

Nurses' Experience of the Early Identification of Depression in the Primary Care Setting of South Africa

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The objective of this study was to explore and describe nurses' experience of the early identification of depression in the primary care setting of South Africa. A total of 55 female nurses participated in the study (50=black; 5=white). Data were collected through in-depth interviews and naïve sketches. Data were analysed using a descriptive method of open coding. Nurses' experiences were paradoxical in that they perceived both a disrupted and a positive interactional flow between the national health care, community, family and client. Their experiences were also influenced by context of practice—especially the inequitable distribution of resources. Lack of awareness about depression, community and family involvement, and nurses' personal awkwardness towards mental health issues remains a challenge.

Keywords: depression, early identification, primary care, developmental coaching

Depression is known as the “common cold of mental health” (AANS, 2009; Wood, 2008). According to the refined disability adjusted life years (DALY) estimates for South Africa, major depression accounts for the greatest proportion of neuropsychiatric disease burden measured in years lived with disability (YLDs) and is rated among the top ten single causes of overall disease burden (Bradshaw, Norman & Schneider, 2007). Major depression is also the second leading cause of YLDs for South African woman after HIV (Norman, Bradshaw, Schneider, Pieterse, & Groenewald, 2006). It is furthermore associated with high mortality. According to the DSM-IV-TR, up to 15% of individuals with severe depression die by suicide, which emphasises the importance of early identification and treatment.

The co-morbid state of depression incrementally worsens health compared with depression alone, with any of the chronic diseases alone, and with any combination of chronic diseases without depression (Haddad, Walters, & Tylee, 2007). This significant co-morbidity between general medical disorders and psychiatric disorders is key in the South African context, where HIV/AIDS and substance use disorders are extremely prevalent (Emlet, 2007; van Heerden, Hering, Dean & Stein, 2008).

Effects on Families and Communities

Families in which a member is depressed should potentially be seen as families at risk. The burden on families involve caring for a family member, emotional reactions to the illness (problems with self-esteem, powerlessness, fearfulness, loneliness), stress in coping with disturbed behaviour leading to family and relational discord, disruption of household routine, restriction of social activities leading to impaired social role function and economic difficulties (Fawcett, 1993). Children of depressed parents are often in poorer physical health and have an increased incidence of depression, conduct disorders, attention deficit disorders and anxiety disorder. Psychological challenges may include attachment problems, emotional distress and a preoccupation with the conflicts of others. Children of parents with maternal depression have been found to have deficits

in social and academic skills (Burke, 2003). Maritz, Poggenpoel & Myburgh (2008) draws attention to the impact of traumatic life events and subsequent depression on the couple relationship. It is often difficult to ascertain which came first, discord or depression. Spouses and partners often endure the effects of a partner with depression without complaint or acknowledgement and this impacts on relational communication and relational satisfaction (Maritz et al., 2008). Moreover, marital and relational distress is a strong predictor of depressive relapse. Families are required to provide physical and emotional support, but they also bear the negative impact of stigma and discrimination along with the individual suffering from depression. Families form part of a larger community and it is important to view depression within a larger social context.

The impact on communities is large and manifold. There is the cost of providing care, the loss of employment and productivity as well as premature mortality. Hospitalisation and providing treatment represent the most important contributor to health system costs. The European Commission's report on Health and Consumer Protection (2004) and the Consortium for Organisational Mental Health Care (2009) state that depression is linked with longer time off work when compared to other occupational health problems. The report argues that many cost estimates reported are likely to be conservative because they do not take into account the additional costs of reduced work performance by people with untreated depression. No cost of depression can be greater than the loss of human life and its profound impact on the individual, his/her family and the community.

Importance of Early Identification in Primary Care

According to the WHO (2001), the management and treatment of mental disorders in primary health care (PHC) is a fundamental step which enables the largest number of people to get easier and faster access to services and it needs to be recognised that many people are already seeking help at this level. Along with providing treatment and care at primary level, the WHO advocates giving care in the community with the use

of all available resources (WHO, 2001). The organisation believes that community-based services can lead to early detection and intervention as well as limiting the stigma attached to seeking treatment. The early recognition and treatment of depression may assist the client, family and community to continue to function optimally, preventing costly recurrences (Wood, 2008), decreasing the risks for attempted or completed suicides (Barclay, 2010), reducing the disease burden and disability, and improving the overall health of all populations.

Nurses provide the bulk of primary care services in South Africa and are well placed to recognise the early warning signs of depression (Strasser, London & Kortenbout, 2005, Taylor, 2006). According to Taylor (2006), Morse, Dunkin, Buist and Milgrom (2004) and Wood (2008) nurses have a major role to play in providing frontline assessment, intervention and management of mood disorders as they are often the first contact a mental health care user has with primary services. As noted earlier, depression is more often than not seen comorbidly with other common health and mental health problems. Wood (2008) notes that for the vast majority of people, opportunities for the recognition and treatment of primary health problems, and any secondary depression, came as part of routine health-care interventions.

New ways of working in the primary care setting, globally, as well as in South Africa, has seen the roles of nurses expanding and changing. Mivšek, Hundley and Kiger (2008) question the readiness of nurses for these changing roles. They warn that unsympathetic care on the part of primary care front line nurses could in fact contribute to the development of depression. Their findings suggest that nurses often lack the time, knowledge, skills and confidence to assist mental health care users. This in turn, may result in delays in the early identification of depression, increase the risk of suicide, inappropriate treatment and prolong the suffering of mental health care users, their families or carers (Taylor, 2006).

Goals of the Study

The study investigated nurses' experience of the early identification of depression in a primary care setting in South Africa. It also sought to address the question of what can be done by primary care nurses to facilitate the early identification of depression in primary care setting in South Africa. The specific research questions were:

1. What are nurses' experiences of the early identification of depression in a primary care setting in South Africa?
2. What can be done by primary care nurses to facilitate the early identification of depression in the primary care setting of South Africa?

Method

Participants and Setting

Participants were 55 nurses in rural, urban, and informal settlement settings. About 30 clinics were represented. All participants were female, 50 were black and five were white (working experience in PHC clinics = six months to 19 years). Twenty five percent of nurses had a Psychiatric Nursing Science qualification. Seven participants were lecturers in PHC. Purposive sampling (De Vos, Strydom, Fouché & Delpont, 2005) was used in order to ensure that specific elements were included in the sample. This approach employs a considerable degree of selectivity. The researcher also used snowball sampling (De Vos

et al., 2005), where one member of a group referred the researcher to another member.

Ethical Procedure

Informed consent was obtained from all participants by means of a letter communicating the necessary information pertaining to the research. Confidentiality was maintained and participants were informed of the rationale, recording and safe-keeping of audiotaped interviews and transcriptions. Participation was voluntary, and ethical clearance was granted by the University of Johannesburg.

Instrument

Data were collected using nine semi-structured interviews (lasting between 45 and 60 minutes) and 46 naïve sketches (between one and four pages) as described by Giorgi (1985). Naïve sketches proved useful as face to face data collection was not always viable as participants lived or worked in remote areas, busy clinic practices or participants that were unable to meet the researcher. The interview questions were as follow:

How is it for you in your clinic regarding the early identification of depression?

What wishes do you have to improve the early identification of depression in your clinic?

Authenticity was ensured through the principle of fairness. This meant that all the views, perspectives, claims, concerns and voices of participants were heard and accepted (Guba & Lincoln in Denzin & Lincoln, 2005).

Data Analysis

Recorded interviews were transcribed and analysed using the descriptive analysis technique by Tesch (in Creswell, 2003). The transcribed interviews, naïve sketches, field and observational notes were read to gain a sense of the whole. Ideas that came to mind were jotted down in the margin. The most interesting interview was selected and examined to determine what is was about and to establish the underlying meaning. Again any thoughts that came to mind were jotted down in the margin. The ideas were converted into topics that reflected their meaning. Similar topics were clustered together and formed into columns that were arranged into major topics, unique topics and leftovers. The most descriptive label for the topics was chosen. The topics were defined and grouped into main themes and categories.

Results and Discussion

Influence of Competencies and Context

Participants described their experience of the early identification of depression in the primary care setting of South Africa as paradoxical and contextual in nature. On the one hand, there was a dominant discourse of a perceived disrupted interactional flow hampering the early identification of depression. On the other, an alternative yet marginalised discourse emerged of a positive interactional flow facilitating the early identification of depression. The following quotes are taken from the first response of participants after asking the central question and refer to the paradoxical nature of their experience:

It is a challenge, and it is also not very difficult . . . (participant 42)

It is difficult, it is impossible to identify it. (participant 9)

It is difficult to assess a depressed client in my clinic because we don't have a tool or a guideline on how to assess and diagnose whether it is mild or major and the management thereof. (participant 41)

It is impossible to identify unless the person involved is brought to the clinic (participant 44)

Category 1: Disrupted Interactional Flow Hampering the Early Identification of Depression

A dominant discourse of a perceived disrupted interactional flow emerged. The disrupted interactional flow hampering the early identification of depression will now be discussed according to the following sub-categories: national health care; the community; and family and client interaction.

National health care. Although the spirit and intent of the National Health Act of 2003 (National Health Act, Act 61, 2003) is noble, participants seemed to experience the health care system as having insufficient resources, both financial and human, for managing mental health care at primary level, thus impacting on the early identification of depression.

A nurse summarises her experience as follows:

Where I am currently working, at a clinic where we do not have a psychiatric clinic per se. There is only one clinic at X that caters for psychy patients and only one sister attending those with mental disorders. For me it is very unfair for only one clinic, only one sister to cater for the whole community. Very little is done to promote psychiatry at our clinics. We don't have campaigns or workshops regarding depression. Psychiatry is one discipline that is being ignored. (participant 40)

Van Hook and Ford (1998) similarly cited that the differences between general health and mental health disciplines were major problems in the early identification of depression. The equitable distribution of resources proves to be challenging for both the health service provider and the client. The WHO (2001) also states that, although countries may provide mental health care to both urban and remote rural communities, the balance of specialised human and other resources is still located in the urban centres.

Really, it does not exist here because I was trying to recruit the a mental health coordinator, community mental health, to say can we do this training but because of the distances they must travel going to the clinics and all, it was not easy really to uh to help us. (participant 3)

A resource that is in great shortage is time. Nurses may fail to recognise symptoms and to follow best practice recommendations, because they may not have the time to provide evidence-based treatment in primary care settings (WHO, 2001).

The others they just do what they call 'slap-dash.' You know, they just 'top- and-tail.' (participant 2)

History taking, they are unable to go deeper. Issues adding to depth, such as paralanguage are often missed. (participant 1)

Community. Van Hook and Ford (1998) found that community stigma attached to mental health problems and services was a significant challenge to the delivery of mental health services in rural communities. The negativity and misunderstanding that often surround mental illnesses can create fear and cause shame, which in turn causes unnecessary pain and confusion. Obstacles in the provision of mental health services at district level include a culture of not treating clients with psychi-

atric disorders, resulting in the stigmatisation of this population (Van Heerden et al., 2008).

. . . because it is still not as wide . . . and you are not treated as if you have a headache (participant 1)

This could ultimately lead to unwillingness of the person with depression to seek mental health care (Hickie, Davenport, Luscombe, Rong, Hickie & Bell, 2007; WHO, 2001).

Van Heerden et al., (2008) state that community centers are generally poorly equipped, under staffed and unwilling to take on their mental health responsibilities. Cepoiu, McCusker, Cole, Sewitch, Belzile and Ciampi (2007) found that the accuracy of depression recognition by non-psychiatrist practitioners was low and that this could influence the outcome of depression as unrecognised clients were not offered treatment for depression.

In some instances the nurse experiences personal awkwardness with another's emotive expression and refrain from exploring further.

And that must ring a bell, but there are those that say: 'if a person starts to be emotional, you don't have to ask him a further question because you'll disturb them further.' And that's where the problem is, you are unable to go deeper with that. (participant 2)

Nurses also have specific job-related circumstances that can contribute to their own symptoms of depression namely, work-related stress, short staffing, conflict at work, job-dissatisfaction and working with acutely ill patients.

We [nurses] don't feel safe, and in the end we become a victim of depression as well. When you are afraid of coming to work and you think of what you have to face. Pressurised by the by the management, pressurised by the patients as well. We are the victim. (participant 1).

Hall, Ford-Ngomane and Barron (2005) argue that in this general perception of a poor working infrastructure, lack of supervision and trust, feelings of being uncared for by management result in widespread demotivation with subsequent poor service delivery. McAdam and Wright (2005) comment that the competing demands made on nurses, may lead to high levels of stress and burnout. Skripac (2009) refers to nursing discussion forums that suggest that depression amongst nurses are a major problem. She states that job burnout often mimics symptoms of depression.

Participants also felt unsupported by management in that:

"even if you introduce to this [topic of depression] to the management they might say right now we don't have enough people that are trained in that. Mm. We've got only have a handful of people. (participant 1)

I wish nurses would work smarter and forget about pushing queues (fast tracking) in the clinics. This will ensure quality time and digging deeper into what is troubling them. This goes to the manager as well to stop pushing nurses so that the stats are high but quality nursing care and early identification of mental problems are ignored. (participant 11)

Burke (2003) stresses the importance of viewing depression within its social context, as it is a disease which impacts not only the individual but also the wider community and the family.

Families. According to the WHO, it is indeed a rare occurrence to find a family that will be free from any encounter with mental disorders (WHO, 2001). This being said, many family members may lack awareness of an existing mental condition, or they do not know when or where to seek help.

Some people, maybe they don't have family. Or the family do not have the information, or might not have somebody who is learned who is able to say: 'if there is a sudden change in behaviour, go and consult, so that you could check what is happening.' Or they are not able to identify that this person's behaviour is changing. (participant 2)

Families are not only needed to assist in the early identification of behaviour that may indicate depression but are critical in providing understanding, support and care. According to Taylor (2006), a supportive and caring family environment can actually turn off the gene linked to depression thus reducing the risk of depression amongst those with the short form of the 5-HTTLPR gene.

Client. A number of aspects regarding the client and the early identification of depression came to the fore. These included the client's belief paradigm and traditional practices, labelling of depressive symptoms and clients presenting with physical problems.

They would say ...my great Gran is visiting me in my dreams, what does it mean. And that person delays, not coming forward...so it won't be detected early and will only be detected when the disease is advanced. Or the problem becomes serious. So culture also has an impact on early identification of depression. (participant 1)

Hickie et al., (2007) confirmed that when asked about seeking help from non-professional sources, participants indicated that they were likely to seek help from religious persons, herbalists or traditional healers. The WHO (2001) validates that beliefs in witchcraft, ancestral power, supernatural forces, fate, ill will of the gods and so forth can interfere with seeking help and adherence to treatment. Not only is there a difference as to "where" treatment is sought and with "whom" but also in "how" it is voiced.

Dunn (1983, p. 67) remarks that "language provides an apparent order; inasmuch as it facilitates shared perceptions, meanings and interpretations . . ." Different communities label depressive symptoms as "stress" or a "low spirit." A nurse explains:

The thing that you must do . . . you must acquaint yourself with the terms we use in that very area you work in. (participant 10)

Another nurse adds:

. . . the common name is stress. But in some languages like in Tswana we usually say 'Eish...moya waka o ko tlase'...my spirit is down or low. It shows depression. (participant 1)

Castillo (1997) argues cogently that sadness and depressed emotions can have different meanings and can be based in different sociocultural contexts. In some societies, a depressive syndrome is not recognised as an illness at all, and the people have no concept for it in their set of natural representations. Somatic symptoms may be more meaningful and therefore primarily experienced by individuals. Without a concept or language to express or label depressive symptoms, clients often communicate through presenting in primary care with physical symptoms.

Clients normally present with physical ailments, e.g., headache. (participant 21)

It becomes difficult to quickly realize that the psychosomatic illness that the client presents with could be related to depression. (participant 4)

They are not identified early as the concentration is on the physical complaint . . . (participant 46)

Depression is often only investigated if a client returns frequently with unresolved physical complaints.

. . . they visit time and time again . . . (participant 48)

Watts, Bhuntani, Stout, Ducker, Cleator, Garry and Day (2002) found that the majority of participants in their study indicated that they attended a health care facility for physical symptoms only. According to the WHO (2001), mental health problems are often raised jointly with physical concerns. Psychological morbidity is also a common feature of physical disease.

Even in developed countries, only a minority of people suffering from depression seek or receive treatment. Part of the explanation lies in the symptom itself. Feelings of worthlessness, excessive guilt and lack of motivation deter individuals from seeking help.

Category 2: Positive Interactional Flow Facilitating the Early Identification of Depression

In some contexts the nurses' experience is sanguine and there is evidence of a positive interactional flow between the community, family, nurse and client which facilitates the early identification and treatment of depression. The following vignette highlights the process and importance of interactional flow:

. . . the rural people have better insight about mental health, more than in the urban area because maybe the life there is fast and in the rural settings we will have a time to really observe abnormal behaviour . . . They are also participating. Yes. They are not coming to the clinic to fetch medication and then they go. No. They also listen. That is why around here most of the clinics were build by the communities. The communities acknowledge that now they must buy an ambulance. So they make their donations to the chief and an ambulance is bought. So, community participation and involvement play a very important part in response. (participant 3)

Mihály Csíkszentmihályi (2002) puts it that a person is part of a family to the extent he/she invests energy in the goals shared by other people. In the same way, one can belong to a larger interpersonal system by subscribing to the aspirations of a nation or community. It is in this investment of energy and engagement in shared goals, that we create interactional flow on national, community, family and individual level. The shared goal is optimal mental health for all.

Implications for practice. A referral system might serve clients better, as a participant stated:

Collaboration between the mental health hospitals and clinics. (participant 41)

Community participation and education could make a difference:

More campaigns to be carried out, whereby communities are being taught regarding the early detection for depression, since we have high unemployment rate and the HIV & AIDs pandemic. (participant 8)

Health education should be continuous to individuals, families and the community. (participant 13)

Nurse service providers could be more empathic:

Health care workers to have more time to listen and identify problems. (participant 1)

All nurses should be trained:

I think all nurses should go through this course [Training Course for Primary Health Care Nurses on Mental Health and Substance Abuse]. It shouldn't be only those that are doing primary health care. (participant 36)

Groenewald and Thulukanam (2005) argued that certain competencies of professional training programmes are best acquired through real-life workplace experiences. Coaching is gaining ground as a legitimate workbased activity to expand professional development and to assist nurses to cope with, and steer, the increasingly complex and changing health services (Byrne, 2007; Driscoll & Cooper, 2005; Locke, 2008). For example, developmental coaching focuses on performance enhancement and is a learning tool that places accountability at individual level. This approach promotes sustained application of the knowledge, skills and attitudes required in primary care practice. The process may include the development of affirmative beliefs and values through behaviours, moving beyond self-limiting personal and professional beliefs that hinder performance through intrapersonal awareness (Driscoll & Cooper, 2005), improving and sustaining interpersonal skills by actively listening, authentically sharing and effectual communication (Locke, 2008) and fruitful self-reflection through second-order observations (Styhre, 2007).

Developmental coaching may provide the space to articulate concerns, perceived challenges, and individual shortcomings leading to opportunities for new practices. Greater self-awareness may advance intrapersonal flow; improved skills may advance interpersonal flow. Coaching tools such as the GROW model (goals, reality, options, wrap-up) could be transferred to daily professional practice and in turn be taught to clients in the early identification of, and coping with depression, with the nurse serving as a coach. Coaching clients to manage depression may complement more traditional therapies. Coaching is nonstigmatising (Hayes & Kalmakis, 2007) and in the limited time available can make a huge difference as a cost-effective strategy to promote the mental health of nurses and clients alike. When interactional flow is experienced on an individual level, it can be transferred to the family and community.

Limitations of the Study

The limitations of this research were the recruitment of participants from a limited geographical area. The small sample size limits the generalisability of the findings although the findings could successfully be generalised to theory. Further research is recommended on the implementation and valuation of developmental coaching along with mental health training programmes for nurses.

Conclusion

This research provides an in-depth understanding of nurses' experience of the early identification of depression in primary care settings in South Africa. Interactional flow between national health care, the community, family and the client may hamper or facilitate the early identification of depression. What

works are people and the flow they bring to the entire process of the early identification of depression. Developmental coaching could assist nurses to engage fruitfully in the early identification of depression.

References

- American Association of Neurological Surgeons. (2009). Cortical brain stimulation offers hope to people with treatment-resistant major depression. Retrieved May 17, 2009 from www.newswise.com/p/articles/views/
- American Psychiatric Association. (1994). *Diagnostic and Statistical Manual of Mental Disorders*. (4th ed). Washington, DC: American Psychiatric Association.
- Barclay, L. (2010). Managing child and adolescent depression: An expert interview with Bernadette Melnyk. Retrieved May 10, 2010 from <http://www.medscape.com/viewarticle/720910>
- Bradshaw, D., Norman, R., & Schneider, M. (2007). A clarion call for action based on refined DALY estimates for South Africa. *South African Medical Journal*, 97(6), 438–440.
- Burke, L. (2003). The impact of maternal depression on familial relationships. *International Review of Psychiatry*, 15, 243–255.
- Byrne, G. (2007). Guest Editorial: Unlocking potential- coaching as a means to enhance leadership and role performance in nursing. *Journal of Clinical Nursing*, 10, 1987–1988.
- Castillo, R. J. (1997). *Culture and mental illness, a client-centered approach*. Pacific Grove, CA: Brooks/Cole.
- Cepoiu, M., McCusker, J., Cole, M. G., Sewitch, M., Belzile, E., & Ciampi, A. (2007). Recognition of depression by non-psychiatric physicians-a systematic literature review and meta-analysis. *Journal of Internal Medicine*, 23(1), 25–36.
- Csikszentmihályi, M. (2002). *Flow*. London, England: Rider.
- Consortium for Organizational Healthcare. (2009). Retrieved 11 November 2009 from www.comh.ca
- Creswell, J. W. (2003). *Research design: Qualitative, quantitative, and mixed methods approaches*. Thousand Oaks, CA: Sage.
- De Vos, A. S., Strydom, H., Fouché, C. B., & Delport, C. S. L. (2005). *Research at grass roots*. (3rd ed.). Pretoria, South Africa: Van Schaik.
- Driscoll, J., & Cooper, R. (2005). Coaching for clinicians. *Nursing Management*, 12(1), 18–23.
- Dunn, C. (1983). The implications of general semantics for the diagnosis of "mental illness". *Et Cetera: A Review of General Semantics*, 40(1), 67–74.
- Emler, C. A. (2007). Experiences of stigma in older adults living with HIV/AIDS: A mixed methods analysis. *AIDS Patient Care and STDs*, 21(10), 740–752.
- European Commission: Health and Consumer Protection Directorate-General. (2004). Retrieved 19 January 2010 from http://europa.eu.int/comm/health/ph_information/information_en.htm
- Farone, D. W., & Pickens, J. (2007). The Mental Health System and sense of self amongst adults with serious mental illness. *Journal of Human Behaviour in the Social Environment*, 15(4), 35–54.
- Fawcett, C. S. (1993). *Family Psychiatric Nursing*. St. Louis, MO: Mosby.
- Giorgi, A. (Ed.) (1985). *Phenomenology and Psychological Research*. Pittsburgh, PA: Duquesne University Press.

- Groenewald, T., & Thulukanam, M. (2005). Work-integrated learning at a comprehensive higher education institution. *Progression, 27*(1&2), 84–91.
- Guba, E. G., & Lincoln, Y. S. (2005). Paradigmatic controversies, contradictions, and emerging confluences. In N. K. Denzin & Y. S. Lincoln (Ed.), *Qualitative research* (pp. 191–215). Thousand Oaks, CA: Sage.
- Hall, W., Ford-Ngomane, T., & Barron, P. (2005). Health Act and the district health system. *South African Health Review, 2005*, 44–57.
- Haddad, M., & Walter, P., & Tylee, A. (2007). Late life depression. *Primary Health Care, 17*(1), 34.
- Hayes, E., & Kalmakis, K. A. (2007). From the sidelines: Coaching as a nurse practitioner strategy for improving health outcomes. *Journal of the American Academy of Nurse Practitioners, 19*, 555–562.
- Hickie, I. B., Davenport, T. A., Luscombe, G. M., Rong, Y., Hickie, M. L., & Bell, M. I. (2007). The assessment of depression awareness and help-seeking behaviour: Experiences with International Depression Literacy Survey. *BioMedCentral Psychiatry, 7*(48), 1–12.
- Locke, A. (2008). Developmental coaching: Bridge to organizational success. *Creative Nursing, 14*(3), 102–110.
- Maritz, J. E., Poggenpoel, M., & Myburgh, C. P. H. (2008). A parent's experience of the couple relationship after child bereavement in South Africa. *Journal of Psychology in Africa, 18*(4), 603–612.
- McAdam, L., & Wright, N. (2005). A review of the literature considering the role of mental health nurses in assertive outreach. *Journal of Psychiatric and Mental Health Nursing, 12*, 648–660.
- Mivšek, A. P., Hundley, V., & Kiger, A. (2008). Slovenian midwives' and nurses' views on post-natal depression: An exploratory study. *International Nursing Review, 55*(3), 320–326.
- Morse, C., Durkin, S., Buist, A., & Milgrom, J. (2004). Improving the postnatal outcomes of new mothers. *Issues and Innovations in Nursing Practice, 45*(5), 465–474.
- Norman, R., Bradshaw, D., Schneider, M., Pieterse, D., & Groenewald, P. (2006). *Revised DALY estimates for the comparative risk factor assessment, South Africa 2000*. Cape Town, South Africa: Medical Research Council.
- Kripac, T. (2009). Is it depression? How to know and when to get help. *Oncology Nursing Society Connect, 24*(1), 20.
- South Africa (Republic) (2003). *National Health Act (Act No. 61 of 2003)*. Pretoria, South Africa: Government printer.
- Styhre, A. (2007). Coaching as second-order observation, learning from site managers in the construction industry. *Leadership & Organizational Development Journal, 29*(3), 275–290.
- Strasser, S., London, L., & Kortenbout, E. (2005). Developing a competence framework and evaluation tool for primary care nursing in South Africa. *Education for Health, 18*(2), 133–144.
- Taylor, C. (2006). Bipolar disorder: The nurse's role. *Mental Health Practice, 10*(2), 10–13.
- Van Heerden, M. S., Hering, S., Dean, S., & Stein, C. (2008). Providing psychiatric services in general medical settings in South Africa: Mental health-friendly services in mental health-friendly hospitals. *South African Journal of Psychiatry, 14*(1), 4–6.
- Van Hook, M., & Ford, M., (1998). The linkage model for delivering mental health services in rural communities: Benefits and challenges. *Health & Social Work, 23*(1), 53–60.
- Watts, S. C., Bhuntani, G. E., Stout, I. H., Ducker, G.M., Cleator, P.J., McGarry, J., & Day, M. (2002). Mental Health in older adult recipients of primary care services: is depression the key issue? Identification, treatment and the general practitioner. *International Journal of Geriatric Psychiatry, 17*, 427–437.
- Wood, S. (2008). The contribution of nursing to public health practice in the prevention of nursing. *Nursing and Health Sciences, 10*, 241–247.
- World Health Organization. (2001). *The world health report, 2001. Mental health: New understanding, new hope*. Geneva, Switzerland: World Health Organisation.

Author's Notes

Jeanette Maritz was a part-time lecturer in the Psychiatric Nursing Science Department at the University of Johannesburg at the time of the study.

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