DEVELOPING A PROTOCOL FOR CAMPUS HEALTH SERVICE PROFESSIONAL NURSES TO MANAGE STUDENTS WITH MENTAL DISTRESS

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DEVELOPING A PROTOCOL FOR CAMPUS HEALTH SERVICE PROFESSIONAL NURSES TO MANAGE STUDENTS WITH MENTAL DISTRESS

By

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SUPERVISOR: PROF. J. STRÜMPHER

DECLARATION

I, Linda Louise Dalton (student number 180029390), hereby declare that this research paper in partial fulfilment for the degree Magister Artium in Health and Welfare Management is my own work and that it has not previously been submitted by me or anyone else for assessment to another University or for another qualification.

Linda Louise Dalton

December 2010

DEDICATION

My sincerest appreciation to the following people for without their support, assistance and encouragement this study would not have been possible:

To God Almighty

My dearest husband Leon, children and family, for without their support this would not have been possible

My supervisor in this study, Professor J Strümpher, for her guidance, patience and commitment

All the participants who willingly contributed to the success of this study. Without their contribution this study would not have been possible

Mrs Gail Klopper, auditor and editor of this study.

ABSTRACT

Professional nurses working at a campus health service have to cope with challenges such as staff shortages and budgetary constraints associated with working in a complex environment providing primary health care. The aim of primary health care includes promoting health, preventing disease and the early detection and treatment of illness. Mental health services form an integral part of the integrated primary health care package as implemented in the campus health service.

Students attend the Campus Health Service for help related to their health. Health care is provided by professional nurses and counsellors through a comprehensive primary health care service which serves students as well as staff. Some students may state that they experience feelings of being stressed or depressed. Other students may complain of physical symptoms such as headache or upper backache. Upon further investigation emotional problems may be identified as the cause of the psychosomatic symptoms. The professional nurses working in the campus health service verbalised that it is sometimes difficult to identify a mental illness or mental distress as there is no effective assessment tool that they can use. Management of conditions is also problematic as there are no protocols indicating the therapeutic interventions that can be taken.

The research question in this study was therefore: What information should be included in a protocol to assess and manage a student experiencing mental distress that can be used by professional nurses working in a Campus Health Service?

The aim of this study is to develop a mental health care protocol for campus health service professional nurses to assess and manage university students who are experiencing mental distress.

The research design of this study was qualitative, explorative, descriptive, explanatory and contextual. In this study the Delphi research technique was used to create an instrument to standardise mental health care in a campus health service. The Delphi technique is a series of sequential questionnaires or “rounds” interspersed with controlled feedback that seeks to gain the most reliable consensus of opinion of a group of experts. A questionnaire was developed based on an extensive literature review.

The research population of this study consisted of two groups: professional nurses with knowledge of student health care needs and expert psychiatric nurses. The study was conducted at the Campus Health Service at a university in the Eastern Cape. The data collection and analysis was done utilising the Delphi technique.

Trustworthiness was ensured by using the Lincoln and Guba Model utilising the criteria of credibility, applicability, dependability and conformability. In this study the ethical principles of beneficence, non-maleficence, justice and self determination were applied to ensure that participants are treated with respect and consideration and ensured high ethical standards. Informed consent was obtained from the participants in this study.

The findings of this research were utilised to assist the researcher in developing a protocol for mental health care of students in campus health service settings.

Key Terms

Campus Health Service, Nursing Management, Mental Distress, Primary Health Care, Professional Nurse, Protocol, Student.

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CHAPTER 1

INTRODUCTION AND OVERVIEW OF THE STUDY

1.1 INTRODUCTION

The aim of this study is to develop a mental health care protocol for campus health service professional nurses to assess and manage university students who are experiencing mental distress.

In this chapter the following aspects will be discussed:

- Context of research
- Background and literature review
- Research problem and research question
- Research goal
- Concept clarification
- Research design
- Pilot study
- Literature control and review
- Ethical considerations
- Role of the researcher
- Dissemination of results
- Chapter division

1.2 CONTEXT OF RESEARCH

The University, as a higher learning centre, aims to educate and prepare students for a career. To attain this every student needs to be well balanced – mentally, physically and socially. Health, and especially mental health, is important to enable the students to successfully complete their studies. Student life brings about many

challenges such as a high workload, tests, assignments, examinations, financial constraints, stress and many more. With heightened levels of stress and lack of sleep, health problems can occur which may interrupt their studies.

According to the statistics of the Campus Health Service where the researcher works, most undergraduate students using the service are between the ages of 18 and 22 years old. Sadock & Sadock (2007:40) state that this age group is most at risk for unplanned pregnancies, alcohol abuse, HIV infection and sexually transmitted diseases. Post-abortion syndrome is another common problem seen by health care professionals. Coupled with having problems at home in their families of origin, financial worries or choosing the wrong study direction it is not surprising that students sometimes develop mental distress. This is coupled with the normal stressful life of being a student created by the pressure of a heavy workload, tests, assignments and examinations. Most students are adolescents starting adult life away from a known, secure home environment without direct parental support and are required to make their own choices. Given the students' limited life experience these stressors have the potential to create significant periods of crises.

Students attend the Campus Health Service for help related to their health. Professional nurses and counsellors provide health care through a comprehensive primary health care service that serves students as well as staff. Mental health services form an integral part of the integrated health service that is available to assist and manage problems through consultation, evaluation, counselling and referral (Department of Health: 2000(a):23). The African National Congress's National Health Plan for South Africa states that mental health services form an integral part of the integrated primary health care package in South Africa (1994:1). This was later incorporated in the National Health Act no 61 of 2003 (South Africa [SA], 2003:45). Problems however exist on how to transform health practices of the past into one where comprehensive mental health care will be incorporated into every primary health care setting. At the university Campus Health Service where the researcher works there is an emphasis on physical care and the mental health needs of students are not always addressed.

Protocols for the management of mental health needs were identified in other countries during an Internet search. The Cornell University, in the United States of America (Hubble, 2010:1-10) is an example of this. This medical centre provides primary health care to the students and has various protocols in place to deal with mental distress. In comparison, no South African primary health care clinic or campus health service has a mental health care protocol available to professional nurses for use in clinics or campus health services.

1.3 BACKGROUND AND LITERATURE REVIEW

According to the original Alma Ata Declaration (World Health Organization, 1978:1), health is a fundamental human right. In 1948 the World Health Organization (WHO) defined health as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity (WHO, 2008:9). This interpretation is a holistic and comprehensive view of health that recognizes the influence of factors in the social, economic and physical environment on a person's well-being as well as ensuring mental health.

Mental health is a complex phenomenon and the concept necessitates clarification. Mental health or emotional health can be defined as a state of emotional well-being in which a person is able to function comfortably within his/her working and loving relationships and can solve conflicts by coping and adjusting to the current stresses of everyday living. Mental health includes a positive attitude towards themselves, growth, development, self-actualization, integration, autonomy, reality, perception and an ability to cope with their environment (Stuart & Laraia, 2005:865). This does not mean that a mentally healthy person does not have emotional problems nor may not experience severe distress, but rather that they have the ability to cope with the distress (Uys & Middleton, 2004:753).

Figure 1.1 identifies some indicators of good mental health that may include:

empathy, resilience to stress, a sense of belonging, clear thinking, productive behaviour, ability to take care of self and others, a sense of well-being and contentment, flexibility, spirituality (finding meaning in one's life), optimism, self-confidence, respect for others, stable relationships and empathy.

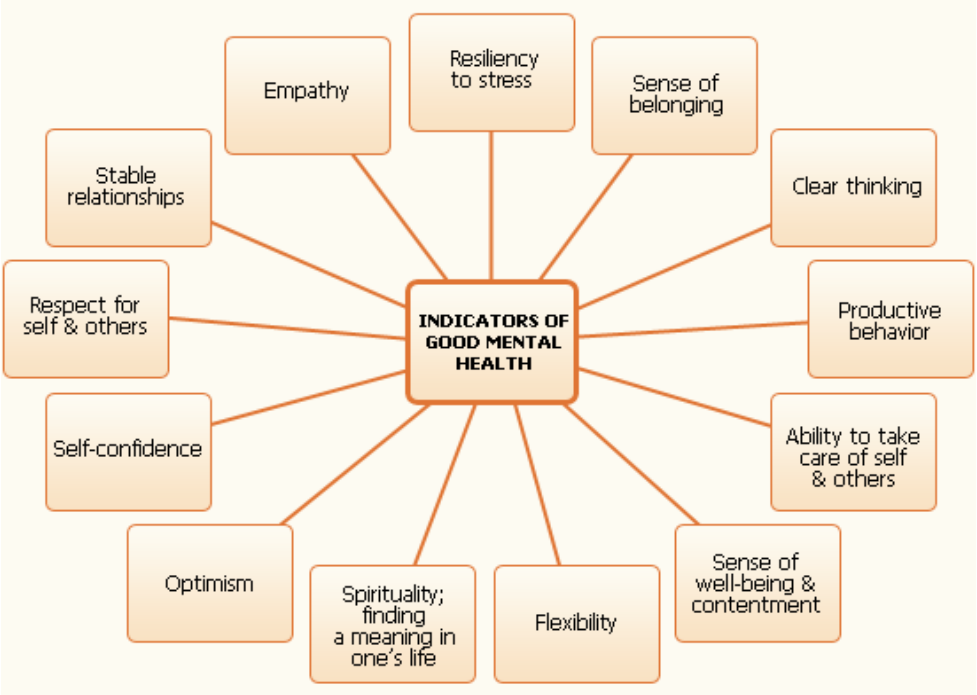


Figure 1.1: Indicators of good mental health. Available: http://www.m-m-clinic.com/r_goodmentalhealth.html (Accessed 25 November 2010)

What is mental distress? The words "distress" and "discomfort" are often used interchangeably. Mental distress can be seen as the precursor for mental illness. Collins (2001:176) defines distress as mental pain, to upset badly or cause physical trouble. The South African Federation for Mental Health (2009:10) states that mental distress is a condition affecting the mental state of a person to such an extent that it causes significant distress to the person, and/or it produces impairment in the person's ability to function socially, occupationally and in caring for themselves in all aspects. Mental discomfort is among the most common conditions affecting health today and although a person experiencing mental discomfort is not mentally ill, the symptoms may be precursors to a more serious mental disorder. Students experiencing excessive amounts of stress may develop problems such as not being able to cope, developing major depression, and may become unsuccessful in their studies. Using Figure 1.1 as a point of reference,

poor mental health will show the opposite signs and symptoms including loss of empathy, loss of resilience to stress, a lost sense of belonging, loss of clear thinking, loss of productive behaviour, loss of the ability to take care of self and others, a loss of sense of well-being and contentment, loss of flexibility, loss of spirituality (finding meaning in one's life), loss of optimism, loss of self-confidence, loss of respect for others, loss of stable relationships and loss of empathy.

What is mental illness? The words "disorder" and "illness" can be used interchangeably. The Mental Health Care Act no 17 of 2002 (SA, 2003:6) defines mental illness as a positive diagnosis of a mental health related illness in terms of accepted diagnostic criteria made by a mental health care practitioner authorised to make such a diagnosis. De Haan (2006:182) states that the exact cause of most mental illnesses is not known. Many of these conditions are caused by a combination of genetic, biological, psychological and environmental factors. Mental illnesses may run in families suggesting that the illnesses may be passed on from parents to children genetically. Kirby, Hart, Cross & Mitchell (2004:82) state that the symptoms of mental disorders vary depending on the type and severity of the disorder or distress. Some of the general symptoms that may be experienced by students and which may suggest a mental illness may include:

- Confused thinking
- Long-lasting sadness or irritability
- Extreme highs and lows in mood, strong feelings of anger
- Excessive fear, worry or anxiety
- Social withdrawal
- Dramatic changes in eating or sleeping habits
- Delusions or hallucinations (seeing or hearing things that are not really there)
- Increasing inability to cope with daily problems and activities
- Thoughts of suicide
- Denial of obvious problems
- Many unexplained physical problems
- Feelings of worthlessness, guilt or anxiousness
- Deterioration in class results, poor concentration, inability to make decisions,
- Abuse of drugs and/or alcohol

(Kirby, *et al*, 2004:80–91; Gamble & Brennan, 2003:42–62; Sadock & Sadock, 2007:14, 36-41)

Mental and behavioural disorders are not exclusive to any special group: they are found in people of all regions, all countries and all societies of the world. According to the World Health Organization's *World Health Report of 2001, a*bout 450 million people suffer from mental disorders worldwide. One person in four will develop one or more mental or behavioural disorder during their lifetime (WHO, 2001:23). Mental and behavioural disorders are present at any point in time in about 10% of the adult population of a country (WHO, 2001:23).

Mental health statistics in South Africa are scarce. Pauw of *Health24.com* reported the following statistics for South Africa (2009:1):

- Approximately five million people in South Africa suffer from a psychiatric disorder. If alcohol and drug abuse are included in this figure, it rockets to a frightening 15 million people
- Approximately 30% of the South African population are likely to suffer from a mental health problem severe enough to require hospitalisation
- The lives of one in five South Africans are significantly affected by a mental disorder
- An estimated 20% of children in South Africa suffer from a mental illness due to the levels of violence and family problems that occur in South Africa
- Nearly 20% of high school students a year think about fatally harming themselves
- General practitioners noticed that 25% of visits to their practice are usually due to some sort of mental problem.

The World Health Organization (2003(b):2) states that the lack of attention to the mental health of young adults may lead to mental disorders with lifelong consequences, undermine compliance with health regimens, and reduce the capacity of individuals to be safe and productive. Mental health problems are real, painful and can be severe. Kent Hubble (2010:2) from Campus Health at the Cornell University in the United States of America states that signs of mental health problems in students include

educational failure, loss of friends and or family conflict. During the course of an academic year students have to contend with a myriad of stressors as mentioned previously that may overwhelm them.

Some teens/young adults are troubled by frequent intense and painful emotions and have to learn to cope with emotions in different ways. Tears, anger, depression and social withdrawal are some of the ways of responding to (and finding relief from) overwhelming stress. While some are able to deal with these feelings, others react differently to their problems because they have not been taught ways to handle their emotions effectively. They are unable to find the words to describe these emotions and the build-up of feelings makes it difficult for them to think clearly. To release this bottleneck of feelings they may cut, burn or otherwise hurt themselves. Self-injury provides immediate relief, but this is a short-term solution with serious consequences (Stuart & Laraia, 2005:763).

If not managed, such intense long and short-term distress can cause emotional, physical, intellectual and spiritual difficulties. It should also be taken into consideration that more severe forms of mental illness such as depression, schizophrenia and even bipolar disorder tend to manifest themselves at this age (Sadock & Sadock, 2007:467). Known or new emotional and mental problems may emerge and pre-existing emotional difficulties may often be intensified. Students experiencing discomfort on an emotional level may seek help from or be brought to a campus health service by friends, lecturers or roommates.

The student experiencing symptoms of mental distress who seeks care at the campus health service will either be referred to a counsellor, a medical practitioner or to the state health care system. In South Africa tertiary institutions provide health care to its staff and students through units called Campus Health Services which are served by:

- Medical doctors to medical aid/private clients and are managed similarly to general practitioners offices, or
- Nurse managed services providing primary health care similar to community clinics. They provide services such as emergency care, family planning,

HIV/Aids care, care for sexually transmitted diseases, and tuberculosis care, treatment for minor ailments and referral for chronic care for students who do not have medical aid cover and cannot afford private medical doctors. Students on medical aid will receive the same care, but will be referred to their own doctors for follow up care.

The patient population of a campus health service may be diverse. Although it mainly consists of students who are young adults, the patient population also includes university employees who may suffer from acute or chronic conditions. The latter group are also recipients of occupational health services. This study will focus only on the need of young adults who are undergraduate students. The employee's health care needs will be excluded from this study.

1.4 RESEARCH PROBLEM AND RESEARCH QUESTION

As already discussed the student experiencing symptoms of mental illness or mental distress may seek care at the campus health service. Some students may state that they are experiencing feelings of being stressed or depressed. Other students may complain of physical symptoms such as headache or upper backache. Upon further investigation emotional problems may be identified as the cause of the psychosomatic symptoms.

The professional nurses working in the campus health service verbalised that it is sometimes difficult to identify a mental illness or mental distress, as there is no effective assessment tool that they can use. Management of these conditions is also problematic as there are no protocols indicating the therapeutic interventions that can be made.

Emotional problems may have various causes as discussed previously. Statistics of the Campus Health Service over the past 5 years show the total clients seen per year and the percentage recorded as psychological problems:

2006: 1 % of the total clients (15020) seen were diagnosed as psychological.

2007: 1 % of the total clients (14785) seen were diagnosed as psychological.
2008: 1 % of the total clients (15504) seen were diagnosed as psychological.
2009: 1 % of the total clients (16453) seen were diagnosed as psychological.
(September) 2010: 1 % of the total clients (13611) seen was diagnosed as psychological.

Although the above statistics suggest a low incidence of mental distress, it is suspected that the problems identified by these statistics are just the tip of the iceberg and that it proves the need for a protocol to assess mental status or mental distress.

By providing staff with a protocol to use as a guide, it is hoped that staff will feel comfortable in dealing with students experiencing mental distress. A protocol could provide them with a guideline should a client require consultation, evaluation, counselling or referral. The protocol will also help in determining if the referral requires a general practitioner, a psychologist, a psychiatrist or hospitalization.

De Vos, Strydom, Fouchè and Delport (2005:101) state that qualitative research questions are messy, flexible and not always predictable. It is however critical to ask the correct questions in order to gain the required data. The research question in this study is:

"What information should be included in a protocol to assess and manage a student experiencing mental distress that can be used by professional nurses working in a Campus Health Service?"

1.5 RESEARCH GOAL

The goal of this study is to develop a mental health care protocol for campus health service professional nurses to assess and manage university students who are experiencing mental distress.

1.6 CONCEPT CLARIFICATION

Concepts used in this study will now be clarified:

1.6.1 Campus Health Service

The National Health Act no 61 of 2003 (SA, 2003:12) defines health services as facilities providing health care services, including reproductive health care and emergency medical treatment, as contemplated in Section 27 of the Constitution of South Africa (1996) and in the Municipal Health Services guidelines. Health services are provided to university staff and students on campus. This service is called a Campus Health Service.

1.6.2 Mental distress

The South African Federation for Mental Health (2009:10) states that mental distress is a condition affecting the mental state of a person to such an extent that it causes significant distress to the person, and/or it produces impairment in the person's ability to function socially, occupationally and in caring for themselves in all aspects. Often a combination of these factors contributes to causing a mental illness or disorder. In this study the term may indicate a student experiencing mental distress that may include emotional discomfort, stress, cognitive symptoms or behavioural symptoms associated with mental discomfort.

1.6.3 Nursing Management

Oxford Thesaurus of English (2004:616) defines the word "manage" as to direct, control, lead, rule, supervise, administer, guide, and/or regulate. This study defines nursing management as professional nurses regulating or guiding the treatment of students experiencing mental distress.

1.6.4 Primary Health Care

In 1978 the World Health Organization defined primary health care as essential health care based on appropriate, acceptable methods and technology, made universally accessible through community participation. The World Health Organization (WHO, 2007:4) recommended that mental health should be part of primary health care and nurses should be trained to identify, treat and refer, where

necessary, persons suffering from mental disorders. In this study a primary health care service refers to a clinic providing health care that includes emergency medical treatment, reproductive health care, chronic health care, minor ailments, HIV/AIDS care, occupational health care and mental health care.

1.6.5 Professional Nurse

Chambers' Concise Dictionary (2004:953) defines a professional as a person belonging to a trained or skilled profession. The Nursing Act no 33 of 2005 (SA, 2005:7) states that a professional nurse is a person registered in terms of section 31 of the Nursing Act. In this study a professional nurse can be defined as a trained nurse who is annually registered with the South African Nursing Council and who is able to provide nursing care in a primary health care service.

1.6.6 Protocol

Chambers' Concise Dictionary (2004:960) defines a protocol as a correct, formal procedure. Oxford Thesaurus of English (2004:759) defines a protocol as a procedure, treaty or contract. In this study it is defined as a formal procedure that guides professional nurses in the management of students who are experiencing mental distress.

1.6.7 Student

Chambers' Concise Dictionary defines a student as a person who follows a formal course of study, especially in higher education (2004:1202). In this study a student is a person studying at the university and who may need the care of a professional nurse working at the Campus Health Service to help them cope with mental distress.

1.7 RESEARCH DESIGN

The design of this study is qualitative, explorative, descriptive and contextual. The Delphi technique will be used to collect and analyze data. These concepts will now be discussed briefly but will be discussed in depth in chapter three.

1.7.1 Qualitative research

The researcher will use valid theory, guided by an extensive literature study, to develop the protocol. The input provided by expert psychiatric nurses as well as by the professional nurses working in a campus health service will ensure that the process will be holistic and inductive and ensure a rigorous intellectual endeavour. This study is qualitative as it relies on consensus of perceptions and not on numbers. These concepts will be discussed in depth in chapter three.

1.7.2 Exploratory research

This study is explorative as there are currently no protocols in South Africa for campus health service professional nurses to use in the care of students experiencing mental distress. In this study the perceptions of these nurses as well as those of psychiatric nurses will be explored. These concepts will be discussed in depth in chapter three.

1.7.3 Descriptive research

In this study descriptions will be given of the literature related to the problem, the protocol that will be developed as well as the research methodology. These concepts will be discussed in depth in chapter three.

1.7.4 Contextual research

This research is contextual in nature as it is executed within the context of developing a protocol to address the mental health care needs of students visiting a campus health care service at a university in the Eastern Cape. These concepts will be discussed in depth in chapter three.

1.7.5 Delphi technique

Hasson, Keeney and McKenna (2000:1008) define the Delphi survey technique as a group facilitation technique, which is an interactive multistage process designed to transform opinion into group consensus. Grobler, Wärnich, Carrell, Elbert and Hatfield (2006:111) state that the advantages of using the Delphi technique include that it can involve key decision-makers, can focus on what is needed or desired for the future and is not bound by the past. In this study the Delphi technique will be used to determine the perceptions of the participants and to

create an instrument by peers to standardise the approach to mental health care within a campus health service provider environment/setting. These concepts will be discussed in depth in chapter three.

1.8 RESEARCH METHODOLOGY

The research methodology will include a brief description of the research population and sampling and of the Delphi technique used for data collection and analysis. To ensure the reliability of the study, trustworthiness will also be discussed. A more detailed description will follow in chapter three.

1.8.1 Research population and sampling

The research population is the total number of persons from which the individuals or units are chosen in the research (De Vos et al, 2005:194). The research sample is a chosen small group that is studied representing the larger population. In this study the research population will consist of a group of experts on the topic being discussed. The Delphi technique requires experts. Two groups of experts will be included.

1.8.2 Data collection and analysis

In this study data collection and analysis will be conducted simultaneously by utilising the Delphi technique. The Delphi technique is an aid based on the consensus of a panel of experts and requires a series of sequential questionnaires or “rounds” interspersed with controlled feedback that seeks to gain the most reliable consensus of opinion of a group of experts and replaces face to face communication (Hellriegel, Jackson, Slocum, Staude, Amos, Klopper, Louw and Oosthuizen, 2006:169). A more detailed description will follow in chapter three.

1.8.3 Trustworthiness

Validity, credibility, soundness and rigour are measures that are built into the research to ensure that the research is valid and that the results will be reliable. Trustworthiness should be ensured to prevent biases in research and to ensure that this study reflects the truth. The Lincoln and Guba Model of trustworthiness

(Morse & Field, 1996:118) will be used to ensure rigour and will be discussed in depth in chapter three.

To ensure trustworthiness of the study, an external auditor will be given all the information related to the paper trail. An auditor in this research is a person responsible for auditing the paper trail and will be an expert in doing qualitative research. The auditor needs to examine the paper trail data showing how the data were collected and analysed to arrive at the conclusions (Punch, 2008:289). A more detailed description of ensuring trustworthiness will follow in chapter three.

1.9 PILOT STUDY

Welman, Kruger & Mitchell (2005:148) state that it is useful to do a pilot study as it detects possible flaws in the measurement procedures and it identifies unclear and ambiguously formulated items. The method of data gathering used in the Delphi technique does not lend itself easily to doing a pilot study. The first round of phase one discussing the signs and symptoms staff may observe in students experiencing mental distress will therefore be used as a pilot to see if the methodology will provide the necessary answers to the research question.

1.10 LITERATURE CONTROL AND REVIEW

Morse & Field (1996:37) state that in qualitative research the researcher should usually not consult literature before doing fieldwork as this may mislead or distract the researcher's perception and ability to make accurate and value-free decisions. The Delphi technique however requires a thorough review of literature as the initial questionnaire and provisional protocol is a working document based on literature. For this reason a comprehensive literature review will be done before the research questionnaire and protocol are developed.

1.11 ETHICAL CONSIDERATIONS

Ethics can be defined as a set of standards of conduct and moral judgements that help to determine right and wrong behaviour (Grobler *et al*, 2006:554). The principles of beneficence, non-maleficence, justice and self determination are among the most important to ensure that participants of the study are treated with respect and consideration.

1.11.1 Beneficence

Beneficence is the ethical principle that means the duty to do good and to prevent harm. The two crucial elements of this principle are to provide benefit or to balance benefit and harm (Daniels, 2008:170). By providing staff with a protocol to use as guidance, it is hoped that staff will feel more comfortable in dealing with students experiencing mental distress.

1.11.2 Non-maleficence

Non-maleficence is the duty to cause no harm to others, and includes actual harm and the risk of harm (Daniels, 2008:170). In this study participants should not be harmed emotionally/physically or in any other manner before, during or after the research as no personal information is required of the participants in this study.

1.11.3 Justice

The principle of justice is based on the concept of fairness and implies fair treatment for all individuals (Daniels, 2008:170). The researcher will endeavour to act responsibly to all participants in the study and to exercise the discipline of reporting the research results accurately and honestly.

1.11.4 Self determination

The principle of self-determination or autonomy is the individual's right to choose and the ability to act on that choice (Daniels, 2008:169).

Privacy, Confidentiality and Anonymity

Participants' privacy (identity), anonymity and confidentiality will be protected at all times. The researcher will maintain confidentiality and anonymity by removing any identifiable information during the Delphi process.

Informed consent

Potential participants should be provided with sufficient information to enable them to decide whether or not they wish to take part in the research. The researcher will therefore provide each individual participant with sufficient understandable information regarding this research study including the information as required by the research ethics committee. This will include the informed consent, the written information given to a participant prior to participation, and the oral information that will be given during a two hour workshop describing mental health or mental illness, the goal of the investigation, the Delphi research process, possible advantages or disadvantages of the process and that a protocol will be developed (through the Delphi process) to aid their future practice.

Participants will be informed that they may withdraw from the research at any time without any prejudice and that participation in the study is voluntary.

Permission to conduct the research was requested from the following authorities:

- The Department where the research will be conducted
- The Institution where the research will be conducted
- The Research Committee of the Institution where the research will be conducted.

The researcher will attempt to maintain the highest ethical standards at all stages of the study.

1.12 ROLE OF THE RESEARCHER

As researcher it is important to be emotionally prepared, be open-minded and non-judgmental at all times and to stay neutral yet empathetic. As the instrument doing the research, the researcher should be responsible, adaptable, knowledgeable, holistic, reliable, and competent yet still be able to gain all the data required to complete the study. De Vos *et al* (2005:353) state that no researcher can exclude their own perspective in a qualitative study and this should be taken into account. The researcher should disclose any biases, values, and context that may be present that may have an influence on the research. The researcher is responsible to ensure validity, rigour and reliability when considering any decision.

1.13 DISSEMINATION OF RESULTS

The study will be disseminated by doing a poster presentation at a student research conference, a poster presentation at the national conference of the South African Association of Campus Health Services, by publishing an article in a peer reviewed journal and by conducting a workshop for colleagues.

1.14 CHAPTER DIVISION

The dissertation has been planned to include the following chapters:

Chapter 1: INTRODUCTION AND OVERVIEW OF THE STUDY
Chapter 2: LITERATURE REVIEW
Chapter 3: RESEARCH METHODOLOGY
Chapter 4: FINDINGS
Chapter 5: RECOMMENDATIONS AND CONCLUSIONS

1.15 CONCLUSION

The aim of this study is to develop a mental health care protocol for campus health service professional nurses to assess and manage university students who are experiencing mental distress. This is done within a framework of a qualitative, explorative, descriptive and contextual research design by using the Delphi Technique.

Chapter two will provide a review of existing literature on mental health care. The concepts of mental health and mental illness, mental health status assessment and treatment will be discussed.

CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

Chapter one provided a brief overview to the purpose of this study. Chapter two covers the key aspects of existing literature on mental health and includes the concepts of:

- Mental health care,
- Mental health and mental illness,
- Mental health status assessment, and
- Treatment in mental health care.

2.2 MENTAL HEALTH CARE

In 2003 the World Health Organization made the following statement in their Mental Health and Policy and Service Guidance Package (2003(b):1-2): “Efforts to improve mental health must take into account recent developments in the understanding, treatment and care of people with mental disorders, current health reform and government policies in other sectors”. They further stated that mental disorders account for nearly 12% of the global burden of diseases and predict that by 2020 it will have increased to 15%. Young adults carry the greatest burden of mental disorders but are the group that should be the most productive section of the population.

During the second half of the twentieth century the world realized that hospital-centred mental health care was too costly and was not effective in promoting health care (Uys & Middleton, 2004:11). This led the South African National Government to committing to improve mental health care at every organizational level, and especially at community level through integration with the primary health care system (Uys & Middleton, 2004:64). Primary Health Care (PHC) aims to

promote health and prevent disease. This includes care for mental distress. The advantages of including mental health care in primary health care are that it:

- Enables nurses and other professionals to understand mental health better and thus combat the stigma attached to mental illness
- Allows for early detection and treatment of mental illnesses in the primary health care settings
- Provides a broader in and out referral and support system to both the patient and the care providers should hospitalization be required
- Makes community rehabilitation possible with mental health care available at PHC centres. This rehabilitation will include case management, psychiatric rehabilitation, crisis intervention, treatment, basic support, enrichment and protection of their rights as patients (Uys & Middleton, 2004:11).

2.2.1 Primary health care

Van Rensburg (2004:28) cites the definition of Primary Health Care of the World Health Organization (WHO:1987) as essential care based on practical, scientifically sound and socially acceptable methods and technology, made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in a spirit of self-reliance and self determination. It forms an integral part both of the country's health system, of which it is the central function and the main focus, and the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system, bringing health care as close as possible to where people live and work and constitutes the first element of a continuing healthcare process.

Health care in South Africa is provided on three broad levels of care namely primary level of care, secondary level of care and tertiary level of care (Van Rensburg, 2004:414).

Primary level of care. This is health care provided as the entry level of care to the public health system and is graded into 4 sub-levels of care:

- Grade I PHC clinics are mobile, satellite and fixed clinics rendering a service up to 8 hours per day, 5 days per week. This is the biggest group of service providers as they need to care for the largest group of health care users and are the entry level of care. The Campus Health Service is a Grade I PHC service providing care to the staff and students visiting the service.
- Grade II PHC are larger clinics rendering a 24-hour service 7 days per week and include maternal and obstetric services and are called day hospitals;
- Grade III PHC are community health centres providing psychiatric mental health care clinics by specialised psychiatric trained nurses and psychiatrists; and
- Grade IV or district hospitals.

*Secondary level of care.*This is health care provided at hospitals for more complicated health conditions that cannot be treated at district hospitals and includes Intensive Care Units, 24-hour casualty services, and may provide specialised psychiatric inpatient care units and 72 hour-assessment/care admission wards.

Tertiary level of care. This is health care provided at specialised hospitals usually serving a province or a specific discipline such as rehabilitation centres or psychiatric hospitals delivering specialised care.

Health care service delivered at PHC level may include preventative, promotive, curative and rehabilitative care (Van Rensburg, 2004:422) and is guided by the PHC package. The comprehensive primary health care package was designed to define parameters for service delivery in primary health care centres and include seven core programs:

- Non-personal health services (health promotion, environmental health),
- Disease prevention (chronic diseases, oral health, communicable diseases), Maternal, child and woman's health (contraceptives, antenatal care, immunisations),

- HIV/AIDS, STI (sexually transmitted infections) and TB (Tuberculosis),
- Health monitoring and evaluation (research),
- Mental Health and Substance abuse,
- Gender issues (violence and sexual abuse).

Specialist registered professional nurses, or clinical nurse practitioners/primary health care nurses, provide the health care in any primary health care service (De Haan, 2005:27). The duties performed by these nurses require that they have additional training in diagnostic skills and techniques, in clinical assessment and in appropriate pharmacology and treatment skills (De Haan, 2005:27). The duties performed by these nurses are guided by the Standard Treatment Guidelines and Essential Drug List (EDL) for Primary Health care to standardise care. As primary health care nurses mostly work independently, these guidelines, norms and standards were set to ensure that all health care provided is on par (De Haan, 2005:27).

2.2.2 Mental health care in primary health care

The National Department of Health (2000(b):22) set the following standards for mental health care providers. These mental health standards and norms clearly state which mental health services should be available in every primary health care service. The standards and norms stipulate that services should be organised in such a manner as to:

- Provide prompt help from or at the clinic if a patient's condition in the community deteriorates.
- Ensure that there is no segregation or stigmatisation of patients who have to use other services at the clinic such as family planning and antenatal care (The Primary Health Care Package for South Africa – a set of norms and standards, 2000(b)).

Competence of health staff should include recognizing mental illness by:

- Considering risk factors for mental health within their catchment area including poverty, ill health, isolated persons and HIV positive clients

- Identify and provide appropriate interventions for patients with depression, anxiety, stress-related problems, substance abuse and special female needs (childbearing, abortion, disability, malignancy etc.)
- Recognise the expression and signs of emotional distress and mental illness early (especially in young patients or in relapse of a psychiatric condition)
- Participate in the promotion of healthy life styles in clinic attendees and the community (The Primary Health Care Package for South Africa – a set of norms and standards, 2000(b)).

Mental health care provided at primary health services should make provision for:

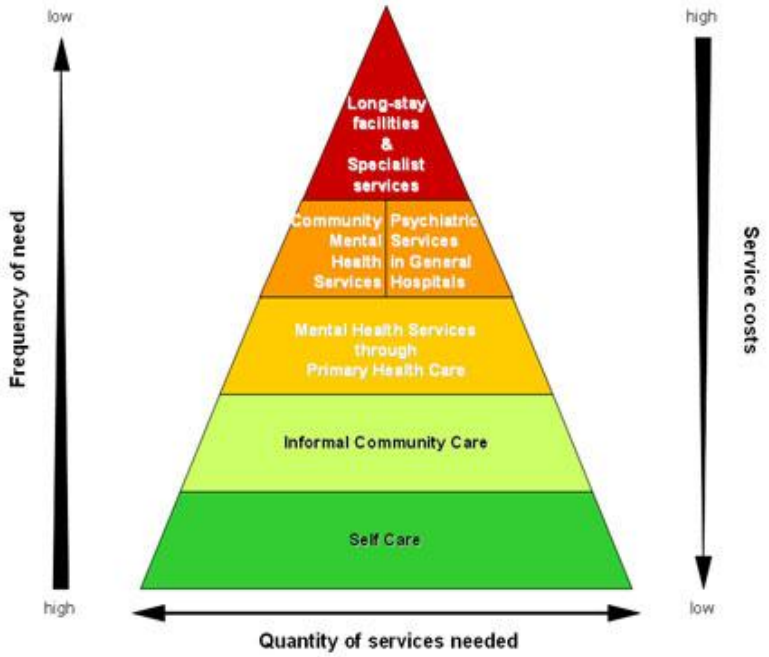
- Designated psychiatrically trained nurses should be able to:
  - Maintain relationships with patients that are just, caring, and based on the principles of human rights
  - Perform an adequate medical examination which identifies the general mental state such as psychotic or depressed
  - Identify the severity and level of crisis
  - Rule out systematic illness, record temperature and blood glucose level,
  - Take a history that includes previous service use such as admission to hospital, family history and evaluate support
  - Develop a sustained therapeutic relationship with patients and their families, know and implement standard treatment guidelines especially the section on delirium with acute confusion and aggression, acute psychosis and depression.

- General nurses should be able to:
  - Detect and provide services for severe psychiatric conditions as a component of comprehensive Primary Health Care
  - Make appropriate and informed referrals to other levels of care
  - Provide basic psychiatric care and assess urgency and severity of symptoms, provide individual community maintenance and care for stable long-term patients who have severe psychiatric conditions and have been discharged from hospital with individualised comprehensive

care which includes an ongoing assessment of mental state, functional ability and social circumstances

- Be familiar with the internationally recognised diagnostic system,
- Have an ability to detect and monitor distress and relapse, have an ability to provide basic counselling and support to patient and family,
- Have referral and support organisations,
- Follow-up of all cases returned to community after hospitalisation and keep a register,
- Facilitate continuity of care of the condition of patients in the community,
- Follow up poor compliance, functional deterioration, substance abuse and family conflict,
- Recognise the onset of mental deterioration in HIV positive patients,
- Prescribe sedation for aggressive or violent patients only as appropriate when other measures fail,
- Cope with disturbed, intoxicated, aggressive or suicidal behaviour without resorting to violence, abuse of undue physical restraint (The Primary Health Care Package for South Africa – a set of norms and standards, 2000(b)).

Graph 2.1 is provided by the World Health Organization (2008:16) and shows the levels of mental health care. The first level – *self-care* - forms the largest group and requires no professional intervention and is low in medical cost. The next level of care - *informal community care* - involves community involvement such as family, friends, and the church. Most persons may only require these forms of care. Should the mental distress/illness become more serious (level 3), the client may be referred to primary health care (PHC) services and/or PHC mental health care facilities. Professional intervention is required at this level. Serious illness (level 4) may require community mental health services or psychiatric services in general hospitals or, in level 5, care in long stay facilities in specialist hospitals. The graph shows that only a small percentage of persons require this level of care, but that the medical cost is very high.



Graph 2.1: Levels of mental health care. (http://www.who.int/mental_health/policy/Integratingmhintoprimarycare2008_lastversion.pdf). (Accessed 4/3/2010).

2.2.3 Campus Health Services

South Africa has 23 Higher Education Institutions. Most South African Higher Education Institutions provide accessible and affordable health care to their staff and students through units, the Campus Health Service, that are served by:

- Medical doctors to medical aid/private clients and are managed similarly to general practitioners offices, or
- Nurse-managed services providing primary health care similar to community clinics. They provide services such as emergency care, family planning, HIV/AIDS care, care for sexually transmitted diseases, and tuberculosis care, treatment for minor ailments and referral for chronic care to students who do not have medical aid cover and cannot afford private medical care.

The patient population of a campus health service may be diverse. Although it mainly consists of students who are young adults, the patient population also includes university employees who may suffer from acute or chronic conditions. The level of care provided at the Campus Health Service of the university where

the study will be done is Grade I PHC care as they provide primary health care to their staff and students 8 hours per day, 5 days per week.

2.3 MENTAL HEALTH AND MENTAL ILLNESS

In 1948 the World Health Organization (WHO) defined health as a state of complete physical, mental and social well being and not merely the absence of disease or infirmity (WHO, 2008:9). This interpretation is a holistic and comprehensive view of health that recognizes the influence of factors in the social, economic and physical environment on a person's well being as well as ensuring mental health. Health, and especially mental health, is extremely important to enable the students studying at the higher education institution to successfully complete their studies. Mental health disorders however are found in all populations, ethnic groups, countries, in men and woman, at all stages of life, rich and poor and in rural and urban settings.

Frisch & Frisch (2006:6) state that there is no singular definition of mental health. A person is mentally healthy when he possesses knowledge of himself, meets his basic needs, assumes responsibility for his behaviour and self growth, has learned to integrate thoughts, feelings and actions, and can resolve conflicts successfully. A mentally healthy person maintains relationships, communicates directly with others, respects others and can adapt to change in their environment. Uys & Middleton (2004:753) define mental health as a state of being in which a person is simultaneously successful at working, loving and resolving conflicts by coping and adjusting to the recurrent stresses of everyday living. This does not mean that a mentally healthy person does not have problems and may even experience severe distress, but the person is generally able to cope with the distress.

Persons who are mentally ill often have the same characteristics as persons who are mentally healthy. The difference however is in the functioning of the individual. Frisch & Frisch (2006:5) state that mental illness is a state in which an individual shows deficits in functioning, cannot view themselves clearly or has a distorted

image of self, is unable to maintain personal relationships, and cannot adapt to the environment. Gamble & Brennan (2003:42) state that mental illness affects the individual's cognitive processes, their beliefs, perceptions and outward behaviour. Mental distress may affect a person's physical health (aches and pains), psychological health (mental functioning and emotions), and behaviour (personal habits, social behaviour and relationship with others).

Frisch & Frisch (2006:6) state that possible signs of mental illness include personality change over time, confused thinking, strange grandiose ideas, prolonged depression, excessive anxiety, fear or suspicion, withdrawal from society, abnormal self-centredness, denial of an obvious problem, suicidal ideation, numerous physical ailments, anger and hostility, delusions, hallucinations, alcohol and drug abuse, and an inability to cope with problems and daily activities such as studies, job or personal needs. These individuals may simply have difficulty in coping or could suffer from a specific mental illness. Signs are the objective observations made by a clinician while symptoms are the subjective experiences of the client.

Kirby, *et al* (2004:311-314) state that mental disorders can be classified in different ways. There are three main models – the biological, the psychological and the social models.

The *biological model* believes that mental health problems are the consequences of biological or physical changes in the brain and even elsewhere in the body and may be caused by infections of the brain, brain injury/defects and heredity (may run in families).

The *social model* believes that the wide influence of social forces such as social class, or a life event can be seen to cause mental disease. Causes may be due to family, friends, work and support networks.

The *psychological model* can be divided into behavioural (how the individual feels and how he behaves), cognitive (how the individual thinks and behaves) and

psychodynamic (emotions/how the individual feels) approaches and focuses on the symptoms and behaviour the individual experiences. The behavioural approach believes that the symptoms experienced are manifested in the behaviour of the distressed individual. As behaviour is learned, it can be 'unlearned' and therefore be cured. The cognitive approach believes that the symptoms experienced are manifested in the thoughts of the distressed individual and the way in which the body responds to these thought processes creates the symptoms, behaviour and attitude (disorder). The psychodynamic or emotional approach believes that the symptoms experienced are manifested in the emotions of the distressed individual. Psychological causes may start after post-traumatic distress disorders.

Some of the mental disorders that may be seen at a campus health service will now be discussed briefly.

Anxiety disorders

Stuart & Laraia (2005:261) state that anxiety is a normal emotional response to a threat that an individual experiences and that it cannot be observed directly. Fear caused by physical or psychological threatening stimuli leads to anxiety. There are four levels of anxiety – mild, moderate, severe and panic. Most individuals agree that anxiety is an uncomfortable and unpleasant experience that most try to avoid.

Anxiety disorders include:

- Post-traumatic stress disorder:

Post-traumatic stress disorder is caused by a traumatic event leading to a response of fear, helplessness or horror. The individual relives the event and tries to avoid being reminded of it (Uys & Middleton, 2004:129-137). The symptoms last for more than a month after the event, and must significantly affect important areas of their life. Treatment includes psychotherapy and pharmacotherapy with serotonin re-uptake inhibitors.

- Acute stress disorder:

Acute stress disorder is caused by a traumatic event leading to a response of fear, helplessness or horror. The individual relives the event and tries to avoid being reminded of it (Uys & Middleton, 2004:129-137). The symptoms usually start two days after the event and last for less than a month after the event. Treatment includes psychotherapy and pharmacotherapy with serotonin re-uptake inhibitors.

- Obsessive-compulsive disorder:

Sadock & Sadock (2007:604) state that a person with obsessive-compulsive disorders may have an obsession, a compulsion or both. An obsession is a recurrent and intrusive thought, feeling, idea or sensation. In contrast a compulsion is a behaviour that is compulsive, conscious and recurrent such as counting, checking or avoiding. A person with obsessive-compulsive disorder experiences both aspects as unwanted feelings that cause anxiety. Giving in to the obsession only increases the anxiety rather than reduce the anxiety. Obsessive-compulsive disorders are often associated with depression or risk for suicide. Treatment includes psychotherapy and pharmacotherapy such as Selective Serotonin Re-uptake Inhibitors.

- Panic disorder – with/without Agoraphobia (fear of open places):

Sadock & Sadock (2007:587) state that an acute intense attack of anxiety accompanied by feelings of impending doom is known as panic disorder. Panic disorders tend to run in families, females are more prone to it and it starts late in the teens and early adulthood. Panic attacks have a rapid onset (minutes) and short duration (lasting 10-15 minutes). The diagnosis is confirmed by the presence of at least four of the following symptoms: palpitations, sweating, trembling, shortness of breath, chest pain, nausea and abdominal distress, dizziness, fear of dying, paresthesia, and chills/hot flushes. Panic disorders are often a chronic disorder and require pharmacotherapy such as Selective Serotonin Re-uptake Inhibitors (SSRI's) and cognitive-behavioural therapy.

- Phobic disorders:

These types of phobic disorders can be diagnosed as: *Specific fear* (animal/natural environment/blood injection-injury type/situational /other), Agoraphobic or Social fear. Sadock & Sadock (2007:597) state that phobia refers to an excessive fear of a specific object, circumstance or situation causing intense anxiety even to the point of panic. A specific phobia is a strong persistent fear of an object or situation, where social phobia is a strong persistent fear of situations where embarrassment can occur. Agoraphobia is the fear of not being able to control a situation. Treatment is seldom sought for phobias. The most effective treatment is behaviour therapy. Pharmacotherapy such as SSRI's may be given.

Mood disorders

Stuart & Laraia (2005:330) state that feelings of joy, fear, anxiety, love, anger, sadness are all normal human emotions. Variations in mood are a normal part of life as a person perceives and responds to the world. Prolonged emotional changes or moods may however influence the person's whole personality and life functioning. Mood disorders include:

- Depressive disorders

Sadock & Sadock (2007:319) state that depression is a condition in which a person feels extreme sadness, withdraws socially, feels guilty and expresses self-deprecating thoughts. Depression is usually self-limiting and resolves by itself between three to six months. Sadock & Sadock (2007:319) state further that 15 to 20% of affected individuals may develop chronic depression and 15% of severely depressed people may eventually commit suicide irrespective of intervention. To diagnose depression the person should have a depressed mood and marked diminished interest or pleasure in all or most activities for 2 weeks for most of the day and most of the time plus at least three of the following symptoms: significant weight loss/gain, decreased /increased appetite, insomnia/ hypersomnia, psychomotor agitation, retardation, fatigue or loss of energy, feelings of worthlessness, excessive inappropriate guilt, inability to think, concentrate or indecisiveness, and recurrent suicidal ideation. If depression is diagnosed the patient should be referred to a psychologist or psychiatrist. Suicidal ideation is a

mental health crisis and requires immediate referral to hospital. Treatment includes psychotherapy and pharmacotherapy (such as antidepressants).

- Bipolar disorders

Bipolar disorder patients experience episodes of severe depression (discussed previously) and episodes of mania. Sadock & Sadock (2007:356) state that mania are distinct periods of either elevated, expansive or irritable moods and the disturbance is sufficiently severe to cause marked impairment in functioning. Symptoms of mania include periods of abnormal, persistent elevated, expansive or irritable mood, grandiosity, decreased need for sleep, more talkative than usual, flight of ideas, easily distracted, increased goal directed activities, impaired social judgement (buying sprees, sexual indiscretions, foolish business investments), and mood disturbances. Treatment includes mood stabilisers such as Lithium or Anti-epileptics such as Epilim and antidepressants. Hospitalisation may be indicated to protect a patient against self-endangerment.

- Suicide

Suicide is not a mood disorder but is included due to the risk with both depression and bipolar disorder. Sadock & Sadock (2007:356) states that suicide is the extremity of a self-inclined, self-destructive act (thought, expression or attempt to take one's own life). Numerous assessment scales exist such as the *SAD PERSONS* scale. *SAD PERSONS,* a mnemonic, was developed by Patterson, Dohn, Bird and Patterson in 1983 and is a 10-point scale used to screen for suicide risk.

An individual is given one point for each item screened positive:

S - Sex (male) (more females attempt, more males succeed)

A - Age less than 19 or greater than 45 years

D - Depression (patient admits to depression or decreased concentration, sleep, appetite and/or libido)

P - Previous suicide attempt or psychiatric care

E - Excessive alcohol or drug use

R - Rational thinking loss: psychosis, organic brain syndrome

S - Separated, divorced, or widowed or single

O - Organized plan or serious attempt

N - No social support

S - Sickness, chronic disease

Table 2.1: Scoring scale for SAD PERSONS

Guideline for action with SAD PERSONS scale	
Total points	Proposed clinical action (counselling/doctor)
0 – 2	Send home with follow-up
3 – 4	Close follow-up, consider hospitalisation
5 – 6	Strongly consider hospitalisation
7 – 10	Hospitalise or commit

(Zastrow & Kirst-Ashman, 2007:321)

This tool may be used to confirm a suspicion of suicidal risk.

Suicidal ideation requires urgent admission to hospital to ensure patient safety. Care for the survivors of the suicide (family and friends) and the caregiver are important.

Psychotic disorders

Stuart & Laraia (2005:387) state that psychosis refers to the mental state of experiencing reality differently from others and experiencing symptoms of thought disorder, hallucinations, social isolation, difficulty in processing emotions and disorganised behaviour. This is usually a severe type of mental disorder where the patient's mind is completely disorganised, they have lost touch with reality and have little or no insight into their illness

- Schizophrenia

Sadock & Sadock (2007:467) state that schizophrenia is a clinical syndrome of variable but profoundly disruptive psychopathology that involves cognition, emotion, perception and other aspects of behaviour. The subtypes are paranoid, catatonic, disorganised, undifferentiated and residual type. Patients usually present with a report of hearing voices, of extraordinary physical complaints, difficulty in thinking or concentrating and confusion, agitation, and extreme and

labile emotional states. This is a chronic illness and the treatment plan includes regular anti-psychotic medication that will reduce agitation, hallucinations and delusions. A psychotic patient can become very aggressive and may need sedation and may even need to be isolated.

Sadock & Sadock (2007:467) state that other examples of psychotic disorders include schizophreniform disorder, schizoaffective disorder, delusional disorder, shared psychotic disorder, culture bound syndromes and other. These conditions are seldom diagnosed and will therefore not be discussed.

Cognitive disorders

Stuart & Laraia (2005:330) state that the ability to think and reason and to behave accordingly is a distinctive feature of human beings. Maladaptive cognitive responses include an inability to make decisions, impaired memory and judgement, disorientation, misperceptions, decreased attention span and difficulties with reasoning.

- Delirium

Sadock & Sadock (2007:322) state that delirium is a syndrome and has many causes. Patients experience symptoms of sudden, short-term confusion and changes in cognition (memory, language, orientation, judgement, problem solving, and interpersonal relationships). Subcategories are based on causes: general medical conditions (infections), substance induced (cocaine, opioids), multiple causes (head injury/kidney disease), and other (sleep deprivation). Treatment includes treating the cause. Delirium is seldom seen in young adults unless it is associated with chemical substances (drugs).

- Dementia

Sadock & Sadock (2007:322) state that dementia is a progressive impairment of the cognition. Patients experience symptoms of severe impairment in memory, judgement, orientation and cognition. Subcategories are based on causes: Dementia may be due to Alzheimer, Vascular dementia (stroke), medical conditions (HIV/head trauma), substance induced (alcohol), or multiple other

aetiologies. Preventative medication (for stroke) or appropriate medication may halt or delay progression of disease. Dementia is not usually associated with young adults.

- Amnesic disorders

Sadock & Sadock (2007:344) state that amnesic disorders are characterised by an inability to create any new memories. Patients experience symptoms of memory impairment and forgetfulness. Subcategories are based on causes: medical conditions (hypoxia), medication (marijuana/diazepam) and others. Modifiers are duration of less than 1 month or more than 1 month. Treatment includes support and psychotherapy. This disorder is seldom observed.

Substance abuse disorders

Sadock & Sadock (2007:381) recognise twelve classes of pharmacological agent that are abused: alcohol, amphetamines, caffeine, cannabis, cocaine, hallucinogens, inhalants, nicotine, opioids, PCP, over-the-counter medication (OTC) (such as sedatives, hypnotics and anxiolytics), and other (anabolic steroids/nitrous oxide). Terminology used in substance abuse include: addiction: psychological addiction (continuous or intermittent craving for the substance), behavioural addiction (substance seeking behaviour), physical addiction (effects on the body, tolerance, withdrawal, and dependence) and intoxication (reversible nondependent experience that produces impairment). Substance abuse disorders will not be discussed individually but the primary health care nurse should be aware of the signs and symptoms of abuse, the treatment available and the referral systems available in the community. Substance abuse and addiction are problems that young adults may be exposed to.

Eating disorders

Sadock & Sadock (2007:727) state that eating disorders are fairly common amongst adolescents and young adults and are commonly known as anorexia nervosa (restricting type/binging and purging type) and bulimia nervosa (overeating with purging/without purging). Treatment entails obtaining the patient's

co-operation, recovery of normal weight and treatment of any family pathology. These disorders occur more frequently among young females than in older adults.

Sleeping disorders

Stuart & Laraia (2005:330) state that sleeping disorders are also commonly found with other disorders. Types include insomnia, hypersomnia and parasomnia. Treatment will be pharmacological after cause (stress/pain) has been managed. This is seldom seen in young adults.

The role of the campus health nurse in treating mental illness is to provide basic psychiatric care and assessment of the urgency and severity of symptoms expressed or experienced by their students, and accordingly management or referral as needed.

2.3.1 Socio-Cultural influences

South Africa is known as the 'rainbow nation', a name that epitomises the country's cultural diversity. Statistics South Africa (2009:1) estimated the population of South Africa for mid-2009 as follows: the total population is 49.3 million people; 52 percent of the population is female; 79 percent is African, 9.1 percent is white, 9 percent is coloured and 2.6 percent is Indian/Asian. South Africa is one of the most complex and diverse countries in the world with 11 official languages namely English, Afrikaans, Ndebele, Sepedi, Xhosa, Venda, Tswana, Southern Sotho, Zulu, Swazi and Tsonga. All these factors and many more not even mentioned create the cosmopolitan cultural picture in South Africa. The role of the campus health nurse is to ensure that they are aware of cultural diversity and ensure that students seeking mental health care are treated with respect and dignity. Mental illness symptoms must always be assessed in relation to the person's cultural background as symptoms often present in a culturally related manner.

The student population statistics for this higher education institution where the study was conducted for 2010 is: African 60%, White 24%, Coloured 14%, and Indian 2%. The male/female ratio is: male 46% and female 54%. Mental health

care requires that the professional nurse should always be culturally sensitive in dealing with ill students as the statistics show that students are representative of all races.

The African traditional health, illness and health care will now be discussed as students seeking care may be from this group as they are the largest percentage of the population of South Africa. Uys & Middleton (2004:129-137) state that traditional healing is a fact of life in many societies and all health care providers should have knowledge of the care provided by the traditional healer. An African traditional healer is a combination of an herbalist, psychologist, psychiatrist, priest and historian. In the African traditional system the human being is seen as a collective being and is a part of the family, the extended family, the community and the ethnic group they belong to.

Uys & Middleton (2004:129-137) state further that illness is viewed as being intentionally caused by:

- The ancestors and God. If God or the ancestors are unhappy with an individual's lifestyle, they may send illness, bad luck or depression
- Evil spirits. Evil spirits (*mafofonyane*) can possess and cause psychotic behaviour (destructive, mischievous and malevolent behaviour)
- Witchcraft. Manipulation of psychic powers is seen as evil work by persons driven with envy and malice and usually treated by small incisions around joints (weak entry points for evil elements). Witchcraft may cause both physical and mental illness
- Pollution. Pollution is caused by accidental impurity (miscarriage/death of spouse) requiring ceremonial cleansing
- Taboos. Cause mental illness (delirium caused by sex during menstruation)
- Poisons. These are believed to cause death, mental illness or misfortune
- Germs. These can cause certain illnesses such as flu (Uys & Middleton, 2004:129-137).

The types of illnesses are treated differently.

- Naturally occurring illness (from flu to epidemic) may be treated by Western medication
- Illness of the African people (caused by witchcraft or ancestral displeasure) does not respond to western medication
- Ancestral belief system (anxiety, psychosomatic, psychological illness) are caused by the neglect of ancestors requiring the offering of ritual sacrifices of a goat/ox and food as token of their hospitality, fellowship and respect to appease the ancestor (Uys & Middleton, 2004:129-137).

Uys & Middleton (2004:137) further state that there are cultural differences between Western and African approaches to mental health care. These include:

- Passive participation versus active participation. In certain African communities people tend to be passive. Males traditionally do not discuss certain issues with women. Female professional nurses therefore need to be aware of this and need to be sensitive when dealing with sensitive issues. Passivity during the consultation is therefore not personally directed at the health care provider
- Visual aids. Life-like illustrations and objects may be used to ensure that the person understands what and where the problem is and how to deal with it
- Tightness. All cultures have norms, values and rules and more so in the traditional cultures of what is right and what is wrong. An example is male circumcision and all the traditions surrounding it
- Individualism and collectivism. Traditional cultures are collectivistic where the group is more important than the progress of the individual. Choices may thus be made to benefit the group rather than the individual
- Vertical versus horizontal cultures. Communication lines of respect and, in the traditional culture, the vertical structure have a clear hierarchy. This is important when dealing with sensitive issues and when choices regarding treatment should be made
- Emotional expression or suppression. The expression of emotion is very culture bound and may be expansive or subdued. The professional nurse

should keep this in mind when managing the emotionally distressed individual

- Masculinity (success and achievement) versus femininity (caring for others) of culture. The traditional culture is usually feminine. This links to the collectivistic nature and traditions of the African culture (Uys & Middleton, 2004:137).

Traditional healers have been used to treat physical and mental disturbances and therefore represent a major therapeutic resource within society. Sadock & Sadock (2007:169) state that the DSM IV TR recommends that, when assessing the mentally distressed individual (student), the cultural identity of the individual including the ethnic group, degree of involvement in both the host and culture of origin, the cultural explanation of the individual's illness, and cultural factors pertaining to psychological environment and levels of functioning should be taken into consideration.

2.4 MENTAL HEALTH STATUS ASSESSMENT

In a primary health care clinic a patient may not initially present as having a mental health problem as most people present with physical complaints (Department of Health (DOH), 2002:169). It is therefore necessary to take a clear history and do a thorough physical examination. Most clients present with physical symptoms such as headache or insomnia but will not immediately state they are experiencing mental distress symptoms. Only through careful physical assessment can a physical cause for symptoms be excluded and can the nurse assess the patient's mental status. Furthermore, every patient presenting with mental illness symptoms should have a thorough physical examination as some physical diseases present with mental illness symptoms such as confusion. These diseases are often serious and may need immediate and correct care.

The DOH (2002:170) suggests, in their core notes for primary health care nurses, that special note be taken of the following when doing the physical assessment:

- *Ear, Nose and Throat*: Signs that chronic otitis media may have spread to the brain, the smell of ketones on a diabetic patient's breath, or any thyroid enlargement
- *Respiratory system*: Anoxia, or any severe chest infections
- *Cardio-Vascular system*: Blood pressure, pulse, temperature, or any signs of heart failure
- *Abdomen*: Liver, renal failure, or acute abdomen in porphyria
- *Central Nervous system*: Pupils (equal and react normally), neck stiffness, or signs of meningeal infections
- *Urinary tract test*s: Glucose (diabetes), protein and blood (infection, renal failure), bilirubin (liver failure, porphyria)
- *Skin*: Pallor (anaemia), jaundiced, cyanosis, or skin lesions of systemic diseases (syphilis, porphyria)
- *Nutritional status*: Signs of Tuberculosis, malnutrition or alcoholism.

The above assessment focuses on organ systems. However the functioning of the brain or symptoms of mental illness/discomfort is not included. Primary health care nurses are taught to assess patients according to systems.

2.4.1 The mental status assessment

Should a mental health problem be suspected, the history taking should be adjusted accordingly (discussion of history taking to follow) and a mental status assessment done as part of the Central Nervous System examination. Stuart & Laraia (2005:184) state that the mental status assessment is the process where information is obtained from the patient in a systematic and structured manner through observations, interviews and examinations. This serves as a basis for diagnosis, outcome identification, planning, implementation and evaluation.

Robertson, Allwood & Gagiano (2001:35) state that the assessment has three functions: it establishes rapport with the patient; obtains information by direct enquiry and observation of the patient and enables the interviewer to give feedback. The aim of the interview is to make a diagnosis and to develop a treatment plan. As there are very few special (physical) investigations that can be done to confirm a diagnosis, it necessitates a comprehensive and meticulous

history taking and a detailed mental status examination. Barry (1996:183) states that one of the challenges of assessing a patient's psychosocial functioning is that it involves processing nonverbal clues as well as integrating other functioning. It is important to note that a mental status assessment is much more difficult to define than a physical assessment as it involves emotions and there are no exact parameters to define what is normal and what is abnormal.

There are various models that mental health care professionals may use to assess an individual's mental status. Some of these will now be discussed.

Psychiatric model

Sadock & Sadock (2007:232-237, 969) state that a mental status examination should describe the patient's appearance, speech, actions and thoughts during the interview. This will now be discussed in more detail.

- *Appearance*: this describes the appearance and overall impression as reflected by the posture, poise, grooming and clothing
- *Behaviour* and psychomotor activity that include mannerisms, tics, gestures, agitation, hyperactivity, gait and agility. It may also include restlessness, wringing of hands, pacing, and other physical manifestations or slowing of body movements, aimless and purposeless activity
- *Attitude* can be described as cooperative, friendly, attentive, interested, frank, seductive, defensive, playful, evasive or guarded
- *Speech* can be described in terms of quantity (talkative, taciturn, garrulous, un-spontaneous), rate of production (rapid, slow, hesitant, dramatic, loud, whispered, slurred, staccato, or mumbled) and quality (stuttering, fluent)
- *Mood and affect* describes the emotions in terms of depth (deep/superficial), duration (labile/fluctuating), intensity (depressed /despairing/irritable/anxious/angry/empty/guilty/hopeless/frightened or perplexed), and fluctuations (laughing/crying) and emotional responses (flat/constricted/blunted/within normal range)
- *Thinking* process (over-abundance/poverty/flight of ideas/slow/ hesitant/vague/empty) and content (delusions/obsessions/compulsions/ repetitive/phobias/ suicidal)

- *Perception* described by their sensory involvement (auditory, visual, taste, olfactory or tactile), the content (ideas/perceptions/beliefs/obsessions) and the circumstances (waking up/falling asleep/stressful events), hallucinations (sensory perception in the absence of external stimuli), illusions (false interpretation of a real stimulus), delusions (irrational belief which has no base in reality and cannot be explained)
- *Sensorium* assesses brain functioning through alertness (altered/fluctuating), orientation (to time/place and person), concentration (impaired), memory (immediate/short/long term), calculations, knowledge and abstract reasoning (dealing with concepts)
- *Insight* describes awareness and understanding of the illness (also blame/denial)
- *Judgement* assesses many aspects of the capability for social judgment (outcome of behaviour)
- *Socialization* includes an inability to fulfil roles such as that of a worker, a spouse, a friend and being unable to meet other social interaction needs.

The findings from the mental status assessment and complete psychiatric history are recorded and include a final summary of both positive and negative findings and interpretation. This will allow the mental health care professionals to make a diagnosis (Sadock & Sadock, 2007:232-237, 969).

The Department of Health (2002:172 – 174) suggested the following model that follows similar lines of assessment:

- History taking: A careful history need to be taken with regards to their present problem, past psychiatric history, present and past medical history, substance abuse, personal history and family history
- Mental Status assessment: The mental status examination focuses on specific areas to create a picture of the illness. To ensure that all areas are covered during the assessment the following memory aid is advised:

  A TOE LIMP –

  Appearance: Starting with the general appearance and behaviour of the person,

Thoughts (this includes the form, flow, and content),
Orientation (to time, place, or person),
Emotion (happy, sad, suspicious, elated, suicidal),
Level of consciousness,
Intelligence and insight,
Memory (including the immediate, recent and long term memory), and
Perception (illusions, delusions, hallucinations).

The functioning model is a model suggested by Strümpher (2006: 115 - 116) and Uys & Middleton (2004:202) that nurses may use to assess and determine the mental status of an individual. This will include their physical functioning, emotional functioning, cognitive functioning, spiritual functioning, behavioural functioning, social and family functioning and utilization of their time.

The *Physical functioning* of an individual includes their general appearance (grooming, self care, health status and vital signs), vegetative state (sleeping/nutrition and elimination), habits (smoking/alcohol use/drug use), medical problems (physical illness/disability/body image/previous treatment), activities of daily living, risk for injury (drug withdrawal/self mutilation or self-destruction), and ability to manage and maintain their environment.

The Emotional functioning of an individual Includes their self esteem, symptoms associated with anxiety (stress/tension/anxiety/agitation/fear/panic), symptoms associated with anger (irritation/frustration/aggression/anger/violence), symptoms associated with grief (sadness/hopelessness/powerless/helplessness/loss/ depression), symptoms associated with elation (agitation, euphoria, mania), grieving (anticipatory, dysfunctional), suicidal ideation (cognitive), post traumatic response, and coping with emotions and non-verbal expression of emotions.

The Cognitive functioning of an individual includes orientation to reality, thought content (obsessions/delusions/compulsions and suicidal ideation), sensory perception (perceptions/hallucinations/body experience/ illusions), memory (short term, long term, intermediate, personal), ability to concentrate, judgement, and

ability to make decisions, ability to solve problems, calculating ability, abstract thinking, intelligence, source of knowledge, speech and reliability.

The Spiritual functioning of an individual includes his/her meaning in life (life goals), future directedness, self-worth, value system, religion (involvement with god and religious groups) and motivation.

The Behavioural functioning of an individual includes manipulation, substance abuse, risk for injury, risk for violence, expression of sexuality, compliance/non-compliance with treatment regime, ability to maintain health and wandering/confused behaviour.

Social and family functioning of an individual includes the ability to communicate with others/ability to build trust/maintain relationships/ability to trust, loneliness/ social isolation/impaired socialization, intimate relationships, socialisation in the family, socialisation among friends and colleagues, socialisation in the community and groups, support systems, ability to fulfil their role in the family, ability to manage stigmatisation, and abuse in the family (spouse, child, granny).

Utilization of time includes their motivation, catatonia, educational background, employment, use of free time and participation in sport (Strümpher, 2006: 115 – 116; and Uys & Middleton (2004:202).

The findings from the functional assessment and a complete psychiatric history will enable the nurse to record a final report that will facilitate a nursing diagnosis.

2.4.2 Diagnosing of mental distress

The Department of Health (2002:174 – 179) states that the primary health care nurse should, after completion of the mental status examination, use the signs and symptoms the patient is suffering from to determine the mental illness. Signs and symptoms commonly occur together in specific syndromes and could be 'clustered' to make a decision with regards to the management of the patient such as the organic cluster, the mood cluster and the psychotic cluster.

Signs and symptoms of the *organic cluster* include: signs and symptoms of a physical illness, sudden change in level of consciousness, loss of orientation for time, place and person, poor attention and concentration, poor memory (immediate, short and long term), and the loss of cognitive ability (calculation, construction, general knowledge, abstract ability). Even if there are features of the mood or the psychotic cluster, it is considered an organic illness and treatment planned accordingly *(*Department of Health, 2002:174 – 179).

Signs and symptoms of the *mood cluster* include: changes in mood (depression/euphoria/elation), changes in vegetative state (sleep/appetite/weight/ libido), changes in the way the patient thinks about him/herself and the world, loss of self esteem, poor concentration, grandiose ideas, inflated self esteem, over-confidence, recklessness and suicidal thought and plans. Even if there are features of the psychotic cluster, it is considered a mood disorder and the patient should be treated accordingly (Department of Health, 2002:174 – 179).

Signs and symptoms of the *psychotic cluster* include: thought disorders (incoherence, tangential, circumstantial thinking, and an inability to make meaningful sentences), delusions, hallucinations, illusions and loss of insight. If there are only signs of psychosis the patient should be treated for a psychotic disorder. It is important to remember that the psychosis is a disease of the mind and that psychotic disorder patients are physically well *(*Department of Health, 2002:174 – 179).

There are various classification systems available to enable the mental health care professional to make a mental distress diagnosis. Stuart & Laraia (2005:69) define a medical diagnosis as the health problem or disease state of the mentally distressed individual. This diagnosis will be made by a general practitioner or a psychiatrist using a system such as the ICD10 or DSM. A nursing diagnosis is a clinical judgement and statement of both the adaptive and maladaptive responses and contributing stressors and assesses the risk factors.

International Classification of Diseases (ICD 10)

The ICD is the WHO's international standard diagnostic classification of health and diseases. It is used to classify diseases and other health problems. In addition to enabling the storage and retrieval of diagnostic information for clinical, epidemiological and quality purposes, these records also provide the basis for the compilation of national mortality and morbidity statistics by WHO member States. Diagnoses are listed according to body systems and are mainly used in Europe. One system is named Brain and Central Nervous system and describes mental illness (Sadock & Sadock, 2007:272).

Diagnostic and Statistical Manual of Mental Disorders (DSM IV-TR)

Stuart & Laraia (2005:69) defines the Diagnostic and Statistical Manual of Mental Disorders (DSM IV-TR) as an approved psychiatric coding system where specific criteria must be present before a diagnosis can be made and is an inter-disciplinary tool. DSM focuses only on psychiatric/mental disorders and does not include other diseases.

The DSM IV-TR evaluates the mentally distressed individual on a five-axis system that measures separate functioning dimensions. Axis I and II are classifications of abnormal conduct, Axis III and IV are directed at aetiological factors and Axis V functioning.

Axis I	Clinical disorders and V-codes
Axis II	Mental Retardation and Personality Disorders
Axis III	General medical conditions
Axis IV	Psychosocial and environmental problems
Axis V	Global assessment and functioning

The DSM assessment provides a diagnosis on different levels and allows for comprehensive mental health care (Sadock & Sadock, 2007:272). This system is used for making a clinical diagnosis and for the prescription of treatment by a medical doctor. The DSM assessment is also used by members of the mental health (multi-professional) team to communicate and utilize different axes for planning their own interventions.

Nursing diagnosis

A nursing diagnosis is made on the following formula:

Description of problem/need + aetiology (“due to”) + observation (“evidenced by”).

This means that the nursing intervention does not only focus on the identified problem/need, but also on addressing the aetiology. When evaluating the success of an intervention, a change should be observed in the evidence from the nursing diagnosis.

2.5 MENTAL HEALTH CARE

Human health and well being are influenced by many factors. Van Rensburg (2004:563) states that health care professionals globally share a moral goal to promote health, alleviate suffering, treat disease and enhance health related knowledge. Mental health care forms an integral part of this care.

2.5.1 The role of the Primary Health Care Nurse

The role of the primary health care nurse is to provide comprehensive and holistic care to the ill and, by implication, the mentally ill person. The role of the campus health nurse includes a responsibility towards the basic rights of the patient (the mentally distressed student) that includes confidentiality, respect and concern, competent care, providing the student with the necessary information with regards to their illness and enabling participation in the planning of their treatment and accepting refusal of care and treatment by the mentally distressed student. The ethical principles of autonomy, beneficence, non-maleficence and justice should be respected in the care of the mentally distressed student.

By implementing the following strategies the nurse will provide holistic care:

- Providing preventative care and early detection of mental illness
- Emergency care
- Referring to a doctor/hospital

- Observing for side effects of psychiatric medication and encouraging long term use of chronic medication
- Giving health education.

2.5.2 Prevention

Stuart & Laraia (2005:2008) state that mental health promotion and mental health prevention are important to mental health care. The absence of mental illness does not mean a person is mentally healthy and mental health promotion is therefore just as important. Uys & Middleton (2004:41-50) state that to enable the prevention of mental distress a comprehensive approach that includes primary prevention (before the illness), secondary prevention (during illness) and tertiary prevention (after illness) is required.

Primary prevention aims to reduce the incidence of mental distress in a community that is basically healthy and to promote strategies that will prevent distress and enhance mental wellness. Examples include debriefing after a traumatic experience, and self-esteem and self-efficacy training. Secondary prevention aims to reduce mental distress through early diagnosis and effective treatment. This requires extensive public health education of students to be aware of the signs and symptoms of mental distress. The primary health care nurse has an extremely important role to diagnose mental distress early and to ensure effective treatment and care is given to the mentally distressed individual. Tertiary prevention is aimed at rehabilitation and treatment as mental illness is one of the most devastating illnesses one can have and places an enormous burden on individuals, their parents and families and even communities and includes strategies such as health education of the public, increasing support, increasing resources, and good controlling of the illness.

The role of the campus health nurse is thus to ensure that mental health education is given on all levels of preventative care, that mental distress is diagnosed early, that mental distress is treated efficiently and effectively and follow-up care and support is provided proficiently to any student experiencing mental distress.

2.5.3 Treatment stages and emergency care

Stuart & Laraia (2005:71) state that there are four treatment stages reflecting the adaptive/maladaptive stages, each with their own nursing interventions.

Mental health promotion stage **-** This goal of this stage is to attain an optimal level of wellness by inspiring quality of life and well being. Health promotion and prevention of mental distress was discussed as primary prevention.

Crisis stage and intervention **-** The goal in this stage is to stabilise the mentally distressed individual by focusing on the risk factors that threaten the individual's health and well being and to guide the individual towards safety.

Acute stage – the goal in this stage is to achieve remission of the mental distress by focussing on the symptoms and maladaptive coping responses and directing towards a treatment plan to ensure symptom relief.

Maintenance stage - The goal of this stage is complete recovery by focussing on the functional status and by reinforcement of the coping responses.

The role of the campus health nurse is thus to facilitate any mentally distressed student, no matter where they are in the recovery process to full recovery and optimal functioning. The crisis intervention will now be discussed in more detail.

A crisis can be defined as a perceived threat or actual stressful event and is a normal part of life and is not preventable. Knowledge of crisis management is a very important skill of the mental health professional. Crisis intervention is a brief and focused intervention aimed at assisting the mentally distressed person not only to cope, but also to manage the stressful event.

A crisis has four phases.

- Phase 1. A crisis activates an anxiety response and, if no relief is found and support is inadequate, the individual will move to the second phase.

- Phase 2. The individual experiences more anxiety as the normal coping mechanism fails.

- Phase 3. New coping mechanisms are tried, or the threat is changed to adjust to old coping mechanisms leading to resolution of problem.

- Phase 4. If there is still no resolution, severe levels of anxiety/panic may develop into stage 4 leading to a psychological crisis.

Factors causing a crisis include the perception of a threat. The resolution strategies are created by situational support and coping mechanisms. The goal of the crisis intervention is to return the individual to the pre-crisis level of functioning by examining the perceived threat, support system and coping resources through warmth, acceptance, empathy, caring and reassurance.

The Department of Health (2002:174 - 179) states that the primary health care nurse should, after completion of the mental status examination, make a decision with regards to the management of the patient. The management of the client should be guided by the following criteria to determine the severity of the crisis and treatment/referral required.

The primary health care nurse can use this diagram in Table 2.2 on page 49-50 as a guide to determine if the patient has a mental health crisis and requires urgent hospitalisation or other care.

Table 2.2 **Mental disorder/emergency care** (source - DOH, 2002:174-179).

Organic Mental Disorders	**Psychotic Disorders**
Organic mental disorder may be caused due to drugs, pneumonia, meningitis, a hormonal crisis, a thyroid crisis, urea and electrolyte imbalances and diabetes. **Treatment plan:** Referral urgently to hospital to have physical conditions treated.	Causes are not easy to identify but may be due to a genetic susceptibility, a chemical imbalance in the brain (a imbalance of dopamine affects the way the brain reacts to certain stimuli, such as sounds, smells and sights and can lead to hallucinations and delusions) or viral infections (in uteri/early childhood). **Treatment plan:** • If this is the first episode of psychosis and patient is acutely psychotic, refer to

	hospital for admission. • If this is not the first episode, but patient unmanageable, refer to hospital for assessment or readmission. • If this is not the first episode, but patient is manageable at home, refer to community psychiatric clinic.
Depression Causes may be due to a genetic susceptibility, or environmental stress and life events such as loneliness, lack of social support, family history of depression, marital or relationship problems, financial strain, early childhood trauma or abuse, alcohol or drug abuse, health problems or chronic pain. **Treatment plan:** • **Patient with severe depression with no suicide risk:** refer to community psychiatric clinic. • **Patient with Bipolar Disorders or Suicide risk:** Referral urgently to hospital.	**Minor Mental Health Problems** Causes may be due stress, anxiety, or a phobia crisis. **Treatment:** • Manage at clinic or if concerned refer to community psychiatric clinic.

2.5.4 Psychopharmacology

The Medicines and Related Substance Amendment Act (S.A, 2002:4) governs all manufacturing, control and use of medication in South Africa. It recognises nurses as prescribing practitioners provided that the South African Nursing Council authorises the registered nurse to do so. The Act determines that prescribing practitioners have to obtain a Schedule 22A (15) permit to keep, use and supply medication indicating which drugs in each schedule nurses have access to (this list is currently being revised but at present allows nurses to prescribe up to Schedule 4 substances). The Act further determines that prescribing practitioners have to obtain a Schedule 22C dispensing licence allowing nurses to dispense medication.

The Nursing Act 33 of 2005 (S.A, 2005:54) determines in Schedule 56(1) that nurses who become prescribing practitioners must complete a prescribed training program followed by registration with the South African Nursing Council to assess, diagnose, prescribe treatment, keep and supply medication for prescribed illnesses and health related conditions. This authorisation will be valid for three years after which the practitioner will have to re-apply for the licence.

Medication in mental illness is initiated to change behaviour, functioning and emotions. Most of the drugs used in the treatment of mental illness are Schedule 5 and higher and treatment at this stage will thus have to be initiated by a doctor. Currently changes have been made in the Medicines and Related Substance Amendment Act to accommodate Nurse Initiated and Managed Anti-Retroviral Treatment (NIM-ART) to initiate treatment of HIV positive persons with Schedule 5 Anti-Retroviral medications. Possibly more changes may follow that will allow primary health care nurses to treat mental illness or distress.

Medications used in mental illness are called psychotropic drugs. The medication will now be discussed according to their functioning (DOH, 2002:387-419).

Anti-psychotics: Anti-psychotics (neuroleptics) are divided into high-potency and low-potency agents. The efficacy of these drugs is the same but potency refers to the dosage required. All anti-psychotics are dopamine antagonists, with most neuroleptics acting as blockers of the D2 receptor. Some agents may also act on the D1 and D4 receptors. Although the blockade is immediate, the anti-psychotic response usually takes at least ten days for a change in symptoms to become noticeable. Neuroleptics are used in three major situations: acute psychosis as a medical emergency, long term treatment of chronic psychosis and as needed for uncontrolled psychotic or aggressive behaviour.

Side-effects of anti-psychotic medication include symptoms of sedation, dry mouth, hypertension, blurred vision, urinary retention, skin reactions, breast engorgement and lactation, changes in blood cells, jaundice, tardive dyskinesia (repetitive movements of mouth, tongue, jaw and neck that may be irreversible and require referral) and neurological side-effects (producing Parkinson-like symptoms of tremor, slow movements, feelings of stiffness, or of being slowed down, expressionless face, slow shuffling gait, and increased muscle tone/rigidity). Anti-cholinergic drugs should be given for the extra pyramidal side effects.

Anti-depressants: Anti-depressants are useful in a variety of conditions including various forms of depression, anxiety and other syndromes. It is important to note

that symptoms of depression will begin to decrease 10 – 21 days after commencing treatment. There are various classes of anti-depressants available on the market such as 1st generation and 2nd generation anti-depressants. 1st generation anti-depressants blocks the reuptake of nor-adrenaline and serotonin (these two chemicals are necessary to control and regulate mood). Second generation antidepressants such as the Selective Serotonin Reuptake Inhibitors act on the serotonin neurotransmitters and have fewer side effects.

1st generation anti-depressants present with a variety of side effects that include dry mouth, constipation, palpitations, headache and weight gain. 2nd generation depressants present with side effects that include nausea, anxiety, decreased appetite and sleep disturbances.

Mood stabilisers

Mood stabilisers are used in illnesses such as bipolar disorders and should be taken life-long. They are used to control motor hyperactivity, talkativeness, flight of ideas, elation and restlessness. Two types of treatment are currently available and are Lithium carbonate and epilepsy treatment (Epilim).

Side-effects of the medication may include symptoms such as tremors, nausea, fatigue, thirst, polyuria, diarrhoea and muscle weakness.

Anxiolitics and Hypnotics drugs

All anxiolitics should be used with care due to their risk of abuse, tolerance, dependence and risk of withdrawal symptoms. They are used for various anxiety and tension illnesses, convulsive seizures, alcohol withdrawal and insomnia. Various classes of the anxiolitics are available and they are divided according to their half-life.

Side-effects of the anxiolitics medication may include symptoms of drowsiness, fatigue, dizziness, ataxia, blurred vision, slurred speech, tremor and hypotension.

Anti-cholinergic drugs:

Anti-cholinergic drugs are not used to treat mental illness symptoms, but to alleviate certain side effects. Anti-cholinergic drugs may *not* be used as preventatives as it may increase the risk of side-effects. They are often used for short periods of time such as three months. After this period the patient's body should have adjusted to the medication and side effects should abate. Anti-cholinergic drugs focus on alleviating the symptoms caused by a lack of dopamine without increasing the dopamine levels in the patient. However they may also present with side effect symptoms that include dry mouth, blurred vision, constipation, dizziness, nausea, nervousness and tachycardia.

The National Department of Health's (2000(b):22) standards and norms require that emergency and routine medication be provided according to the protocol and the Emergency Drug List. This list of medication is aimed at ensuring that every person who requires medication receives it safely and effectively. Primary health care nurses may currently not prescribe most of these drugs for initiation of care.

The role of the campus health care nurse is thus to provide emergency care, refer to the psychiatric clinic for initiation of treatment or refer to the hospital should the illness so require, motivate adherence to the treatment regimes, provide information about drug interactions and monitor the health status of the student for signs of side effects. Special consideration should be given to drug-drug, drug-food and drug-supplement interactions.

2.5.5 Mental health education

Uys & Middleton (2004:216) state that mental health education provides individuals, groups and families with knowledge of and insight into all aspects of promotion of mental health and prevention of mental illness. An important aspect of mental health education is to dispel myths and stereotypes, reduce stigma, and reduce discrimination of persons suffering from a mental illness. Health education is a strategy for promoting the health of the whole population and is thus the basis of preventative medicine and an important component of primary health care.

The National Department of Health (2000(b):22) requires the following health education:

- Patients, relatives and the community should receive high quality information on mental health and mental illness;
- Patients and their supporters should receive individualised education when their situation is reviewed;
- Patients and their supporters should be educated on how to recognise predisposing factors and conditions to prevent relapse.

Clinic staff should use education in the family and community to address ignorance, fear, and prejudice regarding patients with severe psychiatric conditions who attend the clinic.

Health education is an important strategy in caring for the mentally distressed individual and includes information about medication, treatment, lifestyle changes, follow-up care, crisis management and an awareness of stress, risk factors, defence mechanisms and coping skills. Risk factors are traits that predispose an individual to mental distress. The WHO (2004(a):23) identified the following risk factors for mental distress including age, ethnicity, gender, poverty, ill health, loneliness, peer rejection, HIV positive status, substance abuse, violence, stress, academic failure, unemployment and war. Any experience that is interpreted as stressful may lead to a mental distress response. These stressors lead to the use of defence mechanisms as a coping mechanism.

Frisch & Frisch (2006:94) define defence mechanisms as an unconscious response used by individuals to protect themselves from internal conflict and external stress. Denial, projection, suppression, regression and rationalisation are all forms of defence mechanisms a distressed person may use to deal with or avoid a stressful situation. Stuart & Laraia (2005:292) state that by adopting positive health practices many mental illnesses may be prevented. Individual and group discussions in sharing coping mechanisms such as minimising, replacing and resolving feelings of anxiety, anger, frustration, fear and guilt enables the

individual to cope with stressful situations in a healthy manner that does not cause mental distress.

The role of the campus health nurse is thus to ensure that the mentally distressed student and his family and community receive the necessary health education to ensure living productively in their home environment and community environment.

2.5.6 Counselling

The British Association for Counselling and Psychotherapy (Freshwater, 2003:5) defines counselling as an interaction in which one person offers another person time, attention and respect, with the intention of helping the person explore, discover and clarify ways of living more successfully and towards greater well-being. Counselling can thus be described as a process that provides help and support for someone who is concerned, confused and perplexed (Freshwater, 2003:5). The campus health nurse is often the first level of health care and counselling may be required to assist the ill person to deal with a crisis or cope with a trauma. It is however not required of the campus health nurse to do extensive counselling and, should a person require this level of counselling, he/she should be referred to the specialist in the field.

A psychiatrist or psychologist may provide different forms of counselling. These options will now be discussed briefly:

- Psycho-analysis therapy uses free association (speaking without restrictions) that allows rational, logical and relevant explanations of conflicts and turmoil (Antai-Otong, 2008:792). It is based on the work of Freud and is an intensive and time-consuming therapeutic treatment;
- Supportive psychotherapy relies heavily on communication between the therapist and the individual using reassurance, suggestions, persuasion and emotional support in an attempt to assist the mentally distressed individual;
- Behavioural therapy rests on the assumption that human behaviour is learned and can therefore be unlearned. Behavioural therapy is useful when dealing with anxiety disorders, phobias, and depression through strategies such as

systematic desensitising, flooding, positive reinforcement, assertiveness and social skills training (Antai-Otong, 2008:794);

- Cognitive behaviour therapy is used to modify distorted thoughts and maladapted coping mechanisms in depression or anxiety (Antai-Otong, 2008:794);
- Hypnotherapy is the facilitative process of assisting an individual to an altered state of consciousness to create an awareness and a directed focus experience to assist changing behaviour, and to resolve psychological trauma and distress (Frisch & Frisch, 2006:789);
- Individual psychotherapy is a facilitative process in which the therapeutic relationship is used to promote the client's health, growth, and the development of adaptive coping behaviour by often using various psychotherapy concepts. (Antai-Otong, 2008:791);
- Group therapy is a facilitative process where an open or closed group of people is brought together to receive psychotherapy by creating a setting to share, learn from each other, interact with each other and develop a group identity (Frisch & Frisch, 2006:758).

The role of the campus health nurse in counselling is thus to assist the distressed students to examine and understand their problems, conflicts or difficulties and assist these students to change behaviours that may be detrimental to their health. As this may require longer sessions, the professional nurse may not be able to initiate and implement counselling and should rather refer the client to counsellors.

2.5.7 Complementary and Alternative Care

The health care provider should be aware that there are many forms of alternate and complementary treatment available. Mentally ill patients may seek treatment and even cures for their acute or chronic illnesses by utilising this form of care. Van Rensburg (2004:512) states that alternate and complementary treatment can be divided into several groups. Some of these alternative treatments are discussed briefly.

- Professional systems (chiropractic, acupuncture, homeopathy, naturopathy and massage),

  Acupuncture and Acupressure: Kniesl, WIlson & Trigoboff (2004:774) state that several approaches use the application of pressure or stimulation to specific points on the body to promote healing, relieve pain and promote wellness. Acupuncture originated more than 2000 years ago in China and believes that the vital life energy of the body circulates along 12 major and 8 secondary pathways called meridians. These meridians are linked to specific organs and systems and hair-thin needles are placed at acupuncture sites to stimulate these meridians. Acupressure is based on the same principle as acupuncture but uses finger pressure rather than needles such as with the Shiatsu massage or Reflexology.

  Herbal Therapy: Kniesl, *et al* (2004:778) state that natural herbs have been used as medicines across the ages by all cultures and that there are thousands of natural herbs used for symptom relief in a variety of conditions. Examples are St John's Wort for depression, Melatonin for sleeping problems and Kava for anxiety. There are however also many natural herbs that should not be used with any psychiatric medication. Examples are Sage with anticonvulsants, coffee/tea/cocoa with Xanax (Alprazolam) and St John's Wort with Tricyclic antidepressants.

- Popular health reform (mega-vitamins, nutritional supplements, botanicals, macrobiotics, organic food and vegan diet).

- Mind-body (cognitive behavioural therapy, hypnosis, relaxation)

  Meditation: Kniesl, *et al* (2004:772) state that meditation has been associated with religious practices and philosophies for thousands of years but may also be used by persons without any religious association. The state of meditation is equivalent to a state of deep rest where the heart rate slows, the body uses less oxygen and blood waste products are decreased sharply. Meditation exercises are relatively easy to learn and bring immediate relief and pleasure. A person needs a quiet place, a comfortable position, an object to focus on and a passive attitude to practice meditation.

Deep breathing and relaxation: Kniesl, WIlson & Trigoboff (2004:768) state that most people do not realise that they are stressed and allow these stresses to take over and cause illness. Deep breathing and relaxation exercises are based on the belief that the mind and body are interrelated and if the body relaxes the mind will also relax. Examples of this include body scanning to assess body tension, listening to music to enhance relaxation, breathing exercises and progressive relaxation exercises.

- New Age healing (esoteric energies, crystals, magnets, spirits and mediums and Reiki).

- Non-normative scientific enterprises (iridology, hair analysis).

- Parochial unconventional health care includes Ethno-medicine (African traditional medicine), religious healing and folk medicine practices (herbs or copper bracelets for arthritis).

  Traditional treatment: Van Rensburg (2004:541) states that traditional treatment is holistic in nature because of its comprehensive approach in that it not only aims to cure the disease but also to heal the patient. In the African culture, illness is seen as a disturbance or imbalance in the psychical, physical, interpersonal or spiritual level and all of these are taken into account when diagnosing and treating the person. Treatment may include:
  - herbal remedies (one or more plants administered orally, topically, in the ear or nose and even vaginally),
  - bathing and steaming (topical treatment, to wash off ‘bad luck’, to ward off evil spirits),
  - behaviour (counselling to change behaviour),
  - blood cleansing (detoxify body, to open blood vessels and improve blood flow),
  - charms (to bring good ‘luck’),
  - incisions (introduce medication directly into bloodstream), and
  - dancing (relieve stress, exercise),
  - drumming (reinforces treatment, relieves ancestral stress),

- enemas (cleansing method to rid foreign bodies from the lower body),
- emetics (cleansing method to rid foreign bodies from the upper body),
- snuff (herbs in powder form to relieve headache, sinus and mental illness),
- piercing (piercing or pressure to painful area to treat pain),
- smoke inhalation (direct entry to the brain, to ward off evil spirits),
- Sacrifice or prayer to ancestors (used at psychosocial level to deal with ancestral illnesses).
- *Intelezi* (strong herbal mixture used for luck, protection, warding off evil spirits)
- *Ncinda* (small amounts of herbal medicines used for serious diseases of unnatural causes).

Traditional treatment was discussed in more detail as most of our students are of African descent and all health care workers should be aware that they might possibly seek these treatments.

The role of the campus health nurse is thus to ensure that they are aware of the various alternative care available and should treatments conflict to advise the mentally distressed student accordingly.

2.5.8 Hospitalisation

Mentally distressed persons who present a danger to themselves or others in their environment may require urgent admission to a closed environment in a secure facility such as a hospital. The Mental Health Care Act (SA, 2003:16) makes provision for voluntary, assisted and involuntary mental health care.

Voluntary mental health care allows an individual to be admitted to a facility by his /her own choice and/or on medical advice and after an assessment reveals that hospitalisation is required. These persons are allowed to leave the hospital on demand even if it is against medical advice.

Assisted mental health care means the provision of health interventions to persons incapable of making informed decisions due to their mental health status and who do not refuse the health interventions. These individuals are brought for care by a concerned family member or by a health care professional, who may also take the individual home. The Mental Health Care Act (SA, 2003:9) makes provision for assisted health care and has strict guidelines in place to ensure that decisions made are in the individual's best interest.

Involuntary mental health care means the provision of health care to persons incapable of making informed decisions due to their mental health status and who refuse health intervention but who require such service for their own protection or for the protection of others. These individuals are admitted to psychiatric treatment facilities. The Mental Health Care Act (SA, 2003:10) makes provision for involuntary health care and has strict guidelines in place to ensure that decisions made are in the individual's best interest.

72-Hour assessment: Any individual with mental distress may first need to be admitted for 72 hours of observation at an acute psychiatric unit in a general hospital before admission to specialised psychiatric units should the individual's condition require it. Should any admission for emergency observation, voluntary, assisted or involuntary mental health care be required, the Mental Health Care Act (SA, 2003:6) should be followed strictly to protect both the mentally distressed person as well as those caring for that person.

The role of the campus health nurse is thus to ensure that the distressed student is referred to hospital in mental distress emergencies, and receives the correct treatment when required by assisting with the admission to the hospital or care facility.

2.5.9 Referral system and collaboration

The National Department of Health (SA, 2000(b):22) requires a good referral and collaboration system. Collaboration include that staff respect and where appropriate seek collaborative association with local traditional healers; staff

collaborate with all community services such as crisis counselling (Lifeline, priests), mental health groups (especially those for youth and adolescents), and staff collaborate with the planning of any discharge from the hospital to the community.

The role of the campus health nurse is thus to facilitate the process of referral efficiently as required by the distressed student, as well as close collaboration with other mental health care providers and other services that are available in the community such as support groups (anxiety and depression support group). See Appendix 4 for a referral list for 2011.

2.6 SUMMARY

This chapter presented a literature review that included aspects of mental health care, mental health and mental illness, the mental health status assessment, and treatment provided in primary health care for the mentally distressed student.
Chapter 3 will describe the research methodology used in this study.

CHAPTER 3

RESEARCH METHODOLOGY

3.1 INTRODUCTION

The previous chapter presented a literature review discussing the concepts of mental health care, mental health and mental illness, mental health status assessment and treatment.

In this chapter the following aspects of the research methodology will be discussed:

- Rationale
- Goal
- Research design
- Research methodology
- Pilot study
- Literature control and review
- Ethical considerations

3.2 RATIONALE

Students experiencing symptoms of mental illness or mental distress may seek care at the campus health service. The professional nurses working in the campus health service verbalised that it is sometimes difficult to identify mental illness or mental distress, as there is no effective assessment tool that they can use. Management of these conditions is also problematic as there are no protocols indicating the therapeutic interventions that can be taken. Some professional nurses in the campus health service community may not have had much exposure to psychiatry or the care of mentally ill individuals.

By providing staff with a protocol to use, it is hoped that staff will feel comfortable in dealing with students experiencing mental distress as it could provide them with a guideline should a person require consultation, evaluation, counselling or referral.

3.3 GOAL

The research goal of this study was to develop a mental health care protocol for campus health service professional nurses to assess and manage university students who are experiencing mental distress.

3.4 RESEARCH DESIGN

Research is an investigation or enquiry into a phenomenon or an activity that aims at providing a scientific explanation for the phenomena or activity under investigation (Klopper, 2007:11). Research design is thus a detailed plan or blueprint of how the research is going to be done (Babbie & Mouton, 1998:84).

The design for this study was qualitative, explorative, descriptive and contextual. The Delphi technique was used to collect and analyze data. These concepts are now briefly discussed.

3.4.1 Qualitative research

De Vos *et al* (2005:74) states that qualitative methodology rests on the assumption that valid understanding can be gained through accumulated knowledge acquired first-hand by a single researcher. Morse & Field (1996:1) state that qualitative research requires methodological versatility, the researcher needs to have extensive knowledge of social science theory, be able to interact skilfully with others and be persistent, focused and single-mindedly committed to research. Doing qualitative research is an intense experience that enriches lives. Morse & Field (1996:15) state that the principles of qualitative research include:

- Constructing valid theory that guides knowledge development within a discipline
- A holistic and primarily inductive perspective
- A rigorous, time-consuming intellectual endeavour.

The researcher used valid theory, guided by the extensive literature study, to develop the protocol. The input provided by the expert psychiatric nurses as well as by professional nurses working in a campus health service delivery service was used to ensure that the process was holistic and inductive and ensured a rigorous intellectual endeavour. This study was qualitative as it relied on consensus of perceptions and not on numbers.

3.4.2 Exploratory research

An exploratory research design allows the researcher to gain insight into and to understand the situation, phenomenon, individual, community or setting, as not enough information is available (De Vos *et al*, 2005:134). These authors further state that exploratory study arises out of a lack of basic information on any new area of interest. It further assists the researcher to get acquainted with a situation so as to formulate a problem or develop a hypothesis. This often provides the 'what' or starting point for research (De Vos *et al*, 2005:106). Exploratory research therefore aims to find out enough about a problem to formulate useful statements.

This study was explorative as there was currently a lack of documented evidence of protocols for campus health service professional nurses to use in the care of students experiencing mental distress in South Africa. In this study the perceptions of these nurses as well as of psychiatric nurses was explored to establish relevant content to be included in the research protocol.

3.4.3 Descriptive research

Descriptive research is very accurate and precise. According to De Vos *et al* (2005:106) descriptive research complements exploratory research well as it presents the picture of the details of the situation, phenomenon, individual or community and focuses on the "why" and "how" questions. In this study descriptions were given of the literature related to the problem, the protocol that

was developed as well as the research methodology used in the research process.

3.4.4 Contextual research

Welman, et al (2005:191) state that contextual research aims to describe and understand events, actions and processes within the natural and concrete context in which it occurs. This research is contextual in nature as it is executed within the context of developing a protocol to address the mental health care needs of students visiting a campus health care service at a university in the Eastern Cape.

3.4.5 Delphi technique

This study was done at the campus health service of an Eastern Cape university utilising the Delphi technique. The Delphi technique is a series of sequential questionnaires or “rounds” interspersed by controlled feedback that seeks to gain the most reliable consensus of opinion of a group of experts. Hasson, *et al* (2000:1008) defined the Delphi survey technique as a group facilitation technique, which is an interactive multistage process designed to transform opinion into group consensus. Hellriegel *et al* (2006:169) state that because the Delphi technique relies on opinion it is not foolproof, but the consensus arrived at by the panel of experts is much more accurate than a single expert’s opinion.

In this study the Delphi technique was used to create an instrument by peers to standardise the approach to mental health care in a campus health service provider environment/setting. Grobler, *et al* (2006:111) state that the advantages of using the Delphi technique include that it can involve key decision-makers, can focus on what is needed or desired for the future and is not bound by the past. In this study the Delphi technique was used to determine the perceptions of the participants.

3.5 RESEARCH METHODOLOGY

The research methodology includes a discussion of the research population and sampling and the Delphi technique used for data collection and analysis. To

ensure the reliability of the study the strategies used to ensure trustworthiness will also be discussed.

3.5.1 Research population and sampling

The research population is the total number of persons from which the individuals or units are chosen in the research study (De Vos *et al*, 2005:194). The research sample is a selected small group that is studied and that represents the larger population. In this study the research sample was chosen purposefully. De Vos *et al* (2005:328-329) state that purposeful sample selection represents a key decision point in a qualitative study. In purposive sampling clear identification and formulation of criteria for the selection of respondents are important. Experts are necessary when using the Delphi technique as a research method. In this study the research sample could be seen as a group of experts on the topic being discussed.

The sample consists of two groups of experts who were included with the following criteria in mind:

Group 1: Nine professional nurses working at the Campus Health Service were asked to participate in the study to identify the mental health needs of young adults. They were deemed to be the experts on the mental health needs of young adults, and were able to share their perceptions to identify the symptoms of mental distress that students may experience. It was not an inclusion criteria for these nurses to be qualified as psychiatric nurses, but their expertise was in the field of providing primary health care and being experienced in caring for young adults. These nurses are familiar with the evaluation and treatment protocols used in the Campus Health Service and would be the nurses using the new protocol. Currently ten professional nurses are employed at the campus health service and all nurses meeting the inclusion/exclusion criteria were invited to participate in the study. The inclusion criteria to participate in the study were:

- Current registration with the South African Nursing Council as a professional nurse,

- An employee of the Campus Health Service with a minimum employment period of 6 months,
- Computer literacy.

Group 2: Two specialist psychiatric nurses were included in this study. The researcher required this group's perceptions of what the signs and symptoms of mental distress were as well as what effective intervention strategies could be used to manage students experiencing mental distress. These expert psychiatric nurses work at the university as lecturers and were asked to participate in the study. Currently there are three expert nurses employed at this institution – one of whom acted as the supervisor of this study. The remaining expert nurses were approached and invited to participate in the study. This group was selected purposively. De Erlandson, in de Vos *et al* (2005:329), states that the search for data must be guided by processes to provide rich detail to maximise the range of specific information that can be obtained from and about the context. The expert psychiatric nurses are included to add rich detail to the information provided by the respondents. The inclusion criteria for this group to participate in the study were:

- Current registration with the South African Nursing Council as a psychiatric nurse,
- Qualified as an advanced psychiatric nurse,
- At least five years experience in practicing psychiatric nursing,
- An employee of the university with a minimum employment time of 6 months,
- Be computer literate.

3.5.2 Data collection and analysis

In this study data collection and analysis were conducted simultaneously by utilising the Delphi technique. The Delphi technique is an aid based on the consensus of a panel of experts and requires a series of sequential questionnaires or "rounds" interspersed with controlled feedback that seeks to gain the most reliable consensus of opinion of a group of experts and replaces face-to-face communication (Hellriegel *et al*, 2007:169). Hasson, *et al* (2000:1011) state that three issues guide the data collection and analysis stages namely, the discovery

of opinions, the process of determining the most important issues and managing these opinions.

Discovery of opinions raises the question of how many rounds it takes to reach consensus. Traditionally the Delphi technique consists of four rounds, but research has shown that two or three rounds are sometimes sufficient. It is important to know when to stop - too early may provide incomplete results, while not soon enough may lead to sample fatigue (Hasson *et al*, 2000:1011). The Delphi technique has two approaches in research namely quantitative and qualitative. In this study a qualitative approach was utilised based on the perceptions of the participants.

The summary of the steps used in this study will now be discussed. These steps will be discussed in more detail in chapter 4, pages 82 -89. Steps 1 to 3 describe the process the researcher followed to prepare the questionnaire for the research participants while steps 4 to 7 describe the rounds of the Delphi collection and the research analysis process. These rounds redefined the document until consensus was reached among all the participants.

Step 1: The researcher attended a five-day workshop (Training for primary health care nurses in mental health care) provided by the Department of Health on assessing and managing mental health illness. The content of the workshop included the use of a legal framework, mental status assessment and history taking, assessing and managing families related to mental illness in the community, managing psychiatric disorders/mental health problems, the influence of culture on mental health, HIV/AIDS, substance abuse as seen in psychiatric services, dealing with victims of violence and suicide/crises intervention. This information was used as a basis for developing the questionnaire and later the protocol.

Step 2: The researcher developed a questionnaire asking questions regarding the criteria that should be included in the protocol. This was developed after having done an extensive literature study on mental health, mental illness and criteria

indicating mental illness, mental status assessment and intervention in mental distress. The questionnaire was developed into two phases.

Phase 1: Mental status assessment of young adults and focused on the symptoms experienced by students.

Phase 2: Nursing intervention of mental distress and focused on the nursing intervention of these identified mental health problems.

Examples of the questions in *phase 1* were:

- What are the physical symptoms students present with at a Campus Health Service that may indicate *mental distress*?
- What are the physical symptoms students present with at a Campus Health Service that may indicate *stress*?
- What are the physical symptoms students present with at a Campus Health Service that may indicate excessive *grief/loss*?

Examples of questions asked in *phase 2* were:

- If excessive stress or mental distress is identified, what nursing interventions should be suggested and to what organisation/person could the client be referred?
- If excessive grief is identified, what nursing interventions should be suggested and to what organisation/person could the client be referred?
- If a cognitive (thought) disorder is identified, what nursing interventions should be suggested and to what organisation/person could the client be referred?

See appendix 3 for questionnaire.

Step 3: A two hour workshop was held on the 20th August 2010 for all the participants to explain the aim of this study, the Delphi technique, how it was to be implemented in the study, the principles of mental health and mental illness and the benefit of a protocol to both the student in need of emotional care and the professional nurse working in a campus health service managing students. The participants were invited to participate in the study. All participants signed the informed consent form and participant biographical data form (see appendix 2).

Step 4: This was the implementation of the Delphi data collection and analysis research process to determine an assessment protocol. In the first round phase 1 of the questionnaire was sent electronically to each participant in this research study (see appendix 3). Once each participant had completed the questionnaire, the participants returned it electronically to the researcher. The researcher gathered all the answers supplied by the participants and, in consultation with literature, prepared the draft protocol for the second round. The updated questionnaire (or draft protocol) was sent electronically to the participants who were asked if they would like to add or remove any information. Once each participant had adapted the draft protocol, the participants returned it electronically to the researcher. The researcher gathered all the answers supplied by the participants and, using the information provided, prepared the draft protocol for the third round after consulting the group of expert psychiatric nurses. The draft protocol was sent out for the third round and accepted by all participants. Phase 1 of the questionnaire was thus completed and accepted in three rounds.

Step 5: This was the implementation of the Delphi data collection and analysis research process to determine phase 2 of the questionnaire. Each participant received the questionnaire electronically to commence round 1 of phase 2. Once each participant had completed the draft protocol the participants returned the questionnaire electronically to the researcher. The researcher adjusted the draft protocol according to the suggestions by the participants and re-circulated it to commence the second round of phase 2.

Step 6: The draft protocol was circulated to ensure consensus and accepted by all the participants as the final protocol.

By using the Delphi technique the researcher was able, should any participant's answers differ significantly from the majority, to consult with that participant electronically and negotiate the point until consensus was reached. An advantage of receiving each participant's e-mail directly allowed for direct follow-up and allowed for questions and clarification (Hasson, *et al*, 2000:1011). Participants

often needed to be reminded to complete each round of the Delphi process. It was necessary to build a good research relationship as the ongoing response was based on self-selection. Hasson, *et al* (2000: 1011) state that the Delphi technique is paper based or in this case, computer based. By receiving their answers by e-mail, the participant's replies were printed to create a paper trail that was used to ensure validity, transparency, trustworthiness and reliability.

To ensure trustworthiness of the study, an external auditor was appointed. Once the protocol was completed the external auditor was given all the information related to the paper trail of the questionnaire/protocol to assess whether the auditor came to the same conclusion as the researcher. The auditor in this research was the person responsible for auditing the paper trail and was an expert both in doing qualitative research as well as utilizing the Delphi technique. Punch (2008:289) states that the auditor needs to examine the paper trail data showing how the data were collected and analysed to arrive at the conclusions.

3.5.3 Trustworthiness

Various terms are used to ensure trustworthiness namely, validity, credibility, soundness and rigour. These measures are built into the research to ensure that the research is valid and that the results are reliable. Trustworthiness was needed to prevent bias in research and to ensure that this study reflected the truth.

Lincoln and Guba's Model of trustworthiness (Morse & Field, 1996:118) was used to ensure rigour in this study. There are four criteria that can be used to ensure trustworthiness namely truth-value, applicability, consistency and neutrality each with its own set of strategies (Krefting, 1991:214-222).

Truth-value

Truth-value refers to the confidence the researcher has in the findings. It establishes if the researcher is willing to draw inferences from the research design, information and context. Truth-value may also be termed credibility, which may be referred to as internal validity (by collecting data asking different

questions, seeking different sources and using different methods) and aims to ensure that the data gathered is valid. Krefting (1991:215) identified strategies to determine truth-value or credibility that include prolonged and varied field experience, reflexivity, peer examination, member checking and authority of the researcher. The strategies utilised in this study are summarised in Table 3.1 on page 75.

Strategies that the researcher utilised to ensure credibility to the research include:

- Prolonged and varied field experience:

Krefting (1991:10) states that participants will give different information. Babbie & Mouton (2006:277) state that the researcher should stay in the field until the data has been saturated. The researcher had prolonged engagement with the voluntary participants using the Delphi technique to ensure that the data was saturated. The researcher was able to check the perspectives of the participants.

- Reflexivity:

De Vos *et al* (2005:363) define reflexivity as the ability to formulate an integrated understanding of one's own cognitive world. Reflexivity is therefore an assessment of the influence of the researcher's own background or interests on the study and research process and how a researcher engages on a cognitive and emotional level with the research.

- Peer examination:

Babbie & Mouton (2001:276) state that this is done with a colleague of similar status who is outside the context of the study, who has a general understanding of the nature of the study, and with whom you can review perceptions, insights, and analysis throughout the research process. The research sample used in this study is co-workers with experience of working with students. The Delphi technique makes use of peer opinions.

- Authority of the examiner:

Authority can be defined as power, control, right, permitted, expert, specialist, and professional (Oxford Paperback Dictionary and Thesaurus, 2009:56). Thorough supervision was done throughout the research process by the qualified research supervisor who is an expert in qualitative nursing research and an expert psychiatric nurse. An independent auditor ensured that the data is valid.

- Use of an external auditor:

An external auditor can be defined as a researcher not involved in the research process examining both the process and product of the research study. The purpose is to evaluate the accuracy and to evaluate whether or not the findings, interpretations and conclusions are supported by the data (Robert Wood Johnson Foundation, 2008:1). The auditor in this research is an expert in qualitative research and the Delphi technique and is responsible for auditing the paper trail to ensure that data has been accurately interpreted. The external auditor validated the process and results the researcher followed by using the paper trail to ensure objectivity throughout the study.

Applicability

Applicability refers to applying the findings of the study to another context or to other respondents. In qualitative research applicability is referred to as transferability, which is a form of external validity (De Vos *et al*, 2005:346). The researcher did not apply the study directly to other situations but gave the reader sufficient information to apply the protocol. Strategies that the researcher utilised to ensure trustworthiness include dense descriptions and a nominated sample. This is discussed in Table 3.1 on page 76.

- Dense descriptions:

Babbie & Mouton (2001:277) state that applicability relies on the researcher collecting sufficient data in context and reporting them with sufficient detail and precision to allow the reader to exercise judgement. Dense description can be defined as an in-depth description showing the complexities of variables and interactions so imbedded with data derived from the setting that it cannot help but

be valid (De Vos *et al*, 2005:346). A complete and accurate description of the design, methodology and findings of this study was given accompanied by an in-depth literature control.

- Nominated sample or purposive sampling:

Babbie & Mouton (2001:277) state that in purposive sampling a qualitative researcher seeks to maximise the range of specific information that can be obtained from and about that context by purposely selecting informants who differ in opinion. Purposive sampling was done to select the second group of the research sample to include mental health experts. Group 1 included the total population.

Consistency

Consistency or reliability of the findings refers to whether the findings would be consistent if the same research with the same respondents in a similar context would yield the same results (De Vos *et al*, 2005:346). In qualitative research consistency is referred to as dependability, which means the stability of data over a period. Strategies that the researcher utilised to ensure trustworthiness included dense descriptions and peer examination. These will be discussed in Table 3.1 on page 76.

- Dense descriptions:

This was discussed previously.

- Peer examination:

This was discussed previously.

Neutrality

The fourth criterion of trustworthiness is neutrality, which is defined as freedom from bias in the research procedure results. Confirmability in qualitative research is ensured by asking if another researcher would get the same results using the same data (De Vos *et al*, 2005:347). Strategies that the researcher utilised to ensure trustworthiness include reflexivity and making use of an auditor. These are discussed in Table 3.1 on page 76.

- Reflexivity:

This was discussed previously.

- Making use of an auditor

This was discussed previously.

The strategies used by the researcher in this study to ensure trustworthiness are summarised in Table 3.1.

Table 3.1 Summary of strategies to ensure trustworthiness

Criteria	Strategy	Actions	Application
Truth value	Credibility	Prolonged and varied field experience	All participants have vast experience in working with students and the specialist psychiatric nurses are equally experienced in mental health care. The researcher's supervisor has considerable experience in qualitative nursing research to enable the researcher to complete the research. The researcher has been working in the field under study for fourteen years and also has extensive experience in working with students.
			The researcher has been working in a Primary Health care setting, working with students, for 14 years.
			Specialist psychiatric nurses have vast experience in mental health care.
		Peer examiners	The research sample used in the study is professional nurses with extensive experience of working with students. The Delphi technique makes use of peer opinions.
			Participants asked to review proposed protocol for use by staff.
		Triangulation	Triangulation ensured by gathering data through literature control, CHS nurses' view points and from specialist psychiatric nurses.
			The data was analysed by the researcher, an independent auditor and the supervisor.

		Authority of the examiner	Thorough supervision done by qualified researcher who is an expert in qualitative research. An independent auditor will ensure that data is valid.
		Reflexivity	Reflexivity ensured through comparing notes throughout Delphi technique. Self reflection on research processes and findings.
		Making use of an auditor	The auditor is an expert in doing qualitative research and the Delphi technique and is responsible for auditing the paper trail to ensure that data has been accurately interpreted.
Applicability	Transferability	Dense description of research methods	A complete and accurate description of design, methodology and findings were given and accompanied by the literature control.
		Nominated sample	Purposive sampling was done to select the second group of the research sample to include mental health experts.
Consistency	Dependability	Dense description of research methods	See above.
		Peer examination	See above.
Neutrality	Confirmability	Reflexivity	See above.
		Triangulation	See above.
		Confirmability audit	The auditor is an expert in doing qualitative research and the Delphi technique and is responsible for auditing the paper trail to ensure that data has been accurately interpreted.

Adapted from Krefting (1991:214-222)

3.6 PILOT STUDY

Welman, Kruger & Mitchell (2005:148) state that it is useful to do a pilot study as it detects possible flaws in the measurement procedures and it identifies unclear

and ambiguously formulated items. The method of data gathering used in the Delphi technique does not lend itself easily to doing a pilot study.

The researcher developed the research questions for Steps 4 and 5 based on a comprehensive literature review before commencing the study. Phase 1 of the questionnaire was sent electronically to each participant. During this first Delphi round the researcher was alert to identify if all the participants understood the methodology and if the necessary information was gathered by the questionnaire. No problems were experienced.

3.7 LITERATURE CONTROL AND REVIEW

Morse & Field (1996:37) state that in qualitative research the researcher should usually not consult literature before doing fieldwork as this may mislead or distract the researcher's perception and ability to make accurate and value-free decisions. The Delphi technique however requires a thorough review of literature as the initial questionnaire and provisional protocol is a working document based on literature.

A review of the literature is aimed at contributing a clearer understanding of the nature and meaning of the problem (De Vos *et al*, 2005:123). For this reason a comprehensive literature review was done before the research questionnaire and subsequent protocol were developed.

3.8 ETHICAL CONSIDERATIONS

Ethics can be defined as a set of standards of conduct and moral judgements that help to determine right and wrong behaviour (Grobler *et al*, 2006:554). Punch (2008:276) states that all social research involves ethics as it involves collecting data from people about people. The principles of non-maleficence, beneficence, justice and self-determination are among the most important to ensure that participants are treated with respect and consideration.

3.8.1 Non-maleficence

Non-maleficence is the duty to cause no harm to others, and includes actual harm and the risk of harm (Daniels, 2008:170). Welman, *et al* (2005:181) state that the research process (from planning to completion) should at all times keep ethical dilemmas under consideration and ensure that no participant is harmed in any physical or emotional manner. In this study participants were not harmed emotionally/physically or in any other manner before, during and after the research as no personal information were required of them. The topic was also not one that caused recall of painful memory, as the topic is not of a sensitive nature.

3.8.2 Beneficence

Beneficence is the ethical principle that means the duty to do good and to prevent harm. The two crucial elements of this principle are to provide benefit or to balance benefit and harm (Daniels, 2008:170). The participants in this study are colleagues who will be using the protocol and will benefit from the development of a protocol. By providing staff with a protocol to use as a guide, it was hoped that staff would feel more comfortable in dealing with students experiencing mental distress.

3.8.3 Justice

The principle of justice is based on the concept of fairness and implies fair treatment for all individuals (Daniels, 2008:170). All professional codes of conduct, code of ethics and laws were abided by during the research. All professional nurses are bound by the medical/ nursing code of ethics that prohibits harm to others (Babbie & Mouton, 2006:528). The researcher endeavoured to act responsibly towards all participants in the study and to the discipline of reporting the research results accurately and honestly.

3.8.4 Self determination

The principle of self-determination or autonomy is the individual's right to choose and the ability to act on that choice (Daniels, 2008:169). Participants' privacy (identity), anonymity and confidentiality were protected at all times.

Privacy, Confidentiality and Anonymity

Privacy is the right not to grant access to others of one's personal information, which is not intended for others to observe or analyse (De Vos *et al*, 2005:67). Any personal information provided by the study (although no personal information was required) was not made public or accessible to anyone else other than to those involved with the research. Anonymity means that no one was able to identify any of the participant's responses in this study.

The researcher in this study maintained confidentiality and anonymity by removing any identifiable information. No participant's response during the Delphi process was shared with any other participant and, if consensus could not be reached during the Delphi process, participants' names were removed before any information was passed on.

Informed consent

Participants were protected through the concept of informed consent. De Vos *et al*, (2005:57) states that the participant should give informed consent regarding all information, the goal of the investigation, investigation procedures, possible dangers, and any advantages or disadvantages. The results of the research must be clearly stated to the participants, such as the delivering of a paper at a conference, developing guidelines or publishing the findings (Babbie & Mouton, 2006:521). The result of this study was utilised to develop a protocol that fulfilled a need amongst the participants.

In order to receive consent the researcher provided each individual participant with sufficient understandable information regarding this research study and included the information as required by the research ethics committee (see appendix 2) such as the informed consent (see appendix 2), the written information given to a participant prior to participation, and the oral information that were given during a two hour workshop (see appendix 2) that described what mental health or mental illness is, the goal of the investigation, the Delphi research process (see appendix 2), possible advantages or disadvantages and that a protocol was to be developed through the Delphi process.

Participants were informed that they may withdraw from the research at any time without any prejudice and that participation to the study was voluntary.

Permission to conduct the research was requested from the following authorities (see appendix 1):

- The Department where the research was conducted
- The Institution where the research was conducted
- The Research Committee of the Institution where the research was conducted.

The researcher attempted to maintain the highest ethical standards at all stages of the study.

3.9 SUMMARY

This chapter provides a detailed discussion of the research design and methodology of this study as well as the ethical considerations observed in this study. Chapter four focuses on the research process and findings of this study.

CHAPTER 4

FINDINGS

4.1 INTRODUCTION

Chapter 3 described the rationale and goal of this study, the research design, the research methodology, the pilot study, the literature control and review and the ethical considerations observed in this study.

This study aims to develop a protocol for the campus health to identify and manage mental distress. In this chapter the data will be analysed by discussing the following aspects:

- The research process
- Findings of the research study
- Protocol
- Summary

4.2 THE RESEARCH PROCESS

The researcher ensured that all the necessary permission to conduct the study was granted by the university's research committees, the institution and department where the research was conducted (Appendix 1). The participants gave written informed consent (Appendix 2) after the 2 hour preparation workshop as discussed in chapter three.

In this study the research process has been guided by the Delphi technique. Data collection and analysis were conducted simultaneously as described by Hasson, *et al* (2000:1012).

The steps used in this study will now be discussed.

Step 1 to 3 describes the steps the researcher followed to prepare the questionnaire for the research participants. Step 4 was the implementation of the Delphi data collection and analysis research process to determine an assessment protocol. Steps 4 to 6 describe the rounds of the Delphi collection and analysis research process. These rounds redefined the proposed protocol until consensus was reached between all the participants. All data collected were qualitative in nature. Data were collected electronically and were analysed after each round. The Delphi rounds were utilised to determine the symptoms and management. The questionnaire was completed in two phases. Phase 1 concentrated on identifying the symptoms students present with at the campus health service and in phase two management strategies for these symptoms identified.

Phase 1 of the questionnaire was completed in three rounds and phase 2 of the questionnaire in two rounds – the protocol was thus completed in five Delphi rounds. These rounds redefined the proposed protocol until consensus was reached between all the participants.

Step 1:

The researcher attended a five day workshop given by the mental health care section of the Eastern Cape Department of Health called “Training for primary health care nurses in mental health care” to familiarise herself with primary health care assessment methods of mental health. The content of the workshop included the use of a legal framework, mental status assessment and history taking, assessing and managing families related to mental illness in the community, managing psychiatric disorders/mental health problems, the influence of culture on mental health, HIV/AIDS, substance abuse as seen in psychiatric services, dealing with victims of violence and suicide/crises intervention. This information as well as literature was used as a basis for developing the questionnaire/protocol.

Step 2:

The researcher did an extensive literature study on mental health, mental illness, criteria indicating mental illness, mental status assessment and intervention in mental distress. This allowed the researcher to develop a questionnaire asking

questions regarding the criteria that should be included in the protocol. The questionnaire was completed in two phases and focused on assessing the mental health symptoms students present with at the campus health service (phase 1) and the nursing intervention of these mental health problems identified (phase 2). The questionnaire used in this study is attached (Appendix 3).

Step 3:

The total population of professional nurses of the campus health service was invited to participate in the study. Two expert psychiatric nurses were also invited to participate in the study.

These eleven nurses were invited to attend a two hour workshop. The aim of this workshop was to provide the participants with sufficient knowledge to complete the questionnaire. The researcher made use of two facilitators to assist with the workshop - an expert of the Delphi research technique and an expert in psychiatry. The workshop was held at the institution's conference centre on the 24th August 2010 at 14:00. The participants in this study were provided with a light lunch before the workshop commenced.

Information provided to the participants included the research topic, the goal of this study, an overview of the Delphi technique and research process, how it was to be implemented in the study, the principles of mental health and mental illness and the benefit of a protocol to both the student in need of emotional care and the professional nurse working in a campus health service managing this student (see appendix 2 for agenda of workshop).

The first facilitator who assisted with the workshop is an expert in psychiatric nursing and discussed mental health covering the topics of a definition of mental health and mental illness, the signs and symptoms associated with mental health or illness, how it affects the functioning of an individual and assessing an individual's mental status. The second facilitator assisting with the workshop is an expert on the Delphi research technique and discussed the Delphi technique, the

definition, characteristics, methodology, sample, data collection and analysis, ethical consideration, reliability and validity, and conclusion.

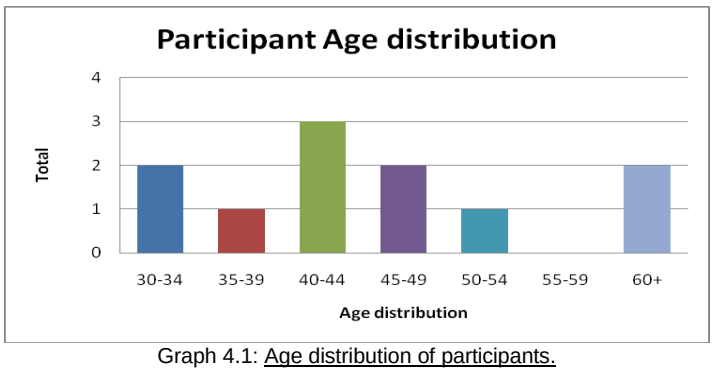
The researcher then discussed an overview of this study, the aim of this study, the benefit of this study, and the research method of this study. The participants were informed of what would be expected of them, how much time they would need to complete the questionnaire and how the information collected would be used. On completion of the workshop the participants were invited to participate in the study. Eleven staff members consented to participate in the study signing the consent forms and completing the biographical data forms.

The biographical information includes gender, age, qualifications and additional qualifications, years of experience in the field, current registration with the South African Nursing Council and computer literacy. The biographical data of the participants are as follows:

- The sample size was eleven participants and consisted of nine professional nurses working at the campus health service and two expert psychiatric nurses working at the institution as academics.

- Ten female and one male.

- The ages of the participants were grouped into 5 year intervals starting at age 30. The age distribution of the participants is shown in graph 4.1. The participant's ages are evenly spread between 30 and 60+ years as seen in graph 4.1.



Graph 4.1: Age distribution of participants.

- All were registered with the South African Nursing Council as registered nurses and all participants in this study are computer literate.

- All are qualified in general nursing, midwifery and community health nursing.

- Five are qualified in psychiatric nursing but have no experience working in the field.

- The participants have varied experience practicing as registered nurses

- Six participants are qualified as occupational health nurses, one in advanced primary health care and one in education.

- The working experience of the nine participants in the campus health service range between one and sixteen years, with more than half the participants working more than seven years at the campus health service as can be seen in the graph below.

Graph 4.2: Years of employment at the campus health service.

- The two expert psychiatric nurses did not work at the campus health service but are both lecturers that have advanced psychiatric nursing with more than 5 years experience practicing psychiatric nursing, namely 12 years and 8 years experience respectively in the field.

All the participants qualified to participate in the research.

Step 4:

In the first Delphi round phase 1 of the questionnaire (see appendix 3) was sent electronically to each participant in this research study.

Phase 1 had seven questions.

- Question1: What are the physical symptoms students present with at a Campus Health Service that may indicate mental distress?
- Question 2: What are the physical symptoms students present with at a Campus Health Service that may indicate stress
- Question 3: What are the physical symptoms students present with at a Campus Health Service that may indicate excessive grief/loss?
- Question 4: What are the physical symptoms students present with at a Campus Health Service that may indicate a cognitive (thought) disorder?
- Question 5: What are the physical symptoms students present with at a Campus Health Service that may indicate a behaviour disorder?
- Question 6: What are the physical symptoms students present with at a Campus Health Service that may indicate their social functional are affected?
- Question 7: What are the physical symptoms students present with at a Campus Health Service that may indicate suicidal ideation?

Once each participant had completed the questionnaire, the participants returned the questionnaire's answers electronically to the researcher. The researcher gathered all the answers supplied by the participants and made a hard copy and analysed the answers. Data analysis was initiated by grouping similar items together such as:

"Tiredness / Fatigue / Lethargy / Severe Tiredness / Tiredness" or

"Concentration Problems / Poor Concentration / Difficulty to Concentrate / Short Attention Span / Wandering Thoughts / No Concentration".

One participant stated the following: “Greet the patient in a friendly manner, ensure privacy and confidentiality, encourage patient to talk, listen without interruption, and be empathetic”. As a protocol should reflect only essential information to ensure easy access to information, only the essential steps and not all the detail suggested by the participants were included. Although the statement is not reflected in the protocol it is important to ensure that any person seeking health care should be treated in this manner.

These answers were compared and adjusted to literature to prepare the draft protocol for the second round. Verbal and non–verbal symptoms were identified for each of the seven questions.

The second Delphi round commenced by sending the updated questionnaire (or draft protocol) electronically to the participants asking if they would like to add or remove any information. Once each participant had adjusted the draft protocol, the participants returned it electronically to the researcher. The researcher gathered all the answers supplied by the participants and, using the information provided, prepared the draft protocol for the third round after consulting the group of expert psychiatric nurses. The information gathered by the 2 previous rounds were discussed with the two expert psychiatric nurses and condensed. McIlrath, Keeney, McKenna and McLaughlin (2009:273) state that following analysis and independent judgement from the research team any response overlaps were reduced. This was the most difficult round as a large number of symptoms were identified that had to be analysed and condensed into a workable document.

The third Delphi round was commenced by electronically sending out the revised document to the participants who were asked to comment. The document was accepted by all participants. Phase 1 of the questionnaire was thus completed and accepted in three rounds. An advantage of receiving each participants e-mail directly allowed for direct follow-up by allowing questions and clarification (Hasson, *et al*, 2000:1011).

Step 5:

The fourth Delphi round to determine phase 2 of the questionnaire (see appendix 3) commenced. Phase 2 had six questions.

- Question 1: If excessive stress/mental distress are identified, what nursing interventions should be suggested and to what organisation/person could the client be referred?
- Question 2: If excessive grief is identified, what nursing interventions should be suggested and to what organisation/person could the client be referred?
- Question 3: If a cognitive (thought) disorder is identified, what nursing interventions should be suggested and to what organisation/person could the client be referred?
- Question 4: If a behaviour disorder is identified, what nursing interventions should be suggested and to what organisation/person could the client be referred?
- Question 5: If social dysfunction is identified, what nursing interventions should be suggested and to what organisation/person could the client be referred?
- Question 6: If suicidal ideation is identified, what nursing interventions should be suggested and to what organisation/person could the client be referred?

The draft protocol finalised in phase 1 was added to the questionnaire to assist the participants to formulate the nursing interventions required by the symptoms identified by the participants in phase 1. The adjusted questionnaire was sent electronically to each participant. Once each participant had completed the draft protocol the participants returned the questionnaire electronically to the researcher. The researcher adjusted the draft protocol according to these responses.

Step 6:

The fifth Delphi round commenced by circulating the adapted draft protocol to all the participants. A hard copy of the draft protocol was given to each campus

health service participant as all these staff members attended a strategic planning meeting before closing for the year end. The questions became more specific in this round (the questions were worded very broadly in the first rounds to ensure that the participants understood clearly what was expected of them and that they covered all the aspects required). The same document was sent electronically to the expert psychiatric nurses. A copy of the protocol guideline and *SAD PERSONS* risk assessment tool was also included. The draft protocol was accepted by all the participants as the final protocol and therefore concluded the final Delphi round.

The Delphi technique made it possible to consult the participant electronically and negotiate the point until consensus was reached should any participant's answers differ. An advantage of receiving each participants e-mail directly allowed direct follow-up and allowed questions and clarification (Hasson, *et al*, 2000:1011). Participants needed to be reminded to complete each round of the Delphi process. It was necessary to build a good research relationship as the ongoing response was based on self-selection. Hasson, *et al* (2000: 1011) state that the Delphi technique is paper based or in this case, computer based. Despite receiving their answers by e-mail, the participant's replies were printed to create a paper trail that was used to ensure validity, transparency, trustworthiness and reliability.

To ensure trustworthiness of the study, an external auditor was appointed to evaluate the paper trail. Once the protocol was completed the external auditor was given all the information related to the paper trail of the questionnaire/protocol to assess whether the auditor also came to the same conclusion as the researcher. The auditor in this research was an expert both in qualitative research as well as utilizing the Delphi technique. Punch (2008:289) states that the auditor needs to examine the paper trail data showing how the data were collected and analysed to arrive at the conclusions.

4.3 FINDINGS OF THE RESEARCH STUDY

All eleven participants who were invited to participate in the study completed each round till the final Delphi round.

4.4 PROTOCOL AND GUIDELINE

The final protocol is presented below. For guideline and flow chart see Appendix 5.

1. Symptoms indicating that a student is experiencing *stress* are:

Stress is a normal and necessary human reaction and can be neutral (have no effect), negative or positive. Positive stress or eu-stress is useful and can motivate or challenge a person. Negative stress or distress is prolonged stress that may cause illness or dysfunction. Stress management involves changing the stressful situation, changing the reaction to the stressful event, taking care of, and making time for rest and relaxation. Identify cause of stress and manage accordingly. (Grobler, *et al*, 2006:389)

- Headaches and migraines
- Insomnia and tiredness
- Musculoskeletal problems such as body aches/pains, neck stiffness/pains and backache
- Gastrointestinal problems such as indigestion, loss/poor appetite, nausea, vomiting & diarrhoea, flatulence, stomach cramps and over/under eating
- Cardiovascular problems such as heart palpitations, chest pain and dizziness
- Respiratory problems such as shortness of breath or hyperventilation
- Concentration problems
- Skin rashes or eczema
- Restlessness, nervousness and fiddling with their hands
- Raised blood pressure
- Tearfulness

Management of stress by the campus health nurse

Assessment:

- Full medical history
- Assess for symptoms of stress
- Eliminate substance abuse

Nursing management:

- Nursing counselling (comforting, supportive interview)
- Health Education (teach stress/anger management)
- Refer to student counselling
- Refer to doctor for medication
- Ensure support system such as family or friends
- Follow-up date in 1 week

2. Symptoms indicating that the student is experiencing excessive *grief/loss* are:

Grief/Loss is a normal human reaction to loss. Normal grief has 3 stages that include shock (numb stage), a reality stage (emotions of anger, guilt, frustration, helplessness, and fear) and a recovery stage. Nursing management includes using coping behaviours (keeping busy), cognitive coping (can do), and interpersonal coping (talking to others, support group). In abnormal grief/loss the person experiences grief as overwhelming and resorts to maladaptive behaviour. Abnormal grief include chronic grief (never reaches conclusion, delayed grief (not at time of loss and stays with individual), exaggerated grief (overwhelming) and masked grief (physical symptoms or maladaptive behaviour). Referral for counselling and support is required. (Frisch & Frisch, 2006:269).

- Headaches
- Concentration problems
- Insomnia
- Fatigue
- Change in appetite, weight loss/gain
- Loneliness and an inability to live life without the person that they have lost
- Crying, verbalising loss
- Variety of facial expressions from sadness to anger
- Become quiet and withdrawn from friends and family
- Restlessness/apathy
- Verbalise suicidal thoughts.

Management of excessive grief/loss by campus health nurse

Assessment:

- Full medical history
- Determine loss
- Determine emotions being experienced
- **Determine suicidal ideation (*SAD PERSONS* tool – see suicidal ideation for tool and management)**

Nursing management:

- Nursing counselling (comforting, supportive interview)
- Refer to student counselling
- Refer to psychologist/grief counsellor/social worker
- Refer to medical doctor for treatment
- Refer to psychiatrist
- Ensure support system such as family or friends
- Follow-up date in 1 week

3. Symptoms indicating that the student is experiencing a *cognitive (thought) problem* are:

Cognitive dysfunction is the loss of intellectual functioning such as thinking, remembering, and reasoning to such a severity that it may interfere with daily functioning. Cognitive dysfunction is common in schizophrenia, depression, drug abuse and more. Referral required. If this is the first episode refer to hospital for admission. If known history, default in treatment and manageable at home, refer to psychiatric clinic; if unmanageable refer to hospital for stabilisation (Uys & Middleton, 2004:756).

- Memory problems
- Concentration problems
- Inappropriate behaviour in public such as exposing themselves
- Obsessive thoughts and/or compulsive behaviour (like counting the tiles on the wall)
- Communication problems such as pressured speech, thought blocking, or flight of ideas
- Verbalise strange ideas/perceptions (psychotic)
- Problems with orientation to time, place and person
- Delirium that may be caused by drugs, infections, metabolic disorders, trauma of the head, oxygen deficiency or psychological illness
- Lack of decision-making skills, poor judgment or poor problem solving skills.

Management of a cognitive problem by the campus health nurse

Assessment:

- Full medical history
- Determine cognitive problems
- Determine risk for self harm or harm to others

Nursing management:

- Nursing counselling (comforting, supportive interview)
- Refer to Psychologist
- Refer to Psychiatrist
- Refer to Psychiatric clinic
- Refer to Hospital casualty department (Dora Nginza Hospital)
- Ensure support system such as family or friends
- Follow up as appropriate

4. Symptoms indicating that the student is experiencing a *behaviour problem* are:

Behaviour or conduct should always be appropriate to culture and development level. Behaviour dysfunction may be caused by various disorders such as phobias, substance abuse, depression, schizophrenia, and many more. This patient should be referred for further evaluation and care immediately. If patient is unmanageable refer to hospital for stabilisation. (Uys & Middleton, 2004:547)

- Other students hassling the patient with regards to his/her behaviour
- Inability to change or control behaviour (obsessive-compulsive)
- Crying
- Inappropriate risk taking behaviour (such as drugs/alcohol/sex/speeding)
- Sudden change in behaviour such as missing classes, or inappropriate laughing
- Aggression
- Hyper alert (eyes constantly looking around) or poor eye contact
- Nervousness and restless movement of hands or fidgeting
- Lack insight about why friends and family may be complaining about their behaviour.

Management of behaviour problems by campus health nurse

Assessment:

- Full medical history
- Determine behaviour problem

Nursing management:

- Counselling (comforting, supportive interview)
- Refer to Psychologist
- Refer to Psychiatrist
- Refer to Psychiatric clinic
- Refer to Hospital casualty department (Dora Nginza Hospital)
- Student counselling
- Follow up as appropriate

5. **Symptoms indicating that the student is experiencing *social dysfunction* are:**

Social dysfunction is an umbrella term used to describe a variety of emotional problems experienced in social situations. Conditions social dysfunction is associated with include alcoholism, anorexia nervosa, stress, attention deficit/hyperactivity disorder, phobia, depression and schizophrenia. This patient should be referred for further evaluation and care immediately. If patient is unmanageable refer to hospital for stabilisation (National Department of Health, 2002:175).

- Loneliness
- An inability to create or maintain friends or relationships
- An inability to trust other people
- No/poor eye contact (exclude cultural influence)
- A change in socialisation (withdrawal/ bothering others with need to socialise)
- Verbalise (or engage in activities) suicidal ideation
- Sudden change in behaviour such as missing classes, going out every night and poor studying habits
- Difficulty in socialising with family, friends, class mates and the community.

Management of social dysfunction by campus health nurse

Assessment:

- Full medical history
- Determine social dysfunction

Nursing management:

- Counselling (comforting, supportive interview)
- Refer to psychologist or
- Refer to psychiatrist or
- Refer to psychiatric clinic or
- Refer to Hospital casualty department (Dora Nginza Hospital)
- Student counselling
- Psychiatric nurse
- Follow up as appropriate

6. Symptoms indicating that the student is experiencing *suicidal ideation* are:

Suicide is the process of purposely ending one's own life and may be triggered by a real or imagined loss. Ensure safety of patient. Never leave patients alone. Patients with a plan, access to lethal means, recent social stressors and symptoms suggestive of a psychiatric disorder should be hospitalized immediately. Patients with:

- *High risk of suicide* - Refer immediately for hospitalisation and doctor/psychiatrist. Antidepressants should be given in small amounts or someone else to control supply.
- *Low risk of suicide* - refer immediately to – psychologist/psychiatrist/counselling.

(National Department of Health, 2002:175)

- A recent loss (death, broken relationship)
- Feelings of desolation, hopelessness and worthlessness, loss of hope in life, problems are so big that nobody can help and that there is no solution
- Using words like " I have nothing to live for"
- Verbalising suicidal plan
- Verbalising self injury, saying goodbye, thanking others for help
- Withdrawn and gradual social isolation
- History of depression or are on treatment for other mental health problems
- History of previous attempts of suicide
- Engage in self mutilation behaviour
- May draw up a will, and give away all their possessions
- Substance abuse.

Management of suicidal ideation by campus health nurse

Assessment:

- Full medical history
- Determine suicidal ideation risk (see *SAD PERSONS* tool below)
- Eliminate substance abuse

Nursing management:

- Nursing counselling (comforting, supportive interview)
- Suicidal contract
- If suicidal risk is high, place patient in care of a responsible person such as a parent or arrange for hospitalisation. If in care of a responsible person discuss suicidal risk behaviour and prevention
- If risk is low, ensure support system such as family or friends and still discuss suicidal risk behaviour with support systems

SUICIDAL RISK TOOL - *SAD PERSONS*.

SAD PERSONS: a mnemonic for assessing suicide risk. *SADPERSONS* is a 10-point scale used to screen for suicide risk. An individual is given one point for each item screened positive:

S - Sex (male) (more females attempt, more males succeed)
A - Age less than 19 or greater than 45 years
D - Depression (patient admits to depression or decreased concentration, sleep, appetite and/or libido
P - Previous suicide attempt or psychiatric care
E - Excessive alcohol or drug use
R - Rational thinking loss: psychosis, organic brain syndrome
S - Separated, divorced, or widowed or single
O - Organized plan or serious attempt
N - No social support
S - Sickness, chronic disease

Guidelines for action with the SAD PERSONS scale	
Total points	**Proposed clinical action**
0 to 2	Send home with follow-up
3 to 4	Close follow-up; consider hospitalization
5 to 6	Strongly consider hospitalization, in the care of a responsible person
7 to 10	Hospitalize or commit

(Zastrow & Kirst-Ashman, 2007:321)

A guideline with a flow chart describes the manner in which the protocol should be used (see appendix 5). Early and correct intervention in mental distress will ensure that students retain/gain optimal health, enabling them to fulfil their dreams in

attaining their qualifications. Appendix 4 also has a referral list with contact numbers to assist campus health nurses referring patients and seeking assistance.

All the data collected in the Delphi research process was given to the external auditor for verification. See appendix 6 for letter of approval.

4.5 SUMMARY

In this chapter the researcher discussed the research process, the findings of the research study and presented the final protocol. The research process involved gaining research permission from all the relevant authorities, the sample used in this study with all the biographical data, the steps involved in the Delphi technique to collect and analyse data, and the final protocol accepted by all the participants.

In Chapter five recommendations and conclusions are made in respect of the study.

CHAPTER 5

RECOMMENDATIONS AND CONCLUSIONS

Chapter 4 described the findings of this research study by scrutinising the research process, identifying the findings and presenting the completed protocol.

In this chapter the focus will be on discussing:

- The findings,
- Limitations of this study,
- Recommendations.

5.1 INTRODUCTION

The goal of this study was to develop a mental health care protocol for campus health service professional nurses to assess and manage university students who are experiencing mental distress.

Students experiencing symptoms of mental illness or mental distress may seek care at the campus health service. The professional nurses working in the campus health service verbalised that it is sometimes difficult to identify mental illness or mental distress as there is no effective assessment tool that they can use. Management of these conditions is also problematic as there are no protocols indicating the therapeutic interventions that can be taken.

Using the Delphi technique a protocol was developed by the participants in this study to manage mental distress by focussing on the following aspects: stress, grief/loss, cognitive disorder, behaviour disorder, social dysfunction and suicidal ideation. After completing the Delphi rounds the protocol was completed and accepted.

The goal of this research has thus been accomplished.

5.2 FINDINGS

The sample in this research study included the total population of the campus health service professional nurses and two expert psychiatric nurses who were chosen purposefully. The biographical data of the participants include ten female nurses and one male professional nurse. Five of the professional nurses working in the campus health service have psychiatric nursing training, but have no experience working in the field.

Focussing on the functioning (emotional, cognitive, behaviour, social, suicidal ideation) of an individual, the questionnaire used in the research study, was developed after and intensive literature review. A questionnaire was developed and was presented to the participants in two phases – phase 1 to determine the symptoms and phase 2 to determine the management of these symptoms. The questions in the questionnaire were worded very broadly in the first rounds to ensure that the participants understood clearly what was expected of them and that they covered all the aspects required.

The protocol consists of the following components:

5.2.1 Symptoms identified and the management of stress

Symptoms indicating stress in a student may include headaches and migraines; insomnia and tiredness; musculoskeletal problems such as body aches/pains; neck stiffness or pains and backache; gastrointestinal problems such as indigestion, loss of or poor appetite, nausea, vomiting and diarrhoea, flatulence, stomach cramps and over or under eating; cardiovascular problems such as heart palpitations, chest pain and dizziness; respiratory problems such as shortness of breath or hyperventilation; concentration problems; skin rashes or eczema restlessness, nervousness and fiddling with their hands; raised blood pressure and tearfulness.

Management of stress includes firstly an assessment that includes a full medical history, an assessment for symptoms of stress, and to eliminate substance abuse.

The nursing management of stress will include nursing counselling with regards to stress, possible triggers, how to minimise or reduce or eliminate stress. Health education will include stress/anger management, relaxation techniques. It may be necessary to refer the student to the Student Counselling Unit for advice on study methods and career counselling. It may also be necessary to refer to a doctor for medication. The professional nurse may provide medication to treat any physical discomfort such as aches and pains. Ensure a support system such as family or friends. The student should be seen within one week for reassessment and follow up care.

5.2.2 Symptoms identified and the management of grief/loss

Symptoms indicating stress in a student may include headaches; concentration problems; insomnia; fatigue; change in appetite, weight loss/gain; loneliness and an inability to live life without the person that they have lost; crying, verbalising loss; a variety of facial expressions from sadness to anger; becoming quiet and withdrawn from friends and family; restlessness/apathy; and verbalising suicidal thoughts.

Management of grief/loss include firstly an assessment that includes a full medical history, an assessment for symptoms of grief/loss, and to determine any suicidal ideation. See Suicidal ideation for management of suicide risk. The nursing management of grief/loss will include nursing counselling using a comforting, supportive interview. The student should also be referred to student counselling, a psychologist/grief counsellor/social worker. The student should be referred to a medical doctor or psychiatrist for treatment. Ensure a support system such as family or friends. The student should be seen within 1 week for reassessment and follow up care. (See Suicidal ideation for management of suicide risk.)

5.2.3 Symptoms identified and the management of cognitive problems

Symptoms indicating stress in a student may include memory problems; concentration problems; verbalise suicidal thoughts; inappropriate behaviour in public such as exposing themselves; obsessive and/or compulsive behaviour (like counting the tiles on the wall); communication problems such as pressured

speech, thought blocking, or flight of ideas; verbalise strange ideas/perceptions; problems with orientation to time, place and person; delirium that may be caused by drugs, infections, metabolic disorders, trauma of the head, oxygen deficiency or psychological illness; and lack of decision-making skills, poor judgment or poor problem solving skills.

Management of a cognitive disorder includes firstly an assessment that includes a full medical history, an assessment for symptoms of a cognitive disorder and to determine any suicidal ideation. See also suicidal ideation for the management of suicide risk. The nursing management of a cognitive disorder includes nursing counselling in a comforting, supportive interview. This client should be referred immediately to a psychologist, psychiatrist, psychiatric clinic or to a hospital casualty department such as the Dora Nginza Hospital locally. Ensure a support system such as family or friends.

5.2.4 Symptoms identified and the management of behaviour problems

Symptoms indicating stress in a student may include other students hassling them with regards to their behaviour; inability to change or control behaviour (obsessive-compulsive); crying; inappropriate risk taking behaviour (such as drugs/alcohol/sex /speeding); sudden change in behaviour such as missing classes, or inappropriate laughing; aggression; hyper alert (eyes constantly looking around) or poor eye contact; nervousness and restless movement of hands or fidgeting; and lack of insight into why friends and family may be complaining about their behaviour.

Management of a behaviour disorder includes firstly an assessment that includes a full medical history, an assessment for symptoms of a behaviour disorder. The nursing management of a behaviour disorder includes nursing counselling in a comforting, supportive interview. The student should be referred immediately to a psychologist or psychiatrist or to a psychiatric clinic or hospital casualty department such as Dora Nginza Hospital. The student should, after the crisis has been managed, be referred to student counselling for cognitive behaviour therapy and possibly a support group.

5.2.5 Symptoms identified and the management of social dysfunction

Symptoms indicating stress in a student may include loneliness; an inability to create or maintain friends or relationships; an inability to trust other people; no/poor eye contact (exclude cultural influence); a change in socialisation (withdrawal/ bothering others with need to socialise); verbalising (or engaging in activities) suicidal ideation; sudden change in behaviour such as missing classes, going out every night and poor studying habits; and difficulty in socialising with family, friends, class mates and the community.

Management of social dysfunction encompasses firstly an assessment that includes a full medical history, an assessment for symptoms of social dysfunction and the determination of any suicidal ideation (See Suicidal ideation for management of suicide risk). The nursing management of social dysfunction includes nursing counselling with a comforting, supportive interview. Refer the student immediately to a psychologist, psychiatrist, a psychiatric clinic or a hospital casualty department such as the Dora Nginza Hospital. The student should be referred to student counselling. A psychiatric nurse may initiate a support group for the students experiencing socialization disorders.

5.2.6 Symptoms identified and the management of suicidal ideation

Symptoms indicating overwhelming stress that may lead to suicidal ideation in a student may include a recent loss (death, broken relationship); feelings of desolation, hopelessness and worthlessness, loss of hope in life, problems are so big that nobody can help and that there is no solution; using words like “ I have nothing to live for”; verbalising suicidal plan; verbalising self injury, saying goodbye, thanking others for help; withdrawn and gradual social isolation; history of depression or where a student is on treatment for other mental health problems; has a history of previous attempts of suicide; engages in self mutilation behaviour; may draw up a will, and give away all their possessions and a history of substance abuse.

Management of suicidal ideation should always be seen as a crisis management and immediate attention should be given to the student’s problems. It will include

firstly an assessment that includes a full medical history, an assessment for symptoms of suicidal ideation, and, to determine suicidal risk, utilising the *SAD PERSONS* tool (see chapter 4 page 96). The nursing management of suicidal ideation includes nursing counselling with a comforting, supportive interview. Should the scale (see chapter 4 page 96) indicate a high risk for suicide, the student should be referred immediately for hospitalisation and medical care provided by a doctor/psychiatrist. Should the scale indicate a lower risk for suicide the student should be referred immediately to a psychologist/psychiatrist/ to student counselling and should include a suicidal contract.

It is of the utmost importance that the student's safety should be ensured. The student may never be left alone and should be left in the care of a responsible adult such as a parent or medical person.

5.3 LIMITATIONS

The researcher identified the following limitations in this study:

The results of this study cannot be easily generalised to campus health services at other universities or other primary health care clinics as a qualitative study was conducted in a single campus health service with a limited number of participants (n=11).

The Delphi technique is very time consuming as the researcher is dependent on the responses of the participants to complete the multiple rounds. As the protocol required 5 Delphi rounds to complete this shows that a considerable time was required to complete the research. Each round itself took a considerable time as participants were ill, the campus health service was under-staffed and extremely busy as students were in the period just before and during exams. This period is stressful to both staff and students. Slow responses from the participants amplified this problem.

It was difficult to refine the information gathered as participants kept adding ideas instead of refining the information. A protocol should only contain essential information. This necessitated the use of the experts and literature to refine the vast amount of data to a workable document.

Although testing of the protocol falls outside the scope of this research, it is recommended for further research.

5.4 RECOMMENDATIONS

Based on the research findings as well as the limitations identified, the following recommendations are presented for consideration:

5.4.1 Recommendations for future research

This research study can be used as a basis for further research regarding the management by professional nurses working in campus health services of students experiencing mental distress at other higher education institutions. The researcher therefore recommends that the same research study be conducted by using a larger sample of registered nurses from different higher education institutions using the same method.

Further research studies can be conducted on the implementation of the protocol to determine the effectiveness of the protocol for registered nurses in the work situation. One study can evaluate the effectiveness of the tool with the goal of refining the protocol. Another study can assess the campus health service nurses experiences using the tool and how effective they deem it to be.

5.4.2 Recommendations for clinical use

It is recommended that professional nurses working in campus health services utilise the protocol to provide holistic primary mental health care to its student at higher education institutions. It is only by using the tool that its effectiveness can

be determined. Using the tool may also indicate whether the identification of mental distress in a student population is statistically higher than the 1% currently identified without the tool.

5.4.3 Recommendations for nursing education

It is recommended that all primary health care professionals are trained in providing effective mental health care to young adults. They should be sensitised to the kind of problems young people experience. The tool may ease identification of mental distress in young adults.

5.5 CONCLUSION

This research study was conducted using a qualitative, explorative, descriptive and contextual design, making use of the Delphi technique to collect and analyze data.

The researcher believes that the protocol could be implemented by professional nurses working in campus health services to standardize mental health care and provide mental health care of a high standard to assist students in regaining the optimal health required to successfully complete their studies.

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APPENDIX 1

APPLICATION FORMS SEEKING RESEARCH APPROVAL

APPLICATION TO CONDUCT RESEARCH - ETHICS COMMITTEE

Student no. 180029390

Contact person: Ms N Ahmed

20 September 2010

Ms LL Dalton
8 Thakwray Avenue
Miramar
Port Elizabeth
6070

FINAL RESEARCH/PROJECT PROPOSAL: MA (Health and Welfare Management)

Please be advised that your final research proposal was approved by the Faculty Research, Technology and Innovation Committee subject to the following amendments/recommendations being made to the satisfaction of your Supervisor:

COMMENTS/RECOMMENDATIONS

1. Title should read as follows: Developing a protocol for campus health service professional nurses to manage students with mental distress.
2. Reorganise content of research problem to ensure a logical exposition.
3. The goal of this study needs to be addressed by furthermore exposition of objectives.
4. Page 7, point 4 (Research Goal) – In the first sentence of the paragraph change research aim to research goal.
5. Supportive literature – Bulleted list could have been rewritten into paragraph style to enhance the content flow.
6. Participants and sampling method – Is having two specialist psychiatric nurses in group 2 of a panel of experts representative?
7. Data Collection – A draft copy of the questionnaire to obtain inclusion criteria for the design of the research protocol should be included as an appendix.
8. Method of analysis – The Delphi method of data collection and analysis is not addressed as a separate heading.
9. Literature control was not addressed.
10. Ethical considerations were very laborious and repetitive and can be effectively shortened.
11. Dissemination of results – The time line is unrealistically short.
12. No indication of literature review and multiple drafts.
13. The writing style will need linguistic refinement and there were minor editorial corrections.
14. The reference list was inconsistent.

Your ethics approval number is **H10HEASDP005** and the FRTI committee number for the proposal is **RTIH10.94.2**

APPLICATION TO CONDUCT RESEARCH
CAMPUS HEALTH SERVICE

Dear Madam
Re: Application to Conduct Research.

Title of research project: DEVELOPING A PROTOCOL FOR CAMPUS HEALTH SERVICE PROFESSIONAL NURSES TO MANAGE STUDENTS EXPERIENCING MENTAL DISTRESS

This letter serves as an application to conduct a research study at the Campus Health Service. I am a professional nurse working at the Campus Health Service of the Nelson Mandela Metropolitan University (NMMU). My name is Linda Dalton, and I am a registered student for the Masters Degree in Health and Welfare Management at the NMMU. I am conducting research in mental health care in primary health care under the supervision of Professor J Strümpher.

The research aim is to meet the emotional health care needs of students attending a Campus Health Service. The goal of this study is to develop a protocol to be used by Professional Nurses to assess and manage students who are experiencing mental distress visiting the Campus Health Service and will standardize mental health care in primary health care at all Campus Health Services.

The research is significant in that by providing staff with a protocol to use as guidance it is hoped that staff will feel comfortable in dealing with students experiencing mental distress.

Dissemination of results will include publish an article in a peer reviewed journal, a workshop for colleagues, a poster presentation at the national conference of the South African Association of Campus Health Services and a poster presentation at a student research conference.

The protocol will standardize mental health care in primary health care at all campus health services in South Africa.

The research will be qualitative in nature. In this study data collection and analysis will be conducted simultaneously by utilizing the Delphi technique. The researcher will develop a provisional document before commencing the study based on the literature review. A contact session will be held with all participants where all instructions will be given verbally with regard to the aim and process of the study. The researcher will discuss the problem and the criteria of mental health and mental illness. Each participant will receive the proposed protocol electronically after the contact session. Once each participant has amended the protocol they will return it electronically to the researcher. The results given by the participants will be analysed and the information used to format the protocol accordingly. The improved document will be distributed to

the participants to start the next round. This process will continue until consensus is reached by the participants on the content of the proposed protocol.

Permission will be sought from the participants. Only those who consent will participate. Participants may withdraw from the study at any time without penalty Participants will not be harmed emotionally/physically or in any other manner before, during and after the research as no personal information is required in this study.

Once I have received your consent I will approach the NMMU campus health staff to participate in the study and arrange to obtain their informed consent.

Your assistance in granting permission for this study will be highly appreciated.

Yours sincerely

Linda Dalton
Researcher, NMMU
041 504 2660 (Professor J. Strümpher, Supervisor, NMMU, telephone 041 504 2617)

Campus Health Service Research Consent Form

I, _Antoinette Petra Goosen___ hereby give permission for Linda Dalton to perform the above mentioned research utilising the Campus Health Staff.

Signed: Antoinette P. Goosen Date: 21 May 2010.

APPENDIX 2

PARTICIPANT WORKSHOP, LETTER OF INFORMATION, CONSENT FORM AND BIOGRAPHICAL DATA COLLECTION FORM

AGENDA OF RESEARCH WORKSHOP

Date: 20 August 2010

Venue: NMMU conference centre, venue 3

Time: 14:00

Welcome	– Me L Dalton
Overview of mental health and mental illness	– Prof J Strümpher
Overview of the Delphi technique	– Me G Klopper
Overview of the research study	– Me L Dalton
Closure	– Me L Dalton

Letter of Information - Participants

Title of study:
DEVELOPING A PROTOCOL FOR CAMPUS HEALTH SERVICE PROFESSIONAL NURSES TO MANAGE STUDENTS WITH MENTAL DISTRESS

Supervisor: Professor J. Strümpher (041 504 2617)

Research student: Linda Dalton (041 504 2660)

Institution: Nelson Mandela Metropolitan University (NMMU)

Dear

Welcome to my research project. You have been selected to take part in a qualitative research study to develop a protocol for campus health service professional nurses to manage students experiencing mental distress. Participation is voluntary and refusal to participate will not result in adverse consequences of any kind. The study forms part of my Master's thesis and the results of this study will be made available in the form of a workshop. A copy of the mini treatise will also be placed in the NMMU library.

Procedures:
All NMMU Campus Health professional nurses will be invited to participate in this study and must meet the following criteria:

- currently be registered with the South African Nursing Council as a professional nurse,
- an employee of the Campus Health Service with a minimum employment time of 6 months,
- be computer literate.

The researcher will develop a provisional document before commencing the study based on a literature review. A contact session will be held with all participants where all instructions will be given verbally with regard to the aim and process of the study. The researcher will discuss the problem and the criteria of mental health and mental illness. Each participant will receive the questionnaire electronically after the contact session. Once each participant has amended the questionnaire the document need to be returned electronically to the researcher. The results given by the participants will be analyzed and the information used to format the working document accordingly. The improved document will be distributed to the participants to start round 2. This process will continue until consensus is reached by the participants on the content of the proposed protocol. Only feedback will be circulated to participants without identifying information. It will take no more than 15 minutes to complete and should not require more that 3 – 5 rounds.

All answers are strictly confidential and you are therefore requested to be honest and answer all the questions to the best of your knowledge.

Please don't hesitate to ask any questions on any aspect of this study. Your full co-operation will assist in developing a protocol for Campus Health Service use.
You are free to withdraw from the study at any time without giving a reason.

Confidentiality
All information is confidential and the results will be used for research purposes only.

Risks/ Discomfort and Cost
There are no risks/discomfort or cost involved from your participation in the study. No personal information will be required.

Benefits of this study
Findings of this research will be utilised to assist the researcher in developing a guideline for mental health care for campus health service professional nurses to assess and manage university students who are experiencing mental distress. The protocol will standardize mental health care at all Campus Health Services.

Dissemination of the results of this study will include: publish of an article in a peer reviewed journal, a workshop for colleagues, a poster presentation at the national conference of the South African Association of Campus Health Services, and a poster presentation at a student research conference.

Persons to contact with problems or questions:
Should you have any questions about your rights as a research subject that you may want answered by an independent source you can contact my supervisor on the above number. If you are not satisfied with any aspect of this study, feel free to forward any concerns to the NMMU Research and Ethics Committee.
Research Ethics Committee contact person: Professor R Du Randt
Telephone number: 041 504 2615

Kind regards
Linda Dalton
(Supervisor: Professor J Strümpher)

RESEARCH INFORMED CONSENT FORM

I, _____ hereby give consent to participate in the following research titled:

DEVELOPING A PROTOCOL FOR CAMPUS HEALTH SERVICE PROFESSIONAL NURSES TO MANAGE STUDENTS EXPERIENCING MENTAL DISTRESS

Signed: _____ **Date:** _____**.**

WITNESS Name: _____ Signature: _____.

RESEARCH STUDENT Name: ___**L L Dalton**_____ Signature**.** LDalton

Participant biographical data.

Please complete all questions.

1. Gender: Male ☐ Female ☐

2. Age:

Age group 30 – 34	
Age group 35 – 39	
Age group 40 – 44	
Age group 45 – 49	
Age group 50 – 54	
Age group 55 – 59	
Age group 60 +	

3. Qualifications:

General Nursing	
Midwifery	
Community health nursing	
Psychiatry	
Other	
Advanced psychiatry	

4. Please state years experience/worked in field

General nursing	
Psychiatric nursing	
Campus Health service	
NMMU	

5. Are you currently registered with the South African Nursing Council as a professional nurse?

Yes ☐ No ☐

6. Are you computer literate with the following computer programs:

	YES	NO
MS Word		
E-mail		

APPENDIX 3

RESEARCH QUESTIONNAIRE

RESEARCH QUESTIONNAIRE

Phase 1:

1. What are the physical symptoms students present with at a Campus Health Service that may indicate mental distress?
2. What are the physical symptoms students present with at a Campus Health Service that may indicate stress?
3. What are the physical symptoms students present with at a Campus Health Service that may indicate excessive grief/loss?
4. What are the physical symptoms students present with at a Campus Health Service that may indicate a cognitive (thought) disorder?
5. What are the physical symptoms students present with at a Campus Health Service that may indicate a behaviour disorder?
6. What are the physical symptoms students present with at a Campus Health Service that may indicate their social functional are affected?
7. What are the physical symptoms students present with at a Campus Health Service that may indicate suicidal ideation?

Phase 2:

1. If excessive stress/mental distress are identified, what nursing interventions should be suggested and to what organisation/person could the client be referred?
2. If excessive grief is identified, what nursing interventions should be suggested and to what organisation/person could the client be referred?
3. If a cognitive (thought) disorder is identified, what nursing interventions should be suggested and to what organisation/person could the client be referred?
4. If a behaviour disorder is identified, what nursing interventions should be suggested and to what organisation/person could the client be referred?
5. If social dysfunction is identified, what nursing interventions should be suggested and to what organisation/person could the client be referred?
6. If suicidal ideation is identified, what nursing interventions should be suggested and to what organisation/person could the client be referred?

APPENDIX 4

REFERRAL LIST 2011

REFERRAL LIST 2011

Clinics (Psychiatric Clinics)

Bloempark	(t) 041 481 3211
Chatty Clinic	(t) 041 506 1185
Korsten Community Health Centre	(t) 041 405 2242
Sr Clark 0760555799/ Sr Johnson 0790988033	
Kwazakhele Community Health Centre	(t) 041 466 7109 (1 day/month)
Laetitia Bam Community Health Centre	(t) 041 978 0711/1178/1150
Middle Street Clinic	(t) 041 994 1253 (1 day/month)
Motherwell Community Health Centre	(t) 041 469 2199/1409
Promat Psychiatric clinic, UTH	(t) 041 992 2546
Rosedale Community Health Centre, UTH	(t) 041 988 2222
Walmer 14th Avenue Clinic	(t) 041 367 2287 (1 day/month)
Walmer 8th Avenue Clinic/ Gqebera Clinic	(t) 041 506 1611 (1 day/month)
West End Community Health Centre	(t) 041 481 2252/3/4/5/6

Provincial Hospitals:

Dora Nginza Hospital:	(t) 041 406 4111
Psychiatric Clinic	(t) 041 406 4543
PHPE Psychiatric clinic	(t) 041 373 0041/0071

Psychiatric Hospitals

Elizabeth Donkin Psychiatric Hospital	(t) 041 585 2323
Fort England, Grahamstown	(t) 046 6227003
Komani, Queenstown	(t) 0458588400
Tower Hospital, Fort Beaufort	(t) 0466451122

Private Hospitals:

Life Healthcare Hunterscraig Psychiatric Hospital (t) 041 586 2664

Doctor Dr Visser (t) 041 583 2121

Student Counselling	South	x 2511
	North	x 3222
	2nd Avenue	x 3854
	Missionvale	x 1106
	George	x 5051

Private Psychologists

Annette Pretorius, Port Elizabeth (t) 041 367 1949 © 083 654 9560
Balakistnen Prema, Schauderville, Port Elizabeth (t) 041 453 6023
Bodisch Anja, Newton Park, Port Elizabeth (t) 041 365 3535 © 082 670 0525
Chris Breedt, Walmer, Port Elizabeth (t) 041 581 1339 © 083 654 3833
Corrie De Witt, Walmer, Port Elizabeth (t) 041 581 1687
Deena Govender, Korsten, Port Elizabeth (t) 041 451 0025 © 083 448 0199
Fatman J. M, Kwamagxaki, Port Elizabeth (t) 041 463 3226
Kempie van Rooyen, Central, Port Elizabeth (t) 041 585 6698
Gerhardt Goosen, Uitenhage (t) 041 922 6599
Greg Smith, Summerstrand, Port Elizabeth (t) 041 583 6212
Leandie Buys, Newton Park, Port Elizabeth (t) 041 373 5800
Shaheda Moosajee, Mercantile, Port Elizabeth (t) 041 453 1313 © 083 400 5825

State Psychologist

Mrs. C. Gouws (t) 041-3730041

Private Psychiatrist

Dr P Crafford, Central, Port Elizabeth (t) 041 581 3622/ 041586 3995
Dr Z Ngam, Korsten, Port Elizabeth (PE) (t) 041 451 5670
Dr I Taylor, Park Drive Medical centre, PE (t) 041 581 8964/ 585 2121
Dr W Van Wyk, Greenacres hospital, PE (t) 041 373 2818
Dr Reino Verster, Newton Park, PE. (t) 041 365 7750
Dr. Gauche (t) 041-3650121
Dr. Prinsloo (t) 041-5812576

State Psychiatrists

Dr. Lik (t) 041-3730041

Dr. van Wyk	(t) 041-5852323
Dr. Gonzales	(t) 041-4064334
Dr. Vascai	(t) 041-4064334

Substance Abuse:

Detoxification: Dora Nginza Hosp Casualty	(t) 041 406 4633
SANCA Alcohol & Drug Centre	(t) 041 487 2827
AA	(t) 041 452 7328
In patient care:	
• Welbedacht	(t) 041 367 4276
• Shepherds Field	(t) 041 775 1741© 083 948 2506
Rei's place	(t) 073 599 3003
To Share Groups:	
• Basheera	(t) 082 774 6333
• John	(t) 084 446 7137
• Fareeda	(t) 082 4931936
• Fazal	(t) 072 064 9664

Alternative Therapy

Support Groups:	
ADHA	(t) 011 8887 655
FAMSA	(t) 041 585 9393
Depression and Anxiety support group	(t) 0800 567 567
Suicide support group	(t) 0800 567 567
Rape crisis support	(t) 072 637 1902/082 815 6446
Lifeline	(t) 041 373 8666
NICRO	(t) 041 5822 555
Mental Health	041-3650502 (support groups)

George Contact details

Social Development (social workers)	(t) 044 801 4300
FAMSA	(t) 044 874 5811
Marie Stopes Clinic	(t) 044 873 4577
SANCA	(t) 044 884 0674

HIV support groups	(t) 044 880 1181

Psychologist:

Janse Van Rensburg	(t) 044 873 5136
Christie Els	(t) 044 8841 252

APPENDIX 5

GUIDELINE

GUIDELINE

Guideline using the protocol for the management of students with mental distress

Goal

This protocol was developed to assist professional nurses working in primary health care in assessing and managing university students who are experiencing mental distress

Rationale

Students experiencing symptoms of mental illness or mental distress may seek care at the campus health service. By using this protocol as guidance, it is hoped that staff will feel comfortable in dealing with students experiencing mental distress as it provides a guideline to identify, manage and refer persons requiring mental health care.

The guideline enables nurses to:

Recognise the expression of stress, grief/loss, cognitive disorder, behaviour disorder, social disorder, and suicidal ideation

Provide appropriate interventions for persons with mental distress,

Standardize mental health care at the campus health service.

Steps to use the protocol

See flow chart below.

Mental distress assessment according to the protocol

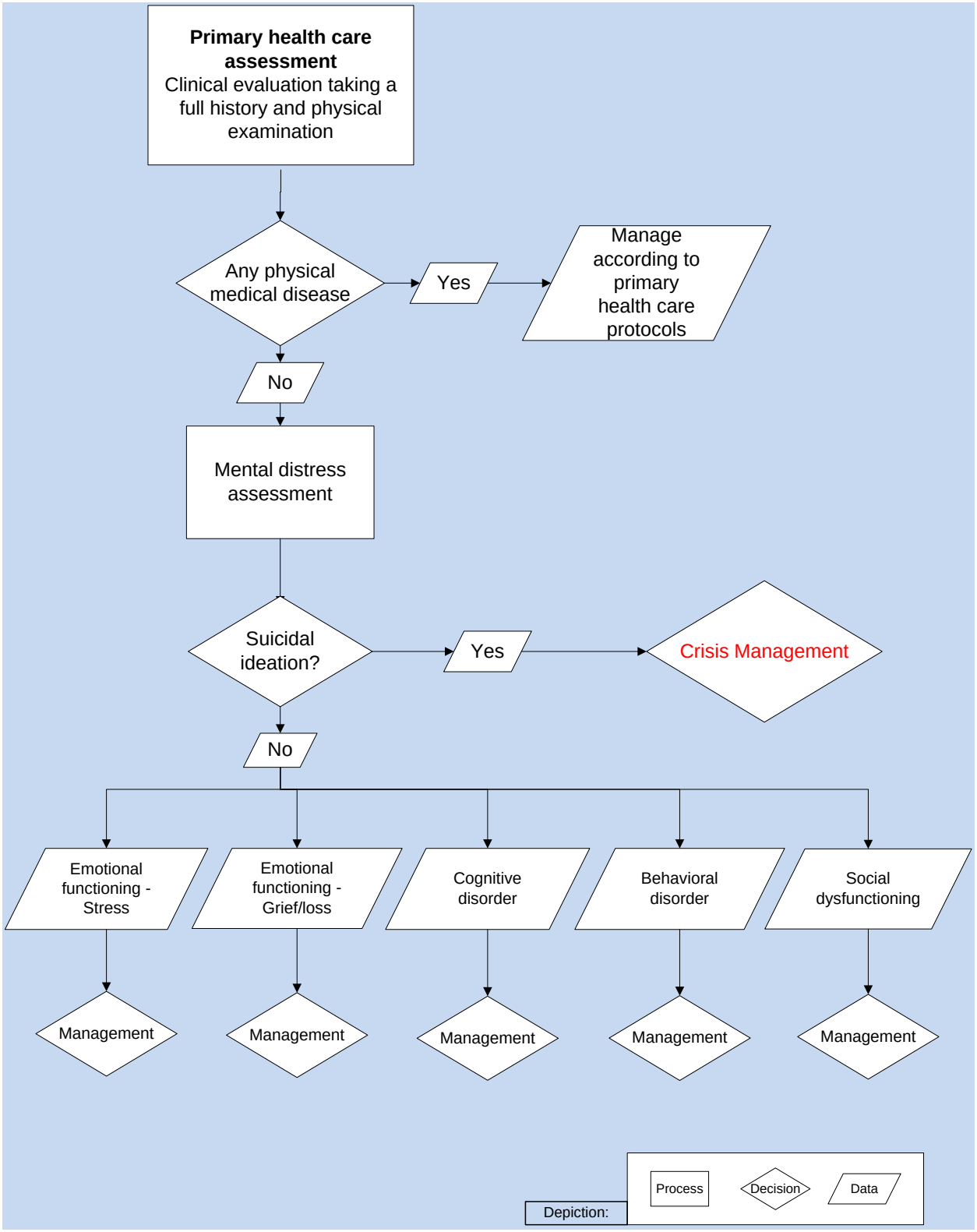
(Emotional functioning (Stress/grief) / cognitive (thought) functioning/ behaviour functioning/ social functioning/ suicidal ideation)

Should the professional nurse identify 2 or 3 symptoms as stated by the protocol, it may indicate mental distress. The client must be consulted further to determine the level of functioning of the patient, complexity of problem, level of risk, diagnosis and patient preference. Manage according to protocol.

Should the professional nurse identify 4 or more symptoms as stated by the protocol, it may indicate serious mental distress. This client needs urgent referral as this will indicate serious illness/ risk for the student. Manage according to the protocol.

Referral list (See Appendix 4).

Figure: Flowchart showing how to use the protocol.



APPENDIX 6

AUDITOR'S REPORT

Auditor's Report

24 Justin Road
Broadwood
Port Elizabeth
6070

TO WHOM IT MAY CONCERN

I have carried out a complete audit of the documents relating to the research project of Ms LL Dalton. The research project is entitled "Developing a Protocol for Campus Health Service Professional Nurses to Manage Students with Mental Distress". Participants in the research were all trained in psychiatric nursing care and were skilled in the provision of health care on university campuses.

I found that the researcher faithfully analysed and reduced all responses received from the participants over three rounds of the 1st phase (identification of signs and symptoms of seven categories of mental health) and two rounds of the 2nd phase (management options). The researcher achieved a protocol that would serve as a useful tool for all professional nurses working on university campuses whether psychiatrically trained or not.

I believe therefore that the researcher has met the essential criterion contained in the title of the research by using her participants' responses correctly.

Yours sincerely

.....AGKlopper.....

AG Klopper