

**A DESCRIPTION OF MENTAL HEALTH CARE PRACTITIONERS AND A
MENTAL HEALTH CARE DIRECTOR'S PERCEPTIONS OF MENTAL
HEALTH CARE NURSES OBTAINING PRESCRIPTION AUTHORITY IN
ETHEKWINI DISTRICT KWAZULU-NATAL**

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DECLARATION

I, Maragatham Ramasamy declare that this dissertation entitled ‘A description of mental health care practitioners and a mental health care director’s perceptions of mental health care nurses obtaining prescriptive authority in eThekweni district KwaZulu-Natal’ is my own work and has not been submitted for any other degree or examination in any other university other than the University of KwaZulu-Natal. I have given complete acknowledgment to the resources referred to in the study.

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.....

Date

DEDICATION

For their relentless support, re-assurance and encouragement, I dedicate this study to my husband Seelan, and children Saieshna and Shivesh. For believing in me, a sense of gratitude, to my late mum, Govindama Munthree and late sister Tammy Naidoo. Collectively, they played an integral role in my success by recognizing my strengths and dispelling my weaknesses, and also, by believing in me and motivating me to attain such astronomical heights in the achievement of my aspirations. This process was a long and winding journey and credit be given to all those pivotal people in my life who contributed in making this dissertation possible.

“Perseverance was definitely the Key to My Success.”

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To God, who has guided me and had given me the strength and will to complete this research.

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ABSTRACT

Aim

To explore Mental Health Care Practitioners and a Mental Health Care Directors perceptions of mental health care nurses obtaining prescription authority in eThekweni District KwaZulu-Natal.

Methodology

A qualitative design was used to gather data through individual interviews and a focus group interview. Purposive sampling was used to select the study setting (five (5) Out Patient Departments, two (2) Community Health Centres, one (1) tertiary educational institution, and one district office), potential participants were not sampled. Participants included; twenty six mental health care nurses (n=26), one (1) psychiatrist (n=1), four (4) medical officers (n=4) and one (n=1) mental health care director. Thematic analysis using the steps outlined by Braun and Clark (2006) was used to analyse the data.

Results

The majority of participants were not aware of policies or legislation allowing nurses to prescribe medication. Participating mental health care nurses from an education setting were more knowledgeable than other participants about current legislation and policy. Study findings indicate that nurses' obtaining prescriptive authority is not on the provincial department of health agenda. In addition, participating psychiatrists and medical officers expressed reservations about nurses obtaining prescriptive authority, specifically independent prescriptive authority. Participating mental health nurses displayed ambivalence related to the pursuit of prescriptive authority.

Conclusion and Recommendations

The challenge for mental health nurses is suggested to be the achievement of a collaborative working relationship within the discipline of nursing, and between the discipline of nursing and medicine / psychiatry. It is suggested mental health care directors, and the SANC, be proactive, look to the future in advising the health minister about access and barriers to mental health care treatment. In addition, the SANC champion the nurse, specifically the mental health care nurse in obtaining prescriptive authority for schedule 5-6 psychotropic medications. Further research is

required to generate more in-depth data, specifically research that explores mental health care nurses' reluctance to pursue prescriptive authority.

ABBREVIATIONS

MHCP	Mental Health Care Practitioner
PHC	Primary Health Care
DG	Director General
WHO	World Health Organisation
KZN	Kwa Zulu Natal
EDL	Essential Drug List
SANC	South African Nursing Council
NP	Nurse Practitioner
MHCU	Mental Health Care User
MHN	Mental Health Nurse

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CHAPTER 1

INTRODUCTION TO THE STUDY

1.1. INTRODUCTION

This chapter introduces the study. The chapter begins with the background to the study, presents the problem statement, purpose and significance of the study, research questions and objectives and concludes with the conceptual framework used to inform the study design.

1.2. INTRODUCTION AND BACKGROUND TO THE STUDY

Mkhize, Kometis (2008) and Petersen (1999) highlight, in keeping with the Alma Ata declaration (1978), that health is a fundamental human right. These authors point to the South African (SA) White Paper on transformation of health care system (1997) endorsement of primary health care (PHC) within an integrated district health care system as evidence of the SA government's commitment to health care for all. This redirection of the health care system towards primary health care has been a transforming event in SA since 1994. The new Mental Health Care Act (17 of 2002) envisaged integration of mental health services into PHC. The restructuring resulted in a shift from institutional mental health care towards decentralization of mental health services. The national and provincial decentralization and integration plan guided by the previously mentioned white paper on transformation (1997) and the new Mental Health Care Act (17 of 2002) (Mkhize & Kometsi, 2008, Petersen, Bhana, Campbell-Hall, Mjadu, Lund, Kleintjies, Hosegood & Flisher, 2009). This integration of mental services into PHC is suggested as critical in meeting the mental health care needs of SAs communities.

In meeting the mental health needs of communities' disease burden and assigned human resources need to be in harmony. International literature suggests the global mental health burden to be 14%, and accounting for over 30% of disability adjusted life years (Burns, 2010). Within Sub Sahara Africa this burden is reported as 10% of the total disease burden (Tomlinson, Grimsrud, Williams & Meyer, 2009). Lund et al (2009) in their review of SA's psychiatric disease burden ranked psychiatric disorders as third in their contribution to the total national disease burden. Despite such local statistics mental health services

remain under resourced, specifically related to budget and thus human resources. A point of reference for human resources, specifically psychiatrists, can be found in international literature. For example, reported international ratios of psychiatrists to general population include; the United States of America (USA), 256 psychiatrist per 100,000; Canada, 214 psychiatrist per 100,000; and United Kingdom (UK) ratios at 230 psychiatrist per 100,000 (Zachariah, Ford, Philips, Lynch, Massaquoi, Janssens & Harries, 2008). According to Jack-Ide, Uys and Middleton (2012) the total numbers of mental health care practitioners (MHCP) working in mental health facilities in SA represents a ratio of 11,95 per 100,000 population. Of these local MHCP; 0, 28 per 100 000 are psychiatrists, 0, 45 medical doctors (not specialized in psychiatry) and 10.8 are nurses. According to Burns (2010) within KwaZulu-Natal (KZN) there are only 38 psychiatrists, a ratio of 0.38 psychiatrists per 100 000 population, and 49 registrars and medical officers working in mental health services. Research studies from other SA provinces also point to a shortage of psychiatrists (Grazin 1998; Burns 2011; Lund, Kleintjies, Kakuma & Flisher, 2009). Clearly current research and health department statistics suggest a lack or shortage of psychiatrists and doctors allocated to psychiatric services, specifically psychiatric clinics (Barret, Boeck, Fusco, Ghebrehinet, Yan, and Saxena, 2009; Bradley & Nolan, 2007; Burns, 2011). These figures support firstly, Miles, Seitio and McGillivray's (2006) argument that nurses are crucial to the delivery of the health care in low and low-middle-income countries, where they account for between 50–80% of all health care professionals. Secondly, Lund et al (2010) and others argument that nurses in low and low-middle-income countries often work with few or no psychiatrist and doctors and are the primary care providers for mental health care users (Barret et al. 2009; Bradley & Nolan, 2007). Barret and colleagues (2009) further argue that in these situations mental health care nurses work out of their scope of practice, and possible clinical expertise. Anecdotal evidence suggests that psychiatric nurses are, with the psychiatrist / doctor's support, prescribing from the essential drug list (EDL), specifically in PHC clinics. These authors argue that in order to meet the communities health care needs nurses often perform roles, including prescribing medication, for which they may not have adequate training, and often in the absence of legislations and regulations (Barret et al. 2009 and Bradley & Nolan, 2007). This debate is not new, Geyer (1998) pointed to nurse's unique contribution to health services while highlighting the prescribing restrictions that impact on health care delivery. In SA the integration of mental health services into PHC has brought attention to the important extended role that nurses play in the delivery health services. Nurse

prescribing, specifically in mental health care, is now a reality in many countries supporting that within the current situation in SA mental health nurse being given authority to prescribe from an EDL is a reasonable and pivotal consideration (Bradley & Nolan, 2007; Hemmingway, McAllister, Baily, Coates, Mitchell & Fenwick, 2004; Van Ruth, Mistiaen & Francke, 2007; Lund, Kleintjies, Kakuma & Flisher, 2009).

The National Health Act (61 of 2003) focuses on PHC and indicates that nurses will be the patient's first contact with the health service. Gray and Jack (2008) after review of the Nursing Act (33 of 2005) argue that the key element that remains in limbo is the designation of special categories of nurses. These authors refer to these special categories of nurses, provided for in Section 56 of Nursing Act (33 of 2005), who have competence to 'assess, diagnose, prescribe treatment, keep and supply schedule 1-4 medications for prescribed illness and health related conditions (Nursing Act 33 of 2005 p 39). This is the designation of certain nurses as 'authorized prescribers' who are referenced in the Medicines and Related Substances Control Act (101 of 1965). However, no new regulations have been issued to cover new permits. In addition, the need for psychiatric nurses to prescribe schedule 5 and 6 psychotropic medicines has been enabled in law, but remains difficult to put into practice (Gray & Jack, 2008). Despite this, it is suggested that nurses prescribing psychotropic medications can be seen as a key driver in facilitating low and low-middle-income countries ability to meet community mental health care needs. It could be argued that the absence of prescriptive authority for nurses burdens the process of psychiatric care with unnecessary referrals and consultations (Hemmingway & Ely, 2009). The legislative authority for nursing practice, and thus prescriptive authority, is the Nursing Act (33 of 2005) section 56 (1). This legislation allows for special provisions relating to nurses who are trained as PHC practitioners. This amendment however does not facilitate meeting mental health care needs timorously due to the medication schedule restrictions applied. Section 56(1) of SA Nursing (Act 33 of 2005) only allows the above mentioned PHC practitioners, PHC nurses, to prescribe schedule 1 – 4 medications from the EDL.

Despite shortages of psychiatrist and doctors in specialist psychiatric clinics, mental health nurses do not have prescriptive authority to prescribe according to the EDL, nor does this group of professionals seem to be perusing this authority.

1.3. PROBLEM STATEMENT

The provision of effective mental health care is a critical issue for most countries, specifically for low and low-middle-income countries, where psychiatrists and doctors are in limited supply (Barrett et. al 2009; Burns, 2010). Despite the governments attempts to make health care more accessible and appropriate through the development of PHC a lack of medical officers, specifically psychiatrist, within these care settings can result in care being delayed or not given at all.

Although mental health nurses obtained prescriptive authority in several high-income countries in an attempt to meet their health care needs (Bradley, Campbell & Nolan, 2004; Jones, 2008; Hemmingway, McAlliater, Bailey, Coates Mitchell & Fenwick, 2004; Nolan & Bradely, 2007; Rana, Bradley & Nolan, 2009) this step is yet to be taken by SA. Although Funk and Ivbijaro (2008) and Gray and Jack (2008) argue that local legislation enables mental health nurses to pursue prescriptive authority this seems to not be happening; either by the profession or health care directors within the department of health. Current legislative and regulatory frameworks, section 56 (1) of Nursing (Act 33 of 2005) and Medicines Related Substance Control act (101 of 1965) do not allow registered nurses to prescribe schedule 5-6 medicines. Thus making the paradigm shift towards integration of mental health service into PHC services difficult when the EDL for psychotropic medication includes, almost exclusively, schedule 5-6 medications. The legal framework within which the mental health nurse practices has not evolved rapidly enough to meet the current changes and needs within the health care system (Jack-ide, Uys & Middleton 2012). Petersen et al (2009) argue that while there has been extensive work to develop norms and standards related to staffing and resources for integrated mental health care within PHC there has been limited data on policy and legislation with regards to mental health nurses prescribing psychotropic medication. Although informal discussion and 'rumor' abounds that mental health nurses are to receive prescriptive authority the researcher could not verify this, no empirical evidence found despite anecdotal discussion within the nursing profession. There seems to be no identifiable process exploring prescriptive authority for nurses, nor do nurses, specifically psychiatric nurses, seem to be perusing this expanded role. It is suggested that the current shortage of psychiatrists and doctors make this an issue that needs urgent attention to facilitate meeting the mental health needs of the community.

1.4. PURPOSE OF THE STUDY

The purpose of this study was to explore and describe the current position of the department of health and perceptions of mental health care directors and mental health care practitioners regarding mental health nurses' receiving prescription authority, specifically as this relates to schedule 5 and 6 psychotropic medications.

1.5. RESEARCH OBJECTIVES AND RESEARCH QUESTIONS

The research objectives are threefold, research questions presented after each objective to facilitate reading:

1.5.1. Objective one

Clarify and outline the current perceptions of a KwaZulu-Natal department of health mental health care director as they relate to mental health nurses receiving prescription authority for psychotropic medication.

Research Questions

- 1.5.1.1. What is the current position of the provincial department of health regarding mental health nurses receiving appropriate training to pursue prescription authority?
- 1.5.1.2. What are the perceptions of mental health care director regarding the department of health position?
- 1.5.1.3. What does the mental health care director perceive as the solution to the shortage of psychiatrists and doctors in mental health care services?

1.5.2. Objective two

Describe the perception of mental health care practitioners towards mental health nurses receiving prescriptive authority.

Research questions

- 1.5.2.1. What are the perceptions of doctors working in psychiatric clinical settings towards mental health nurses receiving prescription authority?

1.5.2.2 What are mental health nurses' perceptions about pursuing and receiving prescriptive authority?

1. 5.3. Objective three

Describe current prescriptive practices of mental health care nurses.

Research questions

1.5.3.1. Do doctors within psychiatric clinical settings consult mental health nurses regarding prescriptions?

1.5.3.2. Are mental health nurses prescribing according to the EDL?

1.6. SIGNIFICANCE OF THE STUDY

There are no local research studies on prescriptive authority for mental health nurses. It is suggested that the findings of this research can provide an opportunity for policy makers, both at national and provincial levels, to introduce dialogue round current perceptions within mental health care practitioner groups regarding prescriptive authority. This study is particularly significant at this time. Firstly, nursing regulations and curricula are under review and the findings of this study are suggested to possibly inform the development of these documents related to nurse's education. Secondly, this research project may facilitate reflection amongst nurse educators to consider a greater practical inclusion of psychopharmacology in the psychiatric nursing curriculum. Lastly, the findings of this study are suggested to stimulate reflection amongst participants, facilitating a discourse around prescriptive authority, needed change in policies and legislations that will allow mental health nurses to prescribe medications and the potential positive impact on mental health care service delivery.

1.7. OPERATIONAL TERMS

1.7.1. Prescriptive authority: authority given through legislation to prescribe written directions regarding medication, dosage and frequency and route. Within this study prescriptive authority is defined as prescribing from the Essential Drug List only (Medicines and related Substances Control Act 101 of 1965).

1.7.2. Mental Health Nurse: Means a nurse who has successfully completed specialist post qualification in education in mental health nursing. This enables the nurse in addition to his/her general role work in a specialist role with individuals and family experiencing/or affected by mental illness in hospitals and in the community (Mosby medical dictionary).

1.7.3. Mental health care Practitioner: Means a psychiatrist or registered medical practitioner or a nurse, occupational therapist, social worker or psychologist who has been trained to provide prescribed mental health care, treatment and rehabilitation services (Mental health care act 17 of 2002). Within this study, the mental health care practitioners include psychiatrists and registered medical practitioners. Although the nurse is a mental health care practitioner within this study this category is specifically referred to as the mental health nurse to facilitate the focus of the recipient of proposed prescriptive authority.

1.7.4. Perceptions: Perceptions are process by which people translate sensory impressions into coherent and unified view of the world around them. Perception is equated with reality for most practical purposes and guides human behaviour (Oxford Dictionary 2012). In this study, perceptions are related to how participants feel about mental health nurse obtaining prescriptive authority.

1.7.5. Dispensing means: Interpretation of a prescription, the selection, manipulation or compounding of the medicine, the labelling and supply of the medicine in an appropriate container according to the medicines act and the provision of information and instruction by the pharmacist to ensure the safe and effective use of medicine by the patient (Medicines and related Substances Control Act 101 of 1965).

1.8. CONCEPTUAL FRAMEWORK

1.8.1. INTRODUCTION

Donabedian's tripartite model (1980), represented in figure 1.1, was used to guide this study. This model views quality as a relationship between structure, process, and outcomes, core concepts within a cycle of quality. As a framework for evaluating quality, each is separately evaluated. Structure standards include; characteristics of the care

providers (number, skill, knowledge and attitudes), their tools and resources, the physical / organizational setting and legislative and policy input that guide practice. Process standards relate to the interpersonal and technical aspects of the treatment process, the actual implementation of practice. Outcome standards focus on changes in patient’s symptoms and or functioning. Donabedian’s model has been developed to assess quality of care in clinical practice; the framework is flexible and can be applied in diverse health care settings (Handler, Issel & Tumock, 2001). Outcomes fed back into the system to facilitate positive change through the modification of structure standards and changes in practice.

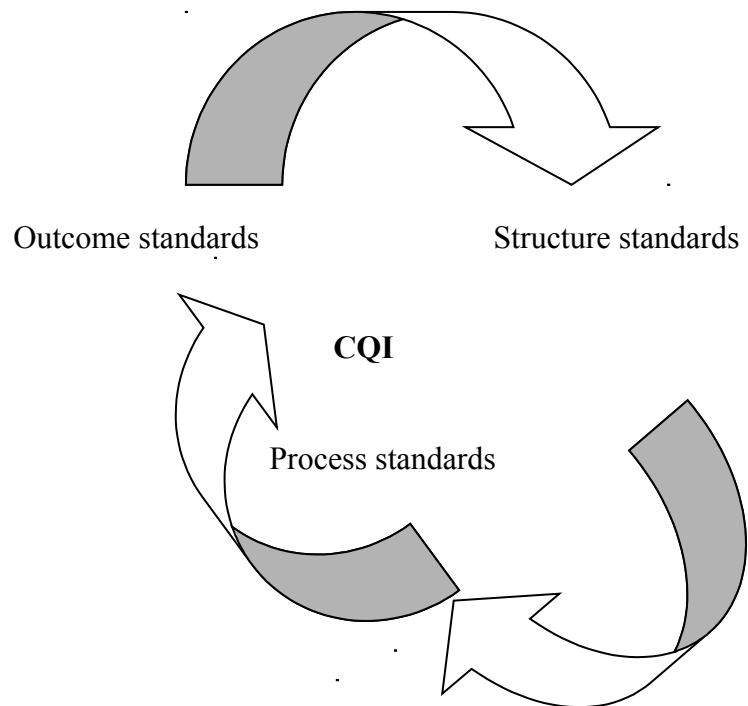


Figure 1: Donabedian’s cycle of quality

1.8.2. APPLICATION TO THIS STUDY

This study focuses on the structure and process standards, represented in figure 2 (P 9). Structure standards included; mental health care practitioners (MHCP) and their knowledge related to legislation and policy controlling prescriptive authority, and their attitudes related to mental health care nurses receiving prescriptive authority for schedule four and five psychotropic medication. In addition, the study will also describe actual current practices of psychiatric nurses as it relates to prescribing Schedule 5 and 6

psychotropic medications. The structure and process standards identified were used to guide the formulation of questions for the semi structured individual interviews (Annexure: 1, p.52).

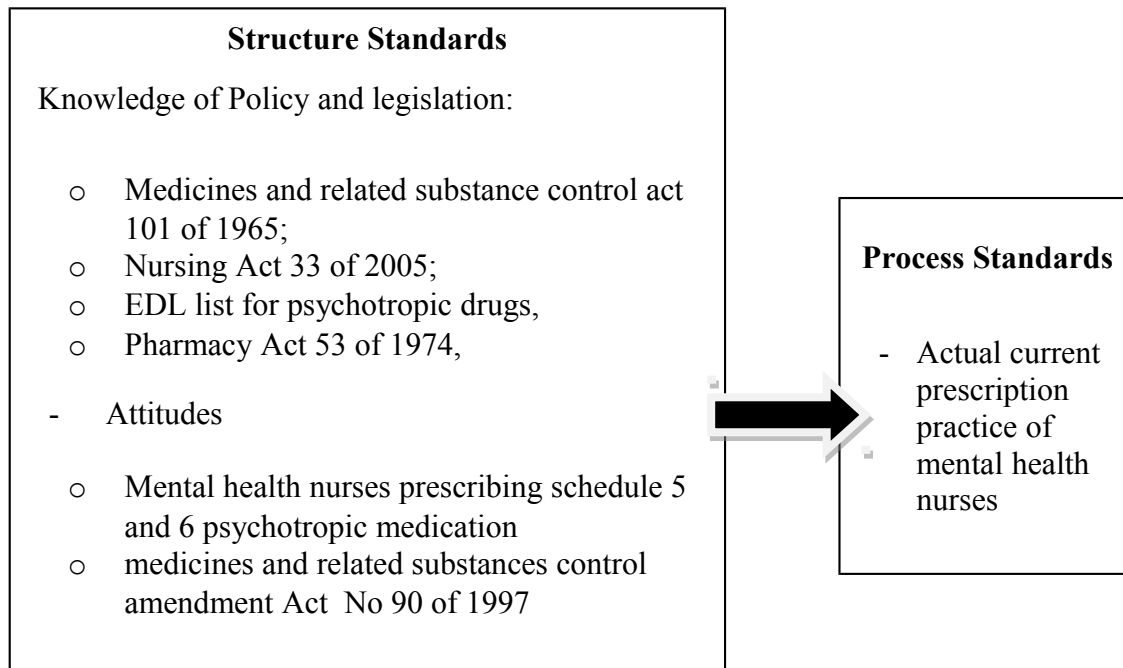


Figure 2: Application of the conceptual model to this study

1.9. SUMMARY OF THE CHAPTER

This chapter introduces current prescriptive policies and legislation and integration of mental health care into PHC and the need for review of prescriptive authority to meet community mental health care needs. What is highlighted is the lack of research related to MHCP attitudes towards obtaining prescriptive authority. Chapter two explores these issues in greater depth.

CHAPTER 2 LITERATURE REVIEW

2.1. INTRODUCTION

The literature review presents the concept of prescriptive authority, specifically as this pertains to nurses, internationally and locally (Geyer, 2001; Jones, Bennet, Lucus, Miller, Courtenay & Carey 2007; Mkhize & Kometis, 2008; Petersen, 1999; Nolan & Bradley, 2007). Local legislation and policy, Nursing Act (33 of 2005) and Medicines Related

Substance Control act (101 of 1965,) is discussed to clarify current positions in SA (Geyer, 2001; Gray & Jack 2008; Gray, Vawda & Jack, 2011). In addition, current literature is used to explore the potential value of psychiatric nurses obtaining prescriptive authority, both to the psychiatric nursing profession and the mental health care system (Nolan & Bradley 2007; Jutel & Menkes, 2010; Geyer, 2001). Current literature that explores constituents (policy makers, psychiatrists, doctors and psychiatric nurses) beliefs and attitudes towards psychiatric nurses obtaining prescriptive authority are presented (Jones, Robson, Whitfield & Gray 2010; Bradley & Nolan 2007; Bradley, Campbell & Nolan, 2004; Rana, Bradley & Nolan, 2009). There is limited research in SA on prescriptive authority for nurses; therefore most of the literature presented is of international origin.

Electronic searches of the literature made use of the following databases; Google scholar and Ebsco host. In addition, a thorough search of the following websites was carried out: WHO; Health Systems Trust; SA Nursing Council; SA National department of health and the KZN Provincial department of health. Key words used to facilitate these searches included; 'prescription authority for nurses' '.....in South Africa', '... Internationally' '... in low and low-middle-income Countries.

2.2. THE CONCEPT OF PRESCRIPTIVE AUTHORITY

Prescriptive authority refers to legislative authority to prescribe written directions regarding medication, dosage and frequency and route (SA Medicines and related Substances Control Act No 101 of 1965). Traditionally prescriptive authority has been conferred on doctors (SA Medicines and related Substances Control Act No 101 of 1965). In USA and UK nurses prescribe medications as a routine component of their clinical role, the main driver for this change being the lack of medical doctors (Dobel-ober, Brimlecombe & Bradley, 2010; Dunn, Cashin, Buckley & Newman, 2008; Jones & Jones, 2005). Current literature reports further that there are nurses prescribing across the globe,

this role emerging due to the different needs of health care settings that varies between countries incorporating urban and rural settings (Courtenay & Carey, 2007; Jones, 2005; Miles, Seito & McGilvray, 2006). Hemmingway (2009) and Jones, Bennet, Lucas, Miller and Gray (2007) indicating that since 2002 pharmacists, physiotherapist and optometrists have been given prescriptive authority. What is clear is that in order to place these prescriptive roles in perspective understanding and unpacking the concept of prescriptive authority is required.

Internationally two types of prescribing have been implemented; supplementary prescribing and independent prescribing. **Supplementary prescribing** is defined as a voluntary partnership between the independent prescriber (doctor) and a supplementary prescriber (nurse or pharmacist) to implement an agreed patient specific clinical management plan with the patient's agreement. In essence, following the doctor's assessment and diagnosis, the nurse and doctor set out an agreed patient specific clinical management plan identifying the medications that can be prescribed by the supplementary prescriber. **Independent prescribing** is defined as the practitioner being accountable for; assessing and diagnosing the client, determining the appropriate medication, treatment, or appliance required to manage the client, and issuing the appropriate prescription (Courtenay & Carey, 2007; Jones & Jones, 2005; Jones, 2008; Jones, Bennett, Lucas, Miller & Gray, 2007,). These authors suggest that supplementary prescribing reflects less independence, prescribing according to an EDL or prescribe protocols, the supplementary prescriber (the nurse) required to consult with the independent prescriber (the doctor) for each and every prescription. Independent prescribing means the nurse can prescribe any medication within the national formulary. The key difference between independent prescriber and a supplementary prescriber is that independent prescribing allows the nurse to independently diagnose the condition and to formulate a treatment plan (Jones, 2008; Skingsley, Bradley & Nolan, 2006). An overview of current literature indicates that these concepts, despite at times slightly different terminology used, are understood and implemented globally (Bradley & Nolan, 2007; Chaston & Seccombe, 2009; Jones & Jones, 2005; McCann & Baker, 2002; Miles, Seito & McGilvray, 2006). For example, in the USA complementary, essentially supplementary, prescribing is used (Kroezen, Francke, Groenewegen & Van Dijk, 2012).

2.3. PRESCRIPTIVE AUTHORITY FOR NURSES

Current literature reports that USA, Sweden, Australia, UK and New Zealand (NZ) have developed legislation and regulatory frameworks to enable nurses to prescribe (Chaston & Seccombe, 2009; Jones & Jones, 2005; McCann & Baker, 2002; Miles et al, 2006). Reported times frames from these countries record; Swedish nurses prescribing as introduced in the early 1990's; USA nurses have had prescriptive authority for the past 25 years; UK nurses have been prescribing for 14 years and the more recent international inclusion is NZ where nurses have had prescriptive authority since 2001 (Chaston and Seccombe, 2009; Jones & Jones, 2005; Miles et al, 2006).

Within Africa, Botswana nurses prescribing has been supported by Government since 1981 with the introduction of a one-year Family Nurse Practitioner programme that incorporated the endorsement of prescriptive authority to nurses for common PHC problems and psychiatry (Miles et al, 2006). Similarly in SA, section 56 of Nursing Act (33 of 2005) makes provision for professional nurses, who have undergone the one year course in clinical assessment and treatment, to diagnose, prescribe, supply and administer medications from the EDL. This local provision is conditional to unavailability of a medical practitioner or pharmacist. It also allows the Director General to regulate the keeping and supply of prescribed medicines, administering or prescribing by nurses, in circumstances where the services of a medical practitioner or pharmacist are not available.

These reports support and are in keeping with the WHO (2011) report that prescriptive authority for nurses is growing around the world as health care systems are burdened with more patients and less medical personnel. Specifically, globally statistics indicate that nurses represent the most prevalent professional group working in the mental health sector (WHO, 2011). What is noted is that in each instance of the successful implementation of prescriptive authority for nurses regulatory control has been core to this transition.

Prescribing programmes within the UK are closely regulated and require a 26-day theoretical input at undergraduate level with a minimum of 12 days supervised practice by a medical practitioner (Jones, Bennett, Lucas, Miller & Gray, 2007). European Union countries require that independent and supplementary prescribing courses contain a practical and theoretical component or internship (Dobel-ober, Brimblecombe & Bradley, 2010; Hemmingway & Ely, 2009; Kroezen, Francke, Groenewegen, Van Dijk, 2012).

Jones and Gray (2010) support the educational input arguing that mental health nurses with a prescribing qualification needed a short course on pharmacology. Kroezen, Francke, Groenewegen and Van Dijk (2012) report that prescriptive authority for nurses in Australia, Canada, and USA is regulated at state, territorial or provincial level. In addition in these three countries there are two crucial aspects determining prescriptive authority; legislation and education. However, legislation and or training are not standard at neither national nor international level. Kroezen et al (2012) report that in some countries, and or states, restrictions are greater than others. For example, prescription in some states within the USA only Nurse Practitioners (NP) have the opportunity to become independent and supplementary prescribers, while in Ireland, Spain, UK, and Southern Australia, all registered nurses can become prescribers on completion of the prescribing course (Kroezen, Francke, Groenewegen & Van Dijk, 2012). Further to Australia as a whole, nurse practitioners have legislated independent prescriptive authority in most states however in some states nurse prescriptive authority remains linked to a collaborative agreement with a physician, in essence supplementary prescribing (Dunn, Cashin, Buckley & Newman, 2008).

Clearly there is evidence of international, African and local initiatives and programs to design and implement legislation recognizing the potential for the inclusion of prescriptive authority within the nurse's scope of practice. Literature seems to support this move for various reasons. Firstly, as introduced in chapter one, nurses are crucial to the delivery of health care, specifically in low and low-middle-income countries where between 50 - 80% of all health care professional are nurses (Miles, Seitio & McGilvry, 2006 and Stevens, Mathijis, & Bomela, 2008) Secondly, by formalizing these training and monitoring processes nurse will be protected from situations were, in order to meet the health care needs of the community, they perform roles for which they are not qualified (Barret et. at 2009). Despite academic opinion and legislative processes, the acceptance of prescriptive authority rests with the nurse.

2.4. NURSE PRESCRIBING: VIEWS OF NURSES AND PATIENTS

Literature on nurse prescribing suggests that before nurses had legal authority to prescribe they were already prescribing for patients or advising general practitioners and interns (Bradley, Campbell & Nolan, 2005; Miles, Seito & McGilvray, 2006; & Nolan & Bradley,

2007). Jutel and Menkes (2010) report that 79% of nurses recommended treatment and 89% discussed treatment with the prescribing doctor, specifically suggesting medication choices to junior doctors and General Practitioners. Such reports suggest a high level of medication knowledge and are the foundation for several authors argument that encouraging more nurses to prescribe would increase the potential to enhance patient care through streamlined services that are accessible and timorous (Jones & Jones, 2005; Nolan & Bradley, 2007; Patel, Robson, Rance, Ramirez, Memon, Bressington & Gray, 2009). This potential improvement in services is evidence in a study by Bradley and Nolan (2007). These researchers reported nurse participants' descriptions of how becoming a prescriber had changed the focus of their nursing role. Prescribing, they said, moved them from a caring towards a curative role, and enhanced their self-esteem, job satisfaction and autonomy (Bradley & Nolan, 2007). These authors also reported that participating nurses firstly, felt that through prescribing they became more aware of medication issues and were able to question or challenge the medication regime and their impact on service users. Secondly, prescribing allowed them to be proactive and supportive and their authority and ability to change dosages made them more aware of side-effects thus averting potential crisis. According to Bradely, Campbell and Nolan (2005) and Bradley and Nolan (2007) nurses have more contact with service users, good communication skills and are well placed to take on prescriptive authority. These authors, and others, also indicated that patients reported that nurses have extra time to discuss treatment, communicate effectively about medications, and close continuing contact that places nurse supplementary prescribers in an ideal position to negotiate treatment schedules (McCann & Clark, 2008; Brooks, Ottoway, Rashid, Kilty & Maggs, 2001). Patients reported that nurses were more accessible and approachable than doctors, and were viewed to have more expert knowledge than doctors, unique areas of knowledge on treatment conditions which differed from doctors (McCann and Clark 2008). These studies as well as Jones and Jones (2005) seem to indicate that patients are in favour of nurses prescribing, some research participants stating a preference for consultation with nurses than doctors. A more recent study by, Tinelli, Blenkinsopp, Latter, Smith and Chapman (2013) reported that most patients were satisfied with nurses prescription, specifically that they (the patients) were told about their medicines and that nurses understood their point of view. Patients felt greater confidence in nurse prescribing than doctors, specifically nurse's willingness to provide information on their condition, nurses knowledge, experience and

patterns of attendance inspired patient confidence (Brooks, Ottoway, Rashid, Kilty & Maggs, 2001; McCann & Clark, 2008).

2.5. PRESCRIPTIVE AUTHORITY WITHIN SA MENTAL HEALTH CARE

Since 1997 integration of mental health into PHC structures has been the official policy of the SA national government. According to national norms for general health care mental health should be included in all PHC services. Local authors arguing that transformation of the health care system must advocate for mental health services to be integrated into PHC (Geyer, Naude & Sithole, 2002; Petersen, 1999). There have been numerous barriers to integration of mental health into PHC, one being restrictions that prohibit PHC nurses from prescribing common psychotropic medications (WHO, 2007). According to Jones and Jones (2005) supplementary nurse prescribing holds the key to rapid developments in psychiatric nursing as this will ensure quicker access to health care and patients will have more information. Current the critical challenges being that most of the drugs prescribed for mental illnesses are schedule 5 and 6, prescriptive restrictions to schedule 4 and below thus makes it impossible for nurses to treat or follow up treatment of mental health care users (MHCU). According to Jack-Ide, Uys and Middleton (2012) the renewal and reinvigoration of PHC, reengineering of PHC, is important to address mental health care. These authors argue that as mental illness constitutes 14% of the global burden of disease, and is one of the leading causes of disability worldwide, integrating mental health services into PHC is the most viable way of closing the existing treatment gap. However, it is suggested that closure of this treatment gap, and thus improved mental health care outcomes, require mental health nurses to have prescriptive authority. Although this is not necessarily peculiar to SA, Burns's (2010) reported patient – psychiatrist ratios within KZN, 0.38 psychiatrists per 100 000 population and 49 registrars and medical officers in the entire province, adds weight to the prescriptive authority for nurses' argument.

WHO (2011) report that in low and low-middle-income countries nurses working in the mental health care sector represent a practitioner population ratio of 5.8 per 100 000 population while psychiatrist represent 0.05 per 100 000 population (Chaston, Seccombe, 2009; WHO, 2011). According to Bruckner, Scheffler, Shen, Yoon, Chisholm, Morris, Fulton, Poz and Saxena (2011) SA has 0.28 psychiatrist per 100 00 population and psychiatric nurses a ratio of 10.8 per 100 000 population. Despite slight differences

between WHO (2011), Burns (2010) and Bruckner et al (2011) it is clear that nurses, specifically in mental health, are in greater supply than doctors. Prescribing should be recognized as more than just a generation of prescriptions; nurses increased knowledge and contribution to the health care team should be acknowledged (Bradley & Nolan, 2007). As stated earlier in this chapter such change requires legislative authority and educational programs.

Legislation for nurse prescribing in SA is guided by several legal frameworks; Medicines and Related Substance Act (No 101 of 1965), Pharmacy Act (No 53 of 1974), Nursing Act (No. 33 of 2005) and Medicines and Related Substances Control amendment Act (No 90 of 1997). As mention in the introduction, chapter one, section 56 (1) of the Nursing Act (33 of 2005) makes special provisions relating to certain nurses prescribing. It allows special categories of nurses, specifically those trained in PHC, to assess, diagnose, prescribe treatment, keep and supply medication, schedules 1-4, for prescribed illness and health related conditions (section 56(1) p39). This provision does not facilitate the provision of schedule 5 and 6 medications needed for maintaining access to the prescribed treatment regimens of MHCUs. However, section 56 (6) of the Nursing Act (33 of 2005) allows the Director General (DG) to authorize the nurse to supply, administer or prescribe medicines were the services of a medical practitioner or pharmacist are not available. This authority of the DG is acknowledged in section 22A (15, p22) of the Medicines and Related Substances Control Amendment Act (90 of 1997). In this section, 22A, the nurse is allowed to supply, prescribe and administer schedule 1-5 medications as authorised by the DG. Despite this legislative authority this provision has not been put into practice yet. While Section 22C (1a, p14) allows the DG, on application in the prescribed manner, to issue nurses registered under the Nursing Act (33 of 2005) section 56(1) (p39a) with a licence to dispense medicines. Clearly SA legislation is in existence. Educative programs to facilitate the process are also documented, once nurses have successfully completed a supplementary course prescribed under the Pharmacy Act only schedule 1-4 as nurses working in PHC need to assess, diagnose and prescribe and dispense medication according to the EDL list.

2.6. SUMMARY OF THE CHAPTER

This chapter focused on prescribing by nurses internationally, current prescribing legislation for nurses in South Africa and the legal framework that guides nurses in South Africa. Prescriptive authority for nurses is growing around the world as health care systems are burdened with more patients and less medical doctors (Chaston & Secombe 2009). This chapter suggests that appropriately trained nurses can safely prescribe medications and that there is a need for government change current legislation and regulatory framework; as South Africa many nurses work in areas where there are no medical officers or pharmacists (Stevens, Mathijs & Bomela 2008).

CHAPTER 3

RESEARCH METHODOLOGY AND RESEARCH DESIGN

3.1. INTRODUCTION

This chapter describes the specific design and methodological steps used to identify mental health care practitioners (MHCP), and a mental health care director's, perceptions of psychiatric nurses obtaining prescription authority. Included in the chapter are; the research paradigm that guided the methodology, the research design, population, sample and sample procedure, data collection process, data analysis. In addition, issues of trustworthiness, academic rigor and ethical considerations are presented.

3.2. RESEARCH PARADIGM

This study is based on an interpretivist paradigm. Polit and Beck (2008, p. 229) state that interpretive researchers rely primarily on in-depth interviews with individuals. The

paradigm provides an opportunity for concerns and practices, and current challenges inherent in working in an environment that does not include prescriptive authority for nurses, to be heard and explored (Weaver & Olson, 2005).

3.3. RESEARCH DESIGN

This study used a qualitative design, semi structured interview questions used to collect data (Polit & Beck, 2008, p. 220), this design was appropriate to this study as it allowed the researcher to gain an understanding of MHCPs perceptions related to psychiatric nurses obtaining prescription authority. Brink (2006, p.113) states that qualitative methodology attempts to understand the phenomenon in its entirety rather than focusing on specific concepts, data collection involving interaction with participants within their own context. In this study participants were actively involved and interviews were conducted in their work setting environment.

3.4. RESEARCH SETTING AND POSITIONING OF THE RESEARCHER

EThekweni Municipality is located on the East Coast of South Africa in the Province of KwaZulu-Natal (KZN). EThekweni is one of the eleven (11) municipalities of Natal and the province's only metropolitan municipality. The Municipality spans an area of approximately 2297km² and is home to 3 442 361 five million people, as population density of 3 605 people per square metre (Dinko & Gaopopolwe, 2011). The geographical area includes thirty five (35%) urban, over 80% of the population living in these urban areas. The black african community makes up the largest section of the population at 65%, followed by the indian community at 21%, White community 6.6% and the coloured community at 2.5%. The predominant home language is isiZulu, spoken by approximately 62% of the population followed by English at 26% (Dinko & Gaopopolwe, 2011).

This research setting that was the focus of the study includes community health centres (CHCs) and psychiatric outpatient department (OPDs) of district hospitals. The numbers of these clinics are described in more detail under (section 3.6) sampling and sampling procedure. The researcher, in her contact with clinic managers while conducting student

supervision, discussed the facilitation of psychotropic prescriptions in the absence of a psychiatrist. The MHCU attend the PHC clinic for 5 months, at the 6th month they attend a specialist psychiatric clinic at either a district hospital OPD or CHC. This 6th monthly visit allows the MHCU to be assessed by a psychiatrist or doctor and scripts are written up for the next five months if MHCU presents with no problems. However, any indication of relapse required that after attending the PHC clinic the MHCU is required to attend the district hospital OPD or CHC for assessment before the six month cycle.

3.4.1. POSITIONING OF THE RESEARCHER

The researcher is a mental health nurse who has completed her advanced psychiatric course (SANC regulation 212) with University of KwaZulu Natal (UKZN) and is currently working as a nurse educator within a college of nursing. The researcher through interaction with mental health nurses identified that they were not prepared for integration. In addition, PHC nurses continued to experience problems with accessing psychiatrists to facilitate psychotropic medication changes and dispensing.

PHC nurses are only allowed to prescribe schedule 1-4, psychotropic medication almost exclusively schedule 5 and 6. In the section above (point 3.4.1) the research outlines the MHCU attendance between PHCs, and district specialist OPDs and CHCs that occurs in order to facilitating script review and issuing. Despite the six monthly script renewal cycles MHCU may be requested to attend more than one clinic in a month if the PHCN is concerned about emergent symptoms. Clearly this is not ideal. Firstly, MHCU have additional cost. Secondly, the onus is on the MHCU, who may be experiencing cognitive and or emotional difficulties to pursue this additional appointment.

The researcher realized that there is a need to explore options related to nurses obtaining prescriptive authority in order to resolve access and timorous treatment. Upon reflection the researcher has twenty one years experience and has come to the realisation that although the researcher is knowledgeable about psychotropic medication there remains a reluctance to acknowledge the researchers own ability as a prescriber. This self-reflection led the researcher to consider if nurses perceptions of self may influence the lack of action to obtain prescriptive authority.

3.5. POPULATION AND TARGET POPULATION

The population included all MHCP and mental health care directors (Polit and Beck, 2008, p. 337). The target population included, firstly, mental health care practitioners (registered mental health nurses, doctors and psychiatrists) working in department of health based psychiatric community and hospital clinical settings within eThekweni district. Secondly, a mental health care director at the level of the district office of the department of health KwaZulu-Natal.

3.6. SAMPLE AND SAMPLING PROCEDURE

Purposive sampling was used to select the psychiatric OPD's and CHC's that would best provide access to potential participants (Burns and Grove, 2009 p 355). This type of non-probability sampling was chosen to provide the researcher with access to potential participants and rich data on current prescriptive practices and legislation currently in place. Such sampling was appropriate and of advantage for this study because it required MHCP'S who were currently practicing. Initially a total of five (5) OPDs, two (2) CHCs and one (1) district office were included as access points to potential participants. These specific settings were selected because they were accessible to the researcher and the participants were, and are, directly involved in patient care, or in the case of the district director planning mental health care services and monitoring service provision.

Within these selected settings the total number of potential participants was Forty six (N= 46). These included; twenty six mental health care nurses (N=26), four (4) of whom are advanced mental health care nurses, thirteen medical officers (N=13) and six psychiatrists (N= 6). The district office included one (N=1) mental health director. The intention was to not sample available participants within the purposefully sampled settings. However, due to non-availability and commitments in other health care settings (nurses=4 medical officers = 6 and psychiatrist = 5), and those who declined to participate (medical officers = 3) the final number of participants was twenty seven (n=27). These participants included; twenty one (n=21) mental health nurses (four (4) of whom were advanced mental health nurses), one (1) psychiatrist and four (4) medical officers and one (1) mental health care director from the district health department.

After consultation with the research supervisor, during the data collection and analysis process, it was decided to include a focus group of specialist mental health nurses to obtain rich data. The rationale for this is described in detail in the data collection procedure (page 21). This group was purposefully sampled from a local nursing college due to accessibility and established relationships with the researcher. A total of five (5) specialist psychiatric nurses were invited and agreed to participate in the focus group.

3.7 DATA COLLECTION PROCEDURE

Once ethical approval was received from UKZN Approval (Annexure 5, p. 57) the researcher approached the provincial department of health for permission to collect data (Annexure 6, letter of request, p. 58; Annexure 7 and 8, approval from department of health, p. 59 and 60). This was followed by requests for permission from managers within the research settings (Annexure 9, p. 61 letter of request; Annexure 10, 11 and 12 p. 63, 64, and 65, proof of permission). Once permission was obtained from managers operational unit managers were contacted telephonically to scheduled appointments for the interviews. At these interviews suitable times for data collection, after 12 pm when the clinics were quiet, negotiated interview dates, suitable interview venues, and permission to conduct the interviews in participants on duty time were negotiated.

On the day of the scheduled interviews the researcher presented an outline of the study proposal and information sheet (Annexure 3, p. 54) to potential participants. Time was given for questions. Field notes, from these interactions, reflecting that potential participants had concern for anonymity, specifically that the interview would be audio recorded. The researcher explained that only she would have access to the recordings, and that the recordings would be transcribed by the researcher verbatim and then destroyed. Participants verbalised being reassured by this, however, the researcher had difficulty encouraging verbalisation and is it possible that this could be due to continued discomfort with the audio recording process. Although the researcher acknowledges participants potential discomfort with audio recording this data collection approach was used to allow precision in recording participants comments and to facilitate excerpts being taken from participant's responses and used to illustrate the researcher's analysis of the data (Polit & Beck, 2008, p.394; Polit & Hunglar, 1999, p. 332). This potential dilemma is explored

more fully in limitations of the study (p. 41). All participants were requested to sign consent (Annexure 4, p. 56).

Individual interviews were conducted in a private room using semi-structured questions (Annexure 2, p. 53). Open ended questions which were designed to explore what current legal frameworks exist for nurses to prescribe medications, and explore not only current practices but also participant's perceptions of nurses obtaining prescription authority (Wahyuni 2012). Demographic data (Annexure 1, p. 52) which related to gender, age, and participants employee status and number of years in current position were also collected to facilitate description of the sample and facilitate potential transferability of the findings. English was used as a medium of communication and all participants were comfortable with this, potential participants having studied in English. Data was collected during December 2011, again in April 2012, and again in October 2013. The reason for the initial 3 month time gap in the data collection process related to obtaining permission from managers. The researcher had to do a number of follow up appointments before written and verbal permission was granted to collect data at some settings. The last data collection period, October 2013, related to the focus group interview introduced by the researcher after consultation with the research supervisor due to the limited data obtained during the initial individual interviews.

Regarding the initial individual interviews the researcher had set aside thirty (30) minutes for each individual interview, however, each interview tended to last no longer than ten to fifteen (10-15) minutes. Chapter four (point, p 4.3,) provides more information regarding these interviews in the presentation and analysis of the data.

The focus group interview participants were approached in their personal capacity and provided with the same information and consent sheet given to individual interview participants (Annexure 3&4, p. 54 and 56). All agreed to participate in a group interview with no follow up questions. The focus group was conducted at a private venue; utilised the same semi structured interview guide used for the individual interviews (Annexure 2, p. 53), was audio recorded and lasted for thirty (30) minutes. A description of this sample and the analysed data is presented in chapter four.

3.8 DATA ANALYSIS

Data collection and data analysis was done concurrently. Transcriptions of data involved listening to the audio recording and typing the contents of the interview into a word document using windows 2008. The transcribed data was read while listening to the audiotape to ensure it was verbatim. The researcher, using the thematic analysis process outlined by Braun and Clark (2006) completed data analysis manually using colour coding on hard copies of the transcribed data. The steps of thematic analysis are briefly presented here, a detailed description of their application is given in chapter 4.3 (P. 29).

Data analysis included, firstly, *familiarizing self with data* by reading and re-reading data during transcription. *In generating codes* the researcher identified emerging categories, key words identified, and coding was done. *In searching for the themes* the researcher refocused the analysis at the broader level of themes rather than codes (categories), followed by all codes being identified and sorted into potential themes, collating all relevant coded data extracts within the identified themes. *Reviewing themes* involved reading all the collated data extracts from each theme and checking if all themes formed a coherent pattern, once the researcher was satisfied with all the themes a thematic map of the analysis was generated. *Defining and naming themes* was then done to identify the story each theme tells thus assisting the researcher to clearly define the final themes. The final step of *producing a report* was done and is represented by chapter 4, illustrated with data extracts to identify the themes.

3.9 TRUSTWORTHINESS AND ACADEMIC RIGOUR

Trustworthiness in qualitative research is used to test rigor thus establishing integrity of the study and is measured by credibility and dependability (Polit and Hungler, 1999, p.717). These concepts are described below and are seen as adding to the potential transferability of the research finding. Transferability in research is the extent to which the findings of one study can be applied to other situations (Polit and Hungler, 1999, p.717).

The researcher explored own values and beliefs regarding prescriptive authority for mental health nurses through self-reflection, this can be found under positioning of the researcher (point,3.4.1 p. 19).To ensure dependability data collection was done by the researcher, with no assistants. The researcher transcribed the audio recordings and checked transcripts

by listening to audio recordings to ensure it was transcribed verbatim. Raw data and interview transcripts and is presented within the research dissertation (Annexure 13, p.66). The data analysis process is described in detail in chapter 4 (p. 29) and the co-coding involvement of the research supervisor. Audio recordings were transcribed by the researcher and then the transcripts copied onto a CD and given to the research supervisor.

Credibility of the study refers to confidence in the truth of the data and the interpretation of the data by the researcher (Polit & Hungler, 1999, p.427). To ensure credibility of the data the researcher listened to the interviews and compared them to the transcriptions.

During the data analysis process the research supervisor independently read and analysed the raw data before meeting with the researcher to discuss codes and emerging themes. An original transcript, raw data, is included in this study to facilitate credibility (Annexure 13, p.66). During discussions with the research supervisor it was agreed that the data from individual interviews did not produce a rich, thick description, the data representing a more quantitative than qualitative depth. The researcher identified that there was little to no evidence of exploration during the interviews. The researcher was unsure if this was due to interview facilitation ability on her part of participant reluctance to explore the issue of nurses and prescriptive authority. After discussion with the research supervisor it was agreed that to clarify, and assist in obtaining richer descriptions, the researcher invited individual informers to a focus group. The raw data from this focus group was analysed separately from the previous individual interviews and is presented in chapter four, the raw data included for review in (Annexure 13, p. 66).

Within this study the researcher included a rich description of the research settings (Point, 3.4 p. 19) and a description of the sample demographics (point, 4.2 p. 27) to assist the reader in determining transferability of the research findings. In addition, within this chapter is included the sampling and data collection process.

3.10 ETHICAL CONSIDERATION

Ethical approval and gatekeeper permission was sought for this study. The research proposal was approved by; the discipline of Nursing, the UKZN Health and Social Sciences ethics committee (Annexure 5, p.57) and the Provincial Department of Health

(Annexure 7 and 8, p. 59 and 60). Permission was received from managers, including unit managers, of the various research settings (Annexure, 10, 11, and 12 p. 63, 64, and 65).

In reviewing the risk benefit ratio the risk to participants was minimal. The participant's right to full disclosure was met by giving them an information sheet and a consent sheet (Annexure 3 & 4) and including time for questions before data collection. Respect for autonomy was achieved by voluntary participation. Participant's had freedom of choice to participate and the right to withdraw at any time. Participants were made aware of this in information sheet (Annexure 3, p. 54). Confidentiality and Anonymity was discussed with participants. Although the participants had signed an informed consent this was not stored with the audio recorded data. Transcription of the audio recordings included no names, participants coded to facilitate data analysis and anonymity. The audio recordings were destroyed and the transcribed data kept under lock and key only assessable to the researcher and research supervisor. In addition, participants were interviewed in a private room and privacy was maintained.

3.11 DATA MANAGEMENT

Audio records were destroyed on completion of accurate transcription of the contents. Electronic copies of demographic data and transcribed interviews are stored on a computer disc in a locked cupboard in the research supervisor's office. A private computer was used by the researcher during the research process and secured by a pass word. This data will remain for five years according to UKZN policy.

3.12 DATA DISSEMINATION

The examined and corrected report will be bound and submitted to the library of the KwaZulu-Natal. The completed study will be prepared with the supervisor, for publication in an accredited nursing journal. In addition a report will be submitted to the provisional department of health.

3.13 SUMMARY OF THE CHAPTER

In this chapter the research methodology was presented. The chapter discussed the process of sample selection, data collection and steps of data analysis. Ethical consideration to the study was also presented. The researcher also presented trustworthiness and academic rigor to ensure credibility of the study.

CHAPTER FOUR

DATA PRESENTATION AND ANALYSIS

4.1. INTRODUCTION

According to Burns and Grove (2009, p.507) qualitative research is a systematic, subjective approach used to describe experiences and give them significance. Qualitative research is intended to achieve depth, richness and complexity. Within this study the initial individual interviews did not achieve depth and this is discussed in chapter 3 (point 3.7) researchers' field notes. Due to the lack of rich data the research sought out individual informers and invited them to a focus group interview, as describe in chapter 3 (point 3.6 p), in an attempt to achieve richer data that addresses the complexity of mental health nurses obtaining prescriptive authority.

The chapter will begin with a description of the participants, phase one and two, followed by a description of the application of Braun and Clark (2006) data analysis process and presentation of the results. Data analysis will be presented as phase one, individual interviews, and phase two, focus group interview within each identified and defined theme. In addition to the initial literature review the research searched literature using Google Scholar (parameters 2006 – 2013) focusing specifically on emerging themes using the following search phrases: 'Doctors reluctance' 'prescriptive authority' 'prescribing

qualifications’ ‘restriction on prescribing in mental health’ and ‘patient outcomes’. Available literature, related to the emerging themes, was limited, no local research was found, four additional international research studies included.

4.2. DESCRIPTIONS OF PARTICIPANTS

4.2.1. Phase one, Individual Interview Participants

During the individual interviews, phase one, a total number of twenty seven (27) participants were interviewed. These included; twenty one (n= 21) professional nurses with basic psychiatric training, which included four (n =4) operational unit managers and three (n=3) advanced psychiatric nurses who had completed the Advanced Mental Health Nursing Certificate under SANC regulation R212; four (4) medical doctors; one (1) psychiatrist; and one (n=1) district mental health care director. Participant’s demographic data is outlined in table 4.1. (p. 28). Participants age distribution ranged from thirty (30) to above fifty one (51+) years. Their gender reflected the current trend in nursing, participants being predominately female (n= 20, 74%) with only 7 males (26%). Experience ranged from three (3) years to more than twenty (20) years, eight (8) participants having more than 20 years of experience, suggesting a wealth of experience amongst the participants.

Table: 4.1. Demographic data of individual interview participants

Participant	Gender	Age groups	Position at work	Years of experience
1	Male	20-30	Registered Nurse	3 years
2	Female	51+	Operational Manager	More than 20 years
3	Female	41-50	Registered Nurse	1-15 years
4	Female	51+	Operational Manager	More than 20 years
5	Female	31-40	Registered nurse *	10-15 years
6	Female	31-40	Registered nurse*	6-10 years
7	Female	31-40	Registered Nurse	6-10 years
8	Male	51+	Psychiatrist	More than 20 years
9	Female	51+	Operational Manager	4-5 years
10	Female	41-50	Registered nurse*	0-3 years
11	Female	51+	Registered Nurse	More than 20 years
12	Female	51+	Registered Nurse	0-3 years
13	Male	31-40	Registered Nurse	6-10 years
14	Female	51+	Registered Nurse	4-5years
15	Male	20-30	Doctor	4-5 years
16	Male	31-40	Registered Nurse	6-10 years
17	Female	41-50	Registered Nurse	16-20 years
18	Female	20-30	Registered Nurse	4-5 years
19	Female	31-40	Registered Nurse	6-10 years
20	Female	31-40	Doctor	6-10 years
21	Male	20-30	Doctor	4-5 years
22	Female	41-50	Registered Nurse	16-20 years

23	Female	51+	Registered Nurse	More than 20 years
24	Female	51+	Operational Manager	More than 20 years
25	Female	51+	Director Mental Health	6-10 years
26	Male	51+	Doctor	More than 20 years
27	Female	51+	Registered Nurse	More than 20 years

* Completed the SANC R212 as an advanced psychiatric nurse

4.2.2. Phase two, Focus Group Interview Participants

There were five (5) participants in the focus group. The age distribution was between forty (40) to sixty (60) years. All were female. Work experience ranged from ten years (10) to twenty years (20) and all held current positions as nurse educators within the undergraduate nursing program.

Table: 4.2. Demographic data of focus group participants

Gender	Age	Position at work	Years of experience
Female	40-50	Nurse Educator	10 years
Female	40-50	Nurse Educator	16-20 years
Female	60	Nurse Educator	More than 20 years
Female	41-50	Nurse Educator	10 years
Female	51+	Nurse Educator	16-20 years

4.3. DATA ANALYSIS PROCESS

In keeping with the data analysis process outlined by Braun and Clarke (2006) the six phases guided the data analysis process. The data was analyzed in two separate sets, data from individual interviews (Annexure, 13 p. 66) and data from the focus group (Annexure, 13 p. 66). In both instances the researcher first *familiarized herself with data* by listening to the audio recordings two (2) times while transcribing the content verbatim. Once transcription was complete the researcher listened to audio recordings once more while reading the transcriptions to ensure it was accurate. In this way the researcher became familiar with the data. The transcribed data was then read three (3) times. The purpose of this was to read the data while specifically focusing on the research objectives and identifying participant's responses. When reading for the third time the researcher began to jot down emerging codes and highlighted them. While *generating initial codes* the researcher identified the following initial codes: no policies and legislation assist doctors and interns, prescribing only repeat and chronic medications, prescribing would lead to easy access for medications, have adequate knowledge for prescribing. All content relating

to these codes was then grouped together related to study objectives (Polit & Beck, 2008, p.81).

The researcher then began to *review, define and name themes*. During this phase the researcher revised the emergent themes, which was then defined and named. This aspect of the process included discussion with and independent review by the research supervisor. The original lists of emergent themes changed and were regrouped to achieve the following themes: prescriptive authority, knowledge and skills, absence of doctors, lack of legislation for prescriptive authority, potential outcomes and current practice guide medical officers in prescribing. Each of these themes is described in detail below and uses extracts from the transcripts to illustrate the theme.

4.3.1. Theme: 1: Prescriptive Authority

Psychiatric nurses in Northern Cape indicated extreme frustration; especially in emergencies such as violent and or suicidal patients, related to their lack of authority to diagnose or prescribe medications (Grazin 1998). According to Rana, Bradley and Nolan (2009) doctors felt that nurses should not be granted full independent prescribing rights. These authors reported that doctors felt that nurses should be restricted to what they can prescribe and to whom. This study further makes a distinction between junior doctors and consultants. Junior doctors felt that nurse should only prescribe repeat medications, while the consultants felt that senior nurses are more suitable to prescribe because of their knowledge and skills and should prescribe in the weekends and after hours.

Psychiatrists and doctors perceptions within this study tended to reflect the reservations about nurses having prescriptive authority reported in previous local and international studies (Grazin, 1998; Rana et al, 2009).

“Prescriptions should be for repeat prescriptions not for first time prescriptions’ (Participant 10).

“It will depend on the seniority of the nurses that is they understand the side effects, indications of medications then they can prescribe” (participant 7).

In contrast the participating mental health care director did not have reservations, comments focusing on work and access to treatment at community level preventing an influx of patients to the hospital.

“If these nurses are actually not in a position to prescribe, it is disadvantaging our case workers” (participant 27).

Most of the nurse participants felt that they should be allowed to prescribe for two reasons. Firstly, they, nurses, are with the patient most of the time, and secondly, doctors are not available especially when MHCU require emergency treatment such as a MHCU who has relapsed or is experiencing severe side effects.

“Yes I would like to have prescriptive authority as it makes things easier at night will be able to prescribe Akineton if patients have side effects instead of phoning the doctor as nurses are all the time with the patients between 12 to 24 hours a day they know the patient’s behaviour as the doctor only sees the patient for 5 minutes” (participant 1).

“Chronic patients and with repeat medications and those who are stable, instead of waiting for the doctor” (participant 5).

“When scripts expire. Scripts already exist, just need to continue with medications see no reason why we cannot continue the prescription” (professional nurse 4).

“Yes I have advance psychiatry it will be an advantage as we are short of doctors and will benefit the patient” (participant 13).

“There is only one psychiatrist and one medical officer lots of patients and sometimes other patients come in the afternoon when doctors are gone” (participant 9).

“Yes when doctor is not here can make a decision” (participant 12).

Zachariah, Ford, Philips, Lynch, Massaquoi, Janssens and Harries (2009) in their study on task shifting in HIV/AIDS concluded that nurses reduced the dependence on doctors by taking on clinical tasks such as determining anti-retro viral treatment (ARV) eligibility

and prescribing first line regimens of treatment while doctors supervised and managed the complex cases, creating a multidisciplinary teams with a better strategic skills mix.

Participants in the focus group agree that mental health nurses should be allowed to prescribe as they compared current prescriptive practices in PHC with anti-retro viral treatment (ARV) and integrated management of childhood illness (IMCI) being prescribed by nurses.

“In keeping with reconstruction, development and integration of MHCU in PHC so it is necessary for them to have prescriptive authority and to dispense” (participant 4).

“In PHC programs there are nurse-initiated management of ARV why cannot there be nurse-initiated management of mental illness” (participant 1).

“Nurses are prescribing in PHC it so important for mental illness; to be included in their management” (Participant 1).

“Nurse initiated management for IMCI works in algorithms so does mental health so why is not possible for mental health nurses to prescribe” (Participant 4).

“As patients should be assessed and treated before being transferred. Integration is not going anywhere, it is here to stay therefore, nurses should receive support from government and policies should be addressed’ (Participant 3).

4.3.2. Theme 2: Knowledge and Skills

According to Bradley, Campbell and Nolan (2005) participants stated that skills required for prescribing are; communication skills, assessment, diagnosis, and pharmacological and prescribing knowledge. In the United Kingdom (UK) prescribing qualifications is a job requirement. According to Jones, Robson, Whitfield and Gray (2010) to be able to prescribe legally a nurse in the UK must attend a 26-day pharmacology course that is a university-based programme and undergo a period of supervised practice with a doctor.

Muse and McGrath (2009) in their study concluded that mental health nurses are better prepared at entry level to prescribe medications as compared to physician’s prior to receiving specialty training in psychiatry. Kaplan and Brown (2007) reported that while some nurse participants wanted to embrace prescriptive authority, and accept the new

responsibilities and accountabilities of prescribing, others indicated perceiving self as having inadequate knowledge, an internal barrier to prescribing. The authors also reported a preparation period for nurses to facilitate knowledge and self-efficacy. Mental health nurses in this study also feel that more educational preparation is needed for them to prescribe medications efficiently.

In this study some of the participants, participating doctors and mental health care director agreed that for nurses to prescribe they must receive special training and practice in pharmacology before they can prescribe. Participants in this study feel that the nursing curriculum should change to include advanced courses in pharmacology.

“If we can actually train nurses” (Participant 27)

“Need to be trained so that we can prescribe” (participant 24)

“At current level no don’t have advanced psychiatry more knowledge and training is needed not comfortable in prescribing however more exposure and training will make me more comfortable “(participant 16)

“My skills are developing however do not have adequate skill at the moment no” (participant 1).

Depends on the pharmacology nurses and sisters have and on experience with drugs (participant 19)

Participants in the focus group also agree that MHN should have advanced training in pharmacology.

“Yes, they are taught pharmacology in the curriculum their test and examination include pharmacology they have the knowledge but cannot prescribe” (Participant 2).

“However, curriculum should change to include advanced courses in pharmacology. There should also be proper guidelines in the ward about prescribing for nurse’s so that nurses are adequately equipped” (Participant 4).

4.3.3. Theme 3: Absence of doctors

Human resource in South Africa is inadequate with only 0.28 psychiatrist per 100,000 of the population and 10 nurses per 100, 000 of the population (Jack-ide, Uys & Middleton 2012). The availability of nurses with training in psychiatric nursing has been enhanced by the introduction of the comprehensive nurse training, SANC R425, in 1986, and also advanced specialist mental health care certificates being offered at the local university (Burns, 2011; Jack-Idle, Uys & Middleton, 2012). These courses suggested to have formed a firm foundation for mental health nurses to pursue prescriptive authority.

In this research study it was identified that some OPDs and CHCs do not have a psychiatrist in attendance, others have one psychiatrist for one day a week. Medical officers who are in daily attendance are only in the OPD for half the day with the result that nurses are faced with suicidal or aggressive patients and have to wait for the doctor. The mental health care director also agrees that the psychiatrists are not in primary health care clinics.

“Psychiatrist is employed at regional level leaving the gap in primary health care and district level” (participant 27).

“There is only one psychiatrist and one medical officer lots of patients and sometimes other patients come in the afternoon when doctors are gone” (participant 9).

“It would be easier for treatment patients do not have to wait for doctors” (Participant 26).

“Yes definitely take of load from doctors as nurses are first line treatment for patients it would make it easier” (Participant26).

“Not decrease work load actually but will help when no doctor is available, as acutely ill patients need certain medication and nurses are able to assess and give the medications this makes it easier and aggressive patients can be managed accordingly by the nurses and advert injury” (Participant 3)

Focus group participants acknowledge that there are appropriately trained nurses who if given prescriptive authority can ensure that service delivery is not compromised in the absence of medical officers.

“Psychiatry is a specialty, so if nurses are trained in prescribing according to the act my colleague as mentioned, it will be good, will benefit psychiatric patient if doctor is not available then MHN can prescribe” (Participant 3)

“Maybe can get mandate to prescribe doctors must also know not there half the time 24-7 nurses are there to diagnose however you can’t diagnose and not treat how are going to treat if you are not on site” (Participant 3).

“In the absence of doctors, patients will not be sent away if nurses have authority to prescribe” (Participant 3).

4.3.4. Theme 4: lack of legislations and policies

Funk and Ivbijaro (2008) and Uys & Middleton (2012) state that new regulation have been passed permitting nurses who complete training to prescribe and dispense psychotropic medications that are on the PHC EDL. However, it is interesting to note that no nurses have been trained yet and this regulation does not appear any of the current Acts. The researcher was not able to find this new legislation any of the current policies and legislation in South Africa.

All participants including the mental health care director in this study were not aware of any policies or legislation allowing nurses to prescribe psychotropic medication.

“Caught me unaware there is some legislation I remember issue when government came up with the issue of integration of mental health in primary health care” (Participant 27).

“At the nursing summit the delegation advised that in terms of policy if we don’t have the delegation to prescribe only medical officer this is actually a problem” (Participant 27).

“No not that I know off” (participant 1)

“No legislation presently” (participant 8).

“Not in South Africa no” (Participant13)

The participants from the focus group were more aware of legislations and policies which allow nurses to prescribe in PHC. This could be due them being nurse educators.

“Previous act 38a of 1978 mandates for nurses to prescribe. It will be a good thing for mental health nurses to prescribe; doctor is not here all the time. Section 56 of Act 33 of 2005 is actually superseding the one I mentioned before; it will be a good thing” (Participant 1).

“WHO in 2007 said nurses should have prescriptive authority, but we are in 2013 and we do not have” (Participant 3).

“Although WHO made recommendations, but unfortunately, in SA we are, still not trained yet to prescribe schedule 5 and 6 drugs” (Participant1).

4.3.5. Theme 5: Potential Outcomes

Patients felt nurse prescribers were more accessible and approachable, effective interpersonal skills, than doctors, they also identified that community nurses have more expert knowledge than doctors (McCann and Clark, 2008). Jones, Bennet, Lucas, Miller & Gray, (2007); Bradley & Nolan, (2007) and Jones & Jones, (2005) agree mental health nurse prescribing challenge nurses to work within a holistic framework, prescriptive opportunities for nurses helping develop nurses clinical skills thus enabling them to take on a proactive lead in service development. Cooper, Anderson, Avery, Bissel, Guillaume, Hutchinson, James, Lymn, McIntosh, Murphy, Ratcliffe, Read and Ward (2008) agree that prescription authority for nurses will increase continuity of care and access to medicines, there will be better utilisation of economic and human resources, reduction in patient waiting times and less fragmentation of care. In addition, Forcuk and Kohr (2009) stress the importance of remembering that while the implication of prescriptive authority is to improve patient access to timely and appropriate care; it has its greatest impact in the community and settings where physicians are unavailable

In this study the mental health care director, individual interview participants and focus group participants agree that integration of mental health into PHC is not effective, and for integration to be effective that changes in practice needs to occur.

“If we are moving now to primary health care approach in terms of access to health services if we say they need to beef up whatever services that will prevent people from community to flood hospitals” (Participant 27)

“In keeping with reconstruction, development and integration of MHCUs in PHC so it is necessary for them to have prescriptive authority and to dispense” (Participant 4).

“Integration is not going anywhere patients are not being given the care that they need despite the fact they have to get the medication that they need” (Participant 3)

“Nurses are prescribing in PHC it so important for mental illness; to be included in their management” (Participant 4).

“Specifically in psychiatry nurse prescribing will decrease relapse” (Participant 7).

4.3.6. Theme 6: Current practice guide for medical officers

In a study done by Nolan and Bradley (2007) mental health nurses stated that they spend a lot of time advising and assisting medical colleagues with prescribing, advising doctors, especially junior doctors, on prescribing was something they had been doing for some time. This activity included recommending medications, when to commence and reduce medications.

They often take on the role of physician's by prescribing and managing medications that they are not authorized to do so. Thus obtaining prescriptive authority would merely legalize what they have been already doing (Barret, Boeck, Fusco, Ghebrehwet, Yan & Saxena, 2009).

Most nurse participants in this study indicated that they are always guiding medical officers in prescribing medication. From the demographic data it is noted that most of the participants have work than 20 years of experience and have a wealth of information, there

are also advanced practice nurses who have the knowledge and skills. When asked by the researcher if such ‘advice giving’ was part of their current practice the responses included;

“Yes all the time” (Professional nurse 2)

“Sometimes if new and under guidance of another doctor tell them what the best ones to use” (Participant 6)

“At some institutions they advise doctors what medications should be given to patients particularly the medical officer” (Participant 27)

“This people are able in one hospital at district level to run solely by the psychiatric nurse.

All interns that go at district level are guided and supported by psychiatric nurses” (Participant 27).

“Yes although we do not have interns doctors do ask for assistance” (Professional nurse 4).

“Yes guide medical officers and interns in prescribing” (Professional nurse 11)

“Yes all the time new interns come once every two weeks they are new to psychiatry not familiar. Yes we do guide them” (Professional nurse 13).

Focus group participant also agree that nurses help doctors in prescribing.

“All the time nurses are well equipped with knowledge they can tell the doctor which tablets/ food are contra –indicated especially with antidepressants the MOAI group” (Participant 4).

“The community service practitioners know a lot about medications therefore they can function effectively” (Participant 4).

“With HIV and AIDS being so prevalent nurse are trained in prescribing ARV and guide doctors in terms of what drugs are contra indicated before any complications arise when prescribing tranquilizers” (Participant 3).

“The psychiatric nurses help doctors by word of mouth but not in writing” (Participant 3).

4.4 SUMMARY OF THE CHAPTER

This chapter presented a description of participant’s demographic variables, analysed data from individual and focus group interviews as well as research studies relevant to the emerging themes. Distinction is made between data from the different participating constituents. The researcher gave a detailed description of the data analysis process, annexures referenced, to ensure trustworthiness of the study. Study results indicate ambivalence on the part of participants, specifically mental health care nurses. Mental health care nurses requesting preparation and new knowledge despite evidence that they currently direct prescriptions. Doctors and psychiatrist wanting their work load reduced without nurses usurping their profession territory.

CHAPTER 5 DISCUSSION AND RECOMMENDATIONS

5.1. INTRODUCTION

The discussion in this chapter is related to study objectives, study results discussed under the three objectives that guided the study. The Chapter concludes with recommendations for nursing policy makers, nursing education, nursing research and conclusion.

5.2. DISCUSSION

The first objective was to describe a KwaZulu-Natal department of health mental health care director they relate to mental health nurses receiving prescription authority for psychotropic medication.

According to current international and local literature there is a new legislation, not yet implemented, permitting nurses to prescribe and dispense psychotropic medications (Funk & Ivbijaro, 2008; Jack- Ide, Uys & Middleton, 2012; Geyer, Naude & Sithole, 2002). These authors indicate that the SANC has to authorize such nurses to prescribe medication once a relevant SANC accredited course is successfully completed. However as yet no nurses have received training, there is no evidence of a SANC accredited prescribers course and the researcher could not find any written evidence of the supposed legislation. The KwaZulu-Natal department of health care director also had no knowledge of any new legislations being passed for nurses to prescribe psychotropic medications. In this study the participating director of mental health care reported that at the 2008 nursing summit it was advocated that policy and legislation needs to be developed for nurses to prescribe schedule 5 and 6 medicines.

The director during the interview focused on integration of mental health care into primary health care and on nurses being the answer to solve integration of mental health into primary health care. The participating director agreed that prescription authority for mental health nurses would improve patient outcomes of integrated, into PHC, mental health care. This study suggests a reluctance by the director of the Kwazulu-Natal department of health to pursue a legislative and policy change for mental health nurses to prescribe schedule 5-6 medications; even though SA's psychiatric disease burden ranked psychiatric disorder as the third contribution to disease burden (Lund et.al 2009). Despite implementation of PHC in 1994 there is little evidence of progress being made by the

department of health to address the issue of nurses receiving prescriptive authority for psychotropic medication. In comparison international literature reports that Swedish nurses received prescriptive in the early 1990's and USA for the past 25 years (Chaston & Seccombe, 2009; Jones & Jones, 2005; McCann & Baker, 2002; Miles et al, 2006).

The second objective of this study related to participants perception of mental health nurses receiving prescriptive authority.

Participants' perceptions related to mental health nurses receiving prescriptive authority indicate that participating psychiatrist and medical officers did not want independent prescriptive authority to be given to the mental health nurse. These participants supported supplementary prescriptive authority, to repeat medication scripts only. This study suggests that doctors are happy for nurses to prescribe for chronic and repeat patients as this will decrease their work load. However, they did not recognize the nurse's level of expertise, qualifications and years of clinical practice making them to be skilled confident practitioners who can diagnose and prescribe safely. The creation of new roles and initiation of collaborative working requires more than a transfer of skills, what is required is a re-configuration of power from one professional group to another (Rana, Bradley, Nolan, 2009). PHC nurse currently prescribe from the EDL which includes schedule drugs 1-4, the medical officers and psychiatrist in this study do not support mental health nurses prescribing from the EDL at any schedule level. These results are suggested to support Patel, Robson, Rance, Ramirez, Memon, Bressington and Gray (2009) research findings that any changes in service delivery results in health professionals consider the potential impact of the change on their professional role. In this study doctors are suggested to be concerned that the nurse would be moving into their practice territory if they obtain prescriptive authority. This could be related to power positions and hierarchal structures within the health care system where prescriptive authority, like admission and referral provide the doctor with power within the system. It seems that doctors were happy for nurses to extend their (the doctors) practice but not for nurses to develop their own practice; as they are concerned about the erosion of doctors traditional roles, professional hierarchies and safety (Cooper et. al 2008). Participants' descriptions of current practice (the third study objective) suggest that this perspective is in fact already in place.

The third objective describes current prescriptive practices of mental health nurses.

Patel et. al (2009) report nurses reluctance to assume responsibility whilst developing their prescribing knowledge and competence. Within this study mental health nurses are suggested as cautious to develop their own prescribing roles. The provision of continuing education and support will be important for sustaining prescribing practices. In this study nurses currently demonstrate their ability to prescribe through advising on medications and dosage. But seem apathetic and ambivalent about prescriptive authority. Currently only PHC nurses according to Nursing Act (33 of 2005) section 56(1) p.39 are allowed to assess, diagnose and prescribe schedule 1-4 medicines; however they are not allowed to prescribe psychotropic medications. The study suggests that while they advise doctors they do not want to become accountable. All clinics in this study have a doctor for half a day; therefore there is a sense of reluctance to move towards prescribing independently. Although there are advanced practice nurses currently working in these clinics there appears to be no motivation to move towards a collaborative relationship with doctors. Lack of competency and confidence by participants appear to be the key barrier in them pursuing prescriptive authority. They appear to be satisfied assisting doctors rather than being independent prescribers. Prescribing is a powerful tool to support recovery but nurses adopting this role need to be competent, confident and aware that it is only one part of the therapeutic toolkit (Hemingway and Ely, 2009). For nurses to prescribe would be moving from a subservient relationship with doctors to one of collaboration.

5.3. RESEARCHER REFLEXIVITY AND STUDY LIMITATIONS

Reflexivity is when the researcher explores personal feelings and experiences that may influence the study and integrates this understanding into the study (Burns & Grove 2009, p.544). Reflexivity in this study allowed the researcher, an advanced practitioner herself; to also identify her own reluctance to prescribe due the responsibility and accountability that accompanies prescribing. The researcher hoped that participant's reflection on current practices on prescribing would motivate them to challenge their practices; as internationally prescriptive practices by nurses is recognized and legislations and policies are in place to support prescriptive practices by nurses. The researcher believes that adequate support from medical officers, mental health care directors and South African Nursing Council would be a key driver in South Africa for nurses to pursue prescriptive authority. The researcher also believes the reluctance of participants in this study to pursue

prescriptive authority is that integration of mental health into primary health care has not been implemented fully yet.

In reviewing the individual interviews the researcher discovered that the interviews did not achieve depth and thick descriptive data. This was due the researcher not exploring adequately as participants answered either “yes I want” or “no need more training” and did not want to add more this. The researcher’s new and limited skill in qualitative interviews resulted in the use of closed questions on occasion; this compounded the researcher’s ability to explore responses. Participants were also initially reluctant to be audio taped which was a barrier to data collection. To ensure the data was reliable and dependable the researcher sought out individual informant and conducted a focus group interview, which achieved depth and a thick description of data. In future studies the researcher would rather source a small number of informants as this achieved a thick data thus allowing the researcher to identify that individual interviews did not yield what the researcher hoped it will. However this does not make the data irrelevant but for a better understanding of the phenomena a selected group of key informants would be more effective. The qualitative method is suggested to have allowed the researcher to see attitudes, motivation, reluctance and knowledge from participants on prescribing which was beneficial in understanding the study clearly (Polit & Beck, 2008, p.70).

5.4. RECOMMENDATIONS

5.4.1 NURSING POLICY MAKERS

The findings in this study suggest that structure and process standards according to Donabedian’s model needs to addressed. Current policies, legislation and prescriptive practices of nurses needs be reviewed. PHC nurses are allowed to prescribe schedule 1-4 medicines, according to the Nursing Act (33 of 2005) section 56 (1) p 39. This does not facilitate mental health care nurses as psychotropic medication is schedule 5 -6. Policy makers, at national and provincial level, need to consider current mental health care outcomes and their possible application to the restrictive prescriptive authority practices currently implemented.

5.4.2 NURSING EDUCATION

It is the researcher's view that the integration of mental health care into PHC will result in re-evaluation of prescribers. Effective mental health care outcomes are facilitated by this prescriptive function. As nurses are the accessible practitioner it is likely that these professionals will be called to facilitate treatment through prescription, specifically from the EDL. To ensure that mental health nurses have the necessary competencies the SANC needs to address current training regulation, curriculum content and scope of practice. The development of a specialist category of nurse seems appropriate and timeous. Nursing educationalist need to consider that current graduates will, in the near future, become involved in prescribing and adapt nursing curriculum to bring the gap between the current mental health nurse practitioners and the specialist nurse practitioner. This study suggests that the advanced mental health nurses, specialist practitioners, have more confidence in accepting prescriptive authority. In the current re-curriculation nurse educators should address core knowledge and skills that would include a practical and theoretical component with in-depth pharmacology, assessment, diagnosis, clinical decision making, evaluation, referral, detection and management of adverse drug reactions. Building self-efficacy amongst mental health nurses.

5.4.3 NURSING RESEARCH

The findings of this study will assist researchers to identify gaps in the nursing curriculum for mental health nurse. More in-depth research is needed on mental health nurses knowledge on psychopharmacology and their level of confidence with regard to prescribing. To ensure the needs of the community is addressed by the prescriptive practice for nurses in South Africa research should reflect current prescriptive practice of PHC nurses and the influence of the shortage of medical officers and psychiatrist in mental health services.

5.5 SUMMARY

This study highlights the perception of prescriptive authority for nurses by doctors, psychiatrists and director of mental health in the Kwazulu-Natal department of health. Nurses working in PHC find themselves responsible for the delivery of mental health services with no medical officers, and are unable to prescribe schedule 5-6 medicines and

often have to send MHCUS away because they do not have the necessary authority to practice effectively. This study suggests that mental health nurses want to embrace the authority to prescribe schedule 5-6 medications and to increase their autonomy so that they are in line with global trends of prescribing.

5.6 CONCLUSION

The challenge for mental health nurses is the lobbying for enabling legislation for prescriptive authority and obtaining education and training opportunities (Geyer, Naude & Sithole, 2002). One of the challenges for mental health nurses would be to achieve a collaborative working relationship between medical officers and psychiatrists. The department of health and mental health care directors need to be proactive in ensuring that there is a change in policies and regulations. Geyer, Naude & Sithole, 2002).

REFERENCES:

Barret, T., Boeck, R., Fusco, R., Ghebrehiwet, T., Yan, J., & Saxena, S. (2009). Nurses are the key to improving mental health services in low and middle-income countries. *International Nursing Review*. Vol. 56, p. 138-141.

- Bradley, E., Campbell, P. & Nolan, P. (2004). Nurse prescribers: who are they and how do they perceive their role? *Journal of Advanced Nursing*. Vol. 51, No. 5, p. 439-488.
- Bradley, E., Hynam, B. & Nolan, P. (2007). Nurse prescribing: Reflections on safety in practice. *Social Science and Medicine*. Vol. 65, p. 599-609.
- Bradley, E. & Nolan P. (2007). Impact of nurse prescribing: a qualitative study. *Journal of Advanced Nursing*. Vol. 59, Issue. 2, p. 120-128.
- Braun, V. & Clarke, V. (2006). Using Thematic Analysis Psychology. *Qualitative Research in Psychology*. Vol. 3, p. 77-101.
- Brink, H. (2006). *Fundamentals of research methodology for health professionals*. 2nd edition. Cape Town: Landsdowner.
- Brooks, N., Otway, C., Rashid, C., Kilty, L. & Maggs, C. (2001). The patient's view: the benefits and limitations of nurse prescribing *British Journal of Community Nursing*. Vol. 6, Issue. 2, p. 342-348.
- Brunckner, T.A., Scheffler, R.M., Shen, G., Yoon, J., Chisholm, D., Morris, J., Fulton, B.D., Poz, M. R. D. & Saxena, S. (2011). The mental health workforce gap in low- and middle-income countries: a needs-based approach. *Bulletin of World Health Organisation*. Vol. 89, p. 184-198.
- Burns, J.K. (2011). The Mental Health Gap in South Africa – A Human Rights Issue. *The Equal Rights Review*. Vol. 6, p. 99-113.
- Burns, K. (2010). Mental Health Services Funding and Development in KwaZulu – Natal: A Tale of Inequity and Neglect. *South African Medical Journal*. Vol.100, No. 10, p.662-666.
- Burns, N. & Grove, S.K. (2009). *The practice of nursing research conduct, critique and utilization*. 6th edition, Philadelphia: WB Saunders.
- Chaston, D. & Seccombe, J. (2009). Mental health nurse prescribing in New Zealand and the United Kingdom: Comparing the pathways. *Perspectives in Psychiatric Care*. Vol. 45, No. 1, p. 17-23.
- Courtenay, M., Carey, N. & Burke, J. (2006). Independent extended and supplementary nurse prescribing practice in the UK: A national questionnaire survey. *International Journal of Nursing Studies*. Vol. 44, p. 1093-1101.
- Courtenay, M. & Carey, N. (2007). Nurse independent prescribing and nurse supplementary prescribing practice: national survey. *Journal of Advance Nursing*. Vol. 61, No. 3, p. 291-299.

- Cooper, R.J., Anderson, C., Avery, T., Bissel, P., Guillaume, L., Hutchinson, A., James, V., Lymn, J., McIntosh, A., Murphy, E., Ratcliffe, J., Read, S. & Ward, P. (2008). Nurse and Pharmacist Supplementary Prescribing in UK- A Thematic Review of the literature. *Health Policy*. Vol. 85, p. 277-292.
- Dinko, K. & Gaopopolwe, E. (2011). Understanding our people a journey through Ethekwini Metropolitan Municipality. *Statistics South Africa*. (cited October 2013). www.statssa.gov.za.
- Dobel-Ober, D., Brimblecombe, N. & Bradley, E. (2010). Nurse prescribing in mental health: national survey. *Journal of Psychiatric and Mental Health Nursing*. Vol. 17, p. 487-493.
- Donabedian, A. *Exploration in Quality Assessment and Monitoring: The Definition of Quality and Approaches to Its Assessments*. Vol. 1, Ann Arbor, Mich: Health Administration Press; 1980.
- Dunn, S.V., Cashin, A., Buckley, T. & Newman, C. (2008). Nurse practitioner prescribing in Australia. *Journal of the American Academy of Nurse Practitioners*. Vol. 22, p.150-155.
- Funk, M. & Ivbijaro, G. (2008). *Integrating Mental into Primary Care: A Global Perspective* World Health Organisation and World Organisation of Family Doctors. World Health Organization. Geneva. Switzerland. p. 1-224.
- Forchuk, C. and Kohr, R. (2009). Prescriptive Authority for Nurses: The Canadian Prescriptive. *Perspectives in Psychiatric Care*. Vol. 45, No. 1, p. 3-8.
- Geyer, N. (2001). Enabling legislation in diagnosis and prescribing of medicine by nurse/health practitioner. *Curationis*. Vol. 24, No. 4, p. 17-24.
- Geyer, N. (1998). Legal limitations for nurse prescribers in primary health care. *Curationis*. Vol.4, p. 28-33.
- Geyer, N. (1997). Expansions in Clinical Nursing Practice. *Health SA Gesondheid*. Vol. 2, No. 1, p. 22-28.
- Geyer, N., Naude, S. & Sithole, N.P. (2002). Legislative Issues Impacting on the Practice of South African Nurse Practitioner. *Journal of the American Academy of Nurse Practitioners*. Vol. 14, No. 1, p. 11-15.
- Gray, A. & Jack, C. (2008). *Health Legislation and Policy*. South African Health Review 2008. Durban: Health System Trust. p. 31-45.
<http://www.hst.org.za/publications/south-african-health-review>. (cited May 2012).

- Gray, A., Vawda, Y. & Jack, C. (2011). Health policy and legislation. South African Health Review 2011. Durban: Health systems Trust. 2011. p. 1-16.
<http://www.hst.org.za/publications/south-african-health-review>. (cited July 2012).
- Grazin, N. (1998). Towards an integrated mental health service. A situation analysis of the lower orange district. South African Health Review 1998. Durban: Health System Trust. p. 1-58.
<http://www.hst.org.za/publications/towards-integrated-menta-health-service>.
 (cited 2012 May).
- Handler, A., Issel, M. & Turnock, B. (2001). A Conceptual Framework to Measure Performance of the Public Health System. American Journal of Public Health. Vol. 91, No. 8, p. 1235-1239.
- Hemingway, S., McAllister, M., Bailey, K., Coates, K., Mitchell, S. & Fenwick, M. (2004). Nurse prescribing in mental health care: What can the USA teach us? Nurse Prescriber. Vol. 1, No. 4, p. 1-6.
- Hemingway, S. & Ely, V. (2009). Prescribing by Mental Health Nurses: The UK Perspectives in Psychiatric Care. Vol. 45, No. 1, p. 24-35.
- Jack-Ide, I.O., Uys, L.R. & Middleton, L.E. (2012). A comparative study of mental health services: South Africa and Nigeria. International Journal of Nursing and Midwifery. Vol. 4(4), p. 50-57.
- Jones, A. (2008). Exploring Independent Nurse Prescribing for Mental Health Settings. Journal of psychiatric and Mental Health Nursing. Vol. 15, p. 109-117.
- Jones, A. & Jones, M. (2005). Mental health nurse prescribing: issues for the UK. Journal of Psychiatric and Mental Health Nursing. Vol. 12, p. 527-535.
- Jones, M., Bennett, J., Lucas, B., Miller, D. & Gray, R. (2007). Mental Health Nurse Supplementary Prescribing: Experiences of Mental Health Nurses, Psychiatrist and Patients. Journal of Advanced Nursing. Vol. 59, No. 5, p. 488-496.
- Jones, M., Robson, D., Whitfield. S. & Gray, R. (2010). Does psychopharmacology training enhance the knowledge of mental health nurses who prescribe? Journal of Psychiatric and Mental Health Nursing. Vol.17, p. 804-812.
- Jutel, A. & Menkes, D.B. (2010). Nurses' reported influence on prescription and use of medication. International Nursing Review. Vol. 57, p. 92-97.
- Kaplan, L. & Brown, MA (2007). Transition of Nurse Practitioners to changes in Prescriptive Authority. Journal of Nursing Scholarship. Vol. 39, No. 2, p. 184-190.

- Kautzky, K. & Tollman, S. M. (2008). A perspective on primary health care in South Africa. *South African Health Review* 2008. Durban: Health System Trust; p. 17-30. <http://www.hst.org.za/publications/south-african-health-review>. (cited May 2012)
- Kroezen, M., Francke, A.L., Groenewegen, P.P. & Dijk, L.van. (2012). Nurse prescribing of medicines in Western European and Anglo-Saxon countries: A survey on forces, conditions and jurisdictional control. *International Journal of Nursing Studies*. Doi:10.1016/j.ijnurstu.2012.02.002. (cited March 2013).
- Lund, C., Kleintjies, S., Kakuma, R., & Flisher, A. J. (2009). Public sector mental health systems in South Africa: inter-provincial comparisons and policy implications. *Journal of Social Psychiatric Epidemiology*. Vol.45, p. 393-404.
- McCann, T.V. & Baker, H. (2001). *Journal of Psychiatric and Mental Health Nursing*. Vol. 9. p. 175 -185.
- McCann, T.V. & Clark, E. (2008). Attitudes of patients towards mental health nurse prescribing of antipsychotic agents. *International Journal of Nursing Practice*. Vol.14, p. 115-121.
- Miles, K., Seitio, O. & McGilvray, M. (2006). Nurse prescribing in low-resource settings: professional considerations. *International Nursing Review*. Vol. 53, p. 290-296.
- Mkhize, N. & Kometsi, M. J. (2008). Community access to mental health services: lessons and recommendations. *South African Health Review* 2008. Durban: Health System Trust. p. 103-111. <http://www.hst.org.za/publications/south-african-health-review>. (cited May 2012).
- Muse, M., and McGrath, R.E. (2010). Training Comparisons among Three Professions Prescribing Psychoactive Medications: Psychiatric Nurse Practitioners, Physicians, and Pharmacologically Trained Psychologists. *Journal of clinical psychology*. Vol. 66, No. p. 96-103.
- Nolan, P. & Bradley, E. (2007). The role of the nurse prescriber: the views of mental health and non-mental health nurses. *Journal of Psychiatric and Mental Health Nursing*. Vol. 14, p. 258-266.

- Oxford Advanced Learner's Dictionary (2012). (10th Ed.) New York: Oxford University Press.
- Patel, M.X., Robson, D., Rance, J., Ramirez, N.M., Memon, T.C., Bressington, D. & Gray, R. (2009). Attitudes regarding mental health nurse prescribing among psychiatrists and nurses: a cross-sectional questionnaire study. *International Journal of Nursing Studies*. Vol.46, p.1467-1474.
- Peterson, I. (1999). Training for transformation: Reorientating Primary Health Care Nurses for the provision of Mental Health Care in South Africa. *Journal of Advanced Nursing*. Vol. 30, No.4, p. 907-915.
- Petersen I., Bhana, A., Campbell-Hall A., Mjadu, S., Lund C., Kleintjies S., Hosegood, V. & Flisher A. (2009). Planning for District mental health services in South Africa: a situational analysis of a rural district site. *Health Policy Plan*. Vol. 24, No. 2, p. 140-150.
- Polit, D.F & Hungler, B.P. (1999) *Nursing Research: Principles and Methods* 6th edition. Philadelphia: Lippincott Williams & Wilkins.
- Polit, D. F. & Beck, C. T. (2008). *Nursing research: Generating and assessing Evidence for Nursing Practice*. 8th edition. Philadelphia: Lippincott Williams & Wilkins.
- Rana, T., Bradley, E. & Nolan, P. (2009). Survey of psychiatrists' view of nurse prescribing. *Journal of Psychiatric and Mental Health Nursing*. Vol. 16, p 257-262.
- Skingsley, D., Bradley, E.J. & Nolan, P. (2006). Neuropharmacology and mental health nurse prescribers. *Journal of Clinical Nursing*. Vol.15, p. 989-997.
- South African Nursing Council. 1997. Regulation R212, as amended January 1997. Pretoria: Government Printer.
- Stevens, M., Mathijs, F. & Bomela, N. (2008). Task Shifting considering legal; and regulatory barriers. Health System Trust 2008. p. 21-37.
<http://www.hst.org.za/publications/task> shifting-considering-legal-and regulatory-barriers. (cited November 2011).
- South Africa. 1997. Medicines and Related Substances Control Amendment Act No. 90 of 1997. Pretoria: Government Printer.
- South Africa. 1965. Medicines and Related Substance Control Act No. 101 of 1965. Pretoria: Government Printer.
- South Africa. 2003. National Health Act No. 61 of 2003. Pretoria: Government Printer.

- South Africa. 2002. Mental Health Care Act No. 17 of 2002. Pretoria: Government Printer.
- South Africa. 2005. Nursing Act No. 33 of 2005. Pretoria: Government Printer.
- South Africa. 1974. Pharmacy Act No. 53 of 1974. Pretoria: Government Printer.
- [Tinelli, M.](#), [Blenkinsopp, A.](#), [Latter, S.](#), [Smith, A.](#) & [Chapman, S.R.](#) (2013). Survey of patients' experiences and perceptions of care provided by nurse and pharmacist independent prescribers in primary care. *Health Expectations*: doi:10.1111/hex.12099. (cited July 2013).
- Tomlinson, M., Grimsrud, A.T., Stein, D.J., Williams, D.R. & Meyer, L. (2009). The epidemiology of major depression in South Africa: Results from the South African stress and health study. *South African Medical Journal*. Vol. 99, p. 367-373.
- Van Ruth, L. M., Mistiaen, P., & Francke, A. L. (2007). Effects of nurse prescribing of medication: a systematic review. *The internet journal of healthcare administration*. Vol. 5, No. 2. Ispb.com/IJHCA/5/2/3313. (cited April 2013).
- Wahyuni, D. (2012). The Research Design Maze: Understanding Paradigms, Cases, Methods and Methodologies. *Journal of Applied Management. Accounting Research*. Vo. 10, No. 1, p. 69-80.
- Weaver, K. & Olson, K. (2005). Understanding paradigm uses for nursing research integration. *Journal of Advanced Nursing*. Vol.19, p. 733-737.
- South Africa. Department of Health. 1997. White Paper for Transformation of the Health System. Pretoria. Department of Health.
- World Health Organization (2011). *Mental Health Atlas*. Geneva. www.who.int/entity/mental-health. (cited April 2012)
- World Health Organization (2007). *Mental Health Atlas*. Geneva. www.who.int/entity/mental-health. (cited April 2012)
- Zachariah, R., Ford, N., Philips, M., Lynch, S., Massaquoi, M., Janssens, V. & Harris, AD. (2008). Task shifting in HIV/AIDS: opportunities, challenges and proposed actions for sub-Saharan Africa, *Royal Society of Tropical Medicine and Hygiene*. 103, p. 549-558.

ANNEXURE 1

FOCUS GROUP AND INDIVIDUAL SEMI- STRUCTURED QUESTIONS

STAKEHOLDERS PERCEPTION OF MENTAL HEALTH NURSES HAVING PRESCRIPTION AUTHORITY

Demographic Data

Tick the appropriate box:

1. Gender: Male
 Female

2. Age: 20-30 years
 31 – 40 years
 41 – 50 years
 51 + years

3. Position at Work: Operational Manager

 Registered Nurse (PND1)

 Registered Nurse (PND2)

 Registered Nurse with Advanced Psychiatry

 Doctor
 Psychiatrist

4. How long have you worked in this position?
 0-3 Years
 4-5 Years
 6-10 Years
 1-15 Years
 16-20 Years
 More than 20 Years

ANNEXURE 2 INDIVIDUAL QUESTIONS

1. What type of legislation that allows psychiatric nurses to prescribe medication?
2. How do you perceive prescriptive authority?
3. Do you guide medical officers and interns in prescribing medications for the mental health care user?

4. Do you prescribe from the EDL list in the absence of doctors or psychiatrist and then get them to write up the prescription? How do you manage cases where a prescription is needed in the absence of a doctor?
5. For you to prescribe do you think you have adequate knowledge and skills?

Questions for Doctors

1. How you perceive the prescriptive authority of nurses.
2. Do you think if psychiatric nurses have prescription authority will decrease the work load?
3. What do think the outcomes for patients will be if nurses prescribe medications?

ANNEXURE 3

INFORMATION SHEET

Information Sheet

I am Mrs. M. Ramasamy a Masters Student in mental health at the University of Kwa Zulu Natal. I am currently completing a research project as part of the course requirements for the master's degree.

The purpose of this study is to explore mental health care practitioners and mental health care director's perception of psychiatric nurses obtaining prescription authority in Durban eThekweni District KwaZulu-Natal.

Ethical Clearance No

The semi structured interview schedule that will be used to generate discussion within the focus group (Annexure: 1).The interview schedule consists of Section A contains demographic data and section B that includes questions generated from the literature to stimulate discussion. (Annexure 1)

The data will be collected using a focus group with semi structured questions.

Please Note:

1. There will be no reference to names of participants, the companies they work for or the academic institutions where data is being collected. Coding will be used to group data to allow for analysis.
2. The researcher will keep all information in strict confidence.
3. The published report and any published article that may occur from the study will make no reference to academic institutions, participant's names, or the companies participants work for.
4. Data will be stored for 5 years in a locked steel cupboard in the researcher's office. The individual interviews will take approximately 30 to 45 minutes you will be given an opportunity to ask questions.
5. The answers you give will have no personal consequences for you as your anonymity is assured. The researcher is completely neutral and has no investment in obtaining specific answers to questions.

The researcher is merely attempting to record your current thoughts and perceptions about psychiatric nurses obtaining prescription authority.

A copy of the report will be given to the University of Kwa Zulu Natal. An article will be submitted for publication within 1 year of the written report. Should you wish, you may have access to the findings of this study through the Department of Nursing, UKZN.

Should you have any questions or concerns you are most welcome to contact myself or my supervisor. Please see contact details below.

Mrs. M Ramasamy

Telephone: 0782038143

Ms A Smith

MA, Mental Health

University of KwaZulu Natal

Email: smitha1@ukzn.ac.za

ANNEXURE 4

Informed consent Form (Adapted from Burns & Grove 2009 p201).

I understand that I am being asked to participate in a research study conducted by Mrs. M Ramasamy, a master's student from the University of KwaZulu Natal – School of Nursing. This study will collect information about mental health care practitioners and mental health care director's perception of psychiatric nurses obtaining prescription authority in EThekweni District Kwa Zulu Natal, if I agree to participate in the study I will complete the demographic questionnaire and participate in the focus group or on an individual basis. No personally identifying information will be included in these forms. I

understand that there are no known risks with this study and that there is no payment for participation in this study. I realize that the knowledge gained from this study may help improve the clinical services provided to mental health care users. I realize that my participation in this study is entirely voluntary, and I may withdraw from the study at any time. If I decide to discontinue my participation in the study, I will continue to be treated in the usual and customary fashion as at present. I understand that all study data will be kept confidential. However, this information will be used as completion of a master's student course requirements, and will be used in nursing publications or presentations. If I need to, I can contact Ms Amanda Smith at UKZN- School of Nursing at any time during the study. The study has been explained to me. I have read and understood this consent form. All of my questions regarding this study have been answered, and I agree to participate. I understand that I will be given a copy of this signed consent form if I request it.

Signature of Subject

Date

Signature of Witness

Date

Signature of Researcher

Date

ANNEXURE 5



Research Office, Govan Mbeki Centre
Westville Campus
Private Bag x54001
DURBAN, 4000
Tel No: +27 31 260 3587
Fax No: +27 31 260 4609
snymann@ukzn.ac.za

29 September 2011

Mrs M Ramasamy (208516623)
School of Nursing

Dear Mrs Ramasamy

PROTOCOL REFERENCE NUMBER: HSS/0941/011M
PROJECT TITLE: Mental Health Care Practitioners and Mental Health Care Directors Perceptions of Psychiatric Nurses obtaining Prescription Authority in eThekweni District KwaZulu-Natal

In response to your application dated 18 July 2011, the Humanities & Social Sciences Research Ethics Committee has considered the abovementioned application and the protocol has been granted **FULL APPROVAL**.

Any alteration/s to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form, Title of the Project, Location of the Study, Research Approach and Methods must be reviewed and approved through the amendment /modification prior to its implementation. In case you have further queries, please quote the above reference number.
PLEASE NOTE: Research data should be securely stored in the school/department for a period of 5 years.

I take this opportunity of wishing you everything of the best with your study.

Yours faithfully



.....
Professor Steven Collings (Chair)
HUMANITIES & SOCIAL SCIENCES RESEARCH ETHICS COMMITTEE

cc. Supervisor – A Smith
cc. Mr S Reddy



Founding Campuses: ■ Edgewood ■ Howard College ■ Medical School ■ Pietermaritzburg ■ Westville

From: Ms M Ramasamy

Telephone No: Work [REDACTED]
Cell phone: [REDACTED]

Email: [REDACTED]

To: [REDACTED]
Acting District Manager

RE- Permission to collect research data from eThekwin District

I Ms M Ramasamy (Student number: 208516623) a Masters student in Mental Health at University of Kwa Zulu Natal and currently employed as a Lecturer at Addington Nursing Campus as Psychiatric Nursing Science and Social Science Lecturer, would like to request permission to collect data from eThekwin district.

Title of research project: Mental health care practitioners and mental health care director's perceptions of psychiatric nurses obtaining prescription authority in eThekwin District Kwa Zulu Natal.

Data will be collected from the following facilities in eThekwin District Kwa Zulu Natal.

1. [REDACTED]
2. [REDACTED]
3. [REDACTED]
4. [REDACTED]
5. [REDACTED]
6. [REDACTED]

I would like to send my findings to South African Nursing Council, Mental Health Care Directors and Mental Health Care Practitioners.

I would also send a copy to District and Provincial Office.

Yours assistance would be greatly appreciated.

Regards

Ms M Ramasamy



health

Department:
Health
PROVINCE OF KWAZULU-NATAL

Health Research & Knowledge Management sub-component

10 – 103 Natalia Building, 330 Langalibalele Street
Private Bag x9051
Pietermaritzburg

3200
Tel.: 033 – 3953189
Fax.: 033 – 394 3782
Email.: hikm@kznhealth.gov.za
www.kznhealth.gov.za

Reference : HRKM146/11
Enquiries : Mrs G Khumalo
Telephone : 033 – 3953189

20 October 2011

Dear Ms M Ramasamy

Subject: Approval of a Research Proposal

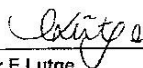
1. The research proposal titled **Mental Healthcare Practitioners and mental Healthcare director's perceptions of psychiatric nurses obtaining prescription authority in eThekweni district, KwaZulu-Natal** was reviewed by the KwaZulu-Natal Department of Health.

The proposal is hereby **approved** for research to be undertaken at [REDACTED]

2. You are requested to take note of the following:
 - a. Make the necessary arrangement with the identified facility before commencing with your research project.
 - b. Provide an interim progress report and final report (electronic and hard copies) when your research is complete.
3. Your final report must be posted to **HEALTH RESEARCH AND KNOWLEDGE MANAGEMENT, 10-102, PRIVATE BAG X9051, PIETERMARITZBURG, 3200** and e-mail an electronic copy to hikm@kznhealth.gov.za.

For any additional information please contact Mrs G Khumalo on 033-3953189.

Yours Sincerely


Dr E Lutge
Chairperson, Health Research Committee
KwaZulu-Natal Department of Health
Date: 25/10/2011

uMnyango Wezempilo . Departement van Gesondheid

Fighting Disease, Fighting Poverty, Giving Hope



health

Department:
Health
PROVINCE OF KWAZULU-NATAL

Postal Address: Private Bag X54318 Durban 4000
ss: 83 Jan Smuts Highway, Mayville, Durban 4001
Tel.031 2405308: Fax. 031 2405500
Email. nan.hoosain@kznhealth.gov.za
www.kznhealth.gov.za

Enquiries: Mr S Yose
Date : 19 October 2011

Ms M Ramasamy
7 Courtown Crescent
Avoca Hills
Durban
4051

**REQUEST TO CONDUCT RESEARCH:
Mental Health Care Practitioners and Mental Health Care Director's perceptions
of Psychiatric Nurses obtaining prescription authority in eThekweni District
KwaZulu-Natal**

I have pleasure in informing you that permission has been granted to you by the District Manager to conduct research on the above research study.

Please note the following:

1. Please ensure that you adhere to all the policies, procedures, protocols and guidelines of the Department of Health with regard to this research.
2. This research will only commence once this office has received confirmation from the Provincial Health Research Committee in the KZN Department of Health.
3. Please ensure that this office is informed before you commence your research.
4. The District Office will not provide any resources for this research.
5. You will be expected to provide feedback on your findings to the District Office.


Mr S Yose
Acting District Manager
eThekweni
Telephone: 031 2405308
Fax : 031 2405500
Email : nan.hoosain@kznhealth.gov.za

uMnyango Wezemipilo . Departement van Gesondheid

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ANNEXURE 9: Draft letter to gate keepers

To: Hospital manager

From: Mrs. M Ramasamy

UKZN Masters Student (mental Health)

Date:

Re: Request to collect data

Dear

I am a psychiatric nursing tutor at Addington Campus, one of the KZN CN campuses, and am also a master's student (Mental Health Nursing) at UKZN School of nursing. As part of my studies I have to conduct research and I am writing to request your permission to collect data at your institution.

The research proposal has been submitted and passed by the ethics committee at UKZN (ethical clearance number HSS/0941/011M)

The purpose of the study is to explore mental health care practitioners and mental health care director's perception of psychiatric nurses obtaining prescription authority in Durban eThekweni district Kwa Zulu Natal.

A non experimental qualitative design with semi structured focus group and individual interviews. I will be requesting participation from the registered nurses, psychiatrists, doctors and provincial and district mental health care managers. Data collection will require that I make contact with hospital management and then the potential participants.

Dates and times for focus groups and individual interviews will be negotiated with hospital management, potential participants so as to ensure no disruption of mental health care services. The attached information and consent sheets give further detail.

Yours sincerely

Mrs. M Ramasamy

Email: premie.ramasamy@kznhealth.gov.za

Phone: 0782038148

Supervisor:

Ms A Smith

Email: smitha1@ukzn.ac.za

Phone: 0312603578

ANNEXURE 10



[REDACTED]

15 February 2012

Mrs Ramsamy

Re: Request to conduct research at [REDACTED]

Dear Mrs Ramsamy

Thank you for informing me of your intention to conduct research at our unit. I am happy for you to proceed. Could you kindly indicate how many staff members are needed and the approximate duration of the interviews.

Wishing you success in your research and studies.

[REDACTED]

Principal Specialist Psychiatrist/lecturer
Head of Psychiatric Unit

[REDACTED]

uMnyango Wezempilo . Departement van Gesondheid

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health

Department:
Health
PROVINCE OF KWAZULU-NATAL



Reference:
Enquiries: [REDACTED]
Ext: 4201
Date: 08 December 2011

Ms M Ramasamy



**REQUEST TO CONDUCT RESEARCH:
Mental Health Care Practitioners and Mental Health Care Director's perceptions of
Psychiatric Nurses obtaining authority by [REDACTED]**

I have pleasure in informing you that permission has been granted to you by [REDACTED] to
conduct research on the above research study.

Please note the following:

1. Please ensure that you adhere to all the policies, procedures, protocols and guidelines of
the Department of Health with regard to this research.
2. This research will only commence once this office has received confirmation from the
Provincial Health Research Committee in the KZN Department of Health.
3. Please ensure that this office is informed before you commence your research.
4. This Facility will not provide any resources for this research.
5. You will be expected to provide feedback on your findings to [REDACTED]



Nursing Service Manager/ Acting CEO

uMnyango Wezemphilo . Departement van Gesondheid

Fighting Disease, Fighting Poverty, Giving Hope

ANNEXURE 12



[Redacted text block]

AD/9/2/3/R

Enquiries: [Redacted]
Extension: [Redacted]

14th December 2011

Principal Investigator:
> Mrs M. Ramasamy

PERMISSION TO CONDUCT RESEARCH AT [Redacted] "MENTAL HEALTH CARE PRACTITIONERS AND MENTAL HEALTH CARE DIRECTORS PERCEPTIONS OF PSYCHIATRIC NURSES OBTAINING PRESCRIPTION AUTHORITY IN ETHEKWINI DISTRICT KWAZULU-NATAL"

I have pleasure in informing you that permission has been granted to you by [Redacted] Management to conduct research on "Mental Health Care Practitioners and Mental Health Care Directors Perceptions of Psychiatric Nurses obtaining prescription authority in eThekwinini District KwaZulu-Natal"

Please note the following:

1. Please ensure that you adhere to all the policies, procedures, protocols and guidelines of the Department of Health with regards to this research.
2. This research will only commence once this office has received confirmation from the Provincial Health Research Committee in the KZN Department of Health.
3. Please ensure this office is informed before you commence your research.
4. [Redacted] will not provide any resources for this research.
5. You will be expected to provide feedback on your findings to [Redacted]

[Redacted signature]
HOSPITAL MANAGER

uMnyango Wezempilo . Departement van Gesondheid

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ANNEXURE13: Raw data

Questions asked of participants precede the participant's response Annexure outlines the semi structures question used in these individual interviews.

OUT PATIENT DEPARTMENT A

Participant 1

Is there any legislation that allows psychiatric nurses to prescribe medication?

No not that I know off

Do you want prescriptive authority?

Yes I would as it makes things easier at night will be able to prescribe Akineton if patients have side effects instead of phoning the doctor as nurses are all the time with the patients between 12 to 24 hours a day they know the patient's behaviour as the doctor only sees the patient for 5 minutes.

Do you guide medical officers and interns in prescribing medications for the mental health care user?

Yes

Do you prescribe from the EDL list in the absence of doctors or psychiatrist and then get them to write up the prescription?

No

For you to prescribe do you think you have adequate knowledge and skills?

Yes, know the need to give drugs at a certain time, know what are the side effects are. Have experience with most of the drugs.

Participant 2

Is there any legislation that allows psychiatric nurses to prescribe medication?

Not that I know off.

Do you want prescriptive authority?

Yes

Do you guide medical officers and interns in prescribing medications for the mental health care user?

Yes all the time

Do you prescribe from the EDL list in the absence of doctors or psychiatrist and then get them to write up the prescription?

No

For you to prescribe do you think you have adequate knowledge and skills?

Yes I do.

Participant 3

Do you think if psychiatric nurses have prescription authority there will be a decrease the work load?

Not decrease work load actually but will help when no doctor is available, as acutely ill patients need certain medication and nurses are able to assess and give the medications this makes it easier and aggressive patients can be managed accordingly by the nurses and advert injury.

What do think the outcomes for patients will be if nurses prescribe medications?

In outpatient setting waiting period becomes shorter do not have to wait for doctors from the ward. Makes lives easier able to get medication fast. Stable patients on medications have to wait for the doctors nurses prescribing will be faster.

In the ward the doctor may forget to write and sign the script this wastes time as the doctor needs to be found for signature. There is no abuse of medications, as there is capable staff.

OUT PATIENT DEPARTMENT B

Participant 4

Is there any legislation that allows psychiatric nurses to prescribe medication?

No nothing

Do you want prescriptive authority?

Yes on certain medications and on certain times sometimes we do need to prescribe when patients come in with side effects needs to prescribe when there is no doctor, when scripts expire. Scripts already exists just need to continue with medications see no reason why we cannot continue the prescription.

Would you consider prescribing repeat medications?

Yes on certain patients.

Do you guide medical officers and interns in prescribing medications for the mental health care user?

Yes although we do not have interns. Doctors do ask for assistance

Do you prescribe from the EDL list in the absence of doctors or psychiatrist and then get them to write up the prescription?

Not at all

For you to prescribe do you think you have adequate knowledge and skills?

Definitely

Participant 5

Is there any legislation that allows psychiatric nurses to prescribe medication?

No

Do you want prescriptive authority?

Yes

With all medications

Chronic patients and with repeat medications and those who are stable, instead of waiting for the doctor. For acute and new patients no

Do you guide medical officers and interns in prescribing medications for the mental health care user?

Yes

Do you prescribe from the EDL list in the absence of doctors or psychiatrist and then get them to write up the prescription?

Yes

For you to prescribe do you think you have adequate knowledge and skills?

Yes

Participant 6

Is there any legislation that allows psychiatric nurses to prescribe medication?

No

Do you want prescriptive authority?

Not really if I don't understand diagnosis's well, don't feel confident enough to prescribe.

If you have adequate training in diagnosis would you then feel comfortable prescribing.

Yes if it would benefit me.

Do you guide medical officers and interns in prescribing medications for the mental health care user?

Sometimes if new and under guidance of another doctor tell them what the best ones to use.

Do you prescribe from the EDL list in the absence of doctors or psychiatrist and then get them to write up the prescription?

No

For you to prescribe do you think you have adequate knowledge and skills?

My skills are developing however I am not at the level of primary health care nurses yet, as psychiatry has changed over time with new developments which we have not been

exposed to , the more we interact with different doctors then we learn about current practices, medications, do not have adequate skill at the moment no.

Participant 7

Do you think if psychiatric nurses have prescription authority will decrease the work load?

It will depend on the seniority of the nurses that is they understand the side effects, indications of medications then they can prescribe.

What do think the outcomes for patients will be if nurses prescribe medications?

Right now I am not sure, as usually in most clinics there is abundance of nurses than doctors. Specifically in psychiatry nurse prescribing will decrease relapse.

In the clinic there is shortage of doctors I am the only one I am also in charge of psychiatric ward and I am constantly busy and sometime there is no one to prescribe. Patients are sent away and when they come back they have relapsed therefore nurse prescribing will improve outcome.

When you say you don't mind nurse prescribing. What is that you mean?

Nurse prescribing will depend on the level of training

Can they prescribe any medications? Like anti-depressant, antipsychotics and anxiolytics.

Certain drugs are of high schedule maybe a problem for nurses maybe ones that are safe and available for them to prescribe.

OUTPATIENT DEPARTMENT C

Participant 8

Is there any legislation that allows psychiatric nurses to prescribe medication?

No legislation presently because we function independently and we have a doctor.

Do you want prescriptive authority?

No because of problems of psychiatric patients' medico legal hazard if medications are incorrectly prescribed and major side effects can occur.

If it is a repeat script:

Yes

Do you prefer prescribing repeat script?

Yes

Do you guide medical officers and interns in prescribing medications for the mental health care user?

No have qualified doctors.

Do you prescribe from the EDL list in the absence of doctors or psychiatrist and then get them to write up the prescription?

No

For you to prescribe do you think you have adequate knowledge and skills?

I do have adequate knowledge and skills but will not like to, but if it is a first time patient it will be beneficial to be assessed by a psychiatrist because all physical examination should be done first before psychiatric intervention is looked at, community nurse do not do physical examination before prescribing sometimes physical symptoms manifest with psychiatric illness., on those ground one should be very cautious.

Prescribing repeat should not be a problem

Yes because has already been seen by psychiatrist.

Should diagnosis and treatment must be done first by the doctor

Yes

Participant 9

Is there any legislation that allows psychiatric nurses to prescribe medication?

No

Do you want prescriptive authority?

Yes

Reason

There is only one psychiatrist and one medical officer lots of patients and sometimes other patients come in the afternoon when doctors are gone.

Do you guide medical officers and interns in prescribing medications for the mental health care user?

Sometimes

Do you prescribe from the EDL list in the absence of doctors or psychiatrist and then get them to write up the prescription?

No

For you to prescribe do you think you have adequate knowledge and skills?

Yes

COMMUNITY HEALTH CENTRE D

Participant 10

Do you think if psychiatric nurses have prescription authority will decrease the work load?

Yes will decrease the work load but prescriptions should be for repeat prescriptions not for first time prescriptions.

What do think the outcomes for patients will be if nurses prescribe medications?

There will be less time wasted by the patient at the clinic; however this must be for repeat prescriptions not first prescriptions.

Are you saying repeat for any psychiatric medications?

Yes

Participant 11

Is there any legislation that allows psychiatric nurses to prescribe medication?

No

Do you want prescriptive authority?

Yes I would like to have it able to learn more about drugs and side effects; however we do know the basics.

Do you guide medical officers and interns in prescribing medications for the mental health care user?

Yes guide medical officers and interns in prescribing.

Do you prescribe from the EDL list in the absence of doctors or psychiatrist and then get them to write up the prescription?

Yes there is EDL list used by doctors only.

For you to prescribe do you think you have adequate knowledge and skills?

Need more in-service new drugs in market which are better. Medications have side effects want to know about current side effects.

Participant 12

Is there any legislation that allows psychiatric nurses to prescribe medication?

No

Do you want prescriptive authority?

Yes when doctor is not here can make a decision.

Do you guide medical officers and interns in prescribing medications for the mental health care user?

Yes guide medical officers and interns in prescribing.

Do you prescribe from the EDL list in the absence of doctors or psychiatrist and then get them to write up the prescription?

Yes there is EDL list used by doctors only.

For you to prescribe do you think you have adequate knowledge and skills? Yes

Participant 13

Is there any legislation that allows psychiatric nurses to prescribe medication?

Not in South Africa, no.

Do you want prescriptive authority?

Yes, I have advance psychiatry it will be an advantage as we are short of doctors and will benefit the patient.

Do you guide medical officers and interns in prescribing medications for the mental health care user?

Yes all the time new interns come once every two weeks they are new to psychiatry not familiar. Yes we do guide them.

Do you prescribe from the EDL list in the absence of doctors or psychiatrist and then get them to write up the prescription?

No telephonic order with acuphase, within 24 hours doctor prescribes it. Yes we do have a EDL list only doctors prescribe from list.

For you to prescribe do you think you have adequate knowledge and skills?

Yes, have advance psychiatry.

Participant 14

Is there any legislation that allows psychiatric nurses to prescribe medication?

No

Do you want prescriptive authority?

Yes it will help a lot

Do you guide medical officers and interns in prescribing medications for the mental health care user?

Yes we have interns on a daily basis we guide them.

Do you prescribe from the EDL list in the absence of doctors or psychiatrist and then get them to write up the prescription?

No not at all.

For you to prescribe do you think you have adequate knowledge and skills? Yes.

Participant 15

Is there any legislation that allows psychiatric nurses to prescribe medication?

Not that I am aware of.

Do you want prescriptive authority?

Yes.

Help you in your practice.

Yes most definitely we will have authority to it legally as we are already doing this with the interns.

Do you guide medical officers and interns in prescribing medications for the mental health care user?

Yes

Do you prescribe from the EDL list in the absence of doctors or psychiatrist and then get them to write up the prescription?

No.

For you to prescribe do you think you have adequate knowledge and skills?

Yes I do have advance psychiatry knowledge and have no recognition to prescribe. Prescribing will be beneficial as service in the clinic will run smoothly in absence of the doctor.

OUTPATIENT DEPARTMENT E

Participant 16

Is there any legislation that allows psychiatric nurses to prescribe medication?

Not that I am aware of from time of being a student until qualified.

Do you want prescriptive authority?

It will help more in medical service, in nursing a lot more legislation needed

Do you guide medical officers and interns in prescribing medications for the mental health care user?

Sometimes rarely.

Do you prescribe from the EDL list in the absence of doctors or psychiatrist and then get them to write up the prescription?

No

For you to prescribe do you think you have adequate knowledge and skills?

At current level no don't have advanced psychiatry more knowledge and training is needed not comfortable in prescribing however more exposure and training will make me more comfortable.

Participant 17

Is there any legislation that allows psychiatric nurses to prescribe medication?

No.

Do you want prescriptive authority?

Yes because primary health care nurses give other medications will definitely help to give psychiatric medications, help with the work load.

Do you guide medical officers and interns in prescribing medications for the mental health care user?

Yes we do.

Do you prescribe from the EDL list in the absence of doctors or psychiatrist and then get them to write up the prescription?

No not allowed.

For you to prescribe do you think you have adequate knowledge and skills?

Yes have the knowledge, beneficial for patients who come in for repeat, just for doctor to prescribe no change have to wait for doctor, primary health care sister can prescribe.

Participant 18

Is there any legislation that allows psychiatric nurses to prescribe medication?

No.

Do you want prescriptive authority?

It will help in everyday practice; aggressive patients come from home relapsed have to wait for doctor.

Do you guide medical officers and interns in prescribing medications for the mental health care user?

Not usually.

Do you prescribe from the EDL list in the absence of doctors or psychiatrist and then get them to write up the prescription?

No.

For you to prescribe do you think you have adequate knowledge and skills?

Clinical practitioner has primary health care knowledge; pharmacology although there are doctors all the time but on night duty and in a psychiatric emergency e.g. when Ativan is needed still have to wait for the doctor having prescription authority will make things easier for the patient.

Participant 19

Do you think if psychiatric nurses have prescription authority will decrease the work load?

Definitely will.

What do think the outcomes for patients will be if nurses prescribe medications?

Depends on the pharmacology nurses and sisters have and on experience with drugs. Outcomes will be different for someone who does not know as compared to someone who has 10-15 years' experience will be of an advantage who knows.

OUTPATIENT DEPARTMENT F

Participant 20

Is there any legislation that allows psychiatric nurses to prescribe medication?

No.

Do you want prescriptive authority?

Yes would benefit patient treated urgently if any problems treated comprehensively.

Do you guide medical officers and interns in prescribing medications for the mental health care user? Yes we do

Do you prescribe from the EDL list in the absence of doctors or psychiatrist and then get them to write up the prescription?

No

For you to prescribe do you think you have adequate knowledge and skills?

Yes we do years of experience and exposure have the necessary skills.

Participant 21

Is there any legislation that allows psychiatric nurses to prescribe medication?

Not that I know off.

Do you want prescriptive authority?

Yes.

How would it help?

Have advanced psychiatry. Work as a consultant but not allowed to prescribe.

Do you guide medical officers and interns in prescribing medications for the mental health care user?

At times yes.

Do you prescribe from the EDL list in the absence of doctors or psychiatrist and then get them to write up the prescription?

No

For you to prescribe do you think you have adequate knowledge and skills?

Yes

Participant 22

Is there any legislation that allows psychiatric nurses to prescribe medication?

No

Do you want prescriptive authority?

Yes most of the times we give treatment we are advanced practitioners need that type of authority.

Do you guide medical officers and interns in prescribing medications for the mental health care user?

Most of the time

Do you prescribe from the EDL list in the absence of doctors or psychiatrist and then get them to write up the prescription?

No

For you to prescribe do you think you have adequate knowledge and skills?

Yes years of experience in psychiatry able to identify patients who have dystonia's and give anticholinergic.

Participant 23

Is there any legislation that allows psychiatric nurses to prescribe medication?

No

Do you want prescriptive authority?

Yes

How would it help?

It will help to treat the patient.

Do you guide medical officers and interns in prescribing medications for the mental health care user?

Yes I do

Do you prescribe from the EDL list in the absence of doctors or psychiatrist and then get them to write up the prescription?

Yes

For you to prescribe do you think you have adequate knowledge and skills?

Yes I do years of experience

Participant 24

Is there any legislation that allows psychiatric nurses to prescribe medication?

Yes there is in the clinic but not in the hospital.

Are you talking about a primary health care practitioner?

Yes not in the psychiatric clinic.

Do you want prescriptive authority?

Yes

How would it help?

Because most of the time there are no doctor, nurse remains with the patient for 24 hours doctors' come here for a few minutes if doctor is nit around must have the right to prescribe.

Do you guide medical officers and interns in prescribing medications for the mental health care user?

Most of the time, but sometimes doctors do not want to be told by nurses.

Do you prescribe from the EDL list in the absence of doctors or psychiatrist and then get them to write up the prescription?

No

For you to prescribe do you think you have adequate knowledge and skills?

Need to be trained so that we can prescribe.

COMMUNITY HEALTH CENTRE G

Participant 25

Is there any legislation that allows psychiatric nurses to prescribe medication?

No legislation at the moment it will be vital and necessary for psychiatric nurses to prescribe psychiatric medications.

Do you want prescriptive authority?

Yes most definitely

Do you guide medical officers and interns in prescribing medications for the mental health care user?

Yes guide medical officers and interns in prescribing.

Do you prescribe from the EDL list in the absence of doctors or psychiatrist and then get them to write up the prescription?

Yes no doctor full time works for 2 hours in the morning when patients who are acutely ill come in needs attention immediately with short acting or long acting preparation of antipsychotic the doctor is telephoned a telephonic script is obtained medication administered doctor then comes and signs it up.

For you to prescribe do you think you have adequate knowledge and skills?

Yes I have 26 years in psychiatric nursing which includes inpatient and outpatient and international psychiatric skills and knowledge in inpatients and outpatients worked in Auckland New Zealand.

Participant 26

Do you think if psychiatric nurses have prescription authority will decrease the work load?

Yes definitely take of load from doctors as nurses are first line treatment for patients it would make it easier.

What do think the outcomes for patients will be if nurses prescribe medications?

It would be easier for treatment patients do not have to wait for doctors.

DEPARTMENT OF HEALTH (DISTRICT OFFICE)

Participant 27

Since integration of mental health into primary health care are there any legislations and policy allowing psychiatric nurses to prescribe schedule 5 and 6 medications.

When you come down to Primary health care there is a tendency of phasing out of mental health as speciality. There is talk about integration does not mean you have to phase out speciality. How do you integrate mental health services with Primary Health Care if we are moving now to primary health care approach in terms of access to health services if we say the need to beef up whatever services that will prevent people from community to flood hospitals.

If we take away some of the delegations at primary health care we are disadvantaging services to community at primary health care level.

Who should prescribe at what level?

If we can actually train nurses, psychiatric nurses are well trained at some institutions they advise doctors what medications should be given to patients particularly the medical officer.

This people are able in one hospital at district level to run solely by the psychiatric nurse. All interns that go at district level are guided and supported by psychiatric nurses. If these nurses are actually not in apposition to prescribe, it is disadvantaging our case workers tendency to go back in the old order whereby things are done differently then. If we are looking at the population that we are now dealing with we need to come with new approach, if possible for me I would say beef up primary health care.

Legislation for prescribing come across any

Caught me unaware there is some legislation I remember issue when government came up with the issue of integration of mental health in primary health care the psychiatrist is employed at regional level leaving the gap in primary health care and district level.

At the nursing summit the delegation advised that in terms of policy if we don't have the delegation to prescribe only medical officer this is actually a problem.

Focus Group

Session 1

What do you think about mental health nurses receiving prescriptive authority?

Participant 1: Previous act 38a of 1978 mandates for nurses to prescribe. It will be a good thing for mental health nurses (MHN) to prescribe; doctor is not here all the time. Section 56 of Act 33 of 2005 is actually superseding the one I mentioned before; it will be a good thing.

Participant 2: Psychiatric nurses must have advanced psychiatry knowledge, capability, and examination saying they are ready to prescribe like the doctors.

Participant 3: Psychiatry is a specialty, so if nurses are trained in prescribing according to the act my colleague as mentioned, it will be good, will benefit psychiatric patient if doctor is not available then MHN can prescribe. They need to have skills in prescribing. Prescriptive authority will benefit rural communities.

Participant 3: In the absence of doctors, patients will not be sent away if nurses have authority to prescribe

Participant 1: Not everyone is given a chance to obtain a dispensing license, as this will give nurses more power to dispense medication. Nurses are the ones who are always there and not doctors.

Participant 4: In keeping with reconstruction, development and integration of MHCU in PHC so it is necessary for them to have prescriptive authority and to dispense.

Participant 3: As patients should be assessed and treated before being transferred. Integration is not going anywhere, it is here to stay therefore, nurses should receive support from government and policies should be addressed.

Participant 1: in PHC, programs there are nurse-initiated management of ARV why cannot there be nurse-initiated management of mental illness.

Participant 1: Nurses are prescribing in PHC it so important for mental illness; to be included in their management.

Participant 4: Nurse initiated management for IMCI works in algorithms so does mental health so why is not possible for mental health nurses to prescribe.

Participant 3: It is said that nurses are the cornerstone yet nurse are not allowed to prescribe so how can we be the cornerstone of health. WHO defines health as state of total wellbeing and there is no health without mental health so mental health nurse prescribing needs urgent consideration.

Participant 3: maybe can get mandate to prescribe doctors must also know not there half the time 24-7 nurses are there to diagnose however you can't diagnose and not treat how are going to treat if you are not on site.

Participant 3: Doctors to be aware not there all the time not taking their job just to support patient

Is there any legislation that currently allows nurses to prescribe?

Participant 2: Well there is, is writing for other countries not in SA.

Participant 3: WHO in 2007 said nurses should have prescriptive authority, but we are in 2013 and we do not have. Unfortunately some things are never done complete, like my colleague as just said.

Participant 1: Although WHO made recommendations, but unfortunately, in SA we are, still not trained yet to prescribe schedule 5 and 6 drugs.

Participant 1: If we are adopting WHO principles we have to practice it. We need procedures and policies in place to support us with this regard, although there is legislation in writing from WHO, no support from government.

Participant 1: South African authorities do not open WHO websites, government should recognize we are professional, accountable practitioners and provide policies for prescribing.

Tell me about the EDL lists that currently exist.

Participant 1: Essential Drug List is there for PHC for differently ailments.

Participant 3: PHC encompasses a one-stop shop including mental health, taking history, diagnosing and prescribing schedule 1 to 4 drugs, nothing for schedule 5 onwards.

Participant 1: We teach about lifestyle modification in PHC, were we prescribing management of illness but we do not go further to prescribe Schedule 5-6 medicines. Therefore, what is the use of us being empowered to diagnose in PHC.

Participant 1: Links with mental health care act, patients must be seen in a PHC setting, good thing for EDL list to be implemented. In terms of EDL, it is problematic when it comes to schedule 5-6; mental health care user is in need of 5 and 6 so if we can have a

Participant 3: way forward by Government helping to change EDL list for nurses. When we talk about one stop shop we are saying not mental health care users; so mean while the transition is here.

Participant 3: Current EDL list does not allow mental health nurses to prescribe only doctors; integration is not going anywhere patients are not being given the care that they need despite the fact they have to get the medication that they need.

Participant 2: Essential to include schedule 5-6 in EDL list for nurse.

Participant 4: The EDL is important if doctor not on site medication can be given otherwise patient will have to come back they come in psychotic receive no help go out being psychotic it is disheartening for this to happen.

Do nurses guide medical officers and interns in prescribing?

Participant 4: All the time nurses are well equipped with knowledge they can tell the doctor which tablets/ food are contra –indicated especially with antidepressants the MOAI group. The community service practitioners know a lot about medications therefore they can function effectively.

Participant 3: With HIV and AIDS being so prevalent nurse are trained in prescribing ARV and guide doctors in terms of what drugs are contra indicated before any complications arise when prescribing tranquilizers.

Participant 3: The psychiatric nurses help doctors by word of mouth but not in writing.

Do nurses have adequate knowledge to prescribe?

Participant 2: Yes, they are taught pharmacology in the curriculum their test and examination include pharmacology it is a council requirement they have the knowledge but cannot prescribe.

Participant 3: Most nurses are also are experienced in psychiatry and have adequate some have advanced psychiatry and are still not able to prescribe.

Participant 2: However, Curriculum should change to include advanced courses in pharmacology. There should also be proper guidelines in the ward about prescribing for nurse's so that nurses are adequately equipped.

Internationally nurses go for a 26-day course to become prescribers do you think this is needed here.

Participant 2: Yes It will be a good thing for South Africa we can be included in the global community.

Participant 3: Need to increase training for Advanced Psychiatry people are always being trained;

Participant 4: for advanced midwifery this is a Government initiated programme yet no consideration are being given to train nurses for advanced psychiatry.

Participant 2: Mental health nurse are not included and left out of the equation while other area in nursing are improved all the time.

Participant 3: Advanced psychiatry done only at University it is expensive Government should look at bursaries to help nurses and study leave also support from managers.

Participant 5: There are not adequate advanced psychiatric nurses in the community; if more nurses are trained will increase knowledge and expertise in prescribing.

Participant 4: Thus they will be able to supervise and guide students in the clinical area.