words, people with mental illness are incapable of making decisions about their own lives (Ihalainen-Tamlander et al., 2016).

Nurses working in psychiatric clinics express more positive attitudes towards people living with mental illness compared with those working in general care. It is likely that mental health-care professionals working in inpatient psychiatric units tend to view individuals with mental illnesses as more dangerous and desire less interaction with these individuals than those working in outpatient psychiatric services (Hsiao et al., 2015). Nursing staff in psychiatric practice should be aware that their attitudes may influence the quality of nursing care they deliver. Certainly, negative attitudes toward mental illness appears to worsen the overall quality of life of individuals with mental disorders (Hsiao et al., 2015).

Furthermore, it would appear that the client's particular problems or illness may inevitably influence discriminatory attitudes displayed by health-care professionals. It has been found that mental health nurses endorse negative attitudes towards major depression compared with schizophrenia (Hsiao et al., 2015). Also, health-care professionals hold more stereotypical views about working with substance users, especially drug addiction, than clients with schizophrenia. In particular, mental health nurses in our study expressed more unfavourable attitudes towards people

with substance abuse followed by schizophrenia and major depression, respectively. Moreover, nurses tend to possess moralistic views about substance abusers with regard to potentially adverse social outcomes (e.g. criminal behaviors) rather than health issues. As such, these negative attitudes held by mental health nurses towards people who have mental illnesses, especially substance abuse, are considered as an obstacle to the quality of mental health nursing care delivered (Hsiao et al., 2015).

In comparisons of mental health-care settings, their study revealed that nurses who work at psychiatric rehabilitation units and outpatient clinics or community psychiatric rehabilitation centres demonstrated more positive attitudes compared with nurses employed at acute psychiatric units (Hsiao et al., 2015). As a consequence, caution is advised when interpreting the results concerning the differences among attitudes of mental health nurses in various mental health-care settings. In general, mental health nurses who were older, had more clinical experiences in mental health care, and possessed greater empathy expressed more positive attitudes towards people with mental illness (Hsiao et al., 2015).

A recent study conducted in the Western Cape (Basson et al., 2014) reported that professional nurses with more experience in the psychiatric field demonstrate a more positive attitude and competency to assist MHCUs than those with less experience in this field. According to Basson et al., (2014) the level of education and training plays a major role in the attitude of professional nurses towards MHCUs. Education may help individuals with mental illness and their families alleviate their self-stigma, and therefore, improve adaptation to living with the hereditary nature of mental illness. Continuing education and training regarding

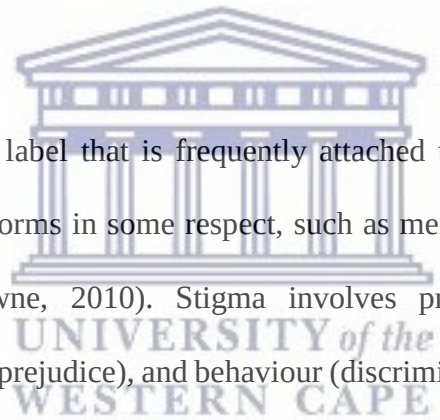
knowledge of nature and treatment effects of mental illnesses may enhance nurses' positive attitudes towards caring for people experiencing mental health problems (Hsiao et al., 2015).

The Theory of Planned Behaviour states that attitude towards behaviour, subjective norms, and perceived behavioural control all shape an individual's behavioural intentions. The theory suggests that behavioural beliefs, normative beliefs and control beliefs influence your intention to perform a behaviour (Ajzen, 2011). The main aim of this theory is to predict and understand the causes of behaviour (Leone, Perugini & Ercolani, 1999). In addition, many of the behaviours studied in the Theory of Planned Behavior include health-related behavior (Knabe, 2012: 43).

According to Knabe (2012), Theory of Planned Behaviour can be broken down into three conceptually independent antecedents leading to behavioral intention (BI): Attitude toward the Behavior (AAct), Perceived Behavioral Control (PBC) and Subjective Norms (SN) according to Ajzen (2011). Attitude toward the act is another predictor of behavioral intention. Attitude toward the act (AAct) is the degree to which performance of the behavior is positively or negatively valued by an individual. Perceived behavioral control refers to people's perceptions of their ability to perform a given behavior. The subjective norm (SN) construct is the perceived social pressure to engage or not to engage in a behavior. Attitude has been defined differently by different authors.

2.3. STIGMATIZATION

In the past as well as currently, clients with an intellectual disability or mental illness are isolated because of misconceptions and myths regarding mental illness. The stigma attached to mental illness is one of the greatest obstacles interfering with the quality of life improvement of clients and their families. Mental health professionals in the past, as well as currently, face a number of factors such as cultural beliefs, stigmatization as well as myths which threaten to derail the successful implementation of efficient mental health care in the community (Basson,2012).



Stigma is a negative label that is frequently attached to persons or groups who deviate from social norms in some respect, such as mental health. It is a form of discrimination (Browne, 2010). Stigma involves problems with knowledge (ignorance), attitude (prejudice), and behaviour (discrimination). Stigma associated with psychiatric disease continues to be a barrier to rehabilitation for many people in our society because staff at MHCUs also discriminate and stigmatize clients with mental illness (Ndetei et al., 2011).

People's tendency to regard mental illness as a stigma is a major hindrance to the development of healthy relationships between the mentally ill and their families. Stigma moreover is the factor that prevents mental health professional from implementing satisfactory mental health care in the community.

According to Corrigan (2004) stigmatization consists of four social-cognitive processes. The first step in the process is a cue such as seeing a member of a certain group and recognizing that something is different about that individual. This recognition that there is something different about the individual activates certain stereotypes within the observer's thought process. These stereotypes can be either positive (for example, men in suits and ties are trustworthy) or negative (for example, that unwashed looking person staring into space must be a mental patient). If the observer him- or herself shares these stereotypical views they are prejudiced. Consequently, prejudice is a result of cognitive and affective responses to stereotypes. Prejudiced stereotyping is deeply harmful to society for it causes discrimination that in its turn "causes mental, physical and socio-environmental damage to another person or group" (Boeh 2015:2). To make sense of lay people's conceptions of mental disorder and how these conceptions lead to stigmatizing, Boeh outlines three theories – attribution theory, essentialism theory and the folk psychiatry model that explain how people understand and interpret the behaviour of others.

Attribution theory was developed by Fritz Heider (1958) to show how people attribute (explain) the causes of events or behaviour. The theory encompasses stigmatization because when people refer to those with mental health conditions they frequently attribute stigmatizing characteristics to MHCUs such as 'people with mental health problems tend to be aggressive'. Essentialist theory comes from the belief that people can be categorized because they have fundamental essences

or stable unchanging characteristics in common that make them different and set them apart from other categories. This tendency of people to notice differences in others and then to put them into categories lends itself to stigmatization of a group. The practice of categorizing and from there to stigmatizing plays a large role in mental illness stigma. The 'mentally ill' are isolated from the 'normal' group and become targets for prejudice and discrimination.

The folk psychiatry model, like attribution theory, was developed in an attempt to model how people explain abnormal behavior. In order for someone to begin explaining a behavior within the framework of the folk psychiatry model, the behavior must be pathologized (Boeh, 2015). Moreover, stigma is a multidimensional construct, the various aspects of which may operate differently according to circumstances such as age, gender and culture (Reavley & Jorm, 2011). It has also been highlighted that certain cultures are more likely to stigmatize mental health problems than others (Papadopoulos, Foster & Caldwell, 2012).

Overton and Medina (2008) reported that the barriers people with a mental illness face in obtaining treatment services, is another way that stigma affects them. The most common barriers include financial challenges regarding paying for treatment, entry into treatment, and negative attitudes of mental health professional toward people with a mental illness. Mental health professionals' attitudes toward someone with a mental illness can perpetuate stigma. If a person with mental illness is able to reach out and seek services, the effects of stigma have been shown to influence the efficacy of his or her treatment (Overton & Medina, 2008). Stigma can originate from the very people in the mental health field who are expected to offer help to

persons with a mental illness. Most well-trained professionals in the mental health disciplines subscribe to the same stereotypes about mental illness as the general public (Overton & Medina, 2008). According to Kapungwe et al., (2010) stigma and discrimination towards the mentally ill have pernicious implications for prevention and treatment of mental illnesses, as well as the rehabilitation and quality of life of those who suffer from mental disorders. Overton and Medina (2008) reported that mental health practitioners are not immune to stigmatizing beliefs. Some, although not all, general and mental health practitioners may also hold certain negative attitudes towards the mentally ill. These negative attitudes may be conveyed to clients and their families and have an influence on their expectations. Fear is such a strong emotion that it may perpetuate stigma by creating more labels that influence clients' behaviors and symptoms.

Mental health practitioners may contribute to the development and reinforcement of mental illness stigma. Practitioners must work from a place of continuous self-examination and self-awareness in order to combat stigma. Health staff should themselves be an important target for anti-stigma initiatives. Besides the limited resources, stigma may be another main factor that hinders people with mental disorder from being treated. Stigma and discrimination are widely experienced by people with mental disorders, even in healthcare faculties. For this reason, it is not enough to promote the mental health staff's knowledge of mental illness. It is more important to train them to combat their own tendencies to stigmatize (Li et al., 2015).

The National Health Plan included mental health as one of the South Africa's health priorities. Mental health was integrated into primary care to eradicate the stigma but unfortunately MHCUs are not treated holistically in these facilities (Ndetei et al., 2011). One of the recommendations of this study was that psychiatric training should be incorporated to address the myths, beliefs and perceptions of mental illness.

De La Rosa and Tanase (2016) also stated that mental health practitioners are less optimistic about client recovery and the consumer's ability to integrate into the community. Mental health practitioners may contribute to the development and reinforcement of mental illness stigma. Practitioners must work from a place of continuous self-examination and self-awareness in order to combat stigma. Health staff should themselves be an important target for anti-stigma initiatives. Besides the limited resources, stigma may be another main factor that hinders people with mental disorder from being treated. Stigma and discrimination are widely experienced by people with mental disorders, even in healthcare faculties. For this reason, it is not enough to promote the mental health staff's knowledge of mental illness.

2.4. SUMMARY

The chapter discussed the literature that was reviewed to gain insight and understanding into factors that can influence the attitude and perception of the nursing staff towards the MHCU. Taking in consideration of all the above-mentioned factors, numerous studies have shown that the level of education and training received plays a major role in the attitude and perception of nursing staff towards mental illness: nurses with more experience have a more positive attitude than those with less experience. It is clear from the above discussions that attitude, whether positive or negative, will determine how a person is going to behave or react to the MHCU and that knowledge plays a major role in the behaviour of the nursing staff.

CHAPTER THREE RESEARCH DESIGN AND METHODOLOGY

3. INTRODUCTION

This chapter gives an account of the research design and methodology that was chosen for this particular study. In this chapter the research design, methodology inclusive of research setting, population and sampling, data collection and instrument, data analysis and ethics are discussed. The different components of the ASMI tool i.e. separatism, stereotyping, restrictiveness, benevolence and pessimistic prediction is also discussed.

3.1. RESEARCH DESIGN

A quantitative, descriptive research design was used to obtain information about the attitudes of nurses towards the mental health care users.

3.2. RESEARCH SETTING

Burns and Grove (2009) define a research setting as a place to conduct research. A natural setting that is uncontrolled and the place where the participant feels most comfortable pertaining to the work environment. Settings were decided on by the researcher in the Cape Metropole. The Metro District Health Services (MDHS) provides a comprehensive primary health service in the metropole. The MDHS consists of 8 sub-districts which are the: Southern, Western, Northern, Tygerberg, Mitchell's Plain, Klipfontein, Khayalitsa and Eastern areas. The sub-districts is further divided into 4 sub-structures: Southern/Western, Mitchells Plain/

Klipfontein, Khayalitsa/Eastern and Tygerberg/Northern. This study focused on the Southern/ Western sub-structure of MDHS comprising 3 District Hospitals, 2 Community Health Centres (24 hours) and 10 Community Day Centres (8 hours). (Western Cape Department of Health, n.d.). Retreat CHC falls under the Metro District Health Services in the southern-western sub-structure. The particular setting was chosen because it is a 24-hour facility and has a huge drainage area and has a trauma unit that operates 24/7.

3.3. POPULATION AND SAMPLING

According to Brink, a study population is the total group of people that is of interest to the researcher (Brink et al., 2006). The study population consisted of 56 permanent nurses of different categories although not all completed the questionnaire.

Table 1: Category and total of nursing staff working at Retreat CHC

CATEGORY	TOTAL
Clinical Nursing Practitioner (CNP)	6
Professional Nurse (PN)	23
Enrolled Nurse (EN)	8
Enrolled Nursing Assistant (EnNA)	19

3.4. SAMPLING

Sampling refers to the process of selecting a portion of the population that conforms to a designated set of specifications to be studied. A sample is a subset of a population selected to participate in the study (Polit & Beck, 2010). All-inclusive sampling was used because of the amount of nurses working at the CHC and to accommodate possible non responses.

3.5. INCLUSION CRITERIA

• The participant has to be registered with SANC as a nurse.

• The respondents have to be permanently employed at the Community Health Centre.

3.6 OBJECTIVES

The following objectives were formulated for this study:

1. To describe socio-demographics of respondents.

2. To determine the negative attitudes of nurses employed in this CHC towards MHCU's (Stereotyping, Seperatism, Restrictiveness, Stigmatization and Pessimistic predictions).

3. To identify the positive attitudes displayed by nurses employed in this CHC towards MHCU's (Benevolence).

4. To determine factors that might influence attitudes of nurses towards the MHCU.

3.7. DATA COLLECTION AND DATA COLLECTION INSTRUMENT

Data was collected using an existing questionnaire (Basson et al., 2014; Ng & Chan, 2000). This study used only primary data collected from respondents through a survey utilising a structured questionnaire that took place 2 weeks in December 2016. Primary data refers to first-hand information that has not yet been published but it also included data/literature of the original author. Consent form was detached from questionnaire and handed to participant to sign and drop in a box that was placed at the facility managers' office. Questionnaire was handed in a sealed

envelope by the researcher, to all nursing staff at the CHC and researcher collected the completed questionnaires. The questionnaires consisted of two sections, Section A: Socio-demographic information, Section B: the Attitude Scale for Mental Illness (ASMI),

Section A consisted of 13 questions pertaining to age, gender, ethnicity, qualification, working experience, education level completed and which department respondents were currently working in.

Section B: An adapted version of the ASMI questionnaire that measures the general attitude towards mental illness developed Ng and Chan (2000) was used. The adapted version is also known as the opinions about Mental illness in the Chinese community (OMICC) (Ng and Chan, 2000).

The 34 Likert scale items included five categories:

strongly disagree = 1, disagree = 2, uncertain =3, agree = 4, strongly agree =5). Questions were sub-divided into six conceptual factors or domains: separatism; stereotyping; restrictiveness; benevolence; pessimistic prediction and stigmatization. Stereotyping and stigmitization were discussed in detail in the literature review. Domain 31-34 was used to answer this objective. The mean score for each item in the domain ranged between 1.0 and 5.0. The items on the Benevolence domain were reverse coded. A better or healthy attitude is demonstrated by a high score on the benevolence domain and low scores on the other five domains while the reverse indicated an unhealthy attitude.

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3.7.1. PESSIMISTIC PREDICTION

Pessimistic prediction is a negative evaluative component towards mental health care users, and shows a strong level of prejudice (Poreddi et al., 2014). For instance, the majority of people believe that MHCUs are responsible for their own condition. This is particularly so if the mental illness is substance-induced psychosis or depression due to social circumstances or staying in an abusive relationship. This factor measured the level of prejudice of nurses towards the MHCU which was covered by questions 27 and 30. De La Rosa and Tanase (2016) also stated that mental health practitioners were less optimistic about client recovery and the consumer's ability to integrate into the community.

3.7.2. BENEVOLENCE

Benevolence relates to kindness towards the MHCU and thus nursing staff who rate high on the benevolence scale will probably be prepared to take full responsibility for the care and rehabilitation of the MHCU. A benevolent nursing staff would also be willing to get personally involved. Hence, the benevolence factor will be used to measure the paternalistic and sympathetic views of nurses towards mental health care users (Poreddi et al., 2014), which answered questions18-23, 25 and 26.

3.7.3. RESTRICTIVENESS

Restrictiveness refers to the way the mentally ill are treated on an in-patient as well as out-patient basis and how they are restricted to certain things in their community and even in their home environment. Restrictions are implemented to protect the relatives and society from the MHCU. Restrictiveness was used to measure the

nurses' views in terms of regarding mental health care users as a threat to society (Poreddi et al., 2014) and was questions 14 and 17. Throughout history and even today people with an intellectual disability or mental illness have been isolated because of misconceptions and myths regarding mental illness. However, research conducted in Kenya in 2011, involving a total of 684 general hospital staff consisting of nurses (47.8%); doctors (18.1%); registered clinical officers (5.1%); students (9.5%) and support staff (19.5%) revealed that most thought mental illness could be managed in general hospital facilities. The older the doctors were, 40 years and older, the more positive they were towards mental illness (Ndetei et al., 2011).

3.7.4. SEPERATISM

According to Basson (2014) separatism refers to the preference of nurses for treating patients with mental illness in an institution rather than at home within the community (Basson et al., 2014). This factor was intended to measure the degree of respondents' attitude of discrimination towards mental illness (Poreddi et al., 2014). Separatism was used to emphasize the uniqueness of the MHCU and questions 1-9 and 24 answered it.

3.7.5. STEREOTYPING

Stereotypes represent collectively agreed upon notions. People who stereotype mentally ill clients were often deemed efficient as they can quickly generate impressions and expectations of individuals who belong to a stereotyped group. For example, they might label all mentally ill clients as aggressive, unkempt, unpredictable, dangerous and living in a world of their own. This stigmatizing

tendency will be used to measure the respondents' maintenance of social distance towards mental health care users (Poreddi et al., 2014) and was covered by questions 10- 13.

3.8. DATA ANALYSIS

Data analysis in quantitative studies is conducted to reduce, organize, and give meaning to the data and to address the research aim(s) and specific research objectives (Burns & Grove, 2003). The quantitative data obtained will be analysed with the Statistical Package for the Social Sciences, (SPSS) version 20.0, for MAC with the help of a statistician. Descriptive statistics: means, median and standard deviations (SD) was calculated for the following variables:

seperatism; stereotyping; restrictiveness; benevolence; pessimistic prediction and stigmatization. For the purposes of this study, the confidence interval was set at 95%. The findings were represented in the form of graphs and tables which is discussed in detail in chapter four.

The modified scale (ASMI) has been validated and reported to yield a Cronbach's Alpha 0.87 (Hahn 2001). Basson's study indicates the Cronbach's Alpha ranged from average to very good ranging from 0.397 to 0.798 (Basson et al., 2014).

An exploratory analysis was done to explore the repeatability in this sample, but further mapping of the psychometric properties was not discussed as it was deemed irrelevant to this study. The study was not to assess the validity and reliability of the ASMI tool.

Table 2: Conceptual factors/Domains of ASMI Tool

Conceptual factors/Domain	Questions
Separatism	1-9 & 24
Stereotyping	10-13
Restrictiveness	14-17
Benevolence	18-23; 25 & 26
Pessimistic prediction	27-30
Stigmatization	31-34

3.9. ETHICAL STATEMENT

This study was done in accordance with the ethical and professional guidelines stipulated by Burns and Grove and Brink to enhance good ethical practices (Brink, 2001:32- 35; Burns & Grove, 2011:111-125). Ethical considerations and principles as specified in the Declaration of Helsinki were also applied and considered due to the fact that human beings were involved in the study. After permission and ethical clearance was obtained from relevant stakeholders (UWC- appendix 5), DOH and facility manager-appendix 4), informed consent (appendix 1) was sought from all respondents after they were informed about what the study entails. The investigator obtained written consent (appendix 2) after the respondents were informed about the purpose, aim of the study and all the relevant information pertaining to the rights of the respondents were explained. The following information was shared with the respondents prior to seeking their consent; the principal investigator, the contact details of the investigator, the title of the research study the purpose of the study, procedures that was followed, the duration of the study and how the results will be used and published (appendix 2).

Confidentiality was enhanced by ensuring that the respondents had the choice to omit their names from consent form and the consent form was separated from the questionnaire and given to participant to complete separately to ensure that confidentiality, privacy and anonymity are enhanced. Respondents were also informed that all the information will be handled confidentially and that no information will be disclosed without obtaining consent and that partaking in the study will not have an effect on current employment. To ensure privacy and anonymity respondents were also informed that the questionnaires will be placed in a lockable cupboard and password protected computers will be used to capture and analyse the data. The research will be stored in a secure location, whereby the researcher and the supervisor would have access to the research in lockable cabinets. The research data will be coded and data will be disposed of after 5 years of the findings being published.

Participation in the study was voluntary and respondents were not forced neither manipulated to participate in the research study.

No known risks or harm was identified during the study as well no benefits or compensation for partaking in study but their input might contribute towards development and implementation of training guidelines for all nursing staff and depending on the results even all other staff working in the health care system.

CHAPTER FOUR: PRESENTATION OF RESULTS

4. INTRODUCTION

Analyses of data during the research study are presented in this chapter. Data were collected using the Attitude Scale for Mental Illness (ASMI) questionnaire (see appendix 3). Tables and graphs are used to explain data collected and to compare the different types of attitude of nursing staff towards the mental health care user either by their years of experience and specific nursing category. Tables and graphs were inserted to explain data collected and analysed.

4.1. SAMPLE REALISATION

A total of 55 nursing staff working at the CHC in the Metro District Services participated in this research. Two of the questionnaires were omitted from the analysis due to incompleteness (respondents responded to alternate questions). The final sample size for the analysis was 53 (N=53). This sample represents 53/55 (95%) of the available nursing staff at the CHC in the Metro District services.

4.2 RESPONDENT'S SOCIO-DEMOGRAPHIC CHARACTERISTICS

Variables that were not completed were excluded in the analysis (n), hence the total next to the (n) indicates how many respondents answered the question from the total sample size (N=53). Only 4 % (2/53) of the sample were males while the majority, 96% of the respondents was female (51/53). The respondents were relatively equally distributed between the 4 stratified age groups, 22.7 % (10/44), 20.5 % (9/44), 27.3 % (12/44) but with majority about 29.5 % (13/44) falling between 56-

65 years age range. Due to personal reasons, nine (9) of the respondents omitted their age as they were not comfortable to divulge their age. Moreover, the majority, 84.6% (44/52), of the respondents were colored whilst black and Indian consisted of 15.4% (8/52) with no white respondents (Table 1).

All 53 respondents completed the questions pertaining to their level of education, 1.9% (1/53 completed grade 8 and 9 respectively, 5.7% (3/53) completed grade 10 and none of respondents completed grade 11 whereas majority 90.6% (48/53) completed grade 12. The majority of sample size was PN's, 52.8%, EN's 18.9% and ENA's consisted of 28.3% of the sample size. The years' experience ranged from 5 respondents working less than a year to 1 respondent (an ENA) that worked at DOH for 42 years. (Table 3).

Table 3: Socio-demographics characteristics of the sample

Variable	Response	Frequency	Percentage
Age (n=44)	20-35	10	22.7%
	36-45	9	20.5%
	46-55	12	27.3%
	56-65	13	29.5%
Ethnicity (n=52)	Black	7	13.5%
	Coloured	44	84.6%
	Indian	1	1.9%
Level of Education (n=53)	Grade 8	1	1.9%
	Grade 9	1	1.9%
	Grade 10	3	5.7%
	Grade 12	48	90.6%
Nursing (n=53)	Professional nurse	28	52.8%
	Enrolled nurse	10	18.9%
	Enrolled nurse assistant	15	28.3%

Duration in the profession (n=51)	less than a year	5 (9.4%)	9.4%
	1-10 years	14 (26.4%)	26.4%
	11-20 years	9 (17.0%)	17.0%
	21-30 years	12 (22.6%)	22.6%
	31-40 years	10 (18.9%)	18.9%
	41-50 years	1 (1.9%)	1.9%
Department currently working in (n=48)	Prep Room	2 (4.1%)	4.1%
	Injection Room	1 (2.1%)	2.1%
	Trauma or Triage	14 (29.2%)	29.2%
	Dressing Room	2 (4.2%)	4.2%
	MOU	22 (45.8%)	45.8%
	MIDC (ARV)	1 (2.1%)	2.1%
	Consultation Room	2 (4.2%)	4.2%
	Other	4 (8.3%)	8.3%

4.3. ASMI Cronbach's alpha (N=53)

The scale/ instrument were used to address objectives 2 and 3. The negative attitudes were captured by the separatism, stereotyping, restrictiveness, pessimistic prediction and stigmatization domains, whereas the positive attitude was captured by the benevolence domain. The initial step was exploration of reliability.

Internal reliability (Cronbach's Alpha) of the various sub scales of the ASMI ranged from average (0.405) to very good (0.763), with the exception of the stereotyping sub scale. The Stereotyping subscale had the lowest Cronbach alpha of 0.312 suggesting poor reliability between the 2 items in this domain. The low reliability could be attributed to the few numbers of items in this sub scale. The Cronbach's alpha is known to be subjected to inflation or deflation by too many or too few items. The aim was to use this validated questionnaire to explore nurse's attitudes

towards MHCU. The attained internal reliability (Table 4), was acceptable to proceed with addressing the set objectives.

Table 4: **ASMI: Cronbach's alpha (N=53)**

	Subscale/Domain	Number of items	Cronbach's Alpha
Scale ASMI	Separatism	10	0.763
	Stereotyping	2	0.312
	Restrictiveness	4	0.752
	Benevolence	8	0.525
	Pessimistic Prediction	4	0.405
	Stigmatization	4	0.623

Table 5 (Individual item mean score), Table 6 (Individual item mean, arranged in descending order per domain) and figure 1 (Scree plot illustrating the extracted components with their Eigen values) display further analysis for each item on the questionnaire to address the stated objectives.

Table 5: Individual item mean score

Descriptive Statistics		
	Mean	Std. Deviation
Q1	3.96	1.04
Q2	2.98	1.05
Q3	1.64	0.92
Q4	2.08	1.17
Q5	2.08	1.40
Q6	1.64	0.92
Q7	2.43	1.08
Q8	2.19	0.90
Q9	1.81	0.83
Q10	2.51	1.12
Q11	2.77	1.22
Q12	2.08	1.21
Q13	2.34	1.18
Q14	1.81	0.96
Q15	2.19	1.08
Q16	1.77	0.72
Q17	1.53	0.95
Q24	1.94	0.97
Q27	3.02	1.17
Q28	2.34	1.11
Q29	3.72	1.13
Q30	3.30	1.12
Q31	2.60	1.20
Q32	1.66	1.09
Q33	1.40	0.91
Q34	1.87	1.08
Q18	1.98	0.84
Q19	1.79	1.12
Q21	2.23	0.87
Q22	1.79	0.72
Q23	4.42	0.77
Q25	2.58	1.25
Q26	2.00	1.37
Q20	2.06	0.93

Table 6: Individual item mean, arranged in descending order per domain

	Descriptive Statistics	
Domain	**Item**	**Mean**
Separatism	Q1	3.96
	Q2	2.98
	Q7	2.43
	Q8	2.19
	Q4	2.08
	Q5	2.08
	Q24	1.94
	Q9	1.81
	Q3	1.64
	Q6	1.64
Stereotyping	Q12	2.08
	Q13	2.34
Restrictiveness	Q15	2.19
	Q14	1.81
	Q16	1.77
	Q17	1.53
Pessimistic	Q29	3.72
	Q30	3.30
	Q27	3.02
	Q28	2.34
Stigmatization	Q31	2.60
	Q32	1.66
	Q33	1.40
	Q34	1.87
Benevolence	Q23	4.42
	Q25	2.58
	Q21	2.23
	Q20	2.06
	Q26	2.00
	Q18	1.98
	Q19	1.79
	Q22	1.79

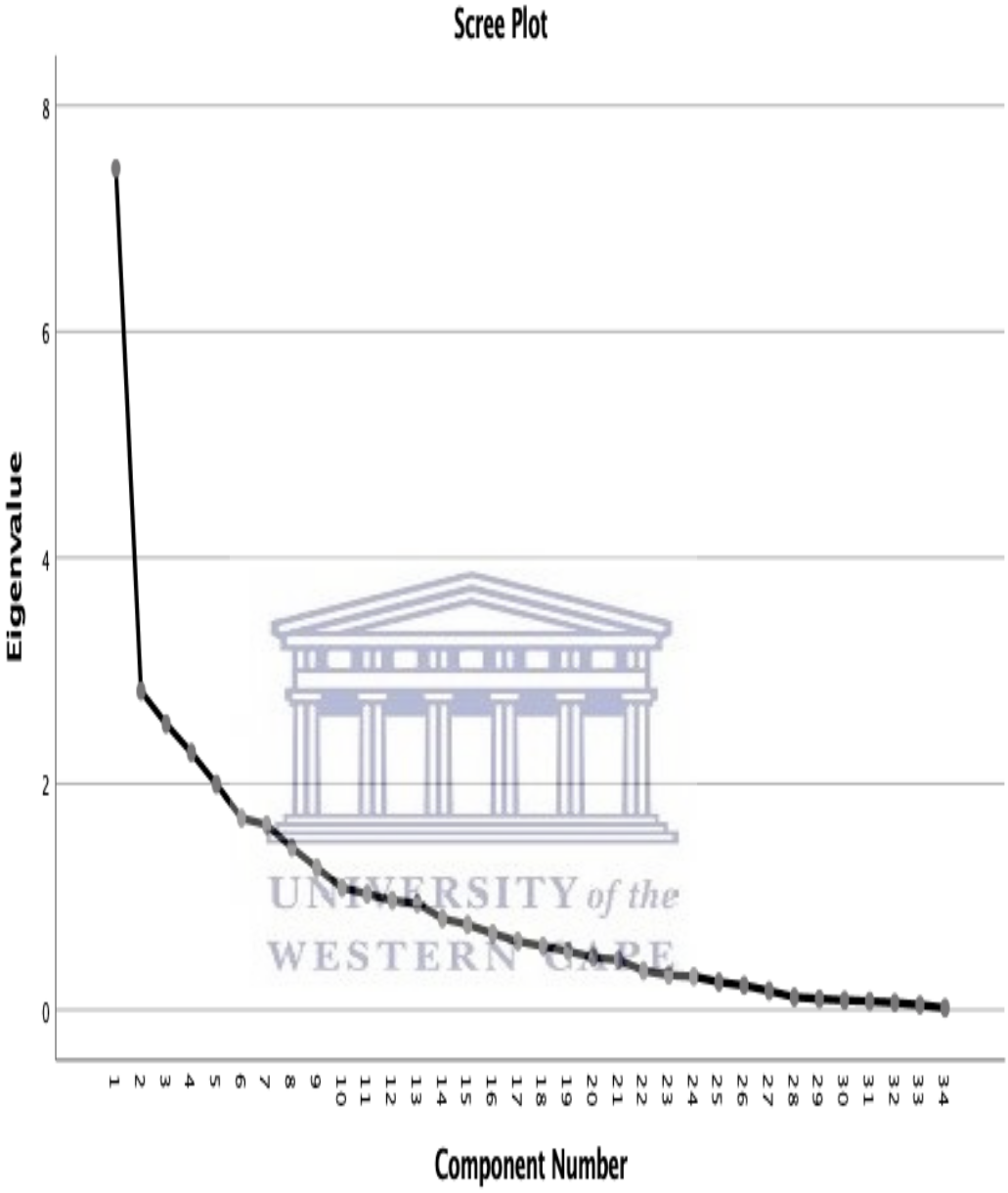

Figure 1: Scree plot illustrating the extracted components with their Eigen values

4.4 OVERALL DESCRIPTION OF THE ATTITUDES OF NURSES TOWARDS MHCU

The domain/construct specific means were used to assess attitudes towards MHCU. The mean scores of the items on benevolence domain was high while the other 5 domains were relatively low to average suggesting healthy attitudes towards MHCU (Figure 2). A specific look at each domain using the 2.0 as the cut off for each domain: Benevolence attitude is favorable at 3.64 (reverse coded) while the average scores on the separatism (2.28), stereotyping (2.21) and pessimistic prediction (3.10) demonstrated poor or negative attitude toward MHCU. Favorable scores were observed on restrictiveness and stigmatization domain. Taken together the overall attitude of nurses towards MHCU appear to be favorable but with specific areas of potential improvement.

An exploratory factor analysis was performed using Principal component analysis (PCA) and Varimax rotation. Varimax rotation method was selected as we did not assume any correlation of the factor. The Kaiser-Meyer-Olkin Measure of Sampling Adequacy was 0.461 and a significant Bartlett's Test of Sphericity ($x^2 = 989.923$, $p<0.001$) suggested an adequate sample size for this analysis. Unlike the original version that had 5 components, our analysis extracted 11 components with an Eigen value of greater than 1 **(see Figure 2 below).** The first component explained 21.89% of the total variance while the 11 components together explained 74.10% of the total variance. Emerging patterns of the factor analysis and how it compares to the original version of the AIMS was not explored as it fell beyond the scope of this thesis.

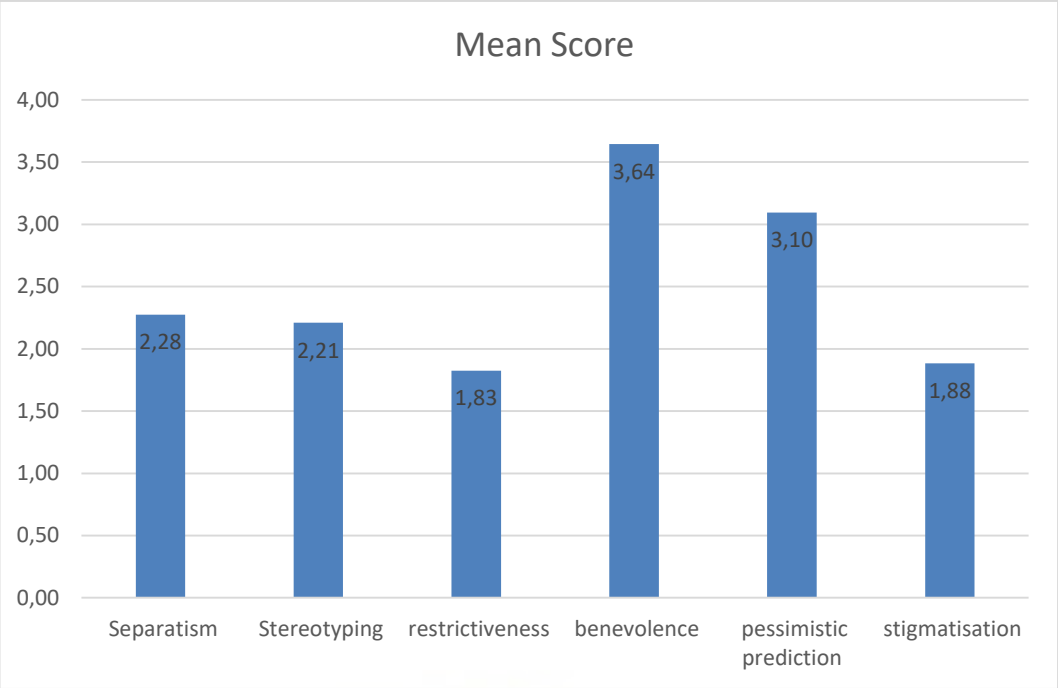

Figure 2: Descriptive statistics of the ASMI domains for the total sample (N=53)

4.5. COMPARISON OF ATTITUDES OF NURSING STAFF TOWARDS THE MHCU BY NURSING CATEGORIES

Independent samples Kruskal-Wallis test indicated no significant difference in mean rank scores between the various nursing categories. The six nursing categories (Regulations 425, 880, 212, 425, 880 and 212) were reduced into 2 categories and further analyzed but the independent sample Man Whitney test was still not significant for the two categories. The difference in the mean rank of stereotyping attitude 15.59 vs. 9.50 between the nurses with diploma vs. those with degree was large despite the non-significant p value of 0.146.

Table 7: ASM domain score for Professional Nurses (N=53)

Domain	Education	(n)	Mann-Whitney U	Wilcoxon W	Test statistics	Significance
Separatism	Degree	23	53	329.5	-0.241	0.81
	Diploma	5				
Stereotyping	Degree	23	32.5	47.5	-1.549	1.21
	Diploma	5				
Restrictiveness	Degree	23	53	329	-0.276	0.782
	Diploma	5				
Benevolence	Degree	23	46	61	-0.695	0.487
	Diploma	5				
Pessimistic prediction	Degree	23	52.5	67.5	-0.304	0.761
	Diploma	5				
Stigmatization	Degree	23	56.5	332.5	-0.061	0.952
	Diploma	5				

Table 8 ASMI subscales scores for Enrolled Nurses (EN) and Enrolled Nursing Assistants (ENA) (N=53)

Scale and Sub scales		Qualification	t-test	Standardised Beta coefficient	p-value	Confidence Interval 95%	
						Lower Bound	Upper Bound
ASMI	Separatism	EN	0.826	0.118	.413	-2.484	5.956
		ENA	1.864	0.267	.068	-0.263	7.068
	Stereotyping	EN	0.785	0.114	.436	-0.824	1.882
		ENA	1.473	0.214	.147	-0.313	2.037
	Restrictiveness	EN	0.204	0.030	.839	-1.891	2.319
		ENA	-0.094	-0.014	.925	-1.914	1.743
	Benevolence	EN	-0.440	-0.062	.662	-3.341	2.141
		ENA	-2.194	-0.311	.033	-4.981	-0.219

	Pessimistic	EN	-0.737	-0.103	.465	-2.634	1.220
		ENA	2.529	-0.353	.015	-3.781	-0.434
	Stigmatisation	EN	-0.476	-0.070	.636	-2.687	1.658
		ENA	-0.335	-0.050	.739	-2.201	1.572

In assessing the relationship between the nursing qualification on the specific attitudes, Professional nursing was used as the reference qualification in the linear regression. The only association that was statistically significant, was the association between pessimistic prediction attitude and qualification. All other attitudes appeared to have no statistical significant relationships. The pessimistic attitude model had a correlation of 0.33 and a total variance of 11.3 %. These were the highest correlation and variance values when compared to the other 5 models. Being an enrolled nursing assistant had a statistically negative association with a pessimistic attitude when compared with professional nurses. An EN was associated with less pessimism (more optimistic attitude) towards the MHCU.

4.6. FACTORS THAT INFLUENCE THE ATTITUDES OF NURSING STAFF TOWARDS THE MHCU

The researcher looked at factors that may influence nurses' specific attitude towards the MHCU. The exploration looked at the influence of participant's age, gender, ethnicity, nursing qualification status, nursing category (degree or diploma), ward currently working in and duration at work on specific attitude towards the mentally ill was explored. Spearman's correlations were used when looking at associations while Independent samples Mann-Whitney tests or Independent samples Kruskal-

Wallis tests was used to explore differences where variables had 2 or more categories respectively. Spearman's correlation analysis demonstrated a significant negative correlation between the number of years working in mental health and display of Separatism attitude (r =.259, p= .033) and Stereotyping attitude (r=.272, p =.027). Independent samples Kruskal-Wallis test indicated a significant distribution of ASMI stereotyping scores and duration in the profession (H= 14.364; df= 5, p= .011) when the duration in the profession was stratified. All other factors did not yield statistically significant associations, not statistically significant.

Duration at work had a low correlation of less than 0.2 with all the attitudes/sub scales and less than 5% of the variance in sub scales could be explained by the number of years one was at work. On the analysis of variance (ANOVA), the regression models generated for the 6 sub scales did not significantly predict the specific attitudes/subscales. A negative association was observed between duration at work and separatism, stereotyping, benevolence and stigmatization attitude. While a positive association was observed between duration at work and restrictiveness and pessimistic prediction. All associations observed were not statistically significant.

Table 7: ASMI subscales scores by duration at work

Scale and Subscale		t-test	Standardised Beta coefficient	P-value	Confidence Interval 95%	
					Lower Bound	Upper Bound
ASM	Separatism	-1.100	-0.152	.277	-0.183	0.053
	Stereotyping	-1.345	-0.185	.184	-0.062	0.012
	Restrictiveness	0.763	0.106	.449	-0.036	0.079
	Benevolence	-1.000	-0.139	.322	-0.117	0.039
	Pessimistic prediction	1.102	0.153	.275	-0.025	0.086
	Stigmatisation	-0.809	-0.113	.422	-0.083	0.035

4.7 SUMMARY

In conclusion it can be said that the nursing staff with more experience irrespective of category of nurse has less of a stereotyping attitude towards mental illness. The longer the nurse worked at the setting and irrespective of their nursing qualification the more positive their attitude towards the MHCU became.

CHAPTER FIVE: DISCUSSION OF RESULTS

5. INTRODUCTION

The study was aimed at assessing the attitudes of nursing staff working at a CHC in the Southern Western sub-district of the MDHS towards the MHCU, therefore also looking at the factors that might influence their attitudes.

1. To describe socio-demographics of respondents.

2. To determine the negative attitudes of nurses employed in this CHC towards MHCU's (Stereotyping, Seperatism, Restrictiveness, Stigmatization and Pessimistic predictions).

3. To identify the positive attitudes displayed by nurses employed in this CHC towards MHCU's (Benevolence).

4. To determine factors that might influence attitudes of nurses towards the MHCU.

5.1. OVERALL DISCUSSION OF RESULTS

This study explored and investigated the attitude of the nursing staff working in a CHC. The results revealed that the nurses had basic knowledge pertaining to the MHCU. The findings also revealed that the nurses displayed positive attitudes towards the MHCU. In addition, the results show that the Theory of Planned Behaviour is well suited for the study since a relationship between intentional behaviour and the behaviour of the nursing staff has been established, which is also dependent on cultural beliefs, age and years of experience.

In comparison with a similar study done in 2012 by Basson, her sample population (60 respondents) was only the professional nurses at a psychiatric hospital whereas

the current study was conducted at a CHC and all categories of nursing staff were included which was 53 nursing staff in total.

The results of the current study indicated that the majority of the respondents in the study were females (51/53) with only 2 (2/53) respondents being males, comparing with Basson (2012), the majority of respondents were also female but compared to this study there are more male respondents. This could be due to the different type of setting being a tertiary and psychiatric hospital compared to the CHC.

Pertaining to the ethnicity it was noted that more than half of the respondents were Coloured with only one Indian and the remainder were Black. There were no white respondents in the current study. The wards currently working in had no significant effect on the staff's attitude and most of the staff ticked of all the boxes as they were working in all areas depending on operational requirements. The majority of the sample size was PNs (by nursing category) consisting of nurses with either the R425, R880, R212 or with "other" which was the primary health care course (CNP) or advance midwifery although there is ENs and ENAs that has longer service records than the PNs.

Despite the fact that the PNs do get training pertaining to mental illness in their four year course irrespective if they have the diploma or degree it was established that the majority of the staff which is the ENs and ENAs combined, revealed that they never had any formal training pertaining to mental health. Although the results show that they have good background knowledge on mental health which could be due to the fact that they might have had someone in their family or community who

was diagnosed with a mental disorder. They acquired experience and knowledge on mental illness at the institution they work as a CHC is the first point of contact for the MHCU. The more they came in contact with a disease or illness the better the understanding. This basically stated the more exposure to the MHCU the more experience gained pertaining to mental disorders and how to handle the MHCU. Although it is well documented in previous studies that the attitudes can be influence by their training and experience the current study revealed that it was not just training but the attitude and years' experience of each individual and their beliefs that form their attitude to the MHCU.

According to Basson et al., (2014) and previous studies that was done it concluded that a health worker in general has negative attitudes towards mental health and its users e.g. They should be feared, they have unpredictable behaviour, they tend to be violent, and MHCU's are more dangerous than "normal" people. The current study contradicts these statements as majority of the respondents disagreed with these statements on the questionnaire. From the results of this study it can be reported that nurses have various attitudes towards the MHCU although majority of the staff are more tolerant towards the MHCU it can be concluded that different factors shapes different attitudes pertaining to mental disorders.

In conclusion it can be said that the younger the respondent and less the experience the more they are fearful and have negative attitudes towards the MHCU although not significant but to the detriment of the MHCU, as previous studies stated that the more negative attitudes of staff members the minimal contact there will be from

MHCU which can lead to poor service delivery and relapsing of the MHCU. The study has shown that there is a relationship between knowledge people have regarding mental illness and the years they worked as a nurse. This study also concludes that age, race, and rank has no significant effect on their attitude towards the MHCU.

The results in this study also indicated that the majority of respondents are of the view that MHCU's can work and still function optimally. The respondents also did not have a problem with MHCU's living in their areas and attending the CHC with other health care seekers. This could be due to the fact that most of the staff resides in the area/ community that they serve. At the current facility some of the MHCU's are permanently employed and this could have contributed to the responses on this statement. It is also noted that the MHCP (which is the researcher) gives continuous in-service training to the staff employed at the CHC which also could have had an impact on the staff's attitudes and the way they answered the questions.

CHAPTER SIX: RECOMMENDATIONS AND CONCLUSION

6. INTRODUCTION

The chapter concludes the study. It briefly discusses the limitations to the study as well as providing recommendations for further and future studies pertaining to the specific attitudes towards mental illness.

6.1. LIMITATIONS OF THE STUDY

The limitations of the current study are:

- That the researcher was employed at the specific CHC during data collection which could have influenced the responses.
- The sample size was small and limited to one CHC so findings cannot be or generalised to other CHC.

6.2. RECOMMENDATIONS

In the current study it is recommended that although positive attitudes are more prevalent than negative attitudes, the DOH should implement basic mental health training in there induction of all new staff employed by them to try an eradicate the myths, beliefs and how people perceive mental illness.

More in depth research needs to be done involving all health care workers, ranging from the security to the facility manager to enable an accurate study pertaining to attitudes towards MHCU's.

6.3. CONCLUSION

The attitudes measured indicated that the nurses in this study were more positive than negative towards mental health care users. There are less stigmatising and discriminating than similar studies that was conducted. MHCU's are also seen as less violent, not so dangerous, and seen as "normal" human beings with same needs as anybody else, who can work, have a family etc.

The results in this study also indicated that the majority of respondents are of the view that MHCU's can work and still function optimally. The respondents also did not have a problem with MHCU's living in their areas and attending the CHC with other health care seekers.

A possible reason for the overall positive attitude could be because the researcher provides continuous in-service training to the staff employed at the CH.

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Appendix 1: INFORMATION SHEET

PROJECT TITLE: ASSESSING THE ATTITUDES OF NURSING STAFF WORKING AT COMMUNITY HEALTH CENTRES TOWARDS MENTAL HEALTH CARE USERS

What is this study about?

This is a research project being conducted by Michelle Hendricks at the University of the Western Cape. We are inviting you to participate in this research project because you have valuable information to contribute to the study. The purpose of this research project is to determine if the level of training and work experience of nurses' influence nurses' attitudes towards the mental health care users.

What will I be asked to do if I agree to participate?

You will be asked to complete a questionnaire distributed by the researcher to the facility manager at the respective CHCs. The completion of the questionnaire will take approximately 20 minutes and should be handed in a sealed envelope to the researcher.

Would my participation in this study be kept confidential?

The researcher undertakes to protect your identity and the nature of your contribution. To ensure your anonymity, the questionnaire does not require you to enter any personal details

To ensure your confidentiality, all questionnaires will be kept confidential and locked in a cabinet where only the researcher has access to. Your identity will be protected in the written study report or any publication. In accordance with legal requirements and/or professional standards, we will disclose to the appropriate individuals and/or authorities' information that comes to our attention concerning

child abuse or neglect or potential harm to you or others. In this event, we will inform you that we have to break confidentiality to fulfil our legal responsibility to report to the designated authorities.

What are the risks of this research?

There may be minimal risks involved in participating in this research study. Risks associated with participating in the study will be minimized, and should any discomfort be experienced, support and counselling will be available and provided to the respondents that may experience any discomfort before, during or after the research.

What are the benefits of this research?

This research is not designed to help you personally, but the results may help the investigator learn more about the attitudes of nursing staff working towards mental health care users**.**

We hope that, in the future, other people might benefit from this study through improved understanding of how attitude of nurses influence the service rendered to mental health care users in community health centres.

Your participation in this research is completely voluntary. You may choose not to take part at all. If you decide to participate in this research, you may stop participating at any time. If you decide not to participate in this study or if you stop participating at any time, you will not be penalized or lose any benefits to which you otherwise qualify. Participation in the research is not a course requirement.

What if I have questions?

This research is being conducted by *Mrs Michelle Hendricks from the School of Nursing* at the University of the Western Cape. If you have any questions about the research study itself, please contact *Mrs Michelle Hendricks* at:
School of Nursing

University of the Western Cape
Private Bag X17
Bellville 7535
Tel.: 073 2689956
Email: 2556197@myuwc.ac.za

Or the study supervisor:
Prof H Julie
School of Nursing
University of the Western Cape
Private Bag X17
Bellville 7535
Tel: 021 959 2749
Email: hjulie@uwc.ac.za

Should you have any questions regarding this study and your rights as a research participant or if you wish to report any problems you have experienced related to the study, please contact:
Prof Karien Jooste
Head of Department: School of Nursing
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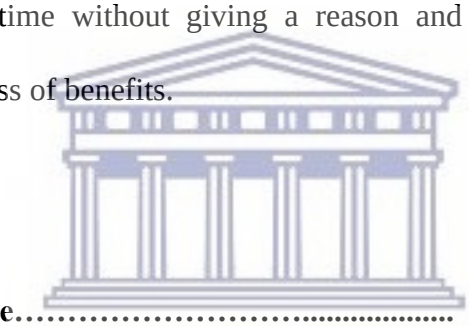
Appendix 2: CONSENT FORM

Title of Research Project: Assessing the attitudes of nursing staff working at community health centres towards mental health care users.

The study has been described to me in language that I understand. My questions about the study have been answered. I understand what my participation will involve and I agree to participate of my own choice and free will. I understand that my identity will not be disclosed to anyone. I understand that I may withdraw from the study at any time without giving a reason and without fear of negative consequences or loss of benefits.



Participant's name…….....

Participant's signature…….

Date……..……

Appendix 3: Questionnaire Nurses' attitudes towards the mental health care users

Thank you for taking the time to complete the questionnaire. Once you have completed all the questions, please seal the questionnaire with the consent form in the self-addressed envelope and keep it until the researcher returns to collect it from you.

This questionnaire consists of section A, the demographics section and section B consist of 34 statements dealing with the attitudes towards mental illness. It will take about 20 minutes to complete.

Please place a tick √ in the box that best represents your agreement or disagreement with each statement.

SECTION A: Demographic Data

1. **Date**

2. **Gender**

Male	Female

3. **Participant Number**

4. **Age in years**

5. **Race**

Black	Coloured	Indian	White	Other

6. **Education**

Gr 8	Gr 9	Gr 10	Gr 11	Gr 12

7. **Nursing diploma**

R880	R212	Other_____

8. Nursing degree

R425	Other_____

9. Enrolled nurse

10. Enrolled Nursing assistant

11. Have you completed the Advanced Mental Health Course

Yes	No

12. How long have you been working as a nurse?

Years	Months

13. Please tick the box that describes the department you presently are working in.

Triage/ Prep room	Injection room	Trauma	Dressing Room	MOU	ARV(MIDC)	Mental health	Other

SECTION B: Attitude Scale for Mental Illness (ASMI)

Please indicate how much you agree or disagree with each of the following statements about working with people with *mental health problems*.

The position of the number you choose to encircle will depend on how strongly you feel about the statement.

The more you agree with the statement the closer your number choice will be to the strongly agree statement.

On the other hand, the more you disagree with the statements the closer your number choice will be to the strongly disagree.

(1) Strongly Disagree (2) Disagree (3) Uncertain (4) Agree (5) Strongly Agree					
1. People with mental illness have unpredictable behaviour.	1	2	3	4	5
2. If people become mentally ill once, they will easily become ill again.	1	2	3	4	5
3. If a mental health facility is set up in my street or community, I will move out of the community.	1	2	3	4	5
4. Even after a person with mental illness is treated, I would still be afraid to be around them.	1	2	3	4	5
5. Mental patients and other patients should not be treated in the same hospital.	1	2	3	4	5
6. When a spouse is mentally ill, the law should allow for the other spouse to file for divorce.	1	2	3	4	5
7. People with mental illness tend to be violent.	1	2	3	4	5

8. People with mental illness are dangerous.	1	2	3	4	5
9. People with mental illness should be feared.	1	2	3	4	5
10. It is easy to identify those who have a mental illness.	1	2	3	4	5
11. You can easily tell who has a mental illness by the characteristics of their behaviour.	1	2	3	4	5
12. People with mental illness have a lower I.Q.	1	2	3	4	5
13. All people with mental illness have some strange behaviour.	1	2	3	4	5
14. It is not appropriate for a person with mental illness to get married.	1	2	3	4	5
15. Those who have a mental illness cannot fully recover.	1	2	3	4	5
16. Those who are mentally ill should not have children.	1	2	3	4	5
17. There is no future for people with mental illness.	1	2	3	4	5
18. People with mental illness can hold a job.	1	2	3	4	5
19. The care and support of family and friends can help people with mental illness to get rehabilitated.	1	2	3	4	5
20. Corporations and the community (including the government) should offer jobs to people with mental illness.	1	2	3	4	5
21. After a person is treated for mental illness they can return to their former job position.	1	2	3	4	5
22. The best way to help those with a mental illness to recover is to let them stay in the community and live a normal life.	1	2	3	4	5
23. After people with mental illness are treated and rehabilitated, we still should not make friends with them.	1	2	3	4	5

24. After people with mental illness are treated, they are still more dangerous than normal people.	1	2	3	4	5
25. It is possible for everyone to have a mental illness.	1	2	3	4	5
26. We should not laugh at the mentally ill even though they act strangely.	1	2	3	4	5
27. It is harder for those who have a mental illness to receive the same pay for the same job.	1	2	3	4	5
28. After treatment it will be difficult for the mentally ill to return to the community.	1	2	3	4	5
29. People are prejudiced towards those with mental illness.	1	2	3	4	5
30. It is hard to have good friends if you have a mental illness.	1	2	3	4	5
31. It is seldom for people who are successful at work to have a mental illness.	1	2	3	4	5
32. It is shameful to have a mental illness.	1	2	3	4	5
33. Mental illness is a punishment for doing some bad things.	1	2	3	4	5
34. I suggest that those who have a mental illness do not tell anyone about their illness.	1	2	3	4	5

Thank you for taking the time to complete the questionnaire

Appendix 4

Permission letter from Department of Health

Western Cape Government
Health

STRATEGY & HEALTH SUPPORT
Health.Research@westerncape.gov.za
tel: +27 21 483 6857: fax: +27 21 483 9895
5th Floor, Norton Rose House,, 8 Riebeek Street, Cape Town, 8001
www.capegateway.gov.za)

REFERENCE: WC_2016RP10_537
ENQUIRIES: Ms Charlene Roderick

University of Western Cape

Robert Sobukwe Road

Bellville

Cape Town

7535

For attention: Mrs Michelle Hendricks

Re: **Assessing the attitude of nursing staff working at community health centres towards mental health care users.**

Thank you for submitting your proposal to undertake the above-mentioned study. We are pleased to inform you that the department has granted you approval for your research.

Please contact following people to assist you with any further enquiries in accessing the following sites:

Retreat CHC	**Henry Lemmetjies**	**021 713 9741**
Vanguard CDC	**Luntu Mbanga**	**021 685 8242**

Kindly ensure that the following are adhered to:

1. Arrangements can be made with managers, providing that normal activities at requested facilities are not interrupted.
2. Researchers, in accessing provincial health facilities, are expressing consent to provide the department with an electronic copy of the final feedback (**annexure 9**) within six months of completion of research. This can be submitted to the provincial Research Co-ordinator (Health.Research@westerncape.gov.za).

3. In the event where the research project goes beyond the *estimated completion* date which was submitted, researchers are expected to complete and submit a progress report (**Annexure 8**) to the provincial Research Co-ordinator (Health.Research@westerncape.gov.za).

4. The reference number above should be quoted in all future correspondence.

Yours sincerely

AT HAWKRIDGE.

DR A HAWKRIDGE

DIRECTOR: HEALTH IMPACT ASSESSMENT

DATE: 16/11/2012.

CC: **K GRAMMER** **DIRECTOR: SOUTHERN/WESTERN**

Appendix 5: Ethical Clearance letter UWC

This research has been approved by the University of the Western Cape's Research Ethics Committee.

HS 16/5/32

OFFICE OF THE DIRECTOR: RESEARCH AND INNOVATION DIVISION

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31 August 2016

Ms MD Hendricks

School of Nursing

Faculty of Community and Health Sciences

Ethics Reference Number HS 16/5/32

Project Title: Assessing the attitude of nursing staff working at community health centres towards the mental health care user.

Approval Period: 29 July 2016- 29 July 2017

I hereby certify that the Humanities and Social Science Research Ethics Committee of the University of the Western Cape approved the methodology and ethics of the above mentioned research project.

Any amendments, extension or other modifications to the protocol must be submitted to the Ethics Committee for approval. Please remember to submit a progress report in good time for annual renewal.

The Committee must be informed of any serious adverse event and/or termination of the study.

Ms Patricia Josias

Research Ethics Committee Officer

University of the Western Cape

PROVISIONAL REC NUMBER - 130416-049

Appendix 6: Editors Letter

30 Fir Lane

Tokai

7945

Phone 0217121641

3 April 2018

To whom this may concern

This letter is to confirm that I edited the Master's thesis of Michelle, Dianna Hendricks (2556197) entitled "Assessing the attitude of nursing staff working at a community health centre towards the mental health care user".

Yours sincerely

Morgan Merrington PhD (UCT1989)