Community mental health care in Thailand:
Care management in two primary care units

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This thesis is presented for the degree of Doctor of Philosophy of
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Statement of Originality

I declare that this thesis is my own account of my research and contains as its main content work which has not previously been submitted for a degree at any tertiary education institution.

Yaowaluck Meebunmak
Abstract

Thailand faces increasing mental health problems, however mental health services are limited. In particular, mental health services provided in communities across the country are not clearly structured. Research in regard to community mental health care is rare.

The purpose of this study was to explore mental health care management in two primary care units (PCUs) in Thailand in order to understand the ways they operate within Thai communities. The specific objectives were to identify mental health care practices and roles of health providers, models of care and influences on mental health care practices in the two PCUs as case studies. An ethnographic approach using participant observation, semi-structured interview, quantitative questionnaire and document analysis was used in gathering data. The participants were seven nurses and three public health workers practising in the PCUs.

Findings enhanced understanding in the context of two PCUs located in communities of the Northern and Central Thailand. Both were local health centres providing a wide range of health services based on the principles of primary health care (PHC).

The PCUs were operated without mental health specialists, however nurses were the main resource in providing mental health care in terms of primary and secondary prevention. Primary prevention was provided through counselling sessions, drug prevention activities and seniors clubs. In addition, the health providers conducted activities of mental health promotion towards particular risk groups after assessing risks. They also gave support to mental health and normal cases that had possible mental health problems. Secondary prevention was provided in home visits, primarily in giving injections. The health
providers played four main roles as educator, consultant, agent and manager in primary and secondary prevention.

There was no single model of mental health care practice provided in the PCUs. Information derived from the present study showed a variety of models underpinning care practices. The nursing process was clearly adopted, as well as integrated care, community participation, collaboration and consultation, and using standard guidelines.

Personal knowledge and interest in mental health were mentioned as an important factor in practising mental health care. Environmental factors such as adhering to policy, being family-oriented, being mindful of economic factors, using Buddhist Principles to guide interactions, guarding against occupational risks, maintaining a teamwork approach and the lack of specialists appeared to be factors influencing mental health care.

This study contributes to the body of knowledge of community mental health care management in Thailand. The findings suggest implications for practices, education, and policy making to improve quality of care.
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Abbreviations

CMHC  Community mental health care
CMHN  Community mental health nurse
CPN   Community psychiatric nurse
DMH   Department of Mental Health
EBP   Evidence-based practice
LAO   Local administration organization
MOPH  Ministry of Public Health
PCU   Primary care unit
PHC   Primary health care
VHV   Village health volunteers
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**Chapter 1**

**Introduction and Overview**

**Introduction**

Historically, Mental Health has been a significant issue related to human living worldwide. Mental health issues have created ongoing difficulties throughout the world, especially in less developed nations. Between 2001 and 2007, the incidence of mental illness increased from approximately 25 percent to 30 percent of the world population (Harlem 2001; Laurance 2007). The implication is that mental health care warrants substantial attention and resources. Thailand, like many other developing countries, faces increasing mental health problems, however, the provision of mental health services are limited. Across a range of mental health problems, there is a need for in-depth examination of the organization of services and care management strategies. Nevertheless, there are barriers to the improvement of mental health care in many countries, and mental health is considered to be a low priority in many health care agendas.

In Thai communities there is a lack of clarity in understanding care management for mental health. There is also a lack of research in regard to Mental Health that would inform mental health management. The focus of this study is therefore to explore mental health care management in community-based primary care units in Thailand in order to understand how it operates within Thai communities. This chapter discusses the background, significance, purpose and clarification of terms used in the study. It concludes with a description of the structure of the dissertation.
Background of the Study

Mental health issues are always a concern for human beings, as mental health is an essential part of life. Any disturbance in mental health affects individuals and society. The World Health Organization (WHO) (World Health Organization 2007) defines health as follows:

Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity….It (mental health) is defined as a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community.

Today, the number of people with mental illness has steadily increased. Yet, many countries place mental health agendas at a low priority in budgeting. In an analysis of mental health budgeting reported by the WHO, one fifth of approximately 100 countries’ spending on mental health was found to be only about one percent of the total health budget (World Health Organization 2007). Yet, the WHO (2007b) has estimated that 13 percent of the care burden is caused by mental health disorders. Of particular note, Thailand spends 2.93% of its health budget on mental health care (Planning Division 2009; The Bureau of the Budget Office of the Prime Minister 2009). Like many other countries, this level of funding for mental health care is inadequate. In Thailand mental health services are provided through institution-based services, such as psychiatric hospitals and general hospitals, with clear structures. In addition, Thai Mental Health care is provided in community-based services integrated with primary care in primary health care units. The community-based services are less clear in their practice structure, therefore this study was designed to examine mental health care provided in community settings. The following section describes Community Mental
health Care (CMHC), a profile of Thailand, and the typical breadth of nurses’ skills and Primary Health Care (PHC) principles as the background to the study.

Community Mental Health Care

Community mental health Care (CMHC) means that public health and community nurses work with chronically mentally ill clients in many community settings (Schultz and Videbeck 2009). Prior to the 1960s when community-based care was not provided as a main service, patients with mental illness received long-term care in institutions. Due to increasing incidence rates in mental health problems, more patients were admitted to hospitals with mental health disorders and psychiatric problems, causing a problem due to the limited number of beds within the hospitals. In 1955, the United States (US) government established a commission to create a plan for meeting the needs of the increasing population in mental health care (Fontaine 2003). In 1963, the US Congress initiated the Community Mental Health Act shifted funding and treatment into community services (Videbeck 2004). As part of this movement, in the 1960s, deinstitutionalization was a significant change in mental health care. The long-stay wards of psychiatric hospital were reduced as the principles of normalization, contextualization and self advocacy were introduced. The concept of normalization viewed people with mental illness as individuals that should have normal lives. The physical and social environments of the individuals were examined as part of contextualization, and housing and community education provided with the focus on maintaining clients in their environment. Self-advocacy suggested that patients should advocate for their own treatment goals and determine their own care. Following this, the locus of Mental Health care shifted into community-based actions (Fontaine 2003; Oliver, Piachaud et al. 2005; Högberg, Magnusson et al. 2006; Sands 2007). As a result, communities assumed important roles in Mental Health care.
Practices responding to the deinstitutionalization policy involved discharging existing hospital patients to the community and decreasing new admissions (Dixon and Goldman 2003; Talbott 2004). In addition, there was transinstitutionalization, which included moving the patients into community centres or local hospitals, resulting in an increase of community-based out-patient services (Sealy and Whitehead 2004). Canada, for example, was a country that adopted transinstitutionalization between the 1970s and 1980s. The outcomes included a rapid closure of beds in psychiatric hospitals, an increasing rate of days of care in the psychiatric units in the general hospitals, and a decrease of total days of care in the psychiatric hospitals and the psychiatric units in the general hospitals (Sealy and Whitehead 2004). Today, the deinstitutionalization movement has been in existence for four decades. During this period, due to population aging worldwide, there are more people being cared for in the community, especially with an increase in chronic conditions, including mental health issues (Hutton 2008).

**Community Mental Health Services**

CMHC focuses on helping the patients to learn basic coping skills necessary to live in their environment. These have been categorized by Fontaine (2003) as in-hospital, out-patient and housing services. Fontaine (2003) describes a model consisting of three types of care. First, in-hospital care is provided within the hospital environment. For instance, in-patients receive community treatment, such as skills training to improve life skills and acute care units provide suitable care for those associated with suicide and homicide. Day hospitalization is for patients participating in hospital care programs for six to eight hours a day and who spend time at home, school or their workplace at other times (Fontaine 2003). Second, out-patient services refer to care provided in terms of day care, medication clinics, and ‘clubhouses’. Day treatment programs provide supportive care to prevent relapse, and to improve social and vocational functioning.
Medication clinics provide medication administration, monitoring of side effects, and education in medication issues. Psychological clubhouses also conduct activities related to recreation, vocational and residential functions (Fontaine 2003). Third, residential facilities refer to transitional half way houses, long term group residences, cooperative apartments, supported housing, intensive care, crisis community residences, foster, family care, nursing home, respite care and mobile emergency treatment (Fontaine 2003). The community-based nursing practices are generally provided in terms of screening programmes to detect mental health conditions and, in the patients’ home, direct observation and family interactions (Fontaine 2003). This study addressed CMHC provided by the community nurses that helped patients with mental illness who living in their homes.

Characteristics and Needs of Patients with Mental Illness in the Community

Fontaine’s (2003) analysis of mental health interventions describes clients with chronic mental illness as experiencing ‘positive’ and ‘negative’ symptoms of illness. ‘Positive’ symptoms are thoughts, behaviours, or sensory perceptions present in a person with a mental disorder, but not present in people in the normal population. These refer to delusion, hallucination and withdrawal. ‘Negative’ symptoms are thoughts, feelings, or behaviours normally present that are absent or diminished in a person with a mental disorder, such as social withdrawal, inability to experience pleasure, lack of energy, and apathy (Fontaine 2003). To live in communities, the patients need skills within five categories (Schultz and Videbeck 2009). The first category is activities of daily living including personal hygiene, grooming, room care, cooking, shopping, budgeting, or public transportation (Schultz and Videbeck 2009). Second, they need vocational skills to engage in paid employment in a competitive or volunteer capacity. Third, leisure
skills mean the ability to choose, plan, and follow through with pleasurable activities such as watching television and reading the newspaper during unstructured time (Schultz and Videbeck 2009). Fourth, health maintenance is required for managing medications, keeping appointments, preventing or treating physical illnesses, and crisis management (Schultz and Videbeck 2009). Finally, people need a broad range of social skills ranging from social conversation to dealing with landlords and service providers to talk about feelings and problems. Mental health clients may have difficulties in more than one group of these activities (Schultz and Videbeck 2009).

Thailand Profiles

Thailand is a developing country situated in the Southeast Asia Continent and covers an area of about 514,000 square kilometres. It is bordered by Myanmar, the Lao People’s Democratic Republic, Malaysia and Cambodia. It comprises four regions; the North, Northeast, Centre and South of the country as shown in Figure 1.1.
The population of Thailand is 62.83 million. Almost all residents (98.1%) are of Thai nationality. The rest are of other nationalities such as Chinese, Myanmar and Lao. Thai people are Buddhists (94.5%), Muslims (4.5%), Christians (0.7%), and other religions (0.1%). In the past, the Thai economy was agrarian with farming for household consumption, and not for commercial or export purposes. Currently, the Thai economic system has shifted into the economic development era. The Thai administrative system comprises central, provincial, and local administration. The central administration works through 20 ministers. The provincial administration consists of 75 provinces throughout the country with its functions being delegated from various central administrative agencies. Lastly, the local administration refers to the autonomous administrative authority of people in each administrative jurisdiction, under the law, having the local council members elected. Local Administrative Organizations (LAOs)
work as local government of communities across the country (Ekachampaka and Taverat 2008).

**Thai Health Agencies**

There are three Thai health agencies involving mental health services and relevant to this study. First, the Ministry of Public Health (MOPH) is the principal mechanism of the Thai national health system and, as the core agency of the government. The MOPH plays the main role in the National Health Service. The administration of the MOPH is divided into two levels which are central and provincial administration. The central administration consists of ten departments, one of which is the Department of Mental Health. The provincial administration is composed of the Provincial Public Health Offices, District Health Offices, hospitals under the MOPH, and primary care units (PCUs) (Jindawattahana, Pipatrojanakomol et al. 2008).

Second, the Department of Mental Health (DMH) is an organization belonging to the MOPH. The DMH has responsibility in establishing mental health status which supports the well-being of the population. The DMH operates mental health activities under the MOPH administrating and budgeting. There are sixteen psychiatric hospitals belonging to the DMH. Nine of those are located in Bangkok, the capital city, and the others are in other provinces. Twelve general hospitals in Bangkok are available for psychiatric-ward admission. Sixty-seven psychiatric wards are open in general hospitals in other provinces (Department of Mental Health 2005; Department of Mental Health 2009).

Third, the primary care unit (PCU) is the health care centre located in each sub-district. The PCUs as a community health service provide a wide range of care including mental health services within a primary health care framework. The PCUs were not prepared to
play roles in specific mental health intervention, but they offer generalist holistic health care. The PCU is a local health care facility that approximately 10,000 residents can access within 30 minutes. One PCU employs four to five staff consisting of nurses and public health officers. The mission of the PCU is to care for the local people in all stages of life from birth until death. The main priority areas of work are disease prevention, health promotion, and basic care interventions. The care provided includes home visits, health monitoring, and additional support for health maintenance. Cases beyond the responsibility of the PCU can be referred to the hospital as a secondary or tertiary unit of care (Arphorn, Brooks et al. 2006; Netrawichien and Boon-Arj 2006).

**History of Thai Community Mental Health Care**

Mental health care in Thailand has a long history. It has undergone continual development over the past century. Once, during the asylum period (1889-1924), mental health services were provided within general health services, religious ceremonies and other administrative activities. The first mental health hospital named ‘The Asylum’ was established in 1889 to provide care for those who seemed to need custodial care, which focused on detaining and containing. In the next period, during 1925-1941, the name ‘Asylum’ was changed to be ‘Psychiatric Hospital’ in order to build up a positive perception from the public. Medical doctors and other staff were launched and trained for working in mental health areas. After that, Thai mental health care moved into the mental health period (1942-1960). At this time, the psychiatric hospital was faced with an increasing number of psychiatric patients that created a limitation of accommodation services. Then, the concept of community mental health care was addressed during 1961-1971. Community mental health care operated as a mobile psychiatric unit, day-care service, rehabilitation programme and community mental health centre. Next, between 1972 and 1981, the Thai health system emphasized integration of mental health
services into general health care provided in general hospitals. After that, health care focused on primary health care. During 1982-1991, health services carried out projects that support fundamental general health care and mental health. From 1992 until now, Thai health care has focused on promoting public participation in creating mental health (Siriwanarangsan, Liknapichitkul et al. 2004).

**The Current Mental Health Situation in Thailand**

There is a trend towards increased mental health problems in Thailand. The prevalence of mental disorders rose from 440.1 per 100,000 population in 1997 to 640.6 per 100,000 population in 2006 (Ekachampaka and Wattanamano 2008). Mental health problems are one of ten main health problems in Thailand. Suicide, homicide, violence, and depression were part of the main causes of death in 2008. Mental illnesses, such as schizophrenia, depression and dementia were amongst the top ten chronic diseases suffered by Thai people (Department of Mental Health 2009). Furthermore, mental illnesses in the communities were related to drug, amphetamines and alcohol misuse.

The Department of Mental Health (DMH) conducted three mental health surveys with Thai population in the central region 2008 (Department of Mental Health 2008). The surveys demonstrated that 46.9, 50.1, and 47.4 percent of respondents experienced stress due to financial and career problems (Department of Mental Health 2008). According to another DMH report of the number of outpatients attending mental health clinics between 1991 and 2006, the prevalence of mental disorders and suicide tended to be increasing amongst Thai people. Outpatient accessed for mental health and suicide care increased from 24.6 per 1,000 population in 1991 to 42.4 per 1,000 population in 2006 (Ekachampaka and Wattanamano 2008; Department of Mental Health 2009).
Causes of mental health problems vary depending on personal and social factors. For example, causes of stress among Thais in 2008 were associated with political issues, socioeconomic conditions and insecurity related to terrorist incidents. Thai people with mental illness are generally dependent on their own families as the majority of patients are unemployed and have no income. In addition, there is no domiciliary support or pension provided to mental health patients. The families are the main caregivers. Stigmatization of mental illness is also obvious in Thai society, meaning patients are more likely to be excluded from social activities (Ekachampaka and Wattanamano 2008).

**Innovative Community Mental Health Services**

Thai CMHC is generally performed in terms of out-patient, housing services and in-hospital services. In-hospital services are available in both psychiatric and general hospitals, with mental health services provided by a community mental health team employed within those institutions. The care provided involves telephone and face-to-face counselling, mental health education and health fairs and stress relaxation clinics. The 1323-line is an example of the telephone counselling. It was accessed by 28,148 of the 65,493,298-population across the country in 2008. Seventeen psychiatric institutions conducted 3,398 sessions of stress relaxation and provided 9,747 telephone-counselling sessions in 2007 and 2008 (Department of Mental Health 2009). The general hospitals with psychiatrists usually conduct out-patient clinics and home visiting services within the community mental health team responsibilities. Some psychiatric hospitals operate day-care as part of their community care options. Rehabilitation-villages are also managed by health workers in their community teams within the psychiatric hospitals. The rehabilitation-villages are for preparing the patients to return to the communities.
Home visiting services have not been allocated by CMHC teams to all patients, due to understaffing. The community health providers employed in the PCUs have responsibilities for visiting the patients at home as one of their roles. At this point, care management has not been evaluated in terms of its effectiveness, resources and barriers. This study represents one step in evaluating the work of the CMHC, focusing on how mental health care within the community is managed from the perspective of those who practise in the PCUs.

**Mental Health Providers**

In 2005, there were 445 psychiatrists, 1,868 psychiatric nurses, 230 psychologists, and 214 social workers in Thailand. The ratios of those mental health personnel to the population were 1: 140,265, 1: 33,414, 1: 271,383 and 1: 291,673 respectively. The mental health providers in regions outside the capital city had more mental health caseloads than those working in the capital. For example, each psychiatrist and mental health nurse employed in the North-Eastern region had the responsibility to care for 463,655 and 49,600-people respectively. In comparison, those ratios in Bangkok, the capital city, were 1: 24,287 and 1: 16,693 (Department of Mental Health 2009). The ratios clearly imply inadequate numbers of psychiatrists and mental health nurses in the communities, indicating a significant need for mental health providers in the country.

**Consideration of Nurses’ Skills**

Thai community-based nurses are not mental health specialists who provide care to patients with mental illness in the local communities. Their skills appear to be broad with a generalist focus. For the purpose of this study, the researcher investigated their care practices based on the use of their own knowledge and experiences. One way of examining the appropriateness of their skills and practice is through Benner’s (2001)
model of nursing skills acquisition. The model categorizes practices performed by nurses in terms of novice, advanced beginner, competent, proficient and expert levels. Novice or beginners who have no experience engage in care situations using objective signals and measurable parameters. Advanced beginners are able to approach the aspects of situations by using a combination of their own experience and guidelines. They can set priorities for their work. Competent nurses have the ability to consider aspects of current and contemplated future activities including abstract issues in the situation. Proficient performers view situations as wholes, not just particular aspects. They have a deep understanding of situations. They are guided by maxims, knowing what would happen from prior decision-making. Maxims can be useful to guide practices because they reflect nuances and identify the realities and uniqueness of various situations. Finally, expert performers may not rely on rules, guidelines, or maxims when managing situations but rather, use intuition from previous experiences in making decisions (Benner 2001). This draws attention to the notion that a nurse who has rich clinical experience may be an expert. When looking at experienced nurses’ judgements, their decision making is often based on intuition. These experienced nurses or experts use ethical, aesthetic and personal evidence as part of their clinical judgement processes. It is interesting to consider whether Benner’s model of clinical judgement will help in understanding the current care practices and decision-making in participants in this study.

**Primary Health Care Principles**

This study is conceptualized within a primary health care framework. This is congruent with the World Health Organization (WHO) in that they have urged all nations to adopt primary health care as a way toward better health (World Health Organization 2008). WHO (2008) has urged all countries to re-commit their health services to the principles
of primary health care. This is based on their acknowledgement that inequities persist throughout the world, and adopting primary health care approaches to health would help guide the world’s health systems toward greater accountability, particularly in health investments (World Health Organization 2008).

The term ‘primary health care’ (PHC) has been used since the 1978 International Conference on Primary Health Care held by the (WHO) and UNICEF at Alma-Ata (Rogers and Veale 2003). The Declaration of Alma Ata introduced the PHC principles as a new approach to establish health and well-being in all countries. The PHC is a philosophy that addresses understanding of health as wellbeing, rather than the absence of disease. Determinants of health are in multiple aspects and sectors, such as health services, housing, education, public works, industry, agriculture, communication and other services (Rogers and Veale 2003). PHC in the Declaration of Alma Ata focused on empowering people to make decisions in relation to health issues in their own lives, families and communities (McMurray 2007). The PHC approach views health as a human right in receiving health care and should be responded to individually and collectively by members of communities.

Thailand, like many other countries, adopted the primary health care (PHC) philosophy from the WHO declaration of Alma Ata in 1978 with the expectation of health for all by the year 2000. The WHO declaration identifies health as a fundamental human right that governments and the international communities should be concerned about, especially the issues of health care inequalities. Thailand also emphasizes PHC as a model underpinning health care to achieve positive health outcomes for the Thai populace.
PHC principles consist of five categories (Talbot and Verrinder 2005; McMurray 2007). First, people should have equal opportunities to access health care services. Health care should be provided equitably, on the basis of need rather than ability to pay or geographic location. Social and political activities should focus on health issues within communities in maintaining health and wellbeing. Second, developing and using technology should be organized appropriately and affordably. Third, health promotion or health education should be emphasized in local and global communities. Fourth, intersectoral collaboration between different services in communities is necessary to contribute towards well-being. Finally, community participation should be established in a partnership relationship between health professionals and communities when making decisions on health care (Green 2004; Talbot and Verrinder 2005; McMurray 2007).

Health Promotion is an important role undertaken by mental health professionals as well as others working with communities. Promoting the health of a community takes place within three domains: primary, secondary, and tertiary prevention (Egger, Spark et al. 2005; Talbot and Verrinder 2005; McMurray 2007). Primary prevention emphasizes the protection of health and prevention of sickness. It refers to actions to protect people from illness and injuries, and to promote and maintain health. Secondary prevention refers to curative care to help persons recover from sickness and prevent deterioration or disability after illness or injury. Tertiary prevention refers to care to help persons become rehabilitated after being sick. It also means assisting patients to cope with their illness and disabilities (Egger, Spark et al. 2005; Talbot and Verrinder 2005; McMurray 2007).
Significance of the Study

Mental health care in Thailand and other countries has changed considerably over the last few decades. The most significant change is the shift from hospital-based care to community-based care. As a developing country, Thailand has limitations towards its progress of improving dramatically in mental health care systems. However, mental health issues are a significant theme and a concern of the Thai government.

A number of studies have indicated that community-based care in mental health is vital (Crawford, Carr et al. 2001; Bower, Jerrim et al. 2004; Cunningham and Slevin 2005). Challenges exist to encourage clients to continue adherence with treatment and maintain living independently in communities, which are both a challenge. There are several models of mental health care in communities throughout the world. However, in Thailand, management and implementation are not based on research evidence. The continuity of care between hospital-based and community-based care providers has not been determined. The effectiveness of mental health services that are provided by local health professionals is also unclear. This fragmented understanding cannot lead to an explanation of what specific practice occurs in localities. In Thai communities, PCUs seem to be one of the most important resources in terms of health. The PCUs provide health care in each locality so that residents can access PCUs for a caring and comfortable atmosphere. However, little is known about mental health care provided by PCUs. Studies examining the implications of mental health care in the PCUs are extremely limited. Knowledge that will be derived from the study can be used to assist care management and understand the practice roles of the community health providers. It can assist in the policy making and decision of mental health provision in the future.
Purpose of the Study

The purpose of this study was to identify good management practice in mental health care in Thai communities. In particular, this study sought to identify knowledge of care management in mental health care operated in the PCUs. The study was also intended to examine models of care used to support good practices in community mental health care. It was also expected to increase the understanding of the resources that support good practice across regions. To this end the following research questions were posed.

1. What are mental health care practices provided and the roles of health care providers in two PCUs in Thailand?
2. Which models of care are most appropriate for mental health problems specific to Thailand?
3. What factors influence mental health care practices in the PCUs?

Clarification of Terms

As the aim of this study was to explore community mental health care provided in Thailand, it was necessary to clarify terms used in the thesis. This section describes meanings of the terms regarding from the Thai perspective. The terms clarified in this thesis may not be consistent with international usage. Instead, they are described to expand understanding in this study. The terms are specified as follows:

Community Mental Health Care (CMHC)

Community mental health care (CMHC) is community-based care designed to decrease the need for more costly inpatient hospital-based care. CMHC generally can be provided as in-hospital, out-patient and housing services (Fontaine 2003). This study looks at the CMHC provided in local health centres, namely PCUs of Thailand. Therefore the CMHC refers care provided by the nurses and other health providers
within the PCUs and patients’ homes to achieve mental health. The CMHC is provided through a variety of their care practices, such as educating, counselling, monitoring mental illness and giving injections.

**Primary Health Care (PHC)**

*Primary health care (PHC)* is a philosophy of holistic understanding of health as wellbeing, rather than the absence of disease. Health depends on multiple determinants: health services, housing, education, public works, industry, agriculture, communication and other services. The locus of care within the PHC framework pertains to health services adjusted by local needs and community involvement, affordable technology; health promotion and preventive care, equity and accessibility of care, and intersectoral collaboration (Egger, Spark et al. 2005; Talbot and Verrinder 2005; McMurray 2007).

**Primary Care Unit (PCU)**

*Primary care unit (PCU)* is a public health service unit that works with communities, families, and individuals to achieve health and well being. The Thai health system emphasizes that the people should utilize a PCU as the first level of care. A PCU has been set up in each and every locality to provide care for 10,000 residents and be accessed within 30 minutes by the consumers. The responsibilities of the PCU include overseeing public health on a continual basis, emphasizing individual, family care and comprehensive care encompassing curative, promotive, preventive and rehabilitative services through maternal and child care, health education, home visits, and health counselling. Cases beyond the responsibility of the PCU can be referred to a secondary or tertiary unit of care.
Care Management

For the purpose of this study, *care management* refers to the care practices responding to people in each age group and patients with mental illness to contribute to their mental health. This study investigated the care management in terms of providing care to those clients, liaising with others health professional or agencies and administration of mental health care; activities which are performed formally and informally by the nurses and public health workers employed within the primary care units.

Community Mental Health Nurse / Community Psychiatric Nurse

The terms *community mental health nurse* (CMHN) and *community psychiatric nurse* (CPN) refer to nurses practising in mental health care in communities (Fontaine 2003; Nolan 2003). The CMHN or CPN is a nurse with specialist training working in communities. However, some CMHNs/CPNs are attached to institutions, such as community mental health centres or other psychiatric institutions. The roles of CMHN/CPN include a wide range of mental health care, such as counselling, anxiety management, and administering anti-psychotic drugs. Some CMHNs may specialize in many different clinical practice areas, such as child care, the elderly, or drug and alcohol problems. Thai CMHNs work only in-wards and CMH teams belonging to hospitals. There is no CMHN employed within the PCU.

Community Nurse

In Thailand, *community nurse* refers to a nurse who works in a community location. The community nurse has roles in providing continuing follow-up session to patients in their homes. The community nurse plays important roles in health promotion and illness prevention. Providing therapeutic care is another crucial role of the community nurse. This is due to the lack of general practitioners in health services located in local
communities. The community nurse is usually involved in health care for an individual, family, and community. The care provided may focus on high risk groups, patients with chronic diseases, people with disabilities, maternal and child, and others in all ages. In recent years, the Ministry of Public Health has attempted to improve health care provided in PCUs. Therefore, a number of community nurses completed the therapeutic nursing course, and then have been qualified as ‘nurse practitioners’ who are competent in performing diagnosis and treatment.

**Public Health Worker**

In Thailand, a public health worker refers to a health provider employed within the PCU. The public health worker has wide roles in health care provided to people in the community. The public health worker engages in health issues related to the environment, local diseases, infectious diseases and epidemics. Thai public health workers might be qualified in graduate or under-graduate education. The public health worker is known as the health provider who works only for the PCU. The hospitals do not employ the public health worker.

**Local Administration Organization (LAO)**

*Local Administration Organization (LAO)* is an organization that operates as a local government agency in each sub-district area across the country. The LAO works under the Ministry of the Interior. The local governor and district council are elected. They govern the community with the funding from the Ministry of the Interior (Ekachampaka and Taverat 2008).
Village Health Volunteer (VHV)

In 2008, there were 791,383 village health volunteers (VHVs) nationwide and they have become part of the health workforce, representing the civic sector and playing a significant role in Thai health system (Chuengsatiansup and Suksit 2008). The VHVs assist in screening for hypertension, diabetes and breast cancer, body mass index (BMI) assessment, child development monitoring and vaccination, communicating with pregnant women and older people, promoting exercise, advice on food hygiene and house-to-house survey on dengue hemorrhagic fever, leprosy and avian influenza. They help in liaising between health providers and villagers by using person-to-person talking and village radio broadcasting.

Healthy Thailand Policy

The Healthy Thailand policy is a main policy driving and determining health care services to the communities. In recent years, the Government has introduced a policy of ‘Healthy Thailand’, aimed at mobilizing the forces of the nation to build a healthy country (Jindawattahana, Pipatrojanakomol et al. 2008). In 2004, the government declared the Healthy Thailand policy and strategies for health promotion as a national agenda. The Healthy Thailand policy is based on the World Health Organization’s guidelines for raising public awareness of health. The Healthy Thailand policy calls for the integration of work in all sectors of Thai society to build learning processes at village, sub-district, district, and provincial levels. Women, older persons, people with disabilities, the underprivileged, young people, and religious leaders were urged to play a greater role (The Government Public Relation Department 2004; Jindawattahana, Pipatrojanakomol et al. 2008).
Buddhist Philosophy

*Buddhist philosophy* is derived from the teachings of Buddha. For the purpose of this study, Buddhist philosophy is mentioned in ways that lay-persons allow it to lead their cognition and practice. The main Buddhist principles are the doctrine of Karma (actions resulting in the goodness or badness of life and happiness or suffering in mind); middle way (eight rules of correct ways to develop oneself along with morality, meditation, and insight; not being in an extreme position); four noble truths (identifying obstructions and efficient problem-solving); no attachment (every thing is changeable, people should understand and accept and be independent); and five aggregates (components of life are body and qualifications, feeling, perception, mental and consciousness). Buddhist Thais adopt these principles to understand and deal with their problems (Kotrasupoti 2003; Mace, Sussex et al. 2008).

Thesis Structure

The thesis comprises six chapters. Chapter 1 introduced the study and provided an overview of the background to the study. The chapter also provided information of community mental health care. This was followed by descriptions of Thailand’s profiles including the mental health organization and health providers. This chapter explained that the study will be conceptualised within the principles of primary health care. The significance and purpose of the study were then explained. Following this, the clarification of terms used in this study was presented.

Chapter 2 provides an extensive literature review of community mental health care management in Thailand and other countries. It identifies some inadequate mental health care operations and the lack of research in identifying community mental health care in Thailand. The chapter concludes with a conceptual framework of the study.
Chapter 3 outlines the methods used in this study. It provides a rationale for the methodological approach to the study. The worldviews/paradigms of inquiry are explained, followed by the research questions. The reasons for employing a case study approach utilizing mixed methods of data generation and analysis are provided. Methods of data collection are described. This chapter then presents techniques used to enhance rigour, which is trustworthiness or confirmability of the study. Finally, ethical considerations are outlined in the chapter.

Chapter 4 presents the analysis of context of case studies to provide understanding about the nature of each community in the study and provide insight into the boundaries and substance of each, with comparative information. This chapter also presents the results from the quantitative inquiry using questionnaires. The findings derived from the quantitative method are presented through two domain sections of the case context and care management. Descriptive statistics such as the mean, standard deviations and percentages used are presented. Descriptive statistics such as the mean, standard deviations and percentages used are presented as well as non-parametric comparative statistics comprising Mann-Wittney U and Kolmogorov Smirnov tests to compare data from each community.

Chapter 5 presents qualitative findings related to community mental health care management in the two PCUs. The results derived from interview, observation, and document analysis are provided. Firstly, mental health care practices provided in the PCUs are described followed by mental health roles of the health providers. The chapter presents models of mental health care perceived by the health providers. Finally, factors influencing the care practices are presented.
Chapter 6 discusses the research findings in relation to the literature. The discussion is presented and addressed in terms of the three research questions focused on mental health care practices, models of care, and factors influencing on care management. This chapter presents limitations, implications and recommendations for practice, education, social and health policy, and future research.
Chapter 2

Literature Review

Introduction

This chapter provides a review of literature in community mental health care (CMHC). The purpose of this literature review is to determine what is known from the published literature, from 1980 to the present on the management of mental health care provided in communities. In the first instance, the search strategy for CMHC is presented, followed by a discussion of current information pertaining to the CMHC. The current research in other countries and the paucity of studies in CMHC in Thailand are also outlined and presented in tabular form. This is followed by identification of the gaps in knowledge in CMHC, which illustrates the need for this study. The chapter ends with presentation of the conceptual framework used for this inquiry.

Search Strategy

In order to ascertain the breadth and depth of the research into this topic, the literature was reviewed widely for research relating to a number of aspects pertaining to community mental health care. The researcher undertook a search of the major databases (Academic OneFile (Gale), CINAHL, Blackwell Synergy, Proquest, PsycInfo and Pubmed) to retrieve English language publications for the studies on the topic of community mental health care for the years 1980 through to 2009. The search parameters were combinations of key words such as ‘community mental health care’, ‘community mental health nurse’, ‘deinstitutionalization’ and ‘primary health care’. The Google search engine was used to search for the terms ‘mental health’, ‘mental illness’
and ‘CMHC AND PHC’. Some references were gained from websites of The Ministry of Public Health, Thailand, the World Health Organization and the Headspace Foundation. The literature reviewed has been organized around four major areas. These are care provided, providers, consumers and environment. The literature presented in this section is summarized and presented in Table 2.1. These studies are analysed in terms of study aims, characteristics, methods, findings and conclusions.

**Literature reviewed on CMHC**

The review of past literature noted that there were four mains areas of research associated with CMHC. The first focused on how mental health care was delivered. The literature illustrates a variety of models of care that have been developed. The second looked at studies of the health providers, including their roles, knowledge and training issues. The literature addressing issues from the consumer’s perception was limited, however those that were accessed provide some useful insights into the CMHC. The studies regarding context of care suggest some environmental factors influenced care provided in the communities. The mental health care managed in communities was nested within four dimensions; models of care, mental health providers, consumers, and environment as shown in Figure 2.1.
Figure 2.1 Four dimensions of community mental health care

Models of care

International studies report that there are a number of models of community mental health care utilized to support the continuous treatment among clients in communities. The literature shows that CMHC used a variety of models such as professional relationships (Edwards, et al., 2006; Fuller, et al., 2005; Holst & Severinsson, 2003; Hyvönen & Nikkonen, 2004; McCann & Baker, 2003; Walsh, et al., 2003), information technology (Griffith & Christensen, 2007; Sakao Public Health Network, 2007), short-term service (Haddad, et al., 2005; Sands, 2007), home-based care (Crawford, et al., 2001; Hyvönen & Nikkonen, 2004; Magnusson, Höberg, Lützén, & Severinsson, 2004; Magnusson, Severinsson, & Lützén, 2003; Muir-Cochrane, 2000; Nolan, Haque, Badger, Dyke, & Khan, 2001; Zeeman, et al., 2002), evidence-based practice (EBP) (Dixon, et al., 2001; Pagaiya & Garner, 2005), case management (Royal Australian and

**Relationship-based**

Community mental health providers based their functions on effective relationships within and across agencies. Prior studies indicate that care models based on relationships can be grouped into three models (Edwards, et al., 2006; Fuller, et al., 2005; Holst & Severinsson, 2003; Hyvönen & Nikkonen, 2004; McCann & Baker, 2003; Walsh, et al., 2003). First, *partnership models* are based on relationships between organizations playing an important role in community mental health care. For example, in Australia, The Regional Aboriginal Integrated Social and Emotional (RAISE) Wellbeing Program reflects a partnership between the Aboriginal Health Service and three mainstream health services (Fuller, et al., 2005). This Program’s aim is to improve Aboriginal community mental health care by the Regional Health Service and the Aboriginal Health Service Team who work in partnership. A case study research was conducted to identify what factors influenced the functioning of the organization, linkage processes and sustainability factors. The data were collected using a Medline search, interviews with service providers and managers (n=23), and a workshop with 17 staff. Content analysis of interview data resulted in the emergence of three themes. These were increased funding, personal relationships and consistency of funding and adequacy of the health workers. Increased funding in building the capacity of Aboriginal health workers as a part of the teams was emphasized from the results of the
study. The linkage processes within the program relied on the personal relationships gained across the partner organizations and individuals. The program’s sustainability depended on the consistency of the funding, and having adequate staff who were able to maintain relationships of partnerships between the local Aboriginal champions and the mainstream services (Fuller, et al., 2005). Therefore, the most important conclusion from this study is that the partnership between organizations is beneficial to enhance mental health care in the local community.

In Thailand, the nurses in primary care units (PCUs) work with the local government or sub-district municipality that has autonomy in each community. As Nuntaboot (2006) claims, local administrative organizations (LAOs) such as municipalities and tambon (sub-district) administrative organizations (TAOs) exemplify the types of local government structures that nurses in Thai communities have to work with. However, it is not clear whether nurses and LAOs are working in partnerships.

Second, there are a variety of collaboration models where providers work together for mutual advantage in community mental health care. An Australian qualitative study was conducted to identify models of collaboration used by community mental health nurses (CMHNs) (McCann & Baker, 2003). The CMHNs (n=24) were interviewed in-depth and observed, the focus being on working with and collaborating between CMHNs and GPs in community mental health care situations. The findings showed that the Shared Care Model, in which nurses provided nursing care with regular contact with the GPs throughout the acute care phase, was effective. This model supported personal and organizational continuity of care when compared to the Specialist Liaison model, in which CMHNs took overall responsibility for care situations (McCann & Baker, 2003).
In addition, a qualitative study undertaken in Norway illustrates collaboration between the health-care professionals in a psychiatric hospital and two community psychiatric services (Holst & Severinsson, 2003). The interviews were conducted with psychiatric nurses, medical practitioners, health and social managers, and cultural workers (n=9) working in the rural and urban community centres. The results reflected the notion that respondents would receive the most benefit from regular interdisciplinary collaboration through meetings and coordination related to client cases (Holst & Severinsson, 2003).

Another study conducted in Finland aimed at clarification of mental health care tools used by primary health care practitioners (Hyvönen & Nikkonen, 2004). The data were collected by means of interviews with 22 nurses and seven doctors (n=29). The findings showed that the practitioners provided care through collaboration, consultation, family-oriented care, and communication with supportive, informative and contextual tools. They also offered monitoring and provision of treatment. The findings identified the use of ideological tools to enhance collaboration, including a shared client-orientation, acceptance and permission, honesty and genuineness and a sense of security in working within the collaborative team. The practitioners collaborated with either the staff or clients (Hyvönen & Nikkonen, 2004). These findings show that collaboration is of major importance to community mental health care management.

In Thailand, community health providers occasionally collaborate with the psychiatric hospital in order to deal with mental health issues emerging in the communities. Although there are few published examples of this, the Department of Mental Health (2006) reported that the staff in PCUs provided counselling to people who suffered from the flooding throughout 1,269 districts in 2006. Those staff assessed mental health problems and prescribed pharmacological interventions using consultation and
collaboration with staff from a psychiatric hospital. However, it is not clear whether the collaboration has been ongoing for other mental health issues in these and other communities.

Third, clinical supervision models have been shown to be effective in some cases, based on relationships between health care providers. There has been some evidence for this in the research conducted in the United Kingdom and Australia (Edwards, et al., 2006; Walsh, et al., 2003). Basically, a clinical supervisor has responsibilities for nursing consultation, advice, and support to a community mental health nurse. Researchers looked at the influence of clinical supervision for CMHNs in the UK in a survey of 260 CMHNs working for communities in 11 Trusts (Edwards, et al., 2006). Three questionnaires used were the Maslach Burnout Inventory (MBI), the Manchester Clinical Supervision Scale (MCSS), and demographic questionnaires. The results indicated a negative correlation between level of burnout and effectiveness of clinical supervision ($r = -0.148$, $p = 0.050$). That meant that if clinical supervision is effective then CMHNs reported lower levels of burnout (Edwards, et al., 2006).

Interestingly, an Australian study reported a group model of clinical supervision developed in Adelaide, Australia (Walsh, et al., 2003). The model was based on safety, impartiality, support, trust and respect. In this study, six nurses had monthly meetings focused on clinical issues. The group discussion relied on group norms, such as having a supportive attitude, commitment, and receptiveness. Each member who was not in hierarchical relations within the workplaces took turns to be the facilitator of the group meeting. The evaluations of this unique group of supervision were measured by using questionnaires completed by the participants after each session and at the end of six months. There were positive results in terms of improved nursing practices, increased
solution identification to problems, support offered by groups, and perceptions of being in a safe group environment (Walsh, et al., 2003).

The findings of these studies suggest that the model of clinical supervision is beneficial to improve clinical practices and support mental health providers in the UK and Australia. In Thailand, however, clinical supervision is not a formal aspect of community mental health care management. The current study, therefore, would explore community mental health practice in communities without a supervisory system.

**Information technology-based**

Information technology has played roles in the dissemination and interactive connection among people in order to enhance the mental health of those in communities (Fontaine, 2003). Psychoeducational websites are one useful resource for people currently to manage mental health problems because their accessibility has become commonplace, and they should be viewed as a tool that can benefit societies. Websites are also used as a device to enhance mental health care to Australian rural communities (Griffith & Christensen, 2007). A study reviewed the existing literature related to utilizing two mental health web-based sites. The BluePage Depression Information and the MoodGYM demonstrate interactive online programs for depression and anxiety. The first web-based program contains screening tests, information about depression, the diagnosis, sources of help, and a downloadable relaxation program. The latter provides interactive cognitive behaviour therapy (CBT). It contains exercises of CBT for self-practice as well as the test for anxiety and depression. The authors analysed a total of 12 studies involving sample sizes ranging from 78 to 19,607 people. The outcome measurements were associated with a range of variables, such as decreased depressive symptoms and improved help seeking. Overall, both internet-based applications have
been shown to be effective in reducing depressive symptoms and stigmatization (Griffith & Christensen, 2007). This study suggests that information technology is a route for online consumers to access mental health services.

In comparison, in Thailand, mental health promotion is established via the Department of Mental Health website. However, there is little evidence of evaluation of outcomes. One example of mental health care on Thai web-based service was reported in a pilot study of Sakaeo Psychiatric Hospital which utilized web-based resources to support mental health care in Submanaoc PCU, Klong Had Hospital, and Wang Num Yen Hospital. An initial survey evaluation reported that the community health providers gained knowledge and felt more confident in providing mental health care. The clients were satisfied with the care received from those providers (Sakaeo Public Health Network, 2007). It can be said that people and local providers who had the ability to access mental health websites were able to gain knowledge and provide or receive effective mental health care. These studies draw the attention that CMHC can be improved using web-based technology.

**Short-term service**

The short-term service is a model of care providing mental health assistance for existing mental health problems in a community. For example, Triage/duty care is a reform provided for mental health care in Australian communities (Sands, 2007). The triage/duty systems refer to services with a single point-of-entry, based in community mental health clinics during business hours. An exploratory research to understand mental health triage nursing work was conducted (Sands, 2007). The data were gathered using a quantitative questionnaire survey with 139 triage nurses and semi-structured interviews with 21 nurses. This study found that the components of the mental health
Triage services were person (client) centred within the community, and mental health activities of care practice consisted of point-of-entry assessment, formulation for decision making and action. The core philosophy consisted of caring, ethics/legal issues, equity and accessibility, clinical experience, skills, and knowledge and advocacy. The triage nurses were involved with community resources and participation, such as inpatient bed services, crisis accommodation and community health resources (Sands, 2007). This study illustrates a single point of entry service for CMHC provided intensively to address existing mental health problems in the community.

Another study presented CMHC as short-term services in community units (Haddad, et al., 2005). The study was conducted to explore district nurses’ involvement in mental health issues in three community settings in Jersey, Lewisham and Hertfordshire, in the UK. The postal questionnaire surveys were sent out and responded to by 217 community and district nurse team members. The results showed that 22 percent of their caseloads were clients with mental health problems and the largest proportion (60%) of the district nurses provided bereavement counselling. In addition, they gave injections and advice in anxiety management, relaxation techniques, dealing with self harm and problem solving. They also monitored the psychiatric medication of the patients (Haddad, et al., 2005). This study shows the diversity of care practices provided to help clients facing mental health problems in the communities. However, little research evidence is available to determine short-time care provided by Thai PCUs.

**Home-based care**

As mental health disorders are more likely to be chronic, patients with mental illness deserve to be monitored and receive ongoing care when they are discharged from the hospital. Providing mental health services to clients in their homes provides many
advantages, such as accurate evaluation and family assessment (Fontaine, 2003). The international literature presents various forms of CMHC provided in the home environment in order to support people with persistent or enduring mental health problems to live within the community. In Sweden, home care for mental illness has been provided by community mental health nurses (CMHNs) as continued care (Magnusson, et al., 2003). A Swedish study investigated care management, where nurses shifted from hospital to community-based care and provided home care for people with mental illness. The researchers conducted interview sessions with eleven CMHNs. The nurses identified themes of care management in home care. The first theme was that the nurses became negotiators, not case managers. The clients then were the centre of care in a home care context within the private sphere. Patients were revisioned as ‘clients’, for whom nurses accepted the need for sensitivity. The nurses therefore maintained concern for clients’ needs and establishing relationships. They made assessments by observing for signs of illness and adequate resources in order to support health and acceptable social behaviour (Magnusson, et al., 2003). The researchers also presented findings related to the nurses’ experiences in another publication (Magnusson, et al., 2004). The 11 Swedish nurse interviewees reported that they experienced loneliness due to having no other professionals working in the community settings. During patient home visits, they helped in acknowledging patients’ problems, observed patients’ everyday life and assessed changes in the patients’ states of health. They reported that establishing trust between the nurse and patients was extremely important in managing care practice through support and supervision (Magnusson, et al., 2004).

An Australian study aimed to investigate similar roles of community mental health nurses (Zeeman, et al., 2002). Twelve CMHNs in Fremantle Hospital completed
questionnaires over five working days. The results indicated that home visits were the foremost aspect of daily workload for the CMHNs (Zeeman, et al., 2002). Another Australian study looked at issues of power in nurse-patient relationships in the community environment (Muir-Cochrane, 2000). The study was undertaken using interviewing and observation about activities provided to the patients by five CMHNs. The study suggested that the home setting was an important element in nurse-patient encounters in which power was shifted to the patients. Besides being effective in maintaining client-centredness, the home visits were undertaken for the purpose of administering medication and sharing of social behaviour (Muir-Cochrane, 2000).

A study conducted in South Staffordshire, UK aimed to identify care provided by CMHNs in two primary care services (Crawford, et al., 2001). The questionnaire surveys were conducted with 37 CMHNs. The study found that counselling, general support, home visits, and administrating medication were interventions provided by the CMHNs to the patients in the communities (Crawford, et al., 2001). Similar care practices were found in another study that used questionnaire surveys to examine mental health nurses’ perceptions of nurse prescribing in the UK (Nolan, et al., 2001). The researchers conducted the surveys with a convenience sample of 73 mental health nurses who attended a one-day conference. They found that 84.49% of nurses in communities gave anti-psychotic injections. The respondents felt that the mental health nurse’s role in prescribing would improve patients’ access to medication, but they were not confident in their capacity to undertake the role (Nolan, et al., 2001).

As emphasized earlier, the study conducted in Finland to identify tools of mental health care used by primary health care practitioners also presented characteristics of home-based care that the nurses provided in the home context and advocated for patients to
live within their community. Like Crawford’s (2001) and Nolan’s (2001) studies above, the nurses gave injections and provided education within the clients’ homes (Hyvönen & Nikkonen, 2004).

These studies reveal insights into community mental health services and suggest that home-based care was beneficial and accessible for residents. The nurses could offer curative and supportive care within a friendly atmosphere. Thai community-based nurses had responsibilities in providing home health care as their main role. Nevertheless, little is known about the community nurses’ roles in dealing with mental illness and their effectiveness.

Evidence-based practice (EBP)

Recently, evidence-based practice (EBP) has become a significant focus in nursing research because it is a model of care relying on realistic optimism that can enhance effectiveness of care. Typically, EBP can help in nursing judgments and improve nursing practices; therefore, EBP has been viewed as an integral part of clinical decision making (McKenna, Cutliffe, & McKenna, 2000). A review of 17 studies focused on family psychoeducation, an EBP that explained that family psychoeducation has a solid research base (Dixon, et al., 2001). The authors found four studies that showed a higher reduction in relapse rate among families who received psychoeducation than among those who received the standard services, ranging from 20 – 50 percent. In addition, six studies showed increased well-being of families, improved participation, and decreased cost of care. Consequently, the Schizophrenia Patient Outcomes Research Team (PORT) recommended family psychoeducation to support the families (Dixon, et al., 2001). This study suggests that EBP is a tool for practitioners to manage their care
practice more confidently. However McFarlane and colleagues (2003) commented that the use family psychoeducation EBP in routine care interventions was limited.

A study using a randomized control trial (RCT) approach conducted in Thailand presented outcomes of four EBP guidelines for uses in a PCU (Pagaiya & Garner, 2005). One guideline that applied to mental health care was the diazepam prescribing guidelines used for adult patients who had anxiety or panic disorder and sleep disturbance. The participants were 18 nurses practising in 18 health centres. They were matched by demographic data and characteristics of the PCUs for both the intervention and control groups. The researchers found that the number of diazepam prescribing by nine nurses in the intervention group was less than that done by the nurses in control group and decreased at the sixth month follow-up period (Pagaiya & Garner, 2005). These findings illustrate that EBPs can be part of improving the quality of mental health care in the Thai community. Nevertheless, much is unknown about the EBP extent that has been used in providing effective mental health care.

Case management
Case management is an effective nursing service, enhancing appropriate use of resources, facilitating continuity of care and promoting cost-effective outcomes (Fontaine, 2003). Case management models have been deemed acceptable in Australia and the UK respectively (Royal Australian and New Zealand College of Psychiatrists Clinical Practice Guidelines Team for The Treatment of Schizophrenia and Related Disorders, 2005; Simpson, 2005). Particularly in Australia, case management has been developed as a variety of models of community-based care. For instance, a comprehensive literature review (1990-2003) was initiated to present clinical practice guidelines for schizophrenia and related disorders (Royal Australian and New Zealand
The review revealed that the community mental health or continuing care teams as ‘case managers’, provided care to people with persistent mental illness in the communities. In addition, the Assertive Community Treatment teams (ACT) provided mobile intensive case management to a more complex subset of patients in the communities (Royal Australian and New Zealand College of Psychiatrists Clinical Practice Guidelines Team for The Treatment of Schizophrenia and Related Disorders, 2005).

In the UK, the care management approach (CPA) based on the principle of case management is an important policy underpinning Mental Health care in England and Wales (Simpson, 2005). For example, a multiple case study was conducted to illuminate factors that facilitated and constrained the community psychiatric nurses (CPNs)’ abilities in the care co-ordinator roles. Seven mental health teams participated in the study (Simpson, 2005). Methods used to collect the data were observations, semi-structured interviews and document reviews. The findings indicated that the CPNs undertook therapeutic and care co-ordinator roles. They intervened in the mental health problems of the clients. They had to do office work, such as storing information into the computer, keeping details in the nursing notes and communicating as a co-ordinator. They perceived these roles as constraints because the document and co-ordinating work took time and overlapped with their CPN role (Simpson, 2005). These two studies provide information on how the CMHC provided through case management (Royal Australian and New Zealand College of Psychiatrists Clinical Practice Guidelines Team for The Treatment of Schizophrenia and Related Disorders, 2005; Simpson, 2005). Conversely, while case management formulations were effective in many countries, case manager servicing community mental health care in Thailand is non-existent today.
**Integrated care**

As many patients may have physical illness, a mental health problem, social difficulties, emotional or relationship problems, or a mixture of all these, assessing their needs may be difficult (Armstrong, 2003). Nurses can engage these patients using integral approaches. The integrated mental health care is an ideal approach for communities. The literature reviewed shows two types of integration; service integration and organizational integration (Gaul & Farkas, 2007; Seloilwe & Thupayagale-Tshweneagae, 2007). The first study described how mental health care was integrated in terms of services in primary care centres. In the USA, an integrated mental health service was established in Jefferson County, Colorado (Gaul & Farkas, 2007). The authors, a psychiatric nurse and a public health nurse, indicated that since 2002 the CMHNs and public health nurses (PHNs) have worked together, such as visiting the clients at home simultaneously. They suggested that the advantages gained from this integrated model were higher accessibility to a population that tended to be resistive to mental health care and gaining a greater trust from clients (Gaul & Farkas, 2007). This study illustrates that integrated care provided by both the mental health and community nurses was serviced effectively in Jefferson, USA.

Further literature reviewed revealed organizational integration in community mental health care (Seloilwe & Thupayagale-Tshweneagae, 2007). One study presented the Botswana mental health care system as an integrated service in the form of organizational integration (Seloilwe & Thupayagale-Tshweneagae, 2007). The psychiatric units were attached to district hospitals in the towns and cities as out patient services. Medication was decentralized from psychiatric units into other health care services. Psychiatric training was organized for general nurses and GPs. This study provided clarification of how the integrated model was established in Botswana.
(Seloilwe & Thupayagale-Tshweneagae, 2007). It provides a template of the organizational integration of a CMHC service.

Similar to care in Botswana, the Thai CMHC is attached to general hospitals (Siriwanarangsan, et al., 2004). In addition, it is provided in PCUs located in each sub-district. Here clients can access health care in accordance with specified standards. People can access a PCU within 30 minutes, and each PCU serves approximately 10,000 residents (Arphorn, et al., 2006; Netrawichien & Boon-Arj, 2006). The PCUs provide the holistic primary assessment, therapeutic care and referring clients to a secondary care centre. Notwithstanding, much is unknown about CMHC in Thai PCUs because research evidence for the effectiveness of mental health care managed in a PCU is rare.

Well-being oriented

There is a notion that people with mental illness in communities are not crazy or a mad sub-species; they have other health conditions (Armstrong, 2003). The community nurses need to focus their concern on contributing to health and well-being. Some studies underline CMHC as promotion of health and well-being through various activities. For example, a review article described ‘Headspace’, a National Youth Mental Health Foundation that plays a role in mental health promotion in young people aged 12-25 years in Australia (Hodges, et al., 2007). The authors emphasized that the Headspace foundation would fund campaigns for local communities to create mental health and wellbeing, and prevent mental health disorders related to substance use in young people. The Headspace planned to build awareness about youth mental health and capacity for managing mental illness in the community (Hodges, et al., 2007). At present, Headspace foundations communicate to the public about mental health
concerns through their website and present activities in promoting mental health and preventing mental illness, such as using, group meeting, brainstorming, musical events and education. These activities are intended to improve the mental health and well-being of young people (National Youth Mental Health Foundation, 2008, 2009).

The CMHC also support well-being by providing accommodation support. A Swedish study aimed to identify nurses’ views in supported housing for clients with mental illness (Högberg, et al., 2006). Nine psychiatric nurses were interviewed. The findings revealed that the nurses perceived that dwelling support can promote well-being of the clients. They were of the opinion that the clients should have privacy and security in their lives, live close to neighbours and be accepted as members of their communities. The nurses felt they had a responsibility to intervene when the patients lived among neighbours in order to prevent the clients and neighbours suffering (Högberg, et al., 2006). This is an example of inter-sectoral thinking; where well-being is considered a product of many things, including health status, housing, and the environment.

An outstanding example of CMHC designed to promote well-being in Australia is that of the Murray Mallee Community Health Service (MMCHS), a regional centre using a PHC framework (Fairlamb & Muir-Cochrane, 2007). The authors explained that MMCHS provided a wide range of services, such as Aboriginal health, diabetes dietetics, domiciliary care, mental health and physiotherapy for Aboriginal people and other consumers. The workers of MMCHS are guided by Mental Health Standards and the spectrum of mental health intervention containing prevention, treatment and continuing care domains. The study reported that mental health workers had a commitment to principles of social justice, community participation, health education
and equity with expectation of outcomes in people’s lives (Fairlamb & Muir-Cochrane, 2007).

The evidence presented above gives a picture of CMHCs that contribute to mental health and well-being. Many activities and variety of care have been reported in the literature, all designed to address mental health as part of well-being. This is not described in Thai communities.

**Health provider**

A number of international studies outline nurses’ common roles as health providers working with mentally ill clients in communities. Community psychiatric nurses (CPNs), community mental health nurses (CMHNs), and district nurses play an important role in care management. This section presents the studies relating to health providers in ways of their roles (Bellali & Kalafati, 2006; Huang, Yen, Liu, & Lin, 2008), working as specialists (Elsom, Happell, & Manias, 2009; McCardle, Parahoo, & McKenna, 2007; McKenna, Keeney, Bannon, & Finn, 2000) and district nurses (Lauder, Reynolds, Reilly, & Angus, 2001; Peakover & Chidlaw, 2007; Thomas, Reynolds, & O’Brien, 2006). Studies also explain the theoretical foundations of the nurses’ roles (Gibb, 2003; Haque, Nolan, Dyke, & Khan, 2002; Nolan, Haque, Bourke & Dyke, 2004; Nolan, Haque, & Doran, 2007), training (McCardle, et al., 2007; Nolan & Brimblecombe, 2007; Seloilwe & Thupayagale-Tshweneagae, 2007), work dissatisfaction (Burnard, Edwards, Fothergill, Hannigan, & Coyle, 2000; Dallender & Nolan, 2002), and multidisciplinary issues (Cunningham & Slevin, 2005).
Roles of health providers

Few would deny that the CMHNs have been in the frontline of CMHC. Research evidence suggests that nurses have pivotal roles in delivering mental health care to the clients in their communities. A Chinese grounded theory aimed to explore roles of CMHNs in caring for people with schizophrenia in Taiwan (Huang, et al., 2008). The participants were 29 CMHNs, 16 patients with schizophrenia, and 16 carers. The participants were observed during home visit sessions provided by the nurses and interviewed individually. The results revealed that CMHN played roles as assessor, supporter, educator, consultant, counsellor, negotiator, harmonizer, collaborator, advocate, placement coordinator, resource provider, care provider, case manager and case finder (Huang, et al., 2008).

Another article presented Greek psychiatric reform between 2002 and 2006 and reported that Greek CMHC was attached to general hospitals, short-term units and crisis intervention centres (Bellali & Kalafati, 2006). The CMHC was also provided through those services. The roles CMHNs utilized were those of supervisor-therapist, liaison person, coordinator and crisis interventionist; however, the authors claimed that there were some limitations in terms of the organizational framework for the nurses to practise these roles. Greek nurses also adopted roles as counsellor, consultant and trainer for the clients and communities. The nurse encouraged the communities to accept the patients in residences and to develop mental health networks (Bellali & Kalafati, 2006). These studies show important roles engaged in by the CMHNs in providing mental health care to the clients and families outside the hospital boundaries. This type of information based on research focusing on the roles of nurses in communities of Thailand is rare.
Community psychiatric nurses / community mental health nurses

Community psychiatric nurses (CPNs) have been seen as professionals with abilities in managing mental health care to individuals, families, groups and communities because they have knowledge of nursing at the basic level and psychological intervention skills (Fontaine, 2003). The literature discusses ways the CPNs and specialists intervene to assist clients in a community environment. Irish researchers undertook a study utilizing a questionnaire survey with 116 CPNs and observation of 13 CPNs in their care situations to explore their roles (McCardle, et al., 2007). The findings revealed that four key roles taken by the CPNs were assessment, medication management, health promotion, and client and family support. They offered listening and discussion with the patients, and provided information when giving injections to the patients. They also gave advice and supportive counselling to the families (McCardle, et al., 2007).

Another qualitative study was conducted to explore the roles of CPNs in Northern Ireland (McKenna, Keeney, et al., 2000). Data were collected through an in-depth examination of caseload registers, activity reports, referral books of 15 CPNs, statistics provided by the Trust, and semi-structured interviews with 11 CPNs. The results found that CPNs spent the most time working with clients including travelling, meeting, and working on documents. Travelling was a substantial role, with CPNs spending between 4 and 5 hours per week. Office work and documentation were also raised as a major burden taking up to 3 hours per week at Centres, and 7 hours per week at home (McKenna, Keeney, et al., 2000).

A cross-sectional correlational study was conducted in Australia to determine the extent to which CMHNs were currently practising beyond the traditional scope of nursing practices (Elsom, et al., 2009). The respondents were 154 CMHNs practising in ten
mental health services, seven located in the metropolitan area and three in rural areas in Victoria. The five-point Likert scale questionnaire sought about the current expanded practices relating to prescriptions, ordering of diagnostic tests, referring, authorizing absence from work certificates, adjusting and changing medications, and giving recommendations to the GPs. The findings showed that the most commonly reported practice was the administration of medication exactly as prescribed by the doctor. However, the majority (65.6%) of participants reported that they were more likely to engage in expanded practices now then they were in the past (Elsom, et al., 2009).

These studies reveal that the CPNs and CMHNs provided advanced care practices to patients with mental illness in the communities and also have administrative duties. Thai psychiatric nurses were employed within the institutions and did not appear to take major roles in direct contact with the patients throughout the communities. The community nurses have responsibilities in visiting those at home, yet research-based knowledge around this issue is limited.

**District Nurse as mental health providers**

District nurses or community nurses have a major responsibility to provide health care to people in communities. They also have played important roles in delivery and continue to provide mental health care in the communities. Several recent research studies conducted in the UK reflect an interest in CMHC provided by community health providers such as district nurses (Lauder, et al., 2001; Peakover & Chidlaw, 2007; Thomas, et al., 2006). As non-specialists, district nurses have full responsibility in providing good mental health care to patients in the communities where there is no psychiatrist and/or psychiatric nurse employed. One qualitative study demonstrates this role (Peakover & Chidlaw, 2007). It was undertaken using observations of district
nurses working with drug misuse clients in England. The researchers carried out a semi-structured interview with 18 district nurses. The interview focused on their understandings and practice experiences in discrimination issues, their roles in helping the patients, and influencing tackling issues of discrimination. The findings showed that the district nurse had to provide care to these clients without specialist knowledge (Peakover & Chidlaw, 2007).

Another study aimed to describe care given by and perceptions of district nurses in Mental Health care (Lauder, et al., 2001). The data were collected by interviews with 15 district nurses in the UK. The findings suggested that the district nurses worked in and were a part of the communities. They provided mental health care, were more approachable and less threatening, and consequently they brought out rich information and identified problems when referring the patients to GP or a specialist. They perceived their limitations in providing specialist care, but could provide support and basic care. They were able to follow hunches because they were insiders who understood the patients within their circumstances (Lauder, et al., 2001).

An action research study focused on district nurses in West Hertfordshire, UK (Thomas, et al., 2006). The study aimed to gain a detailed understanding of the district nurse services, determine capacity for development and formulate plans for the 21st century. The data were collected by using group discussions, focus groups, interviews, clinical audit analysis, workload measurement, and questionnaires with 252 community nurses. The results showed that they had concerns of the lack of clarity in district nurses’ roles, the unclear referral criteria, and the variable workload of team members. The researchers found that approximately 23 percent of district nurse caseloads were mental health clients (Thomas, et al., 2006). Three studies presented information that district
nurses played a main role in managing CMHCs in their geographic areas where there was no CPN. This seemed to be similar to those Thai community nurses who performed care in the communities; however, there remains a need for research to examine their care.

**Theoretical practices**

Many theories and models are relevant to practising in CMHC. These must be integrated to create comprehensive care practice which responds to social, cultural, environmental and biological components of mental health (Fontaine, 2003). There is an area of literature which addresses the theory underpinning CMHC. A study conducted in two mental health Trusts in the UK (Nolan, et al., 2004). The aim was to explore the aspects of CMHNs’ work in terms of the interface between policy and practices. The questionnaires were responded to by 131 CMHNs. A questionnaire survey encompassing open and closed-end questions was administered to each. The questionnaire sought to elicit factors influencing job satisfaction and dissatisfaction, personal values, perceptions of being valued, care model, and recommendations for improving practices. The findings revealed that approximately one-third and one-fifth of the participants adopted the nursing process and eclectic models in their care (Nolan, et al., 2004). Similarly, a comparative study was conducted to determine mental health nursing practice experienced by the nurses in the UK (n=65) and US (n=43) (Nolan, et al., 2007). The questionnaires were used to ask about work of CMHNs, satisfaction, models of care, and suggestion on work improvement. The questionnaires were completed by 108 (59.5%) nurses. The findings showed that they worked as team members and had direct contact with the clients. Their most common care practices were cognitive behaviour therapy (CBT), eclectic therapy and interventions based on Peplau’s model (Nolan, et al., 2007).
A study using grounded theory was undertaken in rural Australia (Gibb, 2003). The study aim was to explore meaning of health and health care led by nurses in rural areas. Ten nurses participated in the interview sessions focused on who provided mental health care and what and how it was provided. Themes emerged in the form of nurses working as isolated professionals, with nurses’ judgement being described as holistic assessment and nurses as agent of healing. Their care practices were shared in responsibility with the clients, controlled with therapeutic tools and theoretical shaping which was assessing and determining of implementation for intervention. They also used intuition in judgement in order to increase rationality and caution in practising (Gibb, 2003). Similarly, another study was conducted to examine the roles of CMHNs in the UK (Haque, et al., 2002). Forty nurses reported perceptions of their roles. In questionnaire surveys, the majority (90%) of nurses stated that their care practices were based on doing the right things, not a particular model. The others raised nursing process (35%) and holistic models (37.5%) as options for intervening (Haque, et al., 2002).

In summary, the findings of these studies illustrate that the nurses frequently utilized the nursing process, CBT, and eclectic models in caring for people with mental illness. Some nurses relied on their intuition. As Thailand’s culture and health system differs from those countries, it is difficult to assume which concepts or theoretical models are used as a basis for mental health care practices, which will be interesting to discover.

**Training**

Education and training for mental health training involves preparation of the nurses to deliver good care practices in mental health, when providing mental health care with other branches of community nursing (Armstrong, 2003). It is aimed at the CMHNs
need to be prepared with the essential knowledge that can be utilized in these areas. Regarding training, some studies discuss specialized training as a factor in mental health care improvement and needed by CMHNs (McCardle, et al., 2007). An Irish study presented earlier showed that 75% of Irish CPNs surveyed claimed that they attended postgraduate courses (McCardle, et al., 2007). The most common training course attended by these nurses was counselling (McCardle, et al., 2007), which underlines the importance of this specialized training.

Studies have drawn attention to mandatory training programs in many countries. Evidently, Botswana has provision for mental health training programmes for 20 nurses every 18 months (Seloilwe & Thupayagale-Tshweneagae, 2007). A study was conducted using internet survey in nursing education in mental health care across 12 European countries (Nolan & Brimblecombe, 2007). The e-mail questionnaire response from 12 senior specialist nurses showed that the specialist mental health training was available in Belgium, Germany, Greece, Holland, Ireland, Italy, Malta, Norway, Romania, Sweden, Switzerland, and United Kingdom (Nolan & Brimblecombe, 2007). The evidence shows that further nursing education was provided in many countries to support nurses working in communities. Similarly, in Thailand, the advancement of mental health nursing training is also available, such as a 4-month postgraduate curriculum in mental health care. However, little is known to what extent the nurses in Thai communities are interested in and enrol in mental health training.

**Job stress and dissatisfaction**

Working in the community environment, CMHNs are faced with many types of stressors and sources of dissatisfaction arising from the symptoms of the patients and roles of the professionals. Two studies undertaken in the UK discussed stress and
dissatisfaction in community mental health work (Burnard, et al., 2000; Dallender & Nolan, 2002). The first study aimed to determine CMHNs’ perceptions of sources of stress in their work (Burnard, et al., 2000). The data were collected using questionnaire booklets responded to by 301 nurses in Wales, the UK. The data were analysed by using content analysis. The results showed the frequently cited stressors were workload, working on documents and administration and managing a wide range mental health issues raised by the patients (Burnard, et al., 2000).

Another study aimed to compare stress perception among mental health workers in the UK (Dallender & Nolan, 2002). The questionnaire survey was used with 50 psychiatrists, 50 hospital-based nurses and 50 CMHNs. The results showed that CMHNs’ sources of job satisfaction and dissatisfaction were more similar to those of psychiatrists than those of hospital-based nurses. The CMHNs had satisfaction in working with autonomy and creativity, having colleagues and working in enthusiastic atmospheres. Their dissatisfaction involved having to do excessive document work, poor relationship with managers, lack of resources, time fulfilling duties, job security, and low pay (Dallender & Nolan, 2002). Working on documents and other office work were an intensive cause of dissatisfaction and stress among those CMHNs.

**Multidisciplinary team**

Multi-professionals working as community mental health teams are effective today because it creates collaboration, co-operation and less emphasis on traditional professional hierarchies (Kirby, Hart, Cross, & Mitchell, 2004). Multidisciplinary approaches utilized in order to meet the needs of clients in communities have been reported in the literature (Cunningham & Slevin, 2005). A qualitative study was conducted focusing on the roles of CPNs in multidisciplinary teams (Cunningham &
Slevin, 2005). Data were collected using five focus groups with 15 CPNs and 13 clients (n = 28). The findings illustrate that the CPNs perceived their roles positively. When working in multidisciplinary team which comprised GPs, social workers, and psychologists, the CPNs complained about unclear boundaries between multidisciplinary health professionals. The researcher concluded that working in community multidisciplinary teams is advantageous because multidisciplinary care responds to many aspects of clients’ needs, but problematic in terms of blurred roles (Cunningham & Slevin, 2005). Therefore, working with multidisciplinary professionals as a team may be facilitating and hindering the delivery of care.

**Consumers**

There is relatively little attention focused on consumer perceptions of CMHC expressed by clients and stakeholders (Adam, Tilley, & Pollock, 2003; Crowe, O'Malley, & Gordon, 2001; Shanley, Watson, & Cole, 2001). The consumers of CMHC include children, adolescents, adults and older persons who need a variety of mental health services. They have the right to control their life, be involved in treatment and receive humane treatment (Fontaine, 2003). Therefore, to provide CMHC, the nurses have to consider the consumers’ responses. Examples of community mental health service viewed by clients were reflected in the following studies. A qualitative study was conducted to explore the clients’ perceptions (n=131) of CMHNs in New Zealand (Crowe, et al., 2001). The clients were interviewed by the ‘consumer advisors’. Data analysis provided findings that most patients were visited by the CMHNs at least fortnightly. They felt very positive about their relationship with CMHNs, monitoring and supports, and received help in coping from CMHNs. Negative consumer perceptions included inadequate information about treatment, consumer rights, and the imbalance of power in relationships (Crowe, et al., 2001).
Another study focused on clients’ perception of Scottish CPNs (Adam, et al., 2003). The qualitative method used was a semi-structured interview among 13 clients about their value in CPNs’ services. Thematic analysis was used to analyse the data. The results showed positive perceptions of non-judgmental and personalized relationships with CPNs, those being caring, understanding, and feeling valued. Talking with CPNs was purposeful, respectful, and included indirect communications with doctors. They also valued the CPNs in providing company and connection to others. In contrast, unhelpful practices entailed rushing, having a chat, and passing clients to ‘derogatory’ carers. These findings reflect that the nurses approached clients in the community mostly positively through relationships, monitoring, and support. Meanwhile, some aspects of care provided did not meet the needs of the clients (Adam, et al., 2003). These studies provide more understanding in how the nurses provided mental health care and how the clients felt about the care provided.

As CMHC always connects with agencies in communities, the stakeholders have become a part of services. A study known as stakeholders’ opinion of CPN nursing was conducted in Scotland (Shanley, et al., 2001). The participants (n = 32) were 12 Health Boards as purchaser representatives from the Health Boards and Fund Holding GPs (FHGPs), ten providers from the National Health Service Trusts (NHS Trusts), and ten users connected with CPNs services in Scotland. This descriptive research, using a telephone survey found that the overall quality of CPN services was good or very good. For example, CPNs had good communication and assessment skills. However, the informants presented that CPNs with a high caseload of 25-34 cases should become specialists and prioritize issues. CPNs should have education in specialist courses. Furthermore, they recommended that CPNs should be employed 24 hours per day and seven days in a week (Shanley, et al., 2001). These findings are important in clarifying
the stakeholders’ views that CMHNs were accepted for their specialized skills and as a part of the community mental health team. However, some aspects of care provided by the CPNs were rated as of a lower standard by the stakeholders. In Thailand, understanding in consumers’ feedback in mental health through clients and stakeholders is limited because studies focusing on stakeholders are rare.

Environment

In the context of community mental health care, clients interact with their surroundings at all times. Therefore, care management must be concerned with the community environment. Prior studies demonstrate that environmental factors influence care management through socioeconomic status (Abas, Vanderpyl, Robinson, & Crampton, 2003; Tello, et al., 2005), beliefs (Burnard, Naiyapatana, & Lloyd, 2006; Sethaboupph & Kane, 2005), job security (Burnard, et al., 2000; Edwards, Burnard, Coyle, Fothergill, & Hannigan, 2001; Magnusson, et al., 2003) and policies (Department of Mental Health, 2007b; Watcharasin, et al., 2006).

Socioeconomic Status

Socioeconomic status is an environmental factor that has a powerful influence on clients’ lives, as shown in a research study focused on socioeconomic status and mental health care services in New Zealand (Abas, et al., 2003). The cohort study was undertaken and involved 872 psychiatric patients in New Zealand between 1998 and 2000. The aim was to identify the relationship between level of deprivation and the use of care. For the purpose of the study, deprivation meant the lack of special advantages for living, such as employment, household income, or bedroom occupancy. The deprivation was measured by NZDep96, with indicators of the ‘least deprived’ area and the ‘most deprived’ area. The utility of mental health care was measured by prevalence
of admission and the number of occupied bed days. The researchers found that people living in ‘most deprived’ areas had higher rates of admission and a longer bed occupation than that those who were in a less deprived area (Abas, et al., 2003).

An Italian study aimed to identify relations between socioeconomic status and the treated incidences and prevalence of mental illness in South Verona, Italy (Tello, et al., 2005). The researchers noted that their results did not show the true incidence and prevalence of psychiatric disease, but rather reflected data on the use of mental health services. The researchers accessed socioeconomic status (SES) through nine Italian censuses, and grouped the data into four categories: SES I-affluent, SES II, SES III, and SES IV-deprived. They also collected data using psychiatric case registers of residents in catchment areas. Their results showed an inverse association between use of community mental health services (home visits and community contacts) and SES. The researchers suggested that this may be indicative of the presence of more severe disorders, greater social suffering and higher demand for community mental health care among those patients living with deprived status (Tello, et al., 2005). A very important finding from these two studies is that there was a strong link between socioeconomic status of clients living in communities and the need for mental health care.

Beliefs

Beliefs can influence community mental health care management in a variety ways. Particularly in Thailand, beliefs relate to patterns of care that occur in rural communities. An ethnographic study aimed to explore the perception of Thai nurses, other health professionals and lay persons in regard to mental health issues in Thailand (Burnard, et al., 2006). The researchers used interviews and observations, including fieldnotes to collect the data. The participants were student nurses, clinical nurses,
nursing instructors, a medical doctor, and a monk (n=24). The findings indicated that drug misuse was one cause of mental illness. Community stigmatization that prevented the patients from society was a common difficulty related to mental illness. The participants believed in Buddhist concepts that bad behaviour or demerit caused mental health disorders. This Buddhist belief suggests that ‘not attachment’, releasing and being independent, and having good behaviour could bring a better life. However, both conventional issues, such as talking with monks and modern-treatment were acceptable among clients and families. The findings are important in reflecting the influence of beliefs on the view of causes of disease and treatment chosen by consumers (Burnard, et al., 2006).

Further, a phenomenological study looked at caregiving in Buddhist families in Thailand (Sethabouppha & Kane, 2005). The researchers carried out the interviews and observation about caregiving provided by fifteen family caregivers. Themes emerging from the analysis showed that Buddhist beliefs influenced caregiving; for instance, they had to look after their children or parents with mental illness, which was a result of their demerit behaviour in the past life. That they relied on the ‘middle way’ helped in coping with the caregiving situation. The caregivers also believed that offering mercy, caring, and helping to others was meritorious, suggesting that they should help their sons, daughters, or parents who had mental illness. They also perceived that mental illness was natural and incurable, so it was common to just accept the illness. Some caregivers meditated and prayed everyday in the belief that this would be a way to relieve the patients’ suffering. The results show that the Buddhist belief is an important factor having influence on care situations in Thai families (Sethabouppha & Kane, 2005). Therefore, Buddhist belief is a significant environmental factor facilitating care provided by families and health providers in Thai communities.
**Job security**

Working in the home-setting within community environments, nurses must be aware of risks of harm (Fontaine, 2003). Several studies focused on this work issue. One part of the study undertaken by Edwards and colleagues (2001) conducted a stepwise multivariate analysis of factors contributing to the stress of CMHNs. The 301 CMHNs she and her colleagues studied identified their stress as trying to maintain a good quality service with long waiting lists, having poor resources, being interrupted while working, not being supported by managers and not having job security (Edwards, et al., 2001). In the Swedish study presented in the section on home-based care, the study revealed that the mentally ill were visited and provided care by CMHNs at their homes (Magnusson, et al., 2003). However, the nurses reported that providing home based-care to the patients with enduring mental illness was problematic due to risks of harm occurring (Magnusson, et al., 2003). It can be said that job security was a significant obstacle and unattractive when working in these environments.

**Policies**

Typically, policies guide practices and these can also be informed by consequences of practising. In Thailand, policies determine community mental health practices via organizational administration. Mental health providers follow the policies announced by government policy-makers. The Department of Mental Health (DMH) takes the role of policy-making. The policies transferred to practices at the grass roots level equate to bureaucratic management taking an active role in the proceedings (Department of Mental Health, 2007b).

Little evidence exists to confirm how practices influence policy-making. An action research study known as ‘The conclusions for administrators’ was undertaken in
Thailand in order to link practice with policy (Watcharasin, et al., 2006). The researchers used in-depth interviews, literature review, a seminar and brain storming, and visiting mental health services in Australia and the UK. The study participants were practitioners and experts. The brief results reflected that the practitioners had difficulties in managing mental health care in primary care units (PCUs). For example, nurses and other health professionals in the PCUs expressed the lack of knowledge and skills in mental health care. The mental health training was conducted in the institutes affiliated with the Department of Mental Health, rather than disseminated through the PCUs. The researchers expected that the results of the study would be used as input for policy making (Watcharasin, et al., 2006), yet the practitioners perceived that mental health reports they had submitted did not create change in the care systems. The research itself appears to be a way the practitioners communicated with mental health policy-makers. This study draws attention to the need for using research in community mental health care as an evidence-based process in policy-making.

In summary, the literature presented discusses CMHC pertaining to four domains; models of care, health professionals, clients and stakeholders, and environment. The international studies indicate that a diversity of models of care were adopted by the nurses. Those were relationship-based, information technology-based, short-term service, home-based care, EBP, case management, integrated care, and well-being oriented. The health professionals who provided mental health care in the communities were nurses and district nurse. They played roles such as educator, collaborator, consultant, counsellor, and negotiator. The clients and stakeholders participated in terms of sharing opinions about the nurse’s care practices. There were some factors influencing on the care practices, such as socioeconomic status, beliefs, job security, and policy.
While there is extensive research on community mental health care in these aspects worldwide, little is known about care management in communities in Thailand. It is difficult to remove the prejudices which stand in the way of doing this in Thailand. In order to provide appropriate mental health and welfare services, research is required to understand the extent of mental health care management in Thai communities. Therefore, this study investigated good management practice in community mental health care of Thailand.
## Summary of research on CMHC

### Table 2.1: Summary of research related to community mental health care

<table>
<thead>
<tr>
<th>Authors &amp; Aims</th>
<th>Sample</th>
<th>Settings</th>
<th>Methods</th>
<th>Findings</th>
<th>Conclusions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abas et al, 2003</td>
<td>872 patients admitted in psychiatric units</td>
<td>Manukau, New Zealand</td>
<td>Cohort study using Patient Information Management System (PIMS) between 1998 and 2000</td>
<td>Patients were schizophrenia (38%), paranoia (8%), bipolar (24%), depressive (12%), and adjustment disorders (8%). Patients from deprived areas had 2.8 times the use of in-patient beds, and used 3.8 times the number of bad days compared to those from least deprived areas.</td>
<td>The needs of mental health care strongly associated with deprivation encompassing low income, unemployment, lack of household car, being in single-parent family, and lack of education and home.</td>
</tr>
<tr>
<td>Adam et al, 2003</td>
<td>13 people with enduring mental disorders</td>
<td>Scottish city, UK</td>
<td>Interviews with 13 patients who were the CPNs’ caseloads</td>
<td>The patients valued personalized relationships and purposeful talking with the CPNs. The CPNs concerned with the patients’ connection to community, were accessible, and had regular visits.</td>
<td>The CPNs established connections between the patients and communities. They helped the patients enhance their potential for living in context of life.</td>
</tr>
<tr>
<td>Bellali &amp; Kalafati, 2006</td>
<td>-</td>
<td>-</td>
<td>Discussion of the Greek mental health profile</td>
<td>Greece contributed mental health community centres and residential services and developed multidisciplinary team. The CMHNs played roles of supervisor, liaison, coordinator, crisis interventionist, and counsellor. They informed community about mental health issues.</td>
<td>Greece established community services and residential centres for rehabilitation. The CMHNs played crucial roles.</td>
</tr>
<tr>
<td>Burnard et al, 2006</td>
<td>3 nurses, 3 student nurses, 14 nurse educators, 1 psychiatrist, 1 monk, 2 lay persons, (n=24)</td>
<td>Thailand</td>
<td>Ethnographic study - Field notes and interviews - Observation and conversation - Data were analyzed by using Atlas.ti. in the form of thematic content analysis</td>
<td>Findings from interviews emerged; wide range of cause of mental illness; mental illness was stigmatization; Buddhist concepts made understanding in life and mental illness; Treatment and care comprised modern and traditional approaches; Reasons for becoming mental health nurse was doing good works.</td>
<td>Thai culture and traditional beliefs were found as part of mental health treatment and care in Thailand.</td>
</tr>
<tr>
<td>Burnard et al, 2000</td>
<td>301 CMHNs</td>
<td>Wales, the UK</td>
<td>Questionnaire booklets and using content analysis</td>
<td>The frequently cited stressors were workload, working on documents and administration and managing a wide range mental health issues raised by the patients.</td>
<td>There were diversity of sources of stress of the CMHNs’ work.</td>
</tr>
<tr>
<td>Crawford et al, 2001</td>
<td>38 primary care staff (reception and administration staff, the GPs, nurses and health visitors)</td>
<td>Two primary care settings in South Staffordshire, UK</td>
<td>Using satisfaction questionnaire</td>
<td>65.4% responded that contact with CMHNs was better; 42.3% commented that referral were more efficient; 23.8% reported that CMHNs provided clinical care, follow up, and crisis intervention; 85% satisfied with CMHNs; 70% thought that having CMHNs was very much better; 80% thought that placing CMHNs raised their awareness in mental health; and over 90% felt that was advantageous.</td>
<td>Placing CMHNs in primary care settings was beneficial to the quality of mental health care.</td>
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<tr>
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| Crowe et al, 2001  
Aim: To evaluate whether CMHNs’ care practices met the needs of patients. | 79 clients | New Zealand | Descriptive research - Using interviews | Most clients were visited by CMHNs at least fortnightly. They thought they received inadequate information about treatment and rights, but appropriated in nursing care, support, coping help, home-based care, and monitoring. They felt less power in the relationships with nurses. | The clients as consumers had satisfaction with the CMHNs’ ability and willingness in providing mental health care at their homes; however, they had dissatisfaction in the imbalance power in relationships. |
| Cunningham & Slevin, 2005  
Aim: To determine the effectiveness of care provided in terms of organization, meeting clients’ needs, and consumers' choices. | 13 service users  
15 CPNs | Northern Ireland | Three focus groups with CPNs and two with the clients (discussion on effectiveness of mental health services) 
-Data were analyzed using thematic content analysis | The clients satisfied with the CPN roles, but confused about multidisciplinary roles. The CPNs expressed satisfaction in organization and multidisciplinary team functions, but disliked blur role boundaries, superficial training, and limited resources. They thought that the clients could comment on the services, but the clients felt it was limited. | The CPNs and clients expressed a range of attitudes to the organization, CPNs, and giving comments related to mental health services. |
| Dallender el al, 2002  
Aims: To explore mental health nurses’ and psychiatrists’ perceptions of their roles | 50 psychiatrists,  
50 hospital – based mental health nurses,  
50community-based nurses (n=150) | West Midlands, UK | Cross-sectional survey study -Using questionnaire (closed and ended questions) | CMHNs’ satisfaction and dissatisfaction were more similar to those of psychiatrists than to those of hospital-based nurses. The CMHNs perceived autonomy, creativity, workplace, contact with the patients and colleagues and work environment as positive working. Dissatisfaction was attributed to excessive administrative duties, poor relationship with managers, lack of time and resource, and low pay. | The CMHNs and psychiatrists had work satisfaction and dissatisfaction in diversity. |
| Dixon et al, 2001  
Aim: To describe family psychoeducation as EBP and barriers to its implementation. | - | - | Discussion of the uses of family psychoeducation as EBP | Psychoeducation were used in ways of reduction in relapse. The barriers in using it as EBP were availability of providers and limitations in training, requisite clinicians, resources, time, and reimbursement. Overcoming factors were dissemination of knowledge, evaluation of programmes, providing resources, and effort change. | Family psychoeducation was advantageous in practices, but limited in using. |
| Edward et al, 2001  
Aim: To identify factors contributing to stress of CMHNs. | 301 CMHNs | Wales, the UK | questionnaire booklets stepwise multivariate analysis | The stress identified were the long waiting lists, having poor resources, interruptions while working, not being supported by managers and not having job security. | A variety of sources of stress was experienced by the CMHNs. |
| Edward et al, 2006  
Aim: To identify the degree of burnout of CMHNs | 212 CMHNs | Wales, the UK | Maslach Burnout Inventory (MBI), Manchester Clinical Supervision Scale (MCSS) and demographic questionaire | 73% had clinical supervision; 36% reported high emotional exhaustion. The nurses who had depersonalization reported higher burnout. There were significant negative correlations between MCSS and emotional exhaustion. | Most CMHNs had supervision. The nurses who had depersonalization were more likely to have burnout; those who received good supervision tended to have less emotional exhaustion. |
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<tr>
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<tr>
<td>Elsom et al, 2009</td>
<td>154 CMHNs</td>
<td>Victoria, Australia</td>
<td>Likert’s scale questionnaire focused on the current expanded practices</td>
<td>Majority (65.6%) of participants reported that they were more likely to engage in expanded practices now than they were in the past. The most commonly reported practice was the administration of medication</td>
<td>Most common practice provided by the CMHNs was medication administration and the current nursing practice expanded.</td>
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<tr>
<td>Fairlamb &amp; Muir Cochrane, 2007</td>
<td>-</td>
<td>Murray Mallee Community Health Service (MMCHS), South Australia</td>
<td>Discussion of the MMCHS model of care based on PHC</td>
<td>MMCHS team provided health care using PHC framework. Mental health care was guided by Mental Health Standards which were included prevention, treatment and continuing care. They concerned with social justice, community participation, health education and equity.</td>
<td>The MMCHS provided care to achieve well-being using the PHC framework.</td>
</tr>
<tr>
<td>Fuller et al, 2005</td>
<td>13 experts</td>
<td>South Australia</td>
<td>Case study -Using MEDLINE search -23 Interviews in 3 meetings -Two case vignettes</td>
<td>RAISE work as partnership between local and Aboriginal health services providing mental health care. The programme driver was shared responsibility. Staff, protocols and communication were linkage processes. The sustainability depended on funding, care management tools and training.</td>
<td>The RAISE programme was underpinned by partnership model provided mental health care for Aboriginal clients.</td>
</tr>
<tr>
<td>Gibb, 2003</td>
<td>13 nurses</td>
<td>5 community mental health settings, New South Wales, Australia</td>
<td>Interviews</td>
<td>The nurses worked alone so their responsibilities were enormous and had higher risks. Their judgement was holistic assessment using intuition. They worked as healer, brought hope, built trust, and kept control and safety.</td>
<td>By working alone in remote areas, the nurses had connection with community, used self-direction, and provided psychological care.</td>
</tr>
<tr>
<td>Griffith &amp; Christensen, 2007</td>
<td>12 papers and reports</td>
<td>Community, school, University</td>
<td>Systematic review</td>
<td>Internet-based applications were effective in reducing depressive symptoms and stigmatization.</td>
<td>Internet-based information can be utilized as self-help and information programme in decreasing depression.</td>
</tr>
<tr>
<td>Gual &amp; Farkas, 2007</td>
<td>-</td>
<td>Jefferson County, the USA</td>
<td>-</td>
<td>This programme was called Public Health and Mental Health: A Model of Success. The holistic care was provided by pair nurses, who worked collaboratively.</td>
<td>Integrating mental health care with Public Health was appropriate in this area.</td>
</tr>
<tr>
<td>Haddad et al, 2005</td>
<td>217 district nurses</td>
<td>Jersey, Lewisham, and Hertfordshire, the UK</td>
<td>Depression Questionnaire (DAQ) postal questionnaire</td>
<td>20% of caseloads had mental health problems involving dementia, psychosis, and alcohol misuse. 60% of nurses were requested to advice on depression. The most common intervention was bereavement counseling. 74% reported that they had not attended any mental health course. They had positive attitudes in working with patients.</td>
<td>The district nurses in primary care needed mental health training particular in managing depression.</td>
</tr>
<tr>
<td>Haque et al, 2002</td>
<td>40 CMHNs</td>
<td>A Mental Health Trust in the UK</td>
<td>Questionnaire Using descriptive statistics</td>
<td>60% reported dissatisfaction in administration, 50% valued in working with the patients, 57.57% appreciated supportive management within the organization. 90% responded that they did not use any model for working. 82.5% viewed that having more time with the patients could improve their care.</td>
<td>The nurses valued working with the clients, while they had little enthusiasm in utilizing a model of care.</td>
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### Table 2.1: Summary of research related to community mental health care (Continued)

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<th>Authors &amp; Aims</th>
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</table>
| Hodges et al, 2007  
Aim: To present Headspace as Mental Health support | - | Australia | - | Headspace is the National Youth Mental Health Foundation that establishes activities to prevent mental health problems in young people. | Headspace focuses on encouraging people to seek help early. |
| Holst & Severinson, 2003  
Aim: To examine factors that influence collaboration between health providers. | 3 CPNs, 2 GPs, 2 managers, 2 cultural workers (n=9) | Norway | Interviews | The CPNs needed more collaboration, regular meetings, and links were hospital-based. The existing collaboration were ad hoc meetings. | Collaboration was necessary for mental health providers in community-based services. |
| Hogberg et al, 2006  
Aim: To describe nurses’ experiences in dwelling support. | 9 psychiatric nurses | Sweden | Interviews | The nurses viewed dwelling support as a moral responsibility to establish well-being and help the patients to be accepted by neighbours. | The nurses provided mental health care in terms of holistic principles to achieve well-being of the patients. |
| Huang et al, 2008  
Aim: To explore roles of CMHNs | 16 CMHNs, 16 patients, 11 carers | Taiwan, China | Observing home visit sessions, Interview | 14 roles found: assessor, supporter, educator, consultant, counsellor, negotiator, harmonizer, collaborator, advocate, placement coordinator, resource provider, care provider, case manager, and case finder. | The CMHNs played important roles in caring patients at homes. |
| Hyvonen & Nikkonen, 2004  
Aim: To describe and analyse the mental health care from practitioners' views. | 4 PHC nurses, 7 nurses, 11 practice nurses, and 7 doctors (n=29) | Pirkanmaa hospital district, Finland | Interviews | Four tools were used by practitioners of primary care services; collaborative, communicative, ideological, and technical tools. They also used themselves as person and practitioner. | The primary health care practitioners were important tools in mental health care, and influenced the type of caring provided to clients. |
| Lauder et al, 2001  
Aim: To describe mental health care given by district nurses. | 15 district nurses | The UK | Interview | The district nurses know the community and were appreciated by the patients because they were embedded, including living in the community as a member. They were gatekeepers in the community. They provided good support, but offered limited psychiatric treatment, supervision and monitoring. | The district nurses played roles in supporting and gatekeeping. They gave basic psychiatric treatment, but offered good support. |
| Magnusson et al, 2003  
Aim: To identify how structure changed from institute to community influenced home care practice | 11 mental health nurses | Sweden | Grounded theory using interviews | Changes were nurse-controlled to client-centred care and establishing relationship with the patients. Risks of harm were problematic. Making decisions for the clients was expressed as burdensome and lonely. | The nurses changed their care practices into everyday life of the patients. |
| Magnusson et al, 2004  
Aim: To describe psychiatric nurses’ experience in changing the focus from in-patient care to community-based care | 11 CMHNs (previous hospital-based nurses) | Sweden | Interviews | The nurses worked autonomously, and experienced loneliness. They motivated the patients to take responsibility for their care. They visited the patients and assessed those at home. They controlled the care including support and supervision. | The nurses provided care at patients’ homes working with the complexity of the patients’ everyday life. |
| McCann & Baker, 2003  
Aim: To identify models of collaboration in promoting continuity of care. | 24 CMHNs | New South Wales, Australia | Grounded theory using interviews and observation | Two models of nurse and GP collaboration were shared care where the nurses contacted GPs throughout the care, and special liaison where the nurses took the main role in practice. | Shared care was beneficial, while specialist liaison was limited. |
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<tr>
<td>McCardle et al, 2007</td>
<td>CPNs</td>
<td>Ireland</td>
<td>116 Questionnaire 33 CPN observation</td>
<td>Main care practices were assessment, medication management, health promotion, and client and family support. There was no evidence of cognitive, behaviour, or family therapy.</td>
<td>The CPNs provided mental health care practices, but did not rely on theoretical models.</td>
</tr>
<tr>
<td>McKenna, Keeney et al, 2000</td>
<td>15 CPNs</td>
<td>Three areas of one Trust in Northern Ireland</td>
<td>In-depth examination of registers, semi-structured interviews, and collection of statistics provided by the Trust</td>
<td>Main source of referral was from GPs. 34.2% spent about 2 weeks in response times between referrals and initial assessment. The CPNs spent time with clients, on travelling, at meetings, and working on documents. 36 and 82% reported the lack of support from colleagues and resources.</td>
<td>The community mental health care provided by CPNs was identified clearly. The agenda for future improvement was presented.</td>
</tr>
<tr>
<td>Muir-Cochrane, 2000</td>
<td>5 CMHNs</td>
<td>A community mental health centre in metropolitan Australia</td>
<td>Participant observation and interviews</td>
<td>The nurses' status was powerful. They decreased the formality, and allowed patients to ask for termination of visiting. They were guests sharing refreshment in social behaviour and gave injections at patients' homes. They spent more time with patients who were resistant to care.</td>
<td>The nurses visited the patients at home with respect in being guest and host. They provided care with a balance of strategies.</td>
</tr>
<tr>
<td>Nolan et al, 2001</td>
<td>73 mental health nurses</td>
<td>The UK</td>
<td>Questionnaire</td>
<td>84.9% provided injections. 79.4% thought that nurses should be able to prescribe. 91.5% were not ready to prescribe and needed training. Nurses were involved in medication administration in ways of educating, monitoring, reviewing medication and advising doctors. They were concerned about litigation.</td>
<td>These nurses were currently involved in the administration of medication, however they were not confident to do prescribing.</td>
</tr>
<tr>
<td>Nolan et al, 2007</td>
<td>65 nurses in UK and 43 nurses in US</td>
<td>The UK and US</td>
<td>Questionnaire</td>
<td>The nurses worked as team members and directly contacted to patients. They used CBT, eclectic and Peplau’s model.</td>
<td>The nurses provided care with teams using several models of care.</td>
</tr>
<tr>
<td>Nolan &amp; Brimblecombe, 2007</td>
<td>12 mental health nurse specialists</td>
<td>12 European countries</td>
<td>Questionnaire</td>
<td>Specialist mental health training were available in 12 counties</td>
<td>Mental health training was provided in European countries.</td>
</tr>
<tr>
<td>Nolan et al, 2004</td>
<td>131 CMHNS from rural and urban settings</td>
<td>2 mental health Trusts in the UK</td>
<td>Questionnaire encompassing opened and closed-ended questions, Using descriptive statistics and identifying categories</td>
<td>The results showed that the nursing, eclectic and medical models were used by the nurses from rural and urban areas. The CMHNS had satisfaction in contact with patients directly, seeing patients' improvement, and working autonomously. They had dissatisfaction in poor communication, faceless managers, and dealing with patients who did not engage.</td>
<td>The nursing process, eclectic and medical model were utilized in the UK. These nurses had motivation to work with the patient, but perceived their work as unsupportive.</td>
</tr>
<tr>
<td>Pagaiya &amp; Garner, 2005</td>
<td>18 nurses</td>
<td>Primary care unit in Thailand</td>
<td>RCT using 3-day training and 4 clinical guidelines. Measurement was baseline with a 6 month-follow-up</td>
<td>At the follow up session, Antibiotic and Diazepam prescribing rates in the intervention groups of children with respiratory syndrome and adults were significantly reduced.</td>
<td>The clinical guidelines implementation was effective in prescribing practice in rural services.</td>
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<td>Authors &amp; Aims</td>
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<tr>
<td>Peckover &amp; Chidlaw, 2007</td>
<td>18 district nurses</td>
<td>2 primary care Trust in North of England</td>
<td>Semi-structured interviews</td>
<td>Prejudge and risks were challenges for the district nurses in providing care for the clients with substance misuse. Some received suboptimal care.</td>
<td>The district nurses faced difficulties in providing care to this group of clients.</td>
</tr>
<tr>
<td>Royal Australian and New Zealand College of Psychiatrists Clinical Practice Guidelines Team for the Treatment of Schizophrenia and Related Disorders, 2005</td>
<td>-</td>
<td>-</td>
<td>Comprehensive literature review (1990-2003) in clinical practice guidelines</td>
<td>The guideline encompassed knowledge of schizophrenia and intervention with evidence presented.</td>
<td>The guideline as an evidence-based resource was presented with recommendations on its implementation to support care for people with schizophrenia.</td>
</tr>
<tr>
<td>Sands, 2007</td>
<td>Triage nurses Australia</td>
<td>Questionnaire survey with 139 nurses Interviews with 21 nurses</td>
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<tr>
<td>Seloilwe &amp; Thupayagale-Tshwenegae, 2007</td>
<td>-</td>
<td>Botswana</td>
<td>CMHC in Botswana shifted from institutions to community-based settings. There appeared to be four types of integration; attachment psychiatric care within general hospitals, decentralization of medication into other services, providing training to general nurses, and placing positions of mental health coordinators.</td>
<td>Four types of integration were used in organizing CMHC in Botswana.</td>
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</tr>
<tr>
<td>Sethabouppha &amp; Kane, 2005</td>
<td>15 family caregivers Northern Thailand</td>
<td>Phenomenological approach using interviews</td>
<td>Buddhist principles addressed by care givers were consequences of past life, compassion, ways of stress management, and acceptance in caregiving.</td>
<td>Caregiving was suffering experienced by care givers. Many viewed care situations through Buddhist beliefs.</td>
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<td>Shanley et al, 2001</td>
<td>32 respondents from Scotland</td>
<td>Telephone survey with respondents from NHS Trusts as providers, FHGPs as purchasers, user organizations as users</td>
<td>CPN services were good. There was insufficiency of numbers of CPNs and time spent with patients. Care should be improved in accessibility, skills and training, and the number of caseloads.</td>
<td>Services provided by the CPNs were good, but organizing of services needs adjustment.</td>
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<tr>
<td>Simpson, 2005</td>
<td>15 CPNs One Trust in South England</td>
<td>Multiple case study of 7 mental health teams using observation, semi-structured interviews, and document reviews</td>
<td>In Care Programme Approach (CPA), the duties associated with care co-ordinator roles and multidisciplinary working were constraints in practising using EBP intervention.</td>
<td>Working as care co-ordinators, nurses had to respond to efficient workloads, which affected mental health nursing intervention.</td>
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<td>Tello et al, 2005</td>
<td>-</td>
<td>Italy</td>
<td>-Index of SES from 9 census was calculated and grouped -Case register in 1996 was collected</td>
<td>Indicators of in-patient, day-patient, out-patient and community services showed an inverse association with SES.</td>
<td>SES was a factor influencing the use of psychiatric services.</td>
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<tr>
<td>Thomas et al, 2006</td>
<td>A group of senior district nurses, lead nurses, professional leads, and managers</td>
<td>West Hertfordshire area, the UK</td>
<td>Action research including developing of the West Hertfordshire Activity and Time Dependency Tool (WHATT)</td>
<td>23% of caseload was mental health cases. Understaffed service, unpredictable workload, and inappropriate use of staff skills prevented effective care.</td>
<td>Caseload management, referral and discharge criteria, and prioritization of visits offered possibility of effective time management. Skill mix review involved the more appropriate use of specialist skills.</td>
</tr>
<tr>
<td>Walsh et al, 2003</td>
<td>2 psychiatric nurses, 2 clinical nurses, clinical nurse consultant, and University academic</td>
<td>Royal Adelaide Hospital Mental Health Service</td>
<td>Evaluation of 6-month supervision group functions using a questionnaire</td>
<td>The group established aims and norms. The group provided a safe group environment, critical evaluation of practices, support, understanding of professional issues, and identification of solutions.</td>
<td>The group supervision implementation was effective in improving community mental health care.</td>
</tr>
<tr>
<td>Watcharasin et al, 2006</td>
<td>Health practitioners and experts</td>
<td>Thailand</td>
<td>In-depth interview Literature review Seminar (practitioners) and brainstorming (experts) Visiting Australia and the UK</td>
<td>The practitioners reported the lack of knowledge and skills. They reported they never caused changes in the care system. Training was distributed inappropriately.</td>
<td>The policy making did not appear to have a bottom-up approach.</td>
</tr>
<tr>
<td>Zeeman et al, 2002</td>
<td>12 CMHNs</td>
<td>Fremantle Hospital, Western Australia</td>
<td>Questionnaire Using descriptive statistics and coding</td>
<td>Range of caseload was 1 to more than 8 cases per day. 72% of contact was in community settings. Home visit was the most frequent aspect of work. 31.7% of liaison was via the telephone, and 21.3% of nurse contact with other nurses. 26.2 and 26.2% of them had face-to-face contact with patients fortnightly and weekly.</td>
<td>The CMHNs played crucial roles in promoting community mental health care.</td>
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</table>
The need for the study

The previous sections have discussed the literature which has been generated around the CMHC issues. Notwithstanding, this review has identified gaps in our understanding of CMHC, particularly Thai CMHC. First, this review has drawn attention to a number of models which have been constructed clearly where the resources and provisions were available, while those were limited in Thailand. Next, extant literature suggests how the nurses provided care to clients and stakeholders in those countries. However, much is unknown about how Thai nurses in the communities provided mental health care to their clients and associated with the stakeholders. Much of the literature is from other countries where the social, economics and cultural contexts differ from Thailand. Hence, the intention of this study is to generate knowledge from the findings which reflect Thai CMHC management.

Conceptual Framework

The literature indicates that current knowledge in relation to CMHC management revolves around four elements of CMHC; care practices, providers, consumers and environment. Nevertheless, the CMHC in Thailand does not appear to be developed in the same ways as those presented in prior research. Differences may depend on insufficient provision of health care, and the social and cultural beliefs of Thai people. The research question for this study emerged as a result of a need to explore and describe Thai CMHC management. The goal of the research was to gain information on how the CMHC is managed in the PCUs.

At this point, the PCUs have their own context. For instance, they are in non-metropolitan surroundings. The consumers also have their own beliefs and culture. The PCUs have adopted the PHC framework to achieve the goals of health and well-being
for the Thai populace. This study therefore adopted PHC as a conceptual framework. For the purpose of this study, the PHC principles encompass accessibility, appropriate technology, intersectoral collaboration, health promotion and public participation. Achievements of well-being are goals of PHC. To conceptualise this study the CMHC comprises domains of care provision, providers, consumers and environment, nested in the PHC framework as showed in Figure 2.2.

![CMHC domains nested within the PHC principles](image-url)

**Figure 2.2** CMHC domains nested within the PHC principles

The conceptual framework of this study is based on the CMHC, PHC and Thai context. That is, CMHC overlaps with community health services based on PHC principles. The purpose of the CMHC is to create mental health, whereas the PHC-based care focused
on health and well-being. Care is provided within the environment such as Thai culture, beliefs, national health system and the socioeconomic factors. Prior research and existing theory predicts that the CMHC will be operated in accordance with PHC principles (Chuengsatiansup & Suksit, 2008; Nuntaboot, 2006; World Health Organization, 2008). This conceptual framework is illustrated in Figure 2.3.

This conceptual framework guided an interpretive inquiry. The use of ethnographic approach was suitable to hear the participant voices through interviews, to observe them within the natural environment, and to analyse this information in conjunction with the document analysis. The quantitative questionnaire also complements the data providing further, specific insights into the study. A case study approach, surrounding the CMHC settings increases the depth of this inquiry.

Figure 2.3 Conceptual framework CMHC provided within the PHC framework
Summary

Mental health is a significant and complex issue. Care within an institutional setting does not enable management of mental health diseases. Community mental health care therefore provides a way to continue treatment episodes with patients living in their environments. The literature reviewed gives some foundation for the understandings of CMHC management world-wide, although little is known of its function in Thailand. The present study is an attempt to clarify this gap in understanding by generating knowledge from the natural conditions of the country.

Little is known about the actual processes or management of community mental health care in Thailand. There appears to be no defined, common structure of mental health care outside the institutional setting. Because Thailand has the capacity to provide comprehensive, effective mental health in communities across the country this study is both important and timely.
Chapter 3
Methodology

The present study focuses on care management in community mental health care settings in Thailand. This chapter presents the methodological approach to the study. In the first section, the worldviews/paradigms of inquiry are explained, followed by the study aims and design. In addition, relevant information regarding data collection and data analysis are described. This is followed by an explanation of techniques used to enhance rigour; that is, the trustworthiness or confirmability of the study. The ethical considerations are also described.

The Worldviews / Paradigms of Inquiry

The inductive approach of naturalistic research, interpretivism and constructivism were used to frame this inquiry in order to generate the knowledge of care management in two communities in Thailand. The method used an ethnographic approach including emic and etic perspectives.

Inductive Approach

Inductive approaches generate knowledge from data gathered. The inductive process is generally used with qualitative research methods as they seek to clarify and provide greater understanding of phenomena, and build explanatory theories (Holland and Campbell 2005; Walter 2006). This is in contrast to deductive approaches which guide theory testing. The inductive researcher typically conducts a study within the naturalistic setting and considers context as a priority (Morse and Field 1995).
The aim of this study was knowledge-generation from the information provided in the two cases. The researcher developed knowledge of natural mental health care management in two Thai communities without testing a prior conceptual framework. The researcher adopted the inductive approach, gathering the data from the health providers and the other sources in the communities, to generate the new knowledge and foster better understanding about community mental health care in two Thai communities.

**Naturalism, Interpretivism and Constructivism**

Unlike positivism, naturalism focuses on reality without manipulation (Laine 1997; Streubert and Carpenter 2007). Three basic views of social research, termed ‘naturalism’ or ‘naturalistic inquiry’ are associated with multiple truths, social change, and social responsibility. First, multiple truths exist, and there is no one correct methodology for scientific inquiry. Second, social change is a desired outcome of research. Third, social responsibility and democratic ideals should guide the research methodology (Streubert and Carpenter 2007). That is, naturalists believe that the knowledge of the social world can be illustrated by doing the research in ‘natural’ and not ‘artificial’ settings (Laine 1997).

Interpretivists view the social world as a ‘real’ objective world, but one constituted of meaning (Holloway and Wheeler 1996; Laine 1997; Clough and Nutbrown 2007). The interpretivist’s focus on human actions is to understand the social world or social life rather than causes of actions (Holloway and Wheeler 1996; Laine 1997; Clough and Nutbrown 2007). In the field, the researchers as interpretivists maintain personal involvement with specific aspects of the study, including participants. They believe that becoming ‘engaged’ in the field brings out the understanding in actions or meaning
rather than causes (Holloway and Wheeler 1996; Laine 1997; Clough and Nutbrown 2007). The interpretive approach shares with constructivism a focus on meaning.

Constructivism, typically associated with qualitative approaches, is based on the assumption that the meaning of phenomena can be understood through participants’ views (Holloway and Wheeler 1996; Laine 1997; Clough and Nutbrown 2007). These views are shaped by social interaction and engagement between participants and others as well as from their own personal experiences (Holloway and Wheeler 1996; Laine 1997; Clough and Nutbrown 2007). The constructivist view is that people’s experiences are context-bound. This means that the participants cannot be free from time and location or the mind of the human actor. Therefore, practical, contextualised interest is the major purpose of the research (Holloway and Wheeler 1996; Laine 1997; Clough and Nutbrown 2007).

For the purpose of this study, these paradigmatic views; naturalism, constructivism and interpretivism represent the philosophical foundation in generating the knowledge of community mental health care management. This is appropriate because, first, the knowledge of community mental health care was derived from people acting and interacting in a community mental health situation. The study was concerned with the social world, which included people, their practices and relationships, beliefs, feelings, and understandings. Data collection techniques required the nurses and other health providers to reflect on the mental health care management through their care practices and relationships with others. Included were their beliefs, feelings, and understandings which converged on mental health care management. Second, when the insiders’ beliefs, feelings, and understandings are presented, the researcher gathered and interpreted them to accomplish a deeper and richer understanding than positivism could
address. Third, the researcher believed that to understand mental health care in communities, the researcher should conduct the inquiry into realistic mental health care situations, which reflected the naturalistic principle.

**Ethnography**

Ethnography is a qualitative research strategy used to determine the values, beliefs, and practices of a cultural group (Morse and Field 1995). The ethnographic approach is more appropriate to the study of social world topics than quantitative methods because it focuses on people and aspects of their lives within social and cultural contexts. It engages the knowledge of insiders’ views rather than universal view. It also relates to interpretation rather than an objective description (Berg 2001; Taylor 2002). The main design feature of ethnographic method is that the data are collected from observation and interviews. ‘Thick’ description and the naturalistic stance are described at the point of time, environment, and other related details (Geertz 2000; Sandelowski and Barroso 2002). Data collection methods generally used are unstructured interviews, participant observations, and fieldnotes. Other data sources may be the uses of documents, records, photographs, maps, genealogies, and social network diagrams. Therefore, fieldwork is essential in ethnographic research and involves working with people for long periods of time in a naturalistic setting (Morse and Field 1995).

The ethnographic approach was adopted as a strategy of inquiry in this study. To understand how the health providers perceived and experienced mental health care practice in the communities, the researcher worked with them in close proximity. Techniques of participant observation and individual interviews were utilized to help the researcher to elicit true responses and feelings from the informants. Further, the lengthy duration of 40 half-days over a period of eight weeks spent with ten participants
also placed the researcher in an appropriate position to empathize with the participants and appreciate the challenges in natural care services. Additionally, the researcher had the chance to review the office documents related to the research in question. This provided the researcher an impartial understanding of the situation and, despite close engagement with the participants, not be totally influenced by their subjective evaluations.

**Emic and Etic Perspective**

The emic perspective is the insider’s view or native perceptions, while the etic dimension refers to the outsider’s perceptions of patients’ problems or issues (Holloway and Wheeler 1996; Holland and Campbell 2005; Have 2007). Ethnography requires information from the informants in terms of emic perspectives and reflects the concern of the researcher in ways of etic dimensions (Holloway and Wheeler 1996).

As the researcher needed an understanding of mental health care management from the informants’ views and experiences, the emic perspective, the insider’s or native perception was therefore sought. The participants were encouraged to speak about themselves. This emphasized the reality and perspectives of participants. In this study, the etic perspective was also important because it retrieved the information which was observed or accounted by the researcher who was closely involved in the culture. This information was interpreted and reported by the researcher as an outsider’s view.

**Study Aims**

This study addressed community mental health care management in Thailand. The objective of the study was to identify management practices in community mental health care in Thailand. Specific objectives were;
1. To identify mental health care practices and roles of providers in two PCUs in Thailand.

2. To explore the models of care for mental health problems specific to Thailand.

3. To investigate the influences on mental health care practices in the PCUs.

**Research design**

As this inductive research was conducted to generate the knowledge from the constructions and perceptions of those in the setting while gathering descriptive, observational data a mixed method design was used in a case study approach. The reason for using both quantitative and qualitative methods was to bring together the strengths of both forms of research to provide more comprehensive evidence than either quantitative or qualitative research alone (Creswell and Clark 2007). The case study is not itself a research method. Instead, it constitutes an approach to the study of singular entities, which may involve the use of a wide range of diverse methods of data collection and analysis. Ref A qualitative case study can be used to describe information in depth and detail, in context and holistically (Laine 1997). Therefore, in this study, the mixed method was adopted to enhance comprehension of information gathered and confirmability of the study.

**Mixed methods / combined methods / multi method research**

This study addressed mental health care management in two Thai communities. Based on either approach alone, quantitative or qualitative data is inadequate by itself to address the research problem. The researcher combined qualitative and quantitative approaches so as to provide a more entire, in-depth knowledge of participants’ perspectives.
Types of mixed methods

Many types of mixed methods are grouped and presented to guide the researchers. The first three ways of combining qualitative and quantitative approaches are integrating methodologies for better measurement, sequencing information for better analysis, and merging findings for better action (Carvalho and White 1997). Another three ways of mixing the data are merging the data: merging or converging the two datasets by actually bringing them together, connecting the data: connecting the two datasets by having one build on the other, and embedding the data: embedding one dataset within the other so that one type of data provides a supportive role for the other dataset (Creswell and Clark 2007). There are also descriptions of the mixed methods as single and multiple studies. The single study involves qualitative and quantitative research methods in collecting and analysing data within a single study. Multiple studies would require quantitative and qualitative studies to be conducted separately as sequential phases (Creswell and Clark 2007).

These four types of mixed methods have been described by Miles and Huberman (1994). Qualitative and quantitative continuous, integrated collection of both kinds of data is the first model. Both qualitative and quantitative methods are used in the same phase of data collecting.

Quantitative method conducted as multiwave survey in parallel with continuous qualitative drive in the fieldwork.

Sequence models mean that qualitative and quantitative data are collected in sequence times. Each time needs different data types.
Morse (2003) describes two main designs with eight types of mixed methods; *simultaneous designs* mean that a one-phase study comprising qualitative and quantitative techniques conducted with unequal weight. Either qualitative or quantitative drives the data collection process (QUAL+qual, QUAN+quan, QUAL+quan, QUAN+qual). *Sequential designs* refer to a two-phase model in which data collecting is driven by either qualitative or quantitative methods (QUAL ➤ qual, QUAN ➤ quan, QUAL ➤ quan, QUAN ➤ qual).

These are six designs of mixed methods described by Sandelowski (2003).

*Sequential designs* are quantitative priority models (QUAN>qual, qual>QUAN) and qualitative priority models conducted in sequence (QUAL>quan, quan>QUAL).

*Concurrent designs* are quantitative priority (QUAN+qual) and qualitative priority models conducted in the same time (QUAL+quan).

*Wave design* is a quantitative method used many times with continuous qualitative fieldwork (Quan wave1 wave2 wave3). *Sandwich design* means collecting data where two sequent models are paralleled in one study (Qual>Quan>Qual).

Finally, another four major types of mixed method designs are presented as follows: *Triangulation designs* refer to a one phase study of qualitative and quantitative methods with equal weight (QUAN + QUAL). There are four types. First, quantitative and qualitative data are combined together in order to compare and contrast the results (QUAN + QUAL ➤ compare and contrast). Second, quantitative and qualitative methods are mixed, and transform one result into the other (QUAN + QUAL ➤ compare and
transform). Third, quantitative results are validated with qualitative results (QUAN + QUAL $\rightarrow$ validate). Fourth, either quantitative or qualitative method embedded in the other can be interpreted overall (QUAN embedded QUAL, QUAL embedded QUAN).

*Embedded designs* are sequence models for experimental or correlation research. *Explanatory designs* are two phase models for explanation of significant, non-significant, and surprising results. Finally, *exploratory designs* are two phases for exploring a phenomenon (Creswell and Clark 2007).

The current study sought to understand the good management practices in Thai communities. The appropriate research design for this study was “QUAL+ quan” (Morse 2003; Sandelowski 2003). The qualitative approach addressed the research question on how mental health care is managed in Thai communities. Therefore, the researcher combined qualitative and quantitative methods together but with a major focus on qualitative data to create a deeper understanding of the informants’ beliefs, feelings and practices so that a more complete picture could be attained. Furthermore, the numerical data derived from the quantitative approach enriched the results of the study.

**Triangulation**

Besides the mixed methods, the trustworthiness of this study can be explained by the uses of triangulation. Triangulation was adopted in order to increase the validity of results and to enhance the information obtained (Flick 2002). Triangulation is a systematic comparison of findings on the same research topic generated by different methods. There are four types of triangulation; data triangulation, investigator triangulation, theoretical triangulation, and methodological triangulation. The current study, first, adopted *methodological triangulation* which is using different methods to
study the same topic (Bloor and Wood 2006). The uses of quantitative and qualitative
methods in seeking the same topic of the study make the knowledge generated
comprehensive. Also, *data triangulation* was addressed by using interviews,
observations, document analysis, and quantitative questionnaires to generate the data of
the same topic from a variety of sources. This provided deeper insight into generating
the knowledge (Gillham 2000). In addition, the results derived from many sources and
different methods enhanced validity when those findings were corroborated (Holland
and Campbell 2005; Willig 2005; Bloor and Wood 2006).

**Case study**

Case study can be defined as the intensive study of a single case for the purpose of
understanding a larger class of similar units (Yin 2003; Gerring 2007). Case is a unit
observed at a single point in time or over some period of time in real-life. It comprises
the type of phenomenon that an inference attempts to explain (Yin 2003; Gerring 2007).
A case can be an organization, a city, a group of people, a community, a patient, a
school, an intervention, even a notion state or an empire. It can be a situation, set of
decisions, agency, neighbourhoods, event, program, organization, time period, critical
incident or an experience (Laine 1997; Gillham 2000; Yin 2003; Willig 2005). This
study aimed to describe the in-depth details of mental health care practised in the
communities. The case study method helped in understanding the mental health care
management as the particular specific phenomenon in the two PCUs under
investigation.

**Features of the case studies**
The study was undertaken during 2008 and focused on the mental health care provided within the PCUs’ environments of community mental health care management in Thailand. A case study was appropriate for the inquiry because of five features. First, the case study is *an idiographic perspective* that researchers are concerned with rather than general cases. Second, *attention to contextual data* means that researchers pay attention to the data in a holistic manner that includes the situation or environment. The cases cannot be separate from their context. Third, *triangulation* integrates information from several sources to gain an in-depth understanding of phenomena. Next, *a temporal element* means that case studies are concerned with occurrences over a period of time. A *concern with theory* means that case studies can facilitate theory generation (Yin 2003; Willig 2005).

**Types of designs for case study research**

There are many types of case study designs established in research. Each design is useful for researching specific research questions (Laine 1997; Willig 2005).

*Intrinsic versus instrumental case studies:* The cases in intrinsic case studies are chosen for specific research questions because they are interesting in their own right (Willig 2005). The researcher wants to know about them in particular, rather than about more general problems. In contrast, in instrumental case studies, the researcher wants to know how the topic of interest within the cases constitutes exemplars of a more general problem. The instrumental case study therefore refers to research where a particular case is examined to provide insight into an issue (Willig 2005).

*Single-case versus multiple-case studies/collective case studies:* The single case can represent a unique or extreme case that is of intrinsic interest (Miles and Huberman...
1994; Yin 2003; Willig 2005). A positivist case may constitute a critical test for a well-formulated theory and may be revelatory in that it was inaccessible before. In contrast, the multiple-case studies/collective case studies provide the researcher with the opportunity to develop theory with analysis from many cases. The researcher also can account for all instances associated with the phenomena under investigation. The assumption is that the cases will lead to better understanding of the issues (Miles and Huberman 1994; Yin 2003; Willig 2005).

Cross-case method versus within-case/case study method: There are two approaches in conducting case study research. The first approach is a cross-case method, studying a large number of cases (Miles and Huberman 1994; Gerring 2007). The cross-case research design is suitable for testing existing theories or hypotheses. The second is a within-case or case study method, looking at a particular case. The within-case is almost always nested in the larger unit (Miles and Huberman 1994; Gerring 2007). Gerring (2007) comments that researchers may choose to observe a number of cases superficially (cross-case), or a few cases more intensively (within-case). The case study research design is more useful for generating new knowledge (Miles and Huberman 1994; Gerring 2007).

Descriptive versus explanatory case studies: Descriptive case studies are concerned with providing a detailed description of the phenomenon in the context (Willig 2005). The cases should allow the researcher to obtain new insight or a better understanding of the phenomenon. In contrast, explanatory case studies describe the particular occurrences in detail and with sufficient evidence (Willig 2005). Yin (2003) illustrates four case study designs. First, single case designs (holistic) refer to a single case as a single unit with its own context. Next, single case designs
(embedded) refer to multiple units embedded in one case studied within the same context. Multiple-case designs (holistic) are multiple cases interested with their own contexts. Finally, multiple-case designs (embedded) are multiple units embedded in each case. These cases have their own contexts (Yin 2003).

This study was based on concepts of five case study designs, which were instrumental, multiple cases, within-case, descriptive, and multiple cases (embedded) design. First, based on the instrumental case study design, the cases constitute exemplars of a more general context. Here, the research addresses community mental health care management. Therefore, the cases were selected in order to explore how mental health care management exists in general care management in the PCUs. Second, two PCUs taking the role of multiple case studies provided the researcher the opportunity of comparison between two similar PCUs to confirm trustworthiness. Third, studying within-case encouraged the researcher to gain deeper knowledge in two particular settings. Next, descriptive case studies drew insight/new knowledge in mental health care in Thai communities. Lastly, the researcher studied several units with health providers embedded in two cases and the PCUs in each context. That is, the multiple-case design (embedded) was used in this research.

Cases, Participants and the Selection

Boundaries of Cases

Doing case study research, it is necessary to define a ‘bounded’ case (Yin 2003). The boundaries of cases means clarification of the research questions asked, the data sources used, the settings and the persons involved (Holloway and Wheeler 1996). This study looked at the two PCUs as the cases. They were the local health centres affiliated to the Ministry of Public Health, Thailand. This study addressed mental health services
provided by the PCUs’ health workers. The PCUs’ services were engaged within the scope of mental health care practice provided, models of care, and factors influencing care. This information was provided by the health workers within the PCU context and the official documents relating to mental health care situations.

**Selection of Cases and Participants**

**Purposive sampling**

Purposive sampling was a criterion-based selection of participants or settings. Certain criteria were defined, and the sample was chosen accordingly. The sample was selected based on what was known about the target population and the purpose of the study (Holloway and Wheeler 1996; Berg 2001; Yin 2003; Walter 2006). Purposive sampling was used to select the cases and participants of this study. The researcher defined some characteristics, related to mental health care management, of the PCUs and the participants in order to gain rich and in-depth information.

**Criteria**

The criteria for case selection included a requirement that the PCUs would be large enough to provide the perspective of a community-based service. They were therefore chosen on the basis of being a typical PCU local health centre, employing at least five health providers to provide health care, including mental health care to the communities. Two similar PCUs were selected as cases to support confirmability of multiple-case studies (Yin 2003). They were similar in the number of health workers, and their distance from the city and the local hospitals. Both PCUs were located in the rural communities and provided health care to the Thai population, not other ethnic groups. The informants had to be people who have undergone or are undergoing experiences of which the researcher can gain useful information (Holloway and Wheeler 1996). In this...
study, sample selection criteria include the fact that participants must be nurses or other health providers, who have provided mental health care in the PCUs for at least one year. All were persons who volunteered to participate in the study.

The researcher began selecting the PCUs by choosing the Central and Northern regions because they were safe areas at that time. Then the researcher considered three provinces from each region regarding the convenience and affordability in travelling and lodging. After that, the researcher contacted those public health offices by telephone to inquire about the characteristics of the PCUs affiliated with those public health offices. The two PCUs selected for the study met the criteria and were feasible in terms of travelling and lodging during collecting the data.

**Recruitment**

Recruitment commenced when the researcher used the criteria to select target PCUs from the lists of organizations belonging to The Public Health Offices of the Regions. The researcher introduced the study project to the health providers practising within the PCUs. A brief overview of the study was provided followed by a request for formal permission. The researcher conducted meetings with the participants to provide them with the details of the study and addressed the ethical issues. After they were fully informed, none had an issue and all were willing to participate. Then, they signed the consent forms.

**Cases and Participants**

Two PCUs located in the Northern and Central Thailand constituted the cases. The participants were seven nurses and three public health workers employed within the two
PCUs, and willing to talk about their experiences and perceptions in mental health care provided in the PCUs.

**Data collection**

The researcher spent four weeks in each site to collect the data. The first data collection in the Northern setting was conducted from 22\textsuperscript{nd} June to 18\textsuperscript{th} July 2008. The Central setting was studied between 3\textsuperscript{rd} and 29\textsuperscript{th} August 2008.

**Data collection methods**

The researcher defined the frame of data collection in the fields to answer the research question focusing on mental health care practices, models of care, and influences on mental health care practices within the context of the PCUs. The instruments used in the inquiry were participant observations, semi-structured interview, official document analysis, and quantitative questionnaires.

**Participant observations**

The researcher conducted the participant- observations focusing on the practices in their employment settings. The observations were conducted during 20 half-days of four weeks in each place.

The observation guide:

1. Daily mental health care in the PCU and community (How does the care take place? Who undertakes what care practice roles? Who are involved? Which specific situation is an antecedent?)

2. Care activities related to established policies, such as home visiting regarding mental health policies, counselling a person with attempted suicide, or referring patients to the hospital.
3. Formal and informal meetings relating to mental health care decision making.

**Semi-structured interview**

The semi-structured interviews were used with ten participants in this study. Each interview session was approximately one hour.

The interview Questions:

1. Can you describe your mental health role? What do you do? How?
2. What do you believe are the most important influences on mental health care? Why?
3. In your opinion how do mental health policies direct practices and vice versa (How do practices direct policies)?
4. How do you manage noncompliant patients, and on what criteria is this based?
5. What helps and/or hinders you in making decisions for mental health care?

**Official document analysis**

The researcher examined the official documents involving mental health and psychiatric care management.

The document analysis guide:

1. The records/reports of work (What type of work done in the PCU?)
2. The records of the model such as the signed contract between the PCU and other organizations in mental health projects, the procedure, or the protocol.
3. Project reports relating to mental health care (What are the main reasons/background of mental health projects/tasks? Who does management? Who provides support? What are the facilities?)
4. The organization plan and reports of activities/projects/tasks (Is this in accordance with mental health policies? Are there other policies mentioned in the reports?)

5. Records of meetings relating to mental health care agenda such as mental health project discussions or meetings for managing mental health situations.

**Quantitative questionnaires**

The quantitative questionnaires were used to collect participants’ demographic data and care provided. Questions were developed to explore the duration of experience in working in the community, specific training undertaken gained or further education received while working with caseloads, and current workloads. The participants were asked about demographic data and their care practices by using closed-ended questions.

**Translation Process**

This study was undertaken by a Thai researcher with Thai health providers in Thailand. Therefore, all instruments, English version were translated into Thai by the researcher. Then, a bilingual Thai nursing lecturers and an Australian nursing research instructor who was fluent in Thai language translated them back into English versions. Overall, the two back-translation versions were similar. There were a few different words used for the same meanings in the back-translations such as ‘liaison’ and ‘communication’ and ‘noncompliant’ and ‘resistant’. All key words from the back-translation versions were same to those in the original version developed by the researcher. The information sheet, leaflet, consent forms, and findings of the study were translated by the researcher.

**Validity of Instruments**
The researcher developed interview questions, observation and document analysis guides, and quantitative questionnaires based on the research questions and principles of community mental health care. All questions and guides used as the instruments were commented on by two nursing instructors who were experts in mental health and community health care and one senior nurse working for a PCU. The experts considered the content of all questions and guides whether they associated with elements of community mental health care practices to ensure content validity (Burns and Grove 1997). The researcher reconsidered and adjusted them for appropriateness and accuracy.

A pilot study can be undertaken to identify feasibility of the research instruments (Roberts and Taylor 1998). In this case, the researcher piloted the instrument with 25 nurses who worked for PCUs in other regions. One refinement in terms of the use of an interview question was required after the pilot. In the original version, the interview questions comprised of five questions which included a question about what mental health situation was dealt with by the health provider. Twenty-two of the nurses in the trials responded that dealing with non-compliant patients were problematic. Therefore, the researcher selected this situation to be representative and changed this question into how they dealt with non-compliant patients instead, to focus on one particular situation. In term of literacy, all nurses could understand all questions. In addition, these nurses as untrained persons responded that these instruments looked valid in terms of what and how the nurses work on mental health issues in the community. This was able to confirm face validity of the instruments. Even though the face validity is weak evidence, it may be useful when using with other types of validity because it relies on subjective judgement (Burns and Grove 1997).

Procedure
The researcher conducted participant-observations focusing on mental health services, which are part of their normal work. The observations were conducted during 20 half-days of the four weeks of work in each setting. The researcher was not disruptive to the participants’ work. However, it was natural to involve the patients with mental illness. The researcher communicated the study to the patients and their guardians in advance. Then the researcher asked them for permission to be observed. All agreed for the patients to take part in the study with signed consents. These sessions were conducted at the PCUs and the patients’ homes.

The semi-structured interviews were used in the 3rd and 4th week. The researcher provided the questions in advance to participants. Then a mutually appropriate time was scheduled to conduct the interviews, which were audiotaped. Each participant was asked to be interviewed no longer than one hour.

The quantitative questionnaires were used to collect the quantitative data relating to the participants’ demographic data and care practices. The participants took about 10 minutes to complete the questionnaires.

The researcher read the official documents involving mental health and psychiatric care management.

**Data analysis**

The qualitative and quantitative data were integrated as illustrated below. The researcher adapted the data analysis model from Creswell’s model (Creswell and Clark 2007). The quantitative method was used to embellish and validate a primarily qualitative technique.
Quantitative analysis was conducted using version 14.0 of the Statistical Package for the Social Sciences for Window (SPSS) for frequency, percentages, means, and standard deviations. Qualitative data were interpreted by the researcher manually as they were collected. Data preparation was done by the researcher transcribing interviews in the Thai language. The tapes were transcribed word for word, not paraphrased. All expressions, including exclamations, laughter, and expletives were recorded in square brackets. The researcher’s attitude and comments in the content were recorded in the left margins. The right margin was for recording the researcher’s comments on the interview process. Data from observations and documents were analysed in relation to the interview data, which were a form of data triangulation to ensure rigorous analysis. The researcher adopted analytic steps that were adapted from thematic analysis; step-by-step from (Braun and Clarke 2006) and Burnard’s thematic content analysis (Burnard 1991; Jubb and Shanley 2005). Thematic analysis was suitable for this study because it supported flexibility and demarcation in capturing the themes as they emerged (Braun and Clarke 2006). Burnard’s thematic content analysis helped in framing themes that emerged (Burnard 1991).
After reading, re-reading and preparing summary information, the researcher familiarised herself with the information gathered. After that, the researcher began making lists for framing all codes into three groups related to the research questions. These were the care practice (tasks, workloads, caseloads, roles, duties, and creative work), the models of care (patterns of work, models, theories and principles), and data associated with the factors influencing the care (social, policies, surroundings, economics, funding, atmosphere, agencies, government, motivations, beliefs, colleagues, systems, administration, organization, and dissatisfaction).

Following this step, the qualitative data were coded, and categorized by the researcher using an iterative process of going through all data sources, and selecting interesting features of the data. The significant data related to the research questions were highlighted. Then, they were cut and glued to hand-cards. The hand-cards were recorded with the codes of data sources onto these cards (codes). In this process, the related quantitative data were included to confirm the coded findings. This was an affirmation of methodological triangulation and helped enrich the data.

The codes were grouped for congruency. The researcher searched for the themes as they emerged. They were checked for relevancy to the lists of data in order to answer the research questions. Each group were organised by headings. Some codes became the main themes and others were categories and sub-categories. Additional codes were used more than one time. Following this, all codes were re-categorized appropriately into themes (headings), categories, and/or sub-categories. These were generated as a thematic chart of analysis. The researcher selected vivid meaningful examples, and placed them into the chart.
Overall, each category was checked by four representatives of the participants in terms of appropriateness (Burnard 1991). The four representatives were selected by the researcher according to their roles and knowledge background. Two of them were the chiefs of the PCUs and had insight in their workplaces. Three of those had a good understanding of research, as they had completed higher education. Through the process of analysis, there appeared to be re-reading, re-adjustment, and re-checking because the qualitative analysis was not just a linear approach moving from step one to the next, but involved ongoing consideration throughout the phase (Braun and Clarke 2006).

**Trustworthiness / Credibility**

Trustworthiness / Credibility of research can be enhanced by prolonged engagement, persistent observation, triangulation, peer debriefing, negative case analysis, referential adequacy, and member checks (Holland and Campbell 2005). To enhance trustworthiness, the researcher conducted this study with five criteria of trustworthiness.

**Prolonged engagement:** Prior to working in the field, the researcher as a Nursing Educator at the Ministry of Public Health, Thailand, was familiar with PCUs providing health care in communities. The researcher conducted the study in the field for four weeks in each place. That is, the investigating process ensured sufficient time was taken to provide the scope for the study. The researcher spent time in building trust, learning the cases with contexts, and testing for misinformation.

**Persistent observation:** The researcher conducted the participant observation in day-to-day activities for 20 half-days in each PCU. This provided the depth identified as elements of mental health care management in Thai communities.
Triangulation: Triangulation is a major criterion for evaluating the rigour of qualitative research or naturalistic inquiry (Laine 1997). In this study, the researcher adopted data triangulation and methodology triangulation in order to confirm the findings generated through several sources comprising the observation, interview, survey, and document analysis, and two research methods.

Referential adequacy: The researcher had several forms of recording the activities in the field. Additionally, they will be stored safely for five years and archived for future reference.

Member checks: The test of credibility is often referred to as member checks. The findings of the study and interpreted information were tested in two ways. First, all participants were invited to check the transcriptions to see if they accurately reflected their views. This was done individually before further analysis. In that time, they could verify or modify any topic in their own context if they wished. Then, the four selected informants were asked to check all themes and categories as interpreted by the researcher. All accepted this responsibility, and all agreed with the themes and categories. Second, the summaries of the research results were provided to all the people working there to confirm the data as displayed in summary results.

Auditability

Auditability is a concept of accountancy of qualitative research. Laine (1997) presents the Halpern audit trail categories. Those are raw data, data reduction and analysis products, data reconstruction and synthesis products, process notes, materials relating to intentions and dispositions, and instrument development information.
The researcher conducted the study in consideration of auditability in six aspects. First, the raw data was illustrated with audiotapes recording and transcripts, written fieldnotes, document recordings, and written questionnaires. Second, the data reduction and analysis products were completed in forms of the write-ups of fieldnotes, summaries, and quantitative summaries. Third, the data reconstruction and synthesis products were recorded in the structure notes of categories (theme emerged), findings and conclusions, and a final report with connections to the existing literature. Fourth, each step of the study was undertaken sequentially. Fifth, the researcher recorded regularly the personal notes related to motivation and expectations during the fieldwork. Several forms of recording were used during the fieldwork, including the observational notes, field notes, document summaries, contact summary sheets, memos, and data accounting sheets. Sixth, the types of instrument that were used to derive data were presented with the observation formats, questionnaires, interview guides, and document analysis guides.

All of the above steps illustrate the researcher’s interest in the subject matter of the study, the views of the researcher in the subject issues, the approach of the knowledge gained and the methods used for data reduction, analysis and presentation.

**Construct Validity**

Rigour of case study tactics is demonstrated as four designs tests; construct validity, internal validity, external validity, and reliability (Yin 2003). The rigour of this research as a multiple-case study design can be affirmed by the construct validity test. The *construct validity test* was applied in terms of using multiple sources of evidence. The data were collected from the semi-structured interviews, the participant observations, questionnaires, and the document analysis. These data contributed to the robustness of
the study by using data triangulation (Laine 1997; Yin 2003). Methodological triangulation also confirmed the construct validity of this study by using quantitative and qualitative methods. Both questionnaires and open-ended questions in the semi-structured interview were used to elicit qualitative and quantitative data from the informants (Miles and Huberman 1994; Laine 1997; Yin 2003). In addition, the key informants reviewed the draft case study report, which was a way of defending construct validity (Yin 2003).

**Ethical considerations**

Prior to data collection, this research project was approved from the Murdoch University Human Research Ethics Committee and the selected Public Health Offices within the Ministry of Public Health in Thailand.

On receiving ethical approval, the researcher contacted the Head of two PCUs, and introduced the project and asked permission to conduct the study. The leaflets of brief information and invitation were presented on notice boards. The staff interested in participating in the study contacted the researcher by phone and email. The researcher gave them the brief information. Following this, the researcher conducted the meeting to inform them of all details and ethical issues. They signed consent forms to be participants once they were fully informed.

The participants had right to refuse to be observed, however, all participants allowed the researcher to conduct the observation sessions. In the observation sessions was natural to involve the patients with mental illness. The researcher communicated the study to the patients and their guardians in advance. Then the researcher asked them for permission to be observed. When they agreed for the patients to take part in the study,
the guardians signed the consent forms. The guardians were invited to stop the session at any time if the patient felt distress. The researcher also used the discomfort criteria to decide whether to stop the observation sessions early. In this study, all observation sessions were conducted completely without patients’ discomfort.

For the interview sessions, the researcher provided the questions in advance to participants. The participants had the right to refuse the audiotape recording, however all participants allowed their interviews to be audiotaped. The researcher asked for permission from the heads of the PCUs before each interview commenced. The interviews were conducted in the PCU offices without disturbing the participants' work schedules.

The researcher analysed the official documents involving mental health services. The researcher asked permission from the head of the PCU before accessing the document.

This study focused on community mental health care management within the legal and regulatory requirements of Thailand. In this respect, it was an ethnographic study of the mental health clinic culture, not the Thai culture per se. However, as is the case with all cultural groups, workplace beliefs and practices presented by the participants were influenced by their cultural beliefs. The researcher approached the participants with respect and provided necessary privacy with regard to their beliefs, customs, cultural heritage, and legal issues.

All participants had a chance to check the prescriptions individually before analysis publication. In that time they could verify or modify any topic if they chose to do so. When the researcher completed analysing the data, four of them checked the themes
emerged from analysis. Summaries of the research results were provided to all participants, and copies of the research reports and reprints of articles would supplied to the participants’ workplaces.

The participants were assured privacy and confidentiality. Their names were not used in the event that the information they provided was published. Participants’ names appearing in personal data files were used only by the researcher to clarify the interview, then a pseudonym was assigned to each participant to ensure that data were de-identified. Participant names were not recorded on the data from observation, readings of official documentation, or from interviews. The data were kept separately from the personal data. Both personal data and data derived from the study were kept in a secure, locked cabinet at Murdoch University for five years. After that, they will be destroyed. Individuals who could access to these data are the researcher and the chief investigator with the participants’ permission.

The researcher carried out the research maintaining anonymity of the participants throughout the study. There was a low risk of inadvertently identifying them, because there were no unique identifiers and the data were hidden from public scrutiny. The researcher avoided using identified-linked pseudonyms, locality associations, social categorizations, and gender identifiable information. The participants were ten of 25,125 health providers within their community. The two PCUs were located among 4,791 PCUs in the regions (Ministry of Public Health 2008). The characteristics of the PCUs selected were typical of other PCUs and therefore not distinguishable. It was thus inferred that anonymity was preserved.
Summary

In summary, this study utilized an ethnographic case study design to identify the practice of mental health care in two Thai communities. A mixed method, qualitative design was used in the data management. The data were collected through participant observation, individual interview, quantitative questionnaires, and document analysis. The participants were respected and protected followed the research ethics issues. The qualitative and quantitative data were analysed using thematic and descriptive analysis. The findings of the study are presented in chapter 4 and 5.
Chapter 4
Case Context and Quantitative Results

Introduction
Doing research through case study requires considering the context as well as the case, so both case and context are presented in these chapters. This study views the PCU as the case study and the health providers as sub-units within the cases. Data are derived from being with participants via ethnographic study to establish communication, observation, and some document analysis. This chapter focuses on the context of the case studies. This is to understand the nature of the cases and provide insight into the boundaries and substance of the case studies. The chapter also presents the results from the quantitative inquiry using questionnaires. The respondents were ten health providers employed within two PCUs located in the Northern and Central Regions of Thailand. In order to quantify the scope of care management related to mental health care, the health providers were asked to respond to the survey questionnaires, which were based on close and open ended questions and some rating scales. The findings derived from this quantitative method are presented through two main sections of case context and care management. This chapter also provides comparative analysis based on the quantitative data collected.

Context of cases
Location
The Northern PCU was located in the North Region of Thailand. It was five kilometres from the city and ten kilometres from the local hospital. The Northern PCU was located on flatland. A river passed through the plain approximately one kilometre from the PCU
There was one Buddhist temple and one Christian Church near the PCU. There was no school located in the community of the Northern PCU. One distance learning facility provided non-school education for the community. The office of the Local Administrative Organization (LAO) was located one kilometre from the PCU office. The Central PCU was located in central Thailand. It was ten kilometres from the city and the local hospital. The Central PCU was located on a plain, 50 metres from the LAO and one kilometre from the community’s school. It was opposite the community’s Buddhist temple. There were three Buddhist temples and three schools located in the community.

**Physical Condition of the PCUs**

The Northern PCU office was a two-storey building. The upstairs was for Thai massage and herbal aroma therapy. All massage therapists have been trained and certified. Sometimes, this room was used as a convention room to educate consumer groups in health care. One small room upstairs was the Head’s office. Downstairs was divided into several rooms: a treatment room for wound dressing and giving injections, the first contact and screening area, the gynaecology service and counselling room, the medical supply room, the dental service room, and the computer and documentation area. One open hall used for group meetings with stakeholders was located besides the building. There were three lodges for workers and families who needed accommodation. The Central PCU office was a two-storey building. The second floor served as a meeting room. It also contained a small room for colleague meetings and computer work, a dental care room, and a small room for the Head’s office. The first floor was divided into several rooms. These were a treatment area, a wound dressing and injection room, a first contact and screening area, a gynaecological service and observation room, a counselling and medical supply room, and a computer and documentation area. There
were three lodges for workers and families who needed accommodation. A public park area containing physical exercise equipment was open to all people.

**Chain of Command**

The Northern and Central PCU were local health centres under the Ministry of Public Health. The health providers were supervised by the Provincial Public Health Office, which received health policies from the MOPH. However, to provide health services in the communities, they also were directed by the local governor, under the Ministry of the Interior.

**Services Provided to Community**

The Northern PCU provided general care to the 6,424-person population of the sub-district, and it also welcomed people from other areas. Consumers included labourers, government officers, merchants, and farmers. Most of the population are Buddhists. Christians were a minority. The PCU provided general health care from birth through death in order to maintain the populace’s well-being. They also provided health services in crisis situations such as flooding and Bird Flu epidemic. Health workers probably did not function at full capacity in the course of their daily work due to meetings outside the PCU. They also alternated night shift work, with one worker on duty per night. Some workers helped the community through non-clinical work such as local election committees or specialized Local Administrative Organization (LAO) activities. The Central PCU provided health services to the 10,725-person population of the sub-district and other sub-districts. The consumers comprised labourers, government officers, merchants, farmers, and students. They were Buddhists and Christians. The PCU provided general health care in order to maintain the populace’s well-being. They also dealt with health crises such as flooding and Dengue Hemorrhagic Fewer epidemic.
They provided health services at the PCU office during regular office hours. Additionally, some workers may be on duty outside office hours due to home visits, schoolchildren care, and meetings.

**Caseloads**

In describing the service provided to mental health cases, the health providers were asked to calculate the ratio of mental health cases and 100 normal cases in which they were engaged. The average number of mental health case ratio responded by the informants belonging to the Northern PCU and Central PCU were .93 (S.D.0.15) and one (S.D.0.24) mental health case in every 100 normal cases. These data are presented in Table 4.1

**Table 4.1: Average Mental Health Caseload of Participants in The Northern and Central PCUs**

<table>
<thead>
<tr>
<th>Caseload:100 Normal Case</th>
<th>Northern PCU</th>
<th>Central PCU</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Average (x)</td>
<td>SD</td>
</tr>
<tr>
<td>Mental Health Case</td>
<td>0.93</td>
<td>0.15</td>
</tr>
</tbody>
</table>

The Kolmogorov-Smirnov Test was used to compare the caseload ratio reported by the two groups of respondents. For these analyses, no significant differences of responses was found between health provider employed within the Northern and those in the Central PCU (see Table 4.2)

**Table 4.2: Comparison between Caseload of Participants Working in The Northern and Central PCUs**

<table>
<thead>
<tr>
<th>Caseload:100 Normal Case</th>
<th>Northern PCU Ratio</th>
<th>Central PCU Ratio</th>
<th>Kolmogorov-Smirnov Test</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health Case</td>
<td>0.93</td>
<td>1.00</td>
<td>.819</td>
</tr>
</tbody>
</table>

* p value < 0.05
**PCU Workers**

There were ten officers employed within the Northern PCU. The Head was a public health worker who provided health care and administrates PCU functions. He graduated with a Master’s Degree in Education Administration. One nurse completed further education in medical law and a three-month Nurse Practitioner course. Another nurse also completed the Nursing Practitioner course. One nurse completed Master’s Degree in Education Administration. The other nurse was a Registered Nurse. The other public health worker graduated with a Bachelor’s Degree in Public Health. These five workers participated in the interview sessions. The additional staff consist of: one dental public health worker and one assistant who provided dental care; one nursing aide who worked as a clerk in patient filing and first screening, and who sometimes helped in wound dressing; and one office maid who kept the office clean and tidy at all office time. In total, ten workers performed the PCU services. There were ten officers employed within the Central PCU. The Head was a nurse who provides health care and oversees PCU operations. The other two nurses have completed further education in the three-month course of Nurse Practitioner. One nurse was a Nurse Practitioner and studying in Master’s Degree in Nursing. One public health worker graduated with a Bachelor’s Degree in Public Health. These five workers participated in the interview sessions. Two other NPs, who have just moved into the PCU, did not take part in the interview session. One dental public health worker provided dental care to adults and students belonging to the community’s school, and one clerk worked in patient filing and first screening. Another nurse was leaving for short course training. Occasionally, another worker was hired to organize computer-based documents. One office maid kept the office clean and tidy during office hours. In total, ten workers were employed full time and one worker assists with documentation as needed.
Disciplines

The questionnaire survey found that mental health care practices were provided in the two PCUs through two disciplines employed, namely, nurses and public health workers in the two Thai communities (see Table 4.3). The data also revealed that the majority of health providers were nurses. As presented in Table 4.3, three of the five informants employed within the Northern PCU were nurses and of these only two were public health workers. Similarly, within the Central PCU respondents, four were nurses while only one of the respondents was a public health worker.

Table 4.3: Disciplines of Health Workers Working in The Northern and Central PCUs

<table>
<thead>
<tr>
<th>Discipline</th>
<th>Northern PCU (n=5)</th>
<th>Central PCU (n=5)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Public Health Worker</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>5</td>
<td>5</td>
</tr>
</tbody>
</table>

Experience

The respondents identified themselves as health providers with experience ranging from 2 to 27 years providing care practices in the PCUs. Table 4.4 displays the responses of the informants relative to the length of time undertaking tasks that involve mental health care. The average number of years working for the Northern PCU and Central PCU were 9.8 (S.D.9.23) and 12.8 years (S.D.11.69) with a range of 2 to 24 and 3 to 27 years respectively. These data are presented in Table 4.4.

Table 4.4: Average and Range of Years of Experience of Participants Working in The Northern and Central PCUs

<table>
<thead>
<tr>
<th>Years of Experience</th>
<th>Northern PCU (N=5)</th>
<th>Central PCU (N=5)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Average (x)</td>
<td>SD.</td>
</tr>
<tr>
<td>Years working for the PCUs (years)</td>
<td>9.8</td>
<td>9.23</td>
</tr>
</tbody>
</table>
Table 4.5 details ranges of years in general and mental health practices in the PCUs. Of the five health providers within the Northern PCU, two had experience ranging from 0 to 5. Likewise, two of the health providers at the Central PCU spent the same duration in practice as those two health providers. Only one respondent belonging to the Northern PCU reported more than 20 years working in providing health care. Two respondents employed within the Central PCU reported their practicing years to be in the range of 21 to 30.

Table 4.5: Experience Year in Working of Participants in The Northern and Central PCUs

<table>
<thead>
<tr>
<th>Years of Experience</th>
<th>Northern PCU (n=5)</th>
<th>Central PCU (n=5)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-5 years</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>6-10 years</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>11-15 years</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>16-20 years</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>21-25 years</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>26-30 years</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>5</strong></td>
<td><strong>5</strong></td>
</tr>
</tbody>
</table>

The similarity of ranges of years of experience in care practice reported by all informants belonged to the two PCUs is confirmed by The Mann-Whitney U Test and Kolmogorov-Smirnov Test. As shown in Table 4.6 there were no significant differences in the responses of the two groups of respondents.

Table 4.6: Comparison of Experience Years between Participants Working in The Northern PCU and Central PCU

<table>
<thead>
<tr>
<th>Years of Experience</th>
<th>Northern PCU Average (x̄)</th>
<th>Range</th>
<th>Central PCU Average (x̄)</th>
<th>Range</th>
<th>Mann-Whitney U Test</th>
<th>Kolmogorov-Smirnov Test</th>
</tr>
</thead>
<tbody>
<tr>
<td>Years of Experience</td>
<td>9.8</td>
<td>2-24</td>
<td>12.8</td>
<td>3-27</td>
<td>.527</td>
<td>1.000</td>
</tr>
</tbody>
</table>

*p value < 0.05
Training

The health providers employed within the two PCUs gave a similar opinion of the mental health training they received. The majority of both informant groups received training in counselling. Furthermore, they accessed a variety of other courses, mainly in mental health assessment, suicide prevention, home care for mental illness, psychiatric drug administration, counselling for drug addiction, and care for autistic children. These data are presented in Table 4.7. Counselling courses were reported as the most frequently attended by the respondents. Three health providers from the Northern PCU and five health workers employed within the Central PCU responded that they used to attend counselling training courses. The other remaining courses were reported as being accessed by one to three health providers. One health worker might participate more than one course.

Table 4.7: Mental Health Courses Registered by Participants in The Northern and Central PCUs

<table>
<thead>
<tr>
<th>Training / Education Received</th>
<th>Northern PCU (N=5)</th>
<th>Central PCU (N=5)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Counselling</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>Mental Health Assessment</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Prevention of Suicide Behaviour</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Home Care for Mental Illness</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Psychiatric Drug Administration</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Drug Misuse Counselling</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Autistic Care</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Never Received Training Relating to Mental Health Care</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>8</td>
<td>17</td>
</tr>
</tbody>
</table>

Relationship with the Community

The PCU officers from the North had good relationships with the LAO staff, and the organizations assisted one another in working for the community. However, the PCU
officers strictly avoided becoming involved in local politics. As was characteristic of those with careers in public health, they always acted as givers and were friendly towards all groups of people. They provided health care with no expectation of fees or profit, committed to ensuring that all people receive the health care which was their right. Therefore, the health care providers were valued as helpers, which led to good relationships with the community. Furthermore, health care providers remained involved in various social activities with other people, such as donating food and money to the temple, so they had also become a part of the community. The PCU officers form central Thailand had established good connections with LAO staff, teachers, and monks. Other organizations supported and participated in PCU activities. For example, people from these organizations, the students, and villagers helped to kill mosquitoes and destroy their habitations. On the other hand, the PCU has supported these organizations in other projects besides normal health care. For instance, the PCU provided medicine for schoolchildren’s activities outside the school. They also asked the monks to donate food for patients who were poor. The monks sent a plenty of food to the PCU one day per week. The PCU’s maid placed this food on trays for the patients who lacked money. Informal practices such as these have built a good relationship between the PCU staff and the community.

As of 2007, there were 130 village health volunteers (VHVs) distributed throughout the Northern community. These VHVs helped in health activities such as checking mosquito larvae inside each household, allocating glasses donated to aged people, and assisting with other health issues. The MOPH provided one motorcycle for visiting patients at homes, and VHVs also used their own vehicles. They hired a van when they need to go outside as a team. GP service was provided for one day per month, supported by the local hospital. There are 160 village health volunteers (VHVs) distributed
throughout the Central community. These VHVs helped with health activities such as checking households for mosquito larvae and providing assistance with other health issues. The MOPH provided a motorcycle and a van for visiting patients at home and visiting the community as a team. The local hospital provided one GP to provide treatment at the PCU for four days per month.

Mental Health Care Management

This section of the chapter presents findings related to mental health care management responded through questionnaires. It provides data on mental health care practice, models of care, and factors that would influence care practice elicited from respondents in the two settings.

Mental Health Practice

Workload

The health providers from the Northern PCU and Central PCU reported their mental health workloads as 5.60 and 10.20 (S.D.4.82 and 7.66) hour/worker/week respectively (see Table 4.8). They broke down the workloads into family counselling, home visiting, educating, meeting related to care practice and care management, documentation, and liaisons. Family counselling was considered the most frequently occurring aspect of their mental health workload. The respondents also considered home visiting and educating as other components of the main mental health workload (see Table 4.8). Four respondents from the Northern PCU practised family counselling amounting to 11 hours per week with the average of family counselling work at 2.2 hour/worker/week. They spent five hours per week in visiting clients at homes on an average of one hour/worker/week. They estimated four hours spent in teaching clients on mental health coping strategies on an average of 0.8 hour/worker/week. Similarly, four health
providers from the Central PCU considered their three major workloads as family counselling, home visiting, and educating clients in mental health coping, with the average rate of 4, 3.4, and 1.6 hour/person/week respectively. Table 4.8 displays data relating to the Northern and Central PCU informants’ estimate of their role activities.

Table 4.8: Average Mental Health Workload and The Number of Participants Practising in The Northern and Central PCUs

<table>
<thead>
<tr>
<th>Mental Health Workload per Week</th>
<th>Northern PCU (N=5)</th>
<th>Central PCU (N=5)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Practice (Hour/ Week)</td>
<td>SD</td>
</tr>
<tr>
<td>-Family Counselling</td>
<td>11 22 277</td>
<td>4</td>
</tr>
<tr>
<td>-Visiting Clients at Homes</td>
<td>5 1 100</td>
<td>3</td>
</tr>
<tr>
<td>-Teaching Clients in Mental Health Coping</td>
<td>4 08 083</td>
<td>3</td>
</tr>
<tr>
<td>-Meeting Relating to Mental Illness Patients</td>
<td>1 02 044</td>
<td>1</td>
</tr>
<tr>
<td>-Meeting Relating to Organizing Mental Health Works</td>
<td>1 02 044</td>
<td>1</td>
</tr>
<tr>
<td>-Documentation in Mental Health Work</td>
<td>5 1 122</td>
<td>3</td>
</tr>
<tr>
<td>-Liaison and Travelling for Mental Health Care</td>
<td>1 02 044</td>
<td>1</td>
</tr>
</tbody>
</table>

Models of Care Practice

All respondents from the two PCUs responded that the mental health care practices were conducted using integrated care. Furthermore, because of the lack of a specific model, the health providers employed within the Central PCU voiced concern about delegation, consultation, and cooperation. One of them asserted that there appeared to be no clear model used in practising mental health care with regards to the above concerns. These data are presented in Table 4.9. It shows the patterns of their practices with details of frequencies and percentages. All respondents in both PCUs claimed the
integrated care model as reflecting the pattern of their care practices. Four health providers employed within the Central PCU perceived that they also provided mental health care based on the model of delegation of work. Furthermore, two workers described consultation, and the other two indicated cooperation as other models of their care practices. Even though they were using consultation and cooperation, they have expressed concern about these things as suggested above, due to the lack of a specific model. Only one health worker considered that no model could be identified as the model of care.

Table 4.9: Models of Care Practice Provided in The Northern and Central PCUs

<table>
<thead>
<tr>
<th>Models of Mental Health Care Practice</th>
<th>Northern PCU (N=5)</th>
<th>Central PCU (N=5)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Partnership Model</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Collaboration Model</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Supervision Model</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Integrated Model</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Others</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Delegation</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>Consultation</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Cooperation</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>No Model Identified</td>
<td>0</td>
<td>1</td>
</tr>
</tbody>
</table>

Decision making in dealing with non-compliant patients

In order to define ways in which clinical practice was undertaken, the study concentrated on situations of non-compliant patients that typically happened in communities. All respondents confirmed that patients and families took part in decision making in situations of non-compliance, as shown in Table 4.10. There are lists of team colleagues, individual workers, and the hospital team named as other groups involved in decision making (see Table 4.10). Of all respondents of the Northern PCU, the health providers agreed that the patients and families took part in decision making. Only one of
them asserted the team colleagues as other persons involved in decision making. Similarly, all informants from the Central PCU allowed the patient and families to make decision in the non-compliant situations. Furthermore, three health workers considered that the individual provider took part in decision making. Two and one of those considered team colleagues and hospital team, respectively, as other persons involved in the mental health situations. Some informants responded to more than one form of decision making. These data are displayed in Table 4.10.

**Table 4.10: Decision Making in Non-compliant Situations in The Northern and Central PCUs**

<table>
<thead>
<tr>
<th>Decision Making in Dealing with Non-compliant Patients</th>
<th>Northern PCU (N=5)</th>
<th>Central PCU (N=5)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Head of PCU</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Team Colleagues</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Individual Provider</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Patients and Family Members</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Others: Hospital Mental Health Team</td>
<td>0</td>
<td>1</td>
</tr>
</tbody>
</table>

**Factors Influencing Mental Health Care Practice**

The health providers from the two PCUs perceived that their care practice related to mental health services were influenced by The Ministry of Public Health (MOPH), The Department of Mental Health (DMH), and the Local Administrating Organization (LAO). Besides the organizations, they also viewed their workloads, the health staff, and policies as the other influences.

**Organization**

Two health workers from the Northern PCU indicated that their care practices were influenced by the LAO. The MOPH, DMH, staff and overall workload were also perceived as other factors influencing the care practices individually by one respondent.
Three health providers of the Central PCU perceived the MOPH as an influential factor. Likewise, the other three respondents indicated that the DMH influenced their care practices in relation to mental health services. Another respondent affirmed that policies from the local public health office and local hospital impacted on their care practices. The data relating to the factors influencing care practices are illustrated in Table 4.11.

Table 4.11: Factors Influencing on Mental Health Care Practices in The Northern and Central PCUs

<table>
<thead>
<tr>
<th>Factors Influencing Mental Health Care</th>
<th>Northern PCU (N=5)</th>
<th>Central PCU (N=5)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ministry of Public Health</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Department of Mental Health</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Local Administrative Organization</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Others</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staff</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Overall workload</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Policies from the Local Public Health</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Office and Local Hospital</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

**Familiarity with policies**

Policy was another factor influencing on mental health care practice. In identifying the extent of the health providers’ familiarity with policies related to mental health services, data from those expressing either familiarity or no familiarity with the policies is shown in Table 4.12. One similarity is that three respondents from the Northern PCU and Central PCU explained that they were not familiar with the policies related to mental health services. Only two of each PCU were familiar with mental health policies (see Table 4.12).
Table 4.12: Familiarity with Mental Health Policy Perceived by Participants in The Northern and Central PCUs

<table>
<thead>
<tr>
<th>Familiarity with Mental Health Policy</th>
<th>Northern PCU (N=5)</th>
<th>Central PCU (N=5)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Familiarity</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>No Familiarity</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Total</td>
<td>5</td>
<td>5</td>
</tr>
</tbody>
</table>

Policies and practices
In identifying the policy that directed practice, the respondents were asked to rate the degree in which they agreed with the statement that policy directed practice. A 6-point response scale, ranking from ‘never’ to ‘every time’ was used. The respondents’ opinions were divided into five levels of agreement: never directed, seldom, sometimes, often, and every time. One similarity is that three respondents of each PCU agreed with the statement that policy directed their care practices but these were at the level of ‘Sometimes’ to ‘Every time’. Nevertheless, two respondents employed within the Northern PCU considered that the policy never directed practice. These data are shown in Graph 4.1.

Graph 4.1: The Proportion of Health Providers from The Northern and Central PCUs Who Rated Policy Directed Care Practice
The health providers were asked to rate the extent in which they agree policy makers were informed of their practices. A 6-point response scale, ranging from ‘Never’ to ‘Very much’, was used. The respondents responded in broad from ‘Never’ to ‘Much’ as illustrated in Graph 4.2. Three respondents of the Northern PCU perceived that they had opportunities for informing the policy makers from ‘Moderate’ to ‘Much’. Two respondents thought that policy makers were not informed. In comparison, the majority of the respondents of the Central PCU appeared to rate fewer opportunities to inform policy makers. Three persons of those chose ‘Never’, and two rated from ‘less’ to ‘least’ in identifying the extent to which they had a chance to inform policy makers of their practices.

Graph 4.2: The Proportion of Health Providers from The Northern and Central PCUs Who Rated Policy as Being Informed by Care Practice

Summary

Context of Cases

Overall, there are some similarities and differences between these two case studies. Both PCUs are located within their communities and provide general health care both to the local populations and people from other areas. Their surrounding environments are similar, both in landscape and in proximity to other organizations, local hospitals, and
cities. They had the same chains of command and lines of support with the Ministry of Public Health and the Ministry of the Interior. They received the same support and facilities from outsiders, providing for mutual assistance between the PCUs and the others involved. Both health providers employed within the two PCUs have developed good community relationships and were accepted by the people in their areas.

However, there are minor differences in population, as the Central PCU had more consumers than the Northern PCU. As a result, the frequency of monthly GP service was greater in the Central PCU than in the Northern PCU. Therefore, it can be assumed that these differences are related to situational factors rather than indicating any problem in one group’s approach to practice, compared with the other.

Although the data presented in this session do not correspond to the research questions, they provide a foundation from these two settings that describe the context of the case studies. This helps to understand the aspects of community mental health care management presented later.

**Care Management**

The quantitative findings presented in this session were elicited from ten respondents from the two specified settings as case studies. These were analysed using quantitative statistics, frequencies, and standard deviation. In order to highlight the perspective of case study research, a summary of the findings is presented below.

**Case Study 1: The Northern PCU**

Five health providers employed within the Northern PCUs responded to the questionnaire survey. The respondents comprised three nurses and two public health
workers. They had spent, on average, 9.8 (S.D.9.23) years in general care practice including mental health care. They reported the ratio of mental health caseload to a normal case, at 0.93: 100 on average. Four respondents were educated in mental health care focusing on counselling, suicide prevention, home care for mental illness, drug administration and counselling for drug user. Only one respondent was never trained in a mental health course. Family counselling was reported as the largest proportion of mental health workload, at 2.2 hour/worker/week. The second largest proportion of workload was visiting patients at homes and doing documentation, with 1 hour/work/week. Three main factors influencing mental health care practices were The Ministry of Public Health (MOPH), The Department of Mental Health (DMH), and the Local Administrative Organization (LAO). All respondents reported the model of care practised as integrated care. Again, all health providers allowed patients and families to be involved in decision making in mental health situation. Three workers expressed that they were not familiar with mental health policy. Three health workers reported that they ‘sometimes’ or ‘often’ practised in accordance to the policy. And there were three respondents perceived that they had ‘moderate’ to ‘much’ chance in informing their care practice to policy makers.

Case Study 2: The Central PCU

Five health providers from the Central PCUs responded to the questionnaire survey. The informants consisted of four nurses and one public health worker. They experienced, on average, 12.8 (S.D.11.69) years in general care practice including mental health care at the PCU. They reported a ratio of mental health caseload to normal case, at 1: 100 on average. All respondents were trained in mental health care focusing on counselling, assessment, suicide prevention, home care for mental illness, drug administration, counselling for drug users, and care for autistic children. Family counselling was
reported as the largest proportion of mental health workload, at 4 hour/worker/week. The second largest proportion of workload was visiting patients at homes and doing documentation, with 3.4 and 1.6 hour/work/week respectively. Three main factors influencing mental health care practices were The MOPH, DMH, and LAO. All respondents mentioned that their care practices were based on an integrated care model. One hundred percent of the health providers allowed patients and families to be involved in decision making in mental health situations. Furthermore, they also asserted that team colleagues, individual judgement and the hospital team played a part in decision making. Three of them reported not being familiar with mental health policy. They rated policy directed care practice as being from ‘seldom’ to ‘every time’. Three health workers perceived that they had no chance in communicating their care practice to policy makers, whereas two respondents rated their opportunities to inform policy makers of their care practice as being from ‘least’ to ‘less’.

In combination, the two groups comprised professionals practising mental health care in the communities, included seven nurses and three public health workers. They spent between 2 and 27 years in providing care at the PCUs. Mental health caseload as reported was approximately 1: 100 normal cases. The mental health course that they attended was mostly (four persons) in counselling training. Family counselling was the most popular care practice provided in the mental health field. The majority (four persons) of the respondents provided family counselling as a care practice. The MOPH and DMH were two main factors affecting their care practices. The care practices were based on integrated care. All respondents made decisions after consulting with patients and families. Three respondents expressed not being familiar with mental health policies, while the others felt some level of familiarity. However, eight of ten respondents reported that their care practices were ‘seldom’ to ‘every time’ directed by
policies related to mental health. Five of ten respondents reported no chance in communicating with policy makers, while the others responded having ‘least’ to ‘much’ chance in communicating with policy makers.

The following chapter presents the qualitative findings comprising data from individual interview, observation, and document analysis related to mental health care practice and management.
Chapter 5
Qualitative Findings

Introduction

This study addressed community mental health care management in Thailand. The objective of the study was to identify good management practice in community mental health care in Thailand. More specific objectives were to identify mental health care practices, models of care and influences on mental health care practices in two PCUs in Thailand.

This chapter presents the findings from interview, observation, and documents analysis focused on mental health care management. The first section of the chapter presents the scope of mental health care practice provided in the PCUs. The next section provides data related to the models of care of mental health services. This is followed by data relating to the influences on mental health care.

In order to maintain the anonymity of participants, each is referred by an abbreviation of their workplaces and a number. The ‘N’ and ‘C’ mean the Northern PCU and Central PCU. The names of other institutes are presented with the unidentified abbreviations.

Mental Health Care Practice

In describing mental health care practice, the data can be expressed in terms of functions and roles. The function is both mental health promotion and prevention. Information related to care practice as a role of the health providers provides insight in
the manner in which they take responsibilities for mental health care. Data illustrating each care practice are presented in figure 5.1.

**Figure 5.1:** Care Practices Related to Mental Health Care

<table>
<thead>
<tr>
<th>Mental Health Care Practices</th>
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</thead>
<tbody>
<tr>
<td>Mental Health Functions</td>
</tr>
<tr>
<td>- Promotion &amp; Prevention</td>
</tr>
<tr>
<td>- Prevention of Exacerbation</td>
</tr>
<tr>
<td>Mental Health Roles</td>
</tr>
<tr>
<td>- Educator</td>
</tr>
<tr>
<td>- Consultant</td>
</tr>
<tr>
<td>- Agent</td>
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<tr>
<td>- Manager</td>
</tr>
</tbody>
</table>

**Mental Health Functions**

As described in Chapter 2, being the first level of health care provided in communities of Thailand, the PCUs provide care mainly in preventive and curative care. The principle of care is based on a holistic concept, which integrates physical, mental, and social care for health. However, in mental health care, the service emphasizes prevention rather than therapeutic care service. As one participant, a public health worker said,

_As you know, unlike other health care, we do not diagnose the illness related to mental illness here. We have never taken the role of a therapist in mental health service. The diagnosis towards mental illness is not performed within the PCU._

(N-5)

One nurse explained that,

_I have not worked for mental illness directly. I only dealt with mental health aspect in my patients with chronic disease like hypertension cases. I communicated them friendly and listened all they talked. That made them happy and helped in mental illness prevention._

(N-3)

With this point of view, this section presents the picture of mental health care practice managed in the PCUs. The participants described their care practices related to mental health care as very broad depending on their own delegated responsibilities. In addition,
the data revealed from observation sessions and document analysis shape the picture of the mental health care practice provided. This practice typically covers two parts. First, practice is focused on mental health promotion towards persons at risk in order to prevent them from falling victims to mental illness. Also, seeking untreated patients with the aim of possibly providing them help is involved in preventive care practice. A second major part of practice is monitoring and prevention of exacerbation in patients with mental illness.

**Mental Health Promotion and Prevention**

A range of activities is involved in working with the groups at risk. These activities offered by the health providers include drug prevention activities, senior clubs, mental health promotion activities, screening for mental health problems, counselling sessions, and giving other supports, all of which were evident in the PCUs.

**Drug Prevention**

The health providers employed within the Northern PCU recognized drug prevention for youth as a mental health promotion care practice. One public health worker said “We take part in the projects of drug prevention; that is the drug prevention camp in each year.” (N-1) Another public health worker described his role in drug prevention as a part of mental health illness prevention:

I’m not delegated to take the main role in mental health services. I mainly take responsibility as a key worker in drug addict care. However, I think that the two roles are interdependent. I did counselling sessions for the addicted persons. As well as, I encouraged young people to participate in the ‘To be No.1’ club (The drug prevention project sponsored by the government). (N-5)

Later, he also described his practice that,

I motivated and gathered drug addicted persons to be treated in psycho-social group therapy undertaken in the hospital, Ministry of Public Health. Furthermore, colleagues and I conducted a Drug Prevention Camp sponsored...
The health providers employed within the Central PCU described the task of drug prevention in a similar fashion. One nurse explained that,

*In the PCU, there is one staff working as the key worker of drug prevention. I don’t work for that, but I help as a team member. I conducted activities to prevent drug use in the schools. That’s my role.*  

(C-3)

One health worker who takes responsibility in drug prevention made the following comment:

*What I did was to locate drug addicted persons and encouraged them to receive therapeutic sessions (conducted in the hospital). This project was directed to the PCU staff by the ex-government through the policy of drug control and I was delegated in reaching those persons to be treated.*  

(C-2)

The reason for this emphasis on drug use was explained in one nurse’s comments:

*Nowadays, drug use causes several mental health problems. We aimed at protecting the youth groups. We conducted the ‘To be No.1’ club project. I encouraged persons between the ages 14-24 years old to join as members of the club. I must reach at least 50 percent of this age group population. I promoted them to have good activities such as playing sport games and reject drug using in daily life.*  

(C-1)

The document of the Northern PCU Report: 2006 reviewed within the Northern PCU revealed that in 2006, there were 62.56 percent of population of age 10-24 years old being members of the To be No.1 club. The Northern PCU cooperated with the Local Administrative Organization (LAO) in three activities of the club. Those activities were training in countering drug use, teaching in planting organic vegetables, and broadcasting about drug prevention. The LAO sponsored 20,000 Bath (estimate 700 AUD) of funding. In 2005, two patients with drug addiction took part in the seven sessions of psycho-social group therapy in the hospital. The drug protection issue was stated in the emotional domain of the Healthy Thailand Campaign with the criteria of project success that at least 50 percent of young people join the ‘To be No.1’ club.
Similarly, the document of the ‘To be No.1’ Project by the Central PCU indicated that sport team activities and aerobic exercises would be the main activities in the project.

The interview data and documented information illustrate that within both PCUs, the ‘To be No.1’ activity appeared to be a care practice that was considered mainly as mental health promotion for the youth group. It emphasized the prevention of drug use that may cause other mental health diseases.

**Senior Clubs**

Mental health promotion in aged persons is provided through the activities of the senior clubs. One public health worker of the Northern PCU explained that, “the senior clubs were conducted to promote well-being of elderly persons and directed by the Ministry of Public Health.” (N-5) The details of practices in the senior clubs are informed by one nurse’s account:

> Aa...in the senior club, I encouraged the aged members to do meditation. This can promote mental health status. Yes...yes I taught them how to practice meditation and maintain awareness with Sati practice (Buddhist style). Those are the activities I provided for the senior persons living in the villages. (N-4)

This is elaborated further in another nurse’s account from the Central PCU:

> For the elderly persons, I tried to establish the senior club with more structure. First, we gathered the aged people in the community to build up the club. Now, we encouraged them to conduct regular activities in promoting happiness and well-being. (C-3)

Observation carried out at the Northern PCU during senior club meeting reflects a mental health promotion practice culture. The following described one session of the senior club activity. During a half-day of monthly meeting, the members came about 9 am. The health providers carried out blood pressure and weight checks. At that moment, the members enjoyed talking among themselves and with the PCU staff. Then they
began the activity as scheduled with Buddhist praying. The chair-member announced
the event schedule and other information. Some members were still talking with friends
all the time. After a speaker talked about self care, they performed singing and dancing.
After that some members donated money for the club and public. They had lunch
sponsored by the LAO and celebrated members’ birthdays.

The Northern PCU documents revealed reports on the senior clubs as part of the annual
reports. In 2006, 59.33 percent of the elderly population participated as members of the
clubs, surpassing the goal of having 50 percent of aged population being members. The
organization of senior clubs was considered as an important emotional aspect of the
Healthy Thailand Policy, which was presented in an official document. The members
conducted monthly meeting including doing exercise, visiting the sick members, doing
recreation, conducting religious activities, conserving Thai culture and local wisdom,
and supporting health promotion activities. Likewise, the senior club document of the
Central PCU recorded similar activities run in the same way with the Northern senior
club.

Data derived from the interview, observation and document review revealed the senior
club activity as a care practice in promoting mental health towards elderly persons
living in two communities.

Activities of Mental Health Promotion

Activities of mental health promotion were undertaken towards particular risk groups.
The activities were held for a variety of target groups depending on the staff views
about mental health risks and needs. An example given by one nurse employed within
the Northern PCU was the project of promoting EQ among children. She said,
About the project for children that we talked before ... we taught the parents what the EQ in children were. ... I taught them how to look after the children (to develop high level of EQ scoring). I thought that probably these laypersons didn’t care about issues of child development. They didn’t care when their children would begin talking. They were not interested in that. They didn’t think the tales were necessary. Toys were not involved in looking after the offspring, they perceived. I also discussed these issues with them. (N-2)

Observation carried out during a half-day activity of the EQ project in the Central PCU revealed that activities conducted by the health providers for children were part of mental health care practice. Four health providers ran activities related to the EQ topic. There were 35 parents attending the session and questioned some points with the speakers. The parents received one storybook, toothbrush for kids, and powdered milk gift sets sponsored by a company.

Similarly, the activities of mental health promotion were also conducted in the Central PCU. Two nurses employed within the Central PCU also described a mental health promotion activity towards a number of people in a village as Healthy Village Project. One nurse described,

*Colleagues and I conducted a mental health promotion project in 2006. We went into the villages. We provided general health assessment, recreation activities, and screening for depression.* (C-4)

Another nurse also asserted,

*Once, we conducted a project named Healthy Village in ... I think in 2006. We cooperated with the village health volunteers (VHVs). We went into each house in the villages. We cooperated with the community in screening mental health problems. We tally the raw data together in the community. Then we organized activities for all people in the villages. At that time, the activities were focused on emotional management, which encouraged people to care for each other in the community.* (C-3)

She also added that what motivated them to undertake the Healthy Village Project was The Healthy Thailand policy, which was announced to them in that year. The
community participated in setting problem priorities. Then they conducted the activities to promote mental health for people in the community.

Documents related to the mental health promotion project of the Northern PCU revealed that the EQ project created by the staff aimed at children as a risk group, and identified their needs. This was presented as part of the background and significance of the project report; whereas, the Healthy Village project of the Central PCU was concerned with the policy more than meeting the needs of consumers. However, when reviewed in the details of the Healthy Village report, data illustrated that the community actually did take part in setting priorities for their needs. Then, they chose one focus of the project as emotional management. Both campaigns of the two PCUs were care practices conducted during a particular time. There was no regular monthly routine report, unlike other care practices. Only the evaluation reports of projects were presented as evidence.

The data collected throughout the interview, observation and document review illustrated that the activities of mental health promotion conducted in the two PCUs focused on the needs of particular risk groups. These care practices were performed autonomously.

**Screening**

The health providers employed within the Northern PCU perceived screening in mental health illness as a care practice in preventive care. One nurse explained that the routine jobs in screening for Depression and Suicide were conducted monthly by the key worker. She also described her practice in screening for mental health problems that,

> Once, colleagues and I were delegated to screen for people with stress throughout the villages. We used the checklist forms of stress as a tool. We found that there were fewer people experiencing stress. (N-2)
Stress Questionnaires (Suanprung Stress Test: SPST-20) were used to survey mental health screening practised in the Northern PCU. According to the documents, in October 2006, there were 43.5 percent (N=87) of consumers (N=200) expressing high level of stress and severe level of stress were found in 13 percent of all respondents (N=200).

Similarly, one nurse as the key worker in mental health care working for the Central PCU defined her duties as focusing on screening for depression and suicidal behaviours. She gave the details of her practices as following.

_I usually conduct Depressive screening towards normal consumers. Uhm... However, I think what I did was not perfect. I just do it by using The Depressive Screening Forms. The form comprised questions and criteria identifying Depression. For example, I suppose that I found a client with high scores of Depression. Next, I must conduct the Suicidal pattern screening. Anyway, I’ve never found the client who had suicide problems. So, what I have done is giving advice and providing counselling sessions in depressive management. I conducted the screen practices and reported regularly in the end of month._

(C-4)

In describing the screening job related to mental health issues, one nurse gave an example,

_In the past, we provided mental health issue screening, such as Autistic and EQ in children. There were forms of symptoms checklists that we used as a checklist tool. If I found a case that appeared more than five times on the lists, I would refer the case to the hospital._

(C-3)

Only one of the monthly reports of Out-patient Service documents belonging to the two PCUs presents records of Depression and Suicide screening practised in each month. This presented the details of the number of cases with completed and uncompleted suicide, the ways in which the suicides behaved, and causes of the suicide behaviour illustrated with checklists.
Data obtained from interview and documents corroborated the fact that the health providers of the two PCUs provided mental health screening, such as depression, stress, and mal-development in children.

**Counselling**

Counselling is the most frequent care practice related to mental health, according to the participants interviewed. Data revealed that clients needing counselling had a broad range of problems. Sometimes, assistance was sought for physical problems but the mental health problems were hidden. The health workers had experience with all types of clients. One nurse employed within the Northern PCU made comments focused on her care practice in the counselling session:

> It’s based on the principle of counselling. These were listening ...and listening. I mean listening with understanding and empathy. As well as, I used the sentences like “You did well”, “You must be patient”, and “You did the right thing”. And, I sought the good points for her (client). For instance, I said to her that “Look! Your husband was very nice because he understood and accepted you.” I also claimed that her kids understood what the problems were. I supported that all family members accepted her and she was a very lucky person. (N-2)

She added that,

> Another client came with the need for counselling. She felt stressed. She wanted to talk with someone who had capacity in providing counselling support. ... I provided her one session of counselling per month for a half-year. (N-2)

And, she asserted another experience of counselling in relation to the stress screening that,

> We found that there were fewer people experiencing stress. Actually, I didn’t know what I should do to help those persons with stress. However, I went into the community again. I met the cases individually and offered help with counselling sessions. (N-2)

Another staff claimed that he conducted counselling sessions as part of his typical holistic care. He said,
When a client complained about his discomfort due to headaches, I thought that he probably felt stress. He just asked me to treat his discomfort with some tablets. I asked him many questions, and then he spoke out the problems that caused his stress. You know...finally the client finished talking and said that he didn’t want the tablet anymore. (N-5)

One nurse described her experience in counselling practice provided to normal people.

She described,

*The parents with their child came here because the child had serious problems. (Electrocuted) They (parents) had financial problems because only the father could work. The mother couldn’t work. The child...became worse. .... She just lay with her opened eyes and waited for the mother to feed her. That is, for this case, I helped them with counselling sessions.* (N-3)

The health providers employed within the Central PCU made similar comments about their care practice as providing counselling sessions to a range of consumers with a variety of problems. They mainly listened, supported, advised and provided important information to the patients. The ways in which counselling was provided as a care practice was illustrated by three health providers’ accounts. One nurse said,

*I had clients with alcoholism. Some of them wanted the counselling sessions, due to frustration with themselves. And, I provided the sessions of counselling to them.* (C-5)

One public health worker said,

*Well...most counselees were housewives. Some of them asked me for the counselling sessions directly. I found that some clients became depressed due to financial problems. Drug using among their children was also a cause of their suffering.* (C-2)

He elaborated further that,

*The number of clients participated in the counselling sessions because they wanted emotional ventilation. They usually felt better after they had a chance to talk with a person who understood. After ventilation by the client, I started talking to him or her about the cause of problems. You know? ... Sometimes, the problem was so little, but he or she couldn’t see that. ... At that time, the case*
Observation of counselling care practice provided in the Northern PCU revealed an interesting case in which one nurse provided counselling to a normal patient with back pain, who had returned with the same health problems for many sessions. The nurse offered to refer the patient to the hospital so that a specialist would treat her. The patient began crying and explained that she already had an appointment for a spine operation. But, she missed that and quit the hospitalized care. At that time, this nurse offered the counselling session to her. Through the counselling session, the nurse listened and supported with encouragement: “I see”, “I understand”, and “Yes, it’s true”. The nurse advised reorganizing bedtime and talking with her family. When asked by the patient whether she should see the psychiatrist the nurse provided referral information for the Department of Psychiatry.

Another counselling session for a client with alcoholism was observed in the Central PCU, in which the nurse used similar techniques as those used in the Northern PCU. The client wanted to withdraw from drinking, and the nurse listened to the client’s complaints and needs in the treatment room. She supported him with sentences like, “To withdraw yourself from consuming alcohol is not too difficult. You begin doing the right thing” She did not advise anything. She explained later that this patient knew his situation well. She confined her guidance to referral information about the place, date and time of the Alcoholic Clinic in the A Hospital. This illustrated the patient empowerment approach of primary health care, where the nurse assumed a supportive, but not directive role.
The extent of counselling carried out was reinforced in data from The Practical Plan in Public Health Care: Budget Year 2007 of the Northern PCU. This document illustrated that counselling was a main care practice stated in part of Strategy 2: Improve continued care services, Activity 2: Counselling service. The Records of Counselling document also underlined the role of counselling as a mental health care practice performed in the Northern PCU. The examples of counselees were persons attempting suicide, patients with AIDS/HIV, drug misuse clients, adults and children with obesity, persons with insomnia, people with anxiety, diabetes mellitus among family members, and chronic wounded patients, etc.

Similarly, when care planning documents were examined, counselling was also documented as a major care practice in mental health care in the Central PCU. The Strategic Plan: Budget Year 2007 presented counselling as the mental health service domain of the plan. The counselling care provided was recorded in the individual health record, which was collected within each family health folder called the Family Folder. Types of counselee and problem were similar to those found in the Northern PCU, related to clients with physical and mental health issues.

The data generated from interview and observation indicated that the nurses and public health workers were all doing very significant amounts of counselling and going into depth with their clients, in some cases, saving their lives and helping families preserve their family health. Also it seems they were very well prepared for the counselling role. The counselling sessions were provided to a range of cases and problems. The data also illustrated the use of techniques in listening, giving advice and information, and providing verbal support by the health providers.
Giving Support

To deal with mental health issues as one aspect of health, the health providers had to face complex problems. They explored strategies to support the mental status of consumers. One nurse employed in the Northern PCU described the unconscious patient and family and help rendered to the same family reported previously, whose child had been electrocuted.

*I lent them the suction instrument set, which was the only one we had, but have hardly been used. I taught them how to use and clean it. I advised them that they must keep it well. ... I gave them a lot of powdered milk packages donated by a company. That could help them with their financial problem. ... I helped in registering the children in disability census of the LAO. Then they received pension for looking after the daughter.* (N-3)

She explained another case of family support.

*I went to the community for home visiting sessions. I found a child who appeared normal, but.... His house was made of cement without roof, door, and window board. However, the boy with his family lived there. They closed their place with a small piece of plastic pad. ... This family comprised the grandmother who looked abnormal, the daughter with a three-year old daughter and the nephew whom his mother had abandoned. I heard from the neighbours that the LAO built this house for them, but they sold roof, doors, and windows. ... I informed the LAO about their housing. Now we are looking forward to hearing from them (LAO).* (N-3)

This case illustrates the comprehensive nature of the assessment, including the family environment, as well as the health issue. In many cases, social issues were also part of the assessment. One public health worker raised the financial problems again and described help from the health workers that,

*This is a complex issue in mental health services. The public health worker and the nurse used to give them some money. I mean we tried doing what we can do.* (N-1)

Similarly, one public health worker within the Central PCU shared his experience with regards to patients with mental illness. He said,
For the poor villagers, that they said they lacked money to go to see the psychiatrist in the hospital meant they didn’t have any money really. I always gave them money for the bus fare. (C-2)

One nurse gave an example of support from the PCU to the family at risk.

I knew a woman who was a single-mother with four boys. She worked as a cleaner in a shopping centre and earned daily salary. She felt stress because she received an official letter informing that she had to relocate in two months. She didn’t know what she should do. I listened to and supported her. What we can help is giving meals to her sons at the PCU in the evening. We received the meals from the monks every fortnight. (N-1)

Clearly, the health providers employed within both PCUs extended their care beyond normal expectations, for example by giving money and meals to their consumers. Even though the help was not of clinical assistance, it helped in decreasing stressors related to mental health problems.

The first domain was focused on mental health promotion and prevention towards people with high risk. The health providers also believed in the importance of screening and in preventing exacerbation of mental illness as another domain of care practice.

**Prevention of exacerbation**

This section presents how the participants perceived and performed the roles for the prevention of exacerbation in patients with mental illness. Data illustrated that preventative care practices included home visiting, giving injections for continued treatment, and making referrals.

**Home visiting**

Visiting patients at home was perceived by the health providers employed within the Northern PCU as prevention of recurrent symptoms. When describing the home visits,
one nurse said that, “We visited patients at homes to see how the patients lived with the families in the community.” (N-4) Another nurse made a comment on visiting a patient at home that, “I talked with his parents and offered help.” (N-2)

Similarly, the nurses employed within the Central PCU described home visits as having “monitored them in the treatment they received.” (C-5), and having “advised the family members how they should spend time with the patient.” (C-3)

Home visits were an opportunity for observations and liaison with family members. In one case, a nurse from the Northern PCU communicated first with the father, and thereafter discussed details of the patient’s symptoms. The nurse asked the patient about her discomfort, taking oral-medicine and sleeping pattern. In another visit, the nurse assessed a patient’s weight and provided guidance on exercise.

One nurse from the Central PCU visited a patient whose mother complained about her suffering in looking after the patient. The nurse listened and used supportive communication strategies, replying with comments like “Yes I know”, “Just you can help him”, and “He couldn’t be better without your help”. (C-4) The nurses asked the patient about his lifestyle. He confirmed that he was good. The nurse asked him to help in some household work. He smiled and said, “Yes, I would help”.

This was a typical outcome from home visiting. Most home visits followed a relatively predictable pattern, including a greeting, informing the patient and family about the purpose of the visit, probing for symptoms or problems, eliciting feedback on treatments, and communicating in a way that recognizes individual problems similar to
the following: “You look drowsy. Do you think this is a side effect?” and “What are your feelings and thoughts, now? Do you feel sad or depressed?” (N-2) Similarly, the other one questioned, “During these few weeks, have you experienced irritated mood?” and “Has he (patient) acted aggressively to you or other family members again?” (C-4) Some nurses engaged patients in discussion of day-to-day activities, and were quite direct in their questions, and in their advice. One nurse said, “What do you do in a day? I think you should help your father in some household work.” and “I notice you might gain weight. ...Have you done any exercise?” She advised that “You should do some exercise instead of lying down through the day, which would cause weight gain.” (N-2) Similarly, the other nurse said, “Why don’t you help your mother in doing household work?” She commented that “You should at least, keep your bed tidy.” and “I disagree that you go out and drink with friends almost everyday.” (C-4)

The health providers offered physical care services and mental help. One nurse gave example that “May I offer you a blood pressure check?” and “Do you want a blood pressure check?” She offered help, “If you feel uncomfortable or distressed, please see me at the office. Maybe, I can help, or I would refer you.” And she said, “If you feel depressed again, please see me or phone me. I’ll help you.” (N-2) Another nurse was unable to take the client’s blood pressure, as she has not brought the equipment, but she invited him, “come to my office any time, otherwise, during the next visit session.” She offered help, “If you have something wrong, please let me know. I’ll contact the hospital for you.” (C-4)

The health providers encouraged the patient to continue treatment. One nurse mentioned, “Well... Please continue taking them (anti-psychotic drug) regularly.”, “Please keep going in taking medicine. Do not give up.”, and “Don’t forget your follow-up session date.” (N-2) Similarly the other nurse said, “Please try to give him
(patient) medicine regularly as you have done.” She allowed the family to contact her as she said, “Don’t forget to call me for isotropic treatment again. I’m pleased to do that.”, and “Do you remember the date of your next follow-up appointment?” (C-4)

Data relating to home visits obtained from interview, observation, and documents suggested that the health providers visited the patients at home to monitor patients living in the communities. During visits, the health providers made small talk first and then emphasized particular problems mentioned in the referral letter from the hospitals. They also recognized the patients and families well. They provided physical care, typically blood pressure check to the patients. The data obtained from the staff of the Central PCU also showed that they used home visiting sessions for monitoring and giving continued treatment at the same time.

**Giving Injection (as a tool)**

Giving injections comprised another part of the mental health role, in some cases, providing an opportunity for monitoring and health teaching. This was evident in observational data as well as the interviews. One nurse practising in the Northern PCU described that,

> I always talked with him or her during my sessions of administering the injection. Mostly, I talked about general issues. I ask him or her whether you were well or what you were doing for your career. I asked about taking oral medicine. As well as, I asked about the symptoms. (N-3)

Another nurse also expressed that discussion of clinical issues with patients often happened during administration of injections that,

> I gave him the injection, and talked with him and the family. I felt OK when I heard that the patient was not treated brutally at home. That was the way I communicated during injection sessions. If the patient was unable to communicate, I interacted with the caregivers instead of the patient. I talked to support them (patient and family). (N-2)
In some cases, being able to administer medications proved to be a substitute for visiting the medical practitioner. For example, one family caregiver went to the hospital for the follow-up session because the patient was non-compliant and didn’t keep the doctor’s appointment. The family member brought the vial to the PCU-nurse, who went to the patient’s home and performed the injection there. (C-1)

Documentary data supported the importance of giving injections as part of mental health care in the two PCUs. Only the care practices recorded in patient’s records within the Family Folders suggested that they gave anti-psychotic injections (Major Tranquillizer with long action). These were provided at the PCU offices and the patients’ homes, some patients needing the injection once a month, while others needed two-month courses.

Part of their assessment was in monitoring side-effects, although they did not seem to have in-depth pharmaceutical knowledge. One nurse said,

I knew that it was a long-acting drug. I’ve never questioned about it. I trusted the psychiatrist who treated the patient … I felt OK when I heard that the patient was not mistreated at home. (N-2)

Similarly, the other nurse said, “I don’t know what type of medicine I give to my patient. Does it control depression? However, he has never had problem with it.” (C-4) These comments suggest that they provided injection, but did not engage in specialized care for patients receiving psychotic drug, nor did they inquire deeply with regards to problems caused by the medication.
Referring

Referrals were also a major part of mental health practice, and also served as a linkage between hospitalized care and community-based care to support the objective of continued treatment and protection against illness exacerbation. Referring patients to the hospitals is a care practice found in the PCUs as the first level of health centre provided in the communities. The PCUs provided curative sessions to normal patients by a general practitioner at least one time per month and by the nurse practitioners every day. However, they did not provide curative sessions to the patients with mental illness. They referred those to be treated by a psychiatrist in the hospital.

A staff member employed within the Northern PCU explained that they do not provide diagnoses. He said, “We don’t provide the diagnosis related to mental illness here. So, when we find a case related to mental illness, we could help by referring him or her to the hospital.” (N-5) One nurse said, “I went to see him at home and wrote the referral letter there.” (N-4) Another nurse said, “I gave them (patient and family) choices of hospitals. They chose the NW Psychiatric Hospital. Then, I referred the patient.” (N-2)

Likewise, the health providers of the Central PCU had experiences in referring. One nurse described,

> After assessment, I was sure that he (patient) needed to be treated by a specialist. I advised the family to motivate the patient to see the psychiatrist. I provided information on the KR Psychiatric Institute and RB Hospital. I explained that the RB Hospital employed two psychiatrists in the Department of Psychiatry. I thought that this was new information for the family. Finally, they agreed to go to the RB Hospital, and then I referred the patient. (C-1)

Referrals worked both ways. One nurse employed within the Central PCU described that,
Even though a patient went to the hospital for admission without referral letter from us, the hospital sent us a referral letter when the patient came home. We received the referral letters from A Hospital and the other institutes. (C-4)

Another nurse explained that,

When I received data on patients who were diagnosed and treated by the psychiatrist, I asked the staff to visit the patients at home and give them counselling sessions. (C-1)

The data presented in this section of this chapter suggested that the overall scope of practices of health providers employed in the PCUs is broad in nature in that they dealt with patients across a variety of issues including mental health aspects. They provided activities of mental health promotion and prevention towards the risk groups. They conducted activities in drug prevention, senior club, and other mental health projects. They provided screening for depression and suicide behaviour as a routine task. Occasionally, they screened for stress and autistic problems. Furthermore, they provided other non-clinical help in order to support mental health status of cases as part of holistic care.

The data also revealed that their functions encompassed continuing treatment and protection of exacerbation towards patients with mental illness in the communities. The findings reflected that mental health diagnosis and prescription was not provided in the PCUs, but that the health providers undertook exacerbation prevention in mental health diseases. They made home visit sessions and gave anti-psychotic injections to the patients. They organized referral sessions if necessary. The following section presents the roles associated with those care practices.
Mental Health Roles

As previously stated, the specialist health providers provided care practices related to mental health promotion and prevention of illness exacerbation. Those are described as task-oriented practices. However, interestingly, the health providers who were non-specialists also had capacities in managing situations for patients with mental illness in their catchments. This section of the chapter describes the roles relating to mental health care of health providers. In considering the information of their care practices, their roles were analysed and separated into four main roles as illustrated below.

**Educator**

As educators, the health providers organized formal and informal education sessions with the aim of creating awareness for mental health issues and managing mental illness situations. One health provider practising in the Northern PCU gave an example of education, “I talked with the patient while giving injection. … . I mentioned the advantages of accessing the follow up session and continuing treatment.” (N-3) She also raised informal education issues during the provision of other health care services. She said that, “When a patient’s father accessed the PCU for his health care service, I asked about the son (patient) and taught him informally about caring for the son.” (N-3) Another nurse educated the patient’s family through printed material. She described that, “I helped by visiting them and giving booklets relating Schizophrenia and stress management that they could read.” (N-2)

Similarly, one nurse practising as the main worker in mental health care of the Central PCU accounted her role that,
I educated people in the community focusing on “Caring for persons with mental health problems”. I did that when I visited the patient at home. At that moment, I taught them about the ways in which they could live with the patient. (C-4)

She also conducted formal education to the VHVs as she said,

And, I provided education sessions for village health volunteers focusing on care for patients with mental illness and other mental health issues. ... For the VHVs, I provided education during the VHV meeting at the PCU. ... I also taught the VHVs that patients with particular symptoms should be sent to the hospital. ... I taught them the characteristics of mental illness, Epilepsy, Psychosis. I mentioned the types of care they need. I taught that caregivers must ensure patients take their medication every day and observe side effects. I mentioned that they should monitor the progress of the patients and prevent suicide. I taught them how to observe and identify patients with mental illness. (C-4)

Another nurse shared that she provided informal education during immunization sessions provided at the PCU. She said, “I mentioned that please give their kids hugs and say “I love you”. I encouraged them to spend time, such as dinner time and TV time with the children.” (C-1)

Observations were carried out when attending an education session in promoting mental health among parents with pre-school children. During the sessions, the nurse from the Northern PCU spoke about how to inculcate EQ in children and teach them manners. Similarly, the health provider team of the Central PCU provided informal education to parents who had children receiving immunization on the tenth of every month. The aim was to help parents in the management of stressful situations.

The data derived from interview and observation revealed that health providers of the two PCUs provided mental health education and prevention rather than emphasizing mental illness issues.
Consultant

The health providers acted as consultants for patients and family who needed information relating to mental health services. One health provider employed within the Northern PCU claimed that, “...I gave them (patient and family) choices of hospitals.…” (N-2) Another nurse gave an example of this,

I gave them choices to see what they could organize. I also considered whether they had any more problems. I mentioned and gave more information in relation to the treatments. This will help them to deal with the problems later. (N-4)

The other nurse gave another example of cooperation to help relieve the stress of patients and their families. She said, “I advised the parents to register the girl for disability card.” (N-3) As a result, the girl received pension from the government.

Similarly, the health providers of the Central PCU shared consultant role as follows.

I recommended the family to begin treating him. I advised the family to motivate the patient to see the psychiatrist. I gave information about the KR Psychiatric Institute and the Department of Psychiatry of RB Hospital. I explained that the RB Hospital employed two psychiatrists. (C-1)

Another nurse explained her role as a consultant in helping a patient who did not keep her follow up session because she was too busy with her job. She also thought that she had become well; therefore, she didn’t continue treatment. The nurse said, “As soon as I heard that, I communicated with the patient’s family. And then, I advised the family to ensure that the patient took the medication everyday.” (C-3)
The data derived from these interviews showed that the health providers of the two PCUs provided consultation to the patients and families in the beginning and maintaining hospital based care throughout.

**Agent to promote continuity of care**

The health provider acted as an intermediary between the hospital-based mental health care and community-based care. They liaised between these services and were an information resource for patients and families. They also contacted other organizations to ensure that their patients and families received the necessary support. One nurse asserted that she helped in informal contact with the hospital because the family wanted convenience in accessing the hospital, but she did not want other people to know. She explained, “I just made note on a plain paper for the family to communicate with the psychiatrist. That helped in providing convenience for my patient.” (N-4)

Similarly, one nurse from the Central PCU experienced one case neglected in receiving medication at the hospital. The patient was treated in another institute and just referred to this hospital. This nurse described that,

*I noted to the hospital staff that the patient named A didn’t receive continued treatment because he didn’t know the procedure of the hospital. I explained the procedure to the patient. I also explained to the hospital staff that this was a treated patient transferred from the other institute.* (C-3)

Their actions revealed that the health providers acted as the agents of the patients and families in engaging hospital care and follow-up in the community.
Manager

Managerial responsibilities are part of the functions of health providers. Their management role included computerized data recording and reporting. One public health worker practising in the Northern PCU described this as follows.

>An assistant (non-professional staff) and I must upload the information pertaining to the care we provide to mental health clients onto the computer database of The Ministry of Public Health every day. (N-5)

Likewise, one nurse from the Central PCU detailed her role in computerized report work that, “Now I feel that the administration work is affecting our care practice. We must complete administration report every day.” (C-5)

Observation carried out when attending the day-to-day work relating to mental health care in both PCUs revealed that there was at least one staff member working on the computerized reporting function every day. All staff spent office hours and also using overtime to record their care practices onto the patient sheet within the Family Folders. In addition, the External Audit session conducted at the Central PCU confirmed that health providers must report on their care practices relating to mental health care regularly.

Data derived from interview and observation showed that health providers complete their paper work, including computerized records, and have to report on their cases daily. The two PCUs employed non-professionals to undertake some office administration and also to help with receiving clients when they come into the PCU.
The findings in this section reveal the care practices related to mental health at the two PCUs. The care practices were found to be task-oriented in terms of health promotion and prevention of exacerbation. They adopted a role domain wherein the care practices included the roles of educator, consultant, agent for continuity of care, and manager. These are described in the Models of Care which follow.

Models of Care

As described in Chapter 2, the PCUs provide a diversity of health care for a range of consumers in the communities. An earlier section of this chapter presented data that indicated two domains of mental health care practices and subcategories performed in the PCUs. This section of the chapter presents the models of care practices. Accordingly, the data were analysed to identify the ways in which the PCU health workers managed their mental health care. The data derived do not reflect a specific pattern as a model of care. However, the care practices can be described as utilizing the nursing process with a holistic approach that encompasses integration, community participation and adopting personal values in the care models used in mental health care, as illustrated in Figure 5.2.
Figure 5.2: Models of Care

Nursing Process
- Assessment
- Planning
- Implementation
- Evaluation

Integrated Care
- Physical & Mental
- Case & Family
- Personal & Social

Community Participation
- Organization Level
- Individual Level

Personal Values Adopting
- Aim of Happiness
- Being Trusted
- Personal Help
- Personal Experiences
- Personal Beliefs

Assessment

The health providers as clinicians identified the needs of clients, then planned and organized implementation towards those based on the context of the community. Data derived from interview revealed that the health providers approached cases through assessment, planning, implementation, and evaluation. They described working in assessment of cases in which their carried out the care practice in accordance to their management plan and past evaluation of the case. Their explanation is analysed below.

The nurses assessed the patients in order to create understanding of how illness developed within each case. One nurse explained that, “I think that the son (patient) had mental health problem when he was child. It was caused by a genetic factor related to his mother’s mental illness.” (N-2) Another nurse made a comment that,
He told me later that all workers drank water from the same bucket that was mixed with Amphetamine. So, I understood that this was the reason why he had an auditory hallucination again. (C-4)

The nurses also assessed the patients to identify the current problems of the patients. For example, “He became withdrawn, staying only in his room. He also became aggressive. Finally, he isolated himself.” (N-2) Another nurse identified that the patient changed his treatment status to become involuntary. She made a comment that “He took the medicine prescribed by the psychiatrist. However, he later decided that he wanted to convert his treatment as involuntary.” (C-4)

In assessing patient’s needs, the health providers had to consider certain criteria in order to know the extent of problems. The first criterion of decision making presented by the participants interviewed are symptoms of mental illness and abnormal general appearances of the patients that are apparent to the health worker, and information provided by the patients’ family. During the interview, one interviewee employed within the Northern PCU described the criteria that guided their decision making.

The criteria helping me in assessing those patients were depression or aggression and abnormal behaviour. That is, despite an apparent change in manners or habits, the patient simply refused to be treated. (N-1)

One nurse raised an example of a non-compliant case in which the family suspected that there might be something wrong with the case. However, the case rejected his problem and refused the therapeutic sessions. The family invited the nurse to provide advice and help at their home. She gave her opinion to the family that the patient needed treatment regarding his strange behaviour and dressing. She explained,

I looked at the patient’s behaviours. I studied him while he was sitting and talking with me. His mannerisms and behaviour appeared abnormal. The way he attired was abnormal. (N-4)
Similarly, one nurse from the Central PCU stated that she approached one non-compliant case. She mentioned the criteria of symptoms that reflected the patient’s need to be treated. She said, “The case hit his sister and niece. He rejected the oral-medicine, but was willing to take the injection.” (C-4) Another nurse described her experiences with two cases that met the criteria for symptoms as follows.

One case, which had never being treated before, the criterion was Auditory Hallucination described by the family. … Another case, at this time, was a young man who is a village health volunteer’s son. He refused to stop talking in the night. (C-1)

As indicated by these data, symptom assessment was the criterion in deciding whether the cases needed to be treated. Examples of symptoms were behavioural changes, abnormal general appearances, strange dressing, excessive talking, hallucination, depression and aggression. Those symptoms were evident in new cases and also among current patients who refused to continue with treatment courses.

The public health workers also assessed refusal of treatment so that they can approach patients appropriately. Some cases refused taking oral-medicine. One nurse from the Central PCU shared his experience with a patient who refused oral medication. He described, “He (patient) rejected the oral-medicine, but had the injection. His mother mixed the oral-medicine with his food for him every day.” (C-4) Some cases were involuntary in being given injections. In describing the injection refused, one public health worker employed within the Central PCU described “There was a case that needed regular injection as part of his treatment. But, he avoided having the treatment both at the PCU and at home.” (C-2) The others refused a therapeutic course of treatment. One public health worker from the Northern PCU gave an example: He said, “… He or she changed the manners and habits, but refused to be treated.” (N-1) Likewise, one public health worker employed within the Central PCU experienced
many cases where patients refused treatment. He explained, “… when the patients refused to go to the hospital, I usually advised the family…” (C-2)

Planning

The nurses had plan in organizing and prioritizing treatment suitable for the patients. For example, when asked how she planned for the case she responded, “I thought that he should be treated for his aggression first.” (N-2) Another nurse demonstrated her clinical planning in saying “I thought that I should monitor him more closely.” (C-4) When asked who was involved in decision making, two health providers from the Northern PCU mentioned that the patient’s family would be the main decision maker. One health worker said, “It must be talking with the family. Also, I must persuade the patient so that he or she might accept the treatment. He or she should agree with the treatment.” (N-1) Another health provider articulated the following family involvement. She said,

I discussed with the relatives first, and then met with the case. I asked about his symptoms and medication. I asked if he wanted to be treated or not. If yes, I asked where he wanted to go. (N-4)

She gave another example of family involvement that,

I discussed with their relatives. Then, I waited to hear their decision. I advised them to take the patient to see the doctor because the patient should receive psychiatric medicine. They had difficulties with my suggestion. So, I gave them other choices and see what they could organize. I also considered whether they had any more problems. I mentioned and gave more information on other health services that can provide treatment. Later, when they have similar problems again, they will be better at coping with the problems. (N-4)

Similarly, one nurse from the Central PCU mentioned the importance of family commitment in managing patients with con-compliance. She said, “When I heard that, I discussed with the patient’s family.” (C-3) Another shared about her experience with a non-compliant case. She said, “I questioned the family caregivers what they thought about this.”(C-1)
One common finding was that the patient's family was involved in decision making during planning in dealing with the patients who became non-compliant.

**Implementation**

The nurses undertook a wide variety of implementation activities. One nurse dealt with the patient with withdrawal and aggression by giving advice including prescribing and referral. She described,

*I gave Amitrip 10 and 5 mg to the stepmother to blend and add into the meals for him. When he calmed down, we took him out of the room. I advised them to go with the case to see the psychiatrist.* (N-2)

The other nurse provided treatment in the involuntary patient’s workplace so that the case received continued treatment. She claimed that, “*I did even giving him injection at the wooden factory where he worked to maintain his treatment.*” (C-4)

Implementation performed in the communities was supported by various resources. Such support included consultation with specialist, meeting with colleagues, knowing community, and VHV’s assistance. The support provided can be appreciated from the following comments of the health providers.

**Consultation**

The health providers employed within the Central PCU appeared to make decisions using consultation, rather than managing the cases all by themselves. Three nurses described their telephone consultation with a specialist. One nurse explained,

*When I had problems, I consulted the staff of the Psychiatric Department of the hospital. There was a staff responsible for community psychiatric services. I asked her what I should do when my patient had abnormal behaviours.*
Sometimes, while I was providing home visit session, I guessed that the patient’s problems could be caused by a particular psychiatric drug. However, I was not sure. So, I rang the hospitalized staff and consulted them. (C-3)

Another nurse also shared her views on the telephone consultation organized by colleagues while dealing with an involuntary patient. She explained,

_The nurse, key worker, phoned a hospital staff. … She described the patient’s symptoms. The hospital staff arranged to see the family caregivers instead of the patient._ (C-1)

Another nurse described her experience in preparing the consultation in advance of managing the non-compliance. She said, “I asked this staff what we could do. The hospital staff encouraged us to ring to them when we needed help.” (C-4)

The data in this segment suggested that the telephone consultation sessions were conducted to manage the problems relating to non-compliant patients in the community.

In comparison, the health workers employed within the Northern PCU did not seek consultation. One nurse said, “No, we have never consulted any specialist, even the psychiatric team in the local hospital nearby.” (N-2) The health providers tended to have informal meetings with colleagues in attempting to manage the situations of non-compliant patients as described in the next section.

**Meeting**

Only the health providers from the Northern PCU asserted the meeting sessions with colleagues as helpful in making decisions with regards to non-compliant patients. One nurse described,

_We sometimes shared our experiences together. …. For one case, we discussed the patient’s father as the caregiver and whether he treated the case well or not. … we talked about whether we should approach this case in a particular way. We didn’t direct them much. Whenever the father came here, I asked about the_
patient and advised him on ways in caring for the patient at home. Those practices I carried out were influenced by the advice shared with my colleagues. (N-3)

She added that,

*In managing non-compliant patients, we had monthly meeting in which we usually discussed together about problems and inconvenience at work. And, we discussed problem-solving together. ... Actually, we usually talked with the colleagues in both psychiatric and other chronic diseases care. It was like I consulted them and let them know the cases in the community at the same time.* (N-3)

One public health worker explained their clinical meeting as described below.

*Oh ... it depended on teamwork. We had monthly meetings. However, it might become weekly meeting, if needed. In clinical problem, like mental illness with non-compliance, we accepted the nurses’ opinions. We listened to them because we accepted the nurses’ knowledge. We could talk together like brother-sister.* (N-1)

Another public health worker added that, “I asked staff A and staff B about the clinical problems of a patient who rejected hospitalized care.” (N-5) One nurse confirmed the usefulness of the meeting that,

*We could ask the head of the PCU for external assistance. The head had good contact with other people and organizations. He knew a range of people including the chief of the LAO. We always asked him for support and funds for facilities. However, in clinical problems, like dealing with a non-compliant patient, he accepted the nurses’ performance.* (N-3)

The interviewees from the Northern PCU reported that they used meetings with colleagues in making decisions in mental health care.

**Knowing Community**

However, despite many previous comments on the value of consultation and meetings, one health staff from each PCU workplace mentioned “knowing community” as supportive to the decision making process in the implementation. One nurse from the Northern PCU explained the way in which she convinced a patient to resume treatment.
I tried and tried. I wanted them (patient and family) to feel comfortable with me first. Later, they trusted me. I needed to give them time. I mean I didn’t force them. I was not aggressive to them. I waited for them to be comfortable with me and accept me. (N-2)

Later, she raised this issue again and explained that because she knew the background of this family, she knew what she should do. She explained that

The parents were educated and well-known persons. They wanted to protect their son from stigmatization. Therefore, they might need time to see how much they could trust me and open up to me. (N-2)

Similarly, one public health worker employed within the Central PCU for 16 years described that he knew the community well and this helped in dealing with non-compliant patients.

As I have worked for long time, I know who this person (patient) was. I recognized his family as well. So I knew whether I should approach him directly. If not, I should ask a person whom he trusted. I believed that a patient usually believe in a particular person. This particular person could help. Uhm ... even a teacher could provide support. ... Some patients believed the police, while some patients trusted the head of village, sub-head, or the LAO staff. ... I couldn’t deal with all the patients by myself. ... Even the monk, sometimes, he helped in negotiating with a patient who was non-compliant. Mostly, the psychiatric patients feared the police. ... I know the police employed within the community area. ... There was a case avoided receiving the treatment. So, I asked the police to help. The police picked him up to the PCU and was with us while we gave injection to him in the treatment room at the PCU. (C-2)

The participants’ comments showed enhanced understanding of how knowing the community well can help in dealing with non-compliant patients. First, knowing the family living in the community contributed to an effective case approach. In addition, knowing the key persons in the community can garner support for interventions.

**Village Health Volunteer’s Assistance**

Assistance from the village health volunteer (VHV) was described by the health providers as another support in managing plans for non-compliant patients. One nurse from the Northern PCU viewed the VHV as a middle person who forged a link between
a patient and the nurse. This made it possible to manage the untreated patient for future treatment. She described,

_They didn’t want to came here (They felt ashamed). They asked this VHV to contact me instead. I gave them my phone number. … Finally, the family agreed to come to see me here._ (N-2)

Similarly, one nurse from the Central PCU discussed the role played by the VHV in helping to approach a patient whose illness deteriorated due to neglecting their oral medication. She confirmed receiving assistance from the VHV that, “_Sometimes, I had better knowledge of the patient after first talking to the VHV. Then I went to the patient at home._” (C-5)

**Evaluation**

The nurses evaluated their implementation conducted for the patients. One nurse mentioned that the problem decreased after implementation. She responded that, “_I visited him regularly. Now he is not aggressive any more._” (N-2) The other nurse made a comment in prognosis, inferring that, “_I found that the case did not fare well in prognosis. He had no job. He didn’t do the household work. He drank. He rejected oral-medication. He acted hostile to the family members._” (C-4)

Observation carried out during practice attendance related to health care revealed that the formal care plan was seldom executed by health providers. However, the Northern PCU-nurse assessed the patient with back pain as having stress and anxiety caused by physical and financial problems. She offered a counselling session as implementation and planned to provide a home visit session to the client as a next step. She also advised some change in the client’s daily activities. She explained that she must see this case again to evaluate the care she provided and do another assessment. This was evidence of
case planning, implementation, evaluation and continual assessment carried out at the patient’s home, which included counselling.

Similarly, in another observation session, one nurse from the Central PCU communicated with a woman to assess her son who was constantly agitated, talkative and was restless at night. After the conversation, the nurse made a comment that the woman should seek treatment for the son from a psychiatric team in the hospital. The nurse advised the mother to talk openly with his son about his abnormal behaviour. A week later, the nurse contacted the woman to evaluate how the patient and family coped with their situation. The woman replied that the way in which the nurse advised did not work well because her son rejected the treatment. The son claimed that there was nothing wrong with him. The nurse did another assessment to make sure that his personality changed would not affect the others. The nurse advised trying again and waiting without forcing him, at least in the first instance. Her strategy was to first assess the situation by discussing it with the patient’s family, then give advice as implementation, then evaluate and plan for help again with the patient’s mother.

The care practices also were recorded in the Family Folder of the two PCUs through assessment, planning, implementation, and evaluation. These documents confirmed that practice was undertaken according to a nursing process approach.

**Integrated Care**

Each health provider took responsibility in caring for people living in one to three villages located in the communities. The health providers engaged consumers as individuals and families with physical and mental health needs. When asked about
models of care provided, the health providers revealed that some patterns of integration were presented.

**Physical and Mental**

In describing how care practices were provided, one nurse who undertook the main role in caring for people with chronic disease within the Northern PCU explained that because of the much higher price of rice in this year, the farmers with hypertension became stressed due to too much working in farms. However, she expressed concern about integrating physical and mental health care in her patients.

* I had to be very careful in advising them. I couldn’t say that you should do less work at the farm. I couldn’t say that. I just motivated them to take enough rest and advised them to take care of themselves. Not only the physical conditions but I also aimed at mental health status of my clients. (N-3)

Similarly, one nurse from the Central PCU described one patient suffering from mental health symptoms caused by alcohol, with increased problems, due to hypertension.

* I used to monitor him for his mental health condition and had to supervise him in taking anti-psychotic medicine. Now the care must be extended to hypertension treatment. (C-5)

Another nurse described her practice as integrated care in that she dealt with a patient with Diabetes Mellitus who became stressed and had increased blood sugar. The patient was disappointed with her daughter who neglected her.

* I talked to her to identify cause (of stress related to blood sugar increased)…Later, I visited her at home and talked with her daughter. I repeated home visit sessions several times. Finally, the daughter became more caring towards her mother and transported the mother to the PCU. (C-3)

Observations also corroborated the integration of care. During a home visit of a paralysed patient and a 60-year old caregiver with hypertension and Diabetes Mellitus, a nurse from the Northern PCU provided a blood pressure check and helped in changing the position of the paralysed patient. The nurse spent time listening to the caregiver’s
grievances. The caregiver experienced stress due to physical burdens, such as changing bed sheets, changing the patient’s position, feeding, and bed bathing. She also could not rest well because her mother groaned loudly at night. The nurse listened with empathy. Lastly, she offered home visits for both the chronic case and the caregiver who expressed stress and experienced fatigue.

Records from the family folders in both PCUs also provided evidence of the provision of integrated care by the health providers, with a focus on physical and mental health problems of patients during the care sessions.

**Patient and Family Care**

A nurse from the Northern PCU illustrated with examples how they provided mental health care to individuals and families at the same time. For example, in the case of the family with a girl who was unconscious caused by electrocution, the parents had great hope, despite a small chance of recovery. The parents were eager to know what they could do for their child. This nurse expressed that,

*I couldn’t destroy their hope. I just want to support them. I did what I could do. ... I helped them with counselling sessions and taught in care practices.*” (N-3)

Similarly, one nurse from the Central PCU gave an example of a woman who had a burden in secretly adding the ground medicine into her son’s meals, cooking four times a day, and keeping an eye on the son at all times. This nurse made comments that, “She (patient’s mother) confided her problems to me. I also supported her in each time I visited the patient.” (C-4) Another nurse described her experience in caring for a patient and her family. She provided care to a mother-daughter who had same hypertension problems and were taken care of by the same doctor at the same PCU, but they didn’t
come together. The mother always missed the follow up sessions and engaged in grievance. The nurse recounted,

I visited both cases at the same time. I discussed this issue with them. Now, the situation had improved and they came together. I made the same appointment for them so that they can come together for all follow up sessions. (C-3)

**Personal and Social**

The integrated personal and social perspective of mental health practice provided protection for patients from social stigmatization. Concern with the issue of social stigmatization faced by patients with mental illness is presented by this nurse’s account. One nurse practising in the Northern PCU experienced one guardian asking her to give injection to a patient. The guardian said to the nurse that, “Don’t ask anything. Just do this.” The nurse described that,

He gave me a vial with the prescribing card … I was sure that it was the right patient and right drug. So I administered the injection without asking many questions. I understood that they wanted to protect themselves from social recognition. (N-2)

She also protected patient and social privacy in a client who needed counselling service, but did not want others to know that she had a mental health problem. The nurse said that, “I provided counselling sessions in the other room (an office room, not for counselling).” (N-2)

One nurse employed within the Central PCU articulated similar views on the need for prevention of social stigmatization. She described a case where a man had good physical condition, but did not receive isotropic treatment at the office. The nurse commented that, “It was like he felt shameful. …. Anyway, we always gave him injections at home.” (C-5)
Documentation of The Records of Counselling Practices in the Northern PCU also reflected practices to protect consumers with stigmatization concerns. In recording the cases with HIV/AIDS who had counselling sessions, the health providers did not record the name and other identified details of the cases. This practice was to protect the confidentiality and privacy of the cases with HIV/AIDS.

**Community Participation**

As described in Chapter 2, PCUs were the first level of health care contact in communities. In order to establish good care practice in mental health jobs, the health providers asked the communities to participate in mental health services. Data illustrating each level of community participation are presented below.

**Organization Level**

One nurse gave an example of the girl with unconscious that, “*We (the PCU staff) informed this case to the LAO. Then the case received some money annually from the LAO.*” (N-3) One public health worker confirmed community participation in mental health care services that,

*The LAO, key persons in community, and VHV’s were very supportive of the mental health activities. The mental health activities were focused on all groups like children, adults, older people, and people with disabilities. Therefore, we needed the cooperation of other organizations.* (N-1)

He gave an example of LAO participation. “*The activities (monthly meeting) of senior clubs for older people were paid by the LAO.*” Furthermore, he mentioned other participation that “*We cooperated with other organizations, even outside the community. Sometimes, we asked for funding support from the District or Province Health Office.*” (N-1)
Similarly, one nurse from the Central PCU asserted an example of community participation. She raised the issue of the senior club that, “We received funding support from the LAO in organizing the annual temple tour for the members.” (C-3). The data in the interview segment suggested that other organizations either within or outside the communities took part in mental health care services.

Observations carried out during the provision of health care services in the Northern PCU reflected community participation in mental health care services. A staff member from the LAO came into the PCU. He talked with the head of the PCU in issues relating to the community and the PCU. At that moment, one nurse informed him of a family needing housing. She described the risks related to mental health problems among the family members. Later, the LAO committees organized help for this family.

In reviewing the documents of The Reports of Practices in Health Education Standard: Year 2006, the Northern PCU’s vision in community participation was presented below.

We are the qualified health service network accepted by the community. We establish cooperation with the community to maintain life-long well-being towards our population.

The document reported the LAO as a sponsor of the senior clubs and the ‘To be No.1’ club. The LAO gave 88,000 and 20,000 Baht (estimate 2,933 and 700 AUD) for these activities. These data confirmed the participation of local organizations in mental health activities. The document also contained photographs taken during the PCU-policy announcement to the public. The head and PCU members announced the health care policy including mental well-being to community who were the LAO staff, the VHVs, chief of villages, and the monk. The data from the documentary analysis reveal that it was common expectation for the PCU to contact other community organizations in order to establish community participation.
Likewise, the vision of the Central PCU was presented as, “… We aimed at contributing to the well-being of individuals within the frame of Healthy Thailand Policy with community participation. …”

**Individual Level**

Individual contact was another level of participation in conducting mental health services. There was a diversity of examples described at the individual level of participation. One nurse employed within the Northern PCU mentioned participation with a village health volunteer (VHV) in approaching a case with mental illness. She explained that “the patient’s parents were well-known. They felt ashamed with the son’s illness. They asked this VHV to contact the PCU instead.” The nurse described, “A village health volunteer (VHV) came to consult me and asked whether I could help a case who was living near to the VHV family.” (N-2) Another nurse described a VHV being involved in community participation. She said, “I often went to the psychiatric patient’s home with a VHV. The VHV knew her area better than me.” (N-4)

Similarly, one nurse from the Central PCU described the VHV as a member of community participating in mental health care practice. She explained that she taught the VHVs to recognize psychiatric symptoms and characteristics of patients needing hospitalization resulted in the VHV participation. She claimed that “I could ask the VHV for help in monitoring patients in the community.” (C-4)

Furthermore, in describing the individual level of community participation, the health providers employed within the Central PCU raised the role of neighbours in mental health care. The nurse described that, “I asked the neighbours for help. For example, I asked them to remind and tell the patient to take psychiatric drugs.” (C-5)
health worker asserted that other individuals could participate in mental health care. He said,

_Uhm … even a teacher could provide support because a teacher had a lot of ex-students and there might be an ex-student who become a patient needing support. … Some patients trusted the police, while some patients trusted the head of village, sub-head, or the LAO staff. … Even the monk, sometimes, he helped in negotiating with a patient who was non-compliant to resume treatment._ (C-2)

The findings generated from health providers, such as VHVs, neighbours, teachers, police, monks, head of village, and LAO staff, demonstrated appreciation of the way many individuals participated in the communities.

**Adopting Personal Values**

In describing the care practices related to mental health, the health providers elaborated on how they had used personal values in caring for their patients, including trust, personal help, experiences, and beliefs. Health providers described the diversity of their care practices in non-specialized care. The interview data illustrated that the achievement of happiness was the purpose of mental health care practices.

**Aim of Happiness**

Happiness was expressed as the purpose of one nurse’s care practice. The nurse from the Northern PCU made a comment that,

_I don’t know what I did was right or wrong. But I provided care related to mental health in order to help sufferers and build up the happiness in my clients._

(N-2)

Likewise, one public health worker employed within the Central PCU claimed that he provided care with the aim of achieving happiness in his clients. He said,

_Mostly, cases came in looking crestfallen but some left with a smile. I also became happy when they are happy. … I wanted him or her to be happier. Hopefully, I... I also became happy._ (C-2)
These data revealed that happiness was a motivating force for health providers in helping patients with mental health issues.

**Being Trusted**

Being trusted was perceived as necessary in providing care practice related to mental health care. One nurse from the Northern PCU asserted her experience of being trusted by the patient and family. She perceived being trusted by patient and family as follows:

*I thought the family trusted me because I’ve never talked about them to others and ensured their confidentiality and privacy. So, other people in the village didn’t know this case.* (N-2)

The Central PCU also established that their mental health care practice was based on trust. One public health worker who had worked for the PCU for 16 years asserted that,

*I usually provided mental health care and other treatments (not mental health care practice). ... I worked with mindfulness. As a result, the consumers trusted me. They felt free to tell me their secret issues. ... Yes, the health provider must be a person whom they could trust. For me, I knew, but never gossiped. So they came and told me their problems. However, if they do not feel confident, they wouldn’t talk to me again.* (C-2)

Data derived from interviews revealed that being trusted helped in providing mental health care towards people in the communities. The health providers spent time in building trust to support their care practices.

**Personal Help**

The health providers perceived personal help as contributing to care practices. One health provider employed within the Northern PCU believed that personal assistance could help patients when formal support was unavailable.

*The assistance from the government, sometimes, was not available to everyone. We always help as much as we can. The other public health workers and the*
nurse gave some money to the case and family (an untreated patient with mental illness and daughter, nephew, and niece) that lacked money for living. We helped because we considered them as fellow human beings. (N-1)

Similarly, one public health worker helped the case by providing personal assistance, and money as a non-specialized technique.

Many cases couldn’t continue their treatment (which was missing the follow-up sessions) because of the lack of money. What I could help was giving them fare for the bus. After that, I told the family caregivers to take the patients to the hospital. (C-2)

**Personal Experiences**

The sharing of personal experience was a tool in helping patients who had mental health problems. This was based on belief that sharing personal experience can help in care practice as a non-specialized technique. One public health worker expressed his experience that,

Uhm...Maybe, I myself used to suffer extremely before. I had a serious family problem. Finally, I was given help. I thought that my problem was more serious than the clients’ problems. So, I shared my experience to encourage them. (C-2)

**Personal Beliefs**

Personal beliefs also drove good care practices related to mental health care. One nurse employed within the Northern PCU described her belief in practising meditation (Buddhist style) that could improve mental health. She said,

I encouraged the aged members to do meditation. This can improve mental health status. Yes...yes I taught them how to practise meditation and maintain awareness with Sati practice (Buddhist style). Those are the activities I provided for the senior persons living in the villages. (N-4)

Likewise, one public health worker viewed “To Let Something”, a principle of Buddhism as a tool in helping clients suffering from mental health problems. He said,

I used religious principles (Buddhism) to encourage them. I couldn’t help much in some issues. So, it must be the religious principles that could help. For example, I used some religious principles to explain to a client, “What the problem was, you should solve that exactly” or “Which problem can be ignored, please let it be”. (C-2)
Data presented in this section provides some insight into models of care specific in the two centres. The health providers adopted nursing process, integrated care, community participation, and non-specialized care in providing mental health care.

**Influences on Practices**

The previous section of this chapter presented the data indicating that the health providers engaged in some forms of preventive mental health care in the monitoring of recurrent illness. The information also revealed that holistic care was provided through nursing process, integrated care, community participation, and non-specialized help. This section of the chapter takes the analysis to another level, identifying some of the factors that resulted in these findings. These factors are divided according to two groups: personal and environment, as illustrated in figure 5.3.

**Figure 5.3:** Factors influencing the mental health care practices

![Factors influencing the mental health care practices](image)

**Personal Factors**

Personal factors include those that have an influence on mental health care practices provided within the PCUs. The participants perceived personal interest, uncertainty about their knowledge, and personal beliefs as factors influencing their care practices.
Interest

Personal interest in helping others was identified by the participants as a major factor. When asked about the most important factor influencing their practices, one nurse employed within the Northern PCU asserted that, “I think my motivation is the most important first factor. I have empathy towards these patients.” (N-4). Another nurse made comments that, “the mental health issues always appeared to be a part of my care practices because I like doing that.” (N-2). She also made the comment that “It was I myself. It’s personal interest. I mean I was not interested in a mental health job but I wanted to make a difference in my patients, helping them to be happy.” (N-2)

Similarly, one nurse employed within the Central PCU viewed that,

I felt empathy. I wished to care for these people. For example, when finished blood taking, I hoped the patients would take their medication and recover and be happy. I didn’t want them to feel sad in coping with chronic disease that requires regular check and treatments. (C-5)

Knowledge

One nurse confirmed that knowledge is an essential qualification in providing care.

What we needed was that we must have the ability to distinguish psychiatric symptoms from the normal cases. This could help in clinical decision making in managing non-compliant patients….Most of training courses were not related to mental health. So, the staff can be considered as not being trained at all in psychiatric care.” (N-3)

One public health worker also addressed the importance of knowledge in clinical decision making. He said,

The decision making done by staff might be different due to the lack of training. We couldn’t avoid the truth that we didn’t have enough knowledge and capacity like the nurses. Probably, other people couldn’t do clinical practices like the nurses did. I wished the nurses would take the responsibility for clinical decision making regarding non-compliant patients. (N-1)

Uncertainty about their knowledge in mental health care was a factor, mentioned by one nurse of the Northern PCU. She said,
That I didn’t know what I should do next also influenced on mental health practices. I heard that there were nursing instructors (who trained the nursing students) within some PCUs. Unfortunately, we didn’t have them here. I used to ask for that because I didn’t know how to approach patients with mental illness. (N-2)

Later, she concluded that, “As I didn’t know what I should do next, I didn’t do much in mental health care practice.” (N-2). Another nurse asserted that, “… I didn’t have much knowledge in practising mental health care.” (N-3). One nurse explained that training for all staff would be advantageous. She said,

Some staff have never studied mental health care before. However, they have responsibilities in this field. Therefore, all staff should be trained for at least one session per year. That would be good if the staff have a chance to learn the same topics. (N-4)

Similarly, one nurse from the Central PCU perceived her knowledge in mental health as insufficient. She explained that,

Even though, I was trained in the Nurse Practitioner Course that involved mental health nursing, I was not confident in providing care from the perspective of mental health care management. The course I studied was very brief and did not provide much knowledge in psychiatric nursing. (C-5)

The Personal Development Record of both PCUs, provided evidence in the documentation of a lack of health provider training in mental health course. They received a half to three-day courses relating to helping people suffering from disaster, caring for autistic children and conducting counselling sessions.

Beliefs

One nurse employed within the Northern PCU believed that Buddhist meditation can promote mental health. Therefore she organized meditation session for clients. She explained, “I encouraged the aged members to do meditation. This can improve mental health status.” (N-4). Likewise, one public health worker used a principle of Buddhism he believed as a tool in helping clients suffering from mental health problems. He said,
“I used religious principles (Buddhism) to encourage them. I couldn’t help much in some issues. So, it must be the religious principles that could help.” (C-2). The data in this segment indicated that the beliefs of the individual health provider appeared to influence mental health care practices.

Environment Factors

Environmental factors affecting mental health care practice were described as policy, family finance, occupational risks, specialist, and teamwork.

Policy

Some participants from the two PCUs were found to be familiar with policies, while others were not. One nurse from the Northern PCU replied that, “Actually, I didn’t know the policy. It was not clear. Once there was an order, I would follow one at a time.” (N-3). Later, she said that, “Actually, there might be a policy but I was not aware of (Laughed).” She confirmed that she has never seen the policy and what it contained. She perceived, “About policy related to mental health, I think it wasn’t clear.” (N-3). Another health provider expressed the view that mental health policy for the PCU was not clear when compared with other aspects of health policies. He explained,

There should at least be a mental health policy. There is almost nothing. If the policy was communicated, I would be happy because we could really work according to the policy. But, now mental health is like a hidden aspect. … I think mental health policy is not clear. If it is possible, I wish it is identified clearly so that we know the frame work and the success indicators. You know? Nowadays most jobs come with indicators. Then, we know what we must do. We can conduct care practices in those issues directed. Outcomes will be good in that consumers receive good care services. Anyway, the policy related to mental health is currently not clear. (N-1)

Likewise, one nurse employed within the Central PCU presented her view of mental health policy in a similar fashion.
I think mental health issues were not addressed properly compared to the other health services. Mental health aspects seemed to be included as part of other health issues. (C-1)

However, as key workers, nurses described the ways in which they felt familiar with mental health policy. One nurse from the Northern PCU asserted that,

_I know the mental health policy announced by The Ministry of Public Health. Nowadays, one of those policies engaged in this region is helping people suffering from disaster. For example, people in this area have to face the problems of flooding. I must help those living in my area._ (N-4)

Similarly, the key worker in mental health jobs from the Central PCU explained that,

_Ahh... There was a mental health policy announced by the Government that there must not be suicide case in communities. So, the mental health problem seemed to be on a decrease. The suicidal behaviour became a standard of The Six O indicators (six indicators of Healthy Thailand Policy) comprising good food, exercise, emotion, and etc._ (C-4)

Interview data reflected that health providers viewed mental health policy as a statement announced by the authority, for the purpose of showing the direction of practices, and standards of practices. They perceived that policies related to mental health were not stated directly in their routine work. As a result, they believed that mental health policy was not clear and they felt unfamiliar with the mental health policy. In comparison, the mental health key workers responded with familiarity with regards to the mental health policy in the ways it directed their work, and they engaged in reporting mental health tasks monthly.

In reviewing the official documents related to mental health policy directing practice, there was an underlying similarity in the documents of the Northern PCU and the Central PCU describing the statement of the Healthy Thailand Policy as The National Policy. It was comprised of eating good food, doing exercise, maintaining good emotion, being in a good environment, avoiding an evil path, and being healthy. This information revealed that the promotion of sound mind in the community could be
linked to the statement on the emotional domain. Second, in reviewing the policy of the two PCUs, there was very little emphasis on mental health aspect. The policy stated that “The PCU aims to provide holistic care for people in the community. …” This infers that mental health forms part of holistic care. Third, in reviewing the document of indicator of monthly report form called the E-Spection Report and the Report 400, it was evident that the mental health key worker took responsibility in completing those items related to issues of mental illness and disabilities. The document indicated the number of patients with mental illness and disabilities, the number of cases who received counselling services, and the activities of senior club and the ‘To be No.1’ club. This information illustrated that mental health policy was stated within the Healthy Thailand Policy and revealed throughout the report forms.

In considering the way policy influenced care practice, the health providers responded that their care practices were directed by policy. When asked if policy directed their practices, one nurse from the Northern PCU replied mental health jobs directed by policies that, “I had to undertake the mental health promotion fair including the activities. … Another activity I did was performing stress assessment.” (N-3). The public health worker said, “I confirm that we must practice following the policy of Department of Mental Health. … Mental health issues were mostly part of other jobs, such as counselling.” (N-1). One nurse claimed that the policy of providing assistance for victims of disaster directed her care practice. She described, “The policy directed my intention that health providers shouldn’t ignore, but help the victims of disasters.” (N-4).

Policy directed practice was also reported by the health providers employed within the Central PCU. One nurse described, “Of course, the policy directed our practices. If not,
we wouldn’t know the objectives nor fulfil the demands of our jobs. We have to see and follow the policy.” (C-1). One public health worker made a comment that, “Mental health? We always practice following the policy which directed the types of tasks we must complete.” (C-2). One nurse said, “I think that health policy directed care practices through the provision of standards as indicators to conduct the care practice.” (C-4).

Another participant from the Northern PCU replied that the care practices were completed according to the routine reporting format. He said,

_**Uh … There is an item on elderly care posted in the E-Spection report. It is a mental health issue. Another one is about drug addict and the ‘To be No.1’ club. In total, there were two items relating to mental health posted in the E-Spection report. Those we must complete.**_ (N-5).

Likewise, one nurse from the Central PCU perceived that standard indicators were the way policy of suicide prevention directed care practice. She said,

_Ahh… There was a mental health policy announced by the Government that there must not be suicide cases in communities. … The suicidal behaviour became a standard of The Six O indicators (six indicators of Healthy Thailand Policy) comprising good food, exercise, emotion, and etc. (C-4)._

She concluded that “the policy directed care practices as indicators provide us with guidelines on how to conduct the care practice.” (C-4). Another nurse described her care practice according to standard of care. She said, “According to the standard of PCUs. I fulfilled mental health task through counselling related to physio-psycho-social care.” (C-3).

On the other hand, the data reflects that the health providers have little opportunity to contribute to policy in their care situations. The participants were asked if they had a chance to inform the policy makers about policy being translated into practices. The following opinions were expressed by the majority of the staff working for the Northern
PCU. One nurse said “No … no.” (N-4) One colleague also said “No … (smiled) … no.” (N-2). Another described her experience that,

Oh (head shaking) absolutely no. I just only provided the care practices. I didn’t communicate with others. No ...I’ve never given feedback to persons of higher authority. I received orders, then performed practices, didn’t give feedback about problems while working according to the policy. I just only visited patients. I just carried out the care practices. (N-4).

Likewise, three health providers from the Central PCU responded in similar fashion, as one nurse commented that “No chance. They asked me to do, then I did (laughed).” (C-1). and one public health worker responded that “Oh! … never. I’ve never had a chance.” (C-2). Another nurse explained that “I have never ..., maybe, because I am not a key worker in mental health service. I didn’t join the meeting. I’ve never communicated with the policy makers.” (C-3).

However, two health providers employed within the Northern PCU described how they were involved in policy making. They provided examples of indirect communication.

One public health worker said,

I communicated indirectly to policy makers through the project reports. These reports might be finished at the LAO or the Administration Organization of Province. Staff from these organizations might communicate those details we reported. However, I didn’t know whether they engaged or not. (N-1).

Another public health worker shared that,

I had a chance to talk when I was trained in a session. I communicated my comments in the questionnaires of evaluation. The organizers told that they would send the comments to the headquarters (The Ministry of Public Health). However, I didn’t know whether they sent them or not. At that time, I had a chance, but it was an indirect form of communication. (N-5).

Similar comments came from the nurses employed within the Central PCU. One nurse asserted,

I had a chance ... when I joined the meetings. I wrote down my comments, but those didn’t help. They (the policy makers) already planned what to do, but the plan was not always feasible in the real situations. (C-4).
Another nurse made a comment that,

_ I’ve never had a chance in giving feedback to the policy makers (smiled). I could do only during the meeting sessions. I made comments to persons who were in positions of meeting the organizer. After that, I didn’t know if they communicated to the higher level._ (C-1).

The data reveal that the health providers perceived that there was very little emphasis on mental health policy in the PCUs. Most interviewees were not familiar with mental health policy. However, all health providers confirmed their care practices directed by the policy. As they had less opportunity in discussion their care practices with policymakers might influence on some policies that were not suitable with the communities.

**Family Economic Situation**

One nurse employed within the Northern PCU described socioeconomic factors as possible indirect influences on her care practice. She related a case in which the patient’s hypertension worsened with increased blood pressure and stress resulting from an increase in the price of rice in 2008. She explained,

_ At present, I think financial issues are a factor. (laughed) … They didn’t care for themselves. They neglected their regular treatments. They didn’t care how their blood pressure were. They just kept working in the farms because the rice was very expensive. … The problem was they did not have sufficient rest and did not take regular medication. They only concentrated on their career and neglected their health._ (N-3).

Later, she concluded that socioeconomic changes influenced patients’ physical and mental health. Therefore, she had to be very careful in looking after those patients and be on the lookout for mental health problems arising from socioeconomic changes. She said, _“I must look at mental health status much more than I did”._ (N-3). That is, she pays more attention to mental health status deterioration arising from the changing family economic factors.
One nurse employed within the Central PCU expressed concern that care management had become more challenging due to socioeconomic changes. She said,

I think that if the patient was a member of family with low income, he or she tended to have less chance in showing progress related to mental health. I found that poor patients usually did not have good rehabilitation. It was difficult to help them. (C-1).

In talking about the influences on care practice, one public health worker from the Central PCU made comments that family finance was one difficulty.

Some patients appeared to be non-complaint. But, here, those said that they didn’t have money and that meant they really lack money and so could not continue with the treatment. (C-2).

He viewed family financial problem as a challenge. He said again that,

There was a patient who didn’t have enough money to go to the hospital for the follow up session. At that time, I helped in giving the bus fee. The bus fee to the hospital was not more than 200 Bath (estimate AUD 7). I could help with the money for transportation and meals. Even though, the patient had the gold card for free health care services, the patient needed some money for the family caregiver to travel with him. Therefore, they wanted the money for two persons in travelling and meals. I gave some money to those who really lacked of money. I had the capacity to help with small amount of money but I could not help if more money was needed. (C-2).

One nurse from the Central PCU opined that having low income was a problem contributing to non-compliance. She explained that,

The family finance is an obstacle. I found a patient whom I considered must be seen by the doctor. But, his finance ... was a problem. Even though the treatment was free for all patients as part of public health care. He still needed the money for travel and meals. Some transport money is needed for the caregiver to go with the patient as well. The success of the treatment depended on the family, I think. If the family paid attention in caring for the patient and had enough money, this would result in effective care. (C-1).

Socioeconomic problems are acknowledged as a factor influencing mental health care practice due to its impact on patients’ commitment in self care. However this was portrayed as an indirect cause-effect.
Occupational Risks

Occupational risks in the form of danger presented to the health providers during their interaction with non-compliant patients also hinder decision-making and care management. One public health worker from the Central PCU described that,

*In dealing with the patient with aggression, I do not know if there is facility to support us. ... There was nothing to guarantee our safety. We might be threatened without any support. Nowadays, I work with a sense of insecurity. Some patients reacted aggressively when they felt unsatisfied. One patient banged the desk. Safety issue was a reason why staff didn’t want to work in this field. However, I still have to do, even though I felt rather fearful of the patient with aggression. A patient should come with the caregiver. One case was upset when he knew that other persons lied to him to force him to have the injection. Of course, I was fearful of this case because giving injection was my duty. If there were more support for such situations, other health providers would be willing to do these jobs.* (C-2).

Specialists

Although the health providers did not raise the specialist issue as a problem, one nurse claimed that the lack of specialists is another factor influencing care practice. She said,

*I think the issue of staff should be highlighted. Particularly, there should be a specialist in mental health care employed within the PCU. When we have problems relating to non-compliance and other issues, this person would be the counsellor.* (C-5).

Teamwork

One nurse acknowledged that working as a team would help in the dealing with patients with mental illness in the community.

*During home visiting session, I went alone to the patient’s home. I rather felt fearful. I wished I didn’t have to go for home visiting without a-colleague. There should be a team instead of working alone. I was fearful ... fearful of being harmed by a non-compliant and aggressive patient.* (N-4).

Summary

This chapter has presented the findings from the individual interview of five health providers employed within the Northern PCU and five health workers of the Central PCU. It illustrates the findings from document analysis and observation of care
practices related to mental health services. The data presented give insight into mental health care management in the community of Thailand. The findings have been divided into three sections, relating to the scope of mental health care practices provided and the models identified. The chapter also presents factors that appear to have some influences on those practices.

The health providers, comprising nurses and public health workers, delivered care practice related to mental health care encompassed within two domains of care. First, promotion and prevention in mental health were provided through activities of drug prevention, senior club, and projects focusing on particular groups. Screening for mental health problems was conducted to seek patients who need help. Counselling and giving support were provided by the health providers with specific techniques. Second, the health providers helped in ensuring regular treatment and preventing illness exacerbation with home visit sessions, giving injections, and organizing referrals. These care practices supported patients with mental illness living in the communities and provided them with treatments. Furthermore, the care practices give insight in mental health roles of the health providers. The health providers acted as educator, consultant, agent, and manager in managing mental health care services in the PCUs.

The care practices were driven through the model of the nursing process comprising assessment, planning, implementation, and evaluation. Those care practices presented also illustrate integrated care of physical and mental health care as the model of care provided by the same health provider at the same time. The integration of care focusing on individual patient and family was conducted together. The care provided with concern for the individual case and social stigmatization was also outlined. To provide care to the patients living in communities, the health providers established two levels of
community participation. The organization level, mostly the LAO, helped in funding support and other domains of well-being. The individual level, such as VHVs, police, and neighbours also took part in mental health care management. The care practices also revealed other non-specialized care gained with the personal values that contributed to good practice. The care practices aimed at ensuring patients’ happiness were driven by a sense of trust, support, personal experience and personal beliefs.

Factors influencing care practices were identified as personal factors and environmental factors. That the health providers had their own interests, knowledge, and beliefs influenced care practices in the focus on mental health issues. Environmental factors as policy appeared to influence the care practice. The family economic status was an environmental factor influencing the success of care management. Specialist, teamwork, and occupational risks were inferred to the other factor influencing on mental health care practice.

The next chapter discusses these findings and the previous chapter in relation to the research questions and previous research findings. It then addresses the limitations of the study and presents the general conclusions. Recommendations for nursing practice, education and further research are then presented.
Chapter 6

Discussion

Introduction

The present study aimed to identify how community mental health care (CMHC) is managed in practice in Thailand. Community health care providers were chosen for the study because they work outside the traditional boundaries of the hospital. Furthermore, they work for primary care units (PCUs) which provide direct and personalised care to people in communities. Interestingly, although they are not specialists, they manage to provide adequate and appropriate mental health care to the patients, in some cases, demonstrating advanced levels of practice. Hence, the study sought to answer the following questions:

1. What are the mental health care practices provided and the roles of health care providers in two PCUs in Thailand?
2. Which models of care are best suited to mental health problems specific to Thailand?
3. What influences mental health care practices in the PCUs?

A multiple case study approach was undertaken for two PCUs in Northern and Central Thailand; mixed methods were used to address these questions. Quantitative questionnaires focused on the context of cases, workloads, practitioners’ preparation for practice, and care management. Individual interviews were used to elicit in-depth information related to the knowledge of care management provided by health care providers and their perceptions of influences on practice. Observation and document
review supported the data retrieved from questionnaires and interviews. These data ensured methodological triangulation, which supported both the confirmation and the completeness of data. The multiple case study approach was appropriate in generating sufficient information to demonstrate transferability across settings; that is, there were a number of common findings from both settings that could be used as a basis for planning in other contexts.

**Key Findings**

Quantitative and qualitative analyses provided a picture of mental health care in two Thai communities. The following summaries of key findings provide an in-depth understanding of good care management in two PCUs. The PCUs were the first contact of health care provided in Thai communities. Their responsibilities included mental health promotion and prevention through drug prevention, senior clubs, mental health promotion activities, screening, counselling, and giving support. They also contributed to the prevention of exacerbation through methods such as home visits and giving injections. Therefore, they undertook roles which included educator, consultant, agent and manager to promote continuity of care. There was no single specific model of care used by the health care providers. However, they used the nursing process, integrated care, community participation, and adopting personal values as models of care. Mental health care practices provided were influenced by a combination of personal and environmental factors. Personal factors included individual interests, knowledge, and beliefs while environmental factors were policy, family economic, occupational risks, specialist, and teamwork issues.

This chapter provides a critical discussion of the findings related to the three research questions and previous studies. As two similar PCUs were investigated in this study,
this chapter presents a discussion of these two PCUs together rather than individually. However, some different findings are discussed separately. This is followed by an explanation of conceptual foundation, limitations of the study and recommendations made for practice, education, social and health policy making, and further research.

**Question 1: What are the mental health care practices provided and the roles of health care providers in two PCUs in Thailand?**

**CMHC as Part of Holistic Care in PHC Framework**

The present study found that CMHC was provided as part of holistic care service within a primary health care (PHC) framework in the two PCUs. This was evident from the fact that the PCUs provided health care for a wide range of health problems, and their activities were underpinned by PHC principles (Chuengsatiansup and Katar 2007). The PHC principles include access to health and health care, equity and social justice, using appropriate technology, emphasizing health promotion, and including intersectoral collaboration and public participation (Talbot and Verrinder 2005; McMurray 2007). The PCUs were established to provide accessible care to nearby residents in rural and semi-rural areas where psychiatric disorders were commonly found (Lorttrakul and Saipanish 2006). Care was also multi-dimensional. The current study found that only 1% of the PCU caseload was specific to mental health care, which differs from the finding of a study conducted in the UK, where 23% of caseloads of district nurses working in four primary care trusts (PCTs) pertained to mental health conditions (Thomas, Reynolds et al. 2006). However, in the current study it is must be noted that when asked about mental health caseloads, the participants only provided the exact number of patients with a diagnosis of mental illness. In fact, they also provided care to
clients who had mental and physical health problems together, which may have resulted in some under-reporting of mental illness. Another reason for this discrepancy is that the participants regarded mental health as one element within holistic care, an approach of care that they have embraced, rather than treating mental health aspect separately. This reflects a PHC orientation to practice.

In addition, the present study found that the PCU providers referred both untreated and non-adherent patients with mental illness to the hospitals. This too reflects PHC practice, which meant that there was co-operation with other organizations, such as hospitals to support holistic care for patients, whether primary or secondary levels of services were required, as advocated by Chuangsatiansup and Katar (2007). It is remarkable that the reality of practice in the PCUs reflected such a comprehensive, holistic type of care and referrals.

That Thailand placed CMHC in the PCUs within the PHC framework seems appropriate, particularly given the WHO report (2008). One report of a Greek CMHC indicated that services were also provided within a primary health care model in attempting to motivate the community to be aware of mental health issues and stigmatization (Bellali and Kalafati 2006). Additionally, an Australian community health centre has also established a Health and Wellbeing Team combining Aboriginal, women’s health and mental health professionals. The team providing mental health care to Aboriginal consumers with commitment to principles of social justice, community participation, health education and equity (Fairlamb and Muir-Cochrane 2007). The studies conducted overseas revealed that it is an advantage to implement certain PHC principles to guide CMHC providing in community services. It could be suggested that to place CMHC in the PCUs, the Thai government needs to consider promotion of
social participation that includes the community as partners in making decisions, using professional team workers to their maximum capability, ensuring systematic structures to guide practice, and identification of networks for consistency. Consequently, mental health roles of the PCUs would be clarified and ideally be carried out in accordance with PHC principles.

**CMHC Provided to Support Health Promotion**

The current study revealed that mental health care provided in the PCUs included health promotion. The study showed many dimensions of primary prevention, to prevent disease and protect healthy people before risk factors emerge, and secondary prevention, aimed at stopping further progression of disease (Egger, Spark et al. 2005).

**Primary Prevention**

The mental health care practices consisted of various forms of mental health promotion and prevention of mental illness by counselling and activities to promote mental health in young, aged, and high risk groups. These activities reflect primary prevention aimed at precautionary activities and protection against sickness (McMurray 2007).

Counselling was the most frequent care provided in the PCUs to promote mental health and prevent mental illness, with nearly all (n=8) health care providers from each setting reporting counselling as part of the workload they provided in a week. These findings are consistent with other studies conducted in the UK, revealing that counselling was one of the key care practices provided by CMHNs and district nurses (Crawford, Carr et al. 2001; Haddad, Plummer et al. 2005). The present study found that clients needing counselling had a broad range of problems, such as intra-family conflict and stress caused by physical problems as well as mental health disorders. During counselling
sessions, the health care providers mainly listened, supported, advised and provided important information to the clients. Similar results were found in a study conducted in the UK (McCardle, Parahoo et al. 2007). The study showed that the CPNs listened to patients’ concerns and supported families through exchanging information, listening to difficulties, giving advice, and providing supportive counselling. Another similarity is that counselling was the postgraduate course most commonly registered for by the CPNs (McCardle, Parahoo et al. 2007). An important finding was also that the health care providers seemed to be prepared to practise counselling. They were well educated and achieved good outcomes. This type of training should be continued, as it can be seen as an opportunity to contribute towards the strengthening of the CMHC by the development of skills of the health care providers in the PCUs. The argument has been made by others that personal skill development is a mean of enhancing care effectiveness (Crawford, Carr et al. 2001).

Besides counselling, primary prevention was driven through several other health promotion activities. One example was seen in drug prevention activities such as the ‘To Be No. 1 Club’, which aimed to prevent drug and substance misuse that might cause mental health disorders. This is an important type of activity in all mental health settings, because of the link between drug use and mental illness (Burnard, Naiyapatana et al. 2006). The club conducted events comprising music and group physical exercise through which it disseminated information about drug use to young people across the country. The club provided treatment and contact information to drug addicted persons wishing to be cured. The To Be No. 1 Club project is similar to Australian campaigns such as those supported by the Headspace Foundation (Hodges, O’Brien et al. 2007). Headspace, the National Youth Mental Health Foundation, assists local communities in establishing the Community of Youth Service (CYS) in order to protect young people
aged 12-25 years from mental illness and substance use disorders. At present, Headspace Foundation carries out activities such as face-to-face counselling, internet-based dissemination, local media announcements, community group activities, and in-school programmes (National Youth Mental Health Foundation 2008). Such strategies to engage young people using various activities are part of mental illness prevention in Thai communities. The PCUs have established such drug prevention campaigns as one mental health care service provided to support primary level of health promotion to communities. However, as drug use is associated with illegal issues, the PCUs must also address several social elements to deal with drug addiction. The current study does not address these social elements; therefore, this might be an area for future research to identify how PHC can be used to guide mental health care of young people with regards intervention, or secondary prevention of drug misuse in the communities.

Regarding mental health promotion towards elderly people, the present study found that senior clubs were adequate and effective in the communities. The health care providers who ran the senior clubs aimed to promote the well-being of older people. Members of the clubs had monthly meetings. The groups ran their own education, exercise, and recreation sessions. They were also provided with health services during meetings. Although there is little evaluative information on the club activities’ mental health outcomes, the senior clubs appear to promote the mental health of rural Thai aged people. This can be explained by the fact that these senior clubs are always open to all older aged persons in the rural communities. This gives non-metropolitan residents an opportunity to have social relationships and activities that support mental health. This is vital as it has been validated in other studies that social relationships tended to protect people from depressive disorder, dementia, and other psychological distress in older people (Fratiglioni, Wang et al. 2000; Shugarman, Fires et al. 2003; Siriwanarangsan,
Konsook et al. 2003). This is especially important in Thai culture as older people in Thailand have less chance to do social activities. They generally like to live with their offspring rather than living in senior lodges with their peers. The situation of Thai older people can be summed up by a journalist (Fernquest 2008):

Parents even use retirement as a way to push their kids to deliver grandchildren, early and often, often something like: ‘Who’s going to look after you in your old age honey, quick start having some children, you got a problem or what?’

Care of older people is particularly important as the number of older persons in Thai society also is expected to increase dramatically, namely 7.5, 11.0, and 14.6 percent of Thai population in 2010, 2020, and 2030 respectively (Wapatanawong and Prasatkul 2009).

Primary prevention was provided to create mental health in people at risk. The ‘Healthy Village’ project to support mental health after assessing risks of depression was similar to the Victorian Health Promotion Foundation (VicHealth) framework developed in Australia. It focuses on primary and secondary prevention with determining mental health and identifying priority of population groups and settings for action to create mental health (Walker, Verins et al. 2004). This clearly shows that working on high risk selected mental health issues was one way to prevent mental illness and protect mental health promotion to the communities. However, it can be argued that this type of mental health care practice provided might not be maintained in the present system. This is because it may depend on the need to create awareness or interest in mental health issues among each health care provider. Primary health care nurses need to be always aware of mental health needs as well as physical health needs for increasing mental health recognition (Armstrong 2003).
Another aspect of primary health care that was evident in the practice of these community health professionals was inter-sectoral collaboration. For example, they helped to contact a local organization to provide housing for a high risk family. They gave a number of packages of powdered milk to an electrocuted child in order to help ease the family’s financial burden. They sent food donated by Buddhist priests to an at-risk poor single mother with four boys who would become homeless. Similarly, a Swedish study found that mental health nurses there viewed facilitating patients in housing as a moral responsibility towards patient well-being. The reasons cited by the nurses for doing so were to provide a sense of security to patients, encouraging self-care, respect for integrity and private life, and acceptance as neighbours and being a part of the community (Högberg, Magnusson et al. 2006). Clearly, the health care providers recognized the structural determinants of health, such as housing, which are not strictly within the boundary of the health sector but are nonetheless important in ensuring that all dimensions of health are looked after. This embodies the intersectoral approach of PHC.

The findings discussed in this section are important in identifying the care practices as primary prevention which promote mental health and prevent mental disorders. Those practices were counselling, drug prevention, promoting aged mental health, protection of high risk groups and support in problems relevant mental health. These care practices are part of health promotion strategies in a PHC framework.

Secondary Prevention

The PCUs did not provide a psychotherapy course; instead, they provided care practices, such as home visits and giving injections to avoid exacerbation. These are ways of secondary prevention to expedite the process of recovering from sickness or
preventing deterioration in health (McMurray 2007). Their practices had a similar to that of CMHNs elsewhere focus in that home visits were the foremost aspect of daily workload for the CMHNs (Crawford, Carr et al. 2001; Zeeman, Chapman et al. 2002). However, it is less than those provided in another UK study conducted by Crowe and colleagues (2001), where most patients were visited by the CMHNs at least fortnightly. This may have reflected the fact that the overall workload of the health care providers in the current study involves a broad range of care rather than addressing any specific issue, and they were allocated time for many of these aspects of health services. In comparison, the CMHNs in the UK study, who were specialists, appeared to focus on mental health cases (Crowe, O'Malley et al. 2001). When considering what health care services are provided during home visits, those in the current study are similar to those in other studies. The health care providers in the present study used home visits to monitor and evaluate intervention, provide anti-psychotic injection, communicate and support families, offer some physical care, give advice, and remind patients of doctors’ appointments for follow-up sessions. Similar results were presented in Swedish and Australian studies that visiting patients at home helped in acknowledging patients’ problems, obtaining information needed for assessment, building nurse-patient relationships and administering anti-psychotic medication (Muir-Cochrane 2000; Magnusson, Höberg et al. 2004).

Second, as nurses, the participants in the present study included anti-psychotic drug injections as part of continuing treatment. This is consistent with findings from other studies which have found that anti-psychotic drug administration was an important intervention performed by nurses in communities (Nolan, Haque et al. 2001; Haddad, Plummer et al. 2005; Elsom, Happell et al. 2009). The present study also suggests that administering injections gave the nurses opportunities to assess and educate the patients.
Similar findings were reported in a study conducted in Finland by Hyvönen and Nikkonen (2004) that while providing medical treatments, practitioners were also involved in communication and monitoring patients’ conditions. The present study found one similarity with an Irish study’s result with regards to the location of care provision in that participants performed injection administrations in both the centres and the patients’ homes (McCardle, Parahoo et al. 2007). The Irish CPNs emphasized the importance of the medication encounter by explaining the functions of medications and side effects and discussing the importance of adherence to the medication regime (McCardle, Parahoo et al. 2007). Similarly, the health care providers in the current study assessed side effects that might result from receiving anti-psychotic drugs and discussed compliance in treatment, which has been identified as a serious problem (Muir-Cochrane 1998).

It was evident that the Thai health care providers did not seem to have in-depth pharmaceutical knowledge. Not surprisingly, one nurse said, “I don’t know what type of medicine I gave to my patient. … However, he never had a problem with it.” This might be because most participants (n=7) in the current study did not attend a psychiatric drug and administration course. Moreover, the current study found that to give anti-psychotic administration to patients in the communities can be difficult because of patients’ resistance, and physical compulsion was common in managing patients who refused to attend appointed sessions and receive injections. The PCUs co-operated with other parts of the community, such as police, teachers, and Buddhist priests, to help prevent relapses, as non-compliance with anti-psychotic medication is well known as a major cause of relapse in patients with psychotic disorders (Gray, Wykes et al. 2002). Clearly, some difficulties existed due to insufficiency in pharmacological knowledge of the health care providers and resistance by the patients.
Interestingly, even though the health providers seemed to have variable knowledge in psychiatric therapy, they showed competence in approaching the patients within their environments. And they used these care giving situations as opportunities to provide education, assessment and monitoring to the patients and support families. That is, they enacted their roles in helping patients who were recovering from illness or preventing them from health deterioration. Furthermore, they undertook assessment during visiting the patients that helped enrich information of patients’ conditions, which would be useful when providing referrals. This type of assessment and referral is known to be part of effective practice (Lauder, Reynolds et al. 2001).

Mental health nursing also has certain risks. For example, occupational risks existed for many nurses in the form of hazards arising from giving injections. Job insecurity presented another risk in terms of occupational stress, and this has also been identified in other studies (Edwards, Burnard et al. 2001). Working with patients with dangerous behaviour might erode the attractiveness of Thai CMHC. Therefore, more attention has to be given to this issue. For example, there might be laws related to psychiatric care, incentives for working with psychiatric patients in various geographic areas, and increased security in working in high risk environments.

Community Health Care Providers Provided CMHC

The information regarding the context of the PCUs indicated that there were neither nursing mental health specialists nor other mental health professionals working within Thai communities. This is consistent with Saxena’s (2007) report that there was only 0.01 per capita of specialist nurse working in community setting in South-east Asian countries, because most low-income countries in the region provide mental health service in hospitals, not community centres. The lack of specialists compelled the
community health care providers to deal with mental health issues in local areas using the PHC framework (Chuengsatiansup and Katar 2007). It can be said that the health care providers tended to view clients in physical, mental, social, and spiritual aspects within the PHC framework with which they felt familiar. Mental health, therefore, was part of the health care they provided generally in the communities.

However, it is true that dealing with mental health issues may be difficult, due to the complexity of cases and the environment. The mental health care providers, therefore, should be prepared through education. The current study found that with regards to the qualifications of health care providers, no one practising in the PCUs was trained to be a mental health specialist. As mentioned previously, the majority (8 persons) of them received training in counselling. For the one to three health care providers who reported receiving training in other courses, these included mental health assessment, suicide prevention, home care for mental illness, psychiatric drug administration, counselling for drug addiction, and care for autistic children. So, they appeared to have the capacity to provide mental illness prevention rather than just psycho-therapeutic care.

A conclusion could be drawn from this information that the number of mental health care professionals is insufficient in the communities of Thailand. This is similar to other many low-income countries in that there is no community mental health service provided in communities (Saxena 2007). Community nurses and public health workers who performed their responsibilities at patients’ homes act as substitute CPNs/CMHNS. As community mental health issues are multifaceted and require comprehensive knowledge, health care providers with adequate counselling skills seems to be the most important resource. However, as they were not mental health specialists, provision of
other assistance such as protocols would help in decision making in mental health care situations.

**Nurses as a Main Resource in Community Mental Health Care**

The present study found that nurses and public health workers were directly involved in providing mental health care to people in their communities. In contrast, mental health provision for communities in many countries, including the UK and Ireland has been through the deployment of GPs, psychologists, counsellors, CMHNs, clinical supervisors, and primary care mental health workers (PCMHWs) (Bower, Jerrim et al. 2004; Cunningham and Slevin 2005). Interestingly, the present study showed that the majority of health care providers who were providing mental health care in communities were nurses, with seven of ten participants being nurses. One participant appreciated the contribution of nurses in mental health care management, stating that ‘...we accepted the nurses’ opinions... (and) knowledge’. This indicates that the nurses play important roles in CMHC in Thailand. However, the nurses also stated a preference for working as team members and with specialised nurses. The DMH, Thailand, appeared to support further education for nurses in psychiatric hospitals rather than in communities. One reason for this issue may be that specialised nurses with psychotherapy training are necessary in institutional-based settings because they can help in secondary intervention. Health care providers in the PCUs commonly do not provide psycho-intervention, and were not in first priority of mental health training. More attention and support should therefore be given to these nurses. Another suggestion would be the employment of more specialists and the formation of multidisciplinary mental health teams within the community setting to provide comprehensive mental health care.
Roles of CMHC Providers

Findings from the current study revealed that the health care providers played roles as educator, consultant, agent and manager for primary and secondary prevention. First, the health care providers played educational roles in both formal and informal sessions for primary and secondary prevention. The health care providers reported that they taught clients how to cope with mental health. One nurse reported that she conducted formal education sessions about mental illness issues to village health volunteers (VHVs) to disseminate knowledge related to mental health care throughout the community. These findings concurred with results of Australian and Chinese studies, which found that education was the main role of CMHNs (Fairlamb and Muir-Cochrane 2007; Huang, Yen et al. 2008). Second, the health care providers acted as consultants for patients and families in identifying symptoms of mental illness. They also provided information about institutional care. They appeared to have information about health systems and consulted with patients and families. Similarly, Bellali and Kalafati (2006) found that consultancy was one role of nurses in community mental health care in Greece. Regarding contact with the patients, Greek CMHNs provided consultation and training in issues of self-management and self-care and identification of symptoms. It appeared that the PCU-nurses played consultant role, one of CMHN’s roles, responding directly to needs of patients and families (Bryant, Forster et al. 2007). The consultant role reflects the expert level of advanced practice nurses (Benner 2001). Third, the health care providers, like Scottish CPNs, acted as intermediaries between the patients and mental health professionals from hospitals (Adam, Tilley et al. 2003). Like other health care providers, they also undertook managerial roles in computerized data recording and reporting to the Ministry of Public Health on pertinent mental health issues occurring and the care management of patients. (Burnard, Edwards et al. 2000; McKenna, Keeney et al. 2000; Dallender and Nolan 2002; Simpson 2005).
There was one important difference between health providers in the two PCUs in terms of decision-making. The health workers in the Northern PCU generally used formal and informal colleague meetings for decision-making in practice. In comparison, those in the Central PCU chose to consult directly with the hospital-based mental health nurses. This may be because there was no previous official organizational connection to promote mental health care between PCUs and hospitals. Even though a networked hospital system has been developed in Thailand, the results found this study show that this has not been used in the PCUs studied. For whatever reason, the participants chose the way best suited to their needs in decision-making rather than relying on the government networks. No explanation was given for this, so it is difficult to determine whether they were unaware of the networks or found them inappropriate. This may be an area for the Thai government to discuss with health professionals.

In summary, the mental health role was based on PHC philosophy. The care practices addressed health promotion in providing primary and secondary prevention, undertaken by non-specialists in mental health care. Nurses were the main resource in delivering mental health care, and they enacted the roles of educator, consultant, collaborator, agent and manager for primary and secondary care. It can be said that with reference to external institutions, the PCUs appeared to have responsibilities in providing mental health care within the PHC framework.

Question 2: Which models of care are best suited for mental health problems specific to Thailand?

One participant, similar to those from another study stated that they did not use a model consistently in practising, but based their methods on what they thought to be right (Haque, Nolan et al. 2002). This is not a surprising issue when CMHC was provided by
non-mental health specialists. In the present study, the reason for perceiving no model underpinning the health care practices was that the participants might not be familiar with ideas of theoretical models backing up their practices. It was also possible that they overlooked the fundamental health care model and tried to think of more specific models of mental health care. As a result, they were unable to identify any models with which they were familiar. This was also a finding of an Australian study that questioned mental health nurses about the use of theoretical models. Only 50% of the Australian nurses were aware of using theory models to guide their practices (Sands 2007).

For those who did use a model, there was no single model of mental health care practice provided in the PCUs. Their holistic approach was slightly different from the therapeutic models of care reported by CPNs/CMHNs in other studies. For example, Nolan and colleagues (2007) conducted a study to identify UK and US nurses’ responses to a wide range of models of care. The results showed the three most popular models used by those nurses. First, cognitive behaviour therapy (CBT) is a therapeutic model encouraging patients to process interpretation of events they perceived appropriately, and it results in mood and behaviour adjustment. Second, Peplau’s model was identified in reference to their using her three phases; introductory, working and termination of the nurse-client relationships (Fontaine 2003; Young 2003). Others use an eclectic model that is dependent on many factors, including the type of patient, the demographic characteristics and the context of care (Nolan, Haque et al. 2007; Sands 2007).

**Nursing Process Model**

The present study showed that health care providers provided mental health care practices through nursing process model comprising assessment, planning,
implementation, and evaluation. It can be said that the nursing process model is widely used to provide nursing practices in their work (Haque, Nolan et al. 2002; Fontaine 2003; Gibb 2003; Magnusson, Severinsson et al. 2003; Hörberg, Brunt et al. 2004; Nolan, Haque et al. 2004; Huang, Yen et al. 2008).

**Integrated Care**

Findings from the present study confirmed that integrated models of care underpinned mental health care practices provided in the two PCUs, as indicated in all findings from the questionnaire survey. Thematic analysis showed that the health care providers engaged consumers through integrated care for individual and family concerns and for physical and mental health needs. They also understood patients as living in social environments with particular social stigmatization issues.

First, physical and mental health care were provided together in the communities. For example, one nurse monitored mental health disorders and also provided treatment for hypertension in a patient during a home visit. The results of the current study showed both similarities and differences to findings from another study, conducted in the USA, focusing on providing holistic care to people in the community (Gaul and Farkas 2007). In the American study integrated physical and mental health care had been provided together to mentally ill people and people at risk. However, this was different from the current study in that the integrated care was provided by a pair, consisting of one public health nurse and one mental health specialist, who visited clients at home together (Gaul and Farkas 2007). In contrast, the current study found that integrated care was provided by one community health care provider.
Second, the health care providers provided care to the patients and offered help to other family members. For example, one nurse always provided a counselling session to a patient’s mother after giving an anti-psychotic injection to the patient. The findings from the current study can be supported by the findings of a Thai study (Sethabouppha and Kane 2005). This phenomenological study was conducted to study caring for mental illness in Thai Buddhist family caregiving. It found that not only patients but also family caregivers were helped, such as in managing stress consequences from their patients, by the health care providers (Sethabouppha and Kane 2005). This could be due to Thai patients being highly likely to live with their families in communities and thus assistance provided by the community health care providers was extended to patients and their families.

Third, the scope of integrated care between personal and social perspectives in this study demonstrated a model of mental health care practice in Thai communities. Evidently, the nurses were able to know whether or not the patients would be ostracized. The nurses knew the case and the community, and were able to contact the patients in subtle ways that maintained their anonymity. For example, one nurse stated that she had never told other people about psychotic disorders found in a patient to save his family from shame and guilt, indicating that, as in other societies, mental illness is generally stigmatized in Thailand (Burnard, Naiyapatana et al. 2006).

Community Participation: Balancing Privacy and Confidentiality

The findings of the present study revealed that the health care providers allowed both organizations and people in the communities to participate in mental health services. First, local administration organizations (LAOs) helped with funding for mental health activities, such as sponsoring temple tours for senior club and other issues relating to
living in the communities, such as housing for poor families. Sands’ (2007) Australian study also aimed at producing a comprehensive, holistic definition and description of mental health triage nursing in Victoria, Australia. Results of the study revealed that community resources, such as crisis accommodation, had been included as an integral component of the mental health triage nursing model through a network of community-based agencies (Sands 2007).

Community participation found in the current study is a strength in providing mental health care in the communities. However, it can be argued that the LAOs as local governors took little responsibility in the provision of funds for mental health activities. As discussed previously, needy patients needed assistance in transportation to see their psychiatrist at the hospital due to the lack of money and no income. The health care providers who faced these situations contributed some money to needy patients. At this point, the community should share support. Since common villages in rural areas did not have support from NGOs and organizations, LAOs should take leadership in helping and participating, such as transporting the patient to the hospitals or recruiting them for some jobs. The LAOs as local governors can be more participative. They should address mental health issues as part of a community development plan seeking co-operation from others, not just PCUs. This would encourage community participation and intersectoral collaboration in community mental health.

Second, another form of community participation identified by the participants in this study was personal participation. The health care providers established diverse individual contacts. People who participated in mental health services were village health volunteers (VHVs), neighbours, teachers, police, monks, heads of villages, and LAO staff. One public health worker described experiences in negotiating with patients
through teachers, Buddhist priests, the head of the village and LAO staff. This success was due to the Thai culture, which placed great respect with teachers and Buddhist priests due to beliefs in the moral qualifications of those people.

The fact that lay persons tended to listen to Buddhist priests was supported by findings from another study suggesting that monks played roles in mental health treatment because they had more time for those wishing to talk to them and receive advice, blessings and treatment in Thailand (Burnard, Naiyapatana et al. 2006). Furthermore, one nurse encouraged the good neighbours who respected the patient as a human being to keep their eyes on a patient. This supported the patient’s mental health. A similar result was found in a Swedish study that many patients were treated kindly by the good neighbours (Högberg, Magnusson et al. 2006). The study suggested that to work in the community, the nurses had to respond to the patients and neighbours because it is of great importance that neighbours see a patient as a human being and a community member (Högberg, Magnusson et al. 2006). Moreover, the nurse had to make sure in confidentiality between their patients and the village health volunteers (VHVs). As mental health is a sensitive issue related to social stigmatization, the nurses had to balance the extent to which the community should be involved in providing care for a particular patient and decide when it would be suitable in order to maintain confidentiality of care and patient privacy. An issue related to this is described by Parr, Philot and Burnst (2004), who wrote that patients living in urban setting might be lonely in a crowd. It could not be assumed that those living in rural area will always have networks to support them, but this often occurs, even though the trade off is that rural people often lack anonymity. Therefore, knowing each other in communities and neighbourhoods can have both advantages and disadvantages for people with mental illness. Importantly, health care providers should consider community participation in
such a way as to ensure balance in its development. Furthermore, the Thai government and populace should have a concern that ‘mental health is everybody’s business (Fairlamb and Muir-Cochrane 2007), and take action in participating in protecting mental health.

Personal Values

Findings from the current study illustrated that the health care providers providing mental health care practices related to their personal values. Their care practices began with purpose of patients’ achievement in happiness. In practical care provided, they contributed trust, gave personal help, and used interpersonal skills and personal beliefs.

Firstly, being trusted was perceived as a necessary foundation in providing mental health care. For example, one nurse took time to build trust and confidence in a patient and his family instead of rushing in and forcing only health care practices. This nurse felt that, for a particular case, the feeling of trust must be a necessary element of care. Similar findings reported in two Swedish studies revealed that the nurses believed trust is an important foundation in working with the patients in communities (Magnusson, Höberg et al. 2004).

Furthermore, personal help appeared to be a part of care in the current study. The health care providers sometimes helped by giving money to poor patients; for example, providing bus fare so the patients and family caregivers could go to follow-up sessions in hospitals. This indicated a personal willingness to help other people who were suffering as well as the fact that the health care providers knew well their clients and clients’ situations. Because the health care providers also had resources in the communities they knew suitable ways to help their clients immediately.
Next, personal experiences were used in managing serious problems, which helped the health care providers to share and influence the patients. For example, one public health worker made it his goal to understand his client’s problem as if it were his own experience. He also shared feelings and experiences, and gave suitable advice to the client. One explanation may be that the health care providers with prior experience in overcoming problems could build up good understanding and confidence in providing mental health care.

Lastly, Buddhist philosophy as personal beliefs underscored the delivery of mental health care in the present study. The health care providers used their own Buddhist beliefs, such as practising meditation and ‘letting it be’, which means understanding and accepting what has happened. Similarly, the ways of Buddhism were also presented in a study of Burnard and colleagues (2006). Their results illustrated that the nurses, as Buddhists, used a Buddhist principle to encourage the clients to accept and face their own problems called ‘non-attachment’. The current study also found that practising meditation, another Buddhist belief, was used by the nurses in helping the clients draw on their own strength. This is also supported by a finding of another study conducted by Sethabouppha and Kane (2005). They found that concentration, a Buddhist belief, led caregivers to relieve stress in looking after the patients with mental illness.

On this point, the health care providers had happiness of the patients as a goal and worked on building trust, helping, and using interpersonal skills and Buddhist beliefs to provide mental health care. The CMHC in Thailand partially depended on personal values utilized by each provider. Even though these practices were not always based on knowledge or evidence, they appeared to be useful in engaging and helping people with
mental health problems in environments because they were established through friendship rather than a curative atmosphere.

**Collaboration and Consultation**

Collaboration and consultation were used to manage mental health care in both communities. Data derived from the Northern PCU indicated that collaboration among colleagues was helpful in managing mental health care practices, including sharing individual skills and knowledge among disciplines. That the nurses collaborated with the public health workers might be because one had a strong social network and another had extensive knowledge of care management. Similar findings of collaboration were found from overseas studies. Collaborations were developed in diverse ways, such as meetings, giving guidance to other professionals, and receiving advice from hospital psychiatric nurses (Holst and Severinsson 2003; Hyvönen and Nikkonen 2004). That they accepted their own opinion as non-mental health providers is similar to the way that district nurses trusted their hunches related to health and circumstances and used them in managing mental health situations (Lauder, Reynolds et al. 2001). Some of these hunches were intuitive. Dreyfus’ model of skills acquisition, adapted for nursing by Benner, explains that an expert is more likely to make a clinical decision with a sense of right rather than adhering to clinical guidelines when it is difficult to respond well in all situations. The expert nurse can manage each situation with the intuitive grasp that comes from good clinical judgement (Benner 2001).

While the Northern PCUs relied on collaboration to support health care practice management, the Central PCUs tended to choose consultation instead. Collaboration and consultation are similar. However, one difference is that collaboration results in equal status during contact, while consultation means unequal power between two parts.
Collaboration and consultation can be established in CMHC informally at the same time, as indicated in other studies. For example, Hyvönen and Nikkonen (2004) found in their study that consultation was one part of collaboration. In this study, information from the Central PCUs revealed that the health care providers used consultation sessions with hospital-based nurses when they struggled in dealing with mental illness patients. One possible explanation for the finding may be that there was no structure for connection between the institution and the community before. So, they chose the means that best suited them. The Central PCU workers might be familiar and have personal contact with hospital-based nurses. They also experienced being supported when consulted. Another explanation is that the message from traditional mental health care was that mental health care was not easily comprehended by a non-specialist team. Fairlamb and Muir-Cochrane (2007) reported that consultation can help the worker to become more experienced in mental health care, and less fearful. Formal collaboration and establishing ongoing consultation are also essential in managing mental health care in Thai communities and ensuring continuity of care.

**Using Standard Guidelines**

To some extent, standard guidelines were adopted through sessions of mental health promotion, such as using national standard guidelines contributed by the Ministry of Public Health (MOPH), Thailand for things like depression screening. People identified by this screening to be at risk were then guided in counselling sessions to prevent suicidal behaviour. Further, they gave functional advice to the parents when they found new cases with autistic disorders. Their decision regarding care practices were also based on the screening manual, including guidelines established by the MOPH, which could be categorized as one level of evidence-based practice (EBP) (McKenna, Cutliffe et al. 2000).
Although there is an absence of previous studies to support these findings from the
current study, Mollica and colleagues (2004) confirmed that using EBP in a population-
based assessment and monitoring was beneficial in identifying the prevalence of mental
health disorders in the community and in planning for early intervention. Kelly,
O'Meara, Howard and Smith (2007) concluded that early intervention for mental illness
in a rural community may be an unmet need, due to a lack of training and evidence-
based approach. The study revealed that the use of standard guidelines is important in
that it might help the community health providers to provide consistent interventions to
people in the communities. Guidelines should also be based on research evidence,
which suggests that, with further research, mental health care could be standardised to
meet evidence-based criteria.

**Question 3: What influences mental health care practices in the PCUs?**

Another purpose of this study was to identify influences on mental health care practices.
The findings from this study, together with the findings from other Thai and overseas
studies, revealed that mental health care practices were influenced by many different
factors. At the individual level, personal knowledge and interest influenced engagement
and motivation in mental health care. Personal beliefs, particularly in Buddhism, also
directed the styles of mental health care. In addition, at the circumstantial level, mental
health care practices were influenced by the national mental health policy and the
patient’s economic status.

**Personal Knowledge and Interests**

Personal knowledge of mental health was mentioned as an important factor in practising
mental health care. The health care providers in the current study appeared not to be
confident in their own knowledge in dealing with mental illness. However, they were
willing to provide counselling to patients and families. These results concurred with results from a study conducted in the UK, which found that district nurses perceived their inability to offer in-depth intervention as a limitation. They provided non-specific monitoring and justified it on the basis of patients’ needs (Lauder, Reynolds et al. 2001). A possible explanation for the findings of the current study is that the health providers might perceive that they were community-based health care providers providing a wide range of care rather than mental health specialist providers. None of them undertook further education in mental health care. This might result in a lack of confidence in managing psychotic patients in their areas. However, they seemed to have competence in providing counselling. This might be because nearly all of them were trained in counselling.

Personal interest in mental health issues was identified as another significant factor influencing mental health care practices. One nurse in the current study reported that she investigated mental health problems of patients because those mental health issues had always interested her. Another nurse reported that she provided psychological care to patients with physical conditions because she wanted to see them become happy. Then, these nurses saw that mental health was important and was associated with physical aspects. In the absence of evidence for general providers’ views, however, it could be said that the nurses felt their care of the physical need was incomplete without mental health needs being met.

One possible improvement in quality of CMHC would be health personnel development particularly in knowledge and attitudes in caring for people with mental health issues.
Buddhist Principles

Personal beliefs in Buddhist principles influenced the particular style of health care. For example, one nurse encouraged elderly persons to practise meditation in order to promote their mental health status. One public health worker advised his counselees to understand and accept when something unpleasant happened. He encouraged them to deal with the causes of problems rather than struggle with the bad consequences. These providers adopted their personal Buddhist principles as part of their health care practices. Similar findings were reported in another Thai study of family caregiving provided to patients with mental illness (Sethabouppha and Kane 2005). The study found that Buddhist philosophy was helpful for caregivers to deal with mental illness; it was the ‘middle way’ comprising appropriate understanding, thinking, talking and acting, and having livelihood, effort, mindfulness, and concentration (Sethabouppha and Kane 2005). Interestingly, the Buddhist belief found in this study concurs with modern therapy like CBT in that both focused on actual problems and dealing with those using cognitive coping styles.

This shows that Buddhist beliefs impacted on CMHC provided in Thailand, where most of the population is Buddhist. Therefore, it would be essential that to work on CMHC in Thailand, the health care providers engaged clients and their problems through Buddhist philosophy. This is because Buddhist principles are not only consistent with CBT, but can be easily applied when providers and consumers are Buddhists.

Mental Health Policy

Mental health policy from the Department of Mental Health (DMH) and the Ministry of Public Health (MOPH) was perceived as a major factor influencing mental health care practices. The policy directed all health care providers in performing health care
practices. They conducted activities such as the ‘To Be No. 1’ and ‘The Senior Club’ in response to policies from the MOPH in promoting mental health in young people and older persons. Interestingly, some health workers felt familiar with the mental health policies, while others did not. An explanation for this is that the DMH attempted to integrate mental health work into the general health services system. The mental health policy, therefore, was a subset of the global health policy made by the MOPH. The PCUs received health policy from MOPH and delegated one worker to be the key worker in mental health care work. Thus, it is reasonable that some workers felt unfamiliar when asked about mental health care policy in the PCUs. Importantly, the results of the current study revealed that the health care providers had less opportunity to inform policy makers of their health care practices. Although three health care providers stated that they had a chance to inform the policy makers of their health care practices, they also commented that they did not know whether the policy makers received those messages. On this point, another Thai study found a similar result in that health providers believed they were wasting their time in doing the mental health reports for higher personnel because those data had no impact in improving mental health service in their areas (Watcharasin, Junsiri et al. 2006).

**Family Economics**

Family economics had a possible indirect influence on care practices. That is, the health care providers had to consider the stress that financial difficulties caused their patients. For example, one nurse had to change her focus from hypertension to stress relief caused by excessive work to relief financial pressure, which, in turn, affected her patient’s high blood pressure. Furthermore, family economics also influenced care practices in terms of hindering continuing treatment. For instance, patients tended to miss their doctors’ appointment for follow-up sessions due to the lack of money for
travelling. The health care providers must help in ways they can so that the patients can continue their treatment regimes. One nurse gave the opinion that the patients who had families in the low economic category were more likely to have a poor prognosis. This finding concurred with an Italian study which aimed to identify relations between socioeconomic status (SES) and the treated incidences and prevalence of mental illness in South Verona, Italy (Tello, Mazzi et al. 2005). Results showed an inverse association between the use of community mental health services and SES. The researchers suggested that this may indicate the presence of more severe disorders, greater social suffering and higher demand for community mental health care among those patients living with deprived status (Tello, Mazzi et al. 2005).

In fact, financial pressure might also cause mental health problems in normal patients. Consequently, the health care providers must understand and adjust their care accordingly. To provide CMHC in a Thai community the health providers should be sensitive to the economic situations of the consumers as it impacted on mental health status and scope of mental health care practices. There should be preparation and training in dealing with potential urgent crises in the communities. For example, in 2008, many Thais had stress caused by higher cost of living and petrol, but prices of agriculture produced by the grassroots people plummeted. The local health providers must understand and notice the consequences of rising living costs and decreasing income and their effects on mental health.

**Cultural issues**

As the current study was conducted in Thailand, it is likely that Thai culture influenced the participants’ perceptions in their communication with the policy makers. This would involve the concepts of ‘Kreang Jai’ and ‘hierarchical structure’, embedded in Thai
social life. Many Thai people always aware of ‘Kreang Jai’ or ‘awe hearth’ when interacting with others (Burnard and Gill 2009). Kreang Jai could mean ‘to be considerate’, ‘to feel reluctant to impose another person’, and ‘not to cause discomfort or inconvenience for another’ (Muenjohn 2009). Kreang Jai behaviour helps in contributing feelings of comfort and respect and avoiding confrontation. It encourages persons to communicate in a ‘roundabout’ way, rather than directly. Kreang Jai also explains the indirect way Thai people gossip and the way compliments are given (Burnard and Gill 2009). In the management field, Kreang Jai may encourage the leaders to keep monitoring and controlling work outcomes because the workers who feel Kreang Jai do not tell something directly, instead they say what the manager wants to hear (Muenjohn 2009). This may be a limitation of the study in that participants may have communicated less with policy makers than members of a different culture. Many Thais might not feel comfortable to speak out directly in public even when they had chance.

This could also be interpreted as a top down rather than bottom up approach, which is also linked to the ‘Hierarchy structure’. The concept of ‘Hierarchy’ in this study could refer to respect for those in senior persons. The hierarchical system in Thai culture refers to the fact that senior people are not argued with by junior people (Burnard and Gill 2009). This concept has been taught and reinforced at an early age and through schooling in Thailand (Burnard and Gill 2009). In the current study, that the participants had less communication with the policy makers, reflecting the top down management caused by the hierarchy system in Thai organizations. In Thai culture both concepts of Kreang Jai and hierarchy should be used to guide polite, respectful, and assertive communication that supports all levels of health care management. However, it is not congruent with primary health care principles, where those working at the community
level have a responsibility to help inform policy-making by giving ‘voice’ to community concerns.

**Limitations of the Study**

In addition to the cultural constraints mentioned above, there are some limitations of this study. First, due to a small number of participants, the findings of this study are not generaliseable to all community health centres nationwide. However, this study does provide insight into mental health care management in communities in Thailand. Data collection in two settings as a multiple case study with two nested case studies builds the trustworthiness of this study. Also, the use of several data gathering methods strengthens the study findings.

Second, the absence of a census related to clients who received psychological care made it difficult to accurately calculate mental health caseloads. In fact, there were a large number of cases with both physical and psychological problems. The health care providers tended to count and record those clients as physical cases because they were far easier to detect and record than psychological conditions. Consequently, the finding that there was one mental health case per every 100 normal cases in this study may reflect under-reporting. However, the multiple sources of data collected support the analysis.

Third, it is possible that participants did not express the real situation fully. For example, some participants had very clear ideas about mental health care policy, while others did not. This might be a consequence of work delegation. The PCUs were small organizations with fewer than ten health care workers; however, they had to respond to all health care issues in their communities. They usually delegated one health care
provider to be a key person in each field. As a result, some of them had limitations in recognizing the policy even though they practised it similarly. Their lack of familiarity with policy-making may also have been a result of cultural norms, where they believed it was not their concern to be involved unless it was part of their designated role.

However, this study tried to decrease the limitations by using multiple methods in collecting data. These also helped in confirming the answers to the research questions and the trustworthiness of the study. Trustworthiness is also argued the basis that data were collected by those who were practising in the area of CMH, and they were considered the most credible source of evidence on what was actually occurring in practice. The thesis has also provided an audit trail, explaining which steps were taken to collect and analyse data.

**Conceptual Framework**

This study aimed to generate knowledge of CMHC provided within the Thai context. The study was conducted in the interpretive paradigm. This allowed the appropriate information to be gathered in a naturalistic context. Adopting mixed methods in this study helped the researcher gather sufficient information, such as mental health workload and communication between the participants and policy makers.

The ethnographic approach brought out further knowledge of CMHC in terms of culture. The ethnographic information highlighted Thai social life and culture related to mental illness, such as stigmatization, neighbourhood, the rural context, and the life of older people in Thai society. Also, it helped in identifying CMHC management within the culture of PCUs as local organizations associated with the Ministry of Public Health and other organizations in the communities. It also reflected how Thai nurses applied
Buddhist philosophy into their care practices. The ethnographic approach capturing the socio-cultural context therefore helped this study generate enriched knowledge of CMHC in Thailand. As an insider, the researcher was able to engage closely with Thai culture as well as the culture of CMHN practice. This strengthened the credibility of the findings.

Using case studies added further depth and greater clarification to existing knowledge of CMHC in two communities. Information gained from each PCU demonstrated a number of common findings, such as mental health care practices and roles of nurses, models of care and factors influencing care practices. Although some differences were found between data of the two cases, this was useful in giving more in-depth knowledge of care within the boundary of cases.

The results of this study confirmed that primary health care principles provide a suitable framework for CMHC in Thailand. The health providers addressed principles of health promotion, intersectoral collaboration, accessibility, and community participation in practising CMHC. Even though they were not mental health specialists, they could provide advanced care to their clients being guided by the PHC framework in everyday life. Most importantly, the way these nurses implemented PHC can be used as a basis for knowledge development of CMHC in Thailand and other countries.

**Implications of the Study**

This study has made a significant contribution to the body of knowledge about care management in mental health care provided in Thai communities. Findings demonstrated that health providers practising in the communities played the main roles in providing mental health care to clients. The study provides a basis to expand
understanding of models of care specific to Thailand. It also illustrated factors influencing mental health care. The findings of this study have important implications for practice, education, and health policy development as described in this section.

**Implications for practice**

As participants identified a wide range of potential roles in mental health care, this supports the argument that the implementation of a national health scheme should be flexible enough to allow PCUs to recruit mental health workers to carry out one or more of the number of important mental health functions and deliver individual psychotherapies.

Although the health providers utilized collaboration or consultation it was not problematic. However, it reflected the lack of formal bridging between institutions and locals. Formal connections should be prepared in catchments in order to connect and prevent gaps between primary and secondary care. For example, the institutions should provide telephone-consultation direct lines for PCU-workers to contact psychiatric institutions.

Further, the fact that the health providers in the PCUs worked well by using standard guidelines in dealing with autistic disorder, depression and suicide pattern reflected the importance and advantage of practice guidelines. The DMH should provide other standard guidelines suitable for the local communities which are feasible in practice. For example, the provision of guidelines for giving anti-psychotic injections would help the health providers in administering injections in a community atmosphere.
Although the PCU-workers as community health providers focused on a wide range of health issues, having information related to mental health care would be useful. There should be opportunities for the health providers from institutions and the PCUs to know each other and share information. For example, the health providers from the PCUs should know hospital-psychiatric team members, how to access the hospital, and more in-depth information about the characteristics of medicines used frequently for patients discharged. The hospital-based providers might need to know the risks of patients living in the communities from the local health providers.

People who live with or close to psychiatric patients need to know how to manage serious mental health conditions. Practical guidelines, such as dealing with depression or suicide prevention should be developed and provided to the population in the communities.

Integration of mental health work into daily workloads of the health providers practising in the PCUs was effective. However, the health providers in the communities needed feasible tools, such as brief explanations about diseases and treatments or protocols that were easy to understand and follow. There also should not be an increased workload for them when practising with the mental health tasks as their workload could become excessive, contributing to their failure in organizing mental health work in the PCUs.

**Implications for education**

Mental health workers in psychiatric institutions appeared to be the first to be enrolled in mental health courses. However, in Thailand, as presented in the current study, the local health providers had to face various mental illnesses in the communities. They should be equipped with the necessary knowledge and skills relating to mental health
care. Further education in mental health care should be provided and allocated to
generalist nurses and community nurses who dealt with mental illness in the PCUs. This
is particularly important in a country that is guided by the PHC philosophy.
Encompassed in the PHC framework is recognition of the importance of the social
determinants of health. Mental health curriculum content often includes social issues,
and this knowledge could be shared with general nurses and others to ensure that the
patient is at the centre of care, and social and emotional issues are acknowledged in all
interactions.

Distance programmes relating to community mental health care should be provided to
the health providers working outside the institutions. Health providers with an interest
in mental health topics would feel free to study and gain selected knowledge that would
be useful for mental health situations in their areas.

Nursing education for undergraduate nursing students should provide mental health
practice courses with an emphasis on community settings; in particular, the nursing
curriculum undertaken by MOPH should provide units of practices in CMHC in the
PCUs. This is because the MOPH has responsibility for producing nurses for
communities across the country. Having experiences and learning from the situations in
the PCUs would provide the support for the nurses practising in the PCUs in the future.

Mental health training should be provided for those RN’s wanting to change from
hospital to CMHC. Also, existing practitioners should be prepared to be mentors for
those having new role initiatives in community settings.
As mental health is not the responsibility of one party, people in the communities need to take part in working with mental health care, particularly in their own lives. Knowledge related to mental health should be disseminated and accessible via national and local media, such as TV-programmes, radio, poster, booklet and leaflet. Importantly, those must be described in lay terms.

**Implication for social and health policy-making**

As a number of patients with mental illness in rural areas were neglected socially, the current study showed that the local health providers tended to help as much as they could. However, such assistance might not be maintained. There should be suitable social welfare, such as free public transportation and pension for people with mental illness.

It seemed that the reporting of mental health care practices to policy-makers was more challenging. There should be more opportunities for health providers who engaged in community mental health care to inform their care practices to policy-makers. For example, there might be one forum of informing practices into policy-making within the annual national mental health conference of Thailand.

As mental health problems were usually complex, support only from local health services might be not enough. Local governors should take responsibility for cooperating with the PCUs to resolve other issues. For example, a local administration organization should be available in transporting patients who are unable to go to see a doctor urgently.
Findings of this study clearly revealed that the PCUs with the nurses employed played crucial roles in CMHC in rural areas. The Thai health system should be improved by recruiting new nurses into the PCUs and retaining those who are already part of community health care to provide holistic care to the communities. Furthermore, community health personnel recruitments should be multidisciplinary in nature and to include psychiatric social workers and clinical psychologists so that they can work as a CMHC team.

**Recommendations for Future Research**

The present study not only enhances knowledge and contributes towards the understanding of community mental health care provided in Thailand, but it also broadens the models of care which are socially suitable for Thailand. Based on the findings of this study, the following recommendations for future research are made.

This study should be replicated in other regions of Thailand to gain more insight into community mental health care provided in those environments. This would help to provide a knowledge base for improving mental health care in both common and specific ways.

Further exploration of multidisciplinary teams who work together without a mental health specialist to manage mental health care would provide deeper understanding of different aspects of care which vary by the nature and the competencies in each discipline.

In addition, the health professionals in this study demonstrated an ability to make decisions that were appropriate in the context and for the needs of their patients. It
would be interesting to further investigate decision-making performed by multidisciplinary teams employed within PCUs, which would provide valuable information as a basis for mental health care improvements.

Further research using quantitative and qualitative methods to examine workloads and caseloads in mental health care provided by PCUs would enrich current information. This might help policy makers in organizing suitable support.

Further quasi-experimental research should focus on the effectiveness of facilities in providing mental health care in the communities. For example, standard guidelines might help non-specialists in dealing with mental health care situations in rural areas.

Further exploration of the perceptions of clients, families and stakeholders regarding mental health care provided by community-based providers would enhance understanding regarding the outcomes of mental health services. This also would add to existing information associated with consumers’ views and help advance knowledge in the development of evidence-based guidelines for practice.

Research comparing the advanced practice role in different areas of nursing work would increase knowledge of nurses’ competence. This might be useful in identifying strengths and maximizing quality of nursing practices in each area.

Study in other factors that influence continuity of mental health care provided in communities in the regions would create a CMHC profile in terms of common and unique characteristics. This information would help CMHC development in countries located in each region.
Summary

This chapter has discussed the findings in relation to the literature. It suggested that Thai CMHC was practised through the PCUs, which are the local primary health care centres. It discussed how mental health care practices were well performed as primary and secondary prevention within the PHC framework. The chapter also reflected PCUs’ factors influencing the provision of mental health care in their areas. It also presented limitations of this study, recommendations for further research, as well as discussed the implications for practice, education and policy making.
References


Department of Mental Health (2007b). Mental health policies. Mental Health Plan

Department of Mental Health (2008a). Mental health budget. Mental health resources.


Department of Mental Health (2009a). Causes of death. Mental Health Statistics


Department of Mental Health (2009c). Mental health services. Mental health resources


Development of a group model of clinical supervision to meet the needs of a community mental health nursing team. *International Journal of Nursing Practice, 9*, 33-39.


Appendix A

Ethics Approval
Thursday, 12 June 2008

Prof Anne McMurray
School of Nursing
Murdoch University

Dear Anne,

Permit No. 2008/042
Project Title Community Mental Health Care in Thailand: Care Management in Two Primary Care Units

Thank you for addressing the conditions placed on the above application to the Murdoch University Human Research Ethics Committee. On behalf of the Committee, I am pleased to advise the application now has:

OUTRIGHT APPROVAL

Permits are granted for three years. You will need to submit an annual report to the Research Ethics Office. Please note you are required to report immediately any unforeseen or adverse events especially if they might affect the ethical standing of the project. Once the project has been completed, please submit a Permit Closure Report. All forms are available on the Research Ethics web-site.

I wish you every success for your research.

Please quote your ethics permit number in all correspondence.

Kind Regards,

Dr. Erich von Dietze
Manager of Research Ethics

cc: Prof Rhonda Marriott
Yaowaluck Meebunmak
Appendix B

Permission Letter for Data Collection
30th April 2008

Ethics Office,
Research and Development,
Murdoch University 6150 WA

Dear Sirs,

I am pleased to inform you that the Public Health Office, XXXX XXXXXXXX, Ministry of Public Health, Thailand has approved Mrs Yaowaluck Meebunmak’s programme of Research Study: “Community Mental Health Care in Thailand: Care Management in Two Primary Care Units”.

Mrs Meebunmak is now authorized to collect the data for her project in XXXX Primary Care Unit, XXXXXXX Province. She can begin collecting the data there after receiving approval from the Human Research Ethics Committee of Murdoch University.

If you have further enquires please do not hesitate to contact Public Health Office, XXXX XXXXXXXX, Ministry of Public Health.

Yours Faithfully,

Mr XXXXXXX XXXXXXX
Head of Public Health Office, XXXXXXX
XXXXXXXXX, Ministry of Public Health
XXXXXXXXX Rd, Ampur XXXXXXX
XXXXXXXXX Province, Thailand 00000

Ph: +66 00000000
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Appendix C

Information Sheet

And Leaflet
Information Letter

We invite you to participate in a research study looking at mental health care management in Thai communities. This study is part of my course for a Degree in PhD in Nursing, supervised by Prof Anne McMurray at Murdoch University.

Nature and Purpose of the Study

In Thailand, it is common practice that the primary care units (PCUs) provide health care services in communities. The care is involved mental health services for mental health patients which have increased steadily in numbers. However, little is known about mental health care services in the PCUs.

Therefore the aim of this study is to explore the good care practices in mental health in the PCUs to understand what type of community mental health care management best fits Thailand communities.

What the Study will Involve

If you decide to participate in this study, you will be asked to complete the following tasks:

Health provider

- Complete the questionnaire that asks about your experiences in mental health services in the community. It is estimated that the questionnaires session will take approximately 10 minutes.
- Participate in an interview in mental health care management that will take approximately one hour of your time.
- Allow me to observe your practice in day to day mental health care without any extra preparation.

Patient

- You will be observed when you are in the consultation with your health provider.

It is possible that you may experience some level of anxiety or stress during the session as a result of some of the tasks. If this occurs you are free to withdraw at anytime during the session. If these feelings persist after the completion of the session, arrangements will be made for you to access support from the public hospital with no charge to you.

Voluntary Participation and Withdrawal from the Study

Your participation in this study is entirely voluntary. You may withdraw at any time without discrimination or prejudice. All information is treated as confidential and no names or other details that might identify you will be used in any publication arising
from the research. If you withdraw, all information you have provided will be destroyed.

If you consent to take part in this research study, it is important that you understand the purpose of the study and the procedures you will be asked to undergo. Please make sure that you ask any questions you may have, and that all your questions have been answered to your satisfaction before you agree to participate.

Benefits of the Study

It is possible that there may be no direct benefit to you from participation in this study.

While there is no guarantee that you will personally benefit, the knowledge gained from your participation may help in mental health care improvement in the future.

If you are willing to consent to participation in this study, please complete the Consent Form. If you have any questions about this project please feel free to contact either myself, Yaowaluck Meebunmak on mbl.08 0430 7805 or my supervisor, Prof Anne McMurray, on ph. +61 8 9582 5503.

My supervisor and I are happy to discuss with you any concerns you may have on how this study has been conducted. If you wish to talk to an independent person about your concerns you can contact Murdoch University's Human Research Ethics Committee on ph. +61 8 9360 6677 or email ethics@murdoch.edu.au

This study has been approved by the Murdoch University Human Research Ethics Committee (Approval No. 2008/042).
การวิจัยนี้เป็นส่วนหนึ่งของงานศึกษาระดับปริญญาโทด้านการควบคุมการด้านสุขภาพจิตในชุมชนของประเทศไทย

การวิจัยนี้เป็นส่วนหนึ่งของการศึกษาระดับปริญญาโทด้านการควบคุมการด้านสุขภาพจิตในชุมชนของประเทศไทย นางอารามกุล มิ่นยาญ ซึ่งมีอาจารย์ที่ปรึกษา การวิจัยคือ ศาสตราจารย์ ดร.มณฑา แม่หมอ (Prof Anne McMurray) ที่คณะมนุษยศาสตร์และสังคมศาสตร์ มหาวิทยาลัยมอร์ช (Murdock University) (การรับรองเลขที่ 2008/042) ถึงการศึกษาระดับปริญญาโทด้านการควบคุมการด้านสุขภาพจิตในชุมชนของประเทศไทย.

การวิจัยนี้มีข้อกำหนดว่า อย่างน้อย ถ้าท่านตัดสินใจจะมีส่วนร่วมกับการศึกษา มีไว้จะใช้ตามที่ต้องการได้ตามข้อกำหนดที่ถูกต้องที่สุด

- ตอบแบบสอบถามที่เกี่ยวกับประสบการณ์ในการทำงานด้านสุขภาพจิตในชุมชน ซึ่งจะใช้วาจากในการตอบแบบสอบถามนี้ประมาณ 10 นาที
- ให้ทางแผนกที่เกี่ยวกับการจัดการบริการด้านสุขภาพจิตในชุมชน ซึ่งใช้เวลาไม่เกิน 1 ชั่วโมง
- ให้ผู้วิจัยได้รับผลการปฏิบัติตามวิธีการด้านสุขภาพจิตที่ทำตามที่กำหนดไว้และรายได้ต้องมีการเตรียมการ อีกต่อไปเป็น

พิเศษ โดดเดี่ยวกันจึงจะไปที่การทำงานของท่าน

อาจเป็นไปได้ว่ากิจกรรมบางอย่างไม่ได้ความเห็นชอบจากท่าน ท่านสามารถถอนตัวจากกิจกรรมได้ ผู้ร่วม

วิจัยได้ทันที และหากความรู้ที่ไม่สามารถไปใช้ในที่สุดกิจกรรมแล้ว เราจะจัดให้ท่านได้รับการช่วยเหลือจากสถานะของท่าน หรือ โรงพยาบาล

การช่วยและประสบการณ์จากการวิจัย

ท่านสามารถร่วมกิจกรรมนี้ได้ตามความสามารถ และสามารถถอนตัวจากการวิจัย เมื่อใดที่ได้โดยท่านไม่ต้องการใน หรือวิทยา

วิจารณ์โดยได้ข้อมูลที่เกิดขึ้น มีกฎหมายที่จะถูกบังคับ การศึกษาที่เกี่ยวกับวิจัยจะไม่มีข้อตกลงที่ทำห่างคิกมูลและไม่ปรากฏ ข้อมูลใดๆที่

บางอย่างเป็นข้าวต้าน การที่ท่านตอบคำถามจากการวิจัยข้อมูลทั้งหมดที่ได้จากท่านจะถูกทบทวนและไม่ปรากฏในเอกสารวิจัย

หากท่านสนใจที่จะเป็นส่วนหนึ่งของการวิจัยนี้ท่านจะเป็นต้องเข้าใจวิธีการและข้อตกลงการวิจัยอย่างลึก แต่ไม่ได้สั่งให้ท่าน

เป็นผู้ร่วมวิจัย ท่านจะต้องไม่ได้ความเห็นต่างกันมากที่ทำให้ท่านไม่ก่อเกิดการวิจัยนี้อย่างลึกเข้าไปในที่นั่นเดียวแล้ว

ประโยชน์ของการวิจัย

เป็นไปได้ว่าท่านจะไม่ได้รับประโยชน์ใด ๆ จากการร่วมในการศึกษาดังนี้ ถึงแม้ว่าท่านจะไม่สามารถรับรองในผล

ประโยชน์ ซึ่งข้อมูลที่เกิดจากงานวิจัยแต่ความรู้ที่เกิดจากงานวิจัยที่ท่านมีส่วนร่วมนี้ อาจได้แก่ประโยชน์ด้านการพัฒนาการ

บริการด้านสุขภาพจิต ของประเทศไทยในอนาคต

หากท่านตัดสินใจร่วมในการวิจัยนี้โปรด_/อย่างน้อย.A

การวิจัย ถ้าท่านมีความสันนิฐานว่าการวิจัยนี้ ท่านสามารถติดต่อที่ จุฬาลงกรณ์ คณะมนุษยศาสตร์และสังคมศาสตร์ (Prof Anne McMurray) ที่พรรษาใหม่ 618 9360 6677 หรือ e-mail ethics@murdock.edu.au

โครงการศึกษาวิจัยนี้ได้รับการรับรองโดยคณะกรรมการจริยธรรมการวิจัยในมนุษยศาสตร์และสังคมศาสตร์ (Murdock University) (การรับรองเลขที่ 2008/042)
Call for Volunteers

Volunteers are needed for a PhD study being conducted through Murdoch University, Australia. The study is looking at aspects of your practices in mental health care management in Thai communities. The aim of this study is to explore the good care practices in mental health in the PCUs to understand what type of community mental health care management best fits Thailand communities. If you work in the PCUs of xxxxxxx Province, Northern Thailand or xxxxxxxProvince, Central Thailand.

I would like to invite you to participate in this study. If you decide to participate in this study, you will be asked to complete the questionnaire, participate in an interview, and be observed in day to day mental health care without any extra preparation.

The study will be conducted for four weeks in two setting between July and September 2008. If you are interested in participating in this study, please contact me, Yaowaluck Meebunmak on mbl.08 0430 7805 or email:yaow999@hotmail.com.

My supervisor and I are happy to discuss with you any concerns you may have on how this study is being conducted and may be contacted by email or telephone:

Chief Investigator/Supervisor:
Professor Anne McMurray:
Email: A.McMurray@murdoch.edu.au
Tel: +61 8 9582 5503

Investigator/PhD Student:
Yaowaluck Meebunmak
Email: 30629351@student.murdoch.edu.au
yaow999@hotmail.com
Tel: 08 0430 7805

We would like to thank you in advance for your assistance with this research project. I look forward to hearing from you.

Yaowaluck Meebunmak

This study has been approved by the Murdoch University Human Research Ethics Committee (Approval No. 2008/042)
สุขภาพจิตชุมชนในประเทศไทย: การจัดการบริการในสถานีอนามัยสองแห่ง
t้องการผสมผสานเครื่องมือการวิจัย

ต้องการผสมผสานเครื่องมือการวิจัยของนักศึกษาปริญญาเอกมหาวิทยาลัยมอร์ดอช (Murdoch University) ประเทศไทยoundation การวิจัยนี้จะศึกษาการจัดบริการสุขภาพจิตในชุมชนของประเทศไทย มีจุดประสงค์เพื่อศึกษาการบริการสุขภาพจิตที่มีในสถานีอนามัย เพื่อที่จะสร้างความเข้าใจ ว่าการจัดบริการสุขภาพจิตรูปแบบใดที่เหมาะสมกับชุมชนของประเทศไทย ถ้าพยาบาลที่สถานีอนามัยในภาคเหนือหรือภาคกลาง ติดบัตรของข้าพเจ้าท่านเข้าร่วมในวิจัยครั้งนี้

หากท่านตัดสินใจที่จะเป็นผู้ร่วมวิจัยท่านจะถูกขอให้ตอบแบบสอบถาม ตอบคำถาม และถูกสังเกตการท่าทางแต่ละวันโดยไม่มีลักษณะการอะไรเป็นพิเศษ การศึกษาจะถูกดำเนินการเป็นเวลา 4 สัปดาห์ ในช่วงเดือนกรกฎาคม-สิงหาคมที่ erm 2551 ถ้าท่านสนใจที่จะเข้าร่วมการวิจัย โปรดติดต่อ

ดิลน์ นางยาลักษณ์ มีบุญมา โทรศัพท์ 08 0430 7805 หรือ
e-mail:30629351@student.murdoch.edu.au.

อาจารย์ประจำการวิจัยและผู้จัดเก็บข้อมูลที่จะชุดคุณท่านท่านในทุกประเด็นที่เกี่ยวกับการศึกษาวิจัยครั้งนี้โดยท่านสามารถติดต่อเราได้ที่ทางโทรศัพท์และ email

หัวหน้าผู้วิจัย: อาจารย์ประจำการ:
Professor Anne McMurray:
Email: A_McMurray@murdoch.edu.au
Tel: +61 8 9582 5503

ผู้จัดเก็บข้อมูล:
นางยาลักษณ์ มีบุญมา
Email:30629351@student.murdoch.edu.au
Tel: 08 0430 7805

ดิลน์หวังเป็นอย่างยิ่งว่าจะได้รับการต้อนรับท่าน และขอขอบคุณทุกท่านที่ไม่จำเป็นต้อง
ช่วยเหลือของท่านต่อการวิจัยนี้ การศึกษาได้รับการรับรองจากคณะกรมการวิจัยในมนุษย์
มหาวิทยาลัยมอร์ดอช (การวิจัยเลขที่ 2008/042)
Appendix D

Consent Forms
Consent Form (Interview session)

Community Mental Health Care in Thailand: Care Management in Two Primary Care Units

Participant (Health Provider)

I have read the participant information sheet, which explains the nature of the research and the possible risks. The information has been explained to me and all my questions have been satisfactorily answered. I have been given a copy of the information sheet to keep.

I am happy to be interviewed and for the interview to be audio recorded as part of this research. I understand that I do not have to answer particular questions if I do not want to and that I can withdraw at any time without consequences to myself.

I agree that research data gathered from the results of the study may be published provided my name or any identifying data is not used. I acknowledge that I might become inadvertently identified, due to the small number of participants. I have also been informed that I may not receive any direct benefits from participating in this study.

I understand that all information provided by me is treated as confidential and will not be released by the researcher unless required to do so by law.

__________________________  ______________________
Signature of Participant           Date

Chief Investigator

I have fully explained to _____________________________ the nature and purpose of the research, the procedures to be employed, and the possible risks involved. I have provided the participant with a copy of the Information Sheet.

__________________________  ______________________
Signature of Investigator                      Date

__________________________  ______________________
Print Name                                        Position
ในยินยอม (สำหรับการสัมภาษณ์)

งานสุขภาพจิตวัยชราในประเทศไทย: การจัดการบริการในสถาบันยุนบุรินพงษ์

ผู้วิจัย (บุคคลที่สุขภาพ)

ข้าพเจ้าได้รับการคัดเลือกและมีการวิจัยและความสนใจที่จะเกิดขึ้นได้ ข้าพเจ้าได้รับทราบ ขอสมัครใช้ในการวิจัยและมีการตอบคำถามในครั้งที่ข้าพเจ้าสังเกตุหัวใจเป็นที่มาของใจแล้ว ข้าพเจ้าได้รับเอกสาร вริ่งขอแบบไว้ 1 ชุด

ข้าพเจ้าได้รับการสัมภาษณ์ ซึ่งการสัมภาษณ์นั้นจะสุขภาพที่มีสิ่งไว้เป็นส่วนหนึ่งของการวิจัย ข้าพเจ้า เข้าใจว่าข้าพเจ้าไม่จับเป็นต้องตอบคำถามบางคำถามที่ไม่ต้องการจะตอบ และการที่ข้าพเจ้า ตอบคำถามในการวิจัย อาจเวลาใดก็ตามจะไม่มีผลใด ๆ ต่อข้าพเจ้า

ข้าพเจ้าได้ให้ความยินยอมในการที่ข้าพเจ้าจะไม่ได้รับข้อมูลหรือข้อมูลที่จะช่วยข้าพเจ้า และอาจว่าข้าพเจ้าจะเป็นหนึ่งในผู้วิจัยจำนวนไม่มากขึ้นอาจถูกขยับขึ้นได้ ผู้วิจัยจะพยายามทุกวิถีทางที่จะป้องกันไม่ให้ข้าพเจ้าถูกย้ายขึ้นได้ โดยจะมีการใช้แบบสอบถามและเก็บข้อมูลของข้าพเจ้า ไว้ต่อหรือ

ตลอดไปในสิ่งที่เอกสารที่ได้ยินจากข้าพเจ้าจะมีเพียงสำหรับท่านนั้นที่ขับขี่ข้อมูลได้ ข้าพเจ้าได้รับ การชี้แจงว่าข้าพเจ้าอาจไม่ได้รับผลประโยชน์ใดๆจากการร่วมวิจัย

ข้าพเจ้ามั่นใจว่าข้อมูลที่มาจากข้าพเจ้านั้นจะถูกเก็บรักษาไว้อย่างปลอดภัย และจะไม่ถูกเปิดเผยโดยผู้วิจัยเกินกว่ามติให้ที่กำหนด

.................................................................

ลายชื่อ/ผู้วิจัย .................................................................

วันที่ .................................................................

พหูพันผู้วิจัย

ข้าพเจ้าได้รับการคัดเลือกและมีการวิจัยสำคัญต่อเศรษฐกิจ

.................................................................

ลายชื่อ/ผู้วิจัย .................................................................

วันที่ .................................................................

ชื่อผู้วิจัยด้วยที่นั่ง .................................................................

ตำแหน่ง .................................................................
Consent Form (Observation Session)

Community Mental Health Care in Thailand: Care Management in Two Primary Care Units

Participant (Health Provider)

I have read the participant information sheet, which explains the nature of the research and the possible risks. The information has been explained to me and all my questions have been satisfactorily answered. I have been given a copy of the information sheet to keep.

I give permission to be observed when I perform my duties as a mental health care provider. I permit the researcher to take note while I interact with the patients. I understand that I can withdraw at any time without consequences to myself.

I agree that research data gathered from the results of the study may be published provided my name or any identifying data is not used. I acknowledge that I might become inadvertently identified, due to the small number of participants. I have also been informed that I may not receive any direct benefits from participating in this study.

I understand that all information provided by me is treated as confidential and will not be released by the researcher unless required to do so by law.

_________________________  ______________________
Signature of Participant     Date

Chief Investigator

I have fully explained to _____________________________ the nature and purpose of the research, the procedures to be employed, and the possible risks involved. I have provided the participant with a copy of the Information Sheet.

_________________________  ______________________
Signature of Investigator                     Date

_________________________
Print Name                                                   Position
ใบอนุญาต (สำหรับการสัญจร)
งานสุขภาพจิตชุมชนในประเทศไทย : การจัดการบริการในสถานีอนามัยสองทาง
ผู้ร่วมวิจัย (บุคลากรสุขภาพ)

ข้าพเจ้าได้จ่ายเงินเพิ่มเติมและเรียนรู้ความเสี่ยงที่จะเกิดขึ้นได้ ข้าพเจ้าได้รับทราบ ข้อ
มูลต่างๆและได้รับการตอบคำถามไปในเว้นที่ข้าพเจ้าสงสัยที่เน้นจุดเป็นที่มาที่ไถ่แล้ว ข้าพเจ้า ได้
รับเอกสารที่จะแจ้งเพื่อกำหนดไว้ 1 ชุด

ข้าพเจ้าอนุญาตที่จะถูกส่งออกไปในขณะที่ข้าพเจ้าปฏิบัติงานในสถานะอยู่ในบริการด้านสุขภาพจิต ข้าพเจ้า
อนุญาตให้ผู้ร่วมวิจัยมีพื้นที่ในการเข้าไปที่ผู้ร่วมวิจัย ข้าพเจ้าจะเข้าใจว่าการที่ข้าพเจ้า ตอบคำถาม
จากการวิจัย ณ เวลาใดก็ตามจะไม่มีผลใดๆ ต่อข้าพเจ้า

ข้าพเจ้าได้ให้ความอนุญาตในการที่จะพักการวิจัยจะไม่ได้พักพิงหรือข้อมูลที่จะเกี่ยวข้องกับข้าพเจ้า และ
เมื่อข้าพเจ้าจะเป็นหน่วยในผู้ร่วมวิจัยจำเป็นไม่สามารถขอพักพิงได้ ได้วินผู้ร่วมวิจัยจะพยายาม ทุกวิธีทาง
ที่จะป้องกันไม่ให้ข้าพเจาถูกภัยขึ้นได้ โดยจะมีการเรียนรู้ข้อมูลเกี่ยวกับข้อมูลของข้าพเจ้า ไว้อย่าง
ปลอดภัยในศูนย์เอกสารที่เกี่ยวข้อง ข้าพเจ้าจะทบทวนผู้ร่วมวิจัยที่มีที่เข้าถึงข้อมูลได้ ข้าพเจ้าได้รับ การรู้
แจ้งว่าข้าพเจ้าอาจไม่ได้รับผลประโยชน์ใดจากการวิจัยครั้นนี้

ข้าพเจ้าขอให้ข้อมูลที่มาจากตัวข้าพเจ้านั้นจะถูกเก็บรักษาไว้อย่างปลอดภัยและจะไม่ถูกเปิดเผยโดย
ผู้ร่วมวิจัยเว้นแต่ถูกกฎหมายกำหนด

ผู้ลงชื่อคุ้มครองสิทธิ์

..............................................................

..............................................................

..............................................................

..............................................................
Consent Form (Observation Session)

Community Mental Health Care in Thailand: Care Management in Two Primary Care Units

Participant (Guardian of Patient with Mental Illness)

I have read the participant information sheet, which explains the nature of the research and the possible risks. The information has been explained to me and all my questions have been satisfactorily answered. I have been given a copy of the information sheet to keep.

I agree that my person ...........................................(full name of patient) for whom I am a guardian may take part in this research project he/she is being consulted by the health provider. I understand that he/she can withdraw at any time without consequences to him/herself.

I agree that research data gathered from the results of the study may be published provided his/her name or any identifying data is not used. I acknowledge that he/she might become inadvertently identified, due to the small number of participants. I have also been informed that he/she may not receive any direct benefits from participating in this study.

I understand that all information provided by him/her is treated as confidential and will not be released by the researcher unless required to do so by law.

___________________________________  ______________________
Patient’s Name (please print)                Date

___________________________________  ______________________
Signature of Guardian        Date

___________________________________  ______________________
Signature of Witness        Date

Chief Investigator

I have fully explained to _____________________________ the nature and purpose of the research, the procedures to be employed, and the possible risks involved. I have provided the participant with a copy of the Information Sheet.

___________________________________  ______________________
Signature of Investigator        Date

___________________________________  Position
Print Name
ไบไอบอม (สำหรับการกล่าวกัน)

งานสุขภาพฉุกเฉินในประเทศไทย: การจัดการบริการในสถานีอนามัยส่งท้าย

ผู้รวัติวิจัย (ผู้ปกครองของผู้ป่วยจิตวิทยา)

ข้าพเจ้าได้อ่านคำขอนี้ที่บ้านด้วยกระแสการวิจัยและความเสี่ยงที่อาจเกิดขึ้นได้ ข้าพเจ้าได้รับทราบ ข้อ

บุญด้านอื่น และได้รับการตอบคำถามที่ข้าพเจ้าสงสัยทั้งหมดลงเป็นหน้าพิมพ์แล้ว ข้าพเจ้า ได้

รับเอกสารคำขอนี้เพื่องับไว้ 1 ชุด

ข้าพเจ้าอนุญาตให้ผู้ที่อยู่ในความดูแลของข้าพเจ้าคือ ...........................(ชื่อผู้ป่วย) เป็นส่วนหนึ่งของ การ

วิจัยเร็วมีในขณะที่ข้าพเจ้าได้รับคำปรึกษาจากบุคลากรสุขภาพ ข้าพเจ้าจึงรู้ว่าผู้ป่วยสามารถ ถอน

ตัวจากภารกิจในเวลาใดก็ตามโดยไม่มีผลใดๆ ต่อตัวผู้ป่วย

ข้าพเจ้าได้ให้ความรับผิดในการที่จะดำเนินการวิจัยจะไม่ได้เพียงทางหรือข้อมูลที่จะขัดขวางผู้ป่วย และแม้

ว่าผู้ป่วยจะเป็นหนึ่งในผู้ร่วมวิจัยจำนวนไม่มากซึ่งอาจถูกจับได้นั้น ผู้วิจัยจะพยายามที่จะทำ

ให้ข้อมูลไม่ให้ตัวผู้ป่วยถูกจับซึ่ง โดยจะมีการใช้万名สมมุติและเก็บข้อมูลของข้าพเจ้าอย่างปลอดภัย

ในสู่กลุ่มเอกสารที่ล้มเหลว ซึ่งจะมีเพียงผู้วิจัยเท่านั้นที่จะเข้าถึงข้อมูลได้ ข้าพเจ้าได้รับการขอนะ ว่าผู้ป่วย

อาจจะไม่ได้รับผลประโยชน์ใดๆจากการร่วมวิจัยครั้งนี้

ข้าพเจ้าได้รู้ว่าข้อมูลที่มาจากตัวผู้ป่วยนี้จะถูกเก็บรักษาไว้อย่างปลอดภัยและจะไม่ถูกเปิดเผยโดยผู้วิจัย

ขอให้เห็นเมื่อกฏหมายกำหนด

................................................................. .................................................................
ชื่อผู้ป่วย (คู่บรรจง) วันที่

................................................................. .................................................................
ลายเซ็นคู่ผู้ปกครอง วันที่

................................................................. .................................................................
ลายเซ็นพยาน วันที่

หัวหน้าผู้วิจัย

ข้าพเจ้าได้อ่านข้อใด .............................................ทราบเกี่ยวกับกลุ่มและการวิจัยวัตถุประสงค์

ข้าพเจ้าได้รับการตอบคำถามที่อาจเกิดขึ้นได้ ข้าพเจ้าได้รับการคำขอนี้ให้ผู้ร่วมวิจัยไว้ 1 ชุด

................................................................. .................................................................
ลายเซ็นคู่ผู้วิจัย วันที่

................................................................. .................................................................
ชื่อผู้วิจัย อดิเรก ต้นหนัง
Appendix E

Instruments for Data Collection
Questionnaires
Demographic Data

1. What is your discipline?
   - Nurse
   - Public health worker
   - Others

2. How long have you been working in the PCUs? ..........year(s)

3. How many mental health cases and normal cases in your responsibility?

<table>
<thead>
<tr>
<th>Mental health cases</th>
<th>Normal cases</th>
</tr>
</thead>
</table>

4. What mental health training have you received?
   - Counselling
   - Mental health assessment
   - Suicide prevention
   - Home care for mental illness
   - Psychiatric drug administration
   - Drug misuse counselling
   - Others

5. How are your workloads in one week?
   - Family counselling ..........hour(s)
   - Visit client at homes ..........hour(s)
   - Educate clients in mental health coping ..........hour(s)
   - Meetings to help clients with mental health topics ..........hour(s)
   - Meetings to organize mental health work ..........hour(s)
   - Documentation in mental health work ..........hour(s)
   - Liaison and travelling for mental health care ..........hour(s)
   - Others

Mental Health Care Management

1. What do you believe are the most important influences on mental health care?
   - Ministry of Public Health
   - Department of Mental Health
   - The Local Administrative Organization
   - Others

2. Are you familiar with any models of mental health care?
   - Partnership model
   - Collaboration model
   - Supervision model
   - Integrated service model
   - Others
   - None
3. Who makes decisions in dealing with noncompliant patients?
   - □ Chief of PCU
   - □ Team colleagues / other disciplines
   - □ Individual provider
   - □ Patients and family members
   - □ Others...........................

4. Are you familiar with mental health policy?
   - □ Yes
   - □ No

5. Do your care practices usually follow mental health policies?

<table>
<thead>
<tr>
<th>Never</th>
<th>hardly</th>
<th>seldom</th>
<th>Sometimes</th>
<th>often</th>
<th>Every time</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

6. Do you, as a practitioner have an opportunity to inform mental health policy making?

<table>
<thead>
<tr>
<th>Never</th>
<th>least</th>
<th>less</th>
<th>Moderate</th>
<th>Much</th>
<th>Very much</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Interview Questions**

The researcher will ask the participants to answer these questions.
1. Can you describe your mental health role? What do you do? How?
2. What do you believe are the most important influences on mental health care? Why?
3. In your opinion how do mental health policies direct practices and vice versa?
4. How do you manage noncompliant patients, based on what criteria?
5. What helps and/or hinders you in making decisions for mental health care?

**Focus of Observation**

The researcher will participated observe in day to day activities, and record the details of care management as following:
1. Daily mental health care in PCU and community (How does it take place? Who do practices? Who are involved? Which specific situation is involved?)
2. Activities related policies e.g. home visiting regarding mental health policies, counselling a person with attempted suicide, or referring patients to the hospital.
3. Formal and informal meeting related mental health care decision making.
Document Analysis

The researcher will read and analyse official documents as below.
1. The records/reports of work (what type of work done in PCU?)
2. The records of the model e.g. the signed contact between PCU and other organization in mental health projects, the procedure, the protocol, the project etc.
3. Project reports related to mental health care (What are the main reasons/background of mental health projects/tasks? Who does management? Who does support? What are facilities?)
4. Organization plan and reports of activities/projects/tasks (Is there concordance with mental health policies? Are there other policies mentioned in the reports?)
5. Records of meetings related mental health care agenda e.g. referral, mental health project
แบบสอบถามการจัดบริการสุขภาพจิตและจิตเวช

ที่ 1 ท่านเป็นบุคคลสาธารณะ ตอบกล่าว

☑ ทำนาย
☑ ท่านที่สาธารณะ
☑ อื่นๆ .................................

ที่ 2 ท่านปฏิบัติงานที่สถานประกอบการ ตอบกล่าว

☑ ใช่..................................................................
☑ ไม่..................................................................

ที่ 3 มีผู้ที่มีสุขภาพจิตและจิตเวช และผู้ป่วยที่ไปที่ร้านในความร่วมมือของท่าน

<table>
<thead>
<tr>
<th>ผู้ป่วยจิตเวช (คน)</th>
<th>ผู้ป่วยทั่วไป (คน)</th>
</tr>
</thead>
</table>

ที่ 4 ท่านเคยได้รับการศึกษาระบบทางจิตเวช เรื่องใดบ้าง (ตอบได้หลายข้อ)

☑ การให้คำปรึกษา
☑ การประเมินทางจิตเวช
☑ การป้องกันการฆ่าตัวตาย
☑ การส่งเสริมการเข้ารับการรักษา
☑ การเรียนรู้ทางจิตเวช
☑ การให้คำปรึกษากับผู้ใช้สารเสพติด
☑ อื่นๆ ..............................................

ที่ 5 ภาวะผู้ด้อยความสุขของท่านเป็นอย่างไรในช่วงวันนี้ล่าสุด

☑ ให้คำปรึกษากับครอบครัวของผู้ป่วย .................................. ช.ม.
☑ เลื่อนผู้ป่วยที่รับ .................................. ช.ม.
☑ ให้ความรู้แก่ผู้ป่วยเกี่ยวกับการควบคุมเหตุการณ์สุขภาพจิต ...
☑ ความประจุจิตเด็กช่วยเหลือผู้ป่วยจิตเวช .................................. ช.ม.
☑ ความประจุจิตเด็กช่วยเหลือการจัดการงานจิตเวช ................. ช.ม.
☑ นักพัฒนาการทางจิตเวช .................................. ช.ม.
☑ นักพัฒนาการทางจิตเวช .................................. ช.ม.
☑ นักพัฒนาการทางจิตเวช .................................. ช.ม.
☑ อื่นๆ .............................................. ช.ม.

ลำดับที่ 2 การบริหารจัดการด้านจิตเวช

1. ท่านคิดว่าอะไรที่มีผลกระทบต่อการจัดบริการด้านจิตเวช

☑ กระทรวงสุขภาพ
☑ กรมสุขภาพจิต
☑ องค์กรปกครองส่วนท้องถิ่น
☑ อื่นๆ ..............................................

2. ท่านคิดว่ามีปัญหาการบริการด้านสุขภาพจิตแบบใด

☑ แผนที่ส่วนร่วมจัดการป้องกันการกระทบต่อสุขภาพจิต
☑ สร้างความเข้าใจในระดับหน่วยงานบุคคลากร
☑ มีที่ปรึกษาทางจิต
☑ ผลสัมฤทธิ์การจัดการด้านสุขภาพจิตต่างๆ
☑ ไม่ได้..............................................
3. ใครเป็นคนเดินใจในการจัดการกับผู้ป่วยที่ไม่ยอมรับการรักษา

☐ หัวหน้าสภานมัย
☐ ผู้ว่าที่จังหวัด
☐ ผู้ให้บริการสุขภาพ
☐ ผู้ป่วยและครอบครัว
☐ อื่นๆ...

4. ท่านรู้สึกที่คุณเคยมีความสุขภาพดี ใช้หรือไม่

☐ ใช้  ☐ ไม่ใช้

5. การปฏิบัติงานบริการของท่าน ได้ดำเนินไปตามนโยบายสุขภาพดี หรือไม่

<table>
<thead>
<tr>
<th>ไม่เคย</th>
<th>เท่าไหร่</th>
<th>น้อย</th>
<th>ครั้ง</th>
<th>มาก</th>
<th>ครั้ง</th>
<th>บ่อย</th>
<th>ทุกครั้ง</th>
</tr>
</thead>
</table>

6. ในฐานะและผู้ปฏิบัติงาน ท่านมีโอกาสให้ข้อมูลเพื่อการสร้างนโยบายสุขภาพ มากน้อยแค่ไหน

<table>
<thead>
<tr>
<th>ไม่มี</th>
<th>น้อย</th>
<th>มาก</th>
<th>มาก</th>
<th>มากที่สุด</th>
</tr>
</thead>
</table>

คำนวณที่ใช้ที่การอภิปราย
1. ท่านมีบทบาทอย่างไรในการสุขภาพดี? ท่านทำงานสุขภาพดีที่มากขึ้นท่านอาจได้รับรางวัล อย่างไร
2. ท่านคิดว่าจะได้รับการเกียรติที่มากกว่าที่ท่านได้ในงานสุขภาพดี? เพื่ออะไร? มีอัตราส่วน อย่างไร อย่างไร
3. นโยบายด้านสุขภาพดีขึ้นเมื่อการปฏิบัติงานของท่านเรียกไม่ และการปฏิบัติงานของท่านเพื่อการสร้างนโยบายหรือไม่ อย่างไร
4. ท่านจัดการอย่างไรในการมีการขึ้นและยอมรับการรักษา การจัดการและมีการ เหมือนกันที่จะไม่ทำ
5. มีโอกาสบางที่จะสนับสนุน หรือเป็นอุปสรรคในการตัดสินใจของท่านในการสุขภาพดี

ประเด็นการอภิปรายการบริการสุขภาพดีที่จะจัดสัดส่วน
1. การจัดบริการสุขภาพดีและจัดตั้งในแต่ละภูมิภาค (ทั้งในสถานีสุขภาพและในชุมชน มีการให้บริการอย่างไร มีใครที่เสี่ยงหรือบัง)
2. การให้บริการด้านสุขภาพ เช่น การให้บริการ การเปลี่ยนผู้ป่วยที่มี การส่งต่อผู้ป่วยจิตเวช ปัจจุบัน
3. การประชุม (ที่เป็นแนวทางการและไม่เป็นทางการ) เพื่อตัดสินใจในการ ให้บริการภัยปัจจุบันจิตเวช

เอกสารและหน่วยงานที่จะขอข้อมูล

1. บันทึก/รายงานผลการสำรวจ และกฎหมายวามูลค่าและคุณสมบัติของหน่วยงาน
2. บันทึกที่แสดงถึงการจัดบริการทางจิตเวช เช่น เอกสารที่แสดง ความร่วมมือระหว่างสถาบันมีผู้ป่วยของงานอื่น ๆ มีการขอความร่วมมือในส่วนของผู้ป่วยจิตเวช
3. โครงการสุขภาพดี ในส่วนเจ้าหน้าที่และผู้ดูแลการจัดโครงการ หรือส่วน ที่แสดงให้เห็นว่ามีการสนับสนุน และปัญหา / อุปสรรค
4. บันทึกการประชุมที่แสดงให้เห็นการตัดสินใจในการให้บริการด้านจิตเวชใน สถานการณ์ต่างๆ
Appendix F

Field Note Forms
Form 1
Observation Jotting Note

Note: one day in the 1st week... Begin with what I see & hear......
...[Their work is complex. Can I get the things I want to see?] .......

 physical: The Northern PCU

Workers = 11

Chief (meeting w. LAO)

4 Nurses (1-meeting, 1-home visit, 2-provide care)

1 Public health worker

Office maid

1 Public health dentist

1 Dentist assistant

1 Nursing assistant & clerk

N-2 => Key worker of Academic area (survey, research, placement course for students)

N-3=> Key worker of chronic disease care

N-4=> Key worker of Mental Health care, Mother & child, Older person services

N-5=> Key worker of prevention of contagious diseases

1st Floor

Document working area

Meet room

Therapeutic area

Drug storage & book shelfs

Counselling room

Treatment room

Front service desk

2nd Floor

Room for Thai massage & meeting

Chief’s room

Toilet

Storage room

Atmosphere: Friendship, greeting w clients, not rushing

Clients: Family planning services, Wound dressing, Hypertension, Diabetes Mellitus, Fewer, Cold, Dentistry services

Payment: Free or cheap price
Form 2
Field Note

Participant Code…N-2, N-3, N-5……… Contact Date…4th July 2008…………

Type of Contact

☐ Interview  √ Observation  ☐ Document analysis

Starting Time…1 pm………… Ending Time……3.30 pm……

Location……the 2nd floor………………………………………………………………

Description of environment

………The large meeting room was decorated with posters, balloons, and welcome board. It was colourful. Microphone and computer with projectors were set. There was no table for participants (consumers). The floor was clean …………………

Content

………I saw N-2, N-3,N-5, the public health dentist, and her assistant prepared this room for the meeting. The topic was “How to look after the children for EQ development” There were about 35 adult persons came with the children. They were parents, grandparents or cousins who looked after the kids. The children as target of this meeting were 0-5 years old. The children played, cried, and slept while the meeting was run. All participants registered and receive a story book, a tooth brush gift set and an EQ booklet. All sat on the floor. The toys were provided to the children. The session began with VCD introduced EQ. Then N-2 greeted the participants and was the moderator. Two guest speakers talked about EQ and its development. The participants raised some questions, for example, how they could control their anger when they were with the children. The speakers introduced ways to talk to the children and tell them about the parents’ angry. The speaker also advised that the parents should not always say no in every thing that the kids wanted to do. This was associated with the Thai families who thought that they should protect their kids from challenges. In fact, the kids should be prevented from harm and risks, but not all new things. They should have chance to learn the world. The participants paid attention at all time. The children slept, sucked the milk, played and cried. At the end of this session, the adult participants had fun with answer the questions from the organizers to get the presents. The nurses (N-2 and N-3) described how to check and promote child’s development. They also taught the parents to use the individual recording book. This book was useful in looking after the kids (0-6 year olds). It was a manual of parents provided by the Minister of Public Health when the mother gave birth…
Form 3
Document Summary

Document Code ……N-PCU doc1……
Date received or picked up ……1st July 2008
Name or description of document ……The Plan of Practising in 2008………..
Location…………………………The Northern PCU…………………………

Event or contact, if any, with which document is associated
…………This document is associated with the care practices, projects, and activities must be conducted in 2008. The events associated were the Aged club meeting, EQ meeting, and the To be No1 activities.

Significant or importance of document
…………This evidence shows what mental health works were posed in the yearly plan of the organization. This reflects that the health workers must provide some care practices related to mental health by using this plan as a guide or scope of work. The data from this document can be used with the data from other sources, such as interview (question 1 about mental health care practices) and observation when the health providers provide mental health care. This is for complementation and/or triangulation confirmation…………………………………………………………………………………..
…………………………………………………………………………………………...

Brief summary of contents
…………The document displayed five strategies in providing health care for the consumers in the community in 2008. The third strategy described health promotion, disease control, and environment management in the community. It was composed of protection of drug through the To be No.1 project which was funded with 52,400 THB from the LAO. There was plan of mental health care emphasized in the emotional theme for this year. The mental health plan described five projects; monitoring of suicide (15,000THB funded), EQ and IQ (5,000 THB funded), Senior club (2,000THB funded), healthy family (8,000 THB funded), and counselling training (15,000 THB funded)…………………………………………………………………………………..
……………………………………………………………………………………………..
Form 4
Contact Summary Sheet

(Emphasize on content/main ideas found in each session)

Participant Code……N-5……
Contact Date…26th June 2008…… Today’s Date…30th June 2008...
Type of Contact
✓ Interview □ Observation □ Document analysis
Location…..in counselling room………………………………………………
Summary

1. What are the main issues or themes that struck you in this contact?
       ………. Factors influencing the care practices were moral (mercy) and like to work on mental health areas.

       Care practices were home visiting psychiatric patients, persons with disability and senior persons.

       Models/patterns of care were visiting them at homes. Sometimes the visiting must be done in weekend or holidays in order to see the cases and other family members together.

       Policy was from the Department of Mental Health, the Ministry of Public Health. This year the policy focused on helping the people suffered from disasters. On the other hand, the health provider had less chance in informing the care practices to the policy makers. ………………………………………

2. Summarize the information you got (or failed to get) on each of the target questions

<table>
<thead>
<tr>
<th>Question</th>
<th>Information (got)</th>
</tr>
</thead>
<tbody>
<tr>
<td>- What are the influences on mental health care practices?</td>
<td>……….personal thinking, interest</td>
</tr>
<tr>
<td></td>
<td>……….personal background and knowledge</td>
</tr>
<tr>
<td></td>
<td>……….lack of teamwork and vehicle</td>
</tr>
<tr>
<td></td>
<td>……….fear to illegal drug seller</td>
</tr>
<tr>
<td>Information (failed)</td>
<td>...........................................not fail ......................</td>
</tr>
<tr>
<td>Information (got)</td>
<td>...........................................colleague consultation ..............</td>
</tr>
<tr>
<td>- How are they managed in the communities?</td>
<td>...........................................sole practice in home visiting ..............</td>
</tr>
</tbody>
</table>
Form 5
Memo

(Pull concepts from several sources)

Location: ……The Northern PCU……

<table>
<thead>
<tr>
<th>Concept</th>
<th>Interview</th>
<th>Observation</th>
<th>Document</th>
</tr>
</thead>
<tbody>
<tr>
<td>- To be No1</td>
<td>✓</td>
<td>-</td>
<td>✓</td>
</tr>
<tr>
<td>- Senior Club</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>- Home visiting</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>- Counselling</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>- Giving injection</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>- Colleague consultation</td>
<td>✓</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>- Community contact</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>- Support (money, housing, milk)</td>
<td>✓</td>
<td>✓</td>
<td>-</td>
</tr>
<tr>
<td>- Lack of Knowledge</td>
<td>✓</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>- Mental health promotion/education</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>- Personal factors (attitude, interest)</td>
<td>✓</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>- Assessment</td>
<td>✓</td>
<td>✓</td>
<td>-</td>
</tr>
<tr>
<td>- Referring</td>
<td>✓</td>
<td>-</td>
<td>✓</td>
</tr>
<tr>
<td>- Screening</td>
<td>✓</td>
<td>-</td>
<td>✓</td>
</tr>
<tr>
<td>- Social / economics</td>
<td>✓</td>
<td>-</td>
<td>✓</td>
</tr>
<tr>
<td>- Physical and mental health care</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>- Support family and patient</td>
<td>✓</td>
<td>✓</td>
<td>-</td>
</tr>
<tr>
<td>- Mental health policy</td>
<td>✓</td>
<td>-</td>
<td>✓</td>
</tr>
<tr>
<td>- Practices inform policy</td>
<td>✓</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>- Not security to care</td>
<td>✓</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>
Form 6
Data Accounting Sheet

(Monitoring and check the data)

<table>
<thead>
<tr>
<th>Research Questions</th>
<th>Questions &amp; Sources</th>
<th>Informant Group 1 (North)</th>
<th>Informant Group 2 (Central)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Interview</td>
<td>Observation</td>
<td>Document</td>
</tr>
<tr>
<td>Care Practices</td>
<td>1</td>
<td>1</td>
<td>1, 3, 4, 5</td>
</tr>
<tr>
<td>Care Models</td>
<td>3.4</td>
<td>3</td>
<td>2.3</td>
</tr>
<tr>
<td>2.1) Model</td>
<td>2</td>
<td>2</td>
<td>2.1</td>
</tr>
<tr>
<td>2.2) Manage</td>
<td>3</td>
<td>3</td>
<td>2.4</td>
</tr>
<tr>
<td>Influences</td>
<td>2</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3.1) Helps</td>
<td>2</td>
<td>2</td>
<td>2.1</td>
</tr>
<tr>
<td>3.2) Hinders</td>
<td>3</td>
<td>3</td>
<td>2.4</td>
</tr>
<tr>
<td>3.3) Policies</td>
<td>4</td>
<td>4</td>
<td>2</td>
</tr>
</tbody>
</table>
Appendix G

Example of Transcription
# Transcription of an Interview

<table>
<thead>
<tr>
<th>Comment on content, and feeling</th>
<th>Interview</th>
<th>Comment on process of interview</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>I hoped this interview would be successful.</strong></td>
<td><strong>Researcher</strong>: Hi Karen, we are now going to begin the interview session about your work on Mental Health field. I will ask you four or five questions related to your practices and ideas on Mental Health care.</td>
<td><strong>Beginning was Okay.</strong></td>
</tr>
<tr>
<td><strong>She was ready. We were comfortable.</strong></td>
<td><strong>Participant</strong>: Okay. [smile]</td>
<td><strong>The first question was asked as I planned.</strong></td>
</tr>
<tr>
<td><strong>Mental health work in the PCU was not easy to be identified. However, she did not neglect the mental health issues.</strong></td>
<td><strong>Researcher</strong>: Can I begin with the first question? … As you are a nurse employed within the PCUs, what are your roles in providing Mental Health care? And, what are your works related to Mental Health services?</td>
<td><strong>Her answer was clear.</strong></td>
</tr>
<tr>
<td><strong>Mental health care system was not been explained clearly.</strong></td>
<td><strong>Participant</strong>: Okay, I will explain about that. There is not clear role……definitely not. [laugh] However, it [mental health care] is generally nested within other jobs. It has never been clear in my mind. Then, when you came, I just have thought that actually it is added in this job and that job. [other jobs] Mental health is an abstract so I haven’t thought which mental health job I was doing. However, I always think about the patients’ minds when I provide care.</td>
<td><strong>I tried to make understanding by summarizing.</strong></td>
</tr>
<tr>
<td><strong>She aware of mental health</strong></td>
<td><strong>Researcher</strong>: Yes</td>
<td><strong>I waited.</strong></td>
</tr>
<tr>
<td><strong>I tried to probe to get in-dept information.</strong></td>
<td><strong>Participant</strong>: That is…. I always ask myself how I can make the clients happy with my care. So I try to smile to them and give them the time. Sometimes I was moody, but I try to smile first as in services.</td>
<td><strong>I tried to make understanding by summarizing.</strong></td>
</tr>
<tr>
<td><strong>She experienced in providing care to the patient with mental illness.</strong></td>
<td><strong>Researcher</strong>: It sounds like mental health work was provided in your normal work. Am I right?</td>
<td><strong>I tried to probe to get in-dept information.</strong></td>
</tr>
<tr>
<td><strong>This case accessed the PCU for mental health service.</strong></td>
<td><strong>Participant</strong>: Uhm…right</td>
<td><strong>I tried to make understanding by summarizing.</strong></td>
</tr>
<tr>
<td><strong>Giving time to her for recalling the case.</strong></td>
<td><strong>Researcher</strong>: How often have you experienced mental health problems raised by the consumer? And, for those how did you deal?</td>
<td><strong>I tried to make understanding by summarizing.</strong></td>
</tr>
<tr>
<td><strong>Participant</strong>: I met one who had the mental health problem. …But, I couldn’t recognize the name.</td>
<td><strong>Researcher</strong>: Another client came with the need for counselling. She felt stressed. She wanted to talk with someone who had capacity in providing counselling support. That person had mental health symptoms. She was educated. She knew well about medicine and the side effects she took orally. She told me all, whereas I knew very little. She could explain how each type of medicine related to her symptoms.</td>
<td><strong>I tried to probe to get in-dept information.</strong></td>
</tr>
</tbody>
</table>
The patient in the community probably did not have the serious symptoms.

The case needed mental health support.

She provided counselling.

She provided the good listening and support.

Her care practices reflected the commitment in providing mental health care.

Researcher: Yes.
Participant: She was able to manage herself in taking medicine. And, she said that she know what the side effects could be.

Researcher: She came to see you…
Participant: She came for talking. She told that she had the problems of obsessive-compulsive behaviour. Her family did business of snack production. At that time, their products were not popular anymore. She had no job and got stress. She was treated with anti-psychotic drugs. She had nothing to do so she came to talk. I always gave her the time for talk. I asked about her family. She said that her husband didn’t worry about her symptoms. He said that was not a big problem. He viewed that she had not a serious mental illness. He didn’t mind. When she came, I usually talk to her friendly. Here, we sometimes talked for an hour. I provided her one session of counselling per month for a half-year. Now, she get better so didn’t come often. Just, recently, she came to say hi, and told me that she was well and busy with the new product of the family company. … I said “okay and don’t forget to give me some snacks”. [laugh]

I followed the story.

I stopped before ending the sentence because I wanted her to explain why the case came to the PCU.

I sought more information.

I listened to the story and waited to capture the message she told.

This nurse provided the good care. The patient had nobody to understand.

The nurse might be interested in mental health caring. I wanted to know if her service was a therapy (counselling) or just talk.

Researcher: Besides the counselling sessions, did you offer medication or other therapy?
Participant: No, I didn’t. … [laugh] because she already had medicine. She was not an ordinary client [laugh]. She knew all about her sick and treatment. She was treated by a doctor in a private hospital in Bangkok, not the public hospital here. That’s she.

Researcher: But, she came to see you. What did you think about the case at that time?
Participant: Uhm… she, however, wanted talking with the nurse here. Nobody talked with her focused on the mental health symptoms. They were not interested. For me, I was interested in this patient. The case like this was rare. I had enough time to talk. I could do because I was not so busy. I gave her the time, and she had someone to talk with. So it was okay, no problem.

She seemed to know what the patient really want.

This nurse provided the good care. The patient had nobody to understand.

Researcher: Can you explain more about your counselling as a mental health service you offered to this case?
Participant: Oh yes. At that time, she told me about her difficulty and stress caused by the obsessive-compulsive pattern. She was stress. I provided counselling sessions to her. My counselling….
The care practice provided by this nurse was underpinned by principles of counselling. The atmosphere of care sounded like friendship.

I wanted to know if her service was a therapy (counselling) or just talk.

I got one topic about counselling as mental health care.

To provide care in the PCU sound more relax.

I thought there must be more care practices.

Here, the nurses were delegated to do mental health work as screening, but it seemed not to be the routine job.

I relied that I got the information about counselling in ways the care for the community.

It’s based on the principle of counselling. These were listening …and listening. I mean listening with understanding and empathy. As well as, I used the sentences like “You did well”, “You must be patient”, and “You did the right thing”. And, I sought the good points for her [client]. For instance, I said to her that “Look! Your husband was very nice because he understood and accepted you.” I also claimed that her kids understood what the problems were. I supported that all family members accepted her and she was a very lucky person.

**Researcher**: Hmm, you provided the counselling as the mental health care.

**Participant**: Yes I did. Having this case is an opportunity to provide counselling as mental health job. Patients with mental illness hardly came into the PCU. However, for this case, I felt comfortable in providing care. We were more likely to be in the same age. So the relationship was like friends.

**Researcher**: I see. … What about other mental health practices? Can you tell me what else you have done?

**Participant**: I’d like to talk about the services outside the PCU. Once, colleagues and I were delegated to screen for people with stress throughout the villages. We used the checklist forms of stress as a tool. We found that there were fewer people experiencing stress. At that time, we asked the villagers to complete the checklist forms by themselves because they all were literate. We carried all the forms filled back to the PCU. Then, We found that there were fewer people experiencing stress. Actually, I didn’t know what I should do to help those persons with stress. However, I went into the community again. I met the cases individually and offered help with counselling sessions. Unfortunately, some cases were among many neighbours, so I offered help and invited them to talk with me at the PCU if they wanted. I told them that I maybe could help with talking or giving some medications. The scores of stress shown made me surprised because normally they were…were…well. They looked normal and never complained any suffer. But, they got stress. When the time has passed, some of them came and asked for counselling sessions. The husband love affair with another woman was an example of the problems.

**Probing. Asking for more information. Asking for clarification the care practice.**
The normal people possibly experienced stress. These cases also needed the mental health services.

The counselling was for the normal and mental health cases in the community. It must be flexible in setting or time.

Researcher: So you provided counselling for normal cases as well.

Participant: Yes, I did. Some cases did not want others to know that they needed counselling services. So... I provided counselling sessions in the other room (an office room, not for counselling). I also gave Amitriptyline to a case for releasing her stress. You know? She took the tablets I gave everyday. She felt it helped. [laugh]

I concluded the topic I caught.

I got one topic about counselling and mental health surveys as mental health care.

And, actually I wanted to know if she provided visiting or other care for the patients with mental illness. I thought this task was important and should be explained.

As a community nurse, she knew the patient well.

The felt shamed.

Stigmatization

Researcher: I concluded the topic I caught.

Researcher: Oh

Participant: But, I gave five to ten tablets per time. Also, I provided the counselling. They probably perceived that I was a friend.

Researcher: Well you provided counselling for mental health and normal cases. You did mental health surveyed in the village. And, how about the mental health cases who didn’t come to see you at the PCU, what have you done for them?

Participant: Oh yes. For this type of patients, I visited them at homes. One case, for example, is a young man. His name is Tony. A village health volunteer (VHV) came to consult me and asked whether I could help a case who was living near to the VHV family. At that time, I didn’t know the patient. I knew that the patient’s parents were well-known. They felt ashamed with the son’s illness. They asked this VHV to contact the PCU instead. I remember that this case took time. The parents were educated and well-known persons. They wanted to protect their son from stigmatization. Therefore, they might need time to see how much they could trust me and open up to me. I waited to hear from them for several months. I didn’t want to force them, unless they trusted me. I understood them. The parents sent the son into the military camp. They hoped that the son might have behaviour changes. They thought that the physical training might help the son. They didn’t bring him to see the doctor at that time. They didn’t want to came here. They asked this VHV to contact me instead. I gave them my phone number. ... Finally, the family agreed to come to see me here.

Asking for clarification.

She assessed

Asked her to clarify dealing with this case.
She detected mental health symptoms.

She used medication again. This sound a tool to approach this case. This is interesting to see how she could manage the client. She set priority of care. She had some information got from media (about Japanese child).

She waited!! She offered help and provided choices. She provided care for whole of case. (family and patient)

She worked for long with this case. Here, she claimed about home visiting

Researcher: Did they accept mental health care now? Participant: It took time to approach this case and family, but I have to wait. I gave them (patient and family) choices of hospitals. They chose the NW Psychiatric Hospital. Then, I referred the patient there.

Followed the story she experienced.

Researcher: Did they accept mental health care now? Participant: It took time to approach this case and family, but I have to wait. I gave them (patient and family) choices of hospitals. They chose the NW Psychiatric Hospital. Then, I referred the patient there.

I wanted to know all of what she did.

Researcher: What did you do after that? Participant: I talked with his parents and offered help. They got stress. I helped by visiting them and giving booklets relating Schizophrenia and stress management that they could read.

I wanted to know the outcomes of the care provided.

Researcher: How are they now? Participant: I visited him regularly. Now he is not aggressive anymore.

Wanted to know the success of approach.

Researcher: Did they accept themselves with mental health issues? Participant: I think they still feel shame with this and don’t want others know what happened in the family.

I want to if she monitored the

Shame with mental illness was an issue in Thailand.

She was welcomed

a genetic factor related to his mother’s mental illness. His mother did not look after him. His parents divorced. The father had a new wife when he was three years old. The stepmother and the father looked after him. They claimed that they loved him. After that, the stepmother had a new son. The patient became not obey. The parents said that they paid much attention to this son, but it didn’t work. The patient became aggressive. When the father went out for work far away, he locked himself in his room. He became withdrawn, staying only in his room. He also became aggressive. Finally, he isolated himself. The parents kept him in his locked room, and didn’t want others know. She used medication again. This sound a tool to approach this case. This is interesting to see how she could manage the client. She set priority of care. She had some information got from media (about Japanese child).

She waited!! She offered help and provided choices. She provided care for whole of case. (family and patient)

Researcher: How did you manage this case? Participant: Amitrip again. I thought that he should be treated for his aggression first. Then we saw and wait for few days. The stepmother was so fear of him. He acted like the Japanese teenagers who locked himself in the room. He stayed there all the times. I gave Amitrip 10 and 5 mg to the stepmother to blend and add into the meals for him. When he calmed down, we took him out of the room. I advised them to go with the case to see the psychiatrist.

I want to clarify the management.
because she really could help them.

She was trustable.

She provided good care practices.

Participant: I am welcomed to see them. I thought the family trusted me because I’ve never talked about them to others and ensured their confidentiality and privacy. So, other people in the village didn’t know this case.

Researcher: Oh! You provided care with privacy.

Participant: Yes, it is. When I met them, I have never told other people about the detail. Even the VHV who firstly contacted me haven’t known about the patient. I kept a secret.

Researcher: You did the right thing, didn’t you?

Participant: Yes, I think so. I understand this family. I think I need to keep this secret. This is important when we care the patients with mental illness in the community. And, I want the consumers to trust me. I am going to work within this community for long. So I should be trusted by them.

Researcher: You did much to serve them.

Participant: I don’t think I have done much for mental health care. (laugh) Just my best.

Researcher: Well that was care for the patient with mental illness. And what else you have done?

Participant: Aa...About the project for children that we talked before...we taught the parents what the EQ in children were. ... I taught them how to look after the children (to develop high level of EQ scoring). I thought that probably these laypersons didn’t care about issues of child development. They didn’t care when their children would begin talking. They were not interested in that. They didn’t think the tales were necessary. Toys were not involved in looking after the offspring, they perceived. I also discussed these issues with them.

Researcher: You created care project for the children group as well. What else you have done?

Participant: ... Just all I’ve said.

Researcher: Oh! You created care project for the children group as well. What else you have done?

Participant: ... I thought I got much information. I might end the session, but she had more data.

Researcher: I thought I got much information. I might end the session, but she had more data.

Participant: I thought I got much information. I might end the session, but she had more data.

Researcher: Things might help or constraint in providing mental health care in the PCU or community.

Participant: ... Uhm... Do you mean.....?

Researcher: I had to make the easier questions.

Participant: ... I had to make the easier questions.

Researcher: Okay, going to the next question. What you have described reflects that you work pretty well in mental health area. In your opinion, what influence on providing mental health care in the community?

Participant: ... Uhm... Do you mean....?

Researcher: Things might help or constraint in providing mental health care in the PCU or community.

Participant: ... Uhm... I think it probably depends on individual. Some nurses are interested in mental health, while some are not. For me, firstly, I always interested in psychological problems. Some persons might think those are nothing. Secondly, that I didn’t know what I should do next also influenced on mental health practices. I heard that there were nursing instructors (who trained the nursing students) within some PCUs. Unfortunately, we didn’t have them here. I used to ask for...
providing mental health care.

Yes, this is exactly what she was influenced by her motivation in mental health care.

The policy related mental health did not help her much in the direction of practices.

And, this confirmation. She worked for mental health aspect without being forced by others, but with her mind. I got the answers which were personal and policy.

that because I didn’t know how to approach patients with mental illness. I am interested in mental health issues, but I know not much in caring in this area. As I told you when I found the cases with stress in the village, I didn’t know what I should do. As a result, I didn’t do much. [laugh] I don’t have the knowledge, however the mental health issues always appeared to be a part of my care practices because I like doing that. There is no criterion of working in mental health. Mental health policy is not clear. Sometimes, I don’t know what I must do for mental health issues or make it better. At present, we just count how many cases of psychosis, neurosis, and epilepsy. Just to see the number of patients. Also, we look at suicide rate, but this doesn’t tell anything. Those are more likely to be the same cases because they are chronic. [laugh] As I didn’t know what I should do next, I didn’t do much in mental health care practice. It was I myself. It’s personal interest. I mean I was not interested in a mental health job but I wanted to make a difference in my patients, helping them to be happy.

I summarized and probed. It was my luck! I could move to the next point smoothly.

Here, I guessed she wasn’t satisfied with policy.

Researcher : You think about personal and policy. And what else?
Participant : No, that’s all I have thought.
Researcher : Well, you’ve just mentioned on the policy. Can you discuss more about it, in way of how much the policy directs the practices and vice versa?
Participant : Hur!...[she stopped for a while]
Researcher : You can begin with whether the policy directs mental health practices.
Participant : Nothing [head movement]

I motivated her to explain more about the issues of policy.

I gave her the direction to think about the policy and practices. Now I was beginning the third question as I planned. I repeat her word to make sure what she just said.

Researcher : What do you mean?
Participant : I mean nothing. No mental health policy.
Researcher : No?
Participant : I said no because there has been no mental health policy informed to us. [laugh] However, we were commanded to do mental health tasks, such as survey for stress and other mental health problems. We often were delegated to do these tasks.
Yes, I agree with her in that the nurses in the PCU organized all about health and mental health was not measurable in the same ways with the physical problems.

Researcher: For?
Participant: I didn’t know. The province officers just said to us like please survey for this...this...this for 200 people. Okay, we did. But we didn’t know what was for what. We sent them the results, we were not informed to do anything later. My friend, another nurse also felt like me. So about mental health policy, I think it is not clear communication to the PCU.

I asked her to explain.

Yes, I agree with her in that the nurses in the PCU organized all about health and mental health was not measurable in the same ways with the physical problems.

Researcher: So you think... ...
Participant: Mental health issues are different from other health care. For example, to screen for diabetes mellitus or hypertension is much easier. We know exactly what we must serve to the patients. But, for mental health it is difficult to make change because mental health is complex issues.

Encouraged her to explain.

Researcher: So do you mean the policy is not clear enough for the practitioners in the PCU?
Participant: Aa.. Maybe the point I said is caused by that I myself lack of knowledge.

She stopped to think again when we talked about policy and practices. This was maybe an agenda affected on her work. And, she said ‘no’. This was clear message.

Researcher: Well, that is what you think about the way policy directs your practice. Now, please tell me about how much the practices inform to policy makers.
Participant: [smile].... [stopped about 8 second]

Moved to another focus, but still be in the issues of policy.

Researcher: Have you had opportunity to give feedback your practices to policy-making?
Participant: [smile] No....no [shake her head]

I used another question to repeat asking.

Researcher: Uhm... Now, before we finish the interview, can we back to the care practices again? I heard from you and I understand what you have done in mental health care practices. Those are great in terms of managing the complex issues for your consumers. How can you decided for those? What are the models or principles of your practising?
Participant: ...Uhm It is difficult to say. I don’t know what I did was right or wrong. But I provided care related to mental health in order to help sufferers and build up the happiness in my clients. To work here, with people in the community, for example with Tony and family, I tried and tried. I wanted them (patient and family) to feel comfortable with me first. Later, they trusted me. I needed to give them time. I mean I didn’t force them. I was not aggressive to them. I waited for them to be comfortable with me and accept me.

This confirmed her personal interests in mental health issues.

This supported her voices in terms of waiting and contributed to the trust.
Knowledge of mental health symptom helped her to decide on her care.

Researcher: What was help in you decision making while your care?
Participant: In my opinion, for Tony, his symptoms were disorientation, withdraw, and aggression. Therefore, I know I must refer him to be treated. Another client experienced nightmares almost every night. I provided that case counselling and treated with amitriptyline. Again it sound I like Amitrip. [laugh] After ten days, he came back and I would see if he felt better. If not, I would refer him. That is, I saw the cases more than one time and see what I should do for them.

I wanted to know if she adopted other models or patterns.

Researcher: Why did you make decision by yourself? How did you do? Have you done with other people or consult others?
Participant: No, we have never consulted any specialist, even the psychiatric team in the local hospital nearby. We don’t know them in personal. To care my patients, I usually talk with the family. I also listen to the family.

No consultation. Listening to family. Had colleague discussion

At this time, I was not sure what agenda was in her mind.

Researcher: What about your colleagues?
Participant: Yes, we work together for that. I, as a nurse was consulted by other health providers in providing mental health care to patients with mental illness or counselling. However, all health providers have skills in providing bedside care like giving injection.

Researcher: Ah…yes.
Participant: However, to care patients with mental illness and family is not always easy. I met a patient who came to the PCU with a luxury car for anti-psychotic injection. Firstly, the guardian asked me to provide care. That guy said to me that, “Don’t ask anything. Just do this. Can you do it?” He gave me a vial with the prescribing card … I was sure that it was the right patient and right drug. So I administered the injection without asking many questions. I understood that they wanted to protect themselves from social recognition. Another colleague told me that this family was a rich and well-known. They don’t want to expose their family member as the patient with mental illness. … Oh I saw. It doesn’t matter. I understood them. I gave him the injection, and talked with him and the family. I felt OK when I heard that the patient was not treated brutally at home. That was the way I communicated during visit sessions. If the patient was unable to communicate, I interacted with the caregivers instead of the patient. I talked to support them (patient and family).

Researcher: So you have skills to giving injection, but sometimes had to deal with other things that were sensitive issues. You did very well with them.
Participant: No I don’t think I did very well.

I focused on the first part of this topic.

Probing.

Seeking in deep.

Listened and waited for agenda.

Checked if my understanding was right.
Researcher: What did make you feel like that? Do you have any difficulty?

Participant: No, bed-side care is not difficult because most patients who kept the vials in their fridges at homes did not have serious problems. The patient came and gave me the vial, then I provided the injection for him/her. I communicated with him/her.

Researcher: What did you talk to the patient while giving injection?

Participant: I asked them in general. How were they? About mental health symptom, family, works or living.

Researcher: Did you talk about medicine and its side effects?

Participant: … [laugh] I knew that it was a long-acting drug. I’ve never questioned about it. I trusted the psychiatrist who treated the patient … I felt OK when I heard that the patient was not mistreated at home. This is….because I did not practise it every day so … [smile]…forgot (information about actions and side effects of medicine). But overall, we care our best.

Researcher: Yes I know as I said you did very well in your areas. How do you feel?

Participant: Yes, I feel good for my mental health care practices. I like it.

Researcher: Well, today I heard from you what mental health care that you and the colleagues provided to the community. I also understand how you manage those care practices. The information you gave are useful to answer the research questions. I will transcribe this tape recorded and give the dialog to you to see later. Thank you very much for this interview.

Participant: [smile] My pleasure.

This showed that she looked not confident in anti-psychotic drug and side-effects. Or she overlooked this issue.

Try to terminate the interview.

Closed-ended question was used because this point was an important skill.